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UNITED STATES BANKRUPTCY COURT
CENTRAL DISTRICT OF CALIFORNIA
LOS ANGELES DIVISION

In re:

VERITY HEALTH SYSTEM OF CALIFORNIA, INC. *et al.*,

Debtor(s).

☐ Affects All Debtors
☒ Affects Verity Health System of California, Inc.
☒ Affects O'Connor Hospital
☒ Affects Saint Louise Regional Hospital
☒ Affects St. Francis Medical Center
☒ Affects St. Vincent Medical Center
☒ Affects Seton Medical Center
☐ Affects O'Connor Hospital Foundation
☐ Affects Saint Louise Regional Hospital Foundation
☐ Affects St. Francis Medical Center of Lynwood Foundation
☐ Affects St. Vincent Foundation
☒ Affects St. Vincent Dialysis Center, Inc.
☐ Affects Seton Medical Center Foundation
☐ Affects Verity Business Services
☒ Affects Verity Medical Foundation
☐ Affects Verity Holdings, LLC
☐ Affects De Paul Ventures, LLC
☒ Affects De Paul Ventures – San Jose Dialysis, LLC

Debtors and Debtors In Possession

Lead Case No.: 2:18-bk-20151-ER

Jointly Administered With:
Case No.: 2:18-bk-20162-ER;
Case No.: 2:18-bk-20163-ER;
Case No.: 2:18-bk-20164-ER;
Case No.: 2:18-bk-20165-ER;
Case No.: 2:18-bk-20167-ER;
Case No.: 2:18-bk-20168-ER;
Case No.: 2:18-bk-20169-ER;
Case No.: 2:18-bk-20171-ER;
Case No.: 2:18-bk-20172-ER;
Case No.: 2:18-bk-20173-ER;
Case No.: 2:18-bk-20175-ER;
Case No.: 2:18-bk-20176-ER;
Case No.: 2:18-bk-20178-ER;
Case No.: 2:18-bk-20179-ER;
Case No.: 2:18-bk-20180-ER;
Case No.: 2:18-bk-20181-ER

Chapter 11 Cases

SUBMISSION OF NINTH REPORT BY PATIENT CARE OMBUDSMAN, JACOB NATHAN RUBIN, MD, FACC, PURSUANT TO 11 U.S.C. § 333(b)(2)

NO HEARING REQUIRED

1820151200407000000000001

Jacob Nathan Rubin, MD, FAAC, the Patient Care Ombudsman ("PCO") appointed under 11 U.S.C. § 333 in the above-referenced chapter 11 bankruptcy cases of the affected debtors and debtors in possession (collectively, "Debtors"), hereby submits his ninth report ("Report") to the Court pursuant to 11 U.S.C. § 333(b) regarding the quality of patient care provided to patients of the affected Debtors. The Report is hereby attached as Exhibit A.

Submitted by:

LEVENE, NEALE, BENDER, YOO & BRILL L.L.P.

By: */s/ Ron Bender*
RON BENDER
MONICA Y. KIM
Attorneys for Patient Care Ombudsman

Exhibit "A"

Table of Contents to

NINTH REPORT BY PATIENT CARE OMBUDSMAN, JACOB NATHAN RUBIN, MD, FACC, PURSUANT TO 11 U.S.C. § 333(b)(2)

IN RE VERITY HEALTH SYSTEMS, INC.
NINTH REPORT OF PATIENT CARE OMBUDSMAN

PURSUANT TO 11 U.S.C. § 333

I. PCO's APPOINTMENT AND SCOPE OF REVIEW

The Debtors are health care businesses as defined under § 101(27)(A). The Court ordered the appointment of a PCO pursuant to 11 U.S.C. § 333 (a)(1) to monitor, and report to the Court, the quality of patient care provided by the Debtors. The PCO, whose appointment by the U.S. Trustee was approved by the Court, performed the duties described in 11 U.S.C. §333(b) and (c). The PCO performed these duties with the assistance of a Court approved, qualified employed expert, Dr. Timothy Stacy. Additionally, the Court approved counsel, Levene, Neale, Bender, Yoo & Brill, L.L.P. to provide legal guidance to the PCO regarding the performance of his duties under the Bankruptcy Code.

Subsequent to the PCO's initial evaluation as identified in his initial Report, the PCO continued to perform contemporaneous monitoring of any issues identified pertaining to a specific Debtor entity and the global issues identified requiring Debtors' immediate attention, and as required by 11 U.S.C. § 333(b) and (c).

The observation period for the ninth report was from February 4th, 2020, through April 4th, 2020. During this period, the PCO reviewed all new E-data room entries such as Joint Commission Reports, Survey Verification and California Department of Public Health (CDPH) filings. In addition, the PCO closely monitored and worked with administration to closely monitor the safe transfer of all St. Vincent's transplant program patients.

The PCO continues to monitor and discuss the exit of the Professional Office Building (POB) tenants to ensure continuity of patient care.

The PCO is in communication with the Chief Medical Officer, Dr. Del Junco, to keep abreast of issues that impact the organization. During this period, the PCO met with hospital

administrative teams via video conferencing. Site visits were restricted due to the COVID-19 pandemic.

II. VERITY SITES REVIEWED BY THE PCO

Debtors continue to operate two acute care hospital centers and a skilled nursing facility operated by Seton Medical Center. Debtors' maintain facilities in Northern and Southern California. These include the following:

a. St. Francis Medical Center (SFMC)

b. Seton Coastside (SMCC)

c. Seton Medical Center (SMC)

III. METHODOLOGY AND MEDICAL STANDARD APPLIED BY THE PCO

The PCO continues to monitor patient care provided by the Debtors by applying the principles and structure of evidence-based review outlined in the PCO's first Report. Specific to this report the PCO will refine his strategy based on the most current and available evidence.

A. Ninth Report Review Strategy

The concentration of this report will specifically address the readiness and hospital system preparedness as it relates to all aspects of the COVID-19 pandemic disaster. The PCO will apply the most current data available to assess the health system's ability to comply with national and community standards during this crisis. The assessment is robust and contains multiple layers that are specific national and regional hospital preparedness strategies to best prepare the hospital system for the expected regional surge of COVID-19 patients.

The PCO is in frequent contact with hospital administrators and the CMO via video, email and telephonically. The meetings communicate critical information to the PCO regarding the level of COVID-19 hospital preparedness for SMCC, SMC and SFMC.

The PCO continued to address and review previous ongoing items of concern. The PCO continued to monitor and follow-up on any unforeseen developments or untoward circumstances caused by the emergent closure of St. Vincent's Medical Center (SVMC), the Liver/Kidney/Pancreas Transplant and Hemodialysis Program termination, and the Professional Office Building (POB) order to vacate.

The PCO has spent several months investigating the suspension and ultimate closure of SVMC's Liver Transplant Service and the potential patient harm inherent in the closure. This included attending the SVMC Attorney General hearing, multiple discussions with administration, communication with the Debtors' attorneys and with Assistant Attorney General's Office.

In the time since the eighth report, the PCO is confident that patients were safely discharged and transferred to an appropriate transplant center or providers capable of caring for these medically difficult patients that require close monitoring, follow-up and continuity of care. Administration performed exceptionally in the difficult process of swiftly and safely transferring these patients while adhering to the strict guidelines of OPTN/UNOS regulations.

While the patients of the Liver/Kidney/Pancreas Transplant Program and Hemodialysis Center were safely discharged or transferred, the doctors of the POB (ordered to vacate by April 30th, 2020), require ongoing care and a safe transition during these uncertain times.

The PCO continues to frequently communicate, either telephonically or on-site visits, with Dr. Del Junco, CMO, and Margaret Pfeiffer, CEO of SVMC.

Through dialogue with the Debtors' management leaders, the PCO was well-informed on the status of all events (positive or negative), corrective action plan progress, results of CDPH investigations, State Board of Pharmacy and Joint Commission surveys.

The PCO and the Debtors' administrative team continue to work closely on the COVID-19 crisis. The frequency of communication between the PCO and administration has significantly increased and remains collaborative.

The diligence of the Debtors to manage the E-Data room punctually assisted the PCO in performing his duties. In addition, professional relationships with administrative and medical staff have developed with the PCO that encourage contemporaneous exchange of information allowing the PCO to address problems and collaboratively develop solutions with the Debtors' management leaders in real time.

B. nCOVID-19: Impact to Hospitals and Health Systems, Preparedness and Warnings from the Frontlines

The PCO performed substantial and exhaustive COVID-19/ SARS-CoV-2 hospital preparedness evidence-based research from multiple sources.

The emerging COVID-19/SARS-CoV-2 pandemic is a rapidly evolving and a dynamic national health crisis with varying degrees of severity of illness. The unique nature of this illness, accompanied with our inability to accurately model the spread or predict geographic concentrations of infected persons, afford the medical community few options other than planning and preparedness to curb mortality. Frankly, we have never seen a health crisis pandemic of this magnitude before. The pandemic is exposing medical preparedness's weaknesses at every turn.

The nature of the virus is at its core novel, which limits our ability to accurately model population health outcomes. As an example, Italy, China, and Spain, experienced massive exposure of the virus with high mortality rates. In contrast, South Korea experienced lower mortality rates. The observed mortality rates (total deaths/total tested positive) that we have seen in these countries are confounded by the limitation of available testing. The denominator is falsely low thus the mortality rates may be lower. Despite the absence of accurate infection data, the mortality rate

seems dependent on the initial response of quarantining and availability of prepared hospitals, supplies, and equipment. Scientists are scrambling to develop a cure or develop strategies to improve the severity of illness of the disease. Most treatment modalities are anecdotal with very few studies available to satisfy any level of statistical significance as to the effectiveness of the treatments.

Those medications that show promise are limited in supply and rarely available in any significant quantity to the frontlines.

New York and Seattle are experiencing catastrophic scenarios as seen in Italy. California is only days away from experiencing a dramatic increase in cases despite the government's early sequestering and social distancing orders. As seen in Seattle and currently in New York, the number of cases could easily overwhelm regional healthcare systems.

COVID-19 is a highly contagious virus that for every person who is infected with the virus that person will also infect four other people. Unlike the influenza virus, where each person usually infects one other person, COVID-19 infections grow exponentially. Epidemiologist's refer to this as the R0 variable. This variable becomes important in public health preparedness. As seen in Italy, China, and Spain, the number of ill patients becomes exponential and can quickly overwhelm a nation's hospital system.

The best information that we have available comes from the providers on the front lines. In review of the most recently published articles, conversations with actual providers from New York City, Seattle, Louisiana, and information from the Centers for Disease Control (CDC) the medical community can forecast what the future "hotspots" will experience and as follows below.

First, we have learned that patients exposed to the virus usually are asymptomatic for 5 to 8 days during which time they are potentially exposing other people in the population.

Second, at around 8 to 11 days, patients will begin to experience mild to severe symptoms including Severe Acute Respiratory Syndrome otherwise known as SARS. At this point there is a rapid decline in the patient's ability to sustain adequate oxygenation without assistance from a ventilator. From the data that reviewed, these patients require on average 15 days of ventilatory support. With the exponential number of patients becoming severely ill and requiring ventilatory support for extended periods of time, this will limit the number of available ventilators for new patients.

Third, the medical community and scientists are scrambling to provide anecdotal treatment modalities and medications that are limited in their supply. For example, one of the treatment modalities for SARS is patient pronation during mechanical ventilation to allow for better lung tissue recruitment. Pronation beds are available but very limited in their supply. Hospitals are currently unable to obtain these beds given the limited supply and increased demand.

Fourth, Hydroxychloroquine and azithromycin are showing some promise in the treatment of COVID-19. Hospitals and healthcare systems are attempting to secure these medications in quantities ahead of immediate need, thus limiting the availability and depleting supply.

Fifth, Remdesivir, showed promise in treating COVID-19 patients but has recently been restricted by Gilead, the manufacture, to patients under 18 years of age and pregnant women.

Next, the medical community continues to provide dynamic and fluid treatment guidelines and modalities for COVID-19. These modalities are mostly anecdotal with limited data and research on their effectiveness. As these become available to the community, supply chains diminish rapidly.

Finally, the providers and hospital staff that care for these patients in great number utilize large numbers of personal protective equipment (PPE).

There is a common message that healthcare providers and public health officials in the hardest hit areas of the world continue to express. First, early social distancing and stay-at-home orders are on the top the list. Second, and equally important is hospital preparedness and availability of supplies including personal protective equipment (PPE) and ventilators. Next, is the need for a consensus on a hospital bioethics algorithm to allocate treatment to those patients that have a higher probability of survival.

Bioethical considerations in this pandemic remain an area of contention. Many providers and bioethicists are understandably struggling to come to a consensus as to allocation of services and equipment. For example, some patients on ventilators may not meet criteria to continue life support based on their comorbidities and likelihood of survival. The physicians are faced with making decisions on who lives and who dies based on available resources and demand. Aside from the ethical dilemma that is inherent in this process, there is a fear of the medical legal consequences. This can weigh heavily on the physicians that must make these decisions in the setting of a crisis. Therefore, it is imperative that each organization adopts a bioethics algorithm that clearly identifies patient inclusion and exclusion criteria to guide and protect physicians making these difficult decisions. It is noteworthy to mention that federal and state bioethics consensus guidelines have yet to be developed. The burden of making these decisions fall on the healthcare organizations and physicians, without guidance and legal protections from the government.

The PCO believes that the messages from the frontlines are very clear in that hospital preparedness and public health readiness plans will limit mortality. Therefore, the concentration of this report will assess the preparedness of the hospitals in the Verity health care system.

The PCO will apply research and personal expertise to develop monitoring strategies for the remaining hospitals.

The COVID-19 pandemic is constantly changing and requires daily assessment of supplies, personnel, bioethics strategies and hospital preparedness policies to protect patients and staff.

The PCO developed a standard review of COVID-19 hospital preparedness derived from multiple organizations, institutions, frontline medical providers and governmental authorities (See below Strategy Scope and Review). The PCO will monitor multiple facets of the hospital's preparedness guided by the most recent research and recommendations from the medical community and governmental agencies.

The PCO's review was guided by the following literature review.

1. Onder, G., Rezza, G., & Brusaferro, S. (2020). Case-Fatality Rate and Characteristics of Patients Dying in Relation to COVID-19 in Italy. *JAMA*. https://doi.org/10.1001/jama.2020.4683

   A review of Case fatality rates in the characteristics of patients who die in Italy from Covid 19. Recommendations for testing surveillance, defining Covid 19 related deaths, and recommendations for testing strategies to determine true mortality rates.

2. *ACEP // COVID-19 CME Collection (free)*. (n.d.). Retrieved April 3, 2020, from https://www.acep.org/corona/covid-19/covid-19-articles/covid-19-cme-collection-free/

   The bundle includes five lectures designed to help participants manage patients in the ED who present with symptoms related to COVID-19. It focuses on telemedicine; different types of ventilators, settings, and management of patients on ventilators; care of critical patients who require ICU care when the ICU is full; respiratory therapy and the pathophysiology and pharmacological management of acute decompensated heart failure.

3. *ACR Recommendations for the use of Chest Radiography and Computed Tomography (CT) for Suspected COVID-19 Infection | American College of Radiology*. (n.d.). Retrieved April 3, 2020, from https://www.acr.org/Advocacy-and-Economics/ACR-Position-

Statements/Recommendations-for-Chest-Radiography-and-CT-for-Suspected-COVID19-Infection

As COVID-19 spreads in the U.S., there is growing interest in the role and appropriateness of chest radiographs (CXR) and computed tomography (CT) for the screening, diagnosis and management of patients with suspected or known COVID-19 infection. Contributing to this interest are limited availability of viral testing kits to date, concern for test sensitivity from earlier reports in China, and the growing number of publications describing the CXR and CT appearance in the setting of known or suspected COVID-19 infection.

4. *AMA Code of Medical Ethics: Guidance in a pandemic*. (n.d.). American Medical Association. Retrieved April 3, 2020, from https://www.ama-assn.org/delivering-care/ethics/ama-code-medical-ethics-guidance-pandemic

The AMA *Code of Medical Ethics* offers foundational guidance for health care professionals and institutions responding to the COVID-19 pandemic. There are several reviewed Opinions from the AMA Code of Ethics that guide physician's response and obligation to the public during disasters.

5. *Announcing CHIME, A tool for COVID-19 capacity planning*. (n.d.). Retrieved April 3, 2020, from https://predictivehealthcare.pennmedicine.org/2020/03/14/accouncing-chime.html

As we prepare for the additional demands that the COVID-19 outbreak will place on our hospital system, our operational leaders need up-to-date projections of what additional resources will be required. Informed estimates of how many patients will need hospitalization, ICU beds, and mechanical ventilation over the coming days and weeks will be crucial inputs to readiness responses and mitigation strategies. To this end, the Predictive

Healthcare team at Penn Medicine has developed a tool that leverages SIR modeling to assist hospitals with capacity planning around COVID-19.

6. Association, A. M. (n.d.). *About Coronavirus Disease 2019 (COVID-19)—Information from JAMA Network, the CDC, and WHO*. Retrieved April 5, 2020, from https://jamanetwork.com/journals/jama/pages/coronavirus-alert

   Fifty articles are presented from JAMA network that includes COVID 19 treatment modalities, Hospital overburden, liability, and obligation of providers despite great physical harm. The contents of this website is extensive with quick reference reformation by leading physicians and scientists.

7. Bai, Y., Yao, L., Wei, T., Tian, F., Jin, D.-Y., Chen, L., & Wang, M. (2020). Presumed asymptomatic carrier transmission of COVID-19. *Jama*.

   A case study report on transmission of Covid 19 from asymptomatic patients. In addition to transmission data, the authors also speak about incubation periods, symptomology, and presentation to severity of illness.

8. CDC. (2020, February 11). *Coronavirus Disease 2019 (COVID-19)*. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

   Provides interim guidance to healthcare providers and hospitals with the most recent and current data. Guidance to testing availability, sensitivity and specificity, and elaboration on laboratory methodology currently in process to allow for further testing in greater numbers.

9. *COVID-19 Radiology-Specific Clinical Resources*. (n.d.). Retrieved April 3, 2020, from https://www.acr.org/Clinical-Resources/COVID-19-Radiology-Resources

The American College of Radiology is closely monitoring guidance from the Centers for Disease Control and Prevention (CDC), World Health Organization (WHO) and other reliable sources regarding the Coronavirus (COVID-19). ACR has collected the radiology-specific COVID-19 guidelines to assist hospitals and physicians in making radiological clinical decisions.

10. *COVID-19 Response Resources for Clinicians | Center to Advance Palliative Care*. (n.d.). Retrieved April 3, 2020, from https://www.capc.org/toolkits/covid-19-response-resources/

Center to Advanced Palliative Care offers a toolkit to providers with clear guidelines and bioethical considerations in response to the Covid 19 virus.

11. *Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2—National Academy of Medicine*. (n.d.). Retrieved April 3, 2020, from https://nam.edu/duty-to-plan-health-care-crisis-standards-of-care-and-novel-coronavirus-sars-cov-2/

Abstract: The novel coronavirus SARS-CoV-2 and resulting disease state COVID-19 pose a direct threat to an over-burdened U.S. medical care system and supporting supply chains for medications and materials. The principles of crisis standards of care (CSC) initially framed by the Institute of Medicine in 2009 ensure fair processes are in place to make clinically informed decisions about scarce resource allocation during an epidemic. This may include strategies such as preparing, conserving, substituting, adapting, re-using, and re-allocating resources. In this discussion paper for health care planners and clinicians, the authors discuss the application of CSC principles to clinical care, including personal protective equipment, critical care, and outpatient and emergency department capacity challenges posed by a coronavirus or other major epidemic or pandemic event. Health care facilities should be developing tiered, proactive strategies using the best available clinical information and building on their existing surge capacity plans to optimize resource use in the event the current outbreak spreads and creates severe resource

demands. Health care systems and providers must be prepared to obtain the most benefit from limited resources while mitigating harms to individuals, the health care system, and society.

12. *Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic*. (n.d.). The Hastings Center. Retrieved April 3, 2020, from https://www.thehastingscenter.org/ethicalframeworkcovid19/

An ethically sound framework for health care during public health emergencies must balance the patient-centered duty of care—the focus of clinical ethics under normal conditions—with public-focused duties to promote equality of persons and equity in distribution of risks and benefits in society—the focus of public health ethics. Because physicians, nurses, and other clinicians are trained to care for individuals, the shift from patient-centered practice to patient care guided by public health considerations creates great tension, especially for clinicians unaccustomed to working under emergency conditions with scarce resources. This document is designed for use within a health care institution's preparedness work, supplementing public health and clinical practice guidance on COVID-19. It aims to help structure ongoing discussion of significant, foreseeable ethical concerns arising under contingency levels of care and potentially crisis standards of care.

13. *Fair Allocation of Scarce Medical Resources in the Time of Covid-19 | NEJM*. (n.d.). Retrieved April 3, 2020, from https://www.nejm.org/doi/full/10.1056/NEJMsb2005114 Covid-19 is officially a pandemic. Although the ultimate course and impact of Covid-19 are uncertain, it is not merely possible but likely that the disease will produce enough severe illness to overwhelm health care infrastructure. Emerging viral pandemics can

overrun a hospital setting and healthcare system. Such demands will create the need to ration medical equipment interventions. Rationing of N95 masks may be most recent and earliest signs of rationing. High filtration N95 mass for healthcare workers are in high demand and are scarce. Healthcare workers are asked to reuse N95 mask when they are meant for single use only. As seen in Italy and South Korea bed shortages and ventilator supplies are rationed. Strategies and bioethical considerations for healthcare systems governments and hospitals need to be established early in the pandemic.

14. *Guidance Relating to Non-Discrimination in Medical Treatment for Novel Coronavirus 2019 (COVID-19)*. (2020). 2.

    Guidance relating to nondiscrimination medical treatment for novel coronavirus 2019. Statement from the governor of California regarding considerations in developing bioethical plans that do not include race, color, national origin, disability, age, sex, or religious affiliation.

15. *ICU Microcosm Within Disaster Medical Response*. (n.d.). Retrieved April 3, 2020, from http://sccmmedia.sccm.org/documents/LMS/ICU-Microcosm-within-Disaster-Medical-Response/story_html5.html

    The society of critical care medicine presents a video slideshow in preparation for medical response to disasters. Video slideshow covers all aspects of critical care, hospital response, and recommendations for handling disasters. Review of recent national disasters include Katrina hurricane and the lessons learned.

16. Lai, C.-C., Shih, T.-P., Ko, W.-C., Tang, H.-J., & Hsueh, P.-R. (2020). Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and corona virus disease-2019

(COVID-19): The epidemic and the challenges. *International Journal of Antimicrobial Agents*, 105924.

The emergence of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2; previously provision-ally named 2019 novel coronavirus or 2019-nCoV) disease (COVID-19) in China at the end of 2019 has caused a large global outbreak and is a major public health issue. It is spread by human-to-human transmission via droplets or direct contact, and infection has been estimated to have mean incubation period of 6.4 days and a basic reproduction number of 2.24–3.58. Currently, controlling infection to prevent the spread of SARS- CoV-2 is the primary intervention being used. However, public health authorities should keep monitoring the situation closely, as the more we can learn about this novel virus and its associated outbreak, the better we can respond.

17. *Office for Civil Rights-bulletin-3-28-20.pdf*. (n.d.). Retrieved April 5, 2020, from https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf

In light of the Public Health Emergency concerning the coronavirus disease 2019 (COVID-19), the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) is providing this bulletin to ensure that entities covered by civil rights authorities keep in mind their obligations under laws and regulations that prohibit discrimination on the basis of race, color, national origin, disability, age, sex, and exercise of conscience and religion in HHS-funded programs.

18. *Optimizing-ventilator-use-during-covid19-pandemic.pdf*. (n.d.). Retrieved April 3, 2020, from https://www.hhs.gov/sites/default/files/optimizing-ventilator-use-during-covid19-pandemic.pdf

Covid 19 outbreak is presenting unprecedented challenges to our healthcare system. According to best projections from the US Public health service commissioned Corps, combined with information on the ground, the availability of precious medical resources will be limited because of numbers of patients and the severity of illness. Among the most important resources will be mechanical ventilators and qualified professional to operate these devices. United States public health services commission core outlines measures to meet the growing demand.

19. Organization, W. H. (2020). *Coronavirus disease 2019 (COVID-19): Situation report, 67*.

World Health Organization presented several situational reports on Covid 19 virus which are reviewed in entirety.

20. *Pandemic Resources*. (n.d.). Retrieved April 3, 2020, from https://www.practicalbioethics.org/resources/pandemic-resources

Ethics in a Pandemic, presented by Carla Keirns, MD, PhD, is first in a series. Dr. Keirns' one-hour presentation covers the history of pandemics, how the 1918 influenza pandemic is influencing our response today, the difference between medical and ethics and public health ethics.

21. Powell, T., Christ, K. C., & Birkhead, G. S. (2008). Allocation of ventilators in a public health disaster. *Disaster Medicine and Public Health Preparedness*, *2*(1), 20–26. https://doi.org/10.1097/DMP.0b013e3181620794

New York State released the draft guidelines for public comment, allowing for revision to reflect both community values and medical innovation. This ventilator triage system represents a radical shift from ordinary standards of care, and may serve as a model for allocating other scarce resources in disasters.

22. *SCCM | ICU Preparedness Checklist*. (n.d.). Retrieved April 3, 2020, from https://sccm.org/Disaster/COVID-19-ICU-Preparedness-Checklist

Society of Critical Care Medicine offers an in-depth review of preparedness as well as offers a checklist that includes logistics and surge capacity, communication, critical care triage, protection of the ICU workforce, staffing capacity and essential equipment and management.

23. *State_COVID-19_Response.pdf*. (n.d.). Retrieved April 3, 2020, from https://www.ncsbn.org/State_COVID-19_Response.pdf

State-by-state review of disaster response.

24. *The Toughest Triage—Allocating Ventilators in a Pandemic | NEJM*. (n.d.). Retrieved April 3, 2020, from https://www.nejm.org/doi/full/10.1056/NEJMp2005689?query=recirc_curatedRelatedarticle

A review from the New England Journal of Medicine of the severe shortages of essential goods and services. They address the implications to withdrawing care, circumstances and considerations with allocating treatments with the understanding that with allocation also comes death.

25. Zhou, F., Yu, T., Du, R., Fan, G., Liu, Y., Liu, Z., Xiang, J., Wang, Y., Song, B., & Gu, X. (2020). Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: A retrospective cohort study. *The Lancet*.

In this retrospective, multicenter cohort study, we included all adult inpatients (≥18 years old) with laboratory-confirmed COVID-19 from Jinyintan Hospital and Wuhan Pulmonary Hospital (Wuhan, China) who had been discharged or had died by Jan 31, 2020. Demographic, clinical, treatment, and laboratory data, including serial samples for viral RNA detection, were extracted from electronic medical records and compared

between survivors and non-survivors. We used univariable and multivariable logistic regression methods to explore the risk factors associated with in-hospital death.

C. Strategy and Scope of Review

Based on the recommendations from exhaustive literature review, personal conversations with providers in Seattle, New York and Louisiana, the following specific items will be reviewed from each hospital.

1. General
    a. Federal and State Executive Orders
    b. Staffing
    c. Equipment availability
    d. Current census
    e. Available beds
    f. Available surge beds
    g. Available specialty units such as ICU

2. Disaster Preparedness
    a. Triage Tents
    b. Visitor policies
    c. Entrance closures
    d. Governmental agencies use of beds for surge patients

3. Supplies
    a. N95 masks
    b. Surgical Masks
    c. Gowns

d. Positive Pressure Helmets

e. Face Shields

f. Ventilators in use and available

4. Clinical Lab Testing Availability and Turn Around Time

5. Supply Chain availability

6. Employee Health

a. Number of Employees Positive

b. Number of Employees Calling Off

7. Emergency Department Readiness

a. Prepared for surge

b. Supplies

8. Pharmacy

a. Medications

b. Vasopressors

c. Sedatives

9. Morgue Capacity

10. Environmental Services

a. Staffing

b. Terminal Cleaning

D. Documents Reviewed in Data Room (One Drive) and at Debtors' Locations.

The data room documents were requested from Debtors and could only be reviewed in read only format. The following items will continue to be included in our evaluation process:

Disaster Plan specific to COVID-19

Bioethics Plan

Command Center Dashboard (Prepared Daily and reviewed bi-weekly)

- Current status of personnel
- Personal protective equipment (PPE)
- Disaster plan specific to COVID-19 Pandemic
- Bioethics plan
- Triage algorithm plan
- Census of persons under investigation (PUI) for COVID-19
- Total tested for COVID-19
- Total positive for COVID-19
- Bed availability
- Potential surge bed availability
- Ventilators available
- Ventilators in use
- Staffing Matrix
- Critical Medication Stock Available and Shortages

CALL PANEL

CDPH-California Department of Public Health reports

MEDICAL EXECUTIVE COMMITTEE (MEC)

PHARMACY SHORTAGE

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT COMMITTEE

MINUTES

RISK MANAGEMENT DATA

VENDORS

LEAPFROG DATA

IV. REVIEW OF DEBTORS BY INDIVIDUAL LOCATION

1. HOSPITALS

1. St. Vincent's Medical Center (SVMC) and Professional Office Building (POB)

A. SVMC Closure

SVMC Liver/Kidney/Pancreas Transplant Programs and the Hemodialysis Center have completely closed and successfully transferred all patients associated with these programs.

These patients were transferred to appropriate providers, transplant centers and hemodialysis centers. Dr. Naraga began performing transplant cases at St. Joseph Medical Center of Orange and is maintaining his satellite office at Good Samaritan Hospital. The transition of care has occurred smoothly without disruption to patient care or continuity.

SVMC, in its current state, will be rebooted as a COVID-19 surge hospital operated, financially supported and staffed by governmental agencies.

During this review period, the PCO learned, through direct contact with providers from outside facilities, that providers were having difficulties with accessing essential medical records from SVMC. The PCO notified SVMC administration regarding the community physicians concerns. In turn, the information technology staff rapidly corrected all technical difficulties. The PCO has not received any further concerns from the medical staff or outside facilities regarding medical record access difficulties.

After further review it appeared that the difficulty in accessing medical records was related to username and password access restrictions and provider performance deficits on appropriate safety measures and signing in from outside facilities. The medical record systems currently meet all federal Health Insurance Portability and Accountability Act regulations.

B. Professional Office Building

The Bankruptcy Court ordered that the POB be vacated by April 30th, 2020. The list of physicians affected by the closure of the POB on the SVMC campus was attached to the PCO's eighth report.

Despite the difficulty in finding other locations, most all the POB tenants have located other offices to provide patient care related services.

The PCO previously contacted some of the physicians on the POB vacancy list, and Dr. Girsky, former Chief of Staff of SVMC. The PCO continues to communicate with some of the physicians and other providers that are scheduled to vacate the POB to monitor continuity of patient care.

During this reporting period, the PCO was notified that most all the tenants of the POB found other localities to continue serving their patients and provide acceptable continuity of care. However, the current COVID-19 crisis is delaying the process of vacating the POB secondary to the shutdown of all nonessential businesses. Many of the tenants are unable to obtain permits for office build outs, remodels, and construction personnel to perform the build outs.

For example, the outpatient pharmacy owner contacted the PCO to inform him that the move to their new location will be delayed secondary to the inability to build out a security wall required by local building codes specific to outpatient pharmacies.

The outpatient pharmacy is a specialized pharmacy that serves approximately 3000 post-transplant patients by providing patients with antirejection medications. Forced closure of this pharmacy would have serious impact to thousands of post transplanted patients, some with irreversible consequences up to and including death. The PCO contacted Verity's CEO with his concerns and was notified that the organization is sensitive to the current COVID-19 pandemic restraints and will not force any tenant out or cause disruption in the necessary services provided by

the tenants. Other tenants are experiencing similar situations and were also offered the same consideration.

2. St. Francis Medical Center (SFMC)

SFMC administration and the PCO discussed the current operational status and CDPH events, administration verified that the current finances are not impacting patient care.

a. California Department of Public Health

The PCO identified two new CDPH self-reported items that were discussed with administration. The action plans and corrective actions are in place and sent to CDPH for review.

The PCO determined that the incidents were unrelated to staffing deficiencies or finances of the Debtors.

b. Trauma Certification

SFMC is an integral part of the Los Angeles Trauma System that is monitored and certified by Los Angeles Emergency Services and the American College of Surgeons (ACS). A recent survey in November 2019, was performed and according to the administration the trauma survey was successful and are waiting for the trauma certification from American College of Surgeons.

SFMC continues to provide trauma services and is certified by Los Angeles City Emergency Medical Services and serves as a designated trauma center.

c. Leapfrog Data and Ratings

SFMC Compass Data has not been updated during this PCO reporting cycle. However, as indicated in the PCO's sixth report, SFMC Leapfrog status increased from an F grade to a C grade. SFMC will continue to put forth initiatives that are expected to further improve the institutions Leapfrog grade.

Unfortunately, considerable amount of capital is needed to obtain high Leapfrog grades and to maintain the grades over time. For example, Computerized Physician Order Entry (CPOE), Bar

Code medication administration, Surgical Volume, and ICU Physician staffing require financial support to increase the Leapfrog scores.

SFMC administration believes that after the institution of an electronic medical records system, Leapfrog statistics will continue to rise. The PCO concurs.

3. Seton Medical Center and Seton Coastside

a. Administration Discussions

The PCO has met via videoconferencing on several occasions with administrative staff and personnel responsible for COVID-19 hospital preparedness. The PCO was updated on the critical elements of the COVID-19 disaster plan and the format of the command center worksheet.

The PCO also was contacted by the State Long Term Ombudsman's office regarding collaborative review of Seton Coastside.

The PCO and administration discussed several the CDPH reports, an update on the skilled nursing facility standard survey and any staffing related issues. The CDPH has received action plans that are acceptable.

The new CT scanner installation and construction plans remain with CAL-OSHA. CAL-OSHA has yet to approve the construction plans despite the potential impact to patient care and expense to the hospital system.

The mobile trailer CT scanner housed outside the emergency department and the CT scanner scheduled for replacement, remain operational and provide adequate care to the patients.

SMC continue to perform well on several quality metric indicators including computerized order entry and geometric length of stay.

The Hospitalist contracts were terminated on September 30st, 2019. According to administration, the Hospital Medicine service did not encounter any interruptions in patient care.

Most of the Hospitalist continue to provide services and remain on the medical staff. No other physician staffing changes were noted during this reporting cycle.

b. CDPH

The PCO reviewed all CDPH reports along with plan of correction details. It does not appear that the incidents were related to the finances associated with the bankruptcy.

c. CMS Findings

As reflected in the last PCO report, CMS has cleared the "*Immediate Jeopardy"* and is no longer under heightened CMS surveillance.

d. Leapfrog Data

SMC leapfrog grade increased to a B rating. Contributing to the increase in the Leapfrog grade is the close relationship with the Hospitalist team and their willingness to adhere to the CMO demands for CPOE compliance, among other factors.

SMC has the highest leapfrog rating in the healthcare system. Administration continues to accent and reinforce positive performance that led to the B rating.

e. Board of Pharmacy Survey

The Board of Pharmacy performed a survey on October 15, 2019. The survey found numerous deficiencies in the area of sterile medication compounding.

The board of pharmacy accepted the corrective action plan and is currently performing well without any further issues.

4. COVID-19 Preparedness Assessment SFMC and SMC

The PCO is in close communication with the debtor's management team and COVID-19 command center leaders. In addition, the PCO reviewed the daily "COVID-19" Command Center worksheet that mirrors many of the PCO's strategy algorithm. The PCO will receive at least bi-

weekly Command Center Worksheets from the SFMC and SMC and discuss with the Debtors' management team.

SFMC and SMC are abiding by all federal and state mandated executive orders and recommendations. The State of California has relaxed nursing staff ratio regulations in order to meet the needs of the community during the COVID -19 crisis.

The State of California has designated SMC as a COVID-19 patient surge hospital and has designated 176 beds for state use. SMC will continue operating and providing care to these patients utilizing their own resources and staff.

As of the date of this report, SFMC and SMC are closely monitoring bed capacity and report to the regional command center the number of occupied and open bed availability.

The PCO has reviewed and discussed the COVID-19 specific disaster preparedness and implementation strategies. SFMC and SMC have instituted a restrictive visitor policy that limits visitors from entering the hospital at any time. The restrictive visitor policy does make special compassionate concessions for brief family visits in the event a patient is expected to die.

SFMC and SMC have instituted restrictive access to the hospital by closely monitoring all points of entry into the hospital. Screening stations are in place at each hospital entry point. Body temperatures and basic demographics are performed on everyone who enters the facility. The emergency departments also have a designated traffic plan for all persons entering the emergency department to limit possible exposure to the staff and public.

Availability of hospital supplies is an area of national concern. As evidenced by reports from the frontline, PPE, ventilators, N95 masks, face shields, gowns and protective positive pressure helmets are in short supply and difficult to obtain quickly from hospital supply chains. The PCO verified that SFMC and SMC are tracking critical supplies needed to protect staff and care for

COVID-19 patients. Administration is identifying alternate supply chain resources to keep critical supplies stocked.

SFMC and SMC pay special attention to availability of ventilators and track the current usage and available ventilators daily. The facilities have mechanisms that trigger alerts when ventilator units are low and implement strategies to obtain emergency units.

If ventilator supply chains are unable to meet the needs of the facilities, the organizations will be forced to implement their Bioethics algorithm.

Both SFMC and SMC utilize Cepheid laboratories methodology of COVID-19 testing with turnaround times of 45 minutes. This methodology and rapid turnaround time quickly identify COVID-19 positive and COVID-19 negative patients effectively eliminating persons under investigation and therefore fast-tracks treatment or discharge.

The command center worksheets also track employee health and staffing. The organization is monitoring the number of employees that are positive for COVID-19 employees and all those that have been tested.

Emergency Department readiness strategies are currently conducted at both facilities. The emergency departments are preparing for COVID-19 surge patients with clear policies in place to address the crisis. Administration assured the PCO that appropriate PPE and supplies are currently adequate.

One of the critical concerns nationally is the availability of appropriate medications to care for COVID-19 patients (these patients are similar in their presentation and needs for critical medications worldwide). The organization tracks and maintains daily records of critical medications needed to manage these patients. The list is updated daily with triggers that identify low stocks of medications.

The PCO reviewed and discussed the pharmacy medication availability with administrative staff of both hospitals and is confident that stockpiles of medications are adequate to support the hospitals for at least one week.

As we have seen in Seattle and New York City, deficient morgue capacity is an unfortunate reality that hospitals must prepare for. SMC and SFMC are working on plans and solutions in case mass mortality is experienced in each region.

Environmental services are considered a critical service in defending against COVID-19 virus spread. We have learned that the COVID-19 virus can survive for up to 36 hours on cardboard, plastics, and stainless steel, the stuff of which hospitals are made.

Terminal cleaning policies, cleaning solutions, cleaning supplies and training are critical in containing the spread of the virus. The PCO was notified by administration that the appropriate steps were taken to train environmental services personnel and that the supplies are available for use.

V. NINTH REPORT CONCLUSIONS

The PCO continues to monitor the progress of those displaced by the SVMC closure, and the remaining hospitals: SFMC, Seton and Seton Coastside.

The non COVID-19 virus patient admissions are small. Local medical providers have worked to limit non-essential admissions. All elective surgeries and admissions were stopped on advice and direction from federal, state and local governments.

CDPH visits were reviewed. The hospitals are following their agreements, are self-regulating, and the PCO can confirm that they are in compliance. The State Long Term Care Ombudsman was contacted and there are no issues.

SVMC and The Professional Office Building

The PCO was informed that government agencies are taking over SVMC via a lease agreement, and that the Debtors will be acting as landlord. As such, the PCO believes that the various governmental agencies will be safely regulating the hospital and will not be under the control of the Debtors, and, thus, the PCO will not be required to monitor patient care at SVMC. The former CEO, Margaret Pfeiffer, is bringing the hospital back online. The Debtors are making all efforts to reopen the hospital in anticipation of a patient surge.

The PCO was informed by tenants of the professional office building that they were unable to relocate under the previous established timetable, despite having new office leases signed and construction in progress. The delays were due to city Building and Safety office closure, along with related construction delays.

The pharmacy in the POB cannot comply with the timeline and is the only pharmacy that supplies the nearly 3000 transplant patients with lifesaving antirejection medications. After a call to the Debtors, the Debtors immediately extended the deadline for vacating the POB.

COVID-19

At Seton, the Debtors report that they have entered into a fixed price contract with the State of California to provide patient surge coverage using approximately 176 Seton hospital beds. Seton is currently implementing its obligations under the contract.

At SFMC, the Debtors are self-funding their needs and are likewise preparing for a COVID-19 patient surge.

The Debtors' adequacy of supplies and personnel to meet their current and anticipated demands at this facility are being followed at least twice weekly, and ad hoc, as issues arrive.

The hospitals were fortunate to have a pre-existing contract with Cepheid, and, thus, they are able to accomplish 45-minute COVID-19 turnaround times. This allows patients to go directly to COVID-19 positive wards from the emergency department. Negative patients are then safely placed in COVID-19 negative wards.

BIOETHICS

Triage may be required to allocate resources and ventilators if the surge is overwhelming. Bioethics guidelines are currently not available from government agencies. As of this writing, the Debtors are planning on following the Torrance Memorial Hospital guidelines until they establish their own guidelines or get direction from the state or federal government. The Torrance guidelines were reviewed and do comport with state nondiscrimination requirements and ethical considerations raised by many authors. Factors including comorbidities, likelihood of survival, modified Sequential Organ Failure Assessment (MSOFA), life expectancy; and not disability or age alone; are all taken into account. Fortunately, no ethical emotionally or distressing choices have had to be made. All agree that the decision should not be made by the treating physician, as the physician's only obligation should be the protection of the single patient at hand.

The PCO will continue to follow guidelines, implementation, and the allocation of resources.

Debtors' Finances and Patient Care

SFMC is self-funded. Seton is partially funded by the State of California. Despite this differential funding, the Debtors are providing state of the art care, and meeting the standard of care at both hospitals, and with no discernible differences between the hospitals.

The Debtors, their officers, providers, and personnel are working tirelessly to care for their communities in these troubling times.

Dated this 6th day of April, 2020

Jacob Nathan Rubin, MD, FACC, Patient Care Ombudsman

PROOF OF SERVICE OF DOCUMENT

I am over the age of 18 and not a party to this bankruptcy case or adversary proceeding. My business address is:

10250 Constellation Blvd., Suite 1700, Los Angeles, CA 90067

A true and correct copy of the foregoing document entitled (*specify*) **SUBMISSION OF NINTH REPORT BY PATIENT CARE OMBUDSMAN, JACOB NATHAN RUBIN, MD, FACC, PURSUANT TO 11 U.S.C. §** 333(b)(2) will be served or was served **(a)** on the judge in chambers in the form and manner required by LBR 5005-2(d); and **(b)** in the manner stated below:

1. **TO BE SERVED BY THE COURT VIA NOTICE OF ELECTRONIC FILING (NEF)**: Pursuant to controlling General Orders and LBR, the foregoing document will be served by the court via NEF and hyperlink to the document. On (*date*) April 6, 2020, I checked the CM/ECF docket for this bankruptcy case or adversary proceeding and determined that the following persons are on the Electronic Mail Notice List to receive NEF transmission at the email addresses stated below:

☒ Service information continued on attached page

2. SERVED BY UNITED STATES MAIL:
On April 6, 2020, I served the following persons and/or entities at the last known addresses in this bankruptcy case or adversary proceeding by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows. Listing the judge here constitutes a declaration that mailing to the judge will be completed no later than 24 hours after the document is filed.

☐ Service information continued on attached page

3. SERVED BY PERSONAL DELIVERY, OVERNIGHT MAIL, FACSIMILE TRANSMISSION OR EMAIL (state method for each person or entity served): Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on April 6, 2020, I served the following persons and/or entities by personal delivery, overnight mail service, or (for those who consented in writing to such service method), by facsimile transmission and/or email as follows. Listing the judge here constitutes a declaration that personal delivery on, or overnight mail to, the judge will be completed no later than 24 hours after the document is filed.

☐ Service information continued on attached page

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

April 6, 2020	Jason Klassi	/s/ Jason Klassi
Date	*Printed Name*	*Signature*

2:18-bk-20151-ER Notice will be electronically mailed to:

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