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UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF NEW YORK

In re:	Chapter 11
Interfaith Medical Center, Inc.	Case No. 12-48226 (CEC)
Debtor.	

THIRD REPORT OF ERIC M. HUEBSCHER
AS PATIENT CARE OMBUDSMAN OF THE DEBTOR
FOR THE PERIOD FROM APRIL 16, 2013 TO JUNE 13, 2013

PLEASE TAKE NOTICE THAT the Third Report of Eric M. Huebscher as Patient Care Ombudsman of the Debtor for the Period From April 16, 2013 to June 13, 2013 was filed on June 14, 2013, a copy of which is attached.

Dated: New York, New York
June 14, 2013

DICONZA TRAURIG LLP

By: /s/ Jeffrey Traurig
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I. INTRODUCTION AND EXECUTIVE SUMMARY

1. This is the Third Report of Eric M. Huebscher, Patient Care Ombudsman ("PCO"), appointed in the Chapter 11 case of Interfaith Medical Center, Inc., the ("Debtor" or "IMC"). This appointment was made pursuant to §333 of the Bankruptcy Code, Bankruptcy Rule 2007.2, and the Order of the Bankruptcy Court (the "Court") entered on December 28, 2012 (the "Appointment Order"), (Docket No. 82.). The effective date of my appointment was January 10, 2013. My first ombudsman report was filed on February 15, 2013. My second ombudsman report was filed on April 16, 2013. Pursuant to the Appointment Order, subsequent reports are required to be filed no less frequently than 60-day intervals. Pursuant to §333 of the Bankruptcy Code, the PCO must:

   a. Monitor the quality of patient care provided to patients of the Debtor to the extent necessary under the circumstances, including interviewing patients and physicians;

   b. File a report with the Court, after notice to the parties in interest, at a hearing or in writing, regarding the quality of patient care provided to patients of the Debtor;

   c. If the PCO determines that the quality of patient care provided to patients of the Debtor is declining significantly or is otherwise being materially compromised, file with the Court a motion or written report, with notice to the parties in interest, immediately upon making such determination; and

   d. Maintain any information obtained by the PCO under §333 of the Bankruptcy Code that relates to patients, including information relating to patient records, as confidential information. The PCO may not review confidential patient records unless the court approves such review in

advance and imposes restrictions on the PCO to protect patient confidentiality.

2. Despite very significant operational and financial challenges experienced by management and the employees of the Debtor, there continued to be a cooperative and collaborative relationship with my office. These challenges have included responding to both the New York State Department of Health (DOH) and Centers for Medicare and Medicaid Services (CMS) survey results, including implementation and monitoring of the respective corrective action plans. Additionally, in preparation for the pending Joint Commission tri-annual survey the Debtor undertook a mock review, in order to prepare most efficiently for the upcoming formal review process. The results of the surveys noted above and associated corrective actions plans will be discussed in some detail further in this report.

3. The psychiatric inpatient unit (8E) where the homicide occurred on March 19, 2013, continued to remain closed during this reporting period. The Debtor has responded to both the Office of Mental Health (OMH) as well as the DOH regarding corrective action plans. The Debtor has told me that it has not been provided with any guidance or direction from either OMH or DOH as to whether their corrective action plan (which is currently in implementation phases) is sufficient and appropriate. The Debtor has told me that it does not know whether 8E will re-open. As I pointed out in my last report, the closure of this unit placed significant financial strain on the Debtor, and the sustained closure has resulted in the termination of all affected employees[1].

4. Our team continued to monitor the Debtor's operations consistent with the two prior reporting periods. Our monitoring process has involved meeting with the Debtor's key executive management, line employees, physicians and patients. While we continued to review aspects of the Debtor's operations consistent with prior periods, our focus weighed more heavily during this reporting period on the results of the CMS/DOH survey results and related corrective action plans. Further, given the Debtor's precarious financial condition and lack of commitment, to date, from presumed funding sources, we augmented our review to include these areas of focus[2].

[1] The Debtor implemented a reduction of force during this reporting period of approximately 45 employees. The most significant portion of this reduction related to the closure of the 8E psychiatric unit. In addition, the Debtor with the authorization of OMH chose to close two other psychiatric programs.

[2] The Debtor has told me that it has not yet been provided with any financial commitment for DIP funding beyond the current funding limits within the standing Cash Collateral Order. The current Order expires at the end of June. I understand that there is another cash collateral hearing scheduled for June 21, which if so ordered would extend the current cash collateral Order to the end of July. I am told by management that the current cash position, regardless of an extension to the current Cash Collateral, is insufficient to support continuing operations beyond July. The Debtor has informed me that it expects to obtain DIP financing coincident with an extension of the cash collateral order. However, absent committed DIP funding as of this report date, the deteriorating financial condition coupled with the absence of a comprehensive contingency plan and specific strategic direction places significant risks on future patient safety and care.

5. The demand for inpatient services has decreased approximately 9% since the last reporting period. This decrease, coupled with the regulatory imposed closure of 8E, continued to place both operational and financial stress on the Debtor. I am told that while demand for hospital services tends to be somewhat cyclical (lower in summer months), this sustained decreased may pose additional financial burdens on the Debtor in the form of further reductions in staff. I will continue to monitor any impact on patient care arising from staff reductions, if they become necessary.

6. In addition to the new physician leadership hired in the emergency department (ED), the Debtor hired a new non-physician administrator to liaise and manage among all functional areas within the ED. In addition, both in response to issues identified in my first report and those similarly noted in the CMS/DOH survey, the Debtor has designed and implemented a comprehensive set of quality metrics so that the outcomes of the ED can be reviewed and actions taken, as appropriate, in a more timely and responsive manner. These personnel enhancements, along with the more effective management tools, have improved the ED operations[3].

7. As in the past reporting periods, we visited all of the eight outpatient/clinic settings on several trips to IMC during this reporting period. These locations provide services in primary care, dental care, alternative housing, behavioral health, mental health, chemical dependence, continuing day treatment, intensive psychiatric rehabilitation therapy, methadone maintenance, medically ill chemical dependent and a mobile crisis team. Many of these programs, along with similar programs at the main building of IMC, are either regulated or monitored by OMH and the Organization of Alcohol and Substance Abuse (OASAS). As part of the reduction in force and funding cessation two of these programs have been slated for closure. The Continuing Day Treatment Program will be closed on or about June 28, 2013. Patients have either been absorbed into the treatment programs within the main hospital or have been referred to other neighboring programs. In addition, the Mobile Crisis Team lost their funding and will close on or about August 28, 2013. Two attempts to relocate this program with other institutions in the borough have been unsuccessful. We found the morale at the later program was compromised with the closure plan. During the last reporting period, we noted a discord between the Residents and Program Director at the Dental Clinic. While the Residents suggested that this discord and various issues might have impacted patient care, the Debtor's medical management believed that the issues were more administrative in nature. Regardless, we monitored the Debtor's actions to evaluate the reasonableness of the Residents' claims and found the Debtor's actions at the present time to be appropriate.

[3] These improvements have included shorter triage times, fewer patients leaving against medical advice, shorter times for inpatient admission and improved diagnostic testing protocols.

II. REGULATORY UPDATE

8. As I stated in my last report, DOH had been delegated to perform two surveys on behalf of CMS. The first survey was conducted in February and the second in March following the incident on 8E. The results of those two surveys were received by the Debtor during May. The findings to the survey results contained an extensive detailed listing of issues, the summary of which can be broken down into three categories. Those categories[4] were the Kurron management contract, issues surrounding the treatment of patients in the ED and the event on 8E. In addition, prior to the receipt of these findings, DOH had sent a letter to the Debtor in late April stating that the DOH found the Kurron contract to be unacceptable, and demanded the removal of Kurron from the management of the Debtor. Prior to the receipt by the Debtor of the DOH survey results, the Debtor affirmatively responded, within the defined timeframes, and cancelled the Kurron contract[5]. The other issues identified within the survey as they relate to the ED and psychiatric/8E unit have been and will continue to be addressed by the Debtor. Those activities have included, but are not limited to, compliance reporting, training, education, expanded Board of Trustees involvement, analytics and qualitative measurement tools and safety. In my opinion, the Debtor is firmly committed to resolving these issues and being able to demonstrate a marked improvement in their overall operations to the DOH and others.

9. I have been advised by IMC's management that OMH has not been responsive to the corrective action plan that was provided with respect to the issues on 8E. As previously mentioned, this unit has remained closed since the event. No date has been set for its re-opening.

10. DOH has stated that a complete survey will be conducted of the Debtor subsequent to the Debtor's receipt of the survey results noted above. No such survey has started as of the date of this report. As a result of the issues identified in the surveys, CMS has delegated the Debtor's Deemed Status[6] from CMS to DOH. Accordingly, all regulatory approvals will now be under the auspices of DOH, including, but not limited to, the Debtor's continuation in the Medicare and Medicaid programs for reimbursement purposes. Joint Commission is scheduled for their tri-annual review during the second half of 2013. It would appear that, given the above set of circumstances, this review will be closely combined with the preliminary survey results and the remedial actions taken, as well as the full DOH survey yet to be initiated. These surveys, among other things, have placed significant stress and demands on the management team and employees.

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[4] These core issues were identified in the First and Second PCO Reports.

[5] Three of the previous Kurron team members were hired by the Debtor (i.e., President and CEO, COO and CFO).

[6] Deemed Status - In order for a health care organization to participate in and receive payment from the Medicare or Medicaid programs, it must meet the eligibility requirements for program participation, including a certification of compliance with the Conditions of Participation (CoP) set forth in federal regulations. This certification is based on a survey conducted by a state agency on behalf of the Centers for Medicare & Medicaid Services (CMS).

III. MONITORING PROCESS

11. As in previous reporting periods, my team and I have continually met with key management and staff during this reporting period. We have also interviewed patients on various units, including those in the ED and psychiatric units. As in the past we have continued to monitor IMC's Quality Assurance/Process Improvement activities. In this regard we reviewed, discussed and/or provided input with respect to IMC's tracking and reporting in the following areas:

    a. Behavioral health;
    b. Infection control;
    c. Admitting;
    d. Central sterile supply;
    e. Clinical engineering;
    f. Clinical resource management;
    g. Employee health;
    h. Environmental services;
    i. Food and nutrition services;
    j. Engineering;
    k. Human resources (staffing/turnover);
    l. Health information management (medical records);
    m. Information technology;
    n. Patient relations;
    o. Risk management (medical malpractice); and
    p. Security.

12. Many of the above areas, while reviewed as part of our routine monitoring processes, were also reviewed in conjunction with the two CMS/DOH surveys. The hospital has worked to address concerns raised in my First and Second PCO Reports in this regard, as well all those identified in the two surveys. While all the issues identified have not been fully resolved, management continues to be vigilant in assuring adherence to their plans.

13. As I discussed in my First and Second reports, both the amount of open medical malpractice claims, as well as the perceived absence of financial reserves for claims asserted after the bankruptcy filing, created discord with the incumbent group of medical providers. In response to these issues, the Debtor and an Ad Hoc Group of Doctors and the Committee of Interns and Residents agreed to a Stipulation establishing certain financial commitments to address this issue.

IV. SIGNIFICANT ISSUES

14. As noted in my previous reports, IMC entered into a non-binding Memorandum of Understanding (MOU) with The Brooklyn Hospital Center (TBHC). As part of this effort, IMC hired a new CRO to replace Kurron's Corbett Price, who had reportedly been performing the same functions as part of the Kurron contract. I

have been told by the Debtor that since the signing of the MOU between IMC and TBHC there has not been any further movement with respect to the planned merger/combination. Further, I have been told by the Debtor that TBHC has not been provided with the requested State funding to begin their due diligence of the planned transaction. I have also been informed by the Debtor that DASNY has instructed their new CRO to develop alternative use plans outside the scope of the IMC/TBHC MOU. It appears that the TBHC transaction contemplated under the MOU may have reached an impasse, given the lack of perceived need for due diligence funding combined with little or no progress over the past 60 days.[7]

15. While the Debtor has informed me that it expects to obtain additional DIP financing, the current lack of financial commitment beyond existing cash collateral funding combined with the lack of strategic direction raises questions as to the future care and safety of the patients if such financing does not become available. Specifically, the patients will be placed in a state of uncertainty as to where they may receive care should the Debtor's operations cease. There also will be timing and logistical issues that will need to be addressed to discharge or transfer patients to other health care facilities, as necessary.

16. The Debtor has told me that it has repeatedly requested direction from appropriate New York State entities and that none has been received. I have also been told that the Debtor has sent a letter to the Governor requesting his personal intervention, given the Debtor's representation of a lack of response from various regulatory agencies. I have been told that as of this report date the Governor has not responded to this letter.

17. In light of the significant financial limitations experienced by the Debtor, I suggested in my Second PCO report that IMC develop a comprehensive contingency/closure plan. I am told that the Debtor has been working on a plan and quantifying the financial requirements. Such a plan would require financing and could take between 60 and 90 days to implement. A closure would deprive the community of critical healthcare.

18. The uncertainty surrounding the implications of the CMS/DOH survey results and whether the Debtor's actions are sufficient adds to the level of uncertainty within the organization. There are any number of possible results, ranging from DOH acceptance to the Debtor's corrective action plan and re-opening of 8E to the Debtor's cessation in both the Medicare and Medicaid programs and hospital closure.

[7] I understand that the Debtor's management and Board representatives met with the DOH and DASNY during the week of June 10, and they were advised that there would be no additional funding for due diligence activities with respect to the IMC/TBHC transaction.

V. CONCLUSIONS/RECOMMENDATIONS

19. The Debtor must immediately take steps to finish a comprehensive contingency plan, that could possible include closure, including detailed planning involving finances, staffing, timing and patient placement. This plan should be immediately sent to the DOH and others in order to gauge the level of potential service interruption within the Debtor's catchment area.

20. The Debtor should continue to work collaboratively with all key stakeholders in possible furtherance of either a transaction with TBHC or others as appropriate. I have been told that on or about June 15, 2013, a new Brooklyn healthcare landscape plan will be proffered to the New York State Legislature for consideration[8]. In closing, I have witnessed a committed group of professionals at all levels in the organization that want to meet the needs of the patient population and surrounding community. In fact, a large number of employees and providers are members of the community and have told me of a vast number of anecdotal stories where the hospital saved a family member or loved one's life. There are approximately 1,500 employees as well as hundreds of medical providers, combined with Residents and Interns that are currently receiving training at IMC. A new class of Residents will enter training programs on July 1. In light of these various issues, I would encourage the Board[9] and others to work constructively with all key stakeholders in furtherance of the most logical mission for IMC that protects the healthcare needs of their patients now and in the future.

VI. SERVICE OF REPORT

21. A copy of this Third Report will be filed with the Court, served on the Office of the United States Trustee, counsel for the Debtor, counsel for the Official Committee of Unsecured Creditors, counsel for DASNY, the New York Attorney General, all parties who filed a Notice of Appearance, and any current patients requesting a copy of the Report.

Dated: June 14, 2013

Submitted by

Eric M. Huebscher
Patient Care Ombudsman for
Interfaith Medical Center, Inc.

[8] The current legislative session ends on June 20, 2013. The next legislative session begins in January 2014, unless the Governor calls for a Special Session.

[9] Since my last report the Board has elected a new Chairman.