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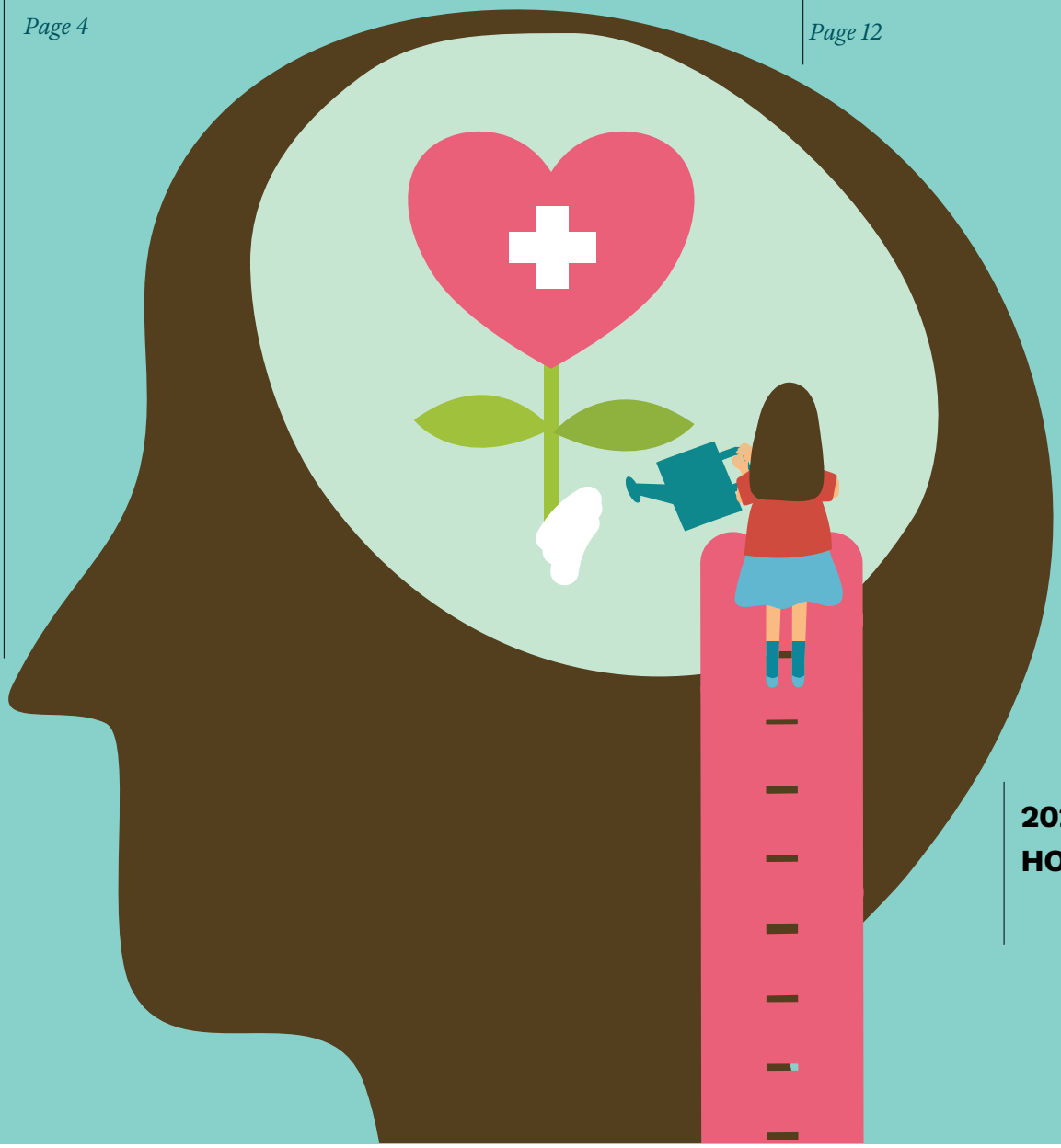

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A Note on Racial Injustice

We are deeply saddened, frustrated, and profoundly disturbed by the senseless murder of George Floyd. We are even more disturbed that this tragedy is not an isolated incident but is another example of the racism and inequality that has plagued our nation for centuries. This is a difficult time for us, and you are not alone in struggling with this situation.

As the events of the past weeks have unfolded, I find myself grappling with a myriad of emotions. As I watch peaceful demonstrations and hear anguished cries for justice that have been raised in this country for centuries, I have thoughts that not much has changed in this country and I am frustrated. Like many of you, I have learned to keep my emotions inside. Yet my reality is full of pain and sadness as I reflect on my own experiences, those that have impacted my family, and those that I see daily on the news. The image of Mr. Floyd brought back images of my sister-in-law's murder at the hands of a self-proclaimed white supremacist not too long ago. There's space for all of us to be angry, to grieve, and to give voice for change.

Even though no one is immune from the impact of racism, hatred, and indifference, I believe in Nelson Mandela's words. There is a cure to the disease that has perpetuated health, income, and education disparities in this country. An African proverb says, "too much tolerance paves the way for trouble." In other words, you will never change what you are willing to tolerate. To remain silent and tolerate racism means that racism will never end.

We, as an association, are committed to advancing diversity, equity, and inclusion within our association and the health law community we support. We further condemn the inequality that exists in our country and the world. AHLA has and continues to move forward initiatives that advance our diversity, equity, and inclusion efforts and continues to look for additional ways to bring our community together and do our part in the fight to end systematic racism, injustice, and inequality and to expand on issues related to health disparities.

No one is born hating another person because of the color of his skin, or his background, or his religion. People must learn to hate, and if they can learn to hate, they can be taught to love, for love comes more naturally to the human heart than its opposite.

Nelson Mandela, 1994

Last year we amplified our efforts to have greater diversity and representation in leadership and in speaking and author opportunities and are making progress. We have expanded diversity and inclusion and unconscious bias education. In fact, the Board and non-Board leaders will receive additional training this year. We will continue to work aggressively with our leaders to offer content about health inequities, discriminatory health practices, and racial disparities that impact our community and the health status of those who receive less than.

Now is not the time to be silent.

David S. Cade
Executive Vice President/CEO

Our lives begin to end the day we become silent about things that matter.

Martin Luther King Jr., 1965

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Feature

Unique Challenges for Behavioral Health Providers in Protecting Health Care Workers While Balancing the Needs of Patients

John C. Ivins Jr., Hirschler; **Kathleen Pankau,** The Joint Commission; and **Emma Pelkey,** Lewis Brisbois

As front-line health care workers battle the COVID-19 pandemic, a silent epidemic of violence against them continues to rise. According to the Occupational Safety and Health Administration (OSHA), 75% of all workplace assaults happen to health care workers, making it one of the most dangerous professions in the United States. Certain settings, such as the emergency department (ED) and psychiatric units, are particularly vulnerable. Recent surveys show 78% of ED physicians reported being targets of workplace violence in the past year, and 75%–100% of nurses on psychiatric units reported being assaulted by a patient at some point in their career.[1]

While these statistics are startling, the actual number is likely higher given that health care workers tend to underreport incidents of violence, viewing it as part of the job. Studies have shown that on average, nurses report only 20%–60% of workplace violence incidents.[2] Even in the ED, where violence is prevalent, only 30% of nurses and 26% of physicians reported incidents of violence according to a national survey.[3]

Although health care employers have responded by prioritizing violence prevention efforts, they still face many challenges in creating a safe workplace, particularly within the behavioral health setting. One of those challenges, and the focus of this article, is balancing the need to provide patients with access to quality care in a nondiscriminatory manner, while also ensuring the safety of health care workers who deliver that care.

Regulatory Requirements Facing Health Care Employers

Like most aspects of health care, there are multiple entities enforcing various regulations, guidelines, and recommendations that seek to address these issues. This article addresses two of those entities—OSHA and The Joint Commission.[4]

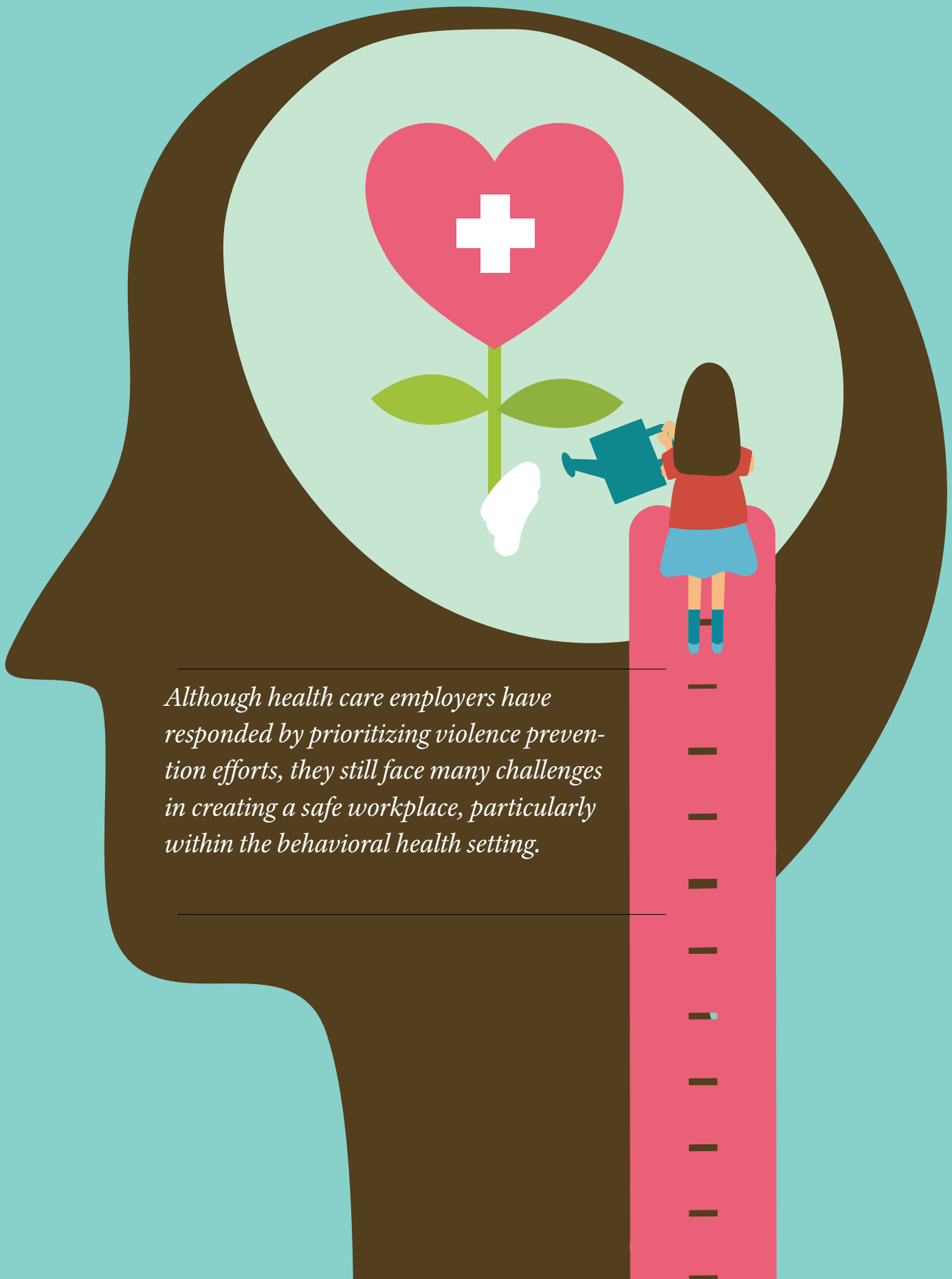
OSHA Workplace Violence Guidelines and Enforcement Through the General Duty Clause

OSHA has issued workplace violence guidelines for health care and social service workers since 1995. These guidelines were revised in 2004 and again in 2015. The 2015 update, entitled *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (Guidelines), is the most recent version.[5] Following its publication, the Department of Labor announced that OSHA would expand enforcement activities to ensure that workplace violence, occurring in specific health care settings, was being addressed. Since then, there have been many reported enforcement actions, a number of the more notable actions involving behavioral health care providers.

While the Guidelines are only "advisory in nature," and do not constitute standards or regulations,[6] they are enforceable by OSHA pursuant to Section 5(a)(1) of the Occupational Safety and Health Act—known as the "General Duty Clause."[7] It requires all employers to provide their employees "with a place of employment [which is] free from recognized hazards that are causing or are likely to cause death or serious physical harm."[8] OSHA's enforcement activities can lead to fines and government oversight; hence, health care employers must address the requirements of the Guidelines. In particular, hospitals; residential treatment facilities; non-residential treatment facilities and related service settings such as clinics and mental health centers; community care settings, including residential facilities and group homes; and field work settings, including health care workers who make home visits, are identified as being the focus of the Guidelines and OSHA enforcement.

The OSHA Guidelines Require a Workplace Violence Assessment and Prevention Plan

To establish a violation of the General Duty Clause, OSHA must show that (1) the employer failed to keep the workplace free of a recognized hazard that was causing or likely to cause death or serious physical harm and (2) there was a feasible and useful method to address it. Under the Guidelines, employers must prepare and implement a Workplace Violence Assessment and Prevention Plan that includes (a) management commitment and worker/employee participation, (b) worksite analysis and hazard identification, (c) identification of controls to eliminate or reduce hazards, (d) safety and training for all personnel, and (e) record keeping and evaluation. The requirements and content for each



Although health care employers have responded by prioritizing violence prevention efforts, they still face many challenges in creating a safe workplace, particularly within the behavioral health setting.

employer's Plan will differ dramatically based on the type of services delivered, where/how such services are delivered, and the perceived and known risks to employees. Employers also should consider OSHA's enforcement manual, *Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents*, which identifies those things, in particular, that OSHA inspectors evaluate.[9]

An OSHA inspector has a number of different compliance/enforcement options available following an inspection, including finding no violation, issuing a Hazard Alert Letter (which typically identifies insufficiencies and needed compliance steps without finding a General Duty Clause violation), or issuing a citation (often accompanied by a fine and compliance requirements).

In recent years, OSHA's enforcement actions have arisen in many contexts, several of which have occurred in the behavioral health setting. Examples include OSHA's citation (upheld in 2019) of an Owings Mills, MD-based employer whose employee was stabbed to death by a mental health patient with a violent criminal history during a home visit;[10] an October 2018 citation against an Orefield, PA psychiatric hospital focusing on treating children/young adults for its failure to protect its employees who were routinely kicked, punched, bitten and scratched while delivering care;[11] a May 2018 citation (including more than $71,000 in fines) of a Bradenton, FL inpatient behavioral facility for failing, for two years, to adequately protect employees from a variety of similar injuries;[12] and the March 2018 pursuit of a Portland, OR behavioral health center for failing to properly log, document, or investigate approximately 300 assaults suffered by its employees during its first seven months of operation.[13]

Recent OSHA Enforcement Actions

Recent cases involving OSHA actions against two different psychiatric hospitals highlight the conditions that can arise at behavioral health facilities and provide a side-by-side comparison of steps taken by each to address issues of workplace violence against their respective employees. In one instance, OSHA's citation against BHC Northwest Psychiatric Hospital LLC d/b/a Brooke Glen Behavioral (BHC), a 146-bed inpatient psychiatric/behavioral health hospital in Fort Washington, PA, was upheld. In the other, OSHA's citation against HRI Hospital, Inc. d/b/a Arbour-HRI Hospital (Arbour), a 62-bed facility in Brookline, MA, was not.

Following OSHA's receipt of complaints describing incidents of patient violence[14] against employees at both facilities, inspectors conducted investigations and citations were issued against BHC and Arbour for failing to protect their employees from injuries arising from physical assaults by their patients. Both facilities appealed their citations. After hearing the evidence in the two cases, the same administrative law judge (ALJ) affirmed the OSHA citation against BHC[15] and vacated the citation against Arbour.[16] BHC appealed the ALJ decision, which the D.C. Circuit affirmed on March 3, 2020.[17]

At BHC, the OSHA Compliance Safety and Health Officer concluded that over the course of one year, there were at least 51 incidents where employees were injured by patients, having been punched, kicked, grabbed, spit on, slapped, bitten, scratched, and hit with objects, sometimes also resulting in injuries to hands, knees, and backs.[18] At Arbour, while the number of incidents was not specifically identified, the OSHA Compliance Safety and Health Officer found that nurses and mental health workers were subjected to similar attacks by patients, finding they had been punched, kicked, scratched, bitten, and hit with objects.[19] It was also determined that both facilities and the industry[20] recognized the hazards present in treating those suffering from behavioral health conditions.

The difference in outcomes concerning the OSHA citations resulted from the efforts taken by the facilities to address types of workplace violence through adequate risk assessment, planning, and active employee involvement in seeking solutions. OSHA conceded that the hazard of employee injury in this treatment environment cannot be eliminated.[21] The focus centered on each facility's efforts to abate the situation. The ALJ and the court found that OSHA met its burden in showing that there were feasible methods not advanced by BHC.[22] By contrast, the ALJ found that because of abatement efforts already implemented by Arbour, OSHA failed to meet its burden.[23]

Health care workers and employers are often caught between two conflicting duties—the duty to provide compassionate, quality care in a nondiscriminatory manner and the duty to protect those who provide the care.

These cases reveal the challenges faced by health care employers—especially those in behavioral health—while seeking to deliver compassionate health care, protecting the well-being of their employees, and addressing requirements in the OSHA Guidelines.

The Joint Commission and Its Sentinel Event Policy

The Joint Commission also addresses workplace violence in its accredited health care settings including

Workplace violence remains a significant threat to the health care system, but steps can be taken to reduce incidents of violence.

nursing homes, laboratories, home care, behavioral health, office-based surgery practices, ambulatory care, critical access hospitals, and hospitals. It has several broad standards that relate directly or indirectly to workplace violence, including Emergency Management standards that require risk analyses and action plans.

The Standards in the Environment of Care chapter require accredited organizations to manage both safety and security risks.[24] Security risks include workplace violence, theft, infant abduction, and more. Organizations must take action to minimize or eliminate identified safety and security risks in the physical environment.

Under The Joint Commission's Sentinel Event Policy, which applies to all accredited programs, an event of workplace violence could be considered a sentinel event. There is a general definition for sentinel events as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. But there are also more specifically enumerated definitions in the Sentinel Event Policy, which include rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of *a staff member, licensed independent practitioner, visitor, or vendor while on site* at the accredited organization.[25] For several years, criminal events have been among the top ten sentinel events reported to The Joint Commission.

Accredited organizations are expected to prepare a thorough and credible comprehensive systematic analysis and corrective action plan within 45 business days of a sentinel event or of becoming aware of the event. Root cause analysis, which focuses on systems and processes, is the most common form of comprehensive systematic analysis used for identifying the factors that underlie a sentinel event, but an organization may use other tools and methodologies to conduct its comprehensive systematic analysis. The corrective action plan identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future.

While The Joint Commission encourages voluntary reporting, accredited organizations are not required to report sentinel events to The Joint Commission. But, if The Joint Commission becomes aware of a sentinel event because of a news article or a complaint submitted to its Office of Quality and Patient Safety, a member of the Office of Quality and Patient Safety may contact the accredited organization to determine whether the comprehensive systematic analysis and corrective action plan were acceptable. If factual indications demonstrate repeated occurrences of workplace violence at an organization, the Office of Quality and Patient Safety will elevate that information to Joint Commission leadership. Leadership could potentially send surveyors to the organization to conduct a for-cause survey centering on risk analysis and mitigation plans.

While reporting is encouraged but not required, reporting a sentinel event to The Joint Commission enables "lessons learned" from the event to be added to The Joint Commission's Sentinel Event Database, thereby contributing to the general knowledge of sentinel events and to the reduction of risk for such events in other organizations. In April 2018, The Joint Commission issued a *Sentinel Event Alert* on workplace violence.[26] Though no new accreditation standards were created to specifically address workplace violence, the Sentinel Event Alert article contained suggested actions to address the growing problem.

Challenges for Hospitals and Other Health Care Settings

The Dilemma: Balancing Access to Care and the Safety of Health Care Workers

While preventing workplace violence seems simple, in practice it is not. Part of the problem is a culture of accepting violence in health care due to a perception that it is part of the job and that patients who commit acts of violence are not responsible for their actions because of dementia, being disoriented, or experiencing a mental health crisis. This is not altogether surprising because health care workers are caregivers by nature; however, such an approach to care can often result in violent incidents going unreported while health care workers put their own health and safety at risk.

Preventing workplace violence can be challenging depending on the health care setting. As noted, violence is particularly prevalent in the ED, likely due, at least in part, to each hospital's obligation to comply with the Emergency Medical Treatment and Labor Act, which requires a medical screening examination and stabilizing treatment for anyone who enters the ED, including any patient who presents a danger to self or others. Other factors such as a lack of de-escalation training, violence prevention programs, adequate staffing, and properly trained security guards may also trigger violence, not to mention the ED environment, which

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is inherently stressful. Lack of mental health resources also creates a challenge to the overall system due to the shortage of psychiatric beds and of long-term placements. Shortages of resources can lead to overcrowding in the ED and increased incidents of violence, particularly when patients require restraint or seclusion.

These challenges illustrate why workplace violence remains such a complex issue. Health care workers and employers are often caught between two conflicting duties—the duty to provide compassionate, quality care in a nondiscriminatory manner and the duty to protect those who provide the care.

Finding a Solution to Curb Workplace Violence in Health Care

While workplace violence in the health care industry has become an epidemic, how to fix the problem is not clear. One option, which has been heavily debated, is whether to impose harsher criminal penalties on patients. However, particularly with behavioral health patients, such an approach raises ethical concerns, including whether patients should be punished for behavior they cannot control and whether punishment serves any deterrent function.

Those opposing harsher criminal penalties argue that, in many cases, a behavioral health patient may assault a health care worker unintentionally due to a cognitive impairment, psychiatric diagnosis, or belief they are protecting themselves. In those situations, the patient may not appreciate what happened because they lack capacity. As a result, attempting to prosecute patients may have no impact on reducing violence and if anything, may result in impediments to housing or employment for patients who are convicted.

On the other hand, those advocating for greater criminal accountability argue that such an approach is necessary to protect health care workers and will, through the deterrence created by harsher penalties, send the message that violence will not be tolerated.

Apart from the Guidelines, there is no federal law or regulation requiring protection against workplace violence in the health care setting, so states have sought legislative solutions. Thirty-eight states have made it a felony to assault a health care worker.[27] Some states, such as Oklahoma, have enacted new laws to increase prison time for assaulting a health care worker.[28] Other states have focused more on prevention to reduce violence. For example, California, Connecticut, Illinois, Maryland, Minnesota, New Jersey, Oregon, and Washington all require employers to have workplace violence prevention programs (New York requires this for public employers).[29]

In practice, hospitals and other health care facilities have implemented a variety of safety measures to curb workplace violence, including sitters, panic buttons, limited badge access, security cameras, metal detec-

tors, security dogs, de-escalation training, increased security and police presence, and rapid response teams to alleviate potentially violent situations and identify potentially violent patients. Additionally, efforts have been made to reduce incidents of violence by seeking to increase safety and reporting through technology that allows staff to more easily (and anonymously) report violent incidents, by creating facility safety assessments, by offering enhanced training on how to identify/defuse potentially violent situations, and by conducting post-incident debriefing sessions.

At the same time, hospitals and other health care facilities sometimes implement safety strategies that may go too far. One example is when mentally ill individuals seek help, and after exhibiting disruptive behavior, are sent, instead, to jail. While some argue that such an approach is appropriate for safety reasons, others contend that it criminalizes mental illness and discriminates against behavioral health patients. Advocates recommend a proactive approach that devotes more resources to preventing workplace violence before it occurs.

In the end, no one will deny that health care workers need to be protected and feel safe at work. The key, however, is finding the right balance between ensuring a safe workplace and providing an accessible location for the public to receive care. There is no one-size-fits-all approach. In developing a plan, health care employers should engage front-line nurses and clinicians who deal with workplace violence regularly to create and establish a comprehensive approach that works well for that facility.

Conclusion

During the current unprecedented public health emergency, it is more important than ever to protect health care workers from incidents of violence. Health care workers cannot provide quality patient care if they do not feel safe. As the pandemic continues, anxiety and stress levels will undoubtedly grow, increasing risks of violence against health care workers. Hospitals and health care systems will need to be prepared in how to manage workplace violence.

In addition to the Guidelines, numerous resources are available for developing a comprehensive workplace violence prevention program. The Joint Commission offers a portal that provides resources and toolkits for preventing workplace violence.[30] The National Institute for Occupational Safety and Health offers a free online training entitled, "Workplace Violence Prevention for Nurses."[31] The Joint Commission, OSHA, and the World Health Organization also have published extensive articles that address workplace violence prevention.[32] Additionally, professional organizations, such as the Emergency Nurses Association, American College of Emergency Physicians, and American Hospital Association, also offer resources on workplace violence prevention.

Workplace violence remains a significant threat to the health care system, but steps can be taken to reduce incidents of violence. The OSHA Guidelines, The Joint Commission standards, and other resources discussed above offer a framework to create and maintain a culture of safety. While implementing systemwide changes cannot happen overnight, these resources provide practical solutions and innovative approaches to address workplace violence in a way that balances access to patient care and the safety of health care workers.

Endnotes

1. *See* Marcelina Behnam, et al., *Violence in the Emergency Department: A National Survey of Emergency Medicine Residents and Attending Physicians*, J. Emergency Med., 565–579 (2011), https://www.medscape.com/viewarticle/742883_print; Laura Iozzino, et al., *Prevalence and Risk Factors of Violence by Psychiatric Acute Inpatients: A Systematic Review and Meta-Analysis*, PLoS One, 10(6) (June 10, 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4464653/.
2. *See* Am. Nurses Ass'n, Issue Brief: Reporting Incidents of Workplace Violence 1 (2019), https://www.nursingworld.org/~495349/globalassets/docs/ana/ethics/endabuse-issue-brief-final.pdf.
3. *See* The Joint Commission, *Physical and verbal violence against healthcare workers*, 59 Sentinel Event Alert 2 (Apr. 17, 2018), www.jointcommission.org/sea_issue_59/ (last accessed May 31, 2020).
4. Ongoing efforts by others at both the state and federal level include Centers for Medicare & Medicaid Services Emergency Preparedness Requirements (which require a yearly all-hazards risk assessment), California's efforts to pass workplace violence prevention regulations, and the *Workplace Violence Prevention for Health Care and Social Service Workers Act* (H.R. 1309, which passed the House of Representatives in November 2019).
5. OSHA, *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, https://www.osha.gov/Publications/osha3148.pdf.

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AHLA thanks the leaders of the Behavioral Health Task Force for contributing this feature article: *Purvi Maniar, Norton Rose Fulbright (Chair); Suzette Gordon (Vice Chair—Educational Programming); Eric Neiman, Lewis Brisbois Bisgaard & Smith LLP (Vice Chair—Member Engagement); Matthew Wolfe, Parker Poe Adams & Bernstein LLP (Vice Chair—Member Engagement); Jennifer Lohse (Vice Chair—Publishing); and Allison Petersen, Integris Health (Vice Chair—Publishing).*

6. The *Workplace Violence Prevention for Health Care and Social Service Workers Act* (which has not yet been acted on by the Senate) directs the Department of Labor to promulgate an occupational safety and health standard addressing this issue.
7. 29 U.S.C. § 654.
8. *Id.*
9. OSHA, *Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents* https://www.osha.gov/sites/default/files/enforcement/directives/CPL_02-01-058.pdf.
10. *See* OSHA, News Release, Region 4 (June 10, 2013), https://www.osha.gov/news/newsreleases/region4/06102013.
11. *See OSHA, Citation and Notification of Penalty* (Oct. 3, 2018), https://www.osha.gov/ooc/citations/KidsPeaceNationalCenters_1306530.pdf.
12. OSHA, News Release, Region 4 (May 2, 2018), https://www.osha.gov/news/newsreleases/region4/05022018.
13. Aimee Green, *State fines Unity mental health $1,650 after workers suffer hundreds of assaults*, Oregonian/OregonLive, Mar. 19, 2018, https://www.oregonlive.com/portland/2018/03/state_fines_unity_mental_healt.html.
14. Arbour treats patients with psychiatric disorders and illnesses who, in many instances, have a history of violence or aggression and are unable to be treated in a less restrictive setting. BHC, a larger facility, treats a wider variety of patients, including patients who pose a risk of harm to themselves or others.
15. *See Secretary of Labor v. BHC Northwest Psychiatric Hosp. LLC*, OSHRC Docket No. 17-0063, 2019 OSAHRC LEXIS 6* (Jan. 22, 2019) (BHC ALJ Decision).
16. *See Secretary of Labor v. HRI Hosp., Inc., d/b/a Arbour-HRI Hosp.*, OSHRC Docket No. 17-0303, 2019 OSAHRC LEXIS 27*; 2019 OSHD (CCH) P33, 711 (Jan. 22, 2019) (Arbour ALJ Decision).
17. *See BHC Northwest Psychiatric Hosp., LLC v. Sec'y of Labor*, 2020 U.S. App. LEXIS 6645, *1 (D.C. Cir. Mar. 3, 2020) (BHC Appellate Decision).
18. BHC ALJ Decision at 3-4.
19. Arbour ALJ Decision at 2.
20. An OSHA expert involved with both cases cited a 2015 study of 614 psychiatric care units where nearly 15,000 patient assaults occurred over a four-year period, 75% of which resulted in employee injury. BHC ALJ Decision at 7; Arbour ALJ Decision at 3-4.
21. Arbour ALJ Decision at 5.
22. OSHA contended that BHC's workplace violence prevention plan was inadequate, noting a number of deficiencies, including the fact that while patient aggression information was obtained at intake, employees were not required to review it and those providing care were not informed of such risks. The plan also focused upon "employee-against-employee violence" versus "patient-against-employee" violence. Further, while BHC had a policy addressing how staff should approach an aggressive patient, the policy, developed in 2003, had never been updated and its existence was widely unknown. The plan also limited the reporting of incidents to only those requiring first aid. Lastly, OSHA found that when the staff made suggestions for addressing these incidents, there was a lack of organizational follow-up. OSHA showed, by contrast, that there were available and feasible means for materially reducing the hazard. These included a comprehensive hazard evaluation, appropriate staffing (having determined that BHC lacked the necessary staffing to address the patient needs and known hazards), an effective method for securing assistance as a preventative measure, a more robust incident documentation and review process, and the involvement of direct care employees on a safety committee that would review workplace violence incidents and assist in the development of better systems and communication with employees. Given the noted deficiencies and these recommended measures, OSHA was found to have met its burden. BHC ALJ Decision at 18, 21, 33-35, 38, 49, 55, 61 and 65.
23. In general OSHA's burden is satisfied if it can demonstrate there are feasible actions that can materially reduce a hazard. To meet this burden, however, OSHA must also show that existing measures are inadequate. It was OSHA's position that Arbour's workplace violence training was insufficient and that the hazard could be materially reduced by employing more effective training methods. OSHA also contended that the facility lacked adequate policies and procedures to materially reduce patient-on-staff violence and that its staffing was inadequate to address these issues. In response, Arbour was able to show that its training was extensive, addressing, in particular, how to identify potentially aggressive patients and providing an entire day of training devoted to de-escalation techniques. The training was further shown to include classroom and "hands-on" learning, and after being trained, new employees shadowed a nurse educator before taking on direct patient responsibilities. All employees also were required to go through annual re-certification that, according to Arbour's expert, provided more annual training on managing patient issues than what is typical in the industry. The ALJ found that OSHA failed to show how its proposed training changes would materially reduce the hazard. Likewise, while OSHA contended that Arbour needed a more comprehensive workplace violence prevention program that included a coordinator, better incident reporting/tracking, and more employee involvement, the ALJ, while recognizing the benefits of OSHA's more comprehensive program, found that it failed to show the existing program was deficient. Lastly, while there was no disagreement that appropriate staffing levels are "critical at any behavioral facility," the ALJ found that OSHA's approach did not call for a higher number of employees, instead, advocating for a different approach for addressing staffing levels at different times. As a result, the ALJ determined that OSHA failed to establish that Arbour's staffing/system was inadequate. Arbour ALJ Decision at 7-10.
24. Comprehensive Accreditation Manuals, The Joint Commission, Environment of Care Chapter, Jan. 2020.
25. *Id.*
26. *See* The Joint Commission, *Physical and verbal violence against healthcare workers*, 59 Sentinel Event Alert 2 (Apr. 17, 2018), www.jointcommission.org/sea_issue_59/ (last accessed May 31, 2020).
27. Kristian Foden-Vencil, *Oregon Legislators Try To Reduce Assaults On Medical Staff*, OPB.org (May 3, 2019), https://www.opb.org/news/article/senate-bill-reduce-violence-nurses-oregon-health-workers-advances/.
28. This is a new law for Oklahoma, and part of the Medical Care Provider Protection Act, which goes into effect on November 1, 2020. *See* Ronn Rowland, *Okla. governor signs law to protect EMS, hospital personnel from violence*, EMS1.com (May 20, 2020), https://www.ems1.com/ems-assaults/articles/okla-governor-signs-law-to-protect-ems-hospital-personnel-from-violence-6OB6YzG6rspiLISv/.
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Outside or Institutional Activity?

Internal Review and Compensation Considerations:

Four-Step Process for AMC Faculty Physician Review and AMC Policy and Procedure Considerations

Deborah Biggs, Comprehensive Outcomes Management Technologies LLC, and **Angie Caldwell,** PYA, P.C.

Academic medical centers (AMCs) provide health care services to communities, while also being leaders in education, research, and innovation. With such strong and competing priorities, financial pressures are high, and the organizational structures are incredibly complex. This complexity creates numerous challenges—including scrutiny of productivity and overall assessment of the faculty physician activity and corresponding compensation paid. A review of faculty activities can be for faculty activities within the AMC (paid by the entities under the AMC institutional umbrella), and it can also be for activity outside the AMC. Depending on the organizational structure, the proposed faculty physician outside activity may require institutional approval; contracts may require review and approval; and, in some cases, the AMC may consider this to be activity of the institution, and contracts and revenue will impact the organization through an institutional contract.

Generally, an AMC recognizes the value of an active faculty participating in intellectual activities that are consistent with the faculty's obligations to the AMC.

This article examines the various policy and operational factors in considering this an institutional activity.

Faculty Physician Outside Activities and Interest

For the purposes of this article, a faculty physician outside activity or interest is an "external activity, relationship, or interest—whether paid or unpaid—related to a faculty physician's work for or position in an AMC and its affiliated entities, that could result in a benefit to a faculty physician or their family."[1] Examples include, but are not limited to, consulting, ownership, or equity in an outside entity; speaking engagements, consulting, or advisory arrangements; and serving on boards of directors. Generally, an AMC recognizes the value of an active faculty participating in intellectual activities that are consistent with the faculty's obligations to the AMC. AMC faculty physicians are often encouraged to pursue such endeavors for institutional and individual educational and research opportunities and prestige purposes. Typically, an AMC will have an outside activity or interest review process to consider conflicts of interest matters with AMC activities; assess the outside activity for any regulatory, fraud, and abuse concerns; and review the arrangement or contract for compliance with AMC policies and procedures. This latter analysis may include, but would not be limited to:

- Reviewing that an outside activity or interest does not interfere with or compromise the faculty physician's primary obligation to the AMC;
- Assessing the planned compensation;
- Ensuring that no, or only incidental, resources of the AMC are used; and,
- Reviewing compliance with the AMC's policies on noncompetition, publications, branding, use of logo, etc.

Institutional Activities

Outside activities require a faculty physician's time, energy, and focus. In some cases, it may be in the best interest of the AMC and faculty physician for these activities to be considered internal, and therefore within the scope of duties and productivity of the faculty physician for the AMC organization. Activities may be considered internal for a variety of reasons. At a minimum:

- The faculty physician and AMC agree on this approach;
- The planned activity is closely aligned with the AMC's mission;
- The economic analysis is acceptable; and,
- The institutional contract can be structured to meet the AMC's policies and procedures.

There are also considerations when a faculty physician's organizational responsibilities, productivity measures, or additional external salary support would benefit from increased institutional activity, and the faculty physician is also engaged in outside activity. In these cases, it may be appropriate to consider making the outside activity an institutional activity and for the commensurate revenue to be part of the AMC's funds flow, faculty physician productivity assessment, external salary support, and compensation plan.

Identifying the outside activity and assessing it for an institutional arrangement can be managed through

an existing approval process, which also considers conflicts of interest/commitment issues. Typically, these processes require the approval of the faculty physician's direct supervisor (e.g., department chair, division chief, etc.), and issues impacting the institution are considered in the process. If the activity is being considered as an institutional activity, it is also appropriate to consider the activity in determining AMC clinical, academic, and research compensation.

As previously noted, the organizational structures of AMCs are complex. Internal to the AMC, the faculty physician's compensation may be funded by the health system, the clinical department, the academic department, and/or the research department from which the faculty physician duties relate. These AMC functions may or may not be structured under one entity. Determining total "stacked" compensation across the AMC and its affiliates may be a challenge.

If the organization does enter into an institutional agreement for the outside activity, the AMC accepts legal risk for the transaction, including ensuring that the total stacked compensation paid to the faculty physician is fair market value (FMV) and commercially reasonable (CR). To the extent the compensation is paid directly to the faculty physician (an "individual agreement"), while the AMC may not be required to ensure that the compensation received by the faculty physician for the outside activity is FMV and CR, it is still a consideration for the AMC.

Institutional Review Process

An AMC may complete the outside activities' institutional review process in four general steps as outlined in the diagram above.

Part 1—Business Arrangement Review

The Business Arrangement Review is the first part of the four-part process and should be completed by the office(s) responsible for development and approval of the business arrangement. The central questions surrounding this review include the "what, why, and how" of the arrangement. Specifically, the following questions should be answered and documented:

- What is the scope of the contract and services under consideration?
  - Does the proposed arrangement advance or support the mission(s) of the organization?
- Why is the organization entering the agreement?
  - How does the activity support the faculty and/or mission(s) of the organization?
- How is the proposed arrangement structured?

Part 2 and 3—CR and FMV Compensation Assessments

Total stacked (i.e., all inclusive) compensation should be FMV and CR for the services a faculty physician personally performs. While the details of determining

If the organization does enter into an institutional agreement for the outside activity, the AMC accepts legal risk for the transaction, including ensuring that the total stacked compensation paid to the faculty physician is fair market value (FMV) and commercially reasonable (CR).

It is important for AMCs to use an institutional approach to guide the assessment of such outside activities and mitigate organization and individual risk.

clinical, academic, and administrative compensation are outside the scope of this article, we will focus on FMV compensation and CR considerations for outside services.

The central concept surrounding CR is to answer the "why" of the arrangement. CR is most clearly defined by the Centers for Medicare & Medicaid Services (CMS) in Stark Law commentary, which states that "an arrangement will be considered 'commercially reasonable' in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable faculty physician (or family member or group practice) of similar scope and specialty, even if there were no potential designated health services (DHS) referrals."[2]

To assess the CR of an arrangement, each analysis should include an understanding of the specific transaction's:

- ***Business purpose,*** including an assessment of whether the arrangement fits the AMC's mission.
- ***Services provider,*** including an assessment of whether the provider has the necessary skills to perform the duties of the arrangement.
- ***Appropriateness for the health care provider's facility and population,*** including an assessment of the legitimate business need for the organization to enter the arrangement.
- ***Suitability,*** including an assessment of the human and capital resources required for the success of the arrangement and overall resources and investments made in the particular service line or by the health care entity.
- ***Aptness of independence and oversight,*** including an assessment of how often the arrangement will be reviewed for compliance.[3]

The central question surrounding the determination of FMV is *how much?* Determining the FMV of any faculty physician compensation arrangement includes assessing quantitative and qualitative factors based on the individual facts and circumstances of the arrangement. Documentation of the assessment is necessary to provide evidence of the conclusions regarding FMV and CR and will help an AMC more thoroughly determine the totality of the compensation paid to a faculty physician to mitigate risks.

While helpful in providing a foundation and direction for proceeding, benchmark survey data does not alone determine the FMV for faculty physician services. Further, other than the Open Payments Program (OPP),[4] data for outside services is not easily accessible or readily available. While approaches for determining FMV will vary among valuators, the definition of FMV is standard: the price at which the property or service would change hands between a willing buyer and a willing seller, neither being under a compulsion to buy or sell and both having reasonable knowledge of the relevant facts.[5]

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4-Step Institutional Review Process Detail

Business Arrangement Review 1

Responsible offices for development and approval of the business arrangement.

Central questions: "What, Why, and How?"

- What is the scope of the contract and services being considered?
- Does the proposed arrangement advance or support the missions of the organization?
- Why is the organization entering into this agreement?
- How is the proposed arrangement structured?

Commercially Reasonable 2

Assesses the overall arrangement.

Central questions: "Why?"

- Is there a legitimate business reason for the organization to enter into the agreement?
- What are the facts and circumstances of the business arrangement?
- Does the proposed arrangement advance or support the missions of the organization?
- Is the proposed arrangement commercially reasonable with no other business arrangements between the organization and the other party?

Fair Market Value 3

Assesses the range of dollars or compensation provided.

Central question: "How much?"

- What is the range of compensation being proposed for the service provided by the organization?
- What are the facts and circumstances of the proposed compensation?
- Is there an appropriate threshold below which minimal review can be employed?
- If the proposed arrangement exceeds the threshold amount consider the following:
  - Specialized nature of the services provided
  - Leadership, regional, national, or international recognition of the person providing the services
  - Innovator in the field or otherwise distinguished from peers

Industry Relations Committee Review 4

Review overall process and final arrangement being proposed.

Central question: "Process?"

- Does the overall arrangement seem reasonable? (Balancing test: Consider the facts and circumstances and if the arrangement seems reasonable considering professional judgment)
- Was the appropriate process followed?

This definition is consistent with the Stark Law definitions of FMV and general market value, summarized as follows:

- ***FMV***: The value in arm's-length transactions, consistent with the general market value.
- ***General Market Value***: The price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.[6]

To determine FMV for outside activities in an institutional arrangement, the valuator will seek to answer the following questions:

- What are the terms of the proposed arrangement? An understanding of the terms should include who is doing what, for how long, where, and the amount of proposed compensation.
- Does the nature of the services require specialized expertise? The likely answer to this question is "yes," as outside services organizations seek leaders in their specialty. However, the valuator should be

careful to ensure that the specialty is required in order for the duties to be performed. For example, a neurosurgeon providing services that a family medicine faculty physician could perform should be compensated at family medicine faculty physician rates.

- How rare is the required expertise?
- Will the service lead to regional, national, or international acclaim or recognition for the faculty physician?
- Will the service lead to regional, national, or international acclaim or recognition for the AMC?
- Will the services be personally performed by the faculty physician?
- Is the value of the service not based on the volume or value of referrals to the hospital provider or another entity?
- Is the outside activity considered an innovation?
- Are there similar services provided by others within the organization? What is the compensation for those activities?
- What does the OPP include as compensation for similar services?
- What is the number of hours and/or level of effort required by the faculty physician to provide the services?
- Is the goal difficult or simple to achieve?
- What is the replacement cost? For example, what is the cost for the AMC to replace the faculty physician who is otherwise consulting under another arrangement?
- Should considerations be made for incremental institutional administrative costs? Particular consideration for this issue may be necessary if the form of the contract (e.g. an institutional contract) substantially increases the cost consideration in meeting the terms of the contract.

Part 4—Industry Relations Committee Review

The fourth step involves a review by the Industry Relations Committee, which is responsible for the overall process and proposed final arrangement. The central theme of this review is *process*. Specifically, this review should answer three main questions:

- Does the overall arrangement seem reasonable? The Committee should consider the entirety of facts and circumstances and whether the arrangement seems reasonable considering professional judgment.
- Was the appropriate process followed? The process should provide a reasonable framework from which to assess institutional arrangements. Deviations from the process should be explored and understood. While exceptions may occur, the related risk may need mitigation.
- Is the appropriate process complete? A final decision on any arrangement should not be made until the process is complete and the Industry Relations Committee is convinced of the gathered evidence.

Building the Institutional Review Policy and Procedure

Policy Development

A policy can provide helpful guidance to individuals within the organization and to the Industry Relations Committee. It is important for AMCs to use an institutional approach to guide the assessment of such outside activities and mitigate organization and individual risk. While many AMCs have such a policy,[7] it often simply defines what an outside activity is, but may not specifically address how the outside activity could be considered an institutional activity or how it is addressed from either a contractual or compensation perspective. The policy, when used in conjunction with the four-step process described earlier, should answer the additional following questions:

- Does the policy outline resources to be provided by the AMC for monitoring, reviewing, and

The complexity of an AMC's mission and organizational structure creates numerous challenges when it comes to evaluating faculty physician activity, productivity, and corresponding compensation.

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administering institutional arrangements? For example, the AMC may provide legal and administrative services, in addition to space, supplies, and other resources.

- What institutional considerations need to be given for unrelated business income tax (UBIT) implications resulting from the outside service?
- Who is responsible for negotiating, reviewing, and reporting on the activity?
- Are the primary missions/activities of the AMC being met by the faculty physician?
- Will there be intellectual property generated as part of the outside activity, and if yes, how will this be handled?
- How will funds flow be handled?
- What is the impact on the faculty practice plan or department compensation plan?
- How will the activity impact faculty physician productivity or required external salary support?
- Is the decision to include the outside activity as an institutional activity a joint decision of the organization and faculty physician, or does the organization have primacy of the decision as the employer of the faculty physician member?

Procedure Development

As mentioned earlier, there are many reasons an organization or a faculty physician may want an outside activity to be considered an institutional internal activity. To begin the process, the faculty physician would need to disclose the potential activity to the organization, generally to the faculty physician's direct supervisor. This is an appropriate first level of review. The direct supervisor, often the department chair or division chief, is in the best position to assess the following:

The proposed activity's fit within the institution;

- Organizational priorities and use of institutional resources;
- Time and effort of the faculty physician and priorities that compete for the faculty physician's attention, including caring for patients, teaching, performing research, publishing scholarly activity, serving on institutional committees, and supporting organization activities;
- The faculty physician's ability to meet primary commitment to and needs of the organization; and
- Impact on the compensation of the faculty physician and benefit of having the activity considered as part of the compensation plan and activity measures.

Following approval by the direct supervisor, the proposed activity can be advanced to the Institutional Review Committee for review and approval.

If the activity is approved by the organization as an internal activity, it makes most sense for the compensation to be processed through appropriate funds flow processes as any other revenue to the organization would be considered. In this case, the compensation should also be considered as part of the faculty member's productivity in meeting the benchmark for any appropriate category of activity (e.g., patient care, research, education) and/or for any goals for external funding and salary support.

Conclusion

The complexity of an AMC's mission and organizational structure creates numerous challenges when it comes to evaluating faculty physician activity, productivity, and corresponding compensation. By deploying the four-step institutional process, an AMC has a means by which to consider, analyze, and document important decision-making surrounding outside activity within an institutional arrangement. Working through this process, an AMC will have increased knowledge and ability to consider outside activities of the faculty as institutional activities of the faculty physicians.

1. Organizations may use different definitions for "outside activity or interest." The definition above is a sample definition used for purposes of this article.
2. 69 Fed. Reg. 16093 (Mar. 26, 2004).
3. PYA, P.C.—*Commercial Reasonableness: Defining Practical Concepts and Determining Compliance in Healthcare Transactions for Physician Services,* https://www.pyapc.com/wp-content/uploads/2019/06/Commercial-Reasonableness-Defining-Practical-Concepts-and-Determining-Compliance-in-Healthcare-Transactions-for-Physician-Services-061119.pdf.
4. *See* https://openpaymentsdata.cms.gov/.
5. Treas. Reg. § 20.2031-1(b) (2005); Rev. Rul. 59-60, 1959-1 C.B.237.
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7. Rebecca Schaefer, *Lurking Legal Issues for AMCs in Faculty-Led Consulting for Industry via Institutional Contracts*, AHLA Connections (May 2019).

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How PDPM Risks and Opportunities Impact SNF Compliance Programs

Amy Dalton, PYA, P.C.

Last October, the Centers for Medicare & Medicaid Services (CMS) replaced its Resource Utilization Group, Version IV (RUG-IV) payment model with the Patient-Driven Payment Model (PDPM).[1] The new payment model has transformed Medicare Part A Skilled Nursing Facility (SNF) stays from a therapy-driven model to one that places more emphasis on nursing services, differentiated payments for medically complex patients, and increased focus on appropriate length of stay.

PDPM creates both challenges and opportunities for the more than 15,000 SNFs across America. These facilities are also impacted by the pending proposed rule regarding Requirements of Participation: Phase III,[2] which will require SNFs to have a functioning compliance and ethics program in place.

However, the bedrock of SNF compliance continues to be the Seven Fundamental Elements of an Effective Compliance Program outlined by the Office of the Inspector General (OIG) in the Compliance Program Guidance for Nursing Facilities and its supplemental guidance. The OIG's Seven Elements are intended to serve as an industry standard, offering a framework and foundation in the development of well-defined plans and strategies to build successful, effective compliance programs. With a strong foundation, providers are successfully positioned to incorporate PDPM and manage its risk factors.

Simply creating a compliance checklist is not sufficient. The program must continuously evolve to meet changing regulatory requirements and organizational needs. The salient question remains: Is our SNF truly effective in deterring fraud, waste, and abuse?

42 C.F.R. 483.85 extends the program scope of the Seven Elements to include SNF contractors and volunteers—and provides additional requirements for organizations with more than five locations.

PDPM Transition Hurdles

Despite SNFs having had time to prepare for PDPM, there continues to be ongoing uncertainty and complex challenges from a clinical and operational perspective. These challenges include:

- Services that are individualized, skilled, medically necessary, and documented appropriately.
- Coding that captures all patient characteristics and comorbidities.
- Alignment of care planning and patient goals.
- Potential revenue cycle and back office challenges.
- Training and documentation consistency across multi-facility organizations.

Best Practices Going Forward

As SNFs become more familiar with the intricacies of PDPM, it's more important than ever to rely on the Seven Elements of effective compliance to develop or revise their compliance and ethics programs. Robust programs mitigate risk, but also help establish a compliance culture that can improve operational efficiencies, reduce costs associated with regulatory non-compliance, and provide a unified framework for ethical operations for an entire organization.

PDPM risks should be delineated in the SNF's compliance work plan—and facilities should conduct a thorough annual risk analysis informed by historical facility performance metrics, such as quality of care, overpayment history, and recent OIG national settlements.

Other best practices include:

- Identifying areas of concern, such as the hurdles listed previously, past survey results, and the rules and regulations governing the SNF.
- Developing training for all applicable personnel involved in providing and billing for the services. The training should encompass the compliance program, Code of Conduct, and the importance of individualized patient care.
- Ensuring interdisciplinary/departmental open lines of communication.
- Developing an auditing and monitoring program that identifies areas for educational opportunities.

- Monitoring changes to the regulations and updating the compliance and ethics program, relevant policies and procedures, and staff training topics.
- Being proactive in preparing, implementing, and adjusting compliance program efforts. Establishing a culture of compliance requires support from organizational leadership and sufficient resources, such as adequate support staff and operational budget.
- Considering the use of a third-party reviewer to explore additional action that may be needed, should a problem be revealed.

Aligning Compliance with the QAPI Program

SNFs across the nation are taking quality programs to new levels by harnessing the mutually reinforcing strengths of quality assurance and performance improvement (QAPI). There's much to be gained by aligning the QAPI program with compliance initiatives, as quality of care remains the primary focus of both OIG Compliance Guideline reports.

The key elements of a successful QAPI program follow:

1. Design and Scope
2. Governance and Leadership
3. Feedback, Data Systems, and Monitoring
4. Performance Improvement Projects (PIPs)
5. Systematic Analysis and Systemic Action

Both the overall compliance program and QAPI initiatives are good examples of the old adage heard in quality improvement circles: If you measure it, it *will* improve.

Moving from Volume to Value

Clearly, the RUG-IV payment model had significant drawbacks. It created an incentive for SNF providers to furnish therapy regardless of the patient's unique characteristics, goals, or needs. PDPM eliminates this incentive and improves the overall accuracy and appropriateness of SNF payments as well as care coordination for the patient.

As SNFs refine and optimize PDPM implementation, it should always be in the larger context of the Seven Elements of an Effective Compliance Program that have guided facilities so well for the past 20 years.

Endnotes

1. 83 Fed. Reg. 39162 (Aug. 8, 2018).
2. 84 Fed. Reg. 34737 (July 18, 2019).

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Seven Elements of an Effective Compliance Program	42 C.F.R. 483.85 Final SNF Compliance Program Requirements
Implementing written policies, procedures, and standards of conduct	Establish written compliance and ethics standards, policies, and procedures that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations. There should be a contact person to whom individuals may report suspected violations, and an alternate method where violations can be reported anonymously without fear of retribution. Disciplinary standards should clearly spell out the consequences for committing violations.
Designating a compliance officer and compliance committee	This individual must report directly to the operating organization's governing body and should not be subordinate to the general counsel, chief financial officer, or chief operating officer.
Conducting effective training and education	Educational materials need to explain in a practical manner what is required under the program.
Developing effective lines of communication	Having written guidelines is not enough. The facility must take steps to effectively communicate the standards, policies, and procedures to the entire staff (including contractors and volunteers).
Enforcing standards through well-publicized disciplinary guidelines	The SNF's policies and procedures must be consistently enforced through appropriate disciplinary mechanisms (including discipline for failing to detect and report a violation to the compliance committee).
Conducting internal auditing and monitoring	Establish monitoring and auditing systems to detect criminal, civil, and administrative violations by employees, contractors, or volunteers. The SNF must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations—and to improve its performance in deterring, reducing, and detecting violations.
Responding promptly to detected offenses and undertaking corrective action	After a violation is detected, the SNF must ensure that all reasonable steps are taken to respond appropriately to the violation and to prevent further similar violations.

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Marked by an integrated approach and unmatched health care regulatory knowledge, the health care practice of Bass Berry & Sims is a team of more than 200 experienced health care attorneys who leverage their diverse strengths to meet the unique demands of their clients. The firm has contributed to the evolution of Nashville as the nation's capital of health care delivery and entrepreneurialism. From this experience, Bass Berry & Sims attorneys know that issues impacting health care organizations require a multidisciplinary team informed by a historical perspective. The firm provides health care regulatory counsel to 35 publicly traded health care companies and more than 200 businesses in the health care industry located throughout the U.S.; has extensive experience in representing investors, lenders, and investment banking firms in financing transactions for health care companies; and has advised on more than $136 billion in health care transactions and more than $52 billion in debt and equity offerings.

Bass Berry & Sims attorneys have been members of AHLA since its inception.

"AHLA educational programs are an invaluable resource that has helped our attorneys to better serve our clients and allowed us to connect with leaders in the health care industry."—*Eleanor Smith, Bass Berry & Sims PLC, Managing Director–Health Care Practice Group, Nashville, TN*

"AHLA has been incredibly important to the growth of not only our firm's health care expertise but the brand, reputation, and credibility of our individual attorneys. AHLA furthers our professional development through the numerous resources, networking opportunities, and leadership roles it offers, and we are grateful for the opportunity to benefit from their unparalleled reach into the health care industry."—*Cynthia Reisz, Bass Berry & Sims PLC, Member, Nashville, TN*

BASS BERRY SIMS

4 Baker Donelson Bearman Caldwell & Berkowitz PC 225

Baker Donelson is one of the leading health law practices in the U.S. With more than 200 health care attorneys in ten states and the District of Columbia, it offers clients a unique perspective. Its attorneys combine a breadth and depth of knowledge in health law with extensive experience in health care operations and up-to-the-minute understanding of critical health policy issues. The firm's scale and collective experience enables it to give clients practical solutions to cutting edge problems. Dedicated teams focus on various segments of the health care industry, including for-profit and nonprofit hospitals and health systems, long-term care providers, ambulatory surgery centers, complex medical groups, dialysis providers, rehabilitation companies, pharmacies, and other key parts of the health care ecosystem. Baker Donelson attorneys learn their clients' business so that they can help them manage legal risk while accomplishing their business objectives. The firm's goal is to be its clients' trusted advisor and valued counselor.

Baker Donelson is proud of its long-standing relationship with AHLA. Baker Donelson Shareholder S. Craig Holden currently serves as President of the AHLA Board of Directors, continuing the firm's tradition of service to AHLA that includes five Past Presidents, three Greenburg Service Award Winners, eight Fellows, seven past Board Members, nine Pro Bono Champions, and numerous Practice Group Chairs and Program Planning Committee Chairs. Baker Donelson attorneys actively seek engagement through individual Practice Groups and are frequent contributors to articles and webinar presentations.

"AHLA is the premier organization for lawyers who focus their time and energy on the health care industry. Membership in AHLA provides a collegial forum to bring together the best of the best from all over the country. AHLA allows us to connect to members

This year's Top Honors roster includes the top ten firms having the most AHLA members as of March 31, 2020.

through conferences and other in-person meetings, as well as learn from our colleagues via written content and online webinars. It is our go-to source for new information on critical changes in health care."—*S. Craig Holden, Baker Donelson Bearman Caldwell & Berkowitz PC, Shareholder, Baltimore, MD*

BAKER DONELSON
HEALTH LAW
A BAKER DONELSON PRACTICE

5 Waller Lansden Dortch & Davis LLP 193

Service to the health care industry is the cornerstone of Waller's legal practice. The firm's experience dates to the passage of Medicare, and its attorneys have been developing innovative solutions to the challenges faced by health care providers for more than 55 years. With its home base in Nashville, TN, Waller is squarely positioned to work directly with the nation's largest and leading health care providers and companies. The firm's nearly 200 health care attorneys—including more than 30 who focus exclusively on health care regulatory compliance—give Waller the flexibility, depth, and experience to provide comprehensive counsel to health care clients across the U.S.

Waller Partner Kim Harvey Looney currently serves on the AHLA Board of Directors, and Waller attorneys are active in numerous Practice Groups. Waller attorneys regularly attend and present at AHLA events and invest their time in the development of whitepapers and other thought leadership for AHLA.

"Waller finds tremendous value in being able to collaborate with a variety of in-house counsel and other health care attorneys, especially within the context of the ever-changing regulatory landscape. AHLA provides an important platform for staying current with emerging issues and developments, networking with industry leaders, and building on relationships that foster effective collaboration."—*Kim Harvey Looney, Waller Lansden Dortch & Davis LLP, Partner, Nashville, TN*

waller

6 Husch Blackwell LLP 186

Husch Blackwell's health care practice is one of the largest in the country with 130+ attorneys across all practice areas, operating out of 18 offices across the U.S. The firm is very experienced in representing health systems, hospitals, academic medical centers, physicians, and other types of health care providers. Husch Blackwell does not see itself as merely providing legal services; with Husch Blackwell you will be getting a partner. The firm's counsel is based on that deep knowledge of your industry, and its focus is always on finding the best way for its tremendous expertise and depth of experience to move your business forward.

Husch Blackwell attorneys are found volunteering in many AHLA leadership opportunities, including serving on the AHLA Board of Directors and as engaged members in Practice Groups, Task Forces, and Committees and Councils. Husch Blackwell attorneys report that the engagement and comradery of participating in AHLA provides them benefits few other associations can match.

"AHLA keeps our team up to date on cutting edge health law issues to better serve our health care clients across the country."—Thomas N. Shorter, Husch Blackwell LLP, Partner, Madison, WI

HUSCH BLACKWELL

7 Mintz Levin Cohn Ferris Glovsky & Popeo PC 162

Mintz is one of the few law firms that has a true health law practice composed of a sizeable group of attorneys who all have a regulatory component to their respective practices and who know and understand every aspect of the health care industry, how it is regulated, and how that regulatory regime affects the business of health care clients. Its national as well as regional client base covers the entire spectrum of the industry and includes leading private equity firms and others investing in the sector. Mintz's FDA team is uniquely situated within its Health Law Practice, giving clients a holistic approach to launching their products and operating in the complicated health care delivery system.

Mintz attorneys are long-time members of AHLA who regularly serve as Practice Group leaders, write for AHLA publications, present on webinars, serve on panels, and use educational programming as a training tool. The Mintz team includes two AHLA Fellows and one AHLA Past President. As Mintz's Health Law Practice continues to grow, an increasing number of its attorneys are taking advantage of AHLA's excellent educational resources.

"AHLA plays an important role in both educating our newer attorneys and keeping our seasoned lawyers current on legal and policy developments that affect their practice on a daily basis. The in-person programming presents an invaluable opportunity to network with our other law firm peers and, more importantly, with our in-house clients."—*Brent Henry, Mintz Levin Cohn Ferris Glovsky & Popeo PC, Member, Boston, MA*

"AHLA is an outstanding forum for training, collaboration, and networking. As a leading Health Law Practice, it's important to us to be connected to the larger health care community."—*Joseph Miller, Mintz Levin Cohn Ferris Glovsky & Popeo PC, Member, Washington, DC*

"AHLA's online and print materials are some of my go-to resources when it comes to answering clients' regulatory and other questions."—*Cassandra Paolillo, Mintz Levin Cohn Ferris Glovsky & Popeo PC, Associate, Washington, DC*

"AHLA offers top-notch programming from noted experts that help keep us informed about the latest developments and gain insight into the trends and issues germane to all areas of health care law. On the flip side, it also offers writing and speaking opportunities that allow us to represent our firm—our brand—which can raise our visibility and introduce us to new colleagues as well as potential clients."—*Nili Yolin, Mintz Levin Cohn Ferris Glovsky & Popeo PC, Member, New York, NY*

MINTZ

8 Epstein Becker & Green PC 152

Epstein Becker Green is one of the country's few "super boutiques," with the majority of its attorneys primarily focused in two of the firm's practice groups: Health Care & Life Sciences and Employment, Labor & Workforce Management. As a result, the firm has a premier health care M&A team, represents industry clients in their most sensitive litigation and investigation matters, and serves as critical outside advisors for industry players on all of their regulatory needs. There is not an area of law that affects health care and life sciences companies that Epstein Becker Green does not touch. Its team includes lawyers who previously worked within the health care industry, and the Health Care & Life Sciences practice collectively houses a broad range of disciplines, including corporate, fraud and abuse, reimbursement, managed care, antitrust, tax, ERISA, litigation, and more.

Epstein Becker Green has a valued history with AHLA and its predecessor organizations—the National Health Lawyers Association and the American Academy of Healthcare Attorneys. Its attorneys are active members of the Association by attending programs; serving as speakers at in-person and virtual programs; authoring articles, books, and other publications; volunteering as mentors and on committees; and participating in the leadership of the organization.

"AHLA is an important organization for both me and my law firm because it expands my horizon of knowledge, ideas, and legal strategy for advising my health care clients. This is achieved because AHLA is a truly collegial group of like-minded attorneys who represent clients in the health care industry; who constantly want to be on the cutting edge of ever-changing laws, regulations, cases, and government investigations impacting their clients; and who are eager to educate each other and brainstorm on how best to advise their clients."—*Gary Herschman, Epstein Becker & Green PC, Member, Newark, NJ*

"While in law school and knowing that I wanted to be a health lawyer, my membership in AHLA (then the National Health Lawyers Association) was an invaluable investment. It provided me with resources to learn more about the various sub-disciplines within health law and the ability to network with highly successful and knowledgeable practitioners. I attribute my success as a health lawyer to my ongoing membership within the Association."—*David Matyas, Epstein Becker & Green PC, Member, Washington, DC*

"As a young attorney, AHLA presented me with many opportunities to develop my brand and reputation in the health care and life sciences industry. The AHLA staff with whom I routinely worked acted as mentors, trying to find me additional opportunities for involvement and development, and I am eager to pay it forward to ensure the next generation of lawyers is offered the same guidance, mentoring, and support I had."—*Anjali Downs, Epstein Becker & Green PC, Member, Washington, DC*

"Throughout my more than 38 years at Epstein Becker Green practicing health law, AHLA has consistently been the forum for thought leadership in connection with both health law issues and career development for health lawyers. During that time, the scope of health law and the needs and diversity of health lawyers has dramatically changed and through all of it, AHLA has adapted and adjusted to such change and has remained a beacon of light for our profession."—*Clifford Barnes, Epstein Becker & Green PC, Member, Washington, DC*

EPSTEIN BECKER GREEN

Don't see your firm or organization on this list? Individuals can join by going to www.americanhealthlaw.org/join.

9 Hall Render Killian Heath & Lyman PC 144

Hall Render is unique because health law is the firm's sole focus. Its attorneys know the industry and how to decipher its many complexities. Because the scope of client needs can encompass multiple niche areas of health law, Hall Render attorneys often collaborate to share their diverse health care experience, providing clients with superior legal advice and business consultation.

Hall Render's attorneys are highly active in AHLA and engage in a variety of ways, from being frequent speakers and authors for AHLA events and publications to holding leadership positions within a number of Practice Groups and Program Planning Committees.

"By providing a diversified program of educational and networking opportunities, as well as newsletters and publications, AHLA helps us track with, and keep on top of, trends in the industry."—*John Ryan, Hall Render Killian Heath & Lyman PC, President and Managing Partner, Indianapolis, IN*

HALL RENDER
KILLIAN HEATH & LYMAN

10 Morgan Lewis & Bockius LLP 118

Morgan Lewis takes a collaborative and integrated approach to serve its health care industry clients. Its lawyers come from a variety of federal and state agencies, in-house positions within the health care provider community, and other health care-related organizations, including the U.S. Department of Health & Human Services, the National Committee on Quality Assurance, the Department of Justice, the Federal Trade Commission, and the Department of Labor. With experience in nearly every area of health care law—including litigation, finance and transactions, coverage and reimbursement, compliance counseling and fraud and abuse investigations, public policy and advocacy, privacy and data security, labor and employment, antitrust, and more—Morgan Lewis attorneys understand the complexity of their clients' legal and operational challenges in this rapidly evolving industry and use their experience across practices to maximize quality and value for their clients.

Morgan Lewis considers AHLA to be a premier organization for the development of health care attorneys and fostering future leaders. A number of Morgan Lewis attorneys are active within AHLA in various capacities and started volunteering with AHLA early in their health law careers.

"AHLA has been almost as important to my career as my law degree is. When I was a junior health care attorney, the AHLA community served as my mentor, giving me all the resources I needed to develop insights and judgment in the world of health care regulation. As an attorney rising up in seniority, AHLA was my colleague, offering me countless opportunities to brainstorm with peers and get a broader perspective. As I approach becoming a senior attorney, AHLA gives me an opportunity to give back. I have learned so much through the organization, and it is always a pleasure to pay it forward in providing presentations and other materials to share my perspective with others. I have undying gratitude for all that AHLA has done to further education and understanding in the health law industry."—*Andrew Ruskin, Morgan Lewis & Bockius LLP, Partner, Washington, DC*

"I've been a member of AHLA for over 30 years, and the most notable benefit for me is the personal relationships I've developed over the years, either by meeting colleagues at in-person meetings or working with members in Practice Groups or Program Planning Committees. In many instances, what may have started as professional relationships have grown into long-term friendships. I attribute that to the many opportunities available to all AHLA members and is why I recommend to all young lawyers pursuing a career in health law to not only join AHLA but become an active participant in the Association.—*Albert Shay, Morgan Lewis & Bockius LLP, Partner, Washington, DC*

"AHLA is important to my firm because it serves as a knowledge resource for us in the ever-changing health care landscape. AHLA's programs and materials help keep us current so that we are able to provide ripe and timely advice to our clients, continuing to help us strive for excellent client service."—*Banee Pachuca, Morgan Lewis & Bockius LLP, Associate, Houston, TX*

Morgan Lewis

Also Recognized

(Firms and organizations having 25 or more AHLA members)

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AHLA would like to thank our sponsors and exhibitors for their generous support of the Association's programs and products. This lists the top 10 companies that provided the highest level of financial support in fiscal year 2020 (June 1, 2019–May 31, 2020).

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10. (tie) JTaylor
10. (tie) Pinnacle Healthcare Consulting

Advertisers

AHLA offers a variety of ways to reach our members through print and online advertising options and electronic member resources. This lists the top 10 companies that provided a high level of advertising support in fiscal year 2020 (June 1, 2019–May 31, 2020).

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Don't see your company on this list? Contact Samantha Roesler, MCI Account Executive, at (410) 584-1996 or samantha.roesler@mci-group.com to learn more about advertising opportunities with AHLA.

AHLA Goes Virtual

In-House Counsel Program

July 9 and 16, 2020

It's not too late to register and join your colleagues who are attending the virtual In-House Counsel Program! Get the cutting-edge educational content that in-house counsel need, earn CLE, CPE, and CCB credits, and connect with and learn from colleagues from across the country.

Speakers at the virtual In-House Counsel Program will address the unique issues faced by in-house counsel. Attendees will learn practical, hands-on ways to function in these challenging times and address the roles and responsibilities that in-house counsel must fill. Live sessions will be held on July 9 and July 16, and there will also be a number of additional presentations available on-demand.

The program will kick-off with a panel discussion on the "Role of In-House Counsel during the COVID-19 Crisis." The panel will examine the role of in-house counsel as trusted advisor, risk manager, and problem solver. This fast-paced discussion will explore the unique challenges and opportunities for in-house counsel during the COVID-19 crisis, including both success stories and cautionary tales from the trenches.

Additional presentations that will help prepare you to advise your organizations on business issues and legal and regulatory developments include:

- What is Artificial Intelligence and Why in Health Care?
- The Impact of COVID-19 on Corporate Governance
- Getting to Yes: Executing a Successful Campaign to Launch a High Profile Health Sector Initiative
- Legal Ethics: Oil and Vinegar or Peanut Butter and Jelly: The Interplay Between Legal and Compliance?

For those new to virtual programs, here is how they work. The speakers pre-record their presentations and are available when their presentations air during the virtual program for an online attendee chat with all the other participants. The attendee chat provides a venue to ask questions of the speakers, share perspectives, expand on the ideas discussed, and connect with other attendees. In addition to viewing sessions live, you will be able to view sessions you miss "on demand" and earn continuing education credits for both the live sessions as well as the on-demand sessions.

Learn, Share, and Connect from Home

In–House Counsel Program Planning Committee

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For more information on sponsorship of AHLA events, please contact veshleman@americanhealthlaw.org.

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Three Positives of Professional Development During a Pandemic

Mara Smith

When I set out my professional development goals for 2020, I envisioned that networking events, in-person conferences, and one-on-one coffee meetings would enhance and enrich my experience as a third-year attorney. However, by the end of March, I realized that my approach to professional development would have to adjust to a world rapidly changing in the face of the COVID-19 pandemic. In reworking my vision for professional development during a pandemic, I found three positives.

1. No Geographic Barriers

One of the best and worst parts about being a member of AHLA's Young Professionals Council (YPC) is that many of my favorite colleagues live in various cities across the country. While this makes reunions at AHLA in-person programs like Fundamentals of Health Law and the Annual Meeting highlights of my year, it also means that I miss connecting with my colleagues in those "in-between" months after we retreat back to our hometowns and busy lives. Living and working during COVID-19 has revealed something that should have been readily apparent long before the pandemic confined many of us to our homes: we can connect "face to face" with anyone, anywhere, at any time using video-chatting platforms. This reality has opened previously untapped opportunities for remote happy hours and coffee meetings with friends and colleagues around the globe. Through this new way of life, I have had the ability to pursue a much wider range of professional development opportunities that might not otherwise have been options for me based on my geographic location.

2. More Flexible Timing

Prior to the pandemic, whether it was late nights in the office or after-hours networking events, it was difficult to find time to set up one-on-one or even small group meetings that supported professional development. Often, such meetings were scheduled months in advance using a system of "scheduling Tetris" that involved sending multiple emails in an attempt to find a window of time that would allow for travel from one location to another while ensuring sufficient time for the meeting. Without diminishing the value of these in-person meetings, the pandemic has given many the gift of time. The "commute" from work to a meeting often involves the closing of one internet browser and the opening of another. This has removed some of the rushed undertones that can accompany in-person meetings during busy weeks and has allowed participants to literally meet where they are.

3. Narrowly Focused Programming

Before the pandemic, I would base my professional development activities on a variety of factors including location, timing, and topic. While I was lucky enough to live in a major U.S. city with plenty of options, these other factors often limited the types of events I could attend. With an increase in virtual professional development events, I have been able to attend the types of events that enrich my professional development without the burden of location and with much less restrictive timing constraints. These virtual events have also allowed me to explore areas that interest me without having to devote significant resources to attending and learning more about a topic.

While the COVID-19 pandemic has presented challenges for young attorneys navigating professional development, I have seen how the shift to virtual professional development has exposed new opportunities. And although I cannot wait to share a drink with my YPC colleagues at an in-person AHLA program, I am grateful that there are still options to do that (at 5:00pm Eastern, 4:00pm Central, 3:00pm Mountain, and 2:00pm Pacific) from the safety of our homes.

Mara Smith currently serves as in-house counsel in the life sciences industry, with a focus on commercial contracting, practicing in New Jersey.

EPSTEIN
BECKER
GREEN

We applaud our first responders, businesses, and other individuals across the nation who are selflessly and bravely confronting the global COVID-19 pandemic. In this unprecedented time, we are proud to partner with clients across industries and provide creative solutions to address the many challenges the pandemic has created.

Our team is here to counsel payors, hospitals, providers, manufacturers, and distributors on cutting-edge matters and to help develop solutions for those on the front line.

With our deepest gratitude, we wish health and safety to all.

The team at Epstein Becker Green

ebglaw.com

More Than Ever: Mentoring During COVID-19

Hema Anwar,
Kaiser Permanente

On March 2, I started a new position, grateful and excited for the upcoming challenges. As I joined my first meeting, which was on COVID-19, I had little idea of what was to come. Working as a health care lawyer during a pandemic takes an emotional toll, regardless of whether you are in your first year of practice or your 27th. Our workloads are intense, but inevitably there is a sense of helplessness because we can only do so much to support our front-line providers and staff. Most of us became health care lawyers to make a positive difference. Responding to this pandemic has created both a supreme challenge and opportunity to fulfill that mission. During the last four months, the mentors and mentees in my network have been critical in guiding me and one another through the ambiguity to define a clearer path forward. In this spirit, I have shared insights from a few of my trusted health law mentors and mentees.

Those of us who are in the latter half of our careers have grown accustomed to having the answers or relying on effective tools and strategies to find the best solutions. With COVID-19, these tried-and-true methods are insufficient, and the need for collaboration and interdependence is critical. Whether interpreting changing guidance on CARES Act funding from HHS, coalescing various memoranda on the cessation of elective procedures, or facing the gut-wrenching prospect of dealing with full Intensive Care Units, being able to share resources and strategies with those whom I have mentored, and with those who have mentored me, has been essential. In these times, the roles of mentor and mentee have often been interchangeable because the questions are new, the stakes are high, and we need a diversity of thought and approach to identify the best solutions.

"What distinguishes the advice of a mentor from that of a colleague or manager is that it derives from a place of altruistic knowledge of the mentee's strengths, vulnerabilities, and needs, and seeks to help the mentee grow and succeed rather than simply solve the problem at hand or maximize the performance of a business department," said Katie Saral, Chief Legal Officer for the Permanente Federation. "As the pandemic has generated so much uncertainty and personal insecurity, that resource—the bolstering wisdom of a trusted advisor in whom one can confide—is an invaluable aid to less experienced lawyers endeavoring to give sound counsel in difficult times."

Unlike other emergencies, this pandemic has hit the U.S. health care system at nearly every level, which has made collaboration across individual health care systems more valuable. Having a network of mentors and mentees both within my own system and outside it, including those from the government, academic medical centers, and private law firms, has been essential in this crisis. It supports the best practice of building mentoring relationships internally and externally on an ongoing basis so that our levels of resources and support are expanded and the quality of health care legal practice is elevated.

Unlike other crises that might hit one institution or sector, this pandemic has had widespread impact and nearly all significant information has been publicly disseminated, which makes sharing and collaboration feasible. As we share insights on how to interpret the FDA's cryptic statements on serology testing and assess pathways for alternative health coverage considering the economic crisis, we also check in on one another's wellbeing. Our willingness to share coping mechanisms, whether they be healthy forms like increased exercise, counseling sessions, and time with family, or more guilty forms like sugary treats, cocktails, and binge-watching Netflix, has allowed us to transcend traditional barriers and form stronger bonds. In her role as Senior Health Care Counsel for USC, Jeannine Taylor finds that promoting self-care in mentoring is crucial. "Both as a mentee and mentor, having people whom I respect remind me of the importance of taking breaks, building in small rewards, and setting boundaries has been immensely helpful," she said.

This is our time to lead our most junior mentees through the uncertainty of the economic crisis and affirm that, while the future may seem dim and uncertain,

this is the perfect time for them to lean in by honing their skills and creating opportunities out of unusual situations. As a regulatory lawyer with Kaiser Permanente, Julia Weisner has made concerted efforts during the pandemic to advise mentees on how to pivot and recover when meaningful work projects and career opportunities are postponed or canceled. "I counsel them to stay positive during this downturn, be crafty in finding alternative ways to gain professional experience, and hone skills through volunteering for public speaking engagements, even if in areas that are outside their primary area of practice," she said.

While it can be easy to give mentees generic advice, such as learning a new area of the law, more concrete suggestions that are achievable in the short term are better. For example, suggesting that a junior corporate lawyer take a Coursera program on reading financial statements or strategic planning, or that a mid-career lawyer team up with an in-house lawyer to write an article, is likely to be well received and lead to other ideas. Gaining new skills and experiences will help sustain our confidence and motivation during this changing time and make us better strategic advisers to our clients. As a Co-Chair of the Health Law Department at Foley & Lardner and Chair of AHLA's Regulation, Accreditation, and Payment Practice Group, Judy Waltz encourages junior associates to overcome confidence issues about their tenure and contribute to the firm's blogs and webinars. Judy has also found that participation in group meetings during the pandemic has been high, showing that in addition to addressing substantive work needs, these meetings have given people the personal interaction they need.

In the early 1990s, my health law seminar courses at Georgetown Law covered timely topics like the rationing of health care, with the Oregon Health Plan as the focal point, and the national health care reform debate, with Hilary Clinton's Health Reform Taskforce ultimately ending in defeat. With a combination of idealism, youth, and a lofty law school setting, I judged our current leaders harshly for their missteps and failures. However, when discussing the issues with my classmates and informal mentors at the time, including professors and a physician family friend, I learned about the complexity of health care and why success was hard to define, let alone achieve. Fast forward 30 years, and it is easy to picture eager health law and policy students studying the American health care system's response to the COVID-19 pandemic. They will question whether there should have been a national testing strategy, how sheltering in place was a very different experience depending on one's economic status, and whether wearing a mask was really considered a political statement. Hopefully, they will also find that the health care lawyers of the time mentored each other to elevate the quality of their work during the crisis, and in doing so, contributed toward the evolution of health care law and provided emotional support during an unprecedented time.

Member News

M. Natalie McSherry has been recognized for legal excellence and client service by the 2020 legal ranking guide, *Chambers USA*. Updated annually, the guide's thorough vetting process ranks attorneys based on technical legal skills, client service, astuteness, diligence, commitment, professional conduct, and other qualities. Ms. McSherry is a principal at the litigation firm Kramon & Graham in Baltimore and chairs the firm's Health Care group.

Member Spotlight

Danica J. Sun
Associate Counsel
Cleveland Clinic Florida
Stuart, FL
sund2@ccf.org

Are you a collector of anything?

Anytime I travel, I collect street art to later frame and display in my home and office. I now have street art from five of seven continents.

What book is on your nightstand?

The Alice Network by Kate Quinn. It is a historical mystery novel featuring the real-life Alice Network in France during World War I. Maybe I wasn't paying attention in history class in high school, but I had no idea there was a real spy network with women that operated in German-occupied France during World War I! It is a compelling read.

What was your most interesting job?

My most interesting job was working as a cabin counselor in the summer during college for Camp Boggy Creek, a free overnight summer camp for children with serious illnesses with medical staff on site. For eight weeks, I was responsible for campers of a different illness group (cancer, heart, rheumatic, epilepsy, gastro) and a different age group (ages 7-17) each week. Before campers arrived, we were prepped by medical staff on what those serious illnesses were and the necessary safety precautions. It was an immense responsibility, but also immensely fun! It was truly a privilege to help those kids have fun and bring them joy.

What television show would you like to make a guest appearance on?

I've always loved watching *Survivor*, but I don't really have a desire to live on a deserted island without food or shelter. Ideally, I'd love to make a guest appearance to participate in one of their physical competitions just to see how I'd do!

What was your best vacation?

A one-week vacation to Chilean Patagonia at the end of this past January with a dear friend and fellow AHLA member, Jennifer Touse. Instead of a hotel, we opted for a yurt and spent every day of the trip hiking. It was one of the most beautiful places I've ever been to and I highly recommend its placement on everyone's bucket list!

Would you like to be featured in our new Member Spotlight section? Please contact agreene@americanhealthlaw.org. We'd love to hear from you!

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Volunteer Pool and Complete Your Volunteer Profile

AHLA has revised the volunteer process. To opt-in to the Volunteer Pool and complete your Volunteer Profile, visit www.american-healthlaw.org/volunteer. This will help us know what kind of volunteer opportunities you are interested in. Going forward, you will receive email alerts when we think you'll be a good fit for a new volunteer opportunity.

AHLA has a wonderful tradition of members sharing their expertise and insight with each other. Members generously donate their time and energy through speaking, writing, and other service to the organization. Volunteers are the heart of the Association—thank you for all you do!

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Robert Andrew Gerberry, Summa Health System

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AHLA's Guide to Health Care Legal Forms, Agreements, and Policies

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TOOLS DEVELOPED BY PRACTICING ATTORNEYS TO SOLVE REAL-WORLD PROBLEMS

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- All forms are now conveniently available online for download as Microsoft Word files.

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July 9 and 16
Virtual In-House Counsel Program

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Virtual Fraud and Compliance Forum

October 22-23
Virtual Tax Issues for Health Care Organizations

November 5-6
Virtual Health Plan Law and Compliance Institute

11-13
Virtual Fundamentals of Health Law

For more information on all AHLA events and to register, go to www.americanhealthlaw.org/education-events or call (202) 833-1100, prompt #2.

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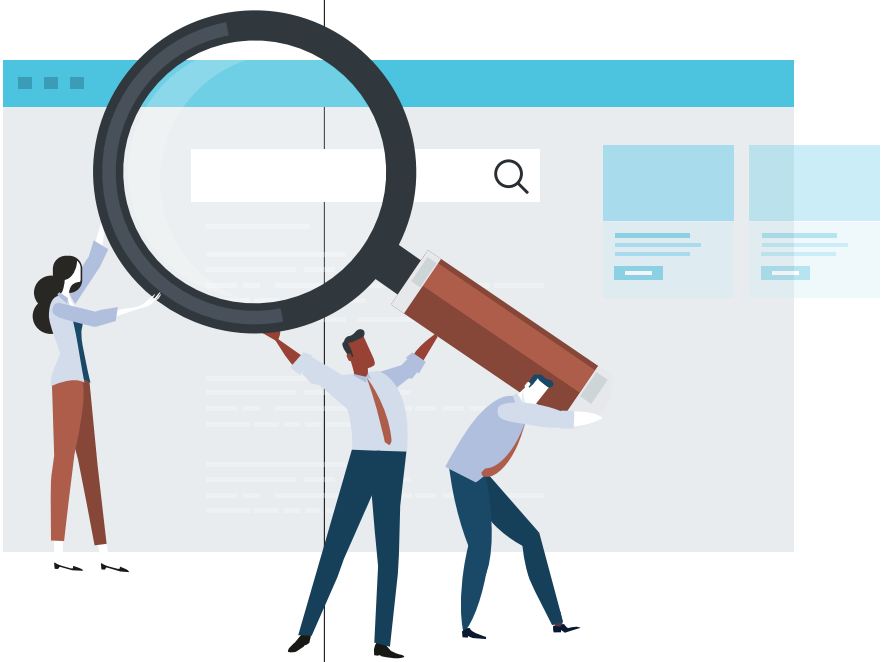

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The expert analysis in this new edition of Health Law Watch will inform readers' next steps as the health law community seeks lasting solutions to these critical issues:

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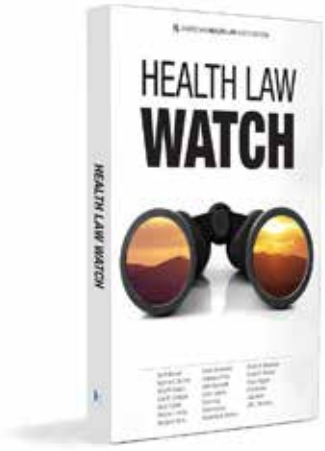

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- Interprets contracts between health care providers and managed care entities to enforce payment obligations; and
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In principle and in practice, the American Health Law Association values and seeks to advance and promote diverse and inclusive participation within the Association regardless of gender, race, ethnicity, religion, age, sexual orientation, gender identity and expression, national origin, or disability. Guided by these values, the Association strongly encourages and embraces participation of diverse individuals as it leads health law to excellence through education, information, and dialogue.

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