2007

The preliminary impact of 2001 Florida tort reform on nursing facility litigation in one county

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The Preliminary Impact of 2001 Florida Tort Reform on Nursing Facility Litigation in One County

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
School of Aging Studies
College of Arts and Sciences
University of South Florida

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Date of Approval:
March 30, 2007

Keywords: somatic and staff-related allegations, nursing home residency, lawsuits, attorneys, settlements

Dedication

This dissertation is dedicated to my God and Savior who continuously show me unconditional love and acceptance, have given me glorious life, relationships and events that became the foundation of this work, a loving and supportive family, and all the opportunities in the world; to my sister, Susie, who spent hour upon hour tenderly, compassionately sharing my woes and my joys, believing in me even when I did not believe in myself, always offering loving acceptance and concern, and motivating me to keep plugging on; to my brother, Tommy, who listened patiently and attentively to me hours without end as I read and reread my work to him, who provided much welcome humor and political discussion, and lovingly offered his opinions and comments, always encouraging me to reach for the stars; to my brother, Doyle, who supported and cheered me on to keep moving ahead and stick to the deadline no matter what (or I'd better look out!) and who always let me know that I had a shoulder to lean on; to my daughters, Andrea Faith and Amanda Kay, who, even with their own young lives full of life-changing events and circumstances – both good and bad, have stood by me constantly, showed copious amounts of love, pride and belief in me, and provided inspiration to complete my studies. Without their support and devotion, this work would have been overwhelming. I thank each one of them for their loving words, kind thoughts, sweet prayers, and continuous presence that have contributed to the successful completion of my research and this stage of my life. I love you all dearly, more than words can express. I hope you each realize how much you mean to me and how very grateful I am. Thank you.

Acknowledgements

This work was supported in part by a grant from the Administration on Aging under the direction of Dr. Kathy Hyer. I want to acknowledge gratefully the support, consideration and infinite patience of my committee co-Chairs, Dr. Larry Polivka and Dr. Lawrence Schonfeld, and my other committee members, Dr. Marion Becker, Dr. Jennifer R. Salmon, and, Dr. Paul Stiles. My thanks are also graciously extended to Dr. Christopher Johnson and Mary Oakley for their beneficial input in data collection and describing the tort reform story. I would also like to thank each staff member of the School of Aging Studies who supplied his or her skills, teaching experience, and encouragement along my way. My heartfelt appreciation goes out to Dr. Debbi Gavin-Dreschnack, Dr. Carla VanderWeerd, Dr. Katie Petrossi, Dr. Celinda Evitt, Helen Zayac, and other Aging Studies students who have been my dear friends, colleagues, and comrades in arms while at USF. I would be greatly remiss if I did not take this opportunity to thank Ginny Chaplin, Pam Staubaugh, Rosa Diaz, Gail Smith, Nancy Hallford, Lydia Hentschel, and Amy Woodbury who so willingly supplied their administrative expertise, advice, and friendship throughout my journey.

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LIST OF ACRONYMS

AHCA	Agency for Health Care Administration
CMS	Centers for Medicare & Medicaid Services
CNA	Certified nursing assistant
MICRA	California Medical Injury Compensation Reform Act
MDS	Minimum Data Set
NOI	Notice of Intent
OBRA	Omnibus Reconciliation Act
RAI	Resident Assessment Instrument

GLOSSARY OF TERMS

Administrative remedy	Taking every available legal step, including appeals, with an agency and its associated organization, to resolve a legal problem.
Allegation	A claim, accusation or assertion yet to be proved.
Chapter 400 claims	Charges base on Fla. Stat. ch. 400.023, Residents' Rights,
Collateral offset rule	Reduces damage awards by any amounts a plaintiff will receive from other sources
Compensatory damages	Monies awarded as compensation for objectively verifiable monetary losses, e.g., past and future medical expenses or earnings, that would not have occurred but for the injury, damages, or death that brought about the lawsuit.
Charges/Counts	Separate statements in a lawsuit stating the basis for initiating that lawsuit. Counts are reinforced by allegations.
Defensive medicine	Medical responses or behaviors carried out in order to avoid liability rather than strictly for the patient benefit.
Dismissed with prejudice	A lawsuit is permanently closed and the plaintiff cannot file another lawsuit against the defendant based on the charges in the complaint being dismissed.
Dismissed without prejudice	Lawsuit is closed but can be re-filed later should the plaintiff desire to do so.
Economic damages	Equivalent to compensatory damages.
Involuntary dismissal	Lawsuit dismissal by the court for its own reasons

Joint and several liability	Under the concept of joint and several liability, should a plaintiff claim harm or loss by two or more defendants, damages can be recovered from any of the defendants regardless of their degree of responsibility. For example, if two defendants are sued and one of them is bankrupt but 80% responsible for the plaintiff's injuries or damages, the plaintiff is able to recover 100% of the damages from the solvent defendant that is only 20% responsible for the injuries or damages.
Loss cost	Overall cost per insurance claim exposure.
Loss ratio	The number of insurance premium dollars collected compared to the number of claim settlement dollars paid.
Minimum Data Set	Mandated, categorically coded and defined process for comprehensive assessment of clinical status and functional capabilities of Medicare or Medicaid certified nursing facility residents.
Non-economic damages	Damages for pain and suffering, emotional distress, physical impairment, mental anguish, disfigurement, inconvenience, loss of consortium or companionship, loss of capacity to enjoy life, and other intangible injuries. These damages do not include any direct economic loss and have no precise value.
Resident Assessment Instrument	a federally-mandated structured, standardized problem identification process used in long-term care facilities. It consists of three components: the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs), which provide a framework for MDS problem identification and resolution; and Utilization Guidelines which provide directions for proper usage of the RAI.
Somatic allegations	Charges that specific debilitating physical conditions were induced or aggravated somehow by the nursing facility.
Staff-related allegations	Staff-related allegations were charges of poor or unprofessional interaction, communication, care, conduct, or management associated with residents.

Voluntary dismissal	All parties were in agreement to end a lawsuit and it was dismissed accordingly.

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Nursing Facility Litigation in One County

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ABSTRACT

Since a substantial increase in lawsuits, settlements, jury trial awards, and insurance premiums involving nursing facilities began in the mid 1990s, addressing litigation has been a growing concern for the industry, consumers and their families, insurance carriers, and state and national elected officials. Curbing lawsuit growth has mirrored medical malpractice containment efforts, focusing on the addition of laws to inhibit litigation. The state of Florida initiated such tort reforms along with mandatory increased nursing facility staffing in 2001.

Through secondary data analyses, this study examined the initial effects of Florida's tort reform measures. Lawsuits filed (N = 546) against any Hillsborough County nursing facility (N =33) from 1999 through 2003 were reviewed. One-way analyses of variance and two-way contingency tables were used to identify variations in the elements, extent, and outcome of lawsuits between pre and post tort reform periods.

Based on nursing facility admission dates, post tort reform lawsuits exhibited multiple significant changes. Lawsuits filed per month dropped to 14% of pre reform monthly filings. On average, lawsuits were associated with shorter residencies, were filed earlier, and settled six months sooner. They were less apt to include combined wrongful death and negligence survival damage claims, charges intentionally addressed by reform

measures in order to eliminate double damage claims. Other lawsuit charges increased, e.g., lethal negligence and breach of fiduciary duty. Mediation was less likely and arbitration attempts more likely to be documented in lawsuits. Mean somatic allegations did not change significantly. Staff-related allegations decreased 21.5% to 8.51 per lawsuit, with 12 out of 22 staff-related allegations decreasing significantly. On average, settlement proposals, total settlements, and attorney fees decreased to 40% and net plaintiff awards to 25% of pre reform amounts.

Overall, it appears that 2001 tort reform impacted post reform litigation substantially. However, further research examining a larger post reform lawsuit sample and longer post reform period is required to verify that research findings are stable and reflect sustained changes. Other factors, e.g., decreased nursing facility professional liability insurance coverage, may have affected the numbers and characteristics of lawsuits filed and require further investigation as well.

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CHAPTER ONE – IMPACT OF LAWSUITS AGAINST NURSING FACILITIES

Statement of the Problem

According to reports from the long-term care industry, liability insurance carriers, attorneys and secondary media sources, lawsuits and settlement amounts involving nursing facilities have increased dramatically since the mid 1990s. Nationwide, 1.6 million persons, approximately 4.5% of the 65+ population (Administration on Aging, 2006), now use long-term care services provided by roughly 16,000 government-certified nursing facilities (Centers for Medicare & Medicaid Services, 2005). Added to this, the rapid escalation in numbers of aging baby boomers and the certainty of increased future need for nursing facilities are intensifying individual and public concerns as to causes and deterrence of complaints and litigation against these businesses. The containment of litigation and any subsequent effects on the improvement, continuation, or decline in numbers or quality of nursing facilities are of great interest and importance to providers, consumers, insurers, and elected officials.

Although many long-term care and insurance industry representatives claim the most obvious gauge of litigation effects can be measured by increased insurance premiums (Carter, 2002; McDonald, 2001; Tyrpin, 2002), the exact role of insurance in the litigation process is unclear. Individual insurance claims are not publicly available for review, and insurance company reports are not documented in a manner that enables direct comparison of insurance industry rates, coverage limits, and settlement practices with changes in the elements (i.e., components and characteristics) and extent (i.e., total

count) of lawsuits. Lawsuits filed within court systems are more readily available, publicly accessible, and contain specific lawsuit details. These valuable details can be used in secondary data analysis to explore litigation trends and correlations of numerous variables, e.g., plaintiff statistics, lawsuit duration, or settlement amounts, across multiple settings and locations including individual facilities, cities, counties, regions, or states.

Commercial publications (e.g., various Jury Verdict Reporters) or on-line legal databases (e.g., Westlaw, Lexis-Nexis™) that collect litigation and jury verdict data in many states are the customary sources for obtaining general information about lawsuits, including nursing facility cases. These services typically list attorney-reported cases that have proceeded to trial resolution but not the majority of cases that are resolved without trial. Reliance on self-reports via attorneys limits the numbers and types of lawsuit data collected by commercial vendors; and, some, if not many such lawsuits, will be missed by researchers (Galanter & Luban, 1993; Johnson, Dobalian, Burkhard, Hedgecock, & Harman, 2004a; Stewart, 2002).

Jury Verdict Reporters normally exclude lawsuits that do not go to trial (90 – 99% of all lawsuits).These cases are commonly filed and settled prior to trial assignment or resolution, or settled before any official complaint filing (Bennett, O'Sullivan, DeVito, & Remsburg, 2000; Hedgecock et al., 2003; Kirkton, 1995). The latter cases (settled before filing) are impossible to analyze without the cooperation and records of insurance carriers and attorneys since there is no public paper trail of cases that do not proceed through public court systems. Furthermore, legal data collection and research services do not cover every county in every state, which also contributes to underreporting of cases. Large gaps in data due to inconsistencies in coverage areas and reporting procedures

produce findings that are not generalizable to the nation or perhaps even to individual states or regions. As a result of such data-related issues, the overall picture of lawsuit activity is incomplete.

Empirical studies examining the elements and extent of lawsuits filed against nursing facilities are limited, but are emerging as an important area of investigation with an accentuation on the role of nursing facility quality of care in such lawsuits (Kapp, 2000b; Stevenson & Studdert, 2003). The nine studies to date that address nursing facility litigation are described in Table 1. These studies illustrate the complexity of determining details from nursing facility legal actions and the correlation of acts with evidence of improper care.

Table 1

Studies Identifying Nursing Facility Litigation

Publication Year	Study focus	Study Period	Region	Nursing facility cases (Total N)	Data sources	Authors
1995	Medical malpractice punitive damage awards	1963-1993	National	29 (270)	Lexis, Westlaw DB[1]; JVRs[2]; AL Judicial Reporting System	Rustad & Koenig
2000	Pressure ulcers	1937-1997	National	66 (173)	Lexis-Nexis, Westlaw DB	Bennett, et al.
2001	All litigation activity	1996-2000	Florida counties (8)	924	Court records	Groller; Lamendola
2002	All litigation activity	1997-1999	Florida facilities (3)	25	Facility records	Johnson & Bunderson
2003	All litigation activity	1990-2000	Florida county (1)	456	Court records	Hedgecock, et al.
2003	All litigation activity	2000-2001	National	4,677	Web-based attorney self-report survey	Stevenson & Studdert
2004	All litigation activity	1993-1997	Florida	48	AHCA[3], FJVR[4], CMS[5]	Troyer & Thompson

Table 1 (Continued)

Publication Year	Study focus	Study Period	Region	Nursing facility cases (Total N)	Data sources	Authors
2004	All litigation activity	1997-2001	Florida counties (30)	2,315	Westlaw DB, OSCAR[6]	Johnson, et al.
2005	Pressure ulcers	1984-2002	National	156	Lexis, Westlaw DB	Voss, Bender, Ferguson, Sauer, Bennett & Hahn

[1]DB = Database

[2]JVRs = Jury Verdict Reporters

[3]AHCA = Agency for Healthcare Administration

[4]FJVR = Florida Jury Verdict Reporter

[5]CMS = Centers for Medicare & Medicaid Services

[6]OSCAR = Online Survey and Certification Reporting system

Analyses examining the effects of legislative tort reform measures on lawsuit frequency, complaints, and allegations commonly associated with nursing facility litigation are even more uncommon than general lawsuit research that simply collects numbers of lawsuits and the lawsuit classification, e.g., medical negligence, slip and fall, breach of contract. Without in-depth data collection and analysis, simply reporting numbers of lawsuits does not fully explain the impact of reform measures instituted by state or national legislative actions. With the passage of Fla. Laws ch. 45 (2001a), legislation designed to decrease nursing facility litigation, Florida has been placed in a unique position to provide an arena for such data collection and analysis. Florida's 2001 legislative efforts had two major aims:

1) reduce the extensive financial impact of litigation, including the cost of general and professional liability insurance premiums, on the state's nursing facilities; and
2) improve quality of care through periodic increases in nursing facility staffing.

This comprehensive set of tort reforms provides a distinct opportunity to observe outcomes of policy modifications. Previous research on the elements, extent, and impact of lawsuits on nursing facility quality and costs is described next.

Extent of Litigation

Medical Malpractice History

Medical malpractice lawsuits involving doctors and hospitals have provided the major data sources for healthcare-related litigation research (Baldwin, Hart, Lloyd, Fordyce, & Rosenblatt, 1995; Doorey, 1995; Ely et al., 1999; Kahan, Goldman, Marengo, & Resnick, 2001; Tussing & Wojtowycz, 1997). This may be due in part to the longer

regulatory and documented litigation history of the medical profession; lawsuits became a major concern for physicians as early as 1850 (Mohr, 2000). Even so, there has been minimal research as to the effectiveness of medical malpractice litigation as a deterrent to preventing future lawsuits (Studdert, Mello, & Brennan, 2004).

In the 1970s, rapidly escalating malpractice insurance premiums began attracting increased research attention. Medical malpractice research has benefited from the availability of national data on licensed health care practitioners and malpractice actions since 1990 (Health Resources and Services Administration, 2000). These data provide a reasonable measure of national, state, and regional prevalence of malpractice lawsuits and reveal limited differences in claims, case type, and duration trends. No such national or state centralized nursing facility litigation and insurance claim data bank currently exists (Kapp, 2000a). Florida's Agency for Health Care Administration (AHCA) currently tracks notices of intent to file lawsuits that are self-reported by nursing facilities and plaintiff attorneys (Agency for Health Care Administration, 2006). This is the foundation of such a data bank, but currently it does not require details regarding complaint outcomes, e.g., settlement amounts, fees, or costs.

Medical malpractice literature has found: 1) no correlation between the number of times physicians experience malpractice claims and the quality of their patient care (Entman et al., 1994; Hickson et al., 1994); 2) lawsuits are not always filed when actual malpractice has occurred; and 3) doctors are often sued when they are not at fault (Brennan, Sox, & Burstin, 1996; Edbril & Lagasse, 1999). These contradictions in lawsuit filing rationale also concern members of the long-term-care industry as skilled nursing facilities face increasing numbers of lawsuits. The varying degrees of regulated

medical care that nursing facilities provide, i.e., the presence and services of medical professionals including registered and licensed practical nurses and doctors, appear to be the rudimental association with medical malpractice. Furthermore, some doctors who hold positions as nursing facility physicians are affected directly by both facility litigation and increased professional medical malpractice liability insurance premiums (Kutner, 1999).

Nursing Facility Litigation History

The shortage of research on nursing facility litigation may be based in part on the lack of uniform national or state standards for reporting nursing facility lawsuit data to central collection agencies as well as other inconsistent recording or reporting methods as noted above (Hedgecock et al., 2003). Nursing facility litigation has been documented as early as 1937 (Bennett et al., 2000), but lawsuits did not increase notably in the 1950s during the early years of nursing facility expansion in the U.S. One study analyzed 270 nationwide medical malpractice lawsuits with punitive damage awards that were filed between 1963 and 1993 and found nursing facilities were defendants in 29 of these cases (Rustad & Koenig, 1995).

Litigation became more active in the mid to late 1980s around the time of the Institute of Medicine's (IOM) report on the inferior quality of nursing facilities (Institute of Medicine, 1986). The subsequent passage of the Omnibus Reconciliation Act of 1987 (OBRA-87) (1987a) regulations requiring use of the Resident Assessment Inventory (RAI) and the Minimum Data Set (MDS) may also be a factor in the increase of nursing facility lawsuits at that time. These regulations provided a national standard of resident care that could be used as a reference in legal actions (Bedell, 2003; Brady, 2001).

Bennett et al. (2000) reported that of the 173 pressure ulcer medical malpractice lawsuits identified from 1937 through 1997, significant increases in the median number of filed cases per year occurred both after the passage of OBRA-87 and following the official publication of the regulations by the Health Care Financing Administration several years later.

The 66 nursing facility defendants identified in the Bennett et al. (2000) study represent only a very small percentage of the total number of lawsuits brought against nursing facilities nationally. Hillsborough County, Florida was found to have 456 nursing facility lawsuits filed from 1991 - 2000, with 81% of all cases filed after 1995 (Hedgecock et al., 2003). In eight other Florida counties, 924 nursing facility lawsuits were filed during 1996 – 2000 (Groeller, 2001a; Lamendola, 2001). This study found nursing facility litigation activity continued to increase each year in these counties reflecting the same pattern established in Hillsborough County. A single, large Tampa, Florida law firm with offices in several states reported having approximately 1,000 pending lawsuits as of January 2001 (Fisk, 2001b; Miller, 2001).

Litigation and Insurance Claims Connection

The most used sources for gauging the extent of nursing facility litigation are insurance company paid claims reports. In the mid 1990s, nursing facilities began to experience extreme increases in general and professional liability insurance premiums (Edwards, 2000; Hedgecock & Salmon, 2001; McDonald, 2001; Oakley & Johnson, 2001; Thomason, 2001) which were thought to be caused by the increasing number of reported insurance claims being paid out in lawsuit settlements. Monetary settlements and jury awards have increased (Bradford, 2000; Hawryluk, 1999; Schapp, 2001). Using the

Lexis-Nexis™ Academic database and combining the terms “nursing facilities,” “litigation,” “million,” and “Nursing Home Litigation Reporter,” a search of January 2003 through January 2005 revealed articles mentioning 17 separate nursing facility lawsuits with jury awards ranging between $1 million and $313 million, an average of $36 million (ALM Properties Inc., 2003; Andrews Publications Inc., 2000; Fisk, 2001a; NLP IP Company - American Lawyer Media, 2002a, 2002b, 2002c, 2002d, 2002e, 2002f, 2002g, 2002h, 2002i; The New York Law Publishing Company, 1999, 2001a, 2001b, 2001c, 2002a, 2002b). These figures are not representative of final amounts all plaintiffs receive. Some plaintiffs are willing to settle for much smaller sums in order to prevent further delay in receiving funds (e.g., the plaintiff in the $313 million case settled for $20 million). Additionally, a state’s limits on non-economic or punitive damages may result in judges reducing some jury awards (Elliott, 1999; Fisk, 1998).

One hypothesis suggests that alleged nursing facility misconduct in resident care results in a circular chain of events. These events include large lawsuit settlements or awards, large insurance claims paid, large premium increases linked to those claims, mounting public awareness through media attention on increasing numbers of lawsuits involving nursing facility misconduct and large settlements (Fisk, 2001b; Groeller, 2001b; Lamendola, 2001; Schapp, 2001; Thompson, 1997), leading to the filing of even more nursing facility-related lawsuits (Flood, 1998; Scott, 2002).

Although lawsuits have been associated with climbing liability insurance premiums as a consequence of claim payments, this relationship is not necessarily accepted by some who feel premium increases are connected to bad economic investments and decisions on the part of insurance companies (Hunter, 2002; Sloane,

2002; The Foundation for Taxpayer & Consumer Rights, 2002). Concurrent trends in increased lawsuits and premiums can be seen in any case. For example, Insurance Services Office, Inc. found nursing facility general liability and medical professional liability insurance premiums increased an average of almost 18% per year from 1992 through 2000 throughout the nation. Florida nursing facilities had a $1,352 insurance claim per occupied bed – 6.5 times greater than the rest of the country (Yezzi, 2002). Losses greater than $50,000 made up 17% of claims nationwide; however, in Florida, 56% of all claims exceeded this amount. Hedgecock et al. (2003) found that Hillsborough County, Florida lawsuit settlements in the latter half of the decade (1996 - 2000) were $485,000 on average, a 70% increase over the mean reported $286,000 settlement during the first half of the decade (1991-1995).

A 2005 Aon Risk Consultants, Inc. analysis of the general and professional liability insurance status of nursing facilities found the national number of claims filed per 1,000 occupied beds in 2004 doubled claims filed in 1996, i.e., 13.1 compared to 6.0. Average claim severity more than doubled from $72,000 to $176,000 as well (Bourdon & Dubin, 2005). Florida reported 34 claims per 1,000 beds in 2004 compared with 38 per 1,000 beds in 2001. The state also experienced a decrease in loss cost (the overall cost per insurance claim) per bed for the same period from $8,870 in 2001 to $7,500 in 2004. However, where some states showed decreases in loss costs and claim numbers, other states increased. For example, Bourdon & Dubin (2005) found Arkansas increased from 23 to 26 claims per 1,000 beds and from $11,480 to $16,980 loss cost per bed from 2001 until 2004. Nursing facility insurers are providing findings that increased lawsuit filing

trends in certain states or regions of the country are occurring with an undeniable financial impact on nursing facilities located in these areas.

In actuality, litigation costs extend well beyond specific states or individual nursing facilities (Office of the Assistant Secretary for Planning and Evaluation, 2002). On a collective level, all taxpayers are affected by loss costs in that most nursing facility beds are funded either by Medicare, Medicaid or both of these publicly funded programs. Medicaid disbursements to nursing facilities were $17 billion in 2003 (Centers for Medicare & Medicaid Services, 2005). In 2003, the average per diem loss cost portion of Medicaid reimbursements rose to 5% from 2% in 1995 (Bourdon & Dubin, 2004). Based on the available 2003 Medicaid nursing facility disbursement figure, that represents approximately $85 million meant for resident care that may have been diverted to the payment of litigation claims in 2003.

Lawsuit Elements

Quality of Care Issues

Lawsuit allegations usually involve the quality of care a resident has received from a nursing facility. Attempting to regulate quality of care may adversely affect the provision of higher quality of care overall. The nursing facility focus may be deliberately placed on more publicly scrutinized matters (Institute of Medicine, 2001) rather than on areas which are not analyzed as closely but that are just as important for residents (Casalino, 1999). For example, facilities may emphasize documentation and the avoidance of any MDS survey infractions rather than unmeasured areas of care such as one-on-one staff interaction with residents, or residents' and their families' satisfaction with care (Mor, 2005; Troyer & Thompson, 2004). The MDS is a mandatory,

standardized screening tool for measuring clinical and functional status of residents used by facilities certified by the Centers for Medicare & Medicaid Services (CMS). As a component of the Resident Assessment Instrument (RAI) process that identifies resident problems and plans resolutions, the MDS has 17 major sections containing more than 400 choices for describing various aspects and levels of a resident's health and functional status. Resident assessment occurs at admission, quarterly thereafter, and upon any significant change in a resident's clinical health status.

Nursing facility survey deficiencies in quality indicators identified in the MDS have been found to have a significant effect on the number of lawsuits filed against facilities (Centers for Medicare & Medicaid Services, 2002a; Johnson, Hedgecock et al., 2004). For example, development and complications from pressure ulcers, an MDS quality marker, have been frequently noted in individually-filed resident-care related lawsuits and are considered one of the most serious quality areas requiring preventative measures in order to avoid deficiencies and possibly lawsuit complaints (Bennett et al., 2000; Hedgecock et al., 2003; National Pressure Ulcer Advisory Panel Board of Directors, 2001; Voss et al., 2005).

Concentrating on what appear to be obvious complaint areas may bring about some quality improvements, but is not necessarily the total answer to avoiding consumer dissatisfaction or lawsuits directed against nursing facilities (Stevenson, 2005; Troyer & Thompson, 2004; United States Government Accountability Office, 2005). The interpretation of quality is important but its subjective nature creates confusion across states, among nursing facilities and even in individual lawsuits. Part of the issue of fewer

available studies may involve how quality of care is defined (Feinstein, 2002) and what role litigation plays in that definition.

Common Claims

The 29 nursing facility lawsuits identified from 1963 – 1993 by Rustad & Koenig (1995) included complaints of death or harm to a resident resulting from insufficient staffing, neglect, development of pressure sores, falls, inappropriate use of restraints, or other less frequent claims. These allegations (claims, accusations or assertions yet to be proved, but listed as support for individual counts or charges in lawsuit documentation), along with violation of residents' rights, abuse, procedural errors, emotional distress, malnutrition, falls, dehydration, and excessive weight loss are familiar charges identified in current nursing facility litigation research (Bennett et al., 2000; Cobb & Warner, 2004; Groeller, 2001b; Hedgecock et al., 2003; Hedgecock & Salmon, 2001; Lamendola, 2001; Moss, 1998; Office of the Assistant Secretary for Planning and Evaluation, 2002; Studdert & Stevenson, 2004; Thompson, 1997; Voss et al., 2005). Previous nursing facility research involving somatic problems, e.g., pressure ulcers (Bennett et al., 2000; Berlowitz, Bezerra, Brandeis, Kader, & Anderson, 2000; Hedgecock et al., 2003), weight loss, malnutrition (Burger, Kayser-Jones, & Bell, 2000), dehydration, urinary incontinence (Brandeis, Ooi, Hossain, Morris, & Lipsitz, 1994; United States General Accounting Office, 1998), infections of multiple origins (Richards, 2002), found these quality of care issues as highly problematic (i.e., related to deficiency citations, quality of care, or litigation) for the nursing facility industry not only by plaintiff attorneys, but also by the federal government, the medical community, the insurance industry, the general public, and the media.

Nursing Facility Characteristics

Research has found that certain nursing facility characteristics, e.g., staffing levels, ownership (profit status), affiliation (chain membership), locale, resident case mix, available beds, and occupancy rate have been associated with either survey deficiencies or litigation. Insufficient staffing has been related to higher levels of dehydration in residents (Kayser-Jones, Schell, & Porter, 1999). Fewer available certified nursing assistant and registered nurse hours have been associated with greater total survey deficiencies including quality of care and quality of life deficiencies (Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000).

For-profit and chain affiliated nursing facilities have been associated with greater survey deficiencies of all types (Harrington, Woolhandler, & Mullan, 2001; Harrington, Zimmerman et al., 2000; Hawes & Phillips, 1986). Northeastern facilities were found to be associated with fewer deficiencies of all types than facilities located in the southern, midwestern or western sections of the country (Harrington, Zimmerman et al., 2000). Sicker resident populations create a greater level of negative conditions that can result in higher and more MDS deficiencies (Harris & Clauser, 2002). Larger nursing facilities have been associated with greater total survey deficiencies than facilities having fewer beds (Harrington, Zimmerman et al., 2000). Higher nursing facility occupancy rates have been associated with greater numbers of survey deficiencies involving pressure ulcers, restraints, and psychoactive drug usage (Castle, 2001).

Nursing facilities having greater numbers of available beds were more likely to be sued (Johnson, Dobalian et al., 2004a, 2004b; Johnson, Hedgecock et al., 2004; Oakley & Johnson, 2001; Polivka, Salmon, Hyer, Johnson, & Hedgecock, 2003). Affiliation and

ownership were not found to be consistent predictors of greater lawsuit activity. For example, in a national study and a Florida statewide study (30 counties), for-profit ownership was found to be a predictor of litigation while chain affiliation was not (Johnson, Dobalian et al., 2004a, 2004b). Conversely, research examining litigation in one Florida county found that chain affiliation was predictive of lawsuits being filed against nursing facilities while for profit ownership was not (Johnson, Hedgecock et al., 2004).

Nursing Facility Regulation

Federal

Context

Regulatory focus and general public opinion of the relationship between nursing facilities and levels of resident care are an integral part of the background of increased nursing facility litigation activity. Nursing facilities did not become a distinct matter of federal attention until 1935 with the inception of the Social Security Administration that required authorized residence locations for recipients of Social Security benefits. Payment of Old Age Assistance benefits were disallowed to residents of public institutions such as poorhouses, so individuals looked for care and assistance in privately-run settings (IOM, 1986).

Federal involvement with nursing facilities began to expand in 1950 after legislation was enacted permitting Social Security benefits to be distributed directly to beneficiaries residing in public institutions including nursing facilities. Amendments to the Hill-Burton Act in 1954 provided funds for nonprofit organizations to construct skilled nursing facilities to be built in conjunction with hospitals, using similar standards

and floor plan designs (IOM, 1986). At that time, troublesome and deficient areas of care quality became increasingly vital to address as federal financial investments in nursing facilities grew along with the numbers of residents rapidly filling available beds.

Beginning in the early 1950s, nursing facilities drew negative public attention and made unpopular headlines with the deaths of at least 229 residents over a 12-year period due to fires from defective-wiring or other facility safety failures (ElderWeb, 2005). Numerous governmental efforts, including the 1956 Commission on Chronic Illness, the 1959 Senate Subcommittee on Problems of the Aged and Aging, and the 1969 – 1973 Moss Committee hearings (IOM, 1986), addressed inconsistent nursing facility standards and procedures throughout the United States. Some of these problems included issues of poor facility environmental quality and resident abuse, and were attributed to the wide variation of licensure and enforcement regulations across states.

The 1965 inception of Medicare and Medicaid amplified federal involvement. The lack of state-wide uniformly structured and enforced nursing facility guidelines resulted in the majority of America's facilities not meeting required federal safety and health criteria (IOM, 1986). Under Medicaid program amendments made in 1967, provision for regulatory oversight was allocated to individual states (IOM, 1986; Latimer, 1998). However, these measures still did not diminish the struggle with problems of nursing facilities that could not satisfy Medicare and Medicaid standards and between 1969 and 1971, over 1,400 facilities closed (National Center for Health Statistics, 1974).

Introduction and enforcement of applicable and practical regulations continued to be a roller coaster ride for nursing facilities, with more lows than highs in public opinion and confidence in the industry. The Health Care Financing Administration contracted

with the IOM to study nursing facilities and recommend regulatory changes that would eliminate or improve substandard facilities, resident abuse, or deficient care identified by various sources and studies from the previous 15 years. In 1986, the IOM produced a report that included compelling recommendations to the federal government on the necessity of keeping residents safe while ensuring the provision of quality care and protection of rights, and assuming accountability for publicly-funded resident-care expenditures (IOM, 1986). Congress passed OBRA-87 (1987a) based upon IOM's recommendations and incorporated the most all-inclusive nursing facility regulations since the 1965 enactment of Medicare and Medicaid (Latimer, 1998).

OBRA-87 led to improvements in some nursing facility care areas (Berlowitz et al., 2000; Sirin, Castle, & Smyer, 2002). However, several federal studies have found that major problems continue to be encountered. During a two-year period, 1999 - 2001, nearly one-third of the country's nursing facilities were cited for abuse of or harm to residents. Texas led the nation with 39% of its 1,148 facilities cited for serious violations (Health Education and Human Services Division, 1998; Minority Staff Special Investigations Division Committee on Government Reform, 2001, 2002). The need for regulations cannot be ignored, but oversight is highly problematic.

Executing Federal Regulations

The Centers for Medicaid & Medicare Services (CMS) contract with individual state surveying agencies to conduct nursing facility assessments every 9 to 15 months to ensure facility adherence to standards outlined in the 1987 Nursing Home Reform Act implemented as part of OBRA-87 (1987b). Before surveyors make an onsite inspection of a nursing facility, specific indicators triggered by MDS nursing facility records

submitted to CMS are used to select resident samples to observe and interview. Because it includes definitions and coding categories, the MDS provides a standardized means for conveying resident problems and conditions within facilities, between facilities, and between facilities and outside organizations (Centers for Medicare & Medicaid Services, 2002a).

Survey deficiencies result in citations that are entered in the CMS Online Survey, Certification, and Reporting (OSCAR) database and are used to rank nursing facilities according to their performance on these measurements. This information is also made publicly available on the Nursing Home Compare website maintained by CMS (2002). Survey citations have been used by plaintiffs' attorneys in case preparation and to discredit facilities by referring to frequency and type of deficiencies cited in state surveys (Fox & Volberding, 1998; Juliano & Fell, 2000; Lubin, 1999; Sullivan, 1996). However, the survey process has been called into question, particularly inconsistencies across states and individual surveyor differences in interpretation of deficiency definitions, and casts some doubt on the soundness of data being reported (Robbins, 1994; Spector & Drugovich, 1989; United States Government Accountability Office, 2005). The survey and what it implies may be an important link between these measures of quality of care and lawsuits in any case.

Florida

Florida addressed nursing facility resident rights well before OBRA-87. In 1976, residents' rights regulations were established in Fla. Stat. § 400.022, and resemble many of the rights adopted in OBRA-87. The Florida law's purpose was to delineate clearly

nursing facility requirements for providing residents with proper, fair, and decent treatment and environmental conditions.

Even with these important changes in place, in 1979 a Miami grand jury convened to investigate complaints of detestable housing conditions and deplorable resident treatment brought against area nursing facilities. Over half of all local facilities were found to have major deficiencies related to unacceptable conditions and inadequate resident care. Acting upon these findings, in June 1980, the Florida legislature created a civil cause of action (Fla. Stat.§ 400.023) which included the right to recover actual and punitive damages along with attorney's fees (Crotts & Martinez, 1996). Actual damages included economic (verifiable monetary losses, e.g., past and future medical expenses or loss of past and future earnings caused by the injury, damages, or death being claimed) and non-economic losses (e.g., damages for pain and suffering, emotional distress, loss of consortium or companionship, loss of capacity to enjoy life, and other intangible injuries that do not include any direct economic loss and have no precise value) incurred due to negligent behaviors on the part of the facility. Punitive damages could be awarded to impose substantial financial redress and penalty for conspicuously offensive and deliberately harmful actions on the part of the nursing facility (Florida Convalescent Centers, Inc. vs. Ellis, 2001). The intent was to make it easier for residents to acquire legal representation by assuring attorneys that fees and costs would be covered even if residents might be elderly and without guaranteed income.

Unintended Consequences of Regulation

Nursing facilities are one of the most regulated health care industries (Deacon, 2000; Schneider, 2000). The process of refining laws and regulations can result in higher

levels of nursing facility compliance and, therefore, improved quality of care for residents (Fries et al., 1997; Kapp, 2000b; Phillips et al., 1997). OBRA-87 regulations have acted as a catalyst in changing certain nursing facility procedures that were detrimental to residents, with resultant positive outcomes demonstrated (Centers for Medicare & Medicaid Services, 2002b; Guttman, Altman, & Karlan, 1999; Harrington, Carrillo, Thollaug, Summers, & Wellin, 2000; Mahoney, 1995; Sirin et al., 2002). Some see OBRA-87 as a solid foundation for ensuring quality of care, but acknowledge that it must be consistently enforced if the intended goals are to be accomplished (Hemp, 1994; IOM, 2001; Schneider, 2000).

However, the establishment of standards also generates a measure of compliance failure, allowing a basis for lawsuits. As noted above, research identified that OBRA-87 resulted in significant increases in the number of lawsuits filed in federal and state appellate courts during the 5-year period immediately following its passage and again for the 5-year period after publication of OBRA-87 regulations in 1992 (Bennett et al., 2000).

Using a "command and control" (Kapp, 2000b) approach to compel adherence to meeting resident quality of care standards has been considered by some as antagonistic and adversarial in nature (Andrzejewski & Lagua, 1997; Studdert et al., 2004) and can lead to "defensive medicine" behaviors (Studdert et al., 2004). "Defensive medicine" refers to often costly medical responses or behaviors carried out strictly to avoid liability rather than to benefit the patient (Anderson, 1999; Wiener & Kayser-Jones, 1989) and is more commonly associated with physicians, clinical problems, and legal actions (Litvin, 2005; Office of the Assistant Secretary for Planning and Evaluation, 2002, 2003). The

general concept is easily transferable to the nursing facility setting when some nursing facilities may not admit high-risk residents or may send residents who suddenly develop a serious pressure ulcer or suffer a rapid general health decline to hospitals in order to avoid possible MDS deficiency citations.

A less serious situation (but one encountered frequently in nursing facilities) is when staff must document care thoroughly for regulation compliance and have very little personal discretion in sharing one-on-one unstructured time with residents even if this is what residents might prefer and could be emotionally constructive for both residents and staff members. The redirection of time, efforts, and finances to meet what are considered measurable standards of care inadvertently can result in failure to care for residents in areas that are equally or more important to the resident and her or his family (Casalino, 1999; Diamond, 1992).

Plaintiff attorneys frequently focus on "standards noncompliance" in nursing facility lawsuits and are often successful because some failing health conditions may not be averted in every resident (Brandeis, Berlowitz, & Katz, 2001). A major problem that facilities face in case defense is getting courts and juries to understand the heterogeneousness of aging and disease processes in the overall elder population and particularly nursing facility residents. For example, regulations that refer to noncompliance due to the presence of weight loss in a resident, do not necessarily take into account the loss of ability to process nutrients and appetite and weight loss as a part of a more prolonged functional decline or disease process that often is a part of dying (Lunney, Lynn, Foley, Lipson, & Guralnik, 2003; Morley, 2001).

Until May 2001, Florida nursing facility lawsuits fell under old provisions of the Residents' rights statutes which asserted "adequate and appropriate health care" as a specific right in meeting a standard of care for nursing facility residents (Fla. Stat. § 400.022, 1976). However, the statutes did not specifically define this wording and it was frequently and broadly interpreted by attorneys as an expression of "strict liability" on the nursing facility's part (Priest, 1991). In other words, nursing facilities might be viewed as having absolute liability for any resident outcomes regardless of any substantiating defense for legitimacy of certain outcomes, e.g., the development of pressure sores as a possible outcome of various combinations of co-morbidities, life-long individual choices, and advanced age. This interpretation contributed to the litigation upsurge nursing facilities and insurance companies were earnestly concerned with in reports to the Florida legislature and the public (Oakley & Johnson, 2001).

Tort Reform

Example: California

Some tort reform policy advocates relate the litigious situation in many states, including Florida, to inefficient and ineffective legislative approaches to litigation (Manos, 2001). They suggest that the right formula has not been generated yet to deflect growing numbers of lawsuits adequately. One state that is considered a positive legislative model is California.

California has the largest number of nursing facilities in the nation with approximately 1,350 facilities (Centers for Medicare & Medicaid Services, 2002). The state enacted legislation in 1975, the California Medical Injury Compensation Reform

Act (MICRA), in an effort to alleviate a "crisis of availability" in liability insurance brought on by increased claims and premiums (Werner, 1995).

MICRA is a tort reform model that is aimed at medical malpractice which tangentially affects nursing facility litigation and has been upheld in federal and California state courts (Coffin, 2002; Hudson, 1990; Yoon, 2001). It incorporates the major components most tort reform advocates promote: a $250,000 cap on non-economic damages; a sliding scale limiting attorney contingency fees to a maximum of 15% of awards over $600,000 (Werner, 1995); a collateral source offset rule wherein juries are notified of any payments plaintiffs may be receiving from any sources for injuries (e.g., health or disability insurance) making lower damage awards possible; and permitting periodic damage award payments instead of one-lump-sum awards. It is believed MICRA's enactment allows the treatment and care of high-risk cases without hesitancy by medical entities. Conversely, it is thought MICRA contributes to a lack of representation for plaintiffs with legitimate complaints because attorneys become reluctant to take cases unlikely to result in damage awards (Hudson, 1990; Zuckerman, Bovbjerg, & Sloan, 1990).

A recent study found MICRA has been successful in reducing medical malpractice insurance costs compared to other states. California ranked third nationally in having the lowest average claim payment, $132,696, in 2004. Furthermore, after adjusting for inflation, as of 1998 MICRA had contained California's average large loss payouts over $1 million to $900,000, well below the state's $1.2 million 1975 average (Hamm, Wazzan, & Frech III, 2005). Interestingly, MICRA has not decreased the

estimated per capita medical malpractice lawsuits filed in the state nor the number of claims filed against California physicians (Hamm et al., 2005).

Furthermore, the quality of care in the state's nursing facilities has been seriously questioned and MICRA appears not to have had any impact on reducing nursing facility deficiency citations (Werner, 1995). A 1998 report by the Health, Education and Human Services Division (1998) prepared for the U.S. Senate Special Committee on Aging found that 30% ($N = 407$) of California's nursing facilities surveyed between 1995 and 1998 had deficiencies that caused death or serious harm to residents and an additional 33% were cited with less serious harm violations. From 2003 to 2005, facilities having deficiencies at the most serious severity level dropped to 11%, but nursing facilities warranting deficiencies for less serious harm rose to 77% (California Healthcare Foundation, 2005; Harrington & O'Meara, 2003).

Although there are measurable insurance claim improvements connected to tort reforms in California, MICRA does not appear to have had the impact on the caliber of nursing facility care that can lead to more lawsuits. This scenario typifies the position that legislation cannot and is not meant to account for every level of care quality (Kapp, 2000b; Office of the Assistant Secretary for Planning and Evaluation, 2003).

Litigation Restraint Mechanisms

A variety of laws have been put in place by state legislatures in efforts to impact litigation. Major legal approaches are described below.

The capping of punitive or non-economic damages as a litigation control is a major point focused on by tort reform advocates in states experiencing excessive malpractice claims (American College of Physicians, 1995; Hudson, 1990; Tyrpin, 2002).

Without guidelines or directives, the jury processes of awarding compensation for intangible injuries or damages, e.g., pain and suffering, or for malicious, willful misconduct are considered by some as too subjective and arbitrary. Providing explicit award limits is meant to prevent the award of damages based on emotionally-charged jury reactions rather than on a more equitable fact-driven basis (Office of the Assistant Secretary for Planning and Evaluation, 2002).

Under the concept of joint and several liability, should a plaintiff claim harm or loss by two or more defendants, damages can be recovered from any of the defendants regardless of their degree of responsibility. For example, if two defendants are sued and one of them is bankrupt but 80% responsible for the plaintiff's injuries or damages, the plaintiff is able to recover 100% of the damages from the solvent defendant that is only 20% responsible for the injuries or damages. Tort reform limits recovery amounts from individual defendants to the proportion of actual fault.

The collateral source rule precludes furnishing juries with evidence of any compensation received from other sources, i.e., independent parties not connected to the case at hand, for losses claimed in the case before them. Tort reform efforts for some states have included enacting laws that allow the jury to be informed of other compensation made to the plaintiff. Collateral sources can be in the form of worker's compensation, social security medical benefits, medical services, or insurance policy claim payments.

Limiting an attorney's percentage of the monetary recovery from settlements or jury awards is meant to reduce litigation by impacting the number of unmeritorious lawsuits that may be filed with the courts. Attorneys may consider more carefully taking

questionable cases when financial gain is restricted yet expenditures may reach the levels of other cases that would be more certain to favor a plaintiff than the case being considered (Litvin, 2005).

Tort reforms requiring the use of alternative resolution methods, e.g., mediation or arbitration, are intended to settle issues before a case officially enters the judicial process. Time and cost savings are the desired outcomes. Time is an important consideration when the older plaintiff is still living.

Periodic rather than lump sum payments enable defendants to distribute the financial impact of damage awards over an extended period. This can prevent possible bankruptcy for the nursing facility or the facility's liability insurer. Additionally, should the circumstances of the plaintiff change, the court has the opportunity to modify the payment schedule accordingly (Congressional Budget Office, 2004).

Reducing the length of time in which a plaintiff can file a complaint after an injury or damage has occurred or has been discovered, i.e., the statute of limitations, is intended to limit liability exposure. The overall purpose is to decrease the cost of insurance (Congressional Budget Office, 2004).

Federal Legislative Efforts

Federal efforts to contain medical malpractice litigation have gained attention over the last several years but no measures have been enacted by Congress. There is concern that passage of federal legislation would displace existing state laws meant to address litigation issues more fully. Major areas currently being addressed by proposed legislation include limiting non-economic damages to $250,000; a three-year statute of limitations or one-year from discovery of injury or damages; limitations of attorneys fees

in settlements of judgments; introduction of collateral source benefits as evidence; periodic payments of future damages exceeding $50,000; and punitive damages awards and limitations guidelines. (National Conference of State Legislatures, 2006b).

State Legislative Activity

From 1984 to 1987, medical malpractice damage tort reforms were enacted by 11 states, and general liability tort reform was adopted by 26 states. With insurance losses and premium increases surging, states responded by enacting various tort liability reforms, attempting to restrain costs and alleviate what was considered to be an insurance premium "crisis," a scenario almost identical to the one voiced over the last several years across the country (American Law Institute, 1993; Flood, 1998; Hillman, 2002; Warfel, 2001).

In the early years of the 21st century, state legislatures became exceptionally active, and during the 2005 legislative session, 48 states presented over 430 bills involving various aspects of medical malpractice reform (National Conference of State Legislatures, 2006b). Of these bills, 60 were ratified by 32 states. Caps on punitive and non-economic damages were components of five of these enactments (National Conference of State Legislatures, 2006c). Thirteen states limited non-economic damages in one form or another. Limits ranged from $250,000 to $1 million per individual or facility. Georgia, South Carolina, Missouri, Texas, and West Virginia incorporated aggregate limits ranging from $250,000 to $1.05 million regardless of the number of defendants, i.e., individuals or facilities. Mississippi enacted automatic increases, taking the $500,000 current limit to $750,000 in 2011 and $1 million in 2017. Other non-

economic damages containment efforts found states aggregating total amounts payable to plaintiffs according to set limits of combined totals.

Table 2 provides an overview of 2002 through 2005 enacted tort reform measures specifically affecting medical liability matters or nursing facilities.

Table 2

Selected Enacted Tort Reform Measures 2002 -2005

	Enactment Year and State			
Reform[a]	2002	2003	2004	2005
Non-economic damages	NV			
Medical liability				
Personnel (e.g., doctors)	MS	AK, FL, OH, OK, CO, TX, WV	MS, OK	AK, IL, GA, MO, SC
Facilities (hospitals, clinics)		TX, WV		IL, GA, MO
Nursing facilities		TX		GA, MO
Punitive damages		AK, AR, MT, TX	MS	MO
Joint & several liability	MS, NV, PA	AR, MN, TX, WV	MS, OK	GA, MO, NH, SC, WV
Statute of limitations	MS, PA	OH		MO
Collateral source	PA	OK	OH	MO
Arbitration, mediation, pre-trial panels	PA	UT		NH, SC
Periodic payment of future damages	PA	AR		GA, IL, MO
Early settlement offers		CO, TX		GA

Table 2 (Continued)

Reform*	Enactment Year and State			
	2002	2003	2004	2005
Other				
Frivolous lawsuits				SC
Attorney fees		OH	FL	
Vicarious liability		CO		
Language/wording[b]	OH, SD, UT	AR, NY		GA, SC

[a]Only changes impacting medical liability areas or nursing facilities (where specifically noted in reforms) have been listed. Measures affecting other types of civil actions have been excluded.

[b]Specifically changes existing laws to clarify meanings or extend applicability to other entities; e.g., in 2002 Utah added "health care facility" to the definition of "health care provider" in the Health Care Malpractice Act so that the state's medical liability reforms would apply to nursing care facilities and residential assisted living facilities.

(American Tort Reform Association, 2005; National Conference of State Legislatures, 2006a)

Florida's Tort Reform Journey

Background

Florida began focusing on tort reforms, specifically addressing limiting monetary damages, in response to a perceived overly reactive litigious environment in the 1980s. In 1988 Florida's medical malpractice laws were amended to limit monetary damages (Medical Malpractice and Related Matters, 2003). Florida's legislature proposed further tort reforms in 1997 to address the concerns of businesses and individuals, including those involved with nursing facilities and healthcare, but these reforms were not passed. In 1998, Florida Senate Bill 874, "Negligence/Liability Law Application," passed but was vetoed by Governor Lawton Chiles on the grounds that it gave unfair advantage to big businesses and was inadequate in compensating innocent victims in its provisions. In 1999, Florida House Bill 775, "Civil Actions," passed and was signed by Governor Jeb Bush. This legislation focused mainly on joint and several liability, punitive damages, vicarious liability of motor vehicle owners, and statutes of repose involving product liability. HB 775 also included caps on damages for the majority of lawsuits. However, the bill provided exceptions for cap limits and legal action requirements for cases that involved: defendants who had been drinking; the abuse of older persons, children, or the developmentally disadvantaged; or Chapter 400 (long-term care facilities) cases (Peck, Marshall, & Kranz, 2000). In effect, HB 775 did not apply to nursing facility litigation.

Florida nursing facilities began notably filing for bankruptcy in 1997. The implementation of the Federal 1997 Balanced Budget Act decreased Medicare reimbursements from cost-based to a prospective payment system and resulted in considerable financial shortfalls for some larger multi-facility nursing facility companies,

contributing to some of these bankruptcies (Brady, 2001; Duncan & Eikman, 2001), but large lawsuit settlements were also considered to be a substantial factor in facility closings. By 2000, insurance carriers had discontinued coverage or increased premiums for Florida nursing facilities, often in excess of 100%, causing some facilities to operate without insurance and exposing them to the risk of closing due to financial losses sustained from costly lawsuits. The Task Force on the Availability and Affordability of Long-Term Care was created in May 2000 (House Bill No. 1993, 2000) to research and address possible solutions in four major areas of public concern: nursing facility alternatives, financing long-term care, improving nursing facility quality, and the impact of litigation and liability insurance on the state's nursing facility industry.

Tort Reform - 2001

As a result of Task Force findings, in 2001 a sweeping nursing facility reform bill was passed, (Committee Substitute for Committee Substitute for Committee Substitute for Senate Bill No. 1202, 2001), which included both tort reforms and quality improvement requirements in nursing facilities (Polivka et al., 2003). Major legislative changes were put in place to protect plaintiffs and reduce costs to nursing facilities with a plan of affecting nursing facility litigation by reducing the statute of limitations, requiring filing prerequisites, eliminating multiple negligence claims alleging death, incorporating specific negligence standards, limiting punitive damages, removing automatic payment of attorney fees, instituting an improvement trust fund, and increasing nursing facility staffing levels.

Statute of Limitations

With the enactment of Fla. Laws, ch. 45 § 43 (2001g), the length of time for filing lawsuits against nursing facilities was lowered from four to two years for an actionable incident or two years from the discovery of a cause for legal action with a maximum filing period of four years. However, if it is shown that intentional concealment or misrepresentation by the nursing facility has prevented discovery of wrongful actions or events, limitations for filing are extended to a maximum of six years from the date of the incident.

Filing Prerequisites

A key objective of the 2001 tort reform legislation was to eliminate as many as possible resident's rights and negligence claims from advancing to the court system for resolution. With Fla. Laws ch. 45 § 5 (2001b), prerequisites were established for filing claims with the intent to produce early pre-court settlements. Plaintiffs are required to participate in pre-suit notice, investigation, discovery, and mediation before a complaint is formally filed.

In the process of pre-suit notice, the claimant or the appropriate representative must inform all parties who may become defendants that there is an assertion of violation of the claimant's resident's rights or failure to meet the expected standard of care. The notice must provide a short summary of the injuries the claimant has sustained and a certificate of counsel indicating sufficient research supports that there is a basis for a prospective lawsuit to be filed. After all parties concerned with the claim have been notified, a lawsuit cannot be filed for 75 days.

During this 75-day investigation period the statute of limitations is suspended, but facility management, insurers, risk managers, or attorneys are to evaluate the claim for liability and damages promptly. Before the end of the 75-day period, the potential defendants are to reject the claim or make a settlement offer in writing. Failure to provide a written response is interpreted by the law as claim rejection. The parties can file a stipulation for an extension time frame, during which the statute of limitations continues to be deferred.

Informal discovery is also performed during this time. Statements may be taken from pertinent individuals and relevant documents are to be produced as requested by either party.

After the defendant's response has been received, representatives of both sides are to attend mediation for discussion of the claim and related damages. Mediation can also be extended upon joint stipulation, during which time the statute of limitations is again suspended. After concluding mediation, the plaintiff has 60 days or the remainder of the applicable statute of limitations to file a lawsuit.

Negligence Survival or Wrongful Death – Not Both

This reform measure allows for the recovery of economic and/or non-economic damages on behalf of a resident's estate under the law of negligence survival as outlined in Civil Practice and Procedure, Fla. Stat. § 46.021 (1951), or the recovery of non-economic damages for pain and suffering of the resident's survivors under Negligence, Fla. Stat. § 768.21 (2003). In the past, damages could be sought on behalf of both the resident's estate and the resident's surviving relatives, which could effectively double the amount of awarded damages. Reducing the filing of dual charges claiming damages

resulting from a resident's death is a mechanism for substantially decreasing risk exposure and larger settlement amounts.

Negligence Standard

With the enactment of Fla. Laws ch. 45 § 39 (2001f), a standard for proving negligence was put into place for use with lawsuits alleging negligence by nursing facilities. The new standard emulates an ordinary negligence claim in that: a duty is owed to the resident, the duty is breached in some manner, the breach constitutes a legal cause of harm, and the resident sustains loss, injury, or death as a result of that breach. This is the same negligence standard applied to physicians in malpractice claims and is comparable with the traditional legal interpretation of "negligence," i.e., measuring the extent to which an injury-causing behavior has deviated from a normally expected behavior (Priest, 1991). There is one major difference, however; the level of care and treatment a physician provides is considered to be the prevailing standard of care if "in light of all relevant surrounding circumstances, (it) is recognized as acceptable and appropriate by reasonably prudent similar health care providers" Medical Malpractice and Related Matters (2002). This concept allows consideration of an event's specificity. For the physician, the existence of a medical injury in a patient does not automatically infer negligence has occurred. This is not always true for nursing facilities. There is no peer review stage of the CMS survey process, and on the MDS, the presence of particular conditions in residents is indicative of failure on the nursing facility's part to provide appropriate care. Incorporating a negligence standard requires plaintiffs to provide evidence that the allegations are highly probable to have occurred and are a legitimate basis for the counts claimed in the lawsuit.

Punitive Damages – Burden of Proof and Award Limits

Constraints for collecting punitive damages from a defendant nursing facility were enhanced in Fla. Laws ch. 45 § 9 (2001c) by placing a strong burden of proof on the plaintiff to show that the actions of any nursing facility defendant(s) were clearly those of "intentional misconduct" or "gross negligence." Under § 9 (2)(a), intentional misconduct "means that the defendant had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result, and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage." Gross negligence signifies "that the defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct (§ 9 (2)(b))."

If punitive damages are sought in a lawsuit, the case must go to trial before a jury who will be presented with the case circumstances upon which to base any award to the plaintiff. Award limits are based upon varying degrees of unprincipled behavior according to Fla. Laws ch. 45 § 10 (2001d) as listed below.

a. For most lawsuits, punitive damages are limited to the greater of three times any awarded compensatory damages or $1,000,000 maximum.

b. In cases where the actions of management or policy makers were financially motivated and the defendant(s) knew their improper, unduly dangerous behaviors could cause injury or harm to a resident, a jury can award damages valued at the greater of four times any awarded compensatory damages or $4,000,000 maximum.

c. If it is proven that a defendant(s) had specific intent to harm a resident and that in fact harm did result, there are no punitive damages award limits.

Attorney Fees

Fla. Laws Ch. 45 § 39 (2001f) also did away with guaranteed recovery of attorney's fees if a plaintiff prevails. Currently, only minimal ($25,000) fee recovery for injunctive or administrative relief involving non-monetary court interventions is permitted. Section 45 states that if punitive damages are awarded attorney fees will be calculated based on the final judgment (2001h). In court files where this information was available in Hillsborough County, attorney fees averaged $189,031 with additional administrative costs of $19,865 per case (Hedgecock et al., 2003). Many tort reform advocates throughout Florida and the nation believe controlling attorney fees will greatly reduce the number of lawsuits filed because of decreased incentive to file this type of lawsuit (Hillman, 2002; Kaufman, 2001; Miller, 2001; Ransom, Dombrowski, Shephard, & Leonardi, 1996).

Quality of Long-Term Care Facility Improvement Trust Fund

Under Fla. Laws Ch. 45 § 45 (2001h), any awarded punitive damages must be equally divided between the plaintiff and a newly created Quality of Long-Term Care Facility Improvement Trust Fund. Monies deposited in the fund can be used for mentoring programs for direct care staff, development and implementation of training programs, economic or other incentives to encourage long-term care careers, establishment of resident and family councils in connection with nursing facility care improvement, addressing inadequate care areas identified through regulatory monitoring, and evaluating special residents' needs (Quality of Long-Term Care Facility Improvement Trust Fund, Fla. Stat. § 400.0239, 2005).

Increased Minimum Staffing Levels

The 2001 tort reform measures addressed concerns regarding inadequate staffing contributing to litigation by increasing certified nursing assistant staffing to 2.3 hours of direct care per resident per day beginning January 1, 2002, to 2.6 hours of direct care beginning January 1, 2003, and to 2.9 hours on January 1, 2004. The January 1, 2004 increase was delayed until January 1, 2007. Minimum licensed nursing staffing was increased to one hour of direct care per resident per day as well. Further changes included new requirements in staff training and provision of care by nursing facility owners and operators. Additionally, nonnursing staff were approved to provide feeding assistance to residents at mealtime.

The need for regulation of the private and public health care sector is without question. People with medical or health needs want assurance they are being cared for in environments and treated by practitioners that meet licensing standards of professional and regulatory agencies. Litigation is considered by some as one way to ensure that meeting professional standards remains the focus of those entities involved in providing medical care and service to consumers.

Tort Reform Impact

As previously noted, the majority of tort reform research has involved the relationship between enacted legislation and insurance claims. In light of this, much of the research relates to insurance company losses and premium rates. Those studies noting effects on medical malpractice claims possibly come closer to reflecting how nursing facility litigation might be impacted through tort reform. Findings from tort reform

research have found various effects in those areas addressed by legislation in multiple states.

For example, non-economic damage caps have been significantly associated with reductions in medical malpractice and general liability insurance claim payments, insurance premiums, and insurance loss ratios (Born & Viscusi, 1998; Thorpe, 2004; Zuckerman et al., 1990) although not necessarily all of these at the same time. Loss ratios in states capping awards were 11.7% lower than in states without caps. Additionally, loss ratios were 13.3% lower in states with discretionary collateral offsets. Loss ratios were 25% lower in states that adopted both reforms. (Thorpe, 2004).

Yoon (2001) found that after passage of ceiling limits for punitive, non-economic, and wrongful death damage awards in Alabama, the average insurance claim award significantly decreased when all reforms were in place. Subsequent nullification of all reform laws resulted in the average award increasing $20,000 more than the average award before passage of ceiling limits. Capping awards and providing for periodic payment of awards were found to decrease significantly amounts awarded to plaintiffs as well as the probability of settling cases out of court (Danzon & Lillard, 1983). Limiting non-economic damage awards has also been associated with reducing the chances that some lawsuits will be filed at all (Browne & Puelz, 1999).

Shortening the statute of limitations has been associated with a significant decrease in the number of lawsuits filed (Zuckerman et al., 1990). Other tort reforms (i.e., joint and several liability, controlling frivolous lawsuit filings, structured/periodic payments, attorneys' fees, collateral source rules, and liability limits) were significantly associated with reduction only in general liability losses (Born & Viscusi, 1998).

Reforms limiting attorney contingent fees were found to increase the probability of cases being dropped, reduce plaintiff award amounts, and decrease the probability of cases going to trial (Danzon & Lillard, 1983).

The current research examined the initial short-term effects of 2001 Fla. Laws ch. 45 tort reform measures on litigation experiences of all nursing facilities in Hillsborough County, Florida, through the secondary data analysis of individual lawsuit files. Differences in the extent, elements, and outcomes of the lawsuits filed, the facilities sued, and the residents/plaintiffs filing lawsuits were analyzed by pre and post tort reform periods as factors to explore a five-year period that included approximately 2.5 years before and 2.5 years after implementation of 2001 legislative changes.

Research Questions and Hypotheses

In 2001, tort reform measures were enacted by the Florida legislature with the goal of reducing litigation and its financial impact on the nursing facility industry, while ensuring better quality of care through increased staffing requirements. Among other modifications, 2001 Fla. Laws ch. 45; placed new limitations on awards and imposed new criteria for proving negligence. These changes were expected to increase the use of arbitration, mediation, and settlement proposals which could lead to earlier lawsuit closure; and reduce the number of lawsuits filed, overall litigation costs, required attorney services, lawsuit duration, and jury awards.

Aimed at investigating the impact of 2001 Fla. Laws ch. 45, the purpose of this study was to answer the following research questions.

1. Did the extent of lawsuits change in the anticipated direction with the passage of nursing facility tort reform laws, i.e., was there a decline in the average number of

lawsuits filed per month post reform, and did the total number of lawsuits filed per nursing facility and per resident/plaintiff decrease post reform?

2. Did lawsuit elements (i.e., charges, allegations, pre court negotiation strategies) change to reflect the intent of the tort reforms, i.e., did the combined use of wrongful death and negligence survival damage claims decline post reform? Or did higher standards for proving negligence result in lawsuits asserting more severe charges and allegations in order to proceed to trial and be awarded damages? Or was there increased use of pre–court settlement strategies that resulted in shorter lawsuits?

3. Did the outcome of lawsuits evidence a decline in total payouts per lawsuit and jury amounts awarded as was expected with tort reform?

4. For either the pre reform or post reform period, will the structural (facility) variables of ownership and affiliation, available beds, and occupancy rate predict changes in the extent (number) of lawsuits filed per nursing facility occupied bed and per facility?

5. For either the pre reform or post reform period, will the structural (facility) variables of ownership and affiliation, available beds, and occupancy rate predict changes in the elements of lawsuits as measured by total somatic and staff-related allegations per occupied bed, per facility, and per lawsuit?

To investigate these questions, the following hypotheses were tested in the study:

1. Post tort reform, the extent of litigation against nursing facilities will decrease as measured by fewer lawsuits filed per month, per facility, and per resident/plaintiff.

2. Post reform, certain lawsuit elements, including use of combined wrongful death and negligence survival damage claim charges and lawsuit duration, will show

reduction. Conversely, other severe lawsuit charges and the use of negotiation methods (i.e., mediation use, arbitration attempts, and settlement proposals) will show increases.

3. Post reform, lawsuit outcomes, including total settlements and related payouts, jury awards, and punitive damage amounts, will manifest decreases from pre reform amounts.

4. Based on previous research, it is predicted that one or more of certain nursing facility structural characteristics will be associated with a greater number of lawsuits filed against facilities. These include ownership (profit status), affiliation (membership in a nursing facility chain), greater number of available beds, and higher occupancy rates. It is also predicted that facilities having these characteristics will have higher average total somatic and staff-related allegations per lawsuit than not for profit, independent nursing facilities operating with fewer beds and lower occupancy rates.

Methodology for this study is outlined in Chapter Two.

CHAPTER TWO – METHODS

Research Sample

All lawsuits against any nursing home in Hillsborough County, Florida and filed during 1999 – 2003 were considered for the study sample. Resident-centered lawsuits are most likely to be filed in the county where a defendant nursing facility is located. The 13th District Circuit Court is located in Hillsborough County and was identified in previous research as one of two Florida court districts having a publicly accessible database and easily available court records (Florida Policy Exchange Center on Aging, 2001). The largest city in the county is Tampa. Hillsborough County is comparable to the nation relative to the 65+ population and median household income (Table 3). However, the state of Florida overall has a larger 65+ population and lower median household and per capita incomes than Tampa and Hillsborough County. Hillsborough County has the fourth largest population in Florida and an estimated average annual population of 1,030,656 during the study period.

Table 3

Comparison of Population and Income Five-Year Averages 1999 – 2003

	Hillsborough County	Florida	U.S.
65+ Population %	12	17.6	12.4
Median household income $	40,663	38,819	41,994
Per capita income $	21,812	21,557	21,587

(U.S. Census Bureau, 2006)

The contact information for 30 active nursing facilities was provided through AHCA (2003) for 1999 – 2003. Five facilities that were active before 1999 were identified from previous research and included because lawsuits were filed against them during the study period (Florida Policy Exchange Center on Aging, 2001). These five facilities included three that were closed during the entire research period, one that was operational during 1999 but subsequently closed, and one that was operational from 1999 through 2001 but subsequently closed. One additional nursing facility was operational during the study period but had no lawsuits filed against it or AHCA occupancy information available and was excluded from the study. The final nursing facility sample size was 28.

Facility ownership (for profit or not for profit) and affiliation (chain or independent), with the exception of six facilities that changed either their ownership or affiliation during the five-year study period, were based on the 1999 – 2003 AHCA information contained in the Commonwealth Fund Nursing Home Staffing dataset housed at the University of South Florida (Hyer, 2006). Ownership and affiliation for the six facilities were determined on the status each facility held for the longest portion of the research period. Multiple linear regression analyses using change in ownership or affiliation as independent variables found no significant differences in total lawsuits.

Available beds for each facility were determined from AHCA's online nursing facility locater. Occupied beds per year for each facility were retrieved from the Commonwealth Fund Nursing Home Staffing dataset (Hyer, 2006). If these data for a specific facility were missing for a particular year, based on availability, the previous or

following year's data for occupied beds was used. This procedure was necessary in 16 out of 144 occupied bed entries (11.1%).

Measures

The court case summary form (see Appendix A) was based on a form developed by Oakley & Johnson (2001) for use in data collection for the Task Force on Availability and Affordability of Long-Term Care and was modified specifically for this study. The modified form consisted of a computerized Microsoft Word© document that included drop-down menus containing applicable multiple choices for data coding. Residents or plaintiffs are the persons bringing lawsuits. Nursing facilities or defendants are the parties lawsuits are filed against.

Variables were based upon previous nursing facility research (Bennett et al., 2000; Berlowitz et al., 2000; Hedgecock et al., 2003) to test the possible effects of tort reform on litigation, i.e., lawsuit factors could possibly exhibit changes after the implementation of the 2001 reform laws. Along with background information, three major types of variables were most likely to be impacted: extent (i.e., total count) of lawsuits, the elements (i.e., components and characteristics), and outcomes (i.e., amounts of settlements, jury awards, and damage claims) of lawsuits (Table 4, Appendix B). These variables will be described more fully later.

Table 4

Study Variables

Category	Variable
Extent of lawsuits	Multiple lawsuit filings
	Lawsuits filed per occupied bed
	Lawsuits filed per nursing facility
Elements of lawsuits	Resident characteristics
	Case characteristics
	Charges
	Allegations
	Negotiation measures
	Duration
	Time intervals
Outcomes of lawsuits	Disposition
	Total settlement amount
	Costs and payouts
	Jury awards
	Punitive damages

There were two units of analysis used in the study: lawsuits and nursing facilities. Units of analysis, associated variable types, and sample sizes are described in Tables 5 and 6.

Lawsuit analyses included extent, elements, and outcome variables (Table 5). Lawsuit analyses using extent and elements variables were based on nursing facility residency admission dates occurring before or after May 15, 2001. All lawsuits with residency admission dates before this date guaranteed the cause of action and associated lawsuit would fall entirely under old statutes (pre reform) ($N = 466$) and all lawsuits with

residency admission dates on or after this date would fall entirely under new reform measures (post reform) ($N = 68$). If nursing facility residency dates were not available, cases with filing dates from January 1, 1999, through May 14, 2001, were categorized as pre reform. Cases filed after this date that did not contain residency admission dates were excluded from analyses because it could not be determined if residencies connected with the lawsuits were based on pre or post tort reform periods ($N = 12$). The pre reform period was 29.5 months in length and post reform was 30.5 months.

For analyses related to outcomes, lawsuits were categorized as pre and post October 6, 2001, the date of full implementation of the 2001 tort reform laws (Table 5). Lawsuits filed prior to this date had uncapped limits for punitive damages as well as guaranteed recovery of attorney fees, while those filed after this date were bound by 2001 Fla. Laws ch. 45 fiscal limits. One case filed after May 15, 2001, but prior to October 6, 2001, was based on full implementation tort reform changes. This lawsuit was classified as post tort reform.

Table 5

Lawsuits as Unit of Analysis – Variable Types and Sample Sizes

	Extent or elements			Outcomes		
	Based on residency admission date[1]			Based on lawsuit filing date		
	Pre	Post	Total	Pre	Post	Total
Period	<5/15/01	≥5/15/01		<10/6/01	≥10/6/01	
Nursing facilities	32	27	33	32	29	33
Lawsuits	466	68	534	380	166	546

[1]12 lawsuits excluded because residency admission dates unknown.

When using nursing facilities as the unit of analysis, facilities closed at any time during the five-year study period ($N = 5$) or that had no AHCA occupancy rate information for the entire study period ($N = 1$) were excluded from analyses. Nursing facility occupancy rate data prior to 1999 were not available so cases were selected from the lawsuit database based upon the admission date of a resident's nursing facility stay occurring between January 1, 1999, and December 31, 2003 ($N = 263$) (Table 6). The nursing facility analytical file included a pre reform subset of 196 lawsuits and a post reform subset of 67 lawsuits. All analyses involving facilities as the unit of analysis were performed based on these categories.

Table 6

Nursing Facilities as Unit of Analysis – Variable Types and Sample Sizes

	Extent or elements Based on residency admission dates between 1/1/99 and 12/31/03		
	Pre	Post	Total
Period	<5/15/01	≥5/15/01	
Nursing facility defendants	26	26	28
Lawsuits	196	67	263

Lawsuits per occupied bed per tort reform period were computed by dividing the number of lawsuits filed against a facility during the particular period by the number of months in the period, and then dividing the result by average number of AHCA- reported occupied beds for the tort reform period. The average number of occupied beds was computed by taking the number of occupied beds for each year, multiplying that by the number of months each figure was applicable for the tort reform period (2001 was split between pre (five months) and post (seven months)), adding the totals, and then dividing

the sum by the number of months in the tort reform period. For example, AHCA reports that during 1999 through 2003, facility A had 114, 100, 106, 113, and 110 occupied beds each year respectively. Average beds for the pre reform period would be computed as follows: ((114*12) + (100*12) + (106*5)) / 29.5 months = 105.02. The post reform computation would appear as ((106*7) + (113*12) + (110*12)) / 30.5 months = 112.07. The average lawsuits per occupied bed was computed by dividing total lawsuits by the average occupancy.

Somatic and staff-related allegations per occupied bed per tort reform period were computed by dividing the total documented somatic or staff-related allegations per facility by the number of months in the period, and then dividing that number by the average number of AHCA- reported occupied beds for the tort reform period (described above). Somatic and staff-related allegations per lawsuit per tort reform period were computed by dividing the total somatic or staff-related allegations per facility documented in a particular period by the number of lawsuits filed against that facility in that same period.

Occupancy rates for tort reform periods were computed by dividing the average number of AHCA- reported occupied beds for the tort reform period (computation previously explained) by the number of available beds for each facility. Based on residency start dates, the average nursing facility occupancy rate for the five-year study period was 87.9%. This compares with a national average of 82.6% for 2003 (National Center for Health Statistics, 2005). The average occupancy rate increased 9.4% to 92.5% post reform.

Extent

The extent of lawsuits was based on the numbers of lawsuits filed. It was examined in relationship to time periods, numbers of lawsuits filed by individual plaintiffs, and number of lawsuits filed per nursing facility.

Elements

The elements of lawsuits were made up of charges, somatic and staff-related allegations, negotiation methods, proceedings, duration, and time intervals between certain motions.

Charges listed in the complaint were coded wrongful death, negligence survival, combined wrongful death and negligence survival, breach of fiduciary duty, misleading advertising claims, vicarious liability, Chapter 400 claims, Other, SB 1202 negligence charges, and lethal negligence. After all data had been collected, the "Other" category was examined for common charges and the following categories were added: loss of consortium, negligence – common law per se, and negligence – medical.

Somatic allegations were charges that specific debilitating physical conditions were induced or aggravated somehow by the nursing facility. Staff-related allegations were charges of poor or unprofessional interaction, communication, care, conduct, or management associated with residents. Appendix B contains a list of all allegations that could be coded.

Negotiation methods used in lawsuits included use of mediation or arbitration, and outcomes of mediation attempts. The number and amount of settlement proposals were also included as a negotiation measure. Two dates could be associated with closure. The closure dates noted on the courthouse public computer database were associated with

orders for dismissal signed by judges. However, 47.1% (N = 257) of lawsuits contained documentation of suit settlement before the dismissal order date. This date was frequently associated with a scheduled mediation date. Time intervals between lawsuit proceedings and lawsuit closure identified possible effects of the filing of particular motions, e.g., would the filing of a motion for punitive damages result in the faster settling of a lawsuit?

Outcomes

Outcomes data included settlements, costs and payouts, jury awards and punitive damage awards. Data were collected from settlement documents, jury verdict documents and any source within case files that referenced attorney fees or costs, total settlement amounts, net to plaintiff amounts, other payouts of any kind, and jury awards. Jury awards and any fees, costs or net amounts to defendants were recorded also. This information was not readily available and the sample was limited.

Data Collection

Institutional Review Board (IRB) approval for exemption was obtained based on secondary data analyses of materials previously collected by a public organization. Formal lawsuit activity and available details from lawsuits filed between January 1, 1999, and December 31, 2003, i.e., approximately two years before and two years after 2001 Fla. Laws ch. 45 tort reform legislation passage, were included. The following data sources were used: AHCA's online facility locater (Agency for Health Care Administration, 2003); the Commonwealth Fund Nursing Home Staffing dataset (Hyer, 2006), and public computer database and court case files located at District 13, Hillsborough County Courthouse, Circuit Civil Department of the Clerk's Office at the George E. Edgecomb Courthouse in Tampa, Florida.

Using AHCA's online nursing facility locater, all active Hillsborough County facilities were identified and coded. Numbers of occupied beds for individual nursing facilities and ownership types were obtained from Commonwealth Fund Nursing Home Staffing dataset (Hyer, 2006) housed at the University of South Florida, School of Aging Studies. These facilities, as well as those previously identified in earlier research (Oakley & Johnson, 2001) but not currently listed on AHCA's online nursing facility locater due to name changes, closings, or other reasons, were systematically searched for using the Hillsborough County Courthouse Public Records computer database at the Clerk of the Circuit Court Public Records office for the time period from January 1, 1999, through December 31, 2003.

Through the process of threading, i.e., researching nursing facility names using all references found in case files, including misspellings, 261 possible defendant names were identified. Using these names, research found 581 lawsuits filed between January 1, 1999, and December 31, 2003, appearing to involve Hillsborough County nursing facilities. After examination of individual court files, 35 cases were eliminated. Ten cases were complaints against assisted living facilities, five were slip-and-fall lawsuits brought by non-residents, four involved nursing facilities located in other counties, two were whistleblower related, one was a worker's compensation case, one involved employer discrimination, and 12 lawsuits were based upon complaints not involving nursing facility residents as plaintiffs. For example, one lawsuit involved a resident's spouse filing a suit against the nursing facility for supposedly accusing the spouse of stealing money from the resident.

After removal of unrelated cases, 546 pertinent lawsuits remained. Of these remaining lawsuits, some or all of the information in the files for 14 cases (2.6%) were unavailable for review. Six cases were checked out to judges and eight cases were unable to be located by courthouse staff during multiple visits to the courthouse. General information about these lawsuits, e.g., opening and closing dates, defendant and plaintiff names, and case dismissal status, could be garnered from the online database. When available this information was used in analyses. All available files were examined and applicable data compiled and coded. In 18 lawsuits (3.3%), two distinct nursing facilities were named as defendants and one lawsuit involved three separate facilities as defendants. Multiple-nursing-facility lawsuits were counted as one lawsuit against each named facility. Two lawsuits sued current and previous facility owners and resulted in separate dismissal dates or separate trials by ownership. In these cases, each separate outcome was counted as an individual lawsuit against the facility. Approximately 38% (*N* = 208) of lawsuits were filed against previous nursing facility owners or management. The remaining 338 lawsuits were filed against the proprietors listed in the 2003 AHCA data set and management and associated entities identified from lawsuits.

All identified lawsuits were recorded in a master list according to Clerk of the Circuit Court-assigned case numbers. Each lawsuit case file was requested from the Clerk of the Court, reviewed and relevant, available information coded using the case summary form. Summary form entries were imported into Microsoft© Excel documents for subsequent transfer into an SPSS database for analysis.

Data Cleaning

Once data had been transferred into SPSS from summary forms, they were examined for anomalies such as outliers, e.g., variable values outside the appropriate range, and miscoded or illogical entries. Associated case numbers were identified and the original summary forms were then retrieved and compared with questionable findings. Necessary corrections were then entered in the SPSS database based on the information retrieved.

Analysis Procedures

Descriptive statistics were used for preliminary review of facility, resident, and lawsuit characteristics. Data entry and statistical analyses were conducted using SPSS 14.0 for Windows, Release 14.0.0 © SPSS Inc. 1989 - 2005. For this study, α was set a priori at 0.05. Statistical procedures for each study research question are described next.

Question One

Did the extent of lawsuits change in the anticipated direction with the passage of nursing facility tort reform laws, i.e., was there a decline in the average number of lawsuits filed per month post reform, and did the total number of lawsuits filed per nursing facility and per resident/plaintiff decrease post reform?

The 29.5-month pre-reform period (January 1, 1999 – May 14, 2001) was compared to the 30.5-month post reform period (May, 2001 – December 31, 2003). Average numbers of lawsuits filed monthly during each tort reform period were computed and compared. Total lawsuits filed pre and post reform against each nursing facility were compared also. Some residents filed multiple lawsuits against multiple facilities. By matching resident names, 461 individuals and two couples were identified

as responsible for the 546 lawsuits filed during the study period. Analysis of variance was used to compare mean numbers of lawsuits filed per resident/plaintiff pre and post tort reform.

Question Two

Did lawsuit elements (i.e., charges, allegations, pre court negotiation strategies) change to reflect the intent of the tort reforms, i.e., did the combined use of wrongful death and negligence survival damage claims decline post reform? Or did higher standards for proving negligence result in lawsuits asserting more severe charges and allegations in order to proceed to trial and be awarded damages? Or was there increased use of pre–court settlement strategies that resulted in shorter lawsuits?

Lawsuits that charged both wrongful death and negligence survival damage charges are considered the most severe. Using the lawsuit database, cases were selected based on having combined wrongful death and negligence survival damage claims. Two-way contingency table analyses, i.e., cross tabulations, were used to evaluate possible relationships between the two tort reform periods and combined wrongful death and negligence survival damage claims, allegations used to support wrongful death and negligence survival charges, and negotiation methods (i.e., arbitration attempts, mediation, settlement proposals). Pearson chi square was used to determine proportional significances. These same measures were then used to analyze all lawsuits to evaluate possible relationships between the two tort reform periods and all lawsuit charges, allegations, and negotiation methods. One-way analysis of variance was used to evaluate the effects of tort reform by testing the relationships between the dependent variable lawsuit duration and tort reform period (pre and post).

Question Three

Did the outcome of lawsuits evidence a decline in total payouts per lawsuit and jury amounts awarded as was expected with tort reform?

Question 3 was addressed through one-way analysis of variance to evaluate effects of tort reform by testing the relationships between pre and post reform and total settlement dollars, attorney fees, attorney costs, Medicare liens, Medicaid liens, other settlement payouts, net to plaintiff, and jury awards and the independent variable of reform period (pre and post).

Question Four

For either the pre reform or post reform period, will the structural (facility) variables of ownership and affiliation, available beds, and occupancy rate predict changes in the extent (number) of lawsuits filed per nursing facility occupied bed and per facility?

Question 4 was partially addressed by using the occupied beds in the nursing facility as the unit of analysis in ordinary least squares multiple linear regression analyses. Variance in numbers of lawsuits per occupied bed were regressed on the structural independent variables of ownership (for profit status), affiliation (chain member), and available beds. Separate multiple linear regressions were conducted for the pre and post tort reform periods. Non-significant models would indicate that lawsuits were not based on structural variables. In model 2, occupancy rate was added to control for facility bed size and per occupied bed was removed as a dependent variable. The regression equations used were:

Model 1

Lawsuits per occupied bed per tort reform period =

$B_{For\ profit} + B_{Chain} + B_{Beds} + B_{Constant}$.

Model 2

Lawsuits per tort reform period =

$B_{For\ profit} + B_{Chain} + B_{Beds} + B_{Occupancy\ rate} + B_{Constant}$

Question Five

For either the pre reform or post reform period, will the structural (facility) variables of ownership and affiliation, available beds, and occupancy rate predict changes in the elements of lawsuits as measured by total somatic and staff-related allegations per occupied bed, per facility, and per lawsuit?

Using the same structural variables for Question 5, ordinary least squares multiple linear regressions were also used to predict total numbers of somatic and staff-related allegations per lawsuit filed. In model 4 occupancy rate was again added to control for facility bed size and per occupied bed was removed from the dependent variables. The regression models used were:

Model 3

Somatic/staff-related allegations per occupied bed per tort reform period =

$B_{For\ profit} + B_{Chain} + B_{Beds} + B_{Constant}$.

Model 4

Somatic/staff-related allegations per lawsuit per tort reform period =

$B_{For\ profit} + B_{Chain} + B_{Beds} + B_{Occupancy\ rate} + B_{Constant}$

In models 2 and 4 the average occupancy rate was added to control for the expected influence of available beds and provide an equalizing factor between facilities.

Prior to conducting the logistic regression analyses, zero order bivariate correlations were performed on the 21 variables used in the four models to test for potential multicollinearity or shared variance between the predictor variables that might impact effect size. Variables were continuous or dichotomous, so Pearson's *r* was used.

The correlation matrix is displayed in Table 7. Among structural variables, significant correlations were found between chain affiliation and for profit ownership ($r = .38$, $p \leq .05$) and between pre and post reform occupancy rates ($r = .66$, $p \leq .01$). The majority of correlations found between lawsuit or allegation variables reflect expected relationships. Pre reform total staff-related allegations were correlated with pre reform somatic allegations per occupied bed ($r = .85$) as were post reform total staff-related allegations with post reform somatic allegations per occupied bed ($r = .61$). Post reform, total somatic allegations per lawsuit showed a negative correlation with all structural variables except chain membership as well as a negative relationship with every other post reform variable. None of the correlations were significant, however. This compares to pre reform total somatic allegations per lawsuit having a positive correlation with all structural variables except for available beds and a positive relationship with all other pre reform variables. This seems to indicate that something consequential occurred post tort reform to impact the relationships between somatic allegations and other variables.

Adjusted R-squared, degrees of freedom, *F*-values, *p*-values, and ordinary least squares multiple linear regressions are reported, as well as standardized beta to show the

relative contribution of the independent variables to each dependent variable for questions 4 and 5. The results of all analyses are described in Chapter Three.

Table 7

Correlations between Structural Variables, Lawsuits, and Allegations (N = 28)

	Correlations	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	For profit	*.38*	-.31	-.05	.16	.28	.17	.19	.27	.27	.15	-.25	.08	.25	.29	.05	.28	.14	.32	-.10	.10
2	Chain membership		-.22	-.05	.17	.36	.16	.19	.32	.33	.07	.27	.33	.07	.01	-.07	.11	-.08	.06	.09	.09
3	Available beds			.12	.36	-.08	.33	.26	-.06	-.11	-.04	.24	-.03	-.02	-.28	-.05	-.03	-.29	-.26	-.13	.12
4	Pre reform occupancy rate				*.41*	.17	.36	*.45*	.13	.23	.13	.27	**.66**	.23	.16	.07	.23	.01	.18	**.50**	.29
5	Pre reform lawsuits filed per facility					**.85**	**.97**	**.97**	**.83**	**.84**	.12	.26	.12	*.43*	.26	.30	*.44*	.17	.30	-*.39*	.33
6	Pre reform lawsuits POBPM						**.86**	**.88**	**.98**	**.98**	.14	.16	.20	*.44*	*.39*	*.44*	*.44*	*.39*	*.41*	-.21	.32
7	Pre reform total somatic per facility							**.96**	**.88**	**.84**	.10	.26	.14	*.42*	.24	.28	*.44*	.16	.30	-*.39*	*.39*
8	Pre reform total staff-related per facility								**.85**	**.90**	.10	.23	.24	**.50**	.34	.34	**.52**	.22	*.39*	-*.41*	*.43*
9	Pre reform somatic POBPM									**.96**	.11	.19	.20	*.41*	.36	*.41*	*.42*	*.37*	*.38*	-.21	.37
10	Pre reform staff-related POBPM										.12	.16	.28	**.50**	*.45*	*.46*	**.50**	*.42*	*.47*	-.24	*.39*
11	Pre reform somatic per lawsuit											.02	.13	.31	.31	.10	.21	.11	.22	.27	.22
12	Pre reform staff-related per lawsuit												.15	.16	.07	.09	.19	.02	.13	.09	.17
13	Post reform occupancy rate													.19	.20	.09	.28	.11	.28	-.34	*.46*
14	Post reform lawsuits filed per facility														**.94**	**.70**	**.94**	**.69**	**.91**	-.31	**.51**
15	Post reform lawsuits POBPM															**.77**	**.85**	**.84**	**.94**	-.19	*.44*
16	Post reform total somatic per facility																**.63**	**.95**	**.73**	-.09	*.40*
17	Post reform total staff-related per facility																	**.61**	**.94**	-.35	**.56**
18	Post reform somatic POBPM																		**.78**	-.07	.33
19	Post reform staff-related POBPM																			-.26	**.52**
20	Post reform somatic per lawsuit																				-.22
21	Post reform staff-related per lawsuit																				

Note. Pearson's $r < 37$ (non-significant); $r = 37 – 48$ ($p \leq 05$ in italics); $r = 49 – 98$ ($p \leq .01$ in boldface type). POBPM = per occupied bed per month.

CHAPTER THREE – RESULTS

Findings

Sample Characteristics

Facilities

There were 33 nursing facilities sued during the five-year period of the study (1999 – 2003). Five were closed during part ($N = 2$) or all ($N = 3$) of the study period. Lawsuits filed against these facilities are included where lawsuits are the unit of analysis. These facilities and their associated lawsuits are not included where facilities are the unit of analysis. The 30 nursing facilities that were open for any portion of the five-year study period had an average of 140 available beds (range 45 -266) and 120 occupied beds (range 28 – 229). Proprietor types included corporations, a religious partnership, three individuals, a continuing care retirement community, and one closed facility that was classified as "other" because exact proprietor type could not be determined.

A total of 29 facilities (88%) were for profit and four (12%) were not for profit (Table 6). Two-thirds (64%) were chain-affiliated and 36% were independent. Most nursing facilities were for profit chains (61%) followed by for profit independents (27%), not for profit independents (9%), and not for profit chains (3%) (Table 8).

The majority of lawsuits (65%) were filed against for profit chain facilities, followed by for profit independents (25%), not for profit independents (7%) and not for profit chain facilities (3%). Two-way contingency table analyses of lawsuits filed during

tort reform periods by nursing facility ownership, affiliation, and proprietor type found no significant differences between periods in these structural variables.

Table 8

Ownership, Affiliation by Nursing Facilities and Lawsuits (N = 33)

	For profit				Not-for profit			
	Chain		Independent		Chain		Independent	
	N	%	*N*	%	*N*	%	*N*	%
Nursing facilities (*N* = 33)	20	61	9	27	1	3	3	9
Lawsuits (*N*= 546)	356	65	139	25	15	3	36	7

Average lawsuit durations based on individual nursing facilities ranged from 13.4 to 39.4 months and average lawsuit-associated residencies based on individual facilities ranged from 2.2 to 50.1 months. Based on lawsuits filed against individual facilities, mean somatic allegations ranged from 3.0 to 6.0 per lawsuit, and mean documented staff-related allegations ranged from 4.0 to 12.3 per lawsuit.

In Appendix C, lawsuit filings are listed per facility by year. On average over the five-year study period, facilities experienced 16.6 lawsuits each or 3.3 per facility per year. Total lawsuits filed against individual nursing facilities ranged from one to 42, with a mode of seven lawsuits. As noted, five facilities were closed for the complete study period or a portion of it. Closure did not prevent litigation, however, and 40 lawsuits (7.3%) involved these facilities.

Lawsuits

There were 546 lawsuits filed during the five-year study period. At the time of review, 51 lawsuits remained open and 495 (91%) had closed. Of lawsuits remaining open, 53% (*N* = 27) were filed in 2001 and 33% (*N* = 17) in 2003. Two lawsuits filed in

1999 remained open at the time of review. On average, during the pre reform period plaintiffs filed lawsuits 16 months after the end of the associated nursing facility residency while post reform lawsuits were filed 12.7 months after a residency ended. This 3.3 month difference was significant, F (1, 478) = 7.02, p = .008, and may reflect sensitivity to the reduction in the statute of limitations implemented in 2001 Fla. Laws ch. 45. Thirty-nine residents filed lawsuits while continuing to reside at the defendant nursing facility.

Residents/Plaintiffs

In lawsuits filed during the study period, women residents were named as plaintiffs in 67.7% of lawsuits (N = 370), men were listed as plaintiffs in 174 cases, and two lawsuits were filed jointly by married couples residing at the same facility. Male plaintiffs were significantly younger (66.1 years) at the time of lawsuit filing compared with female plaintiffs (78.0 years), F (1, 104) = 14.22, p < .000. On average, male plaintiffs also died at a significantly younger age (77.1 years) compared with female plaintiffs (80.1 years), F (1, 338) = 5.21, p = .023. The average lawsuit for male plaintiffs had 26.8 month duration compared with 24.7 month duration for female plaintiffs.

Nursing Facility Residencies

Over the five-year research period, lawsuits involved nursing facility residencies ranging from one day to 10.3 years. The five-year mean for all lawsuit associated residencies was 18.4 months, which was shorter than a national average nursing facility stay of 27.6 months in 2003 (Centers for Medicare & Medicaid Services, 2003).

Men and women plaintiffs differed in residency duration during both tort reform periods but only the post reform difference was significant, F (1, 66) = 5.07, p = .028).

Pre reform, the average female plaintiff residency duration was 22.1 months compared to 17.7 months for men. Post reform, men (2.4 months, F (1, 156) = 6.00, p = .015) and women (4.3 months, F (1, 351) = 26.26, p = .000) had significantly shorter residencies than pre reform.

The average plaintiff residency decreased 17.6 months to 3.1 months in lawsuits filed post tort reform compared to pre reform nursing facility residency duration, which was a significant difference, F (1, 508) = 31.01, $p < .001$. An explanation for this reduction is unknown. It is possible that shorter residencies could be related to the admission of residents with greater levels of declining health and advanced or terminal co-morbidities although statistical analysis showed no significant differences between tort reform periods in the number of residents/plaintiffs who were dead at the time of lawsuit filing, χ^2 (1, N = 530) = 1.43, p = .232.

Filing Relationships

Two-way contingency tables and chi square tests of independence found children were significantly more likely to act as legal representatives in lawsuits involving women plaintiffs, and wives were significantly more likely than husbands to represent their spouses in lawsuits (Table 9). Residents' children were legal representatives in 50% of lawsuits filed in 2003, more than any other filing year and significantly greater than the 32% seen in lawsuits filed in 1999, χ^2 (1, N = 195) = 6.78, p = .009 (not shown). Overall, relatives were legal representatives of residents in 74.4% of all lawsuits.

Table 9

Legal Representatives Relationship with Residents/Plaintiff by Gender

	Women		Men			
	N = 370		*N* = 174			
Relationship	*N*	% suits	*N*	% suits	χ^2	*p*
Child	179	48.4	57	32.8	11.76	.001
Legal guardian, nonprofessional, e.g., best friend	51	13.8	17	9.8	1.74	NS
Undetermined – same surname	35	9.5	25	14.4	2.91	NS
Spouse	33	8.9	44	25.3	26.10	.000
Other relative	24	6.5	9	5.2	0.36	NS
Could not be determined	20	5.4	11	6.3	0.19	NS
Self	15	4.1	9	5.2	0.35	NS
Legal guardian, professional	13	3.5	2	1.1	2.47	NS

Note. NS = non-significant.

Lawsuit Charges

Lawsuit charges did not differ significantly between men and women overall. Lawsuits including loss of consortium charges were significantly more likely to have male plaintiffs, χ^2 (1, N =532) = 9.85, p = .002, and common law negligence charges were more likely to be filed by women, χ^2 (1, N = 532) = 5.00, p = .025.

Allegations

As displayed in Table 10, male plaintiffs were significantly more likely to be associated with amputations, dehydration, pressure ulcers, and malnutrition, while women plaintiffs had more lawsuits alleging urinary tract infections and fracture or other injuries that occurred while residing at a nursing facility. Based upon mean somatic allegations, overall, male plaintiffs appeared to be more seriously ill than female

plaintiffs. No significant differences were found between women and men in staff-related allegations documented in lawsuits.

Table 10

Significant Somatic Allegations by Resident/Plaintiff Gender

	Women $N = 361$		Men $N = 174$			
Allegation	*N*	% suits	*N*	% suits	χ^2	*p*
Pressure ulcer	208	57.6	120	70.2	7.74	.005
Fracture, other injury while residing	189	52.4	72	42.1	4.88	.027
Malnutrition, excessive weight loss	172	47.6	100	58.5	5.45	.020
Dehydration	157	43.5	99	57.9	9.64	.002
Urinary tract infection	96	26.6	32	18.7	3.94	.047
Amputation	11	3.0	16	9.4	9.59	.002

Individual Defendants

Individuals were listed as additional defendants in 81 lawsuits (15.2%). Pre reform, 13.5% of lawsuits added individuals, while post reform, 26.5% did, a significant increase, χ^2 (1, $N = 534$) = 7.74, $p = .005$. As many as eight individuals were added as defendants in one lawsuit. Individual defendants included owners, directors of nursing, nursing facility administrators, corporate managers, board members, trustees, general partners, and physicians. Lawsuits contained as many as 18 defendants, although these were not necessarily individuals. The addition of individuals may represent plaintiff attorneys' efforts to explore all possible financial recovery avenues.

Proceedings That Affected Lawsuits

Pre tort reform, defendant attorneys filed court documents containing references to facility bankruptcy proceedings in 89 cases (19.1%) (Table 11) involving 18 nursing facilities (54.6%), five of which were those facilities that had closed their doors either prior to or during the research period. Post reform there was a significant decrease, with only one lawsuit documenting bankruptcy proceedings. Bankruptcies were most often associated with management corporations named as defendants along with the individual nursing facility.

Insurance company insolvency proceedings affected eight facilities in 6.2% of lawsuits filed pre reform, with no lawsuits documenting these proceedings post tort reform, a significant difference. Pre reform, seven lawsuits involving four nursing facilities were associated with a combination of nursing facility bankruptcy and insurance company insolvency.

The court removed 47 lawsuits (10.1%) from pending status, i.e., actively pursuing litigation, due to bankruptcy or insurance company insolvency issues during the pre reform period. Post reform, no lawsuits were removed from pending status due to these issues, a significant decrease. Court orders reinstating lawsuits to pending status were found in 23 lawsuits (4.9%) pre reform and no lawsuits post reform. One facility was involved in foreclosure actions that involved three lawsuits.

Both nursing facilities and insurers have conveyed their concerns regarding the impact of litigation resulting in the financial failure of their associated businesses. Lawsuit documents involving several nursing facilities in the study and their liability

insurers indicate that this was an issue in Hillsborough County particularly from 1999 through 2001.

Table 11

Bankruptcy, Insolvency, and Foreclosure Proceedings by Tort Reform Period

	Pre		Post			
	N = 465		*N* = 68			
Lawsuit proceedings	*N*	%	*N*	%	χ^2	*p*
Defendant bankruptcy documents filed	89	19.1	1	1.5	13.20	.000
Case removed from pending due to bankruptcy	47	10.1	0	0.0	7.54	.006
Case reinstated to pending	23	4.9	0	0.0	3.52	NS
Insurance company insolvency documents filed	29	6.2	0	0.0	4.49	.034
Bankruptcy and insurance insolvency documents filed	7	1.5	0	0.0	1.04	NS
Foreclosure documents filed	2	0.4	1	1.5	1.15	NS

Disposition

Closed lawsuits (*N* = 496) concluded in a variety of manners. There were 441 cases containing orders for dismissal with prejudice. Dismissal with prejudice means the case is permanently closed and the plaintiff cannot file another lawsuit against the defendant based on the charges in the complaint being dismissed. Dismissed without prejudice means the case is closed but can be re-filed at a later date should the plaintiff desire to do so. Sixteen lawsuits were dismissed without prejudice. Dismissals included voluntarily, i.e., all parties were in agreement to end the lawsuit, and involuntarily, i.e., the court dismissed the lawsuit for its own reasons.

Although it could be assumed that the documents found in the 441 cases dismissed with prejudice were indicators of settlement between plaintiffs and defendants, document wording did not necessarily make this evident. Only 39 lawsuits specifically

defined settlement details. Confidentiality agreements were present in 42 lawsuits. Of filed complaints, 22 noted "That this is an action for damages that exceed ONE HUNDRED FIFTY THOUSAND DOLLARS AND NO/CENTS ($150,000.00)." Settlement results were not available for these files, but this statement clearly describes financial intent on the part of plaintiffs' attorneys was to resolve the lawsuit for no less than $150,000. A discussion of settlement outcomes can be found under Major Findings, *Question Three*.

Of closed lawsuits, the court dismissed 18 cases (3.6%), most frequently for lack or want of prosecution, i.e., failure by one or both parties for at least one year prior to the court order to file documents of any kind indicting lawsuit activity. Failure to serve appropriate papers and failure to respond to a defendant's request to the plaintiff to produce required documents were other dismissal reasons. In 72% of these cases the court did not specify dismissal with or without prejudice, leaving it unclear as to whether plaintiffs in these lawsuits would be able to re-file in the future. Four lawsuits were moved to Federal courts.

Twelve lawsuits concluded in jury trials (2.2% of all lawsuits filed in the research period). This small percentage of cases aligns with professional opinions that less than 10% of lawsuits result in jury trials (*Medical liability in long term care: Is escalating litigation a threat to quality and access?*, 2004; Stevenson & Studdert, 2003). Of these, two ended in mistrials, three resulted in verdicts in favor of plaintiffs and seven in favor of defendants.

Major Findings

Key results for the four research questions are described next.

Question One

Did the extent of lawsuits change in the anticipated direction with the passage of nursing facility tort reform laws, i.e., was there a decline in the average number of lawsuits filed per month post reform, and did the total number of lawsuits filed per nursing facility and per resident/plaintiff decrease post reform?

Based upon residency start dates and tort reform periods, all findings for Question One support Hypothesis One. There was a decrease of 13.5 (85.8%) lawsuits filed per month during the post reform period. The pre reform monthly average for lawsuits filed was 15.73 and the post reform average was 2.23 (not displayed).

The numbers of individual residents involved in lawsuits and the number of lawsuits they were plaintiffs in pre and post reform are listed in Table 12. There were no significant differences between tort reform periods in single or multiple lawsuits filed per resident/plaintiff and the overall mean lawsuits filed per resident was 1.34. Post reform, the percentage of residents filing three lawsuits did decrease while the portion of residents filing one lawsuit increased. The overall result was a slight decrease in the number of cases filed per resident (1.28) post reform.

Pre tort reform, nursing facilities averaged 14.6 lawsuits each. Post reform, lawsuits per facility decreased to 2.4. The aim to reduce the extent of lawsuits was achieved 2.5 years post tort reform.

Table 12

Multiple Lawsuit Filings per Resident/Plaintiff by Tort Reform Period (N = 534)

	Residents					
	Pre		Post		Total Lawsuits	
Lawsuits	*N*	% of period cases	*N*	% of period cases	*N*	%
One	329	70.6	50	73.5	379	70.9
Two	57	24.5	9	25.0	131	24.5
Three	7	4.9	1	1.5	24	4.5
Total lawsuits	466		68		534	
Single residents involved in lawsuits	393		60			
Mean cases filed	1.34		1.28		1.34	

Question Two

Did lawsuit elements (i.e., charges, allegations, pre court negotiation strategies) change to reflect the intent of the tort reforms, i.e., did the combined use of wrongful death and negligence survival damage claims decline post reform? Or did higher standards for proving negligence result in lawsuits asserting more severe charges and allegations in order to proceed to trial and be awarded damages? Or was there increased use of pre–court settlement strategies that resulted in shorter lawsuits

Lawsuit Charges

Passage of 2001 Fla. Laws ch. 45, significantly lowered combined wrongful death and negligence survival damage claims post tort reform, χ^2 (1, 527) = 9.37, p = .002 (Table 13), supporting Hypothesis Two. Negligence survival and medical negligence charges decreased significantly as well. However, lethal negligence, common law negligence, negligence as defined by SB 1202, and breach of fiduciary duty charges increased significantly post reform. In the pre reform period, the six charges most

frequently documented were Chapter 400 residents' rights violations (98%), negligence survival (59%), wrongful death (57%), combined wrongful death and negligence survival damage claims (47%), common law negligence (40%), and vicarious liability (34%).

Post tort reform found Chapter 400 residents' rights violations (96%) were still the most common charge, but these were followed by common law negligence (54%) and wrongful death (49%). Negligence survival charges decreased 24% post tort reform and combined wrongful death and negligence survival damage claims decreased from 47% to 27%. Lethal negligence and breach of fiduciary duty were charged at significantly higher rates in the post reform period thus supporting Hypothesis Two.

Table 13

Lawsuit Charges by Tort Reform Period (N =534)

	Pre		Post			
	N = 466		*N* = 68			
Charge	*N*	%	*N*	%	χ^2	*p*
Chapter 400 residents' rights violations	450	97.8	64	95.5	1.29	NS
Negligence survival	270	58.7	23	34.3	14.07	.000
Wrongful death	261	56.7	33	49.3	1.33	NS
Combined wrongful death & negligence survival damage claims	215	46.7	18	26.9	9.37	.002
Common law negligence	184	40.0	36	53.7	4.53	.033
Vicarious liability	157	34.1	17	25.4	2.03	NS
Breach of fiduciary duty	67	14.8	21	31.3	11.84	.000
Negligence – medical	36	7.8	0	0.0	5.63	.018
Lethal negligence	24	5.2	22	32.8	55.99	.000
Loss of consortium	19	4.1	2	3.0	0.20	NS
Other	18	3.9	1	1.5	0.99	NS
Misleading advertising claims	9	2.0	0	0.0	1.33	NS
SB 1202 defined negligence	8	1.7	5	7.5	7.96	.005

Note. NS = non-significant.

Allegations

Results for this question were mixed in supporting Hypothesis Two. Some of the six leading somatic and staff-related allegations associated with combined wrongful death and negligence survival damage claims decreased post tort reform while others increased. None of the somatic allegation changes was significant while four decreases and two increases in staff-related allegations were significant (Table 14).

Worsening or aggravation of a pre-existing condition was the most frequent somatic allegation for wrongful death and negligence survival charges for the pre reform

(91.2%) and post reform (89.5%) periods followed by pressure ulcers (65.6% and 63.2% respectively).Allegations of infection of a pressure ulcer or wound increased 22.4% post reform, although the increase was not significant. Malnutrition or excessive weight loss and dehydration declined post reform while multiple falls and "other" uncategorized somatic allegations increased during that tort reform period. Fla. Laws ch. 45 § 30 (2001e) incorporated the allowance of nonnursing staff to provide feeding assistance to residents which may have improved nutrition and hydration.

Four staff-related allegations declined post reform including failure to implement, develop, update care plan; privacy or dignity violations; and inadequate staff numbers; and inadequate staff training or communication. Post reform, there were significant increases in allegations of unsafe environment and delays in the provision of care. In the 19 post reform lawsuits charging combined wrongful death and negligence survival damage claims, all cited inadequate, improper resident assessment and 17 cited inadequate preventative, custodial care. However, neither allegation was significantly different from pre reform.

Table 14

Leading Allegations for Combined Wrongful Death and Negligence Survival Damage Claims Per Tort Reform Period (N = 234)

	Pre		Post			
	N = 215		*N* = 19			
Allegation	*N*	%	*N*	%	χ^2	*p*
Somatic						
Worsening, aggravation of existing condition	196	91.2	17	89.5	0.07	NS
Pressure ulcer	141	65.6	12	63.2	0.05	NS
Malnutrition or excessive weight loss	115	53.5	7	36.8	1.94	NS
Dehydration	108	50.2	7	36.8	1.25	NS
Fracture or other injury during residency	100	46.5	10	52.6	0.26	NS
Infection of pressure ulcer or wound	99	46.0	13	68.4	3.50	NS
Multiple falls	90	41.9	10	52.6	0.83	NS
Other	75	34.9	9	47.4	1.18	NS
Staff-related						
Inadequate, improper resident assessment	204	95.3	19	100.0	0.93	NS
Failure to implement, develop, update care plan	203	94.9	6	31.6	75.63	.000
Inaccurate, inconsistent records	202	94.4	16	84.2	3.00	NS
Inadequate staff training, communication	201	93.5	15	78.9	5.20	.023
Privacy, dignity violations	200	93.0	6	31.6	62.57	.000
Inadequate staff numbers	197	91.6	14	73.7	6.34	.012
Inadequate preventative, custodial care	191	89.3	17	89.5	0.00	NS
Unsafe environment	119	55.6	18	94.7	11.03	.001
Delays in care provision	52	24.2	17	89.5	35.79	.000

Note. NS = non-significant.

The same allegation patterns held true for all lawsuits. There were no significant differences in rates for particular somatic allegations, but there were significant differences in 13 out of 22 staff-related allegations (Table 15).

The six leading pre reform staff-related allegations (failure to implement, develop, update care plan; inadequate, improper resident assessment; inaccurate, inconsistent records; privacy or dignity violations; inadequate staff training or communication; and inadequate staff numbers) all decreased post tort reform. All decreases were significant except for the drop in inadequate, improper resident assessment, which was the most cited allegation post tort reform. Allegations of failure to notify family of significant changes, resident abuse, medication errors or mismanagement, failure to protect from abuse as defined by Fla. Stat. § 415, resident neglect, and combined resident abuse with resident neglect decreased significantly post reform also. Post reform, allegations of delays in the provision of care doubled compared to pre reform, and represented the only significant increase in a staff-related allegation in the post reform period. Allegations of an unsafe environment increased post reform as well, but not significantly.

In general the changes noted in all allegations did not support Hypothesis Two that both somatic and staff-related allegations would increase in severity due to the expectation that greater numbers of severe lawsuits alleging more severe allegations would be filed. Somatic allegations remained stable between periods and staff-related allegations showed significant improvement post reform.

Table 15

Staff-Related Allegations for All Lawsuits by Tort Reform Period (N = 532)

	Pre		Post			
	N = 464		*N* = 68			
Allegation	*N*	%	*N*	%	χ^2	*p*
Failure to implement, develop, update care plan[1]	433	93.7	48	70.6	37.81	.000
Inadequate, improper resident assessment[1]	430	93.1	61	89.7	0.99	NS
Inaccurate, inconsistent records[1]	423	91.6	55	80.9	7.64	.006
Privacy, dignity violations	415	89.4	44	64.7	30.65	.000
Inadequate staff training, communication	413	89.0	52	76.5	8.47	.004
Inadequate staff numbers	408	87.9	47	69.1	16.96	.000
Inadequate preventative, custodial care[1]	392	84.8	53	77.9	2.10	NS
Failure to notify family of significant changes[1]	387	83.8	31	45.6	51.84	.000
Abuse	278	59.9	26	38.2	11.38	.001
Unsafe environment[1]	224	48.5	35	51.5	0.21	NS
Failure to protect from foreseeable harm[1]	204	44.2	24	35.3	1.90	NS
Medication errors, mismanagement	196	42.2	13	19.1	13.30	.000
Failure to notify physician	185	39.9	26	38.2	0.07	NS
Failure to protect from abuse (§415)[1]	163	35.3	4	5.9	23.74	.000
Failure to provide materials, devices[1]	153	33.1	11	16.2	7.96	.005
Neglect	136	29.3	7	10.3	10.91	.001
Abuse with neglect[2]	105	22.7	2	2.9	14.36	.000
Delays in care provision	91	19.6	27	39.7	13.87	.000
Failure to carry out physician's orders	71	15.3	11	16.2	0.04	NS
Illegal transfer, discharge	14	3.0	1	1.5	0.52	NS
Failure to question physician's orders (seemingly ill-advised)	3	0.6	0	0.0	0.44	NS
Failure of physician to act	2	0.4	0	0.0	0.29	NS

Note. NS = non-significant.

[1]Pre reform *N* = 462

[2]Pre reform *N* = 463

Negotiation Strategies

Results were mixed in supporting Hypothesis Two in that the use of mediation did not increase post tort reform. However, arbitration attempts and settlement proposals did. Post reform, the percentage of lawsuits using arbitration increased significantly (11% to 29%) while the use of mediation decreased significantly (64% to 31%) (Table 16). Pre reform mediations were significantly more likely to settle fully or to be extended or waived compared with post reform mediations. Plaintiffs were significantly more likely to offer settlement proposals post reform than pre reform (15% vs. 5%).

Table 16

Negotiation Strategies Pre vs. Post Tort Reform

	Pre		Post			
	N = 464		*N* = 68			
Action	*N*	%	*N*	%	χ^2	*p*
Arbitration attempt	50	10.8	20	29.4	18.03	.000
Mediation use	298	64.2	21	30.9	27.46	.000
Mediation extended or waived	86	18.5	3	4.4	8.49	.004
Mediation outcome – fully settled	88	19.0	4	5.9	7.10	.008
Mediation outcome – impasse	102	22.0	9	13.2	2.75	NS
Settlement proposal - either party	99	21.4	17	25.0	0.46	NS
Defendant proposed settlement	63	13.6	5	7.4	2.08	NS
Plaintiff proposed settlement	25	5.4	10	14.7	8.34	.004

NS = non-significant.

N = number of lawsuits.

Although mediation was less likely to be used in the post reform period, there were no differences in numbers of mediation attempts per lawsuit (Table 17). That is, in both periods the parties attempted mediation about one time. There were also no

significant differences in terms of settlement proposals per lawsuit in the pre and post reform periods which averaged 1.68 and 1.88 respectively.

Table 17

Mediation Usage and Settlement Proposals per Lawsuit by Tort Reform Period

	Pre			Post				
	N = 466			*N* = 68				
Action	*N*	*M*	*SD*	*N*	*M*	*SD*	*F*	*p*
Mediation used	298	1.11	0.38	21	1.05	0.22	0.56	NS
Settlement proposals made	99	1.68	1.24	17	1.88	1.62	0.37	NS

Note. NS = non-significant.

Lawsuit Duration

For the entire study period, mean lawsuit duration based on settlement dates was 22.4 months compared to 25.4 months for lawsuits based on dismissal dates ($N = 491$). The interim between these two dates ranged from no difference to 25.7 months, with the mean lawsuit duration being 3.7 months shorter based on settlement dates ($N = 254$) (Table 18).

Based on dismissal dates, lawsuits filed post reform were 6.5 months shorter than lawsuits filed in pre reform, a significant difference, strongly supporting Hypothesis Two. Lawsuit duration using settlement dates was also over six months shorter post tort reform than pre reform but was not significant, $F\ (1, 256) = 3.43$, $p = .065$.

Motions for punitive damages may be an incentive for defendants to settle before jury trials in order to avoid the possibility of having such damages awarded at trial. There were no significant differences between pre and post tort reform in terms of duration of lawsuits and punitive damages motions, but they were significantly less likely to be filed

in the post reform period, χ^2 (1, 534) = 7.78, p = .005. There were no significant differences between pre and post reform in the numbers of punitive motions granted.

Jury trial order dates did not significantly affect lawsuits settling sooner in either tort reform period. The average length of lawsuits proceeding to trial was 31.5 months (range 18.2 – 51.2, *SD* = 10.3), with a minimum of 18.2 and a maximum of 51.2 months (not displayed). According to Rule 2.250 of Florida Rules of Judicial Administration, in civil cases, jury cases should take 18 months total from the time of filing to final disposition, and non-jury cases, 12 months from initial filing until final disposition. At eight months, a case is considered old enough to file a motion requesting a trial date (The Florida Bar, 2007). During the study period, the average time before a jury trial motion was filed was 21.1 months.

Table 18

Closing Dates and Impact of Motions on Lawsuit Duration Pre and Post Reform (N = 534)

		Pre			Post				
	Range	*N* = 466			*N* = 68				
Time period	Months	*N*	*M*	*SD*	*N*	*M*	*SD*	*F*	*p*
Duration									
Based on dismissal date	.97 – 75.4	433	26.1	13.8	59	19.9	11.2	10.70	.001
Based on settlement date	1.53 – 61.1	245	22.7	12.3	12	16.1	9.0	3.43	NS
Time interval									
Lawsuit filing and punitive damages motion	0 – 58.0	123	15.8	11.0	10	16.5	6.1	0.04	NS
Punitive damages motion and settlement date	.30 – 43.6	76	11.8	9.2	3	14.5	7.6	0.24	NS
Granted punitive damages motion and settlement	2.03 - 56.7	73	12.1	9.2	4	12.3	6.7	0.003	NS
Settlement date and court dismissal date	0 – 25.7	243	3.7	4.7	11	3.3	2.6	0.07	NS
Lawsuit filing date and jury trial order date	2.67 – 57.1	131	21.0	13.2	12	21.9	8.4	0.05	NS
Jury trial order date and settlement date	0 – 13.5	86	4.4	2.7	4	3.2	2.6	0.82	NS
Jury trial order date and dismissal date	1.90 – 32.5	129	7.8	5.0	8	8.0	2.9	0.004	NS

Note. NS = non-significant.

Question Three

Did the outcome of lawsuits evidence a decline in total payouts per lawsuit and jury amounts awarded as was expected with tort reform?

Regarding this question, results supported Hypothesis Three. One-way analyses of variance were used to determine means between tort reform periods for settlement proposals, total settlements, attorney fees and costs, Medicare and Medicaid liens, other payouts, and net to plaintiff amounts. Significant decreases were noted between pre and post reform periods in settlement proposal amounts, total settlements, and attorney fees (Table 19). The average post tort reform proposal was 36.9% of the pre reform amount; total settlement was 39.7% of the typical pre reform amount, and attorney fees were

42.2% of pre reform figures. The analyses revealed findings that approached significance, F (1, 19) = 4.07, p = .059. The suggested finding is that the mean post tort reform award to the plaintiff was reduced to only 25.1% of pre reform levels. It should be noted, however, that the post reform sample size (N = 3) was very small.

There were only three plaintiff jury awards. Two awards ($251,333.00 and $929,910) were based on pre reform limits and averaged $590,622. The single post reform jury award was $75,000, an 87% decrease. Only one plaintiff verdict reported punitive damages, an award of $675,000. Two verdicts for defendants included the award of attorney fees, i.e., $31,061 and $555,991. With such a small sample, it was not possible to determine possible tort reform effects, so, Hypothesis Four is not supported with these early findings.

Table 19

Settlement Proposal, Total Settlement, and Payout Amounts by Tort Reform Period (N = 546)

	Pre reform			Post reform					Period differences	
	N = 381			*N* = 165						
Variable	*N*	*M*	*SD*	*N*	*M*	*SD*	Minimum	Maximum	*F*	*p*
Proposal	23	318,200	251,060	8	117,500	87,380	25,000	1,000,000	4.814	.036
Total settlement	31	429,490	393,320	11	170,780	174.070	25,000	2,200,000	4.397	.042
Attorney fees	30	171,760	136,140	10	72,480	72,410	10,000	732,600	4.804	.035
Attorney costs	16	14,430	5,140	3	18,240	14,530	4,050	33,090	0.764	NS
Medicare liens	8	7,910	6,320	2	13,810	1,680	750	20,000	1.581	NS
Medicaid liens	7	5,650	8,770	2	170	70	120	24,530	0.707	NS
Other settlement payouts	6	60,120	81,620	1	2,420	00	2,420	216,910	0.428	NS
Net plaintiff award	17	199,940	124,510	3	50,160	49,720	13,200	525,990	4.070	NS

Note. NS = non-significant.

Question Four

For either the pre reform or post reform period, will the structural (facility) variables of ownership and affiliation, available beds, and occupancy rate predict changes in the extent (number) of lawsuits filed per nursing facility occupied bed and per facility?

Findings for question 4 were mixed in supporting Hypothesis Four. Overall, structural variables were completely unsuccessful at predicting dependent variables based on occupied beds but were more successful in predicting variance in dependent variables based on facilities or lawsuits. Using model 1, analyses did not find that the independent structural variables of profit status, chain membership, or available beds were predictive of the dependent variable of lawsuits per occupied facility bed for either tort reform period (Table 20).

Table 20

Impact of Ownership, Affiliation, and Available Beds on Lawsuits per Facility Occupied Bed (N =28)

	Pre reform				Post reform			
Model 1	*B*	*SE B*	β	*p*	*B*	*SE B*	β	*p*
Constant	.001	.001		NS	.001	.000		NS
For profit	.001	.001	.18	NS	.000	.000	.27	NS
Chain	.001	.001	.30	NS	.000	.000	-.15	NS
Available beds	1.16E-006	.000	.05	NS	-2.04E-006	.000	-.23	NS
Adjusted R^2		.049				.035		
F		1.47				1.33		

Note. NS = non-significant.

Model 2 accounted for 28.2% the variance in total lawsuits filed per facility pre reform (Table 21). The model was significant, with available beds the greatest contributor followed by occupancy rate. The model was not a good fit for the post reform period.

Table 21

Impact of Ownership, Affiliation, Available Beds, and Occupancy Rate on Total Lawsuits per Facility (N = 28)

	Pre reform				Post reform			
Model 2	*B*	*SE B*	β	*p*	*B*	*SE B*	β	*p*
Constant	-11.33	5.12		.037	-3.45	4.41		NS
For profit	2.73	2.01	.25	NS	1.24	0.90	.31	NS
Chain	1.56	1.47	.19	NS	-0.30	0.68	-.10	NS
Available beds	0.04	0.01	.44	.020	0.00	0.01	.13	NS
Occupancy rate	12.14	5.17	.39	.028	4.77	4.29	.24	NS
Adjusted R^2		.282*				-.042		
F		3.65				0.73		

Note. NS = non-significant.

*$p < .05$.

Question Five

For either the pre reform or post reform period, will the structural (facility) variables of ownership and affiliation, available beds, and occupancy rate predict changes in the elements of lawsuits as measured by total somatic and staff-related allegations per occupied bed, per facility, and per lawsuit?

Tables 22 and 23 establish that model 3 was not a good fit for predicting somatic or staff-related allegations per occupied facility bed. Profit status and chain membership were the greatest model contributors, but these factors were not consistent across periods.

Table 22

Impact of Ownership, Affiliation, and Available Beds on Somatic Allegations per Facility Occupied Bed (N = 28)

	Pre reform				Post reform			
Model 3	*B*	*SE B*	β	*p*	*B*	*SE B*	β	*p*
Constant	.004	.005		NS	.005	.002		.026
For profit	.003	.004	.19	NS	.001	.001	.12	NS
Chain	.003	.003	.27	NS	-.001	.001	-.19	NS
Available beds	7.37E-006	.000	.06	NS	-1.28E-005	.000	-.29	NS
Adjusted R^2		.024				.006		
F		1.22				1.05		

Note. NS = non-significant.

Table 23

Impact of Ownership, Affiliation, and Available Beds on Staff-Related Allegations per Facility Occupied Bed (N = 28)

	Pre reform				Post reform			
Model 3	*B*	*SE B*	β	*p*	*B*	*SE B*	β	*p*
Constant	.011	.012		NS	.005	.003		NS
For profit	.007	.008	.17	NS	.003	.002	.30	NS
Chain	.008	.006	.27	NS	-.001	.002	-.10	NS
Available beds	1.14E-006	.000	.00	NS	-1.44E-005	.000	-.18	NS
Adjusted R^2		.026				.031		
F		1.25				1.29		

Note. NS = non-significant.

Model 4 was unsuccessful in predicting the variance in total somatic allegations per lawsuit per facility (Table 24) filed during either tort reform period. The model approached significance ($p = .052$) for predicting variations in total staff-related allegations for the post reform period (Table 25) and suggested that occupancy rate was

the leading model contributor followed by available beds based on the standardized beta values.

Table 24

Impact of Ownership, Affiliation, Available Beds, and Occupancy Rate on Total Somatic Allegations per Lawsuit Per Facility (N = 28)

	Pre reform				Post reform			
Model 4	*B*	*SE B*	β	*p*	*B*	*SE B*	β	*p*
Constant	2.13	3.70		NS	37.42	12.13		.006
For profit	0.88	1.45	.14	NS	-3.05	2.46	-.26	NS
Chain	0.11	1.06	.02	NS	2.48	1.87	.28	NS
Available beds	0.00	0.01	-.01	NS	-.03	.018	-.32	NS
Occupancy rate	2.50	3.73	.14	NS	-29.16	11.78	-.52	.010
Adjusted R^2		-.139				.124		
F		0.24				1.89		

Note. NS = non-significant.

Table 25

Impact of Ownership, Affiliation, Available Beds, and Occupancy Rate on Total Staff-Related Allegations per Lawsuit Per Facility (N = 28)

	Pre reform				Post reform			
Model 4	*B*	*SE B*	β	*p*	*B*	*SE B*	β	*p*
Constant	1.06	5.20		NS	-20.88	8.60		.023
For profit	-3.64	2.04	-.34	NS	1.80	1.75	.20	NS
Chain	3.61	1.49	.45	.024	-0.65	1.33	-.10	NS
Available beds	0.02	0.01	.20	NS	0.02	0.01	.36	NS
Occupancy rate	7.64	5.24	.25	NS	25.95	8.35	.60	.005
Adjusted R^2		.203				.208		
F		2.72				2.77		

Note. NS = non-significant.

Model 4 was used to predict total somatic or staff-related allegations per facility for each tort reform period (Tables 26 and 27). The model significantly predicted the variance in total somatic and total staff-related allegations per facility for the pre reform period. In predicting the variance in total somatic allegations per facility, the leading and only significant model contributor was available beds (41%). Occupancy rate contributed 34% to the model but was not significant. For staff-related allegations, the leading contributor positions were reversed with occupancy rate (43%) the leading model contributor and only significant structural variable. The independent variable available beds contributed 32% to the model but was not significant. Post reform, the model was a poor fit for predicting variation in total somatic or staff-related allegations per facility.

Table 26

Impact of Ownership, Affiliation, Available Beds, and Occupancy Rate on Total Somatic Allegations per Facility (N = 28)

	Pre reform				Post reform			
Model 4	*B*	*SE B*	β	*p*	*B*	*SE B*	β	*p*
Constant	-50.30	26.51		NS	-0.434	21.77		NS
For profit	13.85	10.41	.25	NS	1.613	4.42	.08	NS
Chain	7.00	7.60	.17	NS	-2.041	3.36	-.14	NS
Available beds	0.16	0.07	.41	.034	-0.002	0.03	-.01	NS
Occupancy rate	52.69	26.76	.34	NS	11.834	21.14	.13	NS
Adjusted R^2		.213*				-.143		
F		2.83				0.15		

Note. NS = non-significant.

*$p < .05$.

Table 27

Impact of Ownership, Affiliation, Available Beds, and Occupancy Rate on Total Staff-Related Allegations per Facility (N = 28)

	Pre reform				Post reform			
Model 4	*B*	*SE B*	β	*p*	*B*	*SE B*	β	*p*
Constant	-128.05	59.08		.041	-53.00	39.94		NS
For profit	29.25	23.21	.24	NS	12.87	8.11	.34	NS
Chain	18.03	16.95	.19	NS	-2.41	6.16	-.09	NS
Available beds	0.29	0.16	.32	NS	0.05	0.06	.17	NS
Occupancy rate	151.71	59.64	.43	.018	61.19	38.79	.33	NS
Adjusted R^2		.242*				.028		
F		3.16				1.20		

Note. NS = non-significant.

*$p < .05$.

A breakdown of the mean number of lawsuits and allegations per facility distributed according to combined ownership and profit status is provided in Table 28. For profit chain facilities had the greatest number of lawsuits and allegations than all other facility ownership types. However, differences between combined ownership and affiliation types were not significant for any variable.

Nursing facilities averaging occupancy rates under 91.8% for the entire study period averaged 7.9 lawsuits per facility. Facilities averaging occupancy rates 91.8% or more averaged 10.7 lawsuits per facility. The mean difference was not significant (not displayed).

Analysis of variance found that pre reform, nursing facilities having fewer than 120 available beds had significantly fewer lawsuits than facilities having 120 beds, F (1, 17) = 11.76, p = .003, or more than 120 beds, F (1, 13) = 8.00, p = .014 (not

displayed). However, post reform there were no significant differences between these available bed size groups and numbers of lawsuits.

Table 28

Mean Lawsuits and Total Allegations per Facility by Ownership and Affiliation (N = 28)

	For profit				Not for profit					
	Independent		Chain		Independent		Chain			
	N = 6		*N* = 18		*N* = 3		*N* = 1			
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*
Lawsuits										
Pre reform	6.7	5.5	7.5	3.7	5.0	2.7	7.0		0.34	NS
Post reform	2.5	1.4	2.5	1.6	1.7	0.6	1.0		0.57	NS
Total	9.17	5.9	10.0	4.8	6.7	3.1	8.0		0.43	NS
Total allegations										
Somatic										
Pre reform	30.3	24.8	35.4	19.3	24.7	14.4	25.0		0.34	NS
Post reform	10.8	6.3	10.2	7.7	11.0	1.7	5.0		0.21	NS
Total	41.2	25.5	46.8	24.4	35.7	16.1	30.0		0.34	NS
Staff-related										
Pre reform	71.0	57.7	82.3	43.9	51.0	19.5	73.0		0.44	NS
Post reform	20.5	12.1	21.4	14.9	11.3	5.7	8.0		0.71	NS
Total	91.5	61.3	103.7	54.2	62.3	24.4	81.0		0.55	NS

Note: NS = not significant.

Pre reform, findings support Hypothesis Four that the structural variables of profit status, chain membership, occupancy rate, and available beds would be related to higher numbers of lawsuits and somatic and staff-related allegations. Although post reform these structural variables were related to greater numbers of lawsuits and total staff-related

allegations per facility, independent not-for profit facilities had higher numbers of somatic allegations per facility.

CHAPTER FOUR –DISCUSSION AND CONCLUSIONS

Summary of Findings

Through secondary data analyses, this study examined the initial effects of Florida's 2001 tort reform measures on lawsuits filed against any nursing facility in Hillsborough County, Florida from 1999 through 2003. The extent, elements, and outcomes of lawsuits were compared between pre and post tort reform periods, controlling for structural characteristics of facilities.

Overall, it appears that 2001 tort reform impacted post reform litigation as intended. Post tort reform, lawsuits filed per month dropped to 14% of pre reform monthly filings, they were associated with shorter residencies, were filed sooner, and on average settled six months sooner. There was no reform effect in terms of who sued whom. Women residents were the plaintiffs in most lawsuits and for profit chain facilities were sued most often in both periods. Contrary to earlier research, nursing facility structural variables (ownership, affiliation, and size) showed little influence on the predictability of lawsuits or allegations filed per facility bed. Instead, the structural variables of available beds and occupancy rate were better predictors of total numbers of somatic and staff-related allegations per facility. Mediation was less likely and arbitration more likely to be used.

Mean somatic allegations per lawsuit decreased albeit not significantly. Total staff-related allegations per lawsuit did decrease significantly. In fact, 17 out of 22 staff-related allegations decreased, 12 significantly. Lawsuits were less apt to include

combined wrongful death and negligence survival damage claims. However, other lawsuit charges such as lethal negligence and breach of fiduciary duty were added or increased significantly. At the same time, settlement proposals, total settlements, and attorney fees decreased on average to less than half of pre reform amounts and net to plaintiff totals decreased to slightly more than one-fourth of pre reform amounts.

Discussion

The findings of the present study lend support to the assumption that the initial impact of 2001 Fla. Laws ch. 45 would be a reduction in litigation against nursing facilities. Based upon residency admission dates rather than filing years, analyses found that lawsuits were decreasing post tort reform. This is supported by reports from AHCA that notices of intent (NOIs) to file lawsuits against nursing facilities have consistently decreased on average 20% per fiscal year beginning in study filing year 2002 – 2003, approximately one year after the passage of 2001 Fla. Laws ch. 45 and at which time AHCA was required to begin keeping more detailed records of NOIs (Agency Reporting Requirements, 2002). NOIs filed in fiscal year 2005 - 2006 ($N = 448$) decreased to 38.9% of the 1,153 NOIs filed in fiscal year 2001 – 2002. This could reflect a permanent downward trend in numbers of actual lawsuits filed against nursing facilities.

The reduction in lawsuits observed in this study may be influenced by two nursing facility practices found to occur more frequently post-tort reform, i.e., the incorporation of clauses in residency contracts requiring use of arbitration, and the filing of motions to enforce such clauses should residents assert claims against a facility. Also, increasing liability insurance costs since the late 1990s resulted in some nursing facilities failing to purchase sufficient liability insurance or in some cases not purchasing any

insurance, a practice known as “going bare” (Gottlieb, 2002; Hedgecock & Salmon, 2001; Oakley & Johnson, 2001). As a result, plaintiffs were significantly more likely to offer settlement proposals in 2003 than any other study year.

In both tort reform periods, residents filed lawsuits against multiple facilities. There were 75 residents/plaintiffs involved in the filing of 158 lawsuits (29% of all lawsuits filed by 17% of all plaintiffs). Eight of these residents/plaintiffs filed three lawsuits each. It is not impossible that an individual could reside at two or three separate facilities and receive from each a level of care so deficient that it triggered litigation. However, it seems questionable that particular residents/plaintiffs would receive such deficient care at each facility they chose for residency, yet the majority of the 3,000 to 17,500 possible residents (based on AHCA total occupied beds per year) who resided at the nursing facilities in this study during the five-year research period never brought a lawsuit against any facility. This multiple lawsuit trend may be completely justifiable, but it causes serious consideration of the growing litigious mind-set frequently seen today and the serious financial consequences for court systems, businesses, insurers, policyholders, and taxpayers.

As previously noted, structural characteristics such as facility ownership and affiliation, available beds, or occupancy rate were not strong predictors of lawsuit activity as others have found (Johnson, Dobalian et al., 2004a, 2004b; Johnson, Hedgecock et al., 2004; Oakley & Johnson, 2001). Structural variables were completely ineffective in predicting variance in lawsuits or allegations per occupied nursing facility bed as well as allegations per lawsuit. Only three multivariate models were significant and all were true just for the pre reform period. Within these models only available beds or occupancy rate

were significant contributors. Both structural variables contributed in explaining 28% of the variance in total lawsuits filed per facility. The only significant contributor of variance in total somatic allegations per facility was available beds. Occupancy rate contributed to total staff-related allegations per facility. Post reform, structural variables did not explain the relationship of lawsuits and allegations to nursing facilities. Even though these structural variables did not explain the elements or outcomes of lawsuits, for-profit chain member facilities had higher average lawsuits, somatic allegations, and staff-related allegations than for profit independent, not-for-profit independent and not-for-profit chain facilities. But it was not their ownership or affiliation; it was their available beds or occupancy rate.

On average, nursing facilities with 92% or higher occupancy rates had three more lawsuits filed against them than facilities having lower occupancy rates. During the pre reform period, nursing facilities with fewer than 120 available beds had six fewer lawsuits than 120-bed facilities and five fewer lawsuits than facilities with more than 120 beds. Post reform, facilities with less than 120 beds had one less lawsuit than 120-bed facilities and .2 less lawsuits than facilities with more than 120 beds. The reforms reduced the effect of available beds (facility size) that was found pre reform and in previous research (Johnson, Dobalian, et al., 2004a, 2004b; Johnson, Hedgecock et al., 2004; Oakley & Johnson, 2001), but it appears that high occupancy rates may not be desirable even with higher staffing rates. Future research could include Minimum Data Set data for staffing deficiencies to see how this structural variable impacts or moderates occupancy rates when explaining lawsuit activity.

The dynamics of nursing facility litigation are more complex than just numbers of lawsuits filed or facilities sued, types of charges and allegations, and financial outcomes of proposals and settlements. Lawsuits filed post reform added more defendants, both corporate and individual, with individuals added significantly more often (26.5%), almost doubling pre reform levels (13.5%). Adding more defendants increases the likelihood that based on the combined insurance coverage of many defendants settlements will meet the maximum allowable damage amounts under the law. This practice most likely represents attorney efforts to seek damages from every possible source and may be rising due to extremely low professional liability insurance coverage by at least some facilities. Some nursing facilities base decreased liability coverage on reducing risk exposure. They are also looking for alternatives by using limited liability corporations or restructuring ownership of real estate and facility operations into single purpose entities, thereby minimizing available assets (Casson, 2003; Wager & Creelman, 2004). Just as trial attorneys found ways to work around 2001 Fla. Laws ch. 45 intentions to decrease claims and reimbursement of legal costs, nursing facilities have used strategies to limit their exposure.

Additionally, lawsuits were significantly more likely to contain charges of breach of fiduciary duty. Under Florida Statutes § 737.627, in actions for breach of fiduciary duty, the court is obliged to award taxable costs which include attorney fees (Trust Administration, 2006). Since attorney fees were no longer guaranteed with the passage of 2001 Fla. Laws ch. 45, the increase in breach of fiduciary duty charges appears to be another approach by attorneys to guarantee payment of their fees. It would be of great

interest to see if the percentage of lawsuits containing breach of fiduciary duty charges continues to rise in subsequent years and if other charges become more commonly used.

As previously noted, the mean average post reform residency associated with lawsuits was 3.1 months, only 15% of the pre-reform residency. Post tort reform 9% of lawsuits were associated with residencies lasting one week or less compared with 3.8% pre reform and 70.1% post reform were associated with residencies of 100 days or less compared with 28.8% pre reform. It may be that more residents discharged from hospital stays for conditions requiring a limited recuperative nursing facility stay filed more lawsuits post tort reform. Medicare benefits for skilled nursing facility care end after 100 days and Medicaid has requirements of substantially reduced resident income and assets in order to receive benefits. These factors could contribute to shorter residencies as well. A smaller proportion of residents were deceased at the time of lawsuit filing than there were pre reform (75.0% and 81.2% respectively) indicating that fewer plaintiffs ended their residencies due to death. A logical conclusion would be that residents experiencing greater numbers of somatic allegations attributed to a nursing facility or its staff would depart more quickly from that facility. However, average somatic allegations per resident/plaintiff were slightly fewer, so it appears that overall residents filing lawsuits were not as sick post tort reform as they were pre tort reform. Furthermore, 86.4% of staff-related allegations decreased, 55% significantly, indicating fewer staff-related reasons for residents to end nursing facility residencies post tort reform than pre reform. The staffing increase measures may have changed the relationship with somatic complaints. Whereas somatic allegations were positively correlated with staff-related allegations pre-reform they were negatively correlated post-reform.

Decreased settlement amounts were a desired outcome of 2001 Fla. Laws ch. 45, however, post tort reform there was a definite inequity in the distribution of reduced settlement awards. Overall awards were 40% of pre reform amounts, yet attorneys received 42% of pre reform amounts and residents/plaintiffs received only 25% of pre reform sums.

One concern regarding the changes in litigation found in this study is if the frail, vulnerable resident in a nursing home is served well by 2001 Fla. Laws ch. 45. Although lawsuits are decreasing, it appears that those that are filed are about serious allegations beyond resident rights, which were the most common allegations for both reform periods. So residents with serious complaints are getting their "day in court" even if it ends with arbitration. Yet, in the average settlement, residents have taken a larger loss in the net amount they receive compared with the portion going to their attorneys.

A common societal attitude today is that anything "bad" that happens is preventable or the fault of another. With an increasing population with which much can go wrong related to health, perhaps the intention of tort reform must be judged on measures beyond simply numbers. Our legal system allows redress for actionable causes, so individuals will and should pursue this course when appropriate. The issue becomes entangled when such actions concern complex settings such as nursing facilities where events can be impacted by a number of factors.

When things do go wrong or poorly and there is no doubt this will occur, how they went wrong becomes the crux of the matter. For justice to be disseminated fairly, all contributing factors should be taken into account. This includes calling to task facilities having insufficient or inadequately trained staff, those that redirect monies to company

stockholders rather than their residents' well-being and quality of life, or facility managers and administrators who fail to honor the human dynamics of aging and dying that make taking care of individuals on a long-term basis far more than an ordinary "business."

Family members and residents themselves bear some responsibility in this complex business. Family members or concerned citizens need to understand the limitations of nursing facility care. Even with the highest staffing ratios in the country, Florida, or any other state, cannot provide one-on-one nursing 24 hours a day to each resident. For those residents who are designated as long-term care (as opposed to short-term rehab), they are facing end-of-life and that process is variable and not always a "good death." Although it may appear hard hearted, the resident may also bear responsibility. Lifestyle and genetics affect health and well being. The latter is not preventable, however, the former is. Lastly, many in our society fear aging and death, yet professions that care for our elderly are not adequately valued or rewarded. If society valued a good old age and a good death, it would ensure that people and places that care for our elders had sufficient resources and oversight.

Public education and familiarization with long-term care and local nursing facilities would be a valuable addition to tort reform. Involving children and teenagers, local civic groups, and churches in hands-on experiences that include resident and staff interaction would benefit participants, residents, and staff. First-hand knowledge could dissipate many fears about long-term care and aging, inspire volunteerism and community involvement, and instill respect and compassion for both individuals providing and receiving care.

Understanding as many aspects as possible of nursing home care and its outcomes is imperative as policies are reviewed, written, and rewritten to improve facilities and the experiences of residents. Policy research such as this study that examines the basis of consumers' legal dissatisfaction with nursing home residency experiences not only sheds light on financial implications for the industry, but also brings attention to the role of other possible factors, e.g., the addition of more defendants and other types of charges, that may be counterproductive to legislative litigation control mechanisms. This type of research takes the next step and expands beyond industry-produced reports based on insurance claims data that are normally only internally accessible for review and lack sufficient details to associate possible causes with outcomes or provide other explanatory details.

Policy reforms based on motivation by negative consequences (sticks) for failing to abide by laws and regulations have not been very successful at halting or even slowing down litigation. Perhaps more policy development and implementation should focus on goal setting and the benefit of achieving those goals (carrots) by fostering in nursing facility management and staff intrinsic values to perform consistently at top quality levels, specifically asking about problems nursing facilities encounter and the kinds of help needed to resolve them. Public policy that is based upon a win-win-win situation for all involved parties offers a greater chance for acceptance and adherence and the most positive outlook for success. 2001 Fla. Laws ch. 45 may be one such example.

Frequently, the foundations of public policies and laws are based on standards the public expects in a variety of areas of life. However, principles and compassion cannot be legislated. It is the height of hubris to expect laws to regulate and long-term care

providers to exhibit more care and concern for the elder members of our society than we individually exhibit ourselves.

Limitations

This study required use of public documents filed and maintained at the Clerk of the Circuit Court's Records Office. Data collection was impeded by inconsistency and inaccuracy on the part of attorneys, judges, administrative employees, and private citizens in the handling and oversight of court documents. The data collected and noted on the court case summary form, although general in nature, were not always available in reviewed files, thus possibly influencing the findings of this study.

Lawsuit files lacked documentation consistency particularly relating to settlement details including dates. There was failure to submit necessary documentation to inform the court that parties had come to resolution which sometimes resulted in court dismissal of cases due to lack of prosecution, yet substantial documentation existed in some files to indicate the likelihood of settlement through scheduled mediation had occurred. Lack of filing or late submission of settlement documentation also contributed to some lawsuits appearing to remain open or artificially increasing the length of other lawsuits.

Another limitation of this study included having only a two-year sample of lawsuits filed post tort reform. The limited time frame resulted in a small sample of "pure" lawsuits, i.e., lawsuits filed post tort reform and based on allegations occurring during resident stays that fell completely within all tort reform measures, particularly the quality-focused CNA per resident per day staffing hour increases. Since the last staffing increase did not occur until January 1, 2004, any effects from this increase are not seen in lawsuits analyzed in this research.

The changes in litigation found here may be due to other reasons beyond policy changes. Trial attorneys who are losing business in Florida may be moving to more prolific and lucrative lawsuit landscapes in other states. Or, decreased media coverage of sizeable nursing facility lawsuit awards may have decreased interest in these lawsuits. Facility ownership changes or decreased professional liability insurance coverage may have reduced the potential for large claims, and there may be other unrealized factors that were responsible for the differences found between reform periods.

Future Research Implications

Florida's law now requires that prior to filing a nursing facility lawsuit involving resident's rights' violations or negligence allegations of resident injury or death, nursing facility defendants must be notified that investigation of the plaintiff's circumstances and surrounding events has resulted in the belief that grounds for a lawsuit exist. Defendants are given 75 days to evaluate the presented claims and respond, either by rejecting the claims or making a settlement offer (Chapter 2001-45, §400.0233, Laws of Fla.). Although in this study every lawsuit filed after May 15, 2001, documented this required procedure, public records do not indicate how frequently possible lawsuits are avoided by use of the 75-day evaluation process. Having such data would shed light on the processes and criteria used by attorneys in deciding whether to go forward with a case and insurance companies' decisions to settle a claim or proceed with litigation.

This research revealed that a complete and fully accurate representation of tort reform effects must include matching the time allegations are said to have occurred with the statutes that were in place at the time of occurrence. The typical lawsuit filed in Hillsborough County from 1999 through 2003 was based on a nursing facility stay that

ended 15.5 months before the case was officially recorded as opened. Lawsuit charges, e.g., combined wrongful death and negligence survival damages claims, filed in a specific year are bound by the statutes that are in force at the time of filing. However, allegations, specifically those that are staff-related, typically do not reflect conditions of the filed year because of the interim from the end of residency until the associated lawsuit is filed. Therefore, future research should be undertaken to examine tort reform effects on lawsuits in which all aspects embody pre reform or post reform events. A three-month time frame should be sufficient to return to the 13th District Court of Hillsborough County to compile and analyze data from lawsuits filed from January 1, 2004, through December 31, 2006. Although not all lawsuits would have matured to resolution, particularly those filed during 2006, the three-year period to be reviewed should provide sufficient information to adequately increase the post tort reform sample and see if current findings are sustained. The final staffing increase originally scheduled for January 1, 2004, was delayed until January 1, 2007, so findings would not reflect any influence from the increase to 2.9 CNA hours per resident per day.

There is cause for concern in attributing strictly to tort reform measures the decreased lawsuit filings (based on residency start dates) and reduced settlement and payout amounts found in this research. The issue of minimal or no nursing facility professional liability insurance coverage may be influencing not only the willingness of attorneys to file nursing facility related lawsuits, but also may explain overall reduced settlements. Such influence would nullify many of 2001 Fla. Laws ch. 45's tort reform measures perceived effects. Further research, including interviews with nursing facility administrators or management personnel and attorneys should be conducted to

understand the degree of impact lower liability limits are having on the extent and outcomes of litigation involving nursing facilities.

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APPENDICES

Appendix A

Court Case Summary Form

General Information

1. Court case number: ____ Special Notes ____
2. Date case was filed (opened): ____ 3. Court date closed: ____ Year Filed ____
4. Facility/building code: ____ 5. Total number of case files: ____

Defendant Information

6. Defendants listed in case file match master listing? ____
7. Address in file: ____ Address if available: ____
8. Attorney for defendant(s): ____ List Other ____

1 Bavol, Bush & Sisco, PA	6 Quintaros, McCumber et al.
2 Fowler, White, Gillen et al.	7 Shofi, Hennen & Associates
3 Hill Ward & Henderson	8 Wilson, Elser, Moskowitz et al.
4 Luks, Koleos & Santaniello	9 Ziegler, Steven
5 Murphy & Runyon	10 Other (See list for additional names)

Plaintiff Information

9. Resident/patient: ____ DOB: ____
10. Resident's representative (suing with/on behalf of resident): ____
11. Representative's relationship to resident: ____

1 Cannot be determined	5 Son/Daughter
2 Other relative	6 Legal guardian non professional
3 Legal guardian professional	7 Uncertain but same surname
4 Spouse	8 Self

12. Attorney for plaintiff(s): ____ List Other ____ Non-Wilkes Case ____

4 Beltz & Ruth, PA	31 Nursing Home Abuse Law Center
7 Brunetti, PA	33 Perenich, Carroll, et al
16 Fowler, White, Gillen et al.	43 Trentalange, Michael, PA
25 Milcowitz & Lyons	47 Wilkes & McHugh
27 Morgan, Colling & Gilbert	00 Other (See list for additional names)

13. Resident's dates of stay in facility: From ____ To ____
14. Is resident deceased? ____ If yes, date of death: ____

Appendix A (Continued)

Case Outcome

15. Actual settlement date
16. No documentation indicating dismissal/settlement, yet case is closed
17. Did plaintiff terminate lawsuit at own request or joint stipulation? (voluntary dismissal)
    IF YES: Specified that all parties will bear their own costs and attorney fees?
    Case dismissed (prejudice):
18. Involuntary dismissal (court dismissed plaintiff's suit) Reason:
19. Settlement reached prior to jury trial?
    IF YES: 1) Settlement details confidential/sealed per included statement
    2) Confidentially statement not found, but no $ figures included
    3) Details disclosed as follows:
20. Jury trial resolution? Court order date Trial date
    IF YES: Summarize disclosed jury awards or case outcomes in last section.
21. Mediation used Mediation date Result Mediator
22. Defendant bankruptcy declared?

Complaint Information

Terminology:

1 **0** Statutorily mandated responsibility
2 **0** Owed/breached duty
3 **0** Direct, proximate result
4 **0** Direct, proximate cause
5 **0** Standard of care required of similarly situated, reasonably prudent nursing home employees, etc.
6 **0** Nonaccidental infliction physical/psychological injury
7 Other Verbiage

23. Type of lawsuit specified. List all that apply (Specify "Other")

Y/N		Counts	5/15/01 PRE A	5/15/01 POST B	Y/N		Counts	5/15/01 PRE A	5/15/01 POST B
1	0	Wrongful death	0	0	2	0	Negligence survival	0	0
3	0	Breach of fiduciary duty	0	0	4	0	Misleading advertising claims	0	0
5	0	Vicarious Liability	0	0	6	0	Chapter 400 claims	0	0
7	0	Other (list above)			8	0	SB 1202 negligence charges		
9		Non-lethal negligence	0	0	10		Lethal negligence	0	0

0 Wrongful death without negligence survival
0 Negligence survival w/o wrongful death
0 Chapter 400 alone without wrongful death and negligence survival
0 Wrongful death with negligence survival

24. ALL resident's rights listed in the complaint? ____

25. Separate, specific allegation in complaint of "Failure to provide adequate and appropriate health care"? ____

26. Physical condition allegations. List all that apply ____ (specify other): ____

1	0	Pressure sore(s)	2	0	Infection of pressure sore or other wound
3	0	Sepsis/septicemia	4	0	Gangrene
5	0	Amputation	6	0	Single fall, with injury
7	0	Multiple falls	8	0	Fracture from fall or injury while in facility
9	0	Dehydration	10	0	Malnutrition or excessive weight loss
11	0	Existing condition worsens	12	0	Other (specify above):
	0	Both pressure sores and falls		0	Contractures

27. Other allegations. List all that apply: ____

1	0	Delays in the provision of care			
2	0	Violation of resident's privacy/dignity	3	0	Illegal resident transfer/discharge
4	0	Resident neglect	5	0	Resident abuse
6	0	Medication errors or mismanagement	7	0	Failure to notify physician
8	0	Failure to carry out physician orders	9	0	Failure to question physician orders
10	0	Failure of physician to act	11	0	Inadequate number/retention of staff
12	0	Inadequate staff training/ communication/supervision	13	0	Failure to notify family
14	0	Failure to develop, implement, update adequate, appropriate care plan	15	0	Records/documentation problems
16	0	Inadequate preventative/custodial care	17	0	Failure to provide materials/ devices
18	0	Inadequate/improper assess/monitor	19	0	Failure to protect from abuse (§415)
20	0	Failure to protect from foreseeable harm	21	0	Unsafe environment
	0	Resident abuse with resident neglect		0	Abuse only and no others
	0	Neglect only and no others			

28. Defense's rebuttal statements and/or counter evidence in file? ____

29. Expert witness used? ____ Expert's name: ____ SPSS ID # ____

30. Punitive damages Motion? ____ File date ____ Granted/denied date ____ Punitives denied? ____

31. Settlement proposed? ____ Date ____ Party proposing ____ Amount: ____

32. Death certificate cause of death ____

33. Judge ____

34. Brief account of plaintiff's allegations ____

35. Case notables/comments (list anything exceptional or important about this case): ____

Appendix B

Study Variables

Variable	Label	Measurement	Notes
Sample characteristics			
Filing period	Pre reform	1/1/99 – 5/14/01	29.5 months
	Post reform	5/15/01 – 12/31/03	30.5 months
Facility features			
Ownership	For profit	0,1	Longest held status within study years
Affiliation	Chain	0,1	Longest held status within study years
Available beds	Bed size	45 – 266	
			If these data missing for a particular year, according to availability, the previous or following year's
Occupied beds	Occupied beds	28 -220	AHCA data for occupied beds was used.
Occupancy rate	Occupancy rate	0 – 100%	Calculated

Appendix B (Continued)

Variable	Label	Measurement	Notes
Extent of lawsuits			
Multiple lawsuit filings	One	0,1	
	Two	0,1	
	Three	0,1	
	Total lawsuits	1 - 3	
Lawsuits filed per occupied bed	Lawsuits filed per occupied bed	Calculated	Number of lawsuits filed against facility during tort reform period divided by number tort reform period months divided by average number of AHCA-reported occupied beds for same reform period
Lawsuits filed per facility	Lawsuits filed per nursing facility	0 – 42	
Lawsuit elements			
Resident characteristics	Gender	0 = male, 1 = female	
	Age at death	Calculated	Based on birth and death dates
	Age at filing	Calculated	Based on birth and lawsuit filing dates
	Residency duration – months	Calculated	Based on residency start and end dates

Appendix B (Continued)

Variable	Label	Measurement	Notes
	Somatic allegations per suit	0 -	
	Staff-related allegations per suit	0 -	
	Lawsuit duration – months	Calculated	Based on lawsuit filing and dismissal dates
	Cause of death	List	
Filing relationship	Self	0,1	
	Spouse	0,1	
	Child	0,1	
	Other relative	0,1	
	Undetermined – same surname	0,1	
	Legal guardian, professional	0,1	
	Legal guardian, nonprofessional, e.g., best friend	0,1	
	Could not be determined	0,1	
Case characteristics	Case number	Court assigned number	
	Number of files	1 – 32	
	Residency end until lawsuit filing	Calculated	Based on residency end and lawsuit filing dates

Appendix B (Continued)

Variable	Label	Measurement	Notes
	Individual defendants	0,1	
	Bankruptcy documents filed	0,1	
Lawsuit activity	Bankruptcy & insurance insolvency docs filed	0,1	
	Case reinstated to pending	0,1	
	Case removed from pending due to bankruptcy	0,1	
	Foreclosure documents filed	0,1	
	Insurance company insolvency documents filed	0,1	
	Motion to enforce settlement filed	0,1	
	Punitive damages motion filed	0,1	
	Punitive damages motion granted	0,1	
Counts	Breach of fiduciary duty	0,1	
	Chapter 400 residents' rights violations	0,1	
	Loss of consortium	0,1	
	Misleading advertising claims	0,1	
	Negligence - common law, per se	0,1	
	Negligence - lethal	0,1	

Appendix B (Continued)

Variable	Label	Measurement	Notes
	Negligence - medical	0,1	
	Negligence survival	0,1	
	Other	0,1	
	SB 1202 defined negligence	0,1	
	Vicarious liability	0,1	
	Wrongful death	0,1	
	Combined wrongful death & negligence survival damage claims	0,1	
	All Fla. Stat, § 400.022 resident's rights listed	0,1	
	"Failure to provide adequate and appropriate health care."	0,1	
Allegations			
Somatic	Amputation	0,1	
	Asphyxiation, aspiration, choking	0,1	
	Contractures	0,1	
	Dehydration	0,1	

Appendix B (Continued)

Variable	Label	Measurement	Notes
	Fecal impaction	0,1	
	Fracture or other injury while residing	0,1	
	Gangrene	0,1	
	Infection of pressure ulcer or wound	0,1	
	Malnutrition or excessive weight loss	0,1	
	Multiple falls	0,1	
	Other (conditions not listed)	List	
	Physical assault	0,1	
	Pressure sores	0,1	
	Pressure ulcers and falls	0,1	
	Sepsis/septicemia	0,1	
	Single fall with injury	0,1	
	Skin tears	0,1	
	Urinary tract infections	0,1	
	Worsening, aggravation of existing condition	0,1	
	Total somatic allegations	0 - 12	
Staff-related	Abuse	0,1	

Appendix B (Continued)

Variable	Label	Measurement	Notes
	Delays in care provision	0,1	
	Failure to carry out physician orders	0,1	
	Failure to implement, develop, update care plan	0,1	
	Failure to notify family of significant changes	0,1	
	Failure to notify physician	0,1	
	Failure to protect from abuse §415	0,1	Abuse according to Fla. Stat. § 415.101 is aimed at protecting disabled or elderly adults and requires mandatory reporting of suspected cases to Florida's Adult Protective Services for intervention
	Failure to protect from foreseeable harm	0,1	
	Failure to provide materials or devices	0,1	
	Failure to provide materials, devices	0,1	
	Illegal transfer, discharge	0,1	
	Inaccurate, inconsistent records	0,1	
	Inadequate preventative, custodial care	0,1	
	Inadequate staff numbers	0,1	

Appendix B (Continued)

Variable	Label	Measurement	Notes
	Inadequate staff training, communication	0,1	
	Inadequate, improper resident assessment	0,1	
	Medication errors, mismanagement	0,1	
	Neglect	0,1	
	Neglect with abuse	0,1	
	Physician fails to act	0,1	
	Physician's orders unquestioned (seem ill-advised)	0,1	
	Privacy, dignity violations	0,1	
	Unsafe environment	0,1	
	Total allegations per lawsuit	0 – 12	
Negotiation measures			
	Arbitration attempt	0,1	
	Mediation use	0,1	

Appendix B (Continued)

Variable	Label	Measurement	Notes
	Mediation used	1 - 4	
	Mediation extended or waived	0,1	
	Mediation outcome – fully settled	0,1	
	Mediation outcome – impasse	0,1	
	Settlement proposal - either party	0,1	
	Defendant proposed settlement	0,1	
	Plaintiff proposed settlement	0,1	
	Settlement proposals made	1 - 7	
	Proposal $	$25,000 - $1,000,000	
Duration	Duration based on dismissal date	Calculated	Based on filing and dismissal dates
	Duration based on settlement date	Calculated	Based on filing and settlement dates
Interims	Lawsuit filing until punitive damages motion	Calculated	Based on filing and motion dates
	Punitive damages motion until settlement date	Calculated	Based on motion and settlement dates
	Granted punitive damages motion until settlement	Calculated	Based on motion and settlement dates
	Settlement date until court dismissal date	Calculated	Based on settlement and dismissal dates

Appendix B (Continued)

Variable	Label	Measurement	Notes
	Lawsuit filing date until jury trial order date	Calculated	Based on filing and motion dates
	Jury trial order date to settlement date	Calculated	Based on order and settlement dates
	Jury trial order date to dismissal date	Calculated	Based on order and dismissal dates
Lawsuit outcomes			
Disposition			
Dismissed	With prejudice	0,1	
	Without prejudice	0,1	
	Voluntary	0,1	
	Involuntary	0,1	
Moved to Federal court	Moved to Federal court	0,1	
Jury trial	Jury trial	0,1	
Verdict	Plaintiff	0,1	
	Defendant	0,1	
	Mistrial	0,1	

Appendix B (Continued)

Variable	Label	Measurement	Notes
Total settlement amount	Total settlement $	$25,000 - $2,200,000	
Costs and payouts	Attorney fees	$10,000 - $732,600	
	Attorney costs	$4,050 - $33,090	
	Medicare liens	$750 - $20,000	
	Medicaid liens	$120 - $24,530	
	Other settlement payouts	$2,420 - $216,910	
	Net to plaintiff	$13,200 - $525,990	
Jury awards	Plaintiff awards	$75,000 - $929,910	
	Defendant attorney awards	$31,061 - $555,991,	
Punitive damages	Punitive damages	$675,000	

Note. 0 = no, 1 = yes.

Appendix C

Facility Lawsuit, Allegation, and Residency Data

		Lawsuits filed															
		Year								Allegations				Duration in months			
				2001				Five-year		Staff-related		Somatic		Residency		Lawsuit	
Facility	Available beds	1999	2000	5/15 – 10/5	All other months	2002	2003	Total	*M*	*N*	*M*	*N*	*M*	*N*	*M*	*N*	*M*
648[a]	60																
425	45	0	0	1	0	0	0	1	0.2	1	8.00	1	3.00	1	12.63	1	13.43
195	75	1	1	1	0	0	0	3	0.6	3	10.00	3	5.33	2	50.05	3	20.14
443	80	0	0	0	0	2	1	3	0.6	3	4.00	3	3.33	2	6.44	3	20.19
687	113	0	1	0	0	1	2	4	0.8	3	9.00	3	4.33	3	2.17	4	16.45
202	163	0	0	1	1	1	2	5	1.0	5	10.20	5	6.00	5	29.03	3	39.44
699	96	1	1	0	1	1	2	6	1.2	6	10.17	6	5.33	6	23.78	5	19.01
163	180	7	0	0	0	0	0	7	1.4	6	9.50	6	3.83	4	4.48	6	20.58
418	97	4	0	1	2	0	0	7	1.4	7	10.86	7	4.14	7	13.50	7	24.37

Appendix C (Continued)

		Lawsuits filed															
		Year								Allegations				Duration in months			
				2001						Staff-related		Somatic		Residency		Lawsuit	
Facility	Available beds	1999	2000	5/15 – 10/5	All other months	2002	2003	Five-year Total	*M*	*N*	*M*	*N*	*M*	*N*	*M*	*N*	*M*
803	100	0	2	3	1	0	1	7	1.4	7	12.29	7	5.43	7	13.20	7	30.86
632	109	4	0	1	2	1	1	9	1.8	8	10.63	8	3.50	8	10.62	8	22.84
257	120	1	2	3	1	0	3	10	2.0	9	9.56	9	5.11	9	12.64	8	25.16
677	180	0	2	5	1	2	1	11	2.2	11	11.55	11	5.18	10	11.05	9	18.45
190	120	2	0	3	0	3	5	13	2.6	13	10.92	13	4.77	12	14.78	9	25.21
592	120	5	1	2	1	3	2	14	2.8	14	9.86	14	4.43	13	8.42	14	19.24
152	179	1	3	5	4	1	2	16	3.2	16	11.31	16	4.75	14	21.41	12	25.87
937	179	1	1	8	1	3	1	15	3.0	14	10.14	14	3.79	13	30.10	14	18.12
436	179	8	1	4	1	0	3	17	3.4	17	9.59	17	4.00	16	22.99	13	19.59
582	120	3	3	5	2	1	4	18	3.6	16	9.56	16	5.69	16	30.93	14	24.43
628	120	0	3	9	1	1	4	18	3.6	18	10.67	18	4.72	18	20.18	18	20.03
950	120	1	3	8	3	1	2	18	3.6	17	11.41	17	3.82	16	19.66	15	29.70
682	117	1	0	8	0	3	7	19	3.8	19	11.16	19	5.21	19	8.05	15	25.61
952	120	1	3	8	1	2	4	19	3.8	17	9.47	17	5.59	16	24.13	15	30.32

Appendix C (Continued)

		Lawsuits filed															
		Year								Allegations				Duration in months			
				2001						Staff-related		Somatic		Residency		Lawsuit	
Facility	Available beds	1999	2000	5/15 – 10/5	All other months	2002	2003	Five-year Total	*M*	*N*	*M*	*N*	*M*	*N*	*M*	*N*	*M*
193	120	5	2	7	1	1	5	21	4.2	21	12.00	21	4.52	20	10.11	20	22.33
390	240	5	1	8	3	3	1	21	4.2	21	10.14	21	5.05	18	15.61	17	26.78
901	120	5	5	6	3	3	0	22	4.4	22	10.36	22	5.45	21	14.02	19	27.18
171	120	2	2	5	6	3	5	23	4.6	22	11.23	22	4.36	22	10.34	21	26.75
486	150	3	4	9	2	3	4	25	5.0	25	9.76	25	4.80	24	28.31	22	25.77
199	120	6	6	7	0	5	4	28	5.6	28	9.79	28	4.50	28	10.65	26	20.41
804	120	7	4	8	4	6	5	34	6.8	34	10.97	34	4.32	34	11.69	29	28.02
806	240	5	6	9	4	3	7	34	6.8	33	9.85	33	4.64	31	17.74	28	24.91
873	266	8	9	6	6	2	4	35	7.0	35	10.69	35	4.94	32	25.03	34	26.77
703	174	13	6	12	2	1	8	42	8.4	42	11.55	42	4.76	41	27.77	42	24.31
Total		101	76	160	57	58	94	546									
M	136.5[b]	3.1	2.3	4.8	1.7	1.8	2.8	16.6	3.3		10.48		4.69		18.13		24.66

Note. Shaded cells indicate facility was nonoperational during all or part of the study period.
[a]Facility had no lawsuit activity during study period and is not included in calculations. [b]Does not include beds for facilities nonoperational during all of the study period

Appendix D

IRB Approval

November 7, 2006

Deborah K. Hedgecock, AS, BA
Larry Schonfeld, PhD
School of Aging Studies
MHC 1422

RE: **Exempt Certification** for IRB#: 105116
Title: *A Study of the Preliminary Impact of 2001 Florida Tort Reform on Nursing Facility Litigation in One County*

Dear Ms. Hedgecock and Dr. Schonfeld:

On October 31, 2006, the Institutional Review Board (IRB) determined that your research **meets USF requirements and Federal Exemption criteria 4.** It is your responsibility to ensure that this research is conducted in a manner reported in your application and consistent with the ethical principles outlined in the Belmont Report and with USF IRB policies and procedures.

Please note that changes to this protocol may disqualify it from exempt status. It is your responsibility to notify the IRB prior to implementing any changes.

The Division of Research Integrity and Compliance will hold your exemption application for a period of five years from the date of this letter or for three years after a Final Progress Report is received. If you wish to continue this protocol beyond those periods, you will need to submit an Exemption Certification Request form at least 30 days before this exempt certification ends. If a Final Progress Report has not been received, the IRB will send you a reminder notice prior to end of the five year period; therefore, it is important that you keep your contact information current with the IRB Office. Should you complete this study prior to the end of the five-year period, you must submit a Final IRB Progress Report for review.

Please reference the above IRB protocol number in all correspondence to the IRB c/o the Division of Research Integrity and Compliance. In addition, we have enclosed an Institutional Review Board (IRB) Quick Reference Guide providing guidelines and resources to assist you in meeting your responsibilities when conducting human subjects research. **Please read this guide carefully.**

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-9343.

Sincerely,

Paul G. Stiles, J.D., Ph.D., Chairperson
USF Institutional Review Board

Enclosures: IRB Quick Reference Guide

Cc: Trudy Wittenberg, USF IRB Professional Staff

SB-EXEMPT-0602

Appendix E

Descriptive Statistics for Filing Year Data

Analysis found that on average lawsuits were not filed until 15.5 months after the end of a resident's nursing facility stay (range six days to 49.2 months). For example a typical lawsuit filed in June of 2001 would be based upon a nursing facility stay that ended in March of 2000. This major caveat must be taken into account when reviewing findings in this section. It should not be assumed that documented allegations reference the year in which a lawsuit was filed or are reflective of any tort reform effects in that year, but, rather simply describe the content of lawsuits filed at that time.

If omnibus tests indicated significant differences between years, additional two-way contingency tables and chi square tests of independence were performed on independent pairs of years. If *F* tests indicated overall significance, follow-up tests were conducted to evaluate pair-wise differences between means. If tests of homogeneity of variance were non-significant indicating that the variances between years were similar, Tukey post hoc means differences' results were examined. If variance homogeneity was significant, Dunnett's C tests were used instead since this pair-wise comparison test is based on unequal variances between groups.

Extent of Lawsuits

The mean for lawsuits filed per year for the five-year study period was 109.2 (SD = 62.5). More lawsuits were filed in 2001 than any other study year. In 2002, lawsuits decreased 73.3% from 2001 (N = 58). Post reform period findings based on

residency start dates reflect a decrease in lawsuits for the specific period, but total lawsuits filed yearly increased 62% in 2003 ($N = 94$) from 2002.

Lawsuit Elements

Residency Duration

The mean duration of nursing facility residencies that began between 1999 and 2003 are listed by year in Table E-1. Residencies beginning in 1999 were found to be significantly longer than stays beginning during 2000 through 2003. Overall differences between years in residency duration based on residency start dates was found to be significant, F (4, 252) = 11.28, $p < .001$. Lawsuit-associated residencies starting in 2000 ($N = 100$) were the greatest portion of all lawsuits filed during the research period.

Table E-1

Lawsuit Associated Nursing Facility Residency Duration Having Start Dates 1999 - 2003

		Range		Residency duration - months
Admission year	*N*	Days	Years	*M*
1999	71	2	4.21	12.4
2000	94	2	4.08	8.1
2001	59	1	1.51	3.7
2002	26	3	0.76	2.2
2003	3	1	0.22	1.1
	253		All years	7.6

Note. Only lawsuits having residency admission and discharge dates are included

Individual Defendants

Lawsuits filed in 2002 and 2003 were significantly more likely to include individual defendants than lawsuits filed in 2000 and 2001 (Table E-2). Lawsuits filed in

1999 were significantly more likely to add individuals as defendants than lawsuits filed in 2000.

Table E-2

Individuals Added As Defendants – Comparison of Filing Years 1999 – 2003

	1999				2002				2003			
	df	*N*	χ^2	*p*	df	*N*	χ^2	*p*	df	*N*	χ^2	*p*
1999					1	159	0.20	NS	1	195	2.70	NS
2000	1	177	6.28	.012	1	134	7.45	.006	1	170	14.50	.000
2001	1	318	3.20	NS	1	275	4.20	.041	1	311	14.38	.000
2002									1	152	0.93	NS

Note. NS = non-significant.

Lawsuit Proceedings

Significant differences were found between years in lawsuits filing punitive damages motions (Table E-3). In 2003, there was a decrease of approximately 35% in the proportion of lawsuits filing motions for punitive damages compared to 1999 and 2000. Filing years were also significantly different in the numbers of lawsuits documenting the granting of punitive damages motions, with the smallest proportion of lawsuits noting the granting of such motions occurring in lawsuits filed in 2002 and 2003. Between 1999 and 2003 there was a decrease in documented granted punitive damages motions of approximately 24%. No lawsuits filed in 1999 and 2000 documented motions to enforce settlements, but 10.2% of lawsuits filed in 2001 did, a significant difference.

Table E – 3

Punitive Damages and Settlement Enforcement Proceedings by Filing Year

Action	1999 *N* = 100		2000 *N* = 76		2001 *N* = 213		2002 *N* = 56		2003 *N* = 89		Difference between years	
	N	%	*N*	%	*N*	%	*N*	%	*N*	%	χ^2	*p*
Punitive damages motion filed	44	44.4	35	46.1	45	21.1	12	21.4	9	10.1	46.54	.000
Punitive damages motion granted	28	28.3	13	17.1	24	11.3	6	10.7	4	4.5	25.77	.000
Motion to enforce settlement filed	0	0.0	0	0.0	19	10.2	4	7.7	1	1.4	22.38	.000

Charges

Significant differences between filing years in all lawsuit charges except loss of consortium and "other" category charges are identified in Table E-4. Use of combined wrongful death and negligence survival damage claims decreased significantly in 2002 and 2003 from 2000 and 2001. The use of wrongful death charges in 2002 and 2003 did not decrease to 1999 levels, but was significantly lower during those years compared to 2000 and 2001. Negligence survival charges were documented less in 2003 than any other filing year in the study. Documented use of breach of fiduciary duty charges found 33.3% of all such charges filed in 2003, even more frequently than in 2001 with its greater number of filed cases. Misleading advertising claims were documented more in 1999 than any other filing year.

Vicarious liability charges were documented less in 2003 than any other filing year in the study with the greatest percentage of cases incorporating this charge filed in 1999. Of all Chapter 400 residents' rights charges, 40.5% were filed in 2001. The lowest

percentage of Chapter 400 claims occurred during 2003 and all lawsuits filed in 2000 contained this charge.

In 2003, the use of negligence charges based on SB 1202 definitions constituted 69.2% of all lawsuits documenting this charge. The remainder of lawsuits using this charge was filed in 2002. Increased use of this charge was expected after 2001 Fla. Laws ch. 45 went into full effect October 6, 2001.

Table E – 4

Lawsuit Charges by Filing Year (N = 534)

	1999		2000		2001		2002		2003			
	N = 100		*N* = 76		*N* = 213		*N* = 56		*N* = 89			
Charge	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	χ^2	*p*
Chapter 400 residents' rights violations	95	95.0	76	100.0	210	98.6	54	96.4	83	93.3	9.94	.042
Wrongful death	41	41.0	50	65.8	136	63.8	23	41.1	46	51.7	23.02	.000
Negligence survival	58	58.0	49	64.5	122	57.3	30	53.6	36	40.4	11.22	.024
Wrongful death and negligence survival	38	38.0	40	52.6	109	51.2	18	32.1	29	32.6	16.12	.003
Negligence – common law, per se	39	39.0	29	38.2	89	41.8	17	30.4	50	56.2	11.30	.023
Vicarious liability	58	58.0	30	39.5	54	25.4	17	30.4	17	19.1	43.32	.000
Breach of fiduciary duty	9	9.0	12	15.8	29	13.6	10	17.9	30	33.7	24.14	.000
Negligence - lethal	1	1.0	0	0.0	7	3.3	4	7.1	34	38.2	121.34	.000
Negligence – medical	3	3.0	1	1.3	25	11.7	5	8.9	3	3.4	15.84	.003
Loss of consortium	5	5.0	2	2.6	10	4.7	2	3.6	2	2.2	1.66	NS
Other	1	1.0	5	6.6	10	4.7	1	1.8	3	3.4	4.95	NS
Negligence according to SB 1202	0	0.0	0	0.0	0	0.0	4	7.1	9	10.1	37.02	.000
Misleading advertising	5	5.0	2	2.6	0	0.0	1	1.8	1	1.1	10.87	.028

Note. NS = non-significant.

Medical negligence charges were used significantly more in 2001 (67.6% of all such charges) than any other filing year. Lawsuits filed in 2003 documenting lethal negligence charges constituted 73.9% of all lawsuits claiming this charge during the study period. Significantly more lawsuits filed in 2003 documented use of common law negligence than other filing years, including 2002 which had the lowest documented use of this charge.

Each study filing year was analyzed to identify the five leading lawsuit charges. After all years were compared and duplicate charges combined, vicarious liability, combined wrongful death and negligence survival damage claims, common law negligence, wrongful death, negligence survival, lethal negligence, and breach of fiduciary duty were identified as the seven leading charges for the study period. These charges have been sorted according to 1999 rankings in Table E-5. Chapter 400 residents' rights claims were the leading charge each year, ranging from a high of 100% in 2000 to 93.3% in 2003, and are not displayed.

Leading charges in 2003 differed from previous filing years, eliminating combined wrongful death and negligence survival claims and vicarious liability as leading charges, and adding lethal negligence and breach of fiduciary duty. Increased use of lethal negligence charges may be due to the inability under tort reform measures to file combined wrongful death and negligence survival damage claims, and used with the intent of applying a possible greater level of legal injury accountability. The increased use of breach of fiduciary duty may be based on attorney attempts to place financial responsibility for plaintiffs' charges on business entities associated in any way with and that may be more financially solvent than the defendant nursing facility.

Table E – 5

Leading Five Lawsuit Charges, Excluding Chapter 400 Residents' Rights Claims, per Filing Year

	1999		2000		2001		2002		2003	
Charge	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%
Negligence survival	1	58.0	2	64.5	2	57.3	1	53.6	3	40.4
Vicarious liability	1	58.0	4	39.5	5	25.4	4	30.4		19.1
Wrongful death	3	41.0	1	65.8	1	63.8	2	41.1	2	51.7
Common law negligence	4	39.0	5	38.2	4	41.8	4	30.4	1	56.2
Combined wrongful death & negligence survival damage claims	5	38.0	3	52.6	3	51.2	3	32.1		32.6
Breach of fiduciary duty		9.0		15.8		13.6		17.9	5	33.7
Lethal negligence		1.0		0.0		3.3		7.1	4	38.2

% = Percentage of lawsuits containing charge.

Allegations

Somatic

Initial omnibus two-way contingency table analyses found there were significant mean differences between years in six somatic allegations (Table E-6). Approximately 41% of all lawsuits alleging urinary tract infections were filed in 2002 and 2003 with an average of 36.8% of lawsuits filed each of these years compared to an average of 17.9% for 1999, 2000, and 2001 documenting this allegation (not shown). Contracture allegation documentation reached a high in 2002. Approximately 48% of all sepsis or septicemia allegations were filed in 2001. However, 2002 had the greatest percentage of filed cases documenting this allegation, significantly more than 1999. All other filing years had significantly larger proportions of lawsuits alleging dehydration than 1999 had. Individual pair-wise comparisons found that documented allegations of pressure ulcer or wound infection increased significantly in 2003 over every other filing year except 2000.

Lawsuits documenting pressure ulcers and falls decreased significantly in 2003 from 1999 and 2000.

Lawsuits alleging "other" somatic charges significantly increased from 1999 in 2001, which could be expected with the influx of filed cases that year. Continued increases in documented use of this allegation were seen in 2002 and 2003, which significantly increased over 2000 as well as 1999.

Staff-Related

Initial omnibus tests indicated there were significant differences between years in all but four staff-related allegations noted in lawsuits (Table E-6). The four allegations in which no significant differences were found between years were failure to carry out physician's orders, failure to question seemingly ill-advised physician orders, physician failed to act, and illegal resident transfer or discharge.

Individual pair-wise comparisons found all filing years had significantly larger proportions of lawsuits alleging an unsafe environment than 1999 did. All filing years significantly increased over 1999 levels in allegations of medication errors or mismanagement as well. However, all filing years decreased significantly from the 1999 proportion of lawsuits documenting failure to provide materials or devices.

A significantly larger percentage of lawsuits filed in 2003 contained allegations of delays in the provision of care than any other study filing year. Allegations of resident abuse in lawsuits filed in 2003 increased significantly over 2000, 2001, and 2002. The 2003 proportion of lawsuits having this allegation was lower than the 1999 level, but the difference was not significant.

Lawsuits filed in 2003 contained significantly fewer failure to protect from abuse as defined in Fla. Stat. § 415 allegations than other filing years in the study. Lawsuits filed in 2003 also significantly decreased from all other filing years in the documentation of resident abuse with resident neglect in the same lawsuit. Allegations of resident neglect significantly decreased in 2003 from 2000, 2001, and 2002. The 2003 proportion of lawsuits containing this allegation decreased from the 1999 level as well, but the difference was not significant. Lawsuits filed in 2003 also contained significantly fewer allegations of failure to notify family of significant changes than other study filing years. Allegations of failure to develop, implement or update care plan significantly decreased in 2003 from all other study filing years as well,

Lawsuits filed in 2002 and 2003 documented significantly fewer allegations of failure to protect from foreseeable harm than lawsuits filed in 1999 and 2003. Lawsuits filed in 2002 and 2003 also contained significantly fewer allegations of inaccurate or inconsistent records than 1999, 2000, and 2001.

Table E – 6

Allegations by Filing Year (N = 534)

	1999			2000			2001			2002			2003				
	N = 100			*N* = 76			*N* = 213			*N* = 56			*N* = 89				
Allegation	Rank	*N*	%	Rank	*N*	%	Rank	*N*	%	Rank	*N*	%	Rank	*N*	%	χ^2	*p*
Somatic																	
Worsening, aggravation of existing condition	1	82	82.0	1	69	90.8	1	182	85.4	1	42	75.0	1	79	88.8	8.13	NS
Pressure ulcer	2	69	69.0	2	47	61.8	2	125	58.7	3	34	60.7	2	54	60.7	3.13	NS
Fracture, other injury while residing	3	46	46.0	6	37	48.7	4	103	48.4	6	31	55.4	6	44	49.4	1.31	NS
Multiple falls	4	46	46.0		34	44.7	6	93	43.7	5	32	57.1		35	39.3	4.69	NS
Malnutrition, excessive weight loss	5	43	43.0	3	46	60.5	5	102	47.9	2	35	62.5	4	46	51.7	9.13	NS
Pressure ulcer or wound infection	6	42	42.0	5	39	51.3		82	38.5		19	33.9	3	51	57.3	13.12	.011
Pressure ulcers & falls		31	31.0		24	31.6		26	12.2		12	21.4		13	14.6	23.83	.000
Dehydration		27	27.0	4	44	57.9	3	106	49.8	4	34	60.7	5	45	50.6	24.78	.000
Other		19	19.0		17	22.4		69	32.4		18	32.1		38	42.7	15.36	NS
Contractures		11	11.0		12	15.8		55	25.8		16	28.6		16	18.0	12.81	.012
Urinary tract infection		10	10.0		15	19.7		51	23.9		21	37.5		32	36.0	23.96	.000
Sepsis/septicemia		6	6.0		12	15.8		35	16.4		12	21.4		8	9.0	11.16	.025
Amputation		6	6.0		6	7.9		7	3.3		4	7.1		4	4.5	3.42	NS
Skin tears		4	4.0		5	6.6		22	10.3		7	12.5		8	9.0	4.99	NS

Table E – 6 (Continued)

	1999			2000			2001			2002			2003				
	N = 100			*N* = 76			*N* = 213			*N* = 56			*N* = 89				
Allegation	Rank	*N*	%	Rank	*N*	%	Rank	*N*	%	Rank	*N*	%	Rank	*N*	%	χ^2	*p*
Gangrene		4	4.0		1	1.3		1	0.5		0	0.0		4	4.5	9.27	NS
Asphyxiation, aspiration, choking		2	2.0		3	3.9		13	6.1		2	3.6		8	9.0	5.52	NS
Single fall with injury		2	2.0		5	6.6		12	5.6		4	7.1		4	4.5	3.03	NS
Physical assault		2	2.0		0	0.0		2	0.9		0	0.0		0	0.0	3.88	NS
Fecal impaction		1	1.0		0	0.0		6	2.8		1	1.8		6	6.7	9.18	NS
Staffing -Related																	
Inadequate staff training, communication	1	93	93.0	2	71	93.4	4	192	90.1		41	73.2	3	68	76.4	26.19	.000
Inadequate, improper resident assessment•	2	92	93.9	4	69	90.8	3	199	93.4	3	46	82.1	1	85	95.5	10.38	.035
Privacy, dignity violations	3	91	91.0	4	69	90.8		187	87.8	2	50	89.3		62	69.7	24.26	.000
Inadequate staff numbers	3	91	91.0	6	66	86.8	6	191	89.7	5	44	78.6	6	63	70.8	22.83	.000
Care plan not developed, implemented, updated	5	90	91.8	1	73	96.1	2	202	94.8	1	52	92.9	5	64	71.9	43.36	.000
Inaccurate, inconsistent records•	5	90	91.8	2	71	93.4	1	204	95.8	4	45	80.4	3	68	76.4	32.86	.000
Failure to notify family of significant changes•		80	81.6	6	66	86.8		187	87.8	6	42	75.0		43	48.3	63.21	.000
Failure to protect from foreseeable harm•		75	76.5		34	44.7		77	36.2		15	26.8		27	30.3	61.00	.000
Inadequate preventative, custodial care•		71	72.4		65	85.5	4	192	90.1	6	42	75.0	2	75	84.3	18.83	.001
Abuse		56	56.0		23	30.3		141	66.2		39	69.6		45	50.6	34.70	.000

Table E – 6 (Continued)

	1999			2000			2001			2002			2003				
	N = 100			*N* = 76			*N* = 213			*N* = 56			*N* = 89				
Allegation	Rank	*N*	%	Rank	*N*	%	Rank	*N*	%	Rank	*N*	%	Rank	*N*	%	χ^2	*p*
Failure to provide materials, devices		55	56.1		12	15.8		62	29.1		18	32.1		17	19.1	43.55	.000
Failure to notify physician		40	40.0		12	15.8		90	42.3		28	50.0		41	46.1	22.75	.000
Failure to protect from abuse §415[•]		37	37.8		19	25.0		101	47.4		8	14.3		2	2.2	71.40	.000
Neglect		15	15.0		15	19.7		96	45.1		11	19.6		6	6.7	65.02	.000
Neglect with abuse[2]		15	15.2		8	10.5		79	37.1		5	8.9		0	0.0	70.94	.000
Failure to carry out physician's orders		14	14.0		10	13.2		28	13.1		12	21.4		18	20.2	4.44	NS
Unsafe environment[•]		12	12.2		40	52.6		132	62.0		21	37.5		54	60.7	75.54	.000
Medication errors, mismanagement		9	9.0		35	46.1		115	54.0		23	41.1		27	30.3	62.37	.000
Illegal transfer, discharge		5	5.0		4	5.3		5	2.3		0	0.0		1	1.1	6.15	NS
Delays in care provision		4	4.0		8	10.5		56	26.3		12	21.4		38	32.2	49.07	.000
Physician's orders unquestioned (seem ill-advised)		2	2.0		0	0.0		0	0.0		1	1.8		0	0.0	7.34	NS
Physician fails to act		1	1.0		0	0.0		1	0.5		0	0.0		0	0.0	1.93	NS

Note. NS = non-significant.

[•] For filing year 1999, 98 lawsuits were available from which to compile this variable.

[2]For filing year 1999, 99 lawsuits were available from which to compile this variable.

The six leading somatic and staff-related allegations for each filing year are marked accordingly in Table E-6 that is sorted according to 1999 rankings. Worsening or aggravation of an existing condition was the most frequently documented somatic allegation for each filing year, followed by pressure ulcers each year except for 2002. During that year, the second most documented somatic allegation was malnutrition or excessive weight loss.

As noted previously, allegations of dehydration were greater each year than in 1999 during which it did not rank in the leading six allegations. In 2003 this allegation ranked fifth in frequency. Pressure ulcer or wound infection ranked third in 2003 and was documented significantly more that year than other filing year except 2000 as also noted previously. No other significant differences were noted between years in leading somatic allegations.

The greatest proportion of lawsuits documenting inadequate, improper resident assessment occurred in 2003 and ranked as the leading allegation that year. Inadequate preventative or custodial care which had not ranked at all in 1999 or 2000 and was sixth in 2002, ranked second in 2003. Care plan not developed, implemented, updated ranked fifth in 2003, a significant decrease from all other years as noted previously.

Negotiation Strategies

Two-way contingency tables and chi square tests of independence were used to examine differences between mediation or arbitration use and filing years. Arbitration, mediation, and settlement proposal data are displayed in Table E-7. The percentage of lawsuits attempting arbitration increased significantly in lawsuits filed in 2003. Conversely, documented mediation use decreased significantly, with the smallest

percentage of lawsuits documenting mediation (34.8%) occurring in 2003 compared to other filing years. Of lawsuits documenting mediation use, 23.5% of 2001 cases (N = 213) resulted in full settlements and 33.9% of 2002 lawsuits (N = 56) resulted in impasses, larger proportions than any other study years. Although the percentage of lawsuits documenting settlement proposals increased in 2002 and 2003 over other filing years, the increase was not significant. Plaintiffs were significantly more likely to offer settlement proposals in 2003 than any other filing year.

Table E – 7

Negotiation Methods by Filing Year (N = 534)

	1999		2000		2001		2002		2003			
	N = 100		*N* = 76		*N* = 213		*N* = 56		*N* = 89			
Action	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	χ^2	*p*
Arbitration attempt	1	1.0	1	1.3	39	18.3	7	12.5	22	24.7	37.76	.000
Mediation use	53	53.0	53	69.7	148	69.5	35	62.5	31	34.8	36.64	.000
Mediation extended or waived	0	0.0	1	1.3	69	32.4	10	17.9	9	10.1	73.64	.000
Mediation outcome – fully settled	15	15.0	11	14.5	50	23.5	6	10.7	10	11.2	10.49	.033
Mediation outcome – impasse	11	11.0	19	25.0	52	24.4	19	33.9	10	11.2	19.14	.001
Settlement proposal - either party	22⬩	22.2	15	19.7	42	19.7	16	28.6	22	24.7	2.67	NS
Defendant proposed settlement	16⬩	16.2	11	14.5	27	12.7	9	16.1	5	5.6	5.86	NS
Plaintiff proposed settlement	4⬩	4.0	4	5.3	10	4.7	4	7.1	13	14.6	11.86	.018

Note. NS = non-significant.

⬩For 1999 *N* = 99.

Greatest use of mediation was found in lawsuits filed in 2002 and the most settlement proposals per lawsuit occurred in cases filed in 2003 (Table E-8). Overall, there were no significant differences between years in either variable.

Table E – 8

Mediation Usage and Settlement Proposals per Lawsuit by Filing Year

	1999			2000			2001			2002			2003				
	N = 100			*N* = 76			*N* = 213			*N* = 56			*N* = 89				
Action	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*F*	*p*
Mediation usage	53	1.08	0.33	53	1.04	0.19	148	1.12	0.40	35	1.26	0.56	31	1.03	0.18	.052	NS
Settlement proposals	22	1.36	0.66	15	1.40	0.83	42	1.83	1.55	16	1.88	1.26	22	1.91	1.48	.463	NS

Note. NS = non-significant.

Duration

Lawsuits filed in 2001 had the shortest mean interim from residency ending date until filing date (14.4 months). The longest interim between these dates was 17.6 months and occurred in 2000, followed by 16.4 months for lawsuits filed in 2003. Differences between years were not found to be significant. Significant differences were found between years in lawsuit duration based on dismissal and settlement dates, interim from opening date until punitive damages motions filed, interim between settlement dates and dismissal dates, and interim between jury trial order dates and settlement dates.

Based on dismissal dates, the duration of lawsuits filed in 2003 ranged from 3.4 to 8.1 months shorter than those filed in 1999, 2000, and 2001, a significant difference (Table E-9). Lawsuit duration based on settlement dates found cases filed in 2003 significantly shorter than cases filed in 2001, 16.0 versus 24.3 months respectively. The time difference between settlement and dismissal dates increased significantly in lawsuits

filed in 2003 over cases filed in 1999 and 2000. Motions for punitive damages were filed significantly later in lawsuits filed in 2001 than they were in lawsuits filed in 1999 and 2002. The interim between court-ordered jury trial dates and settlement dates decreased significantly in 2001 and 2003 from 1999.

Table E – 9

Impact of Motions on Lawsuit Duration by Filing Year (N = 534)

	1999			2000			2001			2002			2003			Differences between years	
	N = 100			*N* = 76			*N* = 213			*N* = 56			*N* = 89				
Time period	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*F*	*p*
Duration																	
Based on dismissal date	99	23.85	13.78	74	26.65	14.61	191	28.60	14.05	55	22.16	11.18	78	20.46	10.94	6.72	.000
Based on settlement date	68	21.23	13.52	43	24.31	14.16	106	24.31	11.05	22	18.79	10.19	19	15.97	7.21	2.95	.021
Interim																	
Lawsuit filing and punitive damages motion	38	12.01	9.54	31	15.29	11.94	42	20.87	11.10	13	11.73	3.85	9	16.54	6.18	4.50	.002
Punitive damages motion and settlement date	24	10.90	9.59	24	10.98	10.12	22	13.17	7.75	7	13.24	9.34	2	16.59	9.17	0.40	NS
Granted punitive damages motion and settlement	26	13.46	11.11	16	12.83	10.85	24	10.88	6.03	9	11.05	6.46	2	7.80	0.28	0.42	NS
Settlement date and court dismissal date	68	2.53	4.11	43	2.90	3.70	103	3.94	4.64	22	4.71	4.90	19	6.77	5.94	4.05	.003
Lawsuit filing date and jury trial order date	36	19.14	15.51	29	20.39	14.09	50	24.89	11.28	14	16.22	7.93	15	18.67	8.77	2.03	NS
Jury trial order date and settlement date	29	5.54	3.18	19	4.52	2.17	30	3.48	2.07	7	4.35	2.96	6	1.90	1.77	3.84	.006
Jury trial order date and dismissal date	36	7.83	4.33	28	8.25	5.06	49	7.28	4.49	14	9.47	7.42	11	6.87	4.49	0.70	NS

Note. NS = non-significant.

Lawsuit Outcomes

Analyses of variance were used to determine means for settlement proposals, total settlements, and attorney fees and costs, Medicare and Medicaid liens, other payout, and net to plaintiff amounts for filing years. Tukey post hoc pair-wise comparison tests were conducted to compare means differences between years. Initial omnibus tests found no significant differences between study years in all variables, except attorney costs (Table E-10). However, ANOVAs comparing individual filing years found that 2003 was significantly lower than 1999 in mean total settlements, F (1, 14) = 7.97, p =.014, and attorney fees, F (1, 14) = 4.79, p = .046 (not shown). Differences between 1999 and 2002 included total settlements being significantly lower in 2002, F (1, 16) = 5.03, p = .039, but attorney costs being significantly higher that year, F (1, 5) = 58.92, p = .001 (not shown). The mean net to plaintiff in 2002 was significantly lower than 2000, F (1, 2) = 20.22, p = .046 (not shown). However, there was only one lawsuit in 2002 compared with three in 2000. Significantly lower means were found in 2003 than in 2000 in the following: total settlement, F (1, 6) = 13.25, p = .011, attorney fees, F (1, 5) = 9.28, p = .029 (not shown). Attorney costs were again significantly higher in 2002 than 2001, F (1, 6) = 6.20, p = .047 (not shown). Although only one case noting attorney costs was found in 2002, the $33,089 figure was the highest attorney cost amount reported for the entire study period (N = 19).

Table E – 10

Settlement Proposal, Total Settlement, and Payout Amounts by Filing Year(Thousands of Dollars)

	1999			2000			2001			2002			2003				
Variable	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*F*	*p*
Proposal $	8	338.25	267.42	7	317.86	318.43	9	279.17	193.04	3	135.00	99.62	4	102.50	102.83	0.983	NS
Total settlement $	12	466.75	250.10	4	348.25	97.36	16	413.76	509.53	6	197.65	215.72	4	98.18	96.97	1.169	NS
Attorney fees	13	177.86	101.52	4	141.43	36.22	14	171.06	177.24	6	79.06	86.29	3	43.50	49.62	0.321	NS
Attorney costs	6	12.61	2.47	3	17.01	4.65	7	14.88	6.84	1	33.09	---	2	10.82	9.58	3.206	.046
Medicare liens	1	0.78	---	2	6.86	5.70	5	9.75	6.66	0	---	---	2	13.81	1.68	1.183	NS
Medicaid liens	3	8.59	13.81	1	3.28	---	3	3.50	4.19	0	---	---	2	0.17	0.07	0.368	NS
Other settlement payouts	2	149.46	95.39	1	29.26	---	3	10.85	2.34	1	2.42	---	0	0.00	0.00	2.970	NS
Net to plaintiff	7	267.58	153.06	3	145.69	22.17	7	155.54	92.96	1	30.58	---	2	59.94	66.11	2.132	NS

Note. NS = non-significant.

ABOUT THE AUTHOR

Deborah K. Hedgecock graduated summa cum laude in 1999 receiving a Bachelor's Degree in Psychology from the University of South Florida and entering the Ph.D. in Aging Studies program at USF the same year. Deborah was an instructor for The Life Cycle undergraduate course. She was also a graduate research assistant, working as a lead investigator for the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature and was a co-principal investigator for the Florida Nursing Home Litigation and Liability Insurance Survey conducted for the Florida Health Care Association and Florida Association of Homes for the Aging.. She is the principal author of one report and one article and the coauthor of six articles. She has made several presentations on nursing facility litigation at national conferences of the Gerontological Society of America and spoken at The Florida Conference on Aging, and the Society of Certified Senior Advisors.