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Facilitating Trust and Communication by Hospital Administrations during a Pandemic: Importance of a Multimodal Approach

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Abstract

The SARS CoV-2 (COVID-19) pandemic has put immeasurable stress on hospital and medical staff and healthcare organizations. Communication is often challenging during times of crisis, and leaders may struggle to disseminate changing clinical and administrative directives, as well as receive timely feedback from staff. A multimodal communication strategy that incorporates bidirectional and dynamic tools has potential to foster staff engagement and trust. Leadership presence and engagement as well as awareness of safety, job-related challenges and healthcare workers' stress can facilitate effective communication and ultimately may aid in staff retention. Hospital administrators should ideally balance their communication strategies to both promote efficient delivery and facilitate staff understanding and engagement.

Key words: COVID-19; Health care; WHO; Staff anxiety

Introduction

The COVID-19 pandemic has created numerous communication challenges for hospitals, content (high degree of uncertainty and rapidly evolving messaging), transmission (limited face-to-face communication methods and technology constraints), as well as reception of the communication (staff anxiety, leadership trust challenges and message fatigue). In our recent paper, we explore the specific complexities around administrative communication to staff during pandemic and other system crises [1].

The importance of facilitating and maintaining organizational trust within healthcare systems has been increasingly recognized as central to strategy around policy and communication. Governments and international organizations such as the Organization for Economic Co-operation and Development (OECD) and the World Health Organization (WHO) have focused on transparency and participatory communication with the public, in the global effort to combat disinformation, and what the WHO calls the "infodemic" around COVID-19 [2,3]. For example, Spain has advocated using a single "source of verified, transparent, continuous and rapid information" through official channels to combat false narratives [4,5]. Yet ethicists have argued that COVID-19 has precipitated both a crisis in trust between patients and physicians, as well as in public health leadership [6,7]. Confidence in policy decisions around a novel viral pathogen, early research publication before peer review, high profile journal retractions and the politicization of health policy have all contributed to significant challenges with public trust and engagement [8-10].

Trust is also vital to maintain and foster confidence in leadership within hospitals and healthcare organizations. According to Shruti Dhupia with Harvard Business Publishing, "employees are hungering for communication from their leaders and want that communication to be personal and authentic" [11]. Staff anxiety around safety and personal factors related to employment can significantly impact reception of communication by Health Care Workers (HCWs). National data from Scotland has suggested a greater than three-fold higher risk of COVID-19 hospitalization for patient-facing HCWs and a greater than two-fold higher risk for their family members [12]. Added stress from greater work hour demands, personal economic uncertainty, disrupted sleep patterns and the nature of direct care for patients ill and dying with COVID-19 can contribute as well. Recently published data from a large study of U.S. HCWs found 38% reporting anxiety/depression, 43% work overload and 49% burnout-with inpatient caregivers, women, Black and LatinX workers being at highest risk [13].

Literature Review

HCWs on the front lines can develop an "us vs. them" perception, accusing administration of adopting policy that prioritizes institutional, financial or patient needs above the safety of the staff [12]. There are many examples of tension between HCWs and healthcare administrators over COVID-19 strategy, including those highlighted by a recent report by the Brookings Institution around issues such as hazard pay, access to PPE, safety for low-wage HCWs and respect and recognition for support staff [14].

However, to address these challenges, there are administrative strategies that organizations can adopt to foster trust. Communication framed with an awareness of the issues affecting HCWs will be more likely to resonate with them, especially when coupled with respect and acknowledgement of

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their value for healthcare delivery [15]. Professional organizations such as the American Medical Association and the National Academy of Medicine have online resources for clinicians and staff and also provide direct recommendations to hospital leadership to show awareness and willingness to adopt policies that support staff in workload redistribution, resilience, mental well-being and social support [16]. Transparency and use of communication tools which are dynamic and bidirectional (allowing feedback from HCWs) will sustain trust in critical situations, like institutional PPE shortages [17]. Hospital activities such as staff "town halls" with executive leadership visible and accountable can build a culture of communication and trust. Such town halls have been widely used by healthcare organizations as collaborative "open discussions" and opportunities to for HCWs to "ask questions, provide feedback and learn from others how they are handling various aspects of the "pandemic" [18]. These forums can also be recorded and provided in an asynchronous format, as well as augmented with on-line resources and references to widen the audience and maximize impact [19].

Physician leadership is also essential. Executives and leaders who are active clinically have voices which may be more readily accepted by staff and seen as accountable. When physician leaders are delivering direct patient care and are personally affected by their administrative decisions, it may reduce the "us vs. them" splitting of clinical and administrative staff. Clinical roles for leaders are less common and may be less practical in large hospitals and health systems. Even during times of crisis, a willingness by leaders to contribute clinically at the bedside or in a support role for clinicians can go a long way to facilitating trust and confidence in leadership.

There is no "one size fits all" approach to administrative communication strategy for healthcare leaders. In our recent paper, we present a compass and toolbox for classification and consideration of communication strategy for hospital administrations, based on experience at our county-based public hospital system in northern California (**Figure 1**).

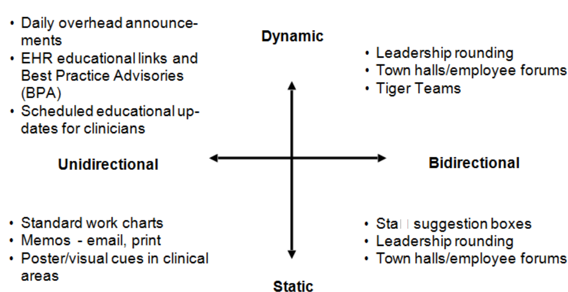

Figure 1: Classification compass for administrative communication tools.

While every system will be different, organizational flexibility and utilization of a variety of communication tools is critical for effective and timely communication, while maintaining a foundation of trust in leadership. Such a multimodal strategy encompasses dynamic communication tools, such as scheduled leadership rounding or town halls, which have the advantage of allowing flexibility to address problems that are evolving, but come at a higher cost in staff hours and expertise. In a pandemic such as COVID-19, dynamic communication represents a premium investment in communication, whereby hospital administration can address evolving communication and policy needs without resending repeated updates by static means. Tiger Teams, a type of Rapid Response Team (RRT), are a skilled nursing resource and mechanism to facilitate communication. They consist of nurses with supplemental COVID-19 training who are up-to-date with institutional policy. They are utilized to troubleshoot acute challenges in COVID-19 management, facilitate education around PPE use and isolation, clarify policy decisions and mitigate staff anxiety [20]. Some tools can be either static or dynamic, such as town halls and leadership rounding, depending on whether they are utilized as a single one-time intervention (static) or developed as an ongoing scheduled process (dynamic) for organizational communication.

Administrative communication can also be unidirectional or bidirectional. In a linear communication model, unidirectional communication allows a sender to direct a message at a receiver, but by definition, there is no feedback or response. Without additional communication tools, leadership are not able to assess to what degree the message was received and understood [20]. In contrast, a transactional communication model demonstrates bidirectional communication, which gives staff opportunity to close gaps in understanding that may not be apparent to healthcare leaders. Promotion of bidirectional communication can potentially reduce anxiety among HCWs, while building mutual trust [19]. Bidirectional communication tools require additional resources and investment by leadership and that cost must be balanced against other organizational needs during a pandemic. However, the investment supports a culture of collaboration and transparency and over time fosters mutual respect with HCWs on the front lines of patient care [21].

Discussion

Finally, an effective multimodal approach will incorporate administrative communication tools that include both direct and indirect communication. Direct tools may reduce the risk of content dilution or misdirection and are advantageous when targeting specific problems and necessary interventions. Indirect tools require less face time from leaders, but potentially run a greater risk of misinterpretation of content or intent. Over delegation or neglect of direct communication can result in distortion of the message and increases risk of staff perception that the administration is disconnected from HCWs. An over reliance on indirect communication risks staff alienation and these workers may question executive accountability during times of crisis.

Conclusion

In summary, health care organizations should develop and utilize an organized multimodal approach to organizational communication with their HCWs, built on a foundation of trust and leadership accountability. Such an approach will include indirect and direct methods of communication, unidirectional

and bidirectional tools for information flow, as well as static and dynamic mechanisms for staff engagement-depending on the specific communication needs. Leadership that approaches its work force in a collaborative way, utilizing transparency whenever possible and continuing to engage its employees and physicians will be more likely to maintain organizational trust during times of pandemic and crisis. However, for organizations to remain nimble and be able to react in a timely way with critical policy decisions and information dissemination during a pandemic, leadership decisions on workforce engagement and tools of communication will have to balance costs and other competing organizational needs. With a balanced multimodal approach to communication that accounts for worker wellbeing, engagement and the complex operational needs of a health care organization, leaders will able to drive their systems with transparency, compassion and ultimately achieve stability and retention of their workforce.

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