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All it takes is a few keystrokes, and your facility's reputation is ruined

Web postings by patients and staff raise troubling issues

[Editor's note: This is the first part of a two-part series on issues surrounding social media and ambulatory surgery. In this issue, we give you some horror stories and tell you how to avoid them. We tell you how to be proactive about your online presence, as well as how to develop a social media policy. Next month, we discuss legal issues and employee training.]

Patients with unrealistic expectations, overworked staff, and the increasing popularity of social media have converged to create a perfect storm of tirades — at least some untrue — against surgery providers and facilities on the Internet. Reputations are destroyed with a few keystrokes. What can be done?

Very little, according to experts interviewed by *Same-Day Surgery*. "You can choose to be part of those conversations or not, but you can't keep from having those discussions happen," says **Ben Dillon**, vice president and eHealth "evangelist" at Geonetric, a Cedar Rapids, IA-based web software solutions company that focuses on healthcare.

Consider these recent examples of online attacks:

• After a patient underwent a facelift by **Barry Eppley**, MD, plastic surgeon, Indianapolis, IN, she claimed that the procedure caused obstruction in her airway and breathing difficulty, Eppley says. He consulted other experts, none

EXECUTIVE SUMMARY

While there is not much that can be done to stop disgruntled patients and staff members from posting negative comments online, a proactive stance can protect your facility's reputation.
• Actively monitor your online reputation.
• Create free profiles on free services such as Facebook, Twitter, and Google+. Ask happy patients to post their comments on your web site and these social media pages.
• Trademark your name.
• Create a social media policy.

of whom had heard of this complication, he says. She created websites to post negative comments or direct potential patients to negative comments, according to Eppley. She posted a negative video about him on YouTube that attracted hundreds of thousands of hits. The patient was featured in an HBO documentary titled "Plastic Disasters." Eppley says he addressed her concerns for a year before he stopped contact with her due to "bizarre and irrational" behavior. The judge ordered her to remove the "false and offensive statements" and fined her $40,000, but the patient had committed suicide the day before the ruling, according to Eppley. Some of her comments still are posted on web sites that are not under U.S. jurisdiction, he says. *(For more on this case, see story, p. 39.)*

• An Arizona plastic surgeon and his physician wife were awarded $12 million after a patient created a website to criticize the physicians and question their credentials. The patient also put negative postings about them on websites that reviewed doctors. The patient, a jazz singer, developed a serious skin condition that she claimed disrupted her life. She submitted several complaints to the state medical board. The physicians said she posted incorrect information and caused their $4.5 million practice to drop to two patients a week.[1]

• A former nurse complained that staff members were being allowed to take photos of sedated patients and post them on Facebook. She subsequently was fired. She claimed violations of the Health Insurance Portability and Accountability Act (HIPAA), among others, and has sued the hospital for more than $15 million over her firing.[2]

Social media cannot be ignored, says **Paul A. Anderson**, ECRI Institute's director of risk management publications.

"First, people in their communities, current patients and their families, and even staff members are already using social media, and some of them are probably talking about the organization on social media," he says. "Without a social media presence, the organization won't know about what's being said, and won't be able to respond if that's appropriate.

Secondly, social media offers another public relations opportunity, he emphasizes. Dillon agrees. "Remember that you're living your brand every day and you should do that in social media just as you do when answering the phone or greeting patients in the waiting room," he says.

Patients are researching potential providers and their facilities prior to their first visit, says **Kim Woodruff**, vice president of corporate finance and compliance for Pinnacle III in Lakewood, CO, which develops and manages single and multi-specialty ASCs. "Maintain an ever-present awareness that everything you put on your site will either support, promote, or damage your reputation," Woodruff says. "Social media is free exposure; therefore, you have to be prepared to deal with the bad as well as the good comments you may receive."

You can't control what is said about you, "real or imagined," says **Neal R. Reisman**, MD, JD,

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FACS, chief of plastic surgery, St. Luke's Episcopal Hospital, and clinical professor of plastic surgery, Baylor College of Medicine, physician at Plastic Surgery Specialists, and attorney at law, all in Houston, TX. "I have heard stories of competitors and even reputation defense companies posting bad reviews to discredit the doctor, or generate business," Reisman says.

In fact, many states and one territory have SLAPP (Strategic Lawsuit Against Public Participation) legislative or judicial protection, he says. *(See list, right.)* The legislation/court rulings protect comments on a public interest issue in a public form, and they include the awarding of attorney's fees, Reisman says.

Here's where to start

Actively monitor your online reputation, social media experts advise. Even if you choose not to create new content, at least be aware of what is being said about your facility, Anderson says.

"By creating free profiles on the most common free services — Facebook, Twitter, Google+, for example — the organization's staff can get familiar with them and keep an eye on what's going on," he says.

Set up alerts at from Google.com/alerts and Socialmention.com that will tell you if your facility's name has been mentioned in social media, provider advises. Woodruff says, "Be vigilant about checking out what's being said, especially on physician ranking sites which you don't 'own.'"

Also, use a search engine to search for your facility's name, and go to the web site GoDaddy.com to purchase all domains with your name, such as your name.com, yourname.me, etc., suggests **Patrick Ambron**, cofounder and CEO of BrandYourself.com.[3]

ECRI Institute, which recently published a free guide to social media, suggests that you assign one person or group to post content on social media, monitor its use, ensure execution of a social media plan, and monitor for violations. *(For information on ordering the ECRI guide, see resource at end of this story. For more on developing a social media plan, see story, p. 40.)*

"Remind users of social media that they must in all circumstances be honest and respectful toward other users," ECRI advises.

Address any potential damage as quickly as you can, Woodruff advises. "Being caught unaware is likely worse than having never established a social media presence in the first place," she adds.

States and Territory with SLAPP Legislative or Judicial Protection**

- Arizona
- Arkansas
- Colorado
- Delaware
- Florida
- Georgia
- Guam
- Hawaii
- Illinois
- Indiana
- Louisiana
- Maine
- Maryland
- Massachusetts
- Minnesota
- Missouri
- Nebraska
- Nevada
- New Mexico
- New York
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- Tennessee
- Utah
- Vermont
- Washington
- West Virginia

** SLAPP is Strategic Lawsuit Against Public Participation.

Source: Neal R. Reisman, MD, JD, FACS, Houston, TX.

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2. HealthLeaders Media. Nurse accuses hospital employees of posting Facebook photos of sedated patients. Accessed at http://bit.ly/vZ2qc3.
3. Manage Your Online Reputation. *Parade*. Feb. 19, 2012.

RESOURCES

The ECRI Institute. has published a free guide to the social media. Web: http://bit.ly/ya9WgL.

The American Medical Association has a policy on professionalism in the use of social media. It is available at http://bit.ly/bswKCB. ■

`The worst nightmare' any person can experience

MD shares lessons learned

When a plastic surgeon tried to assist a patient who requested revisional surgery, what followed was "the worst nightmare any person can

experience," says **Barry Eppley**, MD, plastic surgeon, Indianapolis, IN. The patient created web sites to criticize him, posted a video on YouTube, and even was featured in an HBO documentary.

"All I did was try to help a lady, and it cost me endless amounts of money, time, and damage to my reputation, and I did nothing wrong," Eppley says.

He later learned that the patient's original physician had to issue a restraining order against her after he experienced similar retaliation, Eppley says. "One mistake I made, I learned from it and will never repeat … is that when you have a plastic surgery revisional patient that comes from afar, call the original doctor," he says.

Here are other tips he shares:

• Trademark your name.

Any physician or surgery facility can trademark a name, says Eppley, who eventually took this step that allowed him to sue in federal court for trademark and copyright infringement. Otherwise, it's virtually impossible, short of a federal court order, to have negative information about you removed from the web, he says.

However, Eppley and others agree that legal recourse isn't the best place to start. **Ben Dillon**, vice president and eHealth "evangelist" at Geonetric, a Cedar Rapids, IA-based web software solutions company that focuses on healthcare, says, "I don't think that it's practical for a start, and I doubt that it will be effective. Heavy-handed approaches make your organization look like the bad guy and tend to ultimately backfire."

Most complaints or negative comments can't be resolved via social media, admits **Paul A. Anderson**, ECRI Institute's director of risk management publications, says, "What organizations can do on social media, however, is reach out *[on the same social media]* to those who have concerns or complaints, let them know that you've heard their concern, and invite them to contact the organization to discuss the issue further. Doing this consistently can help emphasize the idea that the organization is patient-focused."

• Be proactive.

Whether you like it or not, your reputation is being forged on the Internet, Eppley says. "You can contribute to it and shape it, or let everyone else do it for you," he says.

Unhappy patients are 16 times more likely to make comments than those who have positive experiences, Eppley says. However, don't ask patients to sign a pre-surgery waiver that says they won't post negative comments after surgery, he advises. Many legal experts believe it is illegal, and it also gives a poor impression of your practice, Eppley says.

Instead, "there are a variety of ways you can create your reputation," he says. Have a Facebook page, and monitor the comments that are posted, Eppley says. Employees can post positive comments, but they should disclose their relationship with your organization, Dillon says.

Let the information that gets indexed and searched on the Internet be the information you help create, Eppley advises. "That's the single best thing you do."

That advice is seconded by **Kim Woodruff**, vice president of corporate finance and compliance for Pinnacle III in Lakewood, CO. "One way to minimize the impact of negative posts is to ensure the positive, informative, current content you are posting is deep enough to 'push down' the relatively few, hopefully, naysayer comments that appear in the search engine queue," Woodruff says.

Forty percent of Internet users don't go beyond the first page of a search engine's results, and almost 85% don't go beyond the second page, she says. "The negative comments do not go away; they just become more difficult for people to find," Woodruff says. ■

How to create a social media policy

According to a recent guide to social media published by ECRI Institute, you should establish a policy that defines whether and how the organization will reply to criticism, complaints, and compliments posted on social media.[1]

"From a compliance perspective, a social media policy is absolutely essential," says **Kim Woodruff**, vice president of corporate finance and compliance for Pinnacle III in Lakewood, CO.

Most organizations should have policies to address the official social media channels of the organization and the use of social media by other employees, says **Ben Dillon**, vice president and eHealth "evangelist" at Geonetric in a Cedar Rapids, IA.

A good starting point is a flow chart from Wexner Medical Center at The Ohio State University, which is based on one from the U.S. Air Force, Dillon says. *(That flow chart is included with the online issue of the April 2012* Same-Day Surgery. *To access that issue, go to*

Components of a Social Media Policy

- Identify who will be responsible for social media on behalf of the organization, whether it's a department or single person.
- Define who else will be permitted to contribute to the organization's official social media presence, and what, if any, approval is needed before content can be disseminated.
- State the goals for using social media, including the intended audiences (e.g., community, current patients, and staff).
- Lay out privacy requirements and consequences for violations.
- Define the tone that the social media is expected to keep — how formal or informal it will be, for example. Remind users to avoid saying inflammatory things, to keep it clean, and so on.
- Define whether and how you'll respond to negative comments from outsiders online.
- Remind staff members not to give medical advice via social media; rather, direct patients to make an appointment.

Source: Paul A. Anderson, ECRI Institute's director of risk management publications ■

Components of Social Media Policy on Employees' Personal Posts

- Refrain from disclosing confidential and proprietary organizational information.
- Avoid exposure of personal identifying information related to a provider, colleague, or patient.
- Assume personal liability for all communications and information published online.
- Because company liability can be incurred for communications that are transmitted via an organizational email address, limit the use of the organizational email address to select individuals.
- Outline a physicians' or employee's right to participate in social media and networks using their personal email address with the caveat that anything published on personal sites should never be attributed to the organization or appear to be endorsed by, or to have originated from, the organization.
- Identify the limitations on material that is allowed to be published online.
- Retain control over the creation and management of organizational online content.
- Respond to an outside party's post containing inaccurate, accusatory, or negative comments about the organization or any of its employees.
- Refrain from publishing comments about controversial or potentially inflammatory subjects.
- Avoid hostile or harassing communications in posts/online communication.

Source: Kim Woodruff, Vice President of Corporate Finance and Compliance, Pinnacle III, Lakewood, CO. ■

same-daysurgery.com. You will need your subscriber number from your mailing label.) Here are some principles from that flow chart:

- **Never disclose any patient information.**

"This typically means that you need to move discussions off-line," Dillon says.

- **Never attack the person making the claim.**

"Maintain an understanding and professional demeanor at all times, Dillon says. "Remember that reacting inappropriately in a public venue is often more damaging than the original comments."

- **Understand the commenter's motivations.**

"There are people who just enjoy trying to get a reaction from individuals and organizations," says Dillon, who adds that such people are commonly known as "trolls." "The worst thing that you can do, when dealing with such an individual, is to respond at all, he says. "This is a hard thing, but ultimately it is sometimes best not to respond at all."

If you think that the individual has a relevant concern or there is some other issue, such as incorrect facts, then "respond to the extent possible without doing anything to violate the patient's confidentiality," Dillon says. He gives this example: "I'm very sorry to hear about your negative experience. I have contacted our patient advocate, and they will be contacting you to discuss the situation."

"[T]his sends a clear message to other readers of the discussion that you care about patients and are taking action to make things right," he says.

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'Distracted doctoring' recognized as hazard

All manner of electronic devices are common in any healthcare setting, and individuals increasingly are likely to use their own smart phones, tablets, and other personal electronics while at work. The proliferation of electronics is leading some patient safety experts to worry that patient safety might be threatened by "distracted doctoring."

The problem is moving higher on the long list of patient safety concerns, says **Gail Gazelle**, MD, an assistant professor of medicine at Harvard Medical School in Boston and one of the first physicians in the country to start a direct patient advocacy practice, www.MDCanHelp.com.

"It is a rare person who does not admit to arriving at a destination while on their cell and not recalling how they drove there. Just as we understand that drivers are distracted by cell calls, cell calls to physicians and nurses provide a concerning distraction," Gazelle says. "There is no question that this can compromise patient care."

Research indicates that clinicians sometimes are astonishingly comfortable about mixing patient care with using their own personal devices. An article in the journal *Perfusion* documented that 55% of technicians who monitor bypass machines admit to talking on their cell phones during heart surgery. Fifty percent also said they had texted during surgery. *(For more on that research, see the story at right)*

About 40% of the technicians said that talking on the cell phone during surgery was "always an unsafe practice," and 50% said the same about texting.

The spectrum of effects is broad, Gazelle says. At one end, focus on a text or call leaves patients feeling as if there is less focus on them, which leaves them even more vulnerable and disempowered, thus less likely to speak up about concerns or problems.

"Knowing what we do about the importance of patient participation in avoiding medical errors, this may not be a small concern," she says. "At the extreme end of the spectrum, the distracted clinician is at risk for overt errors in concentration, judgment, and technique."

Facility policies on the use of personal electronics are necessary but will not solve the problem, Gazelle says. A culture change is more important. Solving the problem will require getting the ear of physician leadership, Gazelle says. Physician leaders must agree that distracted doctoring is a problem, then lead by example, she says. Surgeons in particular should make clear they will not be distracted by their own devices and will not accept others on the team using personal electronics during surgery, she suggests.

Keley John Booth, MD, chairman of anesthesiology at Integris Health in Oklahoma City, OK, also is concerned about distracted doctoring and agrees that a culture change within the institution is the foundation of any solution. "Just as The Joint Commission posted an alert on the disruptive clinician in 2008, I believe we are due for an alert on the use of cellular devices," Booth says. "I also believe that patients and clinicians need to be empowered to tell users that their behavior is putting patients at risk."

Because each subsequent generation is more used to using their devices all the time, Booth predicts that the use of personal devices will only increase unless the institution delivers the message that the healthcare workplace must be an exception to their typical usage.

"We can't stop people from using this technology, but we can make it clear that some times are not appropriate. We have to create an atmosphere in which people are comfortable asking a coworker why they are using their cell phone during patient care," Booth says. "It can be done in a way that isn't confrontational, but by asking you can remind them to think more about when they're pulling out their smart phone and maybe wait until a more appropriate time." ■

Heart surgery techs use cell phones in surgery

Research from SUNY Upstate Medical University in Syracuse, NY, documents that heart bypass technicians admit to using their cell phones during surgery, but they also contend that the practice is unsafe.[1]

There were 439 respondents, with age ranges of 20-30 years (14.2%), 31-40 years (26.5%), 41-50 years (26.7%), 51-60 years (26.7%), and more than 60 years (5.9%). The use of a cell phone during the performance of cardiopulmonary bypass (CPB) was reported by 55.6% of perfusionists. Sending text messages while performing CPB was acknowledged by 49.2%.

For smart phone features, perfusionists report having accessed e-mail (21%), used the internet (15.1%), or have checked/posted on social networking sites (3.1%) while performing CPB.

Safety concerns were expressed by 78.3% who believe that cell phones can introduce a potentially

significant safety risk to patients. Speaking on a cell phone and text messaging during CPB were regarded as "always an unsafe practice" by 42.3% and 51.7% of respondents, respectively. Personal distraction by cell phone use that negatively affected performance was admitted by 7.3%, whereas witnessing another perfusionist distracted with phone/text while on CPB was acknowledged by 33.7% of respondents.

The researchers noted that there are clear generational differences in opinions on the role and/or appropriateness of cell phones during bypass.

"This survey suggests that the majority of perfusionists believe cell phones raise significant safety issues while operating the heart-lung machine. However, the majority also have used a cell phone while performing this activity," the authors wrote. "Such distractions have the potential to be disastrous."

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Same-Day Surgery Manager

It's a growing trend: Hospital off-site centers

Trend predicted to continue into 2012

By **Stephen W. Earnhart**, MS
CEO
Earnhart & Associates
Austin, TX

While it is difficult to surprise me anymore, I discovered that in 2011 we opened more not-for-profit, freestanding, off-site hospital surgery centers then we did actual for-profit surgery centers. In looking at our current workload and "pipeline" projects, it looks like the trend is going to extend into 2012.

Huh!? Who would have guessed?

It actually makes a lot of sense for the second decade of the 2000s.We are noticing that fewer surgeons are investing in surgery centers, building them, or leaving the hospital security blanket to become involved.We are also seeing more surgeons becoming employees of the local not-for-profit hospitals, thus removing the threat of competing with the local hospital.

The continued uncertainty over Obama-care is killing many surgery center projects as potential investor surgeons are nervous about the elections and potential impact it could have, not only on their practice, but on the industry as a whole.The murky waters are having an effect.We have seen that far fewer surgeons are willing to make a $60,000 to $150,000 surgery center investment for a reasonable ownership share. While usually that money comes back to them within a few years, it is still a tough check to cut.

Hospitals, while not flush with cash, certainly have more than surgeons to invest in new facilities.With more surgical procedures going outpatient, investing in a physical/hospital operating room expansion is questionable.While probably not completely accurate, I understand that adding one operating room to a hospital environment is close to $3 million. Assuming that hospitals typically add three operating rooms at a time, it is far less expensive and much less disruptive to build a five-operating room surgery center with investors financing the leasehold improvement in the rent at a fraction of the cost.

Granted, there is no opportunity for the hospital to joint venture such an expansion, which is key to many surgeons, but the surgeons are less willing to put up the cash anyway, assuming the facility is in a convenient location for them and their patients.

If we take the surgeons at their word, the vast majority of them favor a time-efficient surgical environment over a distribution. Clearly that is not 100%, but in interviews with more than 5,600 surgeons on their preferences, an efficiently run surgery environment with rapid turnover and a caring, personable staff is their number one motivator for where they do their surgery.

Not all satellite hospital surgery centers are successful. After reviewing many of them, the key success indicators are design and staff.

Using the same (dare I say it?) boring architects to design the new facility is not a good idea. The reason many hospitals are inadequate in handing outpatient surgery is that they were designed around inpatient cases. There are many architects who have extensive experience in outpatient services, especially ambulatory surgery centers, who can add exciting features. Take the time to interview them.

Simply building a state-of-the-art new hospital outpatient department and rotating the existing hospital personnel usually will not bring success. No, it will

not! The new facility requires dedicated, hand-chosen staff that the surgeons help identify. You want hungry, marketing, motivating staff — that means they smile! — working in your new center. Don't settle for less.

Managing the facility is up for grabs. Some hospitals can do it quite well. Other should stick to the experts and let them run it for them.

If the hospital has an exclusive agreement with an anesthesia group, chances are they will provide that service at the new location as well. Like the staff at the center, anesthesia staff needs to be hand-picked, as not all anesthesiologists are the same. You know what I mean!

Other pluses include ample parking in the new location, direct patient access to the facility, ability to retain hospital reimbursement, no "profit sharing" with surgeons (and no costly investment for the surgeons), improved patient satisfaction, and lastly and just as important, the ability to replace the outgoing outpatient cases with more intensive inpatient volume.

Get cranking! *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 13492 Research Blvd., Suite 120-258, Austin, TX 78750-2254. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.Twitter: @SurgeryInc.]* ■

Staff attitude key to patient satisfaction

Surgery center focuses on its culture

Two recent awards obtained by Siouxland Surgery Center in Dakota Dunes, SD, show this specialty hospital is on the right track with patient satisfaction.

In September 2011, WomenCertified, a referral source for businesses and brands women recommend, named the center among the Top 100 Hospitals for Patient Experience based on female patient satisfaction. In November 2011, the institution received a Summit Award from Press Ganey. Winners of this award must be ranked in the 95th percentile or above for patient satisfaction for a minimum of three consecutive years.

There are many reasons for the high level of patient satisfaction at Siouxland Surgery Center, where about 65% of the surgeries are same day. Results from several evaluation tools, including the Press Ganey patient satisfaction surveys, routinely are reviewed by staff to determine if changes need to be made in order to ensure that patients consistently have the best experience possible, says **Greg Miner**, CEO of Siouxland Surgery Center. The culture of an institution is the basis for the care provided patients, which results in high satisfaction scores, and at Siouxland Surgery Center, staff members are honored to take care of patients and their families, Miner says.

"Culture is something that cannot be measured or scored," he says. "It oftentimes is unexplainable, but culture always begins at the top. It starts with leadership and transfers down to management and the employees."

The reason most individuals chose healthcare as their profession is that somewhere in their lifetime, a "calling" similar to the clergy takes place, Miner says. "We try to make sure everyone that works at Siouxland Surgery Center has had that calling," he says.

Staff vested in success

Nursing staff were attracted to the institution because they could participate in a patient-centric surgically oriented experience, says **Ralph Reeder**, MD, president of Siouxland Surgery Center.

This culture is supported by administrators in several ways, according to Reeder. It includes the following:

- Staff freely discusses with physicians what job barriers they experience, what areas they would like to improve, or how to make positive changes. Physicians take these suggestions to management, and staff members see they individually matter.
- Staff has a yearly bonus linked to the financial performance of the institution that is a sizable part of their income; therefore, they are vested in the success of the surgery center.
- The surgery center has established an internal staff "university" whose job it is to teach and perpetuate the values, competencies, and expectations of the founding members.

"While a good culture can 'just happen,' a great culture needs tending in order to last," says Reeder. *(For advice on steps to take if you are struggling with low patient satisfaction, see p. 45.)*

The early physician owners made sure patient flow was designed to eliminate any frustrating impediments to the doctor while providing the patient with a home-like, non-institutional environment.

Physicians are assisted in many ways. For exam-

ple, computer stations with remote access to each physician's office server are provided at the front OR desk. Following surgery, a family consultation room is immediately available in proximity to the OR front desk. Staff members place a note on the physician's entry door identifying the names of the people in the room and their relationship to the patient.

"In short, our institution has always treated our physicians as a valued customer, understanding that a happy doctor, more likely than not, leads to happy patients," says Reeder. ■

Steps for improving patient satisfaction

Canvas, motivate, educate, and reward staff

Is your institution struggling with low patient satisfaction? **Ralph Reeder**, MD, president of Siouxland Surgery Center, which won a Press Ganey Summit Award for high scores in patient satisfaction, offers the following suggestions:

- Understand the motivation of your physician staff. Determine their financial, clinical, and experiential priorities. If they are not patient-centric, work to understand why not, and then seek their alignment to the clearly established values your institution wants to project and provide.
- Canvas your staff to understand their feelings about patient care and how they feel about the doctors and administration for whom they work. You will need their brutal honesty.
- Establish a core staff group of actual care providers who intrinsically has your desired cultural competencies. Give them the task of educating and rewarding others that emulate their example.
- Reward success generously. ■

Happier patients drive future volume

Give them less anxiety

Previously, some scheduled surgery patients at Spectrum Health in Grand Rapids, MI, failed to return phone calls because they had just spoken to someone.

"They thought that we must be confused because we had just called them," says **Jennifer Nichols**, director of patient access. "The perception that we weren't tightly coordinated on our end fueled any anxiety they may have had about an upcoming procedure."

The problem was that many processes were "separate and siloed," and they were organized around the hospital's needs and not the patient's, according to Nichols. "We know that a coordinated and optimized pre-encounter experience has the potential to positively impact the patient," she says. "We are better prepared for the patient, which makes the day of service more efficient."

Having a successful pre-encounter experience makes the patients more likely to return to the organization if they need care, Nichols adds. "This goes directly to future volume growth," she says. "We, in access, set the initial tone for how the patient perceives their entire encounter."

Patients are far more satisfied with the department's newly implemented model allowing one person to handle all their needs, and this model also makes economic sense, says Nichols. "We want to provide a patient with the best possible personal touch," she says. "That means eliminating redundancies and simplifying contacts."

For the service lines utilizing the new model, patient volume increased 6-10% over the previous year. "We have held staffing in the department flat or slightly decreased, even as we have brought new service lines into the department," Nichols adds. "That is a significant thing in this day and age." ■

Video made in-house to educate staff on falls

Finding a new way to educate employees about fall prevention is a big challenge because, though the topic is important, it can be hard to keep people's attention. One facility found that an educational video starring its own employees and presented with a bit of humor effectively delivers the necessary information

Beginning Oct. 1, 2012, ambulatory surgery centers (ASCs) will be required to submit data on five quality measures, including patient falls, to avoid a payment adjustment in 2014.

The effort at Long Beach (CA) Memorial Medical Center began about two years ago when leaders were seeking a way to improve education efforts and comply with the National Patient Safety Goal on fall prevention, explains **Miriam Wedemeyer**, OTR/L, JD, ergonomics program

director at the hospital, part of MemorialCare Health System (MHS).

"To deal with this issue, our ergonomics team formed a consortium of representatives from adult and pediatric nursing, Occupational Medical Services, the Patient Safety Committee, and adult and pediatric rehabilitation therapies," Wedemeyer says. "After some discussion about how to get people's attention and what we had already done in the past, we knew the ultimate solution was a video."

In preparation, the team members developed a storyboard presentation and piloted it at the hospital's next nursing skills education fair. From there, they located a professional production company that worked closely with the consortium to write the script, film, edit, and produce the video."The consortium itself was cohesive, and ideas flowed freely. Each constituency brought its own expertise to the table," Wedemeyer says.

The project team determined the necessary criteria for a successful training video:

- evidence-based;
- entertaining and interesting;
- simple and practical;
- brief: preferably 5 and no more than 10 minutes;
- multiple scenarios;
- repeatable by multiple trainers to reach all employees;
- consistent message, no matter who presents it and when.

Six month investment of time

From concept to finished product, the project took six months, including securing funding. The video production was funded by grants from the Memorial Medical Center Foundations. Consortium members contributed time as part of their jobs. *(See the story at right for the key information presented in the video.)*

Casting was one of the most important tasks, Wedemeyer says. The consortium wanted to use hospital employees instead of professional actors for two reasons, she explains. First, employees would give the video more of a realistic feel and make it specific to the facility rather than looking like an off-the-shelf education video.

The second reason was that the employees watching the video could see their friends and colleagues in the video, which would keep them interested and entertained, especially in the more comedic moments. *(See the story on p. 47 for more on the comedic element.)* "We wanted as many employees as possible from every one of our six hospital campuses in Los Angeles and Orange counties in the MemorialCare Health System," Wedemeyer says. "They had to be believable, yet entertaining in their roles."

The consortium also wanted a corporate executive to open and close the video, to give it credibility. MHS Executive Vice President and Chief Operating Officer **Tammie Brailsford**, RN, stepped in.

The video shoot took place over two days in an unoccupied patient room and other non-patient locations.

Prior to release, each constituency previewed the video and approved the content. To release the video, Brailsford encouraged the consortium to put on a movie premiere, complete with popcorn. "It became a celebration for the entire enterprise," Wedemeyer says. "Hundreds of employees attended the premiere, where we staged a ceremony for comical awards with statuettes and short acceptance speeches."

The video is made available on the MHS intranet and is frequently used for nursing education. Wedemeyer says it has been a huge success. The keys to the success of the project were the inclusion of multiple constituencies, sponsorship by C-suite executives, and serving up serious material with a "spoonful of humor," she says.

"More than a year later, I still get compliments from employees on how great the video is and that it has impacted their knowledge and implementation of fall prevention procedures and activities," Wedemeyer says. "Its light-hearted nature, especially when the audience knows the players, makes it a highly effective teaching tool." ■

Hospital identifies topics for falls video

While planning its in-house education video on fall prevention, project members at Long Beach (CA) Memorial Medical Center, developed a list of topics to include and criteria for effective training.

These were the important topics and messages they wanted to include:

- Always practice safe patient transfer and ambulation techniques.
- Anyone can fall. Always anticipate the possibility, and prepare a place to sit.
- Err on the side of caution. Get help if unsure of the patient's transfer status.

• Always be in "teaching mode."
• Use firm vocal commands to direct the patient.
• Don't panic, and help the patient remain calm.
• A strong directive such as "Stand!" might elicit a response that provides assistance to minimize potential injury.
• Learn the mechanics of what happens during a fall.
• Keep the patient close. Minimize reaching.
• Don't try to hold up a falling patient. Instead, allow the patient to slide down your thigh. This response accomplishes several goals. It decreases the speed of the fall, decreases the height of the fall, and decreases the risk of injury to the caregiver.
• Don't twist.
• Protect vulnerable anatomical parts.
• Protect the head.
• Target buttocks to floor.
• What to do after the fall:
— Remain calm. What's done is done. The patient isn't going anywhere.
— Get a pillow and make the patient as comfortable as possible.
— Have a nurse assess the patient for injury.
— Don't "gang" lift the patient. Get a mechanical lift device to raise the patient back onto the bed or gurney. ■

Humor helps get the message across

No one wants to sit through another boring education video, so Long Beach (CA) Memorial Medical Center decided to lighten things up with their fall prevention video.

The comedy woven into the educational elements keeps the viewer's attention, explains **Miriam Wedemeyer,** OTR/L, JD, ergonomics program director at the hospital.

"We knew we wanted it to be comedic, because people are inundated with really serious information. Normally when you put on a video, people immediately go to sleep," she says. "We needed to catch their attention with something that was interesting and entertaining even as we were presenting important messages about fall prevention."

With a topic as serious as falls and the potential injuries, the team at first wondered how they could make anything about the video funny. But then they realized that the serious information could be portrayed with a light touch simply by giving the cast the leeway to be silly and goofy in the way they portrayed some scenes, along with some props, Wedemeyer says. The fact that viewers know the actors makes it much funnier than if a stranger were performing, she says.

Several scenes in the movie portray fall hazards in the healthcare environment. They point out to the viewer what is wrong in the scenario, such as cords left exposed in the patient room or bed rails left down. A patient fall is portrayed to show how the hazards led to the fall, and then the scene is shown again with the employee responding appropriately to eliminate the hazards.

Another key part of the video illustrates what the caregiver should do during a fall. Long Beach teaches its employees to facilitate a controlled fall, which allows the patient to slide down the caregiver's leg, rather than trying to hold up the patient. Attempting to hold up the patient puts the caregiver at risk, Wedemeyer says.

"We intended this for nurses and other caregivers, but one of the things I'm most proud of is that others have seen the video and learned some of these important techniques," she says. ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.
1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

■ Do you have dirty medical devices?

■ How to do a hostage drill at your facility

■ Extra preoperative steps to prevent infections – Necessary?

■ Simple 5-item universal checklist as a discharge protocol

CNE/CME OBJECTIVES

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

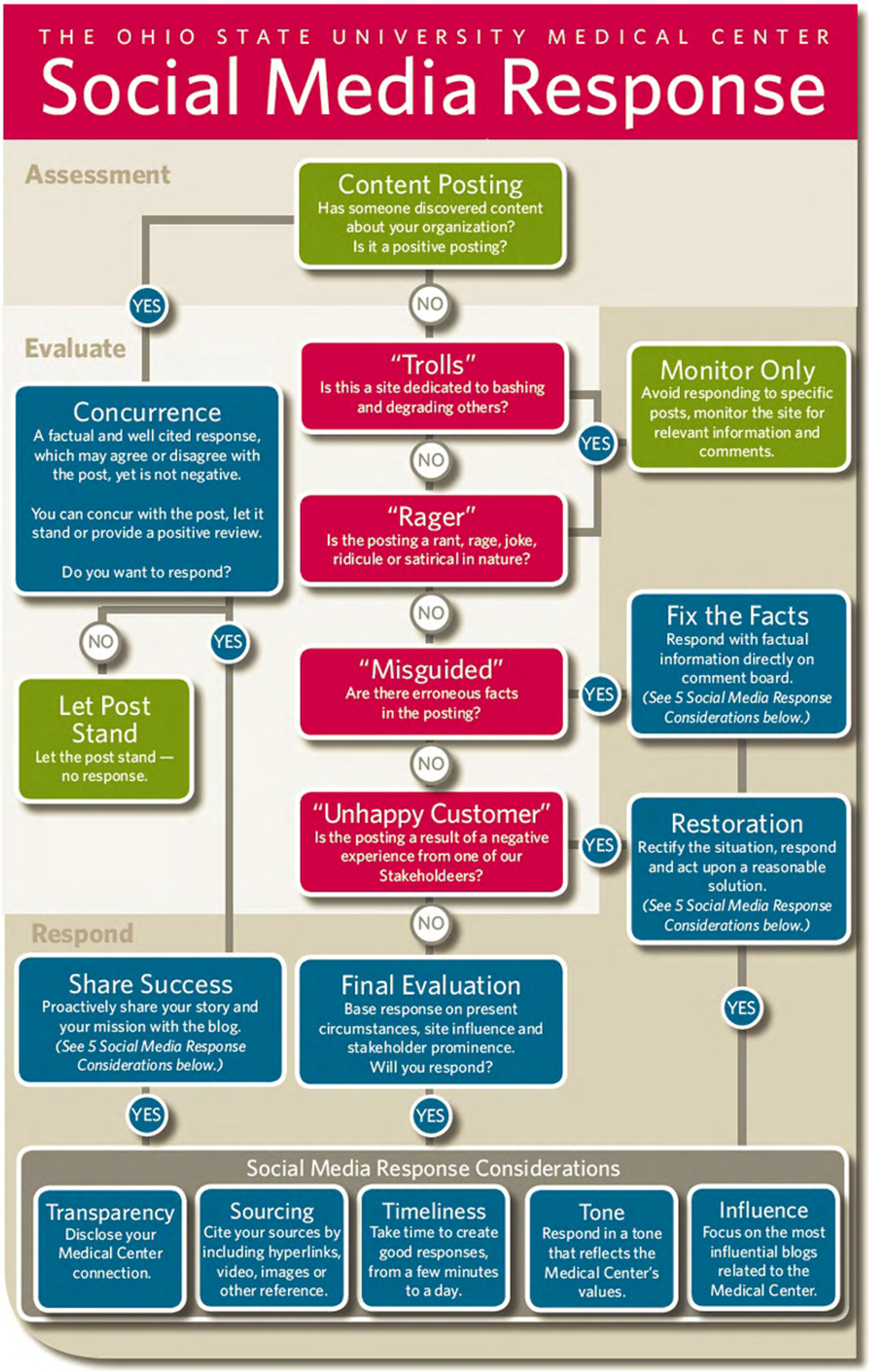
CNE/CME QUESTIONS

1. Why should you not ask patients to sign a presurgery waiver that says they won't post negative comments after surgery, according toBarry Eppley, MD, plastic surgeon?
   A. Many legal experts believe it is illegal.
   B. It gives a poor impression of your practice.
   C. A and B
   D. Neither A nor B.

2. What can often be more damaging than critical comments posted online about your facility, according to Ben Dillon,vice president and eHealth "evangelist" at Geonetric.
   A. Ignoring the comments.
   B. Not monitoring the comments.
   C. Reacting inappropriately in a public venue

3. An article in the journal Perfusion documented that what percent of technicians who monitor bypass machines had talked on cell phones and texted during heart surgery?
   A. 55% admitted to talking on their cell phones, and 50% said they had texted during surgery.
   B. 40% admitted to talking on their cell phones, and 30% said they had texted during surgery.
   C. 25% admitted to talking on their cell phones, and 15% said they had texted during surgery.
   D. 10% admitted to talking on their cell phones, and 5% said they had texted during surgery.

4. In developing the fall prevention video at Long Beach Memorial Medical Center, what did the project team determine was an important element for success?
   A. A light, comedic touch to keep the viewer's attention.
   B. A focus on data and statistics showing the risk of falls.
   C. A detailed explanation of the employer's policy on fall prevention.
   D. A review of workers' compensation cases stemming from falls.



SOURCE: Wexner Medical Center at The Ohio State University, Columbus.

THE OHIO STATE UNIVERSITY MEDICAL CENTER POLICY AND PROCEDURE MANUAL

Title: Social Media

Prepared by: Social Media Policy Committee

Authorized by: *Original signed by the:*

Vice President for Health Services
CEO, The OSU Health System
COO, The OSU Medical Center

CEO, James Cancer Hospital and Solove Research Institute; Director, OSU Comprehensive Cancer Center

Executive Dean for Health Sciences, Vice President for Health Sciences, Dean, College of Medicine

POLICY

Social Media are works of user-created video, audio, text or multimedia that are published and shared in an electronic environment, such as a blog, wiki, instant messaging, email, or video hosting site.

Social Media presents opportunities to engage The Ohio State University Medical Center employees, patients, and community, in conversation to improve people's lives by personalizing health care.

Our policy is that you, the employee, may use Social Media for personal use only during non-working time and in strict compliance with all other terms of this and other Medical Center and University policies.

PROCEDURE

Keep in mind that conduct that would be illegal or a violation of a Medical Center or University policy in the "offline" world would still be illegal or a violation of the policy when it occurs online. While you are entitled to express your opinions and ideas, you have a responsibility not to violate Medical Center and University policies or negatively affect the operations of the Medical Center.

SOURCE: Wexner Medical Center at The Ohio State University, Columbus.

THE OHIO STATE UNIVERSITY MEDICAL CENTER POLICY AND PROCEDURE MANUAL

Title: Social Media

Following the policy will ensure that your actions reflect our core values of integrity, teamwork, innovation, excellence, and leadership while exhibiting a level of professionalism that our customers expect and deserve.

When on-line you are speaking in your personal capacity unless you have prior authorization from your manager or Communications and Marketing to speak for the Medical Center, or hold such position as Media Relations that is preapproved to speak for the Medical Center. This Policy requires adherence to the Social Media Participation Guidelines. The Guidelines are administered by Communications and Marketing.

The Medical Center reserves the right to restrict and monitor employee's use of social media.

What You Should Do:

1. Be smart. Be respectful. Be human.
2. Be authentic. When you post or comment in social media always state your name.
3. Be transparent. State that it is your opinion. Unless authorized to speak on behalf of the Medical Center you must state that the views expressed are your own.
4. Be careful. Protect what personal information you share online.
5. Be responsible and act ethically. When you are at work, your primary responsibility is the work of the Medical Center.

What You Should Never Disclose:

1. Confidential OSU information: If you find yourself wondering whether you can talk about something you learned at work -- don't.
2. Patient information: Do not talk about patients or release patient information.
3. Personnel Information: Do not refer to your co-workers in an abusive or harassing manner.
4. Legal Information: Do not disclose anything to do with a legal issue, legal case, or attorneys.
5. Materials that belong to someone else: Stick to posting your own creations. Do not share copyrighted publications, logos or other images that are trademarked. If you do use someone else's material, give them credit. In some cases you may also need their permission.

SOURCE: Wexner Medical Center at The Ohio State University, Columbus.

THE OHIO STATE UNIVERSITY MEDICAL CENTER POLICY AND PROCEDURE MANUAL

Title: Social Media

Consequences:

Just in case you are forgetful or otherwise do not follow the policy and guidelines, here is what could happen:

1. You could face personal legal troubles and corrective action up to and including termination;
2. OSU could face legal trouble with patients and customers.

All violations must be reported to your manager.

RELATED POLICIES

Finally, here are some of the related policies you must know and follow.

02-20 Sexual Harassment
02-24 Workplace Standards of Conduct
03-22 Patient Confidentiality
03-31 Ethics
03-37 Photography of Patients
07-03 Electronic Resources

The Ohio State University Medical Center Standards for Employee Conduct

The Ohio State University Responsible Use of University Computing and Network Resources

The Ohio State University Web Policy and Guidelines

The Ohio State University Whistle Blower Policy 1.40

SOURCE: Wexner Medical Center at The Ohio State University, Columbus.