

**SUMMER 2009**

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## PRESIDENT'S MESSAGE

In the words of Charles Darwin, *"It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change."* As professionals in the healthcare industry we all are consistently challenged with change. Typically we, as the Risk Managers, are the change agent. We face the contemporary regulatory modifications and impending transformation coming out of the leadership in Washington, DC. The fiscal challenges we all encounter or will in the near future certainly impact the way we do business. Through it all, we must steadily advocate for practical patient safety and risk management strategies to fulfill our mission in these times of uncertainty.

This coming year **AHRMNY** celebrates its 25<sup>th</sup> year anniversary. On March 5<sup>th</sup>, 2010 we are commemorating 25 years of incorporation as the premiere New York Healthcare Risk Management organization. As part of our ongoing commitment to the industry we have re-designed the website. Certain change as you will see is good, and in this case it's terrific. We now will provide you with the opportunity to join or renew your membership and register for our events via the website. You will continue to enjoy access to our job bank, journal, bylaws, and other important information. Stay current by visiting us at [www.ahrmny.com](http://www.ahrmny.com). Please share your comments and recommendation with me.

If you have not read our publication recently, it is time to indulge yourself. Our educational newsletter has grown into a journal and members will now enjoy the dynamic **AHRMNY Risk Management Quarterly**. The journal continues to provide coverage of relevant regulatory topics, clinical liability concerns, legal updates, practical risk management tips, and many other issues of interest to risk management, patient safety, and other healthcare and legal professionals.

We will continue to provide contemporary risk management education sessions throughout the year to meet the needs of our diverse membership. Recent topics have included HIPAA and Privacy, CPLR Article 50-A, Healthcare Acquired Infections (HAIs), Patient Safety Organization (PSO) Regulations, Behavioral Health across the continuum of care and key legal/risk management issues in the defense of psychiatric malpractice cases, Communication Strategies to improve patient outcomes and promote satisfaction and teamwork, Managing Economic Volatility in a Healthcare Institution -the CFO Perspective, Emerging Fiscal Trends in Healthcare Policy, Funding and Legislation, The Emergency Department as the Private Office Substitute and the Impact of the Uninsured, Section-111 Mandatory Reporting for Self-Insured and Captive Insurers under Medicare Secondary Payer Rules, and Directors and Officers Liability. Please contact me with any recommendations you may have.

### *President's Message (cont'd)*

The number of active members in our chapter continues to thrive. This year the number of active members climbed to 276. Active membership provides you the opportunity to keep current on relevant risk management issues and network with other industry professionals. During our 25<sup>th</sup> Anniversary year we are maximizing our efforts to strengthen AHRMNY, and celebrate our expanding membership. We need you to be enthusiastically involved and strongly encourage you to share your talents in one of our working committees. Most committees include a minimal commitment on your behalf to a monthly telephone conference call and some nominal additional activities to meet the goals of the committee.

Your AHRMNY Board is committed to continuing to exceed your expectations and maintain our chapter as the best within the ASHRM family. In the passionate words of Vince Lombardi, *"The price of success is hard work, dedication to the job at hand, and the determination that whether we win or lose, we have applied the best of ourselves to the task at hand."*

Best regards,  
**Mike Midgley**  
President, AHRMNY

## EDITOR'S CORNER

*The Risk Management Quarterly (RMQ)*, the official newsletter 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 newsletter will contain articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulations, as well as notices of improvement and other relevant information of interest to risk managers. The articles are usually written by AHRMNY members, so the newsletter serves as an opportunity for members to showcase their writing talents.

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

Please forward any ideas or submissions for publication in the **RMQ** to "Editors", via email with attachments to: [CGulinello@lmcnc.com](mailto:CGulinello@lmcnc.com)

The deadline for submission & consideration in the next newsletter is October 15, 2009.

### **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

### **Editorial Committee:**

Judith Block

Carol Gulinello

Pamela Monastero

Ruth Nayko

Linda Rowett

Peggy Sullivan

The information presented in  
**THE RISK MANAGEMENT QUARTERLY**  
is for educational purposes only and  
not intended to be relied upon in any  
particular situation.

## GETTING BACK WHAT'S YOURS: PROTECTING PRACTITIONERS' PROPERTY RIGHTS IN MEDICAL RECORDS

By: **Jacqueline Mandell, Esq.**  
**Dennis J. Dozis, Esq.**

In the ordinary course of practice, physicians and medical facilities often receive requests for the release of their records and, in the case of mammogram films and pathology slides, the provider is often forced to release the originals rather than copies or re-cuts. Not infrequently, these medical materials become the subject and indeed the key evidence in litigation and, having released the records pursuant to a duly executed authorization to do so or in accordance with a particular statute, the medical provider finds himself in the unenviable position of having to prepare a defense to litigation without the critical piece of evidence. Fortunately, New York law holds that medical records, including films and pathology slides, are the property of the medical provider, so long as the provider merely “lent” or only “temporarily transferred” possession of the records, films or slides to the patient, but did not “relinquish ownership” of the records.<sup>1</sup>

For example, Public Health Law section 17 expressly provides that an examining, consulting or treating physician or hospital must release ORIGINAL mammograms, rather than copies thereof, upon the written request of any competent patient.<sup>2</sup> In the federal courts, Section 900.12 of Title 21 of the Code of Federal Regulations requires that each facility that performs mammograms shall upon request by, or on behalf of the patient, permanently or temporarily transfer the ORIGINAL mammograms and copies of the patient’s reports to a medical institution, or to a physician or health care provider of the patient or to the patient directly.<sup>3</sup> The Courts will order the patient to return the original medical records to the provider or institution upon a showing that the provider or institution did not transfer ownership of the records upon their release to the patient.

In 1985, New York’s highest court held that financial records and patient records generated at a patient care program of a medical college were property belonging to the college. See Albany Medical College v. McShane.<sup>4</sup> The New York Appellate Division has largely followed this rule. In Paterna v. Zandieh, the plaintiffs sought an order directing the defendant hospital to deliver all of the plaintiff’s original x-rays

to the plaintiff’s counsel for the plaintiff’s expert to review while the litigation was ongoing. The Court held that the x-rays were the property of the hospital and while the plaintiffs had a right to reasonable access to the films, they did not have the right to unsupervised inspection of them. The plaintiffs were permitted to either make copies of the x-rays or examine the originals at the offices of the hospital’s attorney.<sup>5</sup>

A more significant problem occurs when the plaintiff is in possession of the original records and the defendant needs them back in order to prepare its defense to the action. Such was the situation in Gerson v. New York Women’s Medical, P.C. where the defendant physician gave his patient her original mammogram films so that she could consult with another physician. The patient sued the physician and then refused to return the original mammograms to him. In directing the plaintiff to return the films, the Court held that records created by a physician in the examination and treatment of a patient are property belonging to the physician and must be returned where the physician never relinquished ownership of them.<sup>6</sup>

Obviously then, it is critically important that the medical provider take steps to preserve his ownership interest in any records that he releases to the patient. We recommend that before fulfilling a patient’s request for any original records, films or pathology slides, the provider have the patient execute a release form expressly stating that the patient understands that he is obligated to return the medical records to the provider or facility as soon as possible. In the absence of such a release, a court may find that the medical provider “permanently transferred ownership” of the medical records to the patient.

Such was the case in Regensdorfer v. Orange Regional Medical Center, where the plaintiff removed original mammogram films and original pathology slides from the Medical Center. When she brought suit against the institution, she refused to return the films or the slides. The Court found that the defendant had “permanently transferred” ownership

of the original mammogram films to the plaintiff and would not compel the plaintiff to return the films to the hospital. However, the defendant submitted an affidavit from the Director of the Pathology Department stating that the slides were merely loaned to the plaintiff and that there was no intent on the part of the hospital to relinquish ownership of those slides. Since the plaintiff was unable to refute the affidavit, the Court required the plaintiff to return the pathology slides to the hospital.<sup>7</sup>

Similarly, in Chervonskaya v. Bentley, the defendant radiology facility released original mammogram films to the plaintiff pursuant to Public Health Law section 17. When the plaintiff commenced suit against the facility, the defendant sought the return of the original films. Fortunately, upon releasing the films, the defendant caused the plaintiff to execute release forms expressly stating that the plaintiff was obligated to return the original films to the facility. The Court agreed that the defendant never relinquished its ownership of the original films and compelled the plaintiff to return them.<sup>8</sup>

Original radiological films and original pathology slides are undoubtedly the “best evidence” in cases alleging malpractice in the interpretation of those studies. Therefore, while the defendant cannot prevent the plaintiff from examining these crucial records, it behooves the defendant to remain the “owner” of the original materials. Ensuring that the party requesting the original records executes a release clearly expressing that the materials are the property of the provider and the patient remains obligated to return the original records to the provider, will go a long way towards assisting in preparing the defense of litigation.

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#### Brief Bio Sketches

**Jacqueline Mandell** is appellate counsel to the law firm of Kaufman Borgeest & Ryan LLP and she has particular expertise in medical malpractice and general liability matters. She has obtained numerous appellate decisions favorable to the Defense Bar, including a landmark decision on informed consent and the first decision issued by the Second Department on the utilization of Frye hearings. Ms. Mandell has had significant appellate success in medical, legal, dental, and chiropractic malpractice actions as well as general liability matters. Ms. Mandell also has extensive experience in complex motion practice.

**Dennis J. Dozis** is an associate with the law firm of Kaufman Borgeest & Ryan LLP and he also specializes in appellate litigation and complex motion practice. Mr. Dozis handles all types of medical malpractice and general liability matters. Prior to joining Kaufman Borgeest & Ryan LLP, Mr. Dozis served as a court attorney for the Appellate Division of the Supreme Court of the State of New York, Second Judicial Department, where he gained extensive experience in appellate practice.

<sup>1</sup> See Waldron v. Ball Corp., 210 A.D.2d 611, 619 N.Y.S.2d 841 (3<sup>rd</sup> Dept. 1994) lv. denied 85 N.Y.2d 803, 624 N.Y.S.2d 373 (1995) see also Matter of Hernandez v. Lutheran Medical Center, 104 A.D.2d 368, 478 N.Y.S.2d 697 (2<sup>nd</sup> Dept. 1984); Casillo v. St. John's Episcopal Hosp., Smithtown, 151 Misc.2d 420, 580 N.Y.S.2d 992 (Sup. Ct., Suffolk County 1992); Application of Striegel, 92 Misc.2d 113, 399 N.Y.S.2d 584 (Sup. Ct., Orange County 1977); In re Estate of Finkle, 90 Misc.2d 550, 395 N.Y.S.2d 343 (Sur. Ct. 1977) aff'd 59 A.D.2d 862, 399 N.Y.S.2d 183 (1<sup>st</sup> Dept. 1977); In re Culbertson's Will, 57 Misc.2d 391, 292 N.Y.S.2d 806 (Sur. Ct. 1968).

<sup>2</sup> New York Public Health Law § 17.

<sup>3</sup> 21 C.F.R. 900.12.

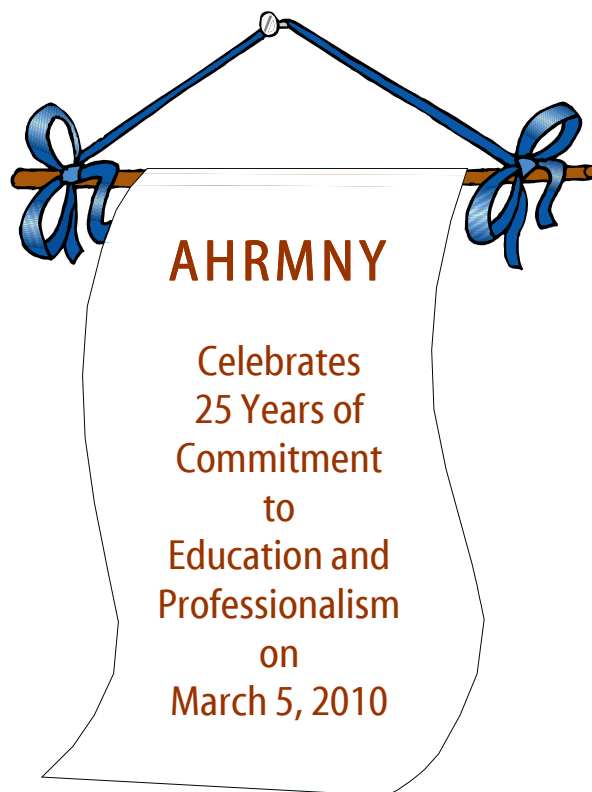
<sup>4</sup> Albany Medical College v. McShane, 66 N.Y.2d 982, 499 N.Y.S.2d 376 (1985).

<sup>5</sup> Paterna v. Zandieh, 130 A.D.2d 471, 515 N.Y.S.2d 54 (2<sup>nd</sup> Dept. 1987).

<sup>6</sup> Gerson v. New York Women's Medical P.C., 249 A.D.2d 265, 671 N.Y.S.2d 104 (2<sup>nd</sup> Dept. 1998).

<sup>7</sup> Regensdorfer v. Orange Regional Medical Center, 21 A.D.3d 359, 799 N.Y.S.2d 571 (2<sup>nd</sup> Dept. 2005).

<sup>8</sup> Chervonskaya v. Bentley, 55 A.D.3d 650, 867 N.Y.S.2d 107 (2<sup>nd</sup> Dept. 2008).



## The Impact of the New York State Office of the Medicaid Inspector General on Long Term Care

By: Ruth Nayko, RN, MBA, CPHRM  
Director, Risk Management & Regulatory Affairs  
St. Francis Hospital

New York has the Nation's largest Medicaid program with over \$46 billion per year.<sup>1</sup> The Office of Medicaid Inspector General (OMIG) was established in 2006 by statute as an independent entity within the New York State Department of Health to improve and preserve the integrity of the Medicaid Program by conducting and coordinating fraud, waste and abuse control activities for all State agencies responsible for services funded by Medicaid. According to the OMIG website, the OMIG Mission Statement is "To improve the efficiency and accountability of the New York State Medicaid program by preventing and detecting fraudulent, wasteful and abusive practices within the Medicaid program."<sup>2</sup>

Since a large percent of long term care is reimbursed by Medicaid, this sector of healthcare providers are the most significantly impacted by OMIG. Long term care includes skilled nursing facilities, assisted living facilities, adult day health care, and home health care.

The New York State Office of the Medicaid Inspector General "2007 Annual Report" represented the first full year of operation of the Office of the Medicaid Inspector General. Fifty-one assisted living facilities (ALF) were identified as having improperly claimed Medicaid reimbursement when their residents were in hospitals. Recovery letters were sent in February 2007 requesting repayment of the per diem rate paid to the ALF while the Medicaid enrollee was hospitalized, resulting in recoveries of \$209,000. In 2007, the OMIG issued 147 nursing facility audits and identified \$37.1 million in overpayments. Nursing facilities' Medicaid rates have two components, operating and capital. The base year for the operating portion is fixed, whereas, each year's capital costs are used for the capital portion of the rate. A new base year (2002) was applied as of January 1, 2009. Thus, the OMIG employees have to analyze more than 650 nursing facilities' 2002 base period costs. This analysis was to have been initiated in November 2008 and will result in the targeting of facilities for audit. The OMIG audits identify inappropriate or unallowable costs, duplicate Medicare Part B payments, services dropped by the nursing facility but included in the reimbursement formula, rate appeal adjustments, and prior audit adjustments to property and operating costs that need to be carried over into subsequent rates (rollovers).

According to the New York State OMIG "2007 Annual Report", at the time the OMIG was created, one of the main issues in controlling Medicaid fraud waste and abuse was the lack of effective program integrity oversight of providers whose conduct did not meet the criminal threshold of intentional fraud provable beyond a reasonable doubt, but who were receiving Medicaid funds

to which they were not entitled. During 2007, OMIG identified the following goals:

- "To work closely with and provide support for, health care providers in developing their internal systems and controls, such as corporate compliance and voluntary disclosure in order to prevent improper payments"<sup>3</sup>
- "To become the national Medicaid leader in the areas of data mining, integration and program measurement"<sup>4</sup>
- "To develop a professional investigative unit capable of conducting and managing complex investigations, while supporting program integrity efforts"<sup>5</sup>

In April 2008, the OMIG issued its first annual work plan for State Fiscal Year 2008-09. The plan was posted on the OMIG web site ([www.omig.state.ny.us](http://www.omig.state.ny.us)) to promote transparency of operations to providers and is useful for compliance officers. The "OMIG Medicaid Work Plan for SFY 2008-09" indicates that key functions include working in a coordinated manner with the Attorney General's Medicaid Fraud Control Unit (MFCU), recovering overpayments and pursuing civil and administrative enforcement actions against those who engage in fraud, waste or abuse or inappropriate acts perpetrated within the Medicaid program, and making information and evidence relating to potential criminal acts which may be obtained in carrying out duties available to appropriate law enforcement agencies. In 2006, the State of New York entered into an agreement with CMS requiring the state to identify fraud and abuse recoveries of \$215 million in Federal Fiscal Year 2008. For the State Fiscal Year 2008-09, the OMIG is conducting Medicaid rate audits for nursing facilities in the following areas: base year, rate appeals, property/capital cost audits, rollovers, dropped ancillary services, patient review instrument, and bed reserve payments.

On April 22, 2009, James G. Sheehan, Medicaid Inspector General New York State Office of the Medicaid Inspector General testified before Committee on Homeland Security and Governmental Affairs Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security on Eliminating Waste and Fraud in Medicare and Medicaid that measured by fraud and abuse recoveries reported to CMS, New York was the most successful state in the nation in Medicaid program integrity over the past year identifying recoveries of over \$550 million. Mr. Sheehan also testified that we need to move to a system that requires and supports providers having an effective and appropriate billing and compliance systems in place. Additionally he stated that

senior executives and board members must be held accountable for failing to have systems to prevent improper billing.

In April 2009, the OMIG issued its second annual work plan for State Fiscal Year 2009-2010 on the OMIG web site ([www.omig.state.ny.us](http://www.omig.state.ny.us)). The plan is more comprehensive and includes more specifics than the 2008-09 plan. The plan clarifies that in 2006, New York State signed an agreement with the United States Department of Health and Human Services to repay health care modernization grants to New York with the state's recovery of more than \$1.6 billion in fraud and abuse payments between October 1, 2007 and September 30, 2011. Known as F-SHRP (for Federal-State Health Reform Partnership), this agreement contains strict requirements for the state to meet in terms of actual recoveries. For FY 2009-10, Governor David A. Paterson and the Legislature have established a goal of \$870 million in state-share recoveries and cost avoidances for OMIG. For FY 2009-2010, temporary staffing costs have been added to nursing facilities' audits.

Jim Sheehan, Medicaid Inspector General's presentation "A View From the OIG: IDATA Mining in Health Care Compliance and Regulation: The Next Phase in Health Program Integrity" states that program integrity means a focus on effective compliance programs including NY-mandatory "effective" compliance programs for skilled nursing facilities, failure to have effective compliance program is basis for exclusion, "effective" compliance program requires disclosure to state of overpayments received, when identified and "effective" compliance program requires risk assessment and remedial measures.

On 6/3/09, James G. Sheehan, Medicaid Inspector General State of New York presented "The Center to Promote Health Care: Medicaid Risk Areas and Health Program Integrity" to the New York Association for Homes and Services for the Aging. The presentation stated that New York has among the highest Medicaid nursing home expenditures including more \$ per day, more days, higher % of Medicaid patients in nursing homes, higher daily rates and a total cost of \$6 billion/year per the DOH/OLTC. Issues specific to skilled nursing facilities were presented. These issues included quality of care such as facilities failing to make required reports of abuse or neglect and/or concealing errors as well as failing to meet minimum standards of care. Other issues include upcoding on review instruments (MDS reviews); early warning signals on financial issues such as cramming operating costs into base years, cars on cost reports; review of new base years approved by the Bureau of Long Term Care Reimbursement as the OMIG's audits will focus on inappropriate and unallowable costs included in the RHCf rates; nursing home billing-bed reserves; RHCf's are required to notify the Department of Health when any previously offered service is deleted, which may lead to a drop in a particular RHCf's rate because an ancillary service is no longer available – OMIG will review whether RHCf's are providing the ancillary services included in their Medicaid per diem rate and whether any changes in billing have occurred; and Medicaid Rate Part B Carve Out

as once the computer match process is developed and tested, the OMIG plans to audit the Part V carve out for facilities with 2002 base rate years or later.

Long term care organizations should start reviewing their compliance programs to assure that they will be prepared to meet the future mandatory New York State OMIG regulation for provider compliance programs. Published in the New York State Register on January 14, 2009 as a notice of proposed rulemaking was A new Part 521, entitled "Provider Compliance Programs" added to Title 18 of the Codes, Rules and Regulations of the State of New York. A key point is that the plan must adequately address medical assistance program risk areas and compliance issues. Risk areas should with due diligence be identified by the provider. New York has added an additional compliance element that "a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law." OMIG will provide nursing home model compliance programs beginning this fall.

Lastly, long term care organizations should review the OMIG "Self-Disclosure Guidance March 12, 2009" that is available on the OMIG web site [www.omig.state.ny.us](http://www.omig.state.ny.us) and replaces the existing Department of Health disclosure protocol. Advantages of self-disclosure may include waiver of penalties and/or sanctions, extended repayment terms, reduction of interest payments, and recognition of the effectiveness of the provider's compliance and a decreased chance of imposition of an OMIG Corporate Integrity Program. The OMIG "Self-Disclosure Guidance March 12, 2009" advises that because of the complexity of some issues surrounding self-disclosures, providers may want to consider obtaining the advice of experienced healthcare legal counsel.

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- <sup>1</sup> Sheehan, J. Statement of Medicaid Inspector General New York State Office of the Medicaid Inspector General before Committee on Homeland Security and Governmental Affairs Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security on Eliminating Waste and Fraud in Medicare and Medicaid, April 22, 2009.
  - <sup>2</sup> New York State Office of the Medicaid Inspector General (accessed on June 2, 2009). Available at [www.omig.state.ny.us](http://www.omig.state.ny.us)
  - <sup>3</sup> Sheehan, J. New York State Office of the Medicaid Inspector General "2007 Annual Report"
  - <sup>4</sup> Sheehan, J. New York State Office of the Medicaid Inspector General "2007 Annual Report"
  - <sup>5</sup> Sheehan, J. New York State Office of the Medicaid Inspector General "2007 Annual Report"



# RISKY BUSINESS

## “When Common Sense is Uncommon”

By: Pamela Monastero, MBA, CASHRM

### Dear Risk Manager:

This column, which will appear regularly in the AHRMNY Newsletter, is designed to assist both the novice and seasoned risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. The column is anonymous and we encourage our members to submit their experiences which may be e-mailed to [Pamela.monastero@nychhc.org](mailto:Pamela.monastero@nychhc.org) or mailed to AHRMNY, P.O. Box on the RISKY BUSINESS form which can be found on our website at AHRMNY.org. The form permits confidentiality.

### COMMON SENSE TIPS FOR STAFF:

Mislabeled specimens and patient identification issues threaten patient safety more than we like to admit. While everyone responds to the sentinel event level issues—the wrong patient, the wrong procedure, etc., the more worrisome events are the ones that occur more frequently—the “near misses” or “good catches” or whatever title we utilize. It is sometimes difficult to collect accurate data on staff carelessness—the phlebotomist who draws the wrong blood, the unlabeled specimen in the pneumatic tube, the patient with multiple wrist bands, etc. Technology such as bar coding is designed to reduce the incidence of patient identification errors but the human error factor will always play a role, despite the most well intentioned education programs, policies and technological breakthroughs. As risk managers know, there is no substitute for staff diligence and double and triple checks. Outlined below are some suggestions and resources for risk managers to consider in addressing patient identification issues and mislabeled specimens.

### TIPS:

1. **Survey your facility for vulnerabilities.** We all know that staff should use two patient identifiers—neither of which should be the patient’s room number or physical location, that staff should utilize read-backs to prevent miscommunication, that staff should discard specimens with incomplete information or inconsistent labels, that staff should label specimen collection containers in the presence of the patient. Unfortunately, staff is also known to take shortcuts or use workarounds or “band-aid” approaches—these are dangerous and pose patient safety issues.
  - a. **Question staff regarding their practices.** Although facilities provide extensive staff education on the use of two patient identifiers, patient read-backs and labeling specimens at the draw site, risk managers might be surprised by the information they uncover during staff interviews. Ask staff to identify the workarounds and “band-aids” they have in place—it is helpful to ask veteran staff to envision themselves as novices prior to identifying the risks. Usually, staff create workarounds because they feel they are lacking resources—staff, equipment, supplies, physical space, etc. Identifying their perceived needs and addressing them with hospital leadership should serve to reduce unsafe shortcuts.
  - b. **Point of care label printers and scanners--survey clinical areas** to determine if label machines are strategically located (e.g. in close proximity to patient care areas or do staff have to walk back and forth from the nursing station to print a label). Label machines are relatively inexpensive and should be installed wherever they are needed—avoiding queuing of labels and print lag times. For instance, if your facility has individual birthing rooms in Labor & Delivery, is there a label machine located in each room (for cord blood specimens, etc.) or must staff travel to the nursing station to retrieve labels?
  - c. **Limit the application of wrist bands** to a limited number of staff members. Apply patient identifiers upon admission, before admission or transfer to another facility. Review the label process for mothers and infants in Labor & Delivery and the newborn nursery if your hospital provides Obstetrical services.
  - d. **Use redundant wristband or identification systems** (e.g. such as in blood cross match specimens, etc.).

- Utilize sample protocols outlined by the National Quality Forum (NQF.org has draft practice evaluation documents such as “Patient Safety and Communication Practices for Laboratory Medicine.” Although the NQF draft has not been finalized as of this writing, the suggestions outlined offer step-by-step recommendations to improve patient safety by implementing “standardized policies, processes and systems to ensure the accurate and legible labeling of laboratory specimens, or other diagnostic specimens, so that the right study is labeled for the right patient at the right time.”)

### **RESOURCES:**

National Quality Forum (NQF.com)  
Joint Commission (jointcommission.org)

#### *Additional Suggested Reading:*

Patient Safety in the Clinical Laboratory: A Longitudinal Analysis of Specimen Identification Errors, Wagar, E.A., Tamashiro, L., Yasin, B. Hillborne, L., Bruckner, D.A., Arch Pathol Lab Med 2006 (Nov); 130:1662-1668.

## **AN INTRODUCTION TO NURSING HOME LITIGATION**

**By: Theodore F. Goralski, Jr., Esq.**

As the population of New York continues to age, increasing numbers of seniors require the benefits of long term care. Across the state, populations in nursing homes continue to swell. An unfortunate and unavoidable side effect of rising resident populations is a surge in lawsuits against nursing homes. Plaintiff’s attorneys across the state have an increasing interest in pursuing these actions for various reasons.

Nursing home cases are more attractive to personal injury attorneys than traditional medical malpractice cases for a variety of reasons. When considering whether or not to take a case, plaintiffs’ attorneys evaluate cases based on factors such as liability, damages and litigation costs. These factors make nursing Home litigation tempting because a lawsuit against a nursing home does not necessarily involve more complex medical malpractice claims. The various medical malpractice reforms in place in New York, would not apply and therefore, the case is easier to prove and litigation costs are lower.

Attorney fees in nursing home negligence litigation offers one-third of the recovery as opposed to the decreased fee scale in medical malpractice cases. Nursing home litigation does not always require expensive expert testimony and has the benefit of a 3 year Statute of Limitations rather than 2½ years. As discussed below, there are statutory causes of action against nursing homes which are easier to prove than

departures from standards of medical practice. Finally, Defendants can take advantage of more favorable jury instructions in malpractice cases.

Managing risk in nursing homes involves a range of obstacles which are unique to long term care. Nursing home populations are naturally at risk for injury. The nature of 24 hour long term care provides constant opportunities for injury. Additionally, the vulnerability of this population evokes sympathy at trial.

A thorough knowledge of the litigation process, the common scenarios of nursing home litigation, and strategies to defend these actions can help to manage the risk presented by such lawsuits and their financial impact on the institution.

### **APPLICABLE LAW**

The landscape of federal and state law applicable to nursing homes is dominated by the Omnibus Reconciliation Act of 1987 (OBRA)(42 U.S.C. 1396r; 42 U.S.C. 1395i-3). This legislation was a reaction to public outcry and to federal reports which criticized the quality of care at nursing homes. The stated goal was for each nursing home resident “to attain or maintain the highest practicable physical mental and psychosocial well being”. OBRA is implemented by the Centers for Medicare and Medicaid services (CMS) which administers the congressionally approved

regulations found in 42 CFR Part 483 of the Code of Federal Regulations. Access to these regulations on the internet can be obtained at <http://www.access.gpo.gov/nara/cfr/waisidx/05/42cfr48305.html>. **The federal government publishes the state operations manual, which serves as a guide for state and federal inspectors. Those guidelines are available at [http://www.cms.hhs.gov/manuals/downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](http://www.cms.hhs.gov/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf)**

Most administrators at long term care facilities are familiar with “the watermelon book” so named because of its pink cover. This publication entitled “The Long Term Survey, Improve Your Facility’s Survey Performance By Increasing Your Knowledge of the Survey Process”, is an invaluable reference for compliance.

New York State’s comprehensive nursing home regulations can be found at 10 NYCRR, Part 415. These regulations are in most cases basically the same as the federal regulations. Litigation against nursing homes in New York is predicated upon Public Health Law (PHL) §2801-d. This section of the Public Health Law provides a cause of action to nursing home residents for damages caused by deprivation of rights or benefits conferred by contract, federal and/or state statute, code, rule or regulation. PHL §2801d creates a minimum amount of damages as well as a framework for the imposition of punitive damages for willful and reckless disregard of residents’ rights. The statute also provides for the award of attorneys’ fees, in certain circumstances.

The potential for punitive damages is of utmost importance from a risk management standpoint. Most insurance policies do not cover willful or reckless acts and thus insurance companies generally disclaim coverage for the cause of action for punitive damages. Therefore, the facility and the attorneys representing the facility in litigation must be cognizant of the potential exposure to punitive damages. A verdict at trial may not only assess compensatory damages, which would be covered by insurance, but could impose punitive damages, which the facility would have to pay from its own funds, regardless of the policy limits with the insurance company. This should be considered when contemplating settlement of lawsuits.

Other causes of action, in any nursing home litigation are similar to those more commonly seen in personal injury law. Common law negligence and medical

malpractice are claimed as a matter of course. Plaintiff’s personal injury lawyers often try to avoid claims of medical malpractice in the nursing home setting for reasons stated above. Generally a claim is classified as medical malpractice as opposed to ordinary negligence, “when it constitutes medical treatment, that is when it involves diagnosis, care and treatment by licensed medical professionals”. Lee v. New York City Transit Authority, 175 Misc2d 632, 668 N.Y.S.2d 1014 (1998) affirmed as modified as 257 A.D.2d 611, 685, N.Y.S.2d (2d Dept 1999). As discussed below many nursing home cases involve falls or pressure sores and current case law is divided on whether or not these claims are for medical malpractice or common law negligence. These are issues that defense attorneys should aggressively pursue on your behalf.

Breach of contract is another commonly claimed cause of action. In most cases defense counsel should seek dismissal of this claim because New York law requires that a breach of contract claim arising from the rendition of medical services be predicated upon an express special promise to affect a cure or accomplish some definite result. Weingrad v. Jacobs, 171 A.D.2d 525, 567 N.Y.S.2d 249 (1<sup>st</sup> Dept). Given this law, it is important to ensure that nursing home medical care providers do not make any explicit promises in rendering care to residents. This is best implemented through goal oriented plans of care. Charting should address the plan in terms of goals rather than expected outcomes. It is equally important that admission agreements explicitly include a clause stating that no cure or specific result is promised.

Plaintiffs sometimes claim a cause of action for negligent hiring and negligent retention of employees. This is often interposed merely as a pretext to obtain personnel files of nursing home employees during the course of pre-trial disclosure. Employers are generally liable for acts and omissions of employees committed in the course of the employee’s job. This cause of action however, covers allegations of wrongdoing associated with acts outside the scope of the employee’s work. This most often involves criminal acts by an employee such as physical abuse. If there are no claims by the plaintiff of any such acts, then defense counsel should move to dismiss these claims. Of course, in cases which do involve such physical abuse defending the case will be an uphill battle, under PHL §2801-d.

Plaintiffs often assert a claim of wrongful death in cases where the resident has passed away. The New York Estates Power and Trust Law applies. EPTL §5-4.3 provides for a fair and just compensation for pecuniary injuries suffered by survivors of a decedent. Pecuniary injuries are the loss of support, services, voluntary assistance, prospect of inheritance from medical and funeral bills. In most situations involving nursing homes the decedent was not providing this type of financial support, and therefore this cause of action will essentially be limited to medical and funeral expenses. (Most likely a relatively minor aspect of damages given the potential exposure for the elements of damage such as pain and suffering and damages pursuant to Public Health Law 2801-d).

Motivated by the provision for punitive damages under 2801-d, many plaintiffs attorneys include causes of action for gross negligence. Under New York law gross negligence is conduct that is so reckless or wantonly negligent as to be the equivalent of a conscious disregard for the rights of others or smacks of intentional wrongdoing, Amaghi U.S.A. Limited v. Jewelers Protection Services Limited, 81 N.Y.S.2d 821, 595 N.Y.S.2d 381 (1993). This is a difficult standard for plaintiffs to prove.

### SCENARIOS LEADING TO LITIGATION

There are several typical scenarios that result in personal injury litigation against nursing homes. Knowledge of these scenarios can help to anticipate problems before they arise. Falls and pressure ulcers are the two most common scenarios. Other potential liability scenarios include abuse, neglect, medication errors, fecal impaction, wandering and elopement, physical and chemical restraints, as well as traditional malpractice.

Many lawsuits result from falls suffered by residents as a result of either defects in the physical plant of the nursing home or from some aspect of the medical condition of the resident. Defects in the physical plant, sometimes referred to as "slip and fall cases," involve more routine safety issues such as wet floors, uneven pavement, debris and loose tiles are just a few of the many hazards that potentially cause falls. Regular inspections should be instituted to address these conditions.

Litigation regarding falls due to the medical condition of the resident is specifically addressed

under 42 CFR 483.20. This federal regulation requires the facility to perform comprehensive assessments of the residents within 14 days of admission (including consideration of risk for falls). Seven days thereafter the facility must establish an individualized plan of care and the comprehensive care plan must be in place by day 21. The facility is, still, of course, responsible for addressing a patient's needs from the moment of admission.

The plan of care should include at the very least information on mobility, balance, ability to transfer, history of falls, history of wandering, gait information, dizziness or other neurological considerations, medication risks, cognition, psychosocial and environmental factors. A plan of care should address the needs raised by these factors. This will include plans for transfers, therapies and possibly restraints.

The issue of restraints is itself, ripe for litigation. Nursing home residents have the right to be free from physical and chemical restraints imposed for the purposes of discipline or convenience and which are not required to treat the resident's medical symptoms 42 CFR 483.13(a). The law essentially codifies the standard of care to use the least restrictive means necessary to protect the resident.

A second major area of nursing home litigation involves pressure sores, and skin ulcers. Under 42 CFR 483.25 and 10 NYCRR 415.12(c)(1) and (2) nursing homes must ensure that residents do not develop pressure sores unless the pressure sores are clinically unavoidable. Residents who have pressure sores must receive necessary treatment to promote healing, prevent infection and prevent new sores from developing. Discussion of proper skin care would require an entire article in and of itself, but every nursing home should have a comprehensive plan in place for addressing patients at risk and for monitoring and treatment of pressure ulcers. This should include personnel with job descriptions specifically dedicated to management of this issue.

Most cases focus on the evaluation of risk for development of pressure sores based on pre-existing medical conditions such as diabetes, poor circulation and lack of mobility. Appropriate intervention such as turning and positioning, use of pressure relieving mattresses, medications, heel protectors and special cushion devices are necessary. Particular attention to nutrition, hydration and skin care are also necessary.

These interventions should be charted every time they are administered.

Federal reimbursement policies prohibit payment for care related to newly acquired pressure ulcers, falls and other events which have been determined to be things that "should not happen". This presents a hurdle to jump when trying to convince a jury that an injury is not due to negligence or substandard care. The law provides a defense that the facility did everything to prevent an ulcer, and therefore the ulcer will be considered to have been "unavoidable". In order to establish that everything was done to prevent the ulcer exemplary charting is a must. A nursing home chart that first documents an ulcer as a Stage III will be difficult to defend. In facilities where charting by exception is the standard, certain conditions are often not documented until it is simply too late. Although it is a heavy burden upon staff to require that every reddened area of skin be documented, such charting is beneficial not only in litigation, but in the actual care of these residents.

Cases involving physical abuse or neglect can result in devastating media attention not only for the facility in question but for the nursing home community in general. These cases in particular result in the negative public image of nursing homes that can infect the jury pool. Under 42 CFR 43.13 facilities are required to develop and implement written policies that prohibit mistreatment, neglect and abuse of residents. The law also requires immediate investigation of all allegations of abuse. Facilities, therefore, are well advised not only to prohibit mistreatment but also to train employees in recognition of mistreatment.

Another major area of exposure to nursing homes is medication errors. Although all of these scenarios can be affected by staffing levels, this area is particularly subject to the need for well trained hospital nurses. Economic pressures affect staffing, making it difficult to provide the most optimal nurse to resident ratio. Nevertheless, it is imperative that medication be administered by licensed professionals and that those licensed professionals follow proper procedures at all times. The process of charting is essential to ensuring that the correct medications go to the correct patients in the correct dosage. 42 CFR 483.25 requires that each resident's drug regimen be free from unnecessary drugs, free from excess dosages of drugs and that the facility be responsible for avoiding significant medication errors.

## INVESTIGATION OF INCIDENTS

In many cases nursing home litigation results from a discreet incident that comes to the attention of facility administration at the time of occurrence. In these situations, an incident or accident report should be completed based on a contemporaneous investigation. The insurance company should be notified, and a file should be maintained in contemplation of potential inquiries. In other situations the facility may not be aware of an impending claim but upon notice of the claim should take immediate steps to create a file so that all relevant information is accessible quickly and is maintained for the duration of the investigation and/or potential lawsuit.

The chart is the single most important document to a lawsuit. A complete and well-documented chart is not only the best way to defend a lawsuit, it is the best way to prevent lawsuits. Unfortunately, all too often, when a case goes into litigation, pages of the chart turn out to be missing. This can result in a devastating instruction to the jury that they may infer that the missing pages included information which would have supported plaintiff's claim. New York Pattern Jury Instructions (PJI) 1:77.

The chart should be sequestered in a separate file and its access limited to individuals working on defense of the claim. Other items which are potentially useful to the defense of an action are any photographs of the resident, all 24 hour reports, incident reports, employee statements, department of health surveys and plans of correction, any contract or agreement entered into upon the resident's admission, policies and procedures relevant to the incident, any information pamphlets provided to the resident, any information pamphlets regarding equipment involved in the incident, all billing records, all staffing records for the period in question, census figures for the period in question, identification of employees involved in care of the resident during the time period in question and current contact information for those employees, any resident handbook used during the time in question, and any other department of health correspondence.

## THE COURSE OF LITIGATION

All litigation is started with a Summons and Complaint which is drafted by the plaintiff's attorney and served upon the nursing home in one of several

different ways usually by a process server bringing it directly to administrative offices. Depending on the method of service, the defendant may have as little as 20 days to respond. Therefore it is important that the matter be reported to the facility's liability insurance carrier as soon as possible so that defense counsel can be assigned and an Answer to the Summons and Complaint prepared. Defense counsel will ultimately obtain a document from the plaintiff's attorney called a Bill of Particulars which should specify the nature of the claims in greater detail. Defense counsel will obtain authorizations to review relevant medical records of the resident and will have the opportunity to take a deposition of the resident or a representative of the estate of the resident if the resident has died.

Next, plaintiff's attorney will be entitled to a deposition of at least one employee of the nursing home. Often, the Court will grant plaintiff the right to depositions of more than one employee. Defense counsel should meet with these potential witnesses well in advance of the depositions in order to review the chart with the employees and to prepare the employees for the deposition. This is not something that should happen on the day of the deposition.

Defense counsel may be required to turn over some of the documents listed above. At the very least they will have had to have provided a copy of the chart. The plaintiff's attorneys will likely ask for rules and regulations and possibly some of the other items. In a best case scenario, those items will be helpful to the defense of the matter. Often, there will be inconsistencies between different documents that will need to be explained. As stated above, missing records of any kind can be fatal to the case.

At this point defense counsel should retain an expert, usually a physician, to assist in identifying problem areas, defenses and other issues important to the litigation. The expert may advise that settlement be considered. In other cases the expert can be used at trial as a persuasive witness. The best trial experts are those who can effectively educate a lay jury.

Throughout this process the defense counsel should be updating the insurance claims personnel and a facility administrator on progress of the litigation and performing reevaluations of liability and damages. Evaluations should include liability of potential codefendants such as hospitals, home health care

the county in which the case will go to trial) can sometimes have an impact on defense counsel's evaluation of the case. Venue is generally determined by the county of the residence of the various parties. Juries in some counties are much more inclined to render high verdicts awarding large amounts of money. Some admission agreements contain valid clauses agreeing to certain venues.

Even litigation that moves quickly will often take over a year from Summons and Complaint to trial, and often, much longer. Overall, the strategy at trial is to convince the jury of the quality of care at the facility and this is most effectively communicated through the employees who testify. Once again, this is where the preparation of the witnesses is paramount. Simply stated, the witnesses become the face of the facility and if the jurors do not like those witnesses, a defense verdict is much more difficult to obtain. Nevertheless, a defense verdict is not impossible in those situations. Regardless of the likeability of witnesses, good charting is still the best way to defend against a lawsuit, and indeed to prevent lawsuits, good charting is yet another subject for a separate article.

## CONCLUSION

As more and more people avail themselves of the services of long term care facilities, the pressures on those facilities to offer the high quality of care necessary to insure the dignity of those patients causes them to face ever increasing difficulties. Even the best facilities offering the highest standard of care will be unable to avoid the occasional injury to residents due to falls, pressure ulcers or a myriad of other dangers to this high risk population. It is therefore imperative that these facilities take proactive steps to reduce and to manage the risk presented by the potential injury to residents. The first step is to identify the problem scenarios as discussed in this article and to understand the litigation process. It is beneficial, therefore, for every nursing home to have a trained risk management professional on staff to anticipate and address potential problems before they arise and to manage the unavoidable incidents that do occur.

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Theodore F. Goralski, Jr. is a trial attorney at McHenry, Horan & Lapping, P.C. in Syosset. The firm specializes in defense of physicians, hospitals and nursing homes in medical malpractice actions as well as representing professionals before the Office of Professional Medical Conduct. Mr. Goralski is a graduate of Cornell University and St. John's University School of Law with 18 years of experience handling all phases of litigation. He can be reached at [tgoralski@mchllaw.com](mailto:tgoralski@mchllaw.com).

**AHRMNY WOULD LIKE TO THANK THE FOLLOWING  
COMPANIES FOR THEIR GENEREROUS CONTRIBUTIONS  
TOWARD OUR JUNE 2009 ANNUALCONFERENCE**



## ANNUAL CONFERENCE SUMMARY

On Friday June 12, 2009, AHRMNY held its 2009 annual conference titled "Risk Financing Tools for New York Healthcare Providers Conquering the Challenging Economic Times."

The conference began with the Annual Business Meeting. Grace Langan, outgoing president announced the new 2009-2010 Officers and Directors of the AHRMNY board: President, Mike Midgley; President Elect, Peggy Sullivan; Past President, Grace Langan; Past Past President, Carolyn Wolf; Secretary Carol Gulinello; Treasurer, Monica Santoro.

New Members of the board are as follows: Robert Marshall, Mary K. Steffany and Diane Longo

The conference consisted of seven speakers.

Dominic Segalla, CFO of Saint Vincent's Medical Center discussed the ways hospitals are managing the current economic volatility. He stated that hospitals are dependent on operating revenue and that revenue has significantly decreased during this time. Also, he added, "Cash is King" since most portfolio values have significantly declined. He acknowledged that the key to financial success while decreasing in adverse patient events is through enhancements in clinical and information technology however, capital investments in these projects is difficult at best due to the economic downturn most hospitals are facing.

Ken Raske, President of GNYHA, spoke on Emerging Fiscal Trends: Healthcare Policy, Funding, and Legislation.

His prediction was that healthcare reform, in Washington, should occur this year. The healthcare delivery system is in need of redesign and medical malpractice reform is required. A summary of the healthcare reform challenge offers the following suggestions for success: cut healthcare production costs, pass savings on to public and private payers to reduce cost on insurance coverage, expand public programs and provide tax credits to help purchase insurance, ensure success by offering public plan.

Dr. Diane M. Sixsmith, Chairman, Department of Emergency Medicine at NY Hospital Medical Center of Queens discussed the changing role of the Emergency Department. Due to the current economic and changing healthcare environment many more people are using the ED as their primary healthcare. This stresses the system and all those who work in it. The staff is frequently burned out, there is a reduction of service and resources, and there is a lack of customer service with overburdened ancillary departments. Dr. Sixsmith presented several case studies, which highlighted for the audience the challenges faced by the ED staff on a daily basis in formulating a correct diagnosis and treatment plan. She offered some clear recommendations to avoid the pitfalls frequently encountered.

David S. Ivill, Esq., Partner, from the law firm of McDermott Will & Emery spoke about the Section 111- Mandatory Reporting for Self-insured Hospitals and Captive Insurers under Medicare Payer Rules. In summary, new Medicare Secondary Payer (MSP), provisions require self-insured hospitals and their captive insurers to report certain data to CMS regarding liability settlements, judgments, awards or other payments to Medicare beneficiaries that relate to medical care. Section 111 will help CMS identify amounts paid to Medicare beneficiaries as a result of claims brought against insurers where a portion of the payment covers medical care that has been or will be covered by Medicare in the future. More information and guidance will be needed by these reporting entities going forward to assure compliance.

Cynthia A. Levernois, Senior Director, Workforce and Behavioral Health, Healthcare Association of NYS (HANYS), discussed the changing NY healthcare job market. There are shortages in all areas of the healthcare workforce including nurse, physicians and allied health professionals. The supply of these professionals is not keeping up with the demand. The demand for nurses is expected to grow by 2-3% each year. The Center for Health Workforce Studies identified the need for 1,400 physicians to fill the gap of those that are retiring from the system. However, the good news is healthcare employment is the fastest growing sector in the country.

Fred Podolsky, Vice President, Alliant Insurance Services, Inc. discussed the management of Director and Officers Liability Program in these turbulent times. He discussed that the D&O market continues to do well; it is now in a fifth year of decreasing premiums. Some tips in reviewing a D&O policy are to watch for holes in the policy that allow the policy to trip into run-off, carve out bankruptcy issues, watch for coverage that includes a provision that if there are misstatements in the application that are material the policy may be voided, and to negotiate the time frame that the insurer can look back at documents filed with any federal or state regulatory agency.

Finally, Susan Chmielecki, Sr. Vice President, Healthcare Product and Risk Mgmt Lead, Darwin Professional Underwriters Inc, ASHRM Board Member gave an update from the ASHRM Board of Directors. She reviewed the mission, vision and goals of ASHRM. The end of year member count for 2008 is 5,300 members. She encouraged the members of the group to volunteer for an ASHRM committee, advising that the nominating committee is a good place to start. One of this year's goals is to develop a searchable database on the website as a resource for members. An Advocacy agenda goal is to be active in legislation for liability reform and Medicare Secondary Payer Mandatory Reporting. She reminded the group that ASHRM offers scholarships for continuing education. Applications are on the web site and the process is not difficult. The annual conference is in Denver this year, from October 22-25<sup>th</sup>.

# AHRMNY

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**Save-The-Date  
for These Upcoming Events**

**October 8, 2009**

8a – 12:30p New York Helmsley Hotel

Topics include: CNA HEALTHPRO Nurse Claims Study, with Risk Management Recommendations  
Section 111 Review and Update

(Conference brochure will be distributed soon).

**December 11, 2009**

Half-Day Conference – location and topics to be determined.

**March 2009**

Evening Conference – Date, location and topics to be determined.

**June 11, 2010**

Annual Full-Day Conference – Location and topics to be determined.



**P.O. BOX 4200 • GRAND CENTRAL STATION • NEW YORK, NY 10163**

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