UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF IOWA

In re:	)	Chapter 11
	)	
CENTRAL IOWA HEALTHCARE	)	Case No. 16-02438-als11
	)	
Debtor and Debtor in Possession.	)	
	)	

PATIENT CARE OMBUDSMAN'S FIRST INTERIM REPORT

Pursuant to 11 U.S.C. §333 of the Bankruptcy Code and the December 22, 2016 Order of this Court directing the United States Trustee to Appoint a Patient Care Ombudsman [D.N. 45], the United States Trustee provided notice of appointment of Susan N. Goodman, RN JD as the Patient Care Ombudsman ("PCO") and directed her to submit regular reports of her evaluation regarding the quality of patient care provided Central Iowa Healthcare ("CIH" or the "Debtor") at the main hospital facility as well as at the various hospital outpatient departments and clinics.

PCO is a Registered Nurse and an attorney with work experience in clinical/operational health care and health regulatory compliance law. In compliance with the federal privacy requirements, the PCO cannot disclose any individually identifiable health information that could distinguish a patient directly or could provide a reasonable basis to do so. *See* 45 CFR §160.103. Accordingly, specific site visit and patient interview dates are not provided although PCO's observations, audits, and interviews occurred between the date of appointment and the filing of this report.

Further, although PCO reviews Debtor's care processes relative to federal and state licensing and quality regulations, PCO does not assume liability for Debtor's compliance obligations under state and federal law and any and all proposed or implementing regulations. Moreover, while PCO may use the auditing tools and guidelines employed by certification agencies and auditors; PCO does not certify the Debtor's compliance with any regulatory standards.

PCO comes now and submits this *Patient Care Ombudsman's First Interim Report* ("**First Report**") detailing site visit review, observations, and analyses of Debtor's operations.

EXECUTIVE SUMMARY

While PCO did not find decline or material compromise in the level of patient care as contemplated in 11 U.S.C. §333(b), Debtor's level of staff/physician bankruptcy fatigue, particularly at the main hospital campus, was notably inconsistent with Debtor's filing date. It was more consistent with what PCO has observed in organizations that are 6 months or more in to the reorganization process. The reported protracted financial and organizational stress that preceded the bankruptcy filing, estimated at year or more, made it particularly difficult for PCO to assess causal connections of some patient and physician feedback relative to the reorganization process. Certainly, the universal feedback from clinicians, staff, and community members was "giddy up" as all expressed anxiousness for clarity regarding Debtor's path forward.

Given the transparency and cooperation exhibited by the Debtor, PCO is comfortable with keeping the report interim at 60 days, with ongoing remote engagement and monitoring so long as the key current leadership, staff, and clinicians remain in place.

RECOGNITION OF DEBTOR'S ENGAGEMENT AND TRANSPARENCY

Debtor's provided PCO with full facility access to assess current operational stressors that could impact patient care on all shifts, in all departments, and at all locations. The level of management engagement was notable with a broad array of service line leadership represented at PCO's introductory meeting. Much of this leadership team recently moved in to their roles after an October 2016 reduction-in-force ("RIF") reduced middle management to one level. The commitment from this team and their respective department team members did not go unnoticed.

OVERVIEW OF DEBTOR'S CAMPUSES

The main hospital campus is located downtown and, not unlike many facilities, consists of a series buildings built together over the time as the hospital footprint grew and changed. The layout consisted of a basement and four floors, with the third and fourth floors largely dedicated

to offices, shared services (typically support departments such as quality, utilization review, etc.) and home and community based services departments. Attached at the first floor level of the hospital, on either side of the main entrance, was a leased obstetrics and gynecology ("OB/GYN") medical office space and Debtor staffed/managed primary care rural health clinic ("Mashalltown Clinic"). In the main entrance parking lot was a one-story brick building that, like the OB/GYN space, was leased space and not part of PCO's visit. Additionally, Debtor's own and lease another large office building across the street from the main hospital. While this physician office building was attached to the hospital by an enclosed walkway on the second floor, it was also not reviewed by PCO.

The "South Campus" or outpatient services building is a new facility located approximately 4 miles southwest of the main hospital campus near the I-30 and Hwy. 14 interchange. Opening in August 2015, the two-story building includes an outpatient surgery department on the second floor, and an expansive diagnostic imaging services ("DIS") department, urgent care, wound therapy, and a leased therapy space (physical, occupational and speech therapies—"PT," "OT," and "SLP") on the first floor. Limited complexity laboratory services are also located on the first floor. While this location does not have a cafeteria, it does have a food service area located in the lobby where limited hot/cold food and beverage options are served.

Three other off campus rural health clinics ("RHCs") are located to the North ("Conrad"), West ("State Center"), and East ("Tama/Toledo") of the main hospital. PCO visited each of these locations in addition to the Main and South campuses.

DETAILED REVIEW

MAIN HOSPITAL CAMPUS

Inpatient clinical areas. Inpatient care areas at the main campus included the medical/surgical/telemetry/pediatrics unit ("MSTP"), the intensive care unit ("ICU"), and the women's center ("OB/GYN/Nursery" or, collectively, "Women's"). Because the MSTP area is licensed to care for pediatric and adult patients, several rooms on one end of the unit are

decorated and stocked for pediatric patients. A separate nurse's station is also on that end of the hall. Nursing staff is unionized at this facility. During PCO's visit, the total inpatient census was in the high teens. PCO interacted with staff on all clinical units and observed care. ICU and MSTP staff interaction included both shifts. PCO did not observe any nurse/patient ratios outside of the reported staffing matrix. Consistently clinical staff reported feeling as though they had been in bankruptcy for all of 2016 and perhaps longer due to ongoing financial strain (worsened, some believe, with the South Campus opening), leadership turnover, and electronic health record ("EHR") challenges with moving from one system to another (CPSI to McKesson/Paragon). Some agency nurse assistance has been needed to cover ICU. The MSTP area had a large hiring of graduate nurses in mid 2016. Several from that pool are now promoting to fill critical care openings. While much of the staff is RN level, several respected, long-tenured LPN level nurses are also integral members of the licensed nursing team. Hospitalist physicians were present and engaged when PCO was in ICU and MSTP. Similarly, a pediatrician was working on the Women's unit when PCO was there. Clinicians universally supported the importance of Debtor facility to the patients in the Marshalltown and surrounding area, and shared staffs' desire for timely clarity moving forward.

Emergency Department ("ED"). The ED has twelve patient rooms, with three rooms that are classified as "safe rooms" for behavioral health ("BH") patients, one room more noticeably so with altered construction, including a bed that is bolted to the floor pad. Debtor reported caring for significant numbers of BH patients and this fact was confirmed in the monthly statistics tracking mean ED visit times and security incident reports. Security has a desk area within the ED just off from the nurses' station for readily available support. Telepsychiatry services are available through outside vendors and those services were confirmed as remaining in place.

Another ED room is set up for OB patients and is pre-stocked with the supplies necessary for that patient population. Two large trauma rooms, each with two beds, were also noted. PCO checked the on-call roster, EMTALA paperwork, linens, supplies, equipment, and staffing. No

concerns, outside of outdated biomedical engineering ("biomed") maintenance checks were noted. Because the biomed challenge cuts across departments and clinics, it will be discussed more fully later in PCO's report.

As eluded to earlier in this report, the ED has faced particular morale and service challenges with the abrupt departure of the ED physician group pre-bankruptcy with subsequent departure of mid-level providers and ED nurses. Coverage has been difficult— accomplished with locum physicians/mid-levels and nursing agency support. Securing long-term provider coverage is on hold until the path forward out of bankruptcy is clear. Certainly, quality data metrics and even, to some extent, patient interview feedback support PCO's concern that a protracted reorganization course is probably not sustainable. That concern, however, cannot eclipse the effort, dedication, and commitment from dedicated remaining staff and clinicians. PCO will remain closely engaged with senior and mid-level leadership for this department to continue to track staffing, morale, patient satisfaction, and outcomes for this department.

Home Care / Public Health Services. PCO met some home care nurses as they returned to the main hospital to chart. The team reported minor supply challenges. Home care leadership and supply chain staff were appropriately engaged and resolving the issue. Unfortunately, PCO did not directly interact with home care leadership and will work to ensure that introduction should a second site visit be necessary. Debtor holds the public health services contract, and PCO did meet the nurse who fulfills that role for the county. No concerns noted. While the largest concentration of contracted physical, speech, and occupational therapists were at the outpatient level on South Campus, PCO did interact with a physical therapist on main campus who was directly employed to provide services through home care. She denied concerns.

Clinician coverage and interviews. PCO was able to interview a large number of physicians and mid-level providers across the main/south campuses and in the RHCs totaling at least 23 providers in all. Certainly, the loss of the ED (emergency department) physicians and mid-level team was correlated to the ongoing financial strain leading up to bankruptcy and was consistently reported as difficult by clinicians. Turnover in the RHC providers, particularly at

the Tama/Toledo location, was also attributed, at least in part, to the challenging financial circumstances preceding the filing. Hospitalist services for both the MSTP and ICU is provided by two teams of three hospitalist physicians working 12-hour shifts with two doctors covering during the day and one at night. One of these teams recently experienced a resignation; again, arguably at least partially attributable to the protracted financial challenges. So long as more departures don't follow, the hospitalist group felt that patient coverage would remain unaffected at current inpatient census levels.

The ED department physician and mid-level coverage is currently accomplished through locum tenens contracts. Debtor leadership is reported as listening to clinical concerns arising from this coverage model and rapidly replacing providers if needed. Patient harm or injury was denied despite the staffing challenges in this area.

The dedication of the remaining clinician team to Marshalltown and its outlying rural communities definitely came through in the interview process as did their continued engagement in driving quality metrics (observed at the trauma committee meeting, for example) and working through supply hiccups. All clinicians denied having any supply challenges that affected patient care and quality or experiencing staffing challenges that affected patient safety. PCO will continue to monitor clinician staffing, stability, and quality metrics, particularly for the ED service area.

Supply chain/materials. This department is remarkably flat with the former buyer for the surgical area taking the leadership role post RIF working with a supply technician staff of ten, including part-time staff. This department is responsible for ordering supplies for the main and south campus locations. The hospital participates in a GPO (group purchasing organization) and reported that GPO pricing has remained in place post bankruptcy filing. The department is set up on a scanning inventory management system with the last inventory recently accomplished. Debtor has experienced isolated supply challenges, without patient impact, as it adjusted to the longer lead times associated with the new prepayment supply acquisition processes. Daily supply committee meetings have been instituted and a check-list created to assist with supply

need prioritization and tracking. The Debtor has done an excellent job working with its vendors to prevent loss of consigned implants and instrument trays. The warehouse was toured and no supply issues were noted. Debtor instituted a "two-bin system" prior to bankruptcy which allowed ordering when half of the par level was utilized to minimize supply outages. This system is crediting with limiting the number of supply outages post bankruptcy.

The current manager/director remaining in her role would be one critical staff position PCO has identified given the number of tasks she has knowledge of and responsibility for. PCO will remain engaged monitoring this critical department.

Facilities / Security / Biomed / Environmental Services ("EVS"). These departments all roll up to one Director. The biggest challenge has been catching up on all necessary PM checks in the biomedical engineering department. Biomed coverage was previously provided through a vendor contract that included a proprietary PM database. When that vendor departed, so did the database. Initial attempted coverage with a second vendor failed. Current coverage is provided on a part-time basis from a technician who normally works full-time at another healthcare facility. An Excel database of all capital equipment has been created, and the Debtor is working to record work order completion in the same file to facilitate auditing. PCO was satisfied in discussions with the engineer that PM priorities were triaged appropriately and asked clinical leadership to continue filtering biomed repair requests so that non-critical repair requests get placed in the queue behind PM updates.

PCO observed maintenance and facility staff at both main and south campuses. In the early morning, staff was noted laying salt on icy areas outside the facility. An older elevator went out of service during PCO's visit. Facility staff immediately engaged with HR to ensure that elevator-dependant employees had appropriate options for access to those departments serviced exclusively by the affected elevator. Facilities also confirmed that safe emergency egress was available for those staff working in affected area. PCO checked fire drill logs and extinguisher tags throughout the facilities, no concerns noted. During the visit, the monthly generator load test was accomplished. The team was working on solving a bankruptcy related

service issue with the shredding vendor. While some shredding bins were noted as completely full, none were overflowing. PCO will monitor the situation to confirm resolution. The dock area and trash compactor was visited, no concerns noted.

PCO complimented the EVS staff. While some parts of the main hospital building are old, PCO consistently found restrooms and the facility areas to be clean and free of odors/trash. Likewise, carpeted hallway areas were well vacuumed. PCO tested hand gel dispensers throughout the facility and did not experience any that were out of gel. Boxes of masks for cold/flu season were also appropriately noted in the facility. EVS staff denied being out of chemicals or supplies used in their duties. Linen, trash, and hazardous waste bins were audited throughout the facility. No concerns suggesting service interruptions were noted. PCO also checked the basement bins in the loading area, no concerns noted.

Nutrition and Dietary. Debtor Main Campus kitchen prepares all patient and cafeteria food, as well as the food that is served at South Campus and for the local "Meals on Wheels" program. Like many departmental leaders, the current Director is new to her role. Preceding bankruptcy, this department engaged budget management measures, driven in large part through the elimination of internal catering and physician food services. Floor stock food (the extra food available to inpatients between meals on the clinical units and in the ED) was simplified and standardized to reduce costs. Debtor already had in place a policy that allowed patients to order desired food off a menu to reduce unnecessary waste from standardized meals. PCO reviewed dietary policies (noted to be current) and metrics with the registered dietician ("RD"), along with the data surrounding compliance with RD referral and follow-up. No concerns noted. Not atypically, patient feedback surrounding care included mixed feedback on the food, although seemingly unrelated to the bankruptcy filing. The worst food complaint was soggy bread with a cold cut sandwich. On the other end of the spectrum, the food was reported as "excellent." PCO randomly ate a meal on the South Campus and found it delicious. Of note, staff does seem to frequent the cafeteria for meals. PCO toured the kitchen area, reviewed processes, and listened to the operational Director's ideas on improving logging compliance. PCO will continue to

monitor the improvements in this area as new processes and tools are developed and implemented.

Of note, Debtor's RD support goes beyond policy development, diet review, and inpatient care referrals. The RD team is also actively engaged in supporting outpatient RD needs at the RHCs and via community outreach programs.

Pharmacy. PCO met with the lead pharmacist, who has been in her role as Pharmacy Director since mid-2014 to review staffing, supplies, and quality data. The department is staffed with 2 licensed pharmacists and 4 certified pharmacy technicians, in addition to the working Director. Two pharmacists retired at the time of the RIF. The Pharmacy policies are well-documented, online, and current. Pharmacy does its own ordering and denied specific supply challenges related to the bankruptcy. PCO reviewed quality tracking related to adverse drug reactions, medication errors, and narcotic log auditing.

Between the site visit and the filing of this report, additional pharmacist coverage, on an urgent, interim basis was necessary. Site leadership promptly relayed interim coverage plan. PCO will remain engaged to monitor this important department.

Laboratory. Lab services are contracted with all the equipment, staff, and supplies owned and managed by the contracted lab vendor. Accordingly, the lab Director felt her staff was somewhat removed from the stressors that other departments experienced in 2016. She reported little turnover and being current with necessary audits, competencies, and proficiencies. She is in the process of moving the lab from CLIA to CAP certification. The Director denied issues with PMs, supplies, blood, or equipment. If equipment redundancy was not possible internally, existing arrangements for coverage through other labs managed by the lab vendor were in place.

EMS Services. Debtor has its own ambulance service and is licensed as a Level III trauma center. This team is actively engaged with the clinician team in supporting care and Debtor protocol development. PCO did not extensively interview members of this team, although noted their consistent presence in the hospital and ED.

Quality / Risk/Infection Control / Compliance. The size of the team covering these important areas is small. The team reported that patient complaints are stable, actually down slightly November/December as compared to the prior rolling two months, and almost exclusively related to patient bill questions/concerns. Prior executive leadership was reported as not embracing a traditional quality assurance/performance improvement "QA/PI" committee process, so this team is enthusiastic about returning to a cross-functional QA/PI process with current executive leadership support. PCO will monitor these efforts as they develop and supports Debtor's move to better integrate departmental quality effort and accountability.

Debtor maintains an internal quality "hotline," which is a voicemail for staff to anonymously report compliance concerns. Debtor indicated that this approach had been longstanding, and not related to a shift in vendor support leading up or after bankruptcy.

Debtor participates in the Iowa Hospital Improvement Innovation Network ("HIIN") and gets state benchmarking data to compare its performance against and access to technical assistance resources on key quality metrics. PCO reviewed a number of quality metrics and departmental performance data. Given the timing of the bankruptcy filing, no post petition bankruptcy quality data is yet available. In looking at the trends in the quality scorecard data across 2016, PCO identified areas, in conjunction with clinical executive leadership, for continued monitoring focus throughout the reorganization process, including but not limited to ED psychiatric holds and turn-around-times, medication error and reaction data, fall data, and critical protocol compliance to national standards. Should PCO identify concerns surrounding post bankruptcy trends or Debtor's response to this metric data, she will file a supplemental report with this Court.

Historically, like many hospital providers, Debtor offered in-house flu vaccination annually. This year, due to financial circumstances, staff was encouraged to use insurance coverage for vaccination through other community providers such as Walgreens. Not surprising, total vaccination rates were lower in 2016 as compared to previous years with in-house flu shot

offerings. Tuberculosis testing in on a 4-year cycle based on local health department data. Compliance remains 97% or greater on all metrics tracked.

Debtor continues with its vendor who provides patient satisfaction survey follow-up ("HCAHPS Data"). Again, while that data is current through December 2016, no post petition data is available for review and analysis. PCO reviewed 2016 data and discussed its implications with the CNO. While most of the fourth quarter metrics demonstrated improvement over third quarter, ongoing challenges in some clinical metrics was noted, reflected in particularly in the ED and M/S areas. Given that many organizations in bankruptcy change HCAHPS vendors, Debtor is in a positive position to be able to continue monitoring and auditing QA/PI efforts from this data through a single company.

The small but mighty quality department also performs chart abstracting for core metrics, utilization review, and clinical documentation specialist tasks. All of these functions relate to licensing regulations, and, ultimately reimbursement. Accordingly, PCO will closely monitor this department for ongoing bankruptcy fatigue and staff departures given the breadth of coverage provided by this relatively lean group.

Admitting. PCO interacted with admitting/registration staff at the south and main campuses. A copy of the *Patient Rights & Responsibilities* and the resource document entitled *Your Information, Your Rights, Our Responsibilities* were both reviewed. HIPAA acknowledgment wording was confirmed in admission packet documents. PCO will follow up further with Human Resources ("HR") and Information Technology ("IT") staff on future visits with particular focus on medical record transition.

Patient and Family Interviews. PCO interviewed eight inpatients/families, or about 40% of the census. Overall the feedback was positive. Comments on the food tended to range from "excellent" to "we need a meat option for breakfast" to a complaint of soggy bread as discussed above. One interview elicited ED care concerns arising from different care encounters with different family members. This feedback was discussed with the appropriate clinical, quality,

and medical leadership to allow further assessment and follow-up. PCO will continue to prioritize patient/family interviews throughout the reorganization process.

SOUTH CAMPUS

Campus Layout. DIS is located on one end of the first floor with therapy services and wound care on the opposite end. Urgent care, lab, and registration areas are between these other departments. The second floor is exclusively dedicated to the outpatient surgery department with a smaller lobby for patients and families in this area.

Wound Therapy. The wound therapy area reported current outpatient wound care visit rates in the mid-teens, with no current hyperbaric patients. The department has two areas with the wound care space at the front of the department and the two-unit, hyperbaric treatment area located to the back of the department. PCO reviewed the supply/medication area for this department, checked for appropriate equipment in the exam rooms, and interacted with staff, a vendor who happened to be visiting with the physician, and a wound-care physician. The physician denied staff or supply concerns impacting his ability to treat patients. Consignment for this area is limited and unchanged post bankruptcy. One recent staff departure was attributed to the bankruptcy. No other concerns related to the reorganization process were noted, and operational improvement opportunities were reviewed with the nurse manager.

Diagnostic Imaging Services ("DIS"). DIS had only one procedure scheduled at the time of PCO's visit that was not appropriate for PCO observation. Department leadership reported that all equipment PMs (preventative maintenance on equipment) were current to manufacturer specifications. Logs, other than those relevant to nuclear medicine, were not available in the department for review. Radiology equipment included CT (128 slice), MRI, ultrasound (x2), mammography, x-ray (x2, one with fluoro capability), portable x-ray and c-arm equipment, and a nuclear medicine ("nuc med") area. The DIS area was spacious with appropriate supplies and linens noted. The crash cart was present with seal and daily/monthly checks confirmed. Physicist oversight remains in place in nuc med and the quarterly audit was reported as happening the day after PCO's visit. PCO interviewed a radiologist on site who denied supply,

staffing, or other concerns related to the reorganization process. Mobile PET (positron emission tomography) scan services were reported as remaining available on the regular, periodic schedule post bankruptcy filing. No concerns noted.

Lab /Pharmacy. The South Campus has a satellite lab area where patient blood draws and limited test kit and chemistry tests are run. At the time of PCO's visit, this area was staffed with a temporary lab technician. The technician denied supply or reagent issues post bankruptcy. Control and temperature logs were reviewed. Competencies and proficiencies were reported as up-to-date and emergency O- blood was noted on site per protocol. No concerns noted.

Necessary department medications are stocked through the Pharmacy at main campus. Those medications not stored in a locked, computerized Pyxis unit were noted to be in locked cupboards on the unit. No concerns noted.

Outpatient Surgery. The bulk of Debtor's surgical procedures are performed at the South Campus location. Staff (clinical and sterile services department "SPD") float between the two locations to cover case needs. PCO directly observed a surgical procedure and confirmed that the supplies, procedures, processes, and staff necessary were present. The surgical core (where sterile supplies are stored) was reviewed with no concerns noted. PCO also toured SPD and met with three team members at this location. Daily quality check logs were reviewed. SPD staff denied supply or equipment issues post bankruptcy. The general surgeon and two nurse anesthetist were interviewed and denied concerns with staffing.[1] While some isolated supply challenges were reported, the clinicians related them to adjusting to the longer, pre-payment process and denied that they had seen any impact on patient care.

Urgent Care. The six-room urgent care saw a total of 16 patients on the day PCO visited. Staff reported that visit load as somewhat slow compared to reported typical census in the mid-twenties. The unit was covered with a mid-level provider (a certified physician assistant, "PA-

[1] Anesthesia services are provided largely by certified registered nurse anesthetist "CRNA" team members with only one physician /anesthesiologist on the team. PCO did not meet the anesthesiologist on the initial site visit and will look to do so on future site visits, if needed.

C"), a nursing assistant, and a licensed practical nurse "LPN." PCO reviewed the supply cabinet. While no significant concerns were noted, the department was out of a needed ace wrap and had to borrow one from the surgical area. Again, staff consensus was that these isolated challenges were related to the change to pre-payment supply acquisition. PCO encouraged team members to review par levels relative to the longer ordering cycle.

Outpatient Therapy. Outpatient therapy services are contracted through a therapy provider. Physical, occupational, and speech therapies are all provided as required by licensing regulations. This department was quite busy with nearly 60 patients seen, from a total of more than 70 scheduled, on the day of PCO's visit. A glass enclosed documentation area was noted with therapists documenting on tablets (properly encrypted with a two-level log on). While operational opportunities were noted (sign-in, hydrochollator, and freezer logs), PCO did not relate these to the reorganization process. Therapists reported uneasiness regarding the potential impact of reorganization on the contract status with their firm. That may have accounted for some of the staff turnover that preceded bankruptcy in 2016 with no post bankruptcy departures yet noted.

RURAL HEALTH CLINICS

Tama/Toledo. The Tama/Toledo RHC is situated to the east of the main hospital campus in a two story brick building not far from the state highway and within a residential community. The contracted therapy provider rents the basement space, providing outpatient therapy services. PCO introduced herself to the therapy team, but did not engage in much assessment given that operational feedback was already provided to the South Campus staff and processes at this clinic mimic those at the other campus.

The primary care office is supervised by the nurse practitioner mid-level provider. The physician was working at the Marshalltown clinic on the day of PCO's visit. The office is staffed with two front-office staff, one coding specialist, and three medical assistants ("MA"). A formerly full-time LPN will also provide coverage as needed on a PRN basis. One medical assistant is able to perform x-ray, phlebotomy, and urine micro review. A second medical

assistant is primarily dedicated to phlebotomy and ensuring all documentation is current related to point of care testing, equipment, and the state vaccine program. A third medical assistant manages documentation related to medication samples. In a word, the MA operation is "ship-shape." The challenge this office faces is rebuilding patient volume as two primary care physicians recently left the office to join a different practice. The mid-level and physician at this office both work in the office one day per week, otherwise they rotate coverage days. The office has four exam "pods" of 3 exam rooms each—a capacity to have four provider teams.

Conrad. This 10-exam room clinic, located North of the main campus, was the busiest PCO visited. The Conrad clinic has a family practice physician and a physician assistant/EMT. Because the providers also support area long term care facilities, a great amount of care coordination and order management is occurring in addition to caring for a large geriatric population. Accordingly, this clinic is staffed with a mix of licensed nurses and MAs. A clinic director is shared between Conrad and Marshalltown. Conrad is x-ray capable with RT coverage provided from the DIS team at main/south campuses. Phlebotomy and point of care lab services are also provided. The clinic providers also report performing various minor office procedures, such as IV hydration. PCO reviewed quality logs and care processes, no concerns noted. PCO did note that this clinic was in need of annual PM checks on its equipment, and reported that information back to main hospital leadership.

State Center. Like Tama/Toledo, the Eastside clinic manager is the mid-level provider, who is currently the clinic's only provider. The clinic has 5 rooms was staffed with an LPN, a MA and individuals for both the front and back office tasks. State Center is also capable of x-ray, phlebotomy, point of care lab testing, and some minor procedures such as casting, splinting, and mole removal. PCO reviewed equipment, care processes, and quality logs. No concerns noted.

Marshalltown. At the time of PCO's visit, Marshalltown had two physician providers. A physician assistant also works out of this clinic. PCO's visit to this clinic was abbreviated, and PCO will spend additional time interacting and observing care at this clinic should future site

visits need to be done. Clinic staff was forthright regarding the patient and town concerns/ questions that they fielded daily. Reported community feedback was that the trust of the town in the hospital had been shaken by the protracted media coverage of the financial challenges. Perhaps because of the location of this clinic on the main hospital campus, these concerns seemed to be more pronounced than what PCO experienced at the outlying RHC offices.

All of the RHCs are on the Athena EHR system, distinct from the different EHR used at the main and south campuses. Hard copy medical records were reported as on-site at the various clinics with no off-site storage. Certainly, relational database access may need to be maintained through Athena at the RHCs and through CPSI and McKesson/Paragon at the main and south campuses should the ultimate buyer not have EHR capability to pull these files in a readable format from a new system.

SUMMARY AND NEXT STEPS

At this juncture, PCO is comfortable with a 60-day report cycle with interim phone and document follow-up so long as key clinical leadership and quality staff remain in place. Because of the level of pre-filing bankruptcy fatigue, PCO will also closely watch staff/clinician departures, adjusting her visit schedule as needed if concerns arise. Remote data sharing and discussion have already begun and are working well. Should a second visit be necessary before closure of sale, PCO will ensure follow-up with home care leadership, IT, and HR as those departments were minimally included in PCO's initial site visit efforts.

Dated: January 24, 2017

MESCH CLARK ROTHSCHILD

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CERTIFICATE OF SERVICE

I certify that a copy of this document was sent to the parties below on January ___, 2017.

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