The Impact of the Press on Medical Practices During a Potential National Health Crisis

Focus Paper

Katherine F. Johnston, MS, FACMPE

October 5, 2016

This paper is being submitted in partial fulfillment of the requirements of Fellowship in the American College of Medical Practice Executives.

I. Introduction

During a health crisis, the media can have a devastating effect on the ability for practices and hospitals to function in its designed manner. Medical practices and hospitals have similar operational requirements. Access to facilities and providers, financial viability, care givers willing and available to treat patients, and access to current health information from government agencies are essential. The media's influence and actions can disrupt a health facility's operations in such a way that these needs are not met and in some cases, can severely impair routine activities. It is possible for the actions of the press to actually impede efforts for the organization to provide patient care.

This paper will describe a situation in which the media had a significant impact on the public perception of the medical community and will present recommendations for managing the media during an emergency or disaster that directly effects the healthcare provider system. Suggestions from reporters and public relations professionals will be presented. Points to consider when developing an emergency preparedness plan, including recommendations from various emergency management plans and press management presentations will be shared. A case study surrounding events of the 2014 Ebola outbreak in Dallas and the effect it had on the pulmonary/critical care practice, physicians, and non-physician practitioners treating the infected patients will be reviewed in the case study. The case study will discuss the issues that needed to be addressed during this crisis and what actions the practice leaders chose to follow as well as the outcomes of their decisions.

II. Background

The concept of dealing with a pandemic event is not a new one to medical practices, and several pandemic preparedness plan templates and publications are available. *Physician Practice Management: Essential Operational and Financial Knowledge, Chapter 8: Bioterrorism and the Physician's Office* provides several checklists and sample scripts for physician practices to use to prepare for such an event. (Wolper, et. al. 2006) An additional resource is the American Health

Lawyers Association publication "Emergency Preparedness, Response & Recovery Checklist: Beyond the Emergency Management Plan". (Belmont et. al. 2004) Disasters, emergencies, and pandemic plans have typically been created with the focus being on physical destruction of a practice/facility, a pandemic event occurring nationwide, or a bioterrorism event. Even so, a MGMA article asked members if their practice had a formal emergency plan. Forty-three percent of the respondents indicated they did not. Furthermore, the survey revealed that 82% of practices believe that emergency preparation is the administrator's job, as opposed to a group effort involving all levels of an organization. (Pope 2006)

The first step in creating any sort of response plan is to assess your practice. As the survey results above suggest, administrators are viewed as the chief planner and responder to an event. However, "administrators make assumptions that their physicians are on top of emerging disease issues and (Centers for Disease Control and Prevention) CDC recommendations," says Drew Di Giovanni, MPH, FACMPE, vice president, quality patient safety CHS Health Services, MGMA member. "We should never assume." (Grimshaw 2014)

Most of these plans do not focus on one aspect of an emergency that if poorly handled, can have devastating effects on a practice: the impact of the public media. Although the chances of an administrator or medical leader ever having to deal with the media is low, the result of doing so poorly could potentially negatively impact a practice if remarks are misinterpreted or the wrong information is communicated. The impact could be severe enough, however, that administrators and medical leaders should consider how they would manage the media if such an event occurred. Televised newscasts can create public hysteria with non-stop coverage of an event. Misinformation and/or the lack of correct information can feed this frenzy, leading to the practice/hospital being "held hostage" by the news media. Unfortunately, oftentimes the media is not as interested in reporting non-sensationalist news, and leaders and administrators may not be given the opportunity to share their side of a story. The events in the case study being presented were horrifying and financially devastating to medical practices and the hospital. Make no mistake, this was a very serious situation. However, the gorier and deadlier the situation, the more humans tend to be drawn to it and the press is ready to share these gory points in minute detail. Don Henley satires the public's obsession with these types of tragic events in the song, "Dirty Laundry," in the following verse:

"We got the bubble headed
Bleached blonde
Comes on at five
She can tell you 'bout the plane crash
With a gleam in her eye
It's interesting when people die
Give us dirty laundry".

The impact this can have on providers and their families can be severe. Providers' morale is lowered as family milestones are missed due to the extra time needed to handle the crisis. Providers report being shunned by their peers, their friends, and the general public. The financial effect this fear and hysteria can have on practices financially can be equally as damaging. If patients are afraid of a patient with a communicable disease in the facility, they are less likely to keep their appointments on that campus. Recovery from an event like this as well as rebuilding one's reputation is daunting. In fact, those that do not have any direct involvement in the creation of the crisis can often be caught up in the negativity through no fault of their own, even if they are ready, willing and able to contribute to mitigating the effects of the event.

The impact this can have on the facility can be just as devastating. If patients are afraid of events transpiring in a facility, they are less likely to complete elective surgeries, complete diagnostic testing, or deliver babies. Hospitals survive by maintaining a specific patient census level; if those levels are reduced for too long, the financial health of the facility serving the surrounding community is compromised. And finally, as the physicians treating these patients, the financial health of their practice is also negatively affected.

III. Case Study

History of Events

On the evening of Saturday, September 20, 2014, Thomas Eric Duncan arrived in Dallas after traveling from Liberia. On Thursday, September 25, Duncan went to the emergency room. After being sent home with antibiotics, he returned again on Sunday. This time, however, it was noted he had recently arrived from West Africa and Dallas County epidemiologists were contacted. On

September 30, 2014, the CDC confirmed the first laboratory-confirmed case of Ebola to be diagnosed in the United States. On October 10, the first of two nurses that had treated Duncan was diagnosed with Ebola; on October 15, the second nurse that treated Duncan was diagnosed with the disease. (Centers for Disease Control and Prevention September 2014)

The media continued to report misinformation and speculation creating a public panic, despite the CDC issuing a press release on September 30, 2014 stating, "The ill person did not exhibit symptoms of Ebola during the flights from West Africa and CDC does not recommend that people on the same commercial airline flights undergo monitoring, as Ebola is contagious only if the person is experiencing active symptoms." (Centers for Disease Control and Prevention September, 2014) This same announcement reiterated the disease could not be spread through casual contact or through the air, but only through direct contact with bodily fluids of a sick person or exposure to objects, i.e. contaminated needles.

Days before either nurse was diagnosed, the international press invaded Dallas. Hysteria grew as the press announced Duncan had flown from Liberia, via Brussels and Washington, D.C., resulting in speculation that he had exposed others to the disease while traveling. Reporters swarmed the apartment complex where Duncan had been living with his fiancé, Louise Troh, and her sons, "pulling aside schoolchildren for interviews and handing out $20 bills to anyone whose apartment had a view of Louise Troh's; after security guards were called in to keep them outside the complex, one reporter actually barricaded herself in a neighbor's apartment rather than give up her hard-won perch." (Burrough 2015)

The media onslaught continued as the Troh family's apartment was decontaminated and city/county officials worked to secure them another place to live. After hours of searching, including considering the mayor's son's property, a call to the Dallas Catholic bishop's chief of staff resulted in the bishop offering the family a place to stay. It took over two hours to make the move. By the time they were ready, media helicopters were still filming overhead and visions of O.J Simpson's televised police chase in a white Bronco caused officials to hesitate. A call was made by Judge Clay Jenkins to the White House, resulting in the air space being cleared. (Burrough 2015)

At the height of the crisis, 177 people in the Dallas area were under some sort of quarantine. These people had to be monitored twice daily for symptoms and medicine and supplies had to be brought in. An event transpired that demonstrated how nervous the public had become when a deputy who had been inside Troh's apartment presented at a CareNow medical clinic complaining of a stomach ache. When he mentioned he had been inside the apartment, a call was placed to 911 and within minutes, news helicopters were circling overhead. "When local stations reported that someone who'd had contact with Duncan was inside, the clinic shut down. Health workers in HAZMAT suits were soon on the scene. Not until the next day would everyone realize it had been a false alarm." (Burrough 2015)

While all this was transpiring, the pulmonary/critical care providers were trying to first treat Mr. Duncan, then the two nurses. The CDC had been called in at the time Mr. Duncan was diagnosed. Repeated requests by hospital administration and the ICU physicians were made to move these patients to a more suitable facility, but CDC representatives declined. The pulmonary/critical care providers held phone conferences twice daily with CDC representatives and with medical staff from two other hospitals that had experience treating patients with the disease. When asked what treatment options were available, three were given, but when CDC representatives were asked which they recommended, they declined to make a recommendation. In the end, the providers decided to use all three, resulting in the eventual recovery of the two nurses. (Kenney Weinmeister, M.D. 2016)

When the second nurse became ill, a series of discussions took place between CDC officials and the county judge, Clay Jenkins. The CDC was concerned there was going to be an outbreak and was demanding to know where the county would treat them. The hospital had already decided to be on divert status as of October 12, 2014, at 1:50 a.m., meaning all incoming ambulances would be diverted to other hospitals and the hospital would take on as few new patients as possible.

> "They kept saying, 'Where are you going to put the next 10 patients? The next hundred?'" Jenkins remembers. "They wanted Parkland (a major county hospital). We only have five flagship hospitals. People were already avoiding Presby. You take two

> down and you're just screwed. There will be people waiting in 16-hour lines at those that remain, dying of heart attacks, asthma, and emphysema." (Burrough 2015)

Finally, the decision was made to transport the two remaining infected patients to facilities out of state that were much better equipped to treat the disease. While the lengthy, very complex preparations to transport them were being made (Kenney Weinmeister, M.D. 2016), hospital workers demonstrated on the hospital campus waiving posters, signs, and giving interviews that they were "Presby Proud" and expressing their support for the two infected nurses. Once the nurses were off campus and the 21-day waiting period for all 177 patients had expired, the media moved on. Finally, the medical community could return to focusing on patient care.

Statement of the Problem

Plainly stated, in this author's opinion, the media created public hysteria that hampered a city's entire health system from being able to perform as effectively as possible. Necessary resources were diverted and the hospitals in the rest of the city were strained due to taking patients that otherwise would have received care at THR Presbyterian Hospital-Dallas. No one can know for sure how many lives were potentially at risk due to patients' unwillingness or inability to seek treatment at their normal providers' office on campus or by being diverted to other facilities. As Judge Jenkins stated, the potential for people to die from conditions that could be treated quickly was a very real concern.

The irresponsibility of the press was mocked in a YouTube comedy performance by an English comedian, in which he compares the U.K. media's response to the U.S. media's response. He states the U.K.'s press response is "…calm, measured. America's? Not so much." The performance then cuts to several newscasts with reporters making histrionic statements, i.e. the disease was "spiraling out of control," and "All Hell is about to break loose!" (Howard 2014)

Specific to the pulmonary/critical care practice, there were three main issues that were of concern: the personal toll on providers, patients, and staff; the operational concerns regarding the ability to provide care; and the financial impact on the group.

Personal Toll

Employees of the pulmonary/critical care practice working in the outpatient clinic reported patients calling the outpatient pulmonary clinic demanding to know what physicians were treating the Ebola patients, even though at least in one instance, the patient had not been seen in the practice since August! (Ivelisa Smith 2016) Another employee of the pulmonary/critical care practice that worked at the off-campus Administration office reported being jostled and pushed by the crowd of reporters when she had to deliver paperwork to the outpatient clinic located on the hospital campus, afterwards requesting she not be asked to return to the hospital campus again. (Meleah Orr 2016)

The effect on the facility was financially devastating, but the effect on the healthcare workers was equally as bad. All of the healthcare workers who had direct patient contact with Duncan were removed from active duty and placed under a 21 day quarantine. For the pulmonology/critical care practice in question, this meant that 3 of the 8 physicians and 1 of 8 Advanced Practice Practitioners (APPs) serving the two, 24-bed ICU units, were furloughed. As a result, important family milestones and events were missed and anxiety among the affected families increased. Further, of the physicians not furloughed, 3 reported receiving calls from concerned parents of children that attended the same schools as their children. Each of these physicians had to not only educate these parents about the illness and assure them their child wasn't at risk, but educate their own children about the disease and comfort them when their classmates reacted in hurtful ways. Finally, staff members at the outpatient clinic location expressed concern for themselves and their providers and required additional education and assurance from their manager that they were not at risk of infection.

The nurse practitioner who was affected conducted an anonymous survey as part of the requirements of her doctoral dissertation in which she asked respondents regarding a nurse's duty to work with Ebola. Social media was used to recruit participants and direct respondents to an online survey. "Participants included critical care nurses [Registered Nurses] who worked during the Ebola patient admissions. Of the 101 participants who met the inclusion criteria, 72 (71.3%) provided analyzable data." (Nagel 2015)

Nagel's research revealed the following:

> "While only 16 (23.2%) respondents reported providing direct care, more than half of all respondents (*n*=38; 55.1%) were asked by their family not to work with Ebola infected patients (EIPs). Respondents were less likely to work if partners (*n*=44; 62.0%) or children were ill (*n*=42; 58.3%), but were more likely to work if colleagues were infected (*n*=48; 66.7%) or dying (*n*=40; 55.6%). Shunning was experienced by 28 participants (38.9%), while 25 (34.7%) knew of others who were shunned." (Nagel 2015)

Practice Operations

The practice executive had only been employed by the practice for approximately 6 weeks at the time the crisis occurred. The executive had no prior experience with a pulmonary/critical care practice and had been employed with a different health system for the previous 8 ½ years. Thus, the executive's experience with private practice administration was not recent. The practice had four outpatient clinics and was associated with four separate hospital critical care units, along with an off-campus Administration office. The practice executive met weekly with the managing partner, who was the main source of information to the executive about what was occurring in the hospital.

The three physicians and one Nurse Practitioner that were treating the patients were removed from the rotation schedule caring for the other ICU patients and providing pulmonary consultations at the hospital. Furthermore, the physicians' outpatient clinics had to be cancelled and the patients rescheduled with the remaining providers or for future appointments. Thus, the remaining providers had to cover the remaining inpatients and pulmonary clinic outpatients with a 37.5% reduction in physicians and a 12.5% reduction in APPs.

Production was further hampered by the requirements of treating the patients. The time required to round on each patient was an issue, essentially requiring one full time physician to round on 1-2 patients. (Kenney Weinmeister, M.D. 2016)

Finally, the managing partner and the physician partner that served as the Chief of Pulmonology and Critical Care spent approximately three hours/day in meetings/conference calls with CDC representatives (an hour meeting in the morning and evening) and hospital and hospital system representatives (one hour daily). The practice was already managing the unavailability of three of its providers, one of which was Dr. Weinstein, the Chief of Pulmonary and Critical Care Medicine. With these meeting requirements, the managing partner's productivity decreased by nearly 40% as well.

Financial Impact

The hospital's census reduced from approximately 400+ patients a day to a little over 200 patients/day. The practice's hospital charges at the Dallas hospital from 9/28/14 to 10/31/2014 reduced from the same period the year before by 34.38%.

The outpatient clinic also experienced a reduction in patient volume. During this same period (9/28/1-10/31/2014) the clinic had almost a 13% reduction in the number of patients seen with a corresponding reduction in gross charges of over 12%.

Issues to Resolve

There were four areas of focus during the crisis that needed to be addressed by the practice executive, the managing partner, and the physician partner Chief of Pulmonary Medicine and Critical Care, Dr. Gary Weinstein. The first issue was to determine how would Dr. Weinstein present himself? As a member of the practice or as a member of the hospital ICU? If the public identified him as a partner of the outpatient pulmonary practice, it could draw the media's attention to the rest of the physicians at that location and potentially to the other three outpatient locations across the metroplex. As it happened, the decision was made as a result of certain events that occurred outside of the practice's control.

At the beginning of the media storm, but before the nurses were diagnosed, it was tacitly agreed upon by the practice executive, managing partner, and ICU Chief that the pulmonary/critical care practice's name would not be mentioned when communicating with the public media. The

strategy was that by not doing so, the press would not link the pulmonary outpatient practice, or the other partners at this facility and the other three outpatient clinics, with the crisis. The decision was a successful one. It is this author's opinion, based on an unofficial survey amongst many friends and family members, that most of the public does not realize pulmonologists are often critical care medicine board certified as well. With a few exceptions, already mentioned, the general public did not equate the pulmonary practice with the disease.

At the hospital however, Dr. Weinstein, as the Chief of the ICU, was the physician representative to the press on behalf of the hospital. Dr. Gary Weinstein worked closely with hospital officials and legal counsel to craft a message of compassion and dedication on the part of the healthcare workers attending the affected patients. On October 7, 2014, the ICU Chief, Dr. Gary Weinstein, was called to testify before the Texas Senate Health and Human Services Committee. (Gordon 2014) Before testifying, the physician had met with hospital public relations and legal professionals, and as such, was representing the hospital care team. (Kenney Weinmeister, M.D. 2016) He was later interviewed by a local news affiliate. The interview began with the reporter saying, "People may be worried that I'm sitting here with you." After Dr. Weinstein told her his body temperature had been normal all of the four times he had checked it that day, she stated, "I was not worried." The interview progressed with questions about Mr. Duncan's care.

> '"I find that remarkably insulting," Weinstein said referring to suggestions Duncan didn't receive adequate treatment because he was black and uninsured.
>
> "I don't know how better to describe that," he added as he was brought to tears. "The team here worked their tails off trying to save his life."' (St. James 2014)

After the registered nurses tested positive for the disease, Dr. Weinstein again demonstrated compassion and dedication on behalf of the hospital workers and administration. As preparations were being made to transfer the nurse to the NIH in Maryland, employees and healthcare workers waved posters and proclaimed their support for the nurse about to leave Dallas. In a videotaped conversation, Dr. Weinstein told her he was proud of her and thanked her for volunteering to care for Duncan. "We love you, Nina," stated Dr. Weinstein. (Hennessy-Fiske 2014)

The second issue to address was what message needed to be communicated to the outpatient clinic staff and the patients? Staff were nervous and concerned about their welfare and that of

their providers. Some of Dr. Weinstein's patients became aware he was one of the physicians treating the infected patients and occasional calls would be received at the clinic expressing concern. And the general hysteria and panic in the community added additional concerns.

The practice executive decided to address the issue in several ways. CDC publications were placed in each outpatient clinic's waiting rooms and copies placed in the exam rooms for patients to take with them. The executive also created a statement assuring the patients that the providers and staff followed all regulatory and medical protocols to insure a safe environment while caring for their patients. This statement was placed at every reception desk. The statement did not directly refer to the critical care aspect of the practice and could have been placed in virtually any medical office in the community. The executive also met with the managers of the four outpatient clinics and educated them with how to respond to individual patient questions using the same script as what was in the statement. For those patients that asked more pointed questions about the physicians involved, HIPAA was referenced (after all, those providers could have potentially become the practice's patients) and assured them that no physicians involved had seen patients in the clinic since the outbreak. Finally, each manager was directed to refer any contact from the media to the practice executive and to communicate all these steps to their staff. Fortunately, no members of the press contacted the outpatient clinics.

By taking these steps, staff members felt more informed and knowledgeable about the disease. As the furlough period progressed, staff members had opportunities to speak with their providers who reassured them they showed no sign of infection. Knowledge that their providers were well and in control of the situation soothed staff fears and empowered them to deal confidently with the questions from patients at the outpatient clinics.

The third issue that needed to be addressed was to determine if there was a provider shortage in the hospital or in the clinic. The practice executive, managing partner, and office manager monitored daily census counts at the hospital. It was decided, if needed, the remaining physicians would assume additional shifts and outpatient patients could be seen by whichever physician was in the clinic, not necessarily their usual provider as had been the custom. As it happened, one of the 24 bed ICU units was closed to care exclusively for the infected patients. Thus, the practice

had to care for 50% of what they typically did. As events in the media unfolded, patients were reluctant to proceed with elective procedures, the hospital was put on divert status, and there was a higher number of outpatient clinic patients cancelling or rescheduling their appointments, so the remaining five physicians were able to provide coverage for the hospital patients and outpatient clinics.

The final issue to be addressed was what measures, if any, could be taken to mitigate the reduction in revenue? The practice executive had previous experience filing a Business Interruption claim with the property and casualty insurance carrier of a prior employer. The practice executive contacted their broker to investigate the possibility of doing so in this situation. The executive worked several days with the broker to make the case that a) there was a significant downturn in revenue, b) these losses were due to four providers being furloughed as a result of the Texas HHS Department's request to do so, and c) by the hospital being a divert status, patients that would normally have been seen were sent to other facilities. Unfortunately, the claim was denied, the insurance carrier stating the loss was not due to business interruption as a result of a covered property loss, nor from an order by a Civil Authority restricting access to the scheduled premises.

The managing partner became aware that the state and/or federal government were discussing the possibility of reimbursing the hospital for some of the expenses incurred with caring for these patients. The practice executive gathered financials to demonstrate the impact on the pulmonary/critical care practice and requested participation in this fund. Ultimately, the practice was reimbursed for the nurse practitioner's salary, taxes, and benefits during the 21 days she was furloughed.

Lessons Learned

The problem was there were assumptions made that in retrospect, were partially or entirely incorrect. Hospital administration and physicians, and city and county officials assumed the CDC was in charge of the situation. In fact, the CDC is a government agency. It has no authority. "There was the assumption that they would take over. And they didn't. The city and county did.

We did everything," stated Jennifer Gates, the councilwoman for the area where Mr. Duncan stayed. (Burrough 2015)

As events unfolded at the beginning of the outbreak, Dallas Mayor, Mike Rawlings, Dallas County judge, Clay Jenkins, and hospital physicians and administration realized the CDC did not have a detailed action plan to assume control of the situation. (Floyd 2015) The value of teamwork and communication between providers was critical. Coordinating activities surrounding the treatment of the patients was left up to local leadership. "I was speaking to the doctor as he was on the tarmac. He hadn't originally intended to stop here (in Ft. Worth), but did at our request," stated Dr. Kenney Weinmeister referring to the retrieval of plasma from a previously infected physician to be used to treat the infected patients. (Kenney Weinmeister, M.D. 2016)

As CDC is a government agency, it is important to understand representatives do not participate with developing treatment plans, the physicians do. They are also not in a position to develop a public relations plan for a community. Practice executives can learn from this practice's experience and proactively determine how they would handle a media storm if one developed around their practice. As with all events that are experienced for the first time, some factors cannot be predicted or planned for; they simply must be dealt with as they occur. Medical practice executives need to realize, however, that staying up to date on current events is critical to being able to respond quickly to a crisis, whether the media exacerbates the situation or not.

In the end, a Dallas Morning News review in August of 2015 showed all the activities involved in dealing with the crisis still cost Dallas-area taxpayers about $825,000, although some of this amount was covered by state reimbursements and private donations. (Floyd 2015)

Another lesson learned is that the federal government does have funds available for emergency-preparedness support, but unfortunately a LEARN (Legislative and Executive Advocacy Response Network) study in July 2008 revealed many medical practices were not tapping into those programs. The programs coordinate drills with governmental agencies, i.e. FEMA, or other local hospitals/care facilities. Medical practice executives need to contact their local hospitals and

emergency management agencies and request participation in disaster drills and the funding required to do so. (Stokes, et. al. 2009)

During the practice's property and casualty insurance annual renewal, the practice needs to inquire about more robust coverage for business interruption insurance. If possible, a broader coverage should be obtained to help cover any losses in the future. As critical care providers, it is not inconceivable that another infectious disease outbreak could occur at any of the four hospitals they are aligned with. No additional coverage was available during the 2015 renewal cycle, but as of the writing of this paper, the practice is reviewing ALL coverages and carriers to determine if a broader scope of coverage is available for this and other coverage types.

Also, during the planning of an emergency/disaster plan, the impact of the media needs to be considered and plans made how to manage communications, if necessary. This pulmonary/critical care practice was lucky, but might not be so again. With that realization, the practice executive and managing partner have agreed to seek out a public relations firm, one recommended by the hospital involved, should the need evolve again.

Finally, all medical practice executives and their physician leaders should have a discussion regarding financial reserves should a disaster occur. Does a line of credit exist with the financial institution used? Is there a section in the partnership agreement that addresses the potential need to draw on partners' distributions? The medical practice executive in this situation was monitoring the financial impact and had projected the impact on cash flow should the situation continue. The medical practice also had a line of credit, and though it was not utilized, was available should the need occur.

IV. Discussion

Research reveals that most medical practices do not have an emergency/disaster preparedness plan. Further, most administrators assume their doctors are up to date on all the emerging diseases and CDC recommendations (Grimshaw 2014). While chances are most medical practice executives will never experience anything as intense as this situation was, a review of the events

does serve to illustrate the need for a preparedness plan. The plan should include not only readiness for a natural disaster or a medical emergency, but also plans for managing media relations.

The first step to developing a practice's preparedness plan is to assess the existing status of the practice. It is recommended that during this assessment, all levels of practice operations are reviewed with an eye to potential exposure if a patient presents with a pandemic illness or bioterrorist disease. How/where are patients checked in and registered? Who conducts the triage process? What is the clinical staff's workflow with each patient (i.e. vitals taken outside the exam room, or inside?), how does the practice's floor plan aid/hamper additional exposure, how is the medical record shared across the organization? What is the level of preparedness with each staff member? Review your patient schedule and arrived patient list. Is there anyone that could have been exposed?

Once these types of questions are answered, the practice can then move to developing a specific plan for its practice. (Appendix A) In the event of a pandemic/bioterrorism occurrence, obvious measures are recommended, such as the following:

- Immunize your staff (if possible).
- Review standard infection control requirements, i.e. proper hand washing, sterilization, OSHA requirements, etc. Ensure appropriate PPE is available at adequate levels for the expected duration of the event.
- Consult the CDC website for status updates and recommendations. Consult state health departments, county/community health departments, local hospital announcements/press releases, law enforcement agencies, etc. frequently to be as current as possible on the state of the emergency.
- Educate your staff on the illness. Keep everyone up to date on emerging issues. Provide basic training to recognize potential symptoms.
- Prepare contingency plans, with focus on the "what if" a key staff member or provider becomes infected. The plan needs to include not only the staff member(s) absence due to their own illness, but absences occurring as a result of caring for family/friends that become ill.

- Consult with the landlord in the event it becomes necessary to disable ventilation systems to prevent the spread of the disease/bioterrorist agent.
- Review your patient schedule and arrived patient list. Is there anyone that could have been exposed? Is there a way to contact patients if the practice closes?
- Communicate with vendors. If medications/supplies are needed to treat a specific disease or agent, are there adequate supplies on hand? If a vaccine or antidote exists, does the practice have adequate stock?
- Conduct annual training with your employees, i.e. OSHA, HIPAA, Network Security audit and training, etc.

With a physical disaster such as a hurricane, tornado, or earthquake, additional measures are recommended, such as:

- Organize a communication plan, i.e. a "phone tree" for each staff member to call a handful of others, who then call another handful of employees in turn, install a 800 phone number for staff members to use before, during, or after a to quickly disperse each days plans and directives across all levels of the organization, and update your website each morning with the status of your practice (assuming it is possible, given the scope of the destruction).
- Set up a "civilian" exchange email, i.e. Yahoo, that is not subscriber based and can be accessed from any computer.
- Develop some redundancy with medical records. Are they scanned daily? Does your EMR reside in a cloud environment or a server? Is the server back-up daily? Is it in a secure data center?
- Is there a disaster supply kit at the facility? Are supplies adequate? Is an AED available and inspected regularly?

These steps are discussed in many different sources and for most practice executives, are the more obvious issues to consider. However, as has been demonstrated with this even, practices must also consider how to respond to the media in the event they are participants to an event being covered by the news media.

One approach is to appoint a Public Information Officer, if the practice is large enough to support one, or contract with an external Public Relations firm to hire an individual(s) to serve in this capacity. These individuals serve as the contact for media inquiries and coordinates communication between the organization and the public. They also assist with developing the message and work with key practice representatives to effectively present the image desired. These individuals have developed relationships with reporters in the community and are invaluable when deciding which station or reporter will be more sympathetic to the message being conveyed. In this case, Dr. Weinstein worked diligently with the hospital professionals to do so, even granting an exclusive interview to one reporter, Janet St. James, which was televised across news affiliates nationally. By effectively working with these public relations professionals, Dr. Weinstein effectively steered attention away from the four pulmonary outpatient clinics and other caregivers providing care to the affected patients.

If a practice executive has to communicate directly with the media, Jeff Crilley, an Emmy Award winning reporter suggests the following in the chapter titled, "Mike Wallace Is Here to See You" from his book, "Free Publicity":

- "Don't stick your head in the sand. The reporters will still be there when you finally come up for air.
- Denying works only if you're truly innocent.
- Half-truths leave you half-naked when the truth comes out.
- Honesty really is the best policy. If you mess up, 'fess up. Apologize and move on.
- Don't be afraid to show your human side.
- Appoint a spokesperson who's comfortable on camera.
- Never show anger, even when you're being attacked. It just doesn't play well on camera. The audience will decide if the reporters are being too tough. It's much better to play the victim of a hostile media instead."

Another suggestion is to have an "elevator speech" or official message prepared to communicate to patients or the media. The pulmonary/critical care practice used elements of this message to develop the script used by the staff when patients called or asked about the disease.

It is important to remember that most audio/visual media communications to the public rarely run more than a minute or minute and a half. (N. Carolina Department of Commerce) The message that is conveyed needs to concise, identifying three key messages to communicate, without too much detail, following the agenda the practice wants to communicate. Make it easy on the reporter. Have your message ready, bridging each point in the message fluidly and from negative to positive, using such phrases as "The bottom line is…", "What's most important here is…", or "It's critical that…" (Johnson, et. al. 2013) Respect the fact they are trying to perform a job too. Be ready and respect their need for information and respect the deadlines they are under. Make sure and understand the audience that will receive the communication and be clear with the tone/angle used. An executive will be much more likely to have a less aggressive exchange if they are well-prepared.

In their MGMA presentation, "Press Relations Training," Liz Johnson and Liz Boten quote Michael Romano, former *Modern Healthcare* reporter, who stated, "A good source, most importantly, is accessible-that is, available on deadline, and informed, willing to provide good information and direct quotes with a little flair." Understand that the media are not necessarily "the enemy", and actually be a useful tool for disseminating accurate and timely information. Further, reporters from different mediums (television, radio, and print) are interested in different things. Following are recommendations for dealing with the press, with additional points provided in Appendix B.

Potential pitfalls to be listening for include reporters repeatedly asking the same question (was the first answer not clear?), restating charged or negative words (repeatedly done with the Ebola media coverage thereby exacerbating the situation), or criticizing others (is almost never received well by the audience). Additionally, be ready to separate issues and/or clarify the issues if the reporter asks multi-pronged, hypothetical, or leading questions. (Johnson, et. al. 2013)

In their "Press Relations Training," Johnson and Bolton present interview do's and don'ts, as follows:

"Do's

- **Do** keep answers simple-don't assume that the reporter, or their audience, has the same background that you have
- **Do** say, 'I don't know, but will find an answer and get back to you'
- If you don't understand a question, **do** ask for clarification, rather than talking around it
- **Do** be prepared to answer the questions you hope aren't asked
- **Do** give examples-give the report something he/she can relate to

Don'ts

- **Don't** ask to see a copy of the story before it is printed
- **Don't** say 'no comment'
- **Don't** argue with a reporter
- **Don't** speak 'off the record'
- **Don't** decline an interview wrap-up 'last word'
- **Don't** assume the interview is over or has not begun"

One of the most important thing an executive can do is to coach all participants to not do two things. One is DO NOT SPECULATE. It makes the practice look ill prepared and not in control of the situation. The second, as stated above, never say "No Comment". It makes it appear the representative is un-cooperative or has something to hide. Use phrases such as "All I can say is…", "I can't answer that until I have more details…", or even "I am happy to try and answer those questions once I have spoken to the right people…" (Ourcommunity.com)

Lastly, consider addressing events offensively, rather than defensively. If appropriate, communicate the message and/or updates to patients and the public by creating a "media room" on the practice's website. If the practice uses social media, i.e. Facebook, Twitter, or LinkedIn, consider proactively posting updates or other communications to the public using these tools. Also to consider if the timing and content are appropriate, to draft and publish a press release on the practice website and/or send it to a sympathetic reporter or news outlet. (Johnson, et. al. 2014)

Conclusion

The news media is a powerful force in our world today. The impact they can have on the public's perception, reception, and actions cannot be underestimated. However, we as medical practice executives can be better prepared to aggressively react to events and protect patients from unnecessary fears.

The Ebola outbreak in Dallas was a serious medical event. The providers and staff worked extremely hard under ever-changing conditions, with patients that were infected with a disease they knew little about. The CDC's presence was appreciated, but misunderstood and in the end, not as effective as was hoped. It was a difficult time, but the media's impact on the hospital operations, the staff, and providers was not productive and only served to make a difficult situation worse. Eventually the hospital's public relations department produced advertisements of their employees stating they were "Presby Proud". The message was finally out there. This group of professionals supported each other and proudly provided the best care they knew how to give under remarkable circumstances. In the interim, however, was a cautionary tale to all medical practice executives of the need for preparations to communicate with the media.

References

Belmont, Elisabeth, Bruce Merlin Fried, Julianna S. Gonen, Anna M. Murphy, Jeffrey M. Sconyers, and Susan F. Zinder. 2004. *Emergency Preparedness: Response & Recovery Checklist: Beyond the Emergency Management Plan*. Washington, D.C.: American Health Lawyers Association. ftp://ftp.cdc.gov/pub/phlpprep/Legal%20Preparedness%20for%20Pandemic%20Flu/8.0%20-%20Non-Governmental%20Materials/8.2%20%20Emergency%20Response%20Checklist.pdf

Burrough, Bryan. 2015. "Ebola in the U.S.: How Dallas Rallied to Prevent an Epidemic." Vanity Fair. 8 January. Accessed 20 June, 2016. http://www.vanityfair.com/news/2015/02/ebola-us-dallas-epidemic.

Centers for Disease Control and Prevention. 2014. "CDC and Texas Health Department Confirm First Ebola Case Diagnosed in U.S." Center for Disease Control and Prevention website. 30 September. Accessed 20 June, 2016. https://www.cdc.gov.media/realeases/2014/s930-ebola-confirmed-case.html.

Centers for Disease Control and Prevention. 2014. "Cases of Ebola Diagnosed in the United States." Center for Disease Control and Prevention website. 16 December. Accessed 20 June, 2016. http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/united-states-imported-case.html.

Crilley, Jeff. 2003."Mike Wallace Is Here To See You." In "*Free Publicity: A TV Reporter Shares the Secrets of Getting Covered on the News*." 63-70. Dallas, TX. Brown Publishing Group.

Floyd, Jacquielynn. 2015. "Looking Back, Dallas Ebola Crisis Showed Cost of Fear, Value of Leadership." *The Dallas Morning News*. 26 September. Accessed 20 June, 2016. http://www.dallasnews.com/news/columnists/jacquielynn-floyd/20150926-dallas-ebola-crisis-showed-cost-of-fear-value-of-leadership.ece.

Gordon, Scott. 2014."Ebola Patient's Misdiagnosis Being Reviewed: Hospital Doctor Declines to Explain Why Patient was Mistakenly Sent Home." *NBC DFW.com*. 8 October. Accessed 20 June, 2016. http://www.nbcdfw.com/news/local/Texas-Senate-to-Hold-Ebola-Hearing-278381951.html.

Grimshaw, Heather. "Your Role in Infection Control." 2014. MGMA website. 7 Oct. Accessed 10 June, 2016. http://www.mgma.com/practice-resources/mgma-connection-plus/online-only/2014/october/your-role-in-infection-control.

"HELP SHEET Media: Preparing a Winning Strategy-Managing a Media Crisis." Publication date not available. *Https://www.ourcoummunity.com.au*. Ed. Our Community. Our Community PTY, Ltd. Victoria, AU. Accessed 06 July, 2016. https://www.ourcommunity.com.au/marketing/marketing_article.jsp?articleId=1520.

Henley, Kortchmar. 1982. "Dirty Laundry." On *I Can't Stand Still*" album, produced by Asylum Records.

Hennessy-Fiske, Molly. 2014. "Dallas Bids Farewell to Ebola-infected Nurse: 'We Love You, Nina'" *Los Angeles Times.* 16 Oct. Accessed 20 June 2016. http://www.latimes.com/nation/la-na-nina-pham-ebola-20141016-story.html.

Howard, Russell. 2014. "The Difference between US vs UK Ebola News Coverage." *YouTube*. YouTube.com. 24 Oct. Accessed 07 July, 2016. https://www.youtube.com/watch?v=lAz-F1QnyCk.

Ivelisa Smith. Interview with Office Manager. Telephone interview by author. 21 June, 2016.

Johnson, Liz, and Liz Boten. 2014. "*Media Magic: Working with Press and Social Platforms to Increase Your Chapter's Visibility.*" Presentation created MGMA leadership. 7 February, 2014.

Johnson, Liz, and Liz Boten. 2013. "*Press Relations Training: A Crash Course in Conducting Successful (and Less Stressful) Press Interviews*." Presentation created for MGMA leadership. 2013.

Kenney Weinmeister, M.D. Telephone interview by author. 18 August, 2016.

Meleah Orr. Interview with Administrative Office employee. Telephone interview by author. 21 June, 2016.

Nagel, Nanci. 2015. "Registered Nurses' Duty to Work With Ebola." PhD diss. A.T. Still University

North Carolina Department of Commerce. Publication date unavailable. "Tips for Dealing With the Media in a Crisis." Accessed 20 June, 2016. http://www.nccommerce.com/Portals/8/Documents/PR/MediaTips.pdf#search="tips for dealing with the media in a crisis"

Pope, Christina. 2006. "Are You Ready for Disaster? Prepararing Your Medical Practice for Pandemic Flu, Hurricanes, Bioterrorism." MGMA Connexion, Vol.6, Issue 7.

August. Accessed 10 June, 2016. http://www.mgma.com/practice-resources/articles/mgma-connexion/2001-2009/are-you-ready-for-disaster.

Stokes, Christopher D., and David N. Gans. 2009. "Ready or Not, Here Comes Disaster." *MGMA Connexion*, January. Accessed 06 July, 2016. http://www.mgma.com/Libraries/Assets/Practice%20Resources/Publications/MGMA%20Connexion/2001-2009/The-Data-Mine-MGMA-LEARN-poll-reveals-medical-groups-state-of-emergency-readiness-MGMA-Connexion-January-2009.pdf.

St. James, Janet. 2014. *"Texas Doc at Center of Ebola Cases in Tears over Loss."* *WFAA-TV*, Dallas-Fort, TX. *USA Today*. 18 October. Accessed 20 June, 2016. http://www.usatoday.com/story/news/nation/2014/10/18/ebola-doctor-dallas/17495951/.

Wolper, Lawrence F., David N. Gans, and Thomas P. Peterson. 2006. "Bioterrorism and the Physician's Office." In *Physician Practice Management: Essential Operational and Financial Knowledge.* 2006. Jones and Bartlett Publishers. Accessed 6 June, 2016. http://www.mgma.com/Libraries/Assets/Practice%20Resources/Tools/Bioterrorism-and-the-Medical-Practice-book-chapter.pdf.