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How to Turn Around a (F)ailing Hospital or Health System

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Abstract

Hospital and health system bankruptcies and closures continue to rise in the United States. Turnarounds of healthcare organizations at risk or already in insolvency present daunting challenges that require new leadership.

There are at least four key components necessary for a successful turnaround: (1) unwavering *suppor*t of the governing board and key stakeholders for the new management team; (2) the right *timing* to start the turnaround process; (3) appointment of a transformational Chief Executive Officer (CEO) who epitomizes the modified democratic management model; the new *leader* should preferentially hold dual MD and MHA/MBA degrees to understand both medicine, the core business, and economics, the other nucleus for the organization's survival; (4) a convincing and inspiring *strategy* that is based on both financial and operational data and includes elements of the blue and red ocean strategies to accomplish a successful turnaround.

From the financial perspective, cash management, expense reduction, and revenue improvement plans must be developed and executed immediately. From the workforce perspective, the new CEO must, from the very beginning, provide regular, honest, and uplifting communication messages to turn internal skepticism to belief and to motivate and inspire all employees. Lastly, to guarantee the sustainability of a successful turnaround, all strategic measures must be re-evaluated on a regular basis with a low threshold to adapt to new changes in order to stay ahead of the competition.

Keywords: Turnaround, Hospital turnaround, Healthcare turnaround, (F)ailing hospital and health system, Struggling hospital and health network, Hospital closure, Hospital bankruptcy, Hospital insolvency, Turnaround components, Modified democratic management model, Transformational vs. transactional leadership styles

Introduction

Bankruptcies and closures of individual hospitals and to a lesser degree, healthcare systems or networks, are no longer the rare exception in America and are not considered anymore to be unusual occurrences.[1] The implications for patient access and outcomes are massive. Closures can also increase the strain on the rest of the healthcare system.[2]

There are many reasons why hospitals and health systems find themselves in distress.[3]

There are obviously financial issues such as declines in reimbursement, skyrocketing labor costs, low cash balances, inability to meet payroll obligations, unfunded pension or professional liability or obligations, noncompliance with debt covenants, difficulty accessing debt, or high vendor debt.[4]

These financial issues are often the result of a decline in patient volume and revenue which is worsened by unfavorable payer contracts and too few commercial insurance patients. In addition, bad debt, a high percentage of "self-pays" (i.e., mostly "no-pays"), too much charity care, too little non-operating revenue (e.g., declines in

investment income or philanthropic donations) are also contributing factors.[5]

There are, of course, patient issues such as clinical quality concerns, inappropriately long lengths of stay, outdated technology or facilities, and low satisfaction scores.

There are workforce issues such as physician and nurse shortages and difficulties in recruiting healthcare professionals.

There are external issues such as significant general inflation, high interest rates, and volatility in capital and investment markets as well as ongoing supply chain disruptions and shortages.[6] Local competitor(s) with deep pockets and ever-increasing gains in the market share may also be a factor.

But, above all, there are leadership issues in the main. Failure to adapt to market changes is usually the result of a failure in an appropriate alignment strategy of the (f)ailing organization. This, in turn, leads to considerable medical and nursing staff dissatisfaction with lack of motivation and further economic down-spiraling. The lack of a clear and successful business strategy may also divide the board of directors and even the senior management team itself.

All these factors contribute to the perfect storm leading to an organization's shut down. The following focuses on how (f)ailing hospitals or health systems can successfully be turned around when four key elements are heeded: (1) support, (2) timing, (3) leadership, and (4) strategy.

Background

According to the American Hospital Association (AHA), in 2023, there are 6,129 hospitals in the U.S. of which 49% are not-for-profit community hospitals, 20% are investor-owned (for-profit) community hospitals, 15% are state and local government community hospitals, and 3% are federal government hospitals.[7]

There about 625 health systems in the United States that vary by size, ownership, and hospital presence. The median number of hospitals in health systems is 2, with a range from 1 to 175. About one-third of systems (n=223) have only one general acute care hospital. The median number of physicians in health systems is 245. A small number of relatively large systems account for a disproportionate share of providers. The 10 largest systems account for 21% of the physicians and for 25% of beds. About 80% of health systems have nonprofit ownership and almost 40% of systems have at least one major teaching hospital.[8]

Bankruptcies and closures of American hospitals and health systems substantially increased during the COVID-19 pandemic.[10] In 2020, more than three dozen hospitals entered bankruptcy.[9]Two years of Covid surges caused a severe financial crisis of hospitals and health systems specifically following the January 2022 Omicron emergence.[9]

Yet the exact number of bankruptcies and closures of hospitals and health systems in 2022 is a relatively small denominator.

According to Beckers Healthcare there were only about 40 hospitals that filed for bankruptcy, closed or announced plans to close in 2022.[11] In 2022, at least 46 large healthcare systems with liabilities of $10 million or more declared bankruptcy, up from 25 in 2021.[12] Moreover, 53% to 68% of the nation's hospitals ended 2022 with their operations in the red, according to the AHA.[13]

In 2023, hospital and healthcare system bankruptcies surged further with liabilities over $100 million in 13 filings during the first six months of 2023, compared to just 15 total cases the prior two years. Five of those 13 bankruptcy filings were cases each with more than $500 million in liabilities. Overall, through June 2023, there have already been 40 healthcare bankruptcy filings. "If trends continue at this annualized rate, the market could see 80 healthcare bankruptcy filings in 2023."[14]

The reasons for this recent surge are somewhat different from prior years. Macroeconomic forces have a major impact such as high interest rates with capital market constraints, pay or rate increases not meeting cost inflation, labor and supply cost increases, Medicare cuts, and

unwinding of the Medicaid continuous Patient Protection and Affordable Care Act (ACA) enrollment.[14]

Despite its well intentions and successes, requirements of the ACA including the need for significant capital investments in IT and other areas in combination with the pressures of declining reimbursement are causing multi-million dollar losses and pushing many more hospitals to the brink of bankruptcy.[5,15]

Matters are particularly dire for rural hospitals: between 2005 and 2022, 186 rural hospitals closed.[16]But in 2023, according to the Center for Healthcare Quality and Payment Reform (CHQPR), 600 rural hospitals are at risk of closing due to persistent financial challenges related to patient services or depleted financial resources.[17]

The closure of a hospital leads directly to a loss of access to medical care in a community and, thus, to the loss of a vital community health resource if and when this resource is needed. However, a (rural) hospital is not paid for its standby capacity even though that capacity is a critical resource for a community. Consequently, in case of closure, residents in rural areas are being forced to travel long distances for emergency or inpatient care.[18] Hospital closures have also an indirect effect on community business production and employment because reduced consumption affects the local economy negatively.

For these reasons, it is important to turn "at-risk" hospitals and health systems around before they collapse. Successful turnarounds almost always guarantee that hospitals remain crucial community resources for years to come. They are also often the largest employers and benefit the entire region.

For successful turnarounds, four components in particular are pivotal in the following order : (1) support, (2) timing, (3) leadership, and (4) strategy.

Requisites for a Successful Turnaround

When a hospital or health system faces the existential threat of bankruptcy or closure, it becomes a governance issue. This requires the full attention and engagement of the board of directors and, if necessary, the dismissal of extant executive leadership by the board.

The board must take a more hands-on approach by closely monitoring levels of financial detail and oversight.[6] Basically, the governing board should become the champion for the organization's financial stability.[19]

But before embarking on a turnaround strategy, the governing board's ***first assessment*** must be an in-depth evaluation of financial and operational data and the quintessential determination if a turnaround is possible at all.[20]Hence, a can did assessment of the hospital's long-term sustainability and options relative to patient volume, market position, financial footing, revenue cycle, payer mix, physician relationships, staff productivity, supply chain, and product services is paramount.[5] Table 1 shows a master plan for a successful turnaround.

Table 1: Turnaround Masterplan

First Assessment: Situation Analysis
• *Is a turnaround feasible based on financial and operational performance data and SWOT analysis?*
If "yes", the following steps should be executed:
Step 1: Approval and Consent
Discussions, agreement and consensus between governing board and key stakeholders/constituencies about expected outcome, process, and timeline
Step 2: Change of Leadership Team
Appoint (new) leadership team to manage the turnaround with a strategic focus on financial re-structuring, operative re-organization, and organizational change
The (new) CEO must develop an effective and comprehensive communication strategy early on to articulate turnaround plans and garner organization-wide support

Step 3: Emergency Action

Develop a cash management plan and financial dashboard to immediately address the negative cash flow situation with the goal of eventually achieving financial stability

Step 5: Business Restructuring

Create a detailed expense reduction plan with a reduced portfolio to stop the financial bleeding

Develop a detailed revenue improvement plan with (1) a patient-centric focus that enhances patient access, care and service quality and (2) a physician/program builder-centric focus for retention and recruitment

Step 6: Return to Normalcy and Future

Accomplish long-term sustainability after successful turnaround: outwork and outsmart the competitors with innovative (e.g., blue ocean) strategies and keep the workforce engaged, inspired, and motivated

However, one important factor must not be forgotten: the existing governing board was part of the processes that brought the organization to its knees. Under such circumstances, re-structure or even complete replacement of the board must be on the table as well, particularly if new financial stakeholders are getting involved. In that regard, a transition to a more active, smaller board but with more oversight to strategy and performance has been proposed.[1]

Support

If the first assessment's conclusion is that a successful turnaround is feasible, then it becomes imperative for the board, corporate (if applicable), and leadership to pull together, act in concert, and commence the process of a turnaround.[21]

Support by the governing hospital board (extant or new) as well as broad community support is crucial in initiating the turnaround stage. Community (leaders') support is essential because 84% of all U.S. hospitals are community-based according to the AHA.[7]Likewise, for investor-owned or for-profit hospitals, the support of the investors and/or stakeholders is critical.

Therefore, the (presumably) new CEO and his/her team, charged with the successful turnaround, must be backed up by a united board.[22] The board's support must be resolute and unwavering in making, and being accountable for, potentially unpopular decisions. It must provide "top cover" and support for the new CEO. Thus, the board becomes the "ultimate keeper" of the mission.[6]

Timing

It is absolutely crucial that boards of directors and executive management teams diagnose symptoms of a (f)ailing hospitals or health system early on. If the diagnosis comes late and if attempts at reversing the trend are made only internally and without changes in strategy or leadership, the chances of failure are high. When it takes too long to act, the situation is usually already so compromised that even promising interventions and strategies go up in smoke.[4]

Timing is also crucial if a (f)ailing organization considers a sale or merger. If the hospital is too long focused on preserving its independence, and plans for a sale or merger come too late by missing the right time, the financial predicaments are usually too deep to save the hospital.[5]: Hence, struggling freestanding hospitals should look for partnership opportunities earlier than later.

Leadership

Successful turnarounds are most commonly associated with certain leadership qualities of the (new) Chief Executive Officer (CEO). Naturally, many of them are different than those of the previous incumbent. The change in leadership frequently causes a fundamental change in culture as well.

Educational backgrounds and academic degrees of current healthcare CEOs

According to a recent report, 50% of healthcare CEOs have an MBA or MHA and did not study beyond it. Another 21% received only a bachelor's degree. Only about 15% of healthcare CEOs hold an MD or PhD. In addition, 5% percent have their JD, and 9% percent hold a master degree in any field.[23] Interestingly, the number of hospital CEOs with the non-academic degree and license of "RN" and without an

additional master's degree is on the rise. A total of at least 12 of the 17 new nurse leaders-turned-CEOs in 2023 were RNs, RNs and BSNs, or BSNs only.[24]

Although the two most common master's degrees for hospital CEOs are a Master of Health Administration (MHA) or a Master of Business Administration (MBA), neither of these degrees requires a background in medicine. Of note, among 24 new CEOs of the nation's 150 largest health system in 2022, there was a 27% year-over-year increase in appointments with an MBA and a 26% decline in those with medical degrees.[25]

These statistics in educational backgrounds and academic degrees of healthcare CEOs don't bode well for (f)ailing hospitals or health systems. If a hospital is on the brink of bankruptcy or closure, a new leader at the helmet is desperately needed who understands both medicine, the core business, and economics, the other nucleus for survival. As mentioned earlier, only 15% of hospital and health system CEOs are MDs and only 35% of physicians in leadership positions have dual degrees. Of note, most of them are not in the field of economics (i.e., MBA or MHA) but are PhD and MPH degrees.[26] Hence, less than 3% of hospital or health system CEOs hold MD and MHA/MBA dual degrees.

This raises an old question. Who should lead healthcare organizations: MDs or MBAs. A 2016 analysis of the extant literature found a positive impact of clinical leadership on different types of outcome measures, with only a handful of studies highlighting a negative impact on financial and social performance. That review lent "support to the prevalent move across health systems towards increasing the presence of clinicians in leadership positions in healthcare organizations."[27] In contrast, an earlier study from 2004 found that the debate that pits the "MDs" against the "MBAs" is misdirected. According to the authors, characteristics other than educational degree appear to have a stronger influence on a CEO's ability to make successful strategic decisions.[28]

A successful turnaround of a (f)ailing hospitals or health system is a daunting task and not for the faint of heart nor for the overconfident egocentric. The personality that is warranted is an individual with ample experience and acumen in medical and economic/financial leadership. Hence, a dual MD/MHA or MD/MBA appears to be predestinated, at least in theory.

In these challenging times of healthcare crises, it is also not surprising that U.S. hospitals have seen 126 CEO exits through October 2023, a 62% increase from the 78 reported in the same time period in 2022.[29]

The high turnover rate was also confirmed in 2022 when 24 new appointees took up the CEO mantle at one of the nation's 150 largest (by total operating revenue) health systems.[25] Moreover, healthcare leaders have the highest turnover rates of all major industries, with 75% of executives considering leaving their profession due to burnout.[30]

However, despite the need for exceptional CEOs, (struggling) hospitals and health systems have resorted to poor leadership decisions. First, candidates are frequently tapped internally despite a meager record of the extant senior management team.[31]Nearly 3 in 5 new CEOs were internal hires with an average of 14 years of service at their organization.[25] "External CEO hiring has been on the decline since 2019 and, in 2023, dropped to the lowest recorded level since 2016.[31] Secondly, a rise in the number of the dual-role CEO has occurred, i.e. stacking leadership of a second hospital atop an existing hospital CEO's duties. What are the reasons for these seemingly antagonistic steps in an environment that needs new faces and strategies? Mounting financial challenges are the reasons to reduce top-heavy C-suites and reallocate funds to essential clinical functions.[31] Dual-role CEOs and internal CEO hirings may reduce on boarding costs, but they are usually not good strategies for a successful turnaround.

Leadership styles

The bottom line is that a turnaround requires a new CEO ***and*** a new leadership team (with very few exceptions). The current or extant leadership has already had its chance in either (1) not taking the organization to the brink of bankruptcy or closure or (2) not instigating a successful

turnaround. Since both options failed, why should that same leadership team be rewarded in continuing business as usual and in clear anticipation of the inevitable, abysmal outcome. It is, therefore, best to replace the existing with a more competent and aggressive leadership team.[22]

Equally important is the requisite that the new CEO's legitimacy as a leader must be steadfastly affirmed by the governing board and other key stakeholders.[22]Only then can he/she exercise strong and effective leadership and make the necessary decisions without falling into the trap of "analysis paralysis" as it happens to weak leaders who have only little or no support from the governing board.

Taking a (f)ailing hospital or health system from the brink of bankruptcy and turning it into a profitable organization takes a strong leader who has the vision, skillset, and determination to execute a successful turnaround.[32] He/she should epitomize integrity, honesty, creativity, accountability, and transparency. Apart from overseeing and directing financial issues, the new CEO must promote good working relationships between the hospital management, board, staff, patients, caregivers, and key community members. A successful turnaround is much more likely under a CEO whose leadership style relies "on trust, teamwork, common sense, and ingenuity"[32] and who assembles a C-suite of like-minded individuals.

As previously shown, a combination of transformational and transactional leadership is essential for hospitals and health systems that are undergoing major re-structuring and re-positioning during the turnaround phase in order to address new challenges and complexities efficiently and successfully.[33]

The new CEO should be a transformational leader who creates the vision and master plan for the turnaround by restructuring the entire organization. He/she should inspire the workforce to strive beyond required expectations. In contrast, the CEO's C-suite should preferentially be comprised of transactional leaders who focus primarily on reinforcement of job performance and improvement as well as on employee motivation. Hence, transformational (CEO) and transactional (C-suite) leadership styles are not competing, but rather complementary as it concerns successful turnarounds of (f)ailing hospitals and health systems.[33]

Management models

Transformational (CEO) and transactional (C-suite) leadership complement the modified democratic management model which may represent the ideal leadership model in modern healthcare.[34] Based on a collaborative team approach and functional participation, the original democratic management model must, however, be modified during times of turmoil such as an organization's turnaround. Such turnarounds in times of crisis frequently require fast decision-making processes and deviation from the purely democratic management model.

As previously proposed, a novel and modified version of this model takes the need for fast decision-making during turnarounds into account by (1) allowing the transformational CEO to use a temporary authoritative management style and (2) implementing internal and external checks and balances, such as mandatory board reporting after each authoritative decision for unforeseen causes. Such checks and balances prevent authoritative decision-making from becoming permanent even during challenging turnarounds.[34,35]

Strategy

The fourth key component for hospital and health system turnarounds is a successful business strategy. The first rule for governing boards and new leadership is to not overstrain scarce (financial) resources. The overambitious aim to meet too many goals at once with too few resources is usually a recipe for failure. One focus should lie instead on developing realistic 1-, 3-, 5-year plans.[36]

This includes first and foremost stabilization of the hospital's finances by engaging in areas with financial promises and avoiding wrong investments. This is easier said than done because it requires tough choices in recruitment and service priorities that should also take community and neighborhood needs into consideration. An effective turnaround plan must define

expected outcomes, benchmarks, milestones, and deadlines from both financial and operative perspectives.[37]

Another important factor to keep in mind if the turnaround finances are not deep enough is to quickly adapt and change strategies as needed.[36]

Physician recruitment and Clinical Service Priorities

When it comes to physician recruitment the governing board and the new leadership must be aware of a common mistake: to "hire lots of doctors right out of residency and hope they become Major Leaguers. This is a high-risk strategy. These doctors may never become great."[22]

Instead of hiring unproven "rookies", the focus should be on recruiting (few) established "program builders", i.e., physicians with a large referral base that can bring an early "home run" to the (f)ailing organization.

The recruitment of top faculty goes hand in hand with another domain that requires tough choices: what are the (new) clinical priority areas and what key initiatives should receive scarce funding resources?

While the focus should really be on fortifying a few clinical key areas, the gamble is what areas to starve and what areas to nurture, not knowing for sure how this gamble will play out.[36]

These decisions should primarily be data-driven both from the financial and operative perspectives, but also keeping community needs in mind. Empowerment through data identifies "the relevant metrics that define excellence, and the potential sources of data for measuring progress" in hospital operations and patient care quality.[22]

A visionary CEO and his team may also draw on the Red vs. Blue Ocean Strategy.

Red vs. Blue Ocean Strategy

This business strategy proposed by Kim and Mauborgne in the early 2000s defines a red ocean as an existing market with many competitors and a blue ocean as a market that is yet to be discovered and without competitors.[38]

This general business strategy can also successfully be applied to healthcare. In the Red Ocean Strategy, the healthcare market is already established, and it is largely understood what services patients and providers want. But the competition is fierce. In the Blue Ocean Strategy, new service markets often generate high-profit margins, and a successful brand can continue for years or even decades. But there is always the risk of completely misjudging the healthcare market and getting it wrong.

Why would this strategy be of relevance to turnarounds of hospitals and health systems? It is obvious that (f)ailing organizations have not been able to beat the competition in the red ocean. One turnaround red ocean strategy is to focus on only a few key areas and hope to become more competitive there. But the blue ocean market is entirely untapped with unknown, uncontested, yet potentially ample clinical potential. A visionary CEO and his/her team should identify and invest in new clinical products that the competitors have not yet pursued or even recognized as potentially profit-making differentiation or low-cost investment paths. Creating and capturing new clinical demands is the name of the game that (f)ailing healthcare organizations should try to embark on and take advantage of.

In the case of a turnaround, blue and red oceans should not be mutually exclusive and competing. They both should be deployed in a complimentary manner to maximize the (f)ailing organizations limited resources.

Finances

As mentioned earlier, the first order of business of the (new) management team is to stabilize the organization'sfinances.[15,36]

The incoming CEO and his/her team must identify quick opportunities to reduce the loss. A diligent in-depth review and analysis of income statements, balance sheets, statements of cash flows, and statements of changes in equity is paramount. These statements provide vital information regarding the organization's revenues, expenses, (non-)operating income, net income (vs. cash flow), assets,

liabilities etc. Rather than a broad-brush review, often a line-by-line examination of the general ledger is not only in order but required.

The information obtained sets the stage for the following financial goals:

The first step is an immediate plan for ***cash management*** to address the negative cash flow situation.[4]To rapidly increase cash and liquidity, the (new) CEO and his/her leadership team must identify and dispose of non-core assets.[37]

The second step is a plan for ***expense reduction***. Current expenses must be compared to last year's and to budget. This helps to identify opportunities down to the smallest detail. The workforce is usually the largest expense and should, therefore, be first evaluated to take swift action. For example, incentives should be created to encourage retirement for non-productive staff and physicians.[21] A thorough review of staffing levels, patterns, and overtimes is necessary as those costs make up about 70% of operating expenses. If necessary, the number of staff must be reduced, and excess employees must be laid off. Hiring freezes must be put in place with few exceptions.[39] Only when and if the organization is again on stable financial footing, expansion of the workforce can be reexamined.[21]

Any expense reduction plan must be "data-driven and thoughtful to mitigate the impact of unintended consequences and to avoid any patient safety or patient satisfaction concerns. In times of desperation, many organizations implement across-the-board reductions and other rudimentary initiatives that aren't strategic or customized to the situation at hand. Such approaches actually punish parts of the organization that have already been focused on achieving operational efficiencies."[4]

The initial focus of expense reduction must be on programs that do not contribute positively to the organization's bottom line. Programs, service lines or departments behind budget must undergo a meticulous review to determine how to increase revenues through innovative marketing strategies and staff adjustments.[39] If there is little or no hope for improvement, program reduction or elimination is the consequence. The elimination of non-profitable or redundant programs should be done quickly to stop the bleeding fast. Moreover, "adjustments to supplies, outside services, and physician contracts, to name a few, can have an immediate, positive financial effect on the hospital."[21] A facility operational review may reveal additional opportunities for cost cutting.[39]

The third step is a plan for ***revenue improvement***. This requires review of all aspects that affect revenues including, but not limited to, patient volume, commercial contracts, pay or mix, charity services etc. Specifically, the revenue cycle and its staffing deserve close attention as it concerns areas of correction such as physician documentation, upfront collections, etc.[21]

The incoming C-suite team must internally scrutinize A/R days and margins for hospital revenue cycle turnaround versus external factors. Contributing factors to organizational failure are mainly internal in nature, "caused by poor management of internal resources and capabilities."[1]Yet outgoing management teams "often point to market factors for lackluster hospital revenue cycle performance. But lagging accounts receivable days and shrinking hospital margins usually indicate that it is time for an internal hospital revenue cycle turnaround project."[40]

"Identifying the degradation in the revenues is the first step toward a long-term solution. Improving existing revenue falls squarely on the shoulders of the CFO…. and putting people in place to improve it. Evaluating the ability of the CFO to meet these goals must be one of the new CEO's first priorities.[21] In that regard it is also interesting to note that a study by Langa beer found that organizations with an unsuccessful outcome tended to have the turnaround driven by the CFO or the finance department, whereas successful turnaround organizations were led by the CEO and the management team. The explanation given was that a CFO typically relies on financial strategies alone, whereas the CEO and the management team offer a more comprehensive view of clinical programs and services.[1]

One mistake to avoid while facing a dire financial situation is to starve or cut

clinical services indiscriminately across-the-board. This contraction strategy usually has only a short-lived positive effect on cost reduction but a lasting devastating effect on patient access. Thus, it frequently results in an unsuccessful turnaround. In contrast, retrenching less and rebounding faster is a better strategy.[1,18]

Most importantly, revenue improvement requires expanding profitable clinical programs and recruiting established physicians known as "program builders" with a large referral base.

Obviously, such high RVU-producers and high-volume generating physicians don't sit on trees. They are extremely sought after in a competitive healthcare market. However, this is where a CEO with dual MD ***and*** MHA/MBA degrees comes in handy. As a physician he/she can talk directly to his/her colleague and lay out his/her vision for the turnaround of the organization. If this vision is inspiring and promises even more business for the clinical program builder, he/she may accept an offer that a non-MD CEO could not have generated. The MHA/MBA degree also comes opportune as the CEO with dual degrees may present an attractive financial offer primarily based on incentives and bonuses if, for example, mutually-agreed-upon RVU numbers or program goals are achieved. Forgoing a high physician base salary in favor of an attractive bonus program saves the organization scarce financial resources, at least initially.

In times of a turnaround when financial resources are scarce, program expansions or even additions require a fresh infusion of capital. Communication between the CEO and the governing board as well as with other key stakeholders is important to assure that the new management team is committed to these programs and in full support of their capital needs. An even stronger point can be made if these programs are relevant to both the community and medical staff.

In addition to expanding profitable service lines, new technologies with easy user operations can retain or attract physicians and patients.[21] Re-structuring efforts to improve and streamline work processes of patient care service lines usually contribute to revenue improvement in the long term.[39]

Another, yet less frequently used strategy for a successful turnaround is "to partner with nearby competitors or alliance partners to jointly offer specific services or other targeted means to reduce expenses in specific areas."[1]

A plethora of operational improvement options during a turnaround have been proposed. They include "converting excess acute care capacity to outpatient services, specialty care or other models of care delivery such as rehabilitation, long term care or alternative medicine. An emergency department can be transformed into an urgent care center, existing operating rooms can be used for outpatient surgical centers and an inpatient floor is a natural fit for a sub-acute care facility. The new use can save the facility, save jobs and respond to community need."[5] Other opportunities include expansion of managed care contracts, promotion of inclusive arrangements, actively marketing the organization's strengths, maintaining proven leadership in the major clinical service lines, and strengthening the (employed) physician practice group.[41]It is obvious that many operational options exist, but they need to be tailored to the specific needs of the (f)ailing organization.

Communication

The need for early and direct communication from the CEO is important for several reasons.

First, it is incumbent on the leader to let all employees know about the organization's dire financial and near-to-failure situation in order to eliminate any ambiguity about the prospect of a potentially impending bankruptcy or closure. That way, everyone is aware that his/her future depends on turning the organization around.[42] Equally important, the CEO must quell a general sense of panic emerging within the organization.[1]In his messages, the CEO must come across as a realistic and honest communicator who delivers both bad and good news on a regular basis.[21] If the CEO fails to do that and if the medical staff, board, and community are not educated about the grim situation and the plans for a successful

turnaround, they will lose faith or even leave the organization.[42]

The second communication objective for the CEO is to build trust and garner support for his/her vision. The earlier a new, convincing, and even inspiring vision about the potentially bright future of the organization is shared and the more people know about it, the higher the chances of success. From the psychological perspective, the CEO must turn skepticism to belief. "Building belief in the vision is critical."[22]

Hence, from the first day onward, the CEO and his/her team must create vision and mission road maps and clearly articulate them along with corresponding functional plans to all employees. The CEO and his/her team must engage the entire workforce, not just the physician leadership, in an honest, open, and structured dialogue that calls for input and feedback. He/she should also provide some form of employee empowerment. This is all part of the modified democratic management model with a transformational, visionary CEO at the helmet, as outlined earlier. Once turnaround plans and documents including tough and potentially unpopular cuts in the workforce and programs have been vetted and general buy-in by most employees has been secured, the implementation phase will be greatly facilitated and widely supported.

However, the CEO's initial communication offense must not stop here. It must be followed by a second wave of broad organizational engagement.[22]

The CEO must continue to meet regularly with task force members, supervisors, managers, clinical staff, board members, and other key stakeholders. He/she should also perform regular hospital rounds to see and to be seen.[39] "Individual meetings with physicians must be undertaken not only to communicate, but also to give the reassurance that these employees are important to both the CEO personally and to the hospital. Every day, for the first 90-120 days, the CEO should have several meetings planned to communicate and reassure….Thereafter, a progress report on successes and failures should be offered with the same enthusiasm and vigor that was presented when this process started. The CEO will, again, reassure the stakeholders that he/she is still laser focused on the plan and that he/she is either still on track, ahead of the game, or devising a course correction."[21]

The relationships that the CEO builds initially through effective communication and positive reassurance will bear fruit during the entire turnaround phase and thereafter. The ideal CEO must not only be a great communicator but also an optimist who wholeheartedly believes in a successful turnaround based on his vision. Lastly, a transformational CEO will celebrate and share the glory of a successful turnaround by recognizing all contributors.[41]

Long-Term Turnaround Sustainability

The best recipe for sustainability after a successful turnaround is to outwork, but also to outsmart, the competition.

Long-term sustainability is not accomplished exclusively with aggressive expense reduction plans although they are required in the early stages of the turnaround. Close adherence to the new revenue and expense benchmarks is essential.

Over time, revenue enhancement opportunities along the lines of the Blue Ocean Strategy become more important. What are clinical services that the community needs but are not offered by competitors? Building new programs with expanding markets creates niches such as, for example, a preventive and personalized medicine program with an emphasis on an individual patient's genetic and molecular matrix. In the Red Ocean Strategy, Centers of Excellence make the organization a patient destination hub for specific clinical services. Ultimately, a successful long-term outcome will be driven by both increases in patient volume and revenue enhancement opportunities.[4]

Other factors that contribute to long-term stability after a successful turnaround include ongoing improvements in patient access, care, and clinical quality; market share increases; an improved payer mix; newest medical technologies and information systems updates; reinvestments for aging equipment and facilities.[41]

The key to long-term sustainability and success after the turnaround is the leadership's obligation to demonstrate special attention to the physician and nursing workforces. Ongoing recruitment of established physician program builders, timely succession planning for retiring physicians, physician incentives and bonuses for strong clinical performances are all prescriptions for a healthy operation as well as not running short on competent nursing staff. Keeping the medical and nursing staff vibrant and engaged is another important ingredient for long-term success that usually diminishes high turnover, burn-out, and job dissatisfaction.[21]

Re-Evaluation

Re-evaluating on a regular basis the effectiveness and efficiency of all changes implemented during the turnaround is essential to avoid falling behind in achieving the goals that are linked to pre-defined expectations and timeline.

Adapting and changing strategies quickly during a turnaround is essential because of unforeseen changes in federal or state laws, financial crises, reimbursement contracts, workforce issues, supply chains etc. A leadership team that either foresees some of the impending challenges and acts quickly to alleviate their consequences has a competitive advantage if it implements corrective actions faster and better than the competition.

The ability to quickly adapt and evolve stronger is a key characteristic of successful healthcare organizations.[1] If that ability is lost, the organization is again on the path to failure including bankruptcy and closure.

Conclusions

The turnaround of a (f)ailing hospital or health system is a daunting task. Before embarking on it, the first order of business is to assess if a turnaround is at all possible based on available financial and operational data. If the answer is yes, four components for a successful turnaround are pivotal: (1) *support* from the governing board and key stakeholders, (2) the right *timing*, (3) new *leadership* by appointing a new CEO with his/her team, and (4) a successful business *strategy*.

Appointing the right CEO is paramount. He/she should be a transformational leader with a clear vision, a broad skill set, and resolute determination and who embraces the modified democratic management model. The new CEO should preferentially hold dual MD and MHA/MBA degrees to understand both medicine, the core business, and economics, the other nucleus for the organization's survival. He/she should also be well versed in financial and communication matters. After the successful turnaround, regular re-evaluations are necessary to not return to old habits and to stay in business long-term, preferentially ahead of the competitors given the organization's positive turnaround experience.

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