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Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, we lost a visionary leader last week. People from around the world mourned the death of Steven Jobs, Apple Co-Founder, who died from complications with pancreatic cancer at the age of 56.

Margaret Flinter: Well, Mark, he was a true visionary and died too young. As so many have said, he imagined tools and products that make life more fun, more interesting, more rich even before we knew we wanted those products. And it felt like the world really recognized this loss across the globe, very unusual for the head of a corporation to elicit such emotion and sorrow when they pass.

Mark Masselli: It really did. Within an hour of the news of his death, people were posting testimonials and homemade obits on Twitter and Facebook; there were shrines at Apple stores and outside his Palo Alto home, lots of them included clever visuals incorporating Apple themes and products.

Margaret Flinter: Well, his legacy lives on. And in the world of health reform and its legacy, last week, there was a new development, a step that moves the federal government closer to defining what is an essential benefit. Really the first time that this has been attempted at a federal level and this is in the health insurance exchange programs that will offer coverage in 2014.

Mark Masselli: That's right. The Institute of Medicine released their report that outlines how the Department of Health and Human Services should develop these benefits. It didn't tell the administration which types of benefits should be included in plans but how to define the minimum benefits. Overall, the report urged HHS to weigh cost in deciding essential health benefits.

Margaret Flinter: Yeah, and cost is one consideration but not all of it. And as I said, that the federal government should allow those states that administer their own health insurance exchange, which I think is actually going to be most of them, to be able to make changes on that list of essential benefits as long as they are consistent with the guiding principles of the Affordable Care Act which is about prevention and also comprehensive benefits. And I think this is especially important because the state of the science changes and evolves all the time around effective treatment and screening and diagnostic tests.

Mark Masselli: And those rules are expected to come out some time next year so more on that to come in the future. Turning to our today's guest, we are joined today by Social Media expert Lee Aase. Lee is the Director of the Mayo Clinic

Center for Social Media. We are happy he can be with us today to share some thoughts about engaging patients and providers and improving patient satisfaction through social media.

Margaret Flinter: And no matter what the story, you can always find all of our shows and hear more about us by Googling CHC Radio.

Mark Masselli: As always, if you have feedback, email us at [www.chcradio.com](http://www.chcradio.com), we would love to hear from you. Before we speak with Lee Aase, let's check in with our producer, Loren Bonner with Headline News.

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Loren Bonner: I am Loren Bonner with this week's Headline News. Healthy People 2010, a national initiative to improve the health of all Americans hasn't lived up to its goals. Experts conducting a final review of the results found that minority and low income groups continue to be less likely to have a regular source of health care when compared to the general population. Although there have been efforts over the past decade to remedy the situation, this and other health disparities persist across race, ethnicity, income level and education. On a more positive note, progress has been made in other areas. Life expectancy at birth went up a year from 76.8 years in 2000 to 77.8 years in 2007 and rates of death from coronary heart disease, stroke and other illness decreased over the course of the decade but health disparities remain a major problem. The U.S. Preventive Task Force, the Federal Panel that regularly assesses preventive medical care downgraded its recommendation for PSA Testing for Prostate Cancer. The 16 member panel says that most men should not routinely get the blood test to check for prostate cancer because the exam does not save lives instead, it leads to unnecessary anxiety, surgery, and complications. In other words, the evidence concludes that the risks appear to outweigh the benefits for those who are showing no signs of the disease. Although the recommendation is likely to create controversy, the influence of the panel's recommendations are being enhanced by the new Federal Health Care Law which will base some of its requirements on the group's ratings.

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Mark Masselli: Today, Margaret and I are speaking with Lee Aase, Director of the Mayo Clinic Center for Social Media, a first of its kind Social Media Center focused on health care. Welcome Lee.

Lee Aase: Glad to be with you.

Mark Masselli: I know many of our listeners have heard of Mayo Clinic and it's known as being a leader in health care in the country and many people from around the world travel to your locations in Minnesota, Florida, Arizona for

treatment. What people might not know is that Mayo Clinic was one of its first to use social media to empower patients and cut red tape that gets in the way of treatment innovations. Lee, was there a moment when you realized that your website was changing the experience patients were having in receiving their health care?

Lee Aase: Well, I think I mean there have been a few little milestones along the way. I think when we did our first podcast in 2005 we used it as a way of delivering the audio files that we already had on our website but on a subscription basis. We had had these audio files on our website already and were averaging about 900 downloads a month. And in the first month of our podcast we got featured in iTunes Podcast Directory and we saw our downloads go from 900 a month to 74000 in a month which just kind of got our attention. So that was an early sign post I guess along the way. I think what we have seen as a gradual evolution where we just look for new applications, for ways to provide more in-depth information to patients and we have definitely had some excellent stories come out of that where people have told us that they found a 10 minute YouTube video that really explained a condition, a really rare condition that they have in a way that was helpful to them and ended up coming thousands of miles here to be seen.

Margaret Flinter: So Lee, many different technologies of course come under the umbrella of social media from podcast as you referenced to YouTube videos, blogs, Twitter, Facebook. And we have tended up until now to talk about using this as vehicles for us to push information out there, push stories, push health care information out but equally important seems that patients are beginning to use the technologies to tell their stories which we then can share with other people. Could you tell us a little bit about what the Mayo is doing to engage patients in telling their stories that can then be shared with other patients?

Lee Aase: Well sure. One of the things that probably our flagship blog is the one called Sharing Mayo Clinic, which is a blog that we launched in January of 2009 as a way for patients to share their experiences with others, to tell their stories, and also for our Mayo employees to tell stories about why they appreciate working at Mayo and why they believe in their work and why they enjoy it. So that's one key way and so either through the comments on the blog or by sending us a story that they ask us to post for them we enable that. But just in July of this year we created our Mayo Clinic Network for patients that's called, it's at [connect.mayoclinic.org](http://connect.mayoclinic.org). And as of right now I think we have about 7100 people who have joined that and this is much more of a Facebook kind of experience only not on Facebook, a place where people can have an identity that's either their first name last name or else it can be they can use the screen name if they want some additional privacy. But they can talk about, they can discuss their stories, they can discuss and ask questions and so that's the next step in making a more highly interactive environment.

Mark Masselli: Lee, you know at the Community Health Center here in Connecticut we are very proud of our residency programs. We have a couple of them. One was the First Family Nurse Practitioner Program in America and now we are just opening up a post-doc in psychology residency. But you, my friend at the Mayo Clinic, are kicking off a social media residency this month. Can you tell us more about this initiative and what led you to establish it?

Lee Aase: The 17<sup>th</sup>, 18<sup>th</sup> and 19<sup>th</sup>, we are holding a three-day conference that we are producing in conjunction with Regan Communications that is sort of your traditional conference where you hear presentations for people who are doing interesting things. Then we have our member meeting for the Social Media Health Network. But what we are doing at the end of the week is instead of kind of the week long boot camp, what we are calling the two days is Social Media Residency. And we are instead of using the military boot camp metaphor, we are saying let's do it like medicine. I mean we are going to have residency, we have residents, we have matching like match -- used for residency. And then also, we have to go in kind of late into the evening. I mean they will be probably wrapping up around 10:00 or 10:30 at Thursday night and up at 8 o'clock the next morning and at it again. But a chance to have a much more hands-on interactive small group of experience. So we are limiting it to no more than 80 participants for that and we will have at least one chief resident or experienced person per table of eight so that it will be not just the beginners kind of how do you get started with things but much more, more advanced just as medical residency is more advanced than medical school, this is that context of how do you apply this and how do you think strategically about using these tools in an organization.

Margaret Flinter: So Lee, the richness of learning and support that patients derive from social media technologies, especially, when organized in a system like yours is pretty obvious. But it also seems it offers enormous benefits for learning to providers, clinicians, health care professionals as well. We hear all the time, we said often times that the length of time between the discovery of a better way to do things and the actual implementation and practice is 16 or 17 years. And I have heard you said that social media has the potential to shorten that gap considerably to get that information out sooner, more widely spread, tested and adopted. What's your experience been at the Mayo, presumably you have all the specialists who could just turn to each other but are they also learning from people around the globe and sharing with people around the globe new best practices?

Lee Aase: Well certainly. I mean we have got a case study that is an example of how that can happen and it does come based on a discovery here at Mayo Clinic of kind of wrist tear ligament, a ligament tear that one of our orthopedic surgeons discovered back around 2001 or so. And it's kind of a long story but what it comes down to is that through some of the social media platforms being able to and then telling the story through our mainstream media as well and how those have interacted between the social and the mainstream media. He sent me an

e-mail last year talking about how he had been invited to present at a plenary session of American Society for Surgery of the Hand and he specifically said social media has driven this into practices in less than two years when it takes 17 years on average, that he is able to connect much more and it's also harnessing the patients who have the condition and enabling them to help spread the word as well. I mean I think we are so early in this in terms of realizing the potential but that's why we have a Center for Social Media and why we are going to be naming a new medical director within the next month because we want to have a physician with dedicated time to be able to help us explore how these tools can be used not just kind of in the PR marketing realm and as you said it's pushing out information but how it can help medical research and education, both patient education and medical education in CME as well as research and then being also applied in improving clinical practice. So we are excited at how things are developing.

Margaret Flinter: This is Conversations on Health Care. Today, we are speaking with Lee Aase, Director of the Mayo Clinic Center for Social Media. Lee, many providers in health care institutions are reluctant to use social media. I guess that's sort of euphemism for saying that the battle lines are drawn within organizations, those who are trying to protect the organization in the name of patient privacy and network security. And on the other side 500 million people on Facebook sharing very personal information and very comfortable tweeting, texting all the time. That's a pretty large divide. How have you managed the conflict at Mayo Clinic and can you give some advice to organizations out there who are trying to figure out how to bring those two sides together?

Lee Aase: Sure. Well, one thing I would emphasize is the continuity between the way people have interacted for generations, for centuries, for millennia. I mean that has all been word-of-mouth, and these electronic tools just make that word-of-mouth spread further and faster. I think the point that I emphasize with those who are reluctant to be involved in these social platforms is that whether you are involved or not, the rest of the world is and that if you just Google your name, or Google your organization's name, you may not like what you see. And part of the reason you might not like what you see is because you haven't put anything out there in these spaces that enables people to react to. And I know that one of our national peers, if you were to Google or go on to YouTube and search for Cleveland Clinic back 4-5 years ago, what you would see was a series of videos by a disgruntled patient that showed up on the first page of results. The way to resolve that is to put up some videos of your own so that then when people are searching for your organization's name, they will see it. So that's one part of it. The other part of it is that patients are thirsty for information and actually nobody cares about health care till they get sick. But once they get sick then they are sponges and they want to find out everything they can and they gravitate online and they are going to go there. And so it's really an ethical and moral obligation from our perspective that you have qualified medical voices participating in those conversations too.

Margaret Flinter: I guess that would lead into something I have been thinking about relative to your work which is that there are thousands, probably tens of thousands apps to engage with your health websites to learn about your condition, online chat rooms and support groups for people who have various issues. And we have seen that Mayo Clinic like the Cleveland like we like to think our Community Health Center is a bit of a good housekeeping seal of approval, right, the \_\_\_\_\_16:54 that this must be reliable information. So maybe you can just share with this a little bit as other organizations large and small are thinking about going down this path what's the organized structure for vetting, for deciding really what content goes up, for involving consumers in helping you think what information is understandable and important so that maybe you can share some of that structure with us.

Lee Aase: Well sure. A big part of what we are doing is providing information, video interviews for instance with subject experts. We have subspecialty expertism so they are talking about an area in which they are really well-versed and really it's their particular area of focus. So it's not just a specialist but a sub-specialist. And what we have found with that is that the bar for creating content is much lower than it used to be because you have consumer grade video cameras that shoot HD, you can actually produce something that's pretty nice without a lot of expense. And so part of what we do is we look at what the interest of the researchers are, what the interests of physicians are that are willing to be out there talking about their particular condition. And as I mentioned before, people don't care about health until they get sick and so it really is a matter of being able to produce a lot of content and then you sort of find out where it goes from there. I mean as people comment on it, as people share then the content that is of the most interest, finds the people who are interested in it. One of our best examples is a video on myelofibrosis that is 10½ minutes and it's Dr. Ruben Mesa from Arizona Campus talking about this. He most likely did a focus group about what disease would you like to hear about; what we said was he had this passion for wanting to be able to communicate about myeloproliferative diseases. But interestingly then online groups that are already out there support groups that have formed around these diseases, somebody found a video and posted it within their network and it's got more than 10,000 views now. So as I said it wasn't we are going to go review our top marketing priorities or **not going** to create a focus group to determine what videos would be most interesting. The most important thing I think is the provider, the physician passion for the topic and what they are able to do now is to connect with those people who share that same interest in a way that was previously impossible.

Mark Masselli: That's kind of the interesting. It's sort of good story telling which has a long tradition of how one shares news, history, creates lore is now, I would sort of substitute it with the word video that you had and it's really about telling good stories. And so how do organizations think about telling those good stories, it's not always the case that you can just put somebody in front of a video and

voila, you will have some miraculous response from the public. And this is of particular concern to you because Mayo is known as an institution that treats rare conditions and so you really want to reach out effectively to that broad population. So what coaching are you doing on the side or how are you creating that ambiance of storytelling?

Dr. Lee Aase: Well a big part of it is to not be too produced. So I think to the extent that a story, a video seems slick it probably is counterproductive. It's counterproductive in two ways, it costs more to do that and then secondly, it doesn't seem maybe as genuine and authentic. I think what we do with our physicians, we ask them to pretend they are talking to somebody in the office who you just diagnosed with this condition or you are trying to provide an overview for an interested family member. And I think we do look for physicians who have that passion and have that ability to tell a story but we do have training and coaching that we do with this. But part of it is just honed through seeing lots of patients and having to have those interactions and it does provide through the consumer grade camera, it does a real window into what the experience is like. In fact we have had patients come to our physicians and say wow! you are just like on your video which is exactly what we are looking for, is that for 100 years people have had an experience at Mayo Clinic and gone home and told their family and friends and that word-of-mouth has been really important. This is a way for people to get a direct peek into that experience because it really is all about that doctor-patient relationship and how they interact.

Mark Masselli: Lee, we like to ask all of our guests this final question. When you look around the country and the world, what do you see in terms of innovations and who should our listeners at Conversations be keeping an eye on besides keeping an eye on you?

Dr. Lee Aase: Well yeah of course. I mean I was able to attend the Medicine 2.0 Conference at Stanford just a week and a half or so ago and heard some great presentations there. I think Bertalan Mesko, who goes by the Twitter handle Berci, is doing some really great things with the platform called Webicina I think. But Berci is a physician who is going for a PHD in genomics I think and he is creating an online platform, created a platform that I think now is in about 18 languages for sharing medical information. I think he is doing some really interesting stuff there and his whole idea is to make things available for free for everyone and being in 18 languages already I think is pretty amazing.

Margaret Flinter: Great. We will follow up on that one day. Today, we have been speaking with Lee Aase, Director of the Mayo Clinic Center for Social Media. Lee, thank you so much for joining us today on Conversations.

Dr. Lee Aase: Glad to be with you, thank you so much.

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Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. This week's bright idea is about a preventive approach to emergency care. In cities across the country, community paramedics are now making home visits to elders and chronically ill patients in an effort to reduce 911 calls, emergencies, and hospital admissions. Around 40 million 911 calls are placed each year in the United States. By bringing paramedics to high risk persons on a preventive basis, the thought is that some of these emergencies can be prevented. In a 15 city area centered in Fort Worth Texas for example, 21 people accounted for more than one percent of the total 911 call volume. So in 2009 , paramedics went out into the community to visit these people and see if they could change that. More than 1000 calls a year were cut with substantial savings to the system. The push for more community paramedics is fueled in part by cash crunch to public sector and looming changes to Medicaid under the new Federal Health Care Law. HRSA, the Federal Health Resources and Service Administration is expected next year to release a system for measuring the performance of community paramedics which could, for the first time, standardize training and create a system that would be able to function alike in rural and big cities. Working with paramedics to create a health care system, that's focused on reducing emergencies and improving safety, now that's a bright idea.

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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