AHRMNY
The Association for Healthcare Risk Management of New York, Inc.

PROGRAM DETAILS AND HANDOUTS

Day 1 - Thursday, October 24th | 6:00 - 8:00 PM

Join us in the East Veranda for our networking reception.
Cocktails and lite bites will be served.

Day 2 - Friday, October 25th | 8:00 AM - 4:00 PM

The full-day conference will be held at in the Main Ballroom with breakout sessions in the Kingfisher Room. Breakfast, lunch, and light snacks will be provided throughout the day.

This packet contains handouts provided in advance by our guest speakers.

- TAB 1 Program Flyer
- TAB 2 Speaker Bios
- TAB 3 Registration List
- TAB 4 HANDOUT - Unlocking the Power of Data in Safety & Risk Management
  - Lori Paine & Eileen Kasda
- TAB 5 HANDOUT - Using the Equity Lens and Root Cause Analysis for Better Health Equity Outcomes
  - Andrea Crawford & Louise Derevlany
- TAB 6 HANDOUT - Contracts ... What Risk Managers Need to Know
  - Gina Kittek & Heather Miller
- TAB 7 HANDOUT - Mitigating Future Economic Damages in Catastrophic Injury Cases
  - Samantha Quinn, Steph Campbell & Diana Free
- TAB 8 HANDOUT - What Tool is Best: RCA, ACA, or FMEA
  - Kathleen Shostek & Anne Huben-Kearney
- TAB 9 HANDOUT - Protected Health Information: Cyber Security & Data Privacy Risk Management
  - Katelyn Cummings, Jacki Goralczyk, Carla Silva
- TAB 10 HANDOUT - Labor Pains: Addressing Obstetrical Challenges in New York
  - Christa Christakis, Adriann Combs, Dr. Victor Klein, Brittany Salmon & Joyce McCormack

Continuing Education Credits:

4.5 Risk Management Credits have been approved by the American Society for Health Care Risk Management (ASHRM). Certificates will be distributed within 2 weeks after the program.

This program is also being reviewed by the New York State CLE Board for Continuing Legal Education Credits. Upon approval, certificates will be distributed to all attending attorneys.

TAB 1

AHRMNY

The Association for Healthcare Risk Management of New York, Inc.

2024 Upstate New York Conference & Reception

October 24-25

The Otesaga Resort | Cooperstown, NY



KEYNOTE SPEAKER
John T. McDonald, III
New York State Assembly Member

Back by popular demand, The Association for Healthcare Risk Management of New York, Inc. is pleased to host another conference in Upstate New York.

- *Keynote Address*
- *Power of Data in Safety & Risk Management*
- *RCA, ACA or FMEA - What tool is best?*
- *Economic Damages in Catastrophic Injury Cases*
- *Obstetrical Challenges in Rural New York*
- *Contracts in Risk Management*
- *Peer Support*
- *Root Cause Analysis*
- *PHI: Cyber Security & Data Privacy Risk Mgt*
- *NY's Liability Environment*

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The Otesaga Resort and Hotel, 60 Lake Street, Cooperstown, NY 13326

Questions - Contact ahrmny@gmail.com

REGISTER HERE

Conference and Registration Details

Thursday, October 24

6:00 PM - 8:00 PM **NETWORKING COCKTAIL RECEPTION**

Attend this preconference networking event with colleagues. Cocktails and light refeshments will be served.

Location: East Veranda - A lovely covered outside space with a connecting inside room

Friday, October 25

8:00 AM - 4:00 PM **EDUCATIONAL PROGRAM**

Attend the full-day conference featuring Keynote Speaker, Assemblymember John T. McDonald III, who will speak to nuances of the Legislative process, the workings and priorities of the Committee on Health and the Committee on Alcoholism & Drug Abuse and his sponsorship and support of healthcare and Risk Management related legislation, including a Bill to "fix" Siegel v. Snyder that will explicitly protect confidentiality of statements made in QA proceedings even if the speaker is unknown. Assemblymember McDonald's speech will be from 9:00-9:30 am.

We will also feature several breakout sessions featuring topics on Data in Safety and Risk Management, Root Cause Analysis in Health Equity Outcomes, Peer Support, New York's Liability Environment, Contracts in Risk Management, Economic Damages in Catastrophic Injury Cases, Best Tool-RCA, ACA, or FMEA, and Cyber Security Panel, and a final plenary session discussing OB Challenges in Rural New York.

REGISTRATION & LODGING

TICKET FEES

$150 Current AHRMNY Member
$200 Nonmember
$175 Membership / Conference Bundle
Nonmember attendees may wish to take advantage of this bundle package.
Sign up for a one-year membership and receive discount on conference fee.

LODGING - DISCOUNTED PRICED ROOMS AVAILABLE AT THE OTESAGA RESORT THROUGH SEPT 9TH

King Room - $239 (not including tax and fees)

Link to reserve room will be provided after registering for the conference.

Click here for registration, lodging, and travel details

Read about AHRMNY's Financial Aid Policy Here

CONTINUING EDUCATION CREDITS

Continuing education credits for this program is pending review by the American Society for Healthcare Risk Management for CEUs toward the designations of CPHRM, DFASHRM, and FASHRM and the New York State Continuing Legal Education Board for CLE credits

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Meet Our Guest Speakers - Click here to view bios

9:00-9:30 - KEYNOTE ADDRESS



John T. McDonald III, RPh
Assembly Member - District 108
New York State Assembly

9:45-10:35 - MORNING BREAKOUT SESSION



Lori Paine, DrPh, MS, RN
VP, Patient Safety Officer
Quality & Safety Institute
Rochester Regional Health



Eileen Kasda, DrPh, MHS
VP, Patient Safety
Safetower



Andrea Crawford, Esq., CPHRM
AED, Risk Management
NYC H+H / Queens



Louise Derevlany, Esq.
AED, Risk Management
NYC H+H / Elmhurst

10:45-11:35 - MID-MORNING BREAKOUT SESSION



Ann Y. Teng, DO, MPH, FACOEM
Chief Wellness Officer & Medical Director
United Health Services, Inc.



Kayla Velie
Manager Medical Command Center
United Health Services, Inc.



Tom Stebbins
Executive Director
Lawsuit Reform Alliance of New York (LRANY)

12:55-1:45 - AFTERNOON BREAKOUT SESSION #1



Gina Kittek, MJ, CPHRM
System Director, Risk Management & Corp Compliance
United Health Services, Inc.



Heather Miller, JD
Sr. Associate General Counsel
UHS Binghamton General Hospital



Samantha E. Quinn, Esq.
Appellate Partner
Schiavetti, Corgan, DiEdwards, Weinberg & Nicholson, LLP



Steph Campbell, Esq.
Partner
Schiavetti, Corgan, DiEdwards, Weinberg & Nicholson, LLP



Diana Free, BSN, CLCP, CPHRM
Managing Partner
Clearview Partners Consulting LLC

1:55-2:45- AFTERNOON BREAKOUT SESSION #2



Kathleen Shostek, RN, ARM, MBA, DFASHRM, CPHRM, CPPS
Healthcare Loss Control Expert
Munich Re Specialty-NA



Anne Huben-Kearney, BSN, MPA, CPHQ, CPHRM, CPPS, DFASHRM
Risk & Patient Safety Consultant



Jacqueline Goralczyk, Esq.
Partner
Pierson Ferdinand



Katelyn Cummings
Vice President, Northeast Zone, Cyber Practice
Marsh



Carla Silva
Director, Professional Liability
Sedgwick Claims Management Services

3:00-3:50 - PLENARY SESSION



Joyce McCormack, RN, BSN, CPHRM
Senior Risk Management Consultant
MLMIC Services, Inc.



Victor R. Klein MD, MBA, FACOG, FACMG
System Director, Quality & Patient Safety
OB/GYN Service Line
Northwell Health



Adriann J. Combs, DNP, NNP-BC
Clinical Director, Associate System Director of Quality & Patient Safety, OB/GYN
Northwell Health



Christa Christakis
Executive Director
American College of Obstetricians and Gynecologists, District II
.



Brittany Salmon, RN
OB Nurse Manager
Lewis County Health System
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Program Agenda

8:00-8:30 **Registration and Breakfast**

8:30-8:40 **Welcome and Announcements**

- *Wilhemina Nyarko, President-elect & Education Chair*

8:40-9:00 **Sponsor and Exhibitor Introductions**

9:00-9:30 **KEYNOTE ADDRESS**

- *John T. McDonald III, RPh*

9:30-9:45 **Break and Transition to Morning Breakout Session**

9:45-10:35 **MORNING BREAKOUT SESSIONS**

A) Unlocking the Power of Data in Safety and Risk Management

- *Lori Paine and Eileen Kasda*

B) Using The Equity Lens and Root Cause Analysis for Better Health Equity Outcomes

- *Andrea Crawford and* Louise Deravlany

10:35-10:45 **Break and Transition to Mid-Morning Breakout Session**

10:45-11:35 **MID-MORNING BREAKOUT SESSIONS**

A) Peer Support: Supporting our Staff During Difficult Events

- *Dr. Ann Teng and Kayla Velie*

B) New York's Liability Environment and How to Fix it

- *Tom Stebbins*

11:35-12:35 **LUNCH BREAK AND VISIT EXHIBITOR TABLES**

12:35-12:45 **ASHRM UPDATE**

12:45-12:55 **Break and Transition to Afternoon Breakout Session #1**

12:55-1:45 **AFTERNOON BREAKOUT SESSIONS #1**

A) Contracts...What Risk Managers Need to Know

- *Gina Kittek and Heather Miller*

B) Mitigating Future Economic Damages in Catastrophic Injury Cases

- *Samantha Quinn, Steph Campbell, and Diana Free*

1:45-1:55 **Break and Transition to Afternoon Breakout Session #2**

1:55-2:45 **AFTERNOON BREAKOUT SESSIONS #2**

A) What Tool is Best: RCA, ACA, or FMEA

- *Kathleen Shostek and Anne Huben-Kearney*

B) Protected Health Information: Cyber Security & Data Privacy Risk Management

- *Katelyn Cummings, Jacqueline Goralczyk, and Carla Silva*

2:45-3:00 **Break and Transition to Main Conference Room**

3:00-3:50 **PLENARY SESSION**

Addressing Obstetrical Challenges in Rural New York

Joyce McCormack, Dr. Victor Klein, Adriann Combs, Christa Christakis, and Brittany Salmon

3:50-4:00 **Wrap up and Closing Remarks**

TAB 2

Assemblymember John T. McDonald III

John T. McDonald III, RPh has served in the New York State Assembly representing the 108th Assembly District since 2013, which consists of parts of Albany, Rensselaer, and Saratoga counties, including the City of Cohoes, his hometown where he previously served as Mayor for 13 years, and the communities of Green Island, North Greenbush, East Greenbush, Rensselaer, Waterford, and the cities of Troy and Watervliet.

A life-long resident of Cohoes, John is a graduate of Keveny Memorial Academy and the Albany College of Pharmacy where he received a BS in Pharmaceutical Sciences in 1985 and was awarded an Honorary Doctorate of Humanities. John is a practicing pharmacist and an experienced small businessman as the previous owner of Marra's Pharmacy, his family business now celebrating 92 years in downtown Cohoes and serving the Capital Region.

As Mayor of the City of Cohoes, John focused on financial accountability, improving quality of life, and expanding economic opportunity. He pursued an aggressive economic development agenda centered on downtown revitalization, adaptive reuse of historic buildings, Hudson and Mohawk Riverfront developments, and gateway improvements. John created a platform for a more transparent and open process for conducting city business, which increased the city's financial stability when he left office in 2012. Just as importantly during John's tenure, the City of Cohoes' population grew by more than 8% which was the first population increase for the City of Cohoes since 1930.

John has also been an active member of the New York State Conference of Mayors where he previously served as President of the statewide organization. He has also chaired the Capital District Transportation Committee, RiverSpark, the Cohoes Industrial Development Agency and the Cohoes Local Development Corporation. John has served on the boards of the New York State Heritage Areas Advisory Board, New York State Workforce Investment Board, State Comptroller's Local Advisory Team, the NYS Local Government Records Management Council and the Board of Governors for the New York State Municipal Insurance Reciprocal, and many other regional councils and commissions. John currently serves on the board of the Albany Convention Center Authority and is a member of the NYS Department of Financial Services Drug Accountability Board. John serves as an Executive Committee member for the National Conference of State Legislatures (NCSL).

As a member of the NYS Assembly, John serves as the Chair of the Governmental Operations Committee. John is a member of the following NYS Assembly Committees: Alcoholism & Drug Abuse, Health, Higher Education, and Ways and Means. John focuses on his strengths in local government, health care, and small business. John has sponsored and passed legislation into law to reduce unfunded mandates to local governments, control the cost of property taxes, support job growth and workforce development, strengthen access to health care, and address the opioid crisis.

Lori Paine, DrPH, MS, RN

Lori Paine currently serves as the Vice President and Patient Safety Officer for Rochester Regional Health. She provides strategic and tactical oversight for the Patient Safety, Clinical Risk Management and Patient Experience. She was the former Senior Director of Patient Safety for the Armstrong Institute for Patient Safety and Quality and The Johns Hopkins Hospital. She has spoken to audiences and consulted with hospitals nationally and internationally on the science of safety, high reliability, event reporting, safety culture, CUSP, and patient and family involvement in safety. She is an adjunct faculty member at the Johns Hopkins University School of Nursing and associate faculty member at the Johns Hopkins Bloomberg School of Public Health. She is a former Labor and Delivery nurse, holds a Bachelor's Degree in Nursing, a Master's degree in Applied Behavioral Science and Change Management and a Doctorate of Public Health.

Eileen Kasda, DrPH, MHS

Eileen Kasda, is a Cofounder, Inventor, and Vice President of Patient Safety for SafeTower, helping to improve safety practices and design analytic solutions for the healthcare. Eileen is the former Director of Patient Safety for Johns Hopkins Health System. She is passionate about applying the science of safety from high-risk industries to the structures and processes to make improvements in patient safety. Eileen led the development of Johns Hopkins event reporting software and supported the structures and processes in which it was used. She is familiar with the challenges of collecting and analyzing data across the continuum of care. She has presented nationally and internationally, speaking about how data can be used to improve culture and design better systems. She has a Masters of Health Science in Health Finance and Management and a Doctorate of Public Health in Healthcare Management and Leadership from Johns Hopkins Bloomberg School of Public Health.

Andrea Crawford, Esq., CPHRM

Andrea Crawford has 30 years experience in healthcare defense. Her career began with Heidell, Pittoni Murphy & Bach where she rose to the level of Senior Associate. Andrea Joined NYC Corporation Counsel in the Medical Malpractice Division in 2004 which was then transferred directly to NYC Health+Hospitals Claims and Litigation in 2007. Andrea served in Claims and Litigation Division of the Office of Legal affairs, first as a litigator and then negotiated settlements in Kings and Queens Counties. Since 2015 Andrea, has served as Associate Executive Director Risk Management for NYCH+H/Queens.

Louise Derevlany, Esq.

Louise Derevlany has 40 years experience in healthcare defense at Heidell, Pitonni, Murphy & Bach where she was a Senior Partner for 30 years. As an esteemed trial Attorney, Louise represented many of the most premier health care systems in New York City, including NYC Health+Hospitals. Louise joined NYCH+H/Elmhurst in the role of Associate Executive Director Risk Management in 2013.

Ann Y. Teng, DO, MPH, FACOEM

Dr. Ann Teng holds many positions within the United Health Services system. As the Chief Wellness Officer, she prioritizes the holistic well-being of the healthcare system's team. Simultaneously, she serves as the Medical Director of the Medical Command Center and the Medical Director of Occupational Medicine and Employee Health Department. Before her medical career, Dr. Teng spent 14 years in EMS and Fire services, earning recognition as the EMS leader of the year in Suffolk County, NY in 2003. Her emergency services background laid the foundation for her current roles. She has taken the values of innovation, scarcity, and her understanding of disaster management to building collaborative teams to respond to the COVID-19 pandemic. She attributes many of her successes today with her ability to take on multiple perspectives, but at the same time keeping mission focused. Dr. Teng enjoys being a lifelong learner. She holds a MPH from Yale University School of Public Health, an MBA on Organizational Leadership from Eastern University, a MALS concentration on Society and Medicine from Stony Brook University, and her Doctor of Osteopathy from New York College of Osteopathic medicine. She completed her Family Residency in UHS and her fellowship in Occupational and Environmental Medicine at Yale, where she also served as Chief Fellow. Today, she holds board certification in Family Medicine, Preventative- Occupational Medicine, and Obesity medicine, demonstrating her commitment to patient care and ongoing professional growth.

Kayla Velie

Kayla Velie has worked in a health and wellness related field for many years. She has been with UHS for over a decade. Kayla is a progressive leader in the areas of employee wellness. She leads the team in the UHS Medical Command Center and serves as chair of the Employee Wellness Committee. She is also responsible for coordinating the UHS Peer Support Debrief teams. She received her Bachelor's Degree in Psychology from SUNY Binghamton in December of 2009. From there, she went on to pursue her Master's Degree in Exercise Science with a concentration in Sport and Exercise Psychology from Ithaca College. Kayla most recently became a Certified Health Coach through the American Council on Exercise and is currently pursuing a certification for Personal Training. Kayla enjoys spending time with her family and has three young daughters who keep her very busy at home.

Tom Stebbins

Prior to joining LRANY in 2011, Tom was a project manager for Horizon Wind Energy, where he developed multiple commercial-scale wind farms in New York and the Northeast United States. Earlier in his career, Tom worked for PBS flagship station WGBH-TV, where he coordinated the national marketing and promotion efforts for programs such as NOVA, Masterpiece Theatre, and Antiques Roadshow.

Tom has been published or quoted in over one hundred publications, including The New York Times, NY Daily News, the Wall Street Journal, and The Economist, and Tom has been interviewed on numerous broadcast radio and TV shows, including NPR, Fox News, and 1010 WINS. He is also a sought-after speaker who has spoken to dozens of organizations across New York -- from Buffalo to Brooklyn, from Rotaries to multi-national business conferences.

Tom is currently on the advisory board of the Progressive Policy Institute and is a previous board member of the Empire State Society of Association Executives.

In his spare time, Tom is an accomplished benefit auctioneer, emcee, and fundraiser who has helped raise millions of dollars for charities all over the world. Tom is personally devoted to the issue of head injury and has worked with his family to build four homes dedicated to the care of people affected by head injuries. Tom has a bachelor's degree from Vassar College and an MBA from Cornell University.

Gina Kittek, MJ, CPHRM

Gina (Overpeck) Kittek, MJ, CPHRM has over 25 years of experience in the health care industry. She is an experienced health care risk manager managing corporate risk management functions. As the System Director of Risk Management and Corporate Compliance, Gina currently manages the risk management program and the corporate compliance functions. She manages the corporate insurance portfolio for the system including a captive insurance company, Southern New York Indemnity Co., LLC, a single parent captive writing professional and general liability coverage. She provides oversight to the management of all claims and litigation for all lines of coverage. Gina is a member of the American Society of Health Care Risk Management (ASHRM) and maintains her Certified Professional Healthcare Risk Management (CPHRM). She continues to serve on committees and task forces of ASHRM. She is also a Member of the Association for Healthcare Risk Management of New York.

Heather Miller, JD

Heather Miller has extensive legal experience, serving as Senior Associate General Counsel at United Health Services. Prior to that, Heather worked as an Assistant General Counsel at Hinman, Howard & Kattell, LLP and as an Associate Attorney at Jones Day. Heather also has a background in education, having taught at The Marvelwood School. Heather holds a JD from Syracuse University College of Law and a Bachelor's degree in History/Government from Clark University.

Samantha E. Quinn, Esq.

Samantha E. Quinn is a partner with the firm of Schiavetti, Corgan, DiEdwards, Weinberg & Nicholson, LLP, which specializes in the defense of hospitals, doctors and other health care providers. She heads the office's appellate practice, and has briefed and argued numerous appeals. She has also had significant success overturning unsuccessful verdicts, including dismissal of several multi-million dollar verdicts later upheld on appeal. Ms. Quinn has handled OPMC investigations for individual physicians, treatment over objection applications for hospital clients and has counseled hospital clients during the course of DOH investigations and other quality assurance matters. Ms. Quinn has a Bachelor of Arts with Honors in History from Brown University and a Juris Doctor from Boston College Law School, and has been a contributing author to the AHRMNY Journal since 2007.

Stephanie Campbell, Esq.

Stephanie Campbell is a partner at Schiavetti, Corgan, DiEdwards, Weinberg & Nicholson, LLP where she defends hospitals, health systems and individual practitioners in complex medical malpractice and general liability claims. In defense of hospitals and practitioners, she frequently drafts and argues complex motions and appeals before the Supreme and Appellate Courts of the State of New York. She is also licensed to practice law in Connecticut. Stephanie received a Bachelor of Science degree with a major in biology from Arizona State University, and following that, obtained her law degree from Pace Law School with a focus in environmental and animal law. She became a member of ASHRM and AHRMNY in 2018 and has attended several ASHRM conferences. She currently serves as Secretary of AHRMNY and is also Co-Chair of the AHRMNY Publications Committee.

Diana Free, BSN, CLCP, CPRHM

Diana Free is a founding partner of Clearview Partners Consulting, LLC, specializing in forensic life care planning and medical billing analysis. Life care planning is a multidisciplinary process that evaluates individuals with disability or chronic health conditions to outline the needs created by the disability. The life care planner develops a plan that includes required items and services, along with specific costs. Forensic life care planning involves performing evaluations for civil and federal litigation purposes as an aspect of economic damages. Clearview Partners Consulting, LLC assists attorneys across the country in estimating costs of projected healthcare economic damages for individuals involved in litigation. Before developing Clearview Partners Consulting, LLC, Ms. Free spent over 30 years in leadership roles in healthcare risk management, healthcare quality and patient safety, patient complaint and grievance process, and healthcare compliance. These prior career experiences and national certification in life care planning have equipped Ms. Free with a unique background for working in forensic life care planning.

Kathleen Shostek RN, ARM, MBA, DFASHRM, CPHRM, CPPS

Kathy Shostek is the Healthcare Loss Control Expert for Munich Re Specialty - North America where she supports the Excess & Surplus Healthcare portfolio and provides risk management and patient/resident safety expertise to clients and insureds. She is an industry recognized risk professional experienced in applying risk reduction techniques and innovative approaches to improve patient safety and reduce liability risks. Kathy's experience is extensive and includes leadership at the acute care level and a corporate multispecialty physician group practice. Kathy was a lead contributor to ASRHM's Patient Safety Playbook and FMEA Playbook, and past chair of ASHRM's Patient Safety Task Force. She serves as faculty for ASHRM's Patient Safety Certificate course and is a past board member of ASHRM. She has served as risk consultant and developer for ECRI's publications. ASHRM has awarded Kathy the Distinguished Service Award for her career contributions to healthcare risk management and patient safety.

Anne Huben-Kearney, BSN, MPA, CPHQ, CPHRM, CPPS, DFASHRM

Anne Huben-Kearney, a Certified Professional in Healthcare Quality, Healthcare Risk Management, and Patient Safety, is currently a Risk and Patient Safety Consultant providing independent consultation for health care organizations and providers, including psychiatry and psychology professionals. Anne has extensive clinical, managerial, and administrative experience, including tertiary care institutions, academic community hospitals, physician office practices and as a risk management consultant for medical professional liability insurance companies. She is a Distinguished Fellow in the American Society for Healthcare Risk Management (DFASHRM), serves on the ASHRM Faculty for the Patient Safety Certificate Program, and was elected to the ASHRM Board for 2020-2022. Anne was editor of the ASHRM Failure Mode and Effect Analysis Playbook (2022) and co-author of the AHA/ASHRM White Paper series on Recognizing and Addressing Implicit Bias - in the Ambulatory Care Setting (2021), - in the Inpatient and Long Term Care Setting (2023) and - in Digital Health (pending publication).

Katelyn Cummings

Katelyn Cummings is a Vice President in the Northeast Zone for Marsh's National Errors and Omissions (E&O)/Cyber Practice. Katelyn has been a part of the Marsh since Fall of 2021 leading renewals for large risk management clients including hospitals and various healthcare organizations. Prior to this, for years Katelyn was an Underwriter with a commercial insurance firm where she headed a large book of business for National E&O/Cyber accounts. Katelyn also has some experience with property underwriting and actuarial science. Katelyn has a Bachelor of Science in actuarial science.

Jacqueline (Jacki) Goralczyk , Esq.

Jacki acts as data breach counsel for organizations across all industries. Jacki serves as a trusted advisor to businesses, helping them navigate the complexities of cyber incidents from initial intrusion through notification and recovery. She works hand in hand with organizations of all sizes to improve data security both pre incident and post recovery to help minimize risk and improve recovery outcomes. Her experience in incident response has made her an asset to Mergers and Acquisitions teams, helping them spot potential cybersecurity and data privacy risks both prior to sale and as part of acquisition due diligence.

She works with incident response vendors including IT, forensics, e-discovery, internal and external counsel, public relations and breach notification vendors to guide clients from initial intrusion through required notifications and post-incident recovery.

Jacki has extensive experience working with Mergers and Acquisitions teams advising on cybersecurity and data privacy, due diligence and preparing clients for both purchase and sale of businesses. She works closely with both M&A counsel and technology and risk management teams to advise clients on short term and long-term risk associated with cybersecurity hygiene and data privacy compliance.

In addition to her specialized roles, Jacki acts as outside general counsel and privacy counsel for small and mid-sized businesses. She provides strategic advice on corporate affairs, contract negotiations, governance, and privacy matters, ensuring robust compliance and effective management of internal legal issues. Jacki has successfully spearheaded the launch of multiple startups throughout her career, leveraging this hands-on experience to offer valuable insights and strategic guidance to businesses. Her deep understanding of the challenges and opportunities involved in starting and scaling companies equips her to provide nuanced advice tailored to the unique needs of each business.

Carla Silva

Carla Silva has been with Sedgwick since 2015 where she is currently a Director. She was previously an attorney in private practice defending accountant and lawyer malpractice suits. Prior to that Carla was a NJ Deputy Attorney General for 6 years.

Joyce McCormack, RN

Joyce has been a Risk Management Consultant since 2014. A registered professional nurse with experience in both the clinical and corporate worlds of healthcare, Joyce has a strong clinical background in both acute and intensive care, along with a dedication to staff education, project development and customer service.

Prior to joining MLMIC, Joyce held roles as the Talent Development Coordinator for a 160 bed long term care facility, and as the Director of the Patient Experience for a 360 bed hospital. She also spent many years as both a Nurse Educator, as well as the Chairperson of the Upstate New York chapter of the National Nursing Staff Development Organization. Joyce is a member and active supporter of the American Society for Health Care Risk Management, the Association for Healthcare Risk Management of New York, Inc., and the Medical Group Management Association of New York, as well as a member of its board. Joyce is a frequent program presenter for our company with our corporate partners, has authored articles on a range of medical malpractice hot topics and is a Certified Professional in Healthcare Risk Management. Joyce works out of our Colonie office.

Victor R. Klein, MD, MBA, FACOG, FACMG

Victor R. Klein, MD, MBA is currently a Perinatologist in the Department of Obstetrics and Gynecology at North Shore University Hospital while serving as the Vice Chair of Obstetrics & Gynecology at North Shore University Hospital and the System Director of Quality & Patient Safety for the Ob Gyn Service Line at Northwell Health. Dr. Klein has been engaged in risk management and patient safety for over 30 years, and has lectured extensively on these fields throughout the country, including the ASHRM annual meeting. Dr. Klein received his medical degree from the State University of New York at Brooklyn/Downstate Medical School. He completed his internship at Kings County Hospital Center, residency in Obstetrics and Gynecology at The Johns Hopkins Hospital, fellowships in Maternal-Fetal Medicine and Medical Genetics at the University of Texas Health Science Center at Dallas, and his MBA in Quality Management at Hofstra University. He is board certified in medical genetics, general obstetrics & gynecology, and maternal fetal medicine, has obtained CPHRM certification, and is recognized as a Fellow of the American Society for Health Care Risk Management. Dr. Klein has been a member of the editorial board and past editor of the Journal of Healthcare Risk Management, is on the Board of Directors for AHRMNY, a past board member for ASHRM, and is on the AHA Maternal & Child Health Council. He is nationally recognized and has written over 75 articles and publications on obstetrics & gynecology, risk management and patient safety. Dr. Klein represents the American Society for Healthcare Risk Management for the Alliance for Innovation on Maternal Health (AIM).

Adriann J. Combs, DNP, NNP-BC

Adriann Combs is a doctorally prepared neonatal nurse practitioner with more than 40 years of practice in perinatal health. Her roles have included Clinical Nurse Educator, Neonatal Nurse Practitioner and her current role as the Clinical Director of a ten maternity hospital system within a large healthcare system in New York State.

Dr. Combs has published and presented on Perinatal Health Care Safety, Perinatal Ethics, Extrauterine Transition, Maternal Hemorrhage, Thermoregulation, Retinopathy of Prematurity and Maternal Morbidity and Mortality.

Most recently, she published two articles related to the impact of COVID-19 on pregnancy. The publications include, “Universal testing for coronavirus disease 2019 in pregnant women admitted for delivery: prevalence of peripartum infection and rate of asymptomatic carriers at four New York hospitals within an integrated healthcare system” and “The care of pregnant women during the COVID-19 pandemic - response of a large health system in metropolitan New York”.

Christa Christakis

Christa Christakis is the Executive Director of the American College of Obstetricians and Gynecologists, District II, a professional membership organization representing 4,000 board certified physicians and other women’s health care providers who practice obstetrics and gynecology in New York State. Christa leads the NY office and works to further ACOG’s mission to advance obstetric and gynecological care and the professional and socioeconomic interests of its members through continuing medical education and advocacy. Christa is responsible for all administrative and financial functions of the ACOG District II office, specializing in membership, medical education, and legislative relations.

Before joining ACOG District II, Christa served as the Senior Director of Quality and Research Initiatives at the Healthcare Association of New York State (HANYS) where she formulated the advocacy agenda and strategies for quality-related regulatory and legislative initiatives that impact HANYS’ member institutions.
Prior to her role at HANYS, Christa served as the Director of Government Affairs for ACOG District II and has served on several community boards, including the Upper Hudson Planned Parenthood Board of Directors. She received her Masters of Arts in Public Affairs and Policy (MPP) from the University at Albany’s Rockefeller College of Public Affairs and Policy.

Brittany Salmon, RN

Brittany Salmon, RN is the OB Nurse Manager at Lewis County Health System. Mrs. Salmon is responsible for oversight, operations, and staff who work in the OB Labor and Delivery Unit. The Maternity service offers prenatal care, labor and delivery, post-partum care and other women’s health services.

Mrs. Salmon is a 2006 graduate of South Lewis Central School. She began her career as an LPN in the Lewis County Residential Health Care Facility after receiving her nursing education as a Licensed Practical Nurse from Howard G. Sackett Technical Center in 2009. She earned her associate degree as a Registered Nurse from Mohawk Valley Community College in 2012. After obtaining her license, she worked as an RN in the hospital's Maternity department until joining South Lewis Central School in 2020 as the Middle School Nurse for students in grades 5-8. While employed at South Lewis, Brittany also continued to work in the LCHS Emergency Department.

Mrs. Salmon has 15 years of clinical experience, including eight years in maternity and childbirth education. She has also worked in the medical-surgical and critical care units and performed charge nurse duties. Brittany maintains certifications in Basic Life Support (BLS), Advanced Cardiovascular Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Neonatal Resuscitation. She also has phlebotomy experience and is a B-EMT with the Turin Volunteer Ambulance Service.

TAB 3

First Name	Last Name	Title	Company
Mark	Ambrose	Sr. Risk Management Consultant	MLMIC Insurance Company
Philip	Artusa	Partner	Kaufman Borgeest & Ryan
Kathleen	Barclay	Partner	O'Connor First
John	Barker	Managing Partner	Barker Patterson Nichols
Sharon	Barron	Manager Regional Perinatal Program	Kaleida Health / John R. Oishei Children's Hospital
Denise	Bartosz	System Director QPS and Loss Prevention	Catholic Health System
Matthew	Batt	Director, Risk Management & Legal Counsel	Catholic Health System
Joseph	Bisch	Attorney	Barbiero Bisch O'Connor Commander
Michael	Brendel	VP, Professional Liability	Sedgwick
Dylan	Braverman	Partner	Barker Patterson Nichols
Catherine	Buckley	Director Clinical Risk Management	Richmond University Medical Center
Hali	Buckley	Partner	Brown, Gruttadaro & Prato
Steph	Campbell	Partner	Schiavetti Corgan
Lisa	Cary	Sr. Director Ambulatory Quality	Northwell Health
Molly	Casey	Partner	O'Connor First
Kathy	Castillo	Senior Account Executive	NAM (National Arbitration and Mediation)
Franchesca	Charney	Director of Risk Management	Vassar Brothers Medical Center
Christina	Christoforo	Attorney	Kaufman Borgeest & Ryan
Christa	Christakis	Executive Director	American College of Obstetricians
Adriann	Combs	Clinical Director, Assoc System Dir, Quality & PT Safety	Northwell Health
John	Coniglio	Attorney	Brown, Gruttadaro & Prato
Nancy	Connelly	RN, CPHRM, DFASHRM	
Dan	Corcoran	CEO	SafeQual
Ruth	Corcoran	Partner	Kaufman Borgeest & Ryan
Adam	Covitt	Partner	Barker Patterson Nichols
Marc	Craw		MLMIC Insurance Company
Andrea	Crawford	AED, Risk Management	NYC H+H / Queens
Laurie	Cross	Administrative Manager, Risk Management	UVM Health Network-CVPHH
Katelyn	Cummings	VP, Northeast Zone, Cyber Practice	Marsh
Rachel	Czajak	Manager, Risk Management	St. Joseph's Health
Marie	Danek	Partner	Phelan Phelan & Danek
Jeffrey	DeGeorges	Partner	Barbiero Bisch O'Connor Commander
Laura	Del Vecchio	Partner	Heidell Pittoni Murphy & Bach
Joseph	DeLuccia	Director of Corporate Accounts	RLDatix
Louise	Derevlany	AED, Risk Management	NYC H+H / Elmhurst
Kathleen	Divers	AVP, Risk Management	MedPro Group - M2
Patrick	Dolan	Partner	Kaufman Borgeest & Ryan
Michelle	Dolaway	Risk Management Specialist	United Health Services
Melissa	Dziak	Shareholder	Marshall Dennehey
Jayne	Eurell	Risk Manager	Paragon Management SNF
Kara	Eyre	Of Counsel	Wilson Elser Moskowitz Edelman & Dicker
Diana	Free	Managing Partner	Clearview Partners Consulting
Alan	Fumuso	Partner	Fumuso Christesen
Lora	Giacomoni	VP, Quality	Northwell Health
Bill	Gianaris	Shareholder	Marshall Dennehey
Mario	Giannettino	Partner	Kaufman Borgeest & Ryan
Lesli	Giglio	SVP, Chief Risk & Privacy Officer	Catholic Health
Jacqueline	Goralczyk	Partner	Pierson Ferdinand
Glen	Gilman	Business Development Manager, Healthcare Tech	Taylor Healthcare
Thomas	Gray	Sr. VP, Risk Management	MLMIC Insurance Company
Elizabeth	Grogan	Partner	O'Connor O'Connor Bresee & First

First Name	Last Name	Title	Company
Barbara	Groshans	AVP, Underwriting	EmPRO Insurance
Dennis	Gruttadaro	Member	Brown, Gruttadaro & Prato
Jose L.	Guzman, Jr.	VP & Director of Risk Management	Hudson Insurance Group
Pamela	Harinstein	Attorney	Heidell Pittoni Murphy & Bach
Courtney	Haskins	Attorney	McPhillips, Fitzgerald & Cullum
Anne	Huben-Kearney	Risk & Patient Safety Consultant	
Jaby	Jacob	VP, Underwriting	EmPRO Insurance
William	Kalish	Partner	Brown, Gruttadaro & Prato
Eileen	Kasda	VP Patient Safety	Safetower
Gina	Kittek	System Director, Risk Mgt & Corp Compliance	United Health Services
Victor	Klein	System Director, Quality & Pt Safety/OB-GYN Service Line	Northwell Health
Karen	Kobus	Vice President, Professional Affairs	Maimonides Health
Loretta	Krez	Partner	Kaufman Borgeest & Ryan
Shelly	Kriete	Senior Risk Management Consultant	MLMIC Insurance Company
Matthew	Lamb	AVP, Risk Management	MLMIC Insurance Company
Meredith	Lander	Attorney	Schiavetti Corgan
Maria	Malone	Manager, Risk Management	St. Peter's Hospital
Anthony	Marino	Partner	Fumuso Christesen
Jennifer	Marti		Rome Health
Robert	Martin	Of Counsel	London Fischer
Joyce	McCormack	Senior Risk Management Consultant	MLMIC Insurance Company
John	McDonald, III	NYS Assembly Member	NYS Assembly - District 108
Cathy	McGovern, MD		Westmed
Lori	Meca	Quality and Risk Manager	Hometown Health Centers
William	Melchior	Directorof Marketing & Company Relations	MLMIC Insurance Company
Erik	Micallef		Schiavetti Corgan
Julie	Mickiewicz	Partner	Kaufman Borgeest & Ryan
Michael	Milchan	Partner	Barker Patterson Nichols
Heather	Miller	Sr. Associate General Counsel	UHS Binghamton General Hospital
Deanna	Mirro-Altmann	Risk Management Consultant	MLMIC Insurance Company
Caitlin	Monjeau	General Counsel	CCP TASS, Inc.
Elizabeth	Morath	Claims Consultant	MedPro Insurance Company
Paula	Moshier	VP Quality	Bassett Healthcare
Junina	Nacua	Lead Risk Manager	Ellis Medicine
Lindsey	Nourse	Attorney	Kaufman Borgeest & Ryan
Wilhemina	Nyarko	Senior Director, Risk Management	The Brooklyn Hospital Center
Zoe	Orecki	Regional Director of Risk Management	St. Joseph's Health
Lori	Paine	VP Patient Safety Officer	Rochester Regional Health
Susan	Pecha	Manager, Risk Management	United Health Services
Emily	Phillips	Attorney	O'Connor First
Bonnie	Portnoy	VP, Risk Management	Mount Sinai Health System
Annemarie	Provencher	Senior Risk Specialist	Coverys
Jennifer	Puglisi	Associate	Kaufman Borgeest & Ryan
Christine	Quinn	Vice President & Chief Risk Officer	EmPRO Insurance
Samantha	Quinn	Appellate Partner	Schiavetti Corgan
Cynthia	Robinson	Partner	Heidell Pittoni Murphy & Bach
Leilani	Rodriguez	Partner	Sholes Miller Rodriguez & Brown
Jillian	Rossi	Risk Management Specialist	Rochester Regional Health
Jonathan	Rubin	Partner	Kaufman Borgeest & Ryan
Brittany	Salmon	OB Nurse Manager	Lewis County Health System
Sharon	Scheuermann	Senior Vice President	Risk Strategies

First Name	Last Name	Title	Company
Mike	Schintz	Business Development Manager	Taylor Healthcare
Kathleen	Shostek	Healthcare Loss Control Expert	Munich Re Speciality-North America
Alexander	Sikoscow	Attorney	Kaufman Borgeest & Ryan
Carla	Silva	Director, Professional Liability	Sedgwick Claims Management Services
Adam	Soderstrom	Property and Casualty Supervisor-Liability	TRISTAR
Joshua	Sokolowski		
Tom	Stebbins	Executive Director	Lawsuit Reform Alliance of New York (LRANY)
Kathryn	Sullivan	Partner	Kaufman Borgeest & Ryan
Marcy	Teal	Chief Nursing Officer	Lewis County General Hospital
Ann	Teng	Chief Wellness Officer & Medical Director	United Health Services
Kitty Joy	Thomas	Risk Manager	Albany Medical Center
Henry	Tilson	Attorney	Kaufman Borgeest & Ryan
Marco	Tomakin	Risk Manager	Albany Medical Center
Lynn	Trentini	Business Insurance Account Executive	OneGroup Insurance Agency
Lisa	Tuggle	CCO	Adirondack Health
Felicia	Velasquez	Risk and Compliance Specialist	Whitney Young Health
Kayla	Velie	Manager, Medical Command Center	United Health Services
Gerryann	Whalen	Sr. Risk Management Consultant	Proassurance
Tiffany	Wickes-DeMillio	AVP, Safety & High Reliability	Catholic Health
Bob	Worden	Hearing Officer	NAM (National Arbitration and Mediation)

TAB 4



1

Objectives

1. Discuss the role of Patient Safety and Risk Management leaders in identifying emerging risks.
2. Discuss common challenges of interpreting patient safety and risk management data.
3. Share innovative analytic approaches to continuously mitigate risks.

2

How Do We Know If a System Is Safe?

Maximize opportunities to learn across the data continuum.

Lagging Indicators → Leading Indicators

Retrospective Data
- Sentinel Events
- Root Cause Analysis
- Claims
- Core Measures

Concurrent Data
- Event Reporting
- Concurrent review
- Trigger tools
- Real-time complaints

Prospective Data
- Near-miss reporting
- Safety rounds
- Mock tracers
- Policy audits

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Some Risks Are Not Easily Measurable

Risks	Internal Signals			External Lenses			
	Event Reports	Safety Culture Assessment	Legal Claims	ECRI	Leapfrog Measures	JC NPSG	JC Sentinel Event Alerts
Medication Safety	X	X	X	X	X	X	X
Retained Foreign Objects	X	X	X		X		X
HIT Safety	X	X		X			X
Handoffs	X	X				X	X
Equipment/Devices	X	X	X			X	X
Patient ID	X	X		X		X	
Workplace Violence	X	X		X			X
Transport	X	X	X				

Real Time → Delayed

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The Strange Rejection of Qualitative Data

	Qualitative Data	Quantitative Data
Examples	Event Reports, Patient Complaints, Legal Claims.	Core Measures, Trigger Tools.
Purpose	To understand phenomena and gain insights through collecting narrative data.	To explain, predict and control phenomena through purposeful collection of numerical data.
Sampling intent	Smaller sample to efficiently obtain an in-depth understanding.	Large random representative sample with the goal of generalizability.
Analysis	Data analyzed are in words.	Data analyzed are numbers.
Interpretation	The validity of conclusions and interpretations are the reader's responsibility.	Conclusions and generalizations are formulated with predetermined degree of certainty.

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The Obsession With Rates

Valid rates require the following to be true:[1]

- A clear definition of the event numerator
- A standard, objective data collection method
- A consistent surveillance system with the means for monitoring what you intend to measure
- A defined population denominator

1. Pham JC, Girard T, Pronovost PJ. What to do with healthcare incident reporting systems. J Public Health Res. 2013.

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Measurement Challenges and Consequences

Incentives to focus on externally defined metrics	Perception that everything needs to be measured	A desire for benchmarking	Regulatory and PFP metrics burden
• Multiple sets of metrics. • Mismatch of resources allocation for internal vs external risks[1] • Creates disincentive to identify internal risks.	• Risks conveyed as rates can be misleading. • Measures that aren't actionable. • Invalid or unreliable measures.	• Limits improvement by anchoring to poor performance. • Staff frustration if outcomes do not improve despite efforts. • "Comfort seeking" vs "problem sensing" [2].	• Data may not be what organization believes is valuable to monitor • State reporting systems may limit local and state-wide learning

1. Meyer GS, Nelson EC, Pryor DB, James B, Swensen SJ, Kaplan GS, Weissberg JI, Bisognano M, Yates GR, Hunt GC. More quality measures versus measuring what matters: a call for balance and parsimony. BMJ Qual Saf. 2012 Nov;21(11):964-8.)

2. Dixon-Woods M, Baker R, Charles K, et al. Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study BMJ Qual Saf 2014;23:106–115.

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7

7

Impacts to Organizations

Data Infrastructure is Resource Intensive	Analytic Capacity is Underdeveloped	Too Much Data and Too Little Information	Transparency is Lost
• Staff time focused on counting and comparing. • Attention on building visual dashboards and charts. • Tools and methods inadequate to find hidden insights in data.	• Dashboards over finding insights. • Myth that more data is better. • Focus on visual tools like Tableau. • Staff distracted by workarounds	• Context stripping leads to knowledge stripping. • Qualitative data is ignored. • Data governance approaches ignore insights.	• Data sharing is limited. • Collaboration is stunted. • Decisions are made in silos.

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8

State of Event Investigations In Healthcare

RCA is the primary event investigation tool used in health systems.

Investigations focus on active factors, overlooking latent factors.

Wide variability in how investigations are conducted.

Hard to know if safety improvement efforts are effective because of:

- A one-size-fits all approach.
- Corrective actions often target human behavior not system-level issues.
- Methods limit shared learning opportunities.

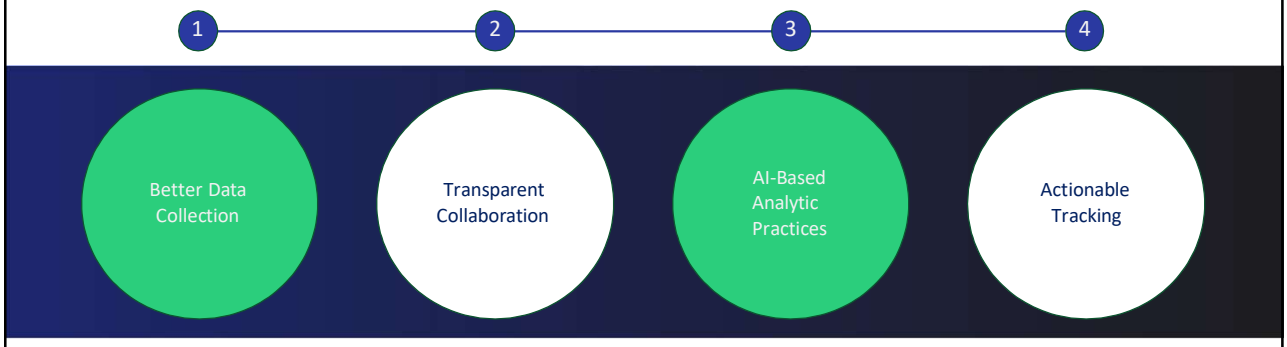
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1- Trbovich P, Shojania KG. Root-Cause Analysis: Swatting At Mosquitos vs Draining The Swamp. BMJ Qual Saf 2017;26:350–353.

9

9

Steps to Unlocking The Power of Data



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10

1. Better Data Collection

Embrace Qualitative Data

- Mine free-text reports to better understand "what happened"
- Don't strip context from data

Supplement Data Sources

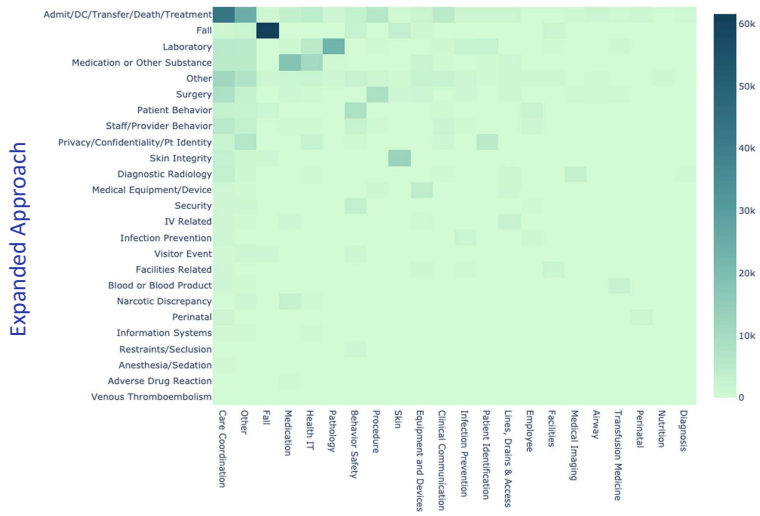
- Robust APIs with EMR and HR systems
- Enrich data for mandatory reporting and PSOs

Include Patients' Voices

- Treat patients as part of the care team
- Manage peer-review privilege protections across data domains

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Identify Converging Risks



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Let's Talk About Biases in Safety

Biases are a fact of life. We need to be aware of their power to mislead us.

Reporting Bias

For its impact on quality of data leaders use to make decisions

Confirmation Bias

For how easily it makes us overlook the real causes of events

Generalization Bias

Makes us overlook variation when sharing lessons learned

Outcome Bias

For its ability to make us quickly judge decisions as good or bad

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13

13

2. Transparent Collaboration

Reporters

- Don't let events go into a "black hole"
- Make it easy for safety event reporters to be involved

Reviewing Managers

- Set expectations on transparent behaviors
- Promote organizational sense making
- Create a digital commons area for collaboration

Leaders

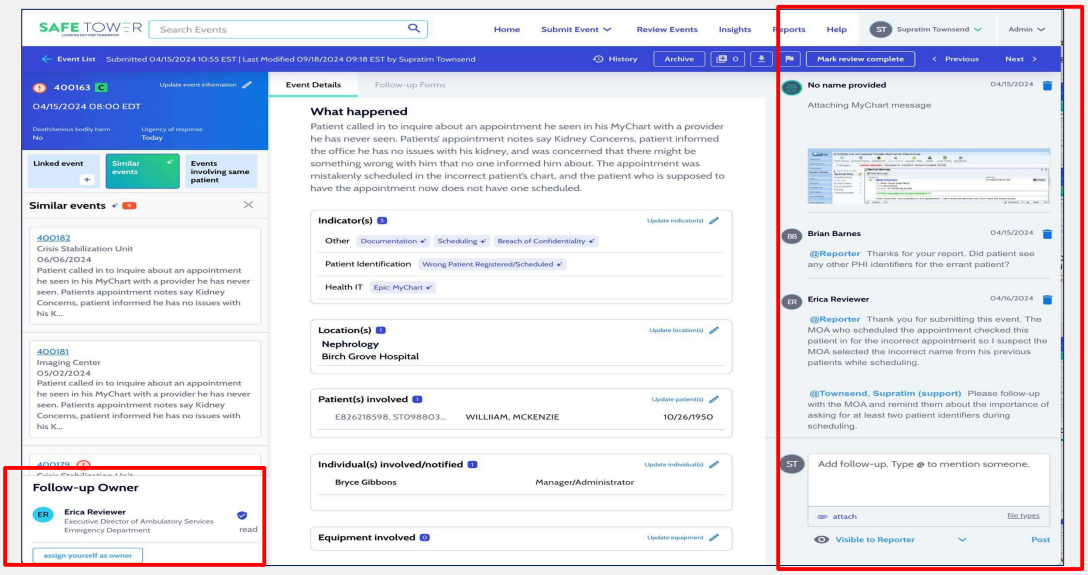
- Escalate in consistent, rule-based ways
- Share trends in real time
- Use asynchronous alerts

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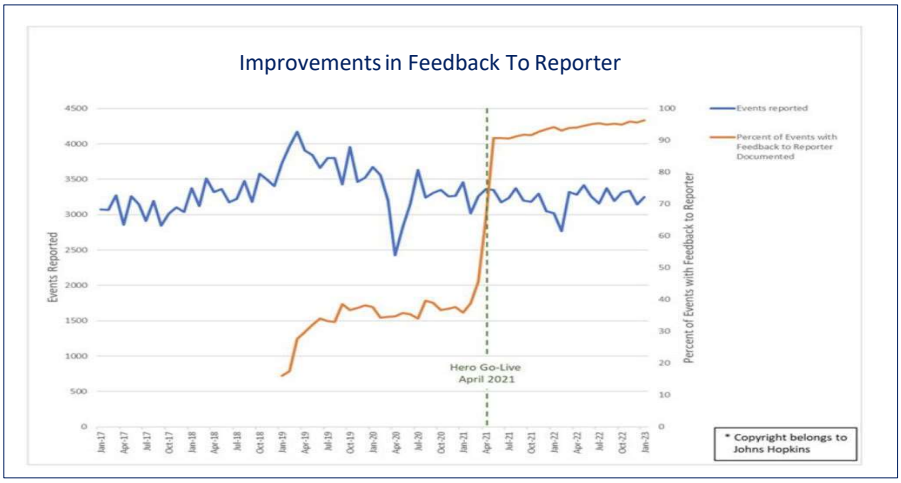
14

14

Helping Reviewers Collaborate



Use Feedback to Reporter as a Process Metric



Kasda E, Robson C, Paine L. Next-Gen Event Reporting Through Hero: A Surveillance System Designed for Culture Transformation andImprovement: A Surveillance System Designed for Culture Transformation and Improvement. Qual Manag Health Care. 2023 Jul-Sep 01;32(3):211-212.

3. Improve Analytic Processes

Don't Confuse IT and Analytic Needs

- Recognize complexity
- Challenge assumptions of current needs

See More Clearly

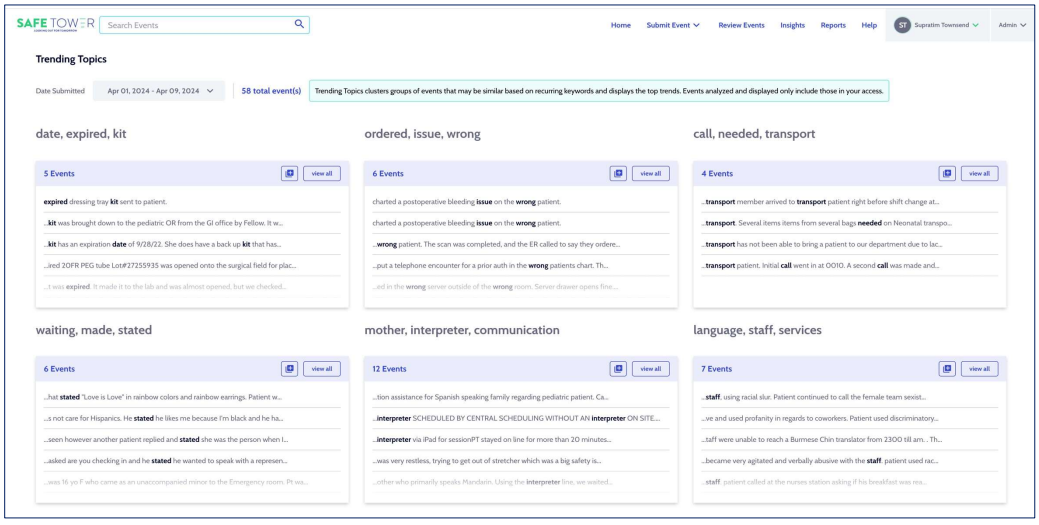
- Detect weak signals and emerging patterns
- Consider multiple data sources

Pay Attention To Variances

- Identify latent and active threats
- Consider culture and context

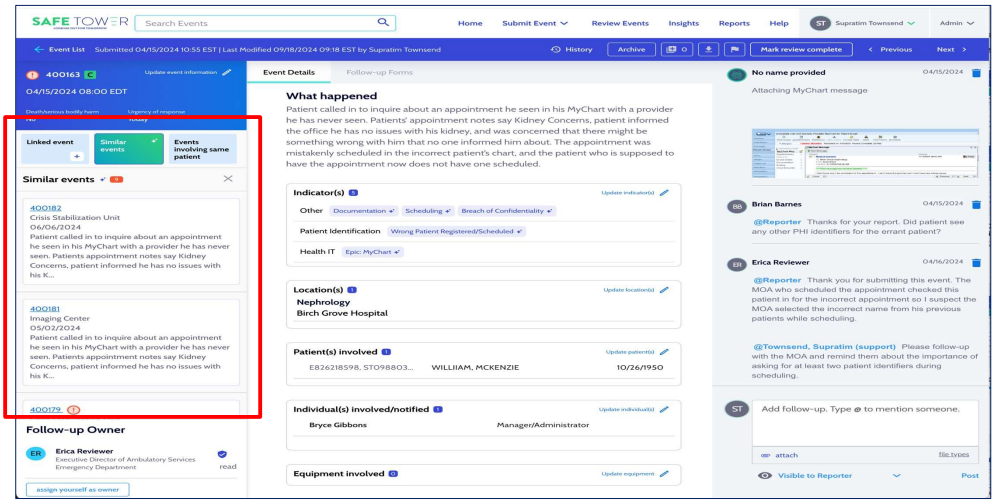
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Use AI To See Hidden Patterns In Your Data



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Be Alerted When Similar Events Are Reported



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19

19

4. Improve Way We Track Performance

Focus on Actionability

- Prioritize based on feasibility
- Measure for impact
- Manage by result

Prepare for Variety

- Evaluate readiness for real-time surveillance
- Assess burden of frequent tracking

Aim for Insights

- Track measures that are valuable
- Well managed data leads to better information

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20

20

Let's Evolve What We Expect From Analysts

So, We Can Improve Our Ability to Surveil

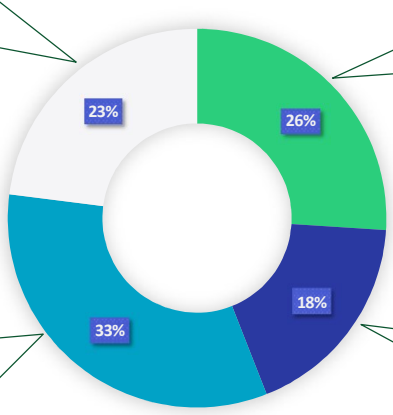
Dashboard Compilers → Data Manipulators → Pattern Identifiers → Safety and Risk Scouts

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21

Evaluate Operational Data

Event Follow Up
Random Sample 300 responses



Appropriate Review

Education was completed with those involved

Reviewer clarified details of the incident, coached staff, and provided guidance on prevention in the future through checks and regular monitoring for errors

Identified individual involved in error, involved nurse educator, planned for review of process during unit huddles and weekly updates

Reviewed protocols with staff involved, directed to available resources, provided cheat sheets

No Follow Up

Limited Review

"Monitor for future events" or other canned text

"Agree with recommendations"

Asking questions

Making broad statements about what should have happened

Stating that others will follow up or will share with others for follow up

Stating what they will do in the future follow up (e.g. bring to a committee)

Minimal Review

- "Reviewed"
- "N/A"
- "Acknowledged"
- "No action needed"

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22

22

Every RCA Doesn't Have to Be Groundhog's Day

- Use tools like AI to learn from multiple events so learning from single events isn't duplicated
- Consider incorporating causes from similar events
- Value qualitative data to identify new insights
- Embrace uncertainty and be willing to unlearn and relearn
- Learn from what went well to preserve defenses and barriers
- Align with leaders on the need for systemic changes
- Create opportunities to share learning across the organization

Questions

TAB 5

NYC HEALTH+ HOSPITALS

UNDERSTANDING AND APPLYING AN EQUITY LENS TO THE RCA PROCESS FOR IMPROVED HEALTH CARE OUTCOMES

Andrea Crawford, Esq., CPHRM
Associate Executive Director
Risk Management
NYCH+H/Queens

LOUISE DEREVLANY, ESQ
Associate Executive Director
Risk Management
NYCH+H/Elmhurst

1

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Session Objectives

After attending this session, participants will be able to:

- Apply an equity lens to Risk Root Cause Analysis
- Utilize a framework to discuss bias or structural inequities that contribute to adverse events
- Apply the equity lens to promote better health outcomes

2

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What is Health Equity?



3

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What is Health Equity?

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

Robert Wood Johnson Foundation

4

NYC HEALTH+ HOSPITALS

How Do You Define Bias?



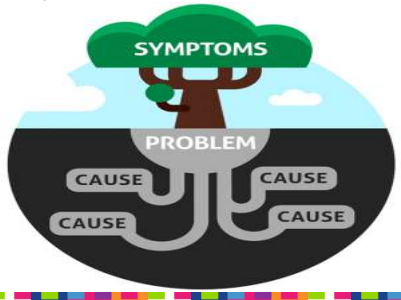
5

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Bias Training – Speaking the Same Language

Must take a proactive approach to continuously investigate, catalogue, and monitor for bias as a contributing factor at:

- the interpersonal level (i.e., explicit bias)
- the human behavioral level (i.e., implicit bias)
- the institutional level (i.e., policies and practices)
- the structural level (i.e., social and political determinants of health)



6

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The Joint Commission and Health Care Disparity

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Reducing Health Care Disparities: TJC Requirements

EP 1: Designate a Leader
The organization designates an individual(s) to lead activities to reduce health care disparities for the organization's patients

EP 2: Assess Health-Related Social Needs
The hospital assesses the patient's health-related social needs and provides information about community resources and support services

EP 3: Identify Health Care Disparities
The hospital identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the organization's patients

EP 4: Develop an Action Plan
The hospital develops a written action plan that describes how it will address at least one of the health care disparities identified in its patient population

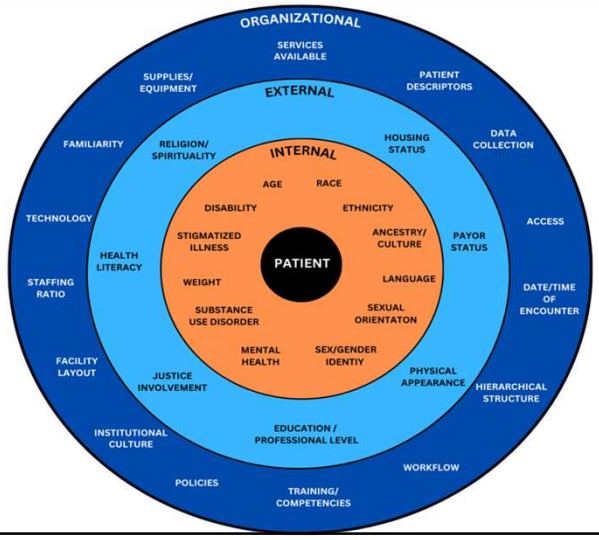
EP 5: Make Improvements
The hospital acts when it does not achieve or sustain the goal(s) in its action plan to reduce health care disparities

EP 6: Keep Stakeholders Informed
At least annually, the organization informs key stakeholders, including leaders, licensed practitioners and staff, about its progress to reduce identified care disparities

7

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Health Equity Wheel – Attribution goes to Mona Kraus, MD, Komal Chandra, PhD and Komal Bajaj, MD for developing this resource



8

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Types of Equity Lens



9

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Evaluation of Bias

- A standardized set of questions to help guide your investigation into understanding whether or not bias and/or inequity contributed to the patient safety event you are reviewing.
- *1. Is it possible that parts of the history, exam, and/or diagnostic workup were potentially included, excluded, deferred, and/or delayed due to the patient's ***?*
- *2. Is it possible that the care team's assessment of symptom severity, clinical risk/urgency, differential diagnosis, and/or patient reliability could have been influenced by the patient's ***?*
- *3. Is it possible that the patient's *** affected the care team's judgment of how likely the patient was to understand, accept, follow through with and/or tolerate a particular plan/treatment?*
- *4. Is it possible that the patient's involvement in their care was potentially impacted by the care team's assumptions about their ***?*
- *5. Is it possible that if the patient's *** were different, the outcome would have been different?*
- *6. Did *** impact the outcome in this case? If yes, how? If yes, what kind of change(s) would prevent this from recurring?*
- Each question focuses on a different part of the clinical encounter and asks you to consider if and how each category of bias presented on the wheel (denoted by ***) may have played a role at that point of the encounter. Rather than explaining each question, we will use a hypothetical case to demonstrate how these questions can be applied.
- **Consider this case:**
- An acutely intoxicated patient with alcohol use disorder comes into the ED. He is well known to staff and comes in regularly. During this visit, like in various before, he mentions that he has chest pain. Given his mental state and history of chest pain with normal findings, an EKG is deferred until he sobers up. As a result, a heart attack is missed and once resuscitated, he is admitted to the ICU in critical condition.
- **Consider the bias category:** Substance Abuse Disorder

10

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Synthesis

- The fifth question brings each of the pieces discussed above together. In the presented case, it is possible that the patient would have gotten an EKG sooner had he not been acutely intoxicated and that as a result, the adverse event would have been prevented.
- The final question in our algorithm puts the event in the context of the health system in which it occurred. In the presented case, it is possible that things like staffing, equipment, and work culture/norms contributed to the outcome.
- **Synthesize the findings:**
- We chose to use the phrase "is it possible that…" because it creates space for further conversation and investigation into each of the bias categories presented on the equity wheel. Considering the questions above may not definitively determine whether or not bias and/or inequity contributed to the adverse event being investigated. In fact, it will probably be very difficult to prove beyond a reasonable doubt that bias and/or inequity contributed to a case. Even so, asking these questions may bring to light gaps in our systems and processes that leave space for bias to impact outcomes. Those gaps are opportunities for targeted corrective actions. In the presented case, reviewers may find that there are barriers for using the existing chest pain workflow in patients with substance use disorder and as a result, implement strategies to encourage and support its equitable application.

11

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The Wheel And Its Categories

- **Age:** Healthcare workers may
- Provide older patients with delayed or inadequate pain management due to assumptions that pain is a natural part of aging.
- Prioritize older patients lower than younger patients in emergency situations, based on assumptions about their likelihood of survival and the value of their remaining years.
- Not include adolescents in the consenting process for a procedure or treatment because they are not legally adults and therefore, cannot make decisions for themselves.
- Inappropriately insist that an adolescent get tested for sexually transmitted infections, even if they deny sexual activity, and not offer that testing to an older patient unless they explicitly ask.

12

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Assigned Sex/Gender:

- **Healthcare workers may:**
- Refer to a patient using incorrect pronouns despite documentation of correct pronouns
- Ask patients inappropriate questions about their genitals and/or surgical status.
- Assume a patients' sex/gender and redirect them to another bathroom.
- Fail to recognize that a female is having a heart attack because they are unfamiliar with the "atypical" presentation.
- Not screen males for intimate partner violence regularly due to stereotypes about who is/isn't affected.

13

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Country of Birth

- **Healthcare workers may:**
- Provide advice and/or follow-up instructions that are not accessible to the patient due to their immigration status.
- Not be familiar with the cultural norms, beliefs, and practices of foreign-born individuals, which can lead to misunderstandings or misinterpretations of symptoms, health behaviors, and treatment preferences.
- Assume that a patient from a particular country is more likely to have a certain health condition, limiting the differential diagnoses considered and resulting in delayed identification of the actual problem. The opposite is also true and providers may fail to consider a diagnosis that is common in a patient's country of origin.
- Inadvertently trigger or exacerbate trauma symptoms during medical procedures and conversations when they are not sensitive to a patient's lived experience of immigration and/or resettlement.
- Dismiss traditional medicines and healing practices as ineffective and harmful, without understanding their cultural significance or potential benefits.
- Misjudge the importance of family involvement vs individual autonomy in healthcare decisions, resulting in otherwise preventable delays in starting or stopping an intervention.
- Not be aware of the cultural significance of certain foods or dietary restrictions, leading to the development of inappropriate treatment plans.

14

NYC HEALTH+ HOSPITALS

Disability

- **Healthcare workers may:**
- Dismiss the preferences and input of patients with disabilities or not involve them in decision-making about their own care, assuming that they are less capable, less intelligent, or less deserving.
- Inappropriately ask things like “what is wrong with you” and say things like “you do not look disabled.”
- Make assumptions about the quality of life and life expectancy of a patient with disabilities, leading to under-treatment, over-treatment, or delays in care.
- Underestimate or overlook the mental health needs of a patient with disabilities, assuming their physical health issues take priority.

- **Hospitals may:**
- Have physical barriers, such as stairs, narrow doorways, or inaccessible restrooms, exam tables, and medical equipment that makes it difficult or impossible for patients to access care.
- Not provide resources for effective communication accommodations, such as sign language interpreters or communication boards, for patients with hearing, speech, or cognitive disabilities.

15

NYC HEALTH+ HOSPITALS

Health Literacy

- **Healthcare workers may:**
- Use overly simplified language and incomplete information when communicating with patients they perceive have lower health literacy, leading to misunderstandings.
- Assume a patient's health literacy based on their race or ethnicity, leading to communication breakdowns.
- Pressure patients into signing forms by not providing enough time and space for them to review and understand those documents, leading to uninformed consent.
- Assume that patients with low health literacy are not interested in their own healthcare, are unwilling to take an active role in their treatment plan, or are uninterested in improving their health, leading to poor provider engagement with the patient.
- Not create space for patients to feel safe asking questions, increasing the risk for errors from miscommunication.

- **Hospitals may:**
- Not offer educational materials and other resources that accommodate for lower or higher health literacy skills, which contributes to suboptimal care and outcomes.

16

NYC HEALTH+ HOSPITALS

Housing Status

- **Healthcare workers may:**
- Not involve patients who are experiencing homelessness in decision-making about their own care, assuming that they are less capable of making informed decisions.
- Ignore, rush, and/or brush aside patients experiencing homelessness due to a belief that they are “freeloaders.”
- Make discharge plans that are not sensitive to the unique circumstances of patients who are experiencing homelessness or housing insecure, leading to higher risk of readmission and complications.
- Treat patients with suspicion and judgment as a result of the stereotype that those experiencing homelessness are “drug-seekers.”
- Convey stigma in their interactions with a patient and as a result, make the patient more reluctant to disclose their health concerns.
- Not offer certain treatments or procedures due to the assumption that people experiencing homelessness are “irresponsible” and will not be able to comply with follow-up care, even if they could benefit from those interventions.

17

NYC HEALTH+ HOSPITALS

Justice Involvement

- **Healthcare workers may:**
- Stereotype patients who have been involved with the criminal justice system as being violent or dangerous and result in fewer and lower quality interactions with the patient.
- Be inappropriately concerned about the possibility of poor surgical outcomes or a complicated postoperative course in this population which may in turn affect their clinical decision making.
- Feel intimidated by the presence of law enforcement at the bedside in cases of sexual assault and delay care to allow officers to finish their interview of the patient.
- Not adequately address a patient’s concern about confidentiality and privacy when paperwork is handed to officers (because the patient can’t have their belongings) or when they take a history or perform a physical exam.
- Believe that patients with a criminal history are not deserving of their services or that they are faking medical conditions to avoid punishment, leading to inappropriate delay or withholding of treatment.

18

NYC HEALTH+ HOSPITALS

Language

- **Healthcare workers may:**
- Not use available language services, even if they are aware of the patient's limited English proficiency, leading to miscommunication and confusion.
- Rely on family members or friends to interpret for patients with limited English proficiency, leading to breaches of privacy, confidentiality, and trust as well as potential misinterpretation by untrained family members.
- Rely on co-workers who speak a different language, rather than interpreters, to help take care of LEP patients, resulting in unplanned pauses of their workflow and increasing risk for error.

- **Hospitals may:**
- Not have adequately resourced language services departments leading to a lack of interpreters and translation services that allow for information to be made available in all languages, as needed.
- Fail to recruit a language-diverse workforce, increasing reliance on the use of interpreter services that are already limited.
- Not monitor the quality of their interpreters (hospital-employed or otherwise), leading to increased risk of with adverse clinical consequences.

19

NYC HEALTH+ HOSPITALS

Mental Health Condition

- **Healthcare workers may:**
- Make decisions about a patient's care without their input or against their wishes, assuming that their mental health condition impairs their decision-making abilities.
- Label patients with mental health conditions in ways that are stigmatizing or diminish their dignity, such as referring to them as "crazy" or "psychotic".
- Dismiss the physical symptoms of a patient with a mental health condition or attribute them solely to their mental health condition, leading to delayed or inadequate treatment for physical health issues.
- Over-rely on restraints and seclusion for patients with mental health conditions due to the assumption that these patients are unpredictable.
- Discharge patients with mental health conditions prematurely due to assumptions that their symptoms are not severe or legitimate.

20

NYC HEALTH+ HOSPITALS

Patient Description

- **Healthcare workers may:**
- Not optimally manage a patient's pain due to documentation of "medication seeking behavior" and subsequent hesitancy with prescribing.
- Delay or offer alternative care for a patient with prior history of leaving against medical advice (AMA) or labeled as "non-compliant" due to the expectation that the patient is likely to leave prior to treatment completion and/or that they are not interested in care.
- Avoid a patient labeled as "aggressive" on documentation, resulting in delayed diagnosis and treatment.
- Dismiss the concerns of a patient labeled as "needy" or as having "multiple complaints" and not pursue the indicated diagnostic workup.

21

NYC HEALTH+ HOSPITALS

Payor Status

- **Healthcare workers may:**
- Not offer an uninsured patient all of the available treatment options due to the assumption that they will not be able to afford it.
- Not account for an uninsured patient's limited ability to get services like homecare and physical therapy as well as medications, resulting in improper discharge plans.

22

NYC HEALTH+ HOSPITALS

Physical Appearance

- **Healthcare workers may:**
- Misjudge the severity of a patient's illness because they "do not look sick."
- Have fewer interactions with patients that "look more aggressive or unfriendly".
- Assume that someone with tattoos or piercings is more likely to engage in risky behaviors, such as drug use, and thus may be less likely to prescribe pain medication or other treatments.
- Assume that a patient who appears to be from a certain racial or ethnic group is more likely to have a certain condition and may not investigate other possible causes.
- Assume that a patient who is younger or appears healthy may not require certain diagnostic tests, leading to missed or delayed diagnosis. Conversely, healthcare workers may assume that a patient who is older or appears frail requires more extensive testing, leading to unnecessary tests and potential harm from the testing itself.

23

NYC HEALTH+ HOSPITALS

Race/Ethnicity

- **Healthcare workers may:**
- Use derogatory/offensive language when talking directly to or about a patient.
- Repeatedly confuse patients of the same race and/or patients with similar names.
- Assume the health behaviors, health literacy, cultural beliefs, and socio-economic status of a patient based on their race or ethnicity.
- Blame health disparities and/or unsuccessful treatments on a patient's behaviors instead of racism.

24

NYC HEALTH+ HOSPITALS

Religion/Spirituality

- **Healthcare workers may:**
- Make derogatory remarks or use offensive language when talking directly to or about a religious or spiritual patient.
- Not be aware of available alternatives for patients who decline standard treatments/procedures that conflict with their beliefs.
- Not consider the unique post-hospitalization needs of a religious or spiritual person, such as access to faith-based support groups or accommodation for religious practices, resulting in suboptimal planning and increased risk for adverse events.

25

NYC HEALTH+ HOSPITALS

Sexual Orientation/Expression

- **Healthcare workers may:**
- Make derogatory remarks or use offensive language when talking directly to or about an LGBTQ+ patient.
- Assume who is and isn't part of a patient's support system, leading to accidental "outing" and other inappropriate disclosure.
- Not be familiar with the unique medical needs of non-heterosexual individuals and provide incorrect counseling, or no counseling at all.
- Refuse to see or treat an LGBTQ+ patient based on personal beliefs or religious views.
- Refuse to recognize an LGBTQ+ patient's family, including a child or a same-sex partner.
- Provide unwanted/inappropriate physical contact, such as fondling, sexual assault, or rape, to LGBTQ+ patients.

26

NYC HEALTH+ HOSPITALS

Stigmatized Illness

- **Healthcare workers may:**
- Use derogatory/offensive language when talking directly to or about a patient with a stigmatized illness.
- Minimize patient concerns because of normal lab and imaging study results, leading to misdiagnosis and/or delayed diagnosis.
- Shame or blame patients with sexually transmitted infections, discouraging them from seeking treatment.
- Express skepticism or lack of understanding toward patients with chronic conditions that have a fluctuating nature.
- Over-attribute a patient's symptoms to their stigmatized health condition rather than conducting a thorough evaluation.
- Avoid contact with a patient due to fear of contagion, even if the disease is not highly contagious and can be easily treated.

27

NYC HEALTH+ HOSPITALS

Substance Abuse Disorder

- **Healthcare workers may:**
- Undertreat pain in a cancer patient if they have a current or prior history of substance use disorder due to the assumption that they are "drug seeking" or that they have a higher tolerance for pain.
- Over or under-attribute a patient's symptoms to their substance use disorder, resulting in missed or delayed diagnosis and treatment.
- Defer parts of the diagnostic workup and/or physical exam when a patient is acutely intoxicated and therefore miss critical clues for clinical diagnosis.
- Be less likely to provide referrals to addiction treatment or social services, especially for patients who frequently visit the hospital, leading to increased risk of relapse, readmission, and other adverse events.

28

NYC HEALTH+ HOSPITALS

Weight

- **Healthcare workers may:**
- Assume that an individual's health concerns are due to their weight and not conduct a thorough medical evaluation, which can result in delayed or missed diagnosis.
- Assume that weight loss is the only solution to a patient's health concerns, leading to a lack of consideration for other treatment approaches that may be more appropriate for the patient's individual needs.
- Give inappropriate medical advice, like encouraging extreme dieting or weight loss methods that are not sustainable or healthy, or they may make assumptions about the individual's ability to exercise or engage in physical activity.

- **Hospitals may:**
- Not have equipment that is suitable for different body shapes and sizes, such as larger hospital gowns, scales, and imaging equipment. This can result in discomfort, embarrassment, and delayed or inadequate medical care.

29

NYC HEALTH+ HOSPITALS

Organization Inequities

- The risk of adverse in-hospital clinical events may increase based on:
- **Access**
- A patient with Medicaid may have to wait four months for a specialty appointment, leading to a delayed cancer diagnosis with a worse prognosis.
- **Culture / Norms**
- A residency culture may value autonomy and inadvertently discourage residents from escalating issues to attendings, resulting in a preventable adverse event.
- **Data Collection**
- Failing to collect and/or regularly update a patient's telephone number can lead to a delay in communicating an abnormal result and lead to an adverse event.
- **Date/Time of Encounter**
- A patient that visits the ED on a holiday may have to wait longer than usual to be seen, leading to an adverse event.
- **Facility Layout**
- A unit in the hospital may not be optimally designed/organized, resulting in higher than expected risks for adverse events such as patient elopement.
- **Hierarchical Structure**
- A trainee may choose to not speak up when they notice an error is about to occur due to fear of professional repercussions, resulting in an avoidable adverse event.
- **Patient Descriptors**
- Medical records may propagate the passing on of inaccurate and/or biased information that directly or indirectly results in an adverse event.

30

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Organizational Inequities Continued

- **Policies**
- A policy that could've prevented an adverse event does not exist and if it does exist, it is not well-advertised, hard to find, or not useful/applicable.
- **Services Available**
- Limited availability of a service, such as ultrasound, may delay patient care and lead to an adverse event.
- **Staffing Ratio**
- There may not be enough staff members available on a patient floor to proactively and effectively mitigate known risks, such as over sedation, resulting in an adverse event
- **Supplies / Equipment**
- The tools required for patient care are not available in a timely manner, resulting in an adverse event.
- **Technology**
- A computer program that is required for patient care becomes unavailable, malfunctions, or is inoperable, leading to an adverse event.
- **Training / Competencies**
- A healthcare worker may not receive timely, appropriate, and regularly reinforced training on how to mitigate known risks, such as falls.
- **Workflow**
- The existence of a complicated process to accomplish a task may result in work-arounds that increase the risk of adverse events.

31

NYC HEALTH+ HOSPITALS

Leverage Incident Reporting System



Allow frontline staff to identify need for investigation of potential bias and structural inequities that contribute to adverse events, near misses/good catches, patient safety risks

32

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Call to Action and Moving Forward

- Apply the bias and equity prompt to the next adverse event in your area/hospital/system
- Apply the prompt to the next patient complaint/grievance
- Incorporate an equity lens into your RCAs
- Encourage healthcare teams to apply a health equity lens in their improvement projects
- Are you meeting TJC health equity standards?

33

NYC HEALTH+ HOSPITALS

Thank You!!!



34

TAB 6

Risk and Reward: The Essentials of Healthcare Contracts and Risk Management

The Association for Healthcare Risk Management of New York, Inc. (AHRMNY)
Upstate Conference, October 25, 2024
Cooperstown, NY

Heather Miller, JD
Gina Kittek, MJ, CHC, CPHRM
United Health Services, Inc., Binghamton, NY

1

Importance of Contracts in Healthcare

- Ensuring patient safety, financial stability & legal compliance
- Contracts play a critical role in managing risks
- Risk Managers need to understand the how any contract fits into managing the many and varied risks of their organization
- Enterprise risk management approach

2

Definition of Contracts

Legally binding agreement between parties

Healthcare contracts involve various stakeholders:

- Hospitals
- Insurers
- Vendors
- Providers

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3

Types of Healthcare Contracts

Provider contracts:

- Agreements between healthcare providers and payers
- Specify services, reimbursement rates, and quality standards
- Third party payer departments

Vendor contracts:

- Contracts with suppliers (e.g., medical equipment, pharmaceuticals, medical supplies)
- Address pricing, delivery, warranties, and performance expectations
- Group purchasing agreements
- Procurement departments
- Compliance requirements

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4

Types of Healthcare Contracts

Employment contracts

Staff contracts (physicians, nurses, administrative staff)

Cover terms of employment, compensation, and responsibilities

Fair Market Value (FMV)

Service agreements

Contracts for outsourced services (IT, maintenance, food & nutrition, etc.)

Defines the scope, deliverables, and payment terms

Equipment Leases

Property Leases, Real Estate Agreements

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5

Key Elements of Contracts

Parties involved:

- Who is entering into the agreement
- Clear roles and responsibilities

Terms and Conditions:

- Understand obligations, rights, and responsibilities
- Payment terms, performance expectations, quality

Payment Terms

- Payment schedules, reimbursement rates
- Penalties for non-compliance

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Key Elements of Contracts

Termination Clauses

- Conditions for contract termination
- Address breach of terms, force majeure

Liability and Indemnification

- Clarify risk allocation
- Who bears the risk in case of adverse events

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7

Key Issues in Healthcare Contracts

Compliance with Regulations

- HIPAA – Ensuring patient data privacy and security
- Stark Law – Avoiding physician self-referral issues
- Anti-Kickback Statute – Preventing improper financial incentives

Risk Allocation

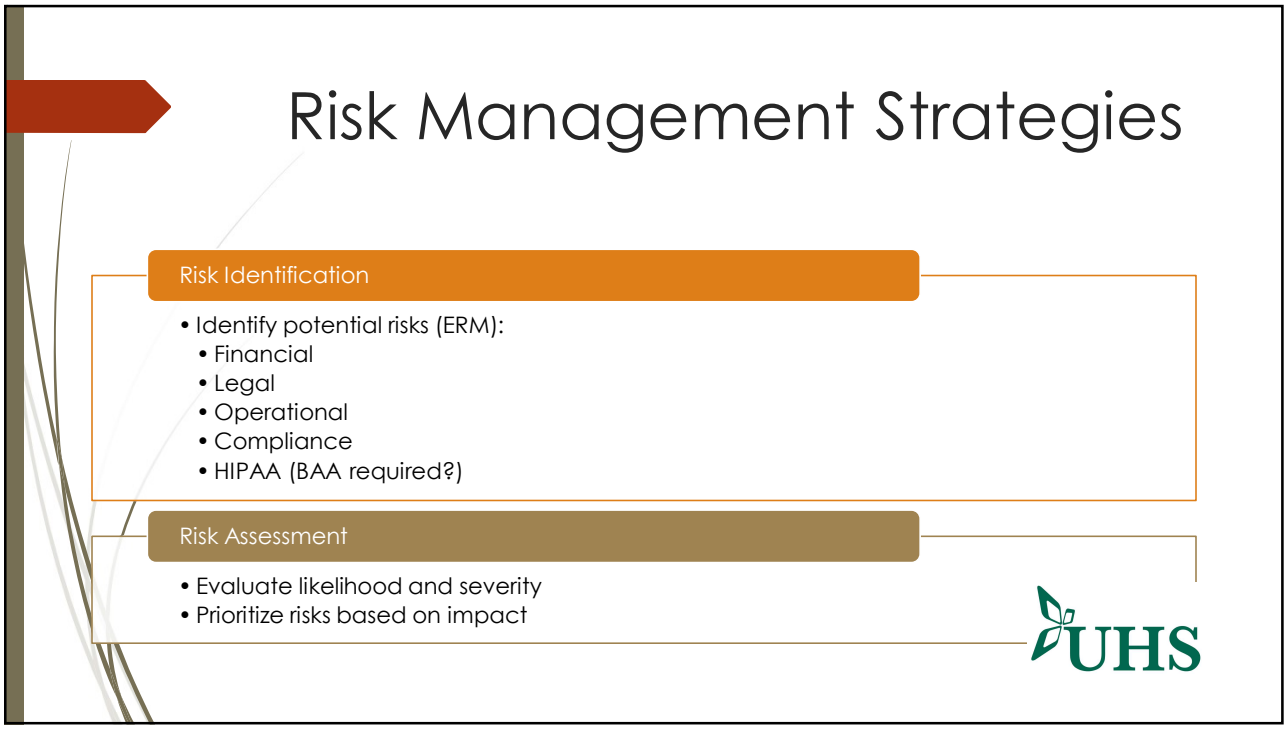
- Indemnification clauses – Protecting against third-party claims
- Liability Limits – Setting caps on financial responsibility
- Insurance requirements – Ensuring adequate coverage

Payment Terms

- Fee-for-service vs. value-based payments – Traditional payment model vs. linking reimbursement to quality and outcomes
- Reimbursement rates – negotiating fair and sustainable rates

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8


Risk Management Strategies
Risk Identification
• Identify potential risks (ERM):
• Financial
• Legal
• Operational
• Compliance
• HIPAA (BAA required?)
Risk Assessment
• Evaluate likelihood and severity
• Prioritize risks based on impact
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9


Risk Management Strategies
Risk Mitigation
• Minimize or eliminate risks:
• Risk-sharing provisions
• Internal controls
• Monitoring mechanisms
• Insurance clauses
Contractual Language
• Avoid ambiguity, thorough review of contract terms
• Specify deliverables and expectations for each party
• Clear documentation, keeping detailed records of all agreements
• Include dispute resolution mechanisms
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10

Case Study

- Provider-Payer
  - A hospital (provider) enters into a contract with an insurance company (payer)
  - Contract Terms:
    - The hospital agrees to provide medical services to the payer's policyholders
    - The insurer agrees to reimburse the hospital based on negotiated rates
    - Termination clause specifies conditions for contract cancellation
    - Liability provisions address malpractice claims
  - Risk Management Strategies
    - Regular audits to ensure compliance with contract terms
    - Clear communication channels for dispute resolution

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11

Case Study

- Vendor Contract
  - A healthcare facility contracts with a medical equipment supplier
  - Contract terms:
    - The vendor agrees to deliver specific equipment (e.g., MRI machines) within a specified timeframe
    - Payment terms include milestones (e.g., partial payment upon delivery, final payment after installation)
    - Warranty provisions cover equipment maintenance and repairs
  - Risk Management Strategies:
    - Due diligence before selecting the vendor (RFP process)
    - Performance guarantees and penalties for late delivery
    - Contingency plans in case of equipment malfunction
    - Uptime/downtime provisions

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12

Case Study

- A hospital hires a new physician
- Contract terms
  - The physician's responsibilities (patient care, administrative duties, on call) are clearly defined
  - Compensation details (sign on bonuses, salary, other incentives, benefits) are specified
  - Non-compete clause prevents the physician from working at competing hospitals
  - Termination provisions (who can terminate, why and when)
- Risk Management Strategies
  - Thorough background checks and credential verification
  - Regular performance evaluations
  - Legal review for compliance with employment laws
  - Compliance with FMV

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13

Case Study

- Service Agreement
- Hospital outsources its IT services to an external provider
- Contract terms:
  - The service provider agrees to maintain the hospital's IT infrastructure (servers, software, security) – clearly define
  - Payment terms include monthly fees
  - Data privacy and security provisions are crucial – BAA?
  - Uptime/Downtime guarantees
- Risk Management Strategies
  - Clearly defined service-level agreements (SLA's)
  - Regular Security Audits
  - Back up and disaster recovery plans

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14

Tips for Successful Contract Management

- Create and follow a structured process
- Stay organized
- Communicate
- Use Technology (Ntracts)
- Perform regular audits

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15

Conclusion

- Importance of understanding contracts for the Risk Professional
- Healthcare risk managers should partner with their Office of General Counsel (or outside counsel) to stay informed and ensure all contractual terms are appropriate
- Healthcare risk managers should request assistance from Corporate Compliance Officer for any compliance concerns
- Remember that each contract is unique, and risk management strategies should be tailored to the specific context.

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16

QUESTIONS???



17

TAB 7

MITIGATION OF FUTURE ECONOMIC DAMAGES IN CATASTROPHIC INJURY CASES

Samantha E. Quinn, Esq.
Appellate Partner
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1

SAMANTHA E QUINN, ESQ.

APPELLATE PARTNER
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Samantha E. Quinn is a partner with the firm of Schiavetti, Corgan, DiEdwards, Weinberg & Nicholson, LLP, which specializes in the defense of hospitals, doctors, and other health care providers.

She heads the office's appellate practice and has briefed and argued numerous appeals. She has also had significant success overturning unsuccessful verdicts, including the dismissal of several multi-million dollar verdicts later upheld on appeal.

Ms. Quinn has handled OPMC investigations for individual physicians, treatment over objection applications for hospital clients, and counseled hospital clients during the course of DOH investigations and other quality assurance matters.

Ms. Quinn has a Bachelor of Arts with Honors in History from Brown University and a Juris Doctor from Boston College Law School and has been a contributing author to the AHRMNY Journal since 2007.

2

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Stephanie Campbell, Esq. is a partner at Schiavetti Corgan DiEdwards Weinberg & Nicholson, LLP, where she defends hospitals, health systems, and individual practitioners in complex medical malpractice and general liability claims. In defense of hospitals and practitioners, she frequently drafts and argues complex motions and appeals before the Supreme and Appellate Courts of the State of New York. She is also licensed to practice law in Connecticut. She became a member of ASHRM and AHRMNY in 2018 and has attended several ASHRM conferences. She currently serves as co-chair of the AHRMNY Publications Committee.

Stephanie received a Bachelor of Science degree with a major in biology from Arizona State University. Following that, she obtained her law degree from Pace Law School with a focus on environmental and animal law. During law school, she suffered a brain injury, which resulted in the permanent loss of taste and smell. On the weekends, you can find her and her husband, Erik, hanging out with their three-year-old son, Lloyd, who likes people to know that he's as fast as a cheetah and that 16+9+4+1=30.

3

DIANA S. FREE BSN, CLCP, CPHRM

MANAGING PARTNER
CLEARVIEW PARTNER CONSULTING, LLC

Diana Free is a founding partner of Clearview Partners Consulting, LLC, specializing in forensic life care planning and medical billing analysis.

Life care planning is a multidisciplinary process that evaluates individuals with disabilities or chronic health conditions to outline the needs created by the disability. The life care planner develops a plan that includes required items, services, and specific costs. Forensic life care planning involves performing evaluations for civil and federal litigation purposes as an aspect of economic damages.

Clearview Partners Consulting, LLC assists attorneys nationwide in estimating the costs of projected healthcare economic damages for individuals involved in litigation.

Before developing Clearview Partners Consulting, LLC, Ms. Free spent over 30 years in leadership roles in healthcare risk management, quality and patient safety, patient grievance process, and healthcare compliance.

These prior career experiences and national certification in life care planning have equipped Ms. Free with a unique background for working in forensic life care planning.

4

Learning Objectives:

- Introduce the notion of challenging plaintiff LCP and economic experts, which defendants are often hesitant to do.
- Introduce pretrial as well as post-trial strategies to challenge the plaintiff's inflated damages for future care.
- Discuss policy considerations, the negative impact of huge damage awards on our healthcare system, and how the defense bar can challenge this.

5



6

MITIGATING FUTURE ECONOMIC DAMAGES IN CATASTROPHIC INJURY CASES

Sustainable verdict values in New York State increasing at alarming rate over past few years

Perez v. Live Nation, 193 A.D. 517 (1st Dept. 2021)

$29 million pain and suffering sustained

Yanes v. City of New York, 199 A.D.3d 551 (1st Dept. 2021)

$20 million pain and suffering sustained

Liciaga v. New York City Transit Authority, 2024 Slip Op 04257 (2nd Dept. 2024)

$16 million pain and suffering sustained

**Collateral source hearing granted re $40 million future medical expenses

7

MITIGATING FUTURE ECONOMIC DAMAGES IN CATASTROPHIC INJURY CASES

Juries inured to huge numbers by plaintiff tactics

Anchoring

suggesting award multiple times highest sustainable verdict

Economic extrapolation

calculating future damages over time rather than for current year only required by 50-A

Result = Runaway Verdicts which threaten viability of our health systems

Future Care - one of the most significant components of damages in a serious injury case

defense attorneys often hesitant to challenge

cross of plaintiff's economist

post trial 5501(c) analysis (deviates materially)

challenging before or even during trial can prevent jury exposure to inflated numbers and mitigate damages

8

MITIGATING FUTURE ECONOMIC DAMAGES IN CATASTROPHIC INJURY CASES

Plaintiff Life Care Plans typically use inflated costs without regard for the availability of insurance, including coverage through Medicare / Medicaid.

Challenging plaintiff LCPs

- Life Expectancy Expert
- Insurance Expert
- Medicare / Medicaid Expert
- Economist

Attacking these Life Care Plans can have a significant impact on damage exposure and facilitate reasonable settlement discussions.

- Pretrial Mediation
- Post-trial Collateral Source Hearing
- Trial Strategies

9

MITIGATING FUTURE ECONOMIC DAMAGES IN CATASTROPHIC INJURY CASES

Three different potential components to challenging future costs put forth in a plaintiff's Life Care Plan

1. **Life Expectancy-** always relevant
2. **Potential private insurance coverage-** may apply
3. **Potential coverage through Medicare/Medicaid-** may apply

Today's presentation will discuss these issues in the context of **catastrophic injuries <u>excluding</u> cases involving birth injuries**

- ❖ Examples of Insurance and Medicare / Medicaid Analysis
- ❖ Defense life care planner
- ❖ Evolving case law and practical implementation
- ❖ Medical Indemnity Fund (MIF) excluded although some arguments applicable

10

Private Insurance –Impact of the Affordable Care Act

Affordable Care Act (ACA)

- became law on March 23, 2010, and underwent significant changes to ensure its protections as of January 1, 2014.
- changes scope of future damages significantly.
- assures that insurer cannot deny coverage to plaintiff on the grounds of pre-existing conditions.
  - ❖ Insurer cannot refuse to sell coverage or renew policies
  - ❖ Injured plaintiffs with significant future medical needs can now obtain insurance coverage which was unavailable before the ACA

Patient Protection and Affordable Care Act § 2705 42 U.S.C. 300gg-4

11

Private Insurance –Impact of the Affordable Care Act

The ACA mandates that all individually purchased medical insurance policies issued in the United States provide a minimum of the following ten essential benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services including oral and vision care

Patient Protection and Affordable Care Act § 1302 42 U.S.C. 18022

12

Private Insurance –Impact of the Affordable Care Act

The ACA

- prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive.
- requires maximum out-of-pocket limits to be imposed for in-network services.
- applies strong directives and incentives to all United States citizens to maintain minimum essential coverage.

Patient Protection and Affordable Care Act §§ *2711, 1302, 42 U.S.C. 300gg-11, 18022(c)(1)*

13

Private Insurance –Impact of the Affordable Care Act

The minimum ACA requirements and protections

guarantee that a plaintiff can obtain most of the services and equipment awarded by the jury at a far lower cost than paying for them dollar-for-dollar and from her own resources.

Growing number of courts around the country are receptive to notion that

reasonable value is what is generally paid in the marketplace

plaintiffs have a duty to mitigate their damages through insurance.

These notions can have a significant impact on case values for purposes of settlement and post-trial analysis

14

EXAMPLE ONE

MP case

29-year-old woman found unresponsive surrounded by multiple empty pill bottles including benzodiazepines and Adderall with history of prior substance abuse and suicide attempts

Presumed overdose; CT done timely; initial imaging mis-read as negative; subsequent imaging confirmed vertebral artery dissection

Patient ultimately was diagnosed as "locked in" – quadriplegic and unable to speak; only able to communicate with eye movements.

The plaintiff's life care plan over an estimated life expectancy of 82.5 years (53 years from the date of injury)

$29,962,624 total / $330,958 annually for home care

$23,868,112 total / $239,410 annually for facility care

15

Joseph Carfi, MD | LIFE CARE PLAN SUMMARY | 08/04/2022

[redacted]

HOME CARE OPTION

	ANNUALIZED COST
MEDICAL CARE	$5,421.60
MEDICATIONS	$13,761.90
DIAGNOSTIC STUDIES	$0.00
EQUIPMENT & SUPPLIES MEDICAL AND HOME	$28,133.06
THERAPIES	$44,231.20
HOME CARE SERVICES	$239,410.80
FACILITY CARE	N/A
ANNUAL TOTAL	$330,958.56

Costs are based upon currently available data

Page 1 of 2

16

Joseph Carfi, MD | LIFE CARE PLAN SUMMARY | 08/04/2022

[redacted]

FACILITY CARE OPTION

	ANNUALIZED COST
MEDICAL CARE	$5,421.60
MEDICATIONS	$13,761.90
DIAGNOSTIC STUDIES	$0.00
EQUIPMENT & SUPPLIES MEDICAL AND HOME	$21,238.51
THERAPIES	$44,231.20
HOME CARE SERVICES	N/A
FACILITY CARE	$178,850.00
ANNUAL TOTAL	$263,503.21

Costs are based upon currently available data

Page 2 of 2

17

[redacted] Preliminary Economic Analysis page: 10

TABLE 2

LIFE EXPECTANCY

[redacted]

		Year and fractional equivalent	Number of years
A.	Date of Birth	[redacted]	
B.	As of Alleged Medical Incident	[redacted]	
1.	Age		29.17
2.	Work-life expectancy		
	59.57	2050.52	30.40
3.	Life expectancy		
	82.47	2073.41	53.30

18

[redacted] Preliminary Economic Analysis page: 9

Table 1
Summary of Economic Damages
[redacted]

	Total	Past*	Future
Lost Earning Capacity (from Table 3)			
Option			
I Home Care	$1,495,356	$92,323	$1,403,033
II Facility Care	$35,118	$2,168	$32,949
Life Care Plan			
LCP 1 Medical Care	$510,717	$0	$510,717
LCP 2 Medication	$1,228,521	$0	$1,228,521
LCP 3 Medical Supply & Equipment			
Option I & II	$844,087	$0	$844,087
Option I Only	$369,317	$0	$369,317
LCP 4 Home Equipment Adaptations Transportation			
Option I & II	$831,338	$0	$831,338
Option I Only	$234,574	$0	$234,574
LCP 5 Therapies	$3,567,750	$0	$3,567,750
LCP 6 Home and Facility Care			
Option I Home Care	$22,556,395	$0	$22,556,395
Option II Facility Care	$16,850,582	$0	$16,850,582
Total Cost Of Life Care Plan Both Options I &II			
Total Cost Of Life Care Plan Option I	$28,467,273	$0	$28,467,273
Total Cost Of Life Care Plan Option II	$23,832,995	$0	$23,832,995
Total Economic Loss Life Care Plan	Total	Past*	Future
Option			
I Home Care	$29,962,629	$92,323	$29,870,306
II Facility Care	$23,868,112	$2,168	$23,865,944

*Past Loss as of September 1, 2022

19

Insurance analysis

Insurance expert such as Susan Combs evaluates case to obtain cost of the specific care forecasted by the plaintiff's life care plan.

- Uses demographic information and actuarial data to determine most comprehensive and appropriate health plan at the least out-of-pocket costs
- Assessment of non-covered items by defense life care planner such as Diana Free
- Analysis of life expectancy by expert - often rehabilitation or neurology
- Possible analysis by economist

Plaintiff must be eligible for individual health insurance through New York's State-run Marketplace

- Must be non-incarcerated lawfully present U.S. resident

20

Items for Insurance Analysis:

1. Plaintiff Life Care Plan
2. Defense Life Care Plan
3. Plaintiff Name & Sex
4. Date of Birth of Plaintiff (the age must be under 65 in order to do an insurance evaluation)
5. Address of the Plaintiff (including zip code) –
6. Life Expectancy of Plaintiff (from Plaintiff's Expert & Defense Expert) –
7. "Reasonable value" report or the cost of the non-covered items from defense Life Care Planner
8. If there is current coverage in place, the Summary of Benefits & Coverages (SBC), Policy Copy (sometimes referred to as an Employee Handbook or Evidence of Coverage), and the premium portion the plaintiff is currently paying out of paycheck on a monthly basis for the coverage.

21

Evaluation by:
Susan L Combs, PPACA, ChHC, REBC
234 Fifth Ave, Ste 501 New York, NY 10001
scombs@combsandco.com
O: 646-736-3737 C: 646-202-0500
May 9, 2024

Case: [redacted] et al.
DOB:
Address: [redacted] Bronx, New York 10458
Life Expectancy: Through Age 51 per Defense Expert
Report: Defense Critique of Plaintiff Life Care Plan
Report Section: Summary of Costs Ages 33-51

Section Description: This section shows the total insurance costs (annualized insurance premium and the annualized maximum out of pocket) from ages 33-Life Expectancy for [redacted]. The total Recurring & Non-Recurring costs that are not covered by insurance per costs from the Plaintiff Life Care Plan provided from ages 33-Life Expectancy for [redacted] and the grand total of the insurance costs, Recurring and Non-Recurring Costs for the Defense Critique of the Plaintiff Life Care Plan.

Option 1: Home Care		
Insurance Costs to Life Expectancy of Through Age 51:		
	Annualized Insurance Premium	$160,525.68
	Annualized Maximum Out of Pocket	$179,550.00
	Total Insurance Related Costs:	**$340,075.68**
Recurring Costs Not Covered by Insurance		
	Medical Care	$0.00
	Medication	$1,525.70
	Equipment & Supplies	$115,987.97
	Therapy	$0.00
	Home / Facility Care	$4,577,100.00
	Total Not Covered by Insurance:	**$4,694,613.67**
Non-Recurring Costs Not Covered by Insurance		
	Medical Care	$0.00
	Medication	$0.00
	Equipment & Supplies	$0.00
	Therapy	$0.00
	Home / Facility Care	$0.00
	Total Not Covered by Insurance:	**$0.00**
Grand Total:		**$5,034,689.35**

Option 2: Facility Care		
Insurance Costs to Life Expectancy of Through Age 51:		
	Annualized Insurance Premium	$160,525.68
	Annualized Maximum Out of Pocket	$179,550.00
	Total Insurance Related Costs:	**$340,075.68**
Recurring Costs Not Covered by Insurance		
	Medical Care	$0.00
	Medication	$1,525.70
	Equipment & Supplies	$115,727.29
	Therapy	$0.00
	Home / Facility Care	$3,178,662.00
	Total Not Covered by Insurance:	**$3,295,914.99**
Non-Recurring Costs Not Covered by Insurance		
	Medical Care	$0.00
	Medication	$0.00
	Equipment & Supplies	$0.00
	Therapy	$0.00
	Home / Facility Care	$0.00
	Total Not Covered by Insurance:	**$0.00**
Grand Total:		**$3,635,990.67**

Evaluation is subject to change based on further information provided by physicians, life care planners, economists or other experts.

22

Case: [redacted] et al.
DOB: [redacted]
Address: [redacted] Bronx, New York 10458
Life Expectancy: Through Age 51 per Defense Expert
Report: Defense Critique of Plaintiff Life Care Plan
Report Section: Demo & Rates
MOOP (In Network Max Out of Pocket) $9,450
Deductible $4,600

Section Description: This page shows the monthly premium for the select health insurance plan (Anthem Gatekeeper X, Bronze, ST, INN, Individual Network). The annualized premium for this plan. The annualized maximum out of pocket that [redacted] would be required to pay in copays, deductibles and coinsurance before the plan would pick up 100% of the covered In Network expenses. The annualized premium total plus the annualized maximum out of pocket.

Age	Monthly Premium: Anthem Gatekeeper X, Bronze, ST, INN, Individual Network	Annualized Premium	Maximum Out of Pocket (MOOP)	Premium + MOOP
33	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
34	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
35	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
36	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
37	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
38	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
39	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
40	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
41	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
42	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
43	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
44	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
45	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
46	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
47	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
48	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
49	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
50	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
51	$ 704.06	$ 8,448.72	$ 9,450.00	$ 17,898.72
Totals: LE Though Age 51		**$ 160,525.68**	**$ 179,550.00**	**$ 340,075.68**

23

Case: [redacted] et al.
DOB: [redacted]
Address: [redacted] Bronx, New York 10458
Life Expectancy: Through Age 51 per Defense Expert
Report: Defense Critique of Plaintiff Life Care Plan
Report Section: Out of Pocket Details - Option 1 (Home Care)

Section Description: This section shows the breakdown of each section of the Life Care Plan evaluation with the annualized total of Recurring and Non-Recurring costs not covered by insurance for ages 33-Life Expectancy for the Defense Critique of the Plaintiff Life Care Plan, Option 1 - Home Care.

Age	Medical Care	Medications	Equipment & Supplies	Therapy	Home / Facility Care	Totals:
33	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
34	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
35	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
36	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
37	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
38	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
39	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
40	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
41	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
42	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
43	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
44	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
45	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
46	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
47	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
48	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
49	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
50	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
51	$0.00	$80.30	$6,104.63	$0.00	$240,900.00	**$247,084.93**
Life Expectancy Totals: Through 51	**$0.00**	**$1,525.70**	**$115,987.97**	**$0.00**	**$4,577,100.00**	**$4,694,613.67**

Non-Recurring Amounts by Section	
Medical Care	$0.00
Medications	$0.00
Equipment & Supplies	$0.00
Therapy	$0.00
Home / Facility Care	$0.00
Totals:	$0.00

Evaluation is subject to change based on further information provided by physicians, life care planners, economists or other experts.

24

Case: [redacted] et al.
DOB:
Address: [redacted] Bronx, New York 10458
Life Expectancy: Through Age 51 per Defense Expert
Report: Defense Critique of Plaintiff Life Care Plan
Report Section: Out of Pocket Details - Option 2 (Facility Care)

Section Description: This section shows the breakdown of each section of the Life Care Plan evaluation with the annualized total of Recurring and Non-Recurring costs not covered by insurance for ages 33-Life Expectancy for the Defense Critique of the Plaintiff Life Care Plan, Option 2 - Facility Care.

Age	Medical Care	Medications	Equipment & Supplies	Therapy	Home / Facility Care	Totals:
33	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
34	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
35	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
36	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
37	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
38	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
39	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
40	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
41	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
42	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
43	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
44	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
45	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
46	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
47	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
48	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
49	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
50	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
51	$0.00	$80.30	$6,090.91	$0.00	$167,298.00	$173,469.21
Life Expectancy Totals: Through 51	$0.00	$1,525.70	$115,727.29	$0.00	$3,178,662.00	$3,295,914.99

Non-Recurring Amounts by Section	
Medical Care	$0.00
Medications	$0.00
Equipment & Supplies	$0.00
Therapy	$0.00
Home / Facility Care	$0.00
Totals:	$0.00

25

Case: [redacted] et al.
DOB:
Address: [redacted] Bronx, New York 10458
Life Expectancy: Through Age 51 per Defense Expert
Report: Defense Critique of Plaintiff Life Care Plan
Report Section: Medical Care (Including Diagnostics & Surgical)

Section Description: This section shows the requested Medical Care for [redacted] from ages 33-Life Expectancy, if the item is covered by insurance, the patient's [redacted] responsibility (copay or co-insurance) and the annualized totals of each item not covered by insurance.

Recommendation				Life Care Plan OOP Annual Estimation: Not Covered by Insurance	
Item/Service**	Frequency	Comment**	Patient Responsibility*	Recurring	Non-Recurring
Rehabilitation Specialist	4x per year to LE	Covered by Insurance.	$75 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Gastroenterologist	2x per year to LE	Covered by Insurance.	$75 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Botox Injections (Physician)	4x per year to LE	Covered by Insurance. Prior approval is required.	$75 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Total Annual Estimation Not Covered:				$0.00	$0.00

Evaluation is subject to change based on further information provided by physicians, life care planners, economists or other experts.
*Maximum Out of Pocket for patient annually, In Network is $9450, then 100% is covered by insurance for all covered services and medications in accordance with stated plan limits.
**Insurance allows for 3 specialist visits per year at a $75 Copay prior to the deductible being met. "Patient Responsibility" shows how coverages is provided when those visits are exhausted.

26

Case: [redacted] et al.
DOB:
Address: [redacted] Bronx, New York 10468
Life Expectancy: Through Age 51 per Defense Expert
Report:: Defense Critique of Plaintiff Life Care Plan
Report Section: Medications

Section Description: This section shows the requested Medications for [redacted] from ages 33-Life Expectancy, if the item is covered by insurance, the patient's [redacted] responsibility (copay or co-insurance) and the annualized totals of each item not covered by insurance.

Drug/Supply Needs:

				Life Care Plan OOP Annual Estimation: Not Covered by Insurance	
Item/Service	Frequency	Comment	Patient Responsibility*	Recurring	Non-Recurring
Invirty 1.0	As Needed to LE	Covered by Insurance. HCPCS Codes: J0152	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Biotin 10mg	1x per day to LE	Covered by Insurance, Tier 3	$70 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Vitamin B Complex	1x per day to LE	Covered by Insurance, Tier 1	$10 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Cyclobenzaprine 10mg & 5mg	1x per day to LE	Covered by Insurance, Tier 1	$10 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Tamsulosin 0.4mg	1x per day to LE	Covered by Insurance, Tier 1	$10 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Fluoxetine 20mg	2x per day to LE	Covered by Insurance, Tier 2	$35 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Clonazepam 0.5mg	2x per day to LE	Covered by Insurance, Tier 1	$10 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Methylphenidate 5mg	2x per day to LE	Covered by Insurance, Tier 1	$10 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Senna S 8mg	2x per day to LE	Not Covered by Insurance. Per Defense LCP Estimations: $0.02/pill or $14.30/yr	100%	$14.60	$0.00
Calcium Polycarbophil 625mg	As Needed to LE	Not Covered by Insurance. Per Defense LCP Estimations: $0.09/pill or $65.70/yr	100%	$65.70	$0.00

27

Bisacodyl 10mg	As Needed to LE	Covered by Insurance, Tier 1	$10 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Botox 200 U	As Needed to LE	Covered by Insurance, Tier 3	$70 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Total Annual Estimation Not Covered:				**$80.30**	**$0.00**

Evaluation is subject to change based on further information provided by physicians, life care planners, economists or other experts.
*Maximum Out of Pocket for patient annually, In Network is $9450, then 100% is covered by insurance for all covered services and medications in accordance with stated plan limits.

28

Case: [redacted] et al.
DOB: [redacted]
Address: [redacted] Bronx, New York 10458
Life Expectancy: Through Age 81 per Defense Expert
Report: Defense Critique of Plaintiff Life Care Plan
Report Section: Supplies & Equipment

Section Description: This section shows the requested Supplies & Equipment for [redacted] from ages 33-Life Expectancy, if the item is covered by insurance, the patient's [redacted] responsibility (copay or co-insurance) and the annualized totals of each item not covered by insurance.

Drug/Supply Needs:

Item/Service	Frequency	Comment	Patient Responsibility*	Life Care Plan OOP Annual Estimations Not Covered by Insurance		
				Recurring: Opt 1	Recurring: Opt 2	Non-Recurring
Incontinent Supplies: Gloves, Chux, Powder, Wipes, Barrier Cream (Option 1 ONLY)	Monthly Needs to LE	Covered by Insurance. HCPCS Codes: A4927, A4927, A4371, A5120, A6550	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Power Wheelchair with Tilt, Leg Rest, Head Array and Sip & Puff Control.	1x every 5 years to LE	Covered by Insurance. HCPCS Codes: E2648, E0948, E0850, E0851, E0856, E0950, E0960, E0371, E0324, E1233, E1028, E1037, E1061, E1004, E1007, E2310, E2311, E2620, E2605, E2621, E2610, E2624, E2625, E0957, E1028, E0978, E0951, E0954, E0960, E0950, E2312, E2373, E2358	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Lightweight Manual Wheelchair with Hand Support & Tilt in Space.	1x every 5 years to LE	Covered by Insurance. HCPCS Codes: E0009, E0261, E0303, E0960, E0961, E1015, E2313, E0981, E2411, E2601, E2624, E0971, E0978, E0950, E0965, E0971, E0950, E2207	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
T3 Back Cushion	1x every 5 years to LE	Covered by Insurance. HCPCS Codes: E2613, E2615	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
T3 Recline Cushion	1x every 2 years to LE	Covered by Insurance. HCPCS Codes: E2622, E2623, E2624, E2625	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Supine Stander (Option 1 ONLY)	1x every 5 years to LE	Covered by Insurance. HCPCS Codes: E0641, E0638	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Bilateral AFOs	1x every 5 years to LE	Covered by Insurance. HCPCS Codes: L1930	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Ankle / Foot Supports for Bed Use (Option 1 ONLY)	1x every 2 years to LE	Covered by Insurance. HCPCS Codes: L1906-L1990	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Resting Hand Splint (Option 1 ONLY)	1x per year to LE	Covered by Insurance. HCPCS Codes: L3806-L3904	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Nutrition Supplies: Feeding Bags, Extension Set, Feeding kit, Tubing, Feeding pump, Tape, Syringes, Gauze, IV Pole (Option 1 ONLY)	As Needed to LE	Covered by Insurance. HCPCS Codes: B4081, B4100, B4155, B4156, B4034, B9002, B4087, B4035, B4036, B9002, B4087, B4088, A4213, A4222, B4100, A4452, A4332, A4358-A4523, E0776	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Total Dynavox	1x every 5 years to LE	Covered by Insurance. HCPCS Codes: E2500, E2502, E2504, E2508, E2510, E2511, E2512, E2599	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00

29

Eye Gaze Computer Access	1x every 5 years to LE	Covered by Insurance. HCPCS Codes: E2510	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Electric Hospital Bed and Pressure Reducing Mattress (Option 1 ONLY)	1x every 10 years to LE (bed) 1x every 3 years to LE (mattress)	Covered by Insurance. HCPCS Codes: E0250-E0373, E0277	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Incontinence Mattress Cover (Option 1 ONLY)	2x every 3 years to LE	Covered by Insurance. HCPCS Codes: T4537	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Rolling Shower / Commode Chair (Option 1 ONLY)	1x every 5 years to LE	Covered by Insurance. HCPCS Codes: E0240	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Hand Held Shower (Option 1 ONLY)	1x every 3 years to LE	Not Covered by Insurance. Per LCP Estimations: $41.17/mn or $13.72/yr	100%	$13.72	$0.00	$0.00
Diapers (Option 1 ONLY)	As Needed to LE	Covered by Insurance. HCPCS Codes: T4521-T4545	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Lift Device with Slings (Option 1 ONLY)	1x every 5 years to LE (lift); 2x every 2 years to LE (slings)	Covered by Insurance. HCPCS Codes: E0621-E0642	50% of charges after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00	$0.00
Van Adapted for Wheelchair Access	1x every 11 years to LE	Not Covered by Insurance. Per Defense LCP Estimations: $67,000/item or $6,090.91/yr	100%	$6,090.91	$6,090.91	$0.00
Total Annual Estimation Not Covered:				**$6,104.63**	**$6,090.91**	**$0.00**

Evaluation is subject to change based on further information provided by physicians, life care planners, economists or other experts.
*Maximum Out of Pocket for patient annually, in Network is $9450, then 100% is covered by insurance for all covered services and medications in accordance with stated plan limits.

30

Case: [redacted] et al.
DOB:
Address: [redacted] Bronx, New York 10458
Life Expectancy: Through Age 51 per Defense Expert
Report: Defense Critique of Plaintiff Life Care Plan
Report Section: Therapy

Section Description: This section shows the requested Therapy for [redacted] from ages 33-Life Expectancy, if the item is covered by insurance, the patient's [redacted] responsibility (copay or co-insurance) and the annualized totals of each item not covered by insurance.

Recommendation

Item/Service	Frequency	Comment	Patient Responsibility*	Life Care Plan OOP Annual Estimation: Not Covered by Insurance: Recurring	Non-Recurring
Physical Therapy	52 sessions per year to LE	Covered by Insurance. 60 sessions per year per diagnosis are covered with prior approval.	$50 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Occupational Therapy	52 sessions per year to LE	Covered by Insurance. 60 sessions per year per diagnosis are covered with prior approval.	$50 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Speech Therapy	52 sessions per year to LE	Covered by Insurance. 60 sessions per year per diagnosis are covered with prior approval.	$50 Copay after the $4600 deductible has been met until the Maximum Out of Pocket of $9450 has been reached for the year, then No Charge for remaining benefit year.	$0.00	$0.00
Total Annual Estimation Not Covered:				**$0.00**	**$0.00**

Evaluation is subject to change based on further information provided by physicians, life care planners, economists or other experts.
*Maximum Out of Pocket for patient annually, In Network is $9450, then 100% is covered by insurance for all covered services and medications in accordance with stated plan limits.

31

Case: [redacted] et al.
DOB:
Address: [redacted] Bronx, New York 10458
Life Expectancy: Through Age 51 per Defense Expert
Report: Defense Critique of Plaintiff Life Care Plan
Report Section: Home / Facility Care

Section Description: This section shows the requested Home / Facility Care for [redacted] from ages 33-Life Expectancy, if the item is covered by insurance, the patient's [redacted] responsibility (copay or co-insurance) and the annualized totals of each item not covered by insurance.

Recommendation

Item/Service**	Frequency	Comment**	Patient Responsibility*	Life Care Plan OOP Annual Estimation: Not Covered by Insurance: Recurring	Non-Recurring
Option 1 - Home Care					
Home Health Aid	24/7/365 to LE	Not Covered by Insurance, as will be deemed "Custodial Care" per Defense LCP Estimations: $27.50/hr or $240,900/yr	100%	$240,900.00	$0.00
Total Annual Estimation Not Covered:				**$240,900.00**	**$0.**

Item/Service**	Frequency	Comment**	Patient Responsibility*	Recurring	Non-Recurring
Option 2 - Facility Care					
Facility	24/7/365 to LE	Not Covered by Insurance, per Defense LCP Estimations: $167,298/yr	100%	$167,298.00	$0.00
Total Annual Estimation Not Covered:				**$167,298.00**	**$0.**

Evaluation is subject to change based on further information provided by physicians, life care planners, economists or other experts.
*Maximum Out of Pocket for patient annually, In Network is $9450, then 100% is covered by insurance for all covered services and medications in accordance with stated plan limits.
**Insurance allows for 3 specialist visits per year at a $75 Copay prior to the deductible being met. "Patient Responsibility" shows how coverages is provided when those visits are exhausted.

32

Evaluation

The applicability of insurance lowered future care costs by millions of dollars

- **$5,034,689.35 total for home care**
  - Almost **$25 million less** than plaintiff LCP total
- **$3,635,990.67 total facility care**
  - Over **$20 million less** than plaintiff LCP total

Key points

- Difference of 30 years in defense life expectancy versus plaintiff LCP
- Insurance analysis but not economist's analysis, so no growth rate applied
- Nonetheless facilitated settlement at pre-trial mediation

33

Medicare/Medicaid analysis

Can work in conjunction with Insurance analysis or separately

Not a viable option in MP case

- Personal dynamics with relatives made ceding control of funds as required for SNT a non-option

Nonetheless, under Medicaid analysis annualized costs of facility care based on Carfi's rates and Medicaid rates:

- Carfi annualized cost: $178,850
- Medicaid annualized cost: $96,725 - $147,460

And annualized costs of a home health aide based on Carfi's rates and Medicaid rates:

- Carfi annualized cost: $239,410.80
- Medicaid annualized cost for 24 hours/day: $174,674.40

34

would have given her the proper guidance that includes the creation of a Special Needs Trust or an equivalent Medicaid preservation Trust vehicle.

As noted above, it is believed that the primary benefit from [redacted] Medicaid coverage will be focused on providing a home health aide. It has been alleged by Dr. Carfi that [redacted] will need help from a personal care aide at $27.33/hr. This hourly rate does not consider that a Special Needs Trust would preserve access to Medicaid and thus allow a Plaintiff like [redacted] to avail herself of maximized Medicaid benefits for personal care aides.

The New York State Department of Health publishes a fee schedule devoted to long term care/reimbursement prices for home health based on location. This is a government document in the public domain and can be found here[1]:

https://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/rates/schedule_of_medicaid_rates.htm

Certified Home Health Agency Schedule of Medicaid Rates

New York State Department of Health - Bureau of Long Term Care Reimbursement
Certified Home Health Agency Schedule of Medicaid Rates
Effective January 1, 2005

OPCERT	PROVIDID	Provider	Region	Nursing	Physical Therapy	Speech Pathology	Occupational Therapy	Home Health Aide	HR/VST	HHA Shared Aide
7001627	0390797	AMERICARE CERTIFIED SS INC	NEW YORK CITY	83.78	98.86	99.23	99.17	18.39	HR	4.6
7001637	3803813	BETH ABRAHAM HLTH SVCS HC	NEW YORK CITY	114.86	169.63	0.01	162.47	15.8	HR	3.95
7001632	2235628	EMPIRE STATE HOME CARE SERVICES INC	NEW YORK CITY	118.62	169.51	114.71	110.08	19.04	HR	4.89
7002653	8973337	EXTENDED NURSING PERSONNEL CHHA LLC	NEW YORK CITY	90.32	95.79	97.86	110.08	15.47	HR	3.87
7001620	3121957	FAM CERT SVCS BKLYN/QUEENS	NEW YORK CITY	88.4	72.57	84.96	73.8	16.01	HR	4
7001631	1702667	FIRST TO CARE HOME CARE	NEW YORK CITY	111.22	79.22	109.62	93.09	17.75	HR	4.44
7001628	7043065	GIRLING HEALTH CARE INC	NEW YORK CITY	118.62	169.51	114.71	110.08	18.54	HR	4.64
7002645	3372148	LITTLE SISTERS OF ASSUM	NEW YORK CITY	100.74	94.3	0	0	17.04	HR	4.26
7002656	2405838	METROPOLITAN JEWISH HOME CARE, INC.-CHHA	NEW YORK CITY	102.26	96.03	99.7	95.57	18.48	HR	4.62
7001625	3121548	PERSONAL TOUCH HOME AIDES NY	NEW YORK CITY	83.75	94.85	79.45	82.2	17.46	HR	4.37
7001629	1544449	RENAYAL HOME HEALTH CARE INC	NEW YORK CITY	87.62	90.75	82.08	93.6	17.87	HR	4.47
7002651	3593026	SELFHELP SPECIAL FAM HC INC	NEW YORK CITY	118.23	169.15	0.01	109.72	17.81	HR	4.45
7001632	1811474	SHOREFRONT JEWISH GERI HHA	NEW YORK CITY	118.6	169.51	114.71	110.08	18.14	HR	4.53
7002648	1226548	VILLAGE CENTER FOR CARE	NEW YORK CITY	99.08	104.81	106.84	99.57	17.53	HR	4.38
7003639	1978568	VIP HEALTH SERVICES INC	NEW YORK CITY	109.37	94.77	85.62	77.25	16.47	HR	4.12
7001600	321828	VISITING NURSE ASSOC OF BKLYN	NEW YORK CITY	118.46	169.51	114.08	110.08	19.04	HR	4.99
7001600	3372151	VNA HEALTH CARE SERVICES INC	NEW YORK CITY	99.86	92.55	102.75	99.13	17.95	HR	4.49
7002652	1827572	VNS GROUP HEALTH HOME CARE	NEW YORK CITY	93.23	86.33	85.74	86.12	16.31	HR	4.82
7002655	321871	VNS OF NY HOME CARE INC	NEW YORK CITY	116.34	99.53	99.04	99.62	18.16	HR	4.54
7002650	3523531	YAI HOME HEALTH SERVICES	NEW YORK CITY	118.07	96.54	83.38	79.66	19.75	HR	4.94

The above list contains each certified agency in New York City for home health aides. It is clear from the chart that the range of providers and costs goes from $15.47/hr. to $19.94/hr. These are significant departures from the $27.33/hr. advanced by Dr. Carfi. I am not a physician and therefore I am not expressing any type of medical opinion on necessity. I am assuming, based on the report of Dr. Carfi, that [redacted] condition would qualify her for total coverage since Dr. Carfi is calling for 24 hour/day care. Medicaid coverage of this nature is dependent on the

plan of care certified by treating physicians for [redacted].[2]

Consequently, I will choose the single highest rate on New York City's fee schedule of $19.94 knowing full well that it is an outlier with most prices in the schedule $1-$2 lower per hour. A comparison to the numbers in Dr. Carfi's life care plan could be very significant for [redacted] in terms of home health care and yet another reason to take advantage of the Special Needs Trust.

The annualized costs of a home health aide based on Carfi's rates and Medicaid rates:

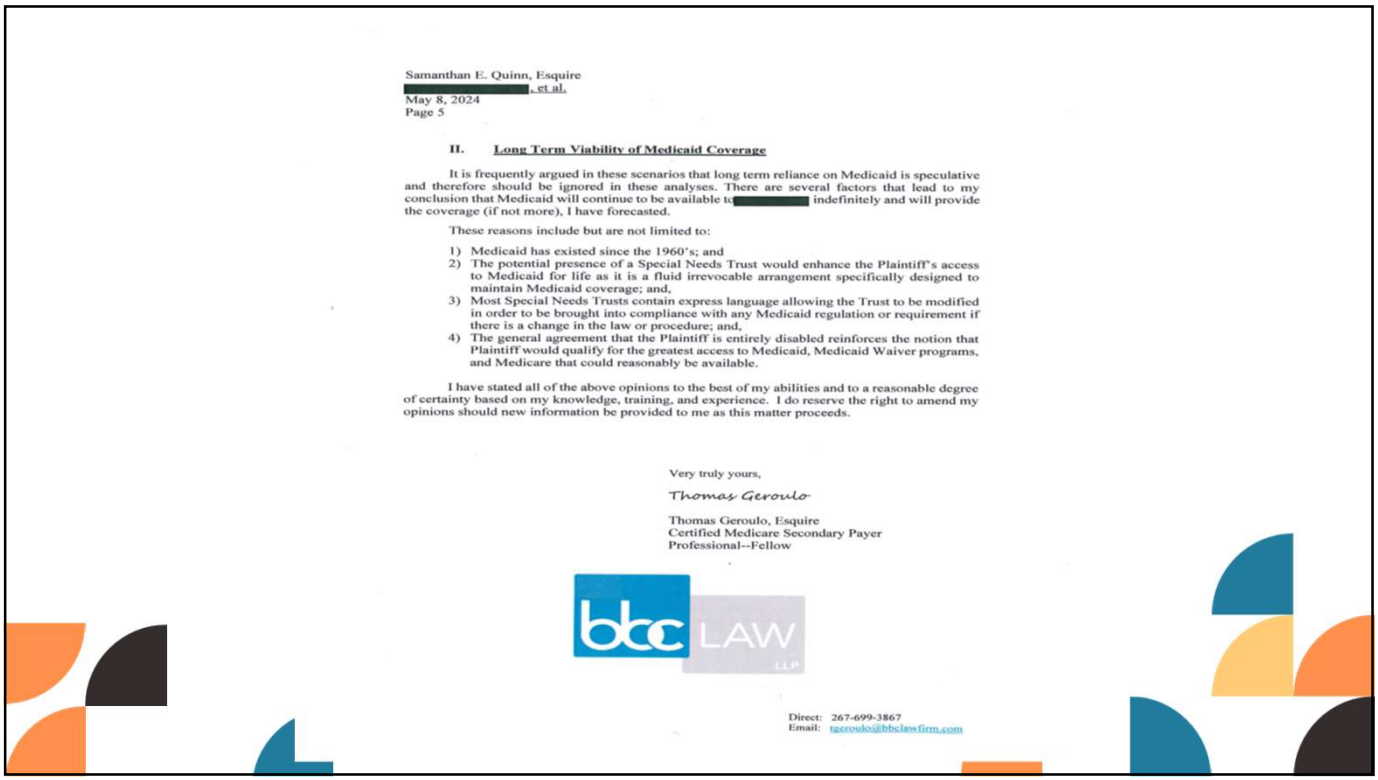
Carfi annualized cost: $239,410.80
Medicaid annualized cost for 24 hours/day: $174,674.40

As an example, if the Plaintiff were to retain Medicaid coverage that provided care from a home health aide for 24 hours per day, she would save approximately $1.62M in a 25-year period on home health care by having a Special Needs Trust that would preserve access to Medicaid. This is a conservative projection since we have selected the highest rate from the fee schedule when it is possible a lower rate will apply.

In addition, I note that Dr. Carfi has projected a daily rate of $490/day for a residential facility placement for [redacted]. In the same fashion as outlined above, a Special Needs Trust could provide access to lifelong Medicaid and Medicaid can and does provide coverage for such care when deemed medically necessary. A survey of rates is publicly available[3] for potentially applicable facilities located in Bronx, NY. For those facilities that are not providing services to ventilation dependent patients (where the price tends to increase due to complexity), there are greater than fifteen (15) facilities that have rates ranging from $265/day to $375/day. Even a facility such as The Plaza Rehab & Nursing Center shows a publicly available rate of $403.85.[4]

Furthermore, I have reviewed the critique of the Carfi Life Care Plan authored by Susan Combs. I defer to Ms. Combs for her opinions on coverage and price. However, I would also like to note that the creation of a Special Needs Trust would allow [redacted] to maintain access to both Medicaid and privately held insurance through the insurance exchanges simultaneously. This is a frequent and recommended strategy for Trust beneficiaries like [redacted] allowing her to maximize coverage over the course of her life. In this instance, the private insurance would be primary in coverage and Medicaid would be secondary. Therefore, Medicaid would likely continue to provide coverage for the home health care as noted above while the private insurance would pay first on the medical items of need where forecasted by Ms. Combs.

[2] https://www.health.ny.gov/health_care/medicaid/program/longterm/pcs.htm



Samanthan E. Quinn, Esquire
[redacted], et al.
May 8, 2024
Page 5

II. Long Term Viability of Medicaid Coverage

It is frequently argued in these scenarios that long term reliance on Medicaid is speculative and therefore should be ignored in these analyses. There are several factors that lead to my conclusion that Medicaid will continue to be available t[redacted] indefinitely and will provide the coverage (if not more), I have forecasted.

These reasons include but are not limited to:

1) Medicaid has existed since the 1960's; and
2) The potential presence of a Special Needs Trust would enhance the Plaintiff's access to Medicaid for life as it is a fluid irrevocable arrangement specifically designed to maintain Medicaid coverage; and,
3) Most Special Needs Trusts contain express language allowing the Trust to be modified in order to be brought into compliance with any Medicaid regulation or requirement if there is a change in the law or procedure; and,
4) The general agreement that the Plaintiff is entirely disabled reinforces the notion that Plaintiff would qualify for the greatest access to Medicaid, Medicaid Waiver programs, and Medicare that could reasonably be available.

I have stated all of the above opinions to the best of my abilities and to a reasonable degree of certainty based on my knowledge, training, and experience. I do reserve the right to amend my opinions should new information be provided to me as this matter proceeds.

Very truly yours,

Thomas Geroulo

Thomas Geroulo, Esquire
Certified Medicare Secondary Payer
Professional--Fellow

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37

Medicare / Medicaid

Medicaid need-based – income below a certain level and/or disability

Medicare age based – must be over 65; can also be based on disability

Medicaid is provided by the government at no cost but can be subject to a lien

Medicare is similar to private insurance, and different plans are available to individuals over 65 and those with qualifying disabilities.

Among the changes under the ACA was the expansion of the scope of Medicaid coverage

38

Special Needs Trust is a statutory vehicle authorized by federal law, 42 U.S.C. §1396p(d)(4)(A), and designed for the express purpose of receiving a substantial sum of money (i.e., through verdict or settlement in a personal injury action) into a Trust that is not controlled directly by the plaintiff.

> Public entity such as Medicaid is then forbidden from counting that same award as income for the purposes of excluding Plaintiff from the benefits of Medicaid based health insurance.

39

42 U.S.C. § 1396p(d)(4)(A) defines a First Party Trust (i.e., one created by the party that can include the receipt of moneys from a lawsuit or claim) as:

> A trust containing the assets of an individual under age 65 who is disabled (as defined in § 1382c(a)(3) of this title and which is established for the benefit of such individual by the individual, a parent, grandparent, legal guardian of the individual, or a court of the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

40

A Special Needs Trust allows the receipt of a substantial amount of money to someone under Age 65 to retain Medicaid benefits so long as

1. the Trust is not controlled by the individual beneficiary; and
2. the "State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual" (i.e., the future Medicaid costs related to the case)

Well-recognized and frequently utilized powerful planning tools directly designed to benefit individuals exactly like plaintiffs with serious injuries.

It is reasonable to assume a plaintiff's counsel would give her the proper guidance, which includes the creation of a Special Needs Trust or an equivalent Medicaid preservation Trust vehicle.

41

Items for Analysis

Importance of development of data during discovery

Importance of consideration of the issue of damages from the beginning of the case

General hesitancy of defense to develop their own life care plan; strategy considerations

42

Items for Medicare/Medicaid Analysis

1. Discovery or other information that confirms Plaintiff's current health insurance situation (an insurance card would be ideal along with answers to interrogatories along those lines).
2. A list of the interrogatories/document requests you have served that deal with health insurance, liens, or related concepts.
3. Insurance face sheets from hospital treatment/or significant medical treatment (the most current ones you have again to show insurance coverage.
4. Whether Plaintiff is on SSI or Supplemental Security Income.
5. Whether Plaintiff is on SSDI or Social Security Disability Income.
6. Lien letters (hopefully itemized for charges/payments) for health bills accumulated to date.
7. Deposition of Plaintiff where applicable.
8. Any deposition testimony from a family member or caretaker that touches on day-to-day care for the Plaintiff and/or coordination of insurance issues.
9. Any correspondence with Medicaid or Medicare.
10. Life care plans from both sides if available
11. Economic reports from both sides if available
12. Life expectancy reports if available
13. Any formal information/discovery on guardianship/conservatorship type proceedings. Probate issues are significant to this analysis.

43

EXAMPLE TWO

PJ case

56-year-old underwent neurosurgery and suffered a spinal cord infarct on the second postoperative day, rendering her quadriplegic.

Significant verdict including roughly $25 million in future economic damages

All analysis post-verdict; currently proceeding with collateral source hearing to determine the impact the special needs trust should have on the future damages, particularly in light of the plaintiff"s death less than a year after the verdict given a 20-year life expectancy.

Plaintiff projections

Impact of Medicare / Medicaid analysis on 50A calculations.

44

LIFE CARE PLAN FOR [redacted]

This Life Care Plan represents a descriptive rationale for the services and equipment that will be needed throughout the life of [redacted]. The Needs Assessment consists of the thought process and justification for the items in the Cost Report. The Cost Report was determined from comprehensive evaluations of [redacted] and review of her medical records.

The Life Care Plan Cost Report represents Ms. [redacted] current objective treatment throughout the remainder of her projected lifespan and its current costs. The items and services in the Cost Report are based upon current impairments, disabilities, handicaps, functional level and long term needs. The costs reported are current and do not reflect the need for economic adjustments based on cost increases of services, equipment and supplies.

NEEDS ASSESSMENT

[redacted] will require medical monitoring by a physiatrist specializing in the treatment of Spinal Cord Injury Medicine bimonthly, Medical Internist semiannually, psychiatrist monthly, Urologist quarterly, and Neurosurgeon annually. She will need psychological treatment weekly for depression and post traumatic stress disorder given the profound history of trauma and life altering events. [redacted] will require podiatric care monthly, dental care quarterly and ophthalmologic care annually.

[redacted] will require 8 hour per day nursing care for her skilled needs (i.e. bladder, bowel, skin and total care). She will need 16 hours of Home Health aid care. The additive effect of age and disability will cause an increase in impairment and dependence. Physical therapy is mandatory given the level of spinal cord injury and muscular deterioration. Physical therapy must be vigilant to prevent heterotopic ossification as she is prone and has already suffered with a right hip fracture. This must be hospital based given the complexities of high tetraplegia. Occupational therapy is warranted given the profound impairment of the hands, activities of daily living, deterioration due to episodic care and the ongoing need for adaptive equipment. This must be hospital based given the complexities of high tetraplegia. A case manager is necessary to monitor [redacted] overall functioning as well as a liaison between her and the service provider.

She will require housecleaning services weekly to keep the environment bacteria and germ free.

[redacted] warrants a power wheelchair with tilt back, sip and puff, power tread tires, and revamping for indoor and outdoor use. Hoyer lift and sling, specialized hospital bed with air mattress system as well as the items listed are medically required given her level of

45

impairment, disability, advancing age-predisposition to medical complications, reduction in endurance and decrease in mobility.

Unanticipated hospitalization costs include those costs incurred by the medical and surgical complications of spinal cord injury that require hospitalizations. These costs include, but are not limited to physician costs, hospital costs, rehabilitation costs, intravenous antibiotics, medications, diagnostic and laboratory testing and therapeutic interventions. These costs also include, but are not limited to those oral antibiotics, medications and therapeutic interventions that will occur as a direct result of complete cervical spinal cord injury.

Careful thought and consideration is given to [redacted]' comprehensive life care medical and service needs. Justification for the services and items contained are mandatory given the profound impairment, disability and handicap caused by the iatrogenic C4 complete tetraplegia that occurred on August 18, 2009.

LIFE EXPECTANCY

Life expectancy for [redacted] is estimated to be 85 years. This is based upon current published data which postulates that life expectancy for females now at 65 years of age have a life expectancy of 20 years. With the Life Care Plan and Specified Care delineated, there is no medical justification that [redacted] will not attain her life expectancy.

Lois S. Saltzman, M.D.
Diplomate, American Board of Physical Medicine and Rehabilitation
Diplomate, National Board of Medical Examiners
Medical Director, Inpatient Rehabilitation, Northport VAMC, NY
Assistant Clinical Professor, Rehabilitation Medicine, Stony Brook University, NY
Diplomate and Lifetime Member, Senior Disability Analyst
Spinal Cord Injury Medicine – Sub-specialty Board Certification #75
Medical Acupuncturist

18

46

SERVICE/ITEM	DURATION	FREQUENCY	UNIT COST	20YRS	TOTAL
Rehabilitation Medicine Spinal Cord Physician	Life Expectancy	Bimonthly	$350		$ 14,000.00
Internal Medicine	Life Expectancy	Semiannually	$350.00		$ 14,000.00
Psychiatrist	Life Expectancy	Monthly	$500		$120,000
Urologist	Life Expectancy	4 x per year	$350.00		$ 14,000.00
Neuro surgeon	Life Expectancy	Annually	$ 500.00		$ 20,000.00
Psychologist	Life Expectancy	Weekly	$250.00		$260,000
Nursing	Life Expectancy	8hrs/day	$43.00		$2,511,200
Physical Therapy-Based on Diagnoses	Life Expectancy	3x/week	$ 1,000.00		$3,120,000
Occupational Therapy based on Diagnoses	Life Expectancy	3x/week	$1,000.00		$3,120,000
Case Manager	Life Expectancy	Monthly	$ 200.00		$ 48,000.00
Dental	Life expectancy	4x per year	$ 250.00		$ 20,000.00
Opthalmologist	Life expectancy	Annually	$ 500.00		$ 10,000.00
Podiatrist	Life Expectancy	Monthly	$ 350.00		$84,000
Housecleaning	Life Expectancy	Weekly	$ 150.00		$ 156,000.00
Attendant	Life Expectancy	16hrs/day	$27.00		$3,153,600
		GRAND TOTAL			$12,664,800.00
**Physical Therapy					
*****Lower End For Hospital Based on Diagnosis	TOTAL=$9,544,800.00	$1,560,000.00	$500.00		$9,544,800.00
Physical and Occupational Therapies-Community Based	Total=$8,298,00.00	$936,000.00	$300.00		$8,298,000
Hospitalizations	$68, 500.00/year				
	TOTAL				
	1,370,000.00				

47

SERVICE/ITEM	DURATION	FREQUENCY/REPLACEMEN	UNIT COS	20yrs	Total
Comprehensive Metabolic panel	Life expectancy	Semiannually	$ 61.00		$2,440.00
CBC with differential	Life expectancy	Semiannually	$ 34.00		$1,360
Lipid Profile	Life expectancy	Annually	$ 109.00		$2,180.00
Urinalysis	Life expectancy	Monthly	$ 40.00		$9,600
Urine Cultures	Life expectancy	4 x Year	$ 56.00		$4,480.00
Radiological Services	Life expectancy				
Chest Xray	Life expectancy	Annually	$ 110.00		$2,200
Ultrasound Bladder	Life expectancy	Annually	$ 176.00		$3,520
Urodynamic Studies					
MRI Cervical Spine	Life expectancy	Annually	$ 1,500.00		$30,000
Pneumovax	Life expectancy	Annually	$ 10.00		$200
Infuenza Vaccine	Life expectancy	Annually	$ 10.00		$200
Stool hemaoccult	Life expectancy	Annually	$ 35.00		$700
		GRAND TOTAL			$ 56,880.00

48

SERVICE/ITEM	DURATION	FREQUENCY/REPLACEMENT	UNIT COST	20YRS	TOTAL
Home Modification					
Home Accomodation	Life expectancy	Barrier Free -ECU			$750,000
Durable Medical Equipment					
Environmental Control Unit	Life expectancy	Every 5 years	$ 20,000.00		$80,000.00
Complete Unit for high C4 tetraplegia					
Build into house					
Manual wheelchair custom system	Life Expectancy	every 5 years	$ 7,000.00		$28,000.00
Parts and repair	Life Expectancy	Annually	$ 2,000.00		$40,000.00
Power Wheelchair Custom system	Life Expectancy	every 5 years	$ 20,000.00		$80,000
Parts and repair	Life Expectancy	Annually	$ 4,000.00		$80,000.00
Hoyer Lift and Sling	Life Expectancy	Every 10 years	$ 7,000.00		$14,000.00
Parts and repair	Life Expectancy	Annually	$ 1,000.00		$20,000
Invacare Micro-Air Bed	Life Expectancy	One Time cost	$ 12,000.00		$12,000
Air Mattress System	Life Expectancy	every 5 years	$ 11,445.00		$45,780.00
	Life Expectancy	every 5 years	$ 6,825.00		$27,300
Activeaid Shower chair Commode system	Life Expectancy	Every 2 yrs	$ 3,500.00		$35,000
Sliding Board	Life Expectancy	Every 2 yrs	$ 50.00		$500.00
Hand Splints	Life Expectancy	Annually	$ 100.00		$2,000.00
Bed table	Life Expectancy	every 5 years	$ 200.00		$800.00
Humidifier with Hep filter	Life Expectancy	every 5 years	$ 350.00		$1,400.00
Portable ramps	Life Expectancy	every 5 years	$ 1,500.00		$6,000.00
Foot Splints	Life Expectancy	Annually	$ 100.00		$2,000.00
Customized van (with lift)	Life Expectancy	every 5 years	$ 70,000.00		$280,000
Maintenance and repair	Life Expectancy	Annually	$ 2,000.00		$40,000
Computer-PC	Life Expectancy	Every 3 years	$ 3,000.00		$21,000
Printer, fax, modem, software	Life Expectancy	Every 3 years	$ 2,000.00		$14,000
Dragon Dictate Software	Life Expectancy	1 Time Cost	$ 500.00		$500.00
		GRAND TOTAL			$1,520,280

49

SERVICE/ITEM	DURATION	FREQUENCY/REPL	UNIT COS	20Yrs	Total
Bladder and Bowel Care					
Surgilube (1 box)	Life Expectancy	Every 2 months	$ 11.00		$1,584
Non-sterile Gloves	Life Expectancy	Monthly	$ 9.95		$2,388
Disposable wipes	Life Expectancy	Every 2 weeks	$ 10.00		$5,200
Disposable chucks (box)	Life Expectancy	Monthly	$ 39.95		$9,588.00
Adult diapers (case)	Life Expectancy	Every 3 months	$ 60.00		$4,800
Adult Depends	Life Expectancy	Every 3 months	$ 15.00		$1,200
Tall Disposable garbage bags (box)	Life Expectancy	Monthly	$ 9.00		$2,160
Leg Bags 32 0z.	Life Expectancy	Monthly	$ 12.00		$2,880
Urinary drainage Bags	Life Expectancy	Monthly	$ 10.00		$2,400
Catheters	Life Expectancy	Monthly	$ 62.00		$14,880
		GRAND TOTAL			$ 47,080.00

50

SERVICE/ITEM	DURATION	DOSAGE	FREQUENCY/R	Monthly	20yrs	Total
Medications						
Baclofen	Life Expectancy	20mg	4x day	$132.00		$31,680
Miralax	Life Expectancy	17g	1 x day	$24.00		$5,760
Advil PM	Life Expectancy	unit dose	1 x day	$18.79/2mont		$2,254.80
Pantoprazole	Life Expectancy	40mg	1x day	$69.00		$16,560
Diazepam	Life Expectancy	5mg	2 x day	$26.00		$6,240.00
Neurontin	Life Expectancy	400mg	1x day	$38.82		$9,316.80
Melatonin	Life Expectancy	3mg	1xday	$9.00		$2,160.00
OxybutyninER	Life Expectancy	15mg	1x day	$81.00		$19,440
Venlafaxine	Life Expectancy	75mg	1 x day	$102		$24,480.00
Albuterol Neb	Life Expectancy	2.5mg	4xday PRN	$101.00		$24,240.00
Xanax	Life Expectancy	0.25mg	1x day	$14.00		$3,360.00
Enemeez	Life Expectancy	unit doose	1x day	$79.99		$19,197.60
Miscellaneous						
Qtips (box)	Life Expectancy		Monthly	$ 5.00	12	$1,200.00
Alcohol Pads (box)	Life Expectancy		Monthly	$ 3.00	12	$720
Hypoallergenic tape (box)	Life Expectancy		Monthly	$ 4.00	12	$960
Isopropyl Rubbing Alcohol	Life Expectancy		Monthly	$ 3.00	4	$720
Hydrogen Peroxide	Life Expectancy		Monthly	$ 1.50	12	$360
Sterile Water	Life Expectancy		Monthly	$ 15.00	12	$3,600
Saline	Life Expectancy		Monthly	$ 15.00	12	$3,600
Fire Extinguisher	Life Expectancy		Annually	$ 35.00	1	$700
Betadine Solution Swabs	Life Expectancy		Monthly	$ 10.00	12	$2,400.00
			GRAND TOTAL			$ 178,949.20

51

GRAND TOTAL FOR LIFE CARE PLAN FOR [redacted]	
MEDICAL SERVICES	$56,880.00
MEDICAL NEEDS	$12,664,800.00
MEDICAL EQUIPMENT	$1,520,280.00
MEDICATIONS	$178,949.20
BLADDER & BOWEL	$47,080.00
HOSPITALIZATION	$1,370,000.00
GRAND TOTAL	$ 15,837,989.20

52

Date of Verdict 8/2/2019
10-Year Treasury Rate 1.86%

III. DETERMINE PRESENT VALUE OF FUTURE DAMAGES

	1st Year PMT	# of Years	Growth Rate	Discount Rate	Present Value
Future Pain & Suffering Paid Periodically	$ 487,500.00	8.00	4.00%	1.86%	$ 4,161,238.84
Future Physician Care	$ 11,200.00	19.80	4.35%	1.86%	$ 278,746.33
Future Nursing Care	$ 283,240.00	19.80	2.75%	1.86%	$ 6,044,459.19
Future Therapies	$ 312,000.00	19.80	6.46%	1.86%	$ 9,586,579.14
Future Medical Care Professionals	$ 19,600.00	19.80	2.75%	1.86%	$ 418,271.43
Future Medications	$ 8,234.52	19.80	5.33%	1.86%	$ 225,772.02
Future Medical Equipment	$ 23,139.00	19.80	4.35%	1.86%	$ 575,887.24
Future Bowel and Bladder Care	$ 2,340.80	19.80	0.20%	1.86%	$ 39,554.07
Future Diagnostic Care	$ 2,844.00	19.80	6.46%	1.86%	$ 87,385.50
Future Misc Medical Supplies	$ 713.00	19.80	0.20%	1.86%	$ 12,048.80
Future Hospitalizations	$ 68,500.00	19.80	5.51%	1.86%	$ 1,912,197.24
Future Dental Care	$ 1,000.00	19.80	4.93%	1.86%	$ 26,348.39
Future House Cleaning	$ 7,800.00	19.80	2.55%	1.86%	$ 163,349.04
Future Vehicle Costs	$ 16,000.00	19.80	0.08%	1.86%	$ 267,502.80
Future Computer Costs	$ 1,666.67	19.80	-8.33%	1.86%	$ 14,461.50
Future Lost Earnings	$ 79,397.72	3.00	1.78%	1.86%	$ 235,953.85
				TOTAL	$ 24,049,755.38

IV. DETERMINE FUTURE DAMAGES PAID IMMEDIATELY AND PERIODICALLY

	Present Value	35% Paid Immediately	65% Paid Periodically	Adjusted 1st Year PMT	8 Month PMTs Verdict to Death
Future Pain & Suffering Paid Periodically	$ 4,161,238.84	NA	$ 4,161,238.84	$ 487,500.00	$ 325,000.00
Future Physician Care	$ 278,746.33	$ 97,561.22	$ 181,185.11	$ 7,280.00	$ 4,853.33
Future Nursing Care	$ 6,044,459.19	$ 2,115,560.72	$ 3,928,898.47	$ 184,106.00	$ 122,737.33
Future Therapies	$ 9,586,579.14	$ 3,355,302.70	$ 6,231,276.44	$ 202,800.00	$ 135,200.00
Future Medical Care Professionals	$ 418,271.43	$ 146,395.00	$ 271,876.43	$ 12,740.00	$ 8,493.33
Future Medications	$ 225,772.02	$ 79,020.21	$ 146,751.81	$ 5,352.44	$ 3,568.29
Future Medical Equipment	$ 575,887.24	$ 201,560.53	$ 374,326.71	$ 15,040.35	$ 10,026.90
Future Bowel and Bladder Care	$ 39,554.07	$ 13,843.92	$ 25,710.15	$ 1,521.52	$ 1,014.35
Future Diagnostic Care	$ 87,385.50	$ 30,584.93	$ 56,800.58	$ 1,848.60	$ 1,232.40
Future Misc Medical Supplies	$ 12,048.80	$ 4,217.08	$ 7,831.72	$ 463.45	$ 308.97
Future Hospitalizations	$ 1,912,197.24	$ 669,269.03	$ 1,242,928.21	$ 44,525.00	$ 29,683.33
Future Dental Care	$ 26,348.39	$ 9,221.94	$ 17,126.45	$ 650.00	$ 433.33
Future House Cleaning	$ 163,349.04	$ 57,172.16	$ 106,176.88	$ 5,070.00	$ 3,380.00
Future Vehicle Costs	$ 267,502.80	$ 93,625.98	$ 173,876.82	$ 10,400.00	$ 6,933.33
Future Computer Costs	$ 14,461.50	$ 5,061.53	$ 9,399.98	$ 1,083.34	$ 722.23
Future Lost Earnings	$ 235,953.85	$ 82,583.85	$ 153,370.00	$ 51,608.52	$ 34,405.68
TOTALS	$ 24,049,755.38	$ 6,960,980.79	$ 17,088,774.59		$ 687,992.80

53

Date of Verdict 8/2/2019
10-Year Treasury Rate 1.86%

III. DETERMINE PRESENT VALUE OF FUTURE DAMAGES

	1st Year PMT	# of Years	Growth Rate	Discount Rate	Present Value
Future Pain & Suffering Paid Periodically	$ 487,500.00	8.00	4.00%	1.86%	$ 4,161,238.84
Future Physician Care	$ 11,200.00	19.80	4.35%	1.86%	$ 278,746.33
Future Nursing Care	$ 283,240.00	19.80	2.75%	1.86%	$ 6,044,459.19
Future Therapies	$ 312,000.00	19.80	6.46%	1.86%	$ 9,586,579.14
Future Medical Care Professionals	$ 19,600.00	19.80	2.75%	1.86%	$ 418,271.43
Future Medications	$ 8,234.52	19.80	5.33%	1.86%	$ 225,772.02
Future Medical Equipment	$ 23,139.00	19.80	4.35%	1.86%	$ 575,887.24
Future Bowel and Bladder Care	$ 2,340.80	19.80	0.20%	1.86%	$ 39,554.07
Future Diagnostic Care	$ 2,844.00	19.80	6.46%	1.86%	$ 87,385.50
Future Misc Medical Supplies	$ 713.00	19.80	0.20%	1.86%	$ 12,048.80
Future Hospitalizations	$ 68,500.00	19.80	5.51%	1.86%	$ 1,912,197.24
Future Dental Care	$ 1,000.00	19.80	4.93%	1.86%	$ 26,348.39
Future House Cleaning	$ 7,800.00	19.80	2.55%	1.86%	$ 163,349.04
Future Vehicle Costs	$ 16,000.00	19.80	0.08%	1.86%	$ 267,502.80
Future Computer Costs	$ 1,666.67	19.80	-8.33%	1.86%	$ 14,461.50
Future Lost Earnings	$ 79,397.72	3.00	1.78%	1.86%	$ 235,953.85
				TOTAL	$ 24,049,755.38

Plaintiff projections

- **Future Medical costs of roughly $14.5 million**
- **$19 million when growth rate applied**

Impact of Medicare / Medicaid analysis on 50A calculations

- Reduces annual cost from $732,810 to approximately $150,000
- **Reduces total cost from $14.5 million to approximately $3,000,000**
- Reduction of judgment of $11.5 million before application of growth rate

54

Life Expectancy

55

2024 Life Expectancy Table

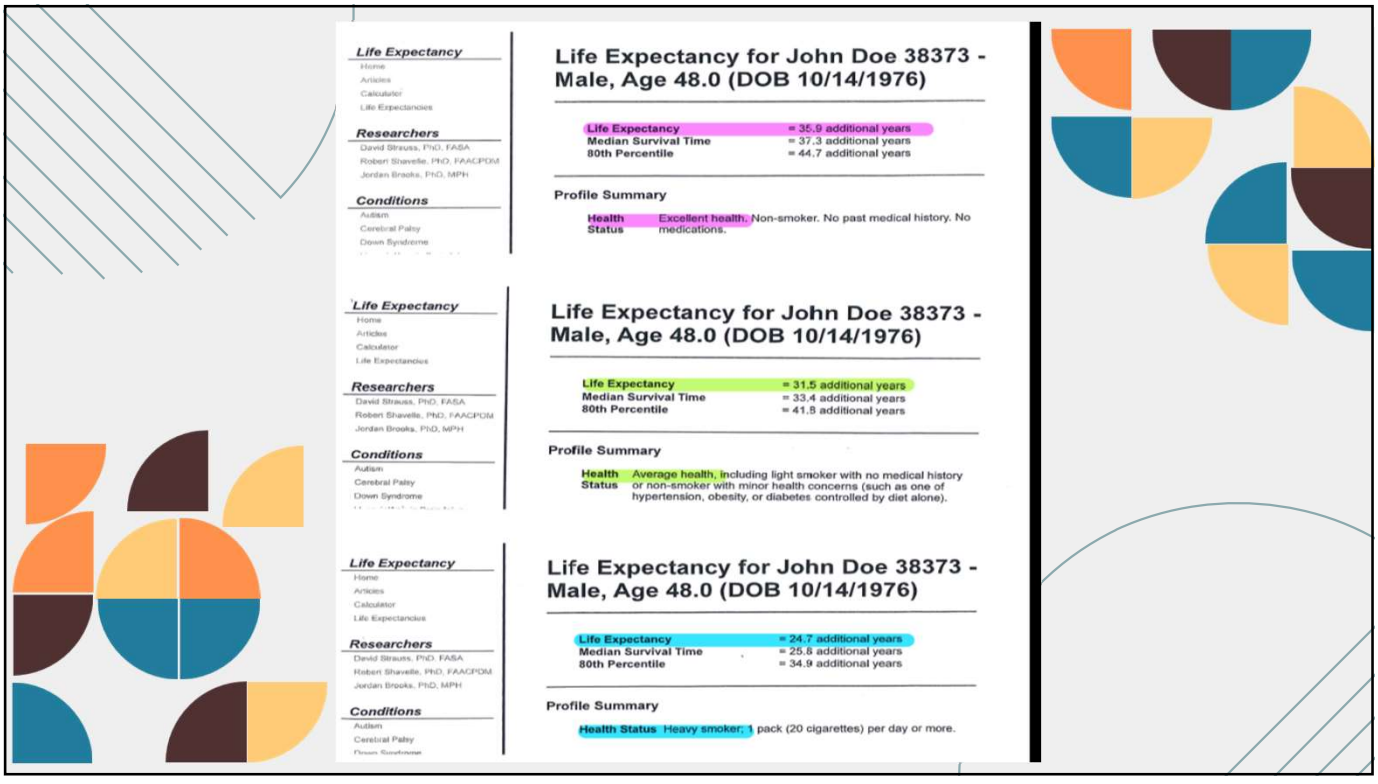
Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
0	73.54	79.30	30	45.34	50.38
1	72.97	78.70	31	44.46	49.44
2	72.00	77.74	32	43.57	48.50
3	71.02	76.75	33	42.69	47.56
4	70.04	75.77	34	41.82	46.62
5	69.05	74.78	35	40.94	45.69
6	68.06	73.79	36	40.06	44.76
7	67.07	72.79	37	39.19	43.83
8	66.08	71.80	38	38.32	42.91
9	65.09	70.81	39	37.45	41.98
10	64.10	69.82	40	36.58	41.07
11	63.10	68.82	41	35.72	40.15
12	62.11	67.83	42	34.86	39.24
13	61.12	66.84	43	34.00	38.33
14	60.14	65.85	44	33.15	37.42
15	59.16	64.86	45	32.30	36.52
16	58.18	63.88	46	31.45	35.62
17	57.22	62.90	47	30.61	34.73
18	56.27	61.92	48	29.77	33.84
19	55.33	60.94	49	28.94	32.95
20	54.40	59.97	50	28.12	32.07
21	53.47	59.00	51	27.30	31.20
22	52.55	58.03	52	26.50	30.33
23	51.64	57.07	53	25.70	29.47
24	50.72	56.11	54	24.91	28.62
25	49.82	55.15	55	24.14	27.77
26	48.91	54.19	56	23.37	26.93
27	48.01	53.23	57	22.61	26.10
28	47.12	52.28	58	21.87	25.27
29	46.23	51.33	59	21.13	24.46

56

2024 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
60	20.41	23.65	90	3.90	4.65
61	19.70	22.86	91	3.62	4.31
62	19.00	22.07	92	3.36	3.99
63	18.31	21.29	93	3.14	3.71
64	17.63	20.52	94	2.94	3.45
65	16.95	19.75	95	2.76	3.22
66	16.29	18.99	96	2.60	3.01
67	15.63	18.23	97	2.45	2.82
68	14.98	17.48	98	2.32	2.66
69	14.33	16.74	99	2.20	2.50
70	13.69	16.00	100	2.09	2.35
71	13.06	15.27	101	1.98	2.21
72	12.43	14.56	102	1.87	2.08
73	11.82	13.85	103	1.77	1.95
74	11.21	13.16	104	1.67	1.82
75	10.62	12.49	105	1.58	1.71
76	10.05	11.83	106	1.49	1.59
77	9.49	11.19	107	1.40	1.49
78	8.95	10.57	108	1.32	1.39
79	8.42	9.96	109	1.24	1.29
80	7.92	9.38	110	1.16	1.20
81	7.43	8.81	111	1.09	1.11
82	6.96	8.26	112	1.01	1.03
83	6.50	7.73	113	0.95	0.95
84	6.07	7.21	114	0.88	0.88
85	5.65	6.72	115	0.82	0.82
86	5.26	6.26	116	0.76	0.76
87	4.88	5.82	117	0.70	0.70
88	4.53	5.41	118	0.65	0.65
89	4.21	5.02	119	0.60	0.60

57



58

Thoughts from a Life Care Planner

Diana Free, BSN, CPHRM, CLCP

59

Before Life Care Planning

30 years as a Healthcare Risk Manager

- Bachelor of Science in Nursing
- Certified Professional in Healthcare Risk Management (CPHRM)
- Certified Life Care Planner (CLCP)

Florida and Georgia

21 years as Director of Risk Management

- Metro-Atlanta Hospital System/Trauma Center
- Rehabilitation Hospital
- Skilled Nursing Home System
- System-wide insurance program
- Self-Insured Trust (SIT)
- System-wide claims program- All lines of coverage
- Root Cause Analysis
- Quality program
- Utilization/Case Management
- Workers' compensation program

60

Forensic Life Care Planning

•Forensic life care planning involves creating a comprehensive plan that outlines the future medical, therapeutic, rehabilitation, and support needs of individuals who have sustained catastrophic injuries or have chronic medical conditions.

•This plan is often used in legal settings to determine the economic value of an individual's future care needs.

•Used by both the Plaintiff and Defendant.

•Based on the specific needs of the person involved, based on information from treaters, other experts, research, pricing information, depositions, etc.

•To be impartial and based on the Life Care Planning process regardless of who hired the Life Care Planner for their opinion.

•Prove the methodology of development and methodology for pricing.

61

Forensic Life Care Planning

Topics considered when developing a plan include:

- Physician services
- Therapy (PT/OT/SPL/ABA/MH Counseling, etc.)
- Medications
- Equipment
- Supplies
- Diagnostic studies
- Procedures/Surgery
- Home care/Skilled Care/Facility Care
- Transportation
- Architectural changes to the home

62

Areas to Evaluate–Life Expectancy

An appropriately evaluated life expectancy is the multiplier of every life care plan.

- Confirm that it is based on the correct age, sex, and race.
- Do you have all the important past medical history?
- Discuss if a life expectancy expert would be of benefit.

International research:

- BMI over 35
- 60+ years of Spinal cord injury/TBI
- Cerebral Palsy
- Cancer History
- Cardiovascular/Pulmonary Disease
- Others

63

Table 2. Life table for males: United States, 2021

Spreadsheet version available from: https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/NVSR/72-12/Table02.xlsx.

Age (years)	Probability of dying between ages x and $x+1$ q_x	Number surviving to age x l_x	Number dying between ages x and $x+1$ d_x	Person-years lived between ages x and $x+1$ L_x	Total number of person-years lived above age x T_x	Expectation of life at age x e_x
0–1	0.005833	100,000	583	99,489	7,354,986	73.5
1–2	0.000416	99,417	41	99,396	7,255,497	73.0
2–3	0.000274	99,375	27	99,362	7,156,101	72.0
3–4	0.000224	99,348	22	99,337	7,056,739	71.0
4–5	0.000175	99,326	17	99,317	6,957,402	70.0
5–6	0.000161	99,308	16	99,300	6,858,085	69.1
6–7	0.000149	99,292	15	99,285	6,758,785	68.1
7–8	0.000137	99,278	14	99,271	6,659,500	67.1
8–9	0.000119	99,264	12	99,258	6,560,229	66.1
9–10	0.000098	99,252	10	99,247	6,460,971	65.1
10–11	0.000084	99,242	8	99,238	6,361,724	64.1
11–12	0.000093	99,234	9	99,230	6,262,485	63.1
12–13	0.000144	99,225	14	99,218	6,163,256	62.1
13–14	0.000248	99,211	25	99,198	6,064,038	61.1
14–15	0.000392	99,186	39	99,167	5,964,840	60.1
15–16	0.000556	99,147	55	99,120	5,865,673	59.2
16–17	0.000719	99,092	71	99,056	5,766,553	58.2
17–18	0.000885	99,021	88	98,977	5,667,497	57.2
18–19	0.001044	98,933	103	98,882	5,568,520	56.3
19–20	0.001199	98,830	118	98,771	5,469,638	55.3
20–21	0.001361	98,711	134	98,644	5,370,868	54.4
21–22	0.001527	98,577	151	98,502	5,272,223	53.5
22–23	0.001678	98,427	165	98,344	5,173,722	52.6
23–24	0.001805	98,261	177	98,173	5,075,378	51.7
24–25	0.001915	98,084	188	97,990	4,977,205	50.7
25–26	0.002015	97,896	197	97,798	4,879,215	49.8
26–27	0.002116	97,699	207	97,596	4,781,417	48.9
27–28	0.002221	97,492	217	97,384	4,683,821	48.0
28–29	0.002334	97,276	227	97,162	4,586,438	47.1
29–30	0.002451	97,049	238	96,930	4,489,275	46.3
30–31	0.002569	96,811	249	96,686	4,392,346	45.4
31–32	0.002682	96,562	259	96,433	4,295,659	44.5
32–33	0.002789	96,303	269	96,169	4,199,227	43.6
33–34	0.002887	96,035	277	95,896	4,103,058	42.7
34–35	0.002982	95,757	286	95,615	4,007,162	41.8
35–36	0.003081	95,472	294	95,325	3,911,547	41.0
36–37	0.003190	95,178	304	95,026	3,816,222	40.1
37–38	0.003310	94,874	314	94,717	3,721,196	39.2
38–39	0.003446	94,560	326	94,397	3,626,479	38.4
39–40	0.003597	94,234	339	94,065	3,532,082	37.5
40–41	0.003772	93,895	354	93,718	3,438,018	36.6
41–42	0.003964	93,541	371	93,356	3,344,299	35.8
42–43	0.004158	93,170	387	92,977	3,250,944	34.9
43–44	0.004353	92,783	404	92,581	3,157,967	34.0
44–45	0.004560	92,379	421	92,168	3,065,386	33.2
45–46	0.004799	91,958	441	91,737	2,973,218	32.3
46–47	0.005090	91,516	466	91,283	2,881,481	31.5
47–48	0.005431	91,051	494	90,803	2,790,198	30.6
48–49	0.005818	90,556	527	90,293	2,699,394	29.8
49–50	0.006241	90,029	562	89,748	2,609,102	29.0

64

Table 11. Life table for Asian, non-Hispanic males: United States, 2021

Spreadsheet version available from: https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/NVSR/72-12/Table11.xlsx.

Age (years)	Probability of dying between ages x and $x+1$ q_x	Number surviving to age x l_x	Number dying between ages x and $x+1$ d_x	Person-years lived between ages x and $x+1$ L_x	Total number of person-years lived above age x T_x	Expectation of life at age x e_x
0–1	0.004015	100,000	401	99,637	8,115,184	81.2
1–2	0.000284	99,599	28	99,584	8,015,546	80.5
2–3	0.000109	99,570	11	99,565	7,915,962	79.5
3–4	0.000150	99,559	15	99,552	7,816,397	78.5
4–5	0.000052	99,544	5	99,542	7,716,845	77.5
5–6	0.000100	99,539	10	99,534	7,617,303	76.5
6–7	0.000097	99,529	10	99,524	7,517,769	75.5
7–8	0.000092	99,520	9	99,515	7,418,245	74.5
8–9	0.000086	99,510	9	99,506	7,318,730	73.5
9–10	0.000079	99,502	8	99,498	7,219,224	72.6
10–11	0.000074	99,494	7	99,490	7,119,726	71.6
11–12	0.000075	99,487	7	99,483	7,020,235	70.6
12–13	0.000087	99,479	9	99,475	6,920,752	69.6
13–14	0.000114	99,470	11	99,465	6,821,278	68.6
14–15	0.000153	99,459	15	99,452	6,721,813	67.6
15–16	0.000193	99,444	19	99,434	6,622,361	66.6
16–17	0.000238	99,425	24	99,413	6,522,927	65.6
17–18	0.000301	99,401	30	99,386	6,423,514	64.6
18–19	0.000387	99,371	38	99,352	6,324,128	63.6
19–20	0.000485	99,333	48	99,309	6,224,776	62.7
20–21	0.000592	99,285	59	99,255	6,125,467	61.7
21–22	0.000688	99,226	68	99,192	6,026,212	60.7
22–23	0.000753	99,158	75	99,120	5,927,020	59.8
23–24	0.000776	99,083	77	99,044	5,827,900	58.8
24–25	0.000771	99,006	76	98,968	5,728,856	57.9
25–26	0.000759	98,930	75	98,892	5,629,888	56.9
26–27	0.000754	98,855	74	98,817	5,530,996	56.0
27–28	0.000756	98,780	75	98,743	5,432,178	55.0
28–29	0.000771	98,705	76	98,667	5,333,436	54.0
29–30	0.000794	98,629	78	98,590	5,234,768	53.1
30–31	0.000819	98,551	81	98,511	5,136,178	52.1
31–32	0.000842	98,470	83	98,429	5,037,667	51.2
32–33	0.000865	98,388	85	98,345	4,939,238	50.2
33–34	0.000889	98,302	87	98,259	4,840,893	49.2
34–35	0.000915	98,215	90	98,170	4,742,634	48.3
35–36	0.000946	98,125	93	98,079	4,644,464	47.3
36–37	0.000985	98,032	97	97,984	4,546,385	46.4
37–38	0.001033	97,936	101	97,885	4,448,401	45.4
38–39	0.001093	97,835	107	97,781	4,350,516	44.5
39–40	0.001167	97,728	114	97,671	4,252,734	43.5
40–41	0.001256	97,614	123	97,553	4,155,063	42.6
41–42	0.001361	97,491	133	97,425	4,057,511	41.6
42–43	0.001481	97,358	144	97,286	3,960,086	40.7
43–44	0.001611	97,214	157	97,136	3,862,800	39.7
44–45	0.001748	97,058	170	96,973	3,765,664	38.8
45–46	0.001888	96,888	183	96,797	3,668,691	37.9
46–47	0.002044	96,705	198	96,606	3,571,894	36.9
47–48	0.002235	96,508	216	96,400	3,475,288	36.0
48–49	0.002475	96,292	238	96,173	3,378,888	35.1
49–50	0.002761	96,054	265	95,921	3,282,716	34.2

65

Table 14. Life table for Black, non-Hispanic males: United States, 2021

Spreadsheet version available from: https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/NVSR/72-12/Table14.xlsx.

Age (years)	Probability of dying between ages x and $x+1$ q_x	Number surviving to age x l_x	Number dying between ages x and $x+1$ d_x	Person-years lived between ages x and $x+1$ L_x	Total number of person-years lived above age x T_x	Expectation of life at age x e_x
0–1	0.011512	100,000	1,151	99,017	6,758,074	67.6
1–2	0.000739	98,849	73	98,812	6,659,057	67.4
2–3	0.000514	98,776	51	98,750	6,560,245	66.4
3–4	0.000415	98,725	41	98,705	6,461,494	65.4
4–5	0.000330	98,684	33	98,668	6,362,790	64.5
5–6	0.000306	98,652	30	98,636	6,264,122	63.5
6–7	0.000298	98,621	29	98,607	6,165,486	62.5
7–8	0.000278	98,592	27	98,578	6,066,879	61.5
8–9	0.000227	98,565	22	98,553	5,968,301	60.6
9–10	0.000155	98,542	15	98,535	5,869,747	59.6
10–11	0.000093	98,527	9	98,522	5,771,213	58.6
11–12	0.000091	98,518	9	98,513	5,672,691	57.6
12–13	0.000203	98,509	20	98,499	5,574,177	56.6
13–14	0.000464	98,489	46	98,466	5,475,679	55.6
14–15	0.000840	98,443	83	98,402	5,377,213	54.6
15–16	0.001270	98,360	125	98,298	5,278,811	53.7
16–17	0.001686	98,235	166	98,153	5,180,514	52.7
17–18	0.002067	98,070	203	97,968	5,082,361	51.8
18–19	0.002374	97,867	232	97,751	4,984,393	50.9
19–20	0.002617	97,635	256	97,507	4,886,642	50.1
20–21	0.002855	97,379	278	97,240	4,789,135	49.2
21–22	0.003097	97,101	301	96,951	4,691,894	48.3
22–23	0.003291	96,801	319	96,641	4,594,943	47.5
23–24	0.003427	96,482	331	96,317	4,498,302	46.6
24–25	0.003518	96,151	338	95,982	4,401,986	45.8
25–26	0.003586	95,813	344	95,641	4,306,003	44.9
26–27	0.003655	95,469	349	95,295	4,210,362	44.1
27–28	0.003734	95,121	355	94,943	4,115,067	43.3
28–29	0.003836	94,765	363	94,584	4,020,124	42.4
29–30	0.003956	94,402	373	94,215	3,925,541	41.6
30–31	0.004079	94,028	383	93,837	3,831,325	40.7
31–32	0.004201	93,645	393	93,448	3,737,489	39.9
32–33	0.004345	93,251	405	93,049	3,644,041	39.1
33–34	0.004522	92,846	420	92,636	3,550,992	38.2
34–35	0.004733	92,426	437	92,208	3,458,355	37.4
35–36	0.004979	91,989	458	91,760	3,366,148	36.6
36–37	0.005247	91,531	480	91,291	3,274,388	35.8
37–38	0.005515	91,051	502	90,800	3,183,097	35.0
38–39	0.005759	90,549	521	90,288	3,092,297	34.2
39–40	0.005982	90,027	539	89,758	3,002,009	33.3
40–41	0.006222	89,489	557	89,210	2,912,251	32.5
41–42	0.006493	88,932	577	88,643	2,823,041	31.7
42–43	0.006775	88,354	599	88,055	2,734,398	30.9
43–44	0.007078	87,756	621	87,445	2,646,343	30.2
44–45	0.007417	87,135	646	86,812	2,558,897	29.4
45–46	0.007804	86,488	675	86,151	2,472,086	28.6
46–47	0.008249	85,813	708	85,460	2,385,935	27.8
47–48	0.008757	85,106	745	84,733	2,300,475	27.0
48–49	0.009317	84,360	786	83,967	2,215,742	26.3
49–50	0.009917	83,574	829	83,160	2,131,775	25.5

66

Suggestions for items to evaluate in a Life Care Plan

- Is the life expectancy in line with the clinical information?
- Do you have sufficient past medical information?
- Are the medications priced as generics and with GoodRx?
- Are services that are to be provided by a medical center priced as self-pay?

67

Future medical expenses – how does private insurance factor in?

Courts are generally reluctant to consider private insurance

Illinois - Verci v. High, 2019 IL App (3d) 190106-B (2019) (Illinois Appellate Court 2019)

This case gives a really good summary of future medical expenses and its relationship to insurance and/or collateral source considerations.

- "Illinois and most other states follow the 'reasonable value approach' to the collateral source rule.
  - Which means plaintiff is entitled to recover the reasonable value of medical services and there is no distinction between private insurance or government programs
  - The vast majority of courts to employ a reasonable value approach hold that the plaintiff may seek to recover the amount originally billed by the medical provider.
    - Application: The plaintiff may place the entire billed amount into evidence, provided that the plaintiff also establishes the bill's reasonableness. Defendants can rebut this evidence and argue that the billed amounts don't reflect reasonable value of the services **but cannot** introduce evidence that the plaintiff's bills were settled for an amount less than the billed amount because to do so would undermine the collateral source rule.
    - It prevents defendants from introducing any evidence that all or part of plaintiff's losses have been covered by insurance.
    - Case remanded

68

Colorado - Scholle v Ehrichs, 546 P.3d 1170 (Supreme Court of Colorado 2024)

- Colorado med mal cases - damages capped at $1 million pursuant to statute but it allows the trial court to exceed the cap limit if plaintiff shows good cause that imposing cap would be unfair.
- Another statute requires the trial court to reduce plaintiff's damages by the amount they are compensated from collateral sources except insurance coverage.
- Court agreed that any windfall should be for plaintiff's benefit and not tortfeasor. Held that trial court can't consider insurance in its good cause analysis

Tennessee Crotty v Flora, 676 S.W.3d 589 2023 (Supreme Court of Tennessee(2023)

- collateral source rule still in effect, plaintiff gets full medical costs regardless of insurance

Florida - Dial v. Calusa Palms Master Association, Inc. 337 So.3d 1229 (Supreme Court of Florida, 2022)

- Ct held that the trial court properly excluded evidence of the plaintiff's eligibility for future benefits from Medicare, Medicaid and other social legislation as collateral sources (citing Joerg v. State Farm Mutual Automobile Insurance Co., 176 So.3d 1247 (Fla. 2015)

69

Louisiana - Bozeman v State 879 So. 2d 692 (Supreme Ct of Louisiana, 2004)

- The collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance for personal injuries and for other eventualities.
- Courts consider insurance a form of investment, the benefits of which becomes payable without respect to any other possible sources of funds.
- If we were to permit a tortfeasor to mitigate damages with payments from plaintiff's insurance, plaintiff would be in a position inferior to that of having bought no insurance, because his payment of premiums would have earned no benefit.
- Defendant should not be able to avoid payment of full compensation for the injury inflicted merely because the victim has had the foresight to provide himself with insurance

Williams v Lafayette City -Parish Consolidated Government 2021 WL 5823514 (Ct of Appeals Louisiana 2021)

- Plaintiff's past medical expenses totaled $301,188.33 parties stipulated that amount paid by insurance was $82,299.67. Court held collateral source rule applies to make inadmissible the amounts paid by his private insurance, past medical award increased back up to $301k.

Bridges v Baton Rouge General Medical Center, 317 So.3d 662 (Louisiana 2020)

- Court talks about whether Medicare/Medicaid is subject to collateral source rule – cite Bozeman "benefit of the bargain" approach – is the plaintiff paying into the fund or not,
- if plaintiff doesn't pay into the fund they don't get the benefit of collateral source because court doesn't want them to get a windfall, if plaintiff does pay into the fund, they do get the benefit of collateral source rule, court doesn't want to benefit the tortfeasors

70

California - Cuevas v. Contra Costa County, 11 Cal. App. 5th 163, 217 Cal. Rptr.3d 519 (Ct of Appeal California, 2017)

- Plaintiff brought malpractice case against physician who allegedly caused her to suffer brain damage.
- At trial, parties presented competing life care plans to prove plaintiff's future medical costs.
  - Plaintiff's plan used undiscounted medical expense,
  - Defendants used anticipated discounted rates that would be accepted as payment should plaintiff maintain coverage under MediCal, or ACA.
- Trial court precluded defendant from introducing evidence of MediCal or ACA under collateral source rule.
- Ct of Appeals determined this was an error. Court concluded collateral source rule is not violated when defendant is allowed to offer evidence of market value of future medical benefits

71

NEW YORK

Liciaga v. New York Transit Authority et al, 2024 WL 3882279, 2024 NY Slip Op 04257 (2nd Dept. August 21, 2024)

Very recent decision

FACTS:

- Plaintiff (23) was riding a bicycle when railroad tie from above ground track struck his back causing fractured vertebrae, severed spinal cord, and permanent paralysis below T7.

TRIAL:

- jury found for plaintiff:
  - Pain and suffering
    - Past: $9 million
    - Future: $60 million (48 years)
  - Medical:
  - Past: $1,174,972
  - Future: $40 million

POST TRIAL MOTION:

1) Set aside verdict on issue of liability as contrary to weight of evidence
2) Set aside verdict as excessive
3) Alternatively: collateral source hearing on issue of future medical expenses (CPLR 4545)

- Defendant's argument: Plaintiff, uninsured, was eligible for insurance coverage through ACA

72

TRIAL COURT DECISION:

1) Set aside verdict on issue of liability: denied
2) Set aside verdict as excessive: denied in part, granted in part
   a. Future medical expenses: verdict was affirmed
   b. Past and future pain and suffering: reduced from $9 million to $4 million (past) and reduced from $60 million to $12 million (future)
3) Collateral source hearing: denied

- Defendants Appealed

APPELLATE COURT DECISION:

Long decision, some of which is not pertinent to our discussion today:

- Question for court -1st impression:
  1. Is defendant entitled to collateral source hearing pursuant to CPLR §4545 in light of plaintiff's eligibility to obtain health insurance through ACA which would obviously reduce future medical expenses?
- Discussion by court
  1. Trial court should have held a collateral source hearing on issue of future medical expenses
     - Insurance benefits not subject to lien payable by plaintiff may constitute collateral source
     - Question is not whether a defendant may be entitled to collateral source offset for future medical expenses that will be paid by private health insurer BUT whether defendant may establish entitlement in situation where plaintiff is eligible for coverage?
     - Court talked about history of CPLR §4545
       - Burden of defendant at hearing to establish entitlement to collateral source reduction of award for past or future economic loss
       - Standard of proof is reasonable certainty (more than preponderance but less than beyond reasonable doubt) i.e. clear and convincing that result is highly probable
       - Applications for collateral source hearings are governed by showing that is less than the ultimate hearing burden.
         - I.e. to be entitled to collateral source hearing defendant must merely tender some competent evidence that plaintiff's economic losses may be replaced or indemnified by collateral source
         - Application for collateral source hearing may be made at any time before judgment is entered (unless directed otherwise by court)

73

- Application:

  1. Defendant submitted affidavit from licensed insurance broker and forensic economist. Broker identified specific policy issued by Fidelis available on NY State Health Plan Marketplace – details are: types of care covered by policy, premium costs, maximum out of pocket costs
  2. Expert opined that if plaintiff obtained Fidelis policy future medical expenses would be reduced from $40 million to $36,348,230, an offset of approx. $3.75 million

- Considerations by court:
  1. Collateral source offset might improperly compel plaintiff to procure insurance against his will
     - Court determined previously plaintiffs might have been deemed uninsurable but ACA ensures preexisting conditions are covered and you can't be denied coverage
     - By showing plaintiff can reduce own future medical expenses by millions by procuring insurance – defendant satisfied burden of demonstrating that such expenses may be paid by collateral source. "stands to reason that the plaintiff would act in his own economic self-interest by taking minimally burdensome steps required to obtain available insurance coverage and defendant should be afforded opportunity to offer evidence at a hearing to demonstrate why plaintiff could be expected to obtain coverage and whether it would reduce out of pocket expenses" (compare this to Louisiana "If we were to permit a tortfeasor to mitigate damages with payments from plaintiff's insurance, plaintiff would be in a position inferior to that of having bought no insurance, because his payment of premiums would have earned no benefit"
  2. Plaintiff is also legally obligated to obtain health insurance pursuant to ACA, thus you can't say its improper to expect plaintiff to perform an act that he is required to perform under federal law
     - Plaintiffs are expected to mitigate damages and can't decline to do so without plausible explanation

74

3. Can insurance a plaintiff may be able to procure but doesn't currently have qualify as collateral source within 4545?
   - Court looked at language of §4545, it simply requires that the collateral source be one that plaintiff will, with reasonable certainty, continuously receive benefits during the period for which defendant is seeking offset
   - Statute doesn't require plaintiff to have applied for or currently be in receipt of the benefits in order for defendant to be entitled to the offset
   - Compared it to Young case which involved social security benefits plaintiff has not yet applied for. Court cautioned that under that logic, plaintiffs would be exempt from applying until after judgment is entered and purpose of §4545 is to eliminate windfalls and double recoveries
4. Will particular health insurance policy limit plaintiff's treatment options?
   - Court examined Malmberg case which held that government was not entitled to collateral source offset because there the government was arguing plaintiff could receive treatment at VA facility and the court didn't want to force plaintiff to treat with VA providers

HOLDING:

- Providing defendant with offset under this circumstance would serve ultimate goal of 4545 which was to eliminate duplicate recovery by the plaintiff, and therefore defendant was entitled to collateral source hearing
- Notably, court issued no decision re: the outcome following the hearing. Matter was remitted to trial court for a collateral source hearing on value of those damages

75

Recommendations

- **Discovery**
  - Obtain insurance and Medicare / Medicaid records and ask for copy of insurance card
  - Request lien information at case inception and periodically, including correspondence from Medicaid or Medicare
  - Ask whether plaintiff is on SSI or SSDI
  - Develop damages data during depositions, including asking about cost of medical insurance premiums and out of pocket costs
  - Ask detailed questions about ongoing medical treatment and future recommended treatment
  - Take deposition of family member(s) involved in management of medical / financial issues if applicable
  - If guardianship / conservatorship, request all supporting documentation
- **Pretrial**
  - Engage experts in LCP, Life Expectancy, Insurance, Medicare/Medicaid, Economics
  - Develop damages arguments in mediation
  - Consider motion for "Frye Hearing" on issues such as life expectancy or applicability of collateral sources
- **Trial**
  - Consult with LCP and consider putting on affirmative evidence to challenge plaintiff LCP
  - Consider motion *in limine* to limit damages / prevent economic extrapolation
  - Consider *voir dire* of plaintiff damages expert on issues of insurance / Medicare / Medicaid Coverage
  - Utilize experts to prepare cross of plaintiff witnesses
- **Post Trial**
  - Post trial motion – 5501 (c) analysis re economic damages and move for collateral source hearing
  - Disclose experts and expert reports in 3101(d) disclosure
  - Collateral source hearing

76

THANK YOU!!!!!!!!

77

TAB 8

Analyzing Events: Which Tool Is Best? RCA, ACA, or FMEA

Speakers



Kathleen Shostek, RN, ARM, MBA, DFASHRM, CPHRM, CPPS
Healthcare Loss Control Expert
Munich Re Specialty-NA



Anne Huben-Kearney, BSN, MPA, CPHQ, CPHRM, CPPS, DFASHRM
Risk & Patient Safety Consultant

Objectives

1. Recall three tools for analysis of an event or a process failure leading to risk of liability loss in healthcare.
2. Identify proactive and reactive uses of Root Cause Analysis, Apparent Cause Analysis, and Failure Mode and Effects Analysis for prevention and risk mitigation.
3. Assess which tool is best to use, based on scenarios involving examples of actual healthcare events.

Poll: Use of Tools

- RCA??
- ACA??
- FMEA??



3

Definition of Root Cause Analysis (RCA)

- Systematic analysis of an event or near miss that has occurred within the healthcare setting.
- Uses methodologies to examine the underlying contributors to an adverse / sentinel event after the event has occurred.
- Goal is prevention of recurrence.

Source: ASHRM Root Cause Analysis Playbook: An Enterprise Risk Management Approach and Implementation Guide, 2015

4

Use of RCA

Proactive

- Identifies contributing factors to events causing harm
- Contributing factors can be addressed to prevent other types of events

Reactive

- Deployed after an event has occurred
- Used to answer why and how an event caused harm

5

Example: Classification of Harm System

Safety Event Class	Level of Harm	Code	Patient Outcome	Suggested Follow-Up Analysis
Serious Safety Event (Reaches the patient)	Death	SSE-1	Unexpected death not related to the natural or expected course of the patient's illness or underlying condition. On balance of probabilities, was caused by or brought forward in the short term by the incident.	RCA, including culpability/ accountability review (CCA)
	Severe Permanent or Temporary Harm	SSE-2	Patient outcome is symptomatic, requiring life-saving intervention or major medical- surgical intervention, shortening life expectancy or causing major, permanent or temporary harm or loss of function.	RCA, including culpability/ accountability review (CCA)
Safety Event (Reaches the patient)	Moderate Permanent or Temporary Harm	SE-3	Patient outcome is symptomatic, requiring intervention (e.g. additional operative procedure, additional therapeutic treatment), an increased length of stay, or causing permanent or temporary harm, or loss of function.	**Options:** RCA, ACA, barrier analysis, including culpability/ accountability review
	Mild Temporary Harm or None	SE-4	Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate, but short-term, and minimal or no intervention (e.g., extra observation, investigation, review, or minor treatment), is required.	**Options:** ACA, barrier analysis, trending analysis, including culpability/ accountability review
	No Detectable Harm/No Harm	SE-5	Patient outcome is asymptomatic. No symptoms are detected and no treatment is required. Not able to discover or ascertain the existence, presence, or fact of harm, but harm may exist; insufficient information is available, or unable to determine any harm. Harm may appear later.	**Options:** ACA, barrier analysis, trending analysis, including culpability/ accountability review
Pre-Patient Event (Does not reach the patient)	Almost Happened	PPE-6	Error or capacity to cause harm was caught by an error detection barrier prior to reaching the patient. The system worked.	Review barrier detection, celebrate success

Figure 2.1, page 22, ASHRM RCA playbook

6

RCA Steps



- Identify Event and Investigate
- Gather Information & Data for Triage
- Analyze: Identify Causal Factors and Root Cause
- Implement Corrective Action Plan
- Measure Effectiveness

7

Best Practices with RCA

- Definition of serious safety events for criteria to conduct RCA
- Standard classification system establishes requirements for RCA
- Consistent application of criteria for conducting RCA reduces variability
- Dissemination of findings to prevent recurrence
- Promotes mutual understanding and value of RCA process in reducing harmful events

8

Definition of Apparent Cause Analysis (ACA)

- Process used to investigate the cause or causes of a medium- or low-risk safety event.
- Designed as a quality improvement measure, ACA is used to explain in detail why an issue or near miss occurs and then make an action plan to correct the issue and prevent its recurrence.

Source: ASHRM Failure Mode and Effects Analysis (FMEA) Playbook for Health Care Professionals, 2022

9

Use of ACA

Proactive

- Preventive
- Near misses
- Brainstorming
- Best available information

Reactive

- Event occurred or nearly occurred
- Smaller-scale issues
- Low complexity level issues
- Most probable cause(s)
  - Factual and objective evidence
  - No assumptions

10

ACA Steps



- Assemble a team
- Describe what happened
- Determine why the event happened
- Determine how defects might be fixed
- Decide which defects will be fixed

11

Best Practices with ACA

- Provide clear, thorough and objective explanation of what happened
- Consider including timeline
- Brainstorm contributing factors
- Identify potential contributing factors or incidental findings
- Determine potential apparent cause
- Ensure time limited

12

ACA (sample)

Privileged and Confidential Risk Management/Patient Safety Document

ACA Report Completed by: _____Date ACA Completed: _____
Date ACA Reported to (Oversight) Safety Committee:_____
Date of Incident _____ Date Reported to Department Manager _____
Type of Incident/Near Miss Event Severity (if serious injury, conduct RCA)
_____
ACA Team Members: (Name, Department, Team Role)_____
Description of Incident/Near Miss and Outcome: (Clear, thorough and objective explanation of what happened. Consider including timeline as applicable.)_____
Contributing Factors:
Potential Apparent Cause Contributing Factor or Incidental Finding

13

Definition of Failure Mode Effect Analysis (FMEA)

- Systematic approach to identify risks associated with a new process (product, practice, policy, etc) or a change in an existing process before implementation.

Source: ASHRM Failure Mode and Effects Analysis (FMEA) Playbook for Health Care Professionals, 2022

14

Use of FMEA

Proactive

- Prevention of error/harm from process failure
- At least one high risk process
- Considers consequences/effects of failure
- Not just for hospitals

Reactive

- Failures or potential failures identified from RCAs or ACAs
- High risk process already implemented; vulnerabilities identified

15

FMEA Steps



- Identify project (scope)
- Assemble a team
- Diagram intended and actual process
- Identify potential failure modes
- For each failure, identify the possible effects
- Put new process in place
- Measure the results

16

Best Practices with FMEA

- Allows REDESIGN before full implementation of technology, process, equipment, et al
- Uses Structured methodology
- Identifies ways in which a process can fail and ranks the severity of the failure
- Estimates the risk associated with each step: Risk Priority Number

RPN = Severity X Occurrence X Detection

Effects Causes Controls

- Evaluates the effectiveness of current controls
- Prioritizes which failures to fix

17

FMEA Template (sample)

Step In Process	Failure Mode	Failure Causes	Failure Effects	Likelihood of Occurrence (1 -5)	Likelihood of Detection (1-5)	Severity (1-5)	Risk Priority / Risk Profile Number (RPN)	Action Plan	Outcome Measures / Monitoring
(Use Brainstorming, Flowcharting, Process Mapping)	*(What could possibly go wrong at each step)*	*(Potential causes of failure at each step)*	*(Potential Impact of the failure at each step)*	*(1 = highly unlikely → 5 = failure almost inevitable)*	*(1 = almost certain to be detected → 5 = remote likelihood of detection)*	*(1 = no patient harm → 5 = permanent patient harm/ death)*	*(Severity x Occurrence X Detection = RPN)*	*(Based on RPN: strong actions to eliminate or control potential failure OR decision to accept the failure mode cause, who responsible to implement plan, timeframe to implement)*	*(Outcome measures/ metrics for measuring effectiveness of action plan, who monitoring, frequency of monitoring and reporting)*

18

Summary: FMEA, RCA, ACA

FMEA	RCA	ACA
Proactive	Reactive ➡ Proactive	Near miss/"Accident waiting to happen"
Structured Methodology	Structured	Brainstorming
Evaluate prior to implementation	Evaluate root causes to an event	Limited issue or concern
System implications	System implications	Unit /department focused
Time intensive	Time & resource intensive	Limited time
Ranks severity of risk	Determines root(s) of error for future prevention	Identifies apparent cause
Credit: ASHRM Patient Safety Certificate program		

19

Time to Practice!



- Each table is a work group
- Read each scenario
- Discuss which tool for analysis you would use
  - It's ok to disagree!
- Describe **why** you selected that tool – give rationales
- Share with the larger group
- Creative liberty encouraged!

20

Which Tool Would You Use? Scenario #1

- 18 yo with history of depression, suicidal attempts seen in ED with suicidal ideation (SI)
- Psychiatry consult – discharged with outpatient therapy, discharged with crisis hot line, outpatient resources
- Month later, first visit with new PCP, again sent to ED for SI after self harm reported
- Psychiatry consult – discharged with outpatient medication, follow up
- Follow up visit with PCP within 10 days post ED discharge, denied SI but PCP scheduled call with therapist for next day
- Later in day, patient found with loaded gun, called mother, threatening to shoot himself
- Brought to ED; involuntarily admitted to an inpatient psychiatric hospital for five weeks.

21

Which Tool and Why?

- RCA??
- ACA??
- FMEA??



22

Which Tool Would You Use? Scenario #2

- Risk management professional read national media reports of nurse arrested for medication error leading to patient death
- Articles reported that patient going for MRI with versed (a sedative) ordered
- But nurse retrieved and administered vecurium, a powerful paralyzer, from computerized medication cabinet
- **What medications are on your institution's medication carts?**

23

Which Tool and Why?

- RCA??
- ACA??
- FMEA??



24

Which Tool Would You Use? Scenario #3

- 2-year-old girl, evaluated in the Emergency Department (ED) diagnosed with allergic urticaria
- Next day, same patient, presented to the ED with worsening hand pain, associated with swelling of her hands, feet, and lower lip and difficulty walking due to pain; believed to be an allergic presentation, potentially precipitated by the recent amoxicillin course.
- Attending physician asked the resident physician to order **2 mg/kg** of methylprednisolone. When the resident physician input the dose into the electronic health record's (EHR) dose calculator, they were instructed to order **190 mg of methylprednisolone**. This order, representing about **12 mg/kg**, was filled by pharmacy staff and **administered by a nurse who was new to the pediatric ED.**

25

Scenario #3 (cont)

- Supervising senior pediatric nurse discovered that the ED intake technician had erroneously switched the patient's height and weight in the EHR, resulting in a documented weight of 96 kg and a height of 15.8 cm.
- An automatic error message was triggered by the exceptional (>30%) difference in weight for consecutive days, between 15.8 and 96 kg, but error message was overlooked by the ED technician.
- No adverse effects noted from the methylprednisolone overdose; patient's family was informed; patient was admitted for monitoring.
- The resulting hospitalization was uneventful, and the patient was discharged after two days with a typical prednisolone taper.

26

Which Tool and Why?

- RCA??
- ACA??
- FMEA??



27

Which Tool Would You Use? Scenario #4

- A 65-year-old female with a documented allergy to latex underwent cricopharyngeal (CP) myotomy and trans-cervical diverticulectomy for a right-sided Zenker's diverticulum.
- Intubation and maintenance of anesthesia stable. No antibiotics administered during the procedure.
- There were no adverse events and surgery to repair the diverticulum was uneventful.
- Near the conclusion of surgery, a latex Penrose drain was placed in the neck surgical incision.

28

Scenario #4 (cont)

- The patient developed generalized urticaria, bronchospasm requiring high airway pressures to achieve ventilation, and hypotension within 5 minutes of placement of the drain.
- The latex penrose drain was removed and replaced with a silicone drain.
- Epinephrine 0.3 mg IM, IV saline, and vasopressors were administered post-operatively to the patient with resolution of symptoms.
- She was later extubated and was hemodynamically stable.

https://psnet.ahrq.gov/web-mm/perioperative-anaphylaxis-after-insertion-latex-drain-patient-known-latex-allergy

29

Which Tool and Why?

- RCA??
- ACA??
- FMEA??



30

Which Tool Would You Use? Scenario #5

- A 57 year-old woman was scheduled for post mastectomy breast reconstruction surgery with implants
- She was positioned on the O.R. table and anesthetized.
- During the final surgical "time-out" and prior to any incisions, it was reported to the surgeon that the breast implants were not available. The ambulatory surgery center had not received them as requested from the central supply service.
- The patient was awakened from anesthesia and recovered without incident. She was informed of the situation and the procedure was rescheduled.

31

Which Tool and Why?

- RCA??
- ACA??
- FMEA??



32

Which Tool Would You Use? Scenario #6

- During a patient visit to a dermatology office, the physician determined that a patient needed a biopsy.
- The specimen was obtained by the physician and placed in a container.
- The specimen was labeled and send to the pathology lab.
- The specimen was found to be mislabeled when it arrived in the lab.
- The specimen was irretrievable (impossible to be obtained again).

33

Which Tool and Why?

- RCA??
- ACA??
- FMEA??



34

Which Tool Would You Use? Scenario #7

- Risk management professional receives a call from Security that a vendor delivering laundry was stuck in the primary elevator from the "receiving dock" to the Emergency Department.
- Delivery person who was stuck reported that the alarm was not working. He knocked on the elevator door for about 20 minutes until someone heard him and notified Security and Maintenance to get the door open enough for him to climb out.
- Security reported that when the delivery person climbed out of the elevator, an ED staff member commented that "this elevator went down 2 months ago - we waited three days for linen and supplies!"

35

Which Tool and Why?

- RCA??
- ACA??
- FMEA??



36

Which Tool Would You Use? Scenario #8

- Mr. Smith and Mr. Jones shared a double occupancy hospital room
- Mr. Smith was treated for headaches following a diagnosis of B cell lymphoma with central nervous system involvement and discharged. Mr. Jones remained hospitalized.
- Both patients had brough their oral home medications to the hospital because their specialty oncology drugs were not on the hospital formulary.
- The meds were verified by a pharmacist, bar-code labeled for the individual patients and placed into the automatic dispensing cabinet so the floor nurse could access, administer, and return the medications to the respective patients at discharge.

37

Scenario #8 (cont)

- Mr. Smith's discharge was reportedly rushed but uneventful. 3 days after discharge, Mr. Smith's son called with concerns about his father's medications - one appeared to be new.
- It was discovered that Mr. Smith was inadvertently discharged with Mr. Jones' medication (ponatnib) along with his own medication (temozolomide).
- Mr. Smith had taken 3 doses of ponatnib, which is only approved for use in certain leukemias. He had not significant effects.
- Mr. Jones (still hospitalized) missed his doses of Ponatinib.

38

Which Tool and Why?

- RCA??
- ACA??
- FMEA??



39

Summary: FMEA, RCA, ACA

FMEA	RCA	ACA
Proactive	Reactive Proactive ➡	Near miss/"Accident waiting to happen"
Structured Methodology	Structured	Brainstorming
Evaluate prior to implementation	Evaluate root causes to an event	Limited issue or concern
System implications	System implications	Unit /department focused
Time intensive	Time & resource intensive	Limited time
Ranks severity of risk	Determines root(s) of error for future prevention	Identifies apparent cause
Credit: ASHRM Patient Safety Certificate program		

40

Summary

- Selecting the best tool to analyze events depends on:
  - The facts of the situation
  - The severity or potential severity of the event
  - The scope of the impact
  - Engagement of the team and culture



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41

Resources

- *Agency for Healthcare Research and Quality (AHRQ)*
  - *Patient Safety and Quality Improvement* Patient Safety and Quality Improvement | Agency for Healthcare Research and Quality (ahrq.gov)
- *ASHRM Failure Mode and Effects Analysis (FMEA) Playbook for Health Care Professionals, 2022*
- *ASHRM Root Cause Analysis Playbook: An Enterprise Risk Management Approach and Implementation Guide, 2015*

42

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TAB 9

Protected Health Information

The unique risks relating to the health care industry

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1

Nature of PHI

Data that

- [R]elates to the past, present, or future physical or mental health or condition of any individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual

- Inherent value of the data itself

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2

Threat Landscape for Healthcare

- Cyberattacks on healthcare organizations are increasing in frequency and severity
- Ransomware, email compromises, phishing, and data breaches pose significant threats to patient data and operations
- Financial losses due to cyber incidents can be substantial, including costs for incident response, remediation, and regulatory fines
- Reputational damage can be severe, impacting patient trust and loyalty
- Compliance failures can result in hefty penalties from regulatory agencies
- The interconnectedness of healthcare systems and the reliance on technology create new vulnerabilities

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3

Deepweb	fullzbuy	section: Simply Fullz 2023 (Part 1) dob: 1968, sex: -, zip: 99022-0424, city: MEDICAL LAKE, state: WA, price: 1.25, country: USA, category: Simply Fullz 2023 (Part 1), fullname: JEFFREY T NELSEN, additional: -
Deepweb	fullzbuy	section: Simply Fullz 2023 (Part 3) dob: 1955, sex: -, zip: 99022, city: MEDICAL LAKE, state: WA, price: 1.25, country: USA, category: Simply Fullz 2023 (Part 3), fullname: MARY ARNST, additional: -
Deepweb	fullzbuy	section: Simply Fullz 2023 (Part 2) dob: 1961, sex: -, zip: 99022, city: MEDICAL LAKE, state: WA, price: 1.25, country: USA, category: Simply Fullz 2023 (Part 2), fullname: LEANNE GARRETT, additional: -
Deepweb	fullzbuy	section: Simply Fullz 2023 (Part 3) dob: 1964, sex: -, zip: 99022, city: MEDICAL LAKE, state: WA, price: 1.25, country: USA, category: Simply Fullz 2023 (Part 3), fullname: RANDY GLEN RAULSTON, additional:
Deepweb	darthmaulshop	price: 2 $, seller: Fullz Seller, section: Personal Data (SSN + DL) firstname: Chanique, city: Phoenix, state: AZ, dob: 12/17/1972, year: 1972, dl_state: AZ, zip: 85042-4563
Deepweb	darthmaulshop	price: 2 $, seller: Fullz Seller, section: Personal Data (SSN + DL) firstname: William, city: Glendale, state: AZ, dob: 02/22/1954, year: 1954, dl_state: AZ, zip: 85303-2101
Deepweb	darthmaulshop	price: 2 $, seller: Fullz Seller, section: Personal Data (SSN + DL) firstname: Brandy, city: Coolidge, state: AZ, dob: 01/28/1977, year: 1977, dl_state: AZ, zip: 85128-8264
Deepweb	darthmaulshop	price: 2 $, seller: Fullz Seller, section: Personal Data (SSN + DL) firstname: Isaac, city: Phoenix, state: AZ, dob: 01/17/1985, year: 1985, dl_state: AZ, zip: 85037-3814
Deepweb	darthmaulshop	price: 2 $, seller: Fullz Seller, section: Personal Data (SSN + DL) firstname: DWAYNE, city: ROXBORO, state: NC, dob: 06/16/1983, year: 1983, dl_state: NC, zip: 27573

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4

HIPAA Security Rule – Three Safeguards to Protecting ePHI

Administrative Safeguards: Policies and procedures for managing ePHI security risks including conducting risk assessments, designating a security official, and implementing a security awareness training program for employees

Physical Safeguards: The physical security of facilities and equipment where ePHI is stored or accessed including measures like controlling access, security cameras, and encrypting devices

Technical Safeguards: The technical security controls used to protect ePHI including access controls, encryption, and audit logs

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5

The Cyber Risk Assessment

A systematic process to identify, analyze, and evaluate potential threats and vulnerabilities to ePHI

- **Asset identification**: Inventorying systems, devices, applications, and data
- **Threat analysis**: Identifying potential threats, both internal and external
- **Vulnerability assessment**: Pinpointing weaknesses in systems, networks, and personnel
- **Impact assessment**: Evaluating the potential consequences of a successful attack
- **Risk prioritization**: Ranking risks based on likelihood and impact

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6

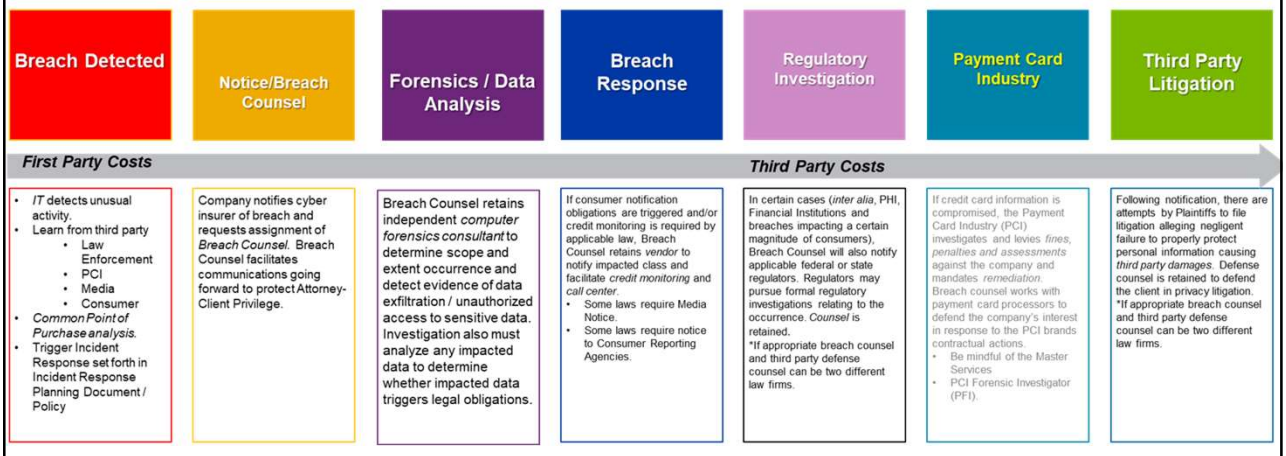
Data Breach Notification

- HIPAA Breach Notification Rule: Outlines the requirements for notifying affected individuals, the Secretary of HHS, and in some cases, the media following a breach of unsecured PHI
- Key components of incident response: Detection, Containment, Digital Forensics, Public Relations, Data Mining, Notification
- Importance of public relations: Managing communication with affected individuals, media, and stakeholders to protect the organization's reputation
- Potential consequences of delayed or inadequate notification: Financial penalties, legal liabilities, and loss of patient trust
- Business associate responsibility: Bas must also comply with breach notification requirements
- Best practices: Develop incident response plans, conduct regular security awareness training, and implement robust security measures to minimize the risk of a breach

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7

Incident Response Lifecycle

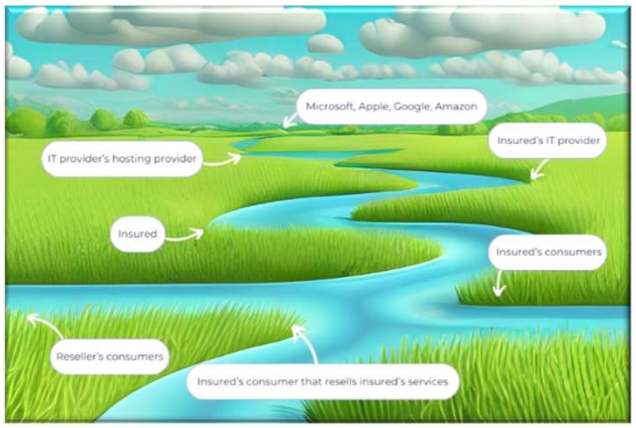


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8

Business Associates & Digital Supply Chain

Those who create, receive, maintain or transmit PHI and also anyone who maintains PHI on behalf of a covered entity, as well as subcontractors of business associates who have access to PHI



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9

Emerging Trends

- Mobile Devices
- AI
- ***Wrongful Collection Liability / "Pixel Liability"***
  - BIPA - Illinois's Biometric Information Privacy Act
  - CIPA - California Invasion of Privacy Act
  - VPPA - Video Privacy Protection Act

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10

Insuring Cyber Risk

- Whether to get coverage
- Getting the right coverage
  - Appropriate to the organizational risks and control environment
- When to file a claim
- Evaluate cyber-insurance coverage of priority third parties managing your entity's PHI

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11

Regulatory Enforcement – The OCR Investigation Process

- The Office for Civil Rights (OCR) within the Department of Health and Human Services (HHS) is responsible for enforcing the HIPAA Privacy and Security Rules
- Common triggers include patient complaints, data breaches (as mandated by HITECH), and routine compliance reviews
- Investigation Process:
  - **Initial assessment**: OCR reviews the complaint or breach report to determine potential violations
  - **Document Request**: OCR requests relevant documentation, including policies, procedures, and system information
  - **On-site Review**: In complex cases, OCR may conduct an on-site visit to assess compliance practices
  - **Interviews**: OCR interviews key personnel to gather information about policies, procedures, and incident response
  - **Analysis and Findings**: OCR analyzes the collected information to determine if HIPAA violations occurred

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12

Potential Consequences of Adverse Findings

- OCR "Settlement" Process:
- Corrective Action Plans (CAPs): Mandated changes to policies and procedures.
  - Civil Monetary Penalties (CMPs): Financial penalties based on the nature and extent of the violation.
  - Public Disclosure: In severe cases, OCR may publicly disclose the violation.
- Factors Affecting Penalties: Severity of the violation, number of individuals affected, organization's history of compliance, and cooperation with OCR
- Example Settlements:

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13

Resolution Agreements and Civil Money Penalties

A resolution agreement is a settlement agreement signed by HHS and a covered entity or business associate in which the covered entity or business associate agrees to perform certain obligations and make reports to HHS, generally for a period of three years. During the period, HHS monitors the covered entity's compliance with its obligations. A resolution agreement may include the payment of a resolution amount. If HHS cannot reach a satisfactory resolution through the covered entity's demonstrated compliance or corrective action through other informal means, including a resolution agreement, civil money penalties (CMPs) may be imposed for noncompliance against a covered entity.

- HHS Office for Civil Rights Settles HIPAA Security Rule Failures for $950,000 – July 1, 2024
- HHS OCR Imposes a CMP on NJ Nursing Facility for Failing to Provide Timely Access to Patient Records - April 1, 2024
- HHS' OCR Settles HIPAA Investigation with Phoenix Healthcare - March 29, 2024
- HHS Office for Civil Rights Issues Letter and Opens Investigation of Change Healthcare Cyberattack- March 13, 2024
- HHS OCR Work with Hospital to Improve Access to Kosher Electronic Devices Use for Virtual Patient Visitation- March 5, 2024
- HHS Finalizes New Provisions to Enhance Integrated Care and Confidentiality for Patients with Substance Use Conditions – February 8, 2024
- HHS' Office for Civil Rights Settles Malicious Insider Cybersecurity Investigation for $4.75 Million - February 6, 2024
- Voluntary Resolution Agreement Between The United States Department of Health and Human Services, Office for Civil Rights ("HHS") and Montiefore – November 16, 2023
- HHS' Office for Civil Rights Settles Optum Medical Care - November 15, 2023
- HHS' Office for Civil Rights Settles HIPAA Investigation of St. Joseph's Medical Center for Disclosure of Patients' Protected Health Information to a News Reporter - November 20, 2023
- HHS' Office for Civil Rights Settles Ransomware Cyber-Attack Investigation with Doctors' Management Services - October 31, 2023
- Green Ridge Behavioral Health, LLC Resolution Agreement and Corrective Action Plan - October 30, 2023
- HHS Office for Civil Rights Settles with L.A. Care Health Plan Over Potential HIPAA Security Rule Violations - September 11, 2023
- Voluntary Resolution Agreement Between The United States Department of Health and Human Services, Office

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14

Thank you!

- Recap: HIPAA and HITECH are critical for protecting patient data. The cyber threat landscape is constantly evolving
- Proactive Measures: Regular risk assessments, employee training, and incident response planning are essential
- Final Thought: By prioritizing HIPAA and cybersecurity, healthcare organizations can safeguard patient information, mitigate risks, and build trust

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15

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16

TAB 10

MLMIC Insurance Company
a Berkshire Hathaway company

Labor Pains:
Addressing Obstetrical Challenges in New York

A panel discussion

Panelists: *Christa Christakis, Executive Director*
Adriann Combs, DNP, NNP-BC
Victor Klein, MD, MBA, FACOG, FACMG
Brittany Salmon, RN, Nurse Manager

Moderator: *Joyce McCormack, BS, RN, CPHRM*

1

Program Objectives:

- At the end of this presentation, the learner will be able to:
  - Describe the current status of women's health care in New York State
  - Speak to the social determinants of health and examine the impact they have on the ability of women to access healthcare across the state, including but not limited to, location, costs, and availability of resources
  - Employ the risk management strategies presented by the panel when managing the delivery of women's healthcare at your organization

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2

2

LABOR PAINS: ADDRESSING OBSTETRICAL CHALLENGES IN NEW YORK

The Status of Rural Obstetrical Services



Victor R. Klein, MD, MBA, FACOG, FACMG
System Director, Quality & Patient Safety
OB/GYN Service Line
Northwell Health



Adriann J. Combs, DNP, NNP-BC
Clinical Director, Associate System Director
of Quality & Patient Safety, OB/GYN
Northwell Health

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

3

3

Addressing Obstetrical Challenges in Rural New York

Adriann Combs, DNP, NNP-BC
Victor R. Klein, MD, MBA, CPHRM
10/25/24

Northwell Health

4

OBJECTIVES

- Define Rural Health Care and why a crisis exists
- Review the availability of maternity care and services in the rural health care community: United States Data
- Review the availability of Maternal/Reproductive Health care in the rural health care community: NYS Data
- Address potential strategies to reduce risk/improve maternal and fetal outcome
- Consider alternative providers/methods to enhance access

EVERY MOTHER AND NEWBORN ARE ENTITLED TO A SAFE DELIVERY IN ANY COMMUNITY IN THE UNITED STATES

Access to care is essential for healthy mothers and babies
Consistent and high-quality maternity care leads to better outcomes
Low patient volumes leads to higher risk management costs



424



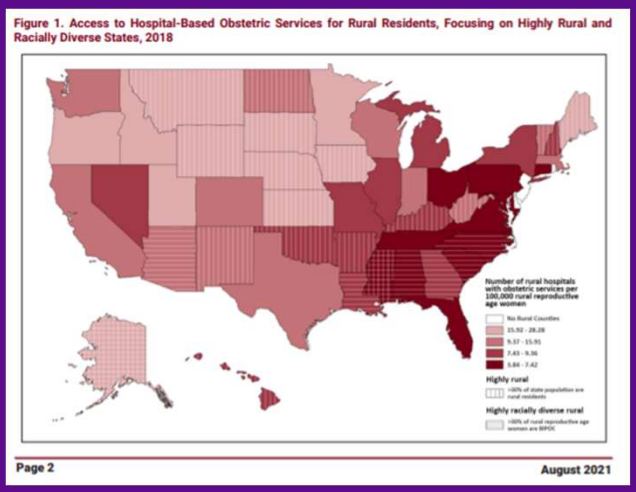
7,000

United States Births

3.7 millions births in the United States in 2019

179 Rural Counties lost access to Obstetrical Care in the last 10 years

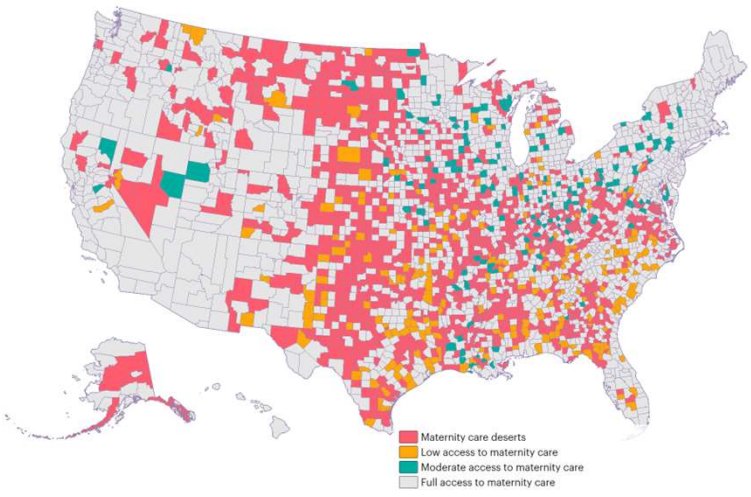
Half of all counties in the United States do not have an Obstetrician



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7

ACCESS TO MATERNITY CARE IN THE UNITED STATES 2024



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8

MATERNAL MORTALITY AND ICU ADMISSIONS RURAL V. URBAN

TABLE 1— Comparison of Maternal Mortality and Maternal Intensive Care Unit Admissions in Rural Versus Urban Areas: United States, 2016–2019

Year	Rural, ASR (95% CI) or AAPC (Range)	Urban, ASR (95% CI) or AAPC (Range)	RR (95% CI)
Maternal ICU admission			
2016	170.6 (158.8, 182.7)	161.7 (157.4, 165.9)	1.06 (0.98, 1.14)
2017	192.2 (179.3, 205.1)	158.7 (154.5, 163.0)	1.21 (1.13, 1.30)
2018	187.4 (174.7, 200.1)	160.7 (156.4, 165.0)	1.17 (1.08, 1.25)
2019	192.3 (179.5, 205.0)	172.4 (167.9, 176.9)	1.12 (1.04, 1.20)
Pooled 2016–2019	185.5 (179.3, 191.9)	163.3 (161.2, 165.5)	1.14 (1.09, 1.18)
AAPC 2016–2019	+3.3 (–5.3 to 12.7)	+2.1% (–3.9 to 8.5)	NA
Maternal mortality			
2016	66.9 (59.1, 74.6)	38.1 (36.0, 40.2)	1.75 (1.54, 1.99)
2017	69.1 (61.4, 76.8)	39.7 (37.6, 41.9)	1.74 (1.53, 1.97)
2018	73.9 (65.8, 82.0)	40.9 (38.7, 43.1)	1.81 (1.59, 2.04)
2019	81.7 (73.2, 90.1)	42.3 (40.1, 44.5)	1.93 (1.71, 2.17)
Pooled 2016–2019	72.9 (68.9, 77.0)	40.2 (39.2, 41.3)	1.81 (1.70, 1.93)
AAPC 2016–2019	+7.0 (2.2 to 12.1)	+3.5 (2.2 to 12.1)	NA

Note. AAPC = annual average percentage change; ASR = age-standardized rate (per 100 000 live births); CI = confidence interval; ICU = intensive care unit; NA = not applicable; RR = rate ratio.

Harrington, K. A., Cameron, N. A., Culler, K., Grobman, W. A., & Khan, S. S. (2023). Rural-Urban Disparities in Adverse Maternal Outcomes in the United States, 2016-2019. *American journal of public health*, *113*(2), 224–227. https://doi.org/10.2105/AJPH.2022.307134

9

BIRTH VOLUME AND SMM URBAN V. RURAL

Table 1. Associations Between Annual Birth Volume Category and Severe Maternal Morbidity (SMM) for Hospitals in Urban and Rural US Counties

Birth volume category	Total patients, No.	SMM incidence, No. (%)	Risk ratio (95% CI)	
			Unadjusted	Adjusted
Urban counties				
Low (10-500 births)	261 553	1316 (0.50)	0.69 (0.61-0.79)	1.00 (0.90-1.11)
Medium (501-1000 births)	860 892	4908 (0.57)	0.78 (0.66-0.93)	1.01 (0.90-1.13)
Medium-high (1001-2000 births)	2 535 466	16 476 (0.65)	0.89 (0.80-1.00)	1.03 (0.96-1.10)
High (>2000 births)	7 365 512	53 507 (0.73)	1 [Reference]	1 [Reference]
Rural counties				
Low (10-110 births)	8182	57 (0.70)	1.48 (1.01-2.18)	1.65 (1.14-2.39)
Medium (111-240 births)	59 374	324 (0.55)	1.16 (0.90-1.49)	1.37 (1.10-1.70)
Medium-high (241-460 births)	175 176	967 (0.55)	1.17 (0.96-1.44)	1.26 (1.05-1.51)
High (>460 births)	277 221	1304 (0.47)	1 [Reference]	1 [Reference]

Kozhimannil KB, Leonard SA, Handley SC, et al. Obstetric Volume and Severe Maternal Morbidity Among Low-Risk and Higher-Risk Patients Giving Birth at Rural and Urban US Hospitals. *JAMA Health Forum*. 2023;4(6):e232110. doi:10.1001/jamahealthforum.2023.2110

10

NYS PREGNANCY RELATED MORTALITY 2018-2020

Figure 13. Distribution of Pregnancy-Related Deaths by Timing of Death in Relation to Pregnancy, 2018-2020



Source: New York State Maternal Mortality Review

Table 4. Distribution of Timing of Pregnancy-Related Deaths in Relation to Pregnancy, by Race/Ethnicity, 2018-2020

Race/Ethnicity	Timing of Death in Relation to Pregnancy Count (%)			
	While Pregnant	Within 42 days	Within 43 to 365 days	Total
Black, non-Hispanic	12 (23.5%)	25 (49.0%)	14 (27.5%)	51 (100%)
White, non-Hispanic	7 (19.4%)	20 (55.6%)	9 (25.0%)	36 (100%)
Hispanic	7 (28.0%)	10 (40.0%)	8 (32.0%)	25 (100%)
Asian, non-Hispanic	2 (22.2%)	4 (44.4%)	3 (33.3%)	9 (100%)

Source: New York State Maternal Mortality Review

Table 5. Distribution of Timing of Pregnancy-Related Deaths by Underlying Causes of Death, 2018-2020

Cause of Death	Timing of Death in Relation to Pregnancy Count (%)			
	While Pregnant	Within 42 days	Within 43 to 365 days	Total
Hemorrhage (Excludes Aneurysms and Cerebrovascular Accidents)	12 (52.2%)	10 (43.5%)	1 (4.3%)	23 (19.0%)
Embolism - Thrombotic (Non-Cerebral)	4 (22.2%)	13 (72.2%)	1 (5.6%)	18 (14.9%)
Mental Health Conditions	1 (5.6%)	4 (22.2%)	13 (72.2%)	18 (14.9%)
Cardiomyopathy	0	4 (40.0%)	6 (60.0%)	10 (8.3%)
Infection	0	8 (80.0%)	2 (20.0%)	10 (8.3%)
Amniotic Fluid Embolism	2 (22.2%)	7 (77.8%)	0	9 (7.4%)
Cardiovascular Conditions	2 (28.6%)	2 (28.6%)	4 (42.9%)	7 (5.8%)
Metabolic/Endocrine Disorders	2 (33.3%)	1 (16.7%)	3 (50.0%)	6 (5.0%)
Cancer	0	1 (25.0%)	3 (75.0%)	4 (3.3%)
Injury	3 (100.0%)	0	0	3 (2.5%)
Hematologic Conditions	0	2 (100%)	0	2 (1.7%)
Hypertensive Disorders of Pregnancy	0	2 (100%)	0	2 (1.7%)
Gastrointestinal Disorders	0	1 (50.0%)	1 (50.0%)	2 (1.7%)
Anesthesia Complications	0	1 (100.0%)	0	1 (0.8%)
Cerebrovascular Accidents	1 (100%)	0	0	1 (0.8%)
Pulmonary Conditions (Excludes Acute Respiratory Distress Syndrome)	0	1 (100%)	0	1 (0.8%)
Unknown	1 (25.0%)	2 (50.0%)	1 (25.0%)	4 (3.3%)
Total	**28 (23.1%)**	**59 (48.8%)**	**34 (28.1%)**	**121 (100%)**

Source: New York State Maternal Mortality Review

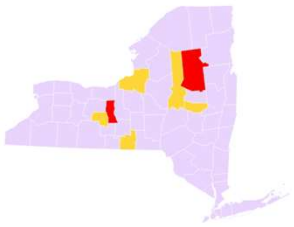
11

ACCESS TO MATERNITY CARE IN NEW YORK

Access to care during pregnancy and around the time of birth is not consistently available across the country. Hospital closures and a shortage of providers are driving changes in maternity care access, especially within rural areas and among Black, Indigenous, and people of color (BIPOC).[3] The level of maternity care access within each county is classified across New York by the availability of birthing facilities, maternity care providers, and the percent of uninsured women (see table). The map shows that in New York, 3.2 percent of counties are defined as maternity care deserts compared to 32.6 percent of counties in the U.S. overall.

FINDINGS

- In New York, there was a 3.3% increase in the number of birthing hospitals between 2020 and 2019.
- In New York, there were 364 babies born in maternity care deserts, 0.2% of all births.
- 1.0% of babies were born to women who live in rural counties, while 0.6% of maternity care providers practice in rural counties in New York.





DEFINITIONS OF MATERNITY CARE DESERT AND LEVEL OF MATERNITY CARE ACCESS

Definitions	Maternity care deserts	Low access	Moderate access	Full access*
Hospitals and birth centers offering obstetric care	zero	<2	<2	≥2
Obstetric providers (obstetrician, family physician†, CNM/CM per 10,000 births)	zero	<60	<60	≥60
Proportion of women 18-64 without health insurance	any	≥10%	<10%	any

Sources: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2022; American Board of Family Medicine, 2017-2020; National Center for Health Statistics, 2021 final natality data.

Note: CNM/CM = certified nurse midwives/certified midwives.
*A county is full access if it meets one or more of the criteria.
†Includes family physicians who provide obstetric care.

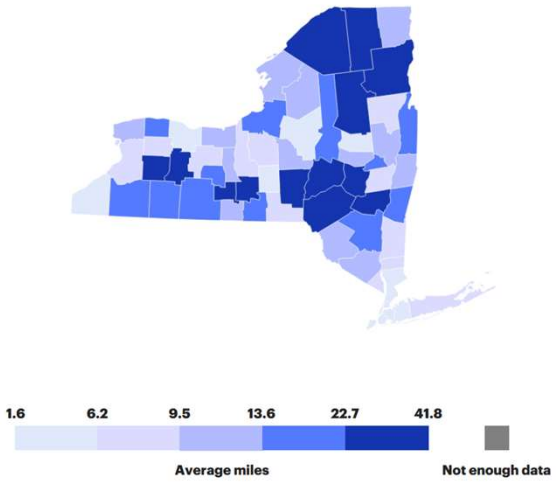
12

FINDINGS

- In New York, women travel 5.8 miles and 12.3 minutes, on average, to their nearest birthing hospital.
- Women living in counties with the highest travel times (top 20 percent) could travel up to 41.8 miles and 53.1 minutes, on average, to reach their nearest birthing hospital.
- Under normal traffic conditions, 0% of women live over 60 minutes from their nearest birthing hospital compared to 1.0% in the U.S.
- 4.2% of women in New York had no birthing hospital within 30 minutes.
- In rural areas across New York, 47.6% of women live over 30 minutes from a birthing hospital compared to 3.8% of women living in urban areas.
- Women living in maternity care deserts traveled 2.7 times farther than women living in areas with full access to maternity care in New York.

On average, women in New York travel 5.8 miles to the nearest birthing hospital.

DISTANCE TO BIRTHING HOSPITAL BY COUNTY



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October 22, 2024 13

13

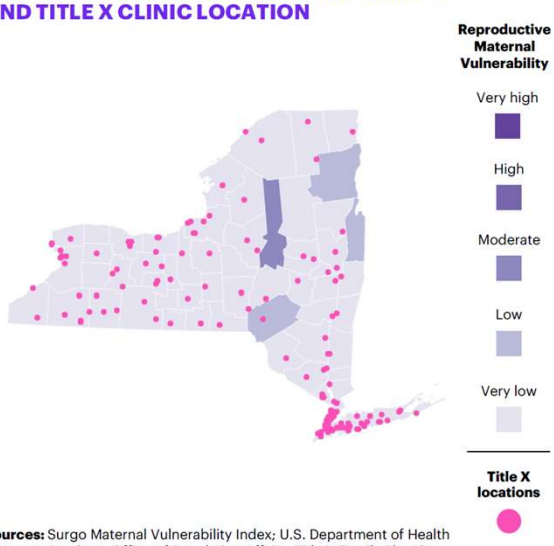
AVAILABILITY OF FAMILY PLANNING SERVICES

Access to family planning services allows for people to achieve their goals around having children, including the timing of and spacing between pregnancies.[7] An unexpected pregnancy or too little time between pregnancies can lead to serious health consequences, including preterm birth, depression, and anxiety.[8,9] Providing access to affordable contraceptives is a strategy to help people attain their family planning goals.[10] Title X clinics are federally funded healthcare sites that provide low-cost reproductive healthcare services including contraceptives, wellness exams, and breast and cervical cancer screenings.[11] The map displays Title X locations and areas where women are vulnerable to poor outcomes due to lack of access to reproductive health services. County level risk data are derived from Surgo's U.S. Maternal Vulnerability Index (MVI), where a darker color indicates greater vulnerability.[12] Overall, women in New York have a very low vulnerability to adverse outcomes due to the availability of reproductive healthcare services.

FINDINGS

- There are 4.0 Title X clinics per 100,000 women in New York compared to 5.3 per 100,000 in the U.S. overall.
- Women living in 98.4% of counties in New York have a very low or low vulnerability to adverse outcomes.
- On average, people living in maternity care deserts in New York, travel 2.8 times farther to reach their nearest Title X clinic compared to people living in full access counties.

REPRODUCTIVE MATERNAL VULNERABILITY AND TITLE X CLINIC LOCATION



Sources: Surgo Maternal Vulnerability Index; U.S. Department of Health & Human Services, Office of Population Affairs. Title X Family Planning Directory (March 2023); United States Census Bureau. "S1301: Fertility." American Community Survey. 2017–2021. Web. 1 Nov 2022.

14

14

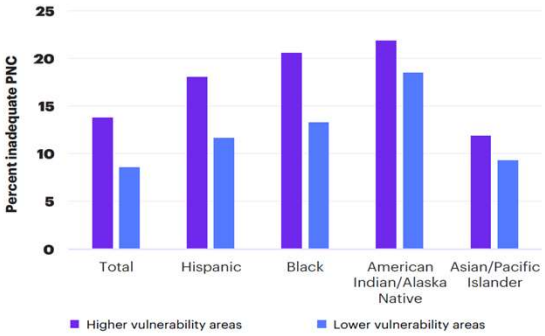
DISPARITIES IN PRENATAL CARE

Early and regular prenatal care (PNC) is an important strategy for reducing the risk of pregnancy complications and adverse birth outcomes.[13] Historically, BIPOC have lower rates of adequate PNC and may be less likely to receive services such as important health screenings and appropriate monitoring of baby's growth.[14,15] Socioeconomic determinants, including poverty, social support and education create barriers to care that can worsen the disparity in PNC usage among BIPOC.[16] The MVI defines areas where women are vulnerable to poor outcomes due to socioeconomic determinants. The impact of the socioeconomic determinants on PNC usage was assessed by examining the percentage of women receiving inadequate PNC in areas with higher and lower vulnerability. In New York, 12.5 percent of women received inadequate PNC compared to 14.8 percent in the U.S.

FINDINGS

- 1.2% of BIPOC did not receive PNC in areas of high socioeconomic vulnerability.
- Among BIPOC, those living in areas of high socioeconomic vulnerability have a 62% increased likelihood of inadequate PNC when compared to those living in areas of low socioeconomic vulnerability.
- Black women living in areas of high socioeconomic vulnerability are 1.5 times more likely to receive inadequate PNC compared to those in areas of low socioeconomic vulnerability.

INADEQUATE PRENATAL CARE BY RACE/ETHNICITY AND SOCIOECONOMIC VULNERABILITY



Sources: National Center for Health Statistics, 2019-2021 final natality data; Surgo Maternal Vulnerability Index.

Note: Inadequate PNC is defined as no prenatal care or care that began during or after the fifth month of pregnancy or that included less than half of the appropriate number of visits for the infant's gestational age. Missing groups are suppressed.

WHERE YOU LIVE MATTERS: MATERNITY CARE DESERTS AND THE CRISIS OF ACCESS AND EQUITY

March of Dimes recommends state policy actions that address access to care; see: https://marchofdimes.org/mcdr-ny

For details on data sources and calculations, see Technical Notes: https://www.marchofdimes.org/peristats/maternitycaretechnotes

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15

CHRONIC HEALTH CONDITIONS AND PRETERM BIRTH

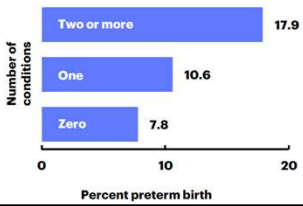
Having a chronic health condition before pregnancy increases the risk of pregnancy and postpartum complications. Preterm birth (PTB), a delivery before 37 weeks gestation, is one example of a complication that can lead to serious health impacts. The burden of chronic health conditions among birthing people is increasing across the U.S.[17,18] Access to healthcare before, during, and after pregnancy is important for appropriate management of chronic health conditions. At the time of birth, women with chronic conditions and their babies may need access to higher-level care, such as specialized providers, hospitals with the ability to perform a Cesarean birth, or hospitals with NICUs. Examining the chronic health burden (CHB) across New York and its relationship to adverse outcomes provides information needed to make important changes that can result in targeted resource allocation, prevention, and appropriate disease management.

The percent of birthing people with one or more chronic conditions was calculated for each county in New York and overall. The following conditions were included due to their availability in birth record data and established association with PTB: pre-pregnancy hypertension and diabetes, smoking, and being underweight or obese before pregnancy. The map describes the county level CHB in relation to the PTB rate. Areas shaded in purple have both a high CHB, greater than the overall state percent, and a high rate of PTB, defined as greater than the national target of 9.4 percent.[19] In New York, the PTB rate was 9.7 percent, compared to 10.5 percent in the U.S. overall in 2021.

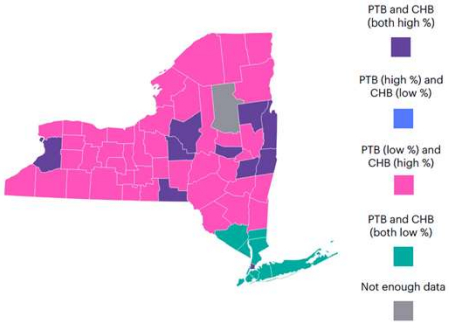
FINDINGS

- In New York, 32.5% of women had one or more chronic health conditions compared to 37.8% in the U.S. overall.
- Women with one or more chronic health conditions have a 53% increased likelihood of having a preterm birth compared to those without any chronic health conditions.
- 16.1% of counties in New York have a high burden of chronic health conditions and a high rate of preterm birth.

PRETERM BIRTH BY NUMBER OF CHRONIC HEALTH CONDITIONS



CHRONIC HEALTH BURDEN (CHB) AND PRETERM BIRTH (PTB) BY COUNTY



16

KEY FINDINGS

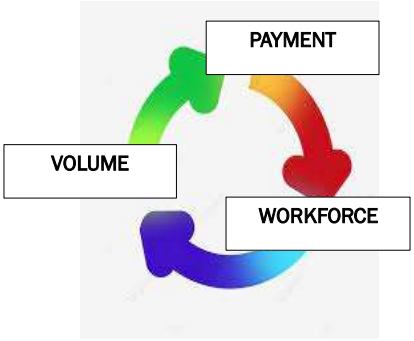
- In New York, 3.2 percent of counties are defined as maternity care deserts compared to 32.6 percent in the U.S.
- 4.2 percent of women had no birthing hospital within 30 minutes compared to 9.7 percent in the U.S.
- Overall, women in New York have a very low vulnerability to adverse outcomes due to the availability of reproductive healthcare services.
- 12.5 percent of birthing people received no or inadequate prenatal care, less than the U.S. rate of 14.8 percent.
- Women with chronic health conditions have a 53 percent increased likelihood of preterm birth compared to women with none.

https://www.marchofdimes.org/maternity-care-deserts-report

17

FACTORS DRIVING RURAL OB CLOSURES

- **Reimbursement**
  - 41% of births are financed by Medicaid
  - Medicaid underpays providers
  - Rural hospitals are more dependent on Medicaid and Medicare
- **Volume**
  - Fewer babies are delivered in rural areas
  - Link between volume and maintaining skill set
- **Workforce**
  - Health care workforce shortages hit rural areas hardest
  - OB services require specialized staff



American Hospital Association™
Advancing Health in America

18

RECENT FEDERAL POLICIES INTENDED TO IMPROVE ACCESS

- **Promoting coverage: 46 states have implemented state option to provide one year of postpartum Medicaid coverage**

- **CMMI: Transforming Maternal Health Model**
  - Access and workforce – expand access to certified nurse midwives, doulas, and community health workers
  - Quality improvement – establishing patient safety bundles and promoting "birthing friendly" designation
  - Whole person care delivery – screening for behavioral health and health-related social needs

Center for Medicare & Medicaid INNOVATION

Medicaid.gov Keeping America Healthy

American Hospital Association Advancing Health in America

Source: AHA Annual Survey, GAO Report to Congressional Committees: Availability of Hospital-Based Obstetric Care in Rural Areas; October 2022

19

WYDEN LEGISLATION

Keep Obstetrics Local Act (KOLA)

- Provide additional funding through the Medicaid Program
  - Requires states to increase Medicaid base payments
  - Implement a low-volume adjustment and a maternity supplement payment
- Require Medicaid Postpartum coverage (rather than a state option)
- Implement Medicaid medical home for pregnancy/postpartum
- Require CMS to provide states with guidance on Medicaid coverage for doulas, certified nurse midwives and other maternal health professionals
- Allow hospitals to request emergency workforce support from a Commissioned Corp.
- Streamline enrollment of out of state providers in Medicaid
- Establish new public reporting requirements on hospitals intending to close OB Services

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20

AVAILABILITY OF MATERNITY CARE AND SERVICES

- OB Services staff intensive, need to be trained and ready
- Family Medicine physicians may lose OB Surgical and OB Emergency skills
- Hospitals with <350 deliveries require nurses to be trained in multiple areas-float
- Malpractice insurers may be reluctant to insure OB Providers in rural hospitals
- Most medical schools are in metropolitan centers
- Newly trained physicians that transition to the “Big City” from the rural environment may be enticed by the financial and social amenities of the metropolitan centers
- OBGYNs are primarily female, time off for maternity care is an expectation
- Certain models of care do not lend themselves to work/life balance

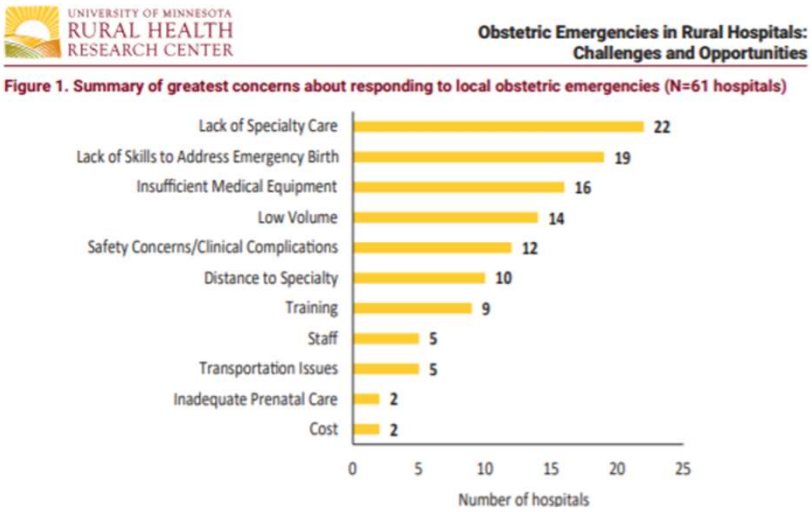
21

OBSTETRICAL EMERGENCIES

- Hemorrhage-DIC
- Shoulder Dystocia
- Fetal Distress-Cat III Tracings
- Uterine Rupture
- Thromboembolism
- Preeclampsia with Severe Features
- Eclampsia/Seizures

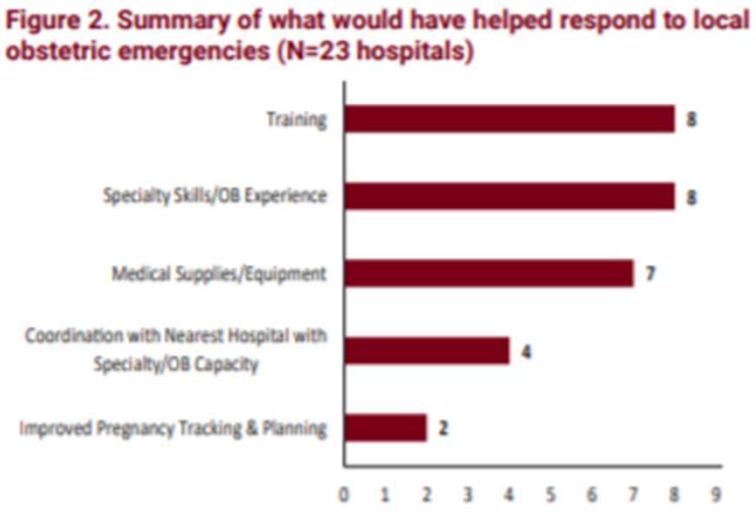
22

OBSTETRICAL EMERGENCIES



23

STRATEGIES TO RESPOND TO LOCAL EMERGENCIES



24

STRATEGIES TO DECREASE RISK

- Increase Federal financial support for rural OB Services
- Address the high cost of malpractice insurance for rural maternity care providers
- Pursue antitrust waivers to allow hospitals to collaborate to improve maternity care access in rural areas.
- Collaborate with stakeholders within your state to identify solutions.
- Partner with Women's Healthcare Practitioners to provide continued/updated education

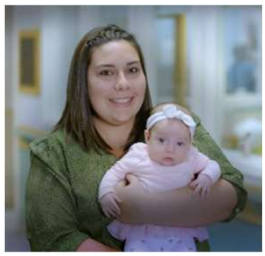
25

THANK YOU

26

LABOR PAINS: ADDRESSING OBSTETRICAL CHALLENGES IN NEW YORK

Rural OB care in Lewis County and Beyond



Brittany Salmon, RN
OB Nurse Manager
Lewis County Health System



Christa Christakis
Executive Director
American College of Obstetricians and Gynecologists, District II

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

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LABOR PAINS: ADDRESSING OBSTETRICAL CHALLENGES IN NEW YORK

Lewis County General Hospital

- In August of 1931, a new healthcare facility opened it doors to a grateful community:
  - Main campus is 14.5 acres
  - 220K square feet of space
  - Meet the needs of 30K residents and visitors in a tri-county area
  - With over 650 employees, it is the largest county employer



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MLMIC Insurance Company
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28

The Experience of Lewis County General Hospital

- **What Did It Look Like**
- Lewis County: October 2021: Can you tell us about those months leading up to that time?
- How did this decision impact the facility, the staff, and the community?
  - What happened to the OB staff?
  - How was this communicated and received by the community at large?
- What was the plan for the patients being seen and planning on having their babies at the hospital at the time of The Pause?

Available options for OB care during The Pause

- **OB services**
- The nearest facilities for births for LCGH moms:
  - **Carthage Hospital:**
    - 25 minutes
  - **Samaritan Medical Center:**
    - 40 minutes
  - **Rome Hospital:**
    - 60 minutes
  - **The Wynn Hospital:**
    - 60 minutes



LABOR PAINS: ADDRESSING OBSTETRICAL CHALLENGES IN NEW YORK

Internal preparations taken before The Pause

- **Safety and Risk**
- What was the plan if an OB patient presented to the ED?
- How often, during The Pause, did you have to operationalize the contingency plan?
- What measures were put in place after The Pause began?
- In an ideal world, what measures would be appropriate in this situation?

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LABOR PAINS: ADDRESSING OBSTETRICAL CHALLENGES IN NEW YORK

The Experience of Lewis County General Hospital

- **The Risk Management Process**



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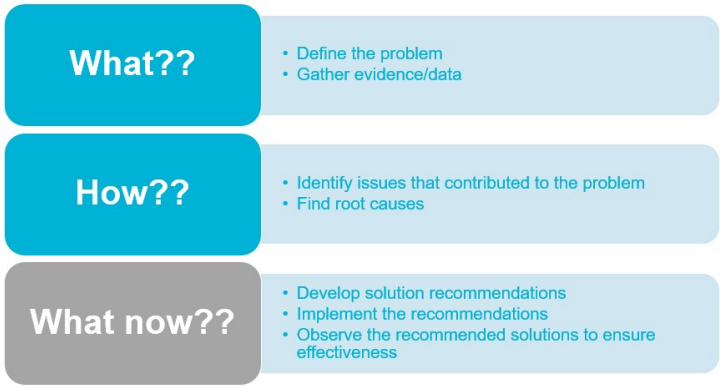
ASHRM Academy. Health Care Risk Management Fundamentals, pg. 45-50 (CPHRM Review coursework)

32

LABOR PAINS: ADDRESSING OBSTETRICAL CHALLENGES IN NEW YORK

The Experience of Lewis County General Hospital

- **Root Cause Analysis**



33 *ASHRM Academy. Root Cause Analysis Playbook, pg. 12-13 (CPHRM Review coursework)*

33

LABOR PAINS: ADDRESSING OBSTETRICAL CHALLENGES IN NEW YORK

The Experience of Lewis County General Hospital

- **Moving forward**
- What can we do for the service line of obstetrics?
- What steps can be taken to bridge the divide between patients and healthcare resources?
- What can I do today to make tomorrow better for the patient population?

34

34

ACOG District II Advocacy

Urging veto of legislation that expands liability exposure and cost

Supporting enhanced Medicaid reimbursement

Opposing interference in the practice of medicine

Advocating for telehealth parity permanence



Facilitating Opportunities to Share Your Hospital Story

ACOG | District II

35

35

Importance of Your Hospital Story

- Paints the picture of the maternity access crisis beyond the numbers and statistics
- Labor and Delivery units are a crucial community service
- Challenges that need to be elevated:
  - Inability of hospitals to TOLAC (trial of labor after cesarean)
  - Reduced access to prenatal care
  - Challenges with staffing, recruitment, burnout
  - Consequences of underfunding

Share Your Successes Too!

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Safe Motherhood Initiative Resources

- 6 patient safety bundles
- Maternal Morality Review Committees in NYS offer a data driven strategy for the work
- Offers education, tools and implementation strategies
- Available at: www.acogny.org



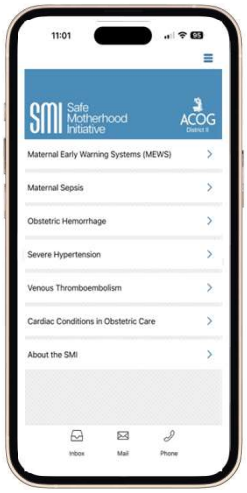
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37

37

SMI Resources and Opportunities

- Request Grand Rounds on bundles
- Reach out and ask a question of our experts
- Attend SMI Meeting, April 3, 2025 in Albany
- Download the SMI App
- Partner with NYS Perinatal Quality Collaborative



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38

38

ACOG Resources

- www.acog.org for clinical guidelines
- https://www.acog.org/womens-health for patient education
- Contact ACOG District II: Christa Christakis, Executive Director, cchristakis@ny.acog.org

ACOG | District II

39

39

Thank You!

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- Brittany Salmon: bsalmon@lcgh.net

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