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

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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
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
Taryn	Fitzgerald	Partner	Barker Patterson Nichols

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First Name	Last Name	Title	Company
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
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
Michael	La Pinta	Associate	Rubin Paterniti Gonzalez Rizzo Kaufman
Meredith	Lander	Senior Associate	Schiavetti Corgan DiEdwards Weinberg & Nicholson
Ari	Leesa	Partner	Kaufman Borgeest & Ryan
Randi	Lehrman	Partner	Shaub Ahmuty Citrin & Spratt
Dawn	Lewis	Senior Vice President	EmPRO 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
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

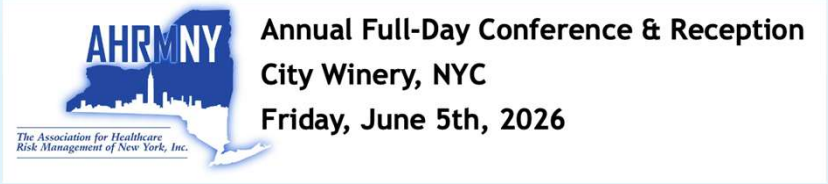
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First Name	Last Name	Title	Company
Wilhemina	Nyarko	Senior Director, Risk Management	The Brooklyn Hospital Center
Alison	O'Dwyer	Partner	Fullerton Beck
Kiki	Orski	President	Peak Performance Consulting
Kerry	Ostendorf	Sr. Risk Solutions Consultant	Princeton Insurance/MedPro Group
Tim	Over	SVP, Business Development	Gallagher Bassett Specialty
Christina	Papadopoulos	Managing Partner	Rubin Paterniti Gonzalez Rizzo Kaufman
Andrea	Patram	Director, Risk Management	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	Partner	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
Samantha	Quinn	Partner	Schiavetti Corgan DiEdwards Weinberg & Nicholson
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
Elizabeth	Sandonato	Partner	Martin Clearwater & Bell
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	Clinical Patient Safety Analyst	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
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

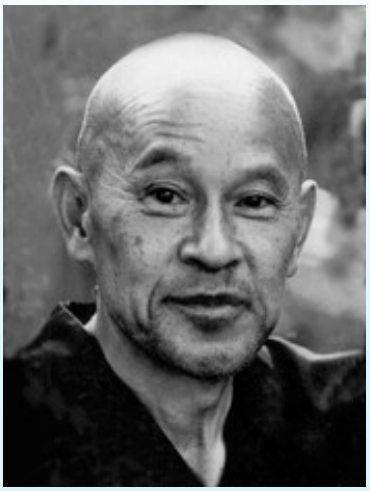
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Learning Objectives:

- 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.

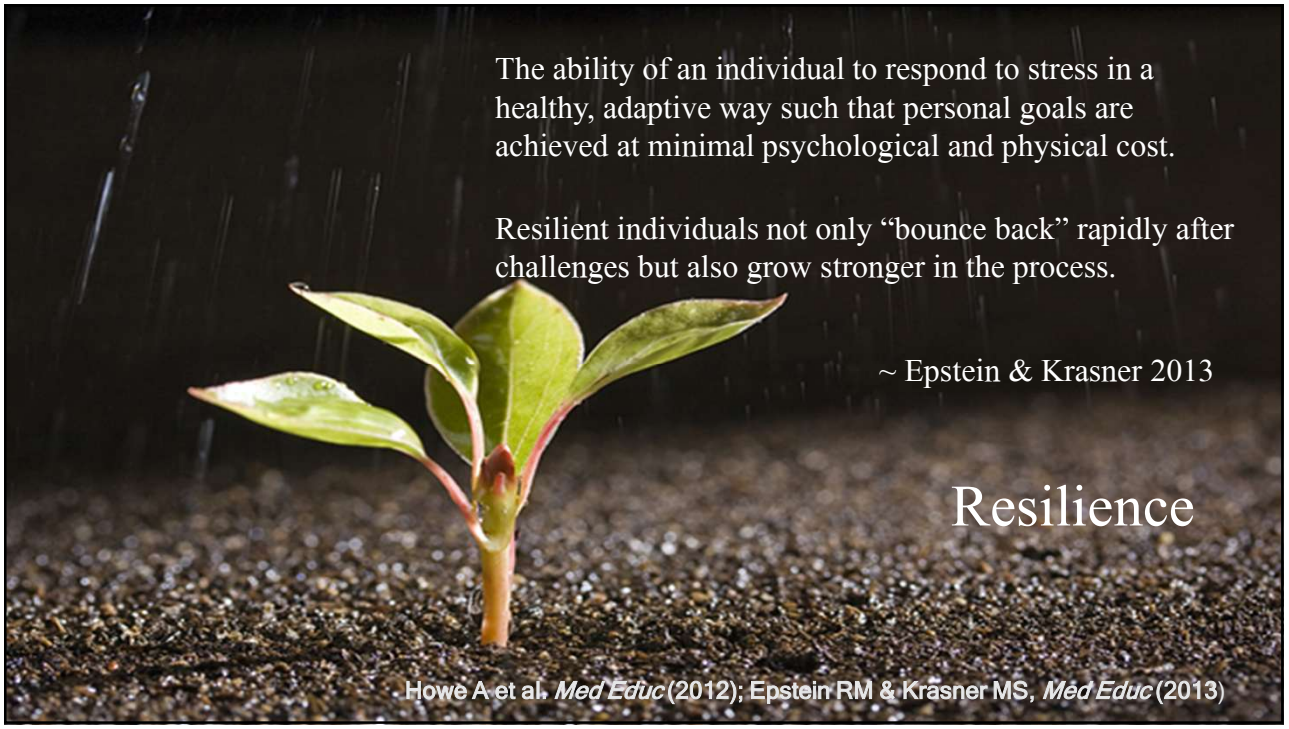
Michael Radetsky, MD "Sudden Intimacies" JAMA, 1985

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

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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.

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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?

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11

Work-related distress

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

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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

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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

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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.

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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

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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:

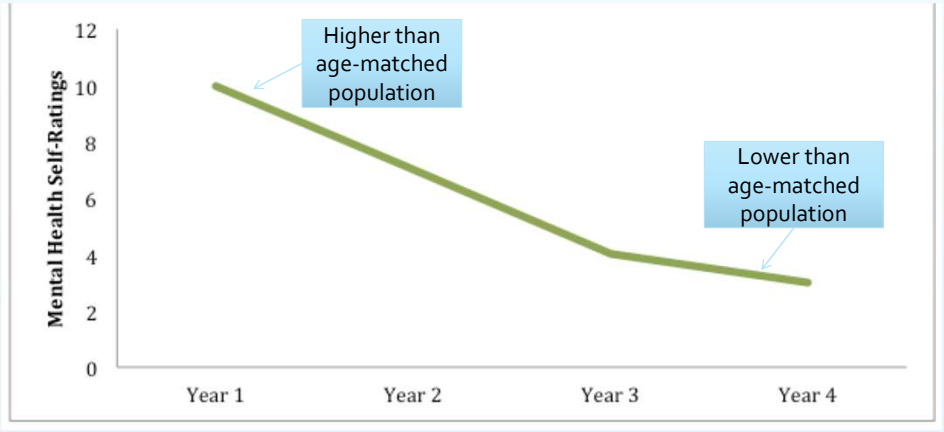
- Lower productivity
- Absenteeism, attrition
- Higher recruitment costs

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

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Medical student mental health and life satisfaction



Kjeldstadli et al. BMC Med Educ (2006)

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What personality characteristics make an exemplary clinician ?

How do those same characteristics become problematic?

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Positive Values		
Service, altruism		
Excellence		
Competence		
Knowledge		
Empathy		
Caring		
Equanimity		

Nedrow A 2013

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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

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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

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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



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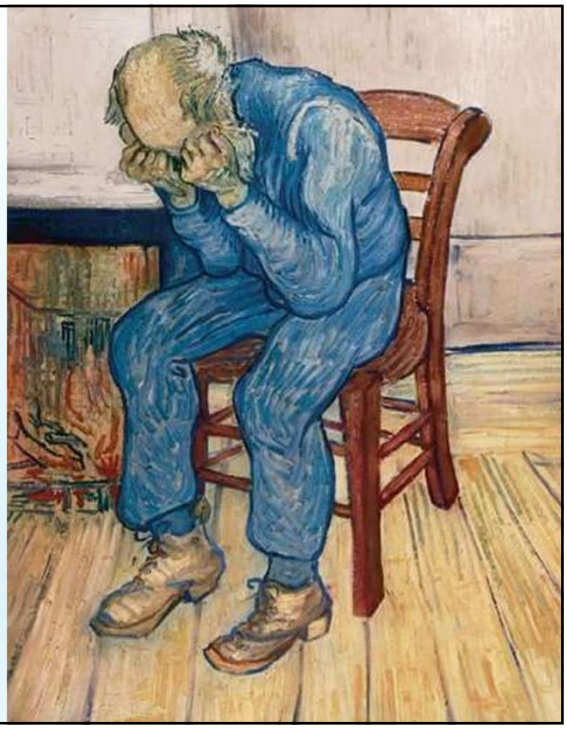
24

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

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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

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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

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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

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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

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



"This doesn't look good."

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What can healthcare institutions do?

Pro-active

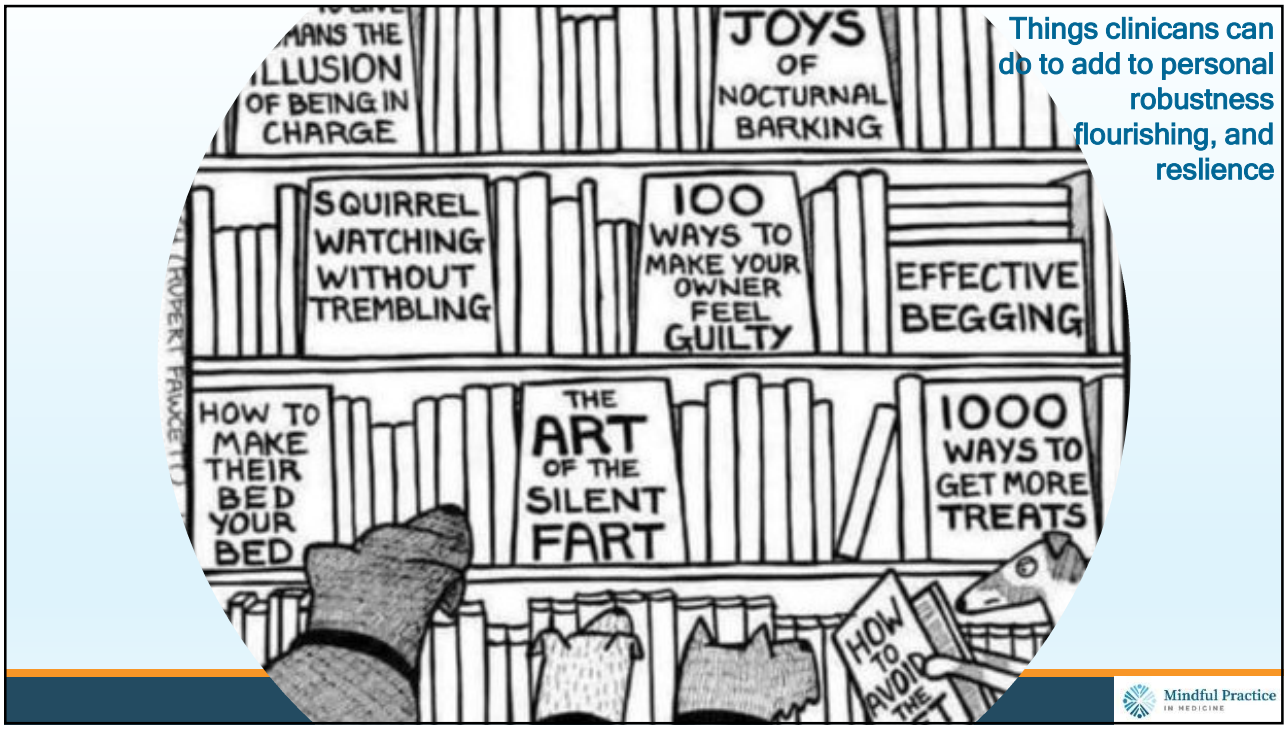
- Keep staff safe
- Flexibility in scheduling
- Measure clinician well-being
- Human factors design
- Reduce regulatory/admin burden
- Coaching programs
- Quiet spaces, food, exercise
- Forums for reflection and self-awareness

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

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Things individuals can do?

- Practice
- Stay engaged
- Listen deeply
- Create community

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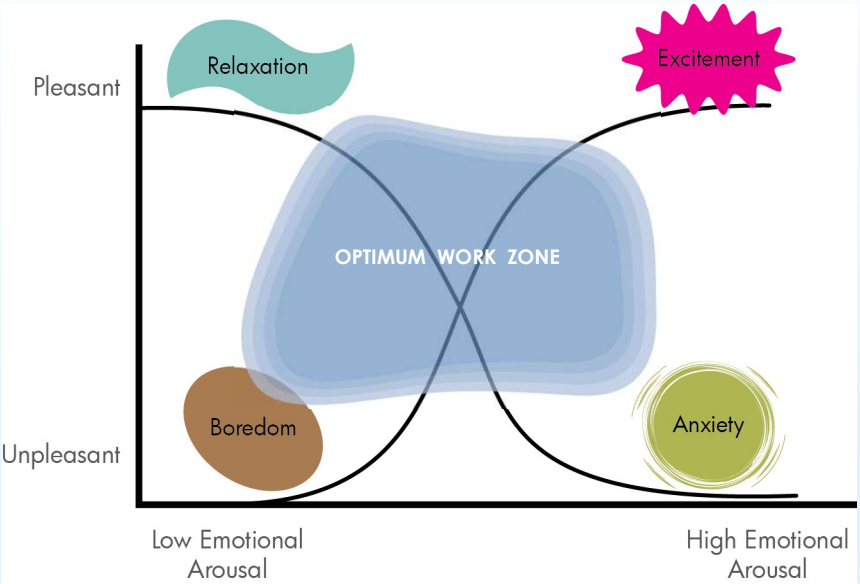
Keys to resilience – the research

- 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)

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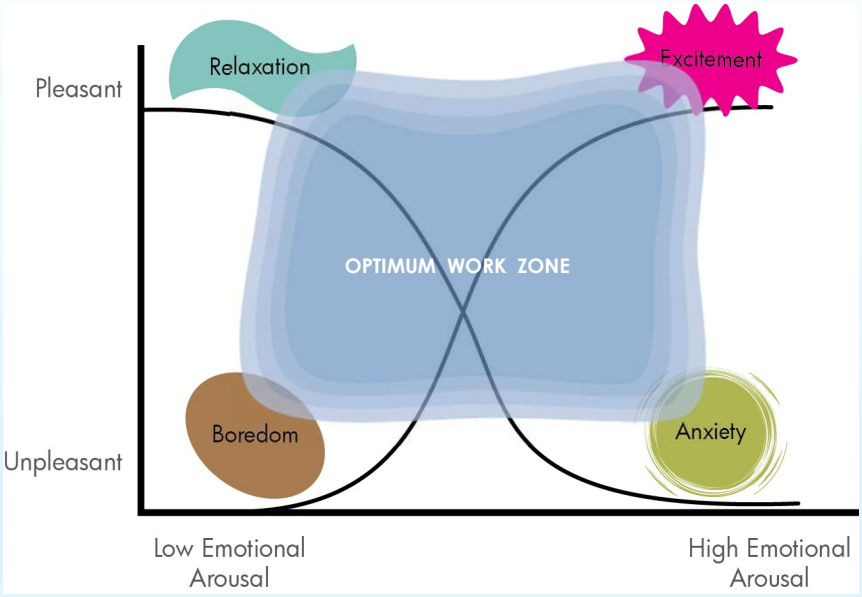
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After Apter M, Reversal theory (1989)

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After Apter M, Reversal theory (1989)

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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



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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?

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20%

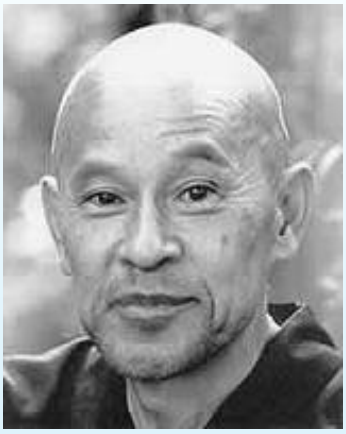
… the extent to which an individual is able to focus their effort on the aspect of work that they find most meaningful

Career Fit

Shanafelt TD, Arch Int Med (2009)

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"The most important thing

is to remember the most important thing."

Shunryu Suzuki-Roshi

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

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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.

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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

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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

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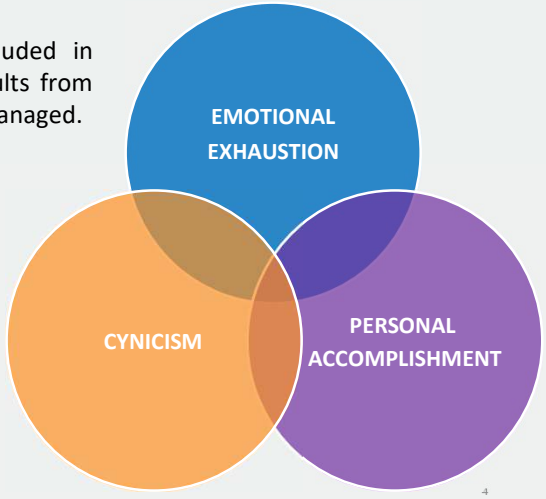
The Association for Healthcare Risk Management of New York, Inc.

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

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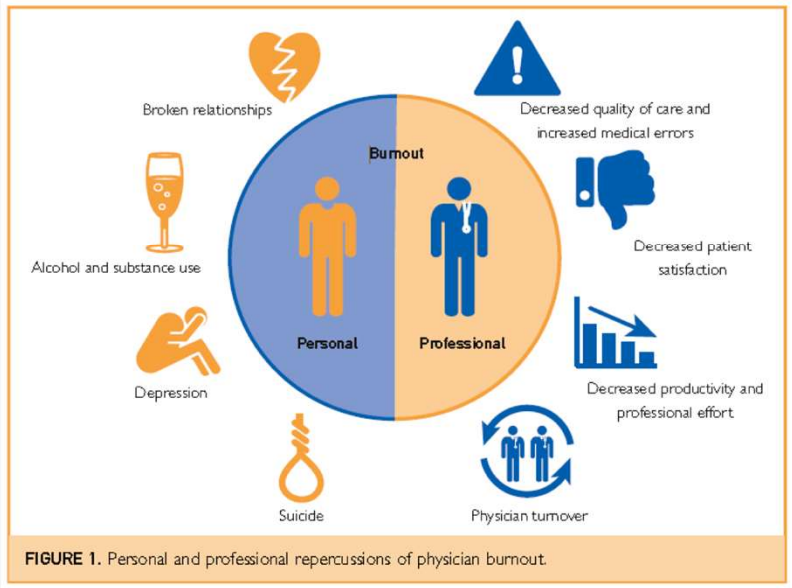


FIGURE 1. Personal and professional repercussions of physician burnout.

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

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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

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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

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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

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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)

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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

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Sources

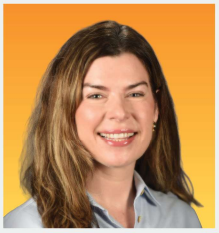
1. Elizabeth Grace Saunders, "**6 Causes of Burnout, and How to Avoid Them**," Harvard Business Review, 7/5/2019
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5. Tremont H. Malpractice Data Underscores Nationwide ED Boarding Crisis. Inside Medical Liability. Medical Professional Liability Association. 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.
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16

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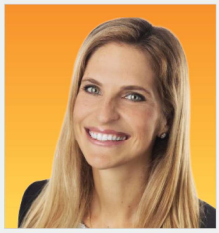
AHRMNY *The Association for Healthcare Risk Management of New York, Inc.*

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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

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2

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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

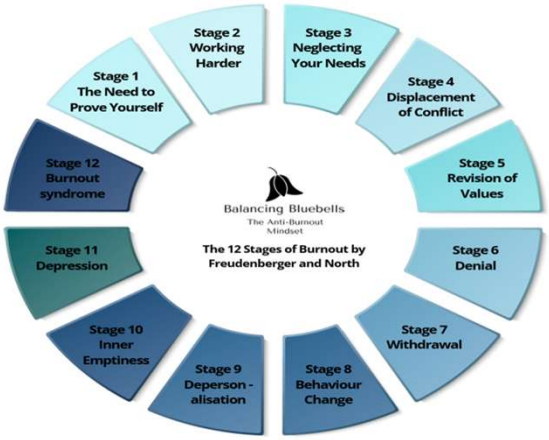
- Emotional exhaustion
- Depersonalization
- Reduced sense of accomplishment
- Apathy
- Physical exhaustion
- Reduced personal efficacy
- Feeling of cynicism
- Detachment

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

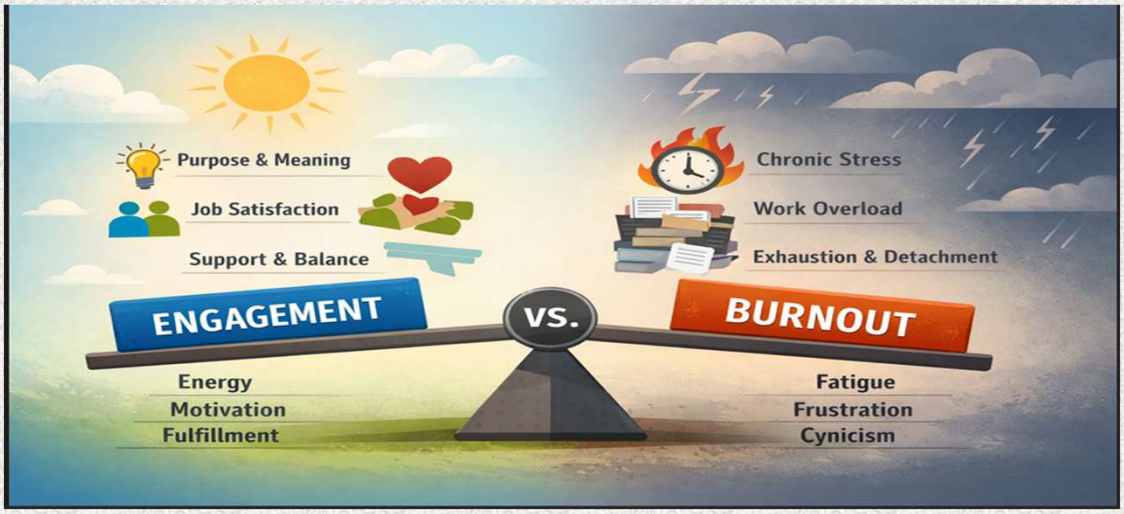
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Stages of Burnout

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

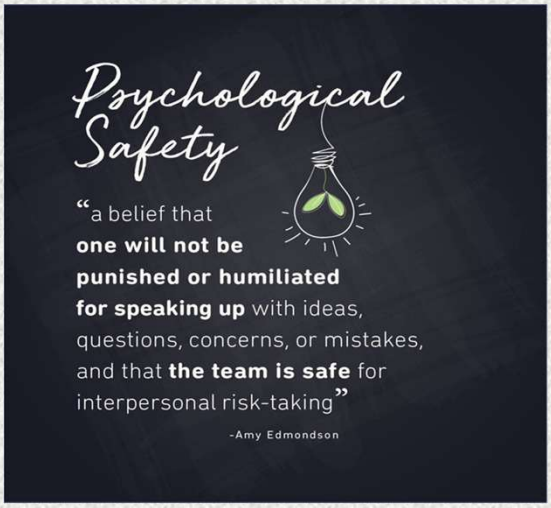
16

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

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What are your questions?

22

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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

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STAY IN TOUCH

TAB 8

VICARIOUS TRAUMA

1

WHAT IS TRAUMA?

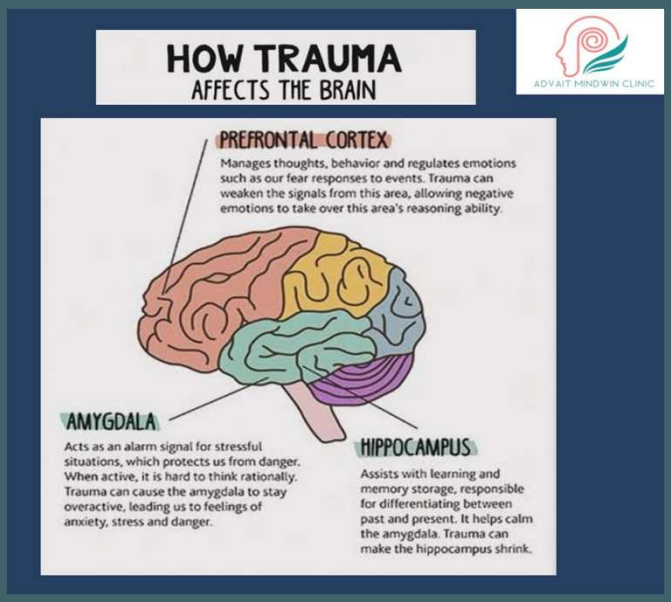
Any disturbing experience that results in significant **fear, helplessness, dissociation, confusion**, or other disruptive feelings intense enough to have a **long-lasting** negative effect on a person's **attitudes, behavior**, and other aspects of **functioning**.

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

Personal and Organizational Mitigation Strategies



10

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**.

11

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)

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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

13

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

14

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

15

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

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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

17

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

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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

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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.

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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.

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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.

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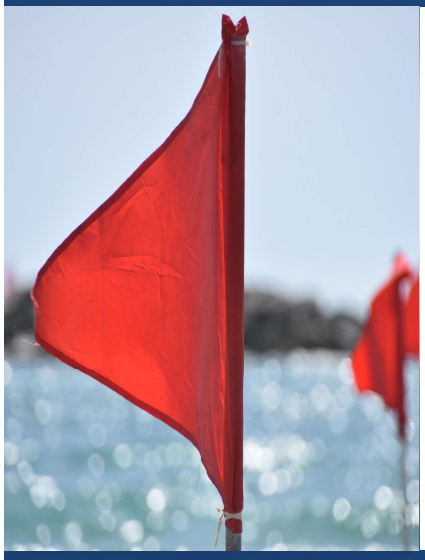
Mental Health Red Flags

- 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.

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Mental Health Red Flags

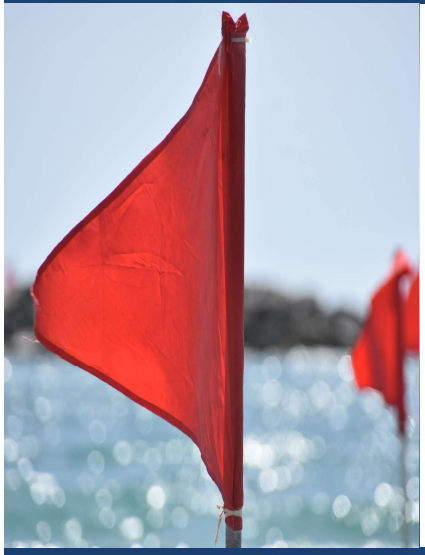
Mental illnesses are common in the United States with estimated that more than one in five U.S. adults live with a mental illness (57.8 million in 2021).

CREDIT – National Institute of Mental Health

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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.

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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

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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).

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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.''.

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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

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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.

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TAB 10

The 4P Solution Notes Page

