AMERICAN BANKRUPTCY INSTITUTE

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The Role of a Patient Care Ombudsman in a Business Bankruptcy

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CONCURRENT SESSION

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NELSON MULLINS BROAD AND CASSEL

The Role of a Patient Care Ombudsman in Complex Healthcare Businesses 15 Years After BAPCPA

Does Anybody Really Care? You Should!

Moderated by

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11 USC 101 (27A)

- (27A) The term "health care business"--
- (A) means any public or private entity (without regard to whether that entity is organized for profit or not for profit) that is primarily engaged in offering to the general public facilities and services for--
  - (i) the diagnosis or treatment of injury, deformity, or disease; and
  - (ii) surgical, drug treatment, psychiatric, or obstetric care; and
- (B) includes--
  - (i) any--
    - (I) general or specialized hospital;
    - (II) ancillary ambulatory, emergency, or surgical treatment facility;
    - (III) hospice;
    - (IV) home health agency; and
    - (V) other health care institution that is similar to an entity referred to in subclause (I), (II), (III), or (IV); and
  - (ii) any long-term care facility, including any--
    - (I) skilled nursing facility;
    - (II) intermediate care facility;
    - (III) assisted living facility;
    - (IV) home for the aged;
    - (V) domiciliary care facility; and
    - (VI) health care institution that is related to a facility referred to in subclause (I), (II), (III), (IV), or (V), if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living.
  - Source: 11 U.S.C.A. § 101 (West)

***See*, In Re Medical Associates of Pinellas, LLC, 360 BR 356 (Bankr. M.D. Fla 2007).**

11 USC 333 (b)(1)(2)(3) and (c)(1)

- b) An ombudsman appointed under subsection (a) shall--
  - (1) monitor the quality of patient care provided to patients of the debtor, to the extent necessary under the circumstances, including interviewing patients and physicians;
  - (2) not later than 60 days after the date of appointment, and not less frequently than at 60-day intervals thereafter, report to 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; and
  - (3) if such ombudsman 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 a written report, with notice to the parties in interest immediately upon making such determination.
- (c)(1) An ombudsman appointed under subsection (a) shall maintain any information obtained by such ombudsman under this section that relates to patients (including information relating to patient records) as confidential information. Such ombudsman may not review confidential patient records unless the court approves such review in advance and imposes restrictions on such ombudsman to protect the confidentiality of such records.
- Source: 11 U.S.C.A. § 333 (West)

FRBP 2015.1 and FRBP 2015.2
Rule 2015.1. Patient Care Ombudsman

- (a) Reports
- A patient care ombudsman, at least 14 days before making a report under § 333(b)(2) of the Code, shall give notice that the report will be made to the court, unless the court orders otherwise. The notice shall be transmitted to the United States trustee, posted conspicuously at the health care facility that is the subject of the report, and served on: the debtor; the trustee; all patients; and any committee elected under § 705 or appointed under § 1102 of the Code or its authorized agent, or, if the case is a chapter 9 municipality case or a chapter 11 reorganization case and no committee of unsecured creditors has been appointed under § 1102, on the creditors included on the list filed under Rule 1007(d); and such other entities as the court may direct. The notice shall state the date and time when the report will be made, the manner in which the report will be made, and, if the report is in writing, the name, address, telephone number, email address, and website, if any, of the person from whom a copy of the report may be obtained at the debtor's expense.
- (b) Authorization to review confidential patient records
- A motion by a patient care ombudsman under § 333(c) to review confidential patient records shall be governed by Rule 9014, served on the patient and any family member or other contact person whose name and address have been given to the trustee or the debtor for the purpose of providing information regarding the patient's health care, and transmitted to the United States trustee subject to applicable nonbankruptcy law relating to patient privacy. Unless the court orders otherwise, a hearing on the motion may not be commenced earlier than 14 days after service of the motion.
- Source: Fed. R. Bankr. P. 2015.1

FRBP 2015.1 and FRBP 2015.2
Rule 2015.2. Transfer of Patient in Health Care Business Case

- Unless the court orders otherwise, if the debtor is a health care business, the trustee may not transfer a patient to another health care business under § 704(a)(12) of the Code unless the trustee gives at least 14 days' notice of the transfer to the patient care ombudsman, if any, the patient, and any family member or other contact person whose name and address has been given to the trustee or the debtor for the purpose of providing information regarding the patient's health care. The notice is subject to applicable nonbankruptcy law relating to patient privacy.
- Source: Fed. R. Bankr. P. 2015.2

FRBP 2007.2

Rule 2007.2. Appointment of Patient Care Ombudsman in a Health Care Business Case

- (a) Order to appoint patient care ombudsman
- In a chapter 7, chapter 9, or chapter 11 case in which the debtor is a health care business, the court shall order the appointment of a patient care ombudsman under § 333 of the Code, unless the court, on motion of the United States trustee or a party in interest filed no later than 21 days after the commencement of the case or within another time fixed by the court, finds that the appointment of a patient care ombudsman is not necessary under the specific circumstances of the case for the protection of patients.
- (b) Motion for order to appoint ombudsman
- If the court has found that the appointment of an ombudsman is not necessary, or has terminated the appointment, the court, on motion of the United States trustee or a party in interest, may order the appointment at a later time if it finds that the appointment has become necessary to protect patients.
- (c) Notice of appointment
- If a patient care ombudsman is appointed under § 333, the United States trustee shall promptly file a notice of the appointment, including the name and address of the person appointed. Unless the person appointed is a State Long-Term Care Ombudsman, the notice shall be accompanied by a verified statement of the person appointed setting forth the person's connections with the debtor, creditors, patients, any other party in interest, their respective attorneys and accountants, the United States trustee, and any person employed in the office of the United States trustee.
- (d) Termination of appointment
- On motion of the United States trustee or a party in interest, the court may terminate the appointment of a patient care ombudsman if the court finds that the appointment is not necessary to protect patients.
- (e) Motion
- A motion under this rule shall be governed by Rule 9014. The motion shall be transmitted to the United States trustee and served on: the debtor; the trustee; any committee elected under § 705 or appointed under § 1102 of the Code or its authorized agent, or, if the case is a chapter 9 municipality case or a chapter 11 reorganization case and no committee of unsecured creditors has been appointed under § 1102, on the creditors included on the list filed under Rule 1007(d); and such other entities as the court may direct.
- Source: Fed. R. Bankr. P. 2007.2

See, In Re Alternate Family Care, 377 BR 754 (Bankr. S.D. Fla 2007), Jerry Seelig and David Hoffman, PCO Appointment: Whose Facts? The Case for Ombudsman Appointment, XXXI ABI Journal 2, 26-27, 74, March 2012

Health Care Debtors Are Very Different Organizations

- HEALTH CARE DEBTORS ARE VERY DIFFERENT ORGANIZATIONS with unique assets and liabilities, they have their own rules and regulations and a unique set of professionals; THEY BRING THE FOLLOWING [and other] CHALLENGES:
  - Getting on the Front Page of the newspaper for the wrong reasons
  - People are sick can get sicker, slip, fall, and even die
  - Patients are difficult customers, now they have Yelp and other tools to rightly or wrongly complain
  - Doctors and other caregivers are bad at business
  - You must learn a unique Language with its own 3'rs – Rules, Regulations and Reimbursement as well the important acronyms including "CPI", "HIPAA", "BAA", and "OCR".
  - Corporate structure/ownership, the ledger, and all of the assets; ***can and probably will be different than what you have worked with in the past.***
  - Valuable and important things most notably medical records and pharmaceuticals can go missing
  - Annual and surprise visitors from the State-Fed-Accreditations' agencies;
  - Alter Ego's playground, your client or you may be responsible for the physician or others' errors
  - Find the Money: is it your money or the property of the United States and/or other payers?
  - Some things can last forever; others not: Continuity of Care & Record keeping.

What is Quality of Care?

- It is the responsibility of the PCO to evaluate the quality of care of Debtors' patients. As defined by the Institute of Medicine Committee,
  - **quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health out comes and are consistent with current professional knowledge.** (Medicare, I. of M. (US) C. to D. a S. for Q.R. and A. in, & Lohr, K.N. (1990a). *Critical Attributes of Quality-of-Care Criteria and Standards. National Academies Press (US).* Retrieved from https://ncbi.nlm.nih.gov/books/NBK235456/ ("Medicare and Lohr").
- Quality healthcare delivery requires technical proficiency, the means to deliver services correctly, the cognitive and communication skills necessary to elicit and evaluate needed information, and the ability to decide which mix of available services is most likely to achieve desired health outcome for patients. When these requirements are not met patient are at risk.

See, First Report by Patient Care Ombudsman, Jacob Nathan Rubin, MD, FACC in In Re: Verity Health System of California, Inc., et al., Case 2:18-BK-201510 ER United States Bankruptcy Court, Central District of California – Los Angeles Division

What are the specific medical standards and review criteria that a PCO must utilize to conduct his review?

- In order to evaluate the processes of the Debtors, the PCO surveyed and evaluated the critical systems in place to assess the Debtors' ability to provide the standard of care during the bankruptcy process. Elements of care delivery were evaluated against criteria that reflect professional standards of good quality care (and, increasingly, patient-oriented measures of satisfaction.)
- Data about processes can be obtained in numerous ways. These include patient reports of care rendered, direct observation of care, review of medical records (or abstracts of records) and similar documents, and analysis of accreditation and monitoring agencies claims or other utilization data. This review was conducted by the PCO.

See, First Report by Patient Care Ombudsman, Jacob Nathan Rubin, MD, FACC in In Re: Verity Health System of California, Inc., et al., Case 2:18-BK-201510 ER United States Bankruptcy Court, Central District of California – Los Angeles Division

Is the review by the PCO only to determine if there has been a deterioration of care arising and related to the bankruptcy?

- Retrospective review of records using explicit criteria is the classic approach to assessing quality in acute care settings using validated generic screening tools in retrospective review of processes and medical records. Medicare & Lohr, 1990c. The PCO examined old records to understand past concerns as an initial starting point.

See, First Report by Patient Care Ombudsman, Jacob Nathan Rubin, MD, FACC in In Re: Verity Health System of California, Inc., et al., Case 2:18-BK-201510 ER United States Bankruptcy Court, Central District of California – Los Angeles Division

If the quality of care before the bankruptcy was poor and the quality of care after the bankruptcy remains the same, is the PCO's job done?

"Pain is nothing compared to what it feels like to quit."
- Unknown

You're never a loser until you quit trying."
- Mike Ditka

"Once you learn to quit, it becomes a habit."
- Vince Lombardi

"There's only one things that can guarantee our failure, and that's if we quit."
- Unknown

"Never stop trying. Never stop believing. Never give up. Your day will come. "
- Mandy Hale

What would constitute the proper protocol to evaluate the quality of care?

- **Administrative**
  - Changes in occupancy/case mix
  - Patient care staffing changes
- **Documents**
  - Quality Plan (initial visit only) & current data
  - Quality/Infection Control/Risk reports and minutes
  - Resident Council minutes
  - Complaint reports/minutes
  - Safety reports/serious events
  - Restraint log
  - Pressure Ulcer log
  - Falls log
  - Psychotropic drug logs
  - Inspection report (local, state or federal)
- **Physical Environment**
  - Residents able to secure personal belonging and property; have adequate personal space
  - Signage (entrance/exits/evacuation routes, PSA)
  - Patient rescue plans and equipment

What would constitute the proper protocol to evaluate the quality of care? (Cont'd.)

- **Resident Appearance, Personal Care, Service, Resident Rights**
  - Residents are clean, dry, well-groomed, nails clean and trimmed
  - Skin intact or on turning schedule and turned with would care given
  - Food quality, appearance temperature availability of condiments acceptable to residents
  - Personal privacy & dignity protected (knock on door, pull curtains)
- **Medication Management**
  - Documentation of meds administered
  - Psychotropic meds; proper documentation; mindfulness of resident consent; risks; contra-indications; representative informed before use
  - Behavior plans to minimize use of psychotropics
  - Prescribing/monitoring of meds that cause over sedation, falls, interactions.
- **Medical Records (Charts)**
  - Care plans collaborative with family and/or representative input
  - Pain assessments done regularly

Is it different for different healthcare business?

- SNF
- CAH
- HOSPITAL / HEALTH SYSTEM
- ALF
- LTAC
- Free Standing ER's

Does a PCO need clinical experience to perform his duties under 11 USC 333?

- *So a team does Increase the size of the PCO pie, yet as early as 2008 in an early Dan case we have:*
- In analyzing the issues before the court, it is important to begin by noting the distinction between the role of an ombudsman as compared to that of other fiduciaries compensated (together with their retained professionals) by the estate. A trustee or debtor in possession and its professionals have the duty of preserving, protecting and maximizing the estate. See, e.g., *Commodity Futures Trading Comm'n v. Weintraub*, 471 U.S. 343, 352 (1985). A committee and its professionals serve a constituency with an economic interest in the estate. See, e.g., *In re Nationwide Sports Distrib., Inc.*, 227 B.R. 455, 463 (Bankr.E.D.Pa.1998). A committee will have a common interest with representatives of other economic constituencies in preserving value for creditors (and even equity owners) as well as enhancing the estate.
- **A patient care ombudsman, on the other hand, is concerned with a constituency[7] whose interests do not necessarily coincide with the economic interests of other case participants.** The ombudsman therefore is not concerned with the economics of the case**. His very job is to ensure that his constituents—patients—are well cared for by the debtor in possession (or trustee**). He may press for the debtor in possession (or trustee) to take costly measures that will deplete rather than enhance the estate and the ultimate recovery of creditors. The result is that the court and other parties cannot view a patient care ombudsman as they do a fiduciary whose job includes improving an estate's value.

***See,* In Re Renaissance Hospital – Grand Prairie, Inc., 2008 W.L. 5746904**

Should PCO's universally be doctors, nurses or healthcare administrators solely?

- As we review the large cases with properly funded PCO, we see that every PCO has been one of the following:
  - Health Care Administrator
  - Clinical Person (be it MD Nurse or other type of caregiver)
  - Attorney with extensive experience in and knowledge of rules, regulations, reimbursement
- And they all added persons with the skills and experience and the understanding of what it is to work a shift in that debtor.

Should the PCO skew his/her findings in order to please the Committee and the Debtor?

- From Renaissance Hospital case:

> "He (the PCO) MAY PRESS FOR the Debtor in Possession to take costly measures that will deplete rather than enhance the estate and the ultimate recovery of creditors."

See, In Re Renaissance Hospital – Grand Prairie, Inc., 2008 W L 5746904

Is the PCO obligated to tell the quality of care story without concern for the economic impact on a bankruptcy exit strategy?

- Advocate for Patients
- Patient Advocacy may have an Economic Impact on EXIT Strategy BUT SO WHAT
- Poor Quality of Care may incentivize New Buyers
- Improvement Guidelines May Actually Be Useful to Buyers

How is the PCO's role different than Medicare and Medicaid surveyors, accreditation bureaus or long term care ombudsmen?

SLTCO ARE TO:	1) Identify, investigate and resolve complaints raised by residents
	2) Provide services to assist residents to protect their rights
	3) Represent Residents before government agencies
NOTE:	Many are Volunteers
Accreditation Bureaus:	Are to Monitor the Delivery of Healthcare by an on-site process that is focused on patient safety and quality
NOTE:	Review is often only every 12-18 months interval.

Does the PCO only recommend change or demand change in the quality of care?

- Debtor may welcome recommendations and institute improved procedures
- Court may have to decide if change is required
- PCO can be friend or foe

Should the PCO partner with the committee and the Debtor to formulate a budget for the work to be done by the PCO?

A. PCO must be given time to assess the level of care before committing to a budget

B. PCO may have to request guidance from the court if the economic constituencies refuse to provide a reasonable budget

At what stage after the appointment should that budget formulation take place?

- Will vary with the size of the case (5, 10, 25, 50, 150 facilities)
- Vary on the type of healthcare business
- Vary on what the PCO believes will be required as additional staff to properly monitor the quality of case
- Vary on location of facilities (multi-state)
- Vary on what sort of records the debtor has retained

Should a PCO be involved in a healthcare business change of control or closure, or do you let the state regulators handle the process?

CHOW — TIMING OF CHOW APPROVAL COULD AFFECT PATIENT CARE. PCO MAY HAVE TO CONTINUE TO MONITOR UNTIL TRANSITION OCCURS.

CLOSURE — TRANSFER TRAUMA was formally approved as an official nursing diagnosis in 1992 as "relocation stress syndrome" and defined as physiologic and/or psychosocial disturbances as a result of transfer from one environment to another.

See FRBP 2015.2

Where do the UST and the Courts stand with respect to the Ombudsman's role to serve as an advocate of patients?

UST OFFICE — Some require clinical skills; other offices do not; most support appointment of counsel and other professionals; most protect cash collateral budgets before PCO is appointed; may support discharge pre- confirmation and plan exculpation.

COURTS — Some read the PCO Reports, offer status conference time, special carve-outs on compensation; Other Courts do not believe that a PCO is needed.

What the heck do we do with patient records?

- **(1)** The trustee shall--
  - **(A)** promptly publish notice, in 1 or more appropriate newspapers, that if patient records are not claimed by the patient or an insurance provider (if applicable law permits the insurance provider to make that claim) by the date that is 365 days after the date of that notification, the trustee will destroy the patient records; and
  - **(B)** during the first 180 days of the 365-day period described in subparagraph (A), promptly attempt to notify directly each patient that is the subject of the patient records and appropriate insurance carrier concerning the patient records by mailing to the most recent known address of that patient, or a family member or contact person for that patient, and to the appropriate insurance carrier an appropriate notice regarding the claiming or disposing of patient records.

11 U.S.C.A. § 351 (West), See also, FRBP 6011