AHRMNY Annual Conference & Reception
Friday, June 6, 2025 – City Winery, NYC
Attendee Handout Materials

Time	Presentation & Speakers	Handouts Included
9:15 AM	**KEYNOTE ADDRESS:** **View from the Bench: Handling Medical Malpractice Cases from Summary Judgment to Verdict to Settlement** Hon. Arthur M. Diamond, J.S.C. (Ret)	Yes - included
Morning Breakout Session		
10:40 AM	**Navigating the Evolving Healthcare Market Relative to Sexual Abuse and Molestation (SAM) Cases** Joseph Calcagno Bonnie Boone (moderator) Aaron Lundberg Sharon Scheuermann (moderator) Jaimee Kass	No Handouts will be provided
	Emerging Role of the Risk Manager in Senior Living Rhonda DeMeno	Yes- included
Mid-Morning Breakout Session		
11:40 AM	**Mitigating Damages: Strategies and New Challenges** Caryn Lilling Adam Bobkin	Yes - included
	Building Trust with Patients: Moving from Noncompliance to Health Literacy Robin Webster Dana Taylor	Yes - included
1:30 PM	AHRMNY Annual Business Meeting	Yes - included
Afternoon Breakout Session		
1:50 PM	**The Vital Role of Onboarding Education for Healthcare Risk Professionals** Robin Lynch	Yes - included
	How to Maximize Privilege Protections under the Patient Safety Act Michael Callahan Abbi Schenkel Tina Weinstein Bonnie Portnoy (Moderator)	Yes - included
2:50 PM	**PLENARY SESSION** **Views from the Bench and Litigators on Medical Malpractice Trends** Hon. Lewis J. Lubell, J.S.C. Besty Baydala Chris DiGiacinto	Yes - included

Also included: Program Flyer
Registered Attendee List

LAW AND MEDICINE

1

HON. ARTHUR M. DIAMOND
STONY BROOK UNIVERSITY
SCHOOL OF MEDICINE
JUNE 6, 2025

1

Course Outline

2

- Overview of the legal system and terms you need to know
  - Trial procedure from summons to verdict sheet
  - NY Statutes that govern your conduct
- The patient/doctor relationship-when does it begin and when does it end
- The constitutional implications of medicine: involuntary commitment, guardianship,
- Abortion, right to die; statutes of limitations; continuing treatment doctrine; foreign objects
- Law of medical malpractice: case studies

2

Burnout & Medical Errors Among American Surgeons (Annals of Surgery, June 2010)

3

- 1999 Institute of Medicine reported up to 100,000 US patients die of preventable adverse events each year.
- Other studies suggest medical errors affect up to 10% of hospitalized patients: commission or omission with potentially negative consequences for the patient that would have been judged wrong by skilled knowledgeable peers
- Of 7,905 surgeons who responded 9% reported making a ' major medical error' in the last 3 months
- 31% identified a 'lapse in judgment as greatest contributing factor
- Physician job satisfaction may influence quality of care and patient
- Relationship (Williams & Skinner, Health Care Manage Rev. 2003)

3

Medical Malpractice Statistics

4

- From 2013-2016 about 6,000 claims filed NYS; 1500 per year
- 2011- $13,790,000 in claims paid out/ $454,726 per claim
- 2016-ready trial cases 55% settled; 12% disposed by motion
- P successful in 23%; consistent with statewide average of 25%
- Average length of disposition: 1,119 days; double complex commercial case

4

Beginning a civil lawsuit

5

Supreme court- Appellate divisions-court of appeals by permission

Summons & complaint

Answer

Discovery procedures- [CPLR 3101]: bill of particulars; expert demand and exchange; depositions; certification

Motion practice: summary judgment/motions to dismiss

Common law v. statutory law/ *stare decisis*

State and Federal jurisdictions

5

Negligence is the establishment of:

-a duty
-breach of that duty that is a substantial factor in causing
-injury that is reasonably foreseeable to the person injured
(Palsgraff v LIRR, 1928)

6

The physician–patient relationship: When does it begin?

7

- When the physician affirmatively treats or advises the patient as to a course of treatment:
  - may be established by mutual consent, express or implied contract;
  - regardless of whether rendered gratuitously or at request of 3rd party
  - *Eiseman v. State of New York (1987)*
  - *Purdy v. Public Administrator (1988)*
  - *Tenuto v. Lederle Labs (1997)*
  - *Davis v. South Nassau Community Hosp (2015)*

7

Criminal Prosecutions

8

- Defenses- New York does not have an "insanity defense"
- Required element of criminal conviction is that defendant had intent to commit the act accused of
- Proven ONLY through psychiatric testimony, New York has defense of 'not responsible by reason of medical disease or defect'

8

Domestic Relations Law DRL Sec 236

9

- Grounds-no longer contested
- Custody-legal & physical; child support
- Maintenance-does your spouse stay at home?
- Equitable Distribution-Marital property-what is and what is not
- Significant change in the law 2016 New York no longer values 'enhanced earnings' capacity of the degree of a spouse who obtains a professional license during the course of the marriage
- Practices are still valued and distributed

DO YOU NEED A PRE-NUP??????????????????

9

The Fourth Amendment

10

- The right of the people to be secure in their persons, houses, papers and effects against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probably cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

10

The 5th Amendment to the Constitution (1789)

11

No person shall be held to answer for a crime unless on a **presentment or indictment of a grand jury**;

nor shall be subject for the same offense to be **twice put in jeopardy of life or limb**;

nor shall be compelled in any criminal case to be **a witness against himself**;

*nor be deprived of life, liberty or property, **without due process of law**….*

11

The 14th Amendment to the US Constitution (1866)

12

All persons **born or naturalized** in the United States…are **citizens of the United States** and of the State wherein they reside.

No state shall make or enforce any law which shall **abridge the privileges or immunities of any citizens** of the United States

Nor shall any State **deprive any person of life, liberty, or property, without due process of law**, nor deny to any person within its jurisdiction the equal protection of the laws.

12

13

Article 9 Mental Hygiene Law The treatment of the mentally ill in New York

The constitutional implications of involuntary commitment

13

14

Article 9 definitions

As used in this article:

- "in need of care and treatment" means that a person has a **mental illness for which in-patient care and treatment in a hospital is appropriate**. (voluntary standard)
- "in need of involuntary care and treatment" means that a person has a mental illness for which care and treatment as a patient in a hospital is **essential to such person's welfare and whose judgment is so impaired that he is unable to understand** the need for such care and treatment.
- "likelihood to result in serious harm" or "likely to result in serious harm" means (a) **a substantial risk of physical harm to the person** as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm. (9.39)
- "need for retention" means that a person who has been **admitted to a hospital** pursuant to this article is in need of involuntary care and treatment in a hospital for a further period.

14

Bringing the involuntary commitment proceeding

15

- person living with one diagnosed with mental illness
- immediate family member
- officer of a recognized health institute, agency or home where such person lives
- director of community services or social services officer
- director of hospital where person is presently hospitalized
- director of substance abuse/alcohol facility proving care to person
- By court order-the guardian or custodian of person
- Certification by two doctors required; alternatives must have been considered

15

§ 9.27 Involuntary admission on medical certification

16

- Certificates of two examining physicians, accompanied by an application for the admission; exam must have been executed within ten days prior to such admission
- A statement of the facts upon which the allegation of mental illness and need for care and treatment are based
- Consider alternative forms of care and treatment
- Prior to admission, examined by a physician who shall be a member of the psychiatric staff of such hospital who certifies
- No patient may be sent to another hospital by any form of involuntary admission unless the mental hygiene legal service has been given notice
- Separately certified that he or she is mentally ill and in need of involuntary care and treatment in a hospital, either physician is authorized to request … members of an authorized police department … to take into custody and transport such person to a hospital

16

IF involuntary admitted on med cert, then what?

17

- If patient does not consent to stay, hospital needs court order within 60 days
- At any time prior to 60th day, the person, relative, friend or MHLS may in writing **demand a hearing;** hearing within 5 days
- Court **hears testimony and examines the person** if deemed advisable; Court may **retain or release**
- If held, **retention is for 6 months**
- Person may ask for **re-hearing within** 30 days to different Judge or
- **Jury** may determine mental illness

17

The Emergency Room Admission on medical certificate of comm director

18

- This admission is for **15 days**
- Must be alleged that person has mental illness and **needs immediate observation** and which is likely to **result in serious harm** to himself or others if not admitted
- Substantial risk of physical harm:
  - threat of or attempt at suicide/serious bodily harm/danger to himself
  - risk of physical harm to others/homicidal behavior or other violent behavior which places others in reasonable fear of physical harm

18

Requirements

19

- Need 1 doctor at admission
- Overt act /threat of violence
- Next 72 hours need a second certificate
- After 72 hours need 3rd PC
- Hearing within five days if requested
- If held, rules regulating involuntary adm apply

19

Emergency Admission for immediate care/treatment

20

- Period is 15 days
- Requires likelihood of serious harm to himself or others
- Retention for 48 hours then 2d PC required
- Written notice required
- Hearing, if requested, within 5 days; if reasonable cause found then rules of involuntary commitment apply

20

14 NYCRR 27.8

21

- Care and Treatment- the Right to Object and Appeal
- Emergency treatment- over objection care may be given where "appears necessary to avoid serious harm to life or limb of the patients themselves or others"
- Patients on voluntary or informal status MAY NOT be given treatment over objection. Director may discharge the patient with recommendations for outpatient care or attempt to convert patient to involuntary status as per MHL.
- Patients on involuntary status- may be treated over objection if head of service approves; if patient seeks to appeal, then to director.
- Patient is entitled to counsel who may bring application to Court to stop treatment.
- Religious objection automatically requires court order.

21

MHL Article 81 The Power to Appoint a Guardian of the person and property

22

- To provide for the **personal needs of that person**, including food, clothing, shelter, health care, or safety and/or to manage the financial affairs of that person.
- The determination of capacity is based upon **CLEAR AND CONVINCING EVIDENCE**
  - person is likely to suffer harm because a) person is unable to provide for their personal needs/property management AND
  - person cannot adequately understand and appreciate the nature and consequences of such inability.
- Court shall consider the **FUNCTIONAL LEVEL AND LIMITATIONS OF SUCH PERSON**:
  - management of ADL's & ability to understand limitations of any inability
  - preferences, wishes and values of the person
  - nature and extent of person's property and ability to manage them
- Court must assess:
  - extent of demands placed on the person; any illness & prognosis; mental disability; substance dependency; medications
  - all other relevant facts and circumstances of functional limitations & ability of person to appreciate same

22

Commencing Art. 81 Proceeding

23

- Petition May Be Brought By:
  - AIP self
  - Distributee
  - Anyone who is concerned with welfare of AIP
- Factual allegations demonstrating inability to provide for one's own needs
- Court, upon signing Order to Show Cause (OTSC), appoints court evaluator to conduct investigation & produce report
  - May seek permission from court to obtain medical records
- If AIP is contesting, shall have counsel.
- Hearing to be held **within 28 days** of OTSC signing
- AIP has **5th Amendment rights**: need not participate in the hearing; petitioner has burden by C & C
- AIP may consent, converting status to PING
- Guardian, Temporary, Special- options for court
- Powers granted should be least restrictive means necessary to protect IP

23

Compare with Public Health Law Sec. 2994-c: Determination of capacity

24

- Attending physician determines decision making capacity to a reasonable degree of medical certainty
- Is subject to a concurring determination
- In general hospital health/social services practitioner must independently determine capacity
- If patient objects court must decide

24

25

The Family Health Care Decisions Act Public Health Law 2994

- determination of incapacity
- decision making by surrogates
- obligations of attending physician
- decision making w/o surrogate

25

26

Rivers v. Katz, 67 NY2d 485 (1986)

- The issue presented in this Article 78 proceeding emanated from a Dutchess County class action brought by involuntarily committed mental patients alleging that the forcible use of antipsychotic medication violated both common law and Constitutional right to determine one's own course of treatment.
  - **NY CA** held that the due process clause of state constitution affords such population fundamental right to refuse such medication.
  - **Facilities argued** that such population is presumptively incompetent to control own course of treatment
  - **Court:** We conclude that neither the fact that they are mentally ill nor that they have been involuntarily committed, without more, is a sufficient basis to conclude that they lack the mental capacity to comprehend the consequences of their decision to refuse medication that poses a significant risk to their health.
- There must be a judicial determination of whether the patient has the capacity to make a reasoned decision with respect to proposed treatment before the drugs may be administered pursuant to the State's *parents patriae* power.
- Treatment must be narrowly tailored to give substantive effect to patient's liberty interest

26

14 NYCRR 27.9

27

- Surgery and certain other treatments
- ECT therapy, surgery, major medical treatment or use of experimental drugs or treatment may be administered to the patient **only upon informed consent** of patient or a person authorized to act on their behalf.
  - if under 18 and no parent or legal guardian OR if one parent objects, director must obtain court order
  - if over 18 but in opinion of director of service does not have the mental capacity to give consent, consent may be obtained from spouse, parent, adult child or if none a court of competent jurisdiction.
  - if over 18 and director unsure of medical capacity, opinion may be obtained from independent consultant who is not employee; director may then determine appropriate steps to be taken
- Emergency doctrine applies
- Facility must have standard procedures in place

27

Medicine and the Fourth and Fourteenth Amendments

28

-When does life begin

-When does it end

-Assisted suicide in New York

- *Roe v. Wade*, 93 S.Ct. 705 (1973)
- *Matter of Father Phillip Eichner,SM* 73 AD2d 431(1980)
- *Myer, Seiff et al v. Schneiderman*

28

CPLR 214, 214–a
Statute of limitations in medical, dental and podiatric malpractice

29

- To be commenced within **two years and six months** with exceptions:
  - The two years and six months is from the time of the act, omission or failure complained OR
  - last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the said act, omission or failure;
  - if the action is based upon discovery of a foreign body in the patient, the action may be commenced **within one year** of the date of such discovery or of the date of discovery of facts which would reasonably lead to such discovery, whichever is earlier.
- **Continuous treatment** does not include examinations undertaken at the request of the patient for the sole purpose of ascertaining the state of the patient's condition.
- **CPLR 3012-a Certificate of Merit unique to medical malpractice actions**

29

Continuous treatment Doctrine- tolling the statute of limitations

30

- Flint v. Zielinksi, 130 AD3d 1460 (4th, 2015)
- Toth v. Community Hosp at Glen Cove, 22 NY2d 255 (1968)
- McDermott v. Torre,et.al, 56 NY2d 399 (1982)
- Borgia v. City of New York, 12 NY2d 151
- Lohans v. Luzi, 30 NY3d 752 (2018)

30

Foreign object v. fixation device

31

- Walton v. Strong Memorial (2015)- the polyvinyl catheter; provides history
- Flanagan v. Mt. Eden (1969)- Dr. leaves surgical clamps in plaintiff's body during 1958 gall bladder surgery
- 1996- abdominal pains begin; x rays show clamps
- Note- this is PRIOR to CPLR 214 a; opens the flood gates
- Rodrigues v. Manhattan Med Group (1990)- the IUD cases
- Rockfeller v. Moront (1993)- the improper suture
- LaBarbera v. NY Eye & Ear (1998)- silastic stents

31

Committee on Pattern Jury Instructions Association of Supreme Court Justices

32

PJI 2:150 Malpractice—Physician

- Malpractice is professional negligence and medical malpractice is the negligence of a doctor.
- Negligence is the failure to use reasonable care under the circumstances, doing something that a reasonably prudent doctor would not do under the circumstances, or failing to do something that a reasonably prudent doctor would do under the circumstances. It is a deviation or departure from accepted practice.
- A doctor who renders medical service to a patient is obligated to have that reasonable degree of knowledge and skill that is expected of an (average doctor, average specialist) who (performs, provides) that (operation, treatment, medical service) in the medical community in which the doctor practices. *([If there is evidence that the doctor should have complied with standards that exceed the standards of the medical community in which the doctor practices, the following should be charged:]* The doctor must also comply with minimum (statewide, national) standards of care.)

32

33

- By undertaking to perform a medical service, a doctor does not guarantee a good result. The fact that there was a bad result to the patient, by itself, does not make the doctor liable. The doctor is liable only if (he, she) was negligent. Whether the doctor was negligent is to be decided on the basis of the facts and conditions existing at the time of the claimed negligence.
- *[This paragraph should only be charged when there is evidence that the doctor made a choice among medically acceptable alternatives. See Caveat 2 below:] A doctor is not liable for an error in judgment if (he, she) does what (he, she) decides is best after careful evaluation if it is a judgment that a reasonably prudent doctor could have made under the circumstances. In other words, a doctor is not liable for malpractice if he or she chooses one of two or more medically acceptable courses of action.*
- If the doctor is negligent, that is, lacks the skill or knowledge required of (him, her) in providing a medical service, or fails to use reasonable care in providing the service, or fails to exercise his or her best judgment, and such failure is a substantial factor in causing harm to the patient, then the doctor is responsible for the injury or harm caused.
- [Where appropriate, add:]
- A doctor's responsibility is the same regardless of whether (he, she) was paid.

33

34

N.Y. Pattern Jury Instr.-Civil 2:150

- The law recognizes that there are differences in the abilities of doctors, just as there are differences in the abilities of people engaged in other activities. To practice medicine a doctor is not required to have the extraordinary knowledge and ability that belongs to a few doctors of exceptional ability. However every doctor is required to keep reasonably informed of new developments in (his, her) field and to practice (medicine, surgery) in accordance with approved methods and means of treatment in general use. A doctor must also use his or her best judgment and whatever superior knowledge and skill (he, she) possesses, even if the knowledge and skill exceeds that possessed by the (average doctor, average specialist) in the medical community where the doctor practices.

34

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

McKinney's Consolidated Laws of New York Annotated
Public Health Law (Refs & Annos)
Chapter 45. Of the Consolidated Laws (Refs & Annos)
Article 29-CC. Family Health Care Decisions Act (Refs & Annos)

McKinney's Public Health Law § 2994-a

§ 2994-a. Definitions

Effective: September 18, 2011

Currentness

The following words or phrases, used in this article, shall have the following meanings, unless the context otherwise requires:

1. "Adult" means any person who is eighteen years of age or older or has married.

2. [Eff. until May 28, 2018. See, also, subd. 2 below.] "Attending physician" means a physician, selected by or assigned to a patient pursuant to hospital policy, who has primary responsibility for the treatment and care of the patient. Where more than one physician shares such responsibility, or where a physician is acting on the attending physician's behalf, any such physician may act as an attending physician pursuant to this article.

2. [Eff. May 28, 2018. See, also, subd. 2 above.] "Attending physician" means a physician, selected by or assigned to a patient pursuant to hospital policy, who has primary responsibility for the treatment and care of the patient. Where more than one physician and/or nurse practitioner shares such responsibility, or where a physician or nurse practitioner is acting on the attending physician's or attending nurse practitioner's behalf, any such physician or nurse practitioner may act as an attending physician or attending nurse practitioner pursuant to this

article.

2-a. [Eff. May 28, 2017.] "Attending nurse practitioner" means a nurse practitioner, selected by or assigned to a patient pursuant to hospital policy, who has primary responsibility for the treatment and care of the patient. Where more than one physician and/or nurse practitioner shares such responsibility, or where a physician or nurse practitioner is acting on the attending physician's or attending nurse practitioner's behalf, any such physician or nurse practitioner may act as an attending physician or attending nurse practitioner pursuant to this article.

3. "Cardiopulmonary resuscitation" means measures, as specified in regulations promulgated by the commissioner, to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. Cardiopulmonary resuscitation shall not include measures to improve ventilation and cardiac function in the absence of an arrest.

4. [Eff. until May 28, 2018. See, also, subd. 4 below.] "Close friend" means any person, eighteen years of age or older, who is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister), who has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs, and who presents a signed statement to that effect to the attending physician.

4. [Eff. May 28, 2018. See, also, subd. 4 above.] "Close friend" means any person, eighteen years of age or older, who is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister), who has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs, and who presents a signed statement to that effect to the attending physician or attending nurse practitioner.

5. "Decision-making capacity" means the ability to understand and appreciate the nature and consequences of proposed health care, including the benefits and risks of and alternatives to proposed health care, and to reach an informed decision.

5-a. "Decisions regarding hospice care" means the decision to enroll or disenroll in hospice, and consent to the hospice plan of care and modifications to that plan.

6. "Developmental disability" means a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law.

7. "Domestic partner" means a person who, with respect to another person:

(a) is formally a party in a domestic partnership or similar relationship with the other person, entered into pursuant to the laws of the United States or of any state, local or foreign jurisdiction, or registered as the domestic partner of the other person with any registry maintained by the employer of either party or any state, municipality, or foreign jurisdiction; or

(b) is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance; or

(c) is dependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including but not limited to: common ownership or joint leasing of real or personal property; common householding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners under paragraph (a) or (b) of this subdivision; or the length of the personal relationship of the persons.

Each party to a domestic partnership shall be considered to be the domestic partner of the other party. "Domestic partner" shall not include a person who is related to the other person by blood in a manner that would bar marriage to the other person in New York state. "Domestic partner" also shall not include any person who is less than eighteen years of age or who is the adopted child of the other person or who is related by blood in a manner that would bar marriage in New York state to a person who is the lawful spouse of the other person.

8. "Emancipated minor patient" means a minor patient who is the parent of a child, or who is sixteen years of age or older and living independently from his or her parents or guardian.

9. "Ethics review committee" means the interdisciplinary committee established in accordance with the requirements of section twenty-nine hundred ninety-four-m of this article.

10. "General hospital" means a general hospital as defined in subdivision ten of section twenty-eight hundred one of this chapter excluding a ward, wing, unit or other part of a general hospital operated for the purpose of providing services for persons with mental illness pursuant to an operating certificate issued by the commissioner of mental health.

11. "Guardian of a minor" or "guardian" means a health care guardian or a legal guardian of the person of a minor.

12. "Health care" means any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition. Providing nutrition or hydration orally, without reliance on medical treatment, is not health care under this article and is not subject to this article.

13. "Health care agent" means a health care agent designated by an adult pursuant to article twenty-nine-C of this chapter.

14. "Health care decision" means any decision to consent or refuse to consent to health care.

15. "Health care guardian" means an individual appointed by a court, pursuant to subdivision four of section twenty-nine hundred ninety-four-r of this article, as the guardian of a minor patient solely for the purpose of deciding about life-sustaining treatment pursuant to this article.

16. "Health care provider" means an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice.

17. "Health or social service practitioner" means a registered professional nurse, nurse practitioner, physician, physician assistant, psychologist or licensed clinical social worker, licensed or certified pursuant to the education law acting within his or her scope of practice.

17-a. "Hospice" means a hospice as defined in article forty of this chapter, without regard to where the hospice care is provided.

18. "Hospital" means a general hospital, a residential health care facility, or hospice.

19. "Life-sustaining treatment" means any medical treatment or procedure without which the patient will die within a relatively short time, as determined by an attending physician to a reasonable degree of medical certainty. For the purpose of this article, cardiopulmonary resuscitation is presumed to be life-sustaining treatment without the necessity of a determination by an attending physician.

20. "Mental hygiene facility" means a facility operated or licensed by the office of mental health or the office of mental retardation and developmental disabilities as defined in subdivision six of section 1.03 of the mental hygiene law.

21. "Mental illness" means a mental illness as defined in subdivision twenty of section 1.03 of the mental hygiene law, and does not include dementia, such as Alzheimer's disease, or other disorders related to dementia.

22. "Minor" means any person who is not an adult.

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22-a. [Eff. May 28, 2018.] "Nurse practitioner" means a nurse practitioner certified pursuant to section sixty-nine hundred ten of the education law who is practicing in accordance with subdivision three of section sixty-nine hundred two of the education law.

23. "Order not to resuscitate" means an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest.

24. "Parent", for the purpose of a health care decision about a minor patient, means a parent who has custody of, or who has maintained substantial and continuous contact with, the minor patient.

25. "Patient" means a person admitted to a hospital.

26. "Person connected with the case" means the patient, any person on the surrogate list, a parent or guardian of a minor patient, the hospital administrator, an attending physician, any other health or social services practitioner who is or has been directly involved in the patient's care, and any duly authorized state agency, including the facility director or regional director for a patient transferred from a mental hygiene facility and the facility director for a patient transferred from a correctional facility.

27. "Reasonably available" means that a person to be contacted can be contacted with diligent efforts by an attending physician, another person acting on behalf of an attending physician, or the hospital.

28. "Residential health care facility" means a residential health care facility as defined in subdivision three of section twenty-eight hundred one of this chapter.

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29. "Surrogate" means the person selected to make a health care decision on behalf of a patient pursuant to section twenty-nine hundred ninety-four-d of this article.

30. "Surrogate list" means the list set forth in subdivision one of section twenty-nine hundred ninety-four-d of this article.

Credits

(Added L.2010, c. 8, § 2, eff. June 1, 2010. Amended L.2011, c. 167, § 1, eff. Sept. 18, 2011; L.2017, c. 430, § 16, eff. May 28, 2018.)

Notes of Decisions (2)

McKinney's Public Health Law § 2994-a, NY PUB HEALTH § 2994-a
Current through L.2018, chapters 1 to 3.

End of Document

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Article 29-CC. Family Health Care Decisions Act (Refs & Annos)

McKinney's Public Health Law § 2994-b

§ 2994-b. Applicability; priority of certain other surrogate decision-making laws and regulations

Effective: September 18, 2011
Currentness

1. This article shall apply to health care decisions regarding health care provided in a hospital, and to decisions regarding hospice care without regard to where the decision is made or where the care is provided, for a patient who lacks decision-making capacity, except as limited by this section.

2. Prior to seeking or relying upon a health care decision by a surrogate for a patient under this article, the attending physician shall make reasonable efforts to determine whether the patient has a health care agent appointed pursuant to article twenty-nine-C of this chapter. If so, health care decisions for the patient shall be governed by such article, and shall have priority over decisions by any other person except the patient or as otherwise provided in the health care proxy.

3. Prior to seeking or relying upon a health care decision by a surrogate for a patient under this article, if the attending physician has reason to believe that the patient has a history of receiving services for mental retardation or a developmental disability; it reasonably appears to the attending physician that the patient has mental retardation or a developmental disability; or the attending physician has reason to believe that the patient has been transferred from a mental hygiene facility operated or licensed by the office of mental health, then such physician shall make reasonable efforts to determine whether paragraphs (a), (b) or (c) of this subdivision are applicable:

(a) If the patient has a guardian appointed by a court pursuant to article seventeen-A of the surrogate's court procedure act, health care decisions for the patient shall be governed by section seventeen hundred fifty-b of the surrogate's court proceedure [1] act and not by this article.

(b) If a patient does not have a guardian appointed by a court pursuant to article seventeen-A of the surrogate's court procedure act but falls within the class of persons described in paragraph (a) of subdivision one of section seventeen hundred fifty-b of such act, decisions to withdraw or withhold life-sustaining treatment for the patient shall be governed by section seventeen hundred fifty-b of the surrogate's court procedure act and not by this article.

(c) If a health care decision for a patient cannot be made under paragraphs (a) or (b) of this subdivision, but consent for the decision may be provided pursuant to the mental hygiene law or regulations of the office of mental health or the office of mental retardation and developmental disabilities, then the decision shall be governed by such statute or regulations and not by this article.

4. If, after reasonable efforts, it is determined that a health care decision for the patient cannot be made pursuant to subdivision two or three of this section, then the health care decision shall be made pursuant to this article.

Credits

(Added L.2010, c. 8, § 2, eff. June 1, 2010. Amended L.2011, c. 167, § 2, eff. Sept. 18, 2011.)

Footnotes

1 So in original ("proceedure" should be "procedure").

McKinney's Public Health Law § 2994-b, NY PUB HEALTH § 2994-b
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NY CLS Pub Health § 2994-c

Current through 2017 released chapters 1-82

New York Consolidated Laws Service > Public Health Law > Article 29-CC Family Health Care Decisions Act

§ 2994-c. Determination of incapacity

1. Presumption of capacity. For purposes of this article, every adult shall be presumed to have decision-making capacity unless determined otherwise pursuant to this section or pursuant to court order, or unless a guardian is authorized to decide about health care for the adult pursuant to article eighty-one of the mental hygiene law.

2. Initial determination by attending physician. An attending physician shall make an initial determination that an adult patient lacks decision-making capacity to a reasonable degree of medical certainty. Such determination shall include an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain decision-making capacity.

3. Concurring determinations.

(a) An initial determination that a patient lacks decision-making capacity shall be subject to a concurring determination, independently made, where required by this subdivision. A concurring determination shall include an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain decision-making capacity, and shall be included in the patient's medical record. Hospitals shall adopt written policies identifying the training and credentials of health or social services practitioners qualified to provide concurring determinations of incapacity.

(b)

(i) In a residential health care facility, a health or social services practitioner employed by or otherwise formally affiliated with the facility must independently determine whether an adult patient lacks decision-making capacity.

(ii) In a general hospital a health or social services practitioner employed by or otherwise formally affiliated with the facility must independently determine whether an adult patient lacks decision-making capacity if the surrogate's decision concerns the withdrawal or withholding of life-sustaining treatment.

(iii) With respect to decisions regarding hospice care for a patient in a general hospital or residential health care facility, the health or social services practitioner must be employed by or otherwise formally affiliated with the general hospital or residential health care facility.

(c)

(i) If the attending physician makes an initial determination that a patient lacks decision-making capacity because of mental illness, either such physician must have the following qualifications, or another physician with the following qualifications must independently determine whether the patient lacks decision-making capacity: a physician licensed to practice medicine in New York state, who is a diplomate or eligible to be certified by the American Board of Psychiatry and Neurology or who is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board. A record of such consultation shall be included in the patient's medical record.

(ii) If the attending physician makes an initial determination that a patient lacks decision-making capacity because of a developmental disability, either such physician must have the following qualifications, or another professional with the following qualifications must independently determine whether the patient lacks decision-making capacity: a physician or clinical psychologist who either is employed by a developmental disabilities services office named in *section 13.17 of the mental hygiene law*, or who has been employed for a minimum of two years to render care and service in a facility operated or licensed by the office for people with developmental disabilities, or has been approved by the commissioner of developmental disabilities in accordance with regulations promulgated by such commissioner. Such regulations shall require that a physician or clinical psychologist possess specialized training or three years experience in treating developmental disabilities. A record of such consultation shall be included in the patient's medical record.

(d) If an attending physician has determined that the patient lacks decision-making capacity and if the health or social services practitioner consulted for a concurring determination disagrees with the attending physician's determination, the matter shall be referred to the ethics review committee if it cannot otherwise be resolved.

4. Informing the patient and surrogate. Notice of a determination that a surrogate will make health care decisions because the adult patient has been determined to lack decision-making capacity shall promptly be given:

(a) to the patient, where there is any indication of the patient's ability to comprehend the information;

(b) to at least one person on the surrogate list highest in order of priority listed when persons in prior classes are not reasonably available pursuant to subdivision one of section twenty-nine hundred ninety-four-d of this article;

(c) if the patient was transferred from a mental hygiene facility, to the director of the mental hygiene facility and to the mental hygiene legal service under article forty-seven of the mental hygiene law.

5. Limited purpose of determination. A determination made pursuant to this section that an adult patient lacks decision-making capacity shall not be construed as a finding that the patient lacks capacity for any other purpose.

6. Priority of patient's decision. Notwithstanding a determination pursuant to this section that an adult patient lacks decision-making capacity, if the patient objects to the determination of incapacity, or to the choice of a surrogate or to a health care decision made by a surrogate or made pursuant to section twenty-nine hundred ninety-four-g of this article, the patient's objection or decision shall prevail unless: (a) a court of competent jurisdiction has determined that the patient lacks decision-making capacity or the patient is or has been adjudged incompetent for all purposes and, in the case of a patient's objection to treatment, makes any other finding required by law to authorize the treatment, or (b) another legal basis exists for overriding the patient's decision.

7. Confirmation of continued lack of decision-making capacity. An attending physician shall confirm the adult patient's continued lack of decision-making capacity before complying with health care decisions made pursuant to this article, other than those decisions made at or about the time of the initial determination. A concurring determination of the patient's continued lack of decision-making capacity shall be required if the subsequent health care decision concerns the withholding or withdrawal of life-sustaining treatment. Health care providers shall not be required to inform the patient or surrogate of the confirmation.

History

Add, *L 2010, ch 8, § 2*, eff June 1, 2010 (see 2010 note below); amd, *L 2011, ch 167, § 3*, eff Sept 18, 2011; *L 2012, ch 56, § 8* (Part J), eff March 30, 2012 (see 2012 note below).

Annotations

Notes

Editor's Notes:

Laws 2010, ch 8, §§ 1 **and 29,** eff June 1, 2010 and March 16, 2010, respectively, provide as follows:

Section 1. Legislative intent. Under article 29-C of the public health law, competent adults have a powerful way to control their medical treatment even after they lose decision-making capacity, by appointing someone they trust to decide on their behalf. This legislation fills a gap that remains in New York law. It adds, inter alia, a new article 29-CC to the public health law, which establishes a decision-making process, applicable to decisions in general hospitals and nursing homes, whereby a surrogate is selected and empowered to make health care decisions for patients who lack capacity to make their own health care decisions and who have not otherwise appointed an agent to make health care decisions pursuant to article 29-C of the public health law or provided clear and convincing evidence of their treatment wishes.

The legislature does not intend to encourage or discourage any particular health care decision or treatment, or to create or expand a substantive right of competent adults to decide about treatment for themselves, or to impair the right of patients to object to treatment under applicable law including court decisions. Further, the legislature does not intend to authorize a surrogate to deny to the patient personal services that every patient would generally receive, such as appropriate food, water, bed rest, room temperature and hygiene. This legislation establishes a procedure to facilitate responsible decision-making by surrogates on behalf of patients who do not have capacity to make their own health care decisions.

This legislation affirms existing laws and policies that limit individual conduct of patients with or without capacity, including those laws and policies against homicide, suicide, assisted suicide and mercy killing.

§ 29. This act shall take effect immediately; provided that sections one through twenty-six of this act shall take effect on the first of June next succeeding the date on which this act shall have become a law; and provided further that effective immediately it shall be lawful for a hospital, as defined in subdivision 18 of *section 2994-a of the public health law*, as added by this act to adopt a policy that is consistent with the requirements of article 29-CC of the public health law as added by section two of this act or the mental hygiene law as amended by sections twenty-five and twenty-six of this act and for a health care provider to accept and carry out a health care decision in accordance with such requirements for a patient in a hospital that has adopted such policy.

Laws 2012, ch 56, §§ 20, **21 (Part J),** eff March 30, 2012, provide as follows:

§ 20. [Expires March 31, 2013] The commissioner of the office for people with developmental disabilities shall provide notification to the temporary president of the senate and the speaker of the assembly sixty days prior to a reduction in capacity of twenty persons or more or closure of a developmental center or other institutional setting which is subject to such reduction or closure pursuant to such commissioner's planned downsizing and closing of institutional capacity.

§ 21. This act shall take effect immediately, provided however, that on or before May 31, 2012 the office for people with developmental disabilities shall submit a report to the temporary president of the senate and the speaker of the assembly on implementation related to the restructuring of developmental disabilities services offices. The office shall also publish the report on the office's website. The report shall include but not be limited to: the plan timeline for transition of each of the developmental disabilities service offices into a state operations offices of the office for people with developmental disabilities; the location of each state operations office, its catchment area, and a list of services that will be administered under its jurisdiction; and the location of each developmental disabilities regional office, its catchment area, and a list of programs under its jurisdiction; and provided further that section twenty of this act shall expire and be deemed repealed on March 31, 2013.

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§ 2994-d. Health care decisions for adult patients by surrogates
McKinney's Consolidated Laws of New York Annotated Public Health Law Effective: September 18, 2011 *(Approx. 3 page*

Proposed Legislation

Effective: September 18, 2011

McKinney's Public Health Law § 2994-d

§ 2994-d. Health care decisions for adult patients by surrogates

Currentness

1. Identifying the surrogate. One person from the following list from the class highest in priority when persons in prior classes are not reasonably available, willing, and competent to act, shall be the surrogate for an adult patient who lacks decision-making capacity. However, such person may designate any other person on the list to be surrogate, provided no one in a class higher in priority than the person designated objects:

(a) A guardian authorized to decide about health care pursuant to article eighty-one of the mental hygiene law;

(b) The spouse, if not legally separated from the patient, or the domestic partner;

(c) A son or daughter eighteen years of age or older;

(d) A parent;

(e) A brother or sister eighteen years of age or older;

(f) A close friend.

2. Restrictions on who may be a surrogate. An operator, administrator, or employee of a hospital or a mental hygiene facility from which the patient was transferred, or a physician

who has privileges at the hospital or a health care provider under contract with the hospital may not serve as the surrogate for any adult who is a patient of such hospital, unless such individual is related to the patient by blood, marriage, domestic partnership, or adoption, or is a close friend of the patient whose friendship with the patient preceded the patient's admission to the facility. If a physician serves as surrogate, the physician shall not act as the patient's attending physician after his or her authority as surrogate begins.

3. Authority and duties of surrogate. (a) Scope of surrogate's authority.

(i) Subject to the standards and limitations of this article, the surrogate shall have the authority to make any and all health care decisions on the adult patient's behalf that the patient could make.

(ii) Nothing in this article shall obligate health care providers to seek the consent of a surrogate if an adult patient has already made a decision about the proposed health care, expressed orally or in writing or, with respect to a decision to withdraw or withhold life-sustaining treatment expressed either orally during hospitalization in the presence of two witnesses eighteen years of age or older, at least one of whom is a health or social services practitioner affiliated with the hospital, or in writing. If an attending physician relies on the patient's prior decision, the physician shall record the prior decision in the patient's medical record. If a surrogate has already been designated for the patient, the attending physician shall make reasonable efforts to notify the surrogate prior to implementing the decision; provided that in the case of a decision to withdraw or withhold life-sustaining treatment, the attending physician shall make diligent efforts to notify the surrogate and, if unable to notify the surrogate, shall document the efforts that were made to do so.

(b) Commencement of surrogate's authority. The surrogate's authority shall commence upon a determination, made pursuant to section twenty-nine hundred ninety-four-c of this article, that the adult patient lacks decision-making capacity and upon identification of a surrogate pursuant to subdivision one of this section. In the event an attending physician determines that the patient has regained decision-making capacity, the authority of the surrogate shall cease.

(c) Right and duty to be informed. Notwithstanding any law to the contrary, the surrogate shall have the right to receive medical information and medical records necessary to make informed decisions about the patient's health care. Health care providers shall provide and the surrogate shall seek information necessary to make an informed decision, including information about the patient's diagnosis, prognosis, the nature and consequences of proposed health care, and the benefits and risks of and alternative to proposed health care.

4. Decision-making standards. (a) The surrogate shall make health care decisions:

(i) in accordance with the patient's wishes, including the patient's religious and moral beliefs; or

(ii) if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. An assessment of the patient's best interests shall include: consideration of the dignity and uniqueness of every person; the possibility and extent of preserving the patient's life; the preservation, improvement or restoration of the patient's health or functioning; the relief of the patient's suffering; and any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

(b) In all cases, the surrogate's assessment of the patient's wishes and best interests shall be patient-centered; health care decisions shall be made on an individualized basis for each patient, and shall be consistent with the values of the patient, including the patient's religious and moral beliefs, to the extent reasonably possible.

5. Decisions to withhold or withdraw life-sustaining treatment. In addition to the standards set forth in subdivision four of this section, decisions by surrogates to withhold or withdraw life-sustaining treatment (including decisions to accept a hospice plan of care that provides for the withdrawal or withholding of life-sustaining treatment) shall be authorized only if the following conditions are satisfied, as applicable:

(a)(i) Treatment would be an extraordinary burden to the patient and an attending physician determines, with the independent concurrence of another physician, that, to a reasonable degree of medical certainty and in accord with accepted medical standards, (A) the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; or (B) the patient is permanently unconscious; or

(ii) The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances and the patient has an irreversible or incurable condition, as determined by an attending physician with the independent concurrence of another physician to a reasonable degree of medical certainty and in accord with accepted medical standards.

(b) In a residential health care facility, a surrogate shall have the authority to refuse life-sustaining treatment under subparagraph (ii) of paragraph (a) of this subdivision only if the ethics review committee, including at least one physician who is not directly responsible for the patient's care, or a court of competent jurisdiction, reviews the decision and determines that it meets the standards set forth in this article. This requirement shall not apply to a decision to withhold cardiopulmonary resuscitation.

(c) In a general hospital, if the attending physician objects to a surrogate's decision, under subparagraph (ii) of paragraph (a) of this subdivision, to withdraw or withhold nutrition and hydration provided by means of medical treatment, the decision shall not be implemented until the ethics review committee, including at least one physician who is not directly responsible for the patient's care, or a court of competent jurisdiction, reviews the decision and determines that it meets the standards set forth in this subdivision and subdivision four of this section.

(d) Providing nutrition and hydration orally, without reliance on medical treatment, is not health care under this article and is not subject to this article.

(e) Expression of decisions. The surrogate shall express a decision to withdraw or withhold life-sustaining treatment either orally to an attending physician or in writing.

Credits

(Added L.2010, c. 8, § 2, eff. June 1, 2010. Amended L.2011, c. 167, § 4, eff. Sept. 18, 2011.)

Notes of Decisions (11)

McKinney's Public Health Law § 2994-d, NY PUB HEALTH § 2994-d
Current through L.2017, chapters 1 to 23.

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Article 29-CC. Family Health Care Decisions Act (Refs & Annos)

McKinney's Public Health Law § 2994-e

§ 2994-e. Decisions about life-sustaining treatment for minor patients

Effective: June 1, 2010
Currentness

1. Authority of parent or guardian. The parent or guardian of a minor patient shall have the authority to make decisions about life-sustaining treatment, including decisions to withhold or withdraw such treatment, subject to the provisions of this section and subdivision five of section twenty-nine hundred ninety-four-d of this article.

2. Decision-making standards and procedures for minor patient. (a) The parent or guardian of a minor patient shall make decisions in accordance with the minor's best interests, consistent with the standards set forth in subdivision four of section twenty-nine hundred ninety-four-d of this article, taking into account the minor's wishes as appropriate under the circumstances.

(b) An attending physician, in consultation with a minor's parent or guardian, shall determine whether a minor patient has decision-making capacity for a decision to withhold or withdraw life-sustaining treatment. If the minor has such capacity, a parent's or guardian's decision to withhold or withdraw life-sustaining treatment for the minor may not be implemented without the minor's consent.

(c) Where a parent or guardian of a minor patient has made a decision to withhold or withdraw life-sustaining treatment and an attending physician has reason to believe that the minor patient has a parent or guardian who has not been informed of the decision, including a non-custodial parent or guardian, an attending physician or someone acting on his or her behalf, shall make reasonable efforts to determine if the uninformed parent or guardian has

maintained substantial and continuous contact with the minor and, if so, shall make diligent efforts to notify that parent or guardian prior to implementing the decision.

3. Decision-making standards and procedures for emancipated minor patient. (a) If an attending physician determines that a patient is an emancipated minor patient with decision-making capacity, the patient shall have the authority to decide about life-sustaining treatment. Such authority shall include a decision to withhold or withdraw life-sustaining treatment if an attending physician and the ethics review committee determine that the decision accords with the standards for surrogate decisions for adults, and the ethics review committee approves the decision.

(b) If the hospital can with reasonable efforts ascertain the identity of the parents or guardian of an emancipated minor patient, the hospital shall notify such persons prior to withholding or withdrawing life-sustaining treatment pursuant to this subdivision.

Credits
(Added L.2010, c. 8, § 2, eff. June 1, 2010.)

McKinney's Public Health Law § 2994-e, NY PUB HEALTH § 2994-e
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McKinney's Public Health Law § 2994-f

§ 2994-f. Obligations of attending physician

Effective: June 1, 2010
Currentness

1. An attending physician informed of a decision to withdraw or withhold life-sustaining treatment made pursuant to the standards of this article shall record the decision in the patient's medical record, review the medical basis for the decision, and shall either: (a) implement the decision, or (b) promptly make his or her objection to the decision and the reasons for the objection known to the decision-maker, and either make all reasonable efforts to arrange for the transfer of the patient to another physician, if necessary, or promptly refer the matter to the ethics review committee.

2. If an attending physician has actual notice of the following objections or disagreements, he or she shall promptly refer the matter to the ethics review committee if the objection or disagreement cannot otherwise be resolved:

(a) A health or social services practitioner consulted for a concurring determination that an adult patient lacks decision-making capacity disagrees with the attending physician's determination; or

(b) Any person on the surrogate list objects to the designation of the surrogate pursuant to subdivision one of section twenty-nine hundred ninety-four-d of this article; or

(c) Any person on the surrogate list objects to a surrogate's decision; or

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(d) A parent or guardian of a minor patient objects to the decision by another parent or guardian of the minor; or

(e) A minor patient refuses life-sustaining treatment, and the minor's parent or guardian wishes the treatment to be provided, or the minor patient objects to an attending physician's determination about decision-making capacity or recommendation about life-sustaining treatment.

3. Notwithstanding the provisions of this section or subdivision one of section twenty-nine hundred ninety-four-q of this article, if a surrogate directs the provision of life-sustaining treatment, the denial of which in reasonable medical judgment would be likely to result in the death of the patient, a hospital or individual health care provider that does not wish to provide such treatment shall nonetheless comply with the surrogate's decision pending either transfer of the patient to a willing hospital or individual health care provider, or judicial review in accordance with section twenty-nine hundred ninety-four-r of this article.

Credits

(Added L.2010, c. 8, § 2, eff. June 1, 2010.)

McKinney's Public Health Law § 2994-f, NY PUB HEALTH § 2994-f
Current through L.2016, chapters 1 to 328.

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(b) the patient assured the medical, dental or podiatric practitioner he would undergo the treatment, procedure or diagnosis regardless of the risk involved, or the patient assured the medical, dental or podiatric practitioner that he did not want to be informed of the matters to which he would be entitled to be informed; or

(c) consent by or on behalf of the patient was not reasonably possible; or

(d) the medical, dental or podiatric practitioner, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which such alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such disclosure could reasonably be expected to adversely and substantially affect the patient's condition.

Credits

(Added L.1975, c. 109, § 1. Amended L.1975, c. 476, § 1; L.1985, c. 760, § 9; L.1986, c. 485, § 13.)

Notes of Decisions (264)

McKinney's Public Health Law § 2805-d, NY PUB HEALTH § 2805-d
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McKinney's Public Health Law § 2994-g

§ 2994-g. Health care decisions for adult patients without surrogates

Effective: August 13, 2015
Currentness

1. Identifying adult patients without surrogates. Within a reasonable time after admission as an inpatient to the hospital of each adult patient, the hospital shall make reasonable efforts to determine if the patient has appointed a health care agent or has a guardian, or if at least one individual is available to serve as the patient's surrogate in the event the patient lacks or loses decision-making capacity. With respect to a patient who lacks capacity, if no such health care agent, guardian or potential surrogate is identified, the hospital shall identify, to the extent reasonably possible, the patient's wishes and preferences, including the patient's religious and moral beliefs, about pending health care decisions, and shall record its findings in the patient's medical record.

2. Decision-making standards and procedures. (a) The procedures specified in this and the following subdivisions of this section apply to health care decisions for adult patients who would qualify for surrogate decision-making under this article but for whom no surrogate is reasonably available, willing or competent to act.

(b) Any health care decision made pursuant to this section shall be made in accordance with the standards set forth in subdivision four of section twenty-nine hundred ninety-four-d of this article and shall not be based on the financial interests of the hospital or any other health care provider. The specific procedures to be followed depend on whether the decision involves routine medical treatment, major medical treatment, or the withholding or withdrawal of life-sustaining treatment, and the location where the treatment is provided.

3. Routine medical treatment. (a) For purposes of this subdivision, "routine medical treatment" means any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition, such as the administration of medication, the extraction of bodily fluids for analysis, or dental care performed with a local anesthetic, for which health care providers ordinarily do not seek specific consent from the patient or authorized representative. It shall not include the long-term provision of treatment such as ventilator support or a nasogastric tube but shall include such treatment when provided as part of post-operative care or in response to an acute illness and recovery is reasonably expected within one month or less.

(b) An attending physician shall be authorized to decide about routine medical treatment for an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article. Nothing in this subdivision shall require health care providers to obtain specific consent for treatment where specific consent is not otherwise required by law.

4. Major medical treatment. (a) For purposes of this subdivision, "major medical treatment" means any treatment, service or procedure to diagnose or treat an individual's physical or mental condition: (i) where general anesthetic is used; or (ii) which involves any significant risk; or (iii) which involves any significant invasion of bodily integrity requiring an incision, producing substantial pain, discomfort, debilitation or having a significant recovery period; or (iv) which involves the use of physical restraints, as specified in regulations promulgated by the commissioner, except in an emergency; or (v) which involves the use of psychoactive medications, except when provided as part of post-operative care or in response to an acute illness and treatment is reasonably expected to be administered over a period of forty-eight hours or less, or when provided in an emergency.

(b) A decision to provide major medical treatment, made in accordance with the following requirements, shall be authorized for an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article.

(i) An attending physician shall make a recommendation in consultation with hospital staff directly responsible for the patient's care.

(ii) In a general hospital, at least one other physician designated by the hospital must independently determine that ~~he or she~~ concurs that the recommendation is appropriate.

(iii) In a residential health care facility, and for a hospice patient not in a general hospital, the medical director of the facility or hospice, or a physician designated by the medical director, must independently determine that he or she concurs that the recommendation is appropriate; provided that if the medical director is the patient's attending physician, a different physician designated by the residential health care facility or hospice must make this independent determination. Any health or social services practitioner employed by or otherwise formally affiliated with the facility or hospice may provide a second opinion for decisions about physical restraints made pursuant to this subdivision.

5. Decisions to withhold or withdraw life-sustaining treatment. (a) A court of competent jurisdiction may make a decision to withhold or withdraw life-sustaining treatment for an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article if the court finds that the decision accords with standards for decisions for adults set forth in subdivisions four and five of section twenty-nine hundred ninety-four-d of this article.

(b) If the attending physician, with independent concurrence of a second physician designated by the hospital, determines to a reasonable degree of medical certainty that:

(i) life-sustaining treatment offers the patient no medical benefit because the patient will die imminently, even if the treatment is provided; and

(ii) the provision of life-sustaining treatment would violate accepted medical standards, then such treatment may be withdrawn or withheld from an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article, without judicial approval. This paragraph shall not apply to any treatment necessary to alleviate pain or discomfort.

(c) Repealed by L.2015, c. 107, § 2, eff. Aug. 13, 2015.

5-a. Decisions regarding hospice care. An attending physician shall be authorized to make decisions regarding hospice care and execute appropriate documents for such decisions (including a hospice election form) for an adult patient under this section who is hospice eligible in accordance with the following requirements.

(a) The attending physician shall make decisions under this section in consultation with staff directly responsible for the patient's care, and shall base his or her decisions on the standards for surrogate decisions set forth in subdivisions four and five of section twenty-nine hundred ninety-four-d of this article;

(b) There is a concurring opinion as follows:

(i) in a general hospital, at least one other physician designated by the hospital must independently determine that he or she concurs that the recommendation is consistent with such standards for surrogate decisions;

(ii) in a residential health care facility, the medical director of the facility, or a physician designated by the medical director, must independently determine that he or she concurs that the recommendation is consistent with such standards for surrogate decisions; provided that if the medical director is the patient's attending physician, a different physician designated by the residential health care facility must make this independent determination; or

(iii) in settings other than a general hospital or residential health care facility, the medical director of the hospice, or a physician designated by the medical director, must independently determine that he or she concurs that the recommendation is medically appropriate and consistent with such standards for surrogate decisions; provided that if the medical director is the patient's attending physician, a different physician designated by the hospice must make this independent determination; and

(c) The ethics review committee of the general hospital, residential health care facility or hospice, as applicable, including at least one physician who is not the patient's attending physician, or a court of competent jurisdiction, must review the decision and determine that it is consistent with such standards for surrogate decisions.

6. Physician objection. If a physician consulted for a concurring opinion objects to an attending physician's recommendation or determination made pursuant to this section, or a member of the hospital staff directly responsible for the patient's care objects to an attending physician's recommendation about major medical treatment or treatment without medical benefit, the matter shall be referred to the ethics review committee if it cannot be otherwise resolved.

Credits

(Added L.2010, c. 8, § 2, eff. June 1, 2010. Amended L.2011, c. 167, §§ 5, 6, eff. Sept. 18, 2011; L.2015, c. 107, §§ 1, 2, eff. Aug. 13, 2015.)

McKinney's Public Health Law § 2994-g, NY PUB HEALTH § 2994-g
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PJI 2:150A Malpractice—Informed Consent

Before obtaining a patient's consent to an operation or invasive diagnostic procedure or the use of medication, a doctor has the duty to provide certain information concerning what the doctor proposes to do, the alternatives to that operation, procedure or medication and the reasonably foreseeable risks of such operation, procedure or medication. It is the doctor's duty to explain, in words that are understandable to the patient, all the facts that would be explained by a reasonable medical practitioner so that when the patient does, in fact, consent, that consent is given with an awareness of (1) the patient's existing physical condition; (2) the purposes and advantages of the operation, procedure or medication; (3) the reasonably foreseeable risks to the patient's health or life which the operation, procedure or medication may impose; (4) the risks involved to the patient if there is no operation, procedure or use of medication; and (5) the available alternatives and the risks and advantages of those alternatives. The first question on this issue that you will be called upon to answer is whether the defendant, before obtaining plaintiff's (decedent's) consent, provided appropriate information.

The question reads as follows:

(1) Did defendant before obtaining plaintiff's (decedent's) consent to the (operation, procedure, use of medication) provide appropriate information?

Plaintiff maintains that the answer to this question is “No,” contending that [set forth the specific risks and/or alternatives that plaintiff claims were not disclosed]. Defendant maintains that the answer to the question is “Yes” and contends that (the information was, in fact, provided, or a reasonable medical practitioner would not provide such information to the patient in a case such as this).

If you answer “No” to the question, the next question you must decide is whether a reasonably prudent person in the plaintiff's (decedent's) position would have decided not to undergo the operation or procedure or take the medication if given appropriate information concerning the risks and alternatives.

The question reads as follows:

(2) Would a reasonably prudent person in plaintiff's (decedent's) position at the time consent was given have decided not to undergo the [state procedure] [state where appropriate: take the medication] if given appropriate information?

Plaintiff maintains that the answer to this question is “Yes,” contending that considering the nature of plaintiff's (decedent's) condition at the time and the risks involved in the (operation, procedure, use of medication) and the available alternatives, a reasonably prudent person would not have consented to the (operation, procedure, use of medication). Defendant maintains that the answer to this question is “No,” contending that considering plaintiff's (decedent's) condition and the need for the (operation, procedure, use of medication) the omitted information would not have caused a reasonably prudent person to refuse to consent to the (operation, procedure, use of medication).



Evolving role of the risk manager in senior living

AHRMNY

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Rhonda DeMeno
RN, BS, MPM, A-IPC, CPHRM
WTW Senior Vice President Risk Control

Rhonda has over 30 years of experience in the senior living industry as an expert on post-acute operations.

She has provided education on a national basis on many topics related to Regulatory Risk and Corporate Compliance. Rhonda is a published author of the Long-Term Care Mock Survey Toolkit and multiple white paper topics on Medicare, Medicaid, and Managed Care payment systems, infection control, COVID-19 related topics, regulatory compliance, and Senior Living operations.

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Objectives

- Discuss the evolving role of the risk manager in senior living
- Identify how risk management plans promote resident safety
- List the numerous risk exposures in senior living
- how a risk management plan can improve resident satisfaction and safety



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Evolution of senior living risk manager

Wears many hats

- Human resource
- DON
- Executive director
- Staffing coordinator
- Social service
- Building services



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Resident/patient safety initiatives

- Identification of hazards
- Assessing risk
- Developing policies and procedures
- Training and education
- Incident reporting and analysis
- Emergency preparedness
- Monitoring and evaluation
- Engaging residents and families
- Compliance and regulations

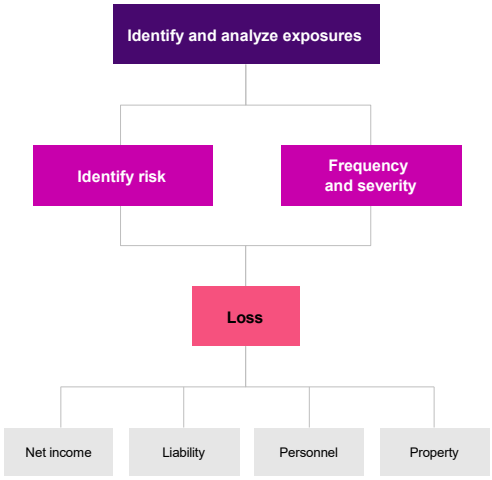


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Risk identification and management of potential claims



Identify **what** is at risk, **why** it is at risk and **how** that loss will impact the organization

Type of value exposed to loss

Potential cause of loss

Extent of projected financial consequence of the loss

Use of data to prioritize resources

Drive risk management activities

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Sources to identify potential claims

Formal source examples



Complaints and grievances



Incident reports, Environmental rounds



Risk assessments

Informal source examples

- Anonymous reports — hotline
- Family concerns
- Resident and employee satisfaction survey's
- Associate exit interviews
- Resident move-out

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Today's exposures senior living

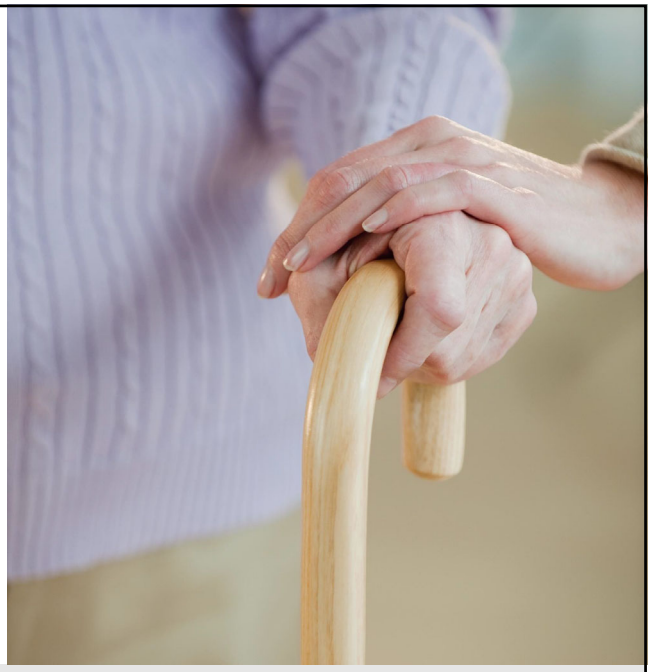
- Property — concerns related to supply chain, scrutinized valuations, rate increases
- Auto — concerns related to CDL certified drivers, distracted drivers
- Workman Compensation — Underwriting concerns due to opioid use, aging workforce, regulatory reform, infection control
- PL/GL incidents and claims
- Cyber breaches
- Legal — Informed consent, POAs and healthcare proxies
- Regulatory — OCR, privacy, confidentiality, HIPAA
- Healthcare operations — policies and procedures
- Resident safety
- Staff safety — OSHA
- Emergency preparedness

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Frequent GL/PL incidents/claims

- Resident falls
- Visitor falls
- Pressure injury
- Medical management
- Failure to treat
- Abuse (financial, physical)
- Elopement
- Infection Control
- Choking
- Other



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In the news…

18.2 million

An $18.2 million final settlement in a class action suit involving allegations of deceptive staffing practices in assisted living communities

[redacted]

Woman, 89, died of brain bleed after 5 falls at N.J. assisted living facility, lawsuit says

NJ.com

Staff allows sexual assault of mom with dementia, saying she 'consented,'

News Tribune

Lawsuit: Mom with dementia was sexually assaulted at Federal Way care home

Federal Way

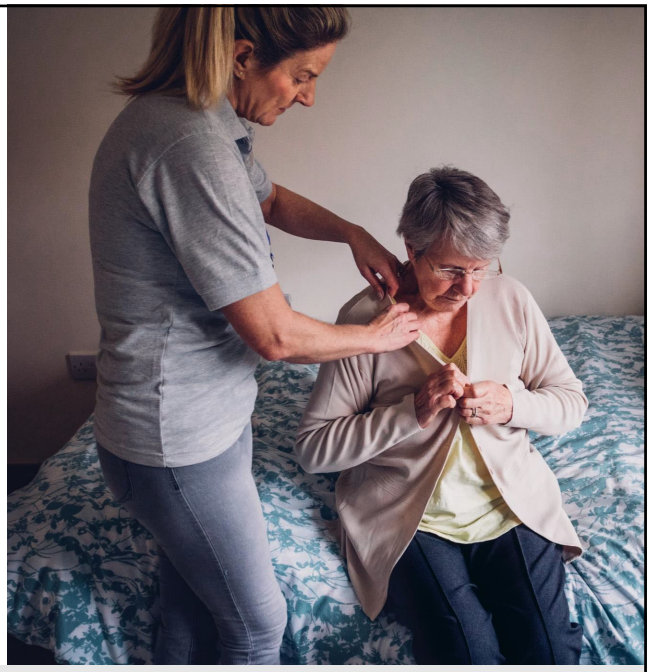
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Just an ordinary day…

It is a Monday morning and Jane; a long-standing member of the care team is on shift today. On what started out as an ordinary busy workday, Jane is notified by a supervisor that law enforcement is waiting in the lobby to speak with her about one of the patients she recently worked with.

What is later learned is that the patient has alleged that they were physically abused and inappropriately touched during a care encounter with Jane.



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What is abuse?

The definition of abuse may vary by state, CMS, setting, or other regulatory/accreditation bodies.

Ensure definitions are called out in policies and in staff training.

Examples of allegations of abuse against an employee by a patient or their family may include:

- Rough handling
- Physical injury
- Neglect
- Verbal or emotional abuse
- Sexual abuse/assault
- Sexual harassment
- Bullying
- Intimidation
- Financial misappropriation
- Inappropriate contact after discharge
- Civil harassment

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Why do allegations occur?

- Communication mishaps
- Lack of training to the demographic served
- Rushing
- Careless encounters
- “One time” background checks
- Handling of prior allegations
- Interacting styles
- Situational awareness
- Organizational history of a failure to act
- Staff code of conduct adherence
- Failure to secure facility



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Responding to allegations

- Follow organizational policies
- Take the allegation seriously
- Provide support to the complainant
- Conduct an investigation
- Report to appropriate agencies
- Take necessary action
- Communicate the outcome
- Monitor the situation



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Organizational escalation

Job aid for all settings

- Incident and event reporting
- Notification and escalating reports

Certain incidents and events that come under the category of general and professional liability are more serious than others and will need additional resources and support to resolve and manage. In general these incidents and events are those that have caused injury to a resident or a visitor.

The following grid is based on the resident incident, accident or unusual occurrences policy and procedure and serves as a supplemental guideline for notifying and escalating this information beyond the community leadership.

Incident or event type	Recommended actions	Notification of corporate leaders	Notification method	Timeframe
Abuse allegations — all types Assault — physical or sexual	If the resident/responsible party has a physical injury or alleges sexual abuse seek medical evaluation immediately. All other allegations make certain that the resident feels safe and comfortable. Notify police/law enforcement and state licensing agency	• Regional Director of Resident Care • Corporate Risk Manager • Vice President of Operations	Phone call when allegation is for physical or sexual abuse followed up by sending the incident report to the Corporate Risk Manager via fax or email?	As soon as resident is stable

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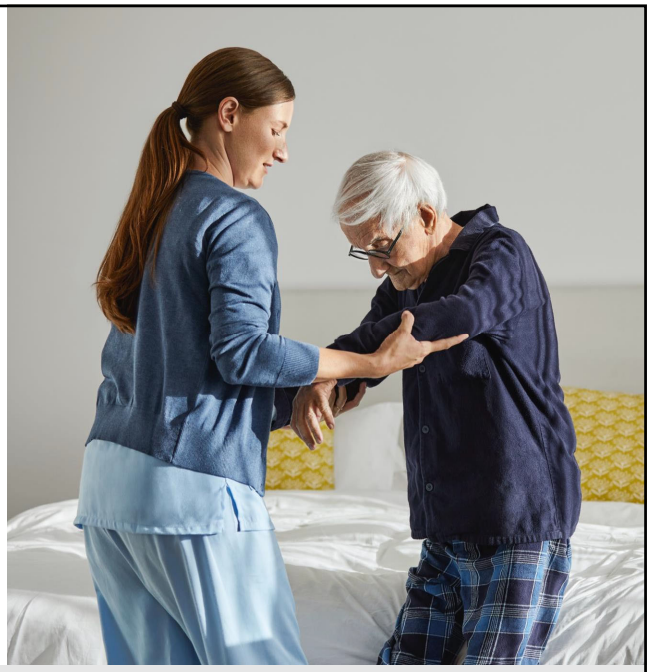
Claim trends

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Trends of increasing acuity in senior living

- Advanced age
- Three or more comorbidities
- Fall risk
- Cognitive risk
- Bowel and bladder
- Infection control history
- Skin assessments
- Abuse



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Severity allegations

Duty
A provider-resident relationship must exist.

Breach
Standard of care was not met.

How courts define malpractice
Four elements must exist for an incident to be considered malpractice:

Harm
Injury resulted in damages.

Causation
Injury was caused by the provider's error.

Top 5 Highest severity allegations

$384,088	$312,107	$311,480	$306,373	$303,883
Resident abuse	Failure to move resident to higher level of care	Failure to follow physician's order	Medication error	Elopement

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Acuity creep

Allegations of failure to move a resident to a higher level of care, representing only **0.8 percent** of claims, experienced a significant increase in severity — up from **$233,602** in the 2021 dataset to **$312,107** in the 2024 dataset.



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Increasing levels of care

- Contributes to improper care allegations
- Failure to notify provider of care changes
- Communication failures with family
- Delays in treatment

Mitigation

- Comprehensive admission assessments
- Education and training on reporting incidents, resident condition changes
- Setting expectations



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Abuse claims



CNA

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WTW 2025 claims study

Risk prevention and risk mitigation

May 2, 2025

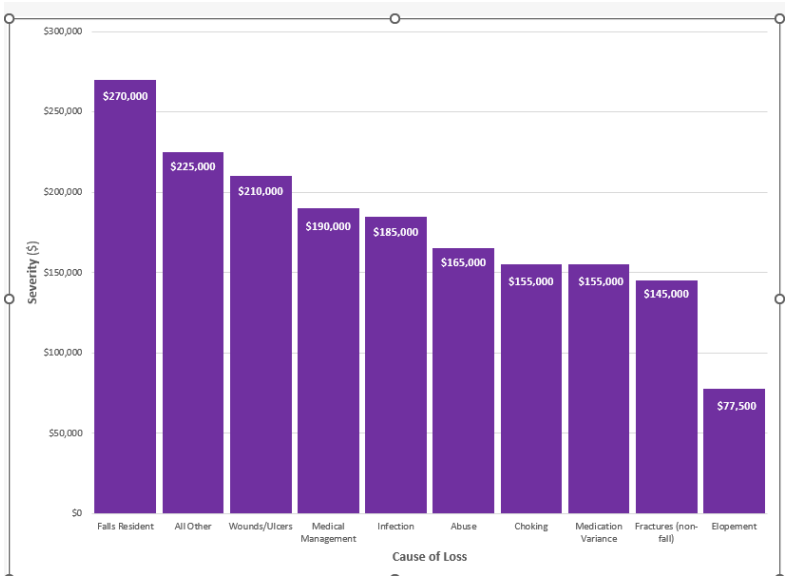
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Claims Severity

- Resident Falls
- Wounds
- Medical Management
- Infection
- Abuse



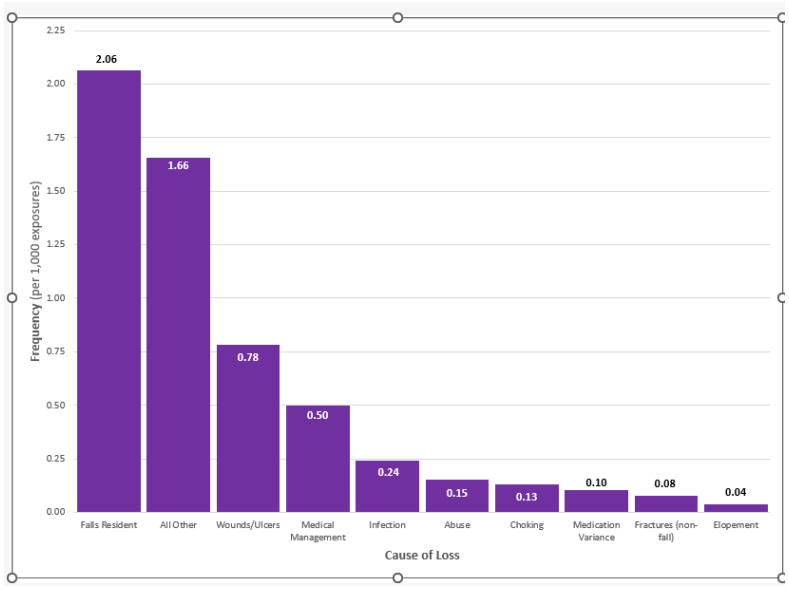
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Claim Frequency

Top 5

- Resident Falls
- Wound/Ulcer
- Medical Management Infection
- Abuse
- Infection



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Study findings

Notable changes year over year

01

Elopement remains the highest severity

02

Abuse is the second most severe loss cost

03

Resident falls account for 31% of total losses

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Trends in independent living

- Independent Living residents longer, healthier lives
- Most are active or very active — exercising 3 – 5 times per week three
- Want to stay in engaged in community — intergenerational activities e.g., volunteering
- Greater knowledge and use of technology e.g., virtual video experiences
- Want more flexibility/choice in programming and culinary experience



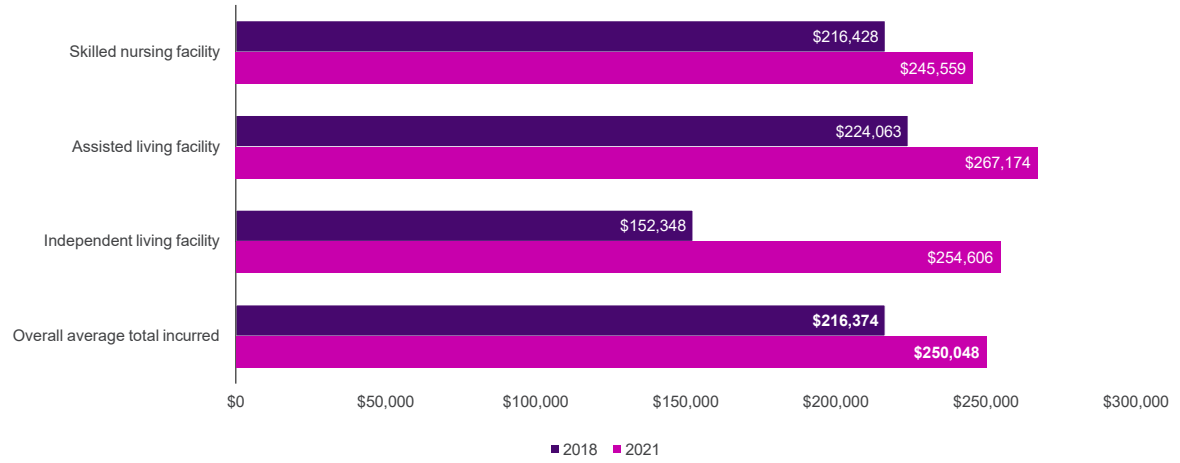
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Emerging risk in independent living

CNA Claims Report



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Risk reduction strategies

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Top 10 operations and risk mitigation plans for senior living in 2025

- Technology investment and integration
- Litigation risk
- Regulatory compliance
- Cyber crime
- Person-centered care and evolving resident and family expectations
- Staff training and retention programs
- Supply demand imbalance
- Executing safety and security programs
- Feedback mechanisms
- Health and wellness programs and enhancements



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Developing the risk management program

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Building a risk management program

Risk management plan
Purpose and goals
Resident safety
Governance/organizational response
Reporting protocols
Review cycle
Proactive risk identification
Identify risk metrics
Risk finance
Communication, education and training
Resident and family grievance
Annual program assessment



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Develop a formal risk management program

Establish culture of safety

- Create written leadership communications plan
- Policy and procedure development
- Educate Associates on reporting risk and hazards
- Annual hazard risk assessments

Develop a comprehensive admission and annual screening process

- Set realistic expectation — UDS, admission agreements
- Adopt electronic medical record and secure documentation and ERM reporting system
- Incorporate risk reduction discussions in team meetings

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Risk management strategy

Conduct comprehensive pre-admission screening to validate correct SL setting

Evaluate staffing practices and clinical guidelines that promote resident safety and satisfaction

Consistent training for all associates; involve associates in problem solving, e.g., RCAs

- Document resident assessments, observations and communications
- Secure and implement a sound incident reporting system
- Set realistic expectations with family and residents, meet regularly include resident and family members in decision making process

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Risk transference

Risk Transference is an example of a risk management strategy involving the contractual shifting of a pure risk from one party to another

Examples:
Purchase of an insurance policy allows a specific risk of loss to be passed from the policy holder/insured to the insurer.

- Additional Insureds
- Providing Indemnification clauses in contracts



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Risk management strategy — purchasing insurance and the broker relationship

Establish relationship with insurance broker
Determine costs and if broker will cover all lines

Determine who will be internal stakeholder for broker relationship

Meet regularly to discuss:
- Markets changes
- Company goals and strategic plan

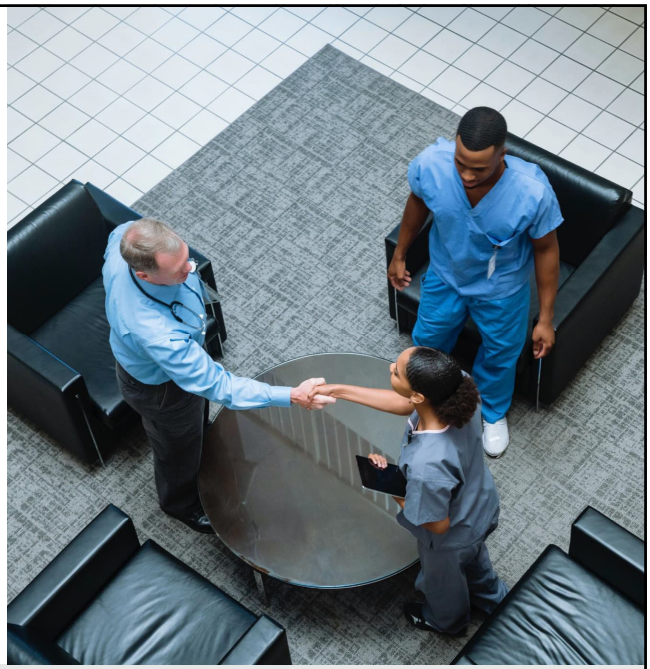
Benefits of broker relationship:
- Best Practices/national insights
- Coverage gaps
- Review of policy language
- Review of additional insured/indemnification language
- Helps secure competitive pricing for insurance coverage
- Risk management services
- Claims management services

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Additional benefits of the broker relationship

- Claims reporting for preservation of coverage for future needs
- Provides guidance in reserving practices, which could impact loss runs and insurance renewals
- Provides dashboard of metrics and data analysis



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Risk management strategy — Risk transference and purchasing insurance

Conduct comprehensive review of all risks/exposures

Confirm which types of insurance coverage is needed to meet regulations and or contractual obligations

Collaborate with broker to submit insurance proposals, and buy coverage

In addition to insurance coverage for PL/GL, WC, Property, consider insurance for emerging risks such as:

- Cyber
- Active Shooter/Workplace Violence
- Environmental incidents
- Governance, D&O
- EPLI

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Senior living and the future of risk management

- Implement program and plan
- Flexibility
- Enhanced safety
- Enhanced resident and staff satisfaction
- Long term, operational success
- Improved market position



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WTW resources

Allegations of abuse readiness program
A comprehensive toolkit for direct caregivers to help plan for, respond to and recover from allegations of abuse.

Toolkit contents:

- Allegation of abuse manager's guide
- Allegation of abuse general guidance
- Organizational activation checklist
- Sample guide for interviewing impacted persons
- Sample guide for interviewing staff and witnesses
- Use of chaperones
- Sample debrief
- Activation decision-grid for acute care
- Activation decision-grid for senior living

Healthcare: Allegations of Abuse Readiness Program

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2025 and upcoming WTW events

Webinar, podcast, publications

- Healthcare risk conference
- Building guardrails for medication management
- Emergency preparedness campaign
  - Podcast
  - Webinar
  - Publications
- Responsible use of AI
- The future of nursing home staffing

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Resources

- https://www.cna.com/sites/default/files/assets/CNA-Aging-Services-Claim-Report-12th-Edition.pdf
- 2025 Senior Living Claims Benchmark Study
- Clinical Risk Management Solutions Guide

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Senior Living Thought Leadership 2025- Through June

Topic	Medium	Date
Fall Management A sophisticated problem with an AI approach	Webinar	1/30/25
Builders Risk	Podcast 1& 2	Released
Functional Movement a new approach to safe resident moving and positioning	Podcast	Released
Leveraging strategy; Avoiding risk and seizing opportunities in senior living	Publication	Released
Unlocking a new model of dementia care	Webinar	Completed 3/27/25
Senior Living Destinations- Aligning Value Based care and quality for seniors	ASHRM webinar	Completed 3/19/25
Emerging healthcare risk for senior living; Measles, Bird Flu and Listeria	Publication	Released
Creative financing	Podcast	Released
Guiderails for safe medication administration in Senor Living	Webinar	4/29/25
Indemnification Issues and risk facing Senior Living	Webinar	Released
Federal skilled nursing facility staffing mandate updates	Publication	Released
Georgia Society healthcare risk management – Allegation of Abuse	Conference speaking	5/2/25 Completed
Emergency preparedness campaign –Before, During and After the Storm preparations for Senior Living	Webinar- podcast – publication	June release webinar 6/5/25

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Questions?
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More Than Just Appellate Counsel

1

1

Rx for Excessive Damages: A Legal Treatment Plan

2

2

It's time for your checkup!



3

3

Topics

- Discussion Points
  - Why defend damages?
  - Reasonable Value
  - Collateral Sources
  - Picking Apart Plaintiff's Plan
  - Anchoring

4

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Why Defend Damages?

- Get a real value for economic damages:
  - Determine causally related needs
  - Determine "reasonable value"
  - Consider collateral sources
  - Estimate a judgment under 50-A
- Provides a basis for negotiations and the foundation for trial

5

5

Traditional Damages Model

- Traditional defense approach to compensatory damages defense
  - Reactive approach
  - Match plaintiff's experts - if they get a life care planner, we get a life care planner
  - Do not put on defense damages experts or present defense numbers at trial

6

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Taking Back Control

- Don't wait: Defendant can anchor the value
- Challenging the plaintiff's damages model
- Rethinking experts
- Targeting items of damages
- Bringing reality back to the courtroom
- Legal challenges

7

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Goal

- This is not a race to the bottom
- Comprehensive, strong and credible damages defense

If you don't believe it, they can't!

8

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Reasonable Value

9

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Reasonable Value Discovery

- Early damages discovery
  - Itemized liens
  - Complete health insurance files
  - School, therapy or home health records, if applicable
  - Liens or litigation funding

10

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Reasonable Value And The Law

- Do not accept plaintiff's values
- In New York, a plaintiff should only be allowed to recover the amounts *paid* for medical care.
- Kastick v U-Haul Co., (292 AD2d 797 [4th Dept 2002])
  - Hospital received payment from No-fault and Medicare and wrote-off the balance.
  - Plaintiff argued damages should include the written-off amounts
  - 4th Dept held the written-off amount "is not an item of damages for which plaintiff may recover because plaintiff has incurred no liability therefor."

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Use "Reasonable Value" Where Collateral Sources Are Uncertain Or Do Not Exist

- Keep the discussion outside the collateral source rule
  - Reasonable value
    - Reasonable value is not necessarily what was billed or what was paid on the plaintiff's behalf
    - Change the language
    - Growing number of courts are accepting the argument that reasonable value is what is generally paid in the marketplace

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Collateral Sources

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Using Collateral Sources

- CPLR 4545 entitles you to an offset!
- Applies to:
  - Uninsured
  - Insured
  - Pension benefits
  - Medicare
  - Medicaid

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Making An ACA Argument

- Understanding where argument is most beneficial
  - Prosthetics cases
  - Orthopedic injuries
  - Significant medication expenses
  - Medicare not involved
  - To address non-home care items where Medicaid involved
- Establish that it is reasonably certain
  - plaintiff will have access to health insurance in the future
  - plaintiff's insurance will cover the items in plaintiff's life care plan

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Making An ACA Argument

- Liciaga v. New York City Transit Authority, 2024 WL 3882279 (2d Dept 2024)
  - **Issue**: Whether defendant could present evidence at a post-trial collateral source hearing of private insurance available to the plaintiff in the future, even though plaintiff was currently uninsured
  - **Holding**: Yes
  - **Key parts of the decision**:
    - Plaintiff could reduce his own future medical expenses by millions of dollars by procuring an insurance policy available to him pursuant to the ACA
    - A reasonable plaintiff would act in his own economic self-interest by taking the minimally burdensome steps required to obtain available insurance coverage
    - The plaintiff's contention that it is improper to expect him to perform an act that he is required to perform under federal law is, therefore, without merit
    - To the extent that a plaintiff can mitigate his or her damages by procuring insurance coverage that would offset some portion of his or her future medical expenses, he or she cannot simply decline to do so without a plausible explanation and avoid potential consequences

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Life Care Plan v. Insurance

Life Care Plan	Insurance Plan
Complications / Hospitalizations	Covered
Drugs and Supplies	98.4% covered
Wheelchair	99.7% covered
Home Accessories and Equipment	97.5% covered
Health Evaluations	Covered
Case Management	Covered
Medical Routine Coverage	Covered
Medical Services	Covered
Orthotics/Prosthetics	Covered
Therapies	35.1% covered

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Picking Apart Plaintiff's Plan

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Bringing Reality Back To The Courtroom

- Confronting the collateral source rule
  - Understand your venue
  - Look for ways to open the door
  - Look for ways to circumvent the collateral source rule

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Life Care Planning v. Case Management

SPECIAL SERVICES						
Description/Service: *(Recommended by)*	**Age Initiated:**	**Through Age:**	**Frequency:**	**Cost:**	**Annual Cost:**	**One Time Cost:**
1) Case management *(Stephen Glass, MD)*	Present	LE	Estimate 24-36 hours/year average	$130-$145 (Midpoint: $137.50)	$4,125	
2) Guardianship Services *(Stephen Glass, MD)*	18	LE	Initial set up:	$5,000-$15,000 (Midpoint: $10,000)		$10,000
			1st 3 months:	$1,000/month		$3,000
			Monthly average charge thereafter	$500-$750 (Midpoint: $625)	$7,500	
Rationale:						
1) For coordination and implementation of medical and home care needs, advocating for goods and services, identification of resources, assistance with hiring/firing of in-home caregivers, crisis intervention, etc. To be used as needed.						
2) For oversight of Elliot's financial needs.						
Cost Sources:						
1) Whitmire and Associates, Sound Options/MaryLynn Pannen, RN, Comprehensive Home and Companion Services 2) Unlimited Guardianship Services, Inc./John Jardine, Guardianship Services of Seattle						

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20

What Is Case Management?



CMSA
CASE MANAGEMENT SOCIETY OF AMERICA

Standards of Practice for Case Management

"Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes."

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MLN
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What Does A Case Manager Do?

The Professional Case Manager is responsible for being patient-centered and is held accountable to maintain the education and skills needed to deliver quality care. The professional case manager should demonstrate knowledge of health insurance and funding sources, healthcare services, human behavior dynamics, healthcare delivery and financing systems, community resources, ethical and evidence-based practice, applicable laws and regulations, clinical standards and outcomes, and health information technology and digital media for effective and competent performance.



CMSA
CASE MANAGEMENT SOCIETY OF AMERICA

Standards of Practice for Case Management

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Case Management v. Life Care Planning

Q. Okay. Did you look at any of the amounts that had been paid for the various services that Elliot has already received in calculating those costs in the future?

A. No. I looked at them. I did not consider them, not consider what was paid. That's not what we do in the Life Care Plan.

Q. As a case manager, you would be looking at that in dealing with individual resources and managing those resources, correct?

A. Yes. We would be looking at, again, what we can get for our medical dollar.

Q. Right. So as I understand it, case management is dealing with helping these disabled people get the care and services they need in the real world, and then life care planning is creating a plan for litigation that may or may not be followed up, but does not include actually working with the client to get the goods and services; is that fair?

A. That's fair.

23

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Case Managers Coordinate Benefits

Q All right. There is no claim, there is no litigation, here is a gentleman who has got a lot of future care needs and you have determined what those future care needs are, now how are we going to pay for them. Would you consider one means by which some of the services and benefits that he needs would be paid for would be through the acquisition of a health insurance policy?

A If he was coming to me as a case manager, yes.

24

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24

Additional Challenges To Billed Rates

- Expose and undermine plaintiff's cost sources
  - Demonstrate all medical costs are derived with regard to insurance
  - Demonstrate plaintiff's data sources come from insurance data
  - Demonstrate plaintiff's expert has no personal knowledge of the data or how it was collected
  - Demonstrate plaintiff's expert is relying on hearsay
  - Demonstrate plaintiff's expert is merely a conduit for someone else's opinion

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Looking Under The Economist's Hood

- Medical Consumer Price Index
  - Based on insurance data

Medical care methodology

The CE tracks consumer out-of-pocket spending on medical care, which is used to weight the medical care indexes. CE defines out-of-pocket medical spending as:

- patient payments made directly to retail establishments for medical goods and services;
- health insurance premiums paid for by the consumer, including Medicare Part B; and
- health insurance premiums deducted from employee paychecks.

While the weight of each CPI medical care related index is determined by out-of-pocket spending, price change reflected by the indexes measure the total reimbursement to medical care providers. This includes medical care payments made by private insurance companies, Medicare Part B, and Medicare Part D on behalf of consumers.

For example, in the **physicians' services** index, we consider the price of an office visit to be the patient's $20 copay, as well as the $80 insurance payment to the physician, for a total of $100. The $100 figure is used when calculating any price change.

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Using Motions To Defend Damages

- Motions to consider
  - Preclude baseless life care plans or limit care claims
    - No foundation
    - No basis for pricing
    - Care not prescribed, desired, or feasible
  - Preclude reliance on billed rates
  - Preclude net-negative discount rates
  - Preclude baseless life expectancy opinions
  - Opening the door

27

27

Anchoring

28

28

Anchoring

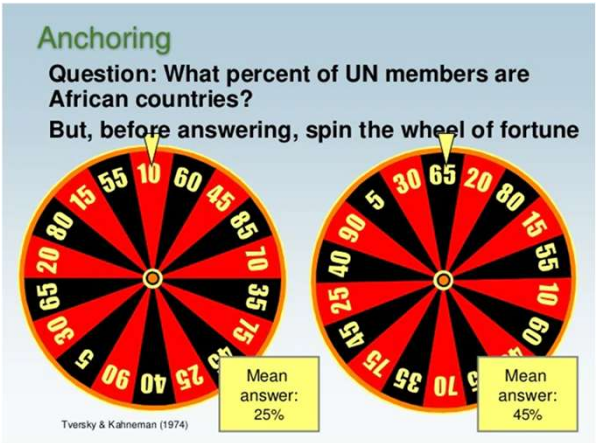
- What is it?
  - Based in psychology
  - People are unduly influenced by the initial number they encounter
  - People start with the recommended number and adjust up or down from that number
  - Anchoring effect can happen with completely arbitrary anchors

29

29

Anchoring

- What is it?
  - Tversky and Kahneman's classic study



30

30

Anchoring

- Does it occur in litigation?
  - Studies consistently show plaintiff's use it to their advantage

Question: How did the jury arrive at the decision to award the plaintiff $20 million in damages?

> **Actual Juror #1:** *We came up with a percentage approach, and that's what we all discussed. We started with what she was asking for – $80 million, which seemed like a very high amount, and went down and down from there.*
>
> **Actual Juror #2:** *None of us had been on a jury before, so we had no idea where to start. What's a life worth? It would have been nice to have some precedent to go by, but we didn't. So, we started with what they gave us, and then took a percentage.*

Christina Marinakis, "How to Counteract the Anchoring Effects of a Plaintiff's Damages Request Jury Reliance on Plaintiff's Damages Ask," Law 360 (August 12, 2019).

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Anchoring

- Research also shows that judges and mediators are susceptible to anchoring
  - Conklin, Michael, Combating Arbitrary Jurisprudence by Addressing Anchoring Bias, 97 Wash. L. Rev. 1 (2019)
- Common mediation anchors
  - Plaintiff's demand
  - Mediator's experience
  - Policy limits
  - Liens

32

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32

Questions?

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Adam Bobkin
abobkin@mlnappeals.com

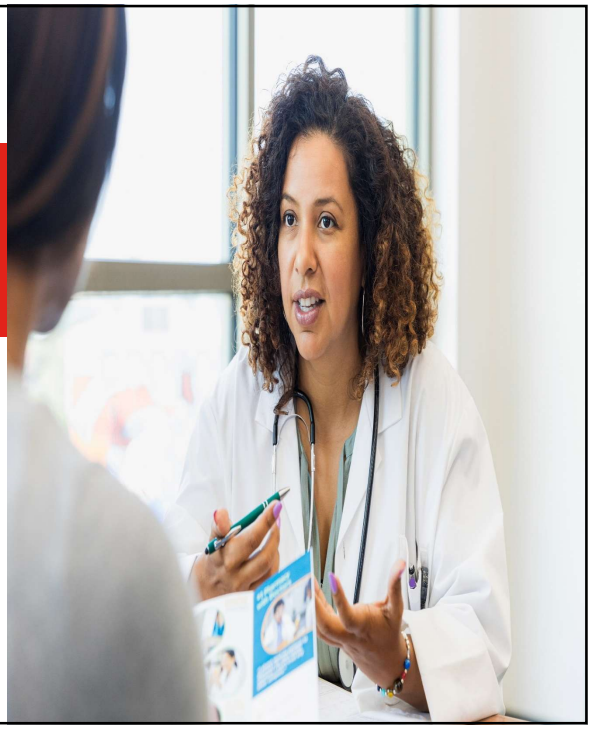
Mauro Lilling Naparty LLP
100 Crossways Park Drive West
Suite 310
Woodbury, New York 11797
T 516.487.5800
F 516.487.5811
www.mlnappeals.com

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Building Patient Trust Through Health Literacy

Dana Taylor, MHA, CPHRM, CPPS
Robin Webster, MHA, BSN, RN, CPHRM, CPPS



1

Disclaimer

The information provided through this activity is for educational purposes only. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice.

2

Disclosure

- No planners, writers, reviewers, faculty, or staff have any relevant financial relationships to disclose

3

Objectives

- Describe how labeling patients as non-compliant can contribute to bias
- Identify 5 common health literacy red flags
- Describe 4 high-risk health literacy situations
- Identify health literacy themes found in claim data

4

KS0

Negative Descriptors and Bias

- Negative descriptors contribute to stigmatization and bias.
- Unconscious bias is associated with lower levels of patient adherence to treatment plans and lower trust in health care.
- Patients who perceive racial discrimination in health care are:

More likely to

- **Delay care**

Less likely to

- **Follow clinician recommendations**
- **Get recommended chronic disease screening**

Sun 2022, Himmelstein 2022, Park 2021

5

Negative Descriptors That Contribute to Bias

- Aggressive
- Agitated
- Angry
- Challenging
- Combative
- Confrontational
- Defensive
- Exaggerates
- Hysterical
- Non-adherent
- Non-compliant
- Non-cooperative
- Refuses to
- Resists
- Unpleasant

Sun 2022, Himmelstein 2022, Park 2021

6

Slide 5

KS0 How do these 2 last slides gel with health literacy—need the link
Kathryn Schaefer, 2024-10-03T13:55:23.812

RL0 0 Agree with these 2 seems like a big leap from literacy although marginalized populations are more likely to have low health literacy because of structural racism [@Kathryn Schaefer]
Robin Lynch, 2024-10-14T19:13:21.765

KS0 1 [@Robin Lynch] from Robin W:The reason why I include the info on negative descriptors and bias is because of health literacy red flags. Patients who display a health literacy red flag are often described using negative descriptors that contribute to bias (e.g angry, challenging, non-compliant, non-adherent, non-cooperative, refuses to, resists). I think it's crucial to increase awareness of the impact of using negative descriptors so we can help STOP the perpetuation of them. Our message is that we want clinicians to think about and explore the why behind the behavior. Is it a barrier to care, a lack of understanding, or a personal choice with true understanding of the risks? The personal example I share re: the patient who missed her scheduled c-section twice is a prime example of a patient who was labeled as non-compliant, but she didn't understand the risks of a VBAC.
Kathryn Schaefer, 2024-10-14T20:11:22.654

Review of MPL Claims Data

The data used to examine the topic of Health Literacy was gathered by using Risk Management issues that address outcomes related to:

Provider to Patient Communication

- Informed Consent
- Provider to Patient communication
- Patient Education/Instruction
- Interpreter Issues
- Communication Over Phone

Patient Factors

- Patient Engagement
- Patient Unhappy with Care/Outcome

Patient Assessment

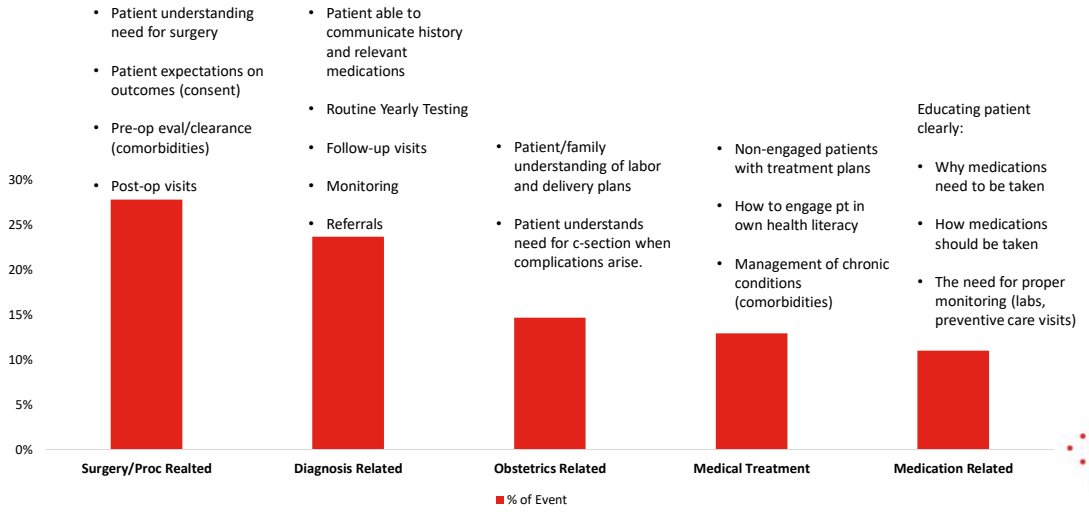
- Obtaining Patient and Family History

Clinical Decision Making

- Managing Treatment
- Managing Surgical Process
- Managing Pregnancy and Delivery Process

7

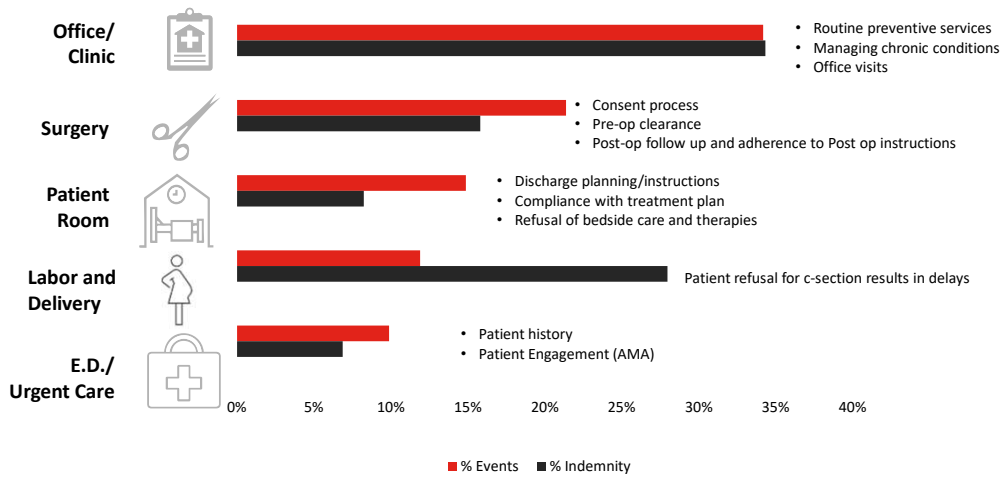
Case Type Categories



Coverys N=1443 Closed events from 2019-2023 with selected RM Issues

8

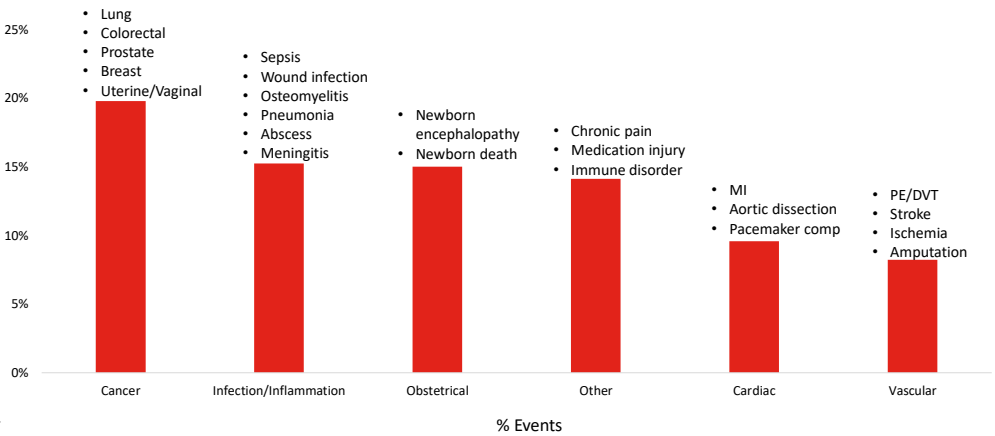
Top Locations



Selection: Coverys N=1443 Closed events from 2019-2023 with selected RM Issues

9

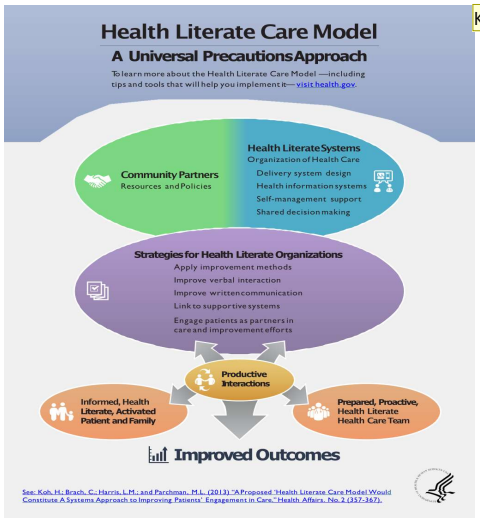
Top Final Diagnosis Impact



Selection: Coverys N= 630 Final Dx coded on Closed events from 2019-2023 with selected RM Issues

10

How Can We Engage or Activate Patients?



KS0

Office of Disease Prevention and Health Promotion. Health Literate Care Model. https://health.gov/our-work/national-health-initiatives/health-literacy/health-literate-care-model

11

What's Health Literacy?

- **Personal health literacy** is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
- **Organizational health literacy** is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

CDC 2023.

12

Slide 11

KS0 Yvonne, I'd love a redraw of this as it's unreadable
Kathryn Schaefer, 2024-10-03T13:33:54.474

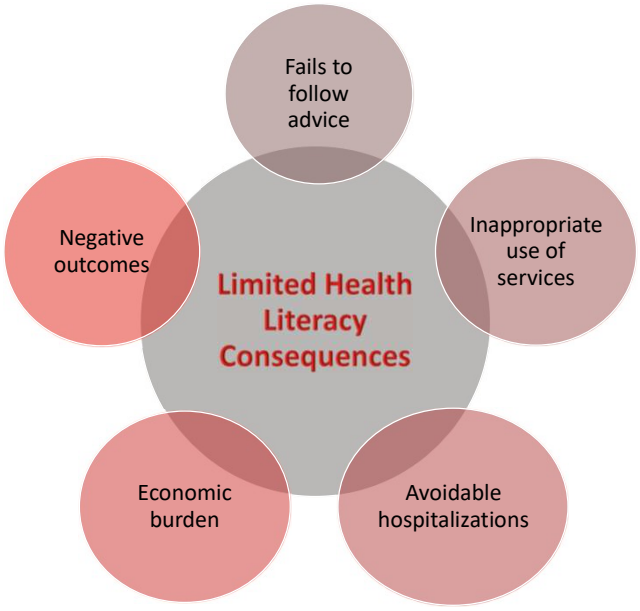
Health Literacy Red Flags

- Delay seeking care
- Angry/Demanding
- Quiet/Passive
- Incomplete forms
- Excuses
- Trouble discussing health
- Trouble listing medications/doses
- Missed visits
- Skip testing/referrals



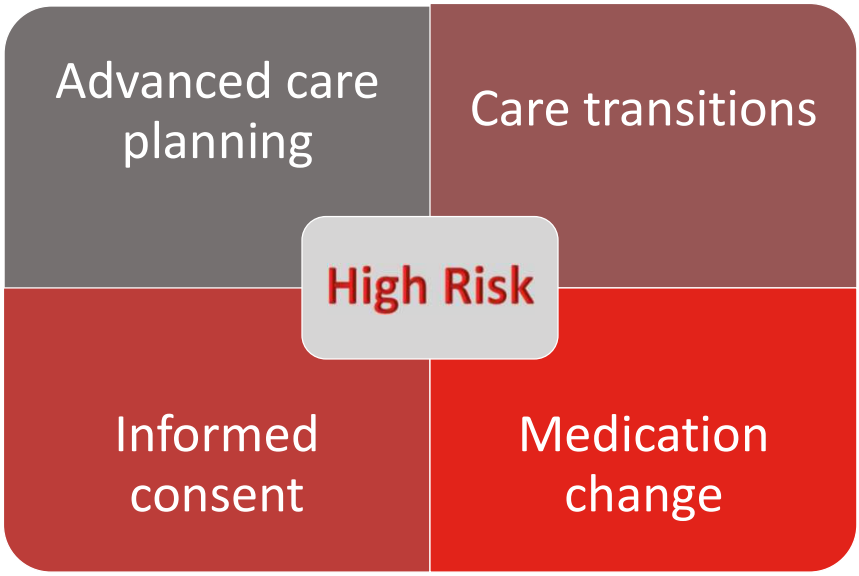
Institute for Healthcare Advancement 2021.

13



Institute for Healthcare Advancement 2021

14



15

Case Study: Cost Impacts Treatment Choice

Allegation: Dentist improperly placed a bridge that caused damage to other teeth

- Dentist recommended a complete bridge
  - Patient chose lower cost, temporary bridge
- Over the years, dentist recommended replacement with a permanent bridge
  - Patient continued to request re-cementing of temporary bridge
  - Patient suffered continuing decay that advanced over the years
- Dentist made numerous referrals to a specialist
  - Patient declined due to cost

16

Case Study: Lack of Engagement Leads to Amputation

Allegation: Patient with long history of diabetes and foot ulcers alleged negligent management of his diabetic foot ulcer led to amputation

- Patient initially began treatment for a small ulcer to the right toe
- Doctor recommended:
  - Wearing custom orthotics to prevent further ulceration
  - Follow-up with a vascular surgeon due to weak pulses in feet
- Patient seen 7 times over the next year
- Doctor provided and documented verbal and written education on:
  - Diet
  - Diabetic foot care
  - Causes and effects of diabetic neuropathy
  - Potential complications
- Patient eventually diagnosed with osteomyelitis and required partial foot amputation

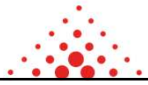
17

Review of Risk Recommendations

18

Risk Recommendation

- Identify an area of health literacy focus
  - Informed consent
    - Informed refusal when patients fail to follow treatment advice



AHRQ 2024.



19

Plain Language Strategies

- Employ basic plain language writing and design principles to ALL patient-facing materials, including **consent forms and refusal of treatment forms**
  - Consider using a health literacy or patient education specialist who is familiar with these design principles
  - Evaluate written materials using a plain language assessment tool
    - Readability formulas ≠ plain language
- Use icon arrays to communicate risk

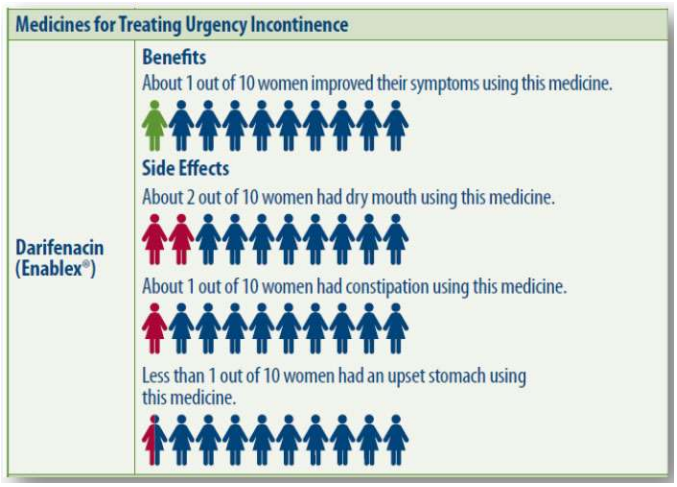


AHRQ 2024.



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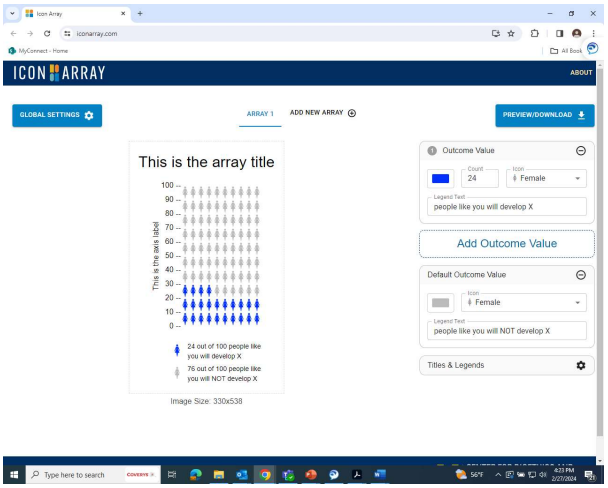
Plain Language Strategies



AHRQ 2020.

21

Plain Language Strategies



https://www.iconarray.com/

22

Informed Consent

- Patients and health care teams can both benefit
- Both clinicians and patients view the informed consent process as a formality – a hurdle to jump – a form that must be signed
  - After signing a form, patients may NOT understand:
    - The risks, benefits, and alternatives, including the option to say no
- Informed consent forms are typically written and reviewed by highly-educated professionals. They can include legalese and clinical terms patients do NOT understand
- Regulatory bodies and accrediting bodies often have reading level requirements; for example, 5th grade reading level

23

Plain Language Consent Form Elements

Title

Permission (Consent) for Surgery or Procedure

Patient Directions

- Please read this form
- Ask about any part you do NOT understand
- Make sure your doctor answers your questions before you sign this form

24

Plain Language Consent Form Elements

Surgery or Procedure Name:

_____

(*Doctor or health care worker enters surgery or procedure clinical name and includes level when applicable*.)

Body Side

On which side(s) of your body will the doctor perform the surgery or procedure? Check one box.

☐ Right side
☐ Left side
☐ Right AND left side (bilateral)
☐ There is NO side for this surgery or procedure

25

Plain Language Consent Form Elements

Patient Teach-Back

Describe the surgery in your own words. This is NOT a test for you. It is to make sure your doctor has explained your surgery or procedure so that you understand it.

_____

_____

_____

26

Plain Language Consent Form Elements

Patient Permission for Blood or Blood Products

Do you give permission for your doctor to give you blood or blood product(s) if your doctor thinks you need to have blood or blood product(s)?

☐ **YES,** I give permission for my doctor to give me blood or a blood product(s)
☐ **NO,** I do NOT give permission for my doctor to give me blood or a blood product(s)

Please tell us why you chose NO

_____

[*Enter reason why patient chose NO]*

27

Plain Language Consent Form Elements

Patient Permission for Surgery or Procedure

I understand and my doctor has told me:

- What I am having done and why I need it
- The chance of success
- How long it will take to get better
- The possible risks of having this done (Can list procedure-specific risks here too)
- What might happen if I do NOT have it done
- What other choices I can make instead of having this done
- What can happen to me if I choose to do something else
- What can happen if I choose NO treatment
- That there is NO guarantee of the results

28

Plain Language Consent Form Elements

Signatures

When you sign this form, you are giving permission to do this surgery or procedure. Make sure your doctor answers your questions before you sign this form.

Patient or Legal Representative Signature	Date/Time
Witness Signature	Date/Time
Doctor's Signature	Date/Time
Translator Name/Number (if applicable)	Date/Time

29

Plain Language Refusal Form Elements

Title

Refusal of Treatment or Test

Patient Directions

- Please read this form
- Ask about any part you do NOT understand
- Make sure your doctor answers your questions before you sign this form

30

Plain Language Refusal Form Elements

Patient Teach-Back

Describe the treatment or procedure in your own words.
This is NOT a test for you. It is to make sure your doctor has explained your treatment or procedure so that you understand it.

_____

_____

31

Plain Language Refusal Form Elements

Patient Refusal of Treatment or Test

I understand and my doctor has told me:

- What treatment or test my doctor thinks I need and why I need it
- What might happen if I do NOT have it done
- What other choices I can make instead of having this done
- What can happen to me if I choose to do something else
- What can happen if I choose NO treatment
- That I can change my mind at any time

Please tell us why you choose NOT to get this treatment or test

_____

32

Plain Language Refusal Form Elements

Signatures

When you sign this form, you are refusing the treatment or test your doctor thinks you need. Make sure your doctor answers your questions before you sign this form.

Patient or Legal Representative Signature	Date/Time
Witness Signature	Date/Time
Doctor's Signature	Date/Time
Translator Name/Number (if applicable)	Date/Time

33

KS0

Risk Recommendations

- Utilize **health literacy universal precautions**
  - Take precautions with ALL patients
  - Improve navigation
  - Create a welcoming, shame-free environment
- Address **organizational health literacy**
- Address **personal health literacy**.
  - Use health literacy strategies, such as plain language and teach-back in interpersonal communications.
  - Create plain language content.

AHRQ 2024.

34

Slide 34

KS0 move to end as a summary/takeaway and start with ICIR example?
Kathryn Schaefer, 2024-10-03T13:56:46.604

Questions?

35

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- Agency for Healthcare Research and Quality. Ten Attributes of Health Literate Health Care Organizations. Content last reviewed January 2024. https://www.ahrq.gov/health-literacy/publications/ten-attributes.html
- Agency for Healthcare Research and Quality. The SHARE Approach—Communicating Numbers to Your Patients: A Reference Guide for Health Care Providers. Content last reviewed September 2020. https://www.ahrq.gov/health-literacy/professional-training/shared-decision/tool/resource-5.html
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- Institute for Healthcare Advancement. Health Literacy Specialist Certificate Program. 2021.

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Resources

- Agency for Healthcare Research and Quality (AHRQ)
  - AHRQ's Making Informed Consent an Informed Choice: Training Modules for Health Care Professionals
  - Always Use Teach-back Training Toolkit
  - Health Literacy: Hidden Barriers and Practical Strategies
  - Health Literacy Universal Precautions Toolkit, 3rd Edition
  - Ten Attributes of Health Literate Health Care Organizations
  - The SHARE Approach – Communicating Numbers to Your Patients: A Reference Guide for Health Care Providers
- Centers for Disease Control and Prevention (CDC), Everyday Words for Public Health Communication
- Health Affairs, Negative Patient Descriptors: Documenting Racial Bias In The Electronic Record
- Institute for Healthcare Advancement, Health Literacy Specialist Certificate Program
- Office of Disease Prevention and Health Promotion, Health Literate Care Model

37

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT



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Josh Hyatt

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4

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6













Creating meaningful learning, collaboration, and recognition

7

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Strategic Plan 2025-2027

CORE PURPOSE
To advance safe and trusted health care.

MISSION STATEMENT
To lead and represent health care risk professionals and support them with resources and knowledge to manage enterprise risk across the health care continuum.

CREATE AND DELIVER TIMELY INSIGHTS

Generate timely content on key topics of interest by cultivating relationships with external industry partners and thought leaders.

Strengthen our collaboration with AHA on critical issues important to ASHRM, its members, and stakeholders.

Optimize ASHRM's communication channels to deliver timely information to members.

DRIVE GREATER GLOBAL RECOGNITION

Actively seek opportunities to increase ASHRM's presence in the global risk management market.

Amplify international engagement in ASHRM's products and services.

INCREASE MEMBER VALUE

Facilitate a welcoming environment that fosters a sense of belonging for members.

Create structured pathways for members to advance their skills from novice to expert.

Expand resources to address the priorities of risk professionals across the spectrum of health care.

8

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Strategic Plan 2025-2027

COMING SOON

New in 2025:

- Resources to help you with planning for increasing cyber risk threats
- A deeper focus on patient safety and the AHA Patient Safety Initiative
- An increased presence at international and national health care conferences
- Member spotlights highlighting the great work you and your peers do every day
- Enhanced engagement through the ASHRM Exchange and Forum

View and download the Strategic Plan at ashrm.org/strategic-plan-2025-2027!

9

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Learning at Your Own Time

eHealthcare LEADERSHIP AWARDS 2022 WINNER

ASHRM Online Learning Library

On-Demand Professional Development Resources for Health Care Risk Professionals

- CE tracking
- HRM Core
- CPHRM Prep
- Self-paced E-Learning
- Live & On-Demand Education

ASHRM PODCASTS

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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

In-Person Learning & Networking



The ASHRM Annual Conference is consistently the best source for qualified, credible and current information relevant to health care risk managers.

- Past ASHRM Annual Conference Attendee

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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Publications addressing risk within 8 crucial ERM domains



A catalog of resources for risk management professionals that include everything from root cause analysis to patient safety, physician office risk management, risk financing, and more.

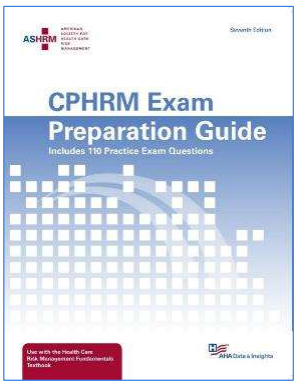
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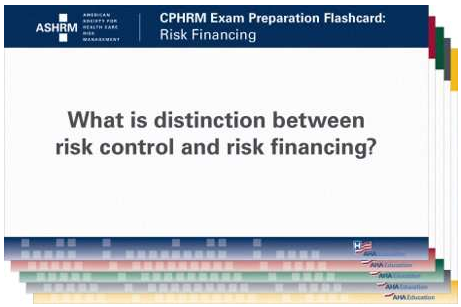
CPHRM Exam and Prep Materials

CERTIFIED CPHRM AMERICAN HOSPITAL ASSOCIATION TM

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In Person and online prep



New! CPHRM Flashcards

ashrm.org/CPHRM

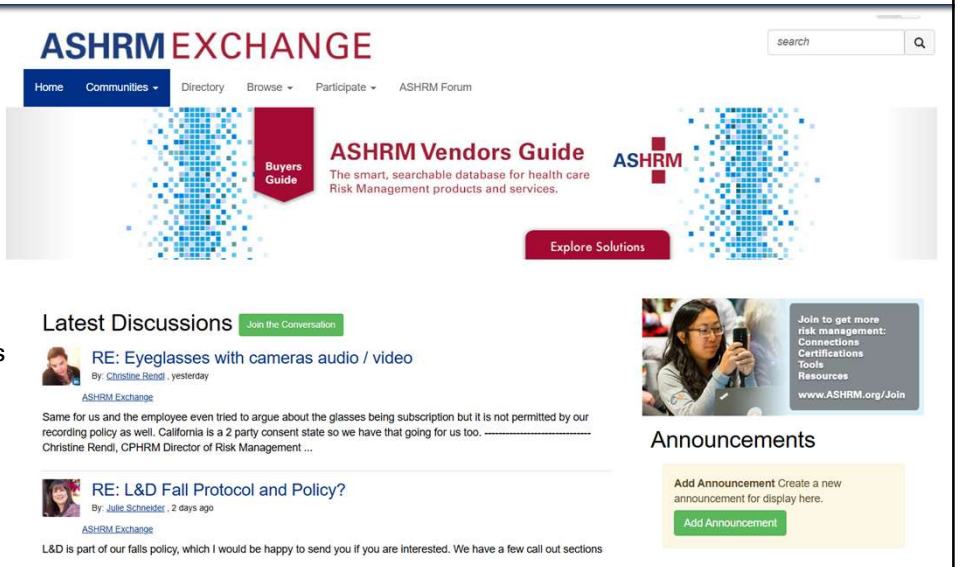
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A Space to Connect

24/7 Access to Risk Management Advice

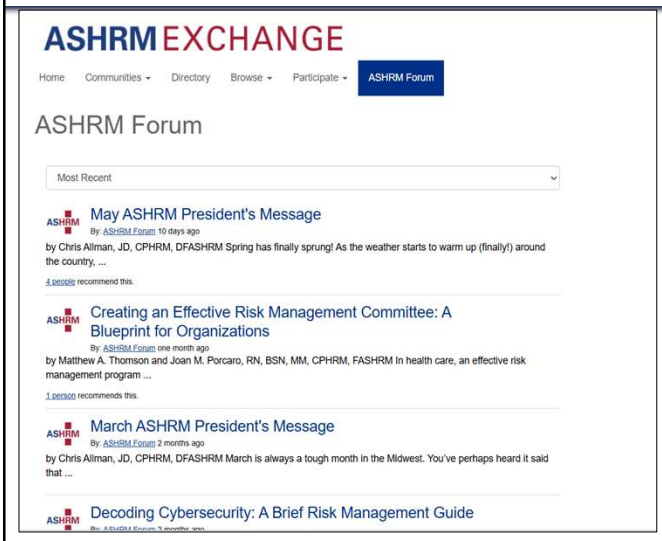
- Discussion Boards
- Resource Library
- Networking
- Member Directory
- Event Announcements
- Emailed Digest



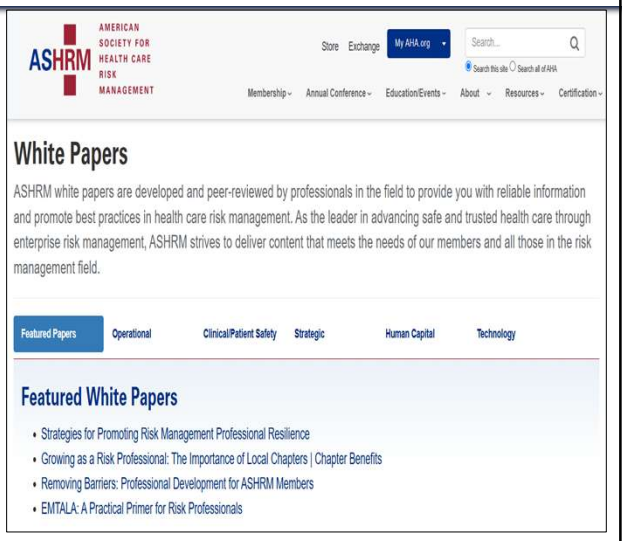
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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Timely Content



https://exchange.ashrm.org/blogs



https://www.ashrm.org/whitepapers

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Elevate the Profession



- Audience expansion
- Member recognition
- Surveys to understand risk functions within organizations

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Recognizing organizational excellence & celebrating individual success



AdventHealth Zephyrhills Hospital and AdventHealth Dade City Hospital

"Reduce Your Patient Fall Rates: Leveraging a 'Bootcamp' Approach to Create a Culture Change"

Innovation Award 2024

Presented By

RLDATIX



Joann Wortham-Moody, RN, DNP, JD, CPHRM

Health Care Risk Professional of the Year 2024



Susan Boisvert, BSN, MHSA, DFASHRM

Presidential Citation Award 2024

Recognizing a written contribution with exceptional technical merit and practical value

"Performance Improvement, Telemedicine, Patient Engagement, and Comparative No-show Rates"

Rawan Narwal-Kasmani, MD, FACP, Associate Program Director, Mercy Health
Tamara J. Vaughan, Mercy Health
Charla A. Ulrich, DNP, MOD, CPHQ, CPPS, CIC, Quality Officer, Bon Secours Mercy Health
Julie M. Stausmire, MSN, APRN, CNS-BC, Clinical Nurse Specialist, Adult Health

John C. West Writing Excellence Award 2024

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Recognizing organizational excellence & celebrating individual success



Monica Cooke, BSN, MA, RN, PMH-BC, CPHQ, CPHRM, DFASHRM

Distinguished Service Award 2024



S. Linda Habibi, JD, MBA, CPHRM
Andrew Smokowicz, MHA, CPHRM
Matthew Hill, CPHRM

Rising Star Award 2024

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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Award Winning Journal

WINNER 2023 APEX® AWARDS FOR PUBLICATION EXCELLENCE

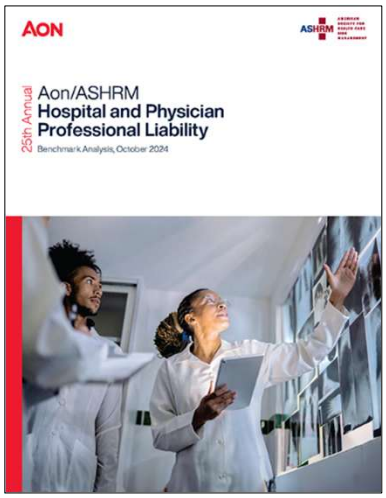
- Insightful, peer-reviewed content
- Published quarterly
- Opportunities for contributing
- Awards CEs
  (1 credit per feature article)



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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Benchmark Report

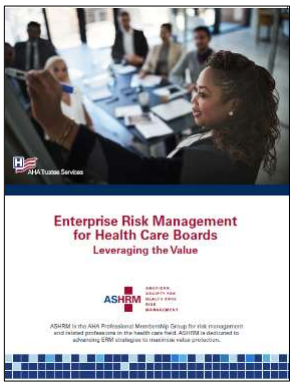


- 2024 report is available: https://www.ashrm.org/aon-ashrm-hospital-and-physician-professional-liability-benchmark-report
- 105 participating health care systems – collectively comprise 29% of the hospital exposures in the country
- A data-based tool for better estimating and understanding self-insured medical malpractice costs relative to those for your peers
- 2025 report is in the works! Will be available by Conference 2025.

20

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Resources for the C-Suite



ashrm.org/ERM-Trustees

Supporting Resources & Tools

ERM Quick Reference Tool
A two-page document to help keep the ERM domains and guiding principles top of mind. Download Tool

Enterprise Risk Management: Readiness Assessment Tool
Gain insight into your organization's readiness to implement ERM practices, or the maturity of ERM initiatives already initiated with this helpful tool. Download Tool

ERM Enterprise Risk Management: Implementing ERM
For more in-depth information and insight into ERM implementation, this white paper outlines the implementation of an ERM program, defines its key structural components in any health care setting, and will help to build consistency in your efforts to develop or move forward your ERM efforts. Download White Paper



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Guidance for Enterprise Risk



Asking the right questions and building relationships.

22

Fellow & Distinguished Fellow

- Opportunity to establish authority
- Avenue to contribute your professional experience
- Lead the next generation through teaching

https://www.ashrm.org/fashrm-designation

https://www.ashrm.org/dfashrm-designation

Recognizing the contribution of our members to risk management

Designation is earned through

Professional experience	Leadership	Continuing education	Professional designations	Publishing	Lecturing

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Supporting You Everyday



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What Questions Do You Have?



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The Vital Role of Onboarding Education for Healthcare Risk Professionals

Robin Lynch, MSN, RN, CHSE, CPPS, CPHFH
Manager, Quality, Risk & Patient Safety, Med-IQ

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1

Are you a risk professional?

2

If you answered yes, did you have an orientation specific to risk?

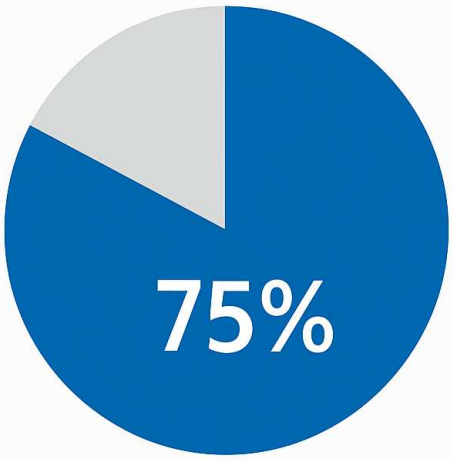
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If you had an orientation specific to risk, how well did it prepare you for your role?

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In a 2022 poll of 114 risk professionals at ASHRM, 75% reported they did not have an orientation specific to risk management.

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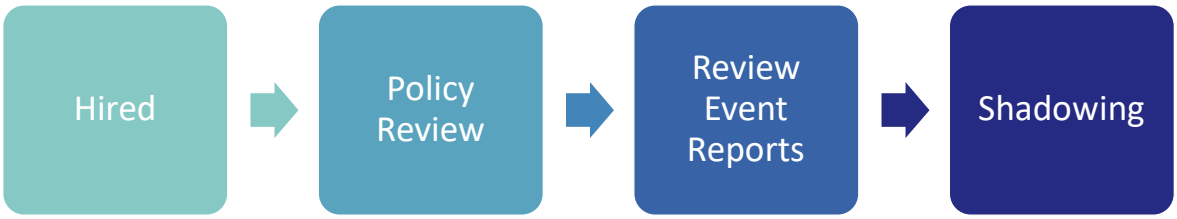
Objectives

- Describe the need for an onboarding curriculum for novice risk professionals
- Identify learning activities that can be included in a risk professional onboarding curriculum
- Outline a week-by-week onboarding curriculum specific to the learners practice setting

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A Familiar Story?



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Risk Professionals NEED Education

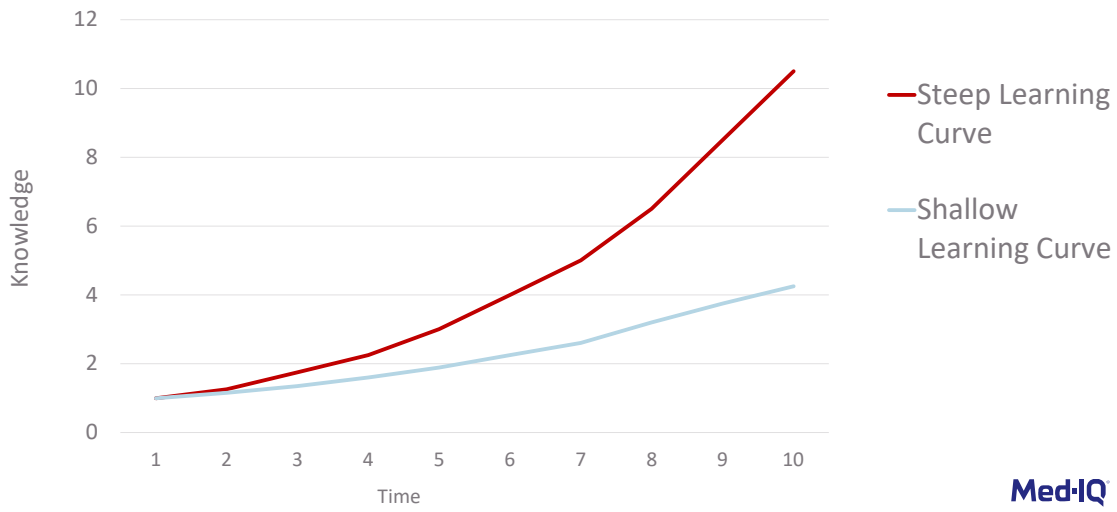
"…the person(s) who hired me moved a month after I started. In other words, I am learning as I go and no formal training has occurred."

"I feel your pain. …I have no one to train me and no risk management experience…I am in the middle of month three and still feel very confused… "

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Risk Management Isn't Easy



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The Problem

- Lack of formal programs
- Limited mentors
- No standardized qualifications
- Variability between organizations
- Role ambiguity
- Complex nature of healthcare

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The Impact



NOBODY IS DOING THE WORK!

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What is Needed?

Learner-centric

Customized

Intentional

Mixed-modalities

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What is Wanted?

Perceived value

- Beneficial content to maintain competency, certification, promotion, or learn new skill

Time-sensitive

- Low learner burden

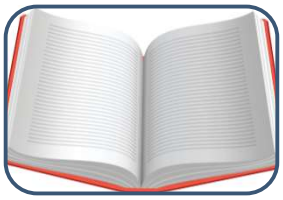
Contextualized content

- Relevant to daily work

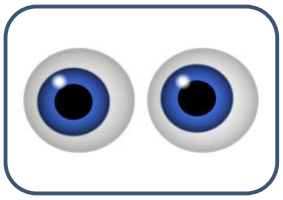
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Designing a Risk Professional Onboarding Curriculum



Self-study



Observation

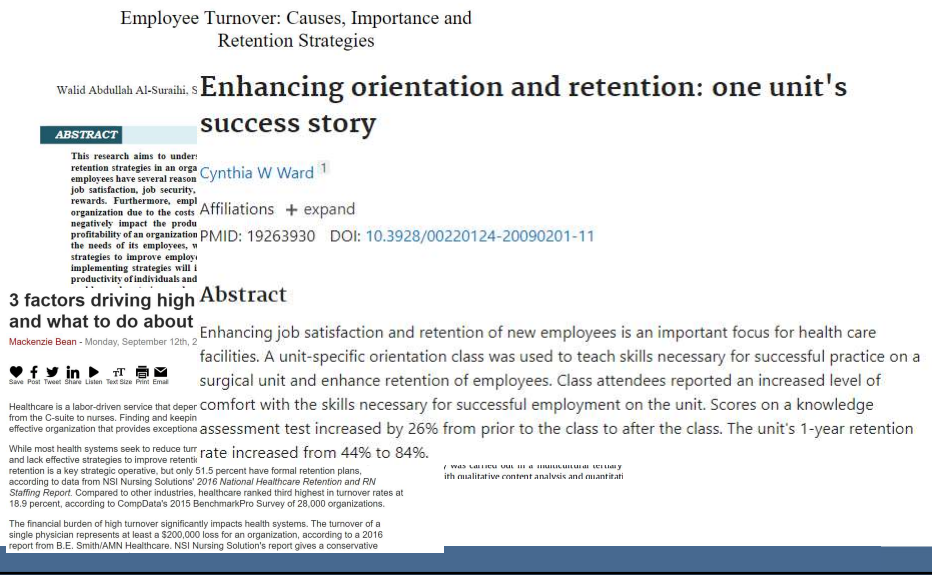


Practice

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Education Supports Retention



Employee Turnover: Causes, Importance and Retention Strategies

Walid Abdullah Al-Suraihi, S

ABSTRACT

This research aims to under retention strategies in an orga employees have several reason job satisfaction, job security, rewards. Furthermore, empl organization due to the costs negatively impact the produ profitability of an organization the needs of its employees, w strategies to improve employ implementing strategies will i productivity of individuals and

3 factors driving high and what to do about

Mackenzie Bean - Monday, September 12th, 2

Save Post Tweet Share Listen Text Size Print Email

Healthcare is a labor-driven service that deper from the C-suite to nurses. Finding and keepin effective organization that provides exceptiona

While most health systems seek to reduce turn and lack effective strategies to improve retenti retention is a key strategic operative, but only according to data from NSI Nursing Solutions' *2016 National Healthcare Retention and RN Staffing Report*. Compared to other industries, healthcare ranked third highest in turnover rates at 18.9 percent, according to CompData's 2015 BenchmarkPro Survey of 28,000 organizations.

The financial burden of high turnover significantly impacts health systems. The turnover of a single physician represents at least a $200,000 loss for an organization, according to a 2016 report from B.E. Smith/AMN Healthcare. NSI Nursing Solution's report gives a conservative

Enhancing orientation and retention: one unit's success story

Cynthia W Ward [1]

Affiliations + expand

PMID: 19263930 DOI: 10.3928/00220124-20090201-11

Abstract

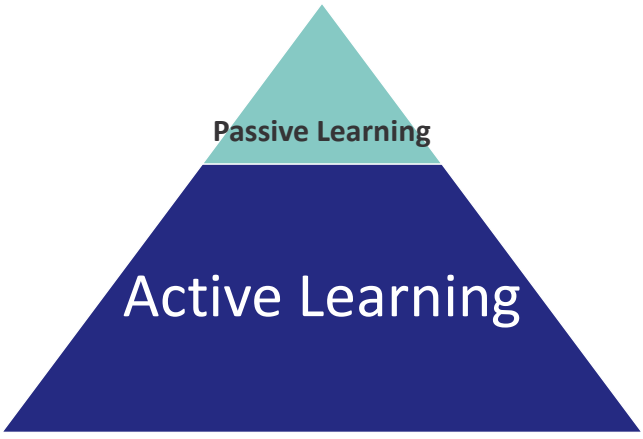
Enhancing job satisfaction and retention of new employees is an important focus for health care facilities. A unit-specific orientation class was used to teach skills necessary for successful practice on a surgical unit and enhance retention of employees. Class attendees reported an increased level of comfort with the skills necessary for successful employment on the unit. Scores on a knowledge assessment test increased by 26% from prior to the class to after the class. The unit's 1-year retention rate increased from 44% to 84%.

ith qualitative content analysis and quantitati

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How do we learn best?



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Considerations for Designing An Education Plan

- Setting
- Culture
- Traditional vs. ERM
- Risk appetite
- Resources
- Qualifications
- Essential skills

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Scenario

Setting	• 250-bed, Community Hospital, Healthcare System
Culture	• On HRO Journey, Just Culture Training
Traditional vs. ERM	• ERM
Risk Appetite	• Risk Adverse
Qualifications	• 3 yrs. Healthcare, Masters & CPHRM not required
Resources	• Director 1x/wk, Senior Risk Mgr. lead orientation, Quality, Compliance, Medical Affairs on-site
Essential Skills	• Outline role specific knowledge and skills (next slide)

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Essential Responsibilities?

Knowledge



Skills



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What competencies are needed by risk professionals?

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Essential Responsibilities?

Knowledge

- Risk Management Process
- Claims Management Process
- Sentinel Event Policy
- Elements of a malpractice claim

Skills

- Conduct FMEA
- Lead a RCA
- Develop an event timeline
- Write a high-level summary of an event

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Develop a Learning Timeline

3-Months

- Conduct risk assessment
- Identify events which require investigation
- Prioritize events for corrective action planning
- Coach managers on just culture

6-Months

- Provide NEO on Risk Management
- Investigate & prepare summary of a sentinel event
- Conduct an HVA
- Respond to a grievance

1-Year

- Lead RCA
- Conduct FMEA
- Claim Analysis
- Prepare an executive summary of KRI & KPI
- Lead an improvement project

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Weekly Learning Goals:

What do I want the new risk professional to know at the end of the week?

- The steps of the risk management process
- The difference between a punitive culture and just culture

What do I want the new risk professional to be able to do at the end of the week?

- Identify risks through rounding
- Use the Incident Decision Tree to provide manager coaching in responding to an event

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Example Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday
Self-study	ASHRM-ERM Policy Review: "Event Reporting" "Sentinel Event"	Review EOC rounding checklist	VA-Patient Safety "Just Culture"	"IHI Trigger Tool for Adverse Events"	Policy Review: "Complaints & Grievances" "Peer Review"
Observation	"The Risk Management Process" "Orientation to Event Reporting System"	"Risk Identification"	"Culture of Safety"	Observe morning safety huddle	"TeamSTEPPS""
Practice	Attend leadership rounds Enter an event report	Round with EOC team	Risk Rounds Use Incident Decision Tree	Review events, Identify which events require investigation Use IHI Trigger Tool Chart Review	Discuss rounding findings Discuss Just Culture activity

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Example Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday
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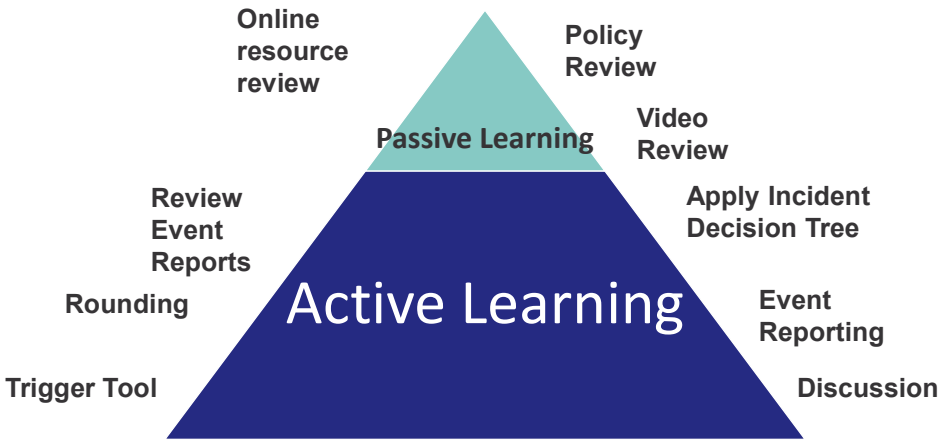
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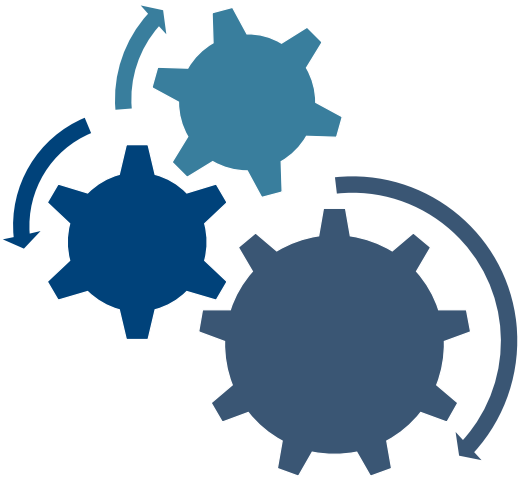
How do we learn best?



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Let's Workshop This!



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Weekly Learning Goals:

What do I want the new risk professional to know at the end of the week?

Available resources?

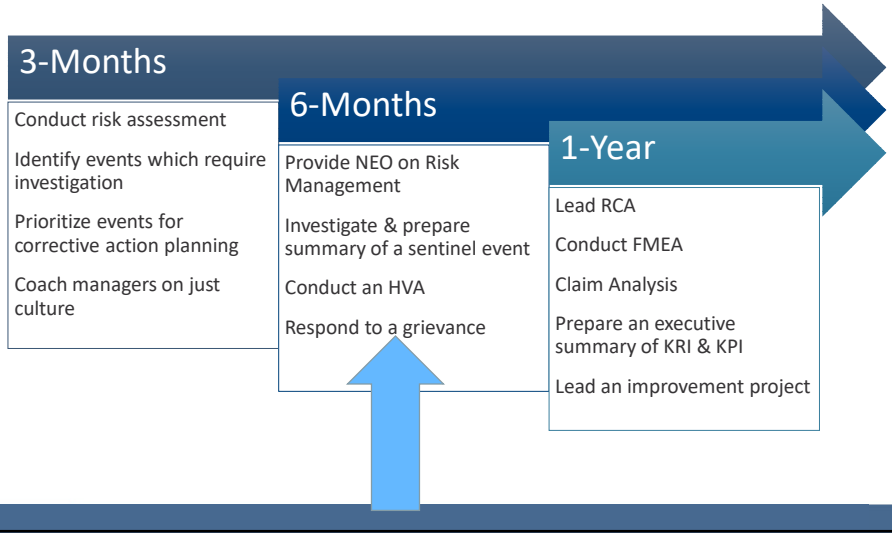
What do I want the new risk professional to be able to do at the end of the week?

Activities to gain experience?

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Customizable



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What is Needed!

Learner-centric

Customized

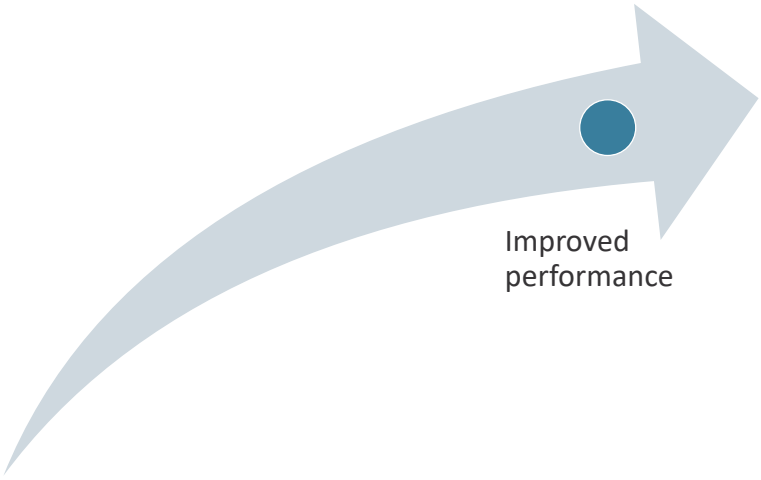
Intentional

Mixed-modalities

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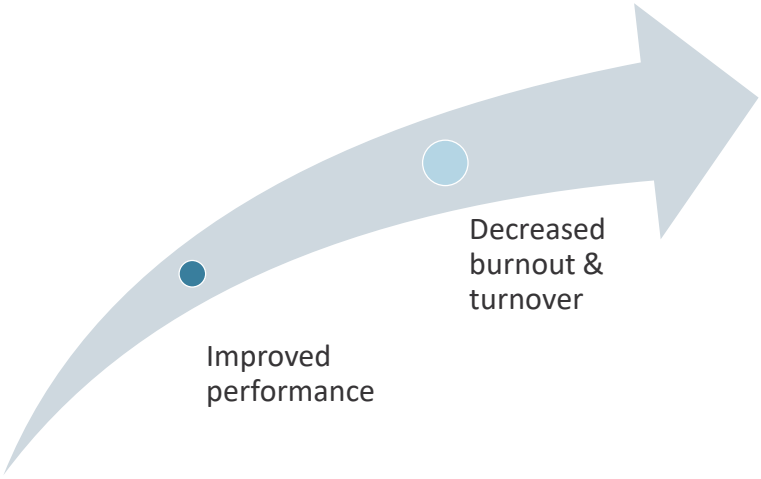
The Result



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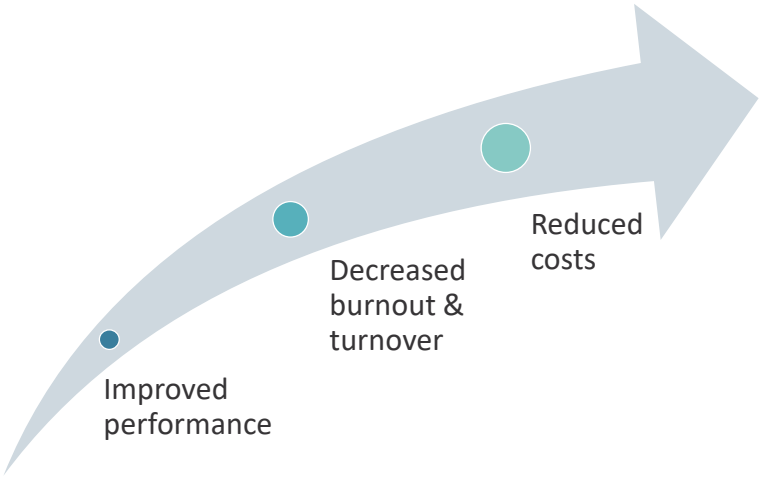
The Result



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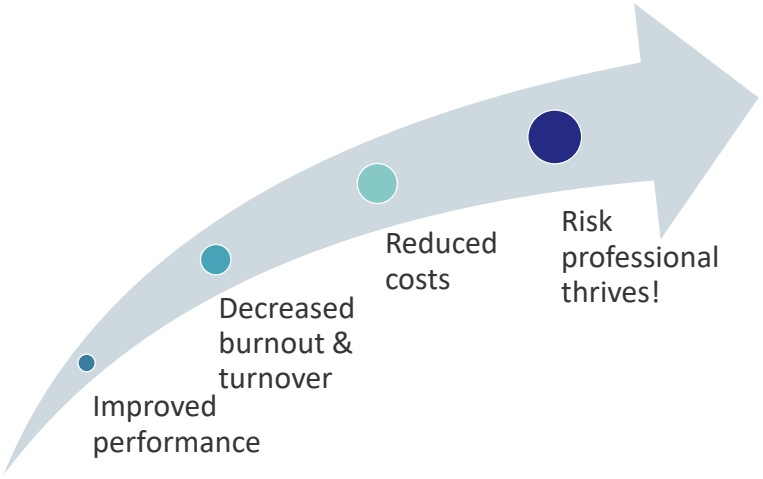
The Result



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The Result



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Thank You

Robin Lynch, MSN, RN, CHSE, CPPS, CPHFH
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Questions

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Hardenburgh Group


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Montefiore Einstein


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Vice President Risk Management & Patient Safety
Mt. Sinai Health System


Abbi Schenkel, Esq.
Director of Risk Management
Montefiore Medical Center

How to Maximize Privilege Protections Under the Patient Safety Act

AHRMNY - 2025 Annual Conference

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

0

Disclosures

- Michael R. Callahan has no disclosures to report
- Tina Weinstein has no disclosures to report
- Bonnie Portnoy has no disclosures to report
- Abbi Schenkel has no disclosures to report

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1

Agenda

- Patient Safety & Quality Improvement Act Overview
- Key Components of a PSES: Insights from Montefiore
- PSES Implementation Roadmap
- Responding to a Regulator's Demand for PSWP



2

2

PSQIA Overview



3

3

Patient Safety & Quality Improvement Act of 2005

Privileged Patient Safety Work Product is any:

- Data
- Reports
- Records
- Memoranda
- Analyses - *ex. Root Cause Analysis (RCA)*
- Written or Oral Statements

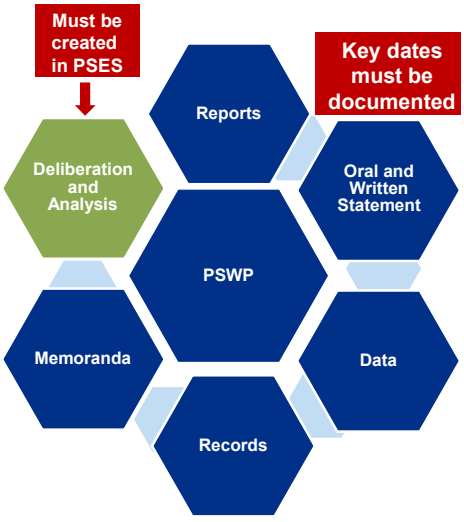
which could improve patient safety, healthcare quality, or health outcomes and that:

- Are assembled or developed by a provider for reporting to a Patient Safety Organization (PSO) and are reported to a PSO
  - Includes information that is documented within a Patient Safety Evaluation System (PSES) for reporting to a PSO
  - Includes the date the information entered the PSES
- Are developed by a PSO for the conduct of patient safety activities
- Identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to a PSES

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What is Patient Safety Work Product (PSWP)



Requirements

Data which could improve patient safety, health care quality, or health care outcomes

- **Data assembled or developed by a provider for reporting to a PSO and are reported to a PSO**

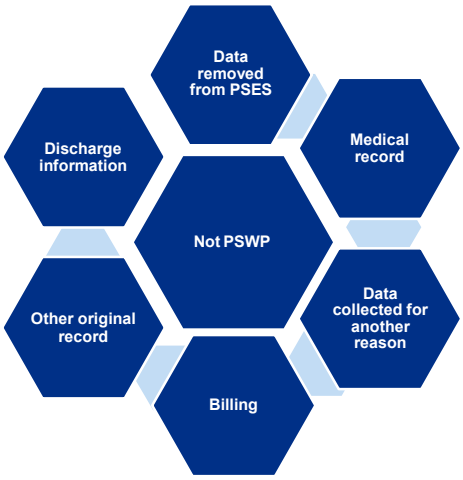
Analysis and deliberations conducted within a PSES

- **Data developed by a PSO to conduct of patient safety activities**

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What is Not PSWP



Information collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system

- Data removed from a patient safety evaluation system

Data collected for another reason

Mandated reports

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Use vs. Disclosure of PSWP

Use:

- PSWP that is used and distributed or shared within a single entity or health care provider holding privileges with the entity holding the PSWP for any legitimate business or other purpose

Disclosure:

- PSWP that is released, transferred, provided, or divulged in any other manner by:
  - An entity or person holding the PSWP to another legally separate entity or person other than a workforce member of or health care provider holding privileges with the entity holding the PSWP
  - A component PSO to another entity or person outside the component PSO and within the legal entity of which the component PSO is a part

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Patient Safety Evaluation System

What Comprises the System's PSES?

- A Patient Safety Evaluation System (PSES) is a structured process within a healthcare organization that is designed to collect, manage, and analyze information about patient safety events, incidents, near misses, and medical errors.
  - PSES encompasses deliberations or analysis
  - PSES encompasses information reported to a PSO
- The purpose of a PSES is to facilitate the collection of Patient Safety Work Product (PSWP) and to set guidelines for the management and analysis of information reported to or by a PSO.

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Key Components of a PSES

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Insights from Montefiore

When Drafting a PSES:

- Be as broad as possible to ensure that the full scope of patient safety and quality activities are covered under your organization's PSES.
- The majority of the PSWP outlined within the PSES is typically classified as deliberations and analysis.
  - It is important to clearly delineate what PSWP is reported and/or created by the PSO since this is the main mechanism by which PSWP gets the protections under the law.
- Incorporate any existing quality policies at your organization.
  - Utilize those existing policies as a guide/starting point for what to include in your organization's PSES.
- Besides a list of what is and is not PSWP, your organization's PSES should include:
  - Description of any workflows for reporting quality and safety related information to or by the PSO
  - How and who can utilize PSWP within your organization
  - Disclosure exceptions
  - Special sections for HR and Complaints & Grievances
  - Training plan

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Patient Safety Activities & PSWP Examples

Examples of Patient Safety Activities:

Patient safety activities may be conducted by any individual, committee or body that has assigned responsibility for any such activities. This includes faculty, staff, trainees, volunteers, and contractors who perform work under the direct control of the health system.

- Patient Safety Committees
- Center for Performance Improvement
- Medical Executive Committees
- Serious Safety Event/Never Event Committees
- Peer Review Board
- Quality Improvement Committees
- Medication Safety Committees
- Bioethics Committees
- Network Performance Group
- Patient Experience Steering Committees

Examples of PSWP:

- Quality Reviews
- Peer review activities and documents
- Incident/adverse event reports
- Focused/Ongoing Professional Practice Evaluations
- Risk Management activities not related to claims and litigation
- Communication (written, oral, or digital) and/or information developed or captured directly or in minutes by individuals or quality and/or patient safety committees
  - Including emails and text messages

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Discussion #1

Navigating the Dual Role of
Risk Management

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PSES Implementation Roadmap

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First Steps

Benefits of Engaging with a PSO and Implementing a PSES:

- Privilege protections under the PSQIA
- Current legal environment in NY has diminished the Public Health Law quality protections
- The Patient Safety Act and a PSES can support Just Culture at Montefiore by bridging the gap between quality improvement and legal protections
- Data-driven insights on patient safety and quality

Initiating the PSES process:

- Contacted experts who educated us on the PSA and the process for drafting a system-wide policy
- Gained understanding of the impact implementing a PSES would have on current quality, safety, and regulatory operations

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Drafting the PSES

Initial Drafting Process and Key Considerations:

- Reviewed sample PSES from another hospital system
- Inventoried current hospital quality policies and workflows
- Agreed on what the PSES would and would not include

Final Draft and Approval:

- Sent initial draft to leadership and key stakeholders for review and edits
- Completed final draft and administrative approval process

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PSES Training & Implementation

Training Prep and Education Rollout:

- Created training matrix outlining key stakeholders and educational needs
- Created training presentation and informational guides
- Trained defense counsel panel and created standardized workflows to evaluate PSWP protections and potential motion practice

PSES in Practice:

- Began evaluating external regulatory requests for PSWP (DOH, OPMC, etc.)
- Drafted cover letters in response to external requests for protected documents
  - Preliminary results from responding to requests have been surprisingly positive
- Case-by-case evaluation and ad-hoc meetings when PSWP is part of a discovery demand in a lawsuit

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Discussion #2

Drafting Considerations: Determining What Is and Is Not PSWP

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How to Respond to a Regulator's Demand for PSWP

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Step-By-Step Guidance

When a Regulator Shows Up Demanding Documentation...

- Do not panic (Most Importantly!)
- Do not prevent surveyors from entering the facility
- Determine if they are there on behalf of CMS and/or the state?
- Make sure that appropriate personnel including legal counsel is contacted and decide who will accompany the surveyors
- Carefully review documents requested by the surveyor if in writing or if verbally requested
- Determine whether any of the information requested is PSWP or privileged under New York law
- If PSWP is requested, provide them the "CMS Guidance to Surveyors" form

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Essential Documentation

Be prepared to provide a copy of the following:

- PSO certification letter from AHRQ
- Copy of the hospital's PSO member agreement
- Copy of the hospital's PSES policy
  - Point out that the specific information they are seeking is PSWP under the policy
- Screen shots or blank/redacted forms of PSWP
- Provide copies of any non-privileged information
- Medical/patient care records
- Relevant policies and procedures
- Action plan relating to the incident if not PSWP
- Permit interviews of involved personnel but they cannot discuss or disclose PSWP

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What Can be Provided to Regulators

Examples of Non-PSWP: Available to Regulators

- Patient name and other demographic information about the patient and the event (date, place, time, etc.)
- Brief description of event
- Names of witnesses and staff involved (for interviews)
- Medical record, care plans, etc. (Can't be protected)
- Staff for interviews (information about their knowledge of anything outside of PSES can't be protected; all their factual knowledge about the event or routine facility operations is available)
- Simple compilations of information about events (falls in last 90 days, etc.). Possibly basic logs for falls, etc.
- MDS data and quality measure reports (can't be protected)
- Information about changes made/plans of correction developed after an event (can't be protected)
- Records regarding the implementation of changes specified in a submitted plan of correction (shows the hospital's progress)

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What Cannot be Provided to Regulators

Examples of PSWP: Not Available to Regulators

- Root cause analysis of specific events (vs. staff interviews about the facility's generic root cause analysis process)
- Research regarding solutions/standards of care
- Substance of deliberations and analysis during team meetings regarding safety issues and events (or interviews with team members on those topics)
- Substantive information from QA meetings and QAPI team meetings
- Expert consultation reports
- Identifiable information furnished to or received from the PSO
- Records of investigatory interviews
- Statistical compilations prepared specifically as part of the investigation of an event or safety issue
- Statistical compilations prepared to help the participant identify events or safety issues (QAPI surveillance)
- Records of measurements or observations not related to a specific plan of correction

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HHS Guidance

If acting on behalf of CMS, provide them with the following statement that is set forth in the HHS guidance regarding PSWP and a provider's external obligations:

"Regulatory agencies and other entities requesting information of providers or PSOs are reminded that, subject to the limited exceptions set forth in the Patient Safety Act and Patient Safety Rule, PSWP is privileged and confidential, and it may not be used to satisfy external obligations. Therefore, such entities should not demand PSWP from providers or PSOs."

(41 Fed. Reg. at 32659 (May 26, 2016 HHS Guidance))

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Additional Actions to Take

What Should You Do If Providing this Information Does Not Satisfy the Regulators?

- Contact Legal Counsel and/or Risk Management
- If acting on behalf of CMS, contact the applicable CMS Regional Office to confirm/discuss that the facility is not required to turn over PSWP
- If acting on behalf of the State, contact the applicable agency administrator or other key contact in the appropriate office that has supervision and oversight over the regulator.
- If all the above attempts to satisfy regulators are not successful, providers may decide to disclose only the PSWP necessary to demonstrate compliance pursuant to the "Authorization by Identified Provider" disclosure exception.

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Discussion #3

Responding to Requests Involving
Both PSWP and Non-PSWP

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Thank You!

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Resources

- SAMPLE PSWP Credentialing Application Language for Provider Authorization
- SAMPLE Patient Safety Evaluation System Training Matrix
- SAMPLE Letter to Regulatory Organization
- CMS Guidance to Surveyors
- SAMPLE Patient Safety Evaluation System Policy
- Patient Safety Act link: 42 U.S.C. sections 299b-21 to 299b-26

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929-731-8509

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KAUFMAN BORGEEST & RYAN LLP

Views from Litigators and the Bench: Trends in Medical Malpractice Litigation

June 6, 2025

Hon. Lewis J. Lubell, J.S.C.
New York Supreme Court,
Westchester County

Betsy Baydala, Esq.
Christopher DiGiacinto, Esq.
Kaufman Borgeest & Ryan LLP

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Trends in Malpractice Litigation

Intro/Today's Topics

Trials

- ***Lessons Learned from the Trial of a Third Party Action***
- ***Successful Trial Strategies***

Mediation

- ***Generally, Mediators, Briefs***
- ***Case Specific Strategies***

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Lessons Learned From The Trial of a Third Party Action

First some basics

What are they? Claims against potentially culpable parties not named in the Complaint

Why consider? Deflect liability, decrease exposure/apportionment, exonerate existing defendants.

Theories? Indemnification (you were negligent and I'm owed), Contribution (we were negligent in different ways).

When to consider? As early as possible, be mindful of deadlines written into pre-printed PC orders.

CPLR Constraints/Judge's view? Typically can't be brought after NOI filing, disruptive, trying to narrow issues for trial not expand issues.

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Lessons Learned From The Trial of a Third Party Action

Basics (cont'd)

Strategies for commencing: Be careful what you wish for! Now fighting battle on two fronts. Be clear about risks v. benefits- how will this play out at trial?

Issue for Judge: What is vouching in? When can you do it?
CPLR allows for procedure to bring in a party not in Complaint.

Claim facts: Radiologist brought in as 3rd party defendant by defendant Hospital & physicians. Plaintiff was a physician who claimed he was paralyzed by poor surgical technique during lumbar discectomy & fusion which caused a subdural hematoma which was not timely diagnosed. Radiologist was brought in because of failing to call in findings revealing hematoma impinging the spinal cord.

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Lessons Learned From The Trial of a Third Party Action (cont'd)

- Big damages
- Expert Disclosures of Third-Party plaintiff targeted 3rd Party Defendant radiologist, and vice versa
- Stage was set for battle among defendants, plaintiff just sat back waiting.

Battle never came…

Trial Considerations/Takeaways:

All defendants should work together to avoid giving plaintiff the narrative advantage "see, they're fighting over who is responsible".

Jury selection/Openings: Defense- if plaintiff claims my client departed, I may have arguments about another party who was responsible. 3rd Party- I may not have much to say unless plaintiff claims I did something wrong directly or indirectly.

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Lessons Learned From The Trial of a Third Party Action (cont'd)

Trial/Cross-Direct of Parties: Defendants/Third Parties did not cross each other at all.

In our case example, this was very difficult. Counsel for main party defendants assured they would have no questions/cross for 3rd Party Defendant if we returned the favor and we did.

Trial/Cross-Direct of Experts: All defendants (main and 3rd Party) cross plaintiff's standard of care experts to defend plaintiff's claims against them. All defendants attack damages experts.

In our case example, case value decreased by 1/2 .

Theme: defendants working together, even in extreme circumstance of 3rd Party claim, will lessen case value and chance of success.

Issues for Judge: Never made it to defense case, if I didn't call my neurosurgeon could plaintiff get a missing witness charge?

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Experts/Missing Witness Charge

What is it? Judge instructs jury to take a negative inference against a party that failed to call/produce a witness at trial but allow party to include its reasons for not calling.

When does it happen? Where an expert has been disclosed to give testimony that may support or even mirror one of plaintiff's experts.

Why would you do that? Where parties disclose against each other, either because of 3rd Party action, disputes about causation.

Fact Pattern: Failure to diagnose stroke case against ED Physician, Neurologist, Hospital and Radiologist who read CT Scan partially correctly – no hemorrhage, but incorrectly – no thrombus. During litigation we moved for SJ with a neurology expert on causation claiming window for TPA was still open. Defendants also moved claiming their clients relied on report of CT imaging. Expert disclosures mirrored SJ motion.

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Experts/Missing Witness Charge (cont'd)

Result: At trial, defendants did not point fingers because we agreed not to call our neurology expert. Plaintiff moved for missing witness charge. We agreed to accept the charge if allowed to write in our reason for not calling the witness "Plaintiff did not meet her burden of proof as against our client". Judge agreed, plaintiff withdrew the motion. We did not call the witness.

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Experts/Missing Witness Charge (cont'd)

Result: At trial, defendants did not point fingers because we agreed not to call our neurology expert. Plaintiff moved for missing witness charge. We agreed to accept the charge if allowed to write in our reason for not calling the witness "Plaintiff did not meet her burden of proof as against our client". Judge agreed, plaintiff withdrew the motion. We did not call the witness.

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Successful Trial Strategies

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Defendant Doctor as a Witness



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Mediation

Not new, but several nuances we can talk about.

Can be highly successful cost effective case resolution strategy in right circumstance

Considerations: Insurers, clients, individual parties with consent on notice- Often see attorneys, carriers, insureds not prepared to engage in good faith.

Picking a mediator: needs to suit your case, JAMS, NAMS lots of qualified mediators with different styles. NYS Courts absolutely best resource!

Trial delay tactic? Unlikely to buy time, delay trial if not pursued in earnest. Clue: if you engage in good faith, more likely to buy time from assigned judge or TAP Judge.

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Mediation (contd)

Mediation Brief: Some Judges/mediators will require, some will not. Sell highlights, focus on mitigation of damages, recent reported verdicts, settlements. Can also spin/defend weakness- can be good time to focus on 3rd Party exposure/defend exposure.

Disclosed v. for mediator only? Some attorneys love to argue, since I disclosed mine, you must be afraid.

In Person v. Virtual? If you have any doubt your adversary is communicating offers, in person with clients present is best. If multiple efforts, ease of scheduling or clients out of state, not concerned about being present, go virtual.

Documents/Demonstrative evidence? Depends on case, if difficult/complicated surgical technique, procedure, medical process, or cases involving imaging, and illustrations or in some cases, animations make sense, why not?

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Mediation (cont'd)

Demonstratives (contd) What if other side uses, and you can't didn't contemplate? Consult your expert, prepare specific arguments that counter demonstratives. Particularly to point out inaccuracies or exaggerations in size or location of anatomy.

Examples/Pitfalls v. Successful strategy:

Plaintiff/injured party present takes offense to opening argument/statement: soften opening statements, use mediator to convey strengths of case to attorney.

Multiple Parties: try to make alliances prior to mediation, work out apportionment in advance if possible. Give client reasonable expectation of goal for apportionment, we think 50-50 would be goal but given liability, 60-40 more reasonable.

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Mediation (cont'd)

Co-defendant issues edict on apportionment, won't exceed certain percentage: in certain circumstances (difficult, high value case), offer full authority indicating most you'll ever get is X. Watch tune change as percentages change.

Initial demand too high (or low): Play good poker, don't be overly upset/happy. Keep them talking.

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Additional Issues/Questions

Thank You!!

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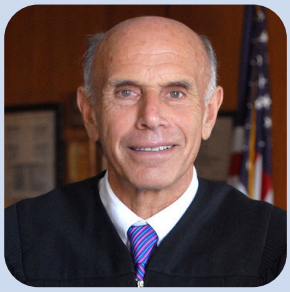


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2025 ANNUAL FULL-DAY CONFERENCE & RECEPTION

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

FRIDAY, JUNE 6TH
8:30 AM - 4:00 PM



FEATURING KEYNOTE SPEAKER:

Hon. Arthur M. Diamond, J.S.C. (Ret)
Supreme Court of the State of New York
Nassau County

CITY WINERY
NEW YORK CITY

This full-day event will feature a Keynote Address by the Honorable Arthur M. Diamond and other dynamic speakers and presentations:

- Navigating Sexual Abuse and Molestation (SAM) Cases
- Emerging Role of Risk Manager in Senior Living
- Mitigating Damages
- Building Trust with Patients
- Professional Onboarding for Risk Managers
- Patient Safety Act & PSOs
- Views from the Bench and Litigators



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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.

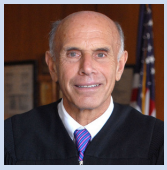
9:15-9:40 Welcome & Announcements



Robert (Bob) Martin
AHRMNY President

Bob will kick off the program welcoming attendees, guests speakers, and sponsors. A rundown of events for the day will be highlighted as well as an opportunity to hear from some of our sponsoring companies.

9:40-10:30 KEYNOTE ADDRESS: View from the Bench: Handling Medical Malpractice Cases from Summary Judgment to Verdict to Settlement



Hon. Arthur M. Diamond, J.S.C. (Ret)
Supreme Court of the State of New York
Nassau County

The Hon. Judge Diamond's address will include topics such as handling of Medical Malpractice cases, Legal Standard, Informed Consent, Evidence, Record Documentation, an Overview of the Family Health Care Decisions Act, and Surrogate Decision Making in the Healthcare Setting.

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

MORNING BREAKOUT SESSIONS

10:40-11:30 Navigating the Evolving Healthcare Market Relative to Sexual Abuse and Molestation (SAM) Cases



Joseph (Joe) Calcagno
Head of Healthcare
Bowhead Specialty Underwriters



Aaron Lundberg, MSW
President and CEO
Praesidium



Jaimee Kass
Complex Claims Examiner
Transatlantic Reinsurance Company



Bonnita (Bonnie) Boone
CEO and Founder
Pro Vista Risk Consulting
MODERATOR



Sharon Scheuermann
Senior Vice President
Risk Strategies
MODERATOR

The incidence and severity of SAM claims have increased significantly. Several states, including New York, have enacted legislation to extend or eliminate the statutes of limitations for filing a SAM claim. Join our panelists as they discuss the impact and prevalence of SAM claims and how it has evolved over the past 5-10 years, understand how SAM is underwritten and priced, and how organizations can manage SAM risk.

10:40-11:30 Emerging Role of the Risk Manager in Senior Living



Rhonda DeMeno, RN, BS, MPM, A-IPC, CPHRM
Senior Vice President Risk Services - Senior Living Center of Excellence
WTW

Since the establishment of the American Society of Health Care Risk Management in 1980, risk managers have focused on implementing safe and effective care practices, preserving financial resources, and maintaining safe working environments for health care. In today's senior living industry, resident health care need have become a priority. Join Rhonda during this session where she will identify the top 5 risk in senior living, describe differing levels of care and risk management mitigation techniques for senior living, and breakdown a senior living claim study to determine emerging claim trends.

Program Agenda (continued)

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

MID-MORNING BREAKOUT SESSIONS

11:40-12:30 Mitigating Damages: Strategies and New Challenges



Caryn Lilling, Esq.
Partner
Mauro Lilling Naparty LLP



Adam Bobkin, Esq.
Partner
Mauro Lilling Naparty

With the rise in jury verdicts nationally and many in the industry now recognizing the effects of social inflation which have led to nuclear verdicts, understanding all the possible avenues to defend against inflated damages claims has never been more important. Join Caryn and Adam as they describe practical strategies for defending damages in medical malpractice and general liability cases for any type of injury in New York, and also address relevant legal hurdles.

11:40-12:30 Building Trust with Patients: Moving from Noncompliance to Health Literacy



Robin Webster, MHA BSN, RN, CPHRM, CPPS



Dana Taylor, MHA, CPHRM, CPPS
Senior Risk Consultant
Coverys

When patients fail to follow treatment advice, health care professionals often label patients as non-compliant. In this presentation, Robin and Dana will describe how labeling patients as non-compliant can lead to bias, describe four (4) high-risk literacy situations, and identify literacy themes found in claims data.

12:30-1:30 LUNCH BREAK

1:30-1:45 Annual Business Meeting / ASHRM Update

Annual election results, ASHRM Updates, and other chapter announcements.

1:45-1:50 BREAK & TRANSITION TO AFTERNOON BREAKOUT SESSIONS

AFTERNOON BREAKOUT SESSIONS

1:50-2:40 The Vital Role of Onboarding Education for Healthcare Risk Professionals



Robin Lynch, MSN, RN, CHSE, CPPS, CPHFH
Manager, Quality, Risk, and Patient Safety
Med-IQ

In a 2022 poll of 114 risk professionals at ASHRM, 75% reported they did not have an orientation specific to risk management. These results demonstrate the unmet educational needs of novice risk professionals. Join Robin as she describes the current state of risk management onboarding education, outline the benefits of active, immersive learning in the new hire education, and identify opportunities to create immersive learning experiences at their respective healthcare organizations.

1:50-2:40 How to Maximize Privilege Protections under the Patient Safety Act



Michael R. Callahan
Senior Consultant
Hardenbergh Group



Tina H. Weinstein, Esq.
Vice President Risk and
Loss Prevention
Montefiore Einstein



Abbi Schenkel
Director, Risk Management
Montefiore Medical Center

This presentation will provide an overview of the Patient Safety and Quality Improvement Act of 2005 (PSA) as well as to educate attendees on how to maximize the privilege protections under the PSA. The presenters will discuss with attendees, whose organizations are a member of a PSO, how to amend their current patient safety evaluation policies in order to expand their protections over additional patient safety activities, how to be better prepared to assert the privilege protections when faced with discovery demands for PSWP, and how to compare and distinguish the privilege protection differences between New York laws and the Patient Safety Act.

Program Agenda (continued)

2:40-2:50 BREAK & TRANSITION TO PLENARY SESSION

2:50-3:40 Views from the Bench and Litigators on Medical Malpractice Trends



Hon. Lewis J. Lubell, J.S.C.
Supreme Court of the State
of New York, Westchester County



Besty D. Baydala, Esq.
Partner
Kaufman Borgeest & Ryan



Christopher DiGiacinto, Esq.
Partner
Kaufman Borgeest & Ryan

This final presentation will wrap up the educational program and will focus on the current state of medical malpractice litigation in New York with an emphasis on resolution through mediation, and recent trends in trials from the perspective of a sitting Supreme Court Justice and medical malpractice litigators.

3:40-4:00 WRAP UP AND CLOSING REMARKS

4:00 - 6:30 PM
NETWORKING RECEPTION



TICKET PRICES

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

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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.

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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

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PARKING

Parking is available through MPG Parking at Pier 57. A 10% parking discount is available when booking online or on their APP. Enter code Wine 23 to apply discount.

AHRMNY Full-Day Annual Educational Conference
Friday, June 6, 2025 - 8:30 am - 4:00 pm
City Winery New York

First Name	Last Name	Title	Company
Sheeba	Abraham	Associate Director, Risk Management	Elmhurst Hospital
Michelle	Acosta	Partner	Fumuso Christesen
Mark	Alexander	Director, Risk Management	Montefiore Medical Center
Chitra	Anbalagan	Senior Resolution Specialist	Gallagher Bassett
Nicholas	Anderson		The Doctors Company
Jenelle	Arnao	Senior Risk Consultant	Coverys
Philip	Artusa	Partner	Kaufman Borgeest & Ryan
Paul J.	Baisley	Ret NYS Supreme Court Justice / Hearing Officer	NAM (National Arbitration and Mediation)
Hugo	Basso	Partner	Fumuso Christesen
Betsy	Baydala	Partner	Kaufman Borgeest & Ryan
Noah	Becker	Director, Risk Management	NYC H+H/Elmhurst
Melissa	Bedward	Clinical Risk Manager	Mercy Hospital Catholic Health
Joseph	Bisch	Partner	Barbiero Bisch O'Connor & Commander
Jillian	Blair	Associate Director, Risk Management	Gotham Health / NYC Health & Hospitals
Suzanne	Blundi	President	MMC Risk Consultants
Adam	Bobkin	Partner	Mauro Lilling Naparty
Mary	Boland	Complex Claims Examiner	FAIRCO
Bonnie	Boone	CEO and Founder	Pro Vista Risk Consulting
Kimberly	Bossert	Claims Manager	Sedgwick
Michael	Brendel	VP Professional Liability	Sedgwick
Steve	Brooks	Assistant Director, Risk Management	NYC H+H/Kings County
Franz	Bruno	Supervisor, Claims & Litigation	Summit Health
Colleen	Buckley	Partner	Shaub Ahmuty Citrin & Spratt
David	Burke	Sr. Director, Business Development	Coverys
Joseph (Joe)	Calcagno	Head of Healthcare	Bowhead Speciality Underwriters
Michael	Callahan	Senior Consultant	Hardenbergh Group
Courtney	Camacho	Clinical Risk Specialist	MCIC Vermont
Steph	Campbell	Partner	Schiavetti Corgan
Kathy	Castillo	Senior Account Executive	NAM (National Arbitration and Mediation)
Valoree	Celona	Chief Underwriting Officer	Coverys
Cindy	Chau	Associate	Schiavetti Corgan
Danielle	Chin	Partner	Shaub Ahmuty Citrin & Spratt
Jill	Chopra	Risk Management Coordinator	Stony Brook University Hospital
Bryanna	Corbett	Associate	Rubin Paterniti Gonzalez Rizzo Kaufman
Karen	Corbett	Partner	Martin Clearwater & Bell
Dan	Corcoran	Founder and CEO	SafeQual
Michael	Coulston	Deputy General Counsel & EMR, Chief Risk Officer	Hospital for Special Surgery
Andrea	Crawford	Assoc Exec Director, Risk Management	NYC H+H/Queens
Angela	Criscuolo	Associate	Rubin Paterniti Gonzalez Rizzo Kaufman
Joan	Cutrone	Clinical Project Manager	NYU Langone Health
Timmery	Davis	Partner	Wilson Elser
Teresa	Dececco	Business Development Leader	Coverys
Anthony	DellaCroce	SVP & Northeast Healthcare Practice Leader	HUB Interntional
Rhonda	DeMeno	SVP, Risk Services, Senior Living Center of Excellence	WTW
Gabrielle	DeYoung	Partner	Heidell Pittoni Murphy & Bach
Arthur M.	Diamond	JSC (Ret)	NYS Supreme Court-Nassau County
Chris	DiGiacinto	Partner	Kaufman Borgeest & Ryan
Erika	DiMarco	Associate Director, Risk Management	NYC H+H/Kings County
Marianna	Dimoski	Director	EmPRO Insurance
Kathleen	Divers	Consultant	MedPro Group
Ida	Doctor	Associate Director, Risk Management	Jacobi Hospital
Doreen	Dufficy	Partner	Barbiero Bisch O'Connor & Commander
Jayne	Eurell	Risk Manager	Paragon Management SNF
Jennifer	Evans	Underwriting Assistant	EmPRO Insurance
Rosemarie	Farrell	Director, Risk Management	Episcopal Health System
Stacey	Fitzmaurice	Partner	Ellenberg Gannon Henninger & Fitzmaurice
Kathleen	Fowler	Director, Risk Management	Hospital for Special Surgery
Ken	Fox	Partner	Lewis Brisbois Bisgaard & Smith
Delores	Frazier	RN	Lota Chi Chapter

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Mamie	Fulgieri	Partner	Barker Patterson Nichols
Kristin	Fusco	Claims Consultant-Northeast & NY	MedPro Group
David	Gannon	Partner	Ellenberg Gannon Henninger & Fitzmaurice
Colin	Garry	VP, Associate General Counsel & Chief Litigation Counsel	Memorial Sloan Kettering Cancer Center
Paul	Gazso	Vice President, National Healthcare Practice	Risk Strategies
Lora	Giacomoni	VP, Quality	Northwell Health
Mario	Giannettino	Partner	Kaufman Borgeest & Ryan
Lesli	Giglio	SVP, Chief Risk Officer & Chief Privacy Officer	Catholic Health
Alejandra	Gil	Partner	Heidell Pittoni Murphy & Bach
Eric	Gingold	Partner	Heidell Pittoni Murphy & Bach
Pamela	Gleit	Attorney	Barbiero Bisch O'Connor & Commander
Melissa	Goldberg	Partner	Abrams Fensterman
Pamela	Goldsmith	Partner	Harris Beach Murtha Cullina
Lisa	Goldstein	Partner	McAloon & Friedman
Jessica	Greguski	Claims Counsel	Northwell Health
Barbara	Groshans	AVP	EmPRO Insurance
Jose	Guzman	VP & Director of Risk Management	Hudson Insurance Company
Sari	Havia	Partner	Shaub Ahmuty Citrin & Spratt
Arpita	Hazra	Clinical Patient Safety Data Specialist	Healthcare Risk Advisors
John	Henninger	Partner	Ellenberg Gannon Henninger & Fitzmaurice
Lori	Herling	Risk Management Director	Stony Brook University Hospital
Jennifer	Higgins	Partner	Abrams Fensterman
Denise	Holzka	Partner	Heidell Pittoni Murphy & Bach
Grace	Hong	Senior Resolution Specialist	Gallagher Bassett
Josephine	Hua	Clinical Patient Safety Database Administrator	Healthcare Risk Advisors
Josh	Hyatt	Director of Consulting, Healthcare	Praesidium
Jaby	Jacob	Vice President	EmPRO Insurance
Jayne	Jahre	Partner	McAloon & Friedman
Marcy	Jean-Baptiste	Associate Director, Patient Safety	MCIC Vermont
Mary	Jordan	Healthcare Liability Nurse Consultant	Gallagher Bassett
Brayden	Kaiser	Sales Executive	SafeQual
Michelle	Kaplan	Risk and Claims Manager	Montefiore Medical Center
Stephanie	Kaplan	Associate	Kaufman Borgeest & Ryan
Deborah	Karlewicz	Risk and Claims Manager	Montefiore Medical Center
Jaimee	Kass	Complex Claims Examiner	Transatlantic Reinsurance Company
Stefanie	Kaye	Claims Supervisor	EmPRO Insurance
Shawn	Kelly	Partner	Kelly, Rode & Kelly
Victor	Klein, MD	System Director, Quality & Patient Safety	Northwell Health
Karen	Kobus	VP, Professional Affairs	Maimonides Medical Center
Peter	Kolbert	SVP, Claim and Litigation Services	Healthcare Risk Advisors, The Doctors Company
Gayle	Kolt	Director, Risk Management and Regulatory Affairs	NYC H+H/Jacobi North Central Bronx
Loretta	Krez	Partner	Kaufman Borgeest & Ryan
Michael	La Pinta	Associate	Rubin Paterniti Gonzalez Rizzo Kaufman
Cristina	LaMarca	AVP, Risk Management	Hospital for Special Surgery
Meredith	Lander	Senior Associate	Schiavetti Corgan
John	Levis		J.C. Levis and Associates
Dawn	Lewis	Senior Vice President	EmPRO Insurance
Caryn	Lilling	Partner	Mauro Lilling Naparty
Alexandra	Lopes	Partner	Heidell Pittoni Murphy & Bach
Kathy	Lospinuso	Director, Risk Management	NYC H+H / Jacobi
Lewis	Lubell	JSC	NYS Supreme Court-Westchester County
Janine	Luckie	Partner	Kaufman Borgeest & Ryan
Aaron	Lundberg	President and CEO	Praesidium
Lauren	Lundquist	Senior Litigation Counsel	Kaufman Borgeest & Ryan
Robin	Lynch	Manager, Quality, Risk & Patient Safety	Med-IQ
Jacqueline	Mandell	Partner	Kaufman Borgeest & Ryan
Jack	Manzi	Account Manager	Risk Strategies
Pamela	Margolin	Associate General Counsel	Memorial Sloan Kettering Cancer Center
Robert	Martin	Of Counsel	London Fischer
Marisol	Martin	Assistant Director	EmPRO Insurance

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Rosemary	Martinson	Partner	Barker Patterson Nichols
Olga	Mavashev	Account Executive	The Hilb Group of NJ
Lisa	McCorkle	Senior Patient Safety Risk Manager	The Doctors Company
Joyce	McCormack	Senior Risk Management Consultant	MLMIC Insurance Company
Stephanie	McDougall	Of Counsel	Shaub Ahmuty Citrin & Spratt
Michele	McEnroe	Of Counsel	Shaub Ahmuty Citrin & Spratt
Andrea	McHugh	AVP, Specialty Claims	Gallagher Bassett
Jeff	McQuilliams	President	SafeQual
Brendan	McSweeney	Claims Management Counsel	Northwell Health
Sam	Mezzich	President, Coverys Specialty Insurance Company	Coverys
Michael	Milchan	Partner	Barker Patterson Nichols
Carolyn	Miranda	Healthcare Liability Nurse Consultant	Gallagher Bassett
Deanna	Mirro Altmann	Risk Management Consultant	MLMIC Insurance Company
Andrea	Mokrzycki	Director	EmPRO Insurance
Pamela	Monastero		
Jennifer	Morency	Clinical Patient Safety Analyst	Healthcare Risk Advisors
Yuko	Nakahara	Partner	Martin Clearwater & Bell
Christine	Nash	Claims Consultant	Gallagher Bassett
Ruth	Nayko	RM Patient Safety Professional	
Christina	Nunn	Partner	McAloon & Friedman
Wilhemina	Nyarko	Senior Director, Risk Management	The Brooklyn Hospital Center
Patricia	Pantalena	Claims Examiner	TransRe
Andrea	Patram	Director, Risk Management	Healthcare Risk Advisors
Tammi	Perosi	Nurse Navigator	Bon Secours Charity
Melissa	Perosi	Regional Risk Manager	AdvantageCare Physicians
Dawn	Pignatelli	Partner	Bartlett LLP
Rachel	Place	Associate	Schiavetti Corgan
Bonnie	Portnoy	VP, Risk Management & Patient Safety	Mount Sinai Hospital
Matthew	Prisco	Partner	McAloon & Friedman
Annemarie	Provencher	Senior Risk Specialist	Coverys
Jennifer	Puglisi	Partner	Kaufman Borgeest & Ryan
Christine	Quinn	VP & Chief Risk Officer	EmPRO Insurance
Alvin	Quitiquit		Hackensack Meridian Health Network
Christina	Reinle	Partner	Heidell Pittoni Murphy & Bach
Susan	Roberts	Chief Legal Counsel	Hackensack Meridian Health Network
Cynthia	Robinson	Partner	Heidell Pittoni Murphy & Bach
Christine	Rockwell	Partner	Kaufman Borgeest & Ryan
Jonathan	Rubin	Partner	Kaufman Borgeest & Ryan
Steven	Rubin	Partner	Rubin Paterniti Gonzalez Rizzo Kaufman
Karen	Ryan	Partner	Schiavetti Corgan
Christine	Samuels	Vice President, Medical Professional Claims	Berkley Healthcare
Laurah	Samuels	Assistant General Counsel	Memorial Sloan Kettering Cancer Center
Charles	Schechter	Partner	Martin Clearwater & Bell
Abbi	Schenkel	Director, Risk Management	Montefiore Medical Center
Sharon	Scheuermann	Senior Vice President	Risk Strategies
Alyssa	Schiffhauer	Senior Litigation Counsel	Kaufman Borgeest & Ryan
Kayla	Schmidt	Associate	Rubin Paterniti Gonzalez Rizzo Kaufman
Shanti	Sebak	Risk Manager	NYU Langone Health
Lori	Shapiro		
Deeba	Siddiqui	SVP, Chief Risk Officer	Hackensack Meridian Health Network
Alexander	Sikoscow	Partner	Kaufman Borgeest & Ryan
Gene	Sobol	Director, Performance Improvement	Maimonides Health
Claudia	Solis	Associate Director	MCIC Vermont
Carol	St. Pierre	Nurse Navigator, Nursing Clinical Coordinator	Mount Sinai Hospital
Erin	Stalzer	Partner	Shaub Ahmuty Citrin & Spratt
Mary	Steffany	Healthcare Risk Consultant	
Kathryn	Sullivan	Partner	Kaufman Borgeest & Ryan
Peggy	Sullivan	Regional Risk Manager	AdvantageCare Physicians
Marie	Tabuzo-Quizon	Clinical Patient Safety Analyst	Healthcare Risk Advisors
Linda	Tallaksen	AVP, Risk Management	AdvantageCare Physicians
Dana	Taylor	Senior Risk Consultant	Coverys
Michelle	Tepper	Director, Forensic Nursing & Family Violence Prevention	Stony Brook University Hospital
Francine	Thomas	AVP, Risk Management	Hudson Insurance Company

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Henry	Tilson	Associate	Kaufman Borgeest & Ryan
Florence	Ulysse	Risk Manager	White Plains Hospital
Shelise	Valentine	Director of Clincial Education	Healthcare Risk Advisors
David	Verschell	Partner	Abrams Fensterman
Suzanne	Vick	Associate Director, Risk Management	NYC H+H / Elmhurst Hospital
Suhlail	Villa	Partner	Schiavetti Corgan
Robin	Webster	MHA BSN RN CPHRM CPPS	
Steve	Weiner	Partner	Kaufman Borgeest & Ryan
Tina	Weinstein	VP, Risk and Loss Prevention	Montefiore Einstein
Rosemarie	White	Senior Director, Risk Management	CareMount Health Solutions
Tiffany	Wickes-DeMillio	AVP, Safety and High Reliability	Catholic Health
Carolyn Reinach	Wolf	Exec Partner - Director, Mental Health Law Practice	Abrams Fensterman