Hospital Near-Death Experience

How Medicare Termination Can Push Your Hospital to the Brink of Closing

A GUIDE FOR HOSPITAL EXECUTIVES
It Can Happen to Anyone

The leadership, staff, and physicians of Haywood Regional Medical Center (Haywood) never imagined their organization would experience involuntary Medicare termination. Termination usually results in closing of the hospital because most cannot survive without Medicare funding. Haywood came close to such demise, but returned from the brink of death to regain CMS certification.

The story of Haywood is your chance to learn from someone else’s mistakes. It should encourage you to take preventative action, to assure that your hospital is not faced with a Near-Death Experience.
Prior to Haywood’s frightening Near-Death Experience, it was quite successful.

This 190-bed medical center was experiencing increased revenue, successfully recruiting physicians, and investing in capital improvements and new facilities. The medical center was very well-respected in the community, and its publicly-reported quality data exceeded national benchmarks. Haywood was honored with national quality awards, including a Health Grades 5-star rating.

However, after several CMS-focused assessments by the state health department, a notice of Immediate Jeopardy arrived, taking many of the medical center’s leaders and staff by surprise.

Several factors contributed to the disruption of Haywood’s seemingly perfect operations.

- The Board of Trustees largely ignored clinical quality data and made the medical center’s financial condition the center of attention.
- The CEO overlooked day-to-day operational problems as he spent increasingly more time engaged with outside organizations.
- The relationship between medical staff and leadership deteriorated as feelings of distrust and lack of respect compounded.
- Vacancies in nursing leadership and inconsistent direction created turmoil among nurses.
- Significant use of agency and traveling nurses without attention to orientation and supervision created numerous care concerns and physician dissatisfaction.

In the months before Haywood lost its Medicare certification, there were signals that should have been apparent on the radar screen of the medical center’s leaders.

Board members accepted quality data prepared by supervisors without questioning the source or the calculations.

Early indications of financial trouble appeared, causing Board members to focus on cost-cutting without analyzing the causes of deteriorating financial performance.

The pressure to address these financial concerns strained communication between the CEO and the Board members as the Board became fixated on the medical center’s financial health during meetings.
The Case of Haywood: Problems Begin to Mount

**Administration** – The CEO, who historically had a good working relationship with the Board and medical staff, had become more active in external activities. He spent a significant amount of time in leadership roles with outside organizations at the expense of leading institutional strategy and operations. His increasing physical absence spoke volumes to staff, physicians, and the Board about the CEO’s commitment to leading the organization.

**Medical Staff** – The medical staff’s distrust of the administration grew in the absence of visible leadership. Previously, the orthopedic service line dissolved after a disagreement between an orthopedist and the CEO. Shortly thereafter, the entire anesthesia physician group resigned, again due to a difference of opinion with the CEO. Finally, the contract with the emergency room physician group was terminated. These changes damaged long-standing relationships with key physicians and contributed to distrust among the medical staff. The Chief Medical Officer (CMO) was not well integrated in nor influential with the medical staff and thus was unable to serve in a vital communications role.

**Nursing** – The nursing department was also in turmoil. Members of the medical center’s administration implemented new processes with the goal of improving nursing practice, but did so without critical nursing and medical staff input. Most of the nursing department directors expressed their opinions about these changes by resigning or retiring. Administrators chose not to hire interim nursing directors due to financial constraints, leaving key clinical departments to function without sufficient leadership.

Changes in requirements and classification of temporary nurses caused many part-time nurses to leave, further exacerbating staffing challenges. Agency nurses were the only option to address scheduling concerns created by lack of full-time staff. Increasing reliance on agency and traveling nurses for core staffing created discontinuities in care delivery. Continuing changes in policies and procedures left nurses confused and frustrated. Morale plummeted as the pace of change increased. Physicians began vocally expressing concerns about the quality and continuity of nursing care – concerns largely falling on deaf ears.
Physician dissatisfaction with the handling of patient care issues finally pushed one practitioner over the edge. Individual quality concerns were ignored and left to fester. Incidents went unreported or landed in a bottomless pit of quality and risk data that staff perceived would never see the light of day again. The quality program, chronically resistant to bad news and led by a single individual, proved ineffective in addressing practitioner and staff concerns. The Board was sheltered from most internal quality data, except for basic benchmarks used to compare hospitals nationally.

An extremely dissatisfied physician wrote a letter to the Board complaining about the manner in which a medication error incident was being handled, but found the Board’s response insufficient. The information became public, triggering a visit from the Centers for Medicare and Medicaid Services (CMS)/North Carolina Department of Health and Human Services (the State). CMS/the State conducted a three-day complaint survey from January 30 through February 1, 2008. Haywood was notified during this survey of the identification of Immediate Jeopardy. The medical center’s Immediate Jeopardy status required the administration to take corrective action within 23 days to avoid Medicare termination and potential closing of the medical center.

The medical center did not meet the following Conditions of Participation:

- Governing Body
- Quality Assurance and Performance Improvement
- Nursing Services
- Pharmaceutical Services
The Case of Haywood: Near Death

**The Silo Approach** – The CEO took a particularly disjointed and guarded approach in response to these findings. He informed neither the Board nor the medical staff of the medical center’s notification of Immediate Jeopardy, downplaying the severity of this threat. When Board members were first alerted to the situation through a newspaper announcement by the State, the CEO assured the Board and the medical staff that the situation was not monumental in impact and was being managed effectively through internal resources.

Preparation of the plan (called a credible allegation of compliance) was left to a single administrator with short tenure in the organization. This individual devised and submitted the plan without involvement from other hospital leaders, medical staff or nursing staff. While final approval was obtained from other administrators, little time was left to question and test the plan’s validity or practicality.

**Death Quickly Approaches** – The written plan was accepted by CMS and the State. However, when regulatory officials conducted a follow-up survey from February 19 through February 22 to ensure that the plan had been implemented, insufficient action had been taken to address the cited areas of non-compliance. Surveyors upheld Haywood’s Immediate Jeopardy status with just a few short hours remaining to correct the deficiencies. Last-minute attempts were inadequate to reverse the path to termination.

**Time Runs Out** – On February 24, Haywood’s Medicare participation was terminated. Following an emergency Board meeting on February 25, the CEO “retired.” A media firestorm ensued. The situation was becoming a nightmare for Haywood and its administration. If the medical center was to stay alive, the administrators and staff needed to acknowledge it was in trouble.
The Case of Haywood: Returning from the Brink of Death

**Experienced, Objective Consultation** – In the case of Haywood, an outside perspective was needed to allow the organization to act quickly and judiciously to regain certification. Compass Clinical Consulting (Compass) was called upon to provide the technical and clinical expertise to chart a path to Medicare recertification.

Haywood had to begin an aggressive and arduous process of change and reinvention. The clarity provided by regulatory consultants helped to outline each step of this journey and provide simple strategies to complete the tasks required for survival.

**An Actionable, Digestible Plan** – In less than a week, leadership experts outlined a plan for creating an environment that would make this journey possible. Immediate action had to be taken to ensure that patients were safe.

1. The first step was to break down the CMS report into manageable sections. Summarizing the problems identified by CMS made them easier to understand and digest, and facilitated the process of determining what corrective measures to take.

2. Next, action teams were established to address each section of the report.

3. Finally, action plans were developed to correct each of the identified areas of non-compliance.

It soon became obvious that more experienced leaders were required to assist Haywood on this journey. Interim leaders were provided for nursing, quality, the emergency department and human resources. Haywood also used an interim CMO who was able to establish strong communication and encourage reengagement of medical staff in this complex process.

**Re-establishing Internal Team Trust** – With the help of Compass consultants, Haywood’s administration was able to bridge the gap between the medical center’s leaders and the medical staff. Previously, the medical staff and employees were kept at arm’s length. Haywood’s interim CMO was able to reestablish trust with the medical staff through public and private communication, obtaining their support for necessary clinical policy changes.

The Haywood team also learned to identify internal experts, regardless of their roles or reporting lines in the organization. For example, a committee was formed to address compliance issues with medication administration. This consisted of physicians, nurses, pharmacists, and clerical staff who were not necessarily formal leaders in the organization. Previously ignored staff members were now able to serve as internal resources for Haywood.

**Rapid Payoff** – Through considerable hard work and dedication, Haywood regained Medicare certification in 110 days, a remarkable turnaround time for such a recovery. A thorough, outside assessment of the organization assisted Haywood’s staff and administrators in the development and implementation of new policies and procedures in preparation for the three CMS surveys needed to regain certification. When CMS returned, the medical center passed the survey with confidence.

After the long process of preparing for a successful survey, administrators had to take one final action. The last step in regaining Medicare certification after termination is to apply for a new provider number, a process that typically involves over 300 pages of documentation. Once Haywood received the new provider number, it needed to be disseminated to nearly every subcontractor, organization and agency associated with the medical center.

After Haywood became recertified as a Medicare provider, physicians returned, patients returned, and eventually so did revenue.
The Real Costs of CMS Termination

This Near-Death Experience took a drastic toll on Haywood. Not only did the medical center take a significant financial hit, but it also experienced leadership turmoil, decreased staff morale and a damaged community image. These costs could be avoided by continuous compliance with CMS requirements. Significant costs of Immediate Jeopardy and subsequent involuntary Medicare termination included:

- A loss of just under $15 million, including a $5.8 million bond issue recalled by the bank
- An estimated $80,000 per day in non-reimbursable care provided primarily through the ED
- Idle, demoralized staff
- A media firestorm
- Threat of sale or forced affiliation of the hospital

Before this Near-Death Experience occurred, Haywood had a cash reserve of approximately $18.5 million. After relying on those resources to stay alive during this rigorous process, the medical center lost just under $15 million. This included a $5.8 million bond that was recalled by the bank. The financial impact of this experience was quite significant considering Haywood’s relatively small size. This impact would be substantially magnified in a larger hospital.

During the period without CMS funding, the interim CEO estimated that Haywood’s clinicians provided approximately $80,000 a day in non-reimbursable care. The average daily census fell from 70 to 4 within days of Medicare termination, leaving staff idle. Patients had to forego care or seek care elsewhere, and physicians were forced to practice at competing hospitals, losing privileges associated with any seniority they had at Haywood. 7

This experience also impacted Haywood’s standing in the community. Haywood was in the local news almost daily for several weeks after its status as a Medicare provider was revoked. The medical center’s Board held frequent public meetings attempting to quiet dissonance, but these only led to more questions on the front page of newspapers state-wide. The community lost trust in what had been viewed as a strong and stable organization. There were news reports about whether or not the medical center would be sold, or merge with a larger healthcare system. 8
An Action Plan for CMS Recertification

It is not uncommon for hospital leaders to believe that this story is rare; that Medicare termination could never occur at their facilities. Administrators often think, “We’ve always done well, why would this time be any different?” However, as both The Joint Commission (TJC) and CMS become more thorough in their survey processes, this thinking may represent false confidence. The following guidelines present a strategy for dealing with Immediate Jeopardy.

Guideline 1: Create a Plan that is Realistic and Patient-Centered

CMS is especially rigorous in the survey process, which focuses on protecting patients. If the survey is being conducted after notification of Immediate Jeopardy, it is vital that measures are implemented to remove the identified immediate threat to patients. Verify that the plan reflects CMS standards and not those of other accrediting agencies such as TJC. Everything delineated in the action plan must be realistic and attainable. CMS surveyors expect all cited deficiencies to be remedied with no errors. CMS follows a zero tolerance policy and only considers the action plan to be successful when the specified goals are achieved 100% of the time. Hospital leaders should constantly be vigilant and always aim for this outcome.

Guideline 2: Involve Your Board – Now and Always

An important lesson to learn from Haywood’s Near-Death Experience is that transparency is not a luxury but a necessity, particularly with the board of directors. The board provides oversight, direction and representation of the “true” owners of the hospital. Informed involvement of board members is a critical requirement for knowledgeable leadership.

CMS requires hospitals to have a governing body (a board of directors) that is legally responsible for the conduct of the hospital as an institution. The key deficiency cited during a complaint survey is attributed to the governing body’s role in oversight of quality care. Many boards take a “rubber stamp” approach to quality issues, often because board members lack the understanding needed to appropriately question quality data and reports, so they instead concentrate on more straightforward topics such as finance.

It is the responsibility of the hospital’s administration to assist board members in mastering their roles in quality oversight through education, conferences, publications and presentations. Board members who are also clinicians are integrally important in supporting the completion of this critical board role. After board members are adequately equipped to process quality information, it then becomes their responsibility to act on the information provided to them. Engaging the board in quality oversight can prove to be an enormous asset when handling accreditation and compliance issues.

Selection criteria for board members should be outlined, documented, and followed to ensure that a board is an effective resource. Clear lines of communication should be established from the front lines of patient care up through the organization and to the board. Collaboration with a board can help prevent a Near-Death Experience like Haywood’s by addressing problems when they arise.
Guideline 3: React Quickly

If the unthinkable happens at your hospital, and Immediate Jeopardy becomes a reality, swift action is vital. Early intervention assures that your plan is ready before the CMS notice hits the papers. Follow these steps within the first 24 hours of Immediate Jeopardy notification to help avoid Medicare termination:

- Initiate a media plan, even if you think you won't need it.
- Identify solution teams.
- Tap into your internal and external experts to clarify what needs to be done.
- Plan on responding to an Immediate Jeopardy notification within 10 days.
  - Develop and implement an action plan within 7 days of notification and send it to the appropriate officials, allowing 3 days for transport.
  - Alert the appropriate office that the action plan has been sent so that CMS regulators are prepared to review the plan when it arrives.
  - If the initial plan is deemed unacceptable, this timeframe allows 12 days for revision of the plan and resurvey.

Being proactive about the media response to a notice of Immediate Jeopardy can help alleviate the potentially devastating consequences of a public relations nightmare. Put a plan in place and develop a clear and consistent message to deliver to all constituents including employees, news reporters, and members of the community. Be sure that the board is notified immediately, before the news reaches reporters, and be transparent with them throughout the process.

Identify teams that will be adept at tackling various areas of non-compliance. Responding to a notice of Immediate Jeopardy should be a team effort, with input from members of leadership, medical staff and key employees at various levels in the organization. Consult with your internal and external regulatory compliance experts to ensure that the plan meets CMS’s requirements.
The Bottom Line

The thought of Medicare termination is terrifying for any hospital leader. This type of hospital Near-Death Experience can be prevented by engaging the board and medical staff, keeping up to date on CMS guidelines and expectations, and being attuned to indications of organizational distress. If Immediate Jeopardy is cited, taking an objective inventory and reacting quickly will be critical to survival. Understanding when to ask for and accept help can be an empowering way to turn the tides.

Endnotes

1 http://www.haymed.org/about_us/news_events/2008/80years.php
3 http://www.smokymountainnews.com/issues/12_06/12_06_06/fr_ER_physicians.html
5 http://www.smokymountainnews.com/issues/02_08/02_27_08/fr_hrmc_timeline.html
6 http://www.citizen-times.com/apps/pbcs.dll/article?AID=/20080228/NEWS01/80227130