



# **COMMUNICATING ABOUT INCENTIVES AND REWARDS**

## **A PRIMER**

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# INTRODUCTION

Recognizing and rewarding hospitals and doctors based on performance is increasingly viewed by policymakers, payers, and purchasers as the new frontier for improving both the quality of health care and the value of the health care dollar. Both public and private purchasers and health plans of various sizes have introduced programs to realign the incentives in health care with quality and efficiency. These programs are proliferating; a database of incentive and reward programs maintained by The Leapfrog Group indicates that as of March 2005, there are at least 90 programs in effect throughout the country.<sup>1</sup>

**Many of the challenges to successful incentive and reward programs can be addressed with effective communications strategies.**

Despite this proliferation of efforts, they face a number of communications challenges. Consumers are exposed to increasing amounts of health care performance information, physicians are reticent about the utility and validity of this kind of comparative data, and journalists have a difficult time trying to explain the nuances in an accessible language that can be widely understood.

As part of its work on the Robert Wood Johnson Foundation initiative, *Rewarding Results: Aligning Incentives with High-Quality Health Care*, The Leapfrog Group has commissioned leading experts in communicating quality-related information to offer their knowledge and advice based on research and experience to help ensure the success of your incentive and reward program. This primer is the first of its kind to help quality improvement leaders like you effectively communicate about pay for performance and its link to better health care quality. This practical tool-kit will help you communicate with three critical audiences: consumers, physicians, and the media. In three chapters, we provide hands-on advice on how to reach these audiences, reflect on which strategies to avoid, and describe which barriers you need to remove to effectively deliver your critical messages and sway opinion.

In Chapter 1, University of Oregon professor Judith Hibbard, M.P.H., Dr.P.H., presents effective, actionable ways to communicate with consumers. Hibbard, who has conducted a number of studies on how consumers use information to make health care decisions, elaborates on the role consumers play in motivating health care providers to improve and describes the steps that purchasers, health plans, and others could use to get them more engaged. She presents four major barriers that hinder consumer use of performance information and the implication of these barriers; examines common reporting approaches that contribute to consumer complacency; and offers effective strategies such as “framing” and “narratives” to get consumers to pay attention.

In Chapter 2, Yale University School of Medicine researchers Leora Horwitz, M.D., Harlan Krumholz, M.D., and Elizabeth Bradley, Ph.D., offer a “how-to” guide for communicating information to health providers about their performance. Horwitz and colleagues make the case that communicating with physicians about their performance is critical to effective quality improvement. This enables physicians to identify where changes in practice are needed, motivates providers to change practice based on their performance, provides key data to evaluate how effective changes are, and spotlights key measures of performance so that providers stay focused on them over time. Using published literature and their own experience, the Yale authors offer practical principles and strategies for communicating performance information when providing feedback.

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<sup>1</sup> The Leapfrog Group, “Leapfrog Compendium,” June 2004, [www.leapfroggroup.org/leapfrog\\_compendium](http://www.leapfroggroup.org/leapfrog_compendium) (March 1, 2005).

In Chapter 3, seasoned experts from Burness Communications, one of the top firms in the United States that specializes in teaching nonprofit health organizations how to communicate effectively, gives you the tools and strategies you'll need to inform the public about what you do and why you do it. Chapter 3 examines why communicating is one of the most important things your organization will do to raise and maintain visibility, what makes a good message, how to develop a message, and how to deliver your message to a variety of audiences. The authors also explain the breadth of media that can help you connect with the public, how to pitch a story to a reporter and stick to a message, and what tools you can use to promote your efforts. This chapter also includes a "how-to" guide on writing news releases, and developing op-eds and letters to the editor; and it offers suggestions on how to use real stories and illustrations to make your program more appealing and understandable to a broad audience.

We hope this primer serves as a useful resource to you and helps you develop successful and effective communications strategies for your incentive and reward programs.

# CHAPTER ONE:

## COMMUNICATING WITH CONSUMERS

### OVERCOMING CONSUMER BARRIERS TO PUBLIC PERFORMANCE REPORTS

More than ever before, we are relying on consumers to help in the effort to control health care costs and to improve the quality of care. Strategies to motivate health care providers to improve often rely on consumers to use performance information to inform their choices. To date, few of these public reporting strategies have been successful with consumers. Even though consumers say they care about the quality of their health care, actual use of the information has been disappointing.

Considerable effort and resources go into creating public reports. What can be done to ensure that they actually get used? Fortunately, there is an emerging evidence-base about how to effectively report comparative performance information. Drawing on that evidence-base, this chapter discusses the major barriers to consumer use of performance information, looks at common reporting approaches that contribute to the problem of non-use, and identifies strategies that have been shown to be effective.

#### **Four major barriers to consumer use of performance information:**

- Consumers do not know that there is a quality gap
- Consumers do not understand what is meant by high quality care
- Indicators are often hard to understand or are not meaningful to consumers
- Using quality information to inform choices is hard cognitive work

### CONSUMERS DO NOT KNOW THAT THERE IS A QUALITY GAP

All of us have heard over and over again that we have the highest quality medical care in the world. At the same time, messages about the significant and pervasive quality gaps in health care have been much less omnipresent. Thus, it is not surprising that there is a widespread belief among consumers that the technical quality of care is high and uniformly so across providers, health plans, and hospitals. If the technical quality of care were actually uniformly high, as many believe, then ignoring public performance reports would make sense.

Consumers know, from their own experiences, that the interpersonal aspects of health care do vary considerably. However, this is an area of care that they feel more qualified to judge on their own.

#### **Implication:**

Consumers often do not understand that there could be adverse consequences associated with a poor provider choice. That there could be a great deal at stake when making health care choices is often not recognized. **In essence, it isn't clear to many people why they should bother.**

## Possible solution:

### Messages that draw consumer attention to possible downsides of a poor choice can help overcome the problem of the invisibility of the quality gap

This is a delicate issue. We want people to understand the risks, but we don't want to scare them or undermine their trust in their providers. It is not realistic to try to educate consumers about the scope and the nature of the quality gap within the confines of a public report. An alternative is simply to draw their attention to possible downsides of a poor choice.

One way to highlight information is to use **decision framing**. Framing emphasizes either a potential loss or the potential gain involved in a choice. Research has demonstrated that the way a decision is framed strongly influences people's preferences, in some cases resulting in complete reversals of preference. For example, Hibbard and colleagues (2000) examined framing effects on the choice of a health plan. In this experiment, one group received comparative CAHPS in the usual way ("how to get the best quality"). Another group received the same data, but the decision was framed as a loss or risk ("protect yourself from problems in health plans"). Framing the health plan decision as a possible loss significantly increased how well the comparative information was understood, how much it was valued, and how much weight it received in choices. Framing highlights the meaning of particular elements of the information and draws the decisionmaker's attention to a potential outcome.

#### **SUCCESS STORY: Highlight Information for Consumers**

- *Decision framing* – emphasizing a potential loss or gain involved in a choice. Consumers need to know a bad decision can put them at risk.
- *Storytelling* – making information more memorable and comprehensive by giving context and meaning to dry data and facts.

Consumers need to know that a bad decision could put them at risk. Framing messages that highlight risks will draw their attention to this possibility and make the reasons for using performance data more compelling.

Another strategy that will highlight information is the use of narratives or stories. Stories tend to make information more memorable and more comprehensible by giving context and meaning to dry numbers and facts. Stories make experiences come alive for the reader in a way that tables and charts cannot. In choices that are made infrequently, consumers are not able to learn from their own past experience and may lack an understanding of what a particular choice might actually mean to their lives. Stories from other consumers who are in similar situations can help the individual understand what might be important to consider in such a choice.

Finally, stories help by making information more engaging and interesting, and thereby improves the motivation to attend to and use information. Narratives can help to make risks, such as the risk of selecting a poor quality provider, more real and increase the chances that an individual will consider such risks in their decision-making. Research shows that narratives help sensitize consumers to the factors highlighted in the story and it helps them to more effectively integrate those factors into choices (Satterfield, Gregory, Slovic 2000).

## **CONSUMERS DO NOT UNDERSTAND WHAT IS MEANT BY HIGH QUALITY CARE**

In a survey in California, consumers indicated that they defined quality of care as: having a choice of doctors, good communication with providers, and doctor qualifications (Kaiser Family Foundation, 2000). This is quite different from the concept of health care quality that is represented in most public performance reports.

### **Implication:**

Consumers will not be in a position to make full use of quality information until they have a better understanding of what is meant by quality of care. People tend to discount as less important concepts they do not understand (Hibbard & Jewett, 1997).

**It is critical that we communicate clearly what we mean by quality of care.**

### **Possible solution:**

**If consumers are given a framework for understanding quality issues, they are more likely to understand and use the information in making choices.**

Educational theory suggests that if you give people a framework for understanding concepts (or the “big ideas”), then they will be more likely to be able to integrate new pieces of information into the framework (Carnine, 1994). Current reporting approaches tend to give people all the little ideas without an organizing framework for them to hang them on. This increases the chances that all the individual facts will have little meaning. Providing a framework would help consumers understand what is meant by quality. It would help them to understand what they should be looking for in seeking high quality care.

So what are the “big ideas” that will help consumers understand? They are the same big ideas, or a translated version, that help policy analysts, health services researchers, and industry leaders understand quality of care issues. The framework put forward in the Institute of Medicine (IOM) report *Crossing the Quality Chasm* is a basis for understanding and evaluating the quality of medical care. The categories in the framework are effectiveness, safety, patient centeredness, timeliness, equity, and efficiency. The framework provides us with a common language and understanding.

If all public reports show performance measures in each of the categories of **safe, effective, and responsive to patients**, consumers would come to understand that these areas are central to quality care and expect information about those areas when choosing a health care provider or delivery system.

If all public reports gave even an abbreviated and translated version of the IOM framework, it would send a consistent message of what high quality should be, for example (Hibbard and Pawlson, 2004):

- *Safe (causes no harm)*
- *Effective (improves health and functioning)*
- *Responsive to patients*

If a single framework were used in a consistent manner and consumers repeatedly saw performance information within that framework, it would take us a long way toward helping consumers understand what quality is. Further, if all public reports show performance measures in each of the categories of— *safe, effective, and responsive to patients*—

consumers would come to understand that these areas are central to quality care and they would also come to expect information about those areas of performance when choosing a health care provider or delivery system.

## **INDICATORS ARE OFTEN HARD TO UNDERSTAND OR ARE NOT MEANINGFUL TO CONSUMERS**

Performance indicators are frequently misinterpreted. For example, some hospital reports include Length of Stay (LOS) or re-admissions as performance indicators. Longer LOS and higher re-admissions are intended to indicate poor performance. However, many consumers will view it as a measure of access and interpret it in the opposite way—a high score shows that patients are able to stay in the hospital for as long as they need to and are re-admitted when necessary.

Some measures are incomprehensible to consumers. For example, reporting on such things as administration of Beta Blockers and Ace Inhibitors assumes a higher level of clinical knowledge than most consumers possess.

Some indicators are understood but consumers do not view them as important or useful.

### **Implication:**

By using reporting categories that are difficult to understand or are viewed as meaningless, we risk either discouraging the use of public reports or inappropriate conclusions about the meaning of the data.

### **Possible solution:**

#### **Including only quality indicators that are understood and viewed as important by consumers will increase the use of public performance reports**

It is always a good idea to select measures for inclusion in a report with all the end user audiences in mind. If the IOM framework (or an abbreviated version) is used, then performance indicators in the categories of the framework would need to be included.

All consumers really want to know is whether the right thing is being done at the right time for patients.

The current practice of labeling performance categories in ways that require the viewer to have an understanding of the clinical issue is neither necessary nor desirable. For example, a label such as: "effective and appropriate treatment," is easier to understand than the label "ACE inhibitors." By allowing the viewer to drill down to find out the details of the measure, the specifics can still be available without burdening the majority of

viewers, who will be satisfied with the more general label.

To assure that the categories of performance and the actual measures used in the report are meaningful and comprehensible to consumers, cognitive testing is essential.

## **USING QUALITY INFORMATION TO INFORM CHOICES IS HARD COGNITIVE WORK**

**Processing information, differential weighting, making trade-offs, and bringing factors together into a choice are difficult cognitive tasks.** Using performance reports to inform choices involves reviewing and *processing* a large amount of information and then applying that information to a choice. Public reports tend to present information on multiple pages, some as long as 60 pages of data. As the number of factors to consider increases, people's ability to use that information to inform their choice decreases. Giving people lots of information can be counter productive (Vaiana & McGlynn, 2002; Hibbard, Slovic, &

Jewett, 1997). Humans can only integrate a limited number of factors into a choice. When asked, it is not uncommon for consumers to indicate they want more information. However when faced with actually using it in choice, they feel overwhelmed by the amount of information.

**Implication:**

When faced with the kind of complexity found in most public performance reports, consumers will likely adopt one of these strategies:

- Do nothing, ignoring the report and stay with their current choice if that is an option;
- Use alternative sources of information, such as friends or family; or
- Take a decision shortcut, using one or two factors that are familiar, while ignoring other important factors.

Any of these strategies could easily undermine the decisionmakers own self-interest. That is, because the task is difficult and burdensome, consumers are less likely to actually use the data to inform their choices (Hibbard, Slovic, and Jewett, 1997).

Having to make *trade-offs* among different categories of factors (e.g. driving further in order to see a higher performing provider) or factors within a single category (e.g. should you choose a hospital that rates well on patient satisfaction but less well on infection rates?) are very difficult cognitive tasks.

*Differential weighting* of factors in a choice is similarly problematic for people. Most performance reports are constructed on the assumption that people will care about different elements of care. The inclusion of multiple performance measures on different elements of care in one report is typically done so that people can pick and choose, and differentially weight factors, according to their preferences. In reality people have a very hard time differentially weighting, and even when they think they are doing so, they often are not (Hibbard, et al 2002). Thus, processing a large amount of information, selecting relevant factors and differentially weighting them, then bringing all the weight factors together into a choice is what is required when using comparative data to select a provider. However, research shows that these are onerous cognitive tasks, ones that human beings are not very adept at.

To summarize, consumers face a number of cognitive challenges in trying to use comparative performance information to inform choices, including:

- Comprehending and processing multi-page reports;
- Being able to apply that information to one's own situation including the ability to anticipate one's future health care needs; and
- Making trade-offs, differential weighting of factors, and bringing all the factors together into a choice.

**Possible solutions:**

**There are three major approaches for reducing the cognitive burden on consumers: provide an information intermediary; provide decision support tools; or use visual data displays that summarize and interpret the information.**

- Provide an information intermediary—someone to help the individual translate and apply the information to their own individual situation.

- Provide decision support tools to do some of the cognitive work for the viewer
  - If information is computer- or Web-based, the use of well-designed decision support tools can help to make decisions easier for consumers by performing many of the difficult cognitive tasks for them. Decision tools can ease the burden involved in decision-making by structuring the decision process and by highlighting the important factors for consideration. Decisions can be broken down into smaller decision steps, and the computer can use the decisionmaker’s own values and preferences to weight variables differentially in a choice. The tool can also bring all the factors together into choice.
- Use visual data displays that summarize and interpret the information for the viewer.
  - An alternative, for use with either electronic or print-based information products, is to use visual displays of information that are designed to lower cognitive effort, making it easier to discern better and worse options. For example, just ordering options on performance, best to worst, helps to make it easier to use that information in making a choice. Another example of evaluability is simply summarizing the data and highlighting better options. Table 1 shows an example of evaluability or “doing the work” for the information user. By looking for the “best value” label the information user does not have to try and summarize the information themselves.
  - Making it easier means that it is more likely to get used. Research shows that information displayed in an “evaluable” format is more likely to actually get weighted and used in choice than the same information in a less evaluable display format (Hibbard, et al 2002). One strategy is to combine print materials with a Web-based report. In the print version, information can be made brief by summarizing and interpreting for the viewer. The print materials can then refer the user to a Web-based version of the report where details can be found by drilling down to more granular information.

Instead of having to think hard about how to interpret information, an “evaluable” display reduces the effort required by providing these evaluations in a simpler form. The evaluability of information can be improved in a variety of ways.

**Exhibit 1. Summarizing and Highlighting Information Reduces Cognitive Burden**

**SUCCESS STORY:  
Summarizing and Highlighting**

To use information in making a choice one must first be able to summarize in one’s own mind what the information is telling them. Information displays that summarize information and help interpret it do some of the hard cognitive work for the viewer. Exhibit 1 shows an example of this.

Using Evaluability and Labels to highlight meaning and reduce burden

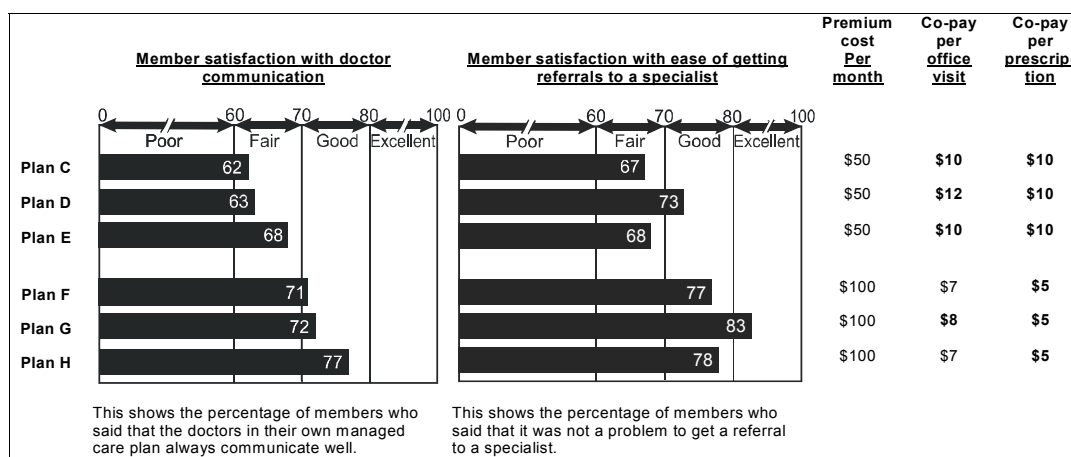
		<u>Consumer ratings</u>	<u>Preventive care</u>	<u>Premium</u>
Health Advantage	<i>Best value</i>	★★★★	★★★	\$80
Secure Horizons		★★★	★★	\$100
Advantage Plus		★	★★★	\$95
Health-Net	<i>Best value</i>	★★★★	★★★	\$85

## SUCCESS STORY: Interpreting the Information

Just adding labels that interpret the numbers for the user (e.g. poor, fair, good, excellent in Exhibit 2) helps to give meaning to data and increases the use of that information in choice. In controlled experiments with consumers, the addition of the labels influenced choice and made the information easier to use. Exhibit 2 shows an example of this.

### Exhibit 2. Labels That Interpret Information Help the Viewer

Adding labels makes information more evaluable.






When data displays become more complex, as in the above table, using evaluable approaches becomes more important and consumers will rely on them more to help them use the information.













































































- **Use symbols that are inherently meaningful.** People who have difficulty deriving meaning from numbers (those with low numeracy skills) are helped by the use of symbols in data displays. Using symbols that are inherently meaningful also reduces the cognitive burden in interpreting the information (see exhibit 3). This is true because the viewer will not have to hold information in their mind while continually referring back to the legend to try and discern the meaning of the data display.
- **Show all the data on one page.** Many public reports have multiple pages of data to process. Data displays that can be viewed on one page require much less cognitive effort to process and use.

## SUCCESS STORY: Order By Performance

Ordering is one of the most powerful of the evaluability strategies. The choice task involves figuring out which is the best option. By ordering the information by performance, much of the difficult work is done for the viewer (see exhibit 3).

### Exhibit 3. Mock-Up QualityCounts Hospital Report by Employer Health Care Alliance Cooperative (Wisconsin)

What the symbols mean:  
 Fewer mistakes, complications and deaths than expected  
 Average number of mistakes, complications and deaths  
 More mistakes, complications and deaths than expected

Regional Hospitals	Surgery	Non-Surgery	Hip/Knee	Cardiac	Maternity
Hospital A					
Hospital B					
Hospital C					
Hospital D					*
Community Hospitals	Surgery	Non-Surgery	Hip/Knee	Cardiac	Maternity
Hospital F					
Hospital G					
Hospital H					
Hospital I					
Hospital J					
Hospital K					
Hospital L					
Hospital M					*
Hospital N					
Hospital O					
Hospital P					*
Hospital Q					*

The QualityCounts report was designed to make it easy for the viewer to be able to quickly identify the better and worse options. All five of the evaluability strategies discussed thus far were used in the design of the data display:

- Two **summary measures** of performance were provided (surgery and non-surgery)
- The hospitals were **ordered by performance** within the two categories of hospitals
- **Inherently meaningful symbols** were used, making it less necessary to hold information in mind while continually referring back to a legend (a plus sign means good, a minus sign means something bad).
- The highest performing hospitals were **"highlighted"** with a color band
- The entire data display could be viewed on **one fold out page**, making it unnecessary to hold information in one's mind as multiple pages are viewed.

To test whether report formats are in fact evaluable, determine how quickly respondents can easily identify high and low performers (or better and worse options). Just asking consumer preferences for report formats does not insure they are evaluable formats or formats that will support decision-making!

In summary, designing public reports so that they are highly evaluable, like the one shown in Exhibit 3, helps sponsors reach reporting goals in three ways:

- It motivates consumers to use the information because the task of incorporating it into choice is made easier;
- It highlights differences and sends the message that choices are consequential; and
- It motivates providers to improve because their reputation is more likely to be affected by a highly evaluable report (Hibbard, et al. 2003).

## **SUMMARY**

While there are serious barriers to consumers using public reports, there are proven strategies that can help:

- Use strategies, such as framing and narratives, to highlight the reason why it is important to pay attention to quality when making health care choices.
- Help consumers comprehend what is meant by quality-of-care by providing them with a framework for understanding quality.
- Use reporting categories that are meaningful and comprehensible to consumers.
- Make the task easier by using evaluable reporting formats that do some of the cognitive work for the viewer.

## **REFERENCES**

- Carnine D.: Diverse learners and prevailing, emerging, and research-based educational approaches and their tools. *School Psych Rev* 23:341-350, Fall 1994.
- Hibbard J.H., Slovic P., Jewett J.J.: Informing consumer decisions in health care: implications from decision-making research. *Milbank Q* 75: 395-414, September 1997.
- Hibbard J.H., Jewett J.J.: Will quality report cards help consumers? *Health Aff (Millwood)* 16:218-28, May-June 1997.
- Hibbard JH, Harris-Kojetin L, Mullin P, Lubalin J, Garfinkel S. 2000. Increasing the Impact of Health Plan Report Cards by Addressing Consumers' Concerns. *Health Aff (Millwood)* 19:138-43.
- Hibbard JH, Slovic P, Peters E, Finucane ML. 2002. Strategies for Reporting Health Plan Performance Information to Consumers: Evidence from Controlled Studies. *Health Serv. Res.* 37:291-313.
- Hibbard J.H.: Engaging Health Care Consumers to Improve the Quality of Care. *Med Care.* 41 (Supp I):61-70, January 2003.
- Hibbard JH, Stockard J, Tusler M, Does Making Hospital Performance Public Increase Quality Improvement Efforts? *Health Affairs.* 2003;22(2):84-94.
- Hibbard JH and Peters EM, Supporting Informed Consumer Health Care Decisions: Data presentation approaches that facilitate the use of information in choice. *Annual Review of Public Health.* Vol 24, 413 – 433. 2003.
- Hibbard JH and Pawlson LG, Why Not Give Consumers a Framework for Understanding Quality? *Joint Commission Journal on QualityImprovement.* June 2004.
- Kaiser Family Foundation, and the Agency for Healthcare Research and Quality: Americans as health care consumers: update on the role of quality information. Highlights of a national survey. <http://www.ahrq.gov/qual/kffhigh00.htm>, Rockville, MD December 2000.
- Satterfield T, Slovic P, Gregory R. *Ecological Economics.* 2000
- Vaiana ME, and McGlynn EA. What Cognitive Science Tells us about the Design of Reports for Consumers. *Medical Care Research and Review.* 59:3-35. 2002.

# CHAPTER TWO: COMMUNICATING PERFORMANCE TO PROVIDERS

## **IMPORTANCE OF RELAYING DATA FEEDBACK TO PROVIDERS**

Despite the recent proliferation of performance measurement tools, there exists little guidance on how best to communicate performance data to physicians. We argue that communicating with providers about their performance is central to effective quality improvement programs, and if done effectively, such data feedback can help sustain improved quality.

This chapter is a practical “how-to guide” for communicating performance information to health care providers about their quality of care. We offer practical principles and strategies for communicating performance information to providers so that it is as effective as possible in supporting other quality improvement efforts. The information in the chapter is based on published literature<sup>1-5</sup> and our own experience concerning performance data feedback for physicians,<sup>6,7</sup> although the principles and strategies may be extrapolated to feedback for other health care providers.

### **Why is Communication of Performance Information Important?**

Many studies<sup>1-7</sup> have demonstrated successful use of data feedback, or communication of performance information to providers, in driving changes in clinical practice. These successes have included changes in laboratory ordering patterns, medication use and treatment choices. In addition, data feedback has been effective in achieving these goals across a range of medical specialties and in both ambulatory and hospital settings.

Communicating performance information with providers is an important component of successful quality improvement efforts. It:

- Identifies where changes in practice are needed;
- Motivates providers to change practice based on their performance;
- Provides key data to evaluate whether changes providers may have made to improve care are “working”; and,
- Keeps a spotlight on key measures of performance, so that providers’ attention remains focused on these areas over time.

Despite evidence suggesting the value of data feedback efforts, not every feedback attempt is successful in changing practice.<sup>8-10</sup> Based on reports of successful and unsuccessful interventions<sup>1-7</sup> as well as our own qualitative work evaluating interventions,<sup>6,7</sup> we have broken down this chapter into two parts:

- General principles that are important for effectively communicating performance information to providers; and,
- Specific strategies that have proven most effective.

## **GENERAL PRINCIPLES FOR COMMUNICATING PERFORMANCE INFORMATION**

- Data must be **valid**. Equally important, data must also be **credible**.
- The **target** of feedback should be carefully chosen.
- Physician **leaders** should be involved early and a positive organizational **culture** established.
- Communication of performance information must be **ongoing** to maintain results.

### **Validity and Credibility**

Key issues are the validity and credibility of the data. Physicians and others often question the validity of performance data when it is first presented.<sup>7, 11</sup> This is particularly the case with poorly-performing providers.<sup>12, 13</sup> It is imperative, therefore, to anticipate objections and to be ready to respond to such objections in a way that promotes the trust in and credibility of performance data.

- **Source.** The source of performance information is an important component of perceived data validity. When developing data for feedback, it is important to consider the following common pitfalls:
  - *Use of administrative or billing databases*  
Concerns are commonly raised about data from administrative or billing databases, and the codes often do not well represent the clinical condition of individual patients. Therefore, such data may be viewed with suspicion by physicians.<sup>14-16</sup> To reduce this problem, the method of data collection should be validated and the results presented to physicians.
  - *Abstraction of data by a non-health care professional*  
Physicians may be quick to denounce data collected by someone who has limited or no clinical experience.<sup>7</sup> If such a person collects data, he or she should be carefully trained and evaluated, and his/her training should be emphasized to physicians.
  - *Presentation of data by a non-health care professional*  
Given their training in scientific disciplines, physicians tend to question data aggressively, including data presented with performance reports.<sup>7, 11, 15</sup> If the presenter cannot address questions based on physicians' clinical concerns, it will be difficult to convince physicians of the data's validity. Data feedback should always be presented by a health care professional knowledgeable enough to address clinical concerns.
- **Timeliness.** The more delayed the feedback, the less credible it is as an indicator of current practice, and the less likely physicians are to act upon the information. Outdated information may be dismissed as irrelevant because of changes in practice and may not create the same urgency for improvement as more immediate feedback.<sup>11</sup> Feedback efforts should therefore occur as close as possible to the time of the event. Published studies with positive results tended to provide feedback

To enhance the **validity and credibility** of performance data:

- Be sure the **source** of the data is trusted
- Ensure **timeliness** of performance data
- Provide the data in a **clear** fashion with **transparent** sources
- Be ready and informed to **respond intelligently to criticism**

within one to two months; many of those with negative results had more delayed feedback periods.<sup>8, 10, 11, 17</sup>

- **Transparency and clarity.** Data presented without explanation of their source are less likely to be accepted than data gathered in a clear and reproducible fashion.<sup>7</sup> Institutions that are clear and forthright about the methods of data collection and analysis will likely be more successful than those that are less explicit about these methods. Such information might include clear definitions of terms, inclusion and exclusion criteria, number of cases reviewed, time period of review, and statistical aids such as the confidence intervals around estimates. It is best to include information on methods of data collection and analysis from the start in presentations of performance information.

In addition, data should be presented in a format that is easily comprehended by physicians and others who may have limited time to spend reading long and involved performance reports. Paying attention to formatting is important, so that information can be transmitted in the clearest and quickest manner possible. Data must be summarized succinctly and simply, with adequate detail appended for those interested in added depth. If questions persist, providers may wish to examine the original data sources directly.

- **Responsiveness to criticism.** If physicians or other health care providers discover flaws in the data collection and analysis, rapid correction of these flaws will improve acceptance of the data.<sup>7</sup> If changes in data collection and analysis methods are impractical, responding quickly and effectively to these criticisms can be helpful for creating an atmosphere in which providers feel the organization is committed to continuous quality improvement, including improvement of its own data. Such responsiveness to methodological questions can create a positive organizational culture that can enhance trust and credibility.

### **Target the Performance Data Feedback**

- **Target personnel.** Performance data feedback should be targeted to all the providers responsible for the performance being measured, including as necessary administrative staff, trainees, nurses, primary care physicians and specialists.<sup>11</sup> In addition, the recipients of performance data feedback must also be in positions to improve upon it. To alter prescribing patterns in an academic teaching hospital, for example, it is best to target the physicians-in-training who write the orders for the medications in addition to their superiors, who can only indirectly change behavior.<sup>18</sup>

Performance data is most meaningful to providers if they are in fact responsible for the processes that affect the performance indicators being monitored. If colleagues, departments or systems outside their control are primarily responsible for suboptimal performance, physicians may become frustrated and angry at being held responsible for a problem they feel is beyond their purview. One study of polypharmacy in the elderly, for example, found that physicians responded to only 40 percent of recommendations to stop a medication, primarily because a different physician was responsible for the prescription.<sup>19</sup>

- **Target performance area.** The information provided for feedback must also adequately target the performance being measured. Data needs to be detailed and comprehensive enough to illuminate not only a problem, but the likely sources of the problem and, ideally, shed light as to appropriate methods of improving

performance.<sup>10</sup> Highlighting high levels of thyroid function test ordering, for example, does not give providers the same insight into possible overuse as highlighting high levels of thyroid function test ordering among elderly patients, patients with known thyroid disease, or women with infertility because different frequencies and intervals of such testing are recommended for each of these groups. At the same time, data should also not be so detailed that the overall message is lost. Including on performance reports enough detail to identify the specific problem and how it might be fixed, yet not overwhelming providers with too much detail, is a careful balance that may require several iterations to get right.

## **Leadership and Culture**

- **Leadership.** Quality feedback programs initiated or endorsed by physician leaders are generally more successful than those imposed by outsiders.<sup>10, 20</sup> Effective physician leaders motivate other physicians to participate; they serve a crucial role in confirming (and conferring) data validity; and they may directly present the data to physicians. It is thus helpful to recruit physician leaders early to support and manage the processes of developing and communicating performance information.
- **Culture.** A culture of quality, in which there is genuine concern for performance improvement and adequate trust within and across disciplines to sustain quality improvement efforts, is one of the most important factors in generating physicians' acceptance of feedback on their performance.<sup>21</sup> Physician leadership is an important facet of this culture, but senior management leadership in quality and the attitudes of "rank and file" physicians toward quality improvement are also important. One study has even found that a positive organizational culture can mitigate much of the negative effect of irrelevant data or data of questionable quality.<sup>22</sup>

## **Continuity**

Even the most effective intervention will lose its potency over time if it is not consistently reinforced and repeated. A one-time communication of performance information may spark short-term action, but if physicians do not receive such feedback regularly they may lose interest, and it will be difficult to sustain the gains made through initial efforts. Most studies find substantial attenuation of improvement efforts within one year after last feedback; some after only six months.<sup>23-26</sup> To be effective for quality improvement, therefore, feedback must be ongoing.

## **SPECIFIC STRATEGIES FOR COMMUNICATING PERFORMANCE INFORMATION**

There are many strategies for effectively communicating performance information to health care providers. This section describes four specific strategies which may be used alone or in combination when providing feedback.

- Individual physician **profiling**
- **Benchmarking** to guidelines, colleagues and peer institutions
- **Incentive** programs
- **Combining** performance information with other interventions

## Individual Physician Profiling

One of the easiest methods of providing feedback to providers is to post performance information in a readily accessible place, such as a hospital website, department newsletter or other format available to a wide variety of providers. However, general distribution of performance information provides little direct motivation for change. Further, as information overload becomes more of a problem for physicians, generally distributed performance information may not even be noticed. And finally, if feedback is provided for a group of providers, members of the group may assume others in the group are the source of problems that may be highlighted in performance information. Physicians markedly overestimate their personal compliance with quality guidelines.<sup>18, 27</sup> Generalized distribution of performance information therefore may have limited effectiveness.

- **Gains of individual physician profiling.** Profiling of individual physicians, on the other hand, provides an effective means of communicating performance information because individuals can review their own performance and potentially compare their actions with that of others or with guidelines. In a recent study,<sup>28</sup> for example, one group that tried to improve colorectal cancer screening rates first tried disseminating the rates of group compliance with recommendations and had no effect. When the researchers switched to distributing individual compliance rates ranked with peers, screening rates increased significantly and remained elevated after one year of follow-up.
- **Cautions of individual physician profiling.** However, profiling physicians' performance in data feedback can be risky. Physicians are often wary of proposals to create individual profiles.<sup>7</sup> In addition to the usual concerns about data quality, particularly issues of adequate risk-adjustment, physicians with low volumes (or for whom small samples are reported) may be concerned that a few cases may unduly affect their quality measures. Further, physicians may worry that poor results will lead to punitive measures;<sup>7, 16</sup> administrators similarly may have concerns that physicians will respond negatively even if punitive measures are not planned.<sup>29</sup> Here the culture of the organization is of paramount importance. Organizations with a clear commitment to quality and a collaborative and trusting work environment may be more successful instituting physician profiling programs.

## Benchmarking

Benchmarking is the practice of including comparative information with data feedback.

- **Gains of benchmarking.** Providing clear comparisons along with performance information is a useful way of making feedback more meaningful. Comparisons may be made to accepted guidelines, to peer institutions (if data are aggregated by institution), or to colleagues (if data are reported for individual physicians). One study of influenza vaccination rates found that giving individual feedback to physicians improved rates significantly, but the improvement was tripled in the group of physicians that received both individual feedback and comparison to top performers in their peer group.<sup>30</sup>
- **Cautions of benchmarking.** Appropriate measures of comparison must be selected in order for benchmarking to be effective. If peer data are used, physicians must

Physicians generally like the comparisons; in one study, 75 percent of physicians appreciated getting comparison data on peers.<sup>31</sup>

believe that their peers treat comparable types of patients for the comparison to be meaningful to them. If guidelines are used, physicians must believe the guidelines are correct and important. One unsuccessful trial to change prescription rates was thought by the authors to have failed because physicians did not believe in the guidelines.<sup>32</sup> Education about the measures can be helpful in this regard.

Benchmark data are also ideally presented at the same time as the performance information. One study that distributed practice guidelines first and then performance feedback every three months afterwards was ineffective; one reason might be that months later physicians did not remember the specifics of the guideline.<sup>8</sup>

### **Feedback Coupled with Incentives**

Coupling feedback with incentives is an increasingly popular strategy. Incentives, when used appropriately, can be an effective adjunct to data feedback in achieving improved quality. Although most incentive programs are monetary, such as pay-for-performance programs, incentives need not be purely financial, nor even explicit. When status and/or professional reputation are founded on quality measures, social and professional incentives exist for improving quality. One qualitative study found that, when interviewed, physicians acknowledged that these implicit incentives affected performance.<sup>11</sup>

- **Gains of incentives.** Rewards for good performance can both create a more positive culture and promote sustained or further improvement. A recent monograph published by the National Health Care Purchasing Institute described several key factors in instituting successful physician incentive programs, based on interviews, published literature and focus groups.<sup>33</sup> The key factors in their study were:
  - The level of trust between the physicians and the individuals and organizations implementing the incentives;
  - The size of the financial incentive;
  - The peer and/or consumer knowledge of individual provider performance;
  - The perceived and actual accuracy of the data on which the incentives are based;
  - The stimulus and need for change recognized among physicians;
  - The level of support for the incentive program in the medical leadership;
  - The practicing physicians' knowledge and understanding of the performance incentives/sanctions; and,
  - The simplicity and directness of the incentive program.

Many of these are consistent with our key principles for meaningful communication of performance information, but some factors, such as the size of the financial incentive, are specific to the strategy of implementing feedback with incentives. Rewards must be perceived as fair and attainable and be significant enough to induce change.

#### ***SUCCESS STORY: Rewarding Good Performance***

Anthem Blue Cross (ABC) Blue Shield of New Hampshire, for example, instituted monetary and non-monetary rewards (such as plaques and publicity for high-performing practices) in 1999 for achieving high levels of performance in several clinical areas including cancer prevention, diabetic care, immunizations and well-child visits. Performance improved for every indicator in 2000. However, in implementing this successful program, ABC found that physicians initially were skeptical of the data, questioned the details of the bonus program, and required frequent meetings and communication before fully adopting the incentive program.<sup>34</sup>

- **Cautions of incentives.** Tying feedback to explicit incentives or disincentives does pose challenges. The perception of implied, or even overt, penalties for poor performance can be a source of distrust of feedback. Penalties (whether monetary, social or professional) may encourage physicians to improve performance, but generally do not foster a culture of enthusiastic support for quality improvement and tend to elicit objections concerning perceived flaws in the data. It is important, therefore, to avoid perceptions of punitive measurement and retain the focus on quality.

### **Combining Communication of Performance Information with Other Intervention Strategies**

Integrating data feedback efforts with other ongoing quality improvement strategies can be helpful in some circumstances as long as strategies do not become overly complicated.

- **Gains of combining data feedback with other quality improvement strategies.** Communication of performance information can be particularly helpful as a component of a larger quality improvement program.<sup>35</sup> As described above, linking performance data to benchmarks can improve efficacy, as may well-designed incentive programs. Other such combinations include feedback with: education of all physicians prior to performance review, education for low-performing providers with or after feedback, or reminders at time of service. Education is the intervention that is most commonly combined with communication of performance information. Educational interventions may be as simple as the distribution of guidelines or goals before the performance review, or as intensive as one-on-one education of outlier physicians. One study<sup>17</sup> of cervical smear quality, for example, divided physicians into four blinded groups: one which received no intervention; one which received feedback on the quality of each smear with its report; one which received feedback and a comparison to quality of peer physicians; and a final group which received feedback, benchmark comparisons and remedial education for poor performers. Each additional intervention improved performance scores relative to the other groups. When done well, combined interventions may produce larger increments of quality improvement than feedback alone.<sup>35</sup>
- **Cautions of combining data feedback and other quality improvement strategies.** Merely adding more components to a data feedback program does not guarantee success. Overly complicated or burdensome programs may not provide additional gains in performance. There are several published studies of failed multi-component feedback programs; often these violate one or more of the basic tenets of good feedback programs described in the first half of this chapter. One Australian attempt to reduce drug-prescribing rates, for example, provided physicians with performance information coupled with both peer information and educational newsletters but was generally ineffective. However, this program was unsolicited, government-driven, not timely (data were provided for the previous two years), unsupported by local physician leaders, and imposed upon physicians, who had no opportunity to provide input into the process.<sup>10</sup>

### **SUMMARY**

Communicating performance information to providers is a necessary step in improving quality of care and can be a powerful tool in quality improvement efforts. However, providing data feedback is not a simple matter, and it can be challenging to design and

implement a successful program. Published examples of failed attempts – as well as the many descriptions of successful programs – provide insight into how best to ensure that provision of performance information is most effective.

Based on the literature and on our own experience, we find that feedback works best when: 1) providers believe in the data provided, 2) the recipients of performance information are both primarily responsible for the performance being measured and in a position to improve upon it, 3) physicians believe in the project and are encouraged by clinical leaders and a positive organizational culture, and 4) when feedback and quality improvement is not a one-time event but an ongoing effort. Performance information may be communicated in a number of ways and settings, but targeted communications with provider-specific information are generally the most effective. Incentives, benchmarking, education and reminders are adjunct methods that can work well in combination with data feedback. Finally, communication of performance information is not sufficient as a stand-alone means of quality improvement; it works best as a complement to a larger quality improvement program with multiple components.

## **REFERENCES**

1. Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback: effects on professional practice and health care outcomes (Cochrane Review). The Cochrane Library. Oxford: Update Software, 2000.
2. Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance. A systematic review of the effect of continuing medical education strategies. *JAMA* 1995; 274:700-5.
3. Axt-Adam P, van der Wouden JC, van der Does E. Influencing behavior of physicians ordering laboratory tests: a literature study. *Med Care* 1993; 31:784-94.
4. Balas EA, Boren SA, Brown GD, Ewigman BG, Mitchell JA, Perkoff GT. Effect of physician profiling on utilization. Meta-analysis of randomized clinical trials. *J Gen Intern Med* 1996; 11:584-90.
5. Mugford M, Banfield P, O'Hanlon M. Effects of feedback of information on clinical practice: a review. *BMJ* 1991; 303:398-402.
6. Bradley EH, Carlson MD, Gallo WT, Scinto J, Campbell MK, Krumholz HM. From Adversary to Partner: Have Quality Improvement Organizations Made the Transition? *Health Serv Res*, in press 2004.
7. Bradley EH, Holmboe ES, Mattern JA, Roumanis SA, Radford MJ, Krumholz HM. Data feedback efforts in quality improvement: lessons learned from US hospitals. *Qual Saf Health Care* 2004; 13:26-31.
8. Baker R, Falconer Smith J, Lambert PC. Randomised controlled trial of the effectiveness of feedback in improving test ordering in general practice. *Scandinavian Journal of Primary Health Care* 2003; 21:219-23.
9. Winickoff RN, Wilner S, Neisuler R, Barnett GO. Limitations of provider interventions in hypertension quality assurance. *Am J Public Health* 1985; 75:43-6.
10. O'Connell DL, Henry D, Tomlins R. Randomised controlled trial of effect of feedback on general practitioners' prescribing in Australia. *Bmj* 1999; 318:507-11.
11. Mannion R, Goddard M. Impact of published clinical outcomes data: case study in NHS hospital trusts. *BMJ* 2001; 323:260-3.
12. Romano PS, Rainwater JA, Antonius D. Grading the graders: how hospitals in California and New York perceive and interpret their report cards. *Med Care* 1999; 37:295-305.

13. Luce JM, Thiel GD, Holland MR, Swig L, Currin SA, Luft HS. Use of risk-adjusted outcome data for quality improvement by public hospitals. *West J Med* 1996; 164:410-4.
14. French WJ. Trends in acute myocardial infarction management: use of the National Registry of Myocardial Infarction in quality improvement. *American Journal of Cardiology* 2000; 85:9.
15. Schneider EC, Epstein AM. Influence of cardiac-surgery performance reports on referral practices and access to care. A survey of cardiovascular specialists. *N Engl J Med* 1996; 335:251-6.
16. Rosenstein AH. Use of performance data to change physician behavior. *JAMA* 2000; 284:1079.
17. Buntinx F, Knottnerus JA, Crebolder HF, Seegers T, Essed GG, Schouten H. Does feedback improve the quality of cervical smears? A randomized controlled trial. *Br J Gen Pract* 1993; 43:194-8.
18. Parrino TA. The nonvalue of retrospective peer comparison feedback in containing hospital antibiotic costs. *Am J Med* 1989; 86:442-8.
19. Kroenke K, Pinholt EM. Reducing polypharmacy in the elderly. A controlled trial of physician feedback. *J Am Geriatr Soc* 1990; 38:31-6.
20. Greco PJ, Eisenberg JM. Changing physicians' practices. *N Engl J Med* 1993; 329:1271-3.
21. Marshall MN, Shekelle PG, Brook RH, Leatherman S. Use of performance data to change physician behavior. *JAMA* 2000; 284:1079.
22. Ginsburg LS. Factors that influence line managers' perceptions of hospital performance data. *Health Serv Res* 2003; 38:261-86.
23. Meyer TJ, Van Kooten D, Marsh S, Prochazka AV. Reduction of polypharmacy by feedback to clinicians. *J Gen Intern Med* 1991; 6:133-6.
24. Rhyne RL, Gehlbach SH. Effects of an educational feedback strategy on physician utilization of thyroid function panels. *J Fam Pract* 1979; 8:1003-7.
25. Gehlbach SH, Wilkinson WE, Hammond WE, et al. Improving drug prescribing in a primary care practice. *Med Care* 1984; 22:193-201.
26. Mayefsky JH, Foye HR. Use of a chart audit: teaching well child care to paediatric house officers. *Med Educ* 1993; 27:170-4.
27. Headrick LA, Speroff T, Pelecanos HI, Cebul RD. Efforts to improve compliance with the National Cholesterol Education Program guidelines. Results of a randomized controlled trial. *Arch Intern Med* 1992; 152:2490-6.
28. Winickoff RN, Coltin KL, Morgan MM, Buxbaum RC, Barnett GO. Improving physician performance through peer comparison feedback. *Medical Care* 1984; 22:527-34.
29. Marshall M, Davies H. Public release of information on quality of care: how are health services and the public expected to respond? *J Health Serv Res Policy* 2001; 6:158-62.
30. Kiefe CI, Allison JJ, Williams OD, Person SD, Weaver MT, Weissman NW. Improving quality improvement using achievable benchmarks for physician feedback: a randomized controlled trial.[see comment]. *JAMA* 2001; 285:2871-9.
31. Buntinx F, Knottnerus JA, Crebolder HF, Essed GG. Reactions of doctors to various forms of feedback designed to improve the sampling quality of cervical smears. *Qual Assur Health Care* 1992; 4:161-6.
32. Balilit Health Purchasing. Profiles of Organizations Using Quality Incentives Executive Summary. (Accessed September 22, 2004, at <http://www.leapfroggroup.org/RewardingResults/index.htm>.)
33. Bailit Health Purchasing, Sixth Man Consulting. The Growing Case for Using Physician Incentives to Improve Health Care Quality. Washington, D.C.: National Health Care Purchasing Institute, 2001.

34. Wensing M, van der Weijden T, Grol R. Implementing guidelines and innovations in general practice: which interventions are effective? *Br J Gen Pract* 1998; 48:991-7.

# CHAPTER THREE: COMMUNICATING TO THE PUBLIC THROUGH THE MEDIA

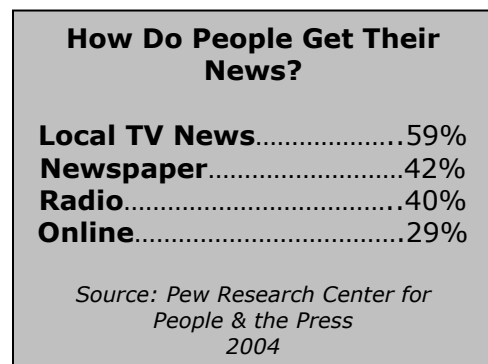
## HOW TO REACH A VARIETY OF AUDIENCES

You get a call from the health reporter at your local newspaper. She has heard a buzz in the community about your project and wants to know more about what you're working on, how it will benefit community members, and what it will cost. Are you prepared to answer her right now, clearly and concisely?

You should be. An article in your local newspaper can have a larger effect than you ever imagined. Why? Your project or research instantly reaches a much wider and influential audience. State and local government leaders, members of your congressional delegation, philanthropists or partners, and the community at large all learn about what your organization is doing.

Examples of what can happen:

The local policymaker better understands the effect your effort could have on the community and writes legislation supporting your issue. A local foundation or business group recognizes that your work aligns with their goals and offers you funding, therefore securing your sustainability. Other media see something in your research that piques their interest and forge a connection with you, providing a conduit to regularly disseminate research to the public. Or, perhaps the loftiest of them all— consumers read the article and go home at night to discuss your issue and the difference it can make in their lives at the family dinner table.



Does it take work to get to this point? You bet. Is it worth it? Absolutely.

Learning how to communicate what you do and why you do it is one of the most important things your organization can do to raise and maintain visibility. In this chapter, you'll learn:

- **Message development:** why it's important, what makes a good message, and how to develop your own messages.
- **Getting your message out:** the different types of media, tips to pitch your story, and vehicles for actually getting your story out to the media.
- **Interview tips and techniques:** how to stay on message, positive ways to respond to negative questions, and how to make sure the information you think is most important rises to the top.
- **How to reach your state and local policymakers:** why taking the time to talk to your local, state or federal legislator is a valuable effort and tips you'll need to keep in mind when making that connection.
- **Writing successful news releases and op-eds:** some basic instructions on how to hook reporters and choose the right opportunities for voicing your opinion.

## **THE IMPORTANCE OF MESSAGE DEVELOPMENT**

Clear, concise messages make an issue or an organization memorable. Without them, the impact on the listener is lost. A message needs to make people stand up and listen. Most media and marketing trainers agree that crafting three strong messages backed with data, and sticking to them no matter the audience, is a strategy for success.

To be memorable, not only do you need powerful messages, but every member of the organization needs to relay them in a consistent manner. You see this play out in politics when a politician, her aide, her press person, and any others who speak publicly on behalf of the candidate, are conveying the same ideas and messages over and over.

To some, “sticking to message” seems repetitive, naïve and “dumbed-down,” but it is how information is effectively delivered in a world full of busy people and short attention spans.

Whether you are talking to your colleague or talking to your grandmother, you should be able to explain in 3 sentences (or less!) what your news is, what the results are, and why anyone should care.

### **Developing Your Message**

Your message is the first, and sometimes the only, information people will have about your issue. It must be **clear, compelling, accurate, and short**.

You can't pack everything into a message. It's crucial to be able to separate important information from background noise. For example, when a friend calls you up and says, “What's new?,” you don't give a laundry list of your activities: “Well, I slept 7 hours last night, then I woke up and brushed my teeth, ate a bowl of cereal, took a shower, got dressed, locked my door on the way out of my house...” You give the highlights of your day: “My wife sent me flowers at work and my son scored 8 points during his basketball game this afternoon.” The same theory applies to message development. Highlights come first.

#### ***SUCCESS STORY: Concise Messages***

“Too many Americans die alone, in pain, and attached to machines.”

— *SUPPORT study*

“Thousands of hospital patients die unnecessarily each year because of medical errors.”

— *IOM Report on Medical Errors*

#### **A Good Message Should:**

- **Communicate clearly to your audience.** A good message makes it clear to your audience that your message is important to them.
- **Use succinct, “real-life” examples.** Use stories to illustrate how your work affects people's lives. Providing anecdotes helps listeners better understand an issue. (See page 27 for more details on the art of storytelling.)
- **Talk about the results, not the process. Don't load your message with details.** This is not the place to include your methodology or history of the problem.
- **Avoid jargon.** Keep it simple. Don't assume your audience is familiar with your topic. Use language that will be understood by a wide audience. By avoiding technical information and the issue's nuances and complexities, you ensure the explanation does not cloud your message.
- **Provide your audience with specific actions they can take.** Be clear to your audience what you are asking of them. If you believe legislation will help address

the problem, then you need to say that and briefly lay out what it should entail. A message is more powerful if you can briefly and concisely delineate what actions would make a difference to your cause.

### **Illustrating Your Message: Stories, Stories, Stories!**

Stories provide a framework for remembering facts. The use of narrative overpowers the use of data, and engages the listener. Anything is enhanced when you can illustrate it.

#### ***SUCCESS STORY: Using a Story to Relay a Message***

Every day, I bear witness to need. Diabetics who don't have enough money to buy the insulin they need. Kids who need dental care. Working mothers-to-be who need prenatal care to make sure that their babies are born healthy. Cancer patients who desperately need treatment.

My job is to help meet the needs of these people and many more. I am a public health nurse for the Fairfax County Health Department's Community Health Care Network. I am part of our country's health care "safety net" of public providers, hospitals, emergency rooms, free clinics, and community health centers that provide care for those who have nowhere else to go. We do our best, but I can tell you from firsthand experience that we cannot do enough.

*Excerpt of an op-ed by Maria Meuse, a public health nurse for the Fairfax County Health Department's Community Health Care Network that ran in a regional newspaper.*

### **GETTING YOUR MESSAGE OUT**

No matter how concise and understandable your message is, if you don't get it out to the public you might as well not have a message at all. The media are the single most effective conduit for delivering your messages and your story to the people you want to reach, and can be vital to the success of your program. The extent to which you can pursue a media effort obviously depends on your communications ability and time.

#### **Understanding the Media**

Before you speak with a reporter, take the time to learn what they write about and who their audience is. This is very easy to do using the Internet. Many papers publicize their circulation. Try to gauge how steeped a reporter might be on your issue based on their coverage of similar issues. Many national health policy reporters are fairly well-versed in many of the issues you care about, and you will be able to have a different type of conversation with these reporters than you might with your local health reporter, who is likely covering several different beats. Obviously, your local reporter will need more angles related to the community, whereas a national reporter will probably be looking for how your effort or research will affect national policy.

Different mediums will require a slightly different message. For example, on a TV or radio talk show, your responses will need to be much shorter "sound bites" than those you might give to a newspaper or magazine reporter. Each reporter looks for something slightly

different. Familiarize yourself with the type of coverage various outlets give issues prior to talking to reporters.

### **Different Types of Media:**

- **Newspapers.** Pay attention to what your local newspaper is covering, and which reporter covers issues most aligned with your subject. When you have a story to pitch to that reporter, it is to your advantage to mention past stories s/he has written about. In addition, monitor the major national papers (*Wall Street Journal, New York Times, Washington Post*) for opportunities to tie your issue to that of a national story.
- **Magazines.** Weekly magazines, such as *Time, Newsweek, and U.S. News & World Report*, publish longer articles. Developing a rapport with reporters for these publications takes time, but can yield coverage of your issues when they are working on an annual hospital issue, for example.
- **Television.** Think in sound bites. Your message will likely need to be pared down even more since local television stories run about 2 minutes. Know the host or interviewer, what their typical interview style is, and how they usually shape health-related stories.
- **Radio.** Like television, your message will have to be brief. Radio sound bites, however, are even shorter than what is heard on television. Most commercial radio interviewers are general reporters so don't assume they know a lot about your issue. Don't get too detailed. Public radio reporters generally cover a beat so they are more content oriented. Illustrative examples help engage a radio audience in both formats.
- **Web.** There are countless opportunities for media attention on the Web. Many news outlets will run wire stories on their websites that they may or may not have printed/broadcast on their station. See 'Alternative outlets for op-eds' on page 37 for a few examples.

### **Pitching Your Story**

You'll need to do your homework to make sure you're reaching the right person at the different outlets. One way to do this is to search topics similar to yours on the news media website to find out who covers your issue area. Take this opportunity to note similar stories and make a link to these in your conversation with the editor or reporter. Before you call or email the reporter, sit down with a colleague and practice your pitch. When you're actually speaking with the reporter, find out how they prefer to receive information (via email, phone call, or fax) before you send them background information.

After you've made your initial introduction, tell them quickly and concisely what the headline of the story is—what is new, different, or surprising in your story. Then be prepared to answer more specific questions about your project and its influence and effect on people in your area, region, or state. Provide local statistics, contacts, and background on the issue, and if possible provide names, phone numbers, and emails of people to interview. Make sure you have their permission first and that they are prepared to receive a call from the reporter.

### **Important reminders about pitching a story:**

**Ask if it is a good time to talk.** If not, get information on better times to call. Avoid calling late in the afternoon or on Fridays.

**Get to the point.** A pitch that clearly frames the story idea in the first or second sentence is infinitely more welcome than one that tiptoes up to it, or worse, buries it under paragraphs of jargon. In almost every case, reporters know instantly whether an idea will work for them.

**Remember: It's a pitch, not a monologue.** Give them enough information up front to pique their interest, but let them interject with questions before too long, certainly within the first 30 seconds.

**Anticipate difficult questions.** Think through what questions reporters are likely to ask you and map out the answers you want to give.

**Give them time.** The smartest pitchers tell reporters about things in a timely fashion. This allows reporters and sources to work together to figure out when and how a piece would work for the outlet.

**Be a resource.** The easier you make it for the reporters, the better the chances they'll bite. Be ready to provide quotes, background, and interview opportunities immediately. The reporter/pitcher relationship is really pretty simple: You want the reporter to cover your story; in exchange, you help make the reporter's job easier.

## **TOOLS FOR COMMUNICATING**

As mentioned earlier, there are many ways to get your message out to a variety of audiences. Here are brief details about some effective ways to get your message out. Some of these are defined in more detail later in the chapter. Regardless of which method you choose, the same basic rules of what makes a good message and how to deal with reporters apply.

### **Basic Tools:**

- **News Release.** Probably the most common way to get information out to the news media. See page 35 for guidelines on writing news releases.
- **Pitch Letter.** Similar to a news release, but shorter and less formal. A pitch letter can be placed in the body of an email and state in a few brief paragraphs of your main findings and what they mean.
- **The Telephone.** Call reporters and give them your pitch directly. Make sure you ask whether they are on deadline. Most journalists prefer to be called before 2 p.m. unless you have breaking news to report.
- **Op-Eds or Letters to the Editor.** Submitting an opinion piece relating to something that appeared in your local newspaper is another way to raise the profile of your research. But competition to be placed is fierce. Opinion page editors get hundreds of unsolicited op-eds a week. And, they read them all. Another option: writing a

#### **WHO KNEW?**

*The New York Times* receives 1,200 unsolicited op-eds each day via mail, email, and fax. The editorial staff reads every single one.

letter to the editor. This is one of the more popular sections of the newspaper and is another way to get your views about something in the public eye. If an article in the newspaper taps into your work or presents a view about something different from your organization's, send an op-ed or a letter to the editor. Editors are very receptive to pieces from experts and leaders in the community who have something valuable to add to a debate. See page 36 for guidelines on writing an op-ed.

- **Feature Story.** Feature stories are lengthier pieces that typically follow the news, rather than lead with it. These are usually human interest stories you see in such outlets as the *Wall Street Journal* or the *New York Times Sunday Magazine*, which often take a topical issue and put a human face on it. Reporters who write features are looking to give texture and context to a complicated story. Features are not easy to pitch; usually reporters are looking for a strong angle to illustrate a public policy dilemma.
- **Editorial Board Meetings.** If you are releasing something that is complicated but clearly newsworthy, editorial board meetings can be successful ways to get your message out there. However, competition for these meetings is fierce, and editors tend to be pretty selective about who they meet with.
- **Press Conference.** Press conferences are good vehicles for getting your message out, but should be used selectively. Hold a press conference only when you have real news to release. In most cases, it is just as effective to issue a news release, especially given the cost and labor involved with organizing a press conference. If you do choose a press conference, make sure you put together a line-up of thoughtful, provocative speakers who will offer reporters something they cannot get without attending.
- **Reaction Statements.** Releasing a reaction statement in response to something in the news can be an effective mechanism for using another issue in the news to draw attention to your own issue. For example, if a study is released stating that the majority of physicians do not think the general public should have access to quality information on doctors, your organization could issue a reaction statement that counters those findings based on your research. This could be disseminated to local media, medical groups in your community, as well as advocacy organizations. If the story appeared in your local newspaper, you also could try writing an op-ed or letter to the editor (see above).
- **Columns.** Sometimes you can catch the ear of a columnist to pique his or her interest in an issue. Even better if they are syndicated so that their prose appears in papers across the country.
- **Policy Briefings.** Similar to a press conference, but designed for a policy audience. These usually occur on Capitol Hill and are a way to educate and inform federal lawmakers, congressional staff, or executive branch staff about an issue your organization is working on. These are open to the public and are held when an organization has some new research or findings to report on that could affect public policy.
- **Desksides or One-on-Ones.** Good media relations is all about the relationship you build with journalists who cover your issue. Reporters have busy schedules but they are always receptive to learning something new about their beat. Take the time to

### **SUCCESS STORY: Letter to the Editor**

Sometimes, your intended course of action may not work out for you. One project submitted an op-ed to a newspaper when it ran a story about a study it commissioned. The op-ed editor said space constraints made it impossible for them to run the op-ed piece, however, they would be interested in a Letter to the Editor. By shortening the op-ed and into a letter format, the organization was able to promote a similar albeit shorter message and gain visibility for its work.

arrange a brief meeting in their offices or at a nearby coffee shop to give them a new angle to a story or a head ups about upcoming research. The lead expert on the issue should attend the meeting armed with key messages. This is also an important way to establish yourself as a local resource over time to reporters. By nurturing your relationship with your local reporter, you become a reliable source they can turn to even when they are not writing about your project but need guidance for another story.

#### **WHO KNEW?**

There are many ways to get your information out to the media, but the easiest and most cost-effective ways are news releases, pitch letters, or just picking up the phone and calling reporters.

- **Advertising.** The most direct route to getting your opinion known to a large audience is through advertising. It is an expensive undertaking and is most effective if the advertisement is run repeatedly for a length of time.
- **Fact Sheets, Issue Briefs.** Reporters would rather have an issue brief versus a journal article; a fact sheet with statistics and key arguments rather than a book or brochure. The bottom line is that whether the message is spoken or written, it needs to be concise and kept to one or two pages.
- **Newsletters.** Sending out a quarterly newsletter can be an effective way to get details about your program out to a wide audience, including reporters. As with all communication, stick to your messages, use stories to illustrate an issue whenever possible, and keep your article brief. These also are vehicles to spur story ideas for reporters.
- **Video News Releases/Radio News Releases.** The majority of the public get their news from local television. A video news release (VNR) is a television news story (usually 1.30 minutes) prepared by a communications firm about your issue. VNRs can be quite costly around \$20-30,000. To choose a VNR approach, your issue must be newsworthy at the time. The firm then pitches the story package to local television producers. If the producers like the story, they will run it on their news broadcasts. The radio news release is the same concept, but is usually a 60-90 second audio story. It is also cheaper, at about \$5,000 per spot. This is a most effective way to reach local, regional and state media.

#### **WHEN YOU ARE INTERVIEWED: TIPS AND TECHNIQUES**

No matter how prepared you are it can be disconcerting to be interviewed by a reporter. There is an inherent lack of control that is hard to overcome when being interviewed. There are also times when you will confront a difficult, unexpected, or hostile question or comment. There are certain techniques that can be useful to help keep you on track and make sure you're getting your message out during the interview. By practicing your messages and anticipating difficult questions ahead of time, you give yourself an extra edge to make sure the message you are trying to get out is clear and non-confrontational.

- **Stick to Your Messages.** Narrow your message to no more than three points and commit them to memory. Return to them consistently.
- **Get Your Main Point Out as Early as Possible.** Deliver your message early on so that you can offer examples and background during the rest of your interview.
- **Know Your Audience.** When a reporter calls, you don't have to do the interview immediately. Ask the reporter when his/her deadline is and if you can call them back in a half hour, and then research the interviewer and publication online, pull out your key messages, practice, and relax before returning the call.
- **Never Assume that Anything is "Off the Record."** Even if a reporter tells you that it is, assume everything you say could be in print or on air the next day.

- **Suggest Additional Sources.** Reporters appreciate building up their database of sources. To help them develop their story, suggest other people they should talk to or organizations they should look into.
- **Be Responsive to a Reporter’s Deadline.** Sometimes the best stories have been lost because the reporter’s phone call wasn’t returned until the next day. If a reporter calls, find out what their deadline is and respond to it.
- **Be Candid and Tell the Truth.** Never say “no comment.” To say “no comment” invites suspicion and leads reporters to wonder if you are hiding something. If you cannot answer a question, just say so or offer to find out the answer and get back to them.
- **Don’t Be Combative.** No matter what the interviewer says to you, do not get defensive. See page 31 for tips on answering negatively-asked questions in a positive manner.
- **Be Selective with Exclusives.** Giving one reporter an exclusive about your research findings can get you front-page coverage but it also can engender bad feelings among other journalists you need to work with in the future. Handing out an exclusive is a risky move and should only be used if there is limited interest in your story and it is the only way to get visibility. If you have solid news, you shouldn’t have to consider exclusives.

### Stay “On Message”

There are a few common techniques that will help you steer the interview in the direction you want.

- **Bridge Your Responses.** “Bridging” allows you to maintain a dialogue with the reporter, and also to link from what the reporter wants to discuss to what you want to discuss. There are two bridging formulas: one for questions you like and another for questions you dislike.
  - **Positive Questions**  
When the reporter asks you a positive, “friendly” question, bridging helps you steer the conversation in the direction you want and to pose a second, related question of your own. Here’s how it works: A reporter asks you a positive question, such as “What is your mission?” You answer. Many spokespeople would stop here. But not you! You bridge to another question that you want to answer by saying, “Another question your readers may be interested in is...” Pose one of the questions you identified that allow you to state your message(s) and then enthusiastically answer your question.
  - **Negative Questions**  
All questions require an answer; however, difficult questions can be sufficiently answered with one word or a short phrase when you use the bridging technique. Here’s how it works: The reporter asks you a negative question, such as, “Is your agency operating at a budget deficit again this year?” Rather than a full-blown answer, you may address the

#### **SUCCESS STORY: Example**

*Reporter asks:* “By offering quality data, aren’t you really just encouraging consumers to leave their provider for the highest performing doctors?”

*You reply:* “No.”

*You bridge:* “The real issue here is improving performance of all of the physicians.”

*You answer:* “Let me explain...”

negative question with a succinct answer (“No,” “Yes” or “I disagree” are favorites) and then bridge to a message that you want to communicate.

- **Other Bridging Phrases**

- “Yes...” (the answer), “and in addition to that...” (the bridge)
- “I don’t know... but what I do know is...” (the bridge)
- “I think what you’re really asking is...”
- “That speaks to a bigger point...”
- “Let me put that in perspective”
- “What I really want to talk to you about is...”
- “The real issue here is...”
- “It’s true that... but it’s also true that...”

- **Hook the Audience.** “Hooking” forces reporters or their listeners/viewers to listen to more information than they expected. When asked a question, you “hook” them by stating that you have two or three key points to share and then enumerate each point as you make it, such as “the first point is... the second is... etc.

- **Flag Important Information.** You “flag” a question by telling the reporter that the information you are about to share is important. Before you answer the reporter’s question, you verbally “flag” it by saying, “That’s a very important point” or “That’s a really good question.” Use this technique when your answer to the question includes one of your key messages. It also helps your audience remember your message by emphasizing or prioritizing what you consider to be most important.

***SUCCESS STORY: Flagging Your Major Points***

“I’ve talked about a lot of things today. It boils down to these three points...”

## **REACHING OUT TO POLICYMAKERS**

Meeting with any elected official – be it a local, state, or federal legislator; health commissioner, or governor - can be a valuable opportunity for you to educate them about the outstanding work you are doing and to establish yourself and your project as a great resource.

***SUCCESS STORY: The Elevator Speech***

Have your “elevator speech” ready. If you can’t answer this question “What do you want from me?” in the amount of time it takes to get from the lobby of the building to the eighth floor, you are not ready for your meeting.

Elected officials are constantly meeting with constituents. You will have very little time to make an impression on them, so be prepared. Let them know how their constituents are being helped by the project; the “innovation” that you are offering; and how it might be relevant to public policymakers.

Whenever possible, tell a story about how your project has affected someone’s life. More tips:

**Know your policymaker.** Invest some time prior to the meeting to discover if there is an intersection between their interests and your own project’s activities. If so, you might thank the member for his or her policy interests and mention

how their concerns correlate with what you’re doing. A good place to start is his/her own website.

**Know what you want the outcome of your meeting to be.** If s/he volunteers to take some action on your behalf, determine which staff member will be the point person. It is important to stay in touch and work with that staff person to make it happen.

**Be flexible.** Elected officials' schedules are notoriously fickle. Your visit may be canceled, run late, or end up being a meeting with a staff member, who could be an inexperienced intern or the chief of staff. The length of time of the meeting will vary as well. If you are running late for a meeting, make sure to call ahead and let the policymaker's office know.

**Leave materials behind.** Bring a limited amount of material to leave behind. The material should include a short (1 or 2 page) description of your project and any local news clips.

**Be patient and follow up.** A good relationship with a policymaker can be a considerable investment of your time—but it can be worth it. Remember to always send a thank you letter following your meeting and keep in touch. Keep staff updated on your project's events and impact within the community. Keep them on your mailing list.

# ADDENDUM

## WRITING A NEWS RELEASE

The news release is an important tool for pitching a story to a reporter. Many will ask for it right off the bat. There is a clear-cut way of writing these, and they are the accepted format read by journalists around the world. Here are some basic instructions for writing a news release:

- Place the phrase "For Immediate Release" and the date on the upper left margin. (Unless the information is embargoed. See page 35 more details.)
- Below this phrase or on the right margin, place your contact person's name and phone number.
- Compose a short headline that clearly describes the news release content and grabs the reader's attention. Center it in bold type on the page. Place concise secondary subheads in italics below the main headline.
- Begin the first paragraph with your dateline. The dateline identifies the city and date where the news originated.
- Put time-critical information related to your activities in the first paragraph. Concisely summarize the facts—who, what, when, where, and why—in the first paragraph.
- In the second paragraph, insert a quote from a leader within your organization, such as the executive director or a board member, about the event or program. Be sure to identify the source of all quotes. Make sure the quote content explains and enhances the story, and that there is a clear relationship between the person quoted and the story. Try to limit the number of quotes to no more than two people.
- Details on the event/program go in the third paragraph.
- The final paragraph covers basic organizational information such as what your organization is about, and the history of the event or program. If you have a list of member organizations, sponsors, or other partners, list them in an attachment rather than incorporating that information into the text of the release. This makes it easier for a reporter or editor to review.
- At the end of your release, type "###" to indicate the end of the copy.

### ***SUCCESS STORY: Sample Headlines***

"Landmark Study Finds That American Adults Get Just 50 Percent of Recommended Care; Major Quality Problems Pose "Serious Threats" to Public Health"

"Adults in Midwest and South Have More Problems Paying Medical Bills Than Those in Other Regions of U.S."

"Study Finds Federal Bioterrorism Funds Have Yielded Only Modest Improvements in States"

### **General Guidelines:**

- Use short, declarative sentences and double-space the lines. Make sure to use an active verb and the word "today" in your first sentence.
- Avoid the use of jargon and explain any acronyms at their first use, e.g. "The Centers for Disease Control and Prevention (CDC)..." Avoid "puff" words and phrases such as "exciting," "very large," "monumental," etc. Be as clear and concise as possible in your descriptions.

- Link the facts of the project or event to an important issue or need in your local community. Using real-life examples helps make the human connection. Highlight benefits of your work to the community.
- Review the release for clarity and flow, and be sure that all words and names are spelled correctly.
- To drum up interest in a press conference or a release to prior to the actual event, particularly for complex information, it is usually effective to distribute an “embargoed” press release. Instead of writing ‘For Immediate Release,’ write ‘Embargoed Until <include date and time>.’ This gives you a chance to talk to reporters about your news before it is actually released, giving them a chance to put together a high-quality story and you a chance to make a news ‘splash.’

See page 40 for a sample news release.

### **WRITING AN OP-ED**

You may choose to write an opinion editorial, or op-ed, and submit it to a local newspaper to strengthen your media outreach. The op-ed is a powerful vehicle to express your opinion on your issues. Op-eds are often viewed as more effective than a letter to the editor because the length allows greater detail and content control. However, they are also very difficult to place.

#### ***SUCCESS STORY: Excerpt from Op-Ed (Published in the Washington Post, December 2004)***

Psychological treatments for pain are grossly overlooked by health care providers and by insurance companies. Take my patient, a 28-year old former Karate champion, married with two small children, who was crossing a street in Manhattan when his life suddenly changed forever. He woke up in a hospital bed in excruciating physical pain to discover his right leg amputated above his knee because he was hit by a car. Fast forward six months later: he is trying to adjust to a prosthesis, has florid Post Traumatic Stress Disorder symptoms, and severe chronic pain.

Drugs are not enough. They take the edge off his physical pain, but don’t ease his emotional pain. He told me he has gone to the roof of his apartment building three times to jump off but says he “hasn’t had the courage” to do it yet. Pain drugs aren’t enough for him.

Yet no one in the busy medical system thought it worthwhile to address his significant depression, his nightly nightmares, and his enormous rage at the doctors who amputated his leg. No one asked him about his now failing marriage and the growing distance between himself and his children. Nor did he know to ask for help. These experiences should serve as a wake-up call for doctors who treat patients, insurance companies who cover them, and Congress, which has an opportunity to make legislative change to support mental health care within our health care system.

You might use an op-ed to:

- Applaud a new program that advances your mission and goals.
- Respond to published reports that may have been released recently.

- Recommend or support a public policy or a proposed initiative that you believe will have a positive impact.

Prior to writing an op-ed, answer the following questions to ensure that you make the necessary points for an effective piece:

- What is the main opinion or argument you hope to express?
- How does your organization help to solve a problem in the community?
- What is the urgency?
- Who does this affect?
- Are there facts or data that can strengthen your case?
- What is your call to action?

### **General Guidelines**

- Generally, op-eds are 800 words or less in length. Before writing an op-ed, check the paper's website for specific submission policies and guidelines.
- Have an opinion and state it forcefully. An op-ed should argue a point, and the point being made should be stated clearly up front. There needs to be a compelling "hook" to generate interest in the op-ed and demonstrate its relevance to the readers and the community.
- Make your case from the top down. Begin with the premise of your opinion and then back up your opinion with facts. Don't present the facts first and save your opinion for the conclusion.
- Support your case with facts. Attribute your facts to a credible source (e.g. the Surgeon General or the Centers for Disease Control and Prevention).
- Submit a timely piece. It should relate to something in the news.
- Speak to your target audience using language that everyone can understand. Don't use jargon.
- Keep sentences and paragraphs short.
- Offer specific recommendations to address the issues you raise.

### **ALTERNATIVE OUTLETS FOR OPINION ARTICLES**

When writing opinion pieces, traditional print newspapers are not your only placement options. With so many people getting their news on the Internet, online magazines and news sites can be excellent venues for getting your message across. There is more room for new ideas online, where thinking outside the box is often encouraged. These outlets are more likely than mainstream newspapers to run unconventional or controversial opinion pieces. They also offer access to different audiences than do conventional newspapers. Here are a few popular alternative outlets for submitting opinion articles:

#### ○ **Salon**

*Salon* is an online magazine whose content runs the gamut from the war in Iraq to the public's fascination with celebrity pregnancies. Articles that focus on current political events dominate the Opinion section. Although the main Opinion section is largely for regular contributors such as Arianna Huffington and Sidney Blumenthal, *Salon* also welcomes articles and letters to the editors.

#### ○ **MSN Slate Magazine**

*Slate*, like *Salon*, is an online news magazine. However, it is a much more straightforward news magazine than *Salon*, focusing on politics and current events,

with articles ranging from the difficulties of providing universal health care to "How to Beat Bill O'Reilly."

- **Harper's Magazine**

*Harper's* is a print magazine that covers news, politics, and culture – providing readers "a unique perspective on the world." With respect to current events, *Harper's* consistently seeks out stories not covered by the mainstream media. Recent articles include "Whitewash as a Public Service: How the 9/11 Report Defrauds the Nation," and "Dying for Dollars: Are you Ready for the Iraqi Gold Rush?" Readers of *Harper's* tend to be older than those who rely on Internet news sites for their information.

These outlets are all very different in terms of content, tone, and readership or listeners. *Salon* and *Slate* are good outlets if you want to reach a younger audience used to getting news and opinion from non-traditional sources. But if your target is more mature readers who enjoy in-depth coverage of current events, you might want to try *Harper's*. Please be aware that all of these outlets receive a heavy volume of submissions – competition is fierce!

## **BACKGROUND ON THE MEDIA**

- ❖ **Wire Services**—need accurate information FAST, have rolling deadlines
  - Major Wires
    - Associated Press, Reuters
    - Stories have broad distribution
    - Have regional, state services
  - Smaller Wires
    - Serve newspaper chains (Gannett, Hearst, Knight-Ridder)
    - Collection of small papers (Cox)
    - Specialized wires
    - Web-based (HealthDay)
- ❖ **Newspapers**—want COMPLETE story
  - Major Papers
    - Papers in major cities have national and international significance (*The New York Times*, *The Washington Post*, *The Los Angeles Times*)
    - Usually daily deadlines
      - If a.m. paper, deadline is late afternoon, or late evening for an emerging story
      - Best time to contact a reporter is 10 a.m. to 3 p.m.
    - Reporters have specialized "beats"
      - Often well-informed
      - Shrinking budgets have led to less specialization
- ❖ **Television**—looking for VISUAL image; need ARTICULATE, CONCISE comments
  - Network News Shows
    - Need story of national or international significance
    - Very limited time
  - Television Magazines
    - Explore issue in depth
    - More directed point of view

- Cable News
  - More on-air time to fill
  - Round the clock deadline
- Interview Shows
  - General interest shows on networks, daytime syndicated
  - May be a “debate” (e.g., Nightline)
  - Local, sometimes specialized
- ❖ **Radio**—looking for SOUND BITES
  - Networks
    - Carry message nationwide, in a matter of minutes
    - Headline format, little detail
    - Will use one dynamic quote “sound bite”
  - Talk Radio
    - Interviews, can feature calls from listeners to expert
    - Usually have a strong perspective
    - Often syndicated
  - Public Radio (lengthy, in-depth reports; influential)
    - National Public Radio (NPR)
      - National and international news
      - Special-interest programming
- ❖ **Trades**—specialty publications geared toward PROFESSIONAL audiences
  - Typically offer more details on policy
    - *Bureau of National Affairs, Modern Healthcare, American Hospital News, Medicine & Health*, quality newsletters
    - Are not typically looking for the consumer angle
    - Are often a major resource for journalists, members of Congress and their staff, Administration officials
- ❖ **Online**—worldwide reach, interactive
  - Increasing number of online news outlets
    - Online version of established mainstream media outlets
      - Abcnews.com, cnn.com
      - More space for story development
    - Online version of medical/science magazines
      - Newscientist.com, sciencenow.org
      - Stories pitched to online magazines may be picked up by the print version
    - Stand-alone news sites (WebMD.com)

## **SAMPLE NEWS RELEASE**

### **For More Information, Contact:**

Janet Firshein, Kari Root 301/652-1558  
Jon Gardner at *Health Affairs*, 301/347-3930

### **EMBARGOED FOR RELEASE**

3 p.m., ET, Thursday, October 7, 2004

### **DARTMOUTH STUDIES SHOW WIDE VARIATIONS IN HOSPITAL CARE AND OUTCOMES FOR CHRONICALLY ILL MEDICARE PATIENTS**

#### ***Study Questions Performance of Leading Hospitals Deemed "The Best" by U.S. News & World Report***

**(Bethesda, MD)** – Medicare patients with similar chronic conditions receive strikingly different care, even among hospitals identified as "best" for geriatric care by the magazine *U.S. News & World Report*, according to Dartmouth Medical School studies released today. The studies, featured in the October 7 Web-Exclusive edition of the journal *Health Affairs*, show that the frequency of physician visits, the number of diagnostic tests, and rate of hospital and intensive care unit (ICU) stays vary markedly. The studies show that a higher intensity of care and higher level of spending are not associated with better quality or longer survival times even in the most renowned teaching hospitals.

In fact, there is evidence that a very high intensity of care for people with certain terminal medical conditions might hasten death, the researchers report. New findings identify, by hospital, where Medicare enrollees are receiving much more intensive care for common medical conditions, raising questions about usual methods of identifying "best" hospitals.

The October 7 Web edition of *Health Affairs*, funded by the WellPoint Foundation, features 20 articles and analyses on medical practice variation by some of the nation's leading health care experts, including John E. Wennberg, MD, MPH, who directs the Center for the Evaluative Clinical Sciences at Dartmouth Medical School in Hanover, NH. The studies were released today at a Washington, DC briefing, sponsored by The Robert Wood Johnson Foundation, which funds the *Dartmouth Atlas of Health Care* project.

Wennberg, the principal investigator and series editor of the *Dartmouth Atlas*, has documented significant geographic variations in medical practice since the early 1970s. He says the significance of these findings is that "for the first time we can use Medicare claims data to measure the performance of individual hospitals and identify those hospitals that appear to be doing a better job managing chronic illness and patient care."

"Because these studies focus on specific providers rather than specific communities, they will advance our understanding of variations in how hospitals deliver care to people at the end of life. Now, hospital quality can be measured with concrete data on experience rather than perceived reputation," says James Knickman, Ph.D., vice president of research and evaluation at The Robert Wood Johnson Foundation.

### **Hospital Care During the Last Six Months of Life**

In the first study, Wennberg and colleagues evaluated the efficiency of 77 hospitals deemed "best" for geriatric care and heart and pulmonary disease in managing chronically ill Medicare patients during the last six months of life. The authors looked at variations in care for more than 90,616 patients age 65 and older suffering from solid tumor cancers,

congestive heart failure, and chronic obstructive pulmonary disease, comparing the illness-adjusted frequency of physician visits, hospitalizations, and ICU stays.

The authors also profiled the use of care and medical resources for patients treated in seven teaching hospitals ranked by *U.S. News & World Report* in 2001 as the top geriatric institutions in the country.

They found striking variations in the amount of care provided with no association between higher intensity of interventions and better outcomes. For example, patients receiving care from New York's **Mount Sinai Medical Center** spent almost twice as many days in the hospital as patients treated at the **Mayo Clinic's St. Mary's Hospital** in Rochester, MN.

The quality of care for those with terminal illnesses also varied widely. The number of patients who died as hospital inpatients, rather than at home or in hospice, varied from 32 percent of all deaths to more than 52 percent, despite the fact that the vast majority of Americans say they would rather not be in the hospital at the time of death.

For example, patients assigned to the **St. Louis University Hospital** were almost 70 percent more likely to spend time in intensive care during the hospitalization in which they died than were people who died as inpatients at **Mayo Clinic** hospitals.

### **Higher Intensity Does Not Lead To Better Care**

A complementary study coauthored by Elliott Fisher, MD, Dartmouth professor of medicine and of community and family medicine, looked at patients who received their initial hospitalization for one of three reasons — heart attack, colorectal cancer, and hip fracture — in one of 299 hospitals that belong to the Council of Teaching Hospitals.

Fisher and colleagues examined patterns of practice, quality of care, and health outcomes in teaching hospitals. In fact, they found that the overall intensity of medical services delivered to patients with serious chronic illnesses varied by up to 60 percent.

Their conclusions: patients in the highest-intensity hospitals spend more time in the hospital and ICU; have more frequent physician visits in the inpatient setting; have more specialists involved in their care; and receive more imaging services, diagnostic testing, and minor procedures.

### **What Remedies Exist?**

Although Wennberg says medical practice variation is "remarkably resistant to change," he believes there are steps the private and public sectors can take to begin to reduce disparities, such as rewarding providers for efficient, high-quality performance. A provision in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 that creates a demonstration to test out this idea is a giant step in the direction of addressing unwarranted variation in health care, he says.

*Health Affairs*, published by Project HOPE, is a bimonthly multidisciplinary journal devoted to publishing the leading edge in health policy thought and research. Copies of the October 7, 2004 Web-Exclusive articles on medical practice variation will be available on-line until **October 22, 2004**, at [www.healthaffairs.org](http://www.healthaffairs.org). Address inquiries to Jon Gardner, *Health Affairs*, at 301/347-3930, or via e-mail, [jgardner@projecthope.org](mailto:jgardner@projecthope.org).

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**Burness Communications, Inc.** ([www.burnesscommunications.com](http://www.burnesscommunications.com)) provides public relations support to non-profit organizations in the United States and abroad. Based outside of Washington, D.C. in Bethesda, Maryland, Burness provides its clients with media and government relations services, writing and publications development, strategic communications counsel, and media training. Burness Communications has served over 250 clients since it was founded in 1986. These include several of the largest foundations in the U.S., international organizations, public and private universities, and small and large non-profits. Specialty areas include: international and domestic health and health policy; global health, with an emphasis on vaccine development; philanthropy; end-of-life issues; and workforce advancement and other urban issues.

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