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Inside

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Meeting the press: Tricks of the trade for giving interviews

Participating in media interviews can result in positive PR for your ED

Emergency department (ED) managers, nurses, and physicians should actively participate in media interviews, urges **Robert Suter, DO, MHA, FACEP**, regional medical director for Questcare Emergency Services in Dallas, TX. "In the age of mass media, the image of your ED and even your entire hospital can hinge on an eight-second sound bite," he says.

In most people's eyes, news reporters are viewed as impartial observers, Suter notes. "If they are talking to you, you gain enormous credibility as an expert. This is credibility that you cannot buy," he says.

Giving interviews is a key advantage in any plan to improve the reputation and marketability of your ED, Suter explains. "Further, administrators know this—they know that you are getting valuable exposure for the hospital, and credibility that only you as a clinician can obtain for them," he says. "They appreciate that, and will remember it when your contract or other issues are discussed."

ED staff are prime candidates for major media stories, stresses **Nan Tolbert,** director of training at Susan Peterson Productions, Inc., based in Washington, DC. "When we train ED physicians, we're always aware that they're the front-line people on cases that could put them on the national news overnight," she says. "For example, when kids overdose on heroin in middle class neighborhoods, or the school shootings occurred in Jonesboro, AK, the first people the media wanted to talk to were the ED physicians who treated those people."

ED staff are involved in cases that reflect trends in society, Tolbert notes. "From everything from health care access to lifestyles, they have the potential to be quoted in media interviews," says Tolbert. "There are so many issues that ED physicians may face, such as access to emergency care, which are timely and on many people's minds."

Overcome defensive attitudes about the news media, says **Peggy O'Leary,** senior medical reporter for WRDW-TV in North Augusta, SC. "There is a general notion that reporters are out to get someone. That might be true for some, but in medical reporting there is genuinely an attitude to help and educate the viewers," she explains.

Your community is eager to hear from you, says O'Leary. "Medical stories come second on a list of what viewers want, with weather as number one,"

she says. "So don't hide when your local TV station calls. It is a great chance for you to reach an interested audience."

Here are some tricks of the trade to consider when giving interviews:

Keep it simple. "Be as upbeat as possible, and speak in short sentences," says Suter. "If a great key concept is buried in a 30-minute rambling sentence, they are not going to be able to use it. You are just making it very hard for the reporter to get your message across."

If you lose an audience with technical terms, the editor may be able to cut some material to salvage the interview, notes Suter. "They will edit you so you don't appear to be rambling. But they may have to use something that wasn't important to you, just because it was shorter," he says. "It's the editor's job to cut, but if you make their job difficult, it's the last interview you'll be asked to do. Your name will come up at the station and they'll say that's the guy who used all that fancy medical terminology."

Be personable. "If you're on TV, look into the camera and speak naturally," says Suter. "If you're talking about a tragedy, complement other providers involved in care. If you're doing a routine story, do not appear overly serious."

Do whatever is necessary to feel comfortable, stresses Suter. "Try to lighten up and relax in this tense situation. Tell the reporter a joke or make small talk as he or she is getting ready to shoot, or imagine how neat your kids are going to think it is to see you on TV, and concentrate on that," he says. "If you can convince yourself that doing this is fun, you are going to be fine."

To appear down to earth, include personal experiences. "When you prepare two or three key talking points in advance, have one or two strong examples from your own real-life experience to back up those key messages," suggests Tolbert.

During radio interviews, act as though you're on camera. "With radio, your voice becomes particularly important. If you behave as if you're on camera, it helps your voice stay animated and energetic," says Tolbert. "Radio studios are filled with distractions, such as the interviewer handling the phone lines. To stay focused, make eye contact and pretend you're having a conversation with the interviewer. Or give yourself a point of focus, and talk to the radio microphone like you're talking to one person listening to you."

Use descriptive language. "Use good examples to help a radio audience visualize what you are talking about," Tolbert says. "That keeps listeners engaged and makes you memorable. Talk like you are having a one-on-one conversation. That's the way a person at home should feel when they see you on camera."

Imagine you are talking to a family at home. "You talk to families all the time, so think of how you'd explain something to them—not [an explanation] filled with jargon that confuses them, but something simple they can hold on to," Tolbert says. "ED physicians and nurses already have these skills, because they do this every day."

Be reachable. "Answer requests for interviews immediately, and give reporters your card with your pager number for future stories," says Suter. "Don't leave a reporter in a lurch before a deadline. If a reporter knows that you will drop everything to help him or her meet a deadline of less than an hour with no notice, they will come back to ask for other stories in the future."

Be prepared. "Try to review the latest medical information on the topic before the interview. Keep references in the ED or your office," says Suter. "Do not speculate on an answer or state anything that you do not know. We all want to be responsible and don't want to spread misinformation. So if you don't know the absolute latest information, then you have a responsibility to look it up."

However, the amount of preparation you need depends on your personality type, says Suter. "To a certain extent, you can never be too prepared. But overpreparation causes some people to tense up," he notes. "If you have more stress from the preparation [than the interview itself], you need to stop. But if you are somebody who gets more relaxed from preparation, you should do that."

Don't worry about making inconsequential errors. "Remember that even if you make some sort of small mistake, you are not taking your oral boards. Ninety-nine point nine percent of the people you are talking to

COMING IN FUTURE MONTHS

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- HCFA bulletin alert
- New nebulizers for children

know less about the subject than you do," says Suter. "No housewife is going to be calling the TV station to call you a fraud. You are educating the community, not presenting your thesis for the Nobel Peace Prize."

Keep in mind that your level of expertise is likely to be sufficient for the purpose of educating the audience, says Suter. "I was once asked to give an interview on lead poisoning. I am not a toxicologist, but I briefly reviewed the literature and gave accurate information on the level they were seeking," he recalls. "The network loved the interview and it was shown many times, because they felt it was a valuable community education piece for people who lived in the inner city."

Don't get defensive. "Don't scowl or say 'no comment,' if confronted with a situation that may make your ED look bad," says Suter. "If the topic is a specific situation where the community is challenging your judgment, you will probably have an idea the reporter may be critical. So, hopefully, you won't get blindsided. That stresses the importance of staff letting the [public relations] director know immediately if there are any issues which may come up."

To avoid being caught unaware, formulate generic statements in advance, Suter suggests. "A better approach would be to take more of a high road. Explain that, because of patient confidentiality issues, we can't discuss that at this time. Or say 'our ED is always committed to providing the highest possible care to patients.' If all else fails, make a general statement about hospital philosophy until everyone can regroup and address a situation."

Counter negativity with simple, positive statements. "Our tendency is to want to defend ourselves, but if you do, you buy into their negative message," says Tolbert. "Never allow reporters to put loaded words into your mouth, such as accusations or insinuations. You can say, that's not my area of expertise, but I'll be happy to put you in contact with so-and-so, who can give you the information you need."

Don't criticize others. Don't be negative or critical of other providers, says Suter. "This can create a situation that ruins relationships for years," he stresses. "You may be talking about a case where a patient was seen at a small hospital and taken to your big hospital. Maybe the care really was substandard at the other place, but don't say 'the patient came here on death's door thanks to the care they received elsewhere.' Don't promote your hospital on somebody else's back. It just makes you look bad."

Involve your hospital's public relations department when necessary. "When it comes to dealing with the media, nobody likes the lone ranger," says Suter. "When it reflects on the hospital's image, the [public relations] PR department will want to be aware of it. They want the same things you want, so work in partnership with them."

Avoid legal risks. "Basically, stay away from anything that would be a negative comment about clinical care. That includes getting into any details if there is a negative outcome, or discussing an approach to care that might be controversial," Suter warns.

Be discreet. "Don't violate patient confidentiality or give information which might hinder a police investigation (if a patient was a crime victim) or endanger anyone," Suter warns. "If you identify the type of weapon used in an assault, it may be something only the criminal knows. If you put it out on TV, that makes it harder for it to be used as evidence in court."

Don't be overzealous. "Don't allow filming to significantly affect patient care," says Suter. "Most EDs were not designed to be TV sets, and they are almost invariably built too small. Given the fact that there isn't a lot of breathing room, if you start putting cameras and cables all over the place, it can really become a major problem."

Be aware of how filming is impacting staff, Suter recommends. "You know that filming is affecting patient care when you start getting glared at by people on duty. At that point, you have to be prepared to call it quits," he says. "Normally, you will get more problems from nurses or staff physicians than you will from anybody else. Patients generally don't complain because it's sort of an event to see TV crews."

An alternate arrangement may be necessary. "A TV crew will want action in the background and that's fine if it works, but you should have a backup plan," says Suter. "Maybe you have an overflow area only used during busiest times where you can film. Get the nurse manager and secretaries to create some action behind the scene and let the people taking care of patients do it in peace."

Encourage staff to participate. "Most staff like being interviewed, but a large minority do not want to be, no matter what," says Suter. "Unless someone is in a job where this skill is critical, I suggest that you let people determine their own comfort level and support them."

Still, training should be offered to staff members. "For those who are interested but afraid, there are a number of media training companies, workshops, and guides that can be used," says Suter. "As long as the story is positive and the opportunity to 'look good' is there, most people like seeing themselves on TV or their names in print. This is really all the incentive you need."

Help develop stories. "Reporters get writer's block at times. If you make it a point to toss ideas their way,

this develops more opportunities," says Suter. "Do this even if you are not the person that they should interview. Maybe you read an article in a journal about a subject that is relevant in your community, or maybe you went to a seminar and heard about new cardiovascular drugs in development that sounded interesting."

Develop relationships with reporters. "Invite reporters to educational events, and occasionally to social events if you see an appropriate tie-in," says Suter. "Try to get to know the reporter, what interests them, and, especially, any common interests."

Avoid technical terms. Use laymen's terms. "Remember to use simple English and not a whole lot of jargon," says **Robert Hockberger, MD, FACEP,** chair of the department of emergency medicine at Harbor-UCLA Medical Center in Torrance, CA.

Most news copy is written at the eighth-grade level, says O'Leary. "This makes stories short and simple so everyone can understand," she explains. "This may be the hardest part for highly educated medical personnel to achieve. But try to relate to telling a child about the procedure on which you are being interviewed."

If the topic is a fairly complex procedure that you are using in your ED, find a way to simplify it for the audience, says O'Leary. "Break it down and keep it simple," she recommends. "You can probably tell when you have lost the reporter. That means you have lost the audience as well."

Learn the art of soundbites. "Try to give concise answers in complete sentences," says O'Leary. "This sounds simple but rarely happens. You may think of an example in the middle of your explanation so you start with that, never finishing your explanation. So give complete thoughts and then move on to examples or other thoughts."

The idea is to quickly convey information to get your point across, says O'Leary. "Of course, we are not looking for 'yes/no' answers. But we are looking for good, to-the-point soundbites of about 7-16 seconds for each question asked," she says. "Don't panic, we will ask more than one question."

Be realistic about how much information you can convey, Suter advises. "Even in an hour-long segment, you will probably only get maximum of three points across to people," he says. "In a short interview, you will probably only get one point across. So you have to focus on that single point, and accept that you won't be able to discuss the issue in depth."

Find out who you're dealing with. "When a reporter calls you, always be sure to find out who they are, what publication they represent, why they have called you about the issue, what is the issue they want to talk about, and do they have some preconceived notion or slant," says Hockberger.

Get as much information as you can, Tolbert recommends. "Do this by interviewing the reporter before they interview you," she says. "Ask what information are they looking for, when is their deadline, [who is] the audience, where the interview will take place, will it be live or taped for editing later, [and] is it part of a larger story?"

Buy yourself time. Try to avoid giving an on-the-spot interview, Hockberger recommends. "Reporters can't wait forever, but if it's in any way possible, schedule the interview in the next day or two," he says. "It's an immense advantage to call the PR people at ACEP for information. They can tell you if they deal with this magazine frequently, and if they are usually supportive of our issues, or sometimes it's the opposite."

Get timely information. ACEP can fax you copies of policies or talking points about controversial or timely, legislative issues, Hockberger notes. "Once you have received that information, try to sit down and figure out one or two soundbites you'd like to get into the interview when you get the chance," he says.

Give a statistic and anecdote. "Reporters don't want to be overwhelmed with data, but you should have at least one statistic to support the message you are trying to convey," says Hockberger. "Also, think of one anecdote, such as a conversation you had with a legislator. Reporters usually like those more than statistics."

Know when to go off the record. "If a question posed to you is confusing, it's fine to pause and ask for clarification," says Hockberger. "You can also say, that last question took me by surprise, and I'd like to go off the record and not be quoted during that period of time."

In this situation, clarify that your response is just for background. "Explain that this topic wasn't what you told me we would talk about," says Hockberger. "Trying to skirt the issue or address it in a superficial way can get you into trouble."

Don't repeat negatives. "A classic example is a reporter saying in the middle of an interview, isn't it true that most patients seen in EDs really shouldn't be there? Or, isn't it true that most physicians managing EDs are in fact unqualified?" says Hockberger. Listen to what they say, then give an answer which doesn't repeat the negative statement, Hockberger recommends. "Instead, come back and say, I believe that physicians are qualified," he says. "Give the answer voiced in a positive way, rather than in a negative or defensive way."

Don't be afraid to position yourself as an expert. "It's a difficult balance. On the one hand, you don't

want yourself held out as an expert in an area you know nothing about," says Hockberger. "But on the other hand, very few people are world authorities on a given topic. So get out there and take a chance."

Don't memorize what you plan to say. "One or two sound bites, a statistic, and an anecdote is all you need," says Hockberger. "Then go in relaxed and comfortable and try to respond to the questions. But as you answer, always look for the opportunity to insert the things you want to get across."

Learn what will be covered in advance. "It is absolutely fair for you to say, 'what is it we are going to be talking about, what are you trying to get from me?' Then if they spring something on you, you can make a decision not to answer or go off the record," says Hockberger.

Don't go off the record on camera. "One thing you have to be careful of is being on camera while you are asking to go off the record," Hockberger warns. "We have all seen 60 Minutes and how bad you look when you walk away in the middle of the interview. However, that usually isn't the way people are treated."

Here are some types of news stories you may be asked to participate in:

National news stories. "For most ED directors, this is a result of community bad luck, as the usual lead is a tragedy," says Suter. "Those with an excellent track record with local media may have a shot at other stories, but this is unlikely."

Your relationships with a national media personality, a network medical reporter/physician, or your specialty association can give you an edge. "For example, ACEP has a network of designated spokespersons that reporters can be referred to on almost every topic," says Suter. "The good news is that, while network coverage is great, your administrator and community are happy with local coverage. After all, people two states away are not going to come to your ED."

Resist being a publicity seeker. "Sending your demo tapes to Dan Rather's producer probably isn't going to help much," says Suter. "Exposure to national media will come from having participated in an event or being a recognized expert on a given issue. Each of the major networks has a medical reporter who coordinates stories. Having a relationship with that individual is good, but that may be difficult without being overly self promoting."

Holiday stories. "Expect a call almost every holiday," says O'Leary. "From firework safety before the Fourth of July, to drinking and driving during the holidays, these are all local angles of big stories that you can offer insight on, because you've seen what happens."

Don't shy away from these stories, says O'Leary. "You are reaching that larger audience, and it could just maybe cut down on your workload if they get the message," she explains.

This is an excellent opportunity to insert prevention tips appropriate to the season, O'Leary notes. "When they want to talk about firework safety, also suggest a little sunburn prevention, how to make sure that BBQ will not make you sick, or even more serious subjects like drowning."

Call the station a week before the big holiday and suggest a few things, says O'Leary. "Then they can plan ahead and won't be calling you at the last minute, or calling your competition. Of course, this is if you have time," she notes.

Major disasters. If a major disaster strikes, you will probably be called upon to comment, says O'Leary. "For instance: How would your ED handle the Oklahoma City bombing? What happens when the president has been shot?" she asks. "These may seem far out, but your local station is looking for a way to tie you in, so jump at it. It's good for business."

If a disaster occurs in your community, hospitals that treat the victims will likely be called. "If all patients were taken to your hospital, it doesn't matter what your relationship is with the reporter, you are going to be called," says Suter. "If you're one of several hospitals that got patients, the network staffers will probably contact their local media outlet in that community and/or ACEP to find out who does a good interview."

Anything that makes your ED unique. "If you have something that makes your ED stand out, let the local media know about it," urges O'Leary. "Call the newsroom and ask for the assignment manager. If there is viewer benefit, they should do the story."

Local incidents. "If several people become ill at a picnic or restaurant and were poisoned with a rare substance, and you are the ED physician who took care of them, you will be called as a source," says Hockberger. "It's worth going to the nearest reference you can get to try and brush up on at least the basics."

Still, it's not necessary to be overly prepared, says Hockberger. "What they are really looking for is an expert in managing the way the patient presents," he notes. "Your job is not to be a toxicologist. But if four people show up acutely ill, you understand there is a good chance there is a poisoning. You give them an antidote, if there is one, and, if there is none, you admit them to where they can be taken care of."

Reporters won't be asking technical questions, says Hockberger. "They will probably ask you, does this happen very often at the hospital? What was it that

tipped you off that this might be a poisoning? How did the family react?" he explains.

Human interest. Reporters like to cover the human interest angle, O'Leary notes. "If you have a patient that benefited from a procedure or piece of equipment, have their name handy," she recommends. "So if the patient is willing, the reporter can talk to them as well."

Be creative with story angles. "If your department adopted a child in a housing project, or a nurse or physician who climbed a mountain, you can present that as a human interest angle to show what great people you have working in your ED," says Suter.

New products or technology. "When a new respiratory nebulizer for kids was developed that was shaped like a teddy bear, the manufacturer managed to get 'ER' to put it on the show. So the network suggested to affiliate reporters to do a follow-up story on the news," says Suter. "Because we had a children's hospital, we were the ones who got that very high profile segment." ■

Use media to confront drug abuse

ED physicians and nurses have a responsibility to address social issues such as drug abuse, argues **Larry L. Alexander, MD, FACEP,** an ED physician

Tips for effective television interviews

Television interviews require you to master body language and be quotable. "Where do I look? What do I do with my hands? The idea of the interview is for it to be like a normal conversation—minus the lights, camera and microphone," says **Peggy O'Leary,** senior medical reporter for WRDW-TV in North Augusta, SC.

Look at the reporter. "Look at the person you are talking to, not at the camera," says O'Leary.

Keep it short. "If it's a TV interview, be much more concise, because you may be quoted in a matter of seven or eight seconds," says **Nan Tolbert,** director of training at Susan Peterson Productions, Inc., based in Washington, DC. "You would rather edit yourself than be edited."

Still, that principle applies even with print interviews. "In a TV interview, you are much more conscious of being concise and giving a soundbite. If you apply those same principles to print interviews, you are much more likely to be quoted accurately," says Tolbert.

Keep it natural. "If you talk with your hands, talk with your hands. Again, act as if you're having a normal conversation," says O'Leary.

Assume the camera is always on you. "Many times, people will move the camera back to you and you never want to be caught off guard," says Tolbert.

Find out whether the show is live or taped. "When it's live TV, it can be more challenging, so take your time. Before you answer, take a breath. Feel comfortable pausing before you answer so you can gather your thoughts," Tolbert advises.

Look the part. "Reporters want you to look like you are in the medical field, so leave the white coat or scrubs on. Wear whatever is appropriate to the topic of the interview," says O'Leary.

Don't dress sloppily or appear to have poor hygiene, says **Robert Suter, DO, MHA, FACEP,** regional medical director for Questcare Emergency Services in Dallas, TX. "If they are calling you at 4:00 in the afternoon and you have a beard, find a razor and shave, comb your hair, and brush your teeth," he suggests.

You should look appropriate to the situation, Suter notes. "If you're the physician who just took care of 100 disaster victims, looking like you just stepped out of a beauty salon is probably inappropriate. But the situations where it's appropriate to look disheveled are very few and far between," he says.

Look presentable. "Sometimes you just cannot get rid of that line on your forehead coming out of surgery, but it doesn't show up," says O'Leary. "On the other hand, sweat catches the light. If you are in a rush or get nervous and can feel the sweat on your forehead, stop the interview. Wipe your forehead—you will be glad you did and so will the reporter. And reporters probably won't tell you if you hair is messed up or you have something hanging from your nose. So stop and do a personal check before you see the camera."

Realize your words will be edited. "When it come to being filmed, you never know what they are going to show," says **Robert Hockberger, MD, FACEP,** chair of the department of emergency medicine at Harbor-UCLA Medical Center in Torrance, CA. "For example, I was once asked to give an interview for a Saturday segment of Entertainment Weekly about the show 'ER.' I was filmed for almost an hour, talked about my childhood experiences that got me interested in emergency medicine, and what I liked and didn't like about the career. I was spliced in for less than five seconds, saying I thought the show 'ER' was realistic." ■

Media Quick Prep

Prepare! Anticipate the reporter's questions by considering all the issues and angles. Organize your answers so they'll be short and to the point.

Relax! Take two deep breaths and smile. Start out with your hands in an open, unlocked position by your sides, so you'll be free to gesture naturally.

Eye contact! Look at the reporter all the time while you're listening to the questions and when you're answering them. You will look more poised and confident.

Smile! Be expressive when you speak. By putting your body and face behind your words, you'll appear more committed to your message.

Stay cool! If you're getting hot under the collar--keep it there. Even if the reporter is rude or hostile, you must appear friendly and cordial.

Source: Susan Peterson Productions, Inc.

at Baylor Healthcare Systems in Dallas, TX. "I think any ED physician recognizes trends in many areas of social life in this country. We get so caught up in work and our own lives, it's often hard to go beyond that," he says. "But we are the perfect people to do this, because we see people at their best and worst. What we have to say carries a lot of weight with people."

When heroin use led to the deaths of several young people in the suburban community of Plano, TX, Alexander felt compelled to take action. "Last summer, one young man was dropped off by two others who left without giving any information whatsoever, and it made me angry," he recalls. "It took us an hour or so after he died to find out his name. I woke up the parents at 3:17 in the morning to have them come to the ED. This one hit me harder than the others."

The incident and others like it led Alexander to begin lecturing on drug abuse at local schools. "What led me to get involved was realizing that people were in denial about this issue," he explains. "People get complacent and say it can't happen here. Then, when we have a death or overdose in the area, they say, 'well it wasn't my kid.' It shouldn't have to take a child dying to make you address this problem. And what if the next one is your kid?"

Alexander regularly gives one-hour presentations at schools for grades kindergarten through 12. "I tell stories about what happens in the ED to illustrate my point, then give the kids 30 minutes to ask me questions. In doing that, I found that kids are often misinformed about drugs," he says. "Parents tend to lecture at their kids instead of talking with their kids, kids talk back to their parents, and the lines of communication break down."

ED staff have credibility with both young people and their parents, Alexander notes. "When people have made a bad decision, the bad outcome winds up in the ED and we have to try to fix it," he says. "Young people accept this coming from me instead of their parents, teacher, or priest because I am not here to lecture them. I am the doctor who tries to save your life if you wind up here. I tell them, I don't want any more of you coming through my ED. I deal with this every day, sometimes more than once a day."

Drug use is widespread in the suburbs, and ED physicians are on the front lines confronting the aftermath, Alexander stresses. "It's not really the inner city kids that are doing it now. It's the white middle class, two-parent family suburban kids for the most part. Heroin use has become a problem in Cleveland, Iowa, Denver, and Portland, OR. When you ask kids why they do it, most of them can't tell you. What's bizarre is that many are school leaders. On the outside, they look like the perfect kids, but inside they feel empty."

Along with lecuturing at schools, Alexander began speaking to reporters about the issue. "I gave my first media interview last summer to a local newspaper because I'd taken care of some of the overdoses, and the city wasn't giving out any information," he explains. "The Dallas newspaper picked up on the story, which hit the national wire service and got syndicated everywhere."

Since Alexander was the only physician quoted in the article, the national reporters sought him out for comment. "Hard Copy and Inside Edition showed up at the hospital and interviewed me, and local stations then reported on my talks," he says. "Channel 1 in Los Angeles, an educational channel that goes to most school districts in the country, did a one-hour documentary."

Over the next few months, *"Dateline," "MTV," "Montel Williams,"* and *"CNN Talk Back Live"* all contacted Alexander to be interviewed about drug abuse, he notes. "CBS, ABC, and NBC have all called for sound bites. It's funny how you give one interview, and so many things grow from that," he says. "I now have my own hour-long talk radio show in Dallas, which invites listeners to call and ask questions. I discuss a drug of the week, such as marijuana, heroin, or alcohol."

To educate the community via news media, you need to communicate in soundbites, says Alexander. "That is what you have to do to get your message across, because that is what sells news," he says. "I'll tell a story about a kid who came in with a heroin overdose. Within that is a take-home message in a one- or two-sentence soundbite. I keep up on current literature so I can provide statistics, if needed, to hammer in certain points. But mainly I focus on personal experience, because that is what tugs the heart strings and gets people thinking."

Some reporters tried to sensationalize the story by implying a cover-up, Alexander notes. "Reporters have come in with their own agenda, trying to get me to speak on behalf of the hospital," he explains. "I explain that the hospital has one official view, while my view is that I've taken care of these patients. But the hospital follows the letter of the law, and unless someone dies it is not reported from a legal standpoint. As long as I know my legal standing is protected, I will give my viewpoint."

Resist playing into a reporter's angle by sticking to your message, says Alexander. "They may come in wanting to sensationalize the story, but that is missing the whole point. Sometimes you can actually bring them around to your side," he explains. "They are there to interview you, but you have just as much right to steer the conversation as much as they do. If you control your responses, no matter which comments they choose to use, your message comes across and you win regardless." ■

ED Spotlight on New Technologies

Digital radiography in emergency medicine

Digital radiography has revolutionized the practice of emergency medicine, says **Col. Matthew M. Rice, MD, JD,** chairman and program director for the department of emergency medicine at Madigan Army Medical Center in Fort Lewis, WA. "We were one of the first hospitals in the nation to install this, and our ED was one of first places to use it. After you get used to looking at a film on a computer screen instead of a light board, it's easy to see the benefits."

Here are some benefits of digital radiography:

Cost savings. In the past, the ED depended on hard copies of x-rays. "That involved a fair amount of expense for the film itself, and with man hours in developing, changing solutions, and making sure they were mixed properly," says Rice.

Digital radiography offers significant cost savings. "With digital technology, the investment goes in upfront with the hardware and software," says Rice. "But then it's less expensive to run each radiograph. In an ED like ours, which sees 100,000 patients a year, you build up a lot of savings."

Quality of films. "It is very difficult to get a poor quality film using this system," says Rice. "The quality is usually almost perfect. When they are not, you can correct some minor deviations by using computer enhancement."

Previous films are easily accessible. "Past X-rays are at your fingertips," notes Rice. "All the hard copies here were scanned into the computer database. So all the old x-rays are stored in a giant disk. If at any time you want to look at a previous CT scan, ultrasound, barium enema, or chest x-ray, you just need to type in the patient's name and identifying information."

Films can be compared easily. "We have two screens side by side, so we can compare films side by side within seconds or minutes," says Rice. "Previously, in the middle of the night, or on weekends and holidays, it was difficult to find old x-rays, and it took a fair amount of time to retrieve them."

The easy access to previous films has improved patient care. "If a patient comes in with lung problems and we take a chest x-ray, we can pull up an old film and see if the findings on the current visit were there on the previous visit," says Rice. "For example, people who have had coronary artery bypass surgery may have changes in their lungs that are weeks, months, or years old. So we can compare the new films with past films to see if the changes are new or old."

This facilitates the eventual diagnosis, Rice says. "If the patient has a small nodule and you don't know if it's benign or not, you don't have to send for a new workup if it was there before and hasn't changed," he explains. "If you suspect that a change on the x-ray may be pneumonia, you may see it was there before. So you know it was a scar of some kind instead of an acute infiltrate."

It's possible to change and enhance the image. "The computer will actually allow us to enhance the image in ways that are almost magical," says Rice. "Before, we'd have to call a patient back and repeat a film. If we were doing a cervical spine x-ray, if the

film didn't quite show the lower thoracic and upper cervical, we might have actually had to take the patient for a CT scan to make sure there are no fractures." Digital radiography allows modification of the film, so you can actually see portions of the image more clearly, he explains.

Computer enhancements measure the density to determine if you are looking at fluid, bone, or soft tissue, says Rice. "We can also reverse the lights and darks in the image, to contrast different things," he notes. "For example, if you are looking for pneumothorax on a chest x-ray, you can see changes that suggest that better."

Storage space is saved. "In the past, we had film labs which took up lots of space. Now, films are stored in the video jukebox storage system, so we save a lot of hospital space," says Rice. "We have taken old films and digitized them for storage. If needed, we can also produce a hard copy film from the digital versions." ■

Use real-time data to reduce delays

From predicting the future to preventing it: The use of real-time data to monitor the ED system and intervene in real time

By James Espinosa, MD, FACEP
Overlook Hospital, Summit, NJ

I genuinely admire anyone crazy enough to stand up and be accountable for emergency systems in general, and emergency departments in particular.

We have responsibility for systems over which we have varying, and generally limited control. Management scholars may roll this sort of frustration into new terms like "stewardship," but at the end of the day, it still turns out that we need a better way of managing.

I would like to share with you a bit of a godsend of an approach that we have developed for use in the Overlook ED, and do a little future-think concerning the obvious implications of the strategy for hospitals and health systems. It has allowed us to propel ourselves from the 20th percentile nationally in patient satisfaction to the 99th percentile nationally. It has allowed us to do more with less resources. And it has allowed me, as an ED manager, some sense that we can prevent ED meltdowns.

Ray Bradbury was right. Ray Bradbury has been variously quoted as having said that the central theme of his brand of science fiction was not so much to predict the future as to prevent the future. He saw his work as a sort of interdiction on a future that was in some ways intuitively obvious to him. I share his intuition when it comes to ED management.

The more one knows about ED management, the more one realizes that the ED really is a sort of hub of a complex web of activities. One of the most frustrating intuitions in the world for an emergency physician to have, is to appreciate the incredible dependency of the ED on the rest of the hospital system.

The conventional approach. Over the years, many of us have become increasingly sophisticated at collecting, analyzing, and extracting the meaning of various ED data streams. We can graphically display the previous weeks, months, and years of many important variables. Some of us can use statistical software to make interesting inferences using the data, and make all manners of predictions about future behaviors of our systems.

Without a doubt, these are vital activities, and are core processes in our management strategies. Recent advances in tracking systems make the pool of potential data streams richer and deeper. Targets emerge for re-engineering efforts. In a recent edition of *ED Management*, we presented examples of efforts to re-engineer x-ray cycle times, for example.

One of the exciting aspects of the work we do at Overlook in this area is the use of "real-time data." We have created a "dashboard" or "instrument panel" of eight critical cycles. These cycles as displayed as small multiples on one screen of our ED tracking system. This is not a proprietary notion. We have shared the concept with everyone who wants to learn. It really is an adaptation from industry. We use a tracking system called "PaTrack," but any tracking system could be used this way.

I adapted the idea through researches into industrial quality management. It turns out there are, for example, steel mills that monitor, in real-time, several critical manufacturing parameters. These include steel thickness, heat, cooling bath temp, and so on. Advanced manufacturing plants and all sorts go a step further, however. Having re-engineered, they look at a core battery of processes in real-time, and make interventions and adjustments in real time, in

order to influence the outcome of the batch of product at hand.

In our adaptation, we look at parameters critically linked to ED efficiency and to patient satisfaction. Data is displayed on one large chart, comprised of eight trend charts, on a 21-inch touch screen. This sort of single chart, with component charts, is known as a "small multiple" chart.

Customer-derived specification lines are laid in on the trend charts. The charts show the status of each function going back three hours until the present, in 15 minute bins of time displayed as bars or points on a line. The parameters we see can be changed on the fly, but we have settled on:

1. Arrivals
2. Occupancy in the department
3. Arrival to bed cycle time
4. Arrival to RN cycle time
5. RN contact to physician contact cycle time
6. Arrival to physician cycle time
7. X-ray cycle time
8. Admission cycle time (decision to admit, to time patient leaves department)

Example: Protecting the gains made in the x-ray re-engineering project. The first of the parameters developed was "x-ray cycle time." A run chart was developed to show x-ray turn cycle time performance in 15-minute bins of time. The radiology technicians and the ED staff monitor this vital sign, along with seven others, at all times.

The customer-specified goal of 30 minutes or less has been translated into a specification line on the "vital sign" indicator of 25 minutes. The technicians know that if performance exceeds the goals for three consecutive 15-minute periods, an intervention is needed. The intervention may include a temporary increase in capacity, through pulling a technician from another area of the hospital, or even that a technician may need to be called in from home. This approach has been very well received by the ED technicians.

The more one sees the system this way, the more one sees "systems pathophysiology" patterns emerging. We see three major sorts of patterns at present. Others will, no doubt, emerge.

- Downstream delay patterns. For example, delays in admission cycle times will manifest first as several 15-minute periods of cycle time trending upward. If the problem persists, and is of a serious enough nature, the next effect will be that ED occupancy will increase. The department becomes virtually smaller, and then it becomes difficult to bring patients into the department, leading to increases in all of the arrival-to-practitioner cycles. Ultimately, this can lead to terribly prolonged arrival-to-physician contact cycle times, which will lead to lower patient satisfaction scores. x-ray cycle times are also a downstream problem. Slow x-ray time can effect the entire ED efficiency in a similar manner.
- Upstream delay patterns. For example, the number of patient arrivals (demand) outstrips available staff (capacity). The first impact will be seen in the arrival to bed cycle, leading to arrival-to-practitioner cycles. Note that once again, in time, unabated, this can lead to prolonged arrival-to-physician cycle times.
- Midstream delay patterns. For example, demand on practitioner resources outstrips capacity. Given sufficient beds in the department, the immediate effect will be on bed-to-nurse, and bed-to-physician cycles, then leading to prolonged arrival-to-practitioner times.

Note that in every sort of pattern, physician contact cycle time is ultimately effected. Physicians may appear to be the root cause of every one of these syndromes. It is tempting for the casual observer to blame all of these scenarios on physicians.

What's the point? Real-time adaptation of capacity to demand. For each of these scenarios and more, we have strategies in place. These are beyond the scope of this column, but are based on best practices and common sense. Using the x-ray cycle time as a paradigm, we first re-engineered ED radiology services, and brought that cycle from 70 minutes to 23 minutes. Then the question changed to getting the most out of the improved system.

The radiology techs look at their cycle on the screen (1 of the 8), and can "swing-in" capacity from the operating room (OR), or from outpatient services, based on the parameters displayed. (3 or more consecutive points trending about the customer spec line of 30 minutes). They release this temporary capacity when the system stabilizes. This sort of approach carries over for physician capacity (arrival to MD treatment time), ED nursing, and, most critically, for the cycle time for admitted patients to be transferred to the floors. The outcomes have been significant. We reduced arrival-to-physician evaluation time (critically linked to patient satisfaction) from 31 minutes (median) to 16 minutes ($P = > 0.0005$). X-ray cycle time dropped as above, with similar significance. Admission cycle time dropped to about 60 minutes. We recently won the 1998 Press-Ganey Award. In addition, our scores in the most recent quarter were at the 99th percentile.

Future think beyond the functional silo mentality: Why can't entire hospitals adopt this approach? ED management of this sort is necessary

but not sufficient. Anyone reading this column who works in the real world immediately recognizes that cycle times in the emergency department (ED) are dependent on a great many hospital-wide cultural, structural, and state-dependent factors. What is the status of telemetry beds? What is the critical care census? What is the hospital occupancy? It seems to us that the same sort of calculus would apply. What if hospital managers could see the behavior of critical hospital processes? Would patterns and trends emerge? One would think that much could be done to intervene at the hospital management level, in real-time.

The power of the strategy: Empowerment of staff to intervene on protocol. Certainly, hospital and ED managers do this sort of intervention every day, based on data available. Part of the power of real-time data is to empower others to make decisions. In the case of the x-ray redesign, agreements were inked in advance concerning exactly what sorts of escalating interventions could be made by the technician on duty.

Hospital systems linkage. Many groups of hospitals have formed alliances of various sorts. In most of these relationships, there is an interdependence based on levels of care provided and centers of expertise. From the ED perspective, we can see that in practice, the transfer patterns are often less efficient than would be desired. Hospitals could learn to visualize their statutes individually, and share these with their partners. Certainly, this would make tremendous sense around critical "product lines," such as critical care.

Other implications. Why is every flu season a surprise? Last year, ED and hospital-related influenza cases created heroic situations in many areas of the country. The media predicted the march of the virus across regions, and yet most hospitals had not geared up. In many of these hospitals, capacity lay fallow and dormant, awaiting additional staffing in order to open units. Contingency plans could have been in place, awaiting real-time data to activate them.

Conclusion: Not a panacea, just another tool. This notion of real-time data, real-time trending, and real-time algorithmic interventions is not a new invention, nor is it a panacea. It is another tool for us to deploy. For those of us in the ED who realize that they are managing a system with remarkable dependencies on the efficiencies and capacities of other hospital functions, it may well be an approach that makes the quality of life better not only for our patients, but also for ourselves as providers. ■

Compliance Plan for Third-Party Medical Billing Companies

By Caral Edelberg, President, Medical Management Resources

The Office of Inspector General released the long-awaited Compliance Plan for Third-Party Medical Billing Companies November 30. The extensive plan identifies the top areas of attention for billing companies and provides suggestions for both small and large billing companies on compliance issues.

Outlined in the plan are seven critical elements that should be included in each billing compliance plan. They include:

- Development and distribution of written standards of conduct, policies, and procedures that promote

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commitment to compliance and address specific areas of potential fraud (i.e., claims submission process, code gaming, and financial relationships with the providers.)
- Designation of a chief compliance officer and/or other appropriate responsible persons or committees responsible for operating and monitoring the corporate compliance program and reporting directly to the CEO and governing body.
- Development and implementation of regular, effective education and training programs for any affected employees.
- Creation and maintenance of a reporting process, or hotline, to assure that complaints are handled appropriately.
- Development of a system to respond to both internal and external allegations of improper and/or illegal activities with assurances of disciplinary action.
- Use of audits and other evaluation techniques to monitor compliance and identify problem areas.
- Investigation and correction of systemic problems with assurances of non-employment of sanctioned individuals.

Although the plan contains many valuable suggestions for the development and maintenance of compliance policies and procedures, it also includes numerous predictably controversial recommendations, which are sure to create many issues between billing companies and their provider clients. The potentially contentious issues include:
- Restricting coders and billing consultants from sharing in any financial incentives which may encourage upcoding claims;
- Ensuring that only properly documented services may be billed;
- Assuring timely and appropriate resolution of overpayments (credit balances);
- Suggesting a program for sanctions for billing supervisors who fail to adequately instruct subordinates or fail to detect non-compliance;
- Self-reporting to the government of corporate misconduct that may violate criminal, civil or administrative law; and
- Requirements for reporting where credible evidence of client misconduct or fraudulent/abusive conduct exists, as well as assurances of billing company's termination of billing activities for the client. ■

Editor's note: *A detailed discussion of the pros and cons of the OIG Billing Compliance plan with helpful suggestions for developing your own unique plan will be featured in an upcoming issue of ED Management.*

CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:
1. Discuss and apply new information about various approaches to ED management.
2. Explain developments in the regulatory arena and how they apply to the ED setting.
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication.