Annual Educational Conference
Friday, June 2, 2023 | 8:30 am - 4:00 pm
City Winery New York

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

Program Handouts

TAB 1 HANDOUT - Program Flyer

TAB 2 HANDOUT - The Human Side of Risk Management in Healthcare
- Speaker: Carol Silva

TAB 3 HANDOUT - Making the Connection: The Importance of Including Risk Managers in Healthcare Resiliency Planning for DAFN Populations
- Speakers: Rosemary McDonnell, Lloyd Bishop, Dennis Boyd, Andrew Dahl, Mary Mahoney

TAB 4 HANDOUT - Past Present Future: The Role of Nursing in Tomorrow's Healthcare
- Speaker: Launette Woolforde

TAB 5 HANDOUT - The Healthcare Risk Profession and the Leadership Imperative
- Speakers: Douglas Borg, Lisa Rathum

TAB 6 HANDOUT - Updates in Medical Malpractice Litigation
- Speakers: Barbara Goldberg, Gregory Cascino

Continuing Education Credits:

4.0 Risk Management Credits have been approved by the American Society for Healthcare Risk Management (ASHRM). Certificates will be distributed within 2 weeks after the program.

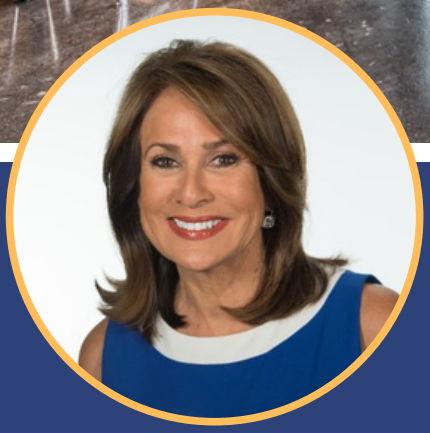
This program is being reviewed by the New York State CLE Board for 2.0 Continuing Legal Education Credits. Upon approval by the NYS CLE Board, certificates will be distributed to all attending attorneys.

TAB 1



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

2023 Annual Full-Day Conference & Reception



KEYNOTE SPEAKER

Carol Silva
Veteran Emmy Award Winner Anchor
News 12 Long Island

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

FRIDAY, JUNE 2

8:30 am - 6:30 pm

CITY WINERY
NEW YORK CITY

25 11TH AVENUE (AT 15TH STREET)
NEW YORK, NY 10011



KEYNOTE SPEAKER

Launette Woolforde
Deputy Chief Nursing Officer
Northwell Health System

Contact

ahrmny@gmail.com
www.ahrmny.com
973-641-5311

4:00 - 6:30 pm

COCKTAIL RECEPTION
IMMEDIATELY FOLLOWING
CONFERENCE

Click here for details and registration

Reserve Your Spot by May 19th

Guest Speakers



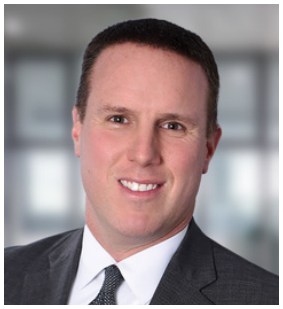
Lloyd C. Bishop
Senior Vice President
Community Health Equity Policy and Services
Greater New York Hospital Association



Douglas J. Borg, MHA, ARM, CPHRM, DFASHRM
Vice President, Risk & Quality
Premier Insurance Management



Dennis R. Boyd, Esq.
Senior Disability and Civil Rights Counsel
NYC Department of Emergency Management



Gregory A. Cascino, Esq.
Partner
Martin Clearwater & Bell LLP



Andrew Dahl
Vice President, Emergency Planning
Greater New York Hospital Association



Barbara D. Goldberg, Esq.
Partner
Martin Clearwater & Bell LLP



Mary Mahoney
Vice President of Emergency Management
& Clinical Preparedness
Northwell Health



Rosemary McDonnell
Senior Accessibility Specialist
DC Homeland Security &
Emergency Management Agency



Lisa Ramthun
RN, MSN, CPHRM, FASHRM, CPHQ
Enterprise Vice President
Clinical Risk & Claims Management
Thomas Jefferson University Health



Carol Silva
Veteran Emmy Award Winning Anchor
News 12 Long Island



Launette Woolforde
EdD, DNP, RN, NEA-BC, NPD-BC, FAAN
Chief Nursing Officer
Northwell Health: Lenox Hill Hospital
Manhattan Eye, Ear & Throat Hospital
Lenox Hill Greenwich Village

Deputy Chief Nursing Officer
Northwell Health System

READ OUR GUEST SPEAKER'S BIOS HERE

Program

REGISTRATION, BREAKFAST, AND ANNOUNCEMENTS

8:30 am - 9:30 am

AHRMNY welcomes attendees to arrive early, check in, enjoy breakfast, and network with colleagues before conference program begins.

9:30 am - 9:45 am

Victor R. Klein, MD

AHRMNY President welcomes all to AHRMNY's Annual Educational Conference and will provide information about the day's program and acknowledgment of our program sponsors.

MORNING KEYNOTE ADDRESS & PLENARY SESSION

9:45 am - 10:45 am

Carol Silva

MORNING KEYNOTE ADDRESS:
The Human Side of Risk Management in Healthcare

Special Keynote Speaker Carol Silva will share her experience on the power of talking to the human in the legalese world of Risk Management and the value of including plain speak in a complicated legal world. Ms. Silva will also discuss minimizing risk by focusing on the "Human Resource" that is your staff and the value of letting your staff know they're a key part of your "team".

10:45 am - 11:00 am

Refreshment Break

11:00 am - 12:00 pm

Rosemary McDonnell
Lloyd Bishop
Dennis Boyd
Andrew Dahl
Mary Mahoney

Making the Connection: The Importance of Including Risk Managers in Healthcare Resiliency Planning for Disability, Access, and Functional Needs (DAFN) Populations

Hear from five experts who will examine the risks associated with insufficient emergency planning for disability, access, and functional needs (DAFN) populations in NYC healthcare facilities in the scope of the 6 critical areas that the Joint Commission deems necessary for evaluation during emergency activations (communications, resources, staff responsibilities, safety and security, patient care, and utilities). The connection between incorporating these populations into resiliency planning will be made by also health equity initiatives that contribute to these efforts.

NETWORKING LUNCH & ANNUAL BUSINESS MEETING

12:00 pm - 1:00 pm

Lunch and Networking Break

1:00 pm - 1:30 pm

Annual Business Meeting - Several AHRMNY Board Members will provide highlights about the New York Chapter. During this session results from the annual Officers and Directors Election will be announced as well as information about upcoming educational programs and member events.

Program

AFTERNOON KEYNOTE ADDRESS & BREAKOUT SESSIONS

1:30 pm - 2:30 pm

Launette Woolforde

AFTERNOON KEYNOTE ADDRESS:
Past Present Future: The Role of Nursing in Tomorrow's Healthcare

Special Keynote Speaker Launette Woolforde will evaluate the current state of the nursing workforce and the impact on healthcare delivery. She will discuss nursing care models of the future and other innovations necessary to meet the future need in healthcare.

2:30 pm - 2:45 pm — **Refreshment Break**

2:45 pm - 3:45 pm — **BREAKOUT SESSIONS**

Douglas Borg
Lisa Ramthun

(1) - The Healthcare Risk Profession and the Leadership Imperative

Healthcare risk professionals often don`t view themselves as leaders within their own organizations. However, the scope and importance of the risk professional`s role puts them in a de facto leadership position, and the effectiveness of their program can depend on whether they are able to recognize the need to act on this leadership imperative. Unfortunately, the lack of consistency and standardization across the profession has left many with few opportunities for the training and experience necessary to become effective leaders. It's more important than ever that today's risk professionals understand how the critical nature of their responsibilities puts them in a unique position to develop their leadership skills and contribute significant value to the strategic success of their organizations.

Barbara Goldberg
Gregory Cascino

(2) - Updates in Medical Malpractice Litigation

Updates on relevant cases related to MIF, COVID Immunity, EDTPA, new cases and trends in medical malpractice litigation, New York's Medical Indemnity Fund, New Insurance Disclosure Laws, Updates on Sustainable Values

3:45 pm - 4:00 pm — **Wrap up and Final Announcements**

4:00 pm - 6:30 pm — **COCKTAIL RECEPTION**

TICKET PRICES:
$175 - Current AHRMNY Members
$225 - Nonmembers
$200 - Conference/Membership Bundle
(Nonmember attendees may take advantage of the discount offered when joining as a member and attending the conference)

Reserve Your Spot by May 19th

CONTINUING EDUCATION CREDITS:
Continuing education credits for this program is pending review by the American Society for Healthcare Risk Management for CEUs toward the designations of CPHRM, DFASHRM, and FASHRM and the New York State Continuing Legal Education Board for CLE credits.

FINANCIAL AID INFORMATION:
Click here for AHRMNY's financial aid policy

CLICK HERE TO REGISTER

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TAB 2



1



2



3

"I've almost never seen a client sued who had good bedside manner."

Medical Malpractice Attorney

4

"How do we respond to basic patient complaints?

How do we record them and share them so that every treatment team knows?"

5

"New York already has the highest medical liability insurance cost in America."

Medical Malpractice Consulting Firm

6

"It's time to revamp the basic patient system."

7

"Much of the motivation comes from how they feel after interactions with physicians and staff – or the lack thereof."

A Healthcare Risk Management Advisor

8

"A physician may have done everything right, but if he or she is not communicating efficiently, respectfully, and honestly with a patient, that patient tends to sue."

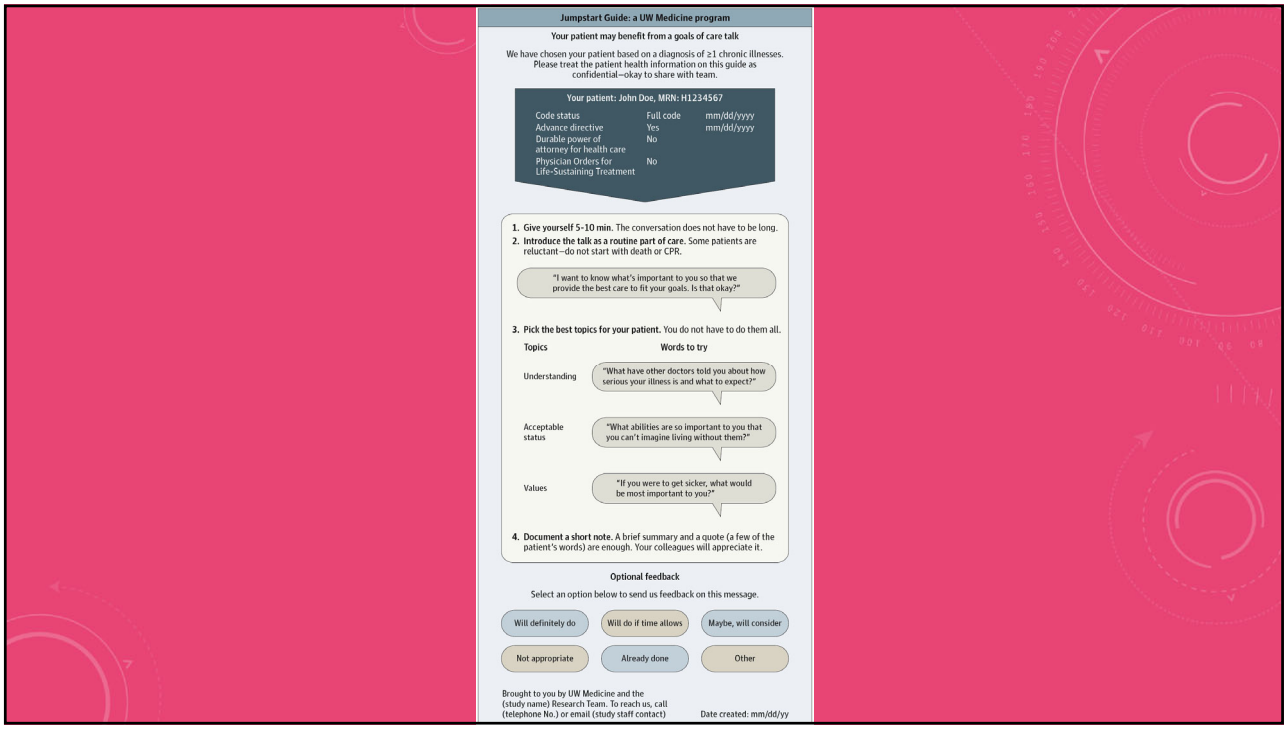
Insurance & Risk Management Law Journal

9

"People are less likely to buy from a company with an employee they perceive as rude, even if the rudeness isn't directed at them."

Harvard Business Review

10



Jumpstart Guide: a UW Medicine program

Your patient may benefit from a goals of care talk

We have chosen your patient based on a diagnosis of ≥1 chronic illnesses. Please treat the patient health information on this guide as confidential—okay to share with team.

Your patient: John Doe, MRN: H1234567

Code status	Full code	mm/dd/yyyy
Advance directive	Yes	mm/dd/yyyy
Durable power of attorney for health care	No	
Physician Orders for Life-Sustaining Treatment	No	

1. **Give yourself 5-10 min.** The conversation does not have to be long.
2. **Introduce the talk as a routine part of care.** Some patients are reluctant—do not start with death or CPR.

"I want to know what's important to you so that we provide the best care to fit your goals. Is that okay?"

3. **Pick the best topics for your patient.** You do not have to do them all.

Topics	Words to try
Understanding	"What have other doctors told you about how serious your illness is and what to expect?"
Acceptable status	"What abilities are so important to you that you can't imagine living without them?"
Values	"If you were to get sicker, what would be most important to you?"

4. **Document a short note.** A brief summary and a quote (a few of the patient's words) are enough. Your colleagues will appreciate it.

Optional feedback

Select an option below to send us feedback on this message.

Will definitely do | Will do if time allows | Maybe, will consider

Not appropriate | Already done | Other

Brought to you by UW Medicine and the (study name) Research Team. To reach us, call (telephone No.) or email (study staff contact)

Date created: mm/dd/yy

TAB 3

2023 AHRMNY Annual Educational Conference

Making the Connection:

The Importance of Including ***Risk Managers*** in Healthcare ***Resiliency Planning*** for ***Disability, Access, and Functional Needs*** Populations

The Problem

- **Lack of risk management involvement in inclusive emergency planning**
- **Disproportionate impact experienced by DAFN populations affected by disasters**
- **Risk associated with not sufficiently incorporating DAFN populations into emergency planning**
- **Lack of awareness, knowledge, & certifications in DAFN-related emergency planning literature/law**

Regulatory Requirements

CMS Emergency Preparedness Rule §484.102(a)(3)

- Hospital's EOP must "address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans"

* The 6 critical areas TJC requires healthcare facilities to evaluate in emergency activations are: (1) communications, (2) utilities, (3) resources & equipment, (4) safety & security, (5) staff responsibilities, and (6) patient care

The Joint Commission Standard EM 12.01.01, EP 2

- Hospital's EOP must "identify patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event"
- "At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence"

Regulatory Requirements cont'd

The Joint Commission National Patient Safety Goal NPSG.16.01.01, EP 1

- The [organization] designates an individual(s) to lead activities to improve health care equity for the [organization's] [patients].
- Note: Leading the [organization's] activities to improve health care equity may be an individual's primary role or part of a broader set of responsibilities.

Legal Requirements

- Stafford Act
- Pandemic and All-Hazards Preparedness Act (PAHPA)
- Executive Order 13347
- Post- Katrina Emergency Management Reform Act of 2006
- American with Disabilities Act of 1990 and ADA Amendments Act of 2008
- Telecommunications Act of 1996
- 21st Century Communications and Video Accessibility Act of 2010
- Assembly Bill 2311 (State Law)
- Rehabilitation Act of 1973
- Architectural Barriers Act of 1968
- Civil Rights Act of 1964

Legal Precedent

2011
Los Angeles (Communities Actively Living Independent and Free et al. v. City of Los Angeles)

2013
New York City (Brooklyn Center for Independence of the Disabled v. City of New York, 2013

2014
District of Columbia (United Spinal Association et al v. District of Columbia et al, 2014)

DC Settlement Agreement Mission Areas

Goal: Ensure the needs of people with disabilities and other access and functional needs are met before, during, and after disasters

- Outreach and Integration
- Accessible Emergency Communications
- Post-Emergency Canvassing
- Evacuation Planning
- Accessible Transportation During Emergencies
- Mass Care (power and sheltering)
- Evacuation Devices
- Emergency Planning, Training, and Exercising

Risk Management Involvement



Justification to hospital leadership



Reducing risk of potential legal exposure and patient safety issues



Addressing disaster-related standards of care, modification of the privileging and credentialing process, and negotiation of mutual-aid agreements with other hospitals

Panel Discussion: The Importance of Including Risk Managers in Healthcare Resiliency Planning for Disability, Access, and Functional Needs Populations

Moderator:

- **Rosemary McDonnell**, DPS, MPS, Senior Accessibility Specialist at *DC Homeland Security & Emergency Management Agency*

Panelists:

- **Lloyd Bishop**, Senior Vice President & Executive Director, Center on Community Health Equity Policy and Services Government Affairs, Communications, and Public Policy at *GNYHA*
- **Dennis R. Boyd**, Esq., Senior Disability and Civil Rights Counsel, *NYC Emergency Management*
- **Andrew Dahl**, Vice President of Emergency Planning at *GNYHA*
- **Mary Mahoney**, Vice President of Emergency Management & Clinical Preparedness, *Northwell Health*

Panel Discussion: The Importance of Including Risk Managers in Healthcare Resiliency Planning for Disability, Access, and Functional Needs Populations

Question 1: How have you seen the risks associated with not inclusively planning for emergencies actualized in your work?

Panel Discussion: The Importance of Including Risk Managers in Healthcare Resiliency Planning for Disability, Access, and Functional Needs Populations

Question 2: What parallels exist between DAFN and DEI work, and how have efforts in health equity changed over the past few years?

Panel Discussion: The Importance of Including Risk Managers in Healthcare Resiliency Planning for Disability, Access, and Functional Needs Populations

Question 3: What ethical issues are at play when it comes to inclusive emergency planning (e.g., evacuation, public health crises, etc.)?

Panel Discussion: The Importance of Including Risk Managers in Healthcare Resiliency Planning for Disability, Access, and Functional Needs Populations

Question 4: How can you best engage key players (e.g., emergency managers, risk managers, etc.) to become advocates for inclusive emergency planning?

Panel Discussion: The Importance of Including Risk Managers in Healthcare Resiliency Planning for Disability, Access, and Functional Needs Populations

Question 5: (in a few words) If you could pick one thing, what would be the biggest improvement you would like to see in inclusive emergency planning in healthcare and beyond?

Thank You



Rosemary McDonnell, DPS, MPS
Senior Accessibility Specialist
DC Homeland Security & Emergency Management Agency
Rosemary.McDonnell@dc.gov

TAB 4



Past, Present, Future: The Role of Nursing in Tomorrow's Healthcare

Launette Woolforde
EdD, DNP, RN, NEA-BC, NPD-BC, FAAN

Chief Nursing Officer
Lenox Hill Hospital, MEETH,
Lenox Health Greenwich Village

Deputy Chief Nursing Officer
Northwell Health

Objectives

By the end of this presentation the learner will:

- Evaluate the current state of the nursing workforce and the impact on healthcare delivery.
- Critique nursing care models of the future and other innovations necessary to meet the future need in healthcare.

Current state of healthcare

- Nearly 30 million nonelderly people in the US are uninsured

(down from more than 46.5 million in 2010)

- Approximately 40 million nonelderly people are underinsured

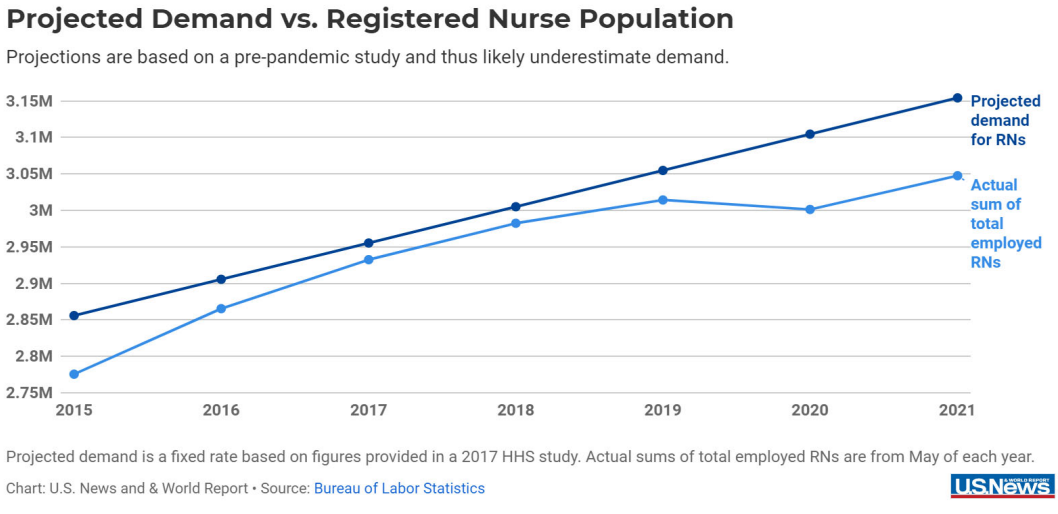
(34% of working adults)

- Inflation and cost of healthcare are high
- Labor shortage persists
- Nurses have options outside of acute care, traditional roles



(Collins et al., August 2020)

Current state of healthcare



Realities of healthcare

- Timely access challenges
- Unmanageable cost
- Complex, co-morbid health conditions
- Sick care model
- Patient-provider discordance



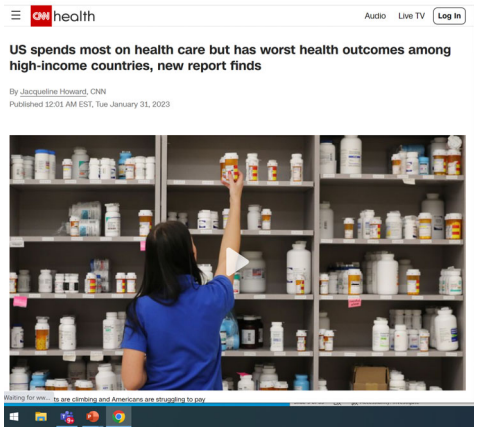
https://blogs.bmj.com/openscience/2018/09/25/navigating-the-maze-together-a-patients-perspective/

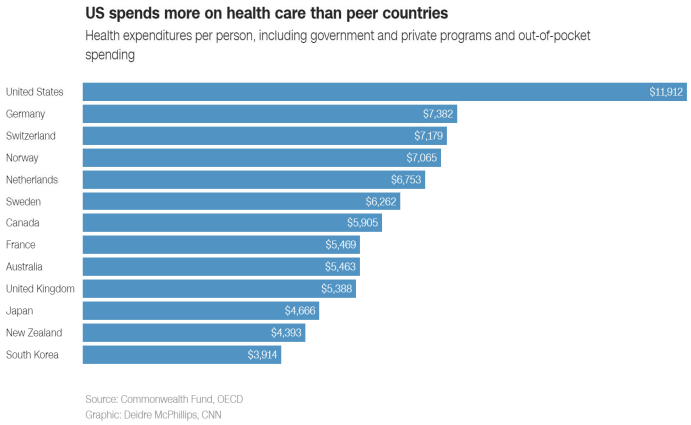
How well are we doing – global view

#	Country	Life Expectancy (both sexes)
1	Hong Kong	85.29
2	Japan	85.03
3	Macao	84.68
4	Switzerland	84.25
5	Singapore	84.07
6	Italy	84.01
7	Spain	83.99
8	Australia	83.94
9	Channel Islands	83.60
10	Iceland	83.52
11	South Korea	83.50
12	Israel	83.49
13	Sweden	83.33
14	France	83.13
14	Martinique	83.13
15	Malta	83.06
16	Canada	82.96
17	Norway	82.94
18	Ireland	82.81
19	New Zealand	82.80
19	Greece	82.80
20	Luxembourg	82.79
21	Netherlands	82.78
22	Guadeloupe	82.74
23	Portugal	82.65
24	Finland	82.48
25	Belgium	82.17
26	Austria	82.05
27	Germany	81.88
28	Slovenia	81.85
29	United Kingdom	81.77
30	Réunion	81.55
31	Cyprus	81.51
32	Denmark	81.40
33	U.S. Virgin Islands	81.17
34	Taiwan	81.04
35	Costa Rica	80.94
36	Chile	80.74
36	Guam	80.74
37	Qatar	80.73
38	Puerto Rico	80.69
39	French Guiana	80.53
40	Maldives	79.89
41	Czech Republic (Czechia)	79.85
41	Mayotte	79.85
42	Barbados	79.64
43	Curaçao	79.41
44	Lebanon	79.27
44	Poland	79.27
45	Cuba	79.18
45	Estonia	79.18
46	United States	79.11
47	Panama	79.10
48	Croatia	79.02
49	Albania	78.96

Maybe we should spend more on care...

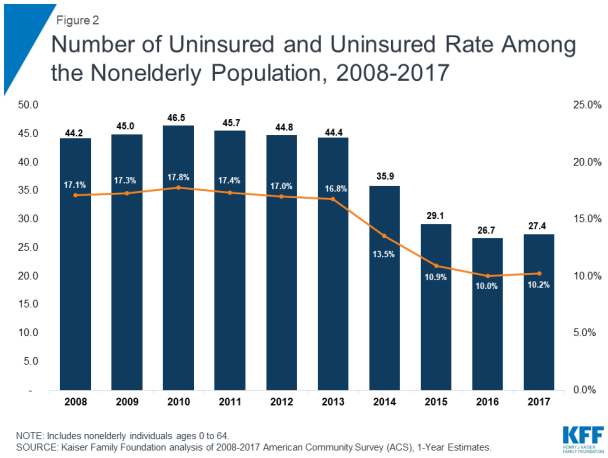
The United States is among the wealthiest nations in the world, but it is far from the healthiest.
(2013, National Academy of Sciences)





Maybe we should overhaul insurance models...

The 2010 Affordable Care Act represented the broadest health care overhaul since the creation of the Medicare and Medicaid programs in 1965.



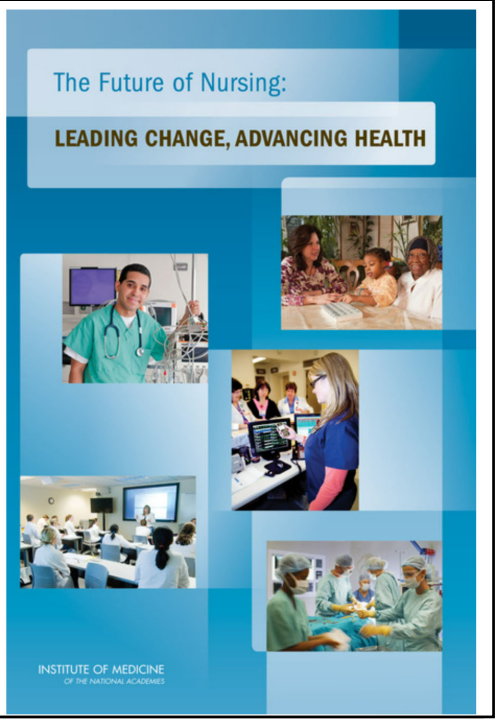
Our opportunity – Nursing!

- Nurses spend the greatest amount of time delivering patient care as a profession.
- Nurses have valuable insights and unique abilities to contribute as partners with other health care professionals in improving healthcare.



Past: A look back

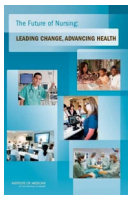
- *The Future of Nursing report,* published in 2010, explored how nurses' roles, responsibilities, and education should change significantly to meet the increased demand for care that would be created by health care reform and to advance improvements in America's increasingly complex health system.



Key proposals from the Future of Nursing Report, 2010

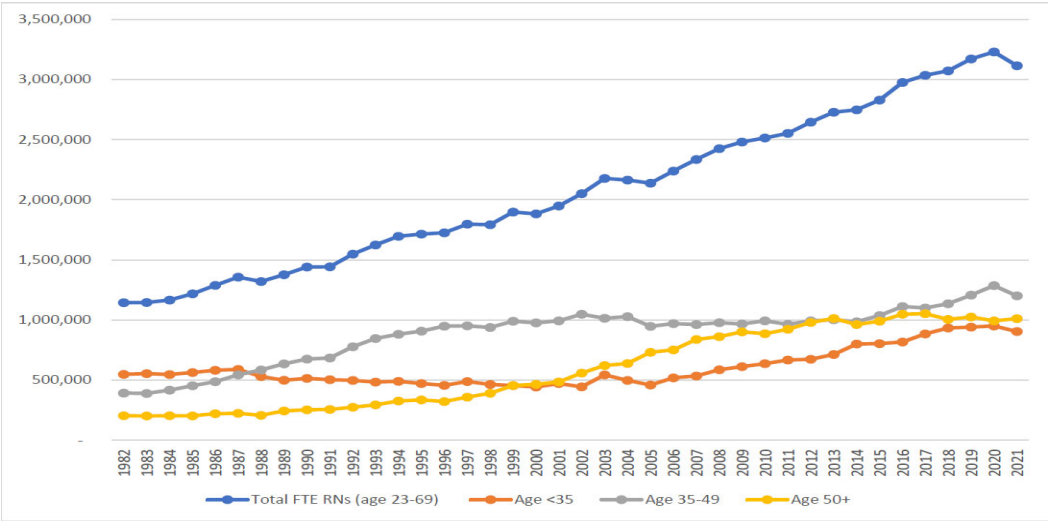
Future of Nursing – 2010 report: Leading Change, Advancing Health

1) Nurses should practice to the full extent of their education and training.
2) Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3) Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
4) Healthcare should focus on effective workforce planning and policy making through better data collection and an improved information infrastructure.



Source: https://nap.nationalacademies.org/resource/12956/Future-of-Nursing-2010-Report-Brief.pdf

Present: Nursing workforce trends

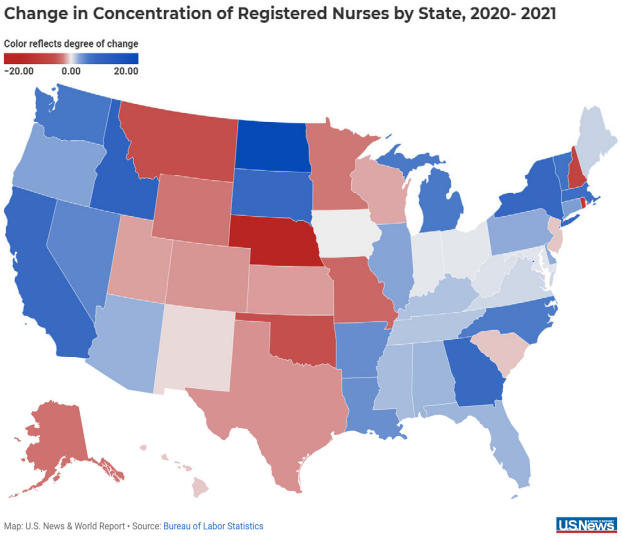


Auerbach, D., Buerhaus, P. et al (2022). A Worrisome Drop In The Number Of Young Nurses published in Health Affairs. https://www.healthaffairs.org/content/forefront/worrisome-drop-number-young-nurses

Present: Nursing workforce trends

- RN turnover is approximately 22.5%, 18.9% in the northeast.
- Average (national) cost of turnover for a bedside RN is $52,350, more in the northeast.
- The RN vacancy rate remains critical at 15.7% nationally.
- Close to 1/3 (32.8%) of all newly hired RNs left within a year, with first-year turnover accounting for 28.7% of overall RN departures.

https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf



Present: Nursing and healthcare snapshot

- Enrollment in entry-level BSN programs increased by 3.3% in 2021.
- Nursing programs are challenged with an insufficient number of faculty, clinical placements, classroom space, as well as budget constraints.
- More than 1 million registered nurses will retire from the workforce by 2030.
- By 2034, there will be 77.0 million people aged 65 years and older compared to 76.5 million under the age of 18, yielding an increased need for geriatric, chronic diseases, and comorbidity care management.
- Average age for an RN is 52 years old.

https://www.aacnnursing.org/news-data/fact-sheets/nursing-shortage

Future: Health equity means better health for all

- The National Academy of Medicine report, *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* calls for a series of policy reforms to unleash the potential of nurses to play greater roles in advancing health equity.



The role of nursing in tomorrow's healthcare

Future strategies don't just involve increasing the number of nurses

Creative nursing strategies targeting ***practice***:

- Promote models that enable nurses to practice at optimal levels.
- Prepare and support nurses to increasingly practice outside of hospital settings.
- Remove tasks and duties that do not require the knowledge and skill of a professional nurse and align them with appropriate roles, including new roles on healthcare teams.

The role of nursing in tomorrow's healthcare

Creative nursing strategies targeting ***sustainability***:

- Prioritize nurse well-being
- Reconnect to purpose in work
- Recruitment and retention
- Technology
- Translate nursing contributions into value
- Implement new staffing models
- Health equity

Nursing care models of the future and other innovations are necessary to meet the future need in healthcare

The role of nursing in tomorrow's healthcare

Promote models that enable nurses to practice at optimal levels

- APRN's
- Scope of practice reviews
- Nurse-driven protocols



The role of nursing in tomorrow's healthcare

Prepare and support nurses to increasingly practice outside of hospital settings

- Greater exposure to non-traditional new graduate roles in nursing schools
- Care coordination
- Continuum and flexibility models



The role of nursing in tomorrow's healthcare

Remove tasks and duties that do not require the knowledge and skill of a professional nurse and align them with appropriate roles

- New roles on healthcare teams
- Task assistive staff
- Robots and cobots
- Administrative, project management, coordination staff

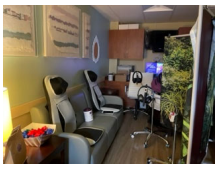


The role of nursing in tomorrow's healthcare

Prioritize nurse well-being

- Understanding stressors
- Investment in stress relief programs
- Wellness maintenance programs as part of nursing role

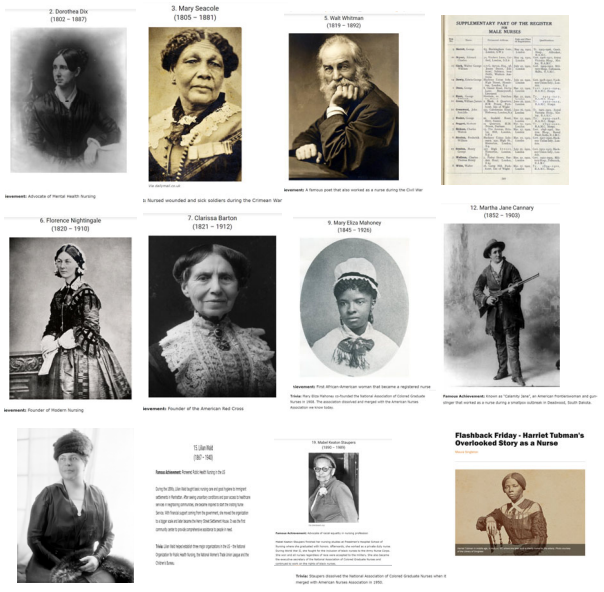




The role of nursing in tomorrow's healthcare

Reconnect to purpose in work

- Finding the why
- Reward and recognition
- Increase time at the bedside



The role of nursing in tomorrow's healthcare

Recruitment and retention

Recruitment strategies

- Pipeline programs
- Academic-practice partnerships

Retention strategies

- Role rotation
- Road maps for professional progression



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Northwell's nurse turnover rate is nearly half the national average: Chief nurse Maureen White on how they did it

Bari Faye Dean - Tuesday, February 7th, 2023

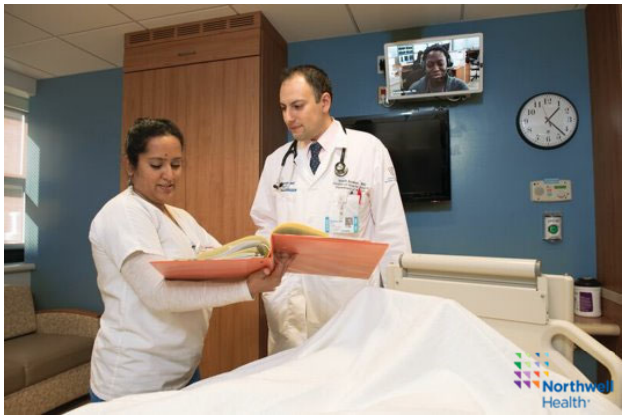
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While hospitals throughout the U.S. are struggling with both attracting qualified nurses and keeping them in place and happy once employed, Northwell Health is seeing nursing turnover statistics far below the national average.

The key to this success, Maureen White, RN, executive vice president and chief nurse executive of New Hyde Park, N.Y.-based Northwell Health, told *Becker's*, is to focus on both recruitment and retention — at the same time — with the intention of creating a nursing pipeline that never runs dry.

The role of nursing in tomorrow's healthcare

- Technology
- Virtual nurse



The role of nursing in tomorrow's healthcare

Translate nursing contributions into demonstrable value

- Any and all opportunities to classify and quantify nursings' value
- Reimbursement models that consider nursing interventions.
- Call out, capitalize on and expand nursings' role on the healthcare team and translate impact into demonstrable value and common language.


Harvard Business Review

Leadership And Managing People | How Great Nursing Improves Doctors' Perf

How Great Nursing Improves Doctors' Performance

by Christina Dempsey and Thomas H. Lee

May 22, 2019

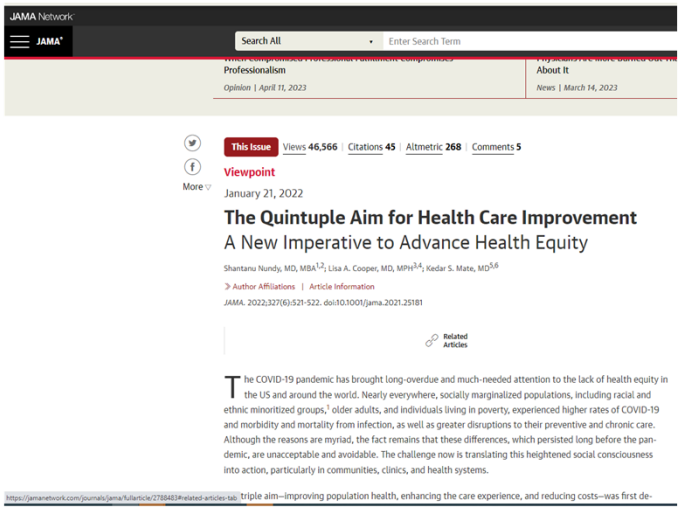
Matthew Rohark/Getty Images

Summary. Programs that foster a culture of excellent nursing have sweeping impacts throughout health care organizations. Hospitals participating in these initiatives see higher nurse satisfaction and retention, improved patient experience and safety, decreased... more

The role of nursing in tomorrow's healthcare

Implement new staffing models

- Team nursing models
- Continuum of care roles
- Licensed practical nurses


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Viewpoint

January 21, 2022

The Quintuple Aim for Health Care Improvement

A New Imperative to Advance Health Equity

Shantanu Nundy, MD, MBA[1,2]; Lisa A. Cooper, MD, MPH[3,4]; Kedar S. Mate, MD[5,6]

Author Affiliations | Article Information

JAMA. 2022;327(6):521-522. doi:10.1001/jama.2021.25181

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The COVID-19 pandemic has brought long-overdue and much-needed attention to the lack of health equity in the US and around the world. Nearly everywhere, socially marginalized populations, including racial and ethnic minoritized groups,[1] older adults, and individuals living in poverty, experienced higher rates of COVID-19 and morbidity and mortality from infection, as well as greater disruptions to their preventive and chronic care. Although the reasons are myriad, the fact remains that these differences, which persisted long before the pandemic, are unacceptable and avoidable. The challenge now is translating this heightened social consciousness into action, particularly in communities, clinics, and health systems.

https://jamanetwork.com/journals/jama/fullarticle/2788483#related-articles-tab triple aim—improving population health, enhancing the care experience, and reducing costs—was first de-

https://jamanetwork.com/journals/jama/fullarticle/2788483

The role of nursing in tomorrow's healthcare

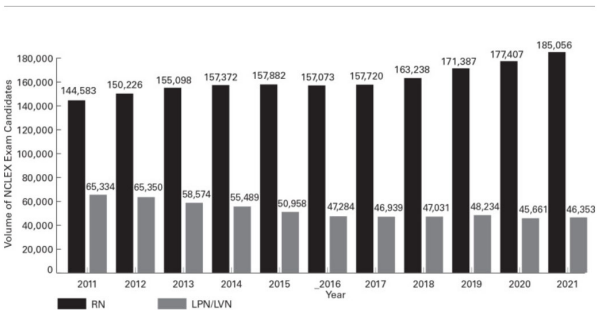
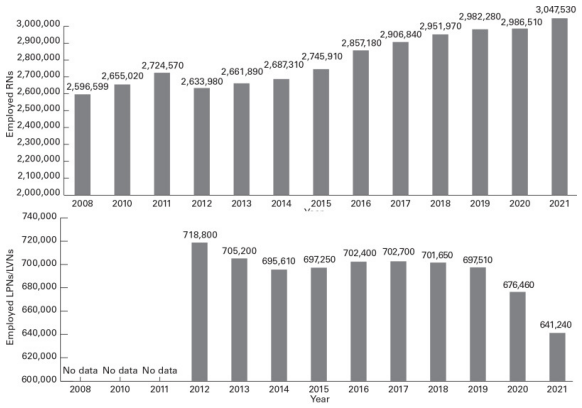


Figure 6 Trend of U.S. RN and LPN/LVN First-time NCLEX Takers, 2011-2021



Sources: The 2010-2021 statistics were taken from the semiannual Occupational Employment Statistics survey published by the U.S. Bureau of Labor Statistics (2022). The 2008 data were taken from the U.S. Department of Health and Human Services Health Resources Services Administration (HRSA)'s National Sample Survey of Registered Nurses (2010).

The NCSBN 2023 Environmental Scan: Nursing at a Crossroads—An Opportunity for Action National Council of State Boards of Nursing. Journal of Nursing Regulation. January 2023 • Volume 13 • Supplement

The role of nursing in tomorrow's healthcare

- Health equity

the state in which everyone has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

- Community partnerships
- Disparities gaps
- Public Health



Nursing will play a key role in the future of healthcare





THANK YOU

References

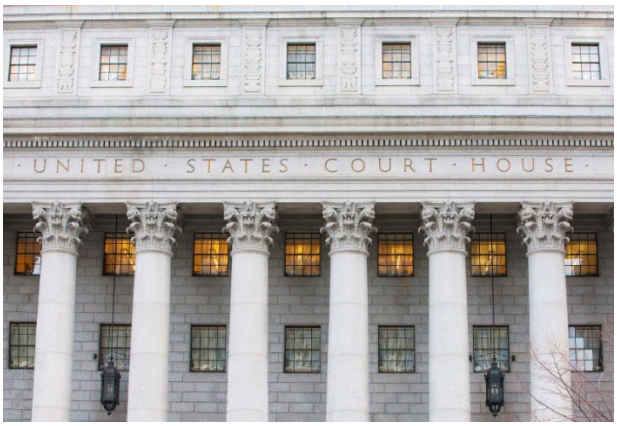
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TAB 5

MCB

MARTIN CLEARWATER & BELL LLP

Updates in Medical Malpractice Litigation



Presented by:
Barbara D. Goldberg, Esq.
Gregory A. Cascino, Esq.

MARTIN CLEARWATER & BELL LLP

Friday, June 2, 2023

AHRMNY 2023 Annual Educational Conference & Reception
City Winery NYC

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

UPDATES IN MEDICAL MALPRACTICE LITIGATION

I. MEDICAL INDEMNITY FUND (MIF) UPDATES

A. Recent decision of interest and amendments to MIF legislation

In 2021, Justice McMahon issued an order holding that an infant who suffered severe brain injury from extreme hypoglycemia was eligible for the MIF, even though the injuries he suffered were not the hypoxic-ischemic injuries stemming from deprivation of oxygen during labor and delivery and did not become apparent until after the infant was discharged from the hospital

Result was based in part on amendments to Public Health Law § 2999-h (1) in 2017 which expanded definition of "birth-related neurological injury" by the insertion of two commas: "birth-related neurological injury" is now defined as "an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery, or resuscitation, ***or by other medical services provided or not provided during delivery admission,*** that rendered the infant with a permanent and substantial motor impairment or with a developmental disability . . . ."

We argued that plaintiffs' allegations that the nursing staff did not adequately instruct the mother as to breast-feeding and that they failed to supplement the breast-feeding with formula qualified as "services . . . not provided during delivery admission"

Legislation removing the Fund administrator's role in determining if a plaintiff is a "qualified plaintiff" and therefore eligible for enrollment in the Fund was effective October 1, 2019

B. Statistics as to current enrollment in the MIF

Section 69-10.19 of the New York State Department of Health (NYS DOH) Regulations requires quarterly annual reports which should "include a review of the various elements contributing to the amount of benefits paid by the Fund and to the expenses of administration of the Fund, including:"

- The number of qualifying plaintiffs
- The mortality experience of the qualified plaintiffs.
- The amount of benefits paid by the Fund
- The patterns of utilization of types of services provided
- Inflationary patterns by types of services provided
- The expenses of administration of the Fund
- The impact of available health insurance on benefits paid by the Fund, and

- Investment earnings of the Fund

Most recent report (January 2023), prepared by Pinnacle Actuarial Resources, notes that as of September 30, 2022, the Fund had accepted 920 participants (901 living) with estimated future benefit payments of approximately $2.889 billion and future administrative expenses of $297.2 million, assuming a discount rate of 2.0% and future medical inflation of 3.0%.

Since the passage of the 2019 legislation eliminating the Fund administrator's role in determining who is a qualified plaintiff, 281 participants have been admitted into the Fund, or approximately 31% of its current membership

20 new participants enrolled in Fund in second quarter of fiscal year 2022-2023

Report also references the December 2016 legislation significantly raising reimbursement rates for the period from July 1, 2017 through December 31, 2019, and notes that Pinnacle Actuarial Resources was asked by the NYS DOH to assume that the increased rates will continue in perpetuity

For the most recent four quarters of the Fund, average benefit payments per participant were $23,824 per quarter; total benefits paid were $83.027 million for these four quarters

Largest category of benefit payments from October 2012 through September 2022 was nursing care (48.11%)

Diagnoses for Fund participants include the following:

- Brachial plexus injury
- Cerebral palsy
- Developmental delays
- Encephalopathy
- Erb's palsy
- Hemiplegia
- Mental retardation
- Neurological disabilities
- Quadriplegia
- Spastic diplegia
- Spastic paraplegia
- Spastic quadriplegia
- Other
- Not available

Participants with injury types of cerebral palsy, encephalopathy or spastic quadriplegia comprised approximately 50% of all the participants, but accounted for approximately 73% of total payments

Report predicts that the liabilities to assets ratio is expected to surpass the 80% threshold for current liability to assets by year end 2023-2024 and the analysis contemplates no new participants added after that time

When, as a result of a new deposit made pursuant to PHL § 2999-i (5), the Fund's liabilities no longer exceed 80 % of its assets, the Fund administrator must enroll new qualified plaintiffs in the order that an application for enrollment has been submitted

II. COVID IMMUNITY AND TOLLING

A. Repeal of COVID-19 immunity statute, the Emergency or Disaster Treatment Protection Act (EDTPA), does not have retroactive effect

Ruth v. Elderwood at Amherst, 209 A.D.3d 1281 (4th Dept. 2022)

Appellate Division found that applying the April 2021 repeal of the immunity conferred by EDTPA retroactively to the past acts of the defendant facilities and health care professionals would expand the scope of their potential liability significantly for past conduct, and accordingly there was a presumption against retroactive effect. The Court also found that the text of the repeal legislation did not contain an express statement requiring retroactive application (as the legislation creating the EDTPA did); the memoranda submitted by the legislators who introduced the legislation was inconclusive on the issue of retroactivity; and the legislative floor debates supported a conclusion that the Legislature intended the repeal to apply prospectively only.

1. As originally enacted in April 2020 (retroactive to March 7, 2020), the EDTPA provided qualified immunity from civil and criminal liability to health care professionals and facilities for harm or damages alleged to have been sustained as a result of an act or omission in the course of arranging for or providing health care services in certain circumstances related to the COVID-19 pandemic, provided:

    - (1) Services must have been arranged for or provided pursuant to a COVID-19 emergency rule or otherwise in accordance with applicable law

    - (2) The act or omission must have been impacted by decisions or activities that were in response to or as a result of the COVID-19 outbreak

- (3) Services must have been arranged for or provided in good faith

2. As a result of the *Ruth* decision, the EDTPA still provides significant immunity for cases arising at the height of the pandemic in spring 2020 through August 3, 2020, when it was first amended

3. August 3, 2020 amendment:

   - As amended in August 2020 the EDTPA provided qualified immunity only when a health care professional or facility provided direct care related to the diagnosis or treatment of COVID-19 and the care was impacted by COVID-19

   - Amendment only applied prospectively, that is, to acts or omissions which occurred on or after August 3, 2020

   - Thus, the EDTPA still provides immunity in cases arising between August 3, 2020 and April 6, 2021, when the EDTPA was repealed

4. *Ruth* is binding on all Supreme Courts statewide under the "Mountain View Doctrine" until the First Department/Second Department/Third Department issues a contrary ruling or the Court of Appeals reverses the Fourth Department *See Mountain View Coach Lines v. Storms*, 102 A.D.2d 663 (2d Dep't 1984)

- Several Supreme Courts within the Second Department have recognized *Ruth* as authoritative under *Mountain View*, and found that the EDTPA repeal does not apply retroactively

- *Crampton v. Garnet Health, Orange Co*. Index. No. EF002981-2021 (April 10, 2023); *DeFonce v. Sky View Rehabilitation and Health Care Center*, 61757/2022 (Westchester Sup. Jan 6. 2023); S*eror v. Clearview Operating Co., LLC.*, 2022 WL 17733516 (Queens Supreme, November 18, 2022).

- Issue of retroactivity of EDTPA repeal raised in *Graves v. Suffolk County* (Second Department Docket Number 2022-02992), which is awaiting an argument date. GNYHA and HANYS have filed *amicus* briefs.

5. Plaintiffs have argued that the EDPTA violates Article 1, §16 of the New York State Constitution, which provides that "The right of action now existing to recover damages for injuries resulting in death, shall never be abrogated; and the amount recoverable shall not be subject to any statutory limitation.".

- While §16 prohibits the Legislature from enacting a "total abrogation" of a right to recover for wrongful death, the EDTPA does not totally abrogate wrongful death claims. Rather it simply creates a higher burden of proof for those

claims that it covers. Claims for wrongful death can still be brought under the EDTPA, where the death was caused by gross negligence, reckless misconduct or willful or intentional criminal conduct.

- Thus far this argument has not been successful and every Constitutional challenge to the EDTPA has been rejected, either expressly or implicitly. *See Robertson v. Humboldt House Rehabilitation & Nursing Center*, Erie County Index No. 805232/2021 (March 8, 2023); *Seror v. Clearview Operating Co., LLC*, 2022 WL 17733516 (Queens Supreme, Nov. 18, 2022); *Hohler v. Garden Gate Health Care Facility*, Erie Supreme Index No. 804700/2002

B. COVID-19 toll

1. Executive Order No. 202.8, issued on March 20, 2022, provided that

   "any specific time limit for the commencement, filing, or service of any action, notice, motion, or other process or proceeding, as prescribed by the procedural laws of the state . . . is hereby tolled from the date of this executive order until April 19, 2020

2. Nine subsequent executive orders extended that period through November 3, 2020

3. While most of the subsequent executive orders stated that the original EO provided for a "suspension," the final EO spoke in terms of a "toll"

4. Three Departments of the Appellate Division have now concluded that the executive orders constitute a toll, and not a suspension:

   - *Brash v. Richards*, 195 A.D.3d 582 (2nd Dept. 2021)

     - Toll "suspends the running of the applicable statute of limitations for a finite time period, meaning that the period of the toll is excluded from the calculation of the relevant time period
     - Suspension, by contrast, "simply delays expiration of the time period until the end date of the suspension," but does not exclude its effective duration from the calculation of the relevant time period

   - *Matter of Roach v. Cornell University*, 207 A.D.3d 931 (3rd Dept. 2022)

   - *Murphy v. Harris,*210 A.D.3d 410 (1st Dept. 2022)

III, NEW DEVELOPMENTS AND CASES IN MEDICAL MALPRACTICE LITIGATION

A. New PJI charge on "loss of chance" proximate causation

PJI 2:150.1 Malpractice—Physician [Supplemental Instruction]

[*Where the loss of chance theory does not apply to every alleged deviation or departure from the standard of care in the case, insert:* I will now give you an additional instruction that applies only to AB's allegations that *(state the deviations or departures to which the loss of chance theory applies)*].

If you find that AB has established [*state the deviations or departures to which the loss of chance theory applies]*, you must then consider whether (those deviations, those departures, CD's conduct) (were, was) (a) substantial factor(s) in depriving AB of a substantial (possibility, chance) for a (better outcome, recovery, cure).
AB is not required to quantify the exact extent to which CD's conduct deprived (him, her) of a substantial (possibility, chance) for a (better outcome, recovery, cure). A substantial (possibility, chance) does not have to be more than fifty percent, but it has to be more than slight. The mere possibility that AB would have had a better chance for an improved outcome or a decreased injury is insufficient.

B. Veto of Grieving Families Act

Governor Hochul vetoed Senate Bell S74A on January 30, 2023, shortly before the deadline for approval. Since the bill was passed during the previous legislative session, the veto was not subject to an "override." Accordingly, the Grieving Families Act will need to be re-introduced and re-passed by the Legislature, and re-presented to the Governor, if it is to become law

C. Recent Introduction of Modified Version of Bill (S6636)

1. Three year Statute of Limitations

2. Act would take effect immediately and apply to all pending cases and cases commenced after its effective date

3. Permits recovery of damages for emotional loss by "close family members," defined as spouse or domestic partner, issue, foster-children, step-children, step-grandchildren, parents, grandparents, step-parents, step-grandparents, siblings or "any person standing in loco parentis to the decedent"

4. Finder of fact will determine who is a close family member

D. UPDATES ON *SIEGEL v. SNYDER*, 202 A.D.3D 125 (2ND DEPT. 2021)

1. The Issue addressed in *Siegel*:

". . . whether the party asserting the quality-assurance privilege with regard to peer-review committee meetings has the burden of demonstrating that any statements made at such a meeting, claimed to be privileged, were made by a person who is not a party to an action."

2. The Court's holding:

". . . we conclude that the party asserting the quality-assurance privilege must demonstrate that any statements made at such a meeting that are claimed to be privileged were made by a nonparty. Therefore, where the meeting's minutes do not identify the speaker, the party-statement exception to the quality-assurance privilege applies."

"It is the defendants' burden to demonstrate entitlement to the quality assurance privilege."

Defendants' motion for reargument or leave to appeal was denied in August 2022. 2022 N.Y. Slip Op. 70223(U).

3. Cases citing *Siegel:*

Newman v. Mount Sinai Medical Center, 205 A.D.3d 548 (1st Dept. 2022)

Defendant Dr. Newman pleaded guilty to sexually assaulting four female patients, including Plaintiff, who came under his care in the Mt. Sinai ED. Plaintiff thereafter asserted claims against Mt. Sinai for, among other things, negligent hiring, supervision, and retention of employees. Plaintiff sought incident reports regarding Dr. Newman, which Mt. Sinai asserted were protected by the privilege afforded to materials created in the quality assurance review process.

The Appellate Division held that Mount Sinai failed to sustain its burden of establishing that it is entitled to invoke the QA privileges for the requested documents "as the only documents covered by that privilege are those generated in connection with a quality assurance review function under Education Law § 6527(3)(*see Siegel v. Snyder*, 202 A.D.3d 125, 137 [2d Dep't 2021]...)"

Mt. Sinai produced an affidavit from its CMO stating that she reviewed the QA materials it maintained in connection with the investigation of Dr.

Newman, and that based on her review, there were no recorded party statements.

However, the Appellate Division held that the CMO's affidavit "fails to make clear what documents were determined to be quality assurance materials, whether the CMO considered materials related to the other three patients to be within the scope of her search, or whether the quality assurance materials may contain statements attributed to anonymous sources, who may be parties (*see Siegel v. Snyder*, 202 A.D.3d at 137, 161 N.Y.S.3d 159). It is therefore not possible on this record to assess the accuracy of the hospital's certification that no party statements relating to any of the four assaults exist within any quality assurance materials. Accordingly, on remand, to the extent it has not already done so, Mount Sinai shall produce any party statements that are contained not in quality assurance materials, but in documents kept and prepared in the ordinary course of business..... Additionally, Mount Sinai shall prepare a privilege log identifying all materials claimed to be protected by the quality assurance privilege and submit the documents for in camera review....."

Hernandez v. City of New York, 207 A.D.3d 450 (2nd Dept. 2022):

Hernandez was an action for violation of the common law right of sepulcher. The plaintiffs alleged that a member hospital of defendant New York City Health & Hospitals Corporation (HHC) improperly released the plaintiff decedent's body to the Office of the Chief Medical Examiner, which then released it to a funeral home, where it was embalmed. Plaintiffs also alleged that an autopsy, which had been authorized by the decedent's wife, was not performed. The plaintiffs sought discovery of records from the hospital's Department of Patient/Guest Relations (Guest Relations), to which they had made a written complaint. HHC provided part of the Guest Relations file in response to the plaintiffs' demand, but maintained that other documents were exempt from disclosure under Education Law § 6527(3) and Public Health Law § 2805-m. Plaintiffs moved to compel compliance with their demand and HHC cross-moved for a protective order. Plaintiffs also sought depositions of two employees of HHC at the time of the decedent's death, one of whom was subsequently produced. In connections with their motion to compel compliance with their document demand, plaintiffs sought a further deposition of that witness, as well as a deposition of the other witness.

After an in camera review, the Supreme Court directed disclosure of the documents as well as the depositions sought by plaintiffs. The Appellate Division, Second Department affirmed, finding that the affidavit of HHC's Director of Quality Management, which had been submitted in support of the cross-motion, was insufficient to demonstrate that the documents at issue were generated by or at the behest of HHC's Quality Assurance Committee.

Regarding the depositions, he Appellate held that HHC had failed to demonstrate that the witnesses would provide only privileged testimony.

The Appellate Division cited *Siegel* in connection with its discussion of Education Law § 6527(3) and Public Health Law § 2805-m. *Siegel* was also cited in support of the proposition that the party asserting the confidentiality provisions is required, at a minimum, to show that it has a review procedure and the information for which the exemption is claimed was obtained or maintained in accordance with that procedure.

IV. SUSTAINABLE VERDICT VALUES

A. Pre-Death Pain and Suffering

1. *Stewart v. New York Hospital Queens*, 214 A.D.3d 919 (2nd Dept., March 22, 2023)

   Sustained $1.3 million for 28 days of pre-death pain and suffering from acute bacterial meningitis and mycotic aneurysm; 73 year old decedent's wife and son testified that he was often holding his head and moaning while complaining of and suffering from nearly constant head pain which was not relieved by medication and worsened over the 28 day period

2. *Small v. The City of New York*, 213 A.D.3d 475 (1st Dept. 2023)

   Affirmed award of $4.5 million, as reduced by the trial court from the jury's award of $22 million, for wrongful death of a 23 year old inmate at Rikers Island; the award consisted of $2.75 million for conscious pain and suffering; $500,000 for fear of impending death/emotional pain and suffering, which lasted anywhere from several hours to two days; and $1.25 million for loss of parental guidance to the decedent's 2 1/2 year old daughter

   The decedent had previously tested positive for tuberculosis while at a federal prison in Florida and was placed on an antibiotic; he was sent to Rikers on February 9, 2001; his treatment continued until April 5, 2002, when he was placed in solitary confinement for a period of 55 days; upon his release he was suffering from severe liver disease and on June 1, 2002 he died from massive liver necrosis; plaintiff's theory of liability was that the defendants caused his death by failing to properly treat, test and monitor his liver condition

3. *Schneider v. Hanasab*, 209 A.D.3d 684 (2nd Dept. 2022)

   Sustained $2 million for conscious pain and suffering from injuries suffered by decedent when he was struck by a vehicle at an intersection while riding

a motorized scooter; decision notes that the testimony of the plaintiff's medical expert regarding the pain the decedent experienced from the injuries suffered as a result of the accident and his death four days later, as well as the plaintiff's observations of the decedent during his hospitalization, "sufficiently demonstrated the degree of the decedent's consciousness and the severity of the pain he suffered as a result of the accident."

Second Department cited its prior decision *in Hyung Kee Lee v. New York Hospital Queens*, 118 A.D.3d 750 (2nd Dept. 2014), which sustained $3.75 million for the decedent's conscious pain and suffering over a period of four days before he choked to death after a series of unsuccessful intubation attempts

Award of $125,000 to decedent's wife for loss of services was reduced to $10,000; Court again cited *Lee*, this time for the proposition that where a loss of services claim is based upon loss of household services, the standard by which to measure the value of the damage "is the cost of replacing the decedent's services;" in *Schneider* the award of $125,000 for loss of services over four days was not supported by the evidence

4. *Bacchus-Sirju v. Hollis Women's Center*, 196 A.D.3d 670 (2d Dep't 2021)

The jury found that the defendant departed from good and accepted medical practice by failing to inform the decedent that an ultrasound revealed the presence of fluid in the cul-de-sac, a portion of the pelvis behind the uterus, by failing to order a CA 125 blood test, and by failing to refer the decedent to a gynecologic oncologist. The jury also found that such departures were a substantial factor in diminishing the decedent's chance for a better outcome.

Second Department sustained the jury's $2 million award for decedent's pain and suffering prior to her death from ovarian cancer.

The jury also awarded $500,000 in past pecuniary losses and $25,000 in future pecuniary losses (over 5 years) to each of decedent's 2 grown children. The Second Department reduced the past pecuniary loss award to $250,000 for one of the children and $100,000 for the other child.

On the issue of pecuniary loss, the Second Department reiterated that "Loss of support, voluntary assistance and possible inheritance, as well as medical and funeral expenses incidental to death, are injuries for which damages may be recovered"…. "In the case of a decedent who was not a wage earner, 'pecuniary injuries' may be calculated, in part, from the increased expenditures required to continue the services she provided, as well as the compensable losses of a personal nature, such as loss of guidance"

B. Kidney injury:

Appleyard v. Tigges, 212 A.D.3d 515 (1st Dept. 2023)

Sustained award of $500,000 for past pain and suffering stemming from injuries related to transient kidney failure, caused by administration of Vancomycin, an antibiotic known for potential renal toxicity, to treat a MRSA infection following arthroscopic knee surgery, reduced from jury award of $3 million

Award covered a period of approximately seven weeks, including three sessions of dialysis over three consecutive days; an additional five days in the hospital with blood transfusions; emotional shock, fear of permanent kidney damage and fear of imminent death

Of note, the Appellate Division held that to the extent the plaintiff relied on cases involving wrongful death and the accompanying "apprehension of impending death," her reliance was misplaced

C. **Orthopedic injuries**

1. *Streit v. Katrine Apts. Assoc., Inc*., 212 A.D.3d 957 (3rd Dept. 2023)

Sustained total award of $750,000 ($100,000 past and $650,000 future) for pain and suffering

Plaintiff tripped over partially obstructed chicken wire connected to a downed fence at her apartment complex; she sustained a three-part humerus fracture which required surgery to her left shoulder and a second surgery to alleviate pain and increase her function; at the time of trial she still had significant limitations on her ability to perform routine tasks and significant pain when she extended her arm, and there was testimony she would never regain normal shoulder function and would have permanent pain and discomfort in her shoulder

2. *Deguilme v. New York City Transit Authority*, 209 A.D.3d 485 (1st Dept. 2022)

Sustained $740,000 for past pain and suffering, $315,000 for future pain and suffering, and $260,000 for past lost earnings

Plaintiff was hit by city bus and sustained a significant bimalleolar fracture requiring surgical fixation with hardware, and subsequently underwent a

second surgery to remove hardware and repair tendon damage; he also sustained hand lacerations and multiple hand fractures

3. *Wynter v. Transdev Serv., Inc*., 207 A.D.3d 785 (2nd Dept. 2022)

Sustained $3 million for past and $2.5 million for future pain and suffering over 30 years

Plaintiff was hit by a city bus, which then ran over his left leg and foot; he suffered a crush degloving injury to his left foot, an open fracture of the big toe, an open dislocation of the first metatarsal joint, and open fractures and dislocations of the second through fifth toes

Plaintiff underwent life-saving and emergent surgery, which included debridement and irrigation of his skin, amputation of his big toe, and setting fractures in his remaining four toes, among other things; he was in the hospital for 29 days, and after discharge, was confined to a wheelchair for 6-7 months, after which he used a walker for an additional 2 months; approximately 6 months after his discharge, an additional surgical procedure was performed, during which the medical team removed the wires from his remaining toes and grafted skin from his left thigh and hip, placing it on top of his left foot

Prior to the accident, plaintiff was active, and engaged in walks and hiking; at the time of trial he could only stand for approximately 2 minutes at a time without the use of an assistive device, such as a cane or crutches, which he would require for the rest of his life; plaintiff also developed arthritis under his remaining toes and experienced significant neurogenic pain; he will need additional surgeries in the future, and prior attempts at utilizing a prosthetic device were unsuccessful

4. **Wrongful death of young adult:**

Vitenko v. City of New York, 210 A.D.3d 931 (2nd Dept. 2022)

Sustained $308,000 for past and $400,000 for future pecuniary loss over 3 years

21 year old male drowned while swimming and mother brought wrongful death action; decedent worked in the family business, helped around the house, and was described as a wonderful and loving son.

Jury awarded $440,000 for past pecuniary loss and $1,050,000 for future pecuniary loss over 15 years; Supreme Court reduced award for past pecuniary loss to $308,000 and future pecuniary loss to $210,000 over 3

years; Second Department increased award for future pecuniary loss to $400,000

V. INSURANCE DISCLOSURE ACT

A. Signed into law on December 31, 2021; appears as CPLR § 3101 (f)

B. Amended February 24, 2022 (retroactive to December 31, 2021)

C. Who must produce, to whom, and when?

1. Defendants, third-party defendants, and defendants on a cross-claim or counterclaim must produce insurance information

2. Production must be made to plaintiff, plaintiff on a counterclaim, or "any other party in the action"

3. Information must be produced 90 days after service of the Answer, with updated information produced at the following times:

- Filing of Note of Issue
- When entering into formal settlement negotiations supervised by the Court
- Voluntary mediation
- When case is called for trial
- 60 days after settlement or entry of final judgment, inclusive of all appeals

D. What must be produced?

1. "Proof of the existence and contents of any insurance agreement in the form of a copy of the insurance policy in place at the time of the loss . . . under which any person or entity may be liable"

- This includes declarations, insuring agreements, conditions, exclusions, endorsements, and similar provisions
- These requirements apply to all primary, excess ,and umbrella policies that relate to the claim being litigated

2. If agreed to by the plaintiff or other party, the producing party may disclose just the declaration page; however,

- A party does not waive the right to receive other information required under law
- A party may revoke the agreement at any time, and the defendant is required to provide a full copy of the insurance policy in effect at the time of the loss

3. Contact information (name and e-mail address) of individual responsible for adjusting claims at issue

4. Total limits available under the policy, meaning the actual funds available after taking into account erosion and any other offsets

5. Applications for insurance need not be produced

E. Miscellaneous provisions

1. Only applies to cases filed after December 31, 2021

2. Disclosure of policy limits as required by CPLR § 3103 (f) does not constitute an admission that the alleged injury is covered by the policy

3. Information concerning the insurance agreement is not admissible in evidence at trial merely by reasons of its disclosure

F. Certification

1. Under CPLR § 3122-b, both the disclosing party and that party's attorneys must certify that the disclosures are accurate and complete

2. They must also certify that reasonable efforts will be undertaken to ensure that the disclosed information remains accurate and complete

3. Certifications are to be sworn in the form of an affidavit or affirmation

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ADMISSIONS
NEW YORK
UNITED STATES DISTRICT COURTS FOR THE EASTERN AND SOUTHERN DISTRICTS OF NEW YORK
UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT
UNITED STATES SUPREME COURT

YEARS IN PRACTICE
35

MEMBERSHIPS
NEW YORK STATE MEDICAL DEFENSE BAR ASSOCIATION
ASSOCIATION FOR HEALTHCARE RISK MANAGEMENT OF NEW YORK
NEW YORK CITY BAR ASSOCIATION

Barbara D. Goldberg

HEAD OF APPELLATE DEPARTMENT – PARTNER

AREAS OF PRACTICE
APPELLATE | MEDICAL MALPRACTICE
GENERAL LIABILITY | PRODUCTS LIABILITY

Martindale-Hubbell AV PREEMINENT Peer Rated for Highest Level of Professional Excellence 2023

Barbara DeCrow Goldberg is a Partner and Head of the Firm's Appellate Department. Ms. Goldberg is well known for her appellate expertise in high exposure and complex cases and has handled hundreds of significant motions and appeals in State and Federal Courts. She is noted for several important decisions in the areas of medical malpractice, negligence, workers compensation and labor law, including *Arons v. Jutkowitz*, 8 N.Y.3d 393 (2007)(holding that plaintiffs could be compelled to authorize defense counsel to conduct ex parte, off-the-record interviews with non-party treating physicians); *Lee v. Astoria Generating Co.*, L.P., 13 N.Y.3d 382 (2009)(holding that the plaintiff's Labor Law claims were pre-empted by the Longshore and Harbor Workers' Compensation Act); and *Castro v. United Container Machinery Group, Inc.*, 96 N.Y.2d 398 (2001) (adopting strict interpretation of "grave injury" under Workers' Compensation Law § 11).

Other significant decisions include *Park v. Kovachevich*, 116 A.D.3d 182 (1st Dept. 2014) (holding that summary judgment should have been granted in favor of hospital in action where plaintiff alleged defendants overly medicated decedent and failed to properly evaluate and diagnose his condition, leading to premature discharge and subsequent suicide); *Hernandez-Ortiz v. 2 Gold, LLC*, 170 A.D.3d 465 (1st Dept. 2019) (affirming summary judgment for defendants in class action lawsuit alleging that defendants took inadequate precautions to protect apartment buildings from flood damage in advance of Hurricane Sandy); and *Longhi v. Lewit*, 187 A.D.3d 873 (2nd Dept. 2020) (granting summary judgment in favor of orthopedic surgeon in action where patient developed paralysis as a result of epidural abscess and later died, because delay alleged against surgeon was not a proximate cause of the injuries). Ms. Goldberg is also known for her expertise regarding New York's structured judgment provisions, CPLR Articles 50-A and 50-B, as well as the New York State Medical Indemnity Fund.

Ms. Goldberg is a member of the OCA's Advisory Committee on Civil Practice. She has published in the areas of medical malpractice, post-verdict practice and appellate practice, as well as lectured at continuing legal education programs and educating industry professionals and attorneys regarding the current CPLR Article 50-A. She has previously served as Chairperson of the Appellate Advocacy Committee of the New York County Lawyers' Association, and is a member of the New York State Medical Defense Bar Association, the Association for Healthcare Risk Management of New York, and the New York City Bar Association. She is rated AV Preeminent® by Martindale-Hubbell®, their highest rating.*

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STATE UNIVERSITY OF NEW YORK, AT GENESEO, B.S.

ADMISSIONS

NEW YORK

UNITED STATES DISTRICT COURTS FOR THE EASTERN AND SOUTHERN DISTRICTS OF NEW YORK

YEARS IN PRACTICE

20

Best Lawyers ONES TO WATCH MARTIN CLEARWATER & BELL LLP 2023

Gregory A. Cascino

PARTNER

Gregory A. Cascino has been with Martin Clearwater & Bell LLP since 2017, previously as Of Counsel, and now as a Partner in the Firm's Appellate Practice Group. With more than 20 years of experience in appellate practice, he has briefed and argued appeals in all Departments of the New York State Appellate Division.

Impressively, Greg is credited with over 190 reported Appellate Division decisions. Greg has represented a wide range of clients, including medical professionals and hospitals, as well as municipalities and school districts in claims involving personal injury, defamation and property damage. Additionally, he has had significant experience in defending commercial litigation and subrogation claims, as well as claims alleging Labor Law violations and premises liability.

Greg received 2023 Best Lawyers®: Ones to Watch recognition for Medical Malpractice Law – Defendants. Attorneys receiving this honor are recognized by their peers early in their careers for outstanding professional excellence.

At MCB, Greg works across all client teams including NYPH, NYU, Jamaica, Brookdale, Flushing, MedPro, MLMIC and Northwell Health. He is also a member of the Firm's Publications Committee and has published articles in the Firm's newsletter. He has also participated in client presentations at MLMIC and Northwell.

Greg received his B.S. from State University of New York in 1998, and his J.D., *cum laude*, from St. John's University School of Law in 2001, where he was an Articles and Notes Editor of the St. John's Law Review. He is admitted to practice in New York and the United States District Courts for the Eastern and Southern Districts of New York.

TAB 6

AHRMNY Annual Conference
June 2, 2023

Healthcare Risk Management & the LEADERSHIP IMPERATIVE



Douglas Borg, MHA, ARM, CPHRM, DFASHRM
Vice President, Risk & Quality
Premier Insurance

Lisa Ramthun, MSN, RN, CPHRM, FASHRM, CPHQ
Vice President, Clinical Risk & Claims
Jefferson

1

Leadership vs. Management

Leadership

"The action of leading a group of people or an organization." That's how the Oxford Dictionary defines leadership. In simple words, leadership is about taking risks and challenging the status quo. Leaders motivate others to achieve something new and better."-Oxford Dictionary

Management

Management is about delegating responsibilities and getting people to follow the rules to reduce risk and deliver predictable outcomes. A manager is responsible for completing four critical functions: planning, organizing, leading, and controlling.

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2

Being a Leader in Your Organization

Step 1

Recognize that you **ARE** a leader, regardless of

- Job title
- Reporting relationships
- Official "responsibilities"



Risk Management has a unique position

- Organization-wide scope
- Broad knowledge of operations
- Singular focus – the well-being of the organization

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3

Unique Position = Unique Challenges

- People don't always understand what we do
- We lack the authority to effect necessary change
- Staff associate us with poor outcomes, bad news, or adverse events
- Our department becomes the catch-all for things nobody else wants to do or doesn't know how to handle
- You may be forced to overcome the negative biases or baggage left behind by the person who held the job before you. OR, you have to manage the unrealistic expectations set by that person.

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4

Taking Stock

Understanding one's personal strengths and weaknesses

- Leadership assessment tools
- Self-evaluations
- Professional and personal peer evaluations



Examples of assessment tools:

- Gallup's Strengths Finder
- DISC
- Myers-Briggs Type Indicator

***Tip**: Check with your Company's HR department to learn what assessment tools the organization uses, along with other resources that may be available to you.*

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5

Becoming a Leader is a Process

- Be **Present**
  - You have to be seen, available
  - Talk to people, build relationships
- Be **Open**
  - Ask questions, be curious
  - Be open to & respect the views of others
- Be **Calm**
  - Slow down, ask questions, gather data, don't judge
  - Be the grown-up in the room
- Be **Humble**
  - Don't act alone
  - Learn about and take advantage of the knowledge and skills of others

Step 2 **Build Trust**

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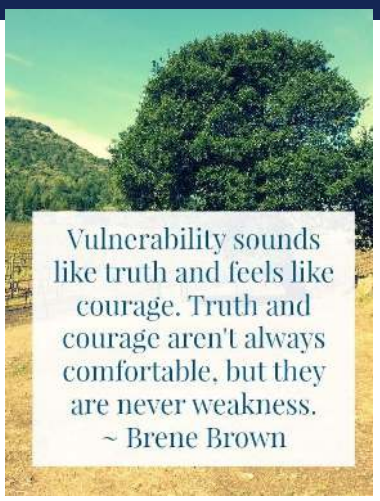
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Relationships are the Key

Vulnerability

Taking action when there is "uncertainty, risk, and emotional exposure."

- **Vulnerability** about our struggles is a great equalizer and it is the seed where strength is born
- **Vulnerability** and **authenticity** create a willingness to take creative risks, share their perspectives without fear of a consequence, and make valuable contributions that can only be expressed within a culture that values trust and inclusion.



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7

Pay Attention to the Little Things

- Be **Objective**
  - Don't judge a situation or person before having all the facts
  - Don't let your personal views drive your actions or responses
  - Avoid Organizational Politics
- Be **Dependable**
  - Follow through, keep promises
  - Be on time, meet deadlines
- **Communicate**
  - Make sure people understand the reasons behind your actions
  - Share information – don't be a data black hole
- Be **Willing to Learn**
  - Recognize when others are the experts
  - Ask people to teach you

Step 3

Build Credibility

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8

Leadership is Proactive

- Respect **Confidentiality**
  - Discretion is one of your most powerful tools
  - It also builds both Trust and Credibility
- Learn to **Prioritize**
  - You'll never get it all done
  - Make sure you understand what is most important
- Be **Collaborative**
  - Learn to work well with others, (even when you don't want to or need to)
  - Helps you understand others, but it also helps them understand you
- Share Your **Vision**
  - Help others understand your function and objectives
  - Identify and demonstrate how everyone's work is connected

STEP 4
Build Confidence

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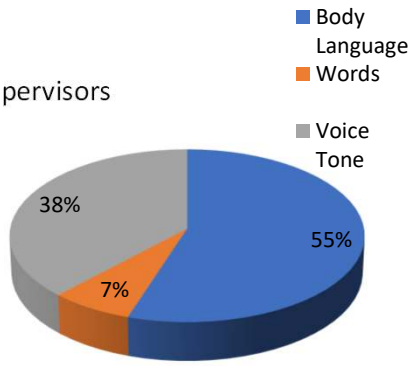
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9

Executive Presence and Effective Leadership

Projecting confidence and authority in any setting
- Formal Meetings
- Informal Gatherings
- Virtual Meetings
- Telephone Conversations
- Social get-togethers with colleagues, subordinates, and supervisors

Unwritten Rules
- Manner of dress
- Behaviors
- Physical Presence
- Verbal Presence
- Non-verbal Communication



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10

Emotional Intelligence

Emotional Intelligence Key Elements

- Self-awareness and self-regulation
- Awareness of others and moderation of others
- Motivation
- Empathy
- Social Skills





Tip: *An excellent way to identify your current level of emotional intelligence is to take the online Emotional Intelligence Assessment from Talent Smart EQ.* https://www.talentsmarteq.com/test/

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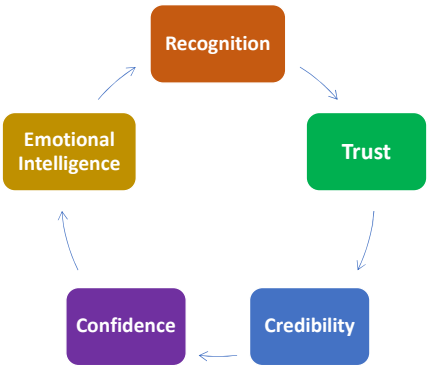
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11

Developing as a Leader: Putting it All Together

Influence vs. Authority

You may lack ***Authority***, but that doesn't mean you can't ***Lead***



Which would you rather have?

- Authority without Influence, *or*
- Influence without Authority

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12

Final Thoughts…

- Know yourself
- Ask for feedback, opinions, ideas
- Learn to delegate
- Accept accountability
- Seek clarity, especially around expectations
- Forge relationships
- Continue to build your network



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