Annual Educational Conference
Friday, June 5, 2026 | 8:30 am - 4:00 pm
City Winery - New York

**Program Handouts - Included in this packet are handouts approved for distribution by guest speakers.**

- TAB 1- Program Flyer
- TAB 2 -Registration List
- TAB 3- HANDOUT - Flourishing Clinicians, Safer Systems: The Hidden Risk Imperative in Modern Healthcare
  - Speaker: Dr. Michael (Mick) Krasner
- TAB 4 -HANDOUT - Unpacking Burnout in the ER: Its Impact on Physicians, Care Environment, and Potential Solutions
  - Speakers: Sasha Sagalovich, Dr. Lara Vanyo, Alison O'Dwyer / Moderator: Christie Nunn
- TAB 5-HANDOUT - Ripple Effects of Harm: Unmasking the 3rd and 4th Victims in Healthcare Safety
  - Speakers: Abdel Disomimba & Alison Thompsen
- TAB 6-HANDOUT - Let's Talk Success: Buy in or Burn Out
  - Speakers: Jenelle Arnao & Anne Huben-Kearney
- TAB 7-HANDOUT - Where Risk Really Lives: Improving Decisions, Communication and Outcomes
  - Speaker: Peggy Cooke
- TAB 8-HANDOUT - Unseen Impact: Identifying and Managing Vicarious Traums
  - Speakers: Carolyn Reinach Wolf & Elizabeth Eckhardt
- TAB 9-HANDOUT - Under Attack: Addressing Healthcare Workplace Violence and the SAVE Act
  - Speakers: Doreen Dufficy & Jennifer Yuen
- TAB 10-HANDOUT - The Hidden Risk No One is Managing
  - Speaker: Kiki Orski

**Continuing Education Credits:**

This program has been approved for 4.25 Continuing Education Credits by the American Society for Healthcare Risk Management (ASHRM). Certificates will be distributed within two weeks following the program.

This program is also under review by the New York State CLE Board for Continuing Legal Education credits. Approval typically takes several weeks. Once approval is received, CLE certificates will be distributed to all attending attorneys.

# TAB 1

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

**Annual Full-Day Conference & Reception**
**City Winery, NYC**
**Friday, June 5th, 2026**

www.ahrmny.com

8:30 am – 4:00 pm – Conference
4:00 pm – 6:30 pm – Reception

**CONFERENCE THEME:**
**Risks Associated with Human Capital and the Correlation with Patient-Centered Care**




Clinician well-being is a critical—and often overlooked—driver of safety, performance, and liability. Drawing on two decades of research and large-scale implementation, Dr. Krasner shows how burnout, moral distress, and the absence of psychological safety function as systemic risk factors with direct implications for patient outcomes and organizational exposure.

Strong policies don't prevent harm—alignment does. Kiki Orski exposes how unclear ownership, cross-functional disconnects, and inconsistent execution create hidden vulnerabilities across healthcare systems. Grounded in behavioral science, the session equips leaders to recognize misalignment and strengthen accountability across teams.

## KEYNOTE SPEAKERS



**Michael Krasner, MD**
**EmPRO Insurance Company**



**Kiki Orski, MBA, RN**
**Peak Performance Consulting**

## Hot Topic Breakout Sessions

- Burnout in Healthcare Risk Management Environments
- 3rd and 4th Victims Identified in Healthcare Safety
- Improving Decisions, Communication & Outcomes
- How Unmanaged Risk Undermines Performance
- Workplace Violence and the SAVE Act
- Mental Health and Wellness

**Networking Reception on the Pier Immediately Following Conference**

Register HERE

QUESTIONS - Contact us at:
ahrmny@gmail.com

# THANK YOU ANNUAL CONFERENCE SPONSORS

## PLATINUM SPONSORS

EMPRO INSURANCE

BPN
Barker Patterson Nichols
STATHATOS-FULGIERI, BRAVERMAN, CHRISOMALLIDES, SINGER, WEINSTOCK, COVITT, LAWLESS, MORALES

M2 LIABILITY SOLUTIONS
Representing MLMIC & MedPro Group
Berkshire Hathaway Companies

BBOC
BARBIERO BISCH O'CONNOR & COMMANDER LLP

TDC GROUP

## GOLD SPONSORS

FULLERTON BECK LLP
Defending healthcare providers in malpractice cases

COVERYS

SHAUB AHMUTY CITRIN & SPRATT

## SILVER SPONSORS

ALERAGROUP

FUMUSO CHRISTESEN LLP

HPM&B
HEIDELL, PITTONI, MURPHY & BACH, LLP

MCB
MARTIN CLEARWATER & BELL LLP

McALOON & FRIEDMAN, PC

RUBIN PATERNITI GONZALEZ RIZZO KAUFMAN

## BRONZE SPONSORS

BARTLETT LLP

HUB

kbr | KAUFMAN BORGEEST & RYAN LLP

WDLD
Wagner, Doman, Leto & Di Leo, P.C.

SCDWN
SCHIAVETTI, CORGAN, DiEDWARDS, WEINBERG & NICHOLSON, LLP

## EXHIBITORS

ABRAMS FENSTERMAN, LLP
ATTORNEYS AT LAW

PRAESIDIUM

SafeQual

# Program Agenda

CLICK HERE TO VIEW SPEAKER BIOS

## 8:30-9:15 Registration and Breakfast

Check in early, grab breakfast, and enjoy some time catching up with friends and colleagues.

## 9:15-9:40 Welcome & Announcements



Wilhemina Nyarko
AHRMNY President

Welcome attendees, guests speakers, and sponsors. A rundown of the day's agenda and opportunity to hear from a few of our sponsors.

## 9:40-10:30 MORNING KEYNOTE ADDRESS: Flourishing Clinicians, Safer Systems: The Hidden Risk Imperative in Modern Healthcare



Michael (Mick) Krasner, MD, FACP
Co-Chief Medical Officer and Vice President of Education
EmPRO Insurance Company

Professor Emeritus of Medicine
University of Rochester School of Medicine and Dentistry

This session distills the evidence linking clinician distress to communication failures, medical error, workforce loss, and rising costs – while highlighting how cultures of presence, teamwork, and meaning protect performance. Attendees will be encouraged to move beyond narratives that separate "well-being" from "system performance" and invites healthcare risk management leaders to widen their lenses: to see costs of burnout, the measurable benefits of psychologically safe and engaged teams, and how their own influence in shaping environments where clinicians and systems either struggle or thrive.

## 10:30-10:40 BREAK & TRANSITION TO MORNING BREAKOUT SESSIONS

# MORNING BREAKOUT SESSIONS

## 10:40-11:30 Unpacking Burnout in the Emergency Room: Its Impact on Physicians, the Care Environment, and Potential Solutions



Sasha Sagalovich, Esq.
Assistant Vice President
Gallagher Bassett



Lara Vanyo, M.D.
Assistant Professor of Emergency Medicine
Weill Cornell Medical College



Christie Nunn, Esq.
Assistant Vice President, Claims Counsel
Sompo



Alison O'Dwyer, Esq.
Partner
Fullerton Beck, LLP

Emergency medicine faces unparalleled pressure—leading all specialties in patient volume, acuity, and malpractice exposure—and consequently carries the highest rate of physician burnout. This panel will explore the key drivers of burnout in the emergency department and the impact on both clinicians and patients. Speakers will examine how burnout contributes to challenges in treatment, outline the current malpractice landscape, and discuss how emerging tools, including AI, can help reduce workload and improve well-being. The session will also highlight practical strategies such as mentorship and organizational support to strengthen resilience and promote physician wellness.

## 10:40-11:30 Ripple Effects of Harm: Unmasking the 3rd and 4th Victims in Healthcare Safety



Abdel Disomimba
BSN, MSH, Fisqua, CLSSGB, CPHQ, CPPS
Associate Director, Risk Management
NYCHHC / Harlem Hospial



Alison Thompsen, RN, MSN, CPHRM
Director, Risk Management
NYCHHC / Harlem Hospital

Harm in healthcare rarely stops with the patient. Adverse events quietly affect leaders, risk managers, and safety professionals who carry the emotional and operational weight of supporting both patients and staff. This session examines these often overlooked "third and fourth victims," showing how repeated exposure to harm can erode decision-making, strain teams, and weaken safety culture. Through real-world cases and emerging evidence, participants will explore the hidden burdens of safety work and learn practical strategies to protect, sustain, and empower those tasked with protecting others—reframing harm as a systemwide experience that demands compassionate, resilient leadership.

**11:30-11:40 BREAK & TRANSITION TO MID-MORNING BREAKOUT SESSIONS**

# MID-MORNING BREAKOUT SESSIONS

## 11:40-12:30 Let's Talk Success: Buy in or Burn Out



Jenelle Arnao, DHS, MS, CPHRM
Certified Risk Management Professional



Anne Huben-Kearney
DFASHRM, CPHRM, CPHQ, CPPS
Independent Risk and Patient Consultant

Midway through 2026, risk professionals continue to face rising adverse events, workforce strain, and persistent cybersecurity threats—all while 77% report emotional exhaustion. When risk leaders are depleted, incident investigations, claims management, and organizational protection suffer, increasing exposure to litigation and reputational harm. This session examines the key drivers of burnout and turnover among risk professionals and highlights evidence-based strategies to restore clarity, capacity, and influence—helping risk teams reclaim their value, voice, and vision.

## 11:40-12:30 Where Risk Really Lives: Improving Decisions, Communication and Outcomes



Peggy Cooke, JD
Founder
Peggy Cooke, LLC

Many patient-harm events stem not from system failures but from human ones—hesitation, silence, miscommunication, and rushed decisions. As evidence grows linking strong human capital to safer care, the risks tied to burnout and low psychological safety often remain hidden. This session positions human capital as a core risk variable and performance driver. Using a four-lever framework—mindset, communication clarity, influence, and decision discipline—we'll show how thinking under pressure and speaking up across hierarchy shape safety and outcomes. Participants will learn where human-driven risk emerges and how targeted investment yields better decisions, stronger collaboration, fewer errors, and improved patient results.

**12:30-1:30 LUNCH BREAK**

## 1:30-1:50 Annual Business Meeting / ASHRM Update

Annual election results will be announced, local chapter updates, ASHRM updates, and other announcements.

**1:50-2:00 BREAK & TRANSITION TO AFTERNOON BREAKOUT SESSIONS**

# AFTERNOON BREAKOUT SESSIONS

## 2:00-2:50 Unseen Impact: Identifying and Managing Vicarious Trauma



Carolyn Reinach Wolf, Esq.
Executive Partner
Abrams Fensterman



Elizabeth Eckhardt, LCSW, PhD
Director
Nassau County Bar Association's
Lawyer Assistance Program

Vicarious trauma can quietly build over time, affecting performance, decision-making, and overall wellness. This session will identify key red flags and walk through a comprehensive Wellness and Mental Health Toolkit that equips participants with strategies to protect their mental health and sustain meaningful work.

## 2:00-2:50 Under Attack: Addressing Healthcare Workplace Violence and the SAVE Act



Doreen Dufficy, Esq.
Partner
Barbiero, Bisch, O'Connor & Commander, LLP



Jennifer W. Yuen, Esq.
Partner
National Co-Chair of the Traumatic Brain Injury Practice
Lewis Brisbois

Workplace violence in healthcare has reached a crisis point, with clinicians five times more likely to be injured than workers in other industries—fueling burnout and worsening staffing shortages. This session reviews the current landscape of violence against healthcare workers and introduces the bipartisan Save Healthcare Workers Act (H.R. 3178/S. 1600), which would establish federal criminal penalties for knowingly assaulting or intimidating hospital personnel. We will also examine New York's recent requirements for enhanced workplace-violence prevention programs and their implications for risk managers. Attendees will leave with clear, actionable insight into emerging federal and state protections and how to strengthen institutional strategies for a safer, more sustainable work environment.

**2:50-3:00 BREAK & TRANSITION TO AFTERNOON KEYNOTE ADDRESS**

## 3:00-3:50 AFTERNOON KEYNOTE ADDRESS: The Hidden Risk No One is Managing



Kiki Orski, MBA, RN
President
Peak Performance Consulting

This keynote session challenges healthcare risk management and legal professionals to rethink where risk originates, shifting focus from policy gaps and compliance and compliance to the operational reality of misalignment. Most healthcare organizations have strong procedures in place. Preventable events happen anyway; not because people lack policies but because they lack alignment. Drawing on behavioral science and the Silo Solution framework, this session exposes the hidden cost of fractured ownership, cross-functional disconnects, and inconsistent execution across clinical, administrative, operational and legal teams.

**3:50-4:00 WRAP UP AND CLOSING REMARKS**

**4:00-6:30 NETWORKING RECEPTION**






### TICKET PRICES

$175 - Current AHRMNY Member
$225 - Nonmember
$200 - Conference/Membership Bundle
(Nonmembers that wish to join AHRMNY may purchase this ticket and receive a discount on their conference fee)

### FINANCIAL AID INFORMATION

Click here for AHRMNY's Financial Aid Policy

### CONTINUING EDUCATION CREDITS:

CEUs and CLEs for this program is pending review by the American Society for Health Care Risk Management and the New York State CLE Board.

### DIRECTIONS TO CITY WINERY NEW YORK

City Winery is located at 25 11th Avenue @ Pier 57, New York, NY 10011

From Bronx, Brooklyn, Queens, Penn Station, or Port Authority, take A, C, or E trains to 14th Street / 8th Avenue Station.

May also take the L train from Brooklyn and Union Square Station. Exit at 15th Street and head northwest on West 15th Street until 10th Avenue. Turn left on 10th Avenue and make 3 right turns and 1 left turn. City Winery will be on the right.

From Bronx, Brooklyn, Queens, Grand Central Station, Penn Station, or Port Authority, take 4, 5, 6, L, N, R and Q trains to 14th Street Union Square Station. Exit station and take M14D-SBS (Chelsea Piers) bus to 10th Avenue / W15th Street stop. Walk one block to 11th Avenue. City Winery will be on the right.

### NEARBY HOTELS RECOMMENDED BY CITY WINERY

Dream Downtown, 355 West 16th Street (near 9th Ave), New York NY 10011
Gansevoort, 18 Ninth Avenue (at 13th Street), New York, NY 10014
The Standard-High Line, 848 Washington Street, New York, NY 10014

Register HERE

### PARKING

Parking is available through MPG Parking at Pier 57. A 10% parking discount is available when booking online or on the APP - enter code Wine23 to apply discount. https://mpgparking.com/
There is also metered parking on the side streets along 14th-16th streets on 10th avenue going east.

# TAB 2

**AHRMNY Full-Day Annual Educational Conference**
**Friday, June 5, 2026 - 8:30 am - 4:00 pm**
**City Winery New York**

| First Name | Last Name | Title | Company |
|---|---|---|---|
| Miguel | Aballay | Senior Data Analyst | EmPRO Insurance Company |
| Tracy | Abramson | Partner | Barbiero Bisch O'Connor & Commander |
| Michelle | Acosta | Partner | Fumuso Christesen |
| Dawn | Adelson | Partner | Aaronson Rappaport Feinstein & Deutsch |
| Chitra | Anbalagan | Assistant Vice President | Gallagher Bassett |
| Jenelle | Arnao | Certified Risk Management Professional | |
| Philip | Artusa | Partner | Kaufman Borgeest & Ryan |
| Pascal | Babmatee | Claims Analyst | Catholic Health |
| Anthony | Barbiero | Partner | Barbiero Bisch O'Connor & Commander |
| John | Barous | Partner | Schiavetti Corgan DiEdwards Weinberg & Nicholson |
| Hugo | Basso | Partner | Fumuso Christesen |
| Betsy | Baydala | Partner | Kaufman Borgeest & Ryan |
| Katrine | Beck | Partner | Fullerton Beck |
| Eileen | Becker | Partner | Fullerton Beck |
| Noah | Becker | Director of Risk Management | New York City Health + Hospitals/Elmhurst |
| Melissa | Bedward | Clinical Risk Manager | Mercy Hospital-Catholic Health |
| Jaqueline | Berger | Partner | Martin Clearwater & Bell |
| Joseph | Bisch | Partner | Barbiero Bisch O'Connor & Commander |
| Sydney | Blumstein | Attorney | Schiavetti Corgan DiEdwards Weinberg & Nicholson |
| Mary | Boland | Senior Claims Examiner | FAIRCO (TransRe) |
| Jad | Bou Monsef, MD | Orthopedic Spine Surgeon / Assistant Professor | SUNY Downstate, Maimonides |
| Jeff | Brady | VP, Patient Safety & Risk | The Doctors Company |
| Michael | Brendel | VP Professional Liability | Sedgwick |
| Franz | Bruno | Supervisor, Claims & Litigation | Summit Health |
| Colleen | Buckley | Managing Partner | Shaub Ahmuty Citrin & Spratt |
| Julian | Buffa | Claims Director | Catholic Health |
| Courtney | Camacho | Clinical Risk Specialist | MCIC Vermont |
| Steph | Campbell | Partner | Schiavetti Corgan DiEdwards Weinberg & Nicholson |
| Benjamin | Carbone | Underwriting Account Manager | EmPRO Insurance Company |
| Stephanie | Carrington | Senior Risk Solutions Consultant | MedPro Group |
| Molly | Casey | Partner | O'Connor First |
| Christina | Christoforo | Attorney | Kaufman Borgeest & Ryan |
| Mark | Coleman | VP, Risk | Hackensack Meridian Health Network |
| Peggy | Cooke | Founder | Peggy Cooke, LLC |
| Dennis | Conway | Adjunct Faculty | Adelphi University |
| Bryanna | Corbett | Associate | Rubin Paterniti Gonzalez Rizzo Kaufman |
| Dan | Corcoran | Founder & CEO | SafeQual |
| Ruth | Corcoran | Partner | Kaufman Borgeest & Ryan |
| Andrea | Crawford | Associate Exec Director, Risk Management | NYC H+H / Queens |
| Angela | Criscuolo | Associate | Rubin Paterniti Gonzalez Rizzo Kaufman |
| Teresa | De Cecco | Business Development Leader | Coverys |
| Cassandra | DeLaMothe | Assistant Director, Risk Management | NYC H+H / Jacobi |
| Anthony | DellaCroce | SVP & Northeast Practice Leader, Healthcare | HUB International |
| Christopher | DiGiacinto | Partner | Kaufman Borgeest & Ryan |
| Christine | DiLeonardo | Risk Consultant | Alera Group |
| Erika | DiMarco | Associate Director, Risk Management | Kings County Hospital Center |
| Marianna | Dimoski | Director, Claims | EmPRO Insurance Company |
| Abdel | Disomimba | Associate Director, Risk Management | NYC HHC / Harlem Hospital |
| Kathleen | Divers | Risk Consultant | MedPro Group |
| Ida | Doctor | Associate Director, Risk Management | Jacobi Hospital |
| Argie | Drakos | Partner | Kerley Walsh Matera & Cinquemani |
| Doreen | Dufficy | Partner | Barbiero Bisch O'Connor & Commander |
| Elizabeth | Eckhardt | Director | Nassau County Bar Association's Lawyer Assistant Program |
| Julianne | Egan | Account Executive | Alera Group |
| Jaymie | Einhorn | Partner | Fullerton Beck |
| Michael | Elefante | Risk Advisor | Hilb Healthcare |
| Emily | Everett | Account Manager | Brown & Brown |
| Rosemarie | Farrell | Director, Risk Management | St John's Episcopal Hospital |
| Carl | Ferdenzi, Jr. | Business Development Director | Med-IQ |

**AHRMNY Full-Day Annual Educational Conference**
**Friday, June 5, 2026 - 8:30 am - 4:00 pm**
**City Winery New York**

| First Name | Last Name | Title | Company |
|---|---|---|---|
| Taryn | Fitzgerald | Partner | Barker Patterson Nichols |
| Stacy | Fitzmaurice | Partner | Shaub Ahmuty Citrin & Spratt |
| Kenneth | Fox | Partner | Lewis Brisbois Bisgaard & Smith |
| Delores | Frazier | RN-Retired | |
| Paul | Gazso | Vice President | Brown & Brown |
| Bill | Gianaris | | Marshall Dennehey |
| Lesli | Giglio | SVP, Chief Risk Officer & Chief Privacy Officer | Catholic Health |
| Mario | Giannettino | Partner | Kaufman Borgeest & Ryan |
| Pamela | Gleit | Partner | Barbiero Bisch O'Connor & Commander |
| Barbara | Goldberg | Partner | Martin Clearwater & Bell |
| Melissa | Goldberg | Partner | Abrams Fensterman |
| Lisa | Goldstein | Partner | McAloon & Friedman |
| Jessica | Greguski | Claims Counsel | Northwell Health |
| Barbara | Groshans | Assistant Vice President | EmPRO Insurance Company |
| Edward | Guardaro, Jr. | Partner | Fullerton Beck |
| Esha | Gupta | Director of Claims | One Brooklyn Health |
| Anthony | Hall | Sr. Director, Risk Management | NYC H+H / Gotham Health |
| Liesl | Hall-Grant | Director, Risk Management | Mercy Hospital-Catholic Health |
| Jaspreet | Hanjra | Operations Manager | Maternal Fetal Medicine Associates |
| Thuhij | Haque | Claims Analyst | EmPRO Insurance Company |
| Sari | Havia | Partner | Shaub Ahmuty Citrin & Spratt |
| Lori | Herling | Risk Management Director | Stony Brook University Hospital |
| Lori | Hertz | Account Specialist | MLMIC Insurance Company |
| Jennifer | Higgins | Partner | Abrams Fensterman |
| Denise | Holzka | Partner | Heidell Pittoni Murphy & Bach |
| Dylan | Horan | Junior Underwriting Account Manager | EmPRO Insurance Company |
| Anne | Huben-Kearney | Independent Risk & Patient Consultant | |
| Josh | Hyatt | Director of Consulting, Healthcare | Praesidium |
| Jayne | Jahre | Partner | McAloon & Friedman |
| Mary | Jordan | Healthcare Liability Nurse Manager | Gallagher Bassett |
| Stefanie | Kaye | Director, Claims | EmPRO Insurance Company |
| Erin | Kelley | Partner | Heidell Pittoni Murphy & Bach |
| Gemma | Kenney | Partner | Barker Patterson Nichols |
| Todd | Kipnes | Principal & General Counsel | Kipnes Crowley Group |
| Gina | Kittek | Systems Director, Risk Management & Corp Compliance | United Health Services, Inc. |
| Victor | Klein, MD | Vice Chairman | Northwell Health |
| Karen | Kobus | VP, Professional Affairs | Maimonides Medical Center |
| Gayle | Kolt | Director, Risk Management & Regulatory Affairs | NYC H+H/Jacobi \| North Central Bronx |
| Michael | Krasner | Co-Chief Medical Officer / VP of Education | EmPRO Insurance Company |
| Alexandra | Kuykendall | Attorney | Lewis Brisbois Bisgaard & Smith |
| Michael | La Pinta | Associate | Rubin Paterniti Gonzalez Rizzo Kaufman |
| Meredith | Lander | Senior Associate | Schiavetti Corgan DiEdwards Weinberg & Nicholson |
| Randi | Lehrman | Partner | Shaub Ahmuty Citrin & Spratt |
| Ari | Lessa | Partner | Kaufman Borgeest & Ryan |
| Dawn | Lewis | Senior Vice President | EmPRO Insurance Company |
| John | Lombardo, MD | Chief Medical Officer | MLMIC Insurance Company |
| Kathy | Lospinuso | RN, BSN, JD | NYC H+H / Jacobi |
| Jasmine | Lyons | Director, Quality Management | Northwell Health |
| Andrea | Maestas | Partner | Lewis Brisbois Bisgaard & Smith |
| Jack | Manzi | Senior Account Manager | Brown & Brown / Risk Strategies |
| Vianset | Marino | Director of Insurance Risk & Finance | Hackensack Meridian Health |
| Robert | Martin | Partner | London Fischer |
| Rosemary | Martinson | Partner | Barker Patterson Nichols |
| Joyce | McCormack | Senior Risk Management Consultant | MLMIC Insurance Company |
| Michele | McEnroe | Of Counsel | Shaub Ahmuty Citrin & Spratt |
| Brendan | McSweeney | Claims Management Counsel | Northwell Health |
| Jeff | McQuilliams | President | SafeQual |
| Wes | Merritt | Senior Account Executive | HUB International |
| Michael | Milchan | Partner | Barker Patterson Nichols |
| Abigail | Mills | Claims Analyst | EmPRO Insurance Company |

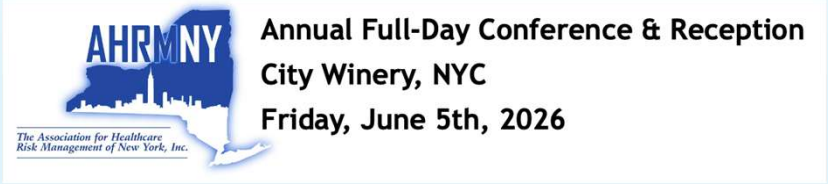
**AHRMNY Full-Day Annual Educational Conference**
**Friday, June 5, 2026 - 8:30 am - 4:00 pm**
**City Winery New York**

| First Name | Last Name | Title | Company |
|---|---|---|---|
| Carolyn | Miranda | Healthcare Liability Nurse Consultant Manager | Gallagher Bassett |
| Andrea | Mokrzycki | Director, Patient Safety | EmPRO Insurance Company |
| Ruth | Nayko | Risk and Patient Safety Professional | |
| Christie | Nunn | AVP, Claims Counsel | Sompo |
| Wilhemina | Nyarko | Senior Director, Risk Management | The Brooklyn Hospital Center |
| Alison | O'Dwyer | Partner | Fullerton Beck |
| Kiki | Orski | President | Peak Performance Consulting |
| Kerry | Ostendorf | Sr. Risk Solutions Consultant | Princeton Insurance/MedPro Group |
| Tim | Over | SVP, Business Development | Gallagher Bassett Specialty |
| Christina | Papadopoulos | Managing Partner | Rubin Paterniti Gonzalez Rizzo Kaufman |
| Andrea | Patram | Director, Risk Services | Healthcare Risk Advisors |
| Melissa | Perosi | Risk Manager | AdvantageCare Physicians |
| Duane | Perricelli | Senior Vice President | Healthcare Risk Advisors, The Doctors Group |
| Dawn | Pignatelli | Partner | Bartlett LLP |
| Rachel | Place | Attorney | Schiavetti Corgan DiEdwards Weinberg & Nicholson |
| Deborah | Platz | VP & General Counsel | United Health Services, Inc. |
| Bonnie | Portnoy | VP, Risk Management & Patient Safety | Mount Sinai Health System |
| Matthew | Prisco | Partner | McAloon & Friedman |
| Christine | Quinn | Vice President & Chief Risk Officer | EmPRO Insurance Company |
| Wayne | Rabinowitz | | |
| Cynthia | Robinson | Partner | Heidell Pittoni Murphy & Bach |
| Christine | Rockwell | Partner | Kaufman Borgeest & Ryan |
| David | Rosen | Assistant Vice President | Gallagher Bassett |
| Jonathan | Rubin | Partner | Kaufman Borgeest & Ryan |
| Kerrianne | Russo | Associate | Rubin Paterniti Gonzalez Rizzo Kaufman |
| Lisa | Russo | Risk Manager | AdvantageCare Physicians |
| Karen | Ryan | Partner | Schiavetti Corgan DiEdwards Weinberg & Nicholson |
| Sasha | Sagalovich | Assistant Vice President | Gallagher Bassett |
| Patricia | Santaniello | Director, Enterprise Risk Management | HMH-Hackensack University Medical Center |
| Sharon | Scheuermann | Senior Vice President | Brown & Brown |
| Alyssa | Schiffhauer | Senior Claim Director | Gallagher Bassett |
| Christy | Schiller | Vice President of Consulting | Praesidium |
| Kayla | Schmidt | Associate | Rubin Paterniti Gonzalez Rizzo Kaufman |
| Alexander | Sikoscow | Partner | Kaufman Borgeest & Ryan |
| Erin | Stalzer | Partner | Shaub Ahmuty Citrin & Spratt |
| Carol | St. Pierre | Nursing Clinical Coordinator | Mount Sinai Hospital |
| Marie | Tabuzo-Quizon | Risk Manager | Healthcare Risk Advisors |
| Linda | Tallaksen | AVP, Risk Management | AdvantageCare Physicians |
| Alison | Thompsen | Director, Risk Management | NYC HHC / Harlem Hospital |
| Deirdre | Tracey | Partner, Appellate Practice | Aaronson Rappaport Feinstein & Deutsch |
| Florence | Ulysse | Risk Manager | White Plains Hospital |
| Lara | Vanyo, MD | Assistant Professor of Emergency Medicine | Weill Cornell Medical College |
| Susan | Vari | Partner | Barker Patterson Nichols |
| Aryan | Vavila | Attorney | Lewis Brisbois Bisgaard & Smith |
| David | Verschell | Partner | Abrams Fensterman |
| Suzanne | Vick | Associate Director, Risk Management | Elmhurst Hospital |
| Suhlail | Villa | Partner | Schiavetti Corgan DiEdwards Weinberg & Nicholson |
| Jonathan | Waldauer | Trial & Appellate Partner | Rubin Paterniti Gonzalez Rizzo Kaufman |
| Steven | Weiner | Partner | Kaufman Borgeest & Ryan |
| Joleen | Werder | Risk Management Coordinator | Stony Brook University Hospital |
| Rosemarie | White | Claims Consultant | MedPro Group |
| Tiffany | Wickes-DeMillio | AVP, Safety and High Reliability | Catholic Health |
| Carolyn Reinach | Wolf | Executive Partner | Abrams Fensterman |
| Bob | Worden | Hearing Officer | NAM (National Arbitration and Mediation) |
| Timothy | Wrede | Risk Management Coordinator | Stony Brook University Hospital |
| Jennifer | Yuen | Partner | Lewis Brisbois |

# TAB 3

# Flourishing Clinicians, Safer Systems: The Hidden Risk Imperative in Modern Healthcare

Michael Krasner, MD, FACP
Co-Chief Medical Officer and Vice President of Education,
EmPRO Insurance Company
Professor Emeritus of Medicine
Co-Director, Mindful Practice in Medicine Programs
University of Rochester School of Medicine and Dentistry




Mindful Practice IN MEDICINE

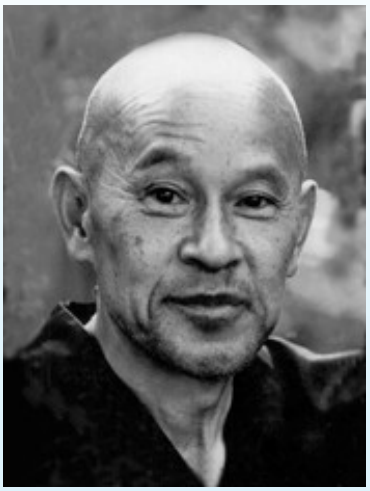
1

# Learning Objectives:

- Examine the evidence linking clinician burnout, moral distress, and psychological safety to patient safety events, liability risk, and organizational performance.
- Analyze how individual, team, and system-level factors interact to either amplify or mitigate clinical risk through their impact on clinician wellbeing and behavior.
- Identify high-leverage strategies that risk managers and healthcare leaders can implement to foster clinician flourishing, strengthen teamwork and communication, and reduce preventable harm and liability exposure.
- Commit to at least one actionable step within their sphere of influence to address clinician wellbeing as a core risk management priority.

Mindful Practice IN MEDICINE

2



*"You are perfect just as you are, and you can use a little improvement."*

*Shunryu Suzuki-Roshi*

Mindful Practice IN MEDICINE

3

# Resilience, Robustness, and Meaning

*Resilience is a capacity that can be grown… in the right environment.*

Epstein & Krasner 2013

*Robustness is not an option in most human lives, to choose its opposite is to become invisible*.

David Whyte, "Consolations", 2021

*Your calling is the place where your deep gladness and the world's deep hunger meet.*

Frederick Buechner, "The Hungering Dark", 1969

Mindful Practice IN MEDICINE

4

# Resilience, Robustness, and Meaning

*…for me fulfillment comes from the sudden intimacies with total strangers–those moments when the human barrier cracks open to reveal what is most secret and inarticulate…. This is the physician's privilege: to be lifted out of the dross of common days in order to experience such clarity of feeling. The intensity of birth and death, pleasure and sorrow, as expressed in the lives of others, has the power to nullify personal boundaries in sudden communion.*

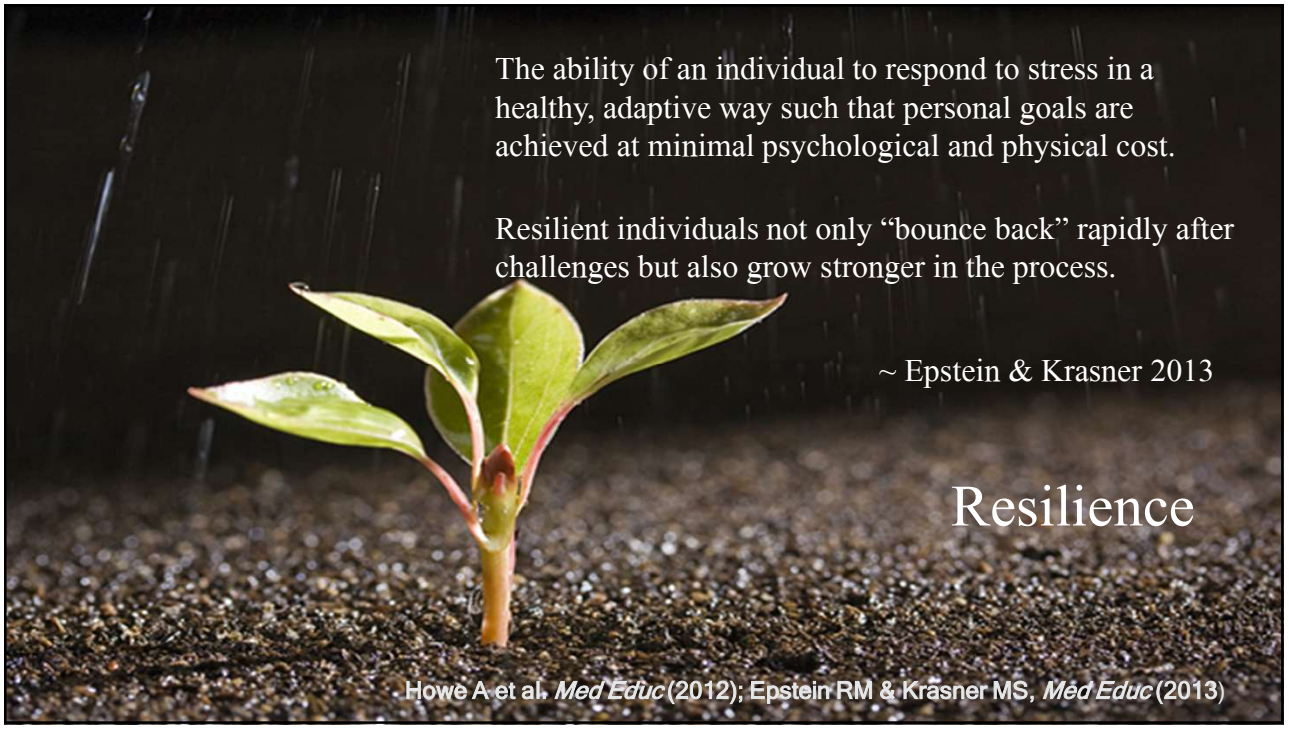
Michael Radetsky, MD "Sudden Intimacies" JAMA, 1985

*Wherever the great dilemma exists is where the great growth is.*

Ann Lamott, "Becoming the Person You Were Meant to Be…, 2009

Mindful Practice IN MEDICINE

5




6

## Clinical Resilience – a systems view

*Clinical Resilience is a dynamic capacity that describes the positive and sustainable adaptation present in individuals, work teams and health organizations to respond to everyday challenges, uncertainty, and stress, helping individuals, teams and organizations provide care that is technically capable, ethically sound, safe, personalized and effective while optimizing professional wellbeing and sustainability of the healthcare workforce.*

Krogh E et al. 2023

Mindful Practice IN MEDICINE

7

## Optimism

*More and more I have come to admire resilience.*

*Not the simple resistance of a pillow, whose foam*

*returns over and over to the same shape, but the sinuous*

*tenacity of a tree: finding the light newly blocked on one side,*

*it turns in another. A blind intelligence, true.*

*But out of such persistence arose turtles, rivers,*

*mitochondria, figs -- all this resinous, unretractable earth.*



"Optimism," (c) Jane Hirshfield, from *Given Sugar, Given Salt* (NY: HarperCollins, 2001); used by permission of Jane Hirshfield, all rights reserved.

Mindful Practice IN MEDICINE

8

## A radical proposal



9

# Imagine…

10

## Imagine…

**…it is 2 years from now, and physicians and other health professionals have navigated the current crisis to the best of their abilities in such a way that they were able to be attentive, energetic, creative, resourceful, and robust. Consider:**

- Your mind: In a few words, describe your quality of mind when you are encountering the health care system that is working at its your best.
- The thread: What about *who health proifessionals are* – their skills, beliefs, qualities, and virtues – enables them to be at your best?
- Their growing edge: What qualities have they had to learn, and how did they learn them?

Mindful Practice IN MEDICINE

11

# Work-related distress

…a problem of ***the relationship between*** your sense of calling and meaning - and the environment in which you work

Mindful Practice IN MEDICINE

12

## Physiology of Stress and Resilience

- *Appropriate* responses to the environments within which we work
- Fight, Flight, Freeze, Fawn, and Connect
- Our nervous system can learn and change in response to stress
- Cultivating awareness is the first step

Mindful Practice IN MEDICINE

13

*"Erosion of the soul… deterioration of values, dignity, spirit and will…"*

**burnout**



Christina Maslach

14

# Burnout 2022

- Affecting 66% of physicians
- Three domains:
  - *Emotional exhaustion*
  - *Depersonalization (cynicism)*
  - *Low sense of personal accomplishment*



Medscape 2022; Maslach 1976

Mindful Practice IN MEDICINE

15

# Burnout

Cost:

$4.6 Billion 2019



Han S, Shanafelt TD, Sinsky CA, et al. *Estimating the Attributable Cost of Physician Burnout in the United States.* Ann Intern Med. 2019;170(11):784-790.

Mindful Practice IN MEDICINE

16

# Moral distress

*… when clinicians know the ethically appropriate action to take but are prevented by obstacles, either internal and/or external, from acting upon it,… undermin[ing] the individual's integrity and authenticity.*

Rushton CH et al 2006; 2017

Mindful Practice IN MEDICINE

17

# Clinician distress really matters

**Quality of care:**

- Lower quality of care
- Riskier prescribing
- Medication errors
- Unsafe behaviors
- Not following protocols

**Personal health:**

- Depression, anxiety, suicide, substance abuse
- Marital/family stress
- Auto accidents

**Pt-clinician relationships:**

- Poor communication
- Erosion of altruism, empathy, compassion
- Lower patient adherence, satisfaction

**Professionalism:**

- Unprofessional conduct
- Poor relationships w/ staff

**Costs:**

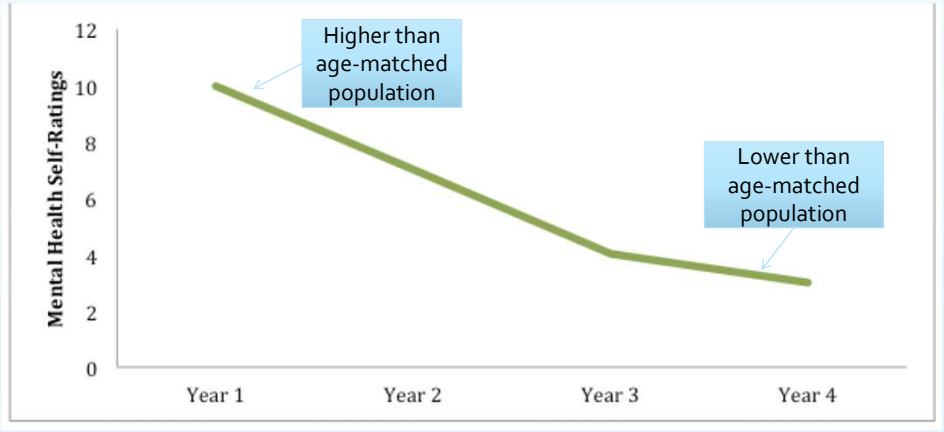
- Lower productivity
- Absenteeism, attrition
- Higher recruitment costs

Fahrenkopf 2008; DiMatteo 1993; Wallace 2009; Shanafelt 2005; Dyrbye 2010; Haas 2000; Sundquist 2000; others…

Mindful Practice IN MEDICINE

18

# Medical student mental health and life satisfaction




Kjeldstadli et al. BMC Med Educ (2006)

Mindful Practice IN MEDICINE

19

What personality characteristics make an exemplary clinician ?

***How do those same characteristics become problematic?***

Mindful Practice IN MEDICINE

20

| Positive Values | | |
|---|---|---|
| Service, altruism | | |
| Excellence | | |
| Competence | | |
| Knowledge | | |
| Empathy | | |
| Caring | | |
| Equanimity | | |

Nedrow A 2013

Mindful Practice IN MEDICINE

21

| Positive Values | The Dark Side | |
|---|---|---|
| Service, altruism | Over-commitment, self-deprivation, entitlement | |
| Excellence | Perfectionism, invincibility, hiding errors | |
| Competence | Omnipotence, imposter syndrome, self-deprecation | |
| Knowledge | Need for certainty | |
| Empathy | Personal distress | |
| Caring | Neglecting oneself and family | |
| Equanimity | Distancing, “othering” | |

Nedrow A. 2013

Mindful Practice IN MEDICINE

22

| Positive Values | The Dark Side | Flourishing |
|---|---|---|
| Service, altruism | Over-commitment, self-deprivation, entitlement | Reframing, balance, gratitude |
| Excellence | Perfectionism, invincibility, hiding errors | Self-compassion, reflective self-questioning |
| Competence | Omnipotence, imposter syndrome, self-deprecation | Knowing one's limitations |
| Knowledge | Need for certainty | Knowing what's unknown, comfort with uncertainty |
| Empathy | Personal distress | Compassionate action |
| Caring | Neglecting oneself and family | Self-care |
| Equanimity | Distancing, "othering" | Engagement |

Nedrow A. 2013

Mindful Practice IN MEDICINE

23

## The work environment

- Distractions/multitasking
- Frequent interruptions
- Emotional intensity and unpredictability
- Overwhelming sociopolitical issues
- Productivity/time pressures
- Dysfunctional computer systems
- Meaningless administrative tasks
- ↓ control / ↑ responsibility
- Isolation



Mindful Practice IN MEDICINE

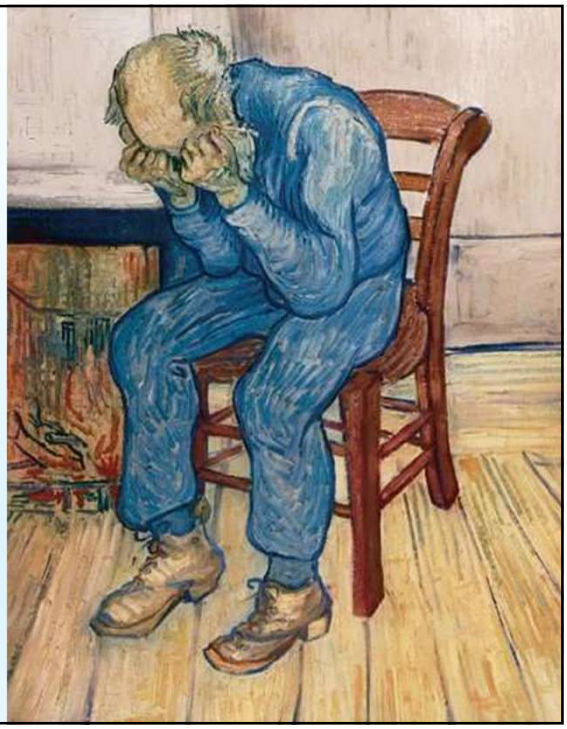
24

# Empathy

… as "exquisite" → leading to shared mind, communion, community, 'being-with'

"Highly present, sensitively attuned, well-boundaried, heartfelt … engagement"

Kearney et al, JAMA 2009



25

# … also can be associated with burnout

… "emotional labor"

"… willingness to subject one's mind to the patient's world…"

"…distressed empathy"

Larson et al 2006, Ekman & Krasner 2017

Mindful Practice IN MEDICINE

26

## Proposing a continuum

| Burnout | Flourishing |
|---|---|
| Withdrawn | Present |
| Emotionally exhausted | Energized |
| Defeated | Bouncing back |
| Going through the motions | Fully engaged |
| Brittle, rigid | Bending, not breaking |
| Cynical, hopeless | Capacity for positivity |
| Hypercritical | A light touch |
| Feeling ineffective | Becoming stronger |
| Treading water | Moving forward |
| Unable to move | Welcoming change |

Mindful Practice IN MEDICINE

27

## Making a difference

### Change the work environment

- Greater control over scheduling, work hours, personnel, and office environment*
- Physical and cognitive ergonomics
- Team structure and roles
- Clear organizational values and leadership

**What clinicians can do to survive, thrive, and flourish in imperfect systems:**

- Yourself - meditation, mindfulness, stress management
- You as a leader - your colleagues, your team, your setting

Mindful Practice IN MEDICINE

28

# Three Domains of the Stanford Wellness Framework

Culture of Wellness: Creation of work environment with a set of normative values, attitudes, and behaviors that promote self care, personal and professional growth, and compassion for colleagues, patients, and self

Efficiency of Practice: Value added clinical work accomplished divided by the time and energy spent

Personal Resilience: Set of individual skills, behaviors, and attitudes that contribute to personal physical, emotional, and social well-being, including the prevention of burnout




©2016 Stanford Medicine

https://wellmd.stanford.edu/about/model-external.html

Mindful Practice IN MEDICINE

29

29

# Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis

Colin P West, Liselotte N Dyrbye, Patricia J Erwin, Tait D Shanafelt

**Summary**

**Background** Physician burnout has reached epidemic levels, as documented in national studies of both physicians in training and practising physicians. The consequences are negative effects on patient care, professionalism, physicians' own care and safety, and the viability of health-care systems. A more complete understanding than at present of the quality and outcomes of the literature on approaches to prevent and reduce burnout is necessary.

*The most common interventions were mindfulness and stress management-focused efforts, communication training, small group discussions, local practice modifications, and duty hour changes.*

*"...both individual-focused and structural or organisational strategies can result in clinically meaningful reductions in burnout among physicians. Further research is needed to determine which interventions may be most effective in specific populations, as well as how individual and organisational solutions might be combined..."*

Jones 1988; Dunn 2007, Ro 2008; Wallace J 2009; West CP 2016; Epstein RM 2016; West CP 2016

Mindful Practice IN MEDICINE

30

## Systemic and organizational responses to create a culture of wellness and greater efficiency of practice:




"This doesn't look good."

Mindful Practice IN MEDICINE

31

## What can healthcare institutions do?

### *Pro-active*

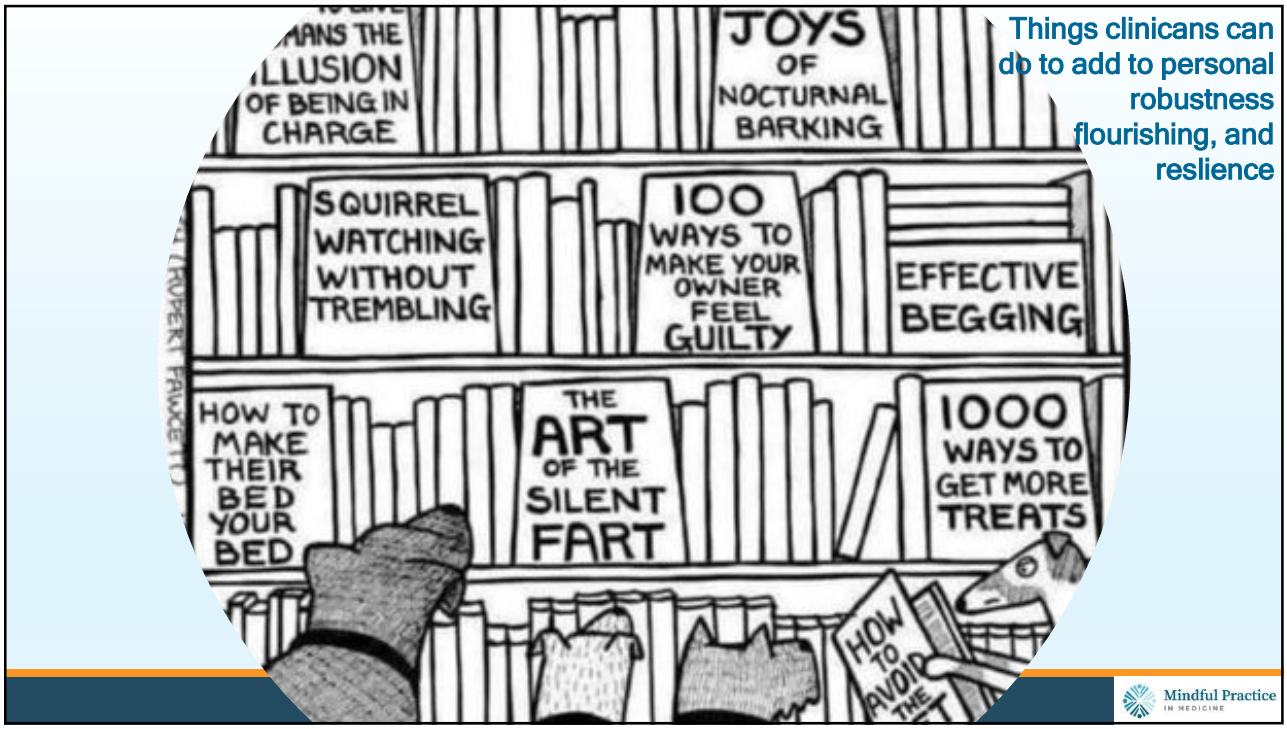
- Keep staff safe
- Flexibility in scheduling
- Measure clinician well-being
- Human factors design
- Reduce regulatory/admin burden
- Coaching programs
- Quiet spaces, food, exercise
- Forums for reflection and self-awareness

### *Reactive*

- Debriefing, peer support, and time off after traumatic events
- Zero tolerance / swift action for abuse, harassment, discrimination, and incivility
- Non-punitive reporting of adverse events
- Non-stigmatizing access to coaching, counseling, and support

Mindful Practice IN MEDICINE

32




33

## Things individuals can do?

- Practice
- Stay engaged
- Listen deeply
- Create community

Mindful Practice IN MEDICINE

34

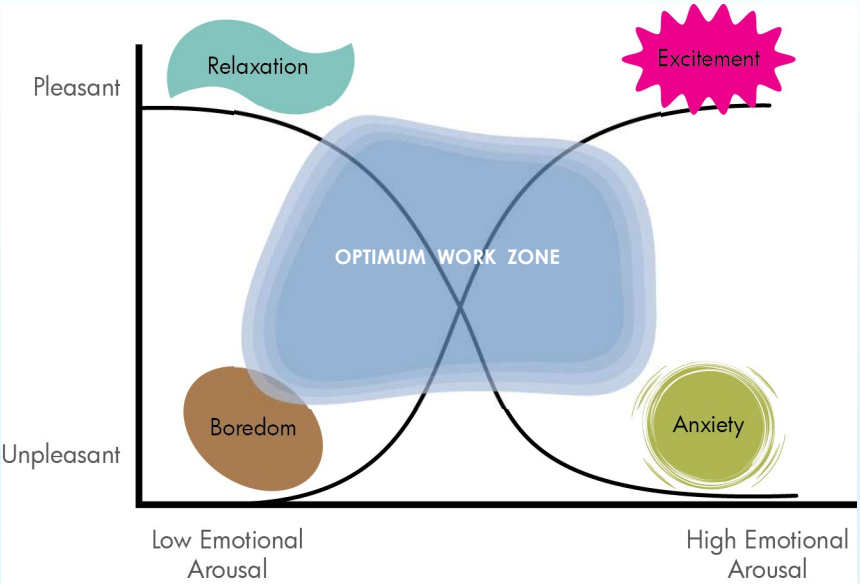
## Keys to resilience – the research

- Emotional intelligence
- Capacity for positivity
- Cognitive reappraisal
- Seeing yourself as others see you
- Stress inoculation
- Your relationships at home and at work
- Your brain and your hormones
- Your social environment
- Your epigenetics

Southwick SM el at.: Resilience (2012)

Mindful Practice IN MEDICINE

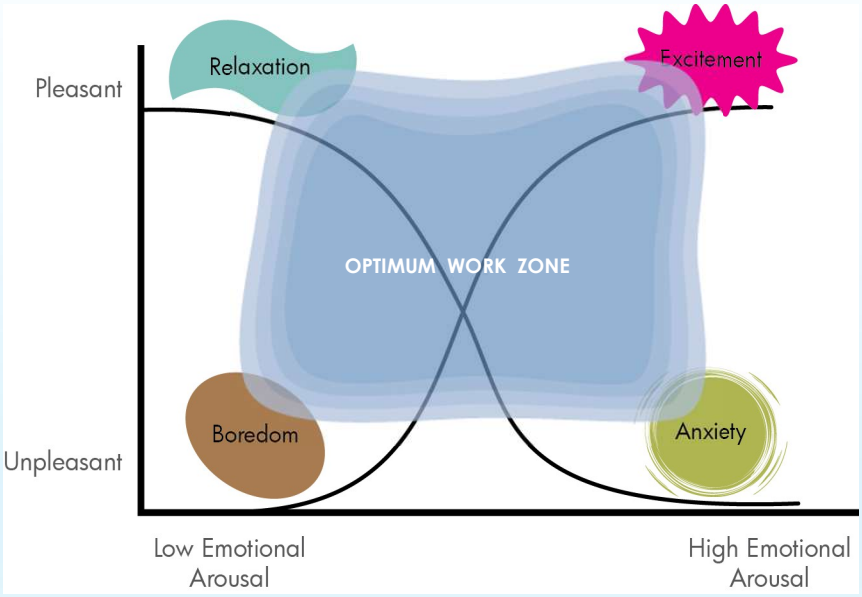
35




After Apter M, Reversal theory (1989)

Mindful Practice IN MEDICINE

36




After Apter M, Reversal theory (1989)

Mindful Practice IN MEDICINE

37

## Healthy/unhealthy responses to stress



### Unhealthy reactions

Unhelpful behaviors that you feel you "can't keep yourself from doing"

### "Survival skills"

These may help you get through a tough time but may be destructive if habitual (avoid being proud of these)

### Mindful responsiveness, resilience, growth

Important to your long-term development as a professional and as a person



Mindful Practice IN MEDICINE

38

## Finding joy and meaning

Of all the activities you do at work, which gives you the most joy and meaning?

What percentage of the time do you spend on those activities?

Mindful Practice IN MEDICINE

39

20%

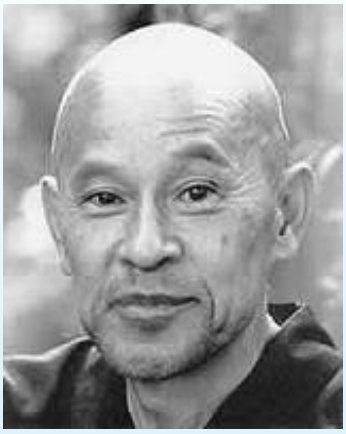
… the extent to which an individual is able to focus their effort on the aspect of work that they find most meaningful

*Career Fit*

Shanafelt TD, Arch Int Med (2009)

Mindful Practice IN MEDICINE

40



*"The most important thing*

*is to remember the most important thing."*

*Shunryu Suzuki-Roshi*

Mindful Practice IN MEDICINE

41

**Flourishing =**
Intention + Skills + Engagement +
Community + Institutional Support

Mindful Practice IN MEDICINE

42

# Readings

Epstein R, Krasner M. Physician Resilience. *Acad Med* 2013.

Epstein, R.M. (2017). Healing the Healer. In *Attending: Medicine, Mindfulness, and Humanity* (pp. 157-175). New York, NY: Scribner.

Epstein RM, Privitera MR: Finding our way out of burnout. JCO Oncology Practice July 2021; Practice 17(7): 375-377. Accession Number: 34152836 PMID: 34152836 doi: 10.1200/OP.21.00233

Harvey SB, Epstein RM, Glozier N, Petrie K, Strudwick J, Gayed A, Dean K, Henderson M. Mental illness and suicide among physicians. Lancet. 2021;398(10303):920-30.

The Stanford Wellness Framework (2016) https://wellmd.stanford.edu/about.html

Mindful Practice IN MEDICINE

43

# Readings

Krogh E; Epstein R; Langer ÁI; Steinebach C. Clinical resilience: toward a unified definition. International journal for quality in health care : journal of the International Society for Quality in Health Care. 2023

Shanafelt TD. Physician Well-being 2.0: Where Are We and Where Are We Going? Mayo Clin Proc. 2021;96(10):2682-93.

Shanafelt T, et al. Building a Program on Well-Being: Key Design Considerations to Meet the Unique Needs of Each Organization. Acad Med. 2019;94(2):156-61.

West CP, et al. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet*. 2016;388(10057):2272-2281.

Mindful Practice IN MEDICINE

44

# TAB 4

*Annual Full-Day Conference Reception, City Winery, NYC*

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

# Unpacking Burnout in the Emergency Room:
## Its Impact on Physicians, the Care Environment and Potential Solutions




1

*Annual Full-Day Conference Reception, City Winery, NYC*

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

## Burnout in Emergency Medicine:

- **Dr. Lara Vanyo:** Burnout in the Emergency Room from the perspective of a physician and expert in the wellness space.
- **Sasha Sagalovich, Esq.:** The litigation landscape in Emergency Medicine and how key stakeholders can help mitigate burnout.
- **Alison O'Dwyer, Esq.:** The Boarding crisis, data, and recommendations.

2

# Overview of Burnout in the Emergency Room

- What it is
- The impact of burnout on providers
- Areas of concern and recommendations

3

*Annual Full-Day Conference Reception, City Winery, NYC*

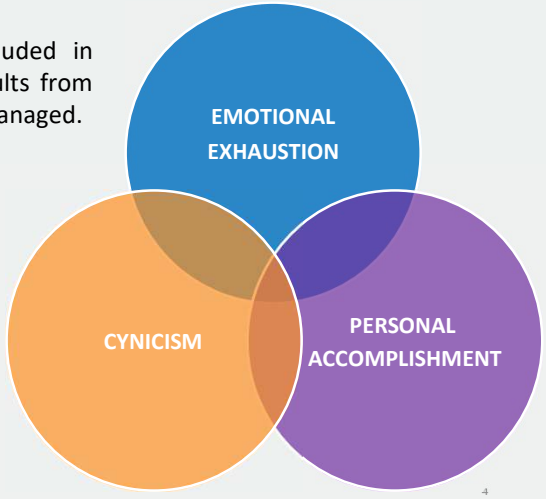
*The Association for Healthcare Risk Management of New York, Inc.*

## Definition of Burnout

Burnout is an occupational phenomenon that is included in the 11th revision of the ICD. It is a syndrome that results from chronic workplace stress that has not been successfully managed.

**Three Dimensions of Burnout:**

1. Feelings of energy depletion or exhaustion
2. Increased callousness, mental distance from one's job, or feelings of negativism or cynicism related to one's job
3. Reduced sense of personal accomplishment




4

4

*Annual Full-Day Conference Reception, City Winery, NYC*

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

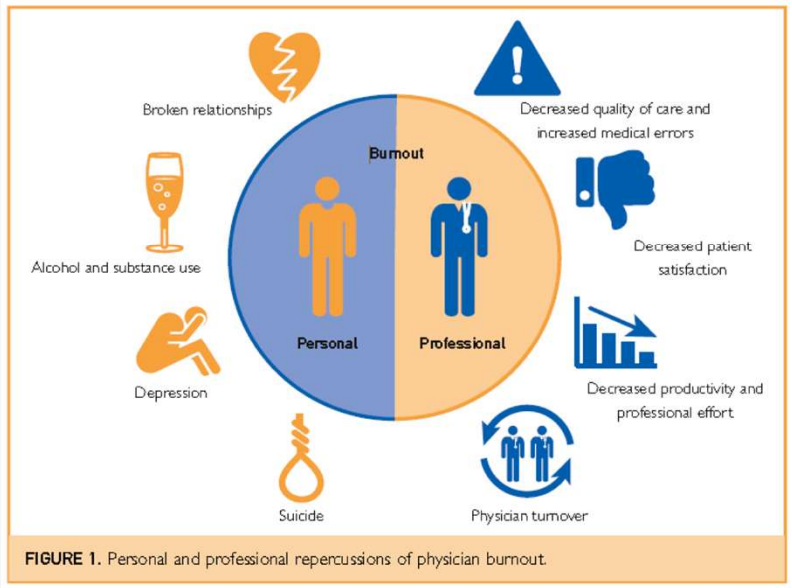



**FIGURE 1.** Personal and professional repercussions of physician burnout.

https://www.mayoclinicproceedings.org/action/showPdf?pii=S0025-6196(16)30625-5

5

*Annual Full-Day Conference Reception, City Winery, NYC*

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

# Healthcare Worker Hierarchy of Needs




https://icahn.mssm.edu/about/departments-offices/oped/well-being

6

# Litigation

- The litigation landscape in Emergency Medicine
- How key players in the malpractice process can play a role in mitigating burnout for the provider

7

*Annual Full-Day Conference Reception, City Winery, NYC*

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

## A High Percentage of Medical Malpractice Cases in New York Arise from Care in the Emergency Room

- A review of Gallagher Bassett's claims data for New York shows that over the past decade, approximately 25% of cases arise from care in the Emergency Room.
- Over 50% of New York medical malpractice cases concern the issue of failure to diagnose.



* Source Gallagher Bassett's proprietary claims database

8

# Case Disposition

- Among closed cases involving the Emergency Room, the average payment, over the last decade was approximately $1 million.
- Death and severe neurological injury constituted over 50% of the payouts.



* Source Gallagher Bassett's proprietary claims database

9

*Annual Full-Day Conference Reception, City Winery, NYC*

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

# National Data

## CRICO /Candello Discover 2026 (Claims data from 2017-2026)

- Nationally, over the past decade, Emergency Room malpractice cases account for approximately 10% of all malpractice suits.
- Payouts in the last 10 years average $665,000.
- National trend in terms of severity level matches that of New York as over 50% of cases relate to death or neurological injury.




10




It takes an average of 1,200 days (over 3 years) for a medical malpractice case involving the Emergency Room to resolve in New York.

* Source Gallagher Bassett's proprietary claims database

11

Annual Full-Day Conference Reception, City Winery, NYC

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

# Boarding, Liability, and Litigation

- What the claims data shows
- What the literature recommends
- Where the regulations stand

12

# Boarding Litigation: What the Claims Data Shows

## CRICO 2024/Candello /CRICO & MPLA 2025

- 314 Cases / $119.9 M total losses
- $635,010 avg. indemnity per case
- Almost half cases involved patient death
- 110% higher odds of payout for boarding vs non-boarding cases
- Higher average NAIC severity score in boarding cases (6.7) compared to non boarding cases (5.8)

13

*Annual Full-Day Conference Reception, City Winery, NYC*

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

# Boarding - What the Literature Recommends

## CRICO 2024 and 2025

**Risk Areas:**

- **1** – Patient Monitoring
  - Solution: Assign a dedicated provider
- **2** – Communication among Providers
  - Solution: Standardize handoff protocols (e.g., I-PASS)
- **3 –** Failure or delay in obtaining a consult or referral
  - Solution: Expand role of consultant services and promote shared accountability across service lines

14

# Boarding: Regulations & Takeaway

## Where the rules stand, and why acting now matters.

**New York:** no boarding regulations

**Federal** - CMS finalized a new reporting measure – voluntary 2027/mandatory 2028

**AECP** – Condition of participation requiring boarding response plans – not yet granted

- Act now – ahead of wherever the rules land
- Protect human capital – invest in physicians

15

Annual Full-Day Conference Reception, City Winery, NYC

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

# Sources

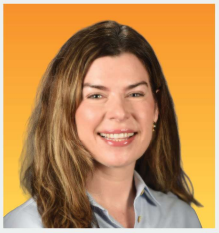
1. Elizabeth Grace Saunders, "**6 Causes of Burnout, and How to Avoid Them**," Harvard Business Review, 7/5/2019
2. Shanfelt, et al."**Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout**." Mayo Clinic, 1/2017
3. https://icahn.mssm.edu/about/departments-offices/oped/well-being
4. Candello Solutions by CRICO, Illuminating Risks: Emergency Boarding Crisis Reflected in Medical Malpractice Data. September 2024.
5. Tremont H. Malpractice Data Underscores Nationwide ED Boarding Crisis. Inside Medical Liability. Medical Professional Liability Association. Fall 2025. Available at mplassociation.org.
6. Centers for Medicare and Medicaid Services. Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Final Rule. CMS Fact Sheet CMS-1834-FC. November 21, 2025.
7. American College of Emergency Physicians. ACEP to CMS: Require Hospital Plans to Address Boarding in Emergency Departments. ACEP Press Release. September 16, 2024.

16

*Annual Full-Day Conference Reception, City Winery, NYC*

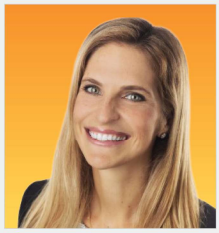
AHRMNY *The Association for Healthcare Risk Management of New York, Inc.*

# Meet our Moderator/Panelists



Moderator
**Christie Nunn, Esq.**
Assistant Vice President,
Claims Counsel
cnunn@sompo-intl.com

SOMPO



Panelist
**Lara Vanyo, M.D.**
Assistant Professor of
Emergency Medicine

Weill Cornell Medicine



Panelist
**Sasha Sagalovich, Esq.**
Assistant Vice President
sasha_sagalovich@gbtpa.com

GALLAGHER BASSETT



Panelist
**Alison O'Dwyer, Esq.**
Partner
aodwyer@fullertonbeck.com

FULLERTON BECK LLP

17

# TAB 5

NYC HEALTH+ HOSPITALS | Harlem

## *Turning Insight into Action:*

**Step 1: Reflect** – What resonated most today?

**Step 2: Identify One Action** – Concrete step to take back.

**Step 3: Evaluate Impact** – How will this action affect:

**Second Victims (Clinicians):** Will it reduce guilt, shame, burnout?

**Third Victims (Safety Stewards):** Will it ease moral distress, role conflict?

**Fourth Victims (Leaders):** Will it strengthen trust, reduce isolation?

**Step 4: Feedback Loop** – How will you gather input from these groups?

**Step 5: Timeline & Accountability** – When will you act, and who will you share it with?

# TAB 6

# Let's Talk Success: Buy in or Burn Out

Jenelle Arnao, DHS MS CPHRM

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

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

AHRMNY Annual Conference
June 5, 2026



1

## Disclaimers

- ***These materials were created for the 2026 The Associated Healthcare Risk Management of New York (AHRMNY) Annual Conference.*** *The opinions, materials, and statements presented are those of the presenters. They are not endorsed by or necessarily represent the views of ASHRM, AHRMNY, or its members.*
- *Republication or reuse of the materials without the permission of the primary speakers is prohibited.*



2

# Presenters



Jenelle Arnao, DHS MS CPHRM
Freelance Risk Professional
jenelle718@gmail.com



Anne Huben-Kearney, BSN, MPA
DFASHRM, CPHRM, CPHQ, CPPS
Risk and Patient Safety Consultant
annechubenkearney@gmail.com



3

# Objectives

1

Provide an updated version of burnout

2

Identify the warning signs of emotional exhaustion in risk professionals

3

Recommend data-driven strategies to restore personal and professional self-efficacy



4

# Definition of Burnout

- "A syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed." [ICD-11]

- "Arises from chronic mismatches between people and their worksetting [sic] in terms of some or all of six areas".*

*Source: Maslach and Leiter, The Truth About Burnout: How Organizations Cause Personal Stress and What to Do About It*



5

# Underlying Causes of Burnout

**Workload**
Increasing demands without time to recover and recuperate.

**Control**
Lack of autonomy or ambiguity/ conflict in fulfilling one's role.

**Insufficient Reward**
Financial, recognition, or social, for work completed.



6

# Underlying Causes of Burnout, continued

**Community**

Includes social support from supervisors, colleagues, other team members, and family.

**Fairness**

Resources allocated in a manner that doesn't favor certain groups or individuals over others.

**Values**

How closely do your personal values align with your organization's values?



7

# How Burnout Is Experienced

- Emotional exhaustion
- Depersonalization
- Reduced sense of accomplishment
- Apathy
- Physical exhaustion
- Reduced personal efficacy
- Feeling of cynicism
- Detachment

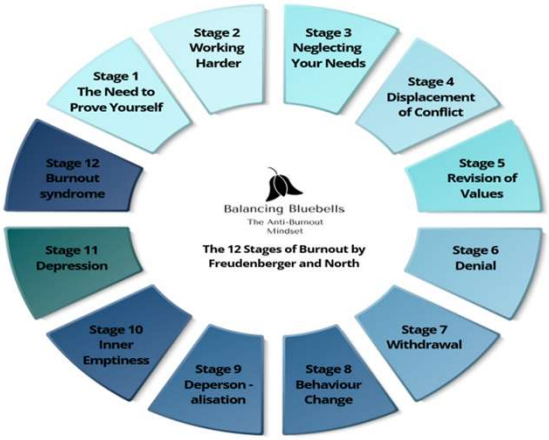
*Sounding familiar to anyone?*

*How many of you are experiencing frying? Burning?*



8

# Wheel of Burnout




https://www.balancingbluebells.co.uk/post/12-stages-of-burnout-working-women



9

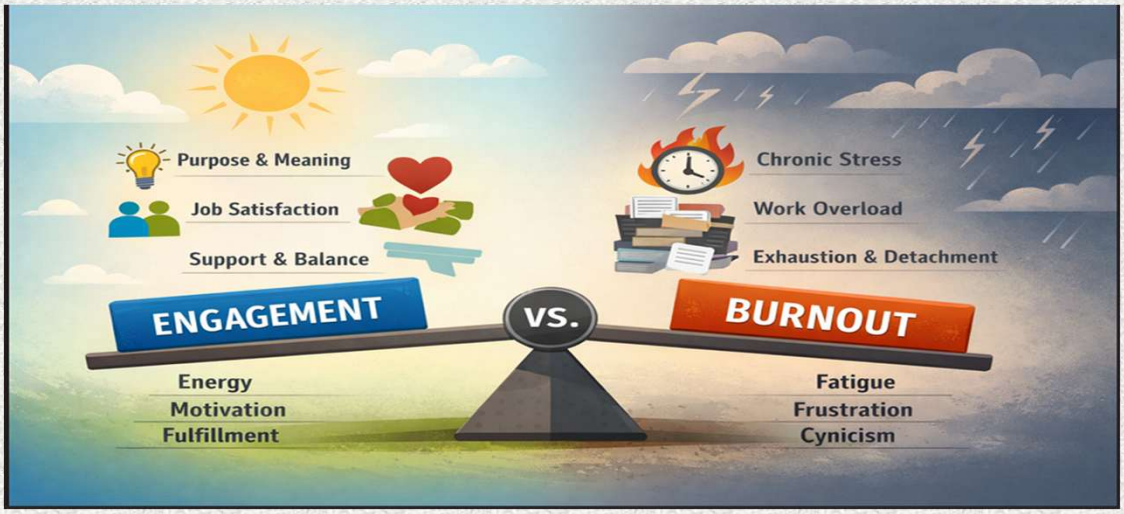
# Stages of Burnout

| https://www.balancingbluebells.co.uk/post/12-stages-of-burnout-working-women | |
|---|---|
| **Stages** | **Strategies** |
| 1. Need to Prove Yourself? | Driven by passion or people-pleasing? |
| 2. Stressed but Pushing Yourself Harder? | Movement vs Progress, Effort vs Effectiveness |
| 3. Neglecting Your Needs? | Remember sleep, nutrition, physical fitness, connection |
| 4. Blaming Others? | Can't be everyone. Self-reflect, take ownership |
| 5. Compromising your values? | Make choices that align with your values |
| 6. Telling everyone you're FINE? | Admit you're not. Can't change what you can't face |
| 7. Withdrawal or Isolation? | Ask and listen to trusted friends/colleagues/mentors |
| 8. Behavior changes? | Follow attitude changes. Ask trusted members of your circle |
| 9. Depersonalization? | Numb, detached. Harmful language toward patients, etc. |
| 10. Inner emptiness? | Avoid unhealthy crutches/extremes |
| 11. Depression? | Blues for more than 2wks, seek professional help |
| 12. Burnout syndrome? | Requires support, resiliency strategies |



10

# Engagement ⟷ as it relates to Burnout






*created with Co-Pilot





# STEALTH© Mode

- Secondary
- Trauma
- Experienced by
- Administrators
- Litigators
- Talent (team members) in
- Healthcare

Credit: Dr. Jenelle Arnao

# What can I do individually?

- Monitor changes in your health
- Use boundaries to protect your time and workload
- Shift competing priorities through delegation and saying "No."
- Rediscover your joy and passion for your position



13

# What can I do individually, continued

- Audit your psychotropic medication use
- Model behavioral changes to your team
- Golden HC rule – do unto yourself as you would to others
- Avail yourself of internal support systems



14

# What can I do corporately?

- Address systemic drivers of occupational burnout
- Utilize tools to screen for burnout
- Promote your confidential employee assistance programs (EAP)
- Implement workplace interventions



15

# What can I do corporately, continued

- Define “Emergency” for your organization
- Develop strong relationships with peers
- Strive for proactive enterprise risk management
- Improve the perception of risk professionals



16

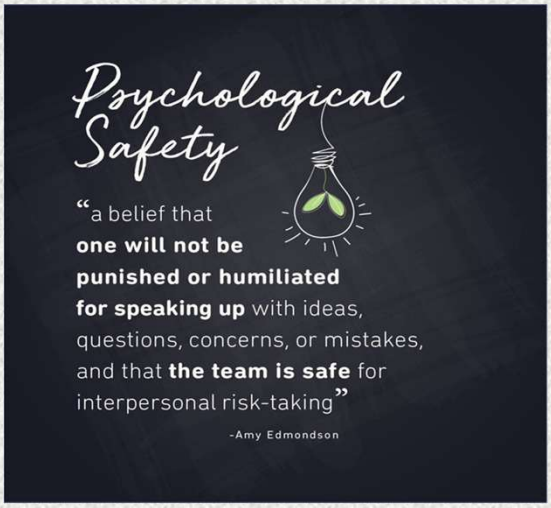
# What can I do corporately, continued

- Demonstrate your worth as a risk professional
- Foster a sense of belonging
- Market your interventions, outcomes, and successes
- Improve the sense of psychological safety



17

# Psychological Safety




- Seek and hear diverse opinions
- Be courageous, speak up!
- Discuss mistakes and lessons learned



18

# IHI's Psychological PPE




19

# In conclusion…

1. Check yourself and others for signs of burnout and STEALTH behaviors
2. Doff your STEALTH behaviors and don your psychological PPE
3. Utilize data-driven strategies to restore personal and professional self-efficacy



20

# Closing thought…



*"It's not the load that breaks you down, it's the way you carry it."*

Lena Horne



21



# What are your questions?

22

# References


- 9 Simple Solutions to Achieve Health Equity: A Guide for Healthcare Professionals and Patients – Dr. Mauvareen Beverley (2024)
- Differential effects of healthcare worker burnout on psychotropic medication use and misuse by occupational level. Hoopsick et al (2024)
- Professionals' Emotional Well-Being in the United States. Gaines et al (2023)
- Prosperous Life MD (website) Wellness and Career Coaching for Physicians
- Psychological PPE: Promote Health Care Workforce Mental Health and Well-Being. Institute for Healthcare Improvement (2020)
- The Recondition: Loving Yourself Through the Trauma: A Science-Based Framework for Healing – Dr. Xenia Barnes (2026)




23

# References, continued


- Relationships between perceived importance of chaplain presence and health professionals' emotional well-being in the US. Gaines et al (2023)
- Rethinking the organizational culture of the health system to address burnout. Sinan et al (2022)
- Risk Management: Breaking the Stigma and Building Trust," – Linda Habibi and Ailish Wilkie Presentation (2024)
- Staff well-being: Is it time to rethink implications for work schedules? Nisbet & Gillian (2022)
- The Truth About Burnout: How Organizations Cause Personal Stress and What to Do About It. Maslach, Christina, Leiter, Michael (2000)
- Your pain is not mine: A critique of clinical empathy. Bioethics (2022)




24

# TAB 7

PEGGY COOKE
COACHING

# Where Risk Really Lives

*Improving Decisions, Communication & Outcomes*

Most patient-harm events aren't system failures — they're human ones: hesitation, silence, miscommunication, rushed judgment. Human capital is a controllable risk variable. These four levers are where you can move it.

FOUR LEVERS — AND THE QUESTIONS TO ASK IN THE MOMENT

## 1 Mindset

*Most patient-harm events aren't system failures —they're human ones: hesitation, silence, miscommunication, rushed. Thought drives feeling drives action drives result. In a hospital, handoffs install mindsets — "difficult family" is an instruction, not a description.*

- What thought am I (or my team) carrying into this — and is it actually true?
- What language did the handoff install — and does it deserve to survive contact with the patient?

## 2 Communication Clarity

*Stress, fear, and hierarchy degrade communication exactly when clarity matters most. Clarity isn't a soft skill — it's the prerequisite for an informed decision.*

- Has the team aligned its message before asking anyone to decide on it?
- If a stranger read only the chart, would they understand what really happened?

## 3 Influence

*Influence decides whether correct information changes a decision. When people are taught speaking up isn't safe, organizations bleed information they never see.*

- What information is not reaching me because someone learned it wasn't safe to send up?
- Have I made it easier for the person closest to the patient to interrupt me?

## 4 Decision Discipline

*Steady, grounded decisions under pressure — not reactive, approval-seeking, or fear-based. Discipline is staying with the purpose when the pressure turns personal.*

- What am I deferring — and is the cost of waiting higher than the cost of acting on what I already know?
- If I'm pausing — is it discipline, or is it avoidance?

**DO ONE THING THIS WEEK** *Pick one conversation, one handoff, or one decision in the next seven days — and run it through one lever. That's where it starts.*

**Peggy Cooke, JD**
Coach · Attorney

**Peggy Cooke, LLC**
peggy@peggycooke.com
**PeggyCooke.com**

STAY IN TOUCH

# TAB 8

# Vicarious Trauma

Association for Healthcare Risk Management of New York

2026 Annual Education Conference
June 5, 2026

Carolyn Reinach Wolf, Esq.

Elizabeth Eckhardt, LCSW, PHD

1

## WHAT IS TRAUMA?

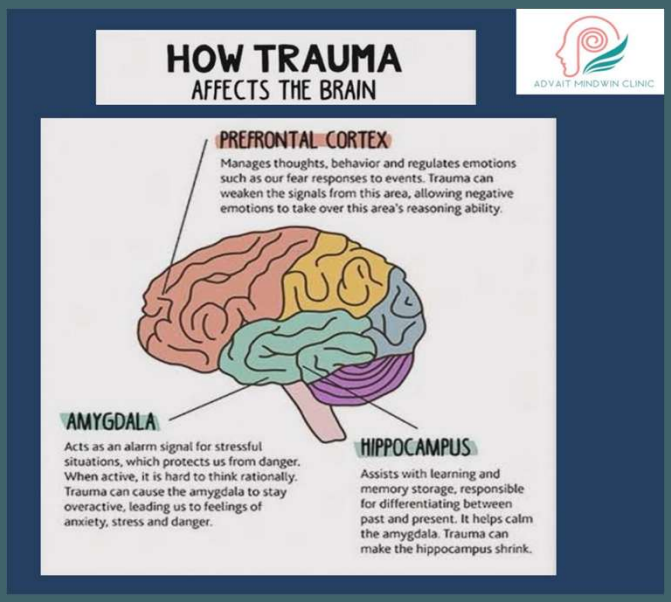
**Any disturbing experience** that results in significant **fear, helplessness, dissociation, confusion**, or other disruptive feelings intense enough to have a **long-lasting** negative effect on a person's **attitudes, behavior**, and other aspects of **functioning**.

Traumatic events include those caused by **human behavior** (e.g., rape, war, industrial accidents) and **nature** (e.g., earthquakes), that can **challenge** an individual's **world view** as a just, safe, and predictable place.

2

2

# TRAUMA AND THE BRAIN




3

# ADVERSE CHILDHOOD EXPERIENCES (ACE)

**Abuse:**

- **Emotional**
- **Physical**
- **Sexual**

**Neglect:**

- **Emotional**
- **Physical**

**Household:**

- **Divorce**
- **Incarceration**
- **Domestic Violence**
- **Mental Health/Substance Abuse**

**Other:**

- **Bullying**
- **Community Violence**
- **Natural Disaster**
- **Acts of Terrorism**
- **Wartime/Refugee Experiences**

4

4

# Vicarious Trauma v. Secondary Trauma

## Vicarious Trauma

**Definition**:

The **profound, cumulative shift in world view** that occurs in professionals when they work with individuals who have experienced trauma.

**Common Symptoms**:

- **Cognitive**: Intrusive imagery and/or a change in world-view, apathy, difficulty concentrating, rigid thinking, brain fog
- **Emotional**: Emotional numbness or detachment from people in need, guilt about not being able to care for others like you once did, inability to sympathize/empathize with others
- **Behavioral**: Easily startled/jumpy, withdrawal, sleep issues, changes in appetite, staff conflict
- **Physical**: Headaches, fatigue, and gastrointestinal issues, impaired immune functioning

## Secondary Trauma

**Definition**:

The **emotional duress** that results when an individual hears about the firsthand trauma experiences of another.

**Common Symptoms**:

- **Cognitive**: Apathy, difficulty concentrating, rigid thinking, brain fog
- **Emotional**: Excessive worry that something bad will happen, overwhelming fear in situations that others would not typically find frightening, helplessness
- **Behavioral**: Easily startled/jumpy, withdrawal, sleep issues, changes in appetite, staff conflict
- **Physical**: Racing heartbeat, shortness of breath, impaired immune functioning
- Symptoms of PTSD.

5

# Compassion Fatigue v. Burnout

## Compassion Fatigue

- Caused by **prolonged exposure to other people's suffering**
- Individuals affected by CF may be harmed by the work they do
- **Cognitive**: Intrusive imagery and/or a change in world-view, reduced concentration, brain fog, memory lapses
- **Emotional**: Emotional numbness or detachment from people in need, guilt about not being able to care for others like you once did, inability to sympathize/empathize with others
- **Behavioral**: Social withdrawal, unhealthy coping mechanisms like substance use, hypervigilance
- **Physical**: Headaches, fatigue, and gastrointestinal issues, impaired immune functioning

## Burnout

- Typically caused by **chronic workplace stress** that impacts an individual's ability to achieve their goals
- Usually caused by **not having enough resources** to do the work
- **Cognitive**: Apathy, reduced concentration, brain fog, memory lapses, decreased executive functioning
- **Emotional**: Cynicism and frustration towards your workplace and/or job, feeling dissatisfied, unappreciated, undervalued, and even resentful
- **Behavioral**: Procrastination, lack of productivity, and increased absenteeism
- **Physical**: Insomnia, heart palpitations, or a weakened immune system from frequent illness

6

# Overlapping Symptoms: What to look for in self and others

- Reduced empathy (e.g., inability to listen effectively when a client shares their story)
- Decreased work satisfaction
- Decreased productivity and effectiveness at work and in personal life
- Becoming emotionally detached and numb in professional and personal life
- Social isolation/emotional disconnection from others
- Perceiving resources and support as chronically outweighed by demands
- Feeling overwhelmed, physically and emotionally exhausted
- Becoming pessimistic, cynical, irritable, and prone to anger
- Viewing the world as inherently dangerous, and becoming increasingly vigilant about personal and family safety
- Secretly self-medicating/addiction (alcohol, drugs, work, sex, food, gambling, etc.

7

# Professions Most at Risk

- **Mental Health Professionals:** Therapists, Social Workers, and Counselors who treat trauma survivors.
- **Healthcare Providers:** Doctors, nurses, and emergency room staff treating victims of accidents, assault or severe illness
- **First Responders:** Police officers, paramedics, and firefighters who arrive at chaotic or life-threatening scenes.
- **Legal Professionals:** Judges, criminal prosecutors, public defenders, immigration attorneys.
- **Child Welfare Workers:** Professionals investigating child abuse and neglect.
- **Journalists and Media Workers:** those on location in war-torn countries, continuing exposure to violent news.

8

8

## Potential Negative Professional Outcomes

- **Impaired Decision Making**: Cognitive fatigue and "brain fog" severely hinder a professional's ability to concentrate, assess risks, and make sound clinical or professional judgments.
- **Decreased Care Quality:** Empathic strain, cynicism, and emotional numbness impede the ability to build effective therapeutic or helping relationships, often worsening client outcomes.
- **Boundary Violations:** Professionals may become over-involved, overstepping their professional roles out of a savior complex, or they may become emotionally detached and withdraw entirely.
- **Burnout:** Left unaddressed, vicarious trauma leads to profound physical, emotional, and mental exhaustion, which heightens absenteeism and job dissatisfaction.
- **High Turnover:** The overwhelming stress frequently drives skilled workers to leave their positions, causing significant talent drain and increased costs for organizations

9

9

## Possible Trauma-Related Behaviors

Appearing angry or defensive

Emotional numbness

Difficulty answering questions

Avoiding eye contact

Hypervigilance

Panic or dissociation

Emotional outbursts

Rapid breathing or shaking

Raised voice or pacing

Dissociation or emotional shutdown

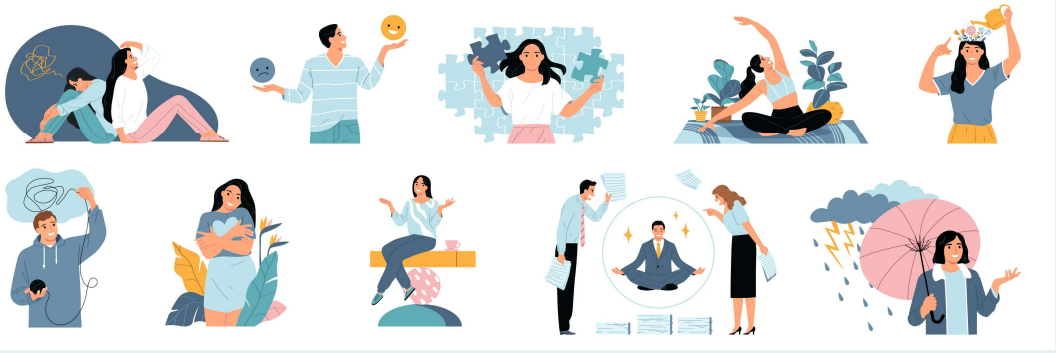
Confusion or inability to process information

Crying, anger, or visible panic

Hypervigilance or fear responses

10

10



# Personal and Organizational Mitigation Strategies

11

## Individual Strategies

- Build awareness. Understand what VT, ST, CF, and burnout are and periodically self-assess for it.
- Debrief. Talk regularly with others who understand and support you. This involves talking about the traumatic material, how you think and feel about it, and how you are personally affected by it.
- Maintain balance in relationships. Take steps to simplify, do less, ask for help, and stop trying to be all things to all people (including your clients). Shift your perspective to how you can work on balance rather than how you can't.
- Be intentional. If you're struggling, put a plan for change in place. Recognize that the personality traits that contribute to your professional success (e.g., perfectionistic, achievement-oriented, driven, fixer) and your work environment might contribute to an imbalance in your life.
- Ask for help.
- Practice self-care.

12

12

# Practicing Self-Care

## Physical

- Get enough sleep
- Stay hydrated
- Engage in physical activities you enjoy!
- Prioritize taking care of health issues
- Eat consistently and make healthy food choices
- Take breaks throughout the day to stretch and walk around

## Social

- Spend time with friends and/or family
- Limit use of social media/technology
- Attend networking/professional development opportunities to connect with others in the field
- Ask for what you need; reach out to others for support



## Emotional

- Seek support (from peers, supervisors, therapists)
- Set and maintain healthy boundaries
- Use tools like ProQOL to monitor levels of burnout and STS
- Take time off regularly, not just when you need a break
- Use breathing exercises to reduce stress
- Engage in hobbies you enjoy

## Spiritual

- Practice meditation
- Engage in mindfulness practices (e.g. focus on the present)
- Have a mantra or quote you can refer to that brings you comfort
- Spend time in nature
- Prioritize activities that align with your values

(Newman & Antonelli, 2022; Singh et al., 2020)

13

# Organizational Strategies: The Four "Rs" of the Trauma-Informed Workplace

1. Realization. Realize the pervasiveness of trauma among staff
2. Recognition. Recognize the type of trauma at play and the impact of witnessing violence
3. Response. Respond to these issues by incorporating an understanding of trauma into workplace practices
4. Resisting re-traumatization. Resist re-traumatization by examining and modifying potentially harmful practices

14

## Organizational Guidelines/Culture and Environment

- Ensure a safe and comfortable physical environment
- Promote a culture of caring, emotional, and social support from peers and supervisors
- Foster connection and cohesion by:
  - Formal debriefing (e.g., critical incident stress management), and/or
  - Informal debriefing (e.g., peer or professionally facilitated support groups, planned social activities)
  - Encourage a diverse workforce
- Have an ongoing system among leadership where staff are recognized for their strengths and accomplishments at work
- Ensure staff have the support & resources needed (e.g. adequate pay, vacation time, reasonable work-loads, regular check-ins with supervisors, clear goals).
- Create a collaborative management-staff Well-Being Team to offer trainings, presentations, and activities to address the negative effects of these issues, strategize ways to help, and promote and practice healthy skills
- Work with EAPs to identify areas of improvement through in-service trainings on self-care or counseling
- Provide a Psychologist Peer Advocate

15

## Organization Guidelines: Management & Supervision

- Supportive, respectful, and effective supervision includes an open discussion of mental health issues, strategies for addressing them, and compliance with relevant policies
- Actively promote a flow of direct and clear communication between frontline staff and upper management
- Provide positive and constructive feedback to staff and deliver it in a manner that is calm and in the staff member's best interest
- Clearly explain staff roles and responsibilities
- Clearly describe performance expectations

16

## Organizational Guidelines: Training and Professional Development

- Provide materials and training about VT, ST, CF, and burnout during new hire orientation
- Provide ongoing, periodic training to new and current employees about these issues. Make sure to cover consequences and strategies to address them.
- Encourage and support staff participation in continuing education opportunities, including outside workshops and conferences
- Promote collaboration with other related organizations for additional information sharing and social support

17

## Organizational Guidelines: Personnel Policies/Hiring Procedures

- During job interviews:
  - Educate applicants about potential mental health issues that may arise on the job to make sure they're aware of the potential risks associated with working with people who have experienced trauma
  - Incorporate questions for applicants to assess their knowledge of VT, ST, CF, and burnout, as well as their awareness and use of effective coping strategies
  - Assess the job candidates' training and preparation for their assigned role. Prepare to provide additional training where necessary
- For current staff:
  - Raise awareness of professional and personal self-care strategies through on-site trainings
  - Encourage staff to practice self-care both on and off work time
  - Include coverage for mental health services in employee health benefits
  - Identify experienced, trained, accessible, and approachable manager/staff to provide confidential support and referrals
  - Reach out to LAP for updates on referral services

18

## Organizational Guidelines: Periodic Evaluations

- Periodic organization-wide assessments via informal discussions with staff, debriefing sessions, and assessment tools (e.g., Professional Quality of Life Scale, Secondary Traumatic Stress Scale)
- Periodic formal evaluations that include questions related to VT, ST, CF, and burnout, and assess employees' perceptions of efforts to reduce their impact
- Anonymous survey to elicit staff feedback and assess organizational satisfaction
- Create opportunities and procedures for staff to vary their duties and alleviate heavy caseloads
- During exit interviews, ask for recommendations to improve the organizations' response to these issues and its impact on staff well-being, turnover, and quality of work life

19

ABRAMS FENSTERMAN, LLP
ATTORNEYS AT LAW



## Mental Health Toolkit

- Goal is safety, stability and support of their loved ones and themselves through:
  - Interventions
  - Mental Hygiene Warrants
  - Inpatient admissions
  - Protective Measures
    - Extreme Risk Protection Orders
    - Orders of Protection
  - AOT and ACT referrals
  - Case management
  - Execution of legal documents
    - Health Care Proxies
    - Powers of Attorney
    - Trusts
    - HIPAA Authorizations
  - MHL Article 81 Guardianships

www.abramslaw.com

20

ABRAMS FENSTERMAN, LLP
ATTORNEYS AT LAW



## Mental Health Red Flags: Recognizing Potential Mental Health Challenges:

Symptoms of vicarious trauma can include:

- Apathy. When an attorney begins to feel numb and detached. This is often experienced as lack of empathy or caring and can make an attorney less able to listen effectively to clients when they tell their stories. This can impact the ability to practice law effectively.
- Racing, intrusive, negative thoughts and images related to the client's traumatic experiences.
- Disturbed sleep, having disturbing images from cases intrude into thoughts and dreams.

www.abramslaw.com

21

ABRAMS FENSTERMAN, LLP
ATTORNEYS AT LAW



## Mental Health Red Flags: Recognizing Potential Mental Health Challenges:

Additional symptoms of vicarious trauma can include:

- Difficulty maintaining work-life boundaries.
- Avoidance of people you love, places, and activities that you used to find enjoyable, leaving work as the only activity.
- Feeling emotionally numb, disconnected or unable to empathize.
- Chronic exhaustion and related physical ailments: Inexplicable digestive discomfort, aches and pains.

www.abramslaw.com

22

ABRAMS FENSTERMAN, LLP
ATTORNEYS AT LAW



## Mental Health Red Flags

- Memory loss.
  - Inability to recall information discussed in prior meetings or communications.
- Communication problems.
  - Difficulty staying on topic, repetitive.
- Lack of mental flexibility.
  - Refusal to consider alternates or discuss the lawyer's recommendation.
- Unable to understand or acknowledge multiple options or viewpoints.

www.abramslaw.com

23

ABRAMS FENSTERMAN, LLP
ATTORNEYS AT LAW



## Mental Health Red Flags

- Disorientation relative to space, time, or location.
- Emotional inappropriateness.
  - Wide range of emotions, inappropriate laughter or crying.
- Behavioral signs.
  - Delusions, beliefs that are unlikely to be true, poor grooming/hygiene.
  - Inappropriate behavior in the courtroom or at the lawyer's office.
- Inability to follow-up with the lawyer's requests for information and documentation.

www.abramslaw.com

24

ABRAMS FENSTERMAN, LLP
ATTORNEYS AT LAW



## Mental Health Red Flags

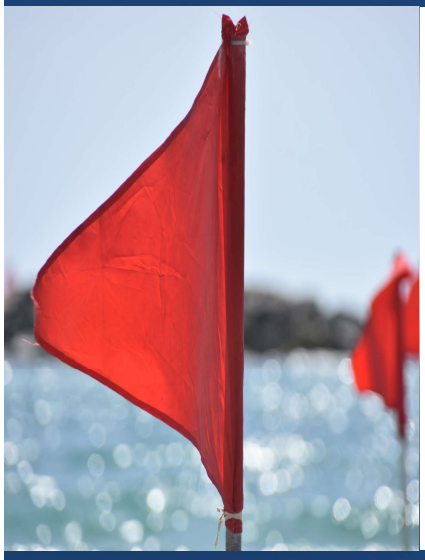
Mental illnesses are common in the United States with estimated that more than one in five U.S. adults live with a mental illness (57.8 million in 2021).

CREDIT – National Institute of Mental Health

www.abramslaw.com

25

ABRAMS FENSTERMAN, LLP
ATTORNEYS AT LAW



## Mental Health Red Flags

**Presumption of Capacity.**
For a typical adult client, capacity will be presumed. It is only when a lawyer observes signs of questionable capacity that an initial determination becomes necessary. Certain cognitive, emotional or behavioral abnormalities may be "red flags," signaling a mental health impairment triggering a capacity determination.

**Observed Signs of Diminished Capacity.**
When determining the extent of a client's diminished capacity, the client should demonstrate an ability to state the basis for his/her decision, and an ability to appreciate the consequences of a decision.

www.abramslaw.com

26

ABRAMS FENSTERMAN, LLP
ATTORNEYS AT LAW



**MENTAL HEALTH LEGAL TOOLKIT**

- **Guardianship or Conservatorship**
- **Management of Legal Affairs**
  - Health Care Proxy
  - Power of Attorney
  - Living Wills
- **Case Management Services**
- **Protective Measures**
  - Orders of Protection
  - Extreme Risk Protection Orders
- **Interventions**
- **Inpatient Hospitalization**
  - Voluntary
  - Involuntary
  - Court Ordered Mental Health Evaluations/Warrants
- **Outpatient Treatment**
  - Partial Hospitalization
  - Assisted Outpatient Treatment

www.abramslaw.com

27

ABRAMS FENSTERMAN, LLP
ATTORNEYS AT LAW



**Protective Measures:**
**Extreme Risk Protection Orders ("ERPO")**

An ERPO seeks to prohibit an individual from purchasing, possessing or attempting to purchase or possess a firearm, rifle or shotgun.

Caution: New York's Red Flag Law, Civil Practice Law and Rules ("CPLR") Article 63-a, has been declared unconstitutional in certain counties:

- R.M. v. C.M., 189 N.Y.S.3d 425, (Sup. Ct. Orange County, April 4, 2023) ("... as currently written, lacks sufficient statutory guardrails to protect a citizen's Second Amendment Constitutional right to bear arms.").
- G.W. v. C.N., 181 N.Y.S.3d 432, (Sup. Ct. Monroe County, December 22, 2022) (ERPO statute unconstitutional).
- Haverstraw Town Police v. C.G., 190 N.Y.S.3d 588, (Sup. Ct. Ulster County, April 20, 2023) (ERPO statute constitutional).

www.abramslaw.com

28

# Thank You

Carolyn Reinach Wolf, Esq.
Cwolf@Abramslaw.com

Elizabeth Eckhardt, LCSW, PHD
eeckhardt@nassaubar.org

29

# TAB 9

I

119TH CONGRESS
1ST SESSION

# H. R. 3178

To protect hospital personnel from violence, and for other purposes.

---

IN THE HOUSE OF REPRESENTATIVES

MAY 5, 2025

Ms. DEAN of Pennsylvania (for herself and Mrs. MILLER-MEEKS) introduced the following bill; which was referred to the Committee on the Judiciary

---

# A BILL

To protect hospital personnel from violence, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Save Healthcare Workers Act''.

**SEC. 2. PREVENTION OF VIOLENCE AGAINST HOSPITAL PERSONNEL.**

(a) FINDINGS.—Congress makes the following findings:

(1) The incidence of assault and intimidation against hospital employees poses a serious national problem.

(2) The problem of assault and intimidation against hospital and health care employees preceded the COVID–19 pandemic. According to an April 2020 Bureau of Labor Statistics report, the health care and social service industries experienced the highest rates of injuries caused by workplace violence and were 5 times as likely to suffer a workplace violence injury than workers overall in 2018. That report also found that the incidence rate for workplace violence against health care workers had steadily increased since 2011. The COVID–19 pandemic exacerbated this growing problem.

(3) Workplace violence in hospitals inhibits hospital employees from performing their duties and thereby disrupts the delivery of health care services and leads to adverse patient outcomes. Violence towards hospital workers also has been associated with decreased productivity and quality of care, employee absenteeism, and increased employee turnover.

(4) State and local authorities are now and will continue to be responsible for prosecuting the overwhelming majority of violent crimes in the United

States, including assault and intimidation against hospital employees. These authorities can address the problem of assault and intimidation against hospital employees more effectively with greater Federal law enforcement involvement.

(5) Existing Federal law is inadequate to address this problem.

(6) Assault and intimidation against hospital employees substantially affects interstate commerce in many ways, including the following:

(A) Health care services are a significant part of the national economy. In 2023, expenditures on health care services accounted for 17.6 percent of the country's gross domestic product. Within health care, hospitals and health systems are economic pillars that create jobs and support economic growth across State lines.

(B) The health care market, and hospitals in particular, are heavily regulated by the Federal Government.

(C) Hospital revenue comes from interstate or Federal sources, such as out-of-State insurers or Medicare.

(D) Hospital employees who are victims of assault or intimidation are prevented from pur-

chasing goods and services, obtaining or sustaining employment, or participating in other commercial activity.

(E) Facilities and instrumentalities of interstate commerce have been used in the commission of assault and intimidation against hospital employees.

(F) Assault and intimidation against hospital employees has been committed using articles that have traveled in interstate commerce.

(7) In Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 329–30 (1991), the Supreme Court of the United States held that it is ''clear'' that hospitals are ''regularly'' engaged in interstate commerce, performing services for out-of-State patients and generating revenues from out-of-State sources.

(8) In Taylor v. United States, 579 U.S._____(2016), the Supreme Court of the United States ruled that activities that affect commerce may be regulated so long as they substantially affect interstate commerce in the aggregate, even if their individual impact on interstate commerce is minimal. In addition, as the United States Court of Appeals for the Fourth Circuit recognized in United States v. Hill, 927 F.3d 188 (4th Cir. 2019), Taylor and

other Supreme Court decisions establish that when Congress may regulate an economic or commercial activity—as it may with respect to hospitals—it also may regulate violent conduct that interferes with or affects that activity. Accordingly, if individuals are engaged in ongoing economic or commercial activity subject to congressional regulation—as hospital employees are—then Congress also may prohibit violent crime that interferes with or affects such individuals' ongoing economic or commercial activity.

(9) Federal jurisdiction over certain violent crimes against hospital employees enables Federal, State, and local authorities to work together as partners in the investigation and prosecution of such crimes.

(10) The problem of assault and intimidation against hospital employees is serious, widespread, and interstate in nature as to warrant Federal assistance to hospitals to combat that activity.

(b) PROHIBITION ON ASSAULT OF HOSPITAL PERSONNEL IN THE PERFORMANCE OF DUTIES.—

(1) IN GENERAL.—Chapter 7 of title 18, United States Code, is amended by adding at the end the following:

**"§ 120. Assault of hospital personnel**

''(a) IN GENERAL.—Whoever knowingly assaults an individual employed by a hospital, or an entity contracting with a hospital or other medical facility, during the course of the performance of the duties of such individual, and, as a result, interferes with the performance of the duties of such individual or limits the ability of such individual to perform such duties, shall be fined under this title, imprisoned not more than 10 years, or both.

''(b) ENHANCED PENALTIES.—

''(1) ACTS INVOLVING DANGEROUS WEAPONS OR ACTS THAT RESULT IN BODILY INJURY.—Whoever, in the commission of any act described in subsection (a), uses a deadly or dangerous weapon or inflicts bodily injury, shall be fined under this title or imprisoned not more than 20 years, or both.

''(2) ACTS COMMITTED DURING EMERGENCY DECLARATIONS.—Whoever commits any act described in subsection (a) during the period of a declaration of a public emergency for the area in which the act is committed shall be fined under this title or imprisoned not more than 20 years, or both.

''(c) AFFIRMATIVE DEFENSE.—It shall be an affirmative defense to a prosecution under this section that—

''(1) the defendant is a person with a physical, mental, or intellectual disability; and

''(2) the conduct of the defendant was a clear and direct manifestation of such disability.

''(d) DEFINITIONS.—In this section:

''(1) HOSPITAL.—The term 'hospital' means any of the following medical facilities:

''(A) A hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))).

''(B) A long-term care hospital (as defined in section 1861(ccc) of such Act (42 U.S.C. 1395x(ccc))).

''(C) A rehabilitation facility (as defined in section 1886(j)(1)(A) of such Act (42 U.S.C. 1395ww(j)(1)(A))).

''(D) A cancer hospital (as described in section 1886(d)(1)(B)(iii) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iii))).

''(E) A children's hospital (as described in section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v))).

''(F) A critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1))).

''(G) A rural emergency hospital (as defined in section 1861(kkk)(2) of such Act (42 U.S.C. 1395x(kkk)(2))).

''(2) DECLARATION OF A PUBLIC EMERGENCY.—The term 'declaration of a public emergency' means any of the following:

''(A) A public health emergency declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act.

''(B) An emergency or disaster declared by the President pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act.''.

(2) CLERICAL AMENDMENT.—The table of sections for chapter 7 of title 18, United States Code, is amended by adding at the end the following:

''120. Assault of hospital personnel.''.

(c) GRANTS FOR THE PROTECTION OF THE HOSPITAL WORKFORCE AGAINST VIOLENCE.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10101 et seq.) is amended by inserting after part OO the following:

## "PART PP—GRANT PROGRAM FOR HOSPITAL WORKFORCE SAFETY AND SECURITY

**"SEC. 3061. GRANT AUTHORIZATION.**

''(a) IN GENERAL.—The Attorney General may make grants under this part to hospitals for the purpose of carrying out programs to reduce the incidence of violence at hospitals, including violence or intimidation against hospital personnel in the performance of their duties.

''(b) USE OF FUNDS.—A grant awarded under this part shall be used to reduce the incidence of violence at hospitals through programs that may include one or more of the following:

''(1) Training hospital personnel to prevent violence or intimidation against others or themselves, including de-escalation training and specialized training in responding to mental health crises.

''(2) Coordination with State and local law enforcement.

''(3) Placement and use of hospital access control technologies, video surveillance, metal detection, panic buttons, status alert systems, restricted access capabilities, and safe patient and staff rooms, and other violence-prevention tools or measures.

''(4) Any other measures that the Attorney General determines may provide a significant improvement in—

''(A) training for violence prevention at hospitals; and

''(B) protection against violence and intimidation of hospital personnel.

''(c) PREFERENTIAL CONSIDERATION IN AWARDING GRANTS.—In awarding grants under this part, the Attorney General shall give preferential consideration, if feasible, to an application from a hospital that—

''(1) has a demonstrated need for improved security;

''(2) has a demonstrated need for financial assistance; and

''(3) has evidenced the ability to make the improvements for which the grant amounts are sought.

''(d) EQUITABLE DISTRIBUTION OF GRANT FUNDS.—In awarding grants under this part, the Attorney General shall ensure, to the extent practicable, an equitable geographic distribution among the regions of the United States and among urban, suburban, and rural areas.

''(e) ADMINISTRATIVE COSTS.—Not more than 2 percent of a grant made under this part may be used for costs incurred to administer such grant.

**"SEC. 3062. APPLICATIONS.**

"(a) IN GENERAL.—To request a grant under this part, the chief executive of a hospital shall submit an application to the Attorney General at such time, in such form, and containing such information as the Attorney General may reasonably require.

"(b) REQUIREMENTS.—Each application under this section shall include—

"(1) a detailed explanation of—

"(A) the intended uses of funds provided under the grant; and

"(B) how the activities funded under the grant will satisfy the purpose of this part;

"(2) an assurance that the applicant shall maintain and report such programmatic and financial data, records, and information as the Attorney General may reasonably require; and

"(3) a certification, made in a form acceptable to the Attorney General, that—

"(A) the programs to be funded by the grant meet all the requirements of this part;

"(B) all the information contained in the application is correct; and

"(C) the applicant will comply with all provisions of this part and all other applicable Federal laws.

''(c) GUIDELINES.—Not later than 90 days after the date of the enactment of this part, the Attorney General shall promulgate guidelines to implement this section.

**''SEC. 3063. ANNUAL REPORT TO CONGRESS; GRANT ACCOUNTABILITY.**

''(a) ANNUAL REPORT.—Not later than 90 days after the end of the fiscal year for which funding for grants under this part is made available, the Attorney General shall submit to Congress a report regarding the activities carried out under this part. Each such report shall include, for the preceding fiscal year, the number of grants funded under this part, the amount of funds provided under those grants, and the activities for which those grant funds were used.

''(b) GRANT ACCOUNTABILITY.—Section 3026 (relating to grant accountability) shall apply to grants awarded by Attorney General under this part. For purposes of the preceding sentence, any references in section 3026 to part LL shall be considered references to part PP.

**''SEC. 3064. DEFINITION.**

''For purposes of this part, the term 'hospital' has the meaning given such term in section 120(d)(1) of title 18, United States Code.

**"SEC. 3065. AUTHORIZATION OF APPROPRIATIONS.**

''There are authorized to be appropriated $25,000,000 for each of fiscal years 2025 through 2034 to carry out this part. Funds appropriated for a fiscal year pursuant to the preceding sentence shall remain available until expended.''.

○

# CHECKLISTS FOR NY PUBLIC HEALTH LAW §2832 AND §2832-A

## I. Checklist for NY PHL §2832 (Workplace Violence Prevention Program)

- **[ ] Establish Program:** Develop and implement a written Workplace Violence Prevention Program (WVPP)
- **[ ] Form WVP Committee:** Establish multidisciplinary committee including Risk Management, Security, Nursing, HR, Legal/General Counsel, Clinical Leadership, Emergency Management, Employee/Frontline Representation, Union Representatives)
- **[ ] Conduct Safety and Risk Assessment:** Perform tailored, annual safety and security assessment that identifies risks based on hospital layout, incident reports and staff feedback.
- **[ ] Develop Written Safety and Security Plan**: Address identified risks, include specific mitigation strategies and reporting/response procedures and update plan to address newly identified material risks and operational changes.
- **[ ] Ensure Employee Involvement:** Actively involve employees and collective bargaining agents in risk assessment, program development, security planning and annual review process. Maintain documentation demonstrating meaningful participation.
- **[ ] Implement Security Measures:** Adopt policies to prevent violence, including engineering controls (e.g., access control, alarms).
- **[ ] Provide Training:** Train staff on identifying, handling, and reporting violent or disruptive behavior. Maintain training attendance/documentation records.
- **[ ] Establish Reporting System:** Maintain incident logs and reports, reviewing them annually.
    - **[ ] Create Incident Logs:** Build a standardized digital or physical system to document every workplace violence incident.
    - **[ ] Capture Required Data:** Ensure logs record the specific date, time, location, involved parties, description of the event, and injuries sustained.
    - **[ ] Retain Records:** Establish a data retention policy that archives these incident records for compliance auditing.
    - **[ ] Execute Annual Reviews:** Use recorded data to analyze trends during your mandatory annual safety and security assessments.
- **[ ] No-Retaliation Policy:** Ensure no retaliatory action is taken against employees who report violence or exercise rights.
- **[ ] Provide and Implement Support Programs**
- **[ ] Align WVPP with CMS Conditions of Participation, Joint Commission standards and Existing Emergency Preparedness Programs**

## II. Checklist for NY PHL §2832-a (Emergency Department Security)

- **[ ] Security Personnel Assignment:** In a general hospital located in a large city or county with 1 million+ population, provide at least one off-duty law enforcement officer or trained security personnel in the ED at all times.
- **[ ] Proximity Requirements:** In a general hospital located in a city or county of less than 1 million, position security personnel to be near or within close proximity to ED.
- **[ ] Exception Review:** Rural, sole community or critical access hospitals are generally exempt but must comply if the Commissioner of the NYS DOH determines they have increased rates of violence.

**KEY DATES AND REQUIREMENTS FOR**
**NY PUBLIC HEALTH LAW §2832 AND §2832-A**

- **Workplace Violence Prevention Program:** Effective September 18, 2026, implement a program to prevent and minimize workplace violence, including threats, injuries and deaths. **Full program implementation by September 18, 2027.**

- **Annual Workplace Safety and Security Assessment:** Beginning January 1, 2027 conduct formal annual workplace safety and security assessments tailored to size, complexity, local geographical factors affecting general hospital.

    - **Records Review:** Identify and analyze relevant threats and hazards, including violent incident reports, logs, concerns or complaints raised by staff, patients, visitors & unions
    - **Physical Security Review:** Evaluate facility layout, access points, visitor management
    - **Protective Factors and Engineering Controls Review:** Examine of alarms, communication systems, physical barriers
    - **Personnel Training:** Evaluate adequacy of employee training policies & security procedures, including the handling of disruptive or violent patients & other persons. Healthcare workers must be trained regarding the role of security in overall hospital operations.

- **Written Safety and Security Plan:** Based on the Safety and Security Assessment, develop and implement a corresponding Safety and Security Plan addressing workplace violence threats and hazards, involving employees and collective bargaining agents.

    - Update to address newly identified material risks and changes in conditions.
    - Specify methods to reduce identified risks (employee training, increased staffing and security, engineering controls such as barriers, lighting, security cameras, alarms and communication systems, safety equipment, general hospital improvements or modifications and other relevant measures).
    - Provide to Employees and Union Representatives:
        - written detailed summary of the safety and security plan
        - information about how to report incidents of workplace violence
    - Share appropriately redacted summaries of incident log, trends and analysis of relevant data with the hospital security or safety committee responsible for workplace violence and ensure the data is part of the workplace violence and assessment process.

- **Documentation:** Maintain all policies, training records, and incident reports on-site.

# SECTION 2832

Violence prevention program

## Public Health (PBH) CHAPTER 45, ARTICLE 28

* § 2832. Violence prevention program. 1. For the purposes of this section, the term "facility" shall mean a general hospital or a nursing home as defined in section twenty-eight hundred one of this article.

2. Within twelve months of the effective date of this section, every facility shall establish a workplace violence prevention program. Such program in a general hospital shall be consistent with regulatory requirements including the Centers for Medicare and Medicaid Services Hospital Conditions of Participation regarding caring for patients in a safe setting 42 CFR § 482.13(c)(2), and emergency preparedness 42 CFR § 482.15(a) and (d)(1), and the workplace violence standards of any accrediting organization deemed by the Centers for Medicare and Medicaid Services under which such hospital maintains accreditation provided however, such standards are comparable to those established by The Joint Commission. The purpose of such a program shall be to protect health care workers, patients, facility residents, and visitors. The program shall, at a minimum, include the requirements set forth in this section.

3. Beginning January first, two thousand twenty-seven, all general hospitals shall conduct, not less than annually, a workplace safety and security assessment and develop a safety and security plan that addresses identified workplace violence threats or hazards. As part of the plan, a general hospital shall adopt security measures and policies, including personnel training policies designed to prevent or minimize identified workplace violence threats or hazards and protect employees, patients, and visitors from aggressive or violent behavior, including but not limited to, credible threats, assaults, injuries, and deaths. In conducting the assessment and developing the plan, general hospitals shall ensure the active involvement of employees, including the recognized collective bargaining agent or agents, if any, and may do so through established general hospital safety and security committees and

existing labor management committees. Nothing in this section shall diminish, supplant or restrict the rights, privileges and remedies of any employee or collective bargaining representative under applicable law, rule or regulation or under the terms of a collective bargaining agreement.

4. The safety and security assessment shall be tailored to the size, complexity, and local geographical factors affecting the general hospital and shall identify and consider relevant threats and hazards, including but not limited to workplace violence incident reports and incident logs, concerns or complaints raised by employees, patients, visitors and recognized collective bargaining representatives, safety and security considerations relating to the general hospital's layout and access points, visitor management, and protective factors such as access control, engineering controls to limit violence or protect employees, alarms and communication systems, and other relevant factors, as appropriate to the general hospital. Additionally, the assessment shall consider the adequacy of employee training policies and security procedures, including the handling of disruptive or violent patients and other persons. Health care workers regularly assigned to provide security in general hospital settings shall be trained regarding the role of security in overall hospital operations.

5. Based on the findings and ongoing review of the workplace violence assessment, general hospitals shall implement a workplace violence safety and security plan, which shall be updated as necessary to address newly identified material risks and changes in conditions. The safety and security plan shall specify methods to reduce identified risks, which may include employee training, increased staffing and security, engineering controls such as barriers, lighting, alarms and communication systems, safety equipment, general hospital improvements or modifications, and other appropriate measures relevant to the general hospital. Each general hospital shall provide a written detailed summary of the safety and security plan to its employees and collective bargaining representatives, if applicable. Each general hospital shall also provide information to its employees and collective bargaining representatives, if applicable, about how to report incidents of

workplace violence. Each general hospital shall share summaries of the incident log, appropriately redacted to protect the privacy of persons involved in an incident, trends and analysis of relevant data with the general hospital security or safety committee responsible for workplace violence and ensure that the data is part of the workplace violence assessment process.

6. Notwithstanding any provision of this section, compliance by a nursing home with the federal regulations 42 CFR 483.71(a)(3) and (b)(1), and 42 CFR 483.73(a)(1), governing nursing homes shall satisfy the requirements of this section for such facilities, provided that such assessments and plans address workplace violence threats and hazards.

* NB Effective September 18, 2026

## SECTION 2832-A

Emergency department security

## Public Health (PBH) CHAPTER 45, ARTICLE 28

* § 2832-a. Emergency department security. 1. A general hospital located in a city or county with a population of one million or more shall be required to have at least one off-duty law enforcement officer or trained security personnel be present at all times in the emergency department, subject to emergent circumstance in any hospital that requires an adjustment in personnel.

2. A general hospital located in a city or county with a population less than one million shall be required to have at least one off-duty law enforcement officer or trained security personnel on premises at all times in a manner that prioritizes physical presence near, or within close proximity to, the emergency department of such hospital with direct responsibility to the emergency department. This shall not apply to hospitals designated as critical access hospitals, sole community hospitals, or rural emergency hospitals. However, if any such hospital experiences increased rates of violence or abuse of emergency department personnel, by an amount to be determined by the commissioner, evidenced by internal reporting pursuant to the violence prevention program or reports to law enforcement the commissioner shall work with the critical access hospital, sole community hospital, or rural emergency hospital to come into compliance with the requirement, to have at least one off-duty law enforcement officer or trained security personnel on premises at all times in a manner that prioritizes physical presence near, or within close proximity to, the emergency department of such hospital with direct responsibility to the emergency department, over a reasonable period of time.

* NB Effective September 18, 2026

119TH CONGRESS
1ST SESSION

# S. 1600

To protect hospital personnel from violence, and for other purposes.

---

IN THE SENATE OF THE UNITED STATES

MAY 5, 2025

Mrs. HYDE-SMITH (for herself and Mr. KING) introduced the following bill; which was read twice and referred to the Committee on the Judiciary

---

# A BILL

To protect hospital personnel from violence, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Save Healthcare Workers Act''.

**SEC. 2. PREVENTION OF VIOLENCE AGAINST HOSPITAL PERSONNEL.**

(a) PROHIBITION ON ASSAULT OF HOSPITAL PERSONNEL IN THE PERFORMANCE OF DUTIES.—Chapter 7 of title 18, United States Code, is amended by adding at the end the following:

**"§ 120. Assault of hospital personnel**

''(a) IN GENERAL.—Whoever knowingly assaults an individual employed by a hospital engaged in interstate commerce, or an entity contracting with a hospital or other medical facility engaged in interstate commerce, on the grounds of a hospital while the individual is engaged in or on account of duties at the hospital shall be fined under this title, imprisoned for not more than 10 years, or both.

''(b) ENHANCED PENALTIES.—

''(1) ACTS INVOLVING DANGEROUS WEAPONS OR ACTS THAT RESULT IN BODILY INJURY.—Whoever, in the commission of any act described in subsection (a), uses a firearm or dangerous weapon or inflicts serious bodily injury, shall, in addition to the penalties provided for in that subsection, be fined under this title, imprisoned for not more than 20 years, or both.

''(2) ACTS COMMITTED DURING EMERGENCY DECLARATIONS.—Whoever commits any act described in subsection (a) during the period of a declaration of a public emergency for the area in which the act is committed shall be fined under this title, imprisoned for not more than 20 years, or both.

''(c) AFFIRMATIVE DEFENSE.—

''(1) IN GENERAL.—It shall be an affirmative defense to a prosecution under this section that—

''(A) the defendant is a person with a physical, mental, or intellectual disability;

''(B) the conduct of the defendant was a clear and direct manifestation of such disability; and

''(C) the defendant, as a result of such disability, was unable to appreciate the nature and quality or wrongfulness of such conduct.

''(2) BURDEN OF PROOF.—The defendant has the burden of proving the defense under this subsection by a preponderance of the evidence.

''(d) DEFINITIONS.—In this section:

''(1) DANGEROUS WEAPON.—The term 'dangerous weapon' means a weapon, device, instrument, material, or substance, animate or inanimate, that is used for, or is readily capable of, causing death or serious bodily injury.

''(2) DECLARATION OF A PUBLIC EMERGENCY.—The term 'declaration of a public emergency' means an emergency or major disaster declared by the President pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.).

''(3) DISABILITY.—The term 'disability' means a disability described in section 3(1)(A) of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102(1)(A)).

''(4) GROUNDS OF A HOSPITAL.—The term 'grounds of a hospital' means the hospital buildings and the land used for the purposes of the hospital, including all buildings, roads, paths, and open spaces.

''(5) HOSPITAL.—The term 'hospital' means any of the following medical facilities:

''(A) A hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))).

''(B) A long-term care hospital (as defined in section 1861(ccc) of such Act (42 U.S.C. 1395x(ccc))).

''(C) A rehabilitation facility (as described in section 1886(j)(1)(A) of such Act (42 U.S.C. 1395ww(j)(1)(A))).

''(D) A children's hospital (as described in section 1886(d)(1)(B)(iii) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iii))).

''(E) A cancer hospital (as described in section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v))).

''(F) A critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1))).

''(G) A rural emergency hospital (as defined in section 1861(kkk)(2) of such Act (42 U.S.C. 1395x(kkk)(2))).

''(6) SERIOUS BODILY INJURY.—The term 'serious bodily injury' has the meaning given the term in section as the meaning given the term in section 1365(h).''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 7 of title 18, United States Code, is amended by adding at the end the following:

''120. Assault of hospital personnel.''.

**SEC. 3. GAO STUDY.**

The Comptroller General of the United States shall conduct a study on—

(1) how this Act, and the amendments made by this Act, has affected workplace violence in healthcare settings; and

(2) whether Federal, State, Tribal, and local prosecutions for workplace violence in healthcare settings have increased or decreased because of the

ability to prosecute these incidents as Federal crimes.

○

# TAB 10

# The 4P Solution Notes Page

