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NIAGARA HEALTH SYSTEM: AN INNOVATIVE COMMUNICATIONS STRATEGY (A)

Alexander Smith and Andrew Scarffe wrote this case under the supervision of Professor Anne Snowdon solely to provide material for class discussion. The authors do not intend to illustrate either effective or ineffective handling of a managerial situation. The authors may have disguised certain names and other identifying information to protect confidentiality.

It was September 2011, and Brady Wood had completed his second month as interim chief communications officer at the Niagara Health System in Ontario, Canada. As a renowned crisis communications expert, Wood had joined the Niagara Health System on secondment from St. Joseph's Health System in Hamilton, Ontario, in the midst of a high-profile outbreak of clostridium difficile (C. difficile). Wood faced a substantial challenge in this interim role. The network of hospitals within the Niagara Health System had been struggling with public reputation and opinion for more than 10 years. It quickly became apparent that the Niagara Health System's challenges extended far beyond the C. difficile outbreak. To regain the confidence of the community, an entirely new communications approach and strategy was desperately needed.

NIAGARA HEALTH SYSTEM

The Niagara Health System (NHS) was a hospital network in the Niagara region of Ontario. The NHS was established in 2000 after eight hospitals amalgamated in a highly complex merger. Its seven hospitals served more than 434,000 residents across 12 municipalities in the region. With more than 4,000 employees, 600 physicians and 1,000 volunteers, the NHS was one of Niagara's largest employers.[1] Exhibit 1 outlines the NHS's financial performance while Exhibit 2 outlines a brief history of the NHS.

The NHS's vision was "Together in Excellence — Leaders in Healthcare." The NHS sought to achieve its mission by:

- Working within an integrated system for a healthier Niagara;
- Providing equitable and timely access for people throughout Niagara to a wide range of patient-focused care and services;
- Providing a full continuum of care through partnerships with other health and social service providers within and beyond Niagara;
- Enhancing community well-being and health care delivery through promotion, education and research; and

[1] *Niagara Health System, "About the NHS," 2014, www.niagarahealth.on.ca/en/about-us, accessed April 22, 2014.*

- Committing to innovation and continuous quality improvement in health services to meet their changing health care needs.[2]

HOSPITAL COMMUNICATIONS IN ONTARIO

The field of health care communications was becoming increasingly complex in Ontario. The unpredictable nature of hospital care meant that crisis communications were a regular occurrence. Several patient and consumer trends were causing this shift. Patients and the general public had diminishing capacities to trust and support hospitals, as patients leveraged social media to become informed and involve themselves in day-to-day operations. Media in general had begun to scrutinize organizations in crisis, in response to consumer demands for such stories. Finally, the field of public relations in health care was slowly shifting its communications approach from the "positive spin" to authenticity — indicating that hospitals were being encouraged to be transparent and open to the general public.[3]

In 2009, the push for hospital transparency was expanded when the Government of Ontario passed legislation removing any admission of guilt from an apology. Under the Apology Act (2009), an apology was considered "an expression of sympathy or regret, whether or not it includes an inference or admission of liability or fault . . . and shall not be considered in determining fault or liability."[4] This concept of hospital transparency was further developed in 2010, when the Ministry of Health and Long-Term Care passed the Excellent Care for All Act, refocusing the health care system to meet the needs of the patient and community, and put them at the centre of the system.[5]

All signs pointed toward a new system that viewed patient trust as central to the therapeutic relationship, outlining the need for community confidence in local hospitals. However, most hospital strategic plans did not yet include any public opinion or reputation metrics, but instead focused on financial stewardship, quality/safety, patient satisfaction and employee engagement.[6] Hospitals were quickly realizing that poor crisis management and negative public opinion led to loss of trust, fewer donations, lack of volunteers, low recruitment and lower government and other funding; the worst-case scenario, when public confidence had been lost, resulted in the board being replaced by a government-appointed supervisor.[7]

COMMUNICATIONS AT NIAGARA HEALTH SYSTEM

Wood had come from St. Joseph's Health System, a consortium parent company that oversaw several communities' long-term and hospital care organizations in southern Ontario. There, Wood had operated as the director for strategy and public relations, specializing in crisis management and public relations. In early 2011, Dr. Kevin Smith, the chief executive officer (CEO) of St. Joseph's Health System, was approached by Dr. Sue Matthews, interim CEO of the NHS, for assistance regarding the communications strategy for a recent C. difficile outbreak. The NHS was being criticized for not only having an outbreak but also how they had handled it and how it had been communicated to the public. Some critics had even

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[2] Niagara Health System, "Vision Mission Values," 2014, www.niagarahealth.on.ca/en/vision-mission-values, accessed May 2, 2014.

[3] Arthur W. Page Society, The Authentic Enterprise Report Summary, New York, 2007, www.awpagesociety.com/wp-content/uploads/2011/09/AE_Summary_4-3.pdf, accessed April 22, 2014.

[4] Government of Ontario, Apology Act, 2009, www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_09a03_e.htm, accessed April 22, 2014.

[5] Ontario Ministry of Health and Long-Term Care, "Excellent Care for All," 2012, www.health.gov.on.ca/en/public/programs/ecfa/, accessed April 22, 2014.

[6] Brady Wood, "Reputation Checklist: An Introduction," 2013 [unpublished].

[7] Brady Wood, "Crisis Communications: C. Difficile Outbreak," 2014 [unpublished].

insinuated that the NHS had not been transparent about the C. difficile deaths and had not declared the outbreak in a timely and appropriate manner. It was ultimately decided that Wood, who had much experience in managing C. difficile communications, would join the NHS team on a seconded basis to help with the crisis.

Wood joined the NHS on secondment in July 2011. He quickly realized that the communication and public relation struggles extended far beyond the recent C. difficile outbreak:

> The Niagara Health System had a higher proportion of negative to positive media probably for 10 years since it was amalgamated in 2000. At the time I became involved, the chorus was speaking out loudly against the hospital for various reasons. And this included elected officials and community groups. Even a government member of provincial parliament was actively criticizing the hospital and calling for the board to be fired, and the same would be said by many of the mayors. The media was also frustrated by its dealings with the hospital.

The C. difficile outbreak was the latest struggle the NHS was facing, but it followed many years of turmoil and upset in the organization's public relations. The existing public relations team had saved all media reports about the NHS since 1999, which quickly became Wood's source of information about the complexity of the organization's public perception. Wood commented:

> I realized quickly that it really had to be a two-prong strategy. One was repair the C. difficile–related upset, and so I looked to best practices in crisis communications and working with the execs to better prepare them and changing the way information was getting out. But then the second and probably more important plank was how are we going to like get a bit of a reboot in terms of how the community perceives the organization?

MANAGING THE C. DIFFICILE OUTBREAK

Clostridium Difficile

Clostridium difficile is commonly abbreviated within the medical community as "C. difficile" or "C. diff." C. difficile is a bacterial infection that most commonly affects older adults in hospitals and/or long-term care homes and presents with "symptoms ranging from diarrhea to life-threatening inflammation of the colon."[8] In North America, more than 500,000 patients were infected by C. difficile each year. Furthermore, in recent years, the infection was being presented more frequently and more severely, and was more difficult to treat.[9]

C. difficile outbreaks in hospitals presented several unique crisis factors. First, the infection was highly complex and involved a mosaic of related clinical themes such as antibiotic stewardship, hand hygiene, cleaning practices, incubation periods and hospital-acquired infections. These themes were difficult to explain to the media and made predicting outbreaks challenging for hospitals. Second, C. difficile outbreaks tended to have a very slow build and a very unclear end. It was difficult for hospitals to know when to publicly release news of an outbreak, and when to declare its end. Finally, the criteria for disclosing information to the public were unclear. There were no provincial guidelines, and some hospitals chose not to disclose outbreaks at all.

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[8] *Mayo Clinic, "C. Difficile Infection," 2014, www.mayoclinic.org/diseases-conditions/c-difficile/basics/definition/con-20029664, accessed May 4, 2014.*
[9] *Ibid.*

These difficulties in managing the C. difficile outbreak were further compounded by challenges unique to the NHS. Firstly, the NHS generally comprised older hospitals with a very low proportion of private rooms — which lowered patient-satisfaction rates and partially contributed to increased rates of infection. Second, the NHS had recently undergone a large management shift (including a new interim CEO), which had led to low community familiarity with hospital leadership. Finally, the organization had been struggling with media relations and community relations for several years. The community did not seem to trust the hospitals or their officials, nor did the media. Third parties were also unlikely to come forward to validate the NHS's response to the crisis.

Managing the C. difficile outbreak communications meant managing both internal and external stakeholders.

Internal Stakeholders

Wood would need to gain the support of the hospital board on the chosen communications strategy. In speaking with the communications team, it was clear that the board of directors had historically been counselled to take a more conservative approach in communicating, which was at odds with the emerging trend of increased transparency and a willingness to work with the media as valued colleagues. Wood counselled that the needed strategy was much more transparent and forthcoming, "emphasizing timely, rapid turnaround of information, apology where necessary, commitment to do better, maximizing transparency on what's going on, etc." This approach was grounded in academic best practices and conclusive evidence.

External Stakeholders

The C. difficile outbreak was an atypical crisis in terms of public transparency and communication. Because hospitals in Ontario were not technically required to publicly declare an outbreak, communication strategies tended to differ greatly from community to community. For example, during an outbreak at St. Joseph's Healthcare Hamilton, Wood had worked very closely with the local public health unit to validate what was being done about the crisis, provide fact sheets and inform the public. He had also helped with question and answer periods in local media outlets. Unfortunately, St. Joseph Healthcare Hamilton's relationship with both the NHS and the regional public health organizations was, at times, strained.

RESTORING PUBLIC CONFIDENCE

Trust and Reputation Study

Soon after arriving at the NHS, Wood knew that public perceptions of the hospital needed to be improved. He immediately committed to understanding the views of the community, and requested that Dr. Terry Flynn, a sought-after crisis communication expert from McMaster University, come to Niagara to conduct a community engagement study. This study was designed to create a platform for change through fostering positive relationships within the community. Flynn engaged in an open listening process through surveys (both online and in-person), polling and interviews. The results indicated that the NHS had a –18.5 per cent reputation score; in other words, nearly 20 per cent more people had a negative perception of the NHS than a positive perception.

Of the participants who indicated they had a positive view of the NHS, 75 per cent listed "service" as the predominant influence of their opinion. Thus, the quality of care service was not the primary challenge.

While patients did not identify "quality of care" as a major issue, of the participants who had a negative view of the NHS, the major perceived problems were long wait times (for emergency rooms, diagnostic tests, specialist appointments and surgeries), lack of focus on "people," closure of facilities, distance to hospital sites, transfer process between hospitals, lack of cleanliness and infectious disease outbreaks.[10]

Although some challenges extended above and beyond the scope of a communications strategy, Wood needed to understand all the problems before a strategy could be drafted. The key findings and recommendations from the reputation score study are provided in Exhibits 3 and 4.

NHS Supervisor

After the report was released, Deb Matthews, the provincial Minister of Health and Long-Term Care, was prompted to appoint a supervisor for the hospital due to the community's lack of confidence in the hospital network. In August of 2011, Dr. Kevin Smith, CEO of St. Joseph's Health System, was appointed supervisor of the NHS, responsible for providing consultation to the NHS regarding its public perceptions. In this role, Smith would have the full powers of the hospital board, and would be responsible for restoring public confidence in the hospital system. As supervisor, Smith would report directly to the Minister of Health and Long-Term Care, who released the following statement:

> I wanted everyone in the Niagara region to have full confidence in the Niagara Health System. I know Dr. Kevin Smith has the experience and knowledge that will enable him to continue to improve patient care and help the NHS regain its stature in the community. I want to keep working with the people of the Niagara region to strengthen the NHS and make sure it remains an anchor in the community for years to come.[11]

The announcement of a hospital supervisor was a last resort for the Ministry of Health and Long-Term Care, and indicated a serious state of emergency in the hospital system. In the history of Ontario health care, every hospital supervisor assignment has been at least partially as a result of poor public perception and unsuccessful reputation management.[12]

Engaging the Community in Meaningful Dialogue

Even before Dr. Flynn had begun developing the community trust and reputation report, Wood was reviewing all of the major media clippings to identify the outspoken people. In his experience, "the people that are most outspoken want to be part of the solution, even if they're harshly critical." Wood met with several upset mayors, advocacy group leaders and community members in an attempt to understand the main issues and initiate positive working relationships. From these brief meetings, it was clear that the community did not feel like it was a part of the hospital. Common responses Wood heard included: "We don't trust the hospital, we've had bad experiences, it's been tough to get information, the relationship feels adversarial, we don't agree with the plan, but when we criticize the plan we're sloughed off." There

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[10] *Niagara Health System, About the NHS, 2014, www.niagarahealth.on.ca/en/about-us, accessed April 22, 2014.*
[11] *Government of Ontario, "Ontario Appoints Supervisor for Niagara Health System," press release, August 31, 2011, http://news.ontario.ca/mohltc/en/2011/08/ontario-appoints-supervisor-for-niagara-health-system.html, accessed May 4, 2014.*
[12] *Brady Wood, Brady, Crisis Communications: C. Difficile Outbreak, 2014. [Unpublished].*

had been no meaningful community engagement, so when people did go to the trouble of complaining, they never felt as though their concerns had been addressed whether they went to the mayor's office or directly to the hospital.

For NHS supervisor, Dr. Kevin Smith, process represented a major component of community engagement. Over several months, he held hundreds of meetings, set up a confidential email account and received more than 2,000 individual responses voicing concerns and opinions on the challenges facing the hospital.

The media in the Niagara region felt neglected by the NHS after years of poor or no responsiveness from the hospital. The staff at the region's three daily newspapers, seven weekly newspapers, several radio and television networks and community blogs, all felt dissatisfied with the NHS. The previous media engagement strategy had involved very canned responses from the NHS, meant to deliver a message rather than engage in authentic, meaningful dialogue. As a result of these poor relationships, nearly all of the media coverage of the NHS represented negative stories. Exhibit 5 outlines the NHS's reputation among the media community.

Leadership Changeover

In the process of attempting to improve on its reputation and public perception, the NHS experienced a significant amount of leadership changeover. In fact, "probably about 50 percent of the leadership team [had] turned over" over the course of the process. This effect presented an interesting dilemma for the NHS, as members of the community perceived the change in leadership to be a good sign that change was happening; however, it may have had a negative residual impact on the internal organization. The high frequencies of turnovers left several employees of the NHS feeling undervalued and negatively affected morale. A new permanent leadership team presented the opportunity for new leadership to receive training in their new roles with emphasis placed on creating authentic relationships with the community.

LONG-TERM STRATEGY

Moving forward, Wood recognized that the communication challenges the NHS was facing were part of a deeper organizational culture problem. Hospital leadership knew that regardless of the strategic approach taken, the communications strategy and culture would need to be unified to achieve a shared goal. The organization needed to institutionalize into common organizational practice the communications and public relations approaches that were used in mediating the C. difficile crisis and those that were leveraged to restore public confidence. Wood was confident that the strategy would be effective short term; however, the unpredictable nature of health care made it certain that although the existing crisis would be managed, more crises would soon follow. The long-term communications strategy could not simply manage crises and act as damage control.

NEXT STEPS

According to Dr. Terry Flynn, hospitals' relationships with their patients and community comprised five key elements: "control mutuality; trust; commitment; satisfaction; and, transparency."[13] Keeping this knowledge, Wood, with assistance from Flynn and the rest of his team, was tasked with developing a

[13] *Terence Flynn, The Niagara Health System Trust & Reputation Study Report, McMaster University, Hamilton, 2011, p. 8.*

strategy to improve the public perception and reputation of the NHS. While Wood's two-pronged approach was heavily grounded in academic theory, such theories had never been tested with such poor reputation scores. It became evident that the success of a new communications and public relations strategy could not rely on theory alone, but required innovative and dynamic leadership to implement and facilitate sustainable, long-term improvement with respects to the public perception and trust in the Niagara Health System. The execution of the strategy would take place in the context of a government-appointed supervisor, Dr. Kevin Smith, who was both overseeing the operations of the organization and acting as the hospital system's primary spokesperson.

Wood knew that any strategy that was developed needed to include immediate steps to improve the public reputation of the NHS. However, the strategy also needed both to be realistic and to recognize ongoing budget issues and the evolving culture of the organization. Wood picked up his pen and got to work.

EXHIBIT 1: NIAGARA HEALTH SYSTEM STATEMENT OF OPERATIONS, 2010–2011

	2011	2010
Revenue		
Ministry of Health and Long-Term Care		
Base allocation	$ 322,090,496	$ 313,077,751
One-time funding, specialized programs	13,879,945	16,127,457
Other	8,407,258	8,364,102
	344,377,699	337,569,310
Cancer Care Ontario	9,728,362	8,111,642
Patient revenue from other payers	34,424,654	32,876,789
Differential and co-payments	4,775,439	6,125,526
Recoveries and miscellaneous	12,780,345	12,531,463
Amortization of grants and donations – equipment	4,747,779	5,422,185
	410,834,278	**402,636,915**
Expenses		
Compensation – salaries and wages	203,882,182	200,057,848
Benefit contributions for employees	58,319,235	55,916,063
Employee future benefits	1,772,718	1,894,584
Medical staff remuneration	37,987,749	35,962,410
Supplies and other expenses	51,013,274	49,457,341
Medical and surgical supplies	27,056,683	26,984,621
Drugs and medical gases	21,906,401	20,614,684
Bad debts	590,865	564,714
Interest – short-term borrowings	1,086,423	875,753
Interest on capital lease obligations	506,835	544,901
Amortization of equipment and software licences	9,153,467	10,081,229
Equipment rentals and leases	2,604,700	3,104,479
	415,880,532	**406,058,627**
Deficit from Operations before Other Votes	**(5,046,254)**	**(3,421,712)**
Deficit from Other Voters	**(76,928)**	**(77,695)**
Other Items	**(2,980,767)**	**(2,366,673)**
One-Time Funding	**–**	**25,000,000**
(Deficit) Surplus	**$ (8,103,949)**	**$ 19,133,920**

Source: Niagara Health System, Financial Statements 2010–2011, 2011, www.niagarahealth.on.ca/en/financial-statements, accessed April 22, 2014.

EXHIBIT 2: HISTORY OF THE NIAGARA HEALTH SYSTEM, MARCH 2000 TO JANUARY 2014

March 2000:	Eight separate hospital corporations amalgamate into one
September 2002:	Resignations of first CEO and first board chair
October 2002:	Investigator appointed to assist NHS and Hotel Dieu Hospital with restructuring
February 2003:	Ontario Nurses Association censures NHS (censure removed in December 2010)
August 2005:	NHS and Hotel Dieu governance and management transfer
September 2005:	Construction of the new healthcare complex approved
July 2008:	Hospital Improvement Plan released
October 2008:	Medical staff vote of non-confidence of NHS leadership
January 2009:	Change in medical leadership
January 2011:	Change in senior leadership
May 2011:	C. difficile outbreak declared at St. Catharines General Hospital site
June 2011:	C. difficile outbreaks declared at GNG and Welland sites
July 2011:	Terry Flynn begins trust and reputation study
August 2011:	Province appoints Dr. Kevin Smith as supervisor of the NHS

Note: CEO = chief executive officer; NHS = Niagara Health Service; GNG = Greater Niagara General Hospital
Source: Company records.

EXHIBIT 3: KEY FINDINGS FROM NIAGARA HEALTH SYSTEM'S REPUTATION SCORE STUDY

Elements of Relationships	Reputation Score (% good opinion – % bad opinion)	Key Findings
Control Mutuality	–32.88	The negative control mutuality score illustrates respondents' belief that they have little to no control over or influence on the NHS. This belief can be caused by a lack of either meaningful dialogue or voice in decision-making.
Trust	–20.84	The negative trust score indicates respondents' lack of confidence in the NHS's integrity, competence and/or ability to deliver what has been promised.
Commitment	+6.17	The positive overall commitment score indicates respondents' belief that the relationship with the NHS is worth the time and energy. This belief is likely indicative of their personal commitment to the NHS.
Satisfaction	–29.77	The negative satisfaction score indicates the NHS's continuous failure to meet respondents' expectations.
Exchange vs. Communal	+20.55	The positive score in exchange vs. communal relationships indicates that respondents see the relationship as more two-sided. In light of other negative indicators, this score is interesting. While respondents don't agree with many of the NHS actions, they do not generally believe the NHS cares only about its own interests.

Source: Terence Flynn, The Niagara Health System Trust & Reputation Study Report, McMaster University, Hamilton, 2011, p. 31.

EXHIBIT 4: KEY RECOMMENDATIONS FROM NIAGARA HEALTH SYSTEM'S REPUTATION SCORE STUDY

Recommendation Area	Actionable Items
Listening, Engaging & Follow-up	• Establish a patient-experience committee; • Add patient-experience resources to improve follow-up; • Establish a community advisory committee; • Add a community and government relations resource; • Develop a relationship scorecard that captures key metrics, communicates results and informs public.
Emergency/Urgent Care Experience	• Consider patient–family communication touch points in ER beyond triage; • Provide a patient-feedback mechanism specific to the emergency room experience; • Create broader awareness of emergency wait times; • Include metric on reputation scorecard.
Cleanliness of Sites	• Consider establishing a walkabout committee to assess public perceptions of cleanliness standards; • Ensure cleanliness is a factor included in all patient satisfaction surveys; • Include cleanliness metric on reputation scorecard.
Changes to Access	• Develop community engagement process.
Patient Access Points	• Engage community members in review of communications regarding points of access.
Employee Engagement	• Survey employees on obstacles and opportunities in delivering patient-centric experiences; • Provide patient experience training to all front-line staff; • Recognize employees who excel in customer-centric delivery through "patient first" type program; • Include metric on reputation scorecard.
Financial Performance	• Focus on improving communications around administrative costs; • Include financial metric on reputational scorecard.
Leadership and Governance	• Continue to build relationships with the media; • Consider regularly scheduled leadership visits to each of the 12 municipalities; • Consider a community-based committee that identifies and/or nominates potential board members; • Continue/increase use of open board meetings.
Addressing Rumours	• Develop a mechanism for identifying and addressing rumors that could have a negative impact on the community and/or the NHS.

Note: ER = Emergency room; NHS = Niagara Health System

Source: Terence Flynn, The Niagara Health System Trust & Reputation Study Report, McMaster University, Hamilton, 2011.

EXHIBIT 5: NEWS EXCERPT: "TOP NEWSMAKER OF 2011: THE NIAGARA HEALTH SYSTEM"

St. Catharines – It was a year that saw Niagara's hospital network struggle with a deadly Clostridium difficile outbreak and endure ongoing public relations challenges. . . . For the NHS, 2011 was about ongoing crisis management. Across Niagara, C. difficile outbreaks were declared at the Greater Niagara General Hospital, St. Catharines General Hospital and Welland County General Hospital — 37 patients with hospital-associated C. difficile infections died. Only one unit at GNGH remains in outbreak mode.

There were also patient-care incidents of concern on hospital properties that were widely reported. In one, Doreen Wallace fell and broke her leg in the doorway of the Niagara Falls hospital on Oct. 8 after washing her hands at a sanitizer. She lay on the floor, injured and bleeding, for what her family said was 28 minutes. Although several staffers helped her, the family said other nurses wouldn't assist Wallace, who is in her 80s. The family said the nurses said there was nothing they could do and they would call for an ambulance.

There were also two prior, similar situations over the summer, involving Niagara Falls Coun. Joyce Morocco and Ridgeway woman Jennifer James. Both were denied care outside the hospital, again with hospital staff telling family members to call 911. James later died.

The NHS has said steps are being taken to ensure similar incidents aren't repeated. Meanwhile, controversy continued over the NHS's conversion of the emergency departments at Douglas Memorial and Port Colborne General hospitals to urgent-care centres as part of its hospital improvement plan. The HIP plan aims to create so-called centres of excellence by centralizing services at different hospitals.

Also in 2011, NHS interim CEO and president Sue Matthews took over from Debbie Sevenpifer. The reason for Sevenpifer's sudden departure in January — and its financial implications for taxpayers — have never been disclosed.

Then on Aug. 31, Kevin Smith was named the provincially appointed supervisor to oversee the NHS. Smith has full control of health system operations and is charged with restoring public confidence in the system.

In November, McMaster University professor Terry Flynn's Trust and Reputation Study found that among Niagarans, there's a "significant lack of trust for the organization" and a "continual feeling of being let down" by the NHS.

Source: St. Catharines Standard, "Top Newsmaker of 2011: The Niagara Health System," December 27, 2011, www.stcatharinesstandard.ca/2011/12/27/top-newsmaker-of-2011-the-niagara-health-system, accessed April 22, 2014.