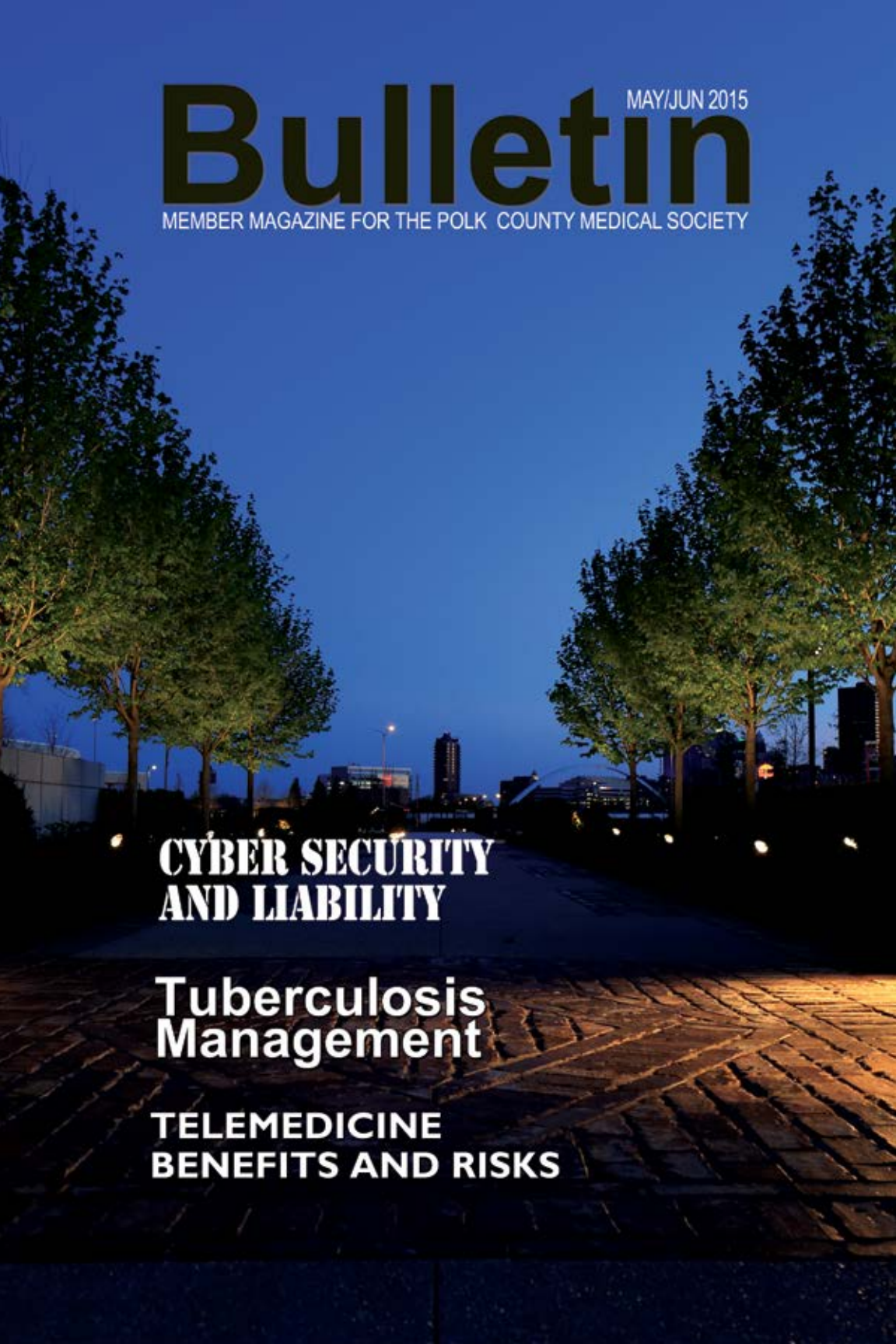
MAY/JUN 2015

Bulletin

MEMBER MAGAZINE FOR THE POLK COUNTY MEDICAL SOCIETY



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THE POLK COUNTY MEDICAL SOCIETY

Official Publication of the Polk County Medical Society

VOLUME 87 No. 3

Des Moines, Iowa
May/June 2015

Bulletin

MAY/JUN 2015

MEMBER MAGAZINE FOR THE POLK COUNTY MEDICAL SOCIETY

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Cover Photo: Greater Des Moines Botanical Gardens, site of the 2016 PCMS Annual Meeting, Thursday, April 7, 2016.

Articles and editorial inquiries should be directed to:

Editor, PCMS Bulletin
1520 High Street
Des Moines, IA 50309

515-288-0172
http://www.pcms.org
e-mail: kjlyman@pcms.org

Publication design and layout by LCS for more information visit www.lymancs.com.

Exciting
2016 Annual meeting
Botanical Gardens

Joel From, M.D.

I hope that everyone can plan ahead to attend next year's PCMS Annual meeting, Thursday, April 7, 2016 at the newly renovated Des Moines Botanical Garden. For those of you who haven't been to the Garden since it was just " the Dome", you are in for a treat. It has been transformed into a wonderful gem for Polk county and the Greater Des Moines area. If you get the chance to visit before the winter, you will be amazed at the expansion. I especially recommend going to the restaurant "Trellis" for lunch. The new outdoor spaces are remarkable.

As a local native, the revival of this facility has made me reminisce back to the time when the Botanical Center opened in 1979. Much like the Garden, Des Moines was a different place in 1979. The Civic Center also opened that year, replacing the old (and condemed) KRNT theater, where the roof had collapsed. West Des Moines, Altoona, Johnston and Ankeny were small suburbs.

Other changes in Polk County involved our medical community. In addition to UnityPoint, Mercy and Broadlawns, there were Des Moines General and Northwest Community Hospitals. The delivery of medical care was centralized. There was no "outreach" of services to rural areas. The hot new technology was the EMI scanner, developed by the Beatles. It stood for Electronic and Musical Instruments and was the first technology to show the brain using Computerized Axial Tomography. The Certificate of Need committee struggled with approving 2 scanners for Des Moines. Today, CT scanners are everywhere throughout our community. We have more PET machines in Polk county than EMI machines were in the entire state of Iowa in 1979.

Des Moines University operated out of the former St. Joseph's Academy, which was a big improvement from the former campus in downtown on 6th street but nowhere near as impressive as the current replacement facilities on Grand Avenue. The enrollment has doubled in size and expanded to include other colleges including Podiatry, Physician Assistant, Health Care Administration and Physical Therapy. Post-Graduate Medical Education has expanded throughout all of our hospital systems.

Things have change across the board for medicine and our community. Reading "The Life and Times of the Thunderbolt Kid" brings back a fond nostalgia of the way things used to be in Des Moines. I love hearing from the senior physicians in our area about the good old days. In reading Bill Bryson's memoir, I can look back 36 years and remember not only the community where I grew up, but also remember my first hospital rotations as a U of I MECO student (Medical Education Community Orientation).

That was in the Summer of 1979.

Cyber Security and Liability:
Assessment, Insurance and Indemnity

W. Darrell Armer, JD

The Anthem health insurance data breach made it clear that protecting patient information remains atop the list of compliance issues because unauthorized disclosures can result in serious consequences. Based on the number of, and the significance of, settlements reached with the US Department of Health and Human Services Office for Civil Rights, the agency responsible for enforcing HIPAA's rules related to security of protected health information, the number of reported breaches and settlements is expected to increase. The Anthem case has resulted in more than 50 class action suits being filed.

Assessment

Under the HIPAA Security Rule, a medical practice must conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of electronic protected health information it holds. Additionally, core measure No. 14 of the Meaningful Use criteria requires that the medical practice conduct or review a security risk analysis and correct identified security deficiencies. A commitment of appropriate resources to conduct the security risk analysis, as well as continued diligence in addressing deficiencies, is critical to reducing liability.

In 2014, HHS released an SRA tool* to guide healthcare providers in small- and medium-sized offices in conducting their risk assessments. The tool is designed to help practices document a risk assessment in a thorough, organized fashion at their own pace by allowing them to assess the information security risks in their organizations under the HIPAA Security Rule. For most medical practices, the security assessment is a daunting and expensive task; however, there is no way to avoid it, especially for medical practices seeking to achieve Meaningful Use. The SRA tool is a collaborative effort by the HHS Office of the National Coordinator for Health Information Technology and the Office for Civil Rights.

When conducting a risk assessment, the required standard is to review the administrative, physical and technical safeguards that a medical practice has in place. Upon completion of the risk assessment, the medical practice should be able to address the vulnerabilities in its policies, processes and systems. For the most part, the physical safeguards can be assessed by walking the space, determining areas that are accessible to patients and employees, discerning the likelihood that a patient or employee may access protected health information in those areas, and looking for ways to better protect the PHI. This can be

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continued from page 5

accomplished by moving certain functions and/or records to private areas, reconfiguring the space, and/or restricting employee access to certain areas. Administrative safeguards can be assessed by a thorough review of the policies and procedures of the medical practice, which must be coordinated with the human resources function.

The technical safeguards generally require the retention of independent third parties that can test the vulnerability of a practice's information/EHR systems. After all, it is the use of EHR systems, coupled with the scale of PHI now housed within an EHR system, that has increased the vulnerability to attack. Because a medical practice generally is not equipped to assess its information/EHR systems, third-party assessments have become critical.

Insurance

As with most risks, a medical practice should utilize insurance to mitigate the financial impact of an unauthorized disclosure or violation of HIPAA or any state privacy laws. Many cyber insurance policies are available and may cover broad forms of data exposure, from technology being compromised to other ways patient information could be revealed, such as employee negligence.

A medical practice needs to fully understand its insurance coverage and the protection and benefits its cyber liability coverage offers. For instance, does the policy provide coverage for violation only of privacy laws, including any fines or penalties that may be assessed under HIPAA/HITECH levied by the Office of Civil Rights or state attorneys general? If it covers fines and penalties, does the policy contain any sublimits on this coverage? Does it provide coverage for fraud resolution, including restoration of healthcare records? Does it provide coverage for theft, loss or disclosures of PHI by your business associates? What loss mitigation options are available after a breach, including credit monitoring for individuals or for families if a minor is involved? What about the costs of forensic IT work and PR/communication strategy? Are risk management services and support available for every insured? These questions are just a sampling of questions you should ask your insurance agent when selecting a cyber-liability policy.

Indemnity

Another important consideration to reduce exposure is your contractual agreement with your business associates. Although the majority of the terms and conditions of Business Associate Agreements are mandated by HIPAA, the indemnification provision remains the most important for a medical practice. In short, indemnification is the concept through which the party at fault makes the other party whole. One of the biggest changes implemented by the release of the HIPAA Omnibus Rule is to hold business associates directly liable for HIPAA violations. Although some might argue that indemnification no longer is required because the business associate will have direct liability, you must consider then purpose of the indemnification provision. The goal is to avoid incurring costs or damages from the act or omission of your business associate. So, although the business associate may be liable to the government as it relates to fines and penalties, the medical practice still is at risk for the costs incurred to respond to and notify individuals about a breach. The indemnification provision in the Business Associate Agreement generally should be viewed on a standalone basis

from the indemnification provision that may be contained in the underlying services agreement between the medical practice and the business associate.

The medical practice should consider the business associate's ability to satisfy the indemnification obligation. Ask each business associate whether he or she carries cyber liability coverage and the terms of that coverage. Otherwise, you may end up with an empty indemnification.

Gray Reed & McGraw, PC. He focuses on commercial transactions, with an emphasis in the healthcare industry. His practice reflects the interplay among corporate finance/securities law, health law, and real estate law. Contact him at 214-954-4135.

*www.healthit.gov/providers-professionals/security-risk-assessment

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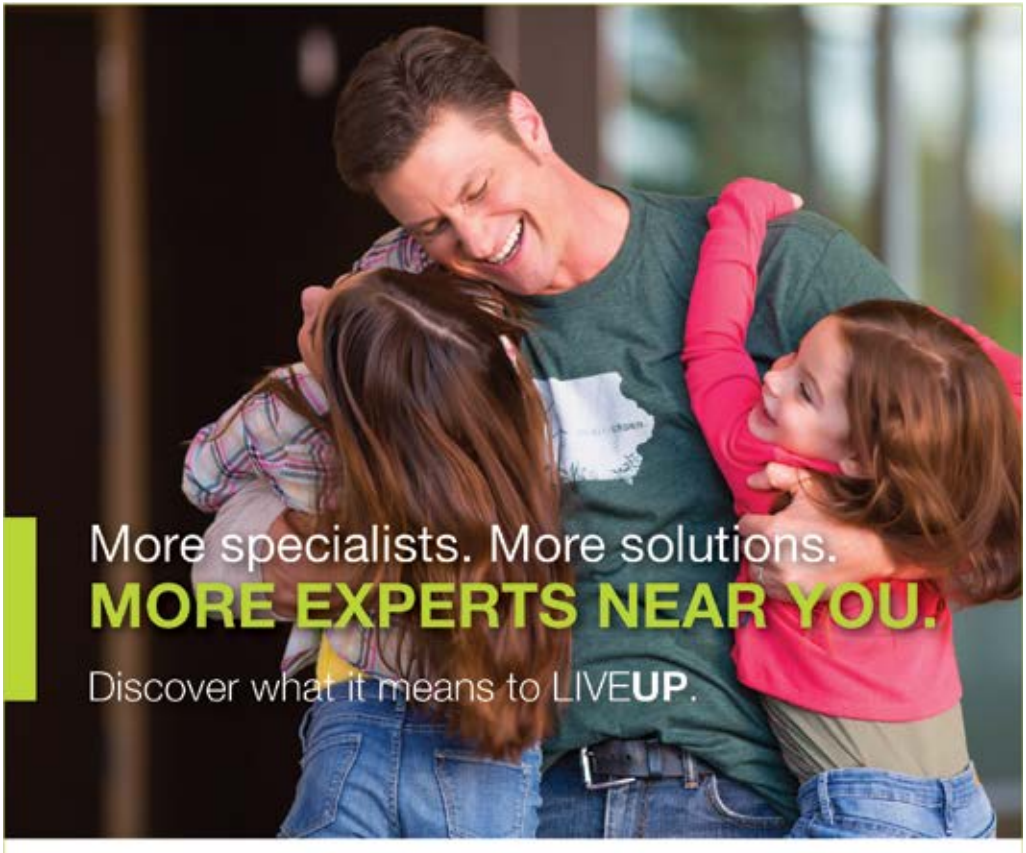

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Management of Tuberculosis
and Latent Tuberculosis Infection

Carlos Alarcon, MD, MPH

You are seeing a patient who has just had a positive Mantoux tuberculin skin test (TST) but a normal chest radiograph; what do you do next? Declare they are free of communicable disease? Not so fast, as this patient could be one of more than 11 million people in the United States who has latent tuberculosis infection (LTBI). While not everyone with LTBI will develop active tuberculosis (TB) disease, about 5-10% of, or 550,000 to 1,100,000 infected people will develop TB disease if not treated. As providers, we need to make sure that we identify and treat those at highest risk for TB disease in order to help eliminate the disease.

Testing for TB

There are currently two testing methods available for the detection of M. tuberculosis in the United States. Most providers use Mantoux tuberculin skin testing (TST), however, some also use Interferon-gamma release assays (IGRAs), such as QuantiFERON TB Gold In-Tube test (QFT-GIT) or T-SPOTTB test. TST testing reactions should be interpreted within 48 to 72 hours of being administered. When reading a TST reaction, the induration must be read and recorded in millimeters (mm). Patients with a prior history of a positive TST result or treatment for TB disease should not have a TST performed. Patients with a positive TST or IGRA should have a chest radiograph ordered as part of their medical evaluation to help distinguish between LTBI and TB. Children less than 5 years of age need to have both posterior-anterior and lateral views; all others need at least a posterior-anterior view. Sputum examination is indicated for persons with positive test results for TB infection and either an abnormal chest radiograph or presence of respiratory symptoms.

Identifying Persons at Risk

Identifying patients with LTBI is important because treatment of LTBI can prevent the infected person from developing active TB disease and stop the further spread of TB. Patients at risk for exposure to persons with TB disease included:

- Known close contacts of a person with infectious TB disease

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FOSTER GROUP® PRESENTS

VECTORS & VIEWPOINTS

2015 PCMS Edition

VECTOR: SMALL CHANGES MAKE A BIG DIFFERENCE

Jon Evans
CFP®, AIF®
Lead Advisor - 401(k)

Today's question:

"What should I be thinking about when investing in my 401(k) plan?"

Similar to a car purchase, you should always "look under the hood" of investment options you are considering. It's important to understand that not all funds are created equal. It's not safe to assume that simply spreading dollars across a number of the available funds will create a well-diversified portfolio.

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- Persons who have immigrated from TB-endemic regions of the world
- Persons who work or reside in facilities/institutions with people who are at high risk for TB, such as, homeless shelters, jails/detention centers, nursing homes, or facilities with immune-compromised patients

Also at risk are those with certain conditions and other factors associated with progression from LTBI to TB disease. These conditions and factors include the following:

- HIV infection
- IV drug use
- Radiographic evidence of prior healed TB
- Low body weight
- Infants and children under the age of 5 who have a positive TB test result
- Recent TST converters (that is, person with baseline testing results who have had an increase of 10mm or more in the size of the TST reaction within a 2 year period)
- Chronic medical conditions like, silicosis, diabetes, renal failure, organ transplant, history of head and neck cancer gastrectomy, and conditions that require prolonged use of corticosteroids/immunosuppressive agents

Classifications of TB Skin Test Reactions

>5mm is positive in:	*>10mm is positive in:*	*>15mm is positive in:*
• HIV infected persons • Recent contacts of a person with known infectious TB • Persons with fibrotic changes on chest radiograph consistent with prior TB • Patient with organ transplants and other immunosupressed	• Recent arrivals to the United States (within 5 years) from high-prevalence areas • IV drug users • Residents or employees of high-risk congregate settings • Mycobacteriology laboratory workers • Person with clinical conditions that increase risk for progression to TB disease • Children younger than 5 years of age • Infants, children, and adolescents exposed to adults in high risk categories	• Persons with no known risk for TB

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Differentiating between LTBI and TB disease

LTBI	*TB*
• No symptoms or physical findings suggestive of TB • TST or IGRA result usually positive • Chest radiograph is typically normal • If collected, sputum smears and culture are negative • Can't spread TB bacteria to others • Should strongly consider and encourage treatment for LTBI to prevent TB disease	• Symptoms may include one or more of the following: fever, cough, chest pain, weight loss, night sweats, hemoptysis, fatigue, and decreased appetite • TST or IGRA result usually positive • Chest radiograph is usually abnormal however on rare occasion in the patient with advanced immunosuppression or extrapulmonary disease can be read as normal • Respiratory specimens are usually smear or culture positive • May spread bacteria to others • Needs treatment for TB disease

Recommended Treatment of LTBI

There are several treatment regimens available for the treatment of LTBI patients; and providers will need to choose the appropriate treatment regimen based on their patient coexisting medical illnesses and potential drug-drug interactions. That said, the Iowa Department of Public Health (IDPH) recommends a 9- month treatment regimen of Isoniazid (INH). Studies have shown that a 9-month regimen is the preferred treatment because it is more efficacious.

Providers simply need to call IDPH or Polk County Health Department, (515) 286-3890, to speak with a communicable disease team member for more information as it relates to LTBI or TB and treatment if they have questions.

TB Reporting

TB: Both clinically suspected and laboratory confirmed tuberculosis disease are to be reported to the Iowa Department of Public Health (IDPH) Bureau of Immunization & TB. Cases of both pulmonary and extrapulmonary disease should be reported to IDPH within one working day.

LTBI: Latent tuberculosis infection (LTBI) is not reportable in Iowa, however IDPH does provide medication to treat LTBI to prevent progression to disease. IDPH provides medication free of charge to treat both LTBI and TB disease. For more information specific information on prescription services: http://www.idph.state.ia.us/ImmTB/TB.aspx?prog=Tb&pg=TbHome

Report To: TB Control Program
Phone: (515) 281-8636 or (515) 281-7504
Fax: (515) 281-4570
24/7 disease reporting telephone hotline: 800-362-2736

Fax LTBI Medication Requests (including the following information) to IDPH at (515) 281-4570:

- **Patient Information Sheet**
- **Chest X-ray Report.** If the patient has no risk factors for TB the chest x-ray must be dated within 6 months of the medication request. If the patient has any risk factors, the chest x-ray must be within 3 months of medication requests
- **Prescriptions.** If the Patient Information Sheet is not signed by the clinician, a separate prescription is required.

Management of TB

The Polk County Health Department Communicable Disease Team provides Directly Observed Therapy (DOT) for patients with suspected/confirmed cases of TB disease in Polk County; and conducts contact investigations for infectious TB.

In Closing

As providers we play a major role in achieving the goal of TB elimination in the United States. Many resources exist to help guide us through making a diagnosis and treatment plan for patients with LTBI. For more specific information: http://www.cdc.gov/tb/publications/ltbi/pdf/TargetedLTBI.pdf , contact IDPH or call your local public health department.

Congratulations to Richard Deming, M.D., who was featured in the Des Moines Register June 7, 2015 as the commencement keynote speaker for the 2015 graduating class of AIB College of Business.

Congratulations to Douglas Dorner, M.D., who was featured in the Des Moines Business Record June 26, 2015 in the Leader Spotlight. Dr. Dorner was named Chief Academic Officer at UnityPoint Health – Des Moines. He has headed the Medical Education and Research department at UnityPoint since 1994.

Congratulations to David Drake, D.O., who received the Des Moines University Multicultural Affairs 2015 Diversity Champion Award on May 6, 2015. The award is in recognition of his contributions to diversity and inclusive programming at Des Moines University.

Congratulations to Thomas Evans, M.D., who has received the Distinguished Service Award, the highest honor given by the Iowa Medical Society. He is the sixth recipient to ever receive the award for those physician leaders who have made outstanding contributions to the profession of health.

Congratulations to Jeff Maire, D.O., who is named Past-President of the Iowa Medical Society Executive Committee.

Congratulations to Paul Mulhausen, M.D., who has been named President-elect of the Iowa Medical Society (IMS) Executive Committee and has also received the IMS Presidential Citation Award. Dr. Mulhausen is the third recipient ever to receive this award, for his service and leadership to IMS.

Congratulations to Kelly Reed, D.O., who has been elected to serve a three-year term on the Iowa Medical Society Board of Directors as an At-Large Director.

Congratulations to Mark Tannenbaum, M.D., who has been elected to serve a three-year term on the Iowa Medical Society Board of Directors as an At-Large Director.

Congratulations to Joyce Vista-Wayne, M.D., who has been elected Chair on the Iowa Medical Society Executive Committee.

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PHYSICIAN LEADERS PICTURED: From left to right: Dr. Michael McCubbin, Sleep Medicine/Allergy; Dr. Tim Rankin, Orthopaedics; Dr. Scott Neff, Orthopaedics; Dr. Daniel McGuire, Orthopaedics; Dr. Stephen Quinlan, Urology; Dr. John Tentinger, Imaging; Dr. Brad Lair, Oncology/Hematology; Dr. Kendall Reed, Gastroenterology.

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In Memory of

Douglas Workman, M.D.

By: Vincent Mandracchia, D.P.M., M.H.A.

Dr. Douglas Workman passed away on March 18, 2015 after a lengthy and courageous battle with colon cancer. Doug was a kind, gracious and humble man whose character was defined by his integrity and optimistic attitude in spite of adversity. He was 51 years old.

The first time I met Doug at Broadlawns Medical Center, I was immediately impressed by his affable manner and genuine smile. It wasn't long after that initial meeting that I came to realize how caring and compassionate an individual he was. That was 16 years ago and not a day goes by that he is not missed by patients, colleagues and staff.

Dr. Workman graduated from Southeast Polk high school in 1982 and attended the University of Iowa where he received his Bachelor's degree in 1985 and Doctor of Medicine degree in 1989. After completing his Family Practice Residency in Davenport, he worked for the next seven years in private practice in Bettendorf, Iowa. From 1999 up until the time of his passing, Doug worked at Broadlawns, initially teaching at the Family Practice Residency Program, and subsequently founding the Primary Care Clinic where he served as Section Chief.

Dr. Workman served two terms on the Southeast Polk School Board and was the Caucus Chairman of his precinct several times. Additionally, he was a committee member of the Colorectal Cancer Roundtable. He also enjoyed hunting, hiking, biking, triathlons, reading, playing the drums and riding his Harley.

Doug's passions were medicine and his family. He was an excellent physician. He was always available for his patients and developed many close relationships with those he cared for. Above all, Doug was a consummate family man. He is survived by his wife of 26 years Joann, son Andrew and daughter Abigail.

With all the great memories I have of Doug, my fondest memory will be the time I visited him in the hospital two days before his death. Instead of lamenting his fate, or complaining about what he had to endure, Doug spent the entire time bragging about his kids and flashing that characteristic smile. That one moment defined the man.

Telemedicine Benefits and Risks

By Jeremy A. Wale, JD, ProAssurance Risk Resource Advisor

The healthcare landscape has changed radically in recent years. Implementation of the Affordable Care Act, expanding roles for nurse practitioners and physician assistants, meaningful use, and ICD-10 preparation are just the highlights. But one change that often gets overlooked is the rapid expansion of telemedicine.

Forty years ago hospitals used a form of telemedicine to reach patients in remote areas. Triaging a patient over the phone is, after all, just another form of telemedicine. Modern technology has opened up many new avenues for patients and physicians to communicate. Today telemedicine encompasses a vast array of services offered by virtually all medical specialties. Telemedicine is defined as "the ability to provide interactive healthcare utilizing modern technology and telecommunications." It includes interactive video, home monitoring devices, scanning and emailing photos, and myriad other ways physicians and patients can communicate without a face-to-face interaction.

Telemedicine is expanding not only by volume, but also by services offered. In 2013, a consulting firm estimated worldwide telemedicine use would grow by 18.5% per year through 2018. Another source opines that the United States telemedicine market "will grow from $240 million in revenue in 2013 to $1.9 billion in 2018"—an annual growth rate of more than 50%.

Telemedicine not only could increase revenue, but also decrease spending. One study revealed a health insurer saved approximately $10 million over six years using telemedicine. The study followed 3,000 congestive heart failure patients receiving in-home monitoring of weight, blood pressure, heart rate, and pulse oximetry. Readmissions dropped by 44% for these patients, boosting savings. Although this study represented a small sample size, the savings realized were significant—just using common telemedicine tools. As telemedicine expands and services become more accessible, cost savings presumably will grow.

Drivers

Several factors are driving the telemedicine explosion, and convenience may be the biggest. A patient can sit in their living room and consult with a dermatologist who can view the problem area. A cardiologist can review monitor readings from their office while the patient is at home. Diabetics can check blood sugar levels and upload the results for their physicians to monitor.

Cost effectiveness makes telemedicine an attractive alternative to traditional healthcare models. Telemedicine allows physicians to consult with more patients within a smaller timeframe. This increases revenue for the

physician, saves patients money on travel expenses, and decreases patients' time away from work and family.

Consultations also can be more efficient for all parties involved. Rather than sending x-rays or medical records to another provider through the mail, images and documents can be sent electronically. The consulting physician can conduct an electronic visit with the patient. This convenience decreases the potential for noncompliant patients (especially with regard to specialist follow-ups), saves time, and increases physician-to-physician collaboration.

Rural communities with limited means to access healthcare still benefit from telemedicine. Someone living 200 miles from the nearest urban area needs to see a dermatologist, but does not have the means to travel the requisite distance. Telemedicine offers that individual an opportunity to speak with a specialist through a computer screen. These patients may end up being treated for something within a couple of days—even hours—for an ailment that, 20 years ago, may have gone undiagnosed for several years.

Drawbacks

While technological advances have helped drive telemedicine, technological failures can be one of its biggest drawbacks. Networks are subject to interruptions, delays, system overloads, or other technical difficulties. Because telemedicine is wholly dependent on working technology, its effectiveness is severely hampered when technology fails.

Privacy, security, and confidentiality are other potential problems. Even when healthcare providers take necessary security precautions, hackers may still access electronic communications—and HIPAA extends to the patient's living room. It's important to take necessary precautions to ensure telecommunications are as protected as possible. Use encrypted emails, consult with cyber-security experts when setting up your telemedicine practice, and develop a well-written consent form that addresses the risk factors of telemedicine.

It also is important not to overlook physical interactions between physicians and patients. Sometimes patients need a physical exam for an effective diagnosis (e.g. broken bones). Seeing patients in person helps establish a trusting, cooperative relationship that may be challenging to build electronically. Both parties may be more engaged if conversations are conducted in-person. This may be less of an issue if you only use telemedicine for established patients. It is still a good idea to suggest an annual in-office examination.

Mobile Apps

Mobile app use is booming. According to one estimate mobile app revenue will reach $13 billion in 2015, with a compounded annual growth rate of 40% over the next six years. The implications are equally enormous.

In January the FDA approved an app for glucose monitoring via a mobile device. This app allows healthcare providers to track

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Where: Wakonda Club

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Michael Nicholson, D.O.

SEPTEMBER BIRTHDAYS

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James W. Hopkins, M.D.
Robert C. Kitterman, M.D.
Kelly L. Reed, D.O.

3
Robert H. Hoyt, M.D.

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Ryan S. Bakke, M.D.

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Joseph Yankey, D.O.

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David C. Ball, M.D.
Jay A. Rosenberger, D.O.

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Manmohan Singh, M.D.

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Becky Jo Davis-Kramer, D.O.
Christopher A. White, M.D.

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Robert O. Thompson, M.D.

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Lydia Holm, M.D.
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James B. Poole, D.O.

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Dante R. Toriello, D.O.

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Martin R. Aronow, D.O.
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Gregory Schmunk, M.D.
Asit K. Tripathy, M.D.

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Thomas D. Dulaney, M.D.
Kevin J. Percival, M.D.

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Vidya Chande ,M.D.

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Benjaminn S. Paulson, M.D.

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Jennifer A. Groos, M.D.
Randall H. Hamilton,M.D.

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patient glucose levels via a smartphone or tablet.

Mobile apps can be used for anything from monitoring patients remotely to facilitating physician/patient communication. A brief review of cardiology related mobile apps revealed several that allow physicians to demonstrate, illustrate, or show videos to patients to help explain certain conditions. Mobile apps also can provide decision support for physicians or help with diagnoses.

Dermatology apps can help patients track moles and other skin lesions to document changes. One app, developed by University of Michigan physicians, includes a skin cancer risk calculator. Another dermatology app claims to be 70% accurate in predicting the severity of a mole; dermatologists are about 85% accurate according to the same article.

Risk Management Considerations

Increased availability and real-time data are key telemedicine benefits. But while these two factors seem to foster patient/physician communication and nurture that relationship, they also may increase your risk exposure.

If you offer electronic availability to your patients, consider how it could negatively impact you when something doesn't go as planned for a patient. A plaintiff's attorney could present to a jury your claim to be available, and then state the patient didn't receive the type of response promised. The attorney could assert your failure to be immediately available directly led to the patient's negative outcome.

Real-time data also can present challenges. On one hand, it may increase your effectiveness as a healthcare provider. However, it also can create professional liabilities, particularly in the event of a claim. Consider: If you receive real-time blood sugar results from a patient and fail to notice a large spike or depression, could you be held liable for a negative outcome? A juror might look at this information and ask, "Why didn't the doctor notice this sooner?"

These examples highlight the importance of full disclosure and informed consent when it comes to telemedicine. It is important patients and healthcare providers are aware of both the advantages and limitations telemedicine presents.

Services providing online consultations to the general public, like "HealthTap," "InteractiveMD," or "MYidealDOCTOR," are another area of liability concern. While these sites are great for patients and provide immediate access, physicians need to consider certain risks before participating:

- Are you licensed to provide medical care in the state the patient is contacting you from?

- Are you required to be licensed in the state the patient is contacting you from?
- How can you track and follow up with patients if necessary?
- How will calls be documented?
- If a liability claim arises, in which state will you have to defend yourself?
- How can you verify treatment recommendations?
- Will your service provider be involved in any way if you have a claim filed against you? (Review your contract with your provider.)
- Does your state's medical board prohibit this practice across state lines?
- Does the patient's state prohibit this practice?
- Are you allowed to prescribe any medications?
- Is the service HIPAA compliant?

Before entering into any agreement, be sure to thoroughly research and consider all of the pros and cons. You also may wish to consult with your insurance agent to determine if your current policy covers internet-based services.

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