Bringing social media in health to the Philippines
“ClinicalKey has become an essential complement to DynaMed and UpToDate when I am at my patient’s bedside.”

Dr. Pierre Harvey  
Microbiologist and infectious disease specialist  
Rivière-du-Loup, Que.

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Guidance on using mobile health applications

Chris Simpson

Half of all Canadian physicians say they’ve used a mobile app in their practices (75% of those under age 35), according to results from the 2014 National Physician Survey involving more than 10,000 doctors. In contrast, only 16.5% of those polled said they had recommended mobile apps to their patients.

Given the relatively recent appearance of mobile apps in health care and the lack of published guidance for physicians in this area, it’s no surprise that many are wary about prescribing these aids to their patients.

However, with the growth of mobile health and the incredible proliferation of apps that allow people to self-diagnose, monitor or treat a wide spectrum of conditions, there’s obviously a need for recommendations to help physicians decide which, if any, apps may be best for their patients.

Some doctors would like to see an approved list of medical or health apps in various categories that are suitable for prescribing to their patients — a formulary, if you like. But with more than 100,000 health and medical apps available for iOS and Android and dozens added almost daily, the logistical and economic challenge of providing such a list is daunting.

As the Canadian Medical Association, we feel it makes more sense — and is in keeping with our general approach to such issues — to develop general principles our members should consider when looking at medical or health-related apps for mobile devices.

With this in mind, the CMA has prepared Guiding Principles for Physicians Recommending Mobile Health Applications to Patients. These guidelines build on the CMA’s earlier work in defining how physicians should appropriately communicate with patients online.

The document, currently being finalized with input from various stakeholder medical organizations, is a high-level summary that spells out how to assess a mobile health application for recommending to help a patient manage specific health and health care information and concerns.

As background, we contend that mobile apps can improve health care outcomes and mitigate costs — but also note that such tools should complement rather than replace the relationship between physician and patient.

The guiding principles articulate characteristics that should be present for a mobile health app to be safe and effective. These include:

- endorsement by a recognized medical or professional organization
- usability
- reliability of information
- privacy and security
- avoidance of conflict of interest

To supplement this document, the CMA has also produced a handout that provides information for patients to consider when assessing whether to use a mobile health app to aid in health management. Both the guidelines and handout will be made available on cma.ca.

Mobile health is one of the fastest-growing areas in health care today. It is important for Canadian physicians to understand when and how to use this technology to assist in providing better care. The CMA is pleased to offer these guidelines to support our members and their patients in this new and rapidly evolving area.

Dr. Chris Simpson is president of the Canadian Medical Association.
Then my alarm went off and I woke — back to reality.

I like my electronic medical record (EMR). I really do. It’s better than paper and, since my penmanship resembles the waddling paths of baby penguins, it helps with legibility. It makes it easy to write prescriptions (even if I can’t electronically send them to the pharmacy yet), and cutting down on paper helps the environment and our office’s bottom line.

But when a doctor across the street retired, we couldn’t import patient records from his office even though we both use the same EMR. The best we could do was convert years of rich data into PDF files and upload these. All the trend data and functionality in the original documentation were gone. And when a patient goes to hospital I have to take my electronic record and print it to paper so that it can be manually entered into the hospital’s EMR upon arrival. The reverse happens upon discharge, although our e-fax does allow us to cut down on some of the paperwork — if not the duplication of testing.

Why do we continue to have so many issues with the interoperability of electronic records? Unfortunately, there is still no business case for EMR/EHR (electronic health record) industry leaders to promote the flow of data between their respective platforms. Simply put, information that is easily accessible in one EMR has to be taken manually by doctors to another EMR provider — or by patients to other doctors, even if those doctors use the same EMR vendor. In addition, many provinces that supported EMR adoption did not plan for interoperability and have little power to ask companies to create these capabilities after the fact. And as recent data breaches involving tens of millions of charts have shown, health care data is valuable on the black market and interoperability increases the need for — and cost of — security. In the early days, EMR interoperability was a relatively minor issue, and some defend previous policies as a choice to have more doctors using an EMR (without interoperability) rather than fewer doctors onboard with more robust interoperability.

Lest I seem cynical, I want to remind you that I am Canadian and point out a very Canadian fact: we are not American. The United States has been dealing with this issue for far longer, and at far greater cost, than we have. The Obama administration recently criticized EMR vendors that obstruct interoperability. The US Senate recently investigated why and how tens of billions of dollars were spent encouraging doctors to sign up for EMRs that didn’t communicate with each other. The systems still don’t communicate, but there are some systems that can. However, once you’ve invested in populating an EMR it’s costly and frustrating to re-enter all that data, and good systems do not currently exist to accurately move information between EMRs.

There is hope when it comes to interoperability. The city of Nanaimo is attempting to develop a “one patient, one record” system, as is the province of Nova Scotia and other jurisdictions. And the CommonWell Health Alliance is attempting to unite leading EMR vendors to create a vendor-neutral platform. This is an amazing time to practise medicine. Technology improves the tools that we use to reach and treat patients. The right tools are being created to allow us to truly think big: whole systems that are city-, province- and countrywide to allow for seamless care, avoidance of unnecessary duplication and streamlined patient care. We must continue to advocate for our patients and our health care system in order to ensure a more connected future.

Dr. Eric Cadesky is a Vancouver family physician, member of the Doctors of BC Board of Directors and member of the Future Practice Editorial Board.
OMA pioneering Insights4Care: data for doctors

Pat Rich

AN AMBITIOUS, WIDE-RANGING PLAN TO COORDINATE AND MANAGE HOW
patient data from electronic medical records (EMRs) is collected and made available to
physicians in Ontario has been initiated by the Ontario Medical Association (OMA).

Insights4Care is a multi-year, multi-phase program intended to gather and collate all
patient data from participating physician practices in Ontario and make the de-identi-
fied data available to individual physicians in usable formats.

The project is unique in North America because of its scope and, more importantly
for physicians, because it is being managed by a physician organization — with physi-
cians the primary audience.

"There are a lot of data being collected
in EMRs across Ontario," said OMA then-
president Dr. Ved Tandan in a recent interview.

"The data are there because patients come to
doctors for care and that gets documented."

As such, he said, the primary goal behind
Insights4Care is "to make sure that data gets
used to improve patient care, to provide bet-
ter outcomes and to help the doctors use that
data to ... full advantage so they can provide
the best quality care for their patients."

The OMA estimates that with more than
8,000 family physicians and 3,000 commu-
nity-based specialists in the province using
EMRs, 80% of all health care information
about residents is contained in EMRs.

"WELL POSITIONED"

"I think the OMA is exceptionally well
positioned to drive out value for physicians," said Sarah Hutchison, chief executive officer
of OntarioMD. "It's really important that
physicians take ownership of this type of
program — designed by physicians and for
physicians," said Tandan.

He acknowledges the medical data gath-
ered has a wide variety of other potential
uses, such as for research and to improve
system efficiency and planning. But he noted
the OMA wants to ensure the primary aim
of the data collection from EMRs and its dis-
semination is to improve direct patient care.

Insights4Care involves a number of com-
ponents ranging from collecting, extracting
and processing patient data to de-identifying,
aggregating and consolidating these data (see
accompanying graphic). The association will
be working with technological partners to
build these components.

The program is being rolled out in an
environment in which physicians are being
asked to share their data with both govern-
mental and non-governmental organizations
with "increasingly complex information
management challenges."

The OMA notes that while the use of pa-
tient health information is guided by various
legal, ethical and regulatory requirements
"there is still a gap in public policy to guide
the fulsome and broader use" of this health
data. Tandan said the OMA is partnering
closely with more than a dozen other orga-
nizations such as the College of Physicians
and Surgeons of Ontario and the Canadian
Medical Protective Association (CMPA) to
ensure Insights4Care provides an acceptable
solution to the challenges physicians face.

INCREMENTAL

Hutchison said the plan is to introduce
Insights4Care incrementally, with the first
priority being to provide physicians with data
about their patients in a consistent manner
that will improve how they deliver care.

As enumerated by the OMA, other
benefits will be:
- providing clinical practice insights at
  point of care
- consolidating multiple sources of medi-
cal information and providing this in a
  unified format
Big data collection in health: coercion or justifiable?

Cécile Bensimon

THE TOPICAL AND CONTROVERSIAL ISSUE OF BIG DATA IN HEALTH CARE had its own session at the recent Quebec Medical Association summit exploring the medical profession’s social contract with society.

Speakers focused on providing a descriptive overview of what big data means in the context of health care. But they also touched on whether the increasing availability of clinical data improves performance by physicians and hospital departments or instead leads to increased surveillance by health administrators and insurers.

Panel members were Patrice Gilbert, CEO of PetalMD in Quebec City, Pascale Lehoux, professor of health administration at Université de Montréal and Dr. Dominique Deschênes, past president of the Quebec College of Family Physicians.

Gilbert, who described himself as a data geek, put the “big” in big data in perspective. Using the example of Kaiser Permanente, an American hospital system that has approximately the same number of patients as the province of Quebec, he explained that their databases hold 30 petabytes of data, the equivalent of 400 years of non-stop HDTV or 2.4 billion filing cabinets worth of data.

He declared the governance of big data is straightforward: it is up to physicians and health administrators to make decisions on what data to collect and analyze, while his role as the team data geek is to help them manage how to do it.

Panellists agreed there are both advantages and risks to the increasing use of big data in health care. While big data analytics has the potential to improve health outcomes and patient care, there are concerns that big data is changing the landscape of, and posing risks to, the privacy and confidentiality of personal health information, and that this will escalate with the widespread implementation of electronic health records.

The panellists posed several questions: To what end is the data collected? Who owns the data? Who will analyze and interpret the data? Will it be physicians for the purposes of performance improvement, or insurers for making decisions about resource allocation?

However, it was clear that the increasing use of large databases in health care is already contributing to a culture change in the health care system and could lead to broader scopes of practice for physicians who are required to manage and analyze patient data.

One panel member observed that there is no consensus within the medical community on whether big data is good or bad.

During the question period, some panel members and participants speculated on whether the constant collection of data by physicians could turn them into mere technicians and undermine the patient–physician relationship.

The panellists concluded big data is an inevitable — and perhaps necessary — trend with more potential than risks.

SEEKING PARTNERS
As such, the organization is now looking for partners to fund the program. The provincial government would normally be an obvious choice, but the current environment makes partnering on this initiative much more difficult.

Program participation will be voluntary, Tandan affirmed. “It’s not our intent to force this on physicians.”

Insights4Care is very much the type of program envisioned in a discussion document prepared by Conrad Amenta, then senior advisor in health information policy at the Canadian Medical Association, with input from health information technology staff from provincial and territorial medical associations across Canada and the CMPA and provincial licensing authorities. Should Canada’s Medical Membership Associations Perform ‘Big Data’ Analytics? was the title of the 2014 document.

The paper concludes: “... it is crucial that medical membership associations explore data sharing between physicians and membership associations and develop their capacity to perform analytics if they wish to remain competitive with EMR vendors.”

Pat Rich is Editor of Future Practice
HIMSS continues to show it all

Pat Rich

Former US president George W. Bush (left) addresses HIMSS
DIVINING THE FUTURE OF HEALTH INFORMATION TECHNOLOGY BY reading the intestines of the Health Information and Management Systems Society (HIMSS) annual meeting could be described — if you will pardon the pun — as being “offaly” difficult.

The conference grows every year, with about 43,000 attendees in Chicago this past April having to choose between numerous keynote speakers and parallel education sessions. An exhibit floor the size of several football fields, featuring some 1,300 exhibitors, also vied for attention.

If you were watching from afar, you had to wade through a Twitter feed with 86,000+ tweets from just over 15,000 participants.

It’s easy to be diverted by the attention paid to George W. Bush’s closing address and his discussion of Vladimir Putin’s dog, or numerous tweets about the Apple watch and its million potential health applications. But the reality is that HIMSS15, as with every annual HIMSS gathering, really does showcase the best and worst of health IT in the United States and touch on the main issues speeding or slowing its implementation.

This year, interoperability and patient engagement remained the two key themes on the minds of US health care providers, policy-makers and IT vendors. The meeting also served as a lightning rod for commentary on health IT-related announcements in the US made just prior to the conference. But there was innovation galore — and not on a small scale.

In his address to the meeting Alex Gourlay, president of Walgreens, the largest pharmacy chain in the US, announced customers in some states would soon be able to arrange video physician visits through a company partner. This is the firm that in 2011 started to allow customers to renew their prescriptions by scanning barcodes on medication bottles using their smartphone.

Gourlay also announced an expansion of the company’s customer loyalty program so members can earn points for engaging in healthy eating and exercise activities.

REWARDS
“Walgreens has also launched rewards for using wearables, making it the first retail program to financially reward customers not just for buying a fitness wearable but for connecting it to Walgreens and continuing to reach ... health and wellness goals,” he said. “But we’re not just talking about fitness trackers. Patients with chronic conditions can also sync their glucometers and blood pressure readers and start earning points for logging their readings on a daily basis.”

While such initiatives show the potential for mobile-enabled, connected and health-conscious consumers to benefit from technology advances, those advocating true patient engagement in health care decisions were not a happy crowd in Chicago.

The reason? The US Centers for Medicare and Medicaid Services announced, prior to the meeting, that in order for
physicians and health care institutions to benefit from the latest round of "meaningful use" provisions encouraging the adoption of electronic health records (EHRs) they would need to change their process. Instead of showing they can provide the ability for at least 5% of their patients to view or download their records electronically, the new requirement states this capability only needs to be shown for a single patient.

REVOLUTION
This move led to revolutionary talk on the conference floor. At a pre-conference symposium on patient engagement, the former national health IT coordinator Dr. Farzad Mostashari called for a day of action to protest the move, describing it as essentially a betrayal of the engaged patient movement.

Other sessions and data presented at HIMSS were more positive, especially an annual survey of decision-makers in US health care institutions showing about three-quarters of them considered patient engagement to be a priority.

Another announcement that preceded HIMSS15 and was much discussed at the meeting — this time by the Office of the National Coordinator for Health Information Technology (ONC) — showed the continuing challenges faced regarding the sharing of health data. The ONC issued a report to the US Congress detailing “data hoarding” by IT vendors and health care providers blocking the electronic exchange of health information.

"Most complaints of information blocking are directed at health IT developers," ONC said in its report. "Many of these complaints allege that developers charge fees that make it cost-prohibitive for most customers to send, receive or export electronic health information stored in EHRs or to establish interfaces that enable such information to be exchanged with other providers, persons, or entities."

INTEROPERABILITY
In this environment, ONC head Dr. Karen DeSalvo continued to emphasize the ongoing importance of interoperability of EHR systems in the US.

"Interoperability is a priority but is really only a means to an end," she said in her closing address. "What we are moving toward is a world in which health IT and interoperability enables better care and better health."

While many large EHR vendors such as Epic and Athenahealth have vowed to waive fees for transferring health records, the issue remains a large one.

As one commentary published in Modern Healthcare during HIMSS noted: "The heart of the problem is that rather than seeing easy information flow as a public good, all players in the game are doing everything in their power to maintain control over the information and wield it as a competitive weapon. Until that is against the law or prohibited by rule, this nation will not achieve health care information interoperability."

Another theme that carried was growing US physician dissatisfaction with the way health IT is being implemented, and more specifically, the EHR options available to them.

Accenture and Epocrates released data based on survey responses from some 1,500 US physicians showing that while computer literacy was growing in the profession respondents remained very frustrated with the systems available.

The Accenture study showed 58% of respondents felt the EHR available through their organization was difficult to use, and as a result 71% felt health IT reduced the time they could spend with patients. The Epocrates survey showed 61% of physicians were unhappy with the degree of interoperability with the EHR system they were using, and more than 90% said the lack of interoperability led to redundant or delayed care.

AHA
American Medical Association President Dr. Robert Wah articulated the more general concerns physicians have with health IT. In speaking notes for an address he gave at a pre-conference symposium, he noted physicians considered EHRs "cumbersome," regulations and compliance requirements excessive, and they felt they had little autonomy when it came to decisions around EHRs.

As a result of these concerns, Wah said the AMA is advocating for changes to promote digital and mobile engagement and input into configuring and designing EHR systems. He described the US as being in the third phase of the digitization of medicine, with this phase being characterized by clinicians analyzing and making better use of data collected by electronic records.
Bringing social media in health to the Philippines

Pat Rich
WHEN HIPPOCRATES CREATED HIS SOLEMN OATH FOR PHYSICIANS HE could not have foreseen the need to warn against taking “groufies” without patient consent or against bashing patients online.

But here we are in 2015, and it makes perfect sense for doctors in the Philippines who wanted to lay solid groundwork for the appropriate use of social media in health care to include both of those injunctions.

An early highlight of the first national summit on health care and social media — which attracted more than 400 delegates to Cebu City, Philippines, in February 2015 — was the signing of a manifesto on social media and medical professionalism. Four doctors who pioneered the use of social media by physicians in the Philippines over the past year presided.

Despite a national infrastructure that can include poor Wi-Fi access and power brownouts, the country is fertile soil for the use of social media given the near-universal use of mobile phones and love of photographs.

TWITTER

Early in 2014, four physicians organized a regular weekly tweet chat (#healthXPh) on medical and health issues. They are: Dr. Remo-tito Aguilar (@bonedoc), orthopedic surgeon; Dr. Ma. Gia Sison (@giasison), occupational medicine specialist; Dr. Iris Thiele Isip Tan (@endocrine_witch), endocrinologist and informatics specialist; Dr. Narciso ‘Buboy’ Tapia (@cebumed), assistant professor at the Cebu Institute of Medicine.

The weekly tweet chat, coupled with Sison’s enthusiastic involvement in several other global chats and Tapia’s blogging expertise, quickly became an established global forum on health issues. New media issues are attracting many health care professionals and students from the Philippines, as well as global participants from Canada, the United States and several other countries.

Growing participation in the chat line and their own burgeoning interest in the ability of social media to improve health care delivery prompted the physicians to find sponsors for and organize the Cebu summit. This was with the addition of Dr. Helen Madamba, a Cebu obstetrician/gynecologist, and all without having met face to face!

The summit featured several high-profile Filipino physicians, health care providers and patients discussing a wide range of topics including medical professionalism, privacy and confidentiality, and education. The conference was live-streamed, meaning input was also provided from international observers via the conference twitter stream (#hcsmPH).

Acknowledgment of the ability of social media channels to improve health care delivery and outcomes came early in the conference.

HEALTH GAINS

“We would like to maximize the utilization of social media for health gains,” said Dr. Merlita Opeña, chief of the research information communication and utilization division of the Philippine Council for Health Research and Development, who provided welcoming remarks. She encouraged all participants at the conference to blog and use other social media tools to discuss and improve health in the Philippines.

Opeña was followed by Dr. Maria Minerva Calimag, president of the Philippine Medical Association, who endorsed the use of social media by physicians. Calimag noted that she had used social media since Day 1 of her presidency to engage people and answer their questions.

“Let us continue on. Let us communicate. Let’s be connected,” Calimag said, in what was billed as an inspirational speech. She also talked of the need for health care institutions to have guidelines in place for the appropriate use of social media and to ensure professionalism.

Ensuring professionalism was a theme that surfaced in the first panel discussion and reappeared, to varying degrees, throughout the meeting.

“Medical professionalism is at the heart of being a good doctor” said Dr. Noel Pingoy, a physician at General Santos Doctors Hospital, who introduced the talk. Pingoy reflected on how the influence of social media on doctors’ personal and professional lives can be “overpowering.”

While noting that physician involvement in social networks can support personal expression, foster camaraderie and help with public health messaging, he said such networks can create new challenges to traditional patient and doctor relationships.

FORBIDDEN

Citing US guidelines, Pingoy identified three activities that should be strictly forbidden to physicians using social media: violating patient confidentiality, reporting private academic information and neglecting work commitments when interacting online.

He encouraged physicians to establish separate profiles or identities for their personal and professional activities on social media. As a presenter at the conference (from the Canadian Medical Association), I later challenged this advice, citing physician experts who felt it was fine for doctors to maintain personal and professional activities using a single account.

Pingoy also raised the interesting question of whether it was appropriate for physicians to share patient narratives on social media channels. He used as an example his personal situation: his mother has pancreatic cancer.

The consensus of speakers was that sharing such stories is acceptable if the patient gives consent or if the information is anonymized.

Issues surrounding the protection of patient confidentiality — especially in hospital settings — were discussed in more detail in another session, mindful of a culture where surgeons have been known to take selfies in the operating room.

“BE AUTHENTIC”

"Be authentic, have fun and do not be afraid,” was the widely tweeted closing statement from Pingoy.

“Social media is about tools, it’s about creating, it’s about exchange [and] it’s about communities and networks ...” responded Dr. Teodoro ‘Teddy’ Herbosa (@Teddybird), former undersecretary of health for the Philippines and professor of medicine at the University of the Philippines, Manila.

He noted he was not a big Twitter user or supporter until he hosted a chat on #healthXPh and came to recognize the channel’s global reach and the fact that communities are no longer subject to geographic boundaries.

Herbosa talked about how medical professionalism changes and evolves over time and asked whether the old rules should still apply in the current networked environment.

“You can’t necessarily apply old-world professionalism and ethics to the new world of medicine,” he said, but noted all health
care providers face challenges and the risk of exposing patient identities inappropriately when using social media.

Dr. Anthony Leachon (@LeachonTony) from the Philippine College of Physicians presented about problems with health literacy among much of the region’s population and how social media can help address this.

Leachon, who led a major advocacy effort on health education and disease prevention, also traced how social media can enhance the opportunity for physicians to act as advocates on health issues. “Be relevant, be innovative and think big!”

During question period, the perennial question of whether physicians should accept Facebook ‘friend’ invitations from patients was raised.

“We are social animals in the Philippines so our culture is more accepting of adding patients to your Facebook account,” said Herbosa. In another session, Tapia stated that he “unfriends” individuals if they become his patients.

**PROMOTION**

Local campaigns were profiled in a session on how to use social media for health promotion. Such campaigns can be done far more cost-effectively than traditional campaigns using print or electronic media, presenters said.

The point was made that “liking” a public health campaign on Facebook is not sufficient engagement; social media or online campaigns must include an explicit call to action.

“Promote online you have to go offline as well,” said Dr. Richard Mata, a pediatrician and dengue fever treatment expert, one of the summit panelists. He noted any good public health advocacy campaign needs a face-to-face component to be successful, especially in a country where online access may not be available to many.

The summit concluded with almost-universal plaudits for the initiative from both those attending and from international observers.

Doctor as patient as social media user

A UNIQUE PERSPECTIVE ON THE DOCTOR AS PATIENT AND THE POWER of social media to help patients manage their condition was presented at the Healthcare Social Media Summit 2015 by two Philippine physicians.

During a session on patient stories, Dr. Ma. Gia Sison — one of the conference organizers and chair of the meeting — presented her experiences as a breast cancer survivor, while Dr. Narciso Tapia — another of the organizers — spoke of using social media to help manage polycystic kidney disease (PKD).

Sison was diagnosed with breast cancer in February 2013 and said while she had always been a strong advocate of preventive medicine and breast self-examination she found out about her cancer accidentally.

“That was the only day that I regretted becoming a doctor because I knew that what I felt was cancer,” she said.

Sison documented that moment and her treatment course in a blog which she had started a year previously. Here’s an excerpt from the April 2013 entry called “The Bungee Jump”:

Way back February 25, 2012, when I first started my blog I only carried with me random thoughts on my personal view on life, love and happiness ... from a medical perspective so to speak and as how I indicated it on the subtitle. Exactly though, a year later, I was diagnosed with Breast Cancer Stage 2A ... Drastic shift in thought as an introduction to this new entry of mine for this year 2013. My blog will focus on the journey I take hand in hand with the big C but allow me to open with this reality that Cancer is not a sentence but just a word. My father saved my life. How? It was roughly 4:30 in the afternoon, February 26, 2013, when he gave me a call to consult a worker who was apparently a victim of a colleague who did not want to issue him a fit to work medical certificate ... but since I was left-handed when answering my phone I supported my left arm with my right arm crossed and with a snap of a finger I felt the lump that has changed my perspective on life ever since. I immediately called my colleague and good friend who was a surgeon. I had my sonomammogram and breast ultrasound on Feb. 28, 2013, and while I was standing having my breast undergo mammogram, thank God for the nice ambiance (pink lights) and nice sounds I did not have a syncopal attack upon seeing my plate in front of me — imagine seeing a palm tree bended to its right with two coconut fruits on it, medically speaking, so “not good” since being a doctor I knew it were enlarged lymph nodes and lymph nodes basically ain’t good. At that point in time, trials did come in three’s: work, health and life 101 ... it was a stark reality that a Higher Power can take away things in a blink of a second not to punish us but rather teach us lessons that have been repeated to us ever since but we were too busy or just basically evasive that it needed to be learned and realized at that time when it was being presented to us. As usual my life was lived again on the fast lane but this time...
health-wise from the point of diagnosis till the day I underwent a Radical Mastectomy to remove the tumor up to my chemotherapy which is ongoing as of present writing with five (5) more to go! All in a span of less than thirty (30) days I underwent hardcore trials in courage, determination and most of all faith.

After getting her diagnosis, Sison said she started to use Twitter through the hashtag #bcsm (breast cancer, social media) to reach out to other breast cancer patients.

She said through the sharing of patient stories on social media she discovered “there is hope beyond diagnosis” — whatever the condition. “I found myself running to social media for support.”

She continued: “Twitter played a very, very crucial key role in convincing me to continue chemo.”

Sison (@giasison) now has more than 8,600 followers on Twitter and is known globally for her positive outlook and participation in medically related tweetchats.

She gave gives tips on how to effectively present patient stories on social media by urging people to tell their stories simply and honestly.

Tapia discussed his experiences by using a blog to tell his story and raise awareness about his condition, which requires regular dialysis.

Tapia said he first learned of his diagnosis while still a medical intern. Though members of his family had kidney disease, he found it very hard to accept and was — in his words — about to give up when he was inspired by the blog post of a woman who has PKD and other health issues but maintains a positive outlook.

Having been inspired by this and other blogs by people with kidney disease, Tapia said he felt he should start his own blog (pinoy-lifewithpkd.blogspot.ca) so he could try and inspire others. “I became a blogger myself.”

The introduction to Tapia’s blog states:

> It is not easy to have PKD. I am sure many people with PKD will agree to this. But it doesn’t mean we will stop living. It doesn’t mean we will let PKD ruin our lives. It doesn’t mean (we) will forever be sad about having PKD and making things bitter for ourselves from now on. There are other things about life to talk about, other things to enjoy. This is what “Even with PKD Life Goes On” is all about.

Tapia used the blog to walk people through all the steps in undergoing dialysis, including “showing how big the needle is” and posting selfies during treatment.

Having started blogging in 2008 with a Friendster account, Tapia also blogs on medical issues from another account and is active in the local community of bloggers in Cebu, where he is a past winner of the Personal Blogger of the Year award.

As a result of his social media activities, including on Facebook and Twitter, he says he is often approached by strangers who inquire about his health and offer support. “It lifts me up,” he said, even if it’s just someone posting a ‘like’ on his Facebook page.

“Social media, as I have experienced it, really helps.”

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“That was the only day that I regretted becoming a doctor because I knew that what I felt was cancer.”

— Dr. Gia Sison
A hospital in 60 seconds: TEGH uses Twitter to engage

Pat Rich

ON MARCH 31, 2015, AT 3 PM THERE WAS AN UNUSUAL OCCURRENCE AT the Toronto East General Hospital (TEGH) as several individuals used Twitter to tell or show what staff were doing during the next minute.

In most Canadian institutions, such an event would have involved few people — and to little purpose. But TEGH, a community teaching hospital, is different because several months ago it instituted a deliberate campaign to use social media strategically to better communicate with patients and staff.

The initiative involved the highest echelons of the hospital leadership, as all senior managers received training and are encouraged to use Twitter on a regular basis. That management team initially consisted of then-CEO Rob Devitt, Vice-President Programs Carmine Stumpo, Vice-President Program Support Wolf Klassen and Chief Nurse Executive Irene Andress. It has also been embraced by current CEO Sarah Downey.

“I absolutely think Toronto East General is a leader and I have had to up my Twitter game in moving from CAMH (the Centre for Addiction and Mental Health),” said Downey during an interview that also involved Stumpo, Klassen and Andress. Andress is the acknowledged social media lead in the group.

“We pride ourselves on having a shared leadership model at TEGH. Social media is the fuel in this fire,” Andress noted during a Twitter chat about TEGH last December, hosted by #hcsma — the Canadian social media health care community.

“As natural ambassadors for the hospital, they tweet to engage their stakeholders, to keep up with advances in their fields and, of course, to tell the TEGH story in their own authentic and genuine way,” is how the hospital describes it in a recent statement.

“It is an incredibly efficient way of getting thoughts out, generating discussion (and telling) what interests you as a leader. It personalizes you,” said Downey.

Stumpo wrote during the December tweet chat: “We want to connect with stakeholders and community. Social media allows us to communicate in a different way.”

Persuading senior management of the value of using Twitter to build awareness was a major early hurdle, the team acknowledges. Andress said one key benefit made obvious was how social media increases engagement with staff. Seeing how use of social media fits with the overall strategic plan of the hospital was also important.

Andress noted that Twitter has allowed management to respond quickly to comments or complaints about care that have been posted by hospital patients. “That’s very satisfying when it happens,” she said.

Training for the senior management team included pointing out the potential risks of using social media and helping the managers learn how to balance the disclosure of personal and private information. The hospital already had policies and guidelines in place to govern the use of social media by staff; these guidelines are reviewed every six months.

“Being misunderstood within the cryptic language is one of my fears,” said Andress, discussing Twitter. “I am continuing to learn how to be clear, yet brief.” Stumpo noted that having his teenage children assist him was also a benefit in learning to use Twitter. “Find something you are comfortable with and start slowly, even if it is just retweeting at first,” he advised.

Having the executive team find the time to tweet on a regular basis was a logistical issue, but this was dealt with by encouraging short, regular tweet sessions. “You build it into your daily routine,” said Stumpo.

Senior management is supported by a communications team that offers regular one-on-one support and sends out alerts on

“It’s vital to reach out to your patients and be engaged where they are. That’s the power of social media.”

— Wolf Klassen
Hospital leaders watching tweets ... and surgeon is OK with that

FOR TORONTO ENDUROLOGY SURGEON DR. RAJIV SINGAL, knowing your hospital management team is monitoring and using Twitter on a regular basis holds no fears.

That’s because Singal, assistant professor with the University of Toronto and robotics lead at Toronto East General Hospital (TEGH), is a regular and experienced Twitter user (@DrRKSingal) with more than 2,000 followers. He’s also a blogger with a broad following, both locally and globally.

In fact, his experience allowed Singal to team up with the hospital administration last November to live-tweet a prostate surgery procedure — just one of the social media innovations introduced by the hospital in recent months.

Singal applauded the hospital’s senior management team for becoming actively involved on Twitter, but notes there’s still a bit of a disconnect in the use of this and other social media channels by front-line physicians and other health care providers.

“It wasn’t long ago that I was sort of a lone wolf here (at TEGH) in terms of social media use,” Singal observed. But slowly, he said, the hospital has come to appreciate the value of social media.

“I think that’s a very good thing.”

Singal noted that there is not always alignment between how physicians view patient advocacy and how it is viewed by the hospital administration. But he said this has not impacted what he chooses to put on Twitter, though he adds he considers carefully what he is posting on social media. “I have always tried to conduct myself in a light that is favourable to East General, and I haven’t changed what I do.”

Physician use of social media remains what Singal describes as “rudimentary,” with only five or six other physicians at TEGH reasonably active on Twitter.

“Many don’t get it and many don’t want to get it,” he said, but he likes to tell colleagues that even though they may decide social media is not for them, “to dismiss something out of hand without exploring it does you a disservice.”

He said this caution around using social media is a bit dissimilar to how physicians approach other aspects of their lives, which is based on careful evaluation. “I do find it a little bit odd that many say ‘I am not even going to look at it (social media)’.”

Singal said the best reason for physicians to use social media is for advocacy: “Social media is a way to engage the public about what physicians think.”
Individual practitioners are often unaware of their patients’ satisfaction with care, their individual resource utilization or any measure of long-term effectiveness of the treatments provided. This is not because doctors don’t want this data. It’s because this data has traditionally been unavailable. Doctors have developed individual or group practice patterns that have shaped many domains of quality, often without the necessary feedback from the system. Furthermore, there have been few methods to share quality data between organizations or to share best practices in many of these domains.

In March 2001, the Institute of Medicine (IOM) released *Crossing the Quality Chasm: A New Health System for the 21st Century*. In this report, principal author Don Berwick, who is now a guru for the health quality movement, argued health care systems should focus on six domains, which would lead to higher quality care. They are: safety, effectiveness, patient-centredness, timeliness, efficiency and equity. This paper was the genesis of an entire field of experts leading the way on delivering higher quality care to patients.

The IOM report made it clear that a deeper focus on these domains should occur at all levels and from each member of the health care team. While many hospitals regularly measure their performance within these domains, having identified metrics for each...
of them, there has been recognition that in order to achieve true gains in the quality of care, physicians must focus on increasing the quality of their practice.

In many ways, doctors have been providing care in the dark. We have no feedback from our patients, no stratification among our peers, no measurement of our impact on health care and no way to know if we are achieving what we hope to achieve.

As hospitals develop systems to monitor their global quality of care, they also develop the capability to acquire data on individual physician performance. In doing so, physicians will have details and accurate data on their quality of care.

**PROVIDER-CENTRIC DATA**

One of the best examples of quality data usage by physicians is the National Surgical Quality Improvement Program (NSQIP). This program, developed by the American College of Surgeons, now includes hospitals in all but three US states and includes 24 hospitals in British Columbia, three in Ontario and two in Quebec. This internationally validated program — with a standardized set of quality measures — provides surgeons with feedback on complications related to their surgery up to 30 days post-procedure. This case-weighted data ranks participating physicians within their centre, country and with the best performing centres. Importantly, the program is underpinned by a robust system of data gathering, analysis and benchmarking, which then allows physicians to adjust their care in an informed fashion.

One critique of such a program is that, although excellent data on the safety, efficiency and effectiveness of the surgeon are gathered, other quality domains remain unaddressed. Tracking of data is also generally limited to a 30-day window. But programs like NSQIP are the foundation of the future of medical care, and this is an opportunity for the NSQIP program to further inform surgeons on the quality of their practice.

**THE PHYSICIAN DASHBOARD**

In discussion with Dr. Joshua Tepper, CEO of Health Quality Ontario (HQO), it has become clear that personalized physician feedback on quality of care is a priority for HQO. Institutions, provinces and possibly specialties across the county may agree to specific quality metrics within each domain of quality and contribute to common pools of case-weighted data. This would all be presented to the physician on a personalized dashboard and updated on a real-time basis to inform practice.

This type of system would allow for the emergence of best practices for advanced imaging, testing and prescribing, possibly leading to cost reductions. More importantly, such a system could foster greater patient-centred focus as institutions hold physicians accountable for patient satisfaction and medical outcome ratings.

**IMAGINING THE FUTURE**

The following scenario gives an idea of how this might work:

You (the physician) head into work a half-hour early to get some paperwork done. You log into your email and see an automated email detailing your quality metrics from last week. You pull out your iPad and click on the app. On the landing page, you see the metrics that you selected to see “at a glance.” On this page, you have included your “advanced imaging resource utilization per 1,000 cases” as an efficiency indicator, “average wait time to an appointment” as an access indicator and “visits to ED within 5 days of consultation” as a safety indicator.

Your wait times are consistently among the lowest in your group and in the 30th percentile nationally. But you see that you have some warnings within the app. Over the course of the past month, your ‘patient satisfaction’ has slipped 10%. You move this metric to the landing page and move the wait time metric out. You then ‘investigate’ your satisfaction data. The program stratifies the data according to type of clinic, day of the week, patient demographics, those receiving a test, etc., and establishes a rank order list of those most associated with a drop in satisfaction. The program links all possible causes to a solution used by a peer elsewhere in the country, and you develop a theory to change your practice.

You then click into each domain of quality to review your ranking and trends on each metric. The others seem within acceptable range. You then receive a message from your chief, who has recognized that your wait times are among the best in the group. She asks you to create a ‘list of methods’ in the system to reduce wait times and to develop a testing strategy for these methods in other clinics within your clinical specialty.

The hospital funds the project because you have a clear track record of success, and this is in line with hospital objectives.

**THE QUALITY COCKPIT**

Ross Baker (PhD), professor at the Institute of Health Policy, Management and Evaluation (IHPME) at the University of Toronto, has often used the analogy of the “quality cockpit.” The tenets of this are that those things that are most important to the clinician are right in front, on a large screen, easily identified. Everything else has a warning or alarm.

This, I believe, is the direction of individualized quality monitoring. We will keep our eye on those things that are most important to our patients, selves and institutions and rely on data systems to warn us when other quality metrics have demonstrated special cause variance.

Dr. Shawn Mondoux is a PGY4 emergency medicine resident at the University of Ottawa.
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