

EXPERT'S REPORT

of the

CD INCIDENT

By:

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July 2, 2010

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A. INTRODUCTION

While riding as a passenger in a Mercedes SUV, CD, a 55 year old man, sustained multiple orthopedic and cognitive injuries as the result of a motor vehicle accident on 8/19/05 in Brooklyn, NY.

Robson Forensic, Inc. was asked to determine if the continuum of services recommended for CD's care are reasonable.

B. MATERIALS AVAILABLE FOR REVIEW

1. Verified Bill of Particulars
2. 2nd Supplemental Verified Bill of Particulars, 10/26/06
3. 3rd Supplemental Verified Bill of Particulars, 10/31/06
4. 4th Supplemental Verified Bill of Particulars, 7/23/08
5. HB; report 7/22/09; expert exchange 9/21/09
6. Dr. D.; report 11/19/08; expert exchange 10/13/08
7. Dr. .F; report 10/08/08
8. Dr. G.; expert exchange 10/13/08
9. Dr. K; report 06/20/09, expert exchange 9/21/09
10. Dr. A; expert exchange 10/13/08
11. Dr. L.; reports 7/30/09, 12/21/07, expert exchange 9/21/09, 12/21/07
12. Dr. P.; report 2/26/09, expert exchange 3/02/09
13. Dr. F.; report 10/28/08, expert exchange 10/13/08
14. Dr. R.; report 10/31/08, expert exchange 10/13/08
15. Medical records from Broward General Medical Center
16. Medical records from Cleveland Clinic, Part 1 & 2
17. Medical records from Professional Ortho & Sports Physical Therapy
18. Medical records from North Shore University Hospital
19. Medical records from MF, MD
20. Medical records from Neurological Specialties of Long Island
21. Medical records from Orlin & Cohen Orthopedic Associates
22. Dr. G. records

- 23. Medical records from University Optometric Center records
- 24. Dept of Treasury, Plaintiff's Income Tax records
- 25. Dr. H.; report
- 26. Medical records from Henderson Mental Health Center

C. BACKGROUND

On 3/18/05, CD brought his car to Maces garage in Brooklyn, N.Y. for servicing. Garage employee, JM, was in the process of driving CD to his office when the Mercedes SUV in which they were driving, collided with a postal service van. CD testified that he does not have a clear recognition of details of the event. North Shore University Hospital (NSUH) records indicate that the vehicle flipped over and CD was extricated with EMS assistance by crawling out of a window.

Medical

Following the accident, CD remained at NSUH for three days. He was treated for scalp lacerations (35 stitches) and right shoulder separation (grade III right acromioclavicular joint). He was discharged on 3/22/05, provided a sling for immobilization and prescribed outpatient physical therapy for range of motion exercises. CT scans of the brain, pelvis and spine were unremarkable.

Over the course of the next several months, CD complained of neck, back and shoulder pain and, of memory deficits, loss of concentration, attention deficits, dizziness, confusion, sleeplessness, and headaches. Within this time period, he underwent physical therapy, neurological, orthopedic and psychiatric evaluations. In November of 2005, he underwent right shoulder surgery and was treated post operatively with physical therapy. He was subsequently diagnosed with spinal injuries; cervical and lumbosacral herniations and discopathy. Neurologically, he was diagnosed with cervical radiculopathy, cerebral concussion and eventually, epilepsy. Treatment included physical therapy and medication. In March of 2006, after being evaluated psychiatrically, CD was diagnosed with depression and cognitive disorder, secondary to Traumatic Brain injury (Axis I), Traumatic Brain Injury with partial loss of consciousness, Post Concussion Syndrome (Axis III), and an inability to pursue work (Axis IV). Treatment for these conditions included psychotherapy with neurocognitive training and medication (stimulants, antidepressants and sedatives as needed). Between 2007 and 2009 CD attempted suicide three times by prescription drug overdose. After each attempt he was hospitalized and transferred to a psychiatric facility for short term care (approximately two weeks) before being discharged to home.

In December of 2008, further neurosurgical evaluation recommended a future option of back surgery to relieve nerve pressure and reduce low back pain.

Psychosocial

Although dates are inconsistent, CD immigrated to the United States between 2002 and 2003 from Israel settling in Queens, New York with his parents. His parents and younger sister had immigrated to the United States in 1986 and prior to the onset of injury, he describes frequent travel from Israel to New York during the years before his immigration. At the time of the accident, CD was residing with his parents in New York. Following the accident, his parents relocated to Florida to be near his sister. CD eventually followed them, relocating from New York to Florida as he reportedly was unable to live independently. He currently resides with his elderly parents who assist him in his activities of daily living and medication management. In December of 2007, he was determined mentally incapacitated to handle his own affairs and his younger sister, Ani, was appointed his legal guardian. CD's neurosurgeon, neuropsychiatrist and orthopedic surgeon remain in New York and he travels independently from Florida to New York for medical treatment. He reports that his sister helps him to make travel arrangements.

Vocational

As per the records reviewed, CD reports and his family corroborates, that while in Israel he graduated high school, earned a Bachelor's degree in Architecture and Interior Design from the University of Tel Aviv and served in the Israeli army for three years in an elite unit of the military. Following his military career, he was involved in several retail businesses in Israel. In his early twenties, for approximately six years, he owned and operated a retail clothing business. He later owned and operated an automobile import and rental business for approximately seven years. Prior to his relocation to New York, he reports owning and operating a computer school in Israel. CD also describes having invented a specialized computer desk (no patent as per documents reviewed) and the designing of a software program for interactive menu's which he sold to his partner.

Following his immigration to the United States, CD was employed in the real estate industry. At the time of injury, he was working at PGI Homes as a real estate agent in Brooklyn, New York. He had worked at this company since 2004. According to CD's deposition of 5/9/06 and his income tax statements, he had a reported income of \$50,691 in 2004 and; \$98,305 in 2005. Deposition revealed that an additional \$63,494 was earned in sales in 2005, but because closing dates were in 2006, they would be reflected in 2006 taxes, which were not available.

Following the motor vehicle accident, he attempted to return to real estate sales for a short time however, due to cognitive deficits in the form of memory loss, organizational and processing deficits, and diminished executive and critical thinking skills; he experienced difficulties performing his job duties and was unable to maintain this position. He has not worked in any capacity since that time.

D. CONDITIONS CLAIMED TO HAVE CAUSED THE INCIDENT

CD was a passenger in a car which collided with a postal van. According to documentation reviewed, he had no premorbid history of orthopedic or cognitive impairment. Medical reports indicate that his current physical, orthopedic and cognitive impairments were a direct result of the motor vehicle accident of 8/19/05.

E. ANALYSIS

In 2007, CD relocated from New York to Florida as he reports that he was no longer able to live independently. His treating doctors remain in New York. He travels independently to New York to receive care by his orthopedist, neurosurgeon and neuropsychiatrist (at most, once monthly). His medications are adjusted and prescribed by these doctors. According to his family, CD 's medications are monitored by his father and he requires verbal prompting for bathing, eating, waking and paying bills. Due to his physical and cognitive limitations, CD's father (age 77) assists him with many of his activities of daily living; laundry, grocery shopping, and cooking. His sister, who lives nearby, is his legal guardian and assists him in money management, travel plans, and answering emails.

The medical assessments and life care plan recommend a continuum of ongoing rehabilitative services for CD in the form of surgical interventions, day treatment, home care, medical and therapeutic intervention, ongoing evaluations and case management.

These services are as follows:

CATEGORY	SERVICE	PURPOSE	FREQUENC Y	DURATION
Surgical intervention	Cervical decompression	Relieve nerve pressure	1	N/A
	Lumbar Diskectomy	Reduce pain	1	N/A
Day Tx	TBI day program	Multidisc intervention	daily	1 year
Home Care	Home aide	Oversee personal care plan	16 hrs/day	24 yrs
	Skilled Nursing Care	Daily meds, assessment	8hrs/day	24 yrs
Medical Care	Neurologist	Monitor (M) Maintain (M), Improve (I)	3x/yr	26 yrs

	PM&R	M/M/I	1x/mo	26 yrs
	Psychiatrist	M/M/I	2x/mo	26 yrs
	Ortho surgeon	M/M/I	1-2/yr	26 yrs
Evaluations	Physical Therapy	Assess, strengthen	1x/yr	25 yrs
Treatment	Psych	Emotional support	2x/wk	1 yrs
	Psych	Emotional support	2x/wk	8 yrs (after TBI tx)
	Psych	Emotional supp	1x/wk	16 yrs
	Physical Therapy	Assess strengthen	1-2x/wk	24 yrs
	Neurofeedback	Cog rehab	2x/wk	3 yrs
Medications	Ambien	Sleep sedative		26yrs
	Naprosyn	Pain/inflation		26yrs
	Topamax	Anti- seizure		26 yrs
	Ritalin	Attention def		26 yrs
	Invega	Schizophrenia		26 yrs
	Pristiq	Antidep		26 yrs
	Buspirone	Anti-anxiety		26 yrs
Misc	Case Mngt/\$ mngt.		5-8hrs/mo	26 yrs

The continuum of care proposed by the life care plan is duplicative, excessive and does not meet the psychosocial needs of CD.

Psychological and home care recommendations for CD include long term care, however, the provider, duration and frequency vary. Medical recommendations by neuropsychologist, Dr. M. (6/20/09), report that “he will need weekly psychiatric care for the next 5 years and access to such care at least once a month for the rest of his life. He would benefit from psychiatric and neurocognitive day treatment programs, a home health attendant, visiting nurse, social worker and case manager” are needed in order for CD to manage his health and personal affairs.

As summarized in Mr. B.'s report, Dr. K.s report of 6/28/09, indicated that CD requires "an assisted living situation with a full time attendant seven days per week, 24 hours per day and a nurse 8 hours day", and twice weekly therapy sessions with a psychologist and psychiatric consultation once to twice a month for monitoring and prescribing medication.

Home Care

If CD were to remain in his home, supervision is required. However, the eight hours per day of skilled nursing care is unreasonable. According to the Occupational Outlook Handbook, 2010-2011 edition, a home based registered nurse provides medical intervention in the form of injections, device monitoring, medication administration, blood exchange services, feeding treatment and wound care. There is no medical or functional indication that daily skilled nursing intervention is warranted.

CDz does not require these services. A visiting skilled care nurse can provide medical monitoring on a once weekly or an as needed basis dependent upon CD's functioning status.

The eight hours per day of nursing services for twenty four years is unreasonable and unnecessary.

All services at this time are provided by his aged parent, a retired carpenter, who has no specific medical training. These services involve activities of daily living; laundry, cooking, grocery shopping, verbal prompting to initiate activity, assistance with personal finances and some assistance with travel. The only service that is at all medically related is medication monitoring. CD's father merely picks up the medication from the store, keeps it out of reach of his son, and monitors its distribution. He is not prescribing or administering it. This is a service that a home health care provider can perform. Although CD requires assistance in activities of daily living, it is minimal. He is able to travel from Florida to New York independently on a regular basis with assistance in travel planning from his sister, and is able to manage his personal hygiene (bathing, toileting, etc) and feed himself. The assistance he requires is during his waking hours.

If CD were to remain in his home, the services of a home health care aide sixteen hours per day with one hour per week of skilled nursing care is reasonable.

What must be considered however, is that in home care, not only are the added responsibilities placed on aging parents and a sibling who has her own family responsibilities, but there is an isolation and lack of structure that exists for CD in his family home. He currently engages in minimal activities; watching TV, reading and attending temple, when able. He has limited social interaction with others and merely maintains his existence. This isolation is counterproductive and provides an environment that allows him to dwell on his limitations rather than focus on adjusting to his current abilities. CD would be an appropriate candidate for a small group residential setting specific to individuals with head trauma that provides continuous services on a

twenty-four hour per day basis, seven days per week, to include supervision, community integration activities, medication monitoring, shuttle service to medical appointments and day programs. This alternative would support individual goal development, promote independent functioning and provide a sense of structure and belonging within a community in a structured environment. A home based residential facility, located within a reasonable distance from his parents and sister would support an improved quality of life for CD.

Treatment

CD's current psychiatric treatment plan is inconsistent and limited by geography. Since relocation to Florida sometime in 2007, he sees his treating doctor in New York on an inconsistent basis (at best, once monthly), receives intensive services in a hospital in Florida when in a crisis situation and is released to home. He then returns to a pattern of inconsistent treatment out of his geographical area, New York. It is apparent, through his three suicide attempts, that this method of treatment has not provided the therapeutic consistency that CD requires to enable him to develop coping strategies to deal with his physical and emotional challenges.

As recommended in his life care plan, CD requires therapeutic intervention to stabilize and maintain his condition; the question arises as to the frequency, duration and provider of these services. The proposed model recommends intensive psychiatric treatment twice weekly for one year, an intensive day treatment program for one year and then an additional eight years of continued intensive psychiatric services twice weekly. After medication management and a total of nine years of intensive psychiatric intervention and one year of intensive day treatment, psychiatric intervention will lessen to once weekly for sixteen years. Concurrent to this regiment, twice monthly sessions with a psychiatrist have been proposed for monitoring, maintenance and intervention of his condition. The proposal indicates that separate services are needed for the counseling psychiatrist and the monitoring psychiatrist. This appears to be a duplication of services as one psychiatrist can perform both of these duties.

Conceptually intensive therapy is designed to be short term and then, as the individual progresses, goals are set for greater independent functioning. It is unreasonable to assume that it would take approximately ten years to stabilize CD's psychiatric condition utilizing consistent twice weekly therapeutic sessions, intensive day treatment, twice monthly monitoring sessions with another psychiatrist, and medication. Once stabilized the life care plan reduces therapeutic intervention to once weekly sessions (sixteen years) and continues the twice monthly monitoring (twenty four years) by a psychiatrist.

The alternative to this recommendation is once monthly monitoring, maintaining and intervention by a psychiatrist for medication with twice weekly sessions with a psychologist or psychiatric social worker; either of whom would provide proficient care to promote therapeutic growth and stabilization and have the ability to communicate regularly with the psychiatrist. After completing one year each of intensive counseling and an intensive day treatment program, therapeutic counseling services can be

reduced to once weekly. It is reasonable to assume that after approximately one hundred therapeutic sessions and one year of intensive day treatment plus medication management, CD would have been provided the consistency needed to address his psychiatric condition, begin to develop the skills necessary to cope with his current situation and be able to maintain that functioning level with once weekly counseling for an extended period of time and continued psychiatric intervention once monthly. Once CD has developed appropriate coping mechanisms and a support system, it is also reasonable to assume that these sessions will reduce to twice monthly, with medication management and continued psychiatric maintenance once monthly. At that point he would still be receiving therapeutic intervention three times per month.

Tables 1 and 2, summarize the proposed and alternative care for CD based upon the life care assessment, medical documentation and rehabilitation counseling experience.

Table 1
Home Care

	SERVICE	FREQUENCY	DURATION
Proposed	Home Health Aide	16 hours/day	24 yrs
	Skilled Nurse Care	8hours/day	24 yrs
Alternative I	Home Health Aide	16/hours/day	24 yrs
	Visiting nurse	1hour/week	24 yrs
Alternative II	Residential home based facility	24/hours/day	24 yrs

Table 2
Psychiatric therapeutic treatment

	SERVICE	PROVIDER	FREQUENC Y	DURATION
		Psychiatrist	2x/month	26 yr
Proposed	Psych Treatment	Psychiatrist	2x/week	1 yr
		Psychiatrist	2x/week	8 yr
		Psychiatrist	1x/week	16 yr
Alternative	Psych Treatment	Psychiatrist	1x/month	26 yr
		Psychologist/ Psych SW	2x/week	1 yr
		Psychologist/ Psych SW	1x/week	8 yr
		Psychologist/ Psych SW	2x/month	16 yr

The United States Bureau of Labor statistics creates national estimates for occupations based upon average hourly and annual wages for each job classification and title and then further disaggregates this information into geographical areas. These estimates are calculated with data collected from employers in all industry sectors in metropolitan and non metropolitan areas in every State. CD currently resides in Weston, Florida. The cities closest to his residence are Fort Lauderdale (25 miles) and Miami (37 miles). Using these labor statistics, local data was gathered for the Fort Lauderdale and Miami areas. According to the most recent occupational employment statistics, May 2009, the national average hourly wage for a psychiatrist is \$ 78.68/hour. This wage increases locally to \$80.38/hour. A psychologist will earn a national average hourly wage \$40.49. The local average hourly wage for this same profession is \$45.00. Nationally, a clinical social worker earns an average hourly wage of \$34.77 and, \$33.64 locally. According to these labor statistics, a home health aide earns a national average hourly wage of \$10.39 with a local hourly wage of \$9.99. A registered nurse earns an average national hourly wage of \$31.99 and a local hourly wage of \$32.16. Table 3 summarizes these national and local wages.

Table 3
U.S. Bureau of Labor Statistics
Occupational Employment and Wages, May 2009

Profession	National average wage/hour	Local average wage/hour
Psychiatrist	78.68	80.38
Psychologist	40.49	45.00
Registered Nurse	31.99	32.16
Clinical Social Worker	34.77	33.64
Home Health Aide	10.39	9.99

Based upon information gathered from an adult home based residential care facility that targets services for individuals with traumatic brain injury in the Fort Lauderdale area, ResCarePremier.com, daily care costs which include on site supervision twenty four hours per day, seven days per week, medication management and community integration activities are approximately \$150/day.

F. FINDINGS

Within the bounds of reasonable technical certainty, and subject to change if additional information becomes available, it is my professional opinion that:

1. In order to be consistent with his needs, the home care plan of CD requires modifications.
 - a. CD's home care needs require supervision, medication monitoring and assistance with activities of daily living.
 - b. CD's home care needs can be met with the services of a home health aide or in a home based residential setting.
 - c. A home based residential setting would provide supervision and medication monitoring while allowing CD the opportunity for structure, socialization, community integration and increased independent functioning.
 - d. Based upon medical documentation and reported functional abilities, CD does not require skilled nursing care eight hours per day, seven days per week.

- e. Nursing oversight can be maintained on a once weekly or as needed visiting nurse basis.
2. The Psychiatric treatment plan requires modifications to adequately meet CD's needs.
 - a. CD's psychiatric condition requires consistent therapeutic care with local medical professional providers.
 - b. CD's weekly therapeutic counseling care can be provided by a psychologist or psychiatric social worker in conjunction with monthly intervention by a psychiatrist.
 - c. With consistent, intensive therapeutic intervention, it is reasonable to assume that CD would develop compensatory coping skills to address his psychiatric condition and subsequently reduce the frequency of his treatment sessions.
 3. The continuum of care proposed by the life care plan is duplicative, excessive and does not meet the psychosocial needs of CD.



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