PRESIDENT’S MESSAGE

Dear Members,

We have had a very mild winter so far and hope that will continue as Spring is around the corner. On March 27th, we are excited about getting together at the Lighthouse International for our Evening Program featuring a Focus Group Presentation Mock Trial. The brochure and registration are now available on the AHRMNY website. Our annual full day conference is also going to be at the Lighthouse International this year on June 8, 2012. We will keep you posted on that day’s topics as soon as they are finalized, but topics tentatively include a speaker on Social Media, Reprocessing of SUDS (Single Use Devices), Perinatal Safety and Managing Clinician Risk through Education, Risk Management and Safety Innovations. We also plan to have breakout sessions for the first time as part of the annual conference.

As always we would also like to thank the continued generosity of our sponsors and contributors. Their support is essential to our organization.

We also had a very successful webinar on February 3, 2012 on Emergency Preparedness. Joseph Marcellino, Director of Emergency Management at Coney Island Hospital, recounted his experiences evacuating CIH during Hurricane Irene and discussed other important issues on this topic. Over 65 people attended and we plan to do more webinars in the future.

It is that time of year again, and our nominating committee will be meeting to nominate the members for vacancies for officers and directors and getting the ballots out to our members to vote. We also want to remind you about the distinguished service award we implemented last year. All AHRMNY members are eligible. Candidates for the award may be nominated by submitting a paragraph of no more than 200 words. The Award is a free annual membership and free registration for the full day conference. All candidates will be voted on by AHRMNY membership via electronic ballot.

We are also pleased to report that we currently received a record high of 309 members. We are thrilled and gratified by the interest and response of our members. Please feel free to reach out to us if you need our support in any way. You can also find our group on LinkedIn.

I hope you enjoy this edition of the Risk Management Quarterly. It contains many interesting, topical and useful articles. Our hardworking Publications Committee has produced another outstanding publication.

Looking forward to seeing you on March 27, 2012.

Jon Rubin
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 is for educational purposes only

WE WANT TO HEAR FROM YOU FOR THE SPRING AND SUMMER EDITIONS

We are asking our readers to submit articles for the spring and summer 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 April 18, 2012.
THE FOUR DOMAINS
OF A MODERN PATIENT SAFETY PROGRAM

A White Paper prepared by:

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2012

Dr. Jason Adelman, M.D., M.S. is the Patient Safety Officer at Montefiore Medical Center, a large integrated healthcare delivery system in Bronx, NY and the University Hospital for the Albert Einstein College of Medicine. After completing the AHA-NPSF Patient Safety Leadership Fellowship, he was selected to be a Senior Fellow of the Health Research & Educational Trust (HRET), the research arm of the American Hospital Association. Dr. Adelman serves on the Editorial Board of the American Society of Professionals in Patient Safety (ASPPS) Journal, is on the planning committee for the National Patient Safety Foundation’s (NPSF) Congress, and serves on the NQF Patient Safety Complications Committee. Dr. Adelman has a master’s of science from Albert Einstein College of Medicine’s Clinical Research Training Program, and focuses his research on the use of information technology to prevent medical errors.

Johanna Chelcun, MHS, PA-C is an Assistant Clinical Professor at Quinnipiac University Physician Assistant Program, a practicing physician assistant in hospital medicine, and was previously the patient safety manager at Montefiore Medical Center in the Bronx, New York.
Background

During the past decade, the field of patient safety has come to play a vital role in healthcare systems and healthcare policy in the United States. The emphasis on patient safety and quality care dates back to the mid- to late-1900’s with the establishment of multiple agencies and non-profit organizations, including the Joint Commission on Accreditation of Healthcare Organizations in 1951 (now “The Joint Commission”), the Agency for Health Care Policy and Research in 1989 (now the Agency for Healthcare Research and Quality, or AHRQ), the Institute for Healthcare Improvement in 1991, and the National Patient Safety Foundation in 1997.

In 1991, Dr. Lucian Leape and colleagues from the Department of Health Policy and Management at Harvard School of Public Health published results of a two-part Harvard Medical Practice Study, a retrospective review of more than 30,000 randomly selected charts from 51 acute care hospitals in New York State.¹² The majority of the 3.7% hospitalized patients who experienced an adverse event were temporarily disabled; however, 16.2% of these adverse events led to permanent disability or death. Extrapolation of these findings estimated more than 98,000 serious adverse events in New York State in that year. Dr. Leape’s publications, in addition to his 1994 JAMA article “Error in Medicine,” emphasized the need to make patient safety a national priority.³

The true beginning of the modern patient safety movement, however, is often marked by the 1999 report by the Institute of Medicine, *To Err is Human*, that publicized the impact of adverse events on the healthcare system.⁴ The IOM report, from the Committee on Quality of Health Care in America, again outlined the results from the Harvard Medical Practice Study and made recommendations to improve patient safety on a national level. These recommendations included:

- Establishment by Congress of a Center for Patient Safety
- A nationwide, mandatory reporting system for adverse events, with a shared taxonomy
- Encouragement of voluntary reporting of events and near misses
- Legislation to extend peer review protections to patient safety data
- Raising expectations for improvements in safety through actions of oversight organizations, professional groups, and group purchasers of health care
- Increased attention by the FDA to the safe use of drugs

Whether the patient safety movement began with the 1999 IOM report or well before that, the timeline of the patient safety era has been revitalized every few years with disheartening cases of adverse events that make national headlines and re-engage the discussion. These reports of detrimental and sometimes fatal adverse events in hospitals remind providers and policymakers of the imperative to improve healthcare safety in the United States.

For over a decade, healthcare organizations across the country have begun to dedicate funding and develop formal programs focused on improving patient safety and preventing medical errors. These programs, often led by physicians and/or nurse executives, study and attempt to mitigate the risks inherent in the organization’s structure and processes, work to achieve compliance with regulations, and improve the organization’s culture of safety.

Patient Safety and Adverse Events

To develop a Patient Safety Program, organization members must first become familiar with the terminology of patient safety and adverse events. In *To Err is Human*, patient safety is described as “freedom from accidental injury.” The National Patient Safety Foundation (NPSF) further defines patient safety as “the prevention of healthcare errors, and the elimination or mitigation of patient injury caused by healthcare errors”.⁵ An adverse event is any injury caused by medical care or intervention. Examples of adverse events include unintended side effects of a medication, known surgical complications, or healthcare-associated infections. Adverse events attributable to errors (of commission or omission) are considered preventable adverse events. Not all adverse events are preventable, and not all medical errors will result in an adverse event - errors that do not result in an adverse event are considered “near misses”.

Eliminating all adverse events in healthcare is a daunting, perhaps unachievable task. However, Patient Safety Programs have the responsibility to decrease harm and improve safety by implementing system changes that prevent errors from reaching patients in both inpatient and outpatient settings.

Resources for Establishing a Patient Safety Program

A successful Patient Safety Program interacts closely with other departments - quality improvement, risk management, customer service, regulatory/compliance, and others. Ancillary departments such as pharmacy, information technology, and bioengineering also play key roles in safety initiatives. A patient safety leader should use all available resources throughout the organization to support projects aimed at preventing medical errors.

A wealth of information and training programs are available to hospital administrators new to the field of patient safety. The National Patient Safety Foundation provides education through its Online Learning Center, Stand Up For Patient Safety Program, and the NPSF Congress held annually. In addition, the NPSF recently established the American Society of Professionals in Patient Safety (ASPPS), the first professional membership organization for patient safety. ASPPS membership is available to patient safety professionals, risk managers, quality leaders, students, patient advocates, and others interested in advancing the safety of patient care.

Other references for patient safety leaders and administrators are listed below. Patient safety professionals within an organization must understand basic patient safety definitions and keep abreast of current topics of interest in the field.

Suggested Patient Safety References:

- Understanding Patient Safety, by Wachter, RM⁶
- The Joint Commission Journal on Quality and Patient Safety
A Comprehensive Patient Safety Program: The Four Domains

The role of a Patient Safety Program within a hospital or healthcare system can be categorized into four domains of responsibility – Regulations, Adverse Events, Best Practices, and Pay-for-Performance (see figure 1). In addition, organizations that lead in patient safety contribute to innovation and research in the field.

Domain 1: Ensuring Regulatory Compliance

A Patient Safety Program must ensure compliance with regulations set forth by the Joint Commission, the Department of Health, the Centers for Medicare and Medicaid Services (CMS), and other state and national regulatory agencies. These regulations are based on common hazards that are universal across healthcare systems. Patient safety may be called on to support a planned or unexpected survey by outside regulators.

Joint Commission National Patient Safety Goals

<table>
<thead>
<tr>
<th>NPSG 1 – Improve the accuracy of patient identification</th>
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<td>NPSG 2 – Improve the effectiveness of communication among caregivers</td>
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<td>NPSG 3 – Improve the safety of using medications</td>
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<td>NPSG 7 – Reduce the risk of healthcare-associated infections</td>
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<tr>
<td>NPSG 15 – The hospital identifies safety risks inherent in its patient population</td>
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Universal Protocol for preventing wrong site, wrong procedure, and wrong person surgery

Figure 1. Four Domains of a Patient Safety Program

- Patient Safety Goals
- State Regulations
- OSHA
- FDA

- Value Based Purchasing (VBP) Measures
- Hospital Acquired Conditions

- Just Culture
- Electronic Reporting
- PSO/Common Formats
- Near Miss Reporting
- RCAs

- Team STEPPS
- WHO Checklist
- Culture Survey
- Simulation
- Patient Safety Walkrounds

Innovate and Research
The Joint Commission also requires that organizations complete an annual proactive risk assessment. A Failure Mode and Effects Analysis (FMEA) is a quality improvement method used in healthcare organizations as an exercise aimed at proactively reducing the occurrence and impact of adverse events. An FMEA examines a specific design or process and evaluates the potential failure points within the process, causes of each failure point, and consequences if the failure were to occur. Risk reduction strategies are then considered for each potential failure, and the revised process is evaluated and compared to the initial process. Lessons learned from the FMEA exercise can be used to re-design systems within the organization for improved safety and quality of care.

Domain 2: Responding to Adverse Events

When adverse events take place, the organization must be prepared to respond in a timely and effective manner. While patient safety regulations address universal hazards, learning from adverse events help hospitals learn about hazards localized to their system. Risk management is usually responsible for performing event investigations and preparing for potential litigation. Patient safety will assist in conducting a root cause analysis to review the case, identify safety concerns, and determine how a similar event can be prevented in the future. Quality improvement plans determined by root cause analysis will likely require time and planning, as well as executive leadership and/or budgetary approval. If the event was specific to one department within the hospital, a risk analysis may be conducted to identify other departments in need of system improvement.

Patient Safety Organizations (PSOs), authorized by AHRQ after implementation of the Patient Safety and Quality Improvement Act of 2005, can provide organizations with support for healthcare system improvement and data analysis. PSOs provide member organizations with protection from legal discovery to encourage voluntary adverse event reporting for aggregation, analysis, and feedback to improve patient safety at a national level. Organizations can utilize PSO support for risk analysis and safety improvement initiatives.

The Just Culture model is a patient safety technique used to assess patient care when an adverse event occurs. In a Just Culture, the focus of an adverse event investigation is shifted from a reflexive tendency to blame the providers involved in the adverse event, to a thoughtful attempt at learning what underlying system errors may have been the true root cause of the event. Just Culture tools guide the fair judgment of physicians, nurses, and other hospital staff involved in an adverse event, and may be used by department chairs, hospital leadership, and peer review committees. Patient Safety Departments play an instrumental role in implementing and educating staff on Just Culture principles.

Root cause analysis, Patient Safety Organization support, and the Just Culture theory can aid in reviewing and learning from adverse events. In addition, Patient Safety may be called upon to assist Risk Management and the Medical Director in disclosing an adverse event to a patient or family. These discussions are often difficult and require advanced communication skills and training.

Domain 3: Financial Incentives to Improve Safety and Quality

Until recently, the business case for patient safety has been the decrease of malpractice claims and length of stay. The 1999 IOM Report, To Err Is Human, recommended increasing financial incentives by tying reimbursement to safety performance. Over a decade later we are beginning to see these financial incentives take hold.

In August, 2007, CMS modified the Inpatient Prospective Payment System (IPPS) to cut additional payments for hospital discharges after October 1, 2008 if they contained selected Hospital Acquired Conditions (HACs), such as hospital acquired infections, which were not present on admission. In 2010, as part of the Patient Protection and Affordable Care Act, CMS established a Value-Based Purchasing (VBP) program that shifts reimbursement funds from low-performing hospitals to high-performing hospitals based on quality data. Although not initially included in the VBP measures, eight selected HACs, including catheter-associated urinary tract infections, retained foreign bodies, and falls with trauma, will likely be added to the outcome measures beginning in fiscal year 2014. Therefore, hospitals with lower HAC rates can earn higher VBP scores and potentially earn back a percentage of Medicare payments initially withheld by CMS.

In essence, pay-for-performance reimbursement systems should ultimately provide organizations additional motivation to make system-wide changes to prevent hospital-acquired conditions by cutting or eliminating payments. By linking payment to outcomes, these programs provide a strong impetus for patient safety improvements. Patient Safety Departments should dedicate time and resources to preventing hospital-acquired conditions, some of which are also National Patient Safety Goals.

While VBP and HAC programs are intended to be the financial "stick" that drives patient safety forward, in 2011 CMS implemented the Partnership for Patients program under Don Berwick’s leadership as the proverbial "carrot", providing resources and guidance for improvement. Partnership for Patients is modeled after the IHI method for change.

Domain 4: Adopting Patient Safety Best Practices

When possible, Patient Safety Programs should research and adopt best practices made available by the World Health Organization, the NPSF, and others. Many of these best practices are not mandated by regulations or value-based purchasing measures, but have been demonstrated to prevent medical errors and improve quality of care. A goal of every organization’s patient safety program should be to proactively implement strategies for preventing medical errors. New and innovative strategies have been developed and proven to prevent adverse events – examples include Dr. Peter Pronovost’s checklists to prevent infections in the ICU at Johns Hopkins, Dr. James Bagian's work with Medical Team Training in the operating rooms at the Veteran’s Health Administration, and more.
Patient Safety Departments should be aware of patient safety best practices and support hospital departments to adopt those that would benefit the organization and improve patient care. Safety initiatives such as the World Health Organization (WHO) Surgical Safety Checklist, medical simulation, and team training are all promising initiatives for reducing medical errors. Frontline staff’s commitment to patient safety can be assessed and promulgated by using the AHRQ Hospital Survey on Patient Safety Culture and Patient Safety Executive Walkrounds. The AHRQ Culture survey, a widely recognized evaluation tool developed in 2004 and administered at over 1,000 hospitals nationwide, provides institutions with a valuable assessment of the culture of patient safety within and between hospital units or departments. Patient Safety Executive Walkrounds communicate the importance of patient safety at a leadership level, and provide an opportunity for staff to report potentially hazardous conditions and receive feedback about safety initiatives.

Innovation in Patient Safety

Healthcare organizations that excel in patient safety keep up with the advancements developed by others, and those that lead in patient safety innovate themselves. Innovations in patient safety occur most often when patient safety experts are fully cognizant of the work of others, and build upon that work. Although many promising advancements in patient safety have been introduced in recent years—including simulation, checklists and team training—additional innovations are needed in order to significantly decrease the frequency and impact of medical errors.

Conclusion

Development of a successful Patient Safety Program requires structure, planning, time, and resources. Patient safety leaders are responsible for complying with regulations (such as the National Patient Safety Goals), responding to adverse events, adopting patient safety best practices, and understanding pay-for-performance measures. A multitude of educational resources and professional enrichment opportunities are available through conferences, publications, and professional organizations. The benefits to the healthcare organization of a successful Patient Safety Program include lower legal expenses, improved revenue from pay-for-performance sources, and reputational gains which directly influences organizational success. Most importantly, a successful Patient Safety Program is essential for healthcare institutions to meet their primary responsibility - provide quality care and to do no harm.

References

5) National Patient Safety Foundation website. [www.npsf.org](http://www.npsf.org)

March 4-10 is National Patient Safety Awareness Week sponsored by the NPSF. This week is memorialized by encouraging everyone to understand the importance of patient safety and to recognize the range of efforts being made to improve health safety in the United States and worldwide. Please visit the National Patient Safety Organization’s website [www.npsf.org](http://www.npsf.org) and the American Society for Healthcare Risk Management’s website [www.ashrm.org](http://www.ashrm.org) for various patient safety programs, webinars, activities and publications offered to help your organization make the most of this important week.

Save the Date:

**Healthcare Risk Management Week (HRM)**

June 18-22 2012

It’s not too early to begin thinking about the importance of healthcare risk managers during HRM Week this June. Please visit the ASHRM website where materials will be available to promote this week at your facility. There will also be information on an ASHRM sponsored webinar to be held on June 20.
Last year the Appellate Division, Second Department upheld the denial of a motion for summary judgment because defendant did not disclose its expert prior to the close of discovery as required under section 3101(d) of the Civil Practice Law and Rules. The decision in Stolarski v. DeSimone\(^1\) thus extends to medical malpractice defendants a rule that previously had affected only plaintiffs, albeit in an inconsistent fashion.\(^2\) Although the legislature and courts have yet to establish clear rules governing the disclosure of experts, medical malpractice litigants on both sides of the caption now are on notice that their failure to retain and disclose experts before the close of discovery could be risky in any case where a summary judgment motion is contemplated. It is especially risky in the ten counties comprising the Second Judicial Department.\(^3\) As a practical matter, risk managers, insurers and defense counsel now must consider retaining outside experts at a much earlier stage of the litigation.

Summary judgment motions are common in medical malpractice cases. Defendants often move for summary judgment in an effort to avoid trial altogether, or at least to sharpen the issues for trial by forcing the plaintiff to reveal his true theory of liability from the multiple claims that are typically alleged in the pleadings.\(^4\) Plaintiffs try to avoid summary judgment because they want their claims to be decided by a jury, or at least to strengthen their settlement position by convincing the court (and the defendant) that their claims have genuine merit. The outcome of such motions almost always depends on each side’s ability to produce a competent expert opinion supporting their respective positions. As discussed below, under Stolarski, the defendant who fails to make timely expert disclosure now risks forfeiting this valuable right.

Expert disclosure in New York is regulated by section 3101(d) of the Civil Practice Law and Rules. It states as follows:

> Upon request, each party shall identify each person whom the party expects to call as an expert witness at trial and shall disclose in reasonable detail the subject matter which each expert is expected to testify. However, where a party for good cause shown retains an expert an insufficient period of time before the commencement of trial to give appropriate notice thereof, the party shall not thereupon be precluded from introducing the expert's testimony at the trial solely on grounds of noncompliance with this paragraph. In that instance, upon motion of any party, made before or at trial, or on its own initiative, the court may make whatever order may be just. In an action for medical, dental or podiatric malpractice, a party, in responding to a request, may omit the names of medical, dental or podiatric experts but shall be required to disclose all other information concerning such experts otherwise required by this paragraph. CPLR §3101(d)(1)(i).

On its face, the statute is limited in scope to experts who are retained for the purpose of providing testimony during trial, not experts who are retained to offer opinions for or against summary judgment. It says nothing about disclosure of experts in the context of summary judgment motions. Indeed, there is no rule requiring the parties to employ the same expert as both a trial witness and an affiant during summary judgment motion practice. Nor does CPLR 3101(d) require a party to respond to a demand for expert witness information at any specific time. It is not uncommon for both sides to disclose their experts shortly before trial, even where, as is often the case, the court previously ordered that such disclosure be made within a specified time frame.

Nevertheless, in the 2005 case of Safrin v. DST Russian & Turkish Bach, Inc.,\(^5\) the Second Department ruled that a lower court properly rejected the affidavit of an expert offered by the plaintiffs in opposition to a summary judgment motion because the plaintiffs failed to identify the expert during pretrial disclosure, but rather served it for the first time in opposition to the summary judgment motion. A few years later, in Construction by Singletree, Inc. v. Lowe,\(^6\) the Second Department upheld the lower court’s rejection of a plaintiff’s expert affidavit submitted in opposition to the defendant’s motion for summary judgment because the expert was not identified until after the note of issue and certificate of readiness were filed, and the plaintiff offered no valid excuse for its failure to give notice of the expert prior to completion of discovery. The court in Singletree reasoned that “the purpose of summary judgment is to determine whether there are genuine issues necessitating a trial,” and since a belatedly disclosed expert opinion cannot be considered at trial, it necessarily follows that defendant is entitled to summary judgment based on plaintiff’s failure to produce an admissible expert in opinion in opposition to the motion.

Safrin and Singletree have been followed often. In Gerardi v. Verizon New York,\(^7\) the Second Department again held that an affirmation of the plaintiff’s expert should not have been considered in determining the defendant’s motion for summary judgment since the expert was not identified by the plaintiff until after the note of issue and certificate of readiness were filed attesting to the completion of discovery, and the plaintiff offered no valid excuse for the delay. Similarly, in Ehrenberg v. Starbucks,\(^8\) the Second Department held that the affidavit of plaintiff’s expert which had been submitted in opposition to a motion for summary judgment should not have been considered since the expert witness was not identified by plaintiffs until after the note of issue and plaintiffs offered no valid excuse for the delay.\(^9\)

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**EARLIER RETENTION OF EXPERTS IS NOW A MUST IN MEDICAL MALPRACTICE ACTIONS**

By: Daniel S. Ratner, Esq. and Patricia Thornton, Esq.
Heidell Pittoni Murphy & Bach LLP
But there is also a distinct line of cases in the Second Department holding that the failure to identify an expert before the filing of the note of issue is not fatal in the absence of a showing by the defendant of willful and prejudicial conduct by the plaintiff. In *Simpson v. Tenore and Guglielmo*, the court considered the affidavit of plaintiff's expert which was submitted in opposition to the defendant's summary judgment motion, even though plaintiff had not previously disclosed the expert, because "there was no evidence that the plaintiff intentionally or willfully failed to disclose the identity of his expert witness, nor has prejudice to the defendants been shown." In *Hernandez-Vega v. Zwanger Pesiri Radiology Group*, the court rejected plaintiffs' argument that the lower court erred in considering the expert affidavits submitted by the respondents in support of their respective motions because they had not complied with the plaintiffs' demand for expert witness information pursuant to CPLR 3101(d)(1). It held that "CPLR 3101(d) (1) does not require a party to respond to a demand for expert witness information at any specific time nor does it mandate that a party be precluded from proffering expert testimony merely because of noncompliance with the statute," unless there is evidence of intentional or willful failure to disclose and a showing of prejudice by the opposing party. Contrary to the plaintiffs' contention, the Supreme Court providently exercised its discretion in considering the affidavits of the respondents' experts as there was no evidence that the respondents' failure to disclose was intentional or willful and there was no showing of prejudice to the plaintiffs.  

*Simpson* and *Hernandez-Vega* were decided before *Safrin* and *Singletree*, so one might have argued that the former cases were overruled by the latter. But in 2009 the Second Department decided *Browne v. Smith*, (after *Safrin* and *Singletree*), in which it excused plaintiff's failure to disclose an expert prior to the note of issue, following the rationale of *Hernandez-Vega*. *Safrin* and *Singletree* are not even cited in the *Browne* decision. The appellate panel in *Browne* simply held that "there was no evidence that the failure to disclose was intentional or willful, and there was no showing of prejudice to the defendants." And yet more recently, in *Santiago v. C&S Wholesale Grocers Incorporated*, the Second Department upheld a lower court's refusal to consider the plaintiff's expert's affidavit since the identity of the expert was not timely disclosed and plaintiff proffered no excuse for the delay. It is no wonder one commentator has observed that "[i]t is difficult to reconcile the Second Department's holding in *Singletree* with its own prior and subsequent jurisprudence ..."  

For its part, the First Department has recognized the *Singletree* line of cases, but its decisions do not turn solely on the lack of disclosure. In *Harrington v. City of New York*, the court held that the motion court properly declined to consider plaintiff's expert's affirmation because plaintiff failed to timely disclose his identity. This aspect of the decision was secondary to the main holding: that the affirmation was insufficient on its merits to defeat the motion. In *Mauro v. Rosedale Enterprises*, the court ruled that it "need not determine whether the affidavit of plaintiffs' expert engineer should not have been considered in light of plaintiffs' failure to identify this expert during pretrial disclosure, despite repeated court orders to do so." Only then did it turn to the opinion's merits before ruling that the "affidavit, even if considered, fails to raise a triable issue of fact, instead citing various broad or inapt engineering rules, regulations and standards." Finally, in *Tierney v. Girardi*, the court held that the lower court "properly excused plaintiff's procedural oversights, including the untimely filing of her expert's affirmation, where there was no showing that plaintiff acted in bad faith or that the late filing prejudiced defendants, and where the court permitted defendants to respond to the supplementary affidavit."  

The Appellate Division, Fourth Department has also weighed in. In *Kozlowski v. Alcan Aluminum Corporation*, it held as follows:  

We reject plaintiffs' contention that the affidavit submitted by defendant's expert should not be considered because defendant failed to disclose the expert's identity in a reasonable time pursuant to CPLR 3101(d) (1) (i). Plaintiffs' remedy for failure to comply with that section is to move before the IAS court for "whatever order may be just" (CPLR 3101[d][1][i]).  

In other words, the Fourth Department held that the failure to disclose an expert under CPLR 3101(d) has no bearing on a party's ability to offer an expert affirmation in support of or in opposition to a summary judgment motion. This is a literal reading of the statute.  

Confusing as they are, none of these cases involved the moving party's (read: defendant's) failure to disclose their expert, but rather affected only the opposing party's (read: plaintiff's) omission.  

From out of this thicket emerged *Stolarski* in April 2011. In *Stolarski*, the decedent, who was depressed following a breakup with her boyfriend, committed suicide after seeing a social worker at defendant Family Services of Westchester, Inc. Her family sued FSW for failing to properly treat decedent. FSW moved for summary judgment. The Second Department affirmed the denial of the motion on the following ground:  

... the Supreme Court properly denied that branch of the separate motion of Family Services which was for summary judgment dismissing the complaint insofar as asserted against it, as Family Services failed to establish its prima facie entitlement to such relief. In this regard, the Supreme Court properly declined to consider the expert affidavits proffered by Family Services in support of its motion. The experts were not identified by Family Services until after the note of issue and certificate of readiness were filed attesting to the completion of discovery, and Family Services offered no valid excuse for the delay (see *Gerardi v Verizon N.Y., Inc.*, 66 AD3d 960, 961, 888 N.Y.S.2d 136; *Wartski v C.W. Post Campus of Long Is. Univ.*, 63 AD3d 916, 917, 882 N.Y.S.2d 192). Accordingly, since Family Services failed to establish its prima facie entitlement to judgment as a matter of law, that branch of its motion which was for summary judgment dismissing the complaint insofar as asserted against it was properly denied, regardless of the sufficiency of the opposing papers (see *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853, 476 N.E.2d 642, 487 N.Y.S.2d 316).
Under Stolarski, defendants who move for summary judgment in medical malpractice cases – and not just plaintiffs who oppose them – are now on notice that their failure to disclose their expert during discovery without a valid excuse can be fatal to their efforts to gain an early disposition without trial.

Practice Points
In the past, a risk manager could put off an outside expert review until a few years into the litigation. But today many courts are putting discovery on a fast track (12-15 months). Moreover, CPLR 3212(a) requires that summary judgment motions be made within 120 days of the completion of the discovery, but many courts are imposing a tighter deadline of 30-60 days. The practical effect of Stolarski and these accelerated deadlines is that risk managers need to be prepared to approve the retention of outside experts within 6 months of the commencement of the lawsuit, roughly around the time of the plaintiff’s deposition. This will allow the expert sufficient time to conduct the review and provide his or her opinion, and for defense counsel to prepare the expert disclosure before the court-imposed accelerated deadline for completing discovery. Failing that, defendants must be prepared to offer a reasonable excuse for their non-compliance and hope that this excuse is accepted by the court. This is not an optimal strategy. To be sure, there may be reluctance to assume the additional cost of retaining an outside expert early in the litigation, but this cost is far outweighed by the benefit of avoiding trial based on a successful summary judgment motion.

A possible way to circumvent Stolarski is for the defendant to act as his or her own expert. Technically, this is allowable on summary judgment, with the added benefit that a party to a lawsuit, unlike a retained non-party expert, does not need to be disclosed under CPLR 3101(d). But this too is a sub-optimal approach to seeking a dismissal on the merits via summary judgment motion. Summary judgment motions supported only by the inherently self-serving opinion of the defendant are subjected to closer scrutiny by the courts and are less likely to be granted.

Finally, moving defendants should be on the lookout for situations in which plaintiff relies on a previously undisclosed expert in opposing the summary judgment motion. The defendant should consider moving to preclude plaintiff’s expert, bearing in mind of course that the rule may apply equally to them in light of Stolarski if defendant did not previously disclose his or her own expert.

Daniel S. Ratner is the Managing Partner of HPM&B and heads the firm’s Appellate Practice group. Mr. Ratner represents hospitals, physicians, pharmaceutical and medical device companies in the defense of medical malpractice and product liability actions. Mr. Ratner works closely with the firm’s trial attorneys in developing legal strategies. He also assists clients with risk management issues, and in advancing positions regarding proposed legislation and regulations that may affect their interests. He was assisted in the preparation of this article by Patricia A. Thornton, an associate of the firm who also represents medical providers in the defense of medical malpractice claims.
Dear Risk Manager:

This column, which will appear regularly in AHRMNY’s Quarterly Journal, is designed to assist both the novice and seasoned risk manager by presenting *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 AHRMNY.org. The form permits confidentiality.

A recent article titled “Elephants in Academic Medicine” explored the “types, causes and consequences of academic health center ‘elephants,’ which the authors define as obvious problems that impair performance but which the community collectively does not discuss or confront” (I call these the 800 pound gorillas in the room!). The concept being “an elephant in a room would be impossible to miss thus, the people in the room who are jointly and cooperatively pretending it is not there have made a collective choice to ignore it.” The authors polled chairs of medicine and surgery at various U.S. medical–degree-granting medical schools. The results of the poll will not surprise the seasoned risk manager. I strongly encourage you to read the article in its entirety and share it with your clinical and administrative leadership.

As risk managers, there is nothing more frustrating than the inability to effect change. Risk management is all about change—change that promotes patient safety, change that pre-identifies issues before they become problems, change that reduces liability exposure, change that makes systems improvements and, most importantly, change that supports improved patient outcomes. We all recognize and appreciate the difficulty in effecting change, especially in the current economic crisis. However, what is most disheartening is the inability to make important changes and strides in patient safety unrelated to cost and resources because of staff who are resistant to change. This occurs even when confronted with obvious patient safety issues (usually this staff is in a position of power or leadership).

We touched on the topic of corporate culture in this column in the Spring 2010 edition. At the time, we stated that change will not happen unless leadership wants it to happen. The culture of any organization is determined by its leaders. A culture of safety encourages the free exchange of ideas, reporting errors and problem-solving.” We also quoted that Board chairs “from high-performing organizations (determined by Hospital Quality Alliance data) selected quality twice as often as chairs from low-performing institutions did.” The column contained various tips and tools, as well as workshops and other resources which are reiterated below for your reference.

The Elephants article is a scientific study that focused on healthcare providers, not administrators, and describes the “organizational silence” we are so familiar with. “Organizational silence” refers to the collective-level phenomenon of doing or saying very little about the problems facing an organization. The silence can be caused by fear of negative feedback, climates that discourage speaking up, centralized decision-making, lack of formal feedback systems and senior leadership fears of receiving criticism. Eventually this culminates into a culture that is less likely to detect and correct errors with the result that performance suffers.

The survey results were as follows:

- **Types of elephants:**
  - The most common ‘elephant’ identified by all chairs is a misalignment between goals and available resources;
  - Other ‘elephants’ ranked were ignoring information that clearly indicates a performance problem; and
  - The unwillingness to give up on a failing strategy.

- **Reasons for organizational silence:**
  - The most common reason identified by all chairs is that speaking up will be ignored;
  - Other reasons identified are fear of repercussions; and
  - Reluctance to deal with a problem once exposed.

- **Consequences of organizational silence:**
  - Low morale;
  - Not learning from mistakes; and
  - Resultant poor decisions as a consequence of inadequate information sharing resulting from elephant dodging.

Two-third of the chairs polled felt that elephants are considerable or widespread in their respective organizations.
Comments included the following:

- 37% of those polled felt that elephants are usually discussed in an appropriate venue;
- 63% felt that elephants are discussed in less constructive venues or not discussed at all;
- 23% felt that top leadership actually encourage people to call out and deal with elephants;
- 55% felt that top leadership state that they want staff to be frank about elephants but that their actions or nonverbal cues indicate otherwise;
- 30% of medicine chairs and 16% of surgery chairs felt that top leaders pretend that elephants do not exist;
- 5% reported that top leaders are unaware that elephants actually exist at all.

With respect to whether certain issues should be ignored and regarding the ease of creating a culture that is more amenable to discussing problems, the results were somewhat encouraging with 62% agreeing that some elephants should not be ignored. Unfortunately, 19% felt that some issues are best left undiscussed.

What was very discouraging was that two-thirds of those polled (67%) felt that creating a culture in which elephants are openly discussed would be very or moderately difficult. 80% felt that the best way to call out elephants is for top leaders to set the example by acknowledging and confronting the elephants. The article points out that organizational silence in the academic health center exists because "conversation is limited, often subconsciously, to a few voices, usually the voices of those in power." The powerful silence the voices of others because they consider other views to be either contrary to the status quo or of limited value. In trying to make sense of environments, leaders routinely regulate, standardize and simplify. These managerial activities which are designed to create order and consistency, often contribute to organizational silence. The result is that people cannot solve the problems they do not talk about and yet the overriding choice made in many organizations is not to talk.

The conclusion is that there is an inability to confront elephants and, in those instances where elephants are identified, they are not discussed in an appropriate venue with all relevant stakeholders. Moreover, since junior staff are more reluctant to speak up, negative information does not readily flow up the organizational hierarchy, resulting in a dearth of information about potential problems. This results in information deficits to decision makers. Therefore, leaders must create the psychological safety necessary to permit the unspoken to be said to create a more open environment. The steps to accomplishing this are identified as driving out fear and leading by example by having senior leaders tackle elephants directly to help eliminate organizational silence.

Risk managers have always played an integral role in identifying elephants. Many of us are relentless in communicating the issues up the chain of command. The better networked the risk manager is with clinical staff and hospital leadership, the greater the success in getting elephants addressed. The real dilemma arises when the elephant is someone(s) whom the risk manager cannot influence especially if he/she has influence at very high levels in the organization, e.g. senior executive staff or the board of trustees.

An interesting follow-up study would be one that focuses on determining whether the elephants specific to any organization related to the "misalignment between goals and resources" occurs because: (a) staff in power positions (the influencers) in certain clinical disciplines get more resources as compared to other areas; (b) poor plans and business lines are fortified and continued because of 'pride of authorship' and lack of innovation ('this is how we've always done things'); (c) an overall failure of senior leadership to develop a vision and actually lead (an ill-defined business plan/lack of strategy); (d) an overall corporate culture that does not buy into change or patient safety; or (e) corruption. Needless to say, any misalignment between goals and resource makes for an unsuccessful strategy.

References:

7. ECRI.org, Medical Leaders in Patient Safety; and The Roles of Healthcare Governing Boards
8. AHA, Hospitals & Health Networks, Jan 2010

From Spring 2010 column - Tools, Resources and Literature:
- ECRI Institute (www.ecri.org)
  "Medical Leaders in Patient Safety”—DVD for physicians and hospital administrators
  The Roles of Healthcare Governing Boards
- Joint Commission (www.jcaho.org)
- Institute for Healthcare Risk Improvement (www.IHI.org)
- American Hospital Association (www.aha.org)
- American College of Healthcare Executives (www.ache.org)
  "The Healthcare Executive’s Role in Ensuring Quality and Patient Safety” November 2008
  "Preventing and Addressing Harassment and Aggression in the Workplace” November 2005
- The Governance Institute (www.governanceInstitute.com)
- Trustee Magazine (www.trusteemag.com)
  "Understanding and Improving Clinical Quality: The Role of Trustees,” James L. Reinersten, MD, September 2003
- National Quality Forum (www.qualityforum.org)
  "Hospital Governing Boards and Quality of Care: A Call to Responsibility” December 2, 2004
- American Society for Healthcare Risk Management (www.ashrm.org)
North Bronx Healthcare Network (NBHN) - Where Quality Matters

The North Bronx Healthcare Network (NBHN) is comprised of two acute care hospitals, Jacobi Medical Center and North Central Bronx Hospital. Jacobi Medical Center is a New York State Regional Perinatal Center, serving the highest risk obstetrical patients in the state. Both facilities are member hospitals of the New York City Health & Hospitals Corporation (HHC). Together, they deliver approximately 4,000 patients annually. Perinatal quality initiatives at NBHN are developed by the NBHN’s Perinatal IHI team. The NBHN’s Perinatal IHI team was originally founded in 2006 with the network’s enrollment in the Perinatal IHI Community of the internationally recognized Institute of Healthcare Improvement. It is a multidisciplinary group comprised of physicians, midwives, nurse practitioners, registered nurses, quality management & administration. The team meets biweekly, and is an active policy setting workgroup with the goal of establishing best practice utilizing evidence-based medicine/practice. Each discipline brings an important perspective to the table with a focus on patient safety and teamwork. Teamwork is the essential component for safe, effective patient-centered care. Patient safety is the central vision of Mr. Alan Aviles, President and CEO of Health and Hospitals Corporation, as well as NBHN Senior Vice President, Mr. William P. Walsh.

Introduction

In an effort to develop guidelines for a new oxytocin protocol, we conducted a quality improvement study for a two week period and found that in general, we are more likely to underestimate fetal weight than overestimate fetal weight. This difference is most stark at the upper limits of fetal weight, >4,000 grams. Our hypothesis was to find out if the error of underestimating fetal weight rather than overestimating fetal weight was statistically significant and whether or not it would be replicated in a larger population.

Objective

Our objective was to compare estimated fetal weights to birth weights in all patients who delivered at North Central Bronx Hospital within a six month period. We planned to determine if there was a pattern to our inaccuracy, particularly when considering infants with a birth weight greater than 4,000 grams.

Methods

Using the labor floor delivery log book and medical charts, we reviewed the medical records of 712 patients who delivered between July 1, 2008 and December 31, 2008. Our study population included:

- Women between the ages of 15 and 45
- Births greater than 35 weeks gestation
- Single gestations

Patients whose charts were not provided by the medical records department or births that took place outside of the facility or immediately upon arrival to labor and delivery were excluded.

We reviewed birth records to compare the recorded estimated fetal weight to the actual birth weight of the baby at delivery.

This study did not involve any clinical intervention or interaction with patients and only involved compiling information that was readily available in medical records.

Our hypothesis was tested using a 2x2 chi-square contingency statistic.

Results

We found that the average number of grams underestimated in birth weights greater than 4,000 grams were significantly greater than in birth weights less than 4,000 grams.

When stratifying birth weights less than 4,000 grams we found that as the birth weight decreases, the average number of grams underestimated also decreases.

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<th>Overestimation</th>
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<td>&lt;4,000 grams</td>
<td>338</td>
<td>291.2</td>
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<tr>
<td>&gt;4,000 grams</td>
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<td>144</td>
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P<0.01

Not only was the amount of grams underestimated greater for those fetus’ who weighed greater than 4,000 grams but the overall percentage of times that the EFW was underestimated was greater when the fetus weighted more than 4,000 grams. This finding was statistically significant.

Conclusion

Current obstetrical guidelines give liberal suggestions for offering an elective cesarean section for fetal macrosomia, defined as greater than 5,000 grams in a non-diabetic patient and greater than 4,500 grams in a diabetic patient. However, these guidelines are not specific for a defined population group, especially in the context of obesity and diabetic guidelines.
Macrosomic infants are at greater risk for shoulder dystocia and subsequent morbidity such as severe Erb’s palsy which may be a lifelong debilitating condition. The co-morbid conditions obesity and diabetes, which are increased in our obstetrical population, have a higher risk scenario for having a delivery complicated by shoulder dystocia. Providers are traditionally taught that the estimate of fetal weight may be underestimated or overestimated by 10-15%. Our study showed that in the case of fetal macrosomia, the closer the actual fetal weight was up to or above 4,000 grams, the more likely the clinician was to underestimate the fetal weight. There may be multiple reasons for this. One possibility may be that while there are standards for measuring fetal weight, it is still a subjective measure. Most providers really do want normal outcomes and labor management. This may sway a particular reading. There may also be the statistical concept of regression toward the mean; when following an extreme random event (such as estimating a larger than normal fetal weight), the next random event is likely to be less extreme (the provider will estimate of the fetal weight to be closer to the fetal weight of the average in a population). This study indicates how important it is for institutions to assess their own data in light of local differences in the patient population.

Such analyses could have quite significant implications for use of oxytocin for the induction or augmentation of labor. Deliveries where oxytocin was used also show an increase in shoulder dystocia. Therefore, if the fetal weight is underestimated by as much as approximately 500 grams (as shown in this study), the likelihood of having a delivery complicated by shoulder dystocia will increase quite significantly.

This information was incorporated into our oxytocin bundle which resulted in a significant decline in Erb’s palsy without a concurrent increase in our cesarean section rate. We recommend that institutions assess and incorporate use of their own data when developing guidelines and protocols, in conjunction with national guidelines.

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**NBHN Perinatal III Team (Authors/Contributors)**

- Susan Gross, M.D., Department of OB/GYN Chairwoman
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**REGULATORY/LEGAL UPDATE**

**HOSPITAL INCIDENT REPORTING SYSTEMS DO NOT CAPTURE MOST PATIENT HARM**

According to the January 6, 2012 report released by the U.S. Department of Human Services Office of Inspector General (OIG), hospital incident reporting systems only capture an estimated 14% of patient harm events experienced by Medicare beneficiaries. The remaining 86% of patient harm events were either not perceived by hospital staff as reportable (61%), or were events that would normally be reported, but were not (25%).

The report finds that hospitals investigated the events that they considered most likely to lead to quality and safety improvements and found that there were few actual policy or practice changes implemented as a result of those reported events.

As a condition of participation in the Medicare program, Federal regulations require that hospitals develop and maintain Quality Assurance and Performance Improvement programs. Hospitals must “track medical errors and adverse patient, analyze their causes and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.”

All of the hospitals that were reviewed had incident reporting systems designed to capture adverse events and hospital administrators reported that they rely on their systems to identify patient safety issues. The study found that hospital surveyors usually evaluate incident outcomes rather than the collection methods utilized unless a problem arises via the survey process.

The report concluded that in the interest of patient safety, the usefulness of incident reporting systems should be improved. OIG is therefore recommending that the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) collaborate to create a list of events to be reported within hospitals. It further recommends that CMS provide guidance to its surveyors to evaluate the events that are reported by hospitals. Additionally, CMS should scrutinize survey standards for assessing hospital compliance with the requirements to track and analyze events and reinforce assessment of incident reporting system as a key tool to improve event tracking.

OIG suggests that CMS surveyors evaluate information collected by hospitals using AHRQ’s Common Format event reporting tools.

AHRQ and CMS have concurred with the recommendations for strengthening hospital reporting systems.
Recently, I came across an article associated with the potential risk exposures of cigarette smoking at long-term care facilities (LTCFs.) The article summarized an incident at a New York State long-term care facility (LTCF) where a resident sustained burns over 60% of his body as a result of unsafe smoking practices. The resident was left in the smoking lounge unsupervised and it was during this time that the resident placed his ‘used’ match on the side of his wheelchair after he lit his cigarette. It is reasonable to state that the resident did not adequately extinguish the match and that led to a blanket on his lap and his clothing catching fire. During this incident, the resident although assessed by staff to be a ‘self-smoker’, was not supervised; as well, the LTCF fell short of their responsibility to apply a smoking apron.

Further adding to the risk exposure of this incident, staff did not respond timely to the evolving situation, and did not follow policies and procedures developed to monitor residents’ smoking. Several other residents who were in the vicinity of the smoking lounge witnessed the fire and the subsequent delay in emergency response. These residents required psychiatric assessment and intervention after observing the event. After a comprehensive regulatory review of the facts which led to this incident, the LTCF was cited by New York State Department of Health (NYS-DOH) for substandard quality of care; declaring that the LTCF created an immediate jeopardy status. Specific to this case, the facility was sanctioned under F-Tag F323 (h): Facility is free of Accident Hazards. The F-Tag definitely makes certain that the LTCF must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A detailed deficiency report of all of the facts associated with this incident can be reviewed at http://nursinghomes.nyhealth.gov/nursing_homes/deficiency/383/68CN.

This case brings to light the delicate balance of supporting a smoke-free environment, promoting resident safety and ensuring that resident rights are not overlooked in the LTC arena.

Many of you reading this article are probably surprised that LTCFs have smoking lounges; especially, when smoking in NY State is banned in most public places and in healthcare institutions. Smoking at LTCFs was partly encouraged because LTC staff and regulators recognized that facilities supported a ‘homelike’ environment and supported their responsibility for sustaining a resident’s right to exercise ‘self-determination.’ Initially, LTCF leaders and regulatory surveyors acknowledged that banning smoking was an inequitable practice for residents living in a healthcare facility that was considered their home. After all, hospitalized patients could be banned from smoking but within a week’s time frame would be discharged back ‘home’ free to live their lives exercising self-determination; which, most likely included resumption of smoking. However, as we learned more about the deleterious effects of smoking, LTC leaders took a more proactive approach to maximize the welfare of all residents and staff at the facility. With recent health related improvements at many LTCFs, a smoke-free environment is now endorsed for all newly admitted residents. The smoke-free policy is reviewed with residents admitted to the LTCF and they must agree to this rule prior to admission.

This paradigm shift is seen at most LTCFs today recognizing that having a smoking cessation program is critical if smoke-free environments are to be supported. As well, in an effort to satisfy the privileges of current smoking residents (often known in the industry as a grand-fathered smoking patient); a smoking lounge would also be maintained. The ultimate goal is to phase-out smoking at all LTCFs as the grand-fathered residents transfer out or expire.

Until this goal is maximized, LTCFs must support enterprise risk management strategies to evaluate and mitigate the actual or potential exposures contributed by residents who smoke. The above mentioned paradigm shift is recognized in many LTCFs where risk management assessments are performed. As such, clients are focused on assessing facility smoking policies; assessing the facility’s incorporation of a smoking cessation program and staff’s responsibilities when monitoring resident smoking lounges.

As well, all smoking lounges are assessed; staff are evaluated while the smoking room is actively utilized and emergency preparedness equipment is also monitored. To assist readers on the critical assessment competencies that should be performed, please refer to the following risk management strategies outlines:

**Resident Interview Smoking Assessment:**
- Assess your marketing and admission packets – do they clearly detail that the facility supports a smoke-free environment?
- Please refer to the attached smoking assessment for a resident admitted to or living at a LTCF. This assessment meets guidelines which are in support of the minimum data set (MDS) 3.0 schedule. http://www.adddata.com/Downloads/Forms/Smoking.pdf

**The Non-Compliant or Unsafe Smoking Resident:**
- Do you have a policy to address the non-compliant/unsafe smoker?
- Are staff aware of how to assess the environment?
- Does the interdisciplinary team meet to discuss the non-compliant/unsafe resident? Are staff aware of documentation and care planning expectations?
- Is there a need to have a psychological services evaluation and input to formulate a plan of care?
Sample Policy for Regulating Smoking in a LT CF:

- Please refer to the sample policy in the following link. Use this policy as a reference point to assess if your policy addresses the most critical elements.

  http://www.tcs.org/tobacco/NHregulating.htm

Smoking Lounge Assessment:

- Is the smoking lounge well ventilated? Is lighting adequate? Do you keep the lounge secured/locked? What is the location of the nearest fire extinguisher?
- Aside from having a certified aide stationed to monitor the smoking lounge, are there video cameras monitoring and/or recording the lounge? Is another staff member at a remote location monitoring the camera? Can these two individuals communicate with each other? If so, do you use two-way radios?
- Is there a telephone and emergency response button in the lounge? How often are they tested to ensure proper working condition? Are staff assigned to monitor the smoking lounge provided with competency training? Are records maintained? Can staff articulate the facility’s policies?
- How far is the smoking blanket in relation to the lounge? Is there a smoking apron? Are they utilized? Do you assess the smoking blanket or apron for cigarette burns after each use? How often are they inventoried? Has the smoking blanket been taken out of the original plastic casing?

As you can see by the various assessments associated with this article, formal policies, procedures, processes and testing are required to promote concrete risk management transparency.

There are valuable lessons learned from the resultant incident which initiated the writing of this article. We do not have the magic wand to go back in time and reverse some of the outcomes of this event; however, we have a responsibility as Risk Managers to proactively think of improved solutions. That said, here is another potential resolution to mitigate a future recurrence: Routinely, LTCFs perform ‘fire and disaster drills’ as this is a regulatory expectation but it is also a good emergency preparedness exercise. Once a year, activate an unannounced fire drill to the smoking lounge area. As staff respond, this is a valuable opportunity to not only review fire and emergency preparedness policies; LTCFs can seize the moment to review, and address smoking practices along with discussions of staff expectations and responsibilities. The lessons learned in this disaster will hopefully prepare us as risk managers to diminish a future error.

REFERENCES.

1 http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfr&tpl=/ecfrbrowse/Title42/42 CFR483_main_02.tpl
2 Center for Medicare and Medicaid Services (CMS) http://nursinghomes.nyhealth.gov/nursing_homes/deficiency
3 ADL Data Systems, Inc. - Assessment form associated with the company’s electronic medical record system.

Jose L. Guzman, Jr. is a Registered Nurse with extensive clinical and administrative experience in the acute care and in the long-term care (LTC) settings including Director of Nursing, acute care hospital management and operations, as well as, in the insurance and case management industries. Mr. Guzman holds a Master of Science degree in Health Services Management with Distinction, and a Bachelor of Science degree in Social and Behavioral Sciences-Summa cum Laude from Mercy College in Dobbs Ferry, NY and Associates in Applied Sciences in Nursing from Rockland Community College.

In 2009, Mr. Guzman served as Chairperson for the American Society for Healthcare Risk Management (ASHRM) PEARLS-LTC Task Force and was a guest lecturer at the 2010 ASHRM Annual Conference. Currently, he is the Director of Risk Management at Hospitals Insurance Company, Inc. in White Plains, N.Y., and serves as the subject matter expert in LTC services. Mr. Guzman serves on the Board of Directors for AHRMN Y, is an Officer for the ASHRM Board of Directors, as a member of the ASHRM nominating committee, serves on the ASHRM annual conference planning committee and was accepted to appear as a guest lecturer at the 2012 ASHRM Annual Conference.

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<td>Mock Trial Presentation</td>
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<td>111 East 59th Street</td>
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<td>Cost: $75 Current AHRMNY Member</td>
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<td>This year’s networking event will feature a Mock Trial Presentation. Please visit the AHRMNY website to register <a href="http://www.ahrmny.com/events.php">http://www.ahrmny.com/events.php</a>.</td>
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<td>Featuring breakout sessions and topics focusing on Social Media, Reprocessing of SUDS, Peri Natal Safety and Managing Clinician Risk through Education, Risk Management and Safety Innovations</td>
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All upcoming programs, events and notices are sent via email. Please be sure we have your current email address. To update your address, please send email to ahrm@optimum.net.
INSURANCE UPDATE

EMPLOYING PHYSICIANS – MEDICAL MALPRACTICE INSURANCE IMPACT

By: Robert Marshall

The American Medical Association estimates that 1 in 6 physicians throughout the United States work for hospitals. In 2009, it was reported that 65% of physicians who changed jobs became employed by hospitals, and in 2010 it is estimated that 49% of all new physicians were hired by hospitals. As more physicians become employed as part of a hospital, or through larger physician groups, there are some key medical malpractice insurance decisions that need to be made for the respective employer and the employee. Even behemoths like care plans such as United Health, Humana and Well Point, to name a few, are employing more physicians.

There is one common theme – it is a unique challenge for respective institutions, and how each institution deals with the risk financing or insurance decisions is dependent, to a large degree, on the organizations risk tolerance. This column identifies some of the insurance questions and challenges that organizations face as they continue to hire more physicians, and take on additional medical malpractice risk.

Hospitals, for example, that maintain their own captive or are part of group captives which insure their respective medical malpractice risk exposure have many questions, including the following:

- Should the captive insure all of these new employed physicians? Has there been precedent set previously on insurance decisions?
- What limits should the captive provide to the employed physicians? Should they be shared, separate, sub limited, claims made or occurrence?
- Will the captive have enough capital to support the additional risk or does it need to contribute more funds?
- Should the captive pick up the potential malpractice liabilities for prior employment activities, so as to avoid the physician having to buy an expensive tail under his/her respective malpractice that he/she maintained prior to hospital employment?
- What are the pros and cons of purchasing separate malpractice policies for these personnel from insurers outside the captive? If the hospitals decide to purchase separate policies outside the captive, who should the physicians buy from and what limits should the physician maintain?
- How will the hiring of these employed personnel potentially impact the future frequency and severity of malpractice claims against our institution and the captive?
- What is the impact of physician malpractice costs in the physician’s employment contract?
- What impact this will have on captive reinsurance costs, if any?
- How should the captive policy extend coverage for terminated personnel if written on a claims-made form?
- From a physician’s perspective he/she should understand how much limit is afforded to him/her, what insurance company is providing the coverage, and how coverage will extend at the time of termination.
- Along with a review of the employment contract, physicians should review the prospective medical malpractice insurance policy through a qualified medical malpractice broker or insurance consultant, and if the policy is written through a captive, the captive financial statements should be reviewed prior to employment.

Hospitals in New York who purchase primary levels (typically $1m per claim) of medical malpractice coverage through a hospital professional liability insurer will typically be required or urged to separately insure physicians in higher risk specialties. While this requirement and structure will give physicians dedicated malpractice limits it will likely be a more expensive proposition for hospitals to separately insure physicians particularly as the employment trend continues. Hospitals who maintain this risk financing structure typically will purchase the separate policies for their physicians through the same carrier that is insuring the hospital to maintain joint defense and joint defense policy credits.

Hospitals that do not have a captive nor a primary layer of coverage through a medical malpractice insurer usually finance their malpractice risks through a dedicated trust fund or pay their medical malpractice liabilities as they come due out of operations. Institutions who maintain this structure have similar questions and challenges to other institutions but have some additional challenges, such as:

- Adequacy of self-insurance funding or the hospital’s ability to assume this additional risk;
- Amount of the medical malpractice limit the hospital should extend to the employed physician under their trust and/or employment contract;
- The physician(s) should be more concerned about the prospective employer’s financial ability to meet future financial obligations should a claim be made against him/her;
- Should the hospital purchase separate malpractice policies for all of their employed physicians under these malpractice structures or, perhaps some of them?
- Should the liabilities be treated as occurrence or claims-made? What are the advantages and disadvantages?

Several larger physician groups in New York State have formed Risk Retention Groups to finance their medical malpractice risk exposures. These groups, like hospitals, who have captives have similar challenges in determining whether to insure all employees under the RRG; how to structure the limits; whether to pick up prior acts; what type of coverage grant should be offered (claims-made or occurrence) and how much premium should be charged. Typically physician RRG’s purchase reinsurance programs within their gross limit structure, and their reinsurance partners may dictate, to some extent, the treatment of prior acts, premium levels, and terms offered through the RRG.

These are just some of the questions and considerations for medical malpractice insurance that institutions need to address when dealing with newly hired physicians.

Rob Marshall is a Senior Vice President and Health Care Team Leader for Willis New York Office.

Willis Group Holdings PLC is a leading global insurance broker. Willis develops and delivers professional insurance, reinsurance, risk management, financial and human resource consulting and actuarial services to corporations, public entities and institutions around the world. Willis has more than 400 offices in nearly 120 countries with a global team of approximately 17,000 associates serving clients in virtually every part of the world.
One of the most rewarding aspects of working in healthcare is experiencing medical science advance in ways that potentially helps thousands, if not more, patients enjoy a longer and higher quality life. These advancements rarely garner the attention of the general public or mass media, but nonetheless can be described as everyday miracles. However, when potential complications arise from these advancements, the media and legal spotlight can be intense.

This is understandable, as medical consumers deserve the protection and safety of oversight and legal recourse. Hospital risk management stands in the forefront of this duality, as advancements in patient care should be encouraged. But, vigilance is necessary to ensure that these advancements are safe. Risk management is not in the position to best serve the latter, which is performed by quality assurance professionals, scientists and physicians. However, risk management can play a vital role in ensuring that all patients are provided the most up to date information before making the informed choice of not only the risks, benefits and alternatives to a particular procedure – but the risks, benefits and alternatives to all devices and pharmaceuticals used.

This is best exemplified by metal on metal hip implants. There is an emerging cottage industry of lawsuits springing up nationwide regarding these prostheses. In fact, as recently as this summer, a multidistrict litigation “MDL” was certified in the Northern District of Texas for all claims against Pinnacle Hip Placement Products – a major producer of these implants. As of February 16, 2012, this MDL consisted of 277 actions. Many of these actions were transferred to this north Texas federal court after being originally commenced in states as far flung as California, Illinois, Michigan and New Jersey.1

NEW MAY NOT ALWAYS BE BETTER

Advancement in medical science has allowed hip replacement surgery to become one of the most common orthopedic surgical procedures in New York.2 This is likely consistent with the statistical breakdown of surgical procedures at your hospital. Thus it is of utmost importance to implement protocols and procedures to ensure that this surgery is performed in conformance with the latest advancements in surgical theory. Of course, the skill and performance of the attending surgeon and hospital staff is crucial to the success of the surgery. However, another factor plays an oversized part in the efficacy of the surgery – and that is of course the implant. This medical device is obviously outside the control of the hospital and is, in fact, directly chosen by outside attending physicians. However, there has been an uptick in litigation due to at least one well-known recall and thus this is a topic of great interest to risk management and medical care provider alike.3

When a hip replacement is performed, the arthritic, damaged hip joint is removed. The ball-and-socket hip joint is then replaced with an artificial implant.4 The materials used in the implant depend on several factors, including the age of the patient, the activity level of the patient, and the surgeon's preference.5 This analysis is most likely performed by the attending surgeon independent of hospital intervention.

Until recently, metal-on-metal implants accounted for nearly one-third of every hip replacement surgery performed each year in the United States.6 According to some estimates, approximately 500,000 patients have received a metal-on-metal replacement hip.7

Originally, the “metal-on-metal” hip implants were regarded by those in the orthopedic community as a major advancement over the previous designs that used both metal and plastic. This was in part based on the belief that, due to their more solid makeup, there would be lower wear rates, and it would thereby last longer. This was a large benefit, because a well-known risk of a total hip arthroplasty is the need for revision.8 As a result, physicians were eager to enlarge the time between surgeries and provide longer lasting efficacy to their patients. However, medical science is unpredictable and there have been recently raised concerns about the wear debris that are generated from this type of implant.

This concern is due to the friction of the metal ball grinding against the metal socket. This friction can cause metal ions to be released into the blood and throughout the entire body. Additionally, some of these tiny metal particles may wear off the device itself and enter the area surrounding the implant, causing local damage. The concentration of these metal ions will increase over time, possibly causing various complications.9 This is a scary prospect, as risk managers, insurers and defense counsel alike all abhor the possibility of infinite claims of damages. It is not a stretch to call plaintiffs bar creative in conceiving an ever broadening spectrum of possible injuries and damages in medical malpractice actions. Thus, the arms race between the defense bar and plaintiffs bar has likely just began to determine what injuries potential plaintiffs will be able to blame on this unintended surgical complication. It cannot be ignored that the very benefit of this device – longer potency – means that the time period of potential harm may be expanded too. While each jurisdiction will need to determine the statute of limitations cut-off for such claims, it is not an exaggeration to state that claims arising from these implants may haunt risk management offices for years to come.

In the United States, there is no official data on the number of all-metal hips that have failed prematurely because the outcomes of orthopedic procedures are not
formally tracked by the government or private companies. However, a recent report from the National Joint Registry of England and Wales, a large British Registry that includes records from about one million people who had hip, knee, and ankle replacements, has concluded that people who get metal hip replacements are more likely to need a replacement compared to those who get a plastic hip replacement.10 11

Traditionally, hip replacements last more than ten years, but these officials noted that some of the metal hip replacements were failing within a few years. In fact, the report noted that almost fourteen percent of patients who got an all-metal replacement needed the joint removed or replaced after seven years. That compares with just three percent of patients who got a hip replacement made of plastic and needed another replacement within the same time.12

In the past year, the media, including the New York Times, has shed light on multiple cases of patients that have undergone the all-metal hip replacement surgery, and have been severely injured due their high failure rate. This has led to many patients having to suffer through months without a hip, and in many cases, serious infection. Again, each jurisdiction must reach its own determination on what damages it will allow a plaintiff to attach to these implants, but current New York law certainly will allow a plaintiff to claim that the faulty hip implant has a competent casual link to an infection following a remedial surgery.

The original assumption, giving preferential treatment to the all-metal hips, was based on the premise that it would be possible for the surgeons to place the metal ball and socket in a position that would create as little friction as possible. However, the Food and Drug Administration has now concluded that there is no way to completely avoid the devices from producing metallic debris.13

In furtherance of this conclusion, last year the FDA ordered manufacturers of all metal hips to undertake emergency studies of patients.14 Lawmakers are calling for a tightening of how the FDA scrutinizes these new implants.

Federal regulators and medical researchers are scrambling to determine how many implant recipients have been injured by the devices. According to one estimate, of the 500,000 patients in the United States that have gotten an all-metal hip in the past decade, there is a strong probability that tens of thousands will have to undergo painful early replacement procedures. Further, even if the share of seriously injured patients stays low, thousands are likely to be affected.15 Of course, the amount of claims arising from truly unaffected patients cannot be discounted. While frivolous, these claims will surely arise as plaintiff’s bar rushes to file lawsuits on the local level and build class actions and MDLs in the federal court.16

Indeed, this situation has already led to scores of lawsuits and complaints against makers of all-metal replacement hips, as well as the surgeons who may have improperly implanted the devices. In fact, one media outlet has counted over 5,000 such claims to present. Some 3,500 patients had filed a lawsuit involving a device made by DePuy, a division of Johnson & Johnson, and the makers of one of the troubled all-metal devices implanted in 40,000 patients in the United States. Ominously, that device was recalled in 2010.17

There is no reason to believe that hospitals will not be affected, as the raw numerical potential of this is voluminous.

Under New York law, a hospital will be vicariously liable for claims against surgeons who perform this procedure if they were authorized by the hospital (as opposed to being the patient’s attending physician). There is also the potential for claims arising directly against the hospital for a failure to limit the use of these devices, or otherwise force their attending surgeons to be properly trained in the implantation of these devices.

Recent studies indicate that these recent events have already led to a drop in the use of metal joints.18 As applied to hospital risk management, an analysis should be performed regarding the authorized implants allowed. Further, patients should be explicitly informed of the potential risks, benefits and alternatives relative to hip replacement surgery – including the risks, benefits and alternatives to implant brands and designs. Also, the informed consent should be well charted.

As always, your hospitals, physicians and medical device manufactures will strive to advance the care provided to patients. This has amounted to great benefit to patients, but vigilance is best as new technology will always be a prime area to be exploited by the plaintiffs bar.

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1 See In Re Depuy Orthopaedics, Inc., 787 F. Supp. 2d 1358 (J.P.M.L. 2011)
2 Greg A Erens, MD, Thomas S Thornhill, MD, Total Hip Arthroplasty
4 Greg A Erens, MD, Peter H Schur, MD, Total hip replacement (arthroplasty)
5 See Total Hip Arthroplasty
8 Greg A Erens, MD, Thomas S Thornhill, MD, Complications of Total Hip Arthroplasty
9<http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/MetalonMetalHipImplants/ucm241604.htm>
11 <http://www.nrcentre.org.uk/NrCentre/Portals/0/Documents/NJR%208th%20Annual%20Report%202011.pdf>
12 See Id.
13 <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/MetalonMetalHipImplants/ucm241604.htm>
15 See id
16 See In Re Depuy Orthopaedics, Inc., 787 F. Supp. 2d 1358 (J.P.M.L. 2011)
18<http://www.nrcentre.org.uk/NrCentre/Portals/0/Documents/NJR%208th%20Annual%20Report%202011.pdf>

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Ari Erlichman is associated with Bower Monte & Greene, P.C. He is a 2011 graduate of Georgetown University Law Center, where he was a member of the moot court and 2010 recipient of the Cali Award given for highest course grade. Since recently joining the firm, Mr. Erlichman has focused his practice on defending medical malpractice and long-term residency claims. During his off-time, Mr. Erlichman enjoys spending time with his wife and two toddlers.
The Neurologically Impaired Infant Indemnity Fund was designed to reduce medical malpractice costs, principally borne by the Medicaid program. In February 2012, the MRT approved a package of recommendations, including “Proposal 131,” which, when Governor Cuomo took office on January 1, 2011, he appointed the Medicaid Redesign Team (MRT) to save money within Medicaid. AHRMNY had 168 registrants and 138 attendees for a packed audience!

Our President, Jon Rubin, provided opening remarks and kicked off the morning, introducing the agenda. Daniel Vulkelich presented a comprehensive overview of the history and current status of reprocessing of single use devices as well as FDA oversight, the safety record of reprocessing and economic and environmental considerations. The Association of Medical Device Reprocessors (AMDR) is a non-profit Washington D.C. based trade association representing the legal, legislative and regulatory interests of third-party reproprocessors of ‘single use’ devices. 95% of the reprocessing is done in the U.S. and over 60 million devices were reported to be reprocessed safely to date. The third-party reprocessing industry emerged approximately two decades ago in the U.S. Reprocessors individually clean, refurbish, inspect, function-test, package and sterilize each device for a cost savings of about 50% to customers.

Mr. Vulkelich explained that the ‘single use’ label does not always mean single use. Single use is not a regulatory requirement, is chosen by the manufacturer and the decision to label a device as single use or reusable rests with the manufacturer. He further stated that some devices may be labeled as single use because the manufacturer chooses not to conduct the studies needed to demonstrate that the device can be labeled as reusable.

The FDA treats reprocessors as manufacturers in terms of regulation (since 2000). Mr. Vulkelich discussed FDA requirements and the topic of informed consent (Mr. Vulkelich stated that it is not necessary as reprocessed devices are legally marketable, subject to FDA device manufacturer requirements and are not investigational or experimental devices). He provided safety statistics (20+ years of clinical history, 60+ million devices reprocessed in the US, zero deaths attributed to reprocessed devices per FDA’s MAUDE database, no insurance claims to date, very few adverse event reports). He provided statistics on cost savings related to reprocessed devices—U.S. hospitals have saved over $600 million to date, with a typical hospital saving $500,000 to $2 million per year. Mr. Vulkelich concluded by stating that reprocessed devices provided an environmental benefit by eliminating more than 13,000 tons of medical waste in the U.S. to date.

There was a robust question and answer session following the reprocessing presentation. In addition, AHRMNY received a flurry of e-mail on the topic. The Risk Management Quarterly will present a follow-up article in the Spring 2012 edition by one of our sponsors, Schiavetti Corgan DiEdwards Weinberg & Nicholson, LLP, that will address some of the questions raised regarding this subject.

The second speaker, the Honorable Douglas McKeon, provided a broad overview of the malpractice environment in New York State. He pointed out that the single largest driver of hospital malpractice costs is obstetrics, with over 40% of payments made in cases involving neurologically impaired infants. In illustration, one of the hospital’s insured by Hospitals Insurance Company Inc. (HIC) calculates a loss of $8,000 per Medicaid-delivered newborn. In a 2010 survey done by Greater New York Hospital Association (GNYHA), hospitals surveyed said medical malpractice costs represented 50% of hospital operating costs. Of five hospitals/systems surveyed, four incurred costs of $120 million or more each.

According to Crain’s, about 50% of medical malpractice costs are due to suits involving neurologically impaired infants. Medicaid pays for approximately 50% of New York State deliveries and, therefore, pays the medical costs of a significant number of children affected by neurological impairment, many of whom have received an award in a medical malpractice action. Specifically, Medicaid pays for approximately 70% of infant deliveries in the Bronx and Brooklyn.

When Governor Cuomo took office on January 1, 2011, he appointed the Medicaid Redesign Team (MRT) to save money within the Medicaid program. In February 2012, the MRT approved a package of recommendations, including “Proposal 131,” which, inter alia, proposes caps on non-economic damages for medical malpractice awards and urged the establishment of a Neurologically Impaired Infant Indemnity Fund. The Fund was designed to reduce medical malpractice costs, principally borne by hospitals, for obstetrical claims. The Fund was projected by GNYHA to reduce medical malpractice costs to hospitals by 20% or $320,000,000.

Judge McKeon explained that the statute relieves defendants (in certain specified obstetrical malpractice actions) from paying the future medical expenses component (“Fund damages”) of any post-April 1, 2011 judgment or settlement and mandates that “qualified plaintiffs” be enrolled in a program (i.e. The Fund) which pays for medical expenses as incurred (PHL §2999-j[6]). There is a collateral source provision requiring qualified plaintiffs to use private insurance before resorting to the fund (PHL §2999-j[6]).

*As reported on 12/1/09 by Hospitals Insurance Company Inc. at the New York State Senate Standing Committees on Insurance, Health and Codes.
Prior to the enactment of the statute, obstetrical malpractice actions (including claims for future medical expenses), were settled with up-front lump sum cash payments, thus pre-paying future medical expenses. If a child died sooner than expected or required a level of future care less than projected at the time of settlement, the unspent (surplus) funds went to the child’s estate for non-medical use instead of being returned to the insurer or medical provider. Once a child is enrolled, the Fund pays for all covered future medical expenses even if care is more extensive than was estimated at the time of settlement.

The definition of a birth related neurological injury is defined in PHL §2999-h[1] as “an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation or by other medical services provided or not provided during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability...or both. This definition shall apply to live births only.” The Fund pays for future medical costs and other expenses (i.e. medical equipment, home modification, vehicle modification, etc.) as described in PHL §2999-h[3]. These expenses were formerly borne by Medicaid. Judge McKeon described the Fund in detail and reviewed how the plaintiff’s attorneys fees are calculated (a portion is paid by a defendant in a Fund) and stated that damages, other than future medical expenses, are paid with lump sum cash. The amount of non-Fund damages is determined by an allocation of the lump sum settlement (the allocation also determines how much of the attorney’s fee is paid by the defendant).

The Judge concluded the presentation by stating that the creation of the Fund was a way to both reduce Medicaid costs and medical malpractice premiums while simultaneously providing a lifetime of guaranteed care for obstetrical mishap victims for the duration of their lives.

Our audience consisted of a number of attorneys and risk managers who posed numerous questions about the Fund, the calculation of attorney’s fees and the definition of a neurologically impaired infant, among other topics.

On February 3, 2012, AHRMNY hosted a successful and well attended one hour Webinar entitled "Emergency Preparedness: Are You Ready?"

Joseph Marcellino, Director of Emergency Management in Coney Island Hospital presented a comprehensive guide for healthcare facilities to optimize readiness when faced with the enormous challenges of safely evacuating patients in the event of a disaster. Evacuation is defined as “movement of patients out of the affected facility when the facility cannot maintain a safe environment of care. Evacuation may be emergent (fire or other immediate life safety threat) or non-emergent (delayed life safety threat or anticipated evacuation).”

He urged the audience to “expect the unexpected” as he shared the firsthand experiences and lessons learned by Coney Island Hospital’s evacuation in advance of Hurricane Irene’s arrival in New York in August, 2011. He offered practical steps toward organizational readiness and addressed complex decisions that must be made prior to ensuing disaster and discussed the need for collaboration with external technical experts, internal command structure, community emergency management and Emergency Medical Services. He emphasized the critical importance of ongoing internal and external communication and described the factors influencing the facility’s actions as proximity/time to event, duration of event, gravity/impact of threat and impact of actions taken.

The presentation raised sobering issues of accountability both to our patients as well as to our communities and stressed the critical need for advance planning and continuous readiness.

We gratefully acknowledge Pamela Monastero, Senior Associate Director Coney Island Hospital, for coordinating this excellent educational program. Pamela Monastero, AHRMNY Board member and the author of the RMQ’s Risky Business Column, provided a comprehensive review of the experience by Coney Island Hospital as well as emergency preparedness strategies for the Risk Manager in the Fall RMQ.
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