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

The Risk Management Quarterly

SUMMER 2012

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PRESIDENT'S MESSAGE

Dear Members:

The Board of Directors wishes to take this opportunity to wish everyone a great summer. We enter the 2012–2013 membership year with a highly successful June conference, a new venue for our conferences, as well as a record high membership of 310.

If you haven't yet (re)registered for your membership, please take the time to register/renew your AHRMNY membership. We are continuing to offer several "specials". In addition to our regular membership available for $100 a year, AHRMNY offers an organizational discount of $250 for three members all from the same company. We are continuing the ECONOMIC STIMULUS PROGRAM in which any current member who successfully refers two new members will receive a complimentary extension of their individual membership for one additional year. At our June conference we welcomed our first two student members. Student memberships are available at half price. More information is available on our membership tab. (http://ahrmny.com/register.php)

I am happy and proud to be serving as President of this wonderful organization and wish to thank you for electing me. I look forward to working with the Board of Directors as well as all of the members to continue advancing the organization's goals. We are hoping to explore a mechanism for bringing New York upstate risk management professionals into our organization. We will continue to search for appropriate ways to make our voices heard in terms of advocacy and will continue to present outstanding educational sessions.

We have tentatively chosen September 28, 2012 for our fall webinar. At our December 2011 half day conference, the topic of the reprocessing of single use devices generated much commentary and discussion in the days following the presentation. Madelyn S. Quattrone, Esq**.** from ECRI will present a follow up discussion by webinar on ECRI's experiences with respect to this topic. More information will follow.

This year, the Annual ASHRM conference will be on October 7th – 10th at the Gaylord National Resort and Convention Center located in National Harbor MD (the outskirts of Washington DC). This conference is always well attended by ASHRM members from NY State. The AHRMNY cocktail reception has become an annual tradition and will be held on Tuesday, October 9th, 5:30-7:30 PM. See page 12 for details and special flyer arriving via email.

We encourage you to share your talents by actively participating on any of the following working committees: Bylaws, Education, Finance, Membership, Nominating, Publications, or Public Relations. If any of these areas interest you we welcome your expertise and encourage you to join and help us our organization achieve its goals and mission of enhancing healthcare risk management and patient safety.

Best wishes

Alvin J. Safran
President
July 1, 2012-June 30, 2013

EDITOR'S CORNER

The Risk Management Quarterly (RMQ), the official journal of the Association for Healthcare Risk Management of New York, Inc. is published four times a year.

RMQ's Mission Statement: To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This journal contains articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulations, as well as other relevant information of interest to risk managers. The articles are usually written by ***AHRMNY*** members, so the journal serves as an opportunity for members to showcase their writing talents.

For the official ***RMQ*** Author Guidelines visit our website http://www.ahrmny.com

Reminder:

Maximum article length 3,500 words

Photo requirements: (high resolution JPEGs – at least 300 dpi)

AHRMNY will not publish those articles promoting products or services

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The information presented in
THE RISK MANAGEMENT QUARTERLY
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WE WANT TO HEAR FROM YOU FOR THE FALL AND WINTER EDITIONS

We are asking our readers to submit articles for the fall and winter editions of the ***RMQ*** that focus on patient safety, environmental safety, current legal and insurance issues and other relevant topics.

RMQ is published four times a year with a distribution of approximately 300 copies per quarter. Please forward any ideas or submissions for publication in the ***RMQ*** to "**Editors"**, via email with attachments to: ahrm@optimum.net

The deadline for submission and consideration for the next journal is **October 3, 2012**.

AHRMNY is celebrating 30 years of providing committed service to Healthcare Risk Management and Patient Safety in New York!

Our custom made banner will be displayed at all of our upcoming programs in 2012.

AHRMNY

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



AHRMNY was founded in 1982 and became officially incorporated on March 5, 1985.

INOCULATING YOUR RESPECTIVE ENTITIES AGAINST THE DANGERS OF UNPAID INTERNSHIPS

By Paul J. Siegel, Ana C. Shields and Adam Guttell

Designating an individual as an "intern" or "trainee" or "volunteer" does not necessarily alleviate the duty to pay minimum wage and, if applicable, overtime or spread of hours pay for days in excess of 10 hours (regardless of time actually worked) – it's just a job title after all. Analyzing who is not truly an employee is essential, especially as Summer months approach and the "hiring" of "interns" begins. This analysis is essential in the context of educational programs that train and place nurses, nurses' aides, physical therapists, and physicians in hospitals or private medical facilities which require internships as part of the curriculum. This article is intended as a guideline for risk managers to evaluate compliance with federal and state labor laws.

A. Federal Criteria

The federal Fair Labor Standards Act (FLSA) defines an employee broadly as "any individual employed by an employer," who it "suffers or permits to work." In 1947, the U.S. Supreme Court held that the FLSA's seemingly limitless definition does not make employees of all persons who, without any express or implied compensation agreement, may work for their own advantage on the premises of another[1]. This exclusion from employee status applies to interns who receive training for their own educational benefit but only if the training meets the following six stringent criteria: (1) The internship, even though it includes actual operation of the facilities of the employer, is similar to training that would be given in an educational environment; (2) The internship is for the benefit of the intern; (3) The intern does not displace a regular employee, but works under close observation of existing staff; (4) The employer that provides the training derives no immediate advantage from the activities of the intern and, on occasion, the employer's operations may actually be impeded; (5) The intern is not necessarily entitled to a job at the completion of the internship; and, (6) The employer and the intern understand that the intern is not entitled to wages for the time spent in the internship.[2]

The U.S. Department of Labor has applied these factors to evaluate the employment status of interns. Thus, for example, unless a hospital, long term care facility or other entity truly derives no immediate advantage from the activities of the intern, he or she is, more likely than not, an employee.

B. New York Criteria

The standard to determine whether an intern, volunteer or trainee is an employee varies depending upon the manner in which the entity is organized.

i. "For-Profit" Entities.

In the case of "for-profit" employers the New York State Department of Labor adopted the same six requirements noted above and then added five additional criteria that an employer must fulfill to establish a true internship.[3] The additional criteria considered are: (1) Clinical training must be performed under the supervision and direction of individuals knowledgeable in the activity; (2) The intern must receive no employee benefits, such as healthcare or discounts; (3) Any training provided should focus upon the intern's field of study, not the healthcare entity's needs or operations; (4) The interview or selection process for the intern should not consider the same factors considered when hiring employees. It should only consider whether the educational purpose is met; and, (5) Advertisements for the position must identify educational and training opportunities, not employment.[4] It is the *entity's burden* to maintain proper records to uphold its classification of the relationship as an internship.

ii. "Not-For-Profit" Entities.

Certain "not-for-profits" workers are exempt from minimum wage requirements under New York Law as set forth below.[5]

1. Volunteers. Volunteers *may* be unpaid, if the organization operates strictly for charitable, educational or religious purposes and meets the following criteria: (1) The volunteer does not replace or supplement paid staff; (2) The volunteer only performs the type of work reserved for volunteers;(3) The volunteer is not required to have set hours; (4) The volunteer is not required to perform involuntary work, *i.e.* he or she may decline specific tasks or assignments without losing the opportunity to continue to volunteer for the organization; (5) The volunteer cannot have a written contract; and (6) The volunteer cannot be paid for their services.

2. Students. Students *may* be unpaid, if working for a charitable, educational, or religious organization and they simultaneously attend an institution of learning working towards a degree and are completing residence requirements for the degree, such as medical students. In these circumstances, the organization must maintain a file that contains the student classification, start date, nature of work performed, and a statement from the student's school attesting that the student is working towards a degree or completing a residency requirement.

3. Trainees. Trainees *may* be unpaid, if it is for a charitable, educational, or religious organization and it includes formal instruction and on-the-job training. The trainee must have limited responsibility and be under another's supervision. The training may only last two to ten weeks.

C. Limiting Potential Exposure And Making A Good Faith Effort To Comply.

An employer who misclassifies an employee as an unpaid intern, volunteer, student or trainee may be liable for back pay, liquidated (double) damages, attorneys' fees and costs. The propensity for such claims to be brought on a class-wide basis substantially increases exposure. New York employers are at an even greater risk given the six year statute of limitations. To limit exposure, payroll practices immediately should be audited to determine whether interns, volunteers, students or trainees have been properly designated as such under New York and Federal law. Consider retaining counsel to conduct the audit to ensure the information obtained is privileged. If necessary the privilege later can be waived to demonstrate that the entity made efforts to comply. Demonstrating efforts of compliance will, in and of itself, reduce exposure. Employers who demonstrate efforts to comply can avoid liquidated damages, reduce the applicable statute of limitations under the FLSA and invoke a complete defense, the good faith defense, under Section 259 of the Portal to Portal Act. To the extent such positions are to remain unpaid, programs should be developed to satisfy the criteria identified above.

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[1] *Walling v. Portland Terminal Co*., 330 U.S. 148 (1947).
[2] See U.S. Department of Labor Fact Sheet #71.
[3] See New York State Department of Labor Fact Sheet P725(4/11).
[4] Id.
[5] See New York State Department of Labor Fact Sheet P726(6/11).

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SPONSOR ACKNOWLEDGMENT

AHRMNY would like to thank the following firms for their generous support in sponsoring all of our educational programs during the membership period of July 1, 2011-June 30, 2012

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THE SECOND VICTIM

By Bonnie Portnoy

Those that enter the healthcare field knowingly put themselves into situations that are likely to be emotionally charged and stressful during their career. Decisions are made on a dime that can have catastrophic results if not the right decision; not only to the patient and family members, but to the provider and the entire health care team. The impact can be felt by the young and new providers, as well as by the older more experienced and seasoned provider. Without immediate support and intervention, the recovery of the provider and a potential career could be at stake.

"National patient safety and quality movements in health care recognize the emotional impact that medical errors and unanticipated outcomes have on patients, families, and clinicians".[1] The IOM report, To Err Is Human, estimated that 98,000 people die from medical errors each year. The Institute for Healthcare Improvement's 5 Million Lives Campaign went even further, and calculated that there are approximately 15 million adverse medical events each year, 6 million of which cause harm to the patient resulting in a significant deviation in the patient care process.[2]

In the hospital setting, this conservatively translates to 12 million health care providers and 12 million affected family members who are emotionally impacted each year.[3] Despite the large number of patients, families, and health care providers affected, only a small number of systems have been set up that address the emotional impact of these events.[4]

The emotional response of the provider was first described in the literature by Albert Wu as the "second victim" phenomenon.[5] Wu noted "…although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the "second victims".[6] Additionally, Scott describes a "second victim" as a health care provider involved in a medical error, an unanticipated adverse patient event, and/or a patient-related injury who becomes victimized in the sense that the provider is traumatized by the event. Second victims frequently feel personally responsible for these unexpected patient outcomes and feel they have failed their patients, second-guessing their clinical skills and knowledge base.[7]

Scott et al. in their study to understand the phenomenon of the "second victim", which was done in order to design and test supportive interventions, found that the participants developed their own ways of coping, yet all described a predictable recovery trajectory.[8] The six stages were identified and named as follows: (1) chaos and accident response, (2) intrusive reflections, (3) restoring personal integrity, (4) enduring the inquisition, (5) obtaining emotional first aid and (6) moving on.[9] They can be loosely compared to the stages of grieving, with the effects analogous to post traumatic stress disorder. The literature further describes provider's feelings of shame, anger, self-doubt, depression and guilt among many other feelings of inadequacy. These effects may be long lasting, with some physicians feeling "permanently wounded" as a result.[10] The feeling of responsibility for a serious medical error enters a vicious cycle by provoking burnout, depression and reduced empathy, which in turn can result in suboptimal patient care and higher odds for future errors.[11]

While institutions do not have a legal obligation to offer support to the "second victim", an ethical obligation exists. Many studies show that health care providers struggle to find support to help them cope with the myriad of emotions that exist, and in many instances found the issues were not addressed at all. The available studies suggest that physicians involved in errors usually do not feel supported in coping with this experience by the institutions they work in. At best, many report that support is random and dependent on the others involved in that event.

Wu et al. reports that nearly a third of surveyed house officers indicated that "the hospital atmosphere inhibited them from talking about the mistakes" and 20% reported that the "administration was judgmental about the mistakes".[12] In another published study 90% of surveyed physicians disagreed that health care organizations lend adequate support in coping with stress associated with medical errors (37% disagreed strongly).[13] We treat our clinicians who are involved in human error and system failures with both blame and shame, and, what may be most harmful, abandonment.[14]

We are taught to aim for perfection, which makes it difficult to admit mistake, and thus ask for assistance when one occurs. It has long been the culture to remain silent about errors, which has not allowed us to provide the compassion and support which is essential. Providers are afraid to reach out for fear of litigation and not being sure what is appropriate to discuss and with whom. We often investigate the events in silos, not sharing our pertinent findings, again hindering the support we provide our "second victim", as well as hindering our efforts to learn from our mistakes and thus improve patient safety. Only recently has begun to shift the culture from the name and blame game to one of transparency, which will ultimately improve the care that we give our patients and our care providers. The traditional way that errors have been discussed in institutions is through Mortality and Morbidity (M&M) conferences. This forum allows discussion of the event and error(s) and integrates them into clinical practice and "best practices" for patient safety and outcomes.[15] However

in actual practice, these forums have been found to be an ineffective mechanism to support the "second victim." Current data shows that M&M conferences are insufficiently used to establish a learning and supportive environment for staff involved in errors.[16]

Providing de-briefing for all providers involved, including those who are directly and indirectly involved, when going through the above described six stages can help mitigate some of the gossip, self-doubt and self-loathing that are exhibited. However, while physicians report communication and interaction with colleagues or supervisors as most helpful to deal with the emotional distress after error involvement, affected individuals often struggle to find support.[17] With well-established systems and practices in place, the question of who the "second victim" can go to in order to get support is no longer of issue. The isolation that is often felt by the "second victim" can also be alleviated with adequate support systems; knowing that they are not alone can help ease them through the remaining stages.

When talking about patient safety, and specifically medication safety, we implore our providers to adhere to "The Five Rights": the right patient, the right drug, the right time, the right dose and the right route. Denham has adopted that concept and proposed "The Five Rights of the Second Victim".[18] They are the five human rights that our health care leaders must consider as an integral part of a fair and just culture when patients are harmed during the process of care; TRUST (Treatment that is just, Respect, Understanding and compassion, Supportive Care, and Transparency and the opportunity to contribute to learning).[19] In summary, Denham's concepts are:

> **Treatment that is just**: to provide the compassion and caring that we provide to our patients. In a ''Just Culture,'' a non-punitive approach of just treatment is adopted that can lead to improving the system that allowed the error to occur. **Respect**: Nurses, pharmacists, and all members of the health care team are susceptible to error and vulnerable to its fallout. In the immediate period after an event, it is second nature to fall into a name-blame-shame cycle, often denying our colleagues even the most basic elements of respect and common decency. We must practice ''the golden rule'' and treat our colleagues with the same respect we would expect. Leaders must encourage their organizations to respect those involved in an event. **Understanding and Compassion:** The instant preventable and unintentional harm occurs to a patient, their caregivers become patients. The caregiver needs time and compassionate help to be able to grieve; to go through the stages articulated by Kubler Ross: denial, anger, bargaining, depression, and acceptance. Leadership must understand the pathophysiology of psychological emergency that occurs when a caregiver unintentionally harms a patient. They must reach out to the second victims with the very compassion that they espouse or seek to deliver to their own patients. **Supportive Care:** Our caregivers are entitled to psychological and support services and we must take a systematic approach to delivering this care in as professional and organized way as we would in treating any other patient. **Transparency and the Opportunity to Contribute:** Improving patient safety hinges on the ability of health care providers to accurately identify, disclose, and report medical errors. We need to allow workers the opportunity to "make things right" when their behavior has contributed to unintentional harm.[20]

Interventions should be established as soon as possible, and the existence of support program/ services should be widely publicized. Clinicians should be part of the response to the event. The response effort should also be tailored to the specific institution- some types of programs might work better in some institutions than others. In addition, specific programs (peer support, employee assistance programs or counseling) for specific sectors of the work force might prove useful.[21] No program will be successful unless there is support by senior leadership (the C-suite). Noted are the comparisons of the "Five Patient Rights" to the "Five Rights of the Caregiver". A program can be developed similar to a Rapid Response Team (RRT) for rescuing a patient to a Rapid Response System (RRS) for rescuing the "second victim".[22] The typical RRT is a group of dedicated, experienced professionals charged with responding to the acute clinical deterioration of a patient rapidly. The RRS in turn would be a dedicated team with knowledge and experience in supporting clinicians during the acute stages following the event.[23]

The University of Missouri Health Care System undertook the task of putting together a RRS. It began in earnest in 2006 where an inter-professional team started to review the literature surrounding the "second victim". They also looked at other support programs that were in existence- The Medical Induced Trauma Support Services (MITSS) and the Critical Incident Stress Management (CISM). A qualitative study of health care providers (small sample size of 31) was then conducted from October 2007-January 2008. Interviews were designed to understand the experience of the "second victim" and to learn what interventions these providers felt would be most beneficial in their recovery.[24]

The second stage of their research was much broader, including 5300 faculty and staff, using a Web-based survey. The survey consisted of four demographic questions and three "yes/no" items to quantify knowledge of the term "second victim" prior experience as a "second victim", and institutional support received.[25] The next two items focused on recent personal experience and support received. The final item was an open-ended text box for the participant to recommend supportive strategies that he or she believed would promote healing and to record what he or she desired from the organization.[26] More than one third of those who responded had heard

of the term "second victim", and one third responded that they were "second victims".[27] Approximately 15% reported seriously thinking about leaving the profession as a result of the event, and 65% reported working the issues out on their own.[28] When it was offered, 35% reported receiving support from colleagues and peers, and 29% received support from supervisory personnel.[29] Eight themes were identified to describe the characteristics of the programs to aid the "second victim". The most frequently cited characteristic was to provide support immediately after the event in a place away from the event (somewhere in the institution) to allow the "second victim" to re-group. Support was preferred to be at the unit base, departmental level, and should be readily accessible and should be staffed by professional, trained counselors.[30]

Based on these findings, senior leadership supported the implementation on an on-demand RRS for the "second victim".[31] It provided support twenty four hours a day, seven days a week and was activate in March 2009. The model used has a three-tiered approach:

Tier 1 promotes basic emotional first aid at the departmental level. It's that immediate "Are you okay?" response. It was estimated that 60% of "second victims" will receive support at this level.

Tier 2 provides additional guidance and nurturing, and will meet the needs of an additional 30% of "second victims". The support is provided by specially trained peer supporters who are adept at noticing the signs and symptoms suggestive of a "second victim" response and can provide instantaneous one-to – one support. The supporters can also provide debriefings for entire teams if needed.[32]

Tier 3 ensures availability and access to professional counseling support and guidance when the stress of the "second victim" exceeds the expertise of the peer RRS. It is estimated that 10% of "second victims" require escalation to the third tier. Examples of members of the tier 3 team include Employee Assistance program personnel, social workers, clinical psychologists and chaplains. Additionally, support is provided to all the team members, who meet monthly for their own debriefing and mentoring.[33]

As stated above, the University of Missouri Health Care System studied the CISM and MITSS peer support programs that were already in place when developing their own program. These support programs are summarized below as knowledge of these programs in addition to the University of Missouri Health Care System's RRS may be helpful for an organization embarking on establishing their own unique peer support program.

Critical Incident Stress Management (CISM) is an intervention protocol designed for dealing with traumatic events, and is used by aviation and pre-hospital personnel after post traumatic community events.[34] Examples of where it has been used include after the Oklahoma City bombing and the terrorist attacks of September 11, 2001. It was first developed for use with military combat veterans and then first responders, but has been adapted for use in other venues.

Some commonly used techniques are debriefing, which is a proactive intervention involving a group meeting or discussion about a particularly distressing critical incident.[35] The CISD is designed to mitigate the impact of a critical incident and to assist the persons in recovery from the stress associated with the event. Ideally it is conducted–within 24 and 72 hours after the incident. Defusing is an intervention that is a shorter, less formal version of a debriefing.[36] It generally lasts from 30 to 60 minutes and is conducted within one to four hours after a critical incident. Like a debriefing, it is a confidential and voluntary opportunity to learn about stress, share reactions to an incident and vent emotions.[37]

Grief and Loss Session is a structured group or individual session following a death and assists people in understanding their own grief reactions, as well as creating a healthy atmosphere of openness and dialogue around the circumstances of the death.[38] Crisis Management Briefing is a large, homogeneous group intervention used before, during and after crisis to present facts, to facilitate a brief, and to allow for controlled discussion, Q & A and information on stress survival skills and/or other available support services.[39]

Medically Induced Trauma Support Services (MITSS) has provided a predictable support network for patients, families, and clinicians following adverse medical events since 2002.[40] It was founded by Linda K. Kenney to "Support Healing and Restore Hope" to patients, families, and clinicians following adverse medical events. MITSS recognizes that everyone involved in an adverse event needs support. They provide direct support to patients and families as well as individual clinicians from the beginning. As an organization, MITSS has advocated that healthcare institutions build their own infrastructures of support for their staff.[41]

In conclusion, a large portion of the health care workforce continues to suffer in relative silence unsupported after a serious event has occurred. As a society, we are implored to provide a readily accessible and effective support structure for all health care providers beginning the moment that events causing anxiety and stress are discovered, and as long as necessary. These initiatives should be established and disseminated throughout an institution so that providers will know the logistics; what is available, what can be expected, and how to access assistance in the aftermath of clinical events.

As discussed throughout this article, given the profound impact of adverse medical events on clinicians, patients, and their families, it is essential that health care leadership provide appropriate support

to its staff. Errors are most often ultimately the failure of leadership, organizations and systems – not the front line staff.[42] The culture "as is" has expected staff to do no harm and to perform their tasks perfectly 100 percent of the time, which we know is not possible; as we are human. Given that the large majority of errors are due to failures of faulty systems and not bad people, providing support to clinicians and other staff at the sharp end of medical care is simply not just the right thing to do; it's the respectful and compassionate thing to do.[43]

We must establish and nurture a culture of quality and safety that is honest, empathetic, respectful, and forgiving. Health care leaders must play an active role in nurturing a climate of compassion and mutual respect. Front line peers, supervisors and other administrators can be trained to provide support at the time of the event. However, commitment from the top levels of leadership with the needed infrastructure and allocation of necessary resources are key elements of the successful support models that have been described. We must respond promptly and proactively in the event of an error, ensuring that all affected staff members are treated with respect, compassion and support from leaders and their colleagues.[44] Anything less and we have not learned our lessons and have failed our patients, their families and our staff. And our staff is our most valuable asset.

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[13] Schwappach, *supra* note 11
[14] Wu, *supra* note 6
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[16] Schwappach, *supra* note 11
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[33] *Id*
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SAVE THE DATE FOR OUR NEXT WEBINAR

AHRMNY will host a Webinar on Friday, September 28, 2012

Topic: Use of Reprocessed Single-Use Medical Devices

Time: 10am – 11am

Speaker: Madelyn S. Quattrone, Esq.
Senior Risk Management Analyst
ECRI

Registration instructions will be emailed and posted on the AHRMNY website (http://www.ahrmny.com/)

Long-Term and Continuing Care Column; Emerging Health Care Technology Column

The AHRMNY Publications Committee is calling for suggestions or topics of interest for future Long-Term Care and/or Emerging Health care Technology columns. Please email any suggestions to the "Editors" at ahrm@optimum.net



Risky Business

"When Common Sense is Uncommon"

By: Pamela Monastero, MBA

Dear Risk Manager:

This column, which will appear regularly in AHRMNY's Quarterly Journal, is designed to support both the novice and seasoned risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. This column is based on the contributions of our constituent members, to whom we are grateful for sharing their experiences. We continue to encourage our members to submit their experiences anonymously for inclusion in this column. Please e-mail any suggestions to Pamela.monastero@nychhc.org or mail to AHRMNY utilizing the RISKY BUSINESS form which can be found on our website at http://www.ahrmny.com/. The form permits confidentiality.

COMMON SENSE TIPS FOR STAFF:

This quarter's column further explores a subject we touched on in our last newsletter-- human factors and ergonomics. The article[1] presented suggested use of human factors and ergonomic (HFE) specialists,* "who study the interactions between people and elements of the system in which they work (physical environment, tasks, tools/technologies and organizational conditions) and redesign systems while systematically considering all of these interactions with the goal of joint optimization of social and technical elements of a system." After writing the column last quarter, I spent a significant amount of time thinking about HFE and comparing the health care industry with other industries and fields. The lack of significant progress regarding patient safety efforts convinced me that the authors of the HFE article were onto something tangible and easily implemented—that the use of HFE specialists could finally be the key to exponential strides in patient safety.

Specialists are used extensively in other industries for various reasons—efficiency, cost savings, safety analyses, accident investigation, etc. and yet, in the health care industry, we generally do not enlist the assistance of specialists in risk reduction efforts such as failure-mode-effect-analyses (FMEA) or in investigating and analyzing sentinel events during the root cause analysis process (RCA). Usually, we are left to our own devices and literature reviews to analyze systems, reduce risk and problem solve. For those of us who are lucky, at the very least, we have the luxury of obtaining objective third parties review our FMEAs and RCAs to provide fresh, unbiased perspectives on our proposed system fixes.

In illustration, thought is given to other industries and how they use specialists, HFE and otherwise, for quality control, efficiency, problem solving, risk avoidance, profit maximization, etc. For instance, the National Transportation Safety Board (NTSB)[2] uses standardized processes and teams of specialists to investigate accidents. The team responds quickly to the accident site, with the necessary tools in hand and secures the area. They begin their review of operations, structures, power sources, systems, air traffic control, weather conditions, survival factors, etc. The NTSB issue manuals for staff to use as reference tools to standardize investigations and practices. In health care, although we use various tools for investigation of events (e.g. interview questions, checklists, review of policies/procedures, sequestering of devices, equipment and documents, expert physician reviews, expert equipment reviews, etc.), we are not nearly as sophisticated in our approaches. For instance, in cases of unexplained deaths or injuries where the injury is difficult to reconstruct or explain, often the evidence is no longer available to the risk manager for review. An example is the case where, on the third day of admission, a patient (with no previously identified neurological/neurosurgical issues) suffers an inexplicable head bleed with herniation of the brain and expires. It is improbable that the syringes/vials of any medications given over the course of several days, or even immediately preceding the acute event, will be available for inspection to determine if there was a medication error that caused the event. Review of systems would include review of stock medications, Pyxis, medication administration records, policies/procedures, etc. Such a review might not, however, draw the appropriate conclusions as to the who, what, when, where, how and why questions that need to be answered. In a different scenario, had an HFE specialist been engaged pre-event to proactively perform a review of medication safety issues to identify potential problem areas, the results most likely would differ from results obtained via 'home-grown' reviews completed by hospital staff.

Another industry example is retail and marketing. For instance, retailers spend millions of dollars collecting and analyzing data to develop plans for store design, product placement, product selection, etc. There are companies that specialize in reviewing shopper habits (e.g. do most shoppers enter a store and go left or right, do they select items that are eye height or bend, do they prefer to pick items from shelves or hanging racks or bins, where should more expensive items be placed, where should convenience items be placed?, etc.). Two practical examples are e.g. Walgreens, CVS, Rite-Aid type stores and Costco, the warehouse retailer. Retailers such as Walgreens/CVS/Rite-Aid sell pharmaceutical items, various sundries but they also sell food items such as sodas, chips and candy (which for the purposes of this article will be labeled 'convenience items'). The smart retailer places these 'convenience' items in the front of the stores so that when students come in after school, they grab their items and run without disrupting elderly clients who may become easily confused or disrupted by the student activity. Video surveillance demonstrated older patrons becoming frustrated and leaving the store without making their purchases. Redesigning product placement to address this issue amounts to smart retailing. In the example of Costco, the warehouse stores are designed like a racetrack, with fresh food in the back so that customers must make their way around the store, browsing through

other products such as furniture, jewelry and electronics. Compare how this relates to hospitals, which in some cases, were built and renovated piecemeal over time. In many facilities, patients have to shuffle between different departments, floors and buildings, usually with the guidance of somewhat confusing signage that may not be in their native language. Our facilities are not always designed with the end customer in mind--they might be built for aesthetic reasons, for staff convenience, or with no rhyme or reason. Given that, how much time and effort is used to analyze patient movement and flow (not just in terms of emergency department to the floors, or critical care/specialty unit flow/utilization or length of stay, what about ambulatory care, etc.)? Are our architectural designs and materials developed with patient safety and patient convenience in mind? One such example is radiology suites—many are designed for out-patient treatment but in-patients are also treated in this area. Are radiology suites designed and configured to accommodate the most vulnerable in-patients, or are they designed to be aesthetically pleasing to ambulatory patients? Hiring the health care equivalent of an HFE specialist who studies design and flow to have input into new buildings or renovation of existing space would be beneficial.

When reviewing systems such as operating room (OR) set ups for equipment, physician preference trays, procedure trays, sterilization, time-out processes, patient flow, OR time, etc.; imagine the value an HFE specialist could add? Perhaps HFE specialists and independent observers from other industries could solve problems that continue to plague us—wrong side surgery, incorrect procedures, procedures done on the wrong patient, anesthesia and medication mishaps, retained foreign objects, etc.? We have been analyzing these cases for years and have not been able to prevent these unfortunate avoidable events.

Patient identification is another area that could benefit from HFE input. So many of my colleagues in risk management continue to grapple with patient identification related events, including mislabeled specimens and blood, patient transport, procedures done on the wrong patients, etc.. We have nearly exhausted our resources (and our brainpower) analyzing these cases to develop solutions, including mandatory checks of two patient identifiers (which is highly reliant on the human element), bar coding, computerized physician order entry, etc. and we continue to look toward technology-based solutions. While various vendors, innovators and inventors have entered the field and technology has vastly improved, the human element factor still plays a dominant role in patient identification errors. Perhaps experts in quality control in manufacturing can play a role here. Quality control experts in manufacturing focus on standardization and have a goal of 'zero' defects.' Hard stops are put in place to ensure that these goals are achieved. In health care, we try to put hard stops in place wherever we can but, often, these measures are circumvented by staff work-arounds that managers could never have anticipated. For example, a policy is in place and staff are educated that only non-ferrous materials are allowed in the MRI suite. Hard stops put in place are metal detectors, wand detectors, signage, non-ferrous code carts and furniture, etc. Despite this, we continue to see MRI accidents with oxygen tanks or floor buffers or other ferrous objects. Because our solutions are not carefully explored and exhausted in terms of hard stops, events continue to occur because staff/others find work-around. For instance, it was reported that housekeeping staff unplugged a metal detector in order to plug in a buffer machine, which was sucked into the MRI by the magnet. An HFE specialist might have anticipated this proactively and suggested that only tamper proof outlets be installed in the MRI suite, thus creating a hard stop to eliminate a potential work around. Another example of hard stops is the electronic medical record (EMR). Many of us who have experience with the EMR use the hard stop of creating 'no pass fields,' which forces staff to stop, take action and then document the actions taken. One hard stop example might be forcing a provider to acknowledge a critical value in the EMR via a no pass field. We think we've solved the problem by forcing the provider to review the critical value and acknowledge it in writing but how do we guarantee the most important piece of this—that the critical value is communicated to the patient and that appropriate clinical action is taken. I doubt any risk manager or provider has a foolproof solution to this yet.

In addition to HFE specialists, there are lessons to be learned from the retail industry as well. For instance, what is described as the "five pillars of retailing," (*Heoxard Berry*) can be applied directly in health care as well. They are: (1) solve the customer's (patient's) problem; (2) treat the customers (patients) with respect; (3) connect with the customer's (patient's) emotions; (4) set the fairest (not the lowest) price—*this pillar is not as relevant in the health care setting and we could substitute "do no harm" as a pillar here!*; and (5) save the customer's (patient's) time.[4]

In conclusion, in order to make the delivery of health care as safe and risk free as possible for our patients and our staff, we need engage the assistance of HFE and other specialists to build better safeguards in our systems.

**Briefly stated, HFE specialists study and design an integrated whole (e.g. the entire hospital vs. a segment such as the emergency room or ICU) to maximize overall performance (inclusive of patient safety), efficiency and quality of working life. The HFE field consists of three domains: (1) physical ergonomics (physical strengths and limitations of humans, e.g. design patient rooms to reduce falls, strategic placement of sinks to increase compliance with hand hygiene, appropriate lighting in medication storage/dispensing areas); (2) cognitive ergonomics (considers the cognitive abilities and limitations of users, e.g. development of education and training programs, usability testing of smart IV pumps, development of decision support tools to reduce diagnostic errors); and (3) macro ergonomics (design of overall work system—interactions and fit between components, e.g. reduce admissions through improved discharge planning and coordination, study of impact of technology on work system, processes and outcomes). As a practical example, a medical device designed using HFE principles and methods (by examining the interaction between medical devices and healthcare providers) would likely result in a reduction in device-related errors.*[1]

Tools, Resources and Literature:

[1]Gurses AP, Ozok AA, Pronovost P. Time to accelerate integration of human factors and ergonomics in patient safety. *BMJ Qual Saf* 2012;21:347-351.
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[3]The Costco craze: inside the warehouse giant, www.cnbc.com
[4]Emerging trends in retail marketing strategy, www.articlesbase.com, July 2009

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SAFETY, MEDICAL ERRORS AND THE ELECTRONIC MEDICAL RECORD

By: Steven E. Pegalis, J.D. and Judith Chervenak, M.D., J.D.

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ALL ARTICLES PUBLISHED HEREIN ARE THE OPINIONS AND ADVICE OF THEIR AUTHORS. AHRMNY AND ITS MEMBERS EXPRESSLY DO NOT ADOPT ANY OR ALL OF THE CONTENTS THEREIN. WE AGAIN PROVIDE FORUM TO NOTED PLAINTIFF'S ATTORNEY, STEVEN PEGALIS. WE INVITE OUR MEMBERS AND READERS TO ENJOY MR. PEGALIS' ARTICLE, WHICH CERTAINLY PROVIDES INSIGHT FROM THE PLAINTIFF'S BAR. THAT SAID, IT IS IMPORTANT TO NOTE THAT THE OPINIONS EXPRESSED THEREIN ARE THOSE OF MR. PEGALIS AND NOT OF AHRMNY AND ITS MEMBERS.

The 21st Century has been a time in which hospitals, physicians and other providers have been integrating computer technology to create and use for their patients the electronic medical record (EMR). Government grants of funds, such as the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, create important cost, compliance and reimbursement issues.[1] Privacy, confidentiality and security concerns related to implementation and use of the EMR also have important legal implications, but these issues are beyond the scope of this article. Here we will focus on medical-legal issues related to the EMR's potential to improve the quality, safety and efficiency of patient care.[2]

The EMR's capability to immediately retrieve relevant data; its software capability to immediately extrapolate data and its capability to communicate in a clear, easily readable manner promote the provider's ability to deliver quality care. In 1999, as the 20th century ended, The Institute of Medicine issued its landmark document "To Err is Human. Building a Safer System." (hereinafter referred to as the "Report").[3] The "Report" noted that risk management programs were focused largely on loss control and the organizational leadership level had not yet embraced risk management in its broader sense of patient safety, which is protecting patients from any accidental injury.[4] In 2002, the Institute of Medicine called for the introduction of information technologies to improve the quality of care.[5] Its' committee on Patient Safety and Health Information Technology recently reviewed the evidence of the impact of the use of this technology on patient safety.[6] It concluded that "specific types of health IT can improve patient safety under the right conditions but those conditions cannot be replicated easily and require continual effort to achieve."[7]

The 21st Century patient safety initiatives have increasingly included risk management professionals in "primary" risk management, meaning patient safety. Therefore risk managers need to be aware of the unique medical liability risks related specifically to implementation and use of the EMR. As Denita Neal notes "history has shown medical innovations are frequently accompanied by the potential for harm."[8] Medical errors that lead to meritorious liability claims create, for risk managers and others, a source of information that can and should be used to make future care safer.

Medical liability would exist if the care was not reasonable leading to avoidable patient injury. Thus, we touch on practical challenges for physicians and other providers. Risk managers should understand these challenges so they can help their institution and its professional providers avoid pitfalls that lead to patient injury.

Medical Liability Pitfalls

For each patient, the core medical record information is the assessment of what is or what might be the patient's underlying problem and the management plan related to that patient's medical issue(s). The crucially important medical assessment must be arrived at in a medical setting individualized for each patient. The patient's past history, history of present illness, current signs, symptoms, and laboratory data are each relevant pieces of information used by the provider to arrive at the assessment. The assessment in turn dictates the management response. Additionally the record documents therapeutic steps and responses.

Some major institutions have undertaken the enormous job of inputting patient data from prior years. Errors can occur when information is entered incorrectly. Other institutions have not yet taken on that burden. Will failure by some to have easily retrievable past data in the system lead to liability when others have the data online available for use? The implementation process can also lead to "hybrid charts" in which one set of notes (e.g., nursing notes) is not yet part of the EMR system and another set of notes (e.g., physician notes) are part of the EMR. Issues can also arise when the computer is down and a separate set of records is created which is not entered into the system in a timely manner. Two sets of notes (the EMR and written notes) can lead to access difficulty and use of incomplete information. Hybrid or incomplete records may omit telephone or other encounters in the EMR which may include important information.

Software system alerts have been created to remind, and thereby alert, physicians with regard to such important issues as patient allergy and/or adverse reaction between two or more medications given at the same time. The unintended consequence of good system functionality has been described as "alert fatigue." In a recent article, Dr. Steven Simon of Harvard was quoted as saying that he believes "doctors and clinicians tend to override, ignore or click through alerts when they happen too often, when they are perceived as being burdensome, when they are perceived as being of low value or when there are too many of them."[9] Alert systems which are set up too often can result in the provider glazing over information that could be crucial to patient outcome.

Some systems have, in support of adverse reaction alerts, clinical decision support guidelines and lockouts. A physician who does not follow the guidelines or overrides the lockout may have good and explainable reasons for those actions. By thinking about those "good" reasons and by "explaining" those reasons by documenting the EMR, the physician is avoiding meritless liability claims and promoting individualized thoughtful care which the EMR should encourage.

Ideally, the EMR can be an enormous timesaving device. Time is not only money, but more importantly enables the provider to have a greater opportunity to think a patient's issue through to an individualized desired health care outcome. It takes time to learn and master the electronic record; therefore, errors can arise if provider's patient loads are not reduced during implementation.[10] Once the system is in place, the time saved may also be used to add more patients than a provider can safely handle.

The EMR timesaving advantages can inadvertently lead to a distraction from patient care. The computer or cell phone should not distract a provider from looking at, and meaningfully connecting with the patient as an individual. Distractions can lead to errors (e.g., failure to finalize or cancel an order or continuing to follow an order that has been cancelled).

The electronic signature added to a note or report printed out by the computer is at first blush a beneficial timesaving device. The pitfall is the "batch accept." For example, reading and electronically signing a "batch" of reports at the same time may promote an "acceptance" of computer-generated information that on an individual basis should be modified. Even worse is a "cut and paste" feature, signing off on information from another patient or carrying forward an error introduced into the records by another provider. The same note must not be used for a group of patients who have similar issues, e.g. post-op patients. Further, if a note is not signed contemporaneously, that may be "innocent", but should be so noted as the EMR can be tracked via an audit trail reflecting when, for example, a note is signed or changed.

Some EMR features allow the computer to fill-in a field automatically. Lack of diligence in reviewing one's own note or a resident's note can lead to error. Checking off "all normal" superficially, or even when not really checked, can lead to serious error and liability. Computer systems that do not talk to one another and/or are not customized to the specific physician or hospital practice can produce an EMR that is not easily minable or retrievable. Failure to read or to print out notes that are easily retrievable may allow inadvertent error.

Communication errors have been and remain a continuing threat to patient safety. Each provider should, by habit, automatically think to himself or herself: "What is being communicated to me?"; "Is the information reliable and adequate?"; "What do I intend to communicate about my patient?"; Last but hardly least, "What is the desired outcome for my patient and, as my patient's advocate, am I promoting that goal?"

Will the pitfalls associated with the EMR, including failure to adopt one, lead to new tort liability theories? Maybe. However, such new theories usually add up to a semantic label that identifies a type of negligence in which the EMR played a role in increasing the risk of harm rather than the intended role of reducing the risk of harm.

Risk for Medical Malpractice Claims

In an article discussing legal issues surrounding the EMR, it was noted that although EMRs present significant opportunities for long term gain, they are quite a thorn in physicians' sides. The article notes that because EMRs include more detailed patient information than what is required in traditional paper records, this fact can either help or hurt the physician's case against malpractice claims. As Mangalmurti et al note, "... there is currently no evidence that use of the EMR reduces diagnostic errors and ... several studies have documented increases in computer-related errors."[11] Various technology related adverse events have been reported to the U.S. Food and Drug Administration.[12] EMRs may even create new standards of care.[13]

Ethically motivated providers wish to use the EMR in the 21st Century to help them deliver quality care. The record is a crucially important means of communication. The Biblical tower of Babel story, as we understand it, relates to an inability of individuals to communicate as a means of punishment for a sin. Providers who take a pride in doing good for their patients would no doubt feel a personal sense of punishment if one of their prime means of communication (the EMR) is less than it should be and no doubt would feel rewarded if the EMR is all that it can be.

Risk management professionals can and are having a positive influence on patient safety. This influence can further reduce the incidence of avoidable bad patient outcomes and also reduce liability insurance costs in a dynamic in which greater complexity adds to the "risk" for error. The result of fewer errors and fewer meritorious liability claims would be a win-win scenario for attorneys and risk managers even though the attorneys would have fewer cases to pursue and the risk managers would have fewer bad outcomes to evaluate.

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[1] Mangalmurti, S, Murtagh, L, Mello, M. Medical Malpractice Liability in the Age of Electronic Health Records, NEJM, 2010; 363:2060-2067.
[2] ACOG Committee Opinion, Patient Safety and the Electronic Health Record, no: 472, November 2010
[3] Kohn, L.T., Corrigan, J.M., Donaldson, R.S. Eds. To Err is Human: Building a Safer Health System, 2000, National Academy of Sciences.
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[5] Bernstein, P, Farinelli,C, Merkatz, I. Using an Electronic Medical Record to Improve Communication Within a Prenatal Care Network, Ob/Gyn 2005;105:607-612.Obstetrics and Gynecology.
[6] Report on Health IT and Patient Safety: Building Safer Systems for Better Care 2011
[7] Ibid.
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[9] Terry, K. Will an EHR Affect Your Malpractice Risk?, Medical Economics,2007:July 6, 55-58.
[10] Hall, T., Minimizing Hybrid Records, Journal of AHIMA, 2008; 79: 42-45.
[11] Mangalmurti, S, Murtagh, L, Mello, M. Medical Malpractice Liability in the Age of Electronic Health Records, NEJM, 2010;363:2060-2067.
[12] ACOG Committee Opinion, Patient Safety and the Electronic Health Record, no: 472, November 2010
[13] Moses,R, Feld,K, Feld,A. Physician Liability: Electronic Medical Records, Am J Gastroenterology 2011;106: 810-814.

Mr. Pegalis is a plaintiff's medical malpractice trial attorney for over 40 years. He has a J.D. Degree from New York Law School where he currently is a member of the Board of Trustees and is an Adjunct Professor teaching Medical Malpractice. He is the author of the three volume text: The American Law of Medical Malpractice (now in its 3rd Edition). He has written and lectured on the subject of patient safety. He moderates the Annual Pegalis and Erickson Lectureship on the Intersection of Law and Medicine to Promote Patient Safety at the New York Law School.

Dr. Chervenak is currently a clinical assistant professor of Obstetrics/ Gynecology at New York University School of Medicine and Associate Director of Obstetrics at Bellevue Hospital Medical Center in New York City. She is a 1980 graduate of the University of Connecticut Medical School, a 2003 graduate of Fordham Law School and she is board certified in Obstetrics and Gynecology and Maternal Fetal Medicine.

AHRMNY Members attending the ASHRM Conference, please mark your calendar for Tuesday, October 9th, 5:30-7:30 pm for our annual cocktail reception. To be held immediately following the last session of the day at the National Pastime Bar & Grill located right on campus in the Gaylord National Convention Center

Email invitation will be sent to all current AHRMNY Members. Please RSVP to ahrm@optimum.net

ANNUAL CONFERENCE SUMMARY

JUNE 8, 2012-LIGHTHOUSE INTERNATIONAL, NYC

Alvin Safran and the Education Committee exceeded all expectations with the June Annual Conference, attended by over 139 members at the Lighthouse International. This was a new venue for the Annual Conference and was perfect for promoting professional development, networking and just catching up with friends. Throughout the day attendees were able to interact with our exhibitors, Vendormate, Sizewise, Sedgwick CMS, Seif & Associates and Medivence.

The day began with a Keynote Address by the Honorable Ann Pfau, NYS Supreme Court, Kings County Civil Term and Statewide Coordinating Judge, UCS Medical Malpractice Matters, addressing the early claims resolution initiative in the metropolitan region. It was of note that of the approximately 4,000 actions filed (72% of those are in the metro region) only 6% are taken to verdict with a median 3.3 years to disposition. The judiciary is committed to being involved in fashioning a solution to what they see as a significant societal problem.

Following the break, attendees, for the first time, were able to attend one of two breakout sessions. Tracy Miller, Esq., Senior Member, Cadwalader, Wickersham & Taft LLP, presented on the Family Health Care Decisions Act. In addition to her extensive healthcare and legal experience Ms. Miller was also the founding Executive Director of the New York State Task Force on Life and the Law. Under her leadership, the Task Force devised the Family Health Care Decisions Act, the health care proxy law, and the law on outpatient do-not-resuscitate orders that comprise the primary body of extant law on treatment decisions in New York State. Two years following passage of the law, Ms. Miller discussed the implications for improving quality of care and reducing cost as well as implementation experiences.

Steve Pelletier, VP Sales & Marketing, Elm Exchange, Inc. and Kevin Bingham, Principle, Deloitte Consulting LLP, who both provided insight into managing clinician risk proactively through online education, conducted the other morning breakout session. They demonstrated the ongoing benefits of bringing in an in house online risk management education program for healthcare professionals to help reduce liability exposure. Much of the discussion then focused on decisions regarding subject matter, format, delivery, ways to influence and measurements of successes.

Following the morning breakout sessions, attendees came together again for a delicious lunch and the annual business meeting. Jon Rubin, President 2011-2012, was commended for his leadership of the organization. As well, our retiring Board members Carol Gulinello, Monica Santoro, Phyllis Dembo and Marcia Levinson were recognized and thanked for their service to AHRMNY. Election results were announced with acknowledgement of re-elected and new members to the AHRMNY Board.

We continued the afternoon with additional breakout sessions. Alvin Safran, Director of Risk & Claims Management, The New York Hospital of Queens along with Robert J. Farley, Esq., Partner, Farley, Holohan & Glockner, LLP cautioned us on the potential for general liability exposure without strong vendor management. Emphasis was placed on contracts, purchase orders and request for proposals (RFP's) along with insuring agreements with emphasis on additional named insureds.

Victor Klein, MD, Director of Patient Safety and Risk Reduction in OB/GYN, North Shore-LIJ Health System, who discussed methods of reducing obstetrical liability, hosted the concurrent afternoon session. As a well-known "obstetrical safety champion", Dr. Klein reviewed risk reduction activities relating to documentation, shoulder dystocia, fetal monitoring and communication.

The educational program formerly ended with an Afternoon Keynote Address on social media and cyber exposure presented by Toby Merrill, VP, ACE Professional Risk and Richard Santalesa, Esq., Senior Counsel, InfoLawGroup LLP. They provided an overview of the new frontier of social media, specifically as it relates to healthcare. Liability related to content, privacy, security and employment practices was explored and best practices shared. As the conference concluded attendees gathered in the lobby for a champagne toast along with "risk management trivia", prizes and the annual gift of an AHRMNY coffee mug and laptop sleeve.



From left to right: Alvin Safran (AHRMNY President-elect), Justice Ann Pfau (annual conference speaker) and Jonathan Rubin (AHRMNY President)



From left to right: Phyllis Dembo (retiring AHRMNY Board Member); Tracy Miller (annual conference speaker), Pamela Monastero (AHRMNY Board Member), Alvin Safran (AHRMNY President-elect) and Carolyn Reinach Wolf (AHRMNY Board Member)



Toby Merrill, VP, ACE Professional Risk and
Richard Santalesa, Esq., Senior Counsel, InfoLawGroup LLP



Robert J. Farley, Esq.





Retiring Board members, Marcia Levinson and Carol Gulinello are presented with an honorary plaque by Jon Rubin (AHRMNY President) for their years of dedicated service



Monica Santoro, retiring AHRMNY treasurer, receives honorary plaque for her years of dedicated service from Jon Rubin (AHRMNY President)



Jon Rubin (President) receives honorary plaque for his term served as president from President-elect, Alvin Safran



Retiring Board Member (Phyllis Dembo) is presented with honorary plaque for her dedicated years of service from AHRMNY President (Jon Rubin)



Victor Klein, MD, Director of Patient Safety and Risk Reduction in OB/GYN, North Shore-LIJ Health System



Conference attendees take a break in main conference room at the Lighthouse International

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