

5 Hospital Crisis Scenarios and How to Overcome Them

By Lindsey Dunn October 05, 2009

Various crisis scenarios threaten hospitals, and when these crises hit, their impact can cause both short- and long-term damage to hospitals, both in terms of reputation and financial performance. Planning in advance for these potential disasters and applying key lessons from individuals who have overcome them can help your hospital prepare to successfully meet these challenges.

Four hospital insiders share their experiences in dealing with five crises and provide recommendations to other hospital leaders who may at one point find themselves dealing with similar situations.

1. Threatened contract with dominant insurer in market

The crisis: A metropolitan community teaching hospital in New England found itself in a very concentrated marketplace where it held approximately 25 percent of the market share among the three hospitals and was the third choice in town from a perception standpoint. The community was dominated by a single managed care payor, and the largest physician group practice in town, which consisted of more than 300 physicians, only contracted with that managed care company. Physicians from the group practice made up approximately 60 percent of the hospital's medical staff but only accounted for 40 percent of revenue. The hospital's contract with the payor was weak, and hospital leadership did not feel the hospital was receiving adequate reimbursement for its services. As a result, the hospital wanted to get out of its relationship with the managed care organization but retain the medical staff.

The solution: The hospital first took part in voluntary mediation, then a binding arbitration process and finally court proceedings before the issue was resolved — a more than two-year process. Throughout its battle, the hospital was committed to open communication with its medical staff, employees and community members about its relationship with the managed care organization and the impact of this relationship on the hospital and its stakeholders, says Mr. Burchill, COO of the hospital during the time the situation described here took place, and now a director at Beacon Partners, a healthcare management consulting firm.

After initial negotiations with the managed care organization failed, leadership from the hospital, managed care organization and group practice underwent voluntary mediation. During mediation, the hospital voiced its concerns regarding revenue and its long-term survivability if it continued with the current contract. The payor expressed concerns about increases in its medical loss ratio, and the physicians expressed concerns about losses of volume if the contract failed to be negotiated. In the end, mediation was unsuccessful.

Next, the groups went through a binding arbitration process. According to Mr. Burchill, the hospital prepared for its time in front of the arbiter as if it were preparing for a trial. "We made a case for the ways in which the hospital had and would have been harmed, including the impact on revenue and volume, and outlined the fair market value of our services," says Mr. Burchill. The arbiter rendered a decision to increase reimbursements, but it was ultimately appealed by the managed care organization. A tribunal judge heard the cases, and in the end, the hospital gain increased reimbursements. The managed care organization ultimately had to raise its premiums but was able to remain the least expensive insurance provider in the area, according to Mr. Burchill.

Mr. Burchill says that hospital leaders faced with the same situation should commit to open communication with all levels of employees and stakeholders, while remaining careful to protect the confidentiality of the proceedings. "If you put the organization in a vacuum, there will be rumors, innuendos and inaccurate information," says Mr. Burchill. "If you take it down to the level of a nurse on a floor caring for a patient, she may question what will happen to the patient if the patient is covered by the insurer. She may worry about her job. If she or her family members are covered by the insurer, she may worry that they will need to find a new provider. Hospital leaders need to provide enough information to alleviate fear and overcome anxiety."

2. Unexpected loss of a leader

The crisis: An acute-care community hospital in the Midwest was forced to let go of its operating room manager immediately. As one of the hospital's most critical departments, it was important that the department continue running without interruption. Additionally, the hospital faced surgeons and staff members who were concerned about inefficiencies in the management of the department and were polarized regarding the loss of the manager.

The solution: The hospital acted quickly, transitioning to a new OR manager, who came from inside the department, within 24 hours and worked to assure that the surgeons and staff had confidence that the hospital and this department, in particular, would be managed efficiently, according to Julie Thompson, RN, MSN, MBA, senior vice president of consulting solutions for B.E. Smith, the consulting firm who was hired by the hospital to manage the situation described in this scenario.

The first step that the hospital leaders and the consultants took was to identify a replacement leader for the department, navigate through likely scenarios that might create challenges for the transition and develop actions to thwart any of these repercussions, says Ms. Thompson. Next, the leaders addressed staffing issues relative to surgery times so that the hospital could ensure that all scheduled procedures could take place.

During the entire process, the hospital's top nursing executive made herself available to the department, assuring surgeons and staff that the issues in the department had the attention of the highest levels of the organization. Having the support of top hospital leadership and a commitment of resources to fix the issue ensures stakeholders that quality will not be compromised.

Hospital leadership also paid attention to the personal side of the department's problems. "Understanding the issues on a personal level is one of the first challenges," says Ms. Thompson. "In this situation, we had to understand the context of the department and its history. We began to understand that physicians were polarized around both sides of leadership — some were grieving the loss of the leader while others were not." Through this understanding, the hospital was able to respond in a way that satisfied both parties.

The consultant successfully stabilized the management of the operating department and completely resolved an issue that could have jeopardized a critical revenue stream for the facility.

3. Serious patient complaint threatens CMS enrollment and accreditation

The crisis: A medium-sized hospital in the Midwest received an unannounced visit from a CMS surveyor following a serious patient safety complaint. Although the hospital was well-known both regionally and nationally for quality and safety, the recent complaint threatened the hospital's CMS enrollment, accreditation and reputation. The organization had an interim, novice quality director who would be required to respond to the visit. The surveyor determined that a violation did occur, and the hospital was given 60 days to resolve the issue or lose its Medicare funding.

The solution: The hospital reacted to the CMS visit by hiring a crisis consultant to assist the hospital and its interim quality director in coordinating a proper response to the violation, according to Patricia Burns, RN, MSN, vice president of consulting services for B.E. Smith, and the consultant dispatched to the hospital described in this scenario. On the day of the CMS visit, Ms. Burns' role was to facilitate the surveyor's inspection and ensure transparency and honesty in the hospital's representation of itself and response to the violation. After the surveyor's visit, hospital leaders and Ms. Burns went to work to determine the root cause of the patient safety violations.

"We did determine that there was a process failure, and helped the hospital work through its existing quality process to figure out solution to the problem," she says. "You don't want to just put a Band-Aid on it. You want to fix it long term."

The hospital then drafted a response to CMS describing the process breakdown and the efforts the hospital had taken to remedy it. The hospital provided a point-by-point coordinated written response to the violation as well as each step in and a timeline for the solution. The CMS visit triggered a notification to the hospital's accrediting body, which the hospital responded to as well.

According to Ms. Burns, the patient safety violation that took place at this hospital is an example of how a bad incident can happen to an otherwise strong hospital. In these situations, she says that it is important for hospital leaders to put the incident in perspective for the organization and its community. "[These situations] can be devastating for hospital staff and the community, so it's important to immediately determine the root cause of the problem, put it in perspective and share the hospital's solution to successfully resolve the issue," she says. "One patient complaint will be generalized to whole organization by the community, but it doesn't mean the whole organization is bad. It just had one process failure."

In the end, the hospital kept its Medicare funding and was able to successfully complete all additional surveys without any issue or citation.

4. Bankruptcy filing

The crisis: A community hospital in the Northeast and its subsidiary nursing home were in the process of filing for bankruptcy protection. The hospital was filing for Chapter 7, while the nursing home was filing for Chapter 11. Both facilities faced significant operating losses due to a variety of problematic issues, including weak managed care contracts, declining volumes and inadequate cash-on-hand to pay vendors. The hospital alone was experiencing a \$3 million loss on net revenue of \$12 million.

The solution: The hospital focused on reorganization efforts that would allow the hospital and its subsidiary to stabilize. Additionally, efforts were made to repair relationships with vendors and renegotiate contracts with both vendors and managed care providers, which would allow the hospital to be more profitable, says Mr. Burchill, CEO of the hospital at the time of its bankruptcy filings.

According to Mr. Burchill, the key in dealing with any bankruptcy situation is paying off debts and then moving forward, which includes addressing issues that may have led to the organization's poor financial performance.

First, the hospital renegotiated and paid off its contracts with vendors. Mr. Burchill says that some vendors received as little as 15 cents on the dollar after the bankruptcy filings, so it was critical that the hospital focus on repairing relationships with these vendors and reworking the business relationship.

Next, the hospital moved to addressing the issues that ultimately led to its financial demise. "Nearly everything was equal in terms of priorities to address financial challenges. There were volume issues, staffing costs, supply costs and reimbursement concerns," says Mr. Burchill. "I recommend working closely with your finance team to combat these issues. Start by renegotiating the structured relationships with your top two or three managed care organizations to see if there is a way to get some relief."

During the entire process, Mr. Burchill made himself visible and available and worked to preserve the hospital's relationships with both vendors and managed care organizations, as well as with community members. "It falls to the CEO to be that key business contact with the vendors and managed care organizations," he says. "Let the vendors know you understand what happened to them, from business perspective, but explain the need to structure a new relationship and keep them as a strategic business partner."

In the end, the hospital that Mr. Burchill oversaw was able to reposition itself and eventually began operating in the black again. Managed care contracts stabilized, medical staff grew, volume improved and the hospital eventually recovered.

5. Natural disaster

The crisis: One of the most devastating tornados in the country ripped through the South in 1997, severely damaging the offices of numerous physicians affiliated with an Atlanta-based pediatric hospital. Although the hospital had a

strong disaster plan and had enacted numerous drills to protect its main hospital facility and its patients, which were not ultimately affected by the storm, the healthcare organization overlooked the importance of developing an action plan for dealing with natural disasters affecting its more than 300 affiliated pediatric physicians with offices in 70 different locations. Approximately 15 percent of the hospital's physician network was unable to occupy their office space to treat patients after the storm, and efforts to repair the damage were estimated to take from 6-12 months.

The solution: The hospital worked quickly to locate temporary office space for the physician practices affected by the disaster so that they could resume business, according to Marty Rosenberg, a principal with EthosPartners, a healthcare management consulting firm, and an executive at the children's hospital during the time of the scenario described here. Other practices allowed the shuttered practices to see patients in their offices, doubling up schedules and opening during weekends in some instances. Another issue facing the networked providers was difficulty in accessing the then paper-based patient records at these shuttered facilities — an additional concern that the hospital had not considered.

According to Mr. Rosenberg, many of the difficulties the hospital faced could have been alleviated if the hospital would have considered its affiliated physicians in its disaster preparedness plans. "We were not prepared for a disaster to hit this critical part of our hospital. We had a disaster plan in place for our inpatient facility, as was required by our accrediting body, but we weren't prepared for the networks, and as a result multiple pediatric practices were completely put out of business for some time," he says.

Mr. Rosenberg also cautions that as healthcare providers become more dependent on electronic health records, there is an increased need to protect that information and an increased need for a backup plan for accessing the information if systems are damaged.

He advises that hospitals view infrastructure as an insurance policy to protect health information. He also suggests that all electronic systems have off-site back-up storage, because the likelihood of systems going down in two locations is very unlikely.

As healthcare systems moved from hospital-centric providers to more integrated delivery systems, systems should ensure that disaster preparedness, both in terms of securing physical locations and electronic data, consider both inpatient and outpatient facilities in the network.

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