# Claims & Litigation Update

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# 2023 Illinois Litigation Trends

- Increased litigation activity from covid slowdown.
- Many cases that were delayed or dormant in 2020-2022 were settled or taken to trial in 2023.
- Some plaintiff-friendly rulings by the Courts.
- Severity continues to be a trend.
- Plaintiff's bar is asking for larger dollar amounts at trial.  No longer a fear of offending juries.
- More defense verdicts than plaintiff verdicts but several large verdicts.
- Increased defense collaboration to discuss strategy in the current environment.

# Large Settlements – IPT 2023

- **Top Ten Claims for 2023 – $24,300,000**
- **7 claims settled at or above $1 million**
  - Birth Injury Case $9.7M
  - Med Dosing/Stevens-Johnson Syndrome $6.25M
  - Spinal Cord Injury During Epidural Injection $2.4M
  - Spinal Cord Injury During Surgery $1.35M
  - Death following Gastric Bypass $1.25M
  - Death following multiple outpatient visits $1M
  - Death following narcotic medication overdose $1M

- **Increase in Top 10 IPT settlement amounts compared to prior years**

# Large Settlements - IRMS

- **Increase in Top 10 IRMS settlement amounts in 2023 compared to prior years**
- **Eight figure settlements**
- **Largest Settlements - Obstetrics, Sexual Misconduct, Failure to Diagnose Cancer**
- **25 claims settled above $1 million**

7 Surgery Related

5 ED – Failure to Diagnose/Admit/Consult

4 Obstetrics/Delivery

3 Nursing – Failure to Monitor/Treat

1 Failure to Diagnose – Radiology, Failure to Diagnose – Physician Office, Sexual Misconduct, Medical Management, Mental Health/Suicide, Failure to Timely Treat

# IPT Top 5 Cause Codes

| Top Five Cause Codes by Count | | | | | |
|---|---|---|---|---|---|
| **Claims Set Up in 2023** | | **Claims Set Up in 2022** | | **Claims Set Up in 2021** | |
| **Falls** | 38 | Negligence in patient care | 35 | Negligence in patient care | 40 |
| **Negligence in patient care** | 33 | Falls | 32 | Covid | 33 |
| **Surgical/Postoperative complication** | 15 | Covid | 15 | Falls | 23 |
| **Failure to diagnose-ED** | 14 | Failure to diagnose-ED | 12 | Postoperative complication | 13 |
| **Failure to Diagnose** | 10 | Deposition assist | 11 | Emergency medicine cause other | 12 |

# IRMS Top 5 Cause Codes

| IRMS<br>Top Five Cause Codes by Count | | | |
|---|---|---|---|
| **2023** | | **2022** | **2021** |
| **1.** | **OB Cause Other (118)** | OB Cause Other (86) | OB Cause Other (76) |
| **2.** | **Falls (79)** | Postoperative Complication (65) | Postoperative Complication (69) |
| **3.** | **Postoperative Complication (72)** | Negligence in Patient Care (61) | Negligence in Patient Care (60) |
| **4.** | **Surgery Cause Other (72)** | Surgery Cause Other (47) | Failure to Properly Monitor (56) |
| **5.** | **Failure to Diagnose/Delay Treatment – ED (68)** | Falls (44) | Surgery Cause Other (50) |

# Update - Verdicts

**2023 Verdicts**

- Based on the jury verdict reporter, more defense verdicts than plaintiff verdicts in med mal cases in all counties (including Cook).
- Many six and seven figure jury verdicts for plaintiffs.
- 8 Nuclear verdicts ($10M+) in Illinois in 2023
  - Largely in Cook County
  - Ranging from $10M - $55M
  - Verdict against MAIC insureds and post-trial settlement (Cook County)
  - Recent $75M verdict in Cook County (2024)
    - Birth injury case
    - Reported high-low agreement

# Update - Verdicts

## Severity Increase Factors

- Anchoring
- Admissions from Depositions
- Social Inflation/Social Media
- Tactics to anger jury/responsibility
- Venue
- Non-Economic Damages

## Defense Considerations

- Witness prep, experts and action plan
- Strategy - Motion for Summary Judgment, Mediation or Trial
- Risk Mitigation
- Motions *in Limine*
- High-Low Agreements
- Preserving appealable issues

# Case Law Update – Wilcox, 2024 IL App (1st) 230355

**Facts**

- Paraplegic patient with abdominal pump implanted that administers antispasmodic drug baclofen into the the intrathecal space of his spinal canal by catheter (replacement needed every 5-10 years due to battery).
- Without the medication, patient at risk for baclofen withdrawal.
- July 28 - Patient's physician determines pump is not working and needs to be replaced.
- Admits to hospital to monitor for withdrawal symptoms.
- Neurosurgeon contacted to perform replacement procedure early the following week.
- Hospital allegedly advised 2000mcg concentration of baclofen necessary for pump by fax and call.
- Multiple physicians and nurses provide care over the weekend.
- Use of hospital text system where some physicians asked nurses to send a message requesting consults.
- Family complaints about progressing symptoms and withdrawal symptoms.
- Pain, mental status changes, muscle spasticity, elevated temperature, heart rate and blood pressure.
- July 31 – added to surgery schedule that morning for afternoon procedure.
- 1:00pm – surgeon learned that pump was not in OR. Arrived 30 minutes later.
- 1:30 pm –surgeon learned that 2000mcg baclofen was not in OR. Arrived at 5pm from another hospital.
- 3:00 pm – code event, patient stabilized but irreversible brain damage and patient passed two weeks later.

# Case Law Update

- Expert testimony that the hospital was directly negligent and committed institutional negligence.
- Trial - Jury Instruction – Was the hospital negligent in the following respects?
  - Allowed a systems failure to exist resulting in the delay of the patient receiving his intrathecal baclofen.
  - Failed to ensure effective communication among the patient's healthcare providers resulting in the delay of the patient receiving his intrathecal baclofen.
- Hospital argued that plaintiff's arguments were agency claims masked as institutional negligence claims and providers' medical judgment was at issue as opposed to any system or administrative issue.
- Verdict in favor of Plaintiff in the amount of $42.4M on both vicarious liability and institutional negligence theories.
- Hospital appealed on multiple issues including institutional negligence allegations being improper and PJI.

# Case Law Update

## 1st District Appellate Court:

- Agreed with hospital that the issues as presented by plaintiff on institutional negligence were broad as to communication between physicians and nurses.
- However, Court felt that there was sufficient evidence to move forward on institutional negligence theory given the facts based on the *method* of communication by providers.
- Found hospital's general policies were violated including one regarding family involvement in care.
- "Facts of this case demonstrated that it was the responsibility of the hospital as an institution to procure the equipment and medication needed by a surgeon in the course of a particular surgery."
- 1st Dist. affirmed trial court rulings.
- Likely Petition for Leave to Appeal to IL Supreme Court.

# Pre-Judgment Interest - Recap

**735 ILCS 5/2-1303(c):**

- 6% prejudgment interest is applied to plaintiff verdicts
- Any cases pending prior to July 2021 - accrues starting 7/1/2021
- New cases – accrues starting on date of lawsuit filing
- Maximum accrual 5 years
- Settlement offer at or before 12 months affects the computation – PJI applies if verdict is higher than offer.  Only computed on the difference between offer and verdict
- Does not apply to governmental entities

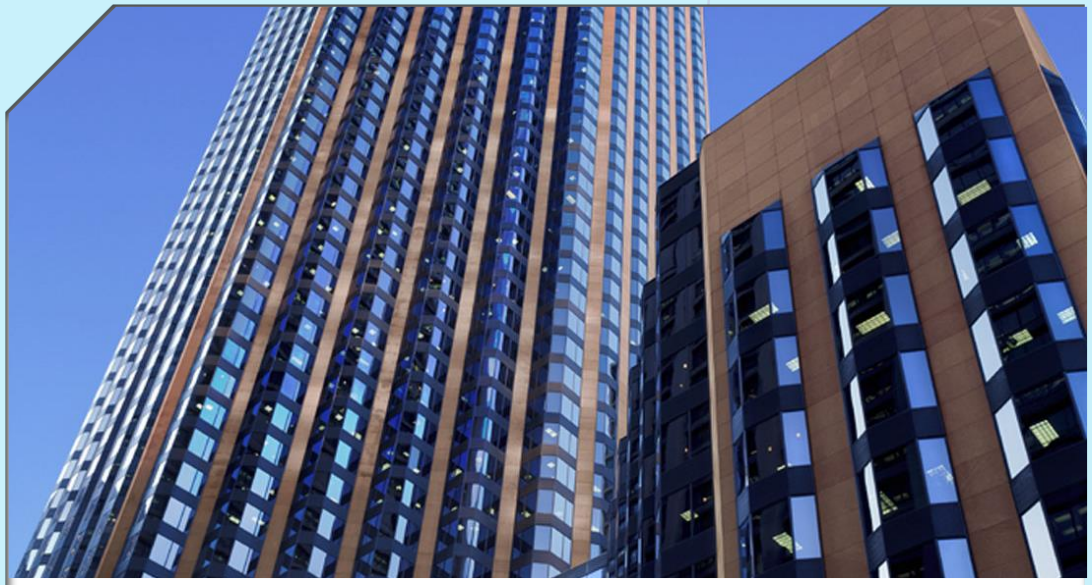
# Pre-Judgment Interest - Appeals

## Challenges

- Several challenges made to PJI including violating due process, equal protection, separation of powers, the right to trial by jury and the inherent power of the judiciary.

## Appeals

- In *Cotton* appeal, 1st Dist upholds PJI noting that PJI is constitutional, within legislative power and referencing the delay in compensation for the tort victim/injured party.
- In *Overstreet* appeal, 4th Dist upholds PJI.
- The Illinois Supreme Court has denied the petition to hear the *Cotton* appeal.
- In recent *Wilcox* appeal, 1st Dist. upholds PJI.  Potential petition for leave to appeal to IL Supreme Court.



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# AGENCY TODAY AND TOMORROW

# TERMINOLOGY

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# AGENCY

**A fiduciary relationship in which the principal has the right to control the agent's conduct and the agent has the power to act on the principal's behalf.**

ACTUAL AGENCY

APPARENT AGENCY

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# ACTUAL AGENCY CASE SITUATION AND CASELAW

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# ACTUAL AGENCY

(1) an employer-employee relationship between the hospital and physician;

(2) the ability by the hospital to control the manner and method in which the physician treats patients; and

(3) the treatment of the patient must occur within the scope of the physician's employment by the hospital.

Hospitals are generally not liable for the acts of physicians who are independent contractors. *Petrovich v. Share Health Plan of Illinois, Inc.,* 188 Ill.2d 17, 31 (1999).

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# ACTUAL AGENCY

## EXPRESS AUTHORITY

Principal explicitly grants the agent authority to perform a particular act

## IMPLIED AUTHORITY

Actual authority proved circumstantially by evidence of the agent's position

# EXAMPLES

- Employed Staff to Patient Direct Care
- Husband Instructs Wife Execute Consent
- Rules and Regulations for Medical Decisions
- Husband Agrees Signature of Wife is Own

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# CASE SITUATION

Patient arrives in ER with wife via ambulance, has tremendous difficulty breathing, cannot speak, severe swelling in neck. Wife signs consent form indicating ER physician is an independent contractor and choice of hospital is not relevant to care requested.
Patient passes away after failed emergency cricothyrotomy by ER physician. Hospital is sued for wrongful death by wife due to alleged negligence of independent contractor.

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# FESE V. PRESENCE, et. al.

**Underlying Facts:** Wrongful Death Case. Adult Male in ER. Negligent Diagnosis and Failure to Establish Airway by Dr. Irving.

**Issue on Appeal:** Consent Form; Express and Implied Authority Over Independent Contractor.

**Significant Facts:** Dr. Irving's employer was CEP America (CEP) and ER Medical Director for Presence. CEP had a PSA with Presence. PSA contained standard language for Presence to remove physicians at CEP for various failures and to approve medical director.

Pamela Fese (wife) signed consent indicating in clear terms all practitioners (not wearing a badge) were independent contractors and not relevant to selecting Presence with signature line indicating "patient's representative."

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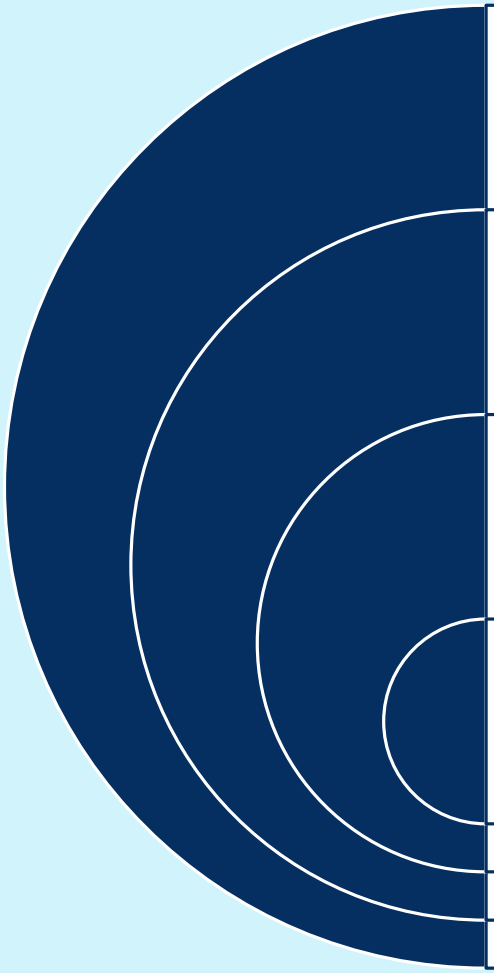
# FESE V. PRESENCE, et. al.



Pamela signed consent form in ER, could not recall when, but was acting on her husband's behalf when she signed, but did not recall her husband asking her to sign any documents.

Presence moved for Summary Judgment arguing Dr. Irving was an independent contractor and to dismiss Presence. Plaintiff argued no authority existed for Pamela to sign consent, Dr. Irving was the ER Medical Director and other issues.

Trial Court granted Motion for Summary Judgment finding: 1)Dr. Irving was an independent contractor and Presence neither retained control or employed; 2) Consent form was clear and established Plaintiff had constructive or actual knowledge of Dr. Irving's independent contractor status.

Appellate Court found: 1) Pamela's husband did not give her authority to sign the consent on his behalf; 2) there was no evidence the husband knew about the independent contractor status of Dr. Irving; 3) there was no evidence the husband relied upon being treated by a specific provider under a theory of apparent agency.

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# IMPLIED AUTHORITY
# CASE SITUATION AND CASELAW

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# CASE SITUATION

Nine-month pregnant patient arrived at ER reporting false labor pains. Patient had a long-standing OB physician on call that day monitored her condition with plans to perform a Cesarian section after time passed from the patient's last meal. An emergency Cesarian section was performed after providers could not locate the fetus' heartbeat. The baby was delivered with severe brain injury due to lack of oxygen during the labor and delivery process. The Hospital had multiple ethical directives and rules and regulations regarding how OB/GYN physicians and patients provided care and were provided for.

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# CASE SITUATION NOTES

Appellate Court found the Hospital's policies, procedures, rules, regulation, ethical directives and other requirements to negate the independent contractor's status. The Court found the Hospital was providing detail directions about when to perform a C-section; the manner of how to administer tocolytic therapy, external fetal monitoring, the induction of labor and preventing the OB physician from performing certain conception and artificial fertilization procedures, sterilization procedures and abortions.

Appellate Court found the Hospital's rules pertained directly to the OB physician's practice of medicine and medical decision-making ability.

Appellate Court ruled the Hospital still maintained control over the OB physician independent contractor and held his status as an independent contractor "should be negated."

It is significant to note the Appellate Court upheld the lower court's decision that the OB physician was not the Hospital's apparent agent, as the patient had a long-standing prior relationship with the OB physician.

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# APPARENT AGENCY
# CASE SITUATION AND CASELAW

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# APPARENT AGENCY

For a hospital to be vicariously liable for negligent medical treatment rendered in the hospital by an independent contractor physician under the doctrine of apparent authority, the plaintiff must establish that:

(1) the hospital, or its agent, acted in a manner that would lead a reasonable person to conclude that the individual who was alleged to be negligent was an employee or agent of the hospital;

(2) where the acts of the agent create the appearance of authority, the hospital had knowledge of and acquiesced in them; and

(3) the plaintiff acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence.

*Gilbert v. Sycamore Municipal Hospital*, 156 Ill. 2d 511 (1993).

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# CASE SITUATION

Patient receives referral from primary care physician to see an orthopedic physician affiliated with a major medical center for pain and swelling in her right knee. The medical center actively advertised this orthopedic physician with vast experience and being part of a team. The patient only seeks out the orthopedic physician because she was recommended to go and does not rely upon or consider the advertisement. The patient was later diagnosed with a cancerous tumor in her right leg resulting in an amputation.

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# Solorzano v. West Suburban, et al.

**Underlying Facts:** Failure to diagnose cancerous tumor by Dr. Romano resulting in right leg amputation.

**Issue on Appeal:** Apparent agency for advertisement by West Suburban Medical Center for Dr. Romano who rents on hospital campus, chair of orthopedic department and received a WSMC badge.

**Significant Facts:** WSMC advertises orthopedic specialists with vast experience, rents an office to Dr. Romano on campus near its main entrance and, provided a WSMC badge to Dr. Romano.

Dr. Romano has held positions at WSMC including president, vice president and president emeritus of the WSMC medical staff. He does not wear a lab coat with WSMC logos. He does not wear his WSMC badge.

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# Solorzano v. West Suburban, et al.

**Significant Facts (con't)**: Plaintiff/patient Solorzano referral order listed Dr. Romano's name and "West Suburban Hospital." Solorzano admitted she would have gone to whatever hospital and doctor her primary care physician recommended, even back to her original orthopedic surgeon, Dr. Magnani at Mount Sinai Hospital.

Solorzano signed a consent at Dr. Romano's office acknowledging payments. The consent did not reference Dr. Romano's relationship with WSMC.

Trial court granted motion to dismiss for WSMC finding Plaintiff failed to show any evidence WSMC held itself out or Plaintiff justifiably relied on WSMC's conduct for her care.

Appellate Court analyzed advertisements that created a question of fact to deny a hospital's dismissal, including phrases like staff had "hundreds of qualified physicians" referring them as "our" physicians; displaying a physician's name and photo without a disclaimer of independent status and how it is irrelevant to the inquiry if a patient actually observes hospital advertisements.

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# Solorzano v. West Suburban, et al.

Appellate Court found WSMC's advertisements to establish a genuine issue whether the hospital held itself out as Dr. Romano's principal by advertising "our team" and "our…compassionate physicians" without a disclaimer of independent contractor status.

Appellate Court also found WSMC should have informed patients that its providers, especially those renting offices on campus, were independent contractors by putting up signs in the professional building.

Finally, the Appellate Court was influenced by the services provided to Solorzano were all located on WSMC campus (snow globe analogy) and medical records were sent directly to Dr. Romano "without any action on Solorzano's part."

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# ANATOMY OF A CONSENT

Use strong universal language like “all” or “none” in describing provider relationships. Words like “most” or “almost all” will always be interpreted as ambiguous and unclear. Use language that limits supervision or control over the healthcare provider as in “not subject to the supervision or control” or “these physicians use their own medical judgment for your care” or “exercise their own medical judgment” or “make their own medical decisions about your care.”

Use common sense meanings and phrases. Words or phrases like “authority” or “apparent agent” or “actual agent” cannot be understood by the average lay person or by a person who is in need of immediate care. Words that have meaning to the patient are better understood like “I” or “your doctor” or “your nurse” or “your care” or “your surgery” and are less likely to be challenged by their attorney.

**Recommend language**: “I acknowledge that the employment or agency status of physicians and other providers who treat me is not relevant to my selection of HOSPITAL for my care. I acknowledge that any questions about the Independent Contractor Disclosure form and the information contained in it have been answered to my satisfaction.”

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# ANATOMY OF A CONSENT

Title Paragraphs with "NOTICE OF INDEPENDENT CONTRACTOR" or "NOTICE OF INDEPENDENT PRACTITIONERS" or use individual's names with the names of their legal employer. Use bold to emphasis, avoid using italic fonts as this may be difficult to read.

The layout and font should be easy to follow. Font should be used that will print out neatly, if necessary. Areas to place initials should be close to clauses, paragraphs or in paragraphs, NOT near the edges.

If the Hospital has many independent providers, consider providing a list with names. It should also contain their specialty and names of their legal employers and a separate phone number. Do NOT use addresses if the provider is on your campus.

If electronic signature pads are used, then use language in the consent patient/representative that a paper copy as been offered and/or available. Questions provided and completely answered. If a document is provided, then have them initial receipt of the document.

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# ANATOMY OF A CONSENT

Risk management should be reviewing all consent forms created by the Hospital/System when patient authorization is obtained to ensure language for independent providers is consistent. Plaintiff attorneys will seek out conflicting or ambiguous language when comparing consents or documents signed by their client or their client's representatives. This creates an issue of fact before the judge or the jury.

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# OTHER AGENCY CRITERIA TO CONSIDER

Keep everyone on the same page. Have a good working relationship with your human resource department or individual to keep track of employment status or independent contractor status. Are there new providers in your Hospital? Do you have clear communication between IT, social networking, marketing, human resources, etc. about agency relationships and Hospital liability. Have a "we are all in this together" mentality. Are there appropriate disclaimers being used for advertisements and websites?

Place signs on Hospital campus indicating which providers are independent practitioners if they rent from the Hospital with easy-to-understand language. Everyone understands "landlord" and "tenant." Placing signs at or near provider offices on campus clearly shows the Hospital is not "holding out."

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# National Practitioner Data Bank (NPDB): Risk Management Insights


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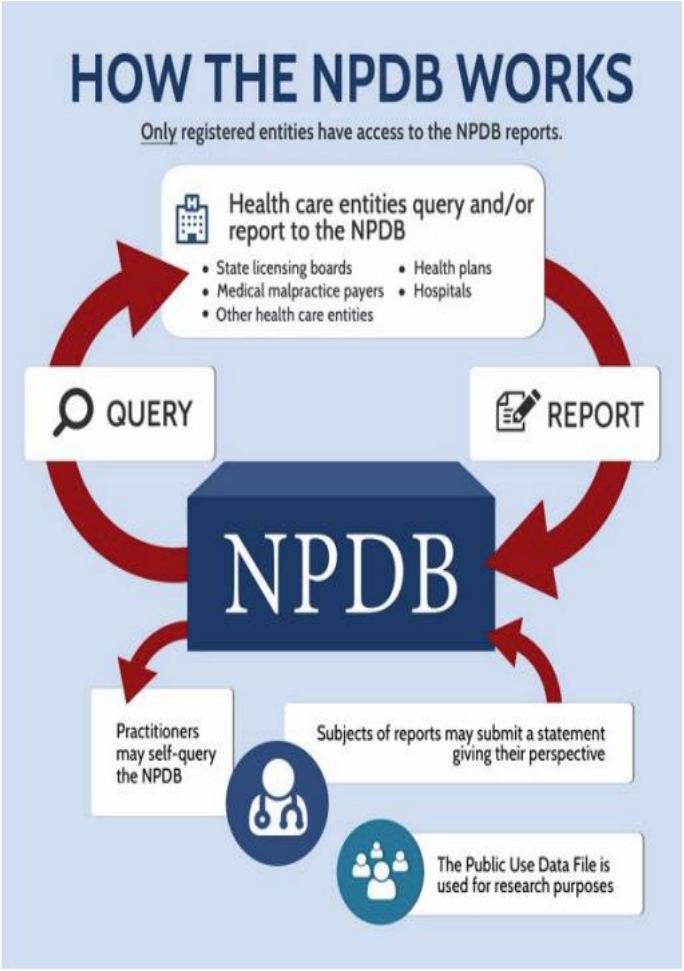
# National Practitioner Data Bank (NPDB)

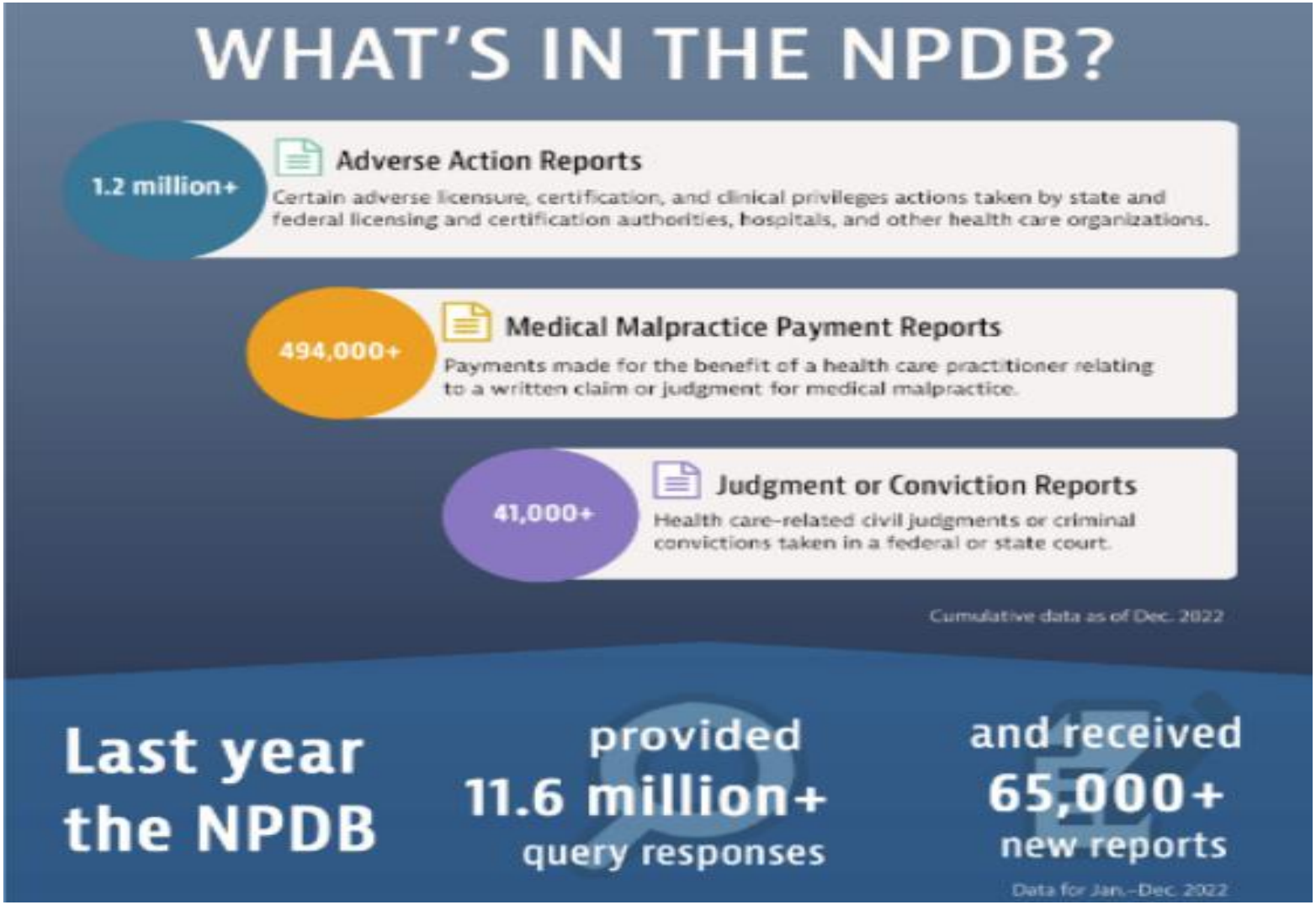
- **What is the NPDB?**
  - An information clearinghouse that collects and releases information related to professional competence and conduct
- **Who gets reported to the NPDB?**
  - Physicians, dentists, other health care practitioners


- **What type of information is collected in the NPDB?**
  - Medical malpractice payments
  - Adverse licensing/certification and credentialing/privileging actions
  - Civil and criminal health care related judgments

# NPDB Queries

- **Who can or must query the NPDB and Why?**
  - Confidential
  - Hospitals must query – staff appointments, privileges, once every 2 years
  - Other healthcare entities may query
  - Practitioners




WHAT'S IN THE NPDB?
1.2 million+
Adverse Action Reports
Certain adverse licensure, certification, and clinical privileges actions taken by state and federal licensing and certification authorities, hospitals, and other health care organizations.
494,000+
Medical Malpractice Payment Reports
Payments made for the benefit of a health care practitioner relating to a written claim or judgment for medical malpractice.
41,000+
Judgment or Conviction Reports
Health care–related civil judgments or criminal convictions taken in a federal or state court.
Cumulative data as of Dec. 2022
Last year the NPDB
provided 11.6 million+ query responses
and received 65,000+ new reports
Data for Jan.–Dec. 2022

# NPDB Query Question

- **Question**
  - Must a hospital query the NPDB before employing an APRN?
- **Answer**
  - It depends
  - Will the APRN be applying for clinical privileges or just working in the clinics?

# NPDB Reporting

- **Who must report to the NPDB?**
  - Hospitals
  - Medical malpractice payers
  - State licensing boards
  - Health plans
  - Other health entities
- **What is reported to the NPDB**
  - Medical malpractice payments (MMP)
  - Adverse clinical privileges actions (ACPA)
  - Adverse licensure or certification

- **Majority of reports come from state licensure entities**
- **30% of reports are for medical malpractice payments**
- **2% of reports are for clinical privileges**

# Basic Reporting Requirements - MMP

- **What must be reported to the NPDB?**
  - Each entity or insurance company that makes a payment for the benefit of a health care practitioner in settlement or satisfaction of a claim or judgment for medical malpractice
  - Must be the result of a written complaint or claim demanding monetary payment for damages
  - Must name the practitioner in the demand for monetary payment/settlement release
  - Payment made on behalf of the practitioner named in claim
  - No dollar threshold - $1 sufficient to trigger reporting requirement

# Basic Reporting Requirements - MMP

- **Non-Reportable Payments**
  - MMPs made solely for the benefit of a corporation such as a clinic, group practice, or hospital
  - A person, rather than a professional corporation or business makes a payment out of personal funds
  - Defendant healthcare practitioner is dismissed from the lawsuit before settlement or judgement and not as a condition in the settlement or release
  - Confidential provisions do not excuse reporting

# Basic Reporting Requirements - MMP

- **MMP Reporting Questions:**
  - Must a physician be reported to the NPDB if a patient requests a refund of payments in a verbal complaint made to the hospital and the hospital reimburses the funds?
  - What if the patient submits a written request for reimbursement, but does not name the physician in the written complaint, and the hospital reimburses the money?
  - What if the written complaint names the physician, but he decides to pay the patient out of his own pocket?

# Basic Reporting Requirements:  ACPA

- **What must be reported to the NPDB?**
  - A professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days, or
  - Accepts the surrender of clinical privileges of a physician, while under investigation related to competency or professional conduct, or
  - In return for not conducting such an investigation or proceeding
  - Must report physicians or dentists, may report other practitioners, e.g. APPs
  - Licensed residents reportable only if outside the scope of a formal graduate program

# Basic Reporting Requirements: ACPA

- **Investigations are not reportable**
- **OPPE not considered an investigation**
- **Summary suspension**
  - > 30 days is reportable,
  - based on professional competence or conduct that adversely affects or could adversely affect health or welfare of patient
  - Result of professional review action
- **FPPE may be reportable if affects privileges and extends beyond 30 days**
- **Nonrenewals and withdrawal of applications are reportable if practitioner fails to renew or later voluntarily withdraws application while under investigation for possible professional incompetence or conduct**

# Basic Reporting Requirements: ACPA

- **ACPA Reporting Questions**
  - Would you need to report to the NPDB a general surgeon who submits an application for medical staff membership and privileges, but withdraws his application for personal reasons?
  - What if the hospital granted temporary privileges to the general surgeon, and received a number of quality of care-related complaints about the general surgeon from other facilities, and the general surgeon indicated he wants to withdraw his membership and privileges request so he hospital does not investigate these complaints?

# Basic Reporting Requirements: ACPA

- **ACPA Reporting Questions**
  - A physician applying for renewal of her hospital clinical privileges failed to provide information about an ongoing licensure investigation. When this was discovered, the hospital suspected that the investigations was related to the physician's professional conduct, even though there had been no harm to patients? Is this reportable to the NPDB?
  - A surgeon has been experiencing post-op complications and an external professional review recommends that the surgeon be proctored for the next 10 procedures. Is this reportable?

# NPDB: Final Thoughts

- Ensure you query as required by law
- MMPs are reported by insuring entities for physicians, but if self-insured for physician risk without a claims handling service, will need to follow reporting requirements for MMPs
- Hospitals must report to the NPDB adverse privileging actions >30days
- Contact IPT/IRMS with questions regarding NPDB reporting

# NPDB Resources

- **NPDB Guidebook**
  **https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp**
- **NPDB Webinars**
  **https://www.npdb.hrsa.gov/community_n_education/webcasts.jsp**

# Questions

# Regulatory Update/ Changing Standards & Guidelines

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# IL Consent by Minors to Health Care Services Act

## 410 ILCS 210/2

*A parent who consents to the performance upon the parent's child of a health care service under this Section shall be entitled, upon request, to inspect and copy the part of that child's records related to the specific health care service for which the parent is treated as the child's personal representative under HIPAA, 45 CFR 164.502(g). For purposes of this Section, each appointment, referral, test, treatment, procedure, or other medical intervention is a separate and distinct health care service for the purpose of determining whether a parent is treated as the child's personal representative under HIPAA, 45 CFR 164.502(g), with respect to that health care service.*

# IL Mental Health & Developmental Disabilities Confidentiality Act

**740 ILCS 110/4**

*The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof:*

*(3.5) the personal representative under HIPAA, 45 CFR 164.502(g), of a recipient, regardless of the age of the recipient;*

For more on "personal representatives" under HIPAA, see HHS Guidance at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html

# IL Freedom of Information Act


**5 ILCS 140/2**

*For a public body that is a HIPAA-covered entity, "private information" includes electronic medical records and all information, including demographic information, contained within or extracted from an electronic medical records system operated or maintained by the public body in compliance with State and federal medical privacy laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act and its regulations, 45 CFR Parts 160 and 164. As used in this subsection, "HIPAA-covered entity" has the meaning given to the term "covered entity" in 45 CFR 160.103.*

# 410 ILCS 180 (P. A.102-1095) Latex Glove Ban Act

**Prohibits use of latex gloves by health care facility personnel on:**

- Unconscious patients
- Patients unable to communicate
- Medical history does not indicate whether patient has an allergy to latex

*Hospital Licensing Requirements: First Comment Period*

# IL Hospital Licensing Act

**210 ILCS 85/6.26 (P.A. 103-0057) Immunization against influenza virus and pneumococcal disease**

- Influenza vaccine: age 50 or older
- Pneumonia age 65 or older

**210 ILCS 85/10.10 (P.A. 103-0211) Nurse Staffing by Patient Acuity**

Requires annual notification of hospital nursing staff of staff's rights under this section

Annual notice must provide a phone number an email address for staff to report noncompliance

Notice must be provided by email or regular mail

*Hospital Licensing Requirements: First Comment Period*

# IL Hospital Licensing Act

**210 ILCS 85/6.34** (P.A. 103-0213) **Emergency room treatment; delay of treatment prohibition**

*Notwithstanding any provision of law to the contrary, a hospital licensed under this Act, in accordance with Section 1395dd(a) and 1395dd(b) of the Social Security Act, shall not delay provisions of a required appropriate medical screening examination or further medical examination and treatment for a patient in a hospital's emergency room in order to inquire about the individual's method of payment or insurance status.*

*Hospital Licensing Requirements: First Comment Period*

# IL Hospital Licensing Act

**210 ILCS 85/11.9 (P.A. 103-0160) Maternal milk donation education**

- Hospital with licensed OB beds
- *Shall provide* information & instructional materials to parents of each newborn, upon discharge from the hospital, regarding the option to voluntarily donate milk to nonprofit milk banks that are accredited by the Human Milk Banking Association of North American.
- General information and contact information for area nonprofit milk banks
- May provide the information electronically

HMBANA (https://www.hmbana.org/file_download/inline/18140142-457f-42f6-a4f1-967802144989

Mothers' Milk Bank of the Western Great Lakes https://www.milkbankwgl.org/for-healthcare-providers/

Clinical Manager, Amber, at amber@milkbankwgl.org

# IL Hospital Licensing Act

**P.A. 103-0169 Polices and Education Related to Maternal Health**

- Applies to hospitals with more than one licensed OB bed
- Airway emergencies during childbirth
- Severe maternal hypertension
- Obstetric hemorrhage
- Management of other leading causes of maternal mortality
- Best practices implemented

*Hospital Licensing Requirements: First Comment Period*

# IL Hospital Licensing Requirements Pediatric Care (250.310 c)

- **Applies to hospitals without a pediatric unit or board certified/eligible pediatrician in-house or on-call 24/7**
- **In-patient or observation admissions**
- **Does not apply to neonates (≤ 28 days)**
- **Written agreement with children's hospital or hospital with licensed pediatric beds**
- Effective 6/01/2024

# IL Nurse Practice Act


**225 ILCS 65/65-43 Full Practice Authority**

(4.5)

- May prescribe up to a 120-day supply of benzodiazepines without a consultation relationship with a physician
- Continued prescription shall require a consultation with a physician

# IL Medical Practice Act of 1987

**225 ILCS 60/54.5**

The written collaborative agreement shall be for services for which the collaborating physician can provide adequate collaboration.

# Health Care Professional Credentials Data Collection Act

**410 ILCS 517/5**

Changes re-credentialing period to three years from two years

# IL Vehicle Code

**625 ILCS 5/11-1421 Conditions for operating ambulances and rescue vehicles**

**(a) 0.5**

The operator of the ambulance or rescue vehicle shall have documented training in the operation of an ambulance or rescue vehicle prior to operating that vehicle. This training shall include the proper use of warning lights and sirens, situations where warning lights and sirens are warranted, and the provisions of this Section.

**(a-5)** The driver of an ambulance or rescue vehicle may proceed past a red traffic control signal or stop sign if the ambulance or rescue vehicle is making use of both the audible and visual signals meeting the requirement of this Section, but only after slowing down as necessary for safe operation.

# 2023 AHA Focused Update on ACLS

- **Routine administration of calcium, sodium bicarb, magnesium not recommended in cardiac arrest**
- **Extracorporeal CPR (ECPR; cardiopulmonary bypass) may be reasonable in select patients in cardiac arrest refractory to standard ACLS, within an appropriately trained and equipped system of care**
- **Identifies situations when emergent angiography is not recommended over a delayed or selective strategy following ROSC**
- **Recommends hospitals develop protocols for post-arrest temperature control between 32º-37.5º C**

https://www.ahajournals.org/doi/10.1161/CIR.0000000000001194

# Cancer screening saves lives.

American Cancer Society

## Screening Recommendations

These recommendations are for people at average risk for certain cancers. Talk to a doctor about which tests you might need and the screening schedule that's right for you. It's a good idea to also talk about risk factors, such as lifestyle behaviors and family history, that may put you or your loved ones at higher risk.

### Ages 25-39

**Cervical cancer screening** recommended for people with a cervix beginning at age 25.

### Ages 40-49

**Breast cancer screening** recommended beginning at age 45, with the option to begin at age 40.

**Cervical cancer screening** recommended for people with a cervix.

**Colorectal cancer screening** recommended for everyone beginning at age 45.

At age 45, African American individuals should discuss **prostate cancer screening** with a doctor.

### Ages 50+

**Breast cancer screening** recommended.

**Cervical cancer screening** recommended.

**Colorectal cancer screening** recommended.

People who currently smoke or used to smoke should discuss **lung cancer screening** with a doctor.

Discussing **prostate cancer screening** with a doctor is recommended.

## Questions to Ask a Doctor:

- What cancer screening tests are recommended for someone my age?
- How often should I get the screening tests?
- Where can I go to get screened?
- How do I schedule my screening tests?
- Will my screening tests (or other costs) be covered by my health insurance?
- What will the screening tests cost if they are not covered by insurance?

## Cancer Screening Conversation Starters

- I care about you and your health. Are you getting regular cancer screening tests?
- Did you know there are tests that can catch changes in your body before they become cancer?
- My breast/colorectal/cervical/prostate/lung cancer screening is coming up. Have you scheduled yours yet?
- Regular cancer screening is important. Is there anything I can do to help you get screened, like finding information, scheduling an appointment, or helping with childcare or transportation?

## Have Questions About Screening?

Visit **cancer.org/getscreened** for cancer screening FAQs, including information about how to schedule a screening test, how to afford screening with or without insurance, and more.



https://www.cancer.org/content/dam/cancer-org/online-documents/en/pdf/flyers/cancer-screenings-save-lives.pdf

# American Cancer Society: Lung Cancer Screening Update

**Low-dose CT Asymptomatic individuals who are:**

- 50-80 years of age
- Currently smoke
- Formerly smoked & high risk (20 or greater pack-year history)

Years since quit should not determine whether to screen

https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21811

# ISMP 2024-2025
# Targeted Medication Safety Best Practices for Hospitals

**New Best Practice 20: *Safeguard against wrong-route errors with tranexamic acid***

**New Best Practice 21: *Implement strategies to prevent medication errors at transitions of care***

**New Best Practice 22: *Safeguard against errors with vaccines administered in inpatient and associated outpatient settings***

https://www.ismp.org/resources/three-new-best-practices-2024-2025-targeted-medication-safety-best-practices-hospitals

# Questions

# 2024 REAP Criteria

Teresa Baumgartner, MJ, RN
Senior Risk and Claims Consultant

Illinois Health and Hospital Association

# REAP 2024

## 2024
## Risk Exposure Adjustment Program Summary

| 2024 Criteria | Total Maximum Credit 8% | Maximum Debit 8% |
|---|---|---|
| OB Department | 2% | 2% |
| Emergency Department | 2% | 2% |
| Surgical Risk and Safety | 2% | 2% |
| Improving Diagnostic Safety | 1% | 1% |
| Medication Safety | 1% | 1% |

| Prior Criteria | No Credit | Maximum Debit 2% |
|---|---|---|
| Apparent Agency | | 2% |

# Summary of Potential Credit/Debit

| | | |
|---|---|---|
| **Total Credit/Debit for hospitals with OB and Surgery** | **8%** | **10%** |
| **Total Credit/Debit for hospitals without OB** | 6% | 8% |
| **Total Credit/Debit for hospitals without OB and Surgery** | 4% | 6% |

# Apparent Agency

- **Adequate insurance coverage = minimum limits of $1/3 million for <u>each</u> provider**
- **Coverage is continuous**
- **Corporation has separate limits of $1/3 million**
- **Limits of coverage are not eroded by defense costs**
- **Risk manager performs an inventory of contracted professional services**

# Apparent Agency

- **Add a statement to the General Consent to Treat form:**
  - *"Further, I understand that physicians practice independent medical judgement in my care and treatment."*
  - *Patient signature lines should include the words "legal representative."*

- ***Make sure the status of non-employed providers is on the home page and in appropriate areas on the website-not embedded***
- ***Make sure to archive changes made to advertising materials and the website-date stamp***
- ***Signage is present in public/common areas as well as in lobby and elevators, and immediately outside patient entry area***

# Improving Diagnostic Safety in Ambulatory Clinic Settings

- **Healthcare literacy**
- **Disclaimer language on preliminary test results posted to patient portals**
- **Review/develop P&P for patient portals communication**
- **Closing the loop on physician referrals**
- **Patient navigator role**

# Improving Diagnostic Safety in Ambulatory Clinic Settings

- **Review/revise cancer screening recommendations/processes for breast, colon, lung, prostate and cervical cancer**
- **Provide education for providers and staff on processes**
- **Patient navigators are responsible to follow up on screening**
- **Develop and/or revise processes to prompt providers to order screenings**
- **Consider utilizing the Safer Diagnosis Instrument**

# Emergency Department

- **Core Components Unchanged**
- **Reduction of Diagnostic Error**
- **Improve Timely Identification and Treatment of sepsis**
  - All patients-adult, pediatric, maternal
  - Appoint senior administrator sponsor, physician and nurse coordinators
  - Perform a gap analysis surrounding sepsis program
  - Implement “Code Sepsis”
  - Provide education on sepsis, necrotizing fasciitis and Fournier gangrene
  - Individualized discharge instructions
  - TAT for test results
  - Monitor blood culture contamination rates

# Emergency Department cont.


- **ED Pediatric Readiness**
  - Evaluate current peds equipment, meds etc.
  - Identify physician and nursing staff champions
  - Assess/develop pediatric competencies and education
  - P&P, guidelines, protocols for safe administration of peds meds
  - Review/revise P&P, etc. related to pediatric sedation
  - Consultations/Transfer agreements

# OB

- **Core Components-essentially the same as last year**
- **Standardized Clinical and Operational Practices**
  - Continued surveillance of community births
  - Identify and communicate with doulas
  - Develop guidelines for the role of doulas in the hospital
  - Safe care of patients with significantly increased BMI
  - Behavioral health assessment
  - SUD assessment and discharge instructions

# OB

- **Communication, Teamwork and Education**
  - Education on risks with increased maternal BMI, behavioral health and SUD

# Medication Safety

**Adopt best practices to improve risks from IVP medications.**

- The committee performs a gap analysis
- Develop action plans to address any gaps
- Monitor process and outcome indicators for success and opportunities for improvement.

# Surgery Risk and Patient Safety

- **Improve Surgical Team Member Communication**
  - Standardized handoff process
  - Standardized handoff process to ICU
  - Standardized surgical safety checklist
  - Surgical fire safety plan and drill
  - Monitor timeout

# Surgery Risk and Patient Safety

- **Improve Perioperative Medication Safety**
  - Team to identify gaps
  - Develop/modify P&P to align with gaps
  - Provide education

- **Maintain ERAS Program as a Standard Model of Care**

# Questions