Executive Hour – Understanding Disability

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STATE of PUBLIC OPINION
COUNTY of YOUR COMMUNITY

RISK AND LIABILITY,
Plaintiff,
vs.

RIGHTS AND RESPONSIBILITY,
Defendant.

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Argued: June 19, 2017
NYSARC Executive Directors

What is Negligence?

Negligence is the determining factor in all personal injury cases, and one of the most common sources of any civil litigation in New York. In order to achieve success in an injury claim, plaintiffs must prove that the responsible person or party's negligence or carelessness was the direct or indirect cause of the injury. Negligence laws define the term as a failure to behave or perform a task with the same level of care or attention that a reasonable person or party would provide under the same circumstances (or taking unreasonable action when a prudent person would not).

Proving negligence means establishing the following:

- **Duty** – This means that the responsible party owed the plaintiff a duty. Here are two examples: a doctor assumes duty by agreeing to treat a patient, and getting behind the wheel of a car is automatically assuming duty to all others on the road.
- **Breach of Duty** – This means that the responsible party breached his or her duty by failing to act as a reasonable or prudent individual would have acted.
- **Proximate Cause** – This means that the breach of duty resulted in injury or harm to the plaintiff.
- **Damages** – This means that the injury caused the plaintiff real measurable or immeasurable damages such as financial costs or mental anguish.

BREACH of DUTY
In The Context of Standard of Care

Medical Malpractice –

A doctor must exercise the reasonable degree of learning and skill ordinarily possessed by physicians and surgeons in the locality where the doctor practices (*Pike* v. *Honsinger,* 49 N. E. 760 (1898)). A doctor must use due care, as measured against the conduct of his peers. Due care requires a doctor to use his best judgment in using his skill and knowledge. A doctor must use his best judgment and whatever superior knowledge and skill he has, even if it exceeds that of the average doctor or specialist in the community where he practices (*Nestrowich* v. *Ricotta,* 767 N. E. 2d 125 (N.Y. 2002)).

Other Professionals and Standard of Care:

- Architect
- Accountants
- Lawyers
- Human Service Professionals

Human Service Professionals – Standard of Care
Olmstead Decision

States are, indeed, moving to re-balance their Medicaid spending to reflect the values of the Olmstead decision; and the federal government is providing incentives for them to do so in provisions such as the Balancing Incentive Payment Program; Community First Choice; Money Follows the Person; and the Medicaid Infra-structure grants to states (MIG). We also see structural changes to federal rules in the new HCBS definition and DOL rules.

Current Status: The Olmstead decision requires states to provide services and supports in the most integrated setting appropriate to the needs of qualified individuals with disabilities. We have come to understand the most integrated setting as one enabling people with disabilities to interact with their nondisabled peers to the fullest extent possible.

(Latest Court interpretation of Olmsted in New York)- O'Toole v Cuomo
Eastern District of New York Civ. Action No.l3-CIV-4166

HCBS Regulations

42 CFR 441.301(c)-

A waiver request under this subpart must include the following-

(1) *Person-centered planning process.* The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

(i) Includes people chosen by the individual.

(ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

(iii) Is timely and occurs at times and locations of convenience to the individual.

(iv) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.

(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

(vii) Offers informed choices to the individual regarding the services and supports they receive and from whom.

(viii) Includes a method for the individual to request updates to the plan as needed.

(ix) Records the alternative home and community-based settings that were considered by the individual.

(2) *The Person-Centered Service Plan.* The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

(i) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

(ii) Reflect the individual's strengths and preferences.

(iii) Reflect clinical and support needs as identified through an assessment of functional need.

(iv) Include individually identified goals and desired outcomes.

(v) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

(vi) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

(vii) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.

(viii) Identify the individual and/or entity responsible for monitoring the plan.

(ix) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

(x) Be distributed to the individual and other people involved in the plan.

(xi) Include those services, the purpose or control of which the individual elects to self-direct.

(xii) Prevent the provision of unnecessary or inappropriate services and supports.

(xiii) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(A) Identify a specific and individualized assessed need.

(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(C) Document less intrusive methods of meeting the need that have been tried but did not work.

(D) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(E) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(G) Include informed consent of the individual.

(H) Include an assurance that interventions and supports will cause no harm to the individual.

Need for Expert Testimony

In professional negligence cases, such as medical malpractice lawsuits filed against physicians, the specific duty owed by the physician to the patient is defined by the profession itself. A member of the profession is needed to tell the judge and jury what the defending physician should have done or not done under the particular circumstances, and whether such conduct constituted negligence by violating the standards of care of the profession. Therefore, in medical malpractice litigation, expert witness testimony is nearly always necessary.

Beauparlant v Helderberg House (Albany County, Keegan, J.)

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The Individual "Plan" of a Person with a Developmental Disability

As Effecting the Legal Standard of Care in Personal Injury Lawsuits

Written by Christopher R. Lyons, Esq.

The Individual "Plan" of a Person with a Developmental Disability As Effecting the Legal Standard of Care in Personal Injury Lawsuits

Most if not all jurisdictions have now developed statutory and regulatory schemes calling for the establishment of individual program plans ("IPP") by service providers for individuals with developmental disabilities. These written individualized plans are based upon appropriate and reliable professional assessments formulated in accordance with professional standards and arrived at in conjunction with the person served and other interested individuals including guardians and representatives. Often the plan is part of case management services provided to persons with disabilities and includes a diagnosis, an assessment of the individual's service needs, and individual service plan, an individual habilitation plan and methods for providing, evaluating and monitoring the services identified in the plan.

Without any particular focus on IPP's, tort lawsuits against service providers have centered on whether the facility met a particular standard of care. The standard of care has been compared to that of a provider of health services. As such, in order to be successful has been argued that a tort lawsuit must evidence a breach of an applicable standard of care with the concurrent injury to the person served and a causal connection between the breach and the person's injury. In medical malpractice cases for example, liability has been found if a physician owes the patient a duty of care, fails to meet the standard of care established by the profession and pertinent case law and negligently injures the patient. With the emerging importance of the IPP, it may be argued that a fact finder assessing breach of a standard of care owed by a provider of services to those with developmental disabilities must first look to the person's individual program plan before arriving at the appropriate standard of care.

Where a service provider is exposed to tort liability, the courts may define the facility's duty in terms of proper establishment of an individual program plan and the assurance that the services identified in the recipient's individual service plan have been delivered in accordance with the laws, rules and regulations governing the provision of those services and the specific determination of what services are appropriate.

One case illustrative of the above is Reasons v. State of Tennessee (1987 Tenn. App. Lexis 2919). In that case the claimant was a thirty-four year old "profoundly retarded" male who alleged that certain employees of the defendant, an intermediate care facility, were negligent in the care rendered to claimant. Specifically, the claimant alleged while eating food prepared at this center, he swallowed a bone that lodged in his esophagus, resulting in a esophageal perforation and infection.

The facts of the case revealed that specific persons served were designated as "charges" for a particular caregiver who had the responsibility of supervising his or her consumers during their meal time. The claimant grabbed a handful of sliced roast beef from the plate of another resident and proceeded to stuff it in his mouth, as a result of which he choked. (The connection between the roast beef and the retrieved bone was never formally resolved!)

The court determined that the plaintiff failed to establish by any proof that the defendant breached the standard of care. The court focused on a requirement that the staff at the defendant's facility develop an individual habitation plan for each resident. This included the ascertainment and establishment of the dietary need of each resident followed by individual observations by the staff. As developed, this claimant's diet plan called for a regular diet with triple portions. A regular diet did not include in its process an active overt screening of each and every meal served to petitioner and any other resident receiving a regular diet to eliminate

absolutely the presence of any bones from it. The court held that the claimant failed to establish that the defendant needed to remove all bones "from all food served to every profoundly retarded patient or resident". Indeed, the court went on to opine that the individual program plan was in keeping with the applicable guidelines that "residents at the center were to be 'normalized' ..." encouraging the patients to develop the best rhythm of life possible, and to do so to allow them to: carry out the customs and routines that are normal...[entitling consumers] the 'dignity of risks' [and] that in order to allow mentally retarded patients to develop their fullest capacity, they should be permitted to run the risk of danger or harm in progressing up the ladder of development.. (i4.).

Another case emblematic of the importance of the IPP in establishing a standard of care is Hunter v. Evergreen Presbyterian Vocational School et al., (338 So.2d 164 [Ct.App. Louisiana]). In that case, the consumer/decedent, was a "moderately to severely retarded young man" who drowned in a pond on the defendant's premises. The consumer worked on the yard maintenance crew as part of his vocational training. Each work group had a staff supervisor. The supervisors, as a rule, did not stay continuously with the crews. At the time of the accident, the supervisor was away from the area near the pond where the consumers were working. While he was gone, the decedent consumer went into the pond apparently to retrieve a yard tool and drowned.

The court identified the principal issue in the case as to whether the standard of care owed by the defendant facility to the decedent consumer required continuous supervision throughout the day. The court held that the facility's duty to use reasonable care in this instance did not dictate continuous supervision. This was based on the defendant's policy to allow its consumers a certain amount of freedom consistent with their "mental capacities" which was "reasonable and necessary to accomplish [the facility's purposes]".

Significantly, the court found that it was "not shown that [the consumer] received continuous supervision at any time during his stay ... and [and that] during those three and one-half years, [the consumer] had given no indication that he was dangerous to himself". Noting that the consumer's only mishap came when he cut himself on the foot with a yard tool, the court found specifically that "this was not sufficient to give [the facility] notice that continuous supervision was necessary for [the consumer/decedent's] safety." Accordingly, the individual program plan developed for this consumer was determined to be appropriate and, based on same, the facility was not liable for the unfortunate death of the consumer.

Often the IPP is pivotal in establishing the standard of care applicable in medical care cases. In Canning v. Lensink, (1993 Conn. Super. Lexis 353), the plaintiff claimed that the defendant's negligence resulted from a departure from the accepted standard of care in like conditions for "a retarded individual who was admitted to the defendant facility for the purpose of respite care". In the Canning case the consumer/decedent died as a consequent of dehydration. There was a great deal of expert testimony that the defendant's own policy required sufficient admission information which was to be current and pre-forwarded to the respite coordinator. That specific information (which was included in the consumer's individual program plan) included known fluid and electrolyte problems in the past and hyper-irritability resulting from dehydration. The court found that the defendant breached the standard "to follow a patient, their symptomatology [and] write notes that can be used to follow the patient [and] to call other medical care and to get the patient to facility where that medical care can be delivered and to know when it is warranted." Based on the health information contained in the decedent/consumer's individual program plan, the facility was further found negligent in that the "care and treatment of [the decedent/consumer] was inappropriate, and that [the facility] breached

the standard of care properly to assess any health medical issue which would warrant continuing nursing observation during the [respite care]". In Canning the consumer's symptoms were ignorea and basic assessment including taking a temperature was not implemented. Accordingly, it can be argued that medical information contained in an individual program plan may also contribute to defining a particular standard of care. which a plaintiff in a tort case must establish and prove breached in order to successfully recover for personal injury.

Individual Program Plan standards have been generally defined as the exercise of reasonable care toward a consumer as the consumer's known condition may require (See e.g., Shackleford v. State of Louisiana DOR 534 So.2d 38 [1989]). In Shackleford. the consumer was kept in a "cottage" with older and larger consumers despite knowledge of repeated injury. The plaintiffs condition (21 year-old severely MR.) and the facts and circumstances peculiar and applicable to plaintiff (history of self injury and violence) were the specific basis for finding liability. The case supports the proposition that all the circumstances known considering an individual's needs and propensities, as determined by the plan, will be considered in determining a breach or compliance with a particular standard of care.

This is not to say, however, that an individual program plan, nor rules, regulations or policies, in themselves establish a standard of care. (See. Darling v. Charleston Community Memorial Hospital, 33 lli.2d 326, 332, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946, 86 S. Ct. 1204, 16 L. Ed. 2d 209 (1966); Williams v. St. Claire Medical Center. 657 S.W.2d 590, 594-95 (Ky. App. 1983); Bly v. Rhoads, 216 Va. 645, 653, 222 S.E.2d 783 (1976). In most jurisdictions, the failure to follow an IPP or such rules and regulations is merely evidence, of negligence not negligence per se. (See e.g., Ziegert v. South Chicago Community Hospital. 99 Til. App.3d 83, 97-99, 425 N.E.2d 450 {1981); Boland v. Garber. 257 N.W.2d 384; 385-87

(Minn. 1977); Foley v. Bishop Clarkson Memorial Hospital 185 Neb. 89, 93, 173 N.W.2d 881 (1970).

Nor does a spontaneous act, not specifically anticipated in a consumer's IPP," attach liability to a service provider. In Johnson v. Department of MR&DD, (35 Ohio Misc.2d 18), the consumer, through his guardian, alleged, that while the consumer was an in-patient at the defendant's disabilities facility, the consumer was "negligently caused, permitted or allowed to receive personal injury and great pain and suffering". The consumer was a sixty-six year old "profoundly retarded male" who resided at a cottage, part of the defendant's overall facility. One evening a caregiver was assisting another consumer in the cottage about thirty feet away from the plaintiff when he was summoned by one of the other consumers to the doorway. He found the plaintiff prostrate with a cut over both eyes and bleeding. It was later learned that the injury was caused by the "unsupervised violent actions of another client". The facility argued that they had not known the other consumer to be abusive and that, although they acknowledged that there were occasionally aggressive consumers on the premises, there were no known aggressive consumers then in the cottage.

The court found that the plaintiff failed to provide expert testimony that the facility should have foreseen the attack or that the plaintiff himself required twenty-four hour attention. A care giver was within thirty feet of the consumer when the accident happened, a sufficient showing that the facility provided the standard of care required.

The above cases illustrate the importance of both establishing and implementing an appropriate individual program plan for each individual consumer and reviewing the plan at the time that a potential loss occurs which may give rise to a lawsuit. As the courts lend credence to the proposition that the standard of care should focus on the individual program plan, the need to

assess the plan becomes more and more important in loss prevention and strategic tort defensive strategies.

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