

TRIAGE BRIEF

Crisis Communications Intelligence for Healthcare Leaders

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FROM THE EDITOR

On March 25th, a 234-bed hospital in Oak Park, Illinois — West Suburban Medical Center — stopped accepting patients. Not because of a mass casualty event. Not because of a ransomware attack. Because it ran out of cash to make payroll.

The CEO sent an email to staff. That was the announcement.

No community statement. No patient notification system activated. No proactive outreach to the Illinois Department of Public Health, which learned of the closure independently and issued a formal statement expressing disappointment at the lack of advance notice and clear communication from hospital leadership. Roughly 70 inpatients had to be assessed for discharge or transfer within hours. Paramedics arrived at the homes of outpatients to tell them their hospital had closed.

I want to be fair to Resilience Healthcare and CEO Manoj Prasad, who appears to have inherited a financially fragile institution and then watched it buckle under the weight of an EHR system that failed to bill anywhere from half to ninety percent of patient encounters for over a year. The financial crisis was real, and the operational failure was severe. None of that is simple.

But this week's issue is not about the financial collapse. It is about the communications collapse that preceded it and accelerated it. West Suburban's story is one I want you to study carefully — because it is not just a story about a small hospital running out of money. It is a story about what happens when institutional leadership treats transparency as optional until it is no longer possible.

Plus: I owe you the debrief on last week's WWYD — The Nurse Assault Goes Viral. I've worked through every decision point below. I think you'll find some of the answers more nuanced than they first appeared.

— Ken Perry, MD, FACEP

THIS WEEK'S STORY

West Suburban Medical Center: When the Money Runs Out and No One Says Anything

Category: [Financial Crisis / Institutional Communication](#) • Urgency: **HIGH** • Scope: [Regional / National Pattern](#)

On the morning of March 25, 2026, Manoj Prasad, CEO of Resilience Healthcare, sent an email to the staff of West Suburban Medical Center in Oak Park, Illinois. The hospital's emergency room, inpatient units, and clinics were closing, effective immediately, he wrote, due to a payroll crisis rooted in a year-long failure of the hospital's electronic health record system to process billing correctly. According to Prasad, anywhere from fifty to ninety percent of the hospital's clinical encounters had gone unbilled for over twelve months — the result of an EHR system that, in his words, "has never functioned correctly." The hospital, acquired by Resilience Healthcare in 2022, owed approximately \$71 million to the state of Illinois, \$50 million to vendors, unpaid property taxes, and outstanding mortgage payments. There was no cash left to make payroll.

What followed was a case study in institutional communication failure. Staff learned of the closure via the email. Patients at the 234-bed safety-net hospital — a facility serving a high proportion of Medicaid and Medicare beneficiaries in one of the Chicago area's most densely populated suburbs — learned through paramedics

dispatched to transfer them. The Illinois Department of Public Health stated publicly that it was “disappointed by the lack of advance notice and clear communication from hospital leadership.” Village officials said they were not notified in advance. State legislators scrambled to identify replacement care options for the community overnight.

MEDICAL REALITY

Safety-net hospitals are not simply healthcare facilities — they are community infrastructure. For the patients who rely on them, a sudden closure is a clinical emergency: patients mid-treatment lose continuity of care, patients on active dialysis schedules face gaps that can be life-threatening, and patients with behavioral health needs may have no alternative facility within accessible distance. When West Suburban closed, its community did not gain a few inconvenient hours in the car. Many of its patients — Medicaid recipients, elderly patients without transportation, individuals without primary care alternatives — lost their hospital entirely. The communications failure was not an administrative error. It was a patient safety event.

THE HISTORICAL PARALLEL

AHERF, 1998: The Largest Nonprofit Health System Bankruptcy in U.S. History

In July 1998, the Allegheny Health, Education and Research Foundation — AHERF — filed for bankruptcy protection, becoming at the time the largest nonprofit health system failure in American history. The Philadelphia-based system had expanded aggressively throughout the 1990s, acquiring hospitals, physician practices, and medical schools across Pennsylvania and beyond. Internally, executives had been aware for months that the organization was in severe financial distress. Externally, almost no one knew.

When the bankruptcy was announced, it came as a shock to staff, patients, physicians, and community members who had received no indication that the hospitals they depended on — Hahnemann University Hospital and MCP Hospital among them — were insolvent. Thousands of employees learned of the crisis through news reports. Patients mid-treatment scrambled for alternatives. Medical residents found themselves in a system that could not guarantee their salaries. The Pennsylvania Insurance Commissioner later noted that the failure of leadership to communicate the organization’s financial deterioration had compounded the harm to every constituency: patients, providers, and the broader healthcare infrastructure of the region.

Twenty-eight years later, the script is nearly identical at West Suburban. Financial distress known internally. Silence maintained externally. Crisis announcement delivered at the moment of collapse, when communication serves no protective function — only damage control.

“Financial distress known internally. Silence maintained externally. The announcement comes at the moment of collapse, when communication can no longer protect anyone.”

HOSPITAL RESPONSE ANALYSIS

How did West Suburban and Resilience Healthcare communicate during this crisis — and what would a stronger response have looked like?

LENS	ANALYSIS
Advance Disclosure	A hospital that cannot make payroll has known about its financial trajectory for weeks or months. The EHR billing failure at West Suburban had been ongoing for over a year. At some point during that year, the appropriate action was to proactively notify the Illinois Department of Public Health, begin conversations with state regulators, and develop a patient communication plan. None of this appears to have occurred. Proactive communication to regulators in a deteriorating financial situation is not optional — in most states it is a licensure requirement. It is also the only communication posture that preserves any institutional credibility.

<p>Staff Notification</p>	<p>An email to staff announcing an effective-immediately closure is not a communications strategy — it is an abdication of one. Staff deserve advance notice proportional to the disruption they will experience. Furloughing an entire hospital’s workforce via email, without organized town halls, HR support, union engagement, or written documentation of severance expectations, generates the exact press coverage West Suburban received: staff scrambling, patients transferred without warning, and a state health department expressing public disappointment.</p>
<p>Patient Communication</p>	<p>Patients were notified by paramedics. That sentence contains the entire communications failure. Any organization with a patient portal, a call system, or a discharge list had the technical means to reach active patients before closure. The absence of patient-directed communication is not a resource problem — it is a prioritization failure. Patients in active treatment have a right to the maximum possible advance notice that an institution can provide before it closes its doors.</p>
<p>Vendor Blame Dynamics</p>	<p>CEO Prasad publicly attributed the billing failure to the EHR system. The EHR vendor publicly disputed that characterization within days. When an institution’s crisis narrative depends on assigning fault to a third party that has not agreed to accept that fault, the resulting public dispute compounds reputational damage. The communications instinct to explain is understandable. The execution — announcing a vendor is to blame before that vendor has been notified of the characterization — invites exactly the public contradiction that followed.</p>
<p>Reopening Narrative</p>	<p>Prasad announced plans to reopen by late June or early July 2026. This commitment, made in the days following the closure, is the right instinct — a forward-looking statement that preserves some community hope. But a reopening commitment made in the absence of a credible financial plan functions as a promise the institution may not be able to keep. Every week that the hospital remains closed erodes the credibility of the reopening timeline. Communicating a reopening date requires the same discipline as any other institutional commitment: only state what you can actually deliver.</p>

THE LESSON & THE RULE OF THUMB

THE LESSON	THE RULE OF THUMB
<p>A hospital’s financial crisis is a communications crisis. The moment leadership knows the institution cannot meet its operational obligations — whether that’s six months from now or six weeks — the communications clock has started. The question is not whether to communicate, but to whom, in what sequence, and with what level of candor. Waiting until the cash is gone eliminates every option except crisis control. West Suburban’s story is not primarily about EHR failure. It is about what happens when institutional silence is treated as a strategy.</p>	<p><i>“No comment is an answer — a bad one.”</i> Reporters print ‘no comment’ next to questions about patient deaths, staff assaults, and hospital closures. It reads as admission or concealment — never as prudence. Replace ‘no comment’ with: ‘We are gathering information and will respond by [specific time].’ That sentence costs nothing and preserves everything. West Suburban had no external statement, no community message, and no patient notification. In the absence of any of those, the story writes itself — and it already has.</p>

WHAT WOULD YOU DO?

This Week’s Scenario: The Environmental Disaster Next Door
Setting: Hospital adjacent to industrial district, mid-sized city • Difficulty: Moderate

At 6:45 a.m. on a Tuesday, a chemical plant fire breaks out two miles from your hospital. Visible smoke drifts across the city throughout the morning. By 10 a.m., your emergency department has seen 34 patients with respiratory complaints — dyspnea, eye irritation, headache, and cough — a volume that represents a 300% spike above your baseline for this hour. Your attending physicians are concerned. The local fire department has issued a statement saying the air quality is ‘safe’ and there is no need for shelter-in-place advisories. A local TV reporter calls your communications director asking whether your hospital is ‘seeing anything unusual.’

You are the CMO.

YOUR DECISION POINTS:

- Your clinical data directly contradicts the fire department's 'air is safe' statement. You have 34 patients in your ED with respiratory complaints consistent with chemical exposure — but you do not yet know what chemical was released or at what concentration. How do you characterize what you are seeing without overstepping your clinical knowledge or appearing to contradict public safety officials on an active incident?
- The TV reporter is waiting for a response. Your communications director wants to say 'we cannot comment on air quality determinations.' You believe that response will be printed as confirmation that your hospital is seeing unusual activity. What does your statement say — and who delivers it?
- By noon, the ED surge continues. You are considering whether to declare an internal mass casualty event to manage resource allocation. That declaration, once made, becomes a public record and will likely leak. What communication steps must accompany that clinical decision?
- Your medical toxicologist tells you the symptom pattern is consistent with hydrogen chloride or similar irritant gas exposure, but emphasizes this is clinical inference, not confirmed. Do you share that assessment publicly, privately with public health officials only, or not at all until it is confirmed?
- By 2 p.m., the fire department revises its statement to acknowledge 'elevated particulate levels' in several ZIP codes near the plant. Your hospital is in one of them. The original 'safe' determination has now been walked back. How do you position your institution's early clinical response — and do you say publicly that your data preceded the official acknowledgment?

Next week's Debrief will walk through each of these decision points. Think through your answers before then.

LAST WEEK'S DEBRIEF

Week 5 Scenario: The Nurse Assault Goes Viral

A patient struck a nurse in your emergency department, fracturing her orbital socket. The aftermath was captured on video. By 7 a.m., the clip had 800,000 views. Three news stations had called. A Facebook group had organized a vigil outside your hospital that evening. Your injured nurse was in surgery. The patient was in psychiatric custody. You were the CMO. Here is how I would have worked through it.

1. The 9 a.m. press inquiry: issue a statement, not a press conference.

Your legal team wants to wait. Do not wait. The 4-Hour Window rule applies with full force here: 73% of hospital reputation damage in a crisis occurs in the first four hours. By 9 a.m. you are already inside that window. Issue a written statement to the two stations before their deadline. The statement does not require complete information. It requires three things: acknowledgment that a serious incident occurred in your emergency department, a commitment to the safety of your staff as your immediate and absolute priority, and a specific next step ('We will provide an additional update by 2 p.m.'). That is the entire statement. Legal can review it in 20 minutes. If your legal team cannot turn around a three-sentence statement in 20 minutes, your 60-minute approval chain is the problem — fix that today.

2. The injured nurse's privacy: lead with humanity, not detail.

You cannot describe the specific injury without the nurse's authorization. You do not need to. Your statement should say: 'A member of our nursing team was seriously injured in our emergency department last night. She is receiving medical care. Our thoughts are with her and her family.' That sentence conveys gravity without violating her privacy. It also communicates something that every watching nurse, physician, and patient care worker needs to hear: that this institution treats its staff as people, not liabilities. Do not say 'an employee' — say 'a nurse.' The distinction matters to every nurse in your building.

3. The vigil: acknowledge it, engage with it on your terms.

Ignoring a vigil outside your hospital, organized by people who care about your nursing staff, is not a neutral act. It signals to your workforce that leadership is more comfortable behind closed doors than standing with them. You do not need to address the crowd or speak at the vigil. But your CMO or CNO should walk outside, briefly and without media staging, to acknowledge the gathering. A 90-second presence — ‘We see you. We share your concern for our colleague. We are committed to her care and to the safety of every member of this team’ — is not a press conference. It is a human act. It will be noticed by your nursing staff in ways that no internal memo can replicate.

4. The CEO’s instinct to express outrage: channel it, don’t suppress it.

Your legal team is right that you cannot characterize the patient given the active psychiatric hold. They are right about the law. But they may be giving you advice that is legally correct and humanly catastrophic. Your nursing staff is watching to see whether leadership is angry — appropriately, institutionally angry — that one of their colleagues was assaulted. Your CEO can say: ‘Violence against healthcare workers is unacceptable. It will never be acceptable. We will do everything in our power to protect the people who care for our patients.’ That statement does not characterize the patient, does not touch the legal proceedings, and does exactly what it needs to do: it signals that leadership considers this assault a moral matter, not only a legal one. Do not let legal caution produce moral silence.

5. The next 72 hours of internal communication: focus on concrete action, not consolation.

A nursing advocacy group has called your facility unsafe. Three nurses on the overnight shift are considering quitting. Your internal communication for the next 72 hours cannot be a newsletter or an all-staff email expressing solidarity. It needs to announce something concrete. Within 24 hours: an emergency security review with a specific completion date. Within 48 hours: mandatory de-escalation refresher training with a schedule. Within 72 hours: a formal commitment to a third-party review of your workplace violence prevention protocols, with a published timeline. Nurses who are considering leaving are not looking for your sympathy. They are looking for evidence that you will change something. Give them the evidence first. The sympathy can follow.

The through-line in all five answers is the same: moral clarity expressed through specific action, not through carefully hedged language. The institutions that lose their nursing staff after events like this are invariably the ones whose internal response consisted of carefully worded statements and nothing more. The institutions that retain them do something concrete, immediately, and communicate it loudly.

QUICK READS

WBEZ Chicago / Wednesday Journal, March 25–26, 2026

West Suburban Medical Center Closes as It Runs Out of Cash to Pay Employees

The most complete accounts of the closure as it unfolded in real time. Read both — WBEZ for the financial arc, the Wednesday Journal for the on-the-ground community impact. Pay particular attention to the Illinois IDPH statement expressing disappointment at the lack of advance communication. That statement is your crisis communications curriculum for understanding what regulators expect before an institution closes, not after.

[wbez.org / oakpark.com](http://wbez.org/oakpark.com)

Chicago Sun-Times, April 1, 2026

West Suburban Medical Center Struggled to Treat Patients Months Before Closing

The Sun-Times obtained inspection reports showing quality-of-care concerns at West Suburban in the months preceding the closure. This piece adds a critical dimension: the financial crisis and the operational crisis were simultaneous. When your institution is struggling to maintain care quality, maintain payroll, and maintain regulatory compliance at the same time, the communications burden compounds. Your spokespeople need to be able to address all three tracks without conflating them.

chicago.suntimes.com

NBC News, April 2, 2026

Medicaid Cuts Threaten Hundreds of Hospitals, New Report Finds

More than 400 hospitals across 44 states are at high financial risk due to the Medicaid cuts in the current federal budget reconciliation bill, according to a new report. West Suburban is not an isolated story. It is the first visible case in what may be a wave of safety-net hospital closures driven by the intersection of Medicaid dependency and revenue cycle dysfunction. Read this piece as the policy context behind the individual story — and ask yourself what your own hospital’s Medicaid exposure looks like.

nbcnews.com

Thank you for reading. The West Suburban story is still developing, and I will follow it if it continues to produce lessons worth discussing. If your hospital is navigating a financial communications challenge — not just a clinical one — I would like to hear about it. Reply directly to this email.

Stay sharp.

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