BELMONT HEALTH LAW JOURNAL

Volume 6

2021-2022

Cite as 6 BELMONT HEALTH L. J. ___ (2023).

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VOLUME 6 **SPRING 2022**

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THE LEGAL ROLE IN BUILDING SUSTAINABLE PUBLIC HEALTH SYSTEMS

KEYNOTE SPEAKER:
MARY BUFWACK, *2019 INDUCTEE OF THE TENNESSEE HEALTHCARE HALL OF FAME & FORMER CEO OF NEIGHBORHOOD HEALTH*

[edited for reading]

FEBRUARY 18, 2022

Lauren Caverly-Pratt: Without further ado, it is my pleasure to introduce Dr. Mary Bufwack. Dr. Bufwack was a 2019 inductee into the Tennessee Health Care Hall of Fame. She served as a CEO of Neighborhood Health, formerly United Neighborhood Health Services, for 29 years. Her work has widely been recognized as having a positive impact on communities whose populations sometimes tend to fall through the cracks of traditional health systems. She earned her PhD in Anthropology from Washington University in St. Louis, and taught Sociology and Anthropology at Colgate University for seven years. Dr. Bufwack has also served on the board of directors and the president of the Tennessee Primary Care Association, as the director of the National Association of Community Health Centers, and as the chair of health care for the Homeless Committee. We are so excited to have her here with us at Belmont today. And so, with that, I'm going to have our symposium director, Grace Benitone who's behind the scenes, have her take control of the slides. And Dr. Bufwack, the floor is yours.

Dr. Mary Bufwack: Thank you so much, Lauren. And I want to welcome everybody today. And thank you so much for your interest in the safety net and in the underserved. When we have this kind of interest, we know that there's going to be some changes coming. Thank you to Deborah and all her crew for setting up this very timely topic for us to discuss today.

I am going to talk about the health care safety net. Which, as I will describe it, is neither safe nor secure at this time. And we're going to look at some legal issues that have an impact on the ability to sustain that safety net. Next slide please. So, first we're going to talk about what really is the safety net, so we're all kind of operating on the same page. Oftentimes the safety net is thought of as the last resort. It's failsafe. It's basic and minimal. But in reality, our definition of what's basic health care, minimum health care, changes. And that’s as it should be. The health care safety net is at best a patchwork. It's generally not really coordinated and oftentimes doesn't even do planning together. But it's usually defined as institutions, who generally have a mandate that relates to the public funding they receive, to actually serve the vulnerable populations. They usually also have a sustainable part of the patient mix that are vulnerable patients, a substantial part. That often includes public health departments, public hospitals, teaching medical centers, community health centers, and other faith-based groups. So you can see quite an autonomous patchwork.

We can also define the safety net by the vulnerable population served. And those populations vary with time and, again, are responsive to the needs of the community, and generally defined as uninsured and low income. But they also target many special populations: minorities, immigrants and refugees, migratory workers, LGBT, homeless, drug users, elderly… all those people who might be marginal, who might have insurance that is perhaps underinsured, marginal, or not accepted in the system, or they lack access to care for a variety of reasons on the frontier, they're rural. And, again, this definition changes based on changes in community needs.

Why talk about sustainability of the safety net now? There is a continuing number of folks… 9.2% of the population… higher in Tennessee… we're always generally higher of 12.1%, but over 600,000 people. Frighteningly, uninsured children have doubled over the last two years. Some of this is due to the problems of Medicaid disenrollment. Other parts of it are due to fear of the use of the system, and we'll talk about that. There's been a growth in the ranks of publicly funded insurance; Medicaid and Medicare now account for one in three Americans. And there are growing public resources used for insurance: the ACA and Medicaid expansion in those states fortunate enough to be serving their uninsured with that option. It's certainly led to a rising demand on the safety net, and this has put pressure on an already stressed-out system. And last, but not least, we have to talk about COVID's devastating impact on the poor and the uninsured, which has really shown many of the weaknesses in the safety net.

I'm going to digress a moment and talk about the COVID impact. Next slide. We know that there have been great racial and ethnic disparities among the many other impacts of COVID-19. Black, Hispanic, and Asian people have had substantially higher rates of infection, hospitalization, and death, in some cases more than double compared to Whites. This is because, obviously, for the lower economic status, crowded living conditions, certainly higher exposure to work… they didn't have the luxury of virtual work… they're oftentimes are essential workers… a higher number of chronic medical conditions… so the past is catching up with us… poor access to health care, is often limited English proficiency or health literacy. And many in these groups have a great distrust and fear, often justifiably, of the major health system.

If we look at COVID's toll… this is a map of Davidson County, and you can see the lower part of the map is Antioch. A

great number of Hispanic immigrants, refugees live in this area. The city core is the multi-population there, but it includes the homeless, public housing like J.C. Napier/Sudekum , and then some of the hotspots grade up into Madison area, kind of that northeast area, and that also is a growing area of low-income housing and ethnic groups. So, I want to make sure we emphasize that we still have people… 50 plus people dying a day in Tennessee. So, while we celebrate a lot of the fall in the rates of Omicron right now, we're still seeing a meaningful death rate that should be of concern to us all.

All of this, the importance of the safety net, COVID impact… we now have an unprecedented opportunity. Our eyes have been opened to address safety net adequacy and these disparities. It will take the clinicians, health systems, scientists, policymakers… and I want to point out, you. Wherever you are, I know you can do something to have an impact on this system.

What I want to focus on today… those community health centers, and that's going to be the safety net for our discussion, not just because I worked in a community health center for 29 years and continue to be affiliated with Neighborhood Health in some ways, but also because they're the critical primary care safety net provider. And I want to distinguish primary care from health department, hospitals, and specialties in many ways. Primary care is really your family doctor. Community health centers really are located in underserved areas. One, to assure the equity, but also to assure ease of access. And as the family doctor, the assumption is that these patients will be in continuous relationship with the community health center. The care at a health center is comprehensive. It includes preventive, chronic, integrated with behavioral health and dental, and serves many public health functions as well… doing family planning, STD testing, immunizations… so it really tries to cover many bases. It coordinates care with specialty and hospital, and, therefore, is looked to also to help cut the system cost so that we don't have unnecessary utilization of hospitals and emergency rooms. There's also a quality component in the goal of community health centers. It's not just to meet the needs of that visit, but to actually improve outcomes. So the point of continuous care is very central to the concept of this particular part of the safety net and should be very important to us as well.

Now, for those of you who don't know a lot about community health centers, and oftentimes you don't, just a little brief history. They were created over 50 years ago under LBJ. Hopefully some of you out there still remember LBJ and his War on Poverty… didn't win it, but we made some inroads. It was simultaneous with

Medicaid and Medicare with the idea of increasing access. But the CHC role was really to go directly to the communities and directly to the people, unlike the insurance models. Community boards composed 51% of consumers and they received funding, actually, directly from the government. I'm going to pick up my papers here. So these consumer boards received money from the federal government, so it didn't go through, unlike many other funding streams, it did not go through the state government or local government. Many of those reasons were because of what was happening in the South at this time. Oftentimes funds were diverted from African American communities and, as part of our systematic racial discrimination structure within the states, that funding wasn't getting where it needed to be. So, in this program, the federal government decided to actually directly fund consumer boards, and that continues to this day as part of the regulation. The community health centers are 51% consumers on their board… were limited to only about 25% who can actually make their living in the health care industry. The point is for community health centers not to be run by the health care system, but to be run by community consumers. So, the role of the CHC was actually supposed to fade with universal health coverage. Well, we know where universal health coverage is today, not… and so has continued to grow. Community health centers now number over 1,400, with over 14,000 clinics that serve over 30 million people annually. These are autonomous nonprofits that create a network across the US, held together loosely by funding streams and key requirements.

Before we move on to health issues within community health centers and among the medically underserved, I want to give a shout out to medical legal partnerships in primary care and many pro bono clinics, as well. These are really invaluable. Health outcomes can be influenced by laws, but they also can be influenced by the inconsistent enforcement or under enforcement of laws. And what both these programs do is embed civil legal expertise in the care team, oftentimes addressing what we call the social determinants of health. And what we find is up to 50 to 85% of patients in this low-income underserved bracket can oftentimes utilize these kinds of legal services. So, they address questions like substandard housing, denial of government supports, family violence, immigration status, and later today I think one of our presenters will be talking about food insecurity. That also is one of these social determinants of health that the legal profession has taken on as an important question to address. And we're extremely grateful for these much more personalistic, but important services, provided by many attorneys.

The impact of this legal system on community health centers and the underserved… I'm going to address basically five areas today. And when I talk about laws shorthand, I'm talking for everything broadly defined like statutes, regulations, executive orders, court decisions. These can be a barrier to care, but they also can be remediation. They can hinder access or help it. And we're going to talk about how they both hinder and help the underserved. So, we're going to look at policies to improve access and focus on the availability, particularly the supply of primary care clinicians, accessibility… bringing outpatient clinics into communities, alleviating structural barriers to care, removing financial burdens… and I'm not going to talk about financial burdens on the system because if we were to talk about the financing of public health and community health centers, we would be here all day. We're going to talk about it for the clients themselves. And we're going to talk about ensuring communication and trust, a very important element in this system.

I want to begin by talking about the supply of primary care clinicians. It's not enough to address just this underlying issue of funding. Much as we would like more of our citizens to be covered by Medicaid, we could get as much Medicaid out there as we could and still, if we didn't have the supply of primary care clinicians, we would have a clogged-up system. So, this is a very important issue of if we're going to have enough primary care clinicians going forward. We know now that medical school graduates are choosing primary care in declining numbers and sharply declining numbers. And that's primarily for two reasons, both very understandable. There's a significant gap in income and potential earning power between specialists and primary care, at least double and generally many times more. And many medical school graduates… most leave school with just an incredible debt burden. It's projected that in 10 years we'll actually have a shortfall from 20 to 50,000 primary care clinicians. So, it's really important that we look at ways to improve the flow of primary care clinicians.

We find two basic ways that work. One is to actually embed primary care residencies in underserved areas. And what we find is those trained in underserved areas are more likely to stay in underserved areas and serve the underserved. There are state efforts to do this. Texas, Georgia, and New Jersey have all had programs that do this very well. We wouldn't necessarily expect these in Texas and Georgia, but they've done a great job of putting the residencies right in the underserved areas. There are also many federal efforts to put medical residencies in community health centers. The other way we've found to get primary care physicians into underserved

areas is actually to diversify the physician workforce. Racial and ethnic minority physicians are more likely to practice in underserved areas, and they're more likely to do this in professional shortage areas. So, one way that there have been efforts to try to increase diversity in health professions is through school administration processes. That is admissions have changed their ways of admitting students so that they admit more diverse racial and ethnic minorities. There's very little evidence that this has worked. To the degree that those minorities have been admitted to many of these programs, they have, like those students in that program, continue to choose specialties. There are also pipeline programs that recruit students into the profession sort of downstream working with high school students, college students, to make these choices. And the University of Illinois has a particularly good program. But none do it quite as well as historically black colleges. Colleges… we have a gem in Meharry in our own community, where they have done just to superb job of recruiting minority providers and also exposing them to underserved populations and maintaining them in underserved populations. I also want to point to the Quillen College of Medicine in East Tennessee, which has a very long and respected tradition of doing this in rural areas. Their rural health program is one of the top ten in the country and also, again, really puts those residents into underserved areas, and those residents tend to want to serve in underserved areas. And also, people who live in rural areas tend to want to go to Quillen so they can stay in rural areas. So that's been just a very important resource for rural areas to draw on.

Other ways that this has been done is to use federal funds to bring primary care physicians to underserved areas. National Health Service Corp. is the stellar program that has done this. When I was with the community health center, I almost always had two to three providers who at any time were receiving loan repayment. Two years of service and they were able to pay off many of their loans. Four years of service and they could generally pay them all off. It's been very effective at keeping physicians in underserved areas and after two years after obligation, 85% are still serving. And after 10 years, over 50% are still serving. So, it's been one of the most effective programs. But currently with the funding available, only about 50% of applicants are actually funded. So, there's more potential there if we had more money upfront to actually do this program.

Another way to increase the supply of primary care clinicians has been the Conrad 30 Program, which is an incentive for foreign-trained clinicians. What we do find about foreign-trained clinicians is they also do tend to practice in underserved areas, and

they tend to remain in underserved areas. So, this has been a very important program because it avoids the J-1 visa issue of having to return to your home country, and the State Department of Health is actually allowed to grant 30 of these waivers a year to help effectively recruit foreign-trained physicians. If you look at the Tennessee state regulations, this program has been found to be very effective in urban areas. Tennessee actually only allows this Conrad 30 Program to be utilized in rural areas. That is because, as I was told on the QT, they don't want the competition in the urban areas where there's plenty of competition. Now I haven't seen competition in the urban areas to serve the underserved, but that's the state logic for keeping foreign-trained physicians using this special program from serving in the urban areas. These are one of the kind of areas where administrative law can certainly be changed to better open this up to other opportunities.

It does not really appear that these new and expanded residencies and these federal efforts are strong enough, big enough, there's enough effort in them, enough of them, to actually counter the market incentives. And so we do… it's important to keep all of those, but we do continue to actually experience this primary care provider shortage. One of the most controversial areas that has been attempted that I want to talk about a bit here, and states have used it, is the scope of practice. Now, as many of you know, these are the laws that detail the services that are allowed to be provided by health professionals. And of most concern here to us are nurse practitioners and physician assistants. Many states… and again scope of practice is very much controlled by the state, even though a nurse practitioner passes a national set of qualifying exams. Nonetheless, just as with licensing, the actual scope of practice is drawn up by the state. The legislature is heavily involved with this, as well as the nursing board and the medical board. So, these tend to vary by state and generally vary in terms of M.D. oversight. What has been found is that a scope that moves towards allowing practice of nurse practitioners to the full extent of their training and licensure has been very important at increasing, not only the numbers of nurse practitioners practicing in a clinic in underserved areas, but has also been very important in expanding care to the underserved, particularly in rural areas. So, this has been a very promising effort that has really encouraged team-based models of nurse practitioners and physicians working together in patient-centered medical homes. And later today, one of the presenters is going to talk more about team-based care.

But here in Tennessee, as many as you know, scope of practice has really generated some real heat down at the legislature with the nursing association and physicians really butting heads over

the last few years about changing the nurse practitioner scope of practice. The nurses' association would like to move towards much greater autonomy in terms of practice. The physician associations generally are not in support of this. And there was even kind of a truce for a couple of years when legislation along these lines wasn't introduced because of the amount of contention around this issue. Currently though, I will say that the legislature is starting to move in these areas. Community health centers, themselves, have a piece of legislation up at this time along these lines. Right now, the scope of practice in Tennessee requires that physicians sign off on 20% of a nurse practitioner charts, so nurse practitioners are paired up with a physician. That physician reviews at least 20% of their charts… generally the more complicated cases… cases with their controlled substances, things that might raise some bells or whistles, or where a physician can be of most use to a nurse practitioner in providing some consultation. That has become burdensome to the degree that it requires, up to now, oftentimes physical presence as well. Electronic health records were just a glint in someone's eye at the time many of these regulations were written. So, we have a piece of legislation at the legislature this year that is garnering a great deal of support that would allow the signing off on charts to be done electronically through the electronic health records. So, we can bring many of the statutes without actually changing the degree of autonomy, but changing the physical presence and making it, again, more attractive for physicians to work with nurse practitioners because of the ease of using electronic health records to review and sign off on charts. So, even within the context of maintaining a scope of practice that as it currently exists in Tennessee, which is quite conservative compared to many other states, changes are still necessary. And those are moving through the legislature, I'm happy to say, and hopefully will encourage more growth in the use of nurse practitioners by physicians to meet some of this uninsured need.

We're going to move on from primary care, and that contention, to accessibility. And that is bringing outpatient clinics into communities. 84 million people live in underserved areas and find it challenging to receive primary care. So, community health centers and rural health centers, which have been exceptionally effective at this, are actually embedded in underserved communities. Neighborhood Health, for instance, not only was downtown among the homeless with homeless health services, but here's a picture of Dr. Pete, who leads our street medicine team. And he's out there in encampments at least two to three times a week providing care directly to the homeless individuals who live in encampments. So, when we say embed in the community, we're talking about really embedding. Other places Neighborhood Health has worked is in

public housing, J.C. Napier/Sudekum. Also, a clinic was put up jointly in Casa Azafran to address the needs of immigrants and refugees. So again, embedded is… it really works. Oftentimes people have said: "Well why don't we bring retail clinics to underserved areas?" That's been tried and right now only about 10% of retail clinics are in underserved areas. Medicaid poses such a challenge. It's not an incentive to them to see the Medicaid recipients. And in many cases, we're not talking about urgent care. With the underserved need, it's not urgent care. What they need is an ongoing source of health care. So, bringing more clinics into these neighborhoods, more community health centers, is still very crucial.

Then there's the issue of alleviating structural barriers. There are structural barriers for the underserved who find it challenging to get primary care with long wait times for appointments. Transportation is one of the structural barriers that oftentimes needs to be addressed. Also, low-wage workers need hours outside of the 8:00 to 5:00, Monday through Friday, "bankers' hours" we used to call them. I'm not sure bankers even work eight to five. But they need those evening and Saturday hours.

Telehealth has become a very important way of delivering health care to challenged populations so that they have increasing access. And we've seen during COVID-19 that telehealth has been invaluable. It's helped us keep people safe. It's helped us keep people at home. And it's helped us address many issues that could not otherwise be addressed. But what we find is always with the underserved is that there are barriers and that it's very difficult, oftentimes, for the uninsured and the underserved to use telehealth. The populations that are low-economic status or limited English proficiency oftentimes have an absence of the technology, so they cannot utilize it. They oftentimes have limited digital literacy. I'm happy to say that our Nashville library system is doing a program now for the elderly in digital literacy, and it's specifically directed at getting the elderly so they can use telehealth, which is wonderful. And we also have unreliable Internet coverage in many areas, particularly rural areas, but also in many homes, making it very, very difficult for telehealth to be used and accessed.

There are also barriers for providers who serves the vulnerable to the use of telehealth. It's an investment in sophisticated and oftentimes expensive equipment. Funds that are oftentimes lacking or difficult to come by when you're serving the underserved. It oftentimes requires face-to-face visits every, say, 12 months or 16 months. This also is being addressed at the legislature because, to

the degree that you need a face-to-face visit to actually get reimbursement for telehealth, it again will limit services. And state laws have been really slow to keep up with those practice demands, and also with practice capabilities of things like telehealth. The other problem we're having right now is the reimbursement for audio only. This has been allowed during the emergency because it was recognized that many people do not have access to technology. So, if we allowed audio only to be used and reimburse that, we could create a lot more access. Now that the emergency is kind of going away, and we're returning to our current version of normal, there are efforts both at the state and federal level to actually make audio only continually reimbursable. So that is going on right now at the Tennessee legislature where there are efforts to build audio only into reimbursement structures that will continue to allow the uninsured and the underserved access to audio only where they are lacking video telehealth. There was a national survey just completed, actually February 1st of this year, that found that there were significant disparities among subgroups in terms of audio versus video telehealth. What it was found was that video telehealth users tended to be young adults 18 to 24, those making over $100,000, those with private insurance, and white individuals. The audio telehealth users tended to be those without a high school diploma, adults over 65, Latinos, Asians, and Blacks. So, you can see the disparity right there. Unless audio only is reimbursable and is approved for utilization of telehealth, we are really again having another discriminatory system in which those who are least served may be excluded from one of the greatest benefits we have had during the pandemic. That is, to use both video and audio telehealth to deliver healthcare. Very important pieces of legislation that we are very confident of actually at the state level, but are somewhat uncertain of it at the federal level whether there was enough commitment at the federal level for audio only to really move that piece of legislation the way it needs to move. But we hope again that that changes a bit and that we do get those federal legal mandates as well.

Alleviating more structural barriers, we talked about transportation. Obviously, the reasons for that is a structural barrier… are the people often without cars. Oftentimes those 65 and older don't have rides. Reliance on public transportation, which oftentimes doesn't exist or exists very poorly, really doesn't allow that much access. Medicaid transportation has suffered many issues too. It requires advance notice, there are issues with children riding along, long waits. Increasingly, Medicaid has tried to leverage ridesharing, and that has shown some promise to be used as emergency transportation. But we have a long way to go to assure

people have access to the transportation they need to actually use health care in a timely way that they would like to use it. We've talked about increasing medical office hours, which are generally 8-5, 7-4, Monday through Friday. North Carolina actually tried incentivizing outside of regular office hours care and found that they actually were able to reduce Medicaid child ER visits through that means. So, we know there are effective ways that we can utilize after-hours care. And CHCs also have a mandate and it's part of their mission. Limited staffing oftentimes limits their hours. But again, places like Neighborhood Health… Neighborhood Health has a clinic in Madison that is open until nine o'clock every night and on Saturdays. And that has provided, really, a lot of service for folks who need it during after-hours and on Saturday. Much more of that really needs to be done. We can learn a lot from urgent clinics on that end of things.

Affordability. There's a problem that uninsured often lack of source of care. They don't have a regular source of care because they are uninsured. Health insurance and other public benefits can have a significant impact on that and insured people tend to more generally have a regular source of care. And where there isn't a regular source of care, we know there is improper use of ERs and hospitals, which could greatly be reduced. The next slide, which you'll see, not right now but in a minute, shows many of the enrollment barriers. Health care benefits are a maze and it's very difficult for the consumer themselves to actually enroll, or move themselves through the enrollment process, because the requirements are different, the poverty level is different. So, navigators are very important in helping people actual get enrolled. That's one area that needs to be addressed.

Cost is another area. We've found that even $1 to $5 can reduce utilization of preventive care and primary care because of such limited income. That is in the light of the fact that health insurance deductibles and co-pays are continuing to increase. So, to the extent that that increases, it actually works to prevent people from getting the preventive and primary care they need. There are even states who want Medicaid plans to incorporate co-pays. There couldn't be anything more destructive for a Medicaid plan than to actually put in co-pays, which can ill be afforded by those receiving Medicaid. 25% of insured said they have put off care due to a copay. The mandates for zero co-pay preventative screenings are limited in their effectiveness, as patients oftentimes don't know the difference between what's preventative care and primary care. So unless this is spelled out, you might go to the doctor and go, am I going to be paid-

billed the copay, or am I not going to have to pay a copay? I don't know.

Value-based insurance designs - I think there's a panel that's going to address this - have oftentimes worked to eliminate copays. Some ACA plans, some Medicare plans, some state employee plans, and these have shown increased visits among their enrollees and do help to reduce hospitalizations and ER visits. So there is, again, a lot to be learned from these value-based designs that the panel will talk about later. I hope along the same lines that there are some very positive things happening in regards to these value based insurance plans.

This is the chart, it shows, if you just look at the household income limits for these different programs. For instance, in Tennessee, pregnant individuals, even those who are undocumented, can receive TennCare or CoverKids. That's less than or equal to 250% of poverty. You go down, and TennCare for parents with minor children is below 106% of the poverty level. For disabled, 135%. For other uninsured adults with things like CoverRx it's under 138%. Project Access is under 200%, Marketplace plans are 100-400%. So you can see this is very confusing. And if you were a person going like, what benefits am I eligible for, you need a navigator to help you around all of this, for it's very, very difficult for an individual to coordinate these, and the inconsistency among plans makes it very user unfriendly. So it's no wonder many people do not have the benefits that they actually could qualify for, because they actually can't navigate this system.

Now I want to talk about this issue of acceptability, that is, ensuring communication and trust. This is a very nuanced area. It's an area that, well, what in the world do we mean, and how in the world do you go about doing that?

Well, many vulnerable patients, and most vulnerable patients that we serve, have experienced some kind of discrimination, disrespect… they feel that they carry stigmas because of their prior contact with the medical system. Many low-income people feel disrespected. People of color, immigrants, LGBT feel exposed, drug users don't often times feel they can trust their providers to share what their drug issues may be. So it is very important that that trust be there to really address the problems and the service needed by these groups.

There are some policy solutions that do affect cultural competency. There are few, but they are very important. The

increased diversity of primary care physicians certainly is one of them. When you see people in the healthcare environment that look like you, talk like you - that's a system that you can feel more comfortable in. Limited English proficiency policies that ensure that languages are available is key.

Neighborhood Health was one of the first Spanish speaking clinics in Davidson County. We began to try to do this as we saw, many of you remember way back when - it's been, gosh, so many years ago now - when some of the first migrants and immigrants who were brought into town were brought into a motel out on, I'm not sure if it was Murfreesboro Road or Nolensville Road, and men were put up in a motel out there and were working on Opryland construction. It was one of the first waves of workers coming into Nashville. After that, of course, it wasn't long before families started coming and various construction booms, and everything continued to bring in immigrants and refugees - Nashville's always been a refugee resettlement area. It's a great way of diversifying the population in Nashville. But it was very difficult for folks to receive any kind of care at all in their first language. Offering languages in medical settings has been a very important part of encouraging people to get more care in the system.

Then, just a patient centered orientation… These are some quotes from our homeless about Doctor Pete and patient centered care. "I mean, he actually comes out to the camp… he's always on point, and he's there for you." Another quote, "there's no judgment and he's always willing to help. He's willing to go down the path that's easiest for me. He's listening, he's a friend, he's not just a doctor. He's helped people stay alive out here."

It's not that Dr. Pete has to be homeless. It is that he has to listen. He has to share their world. So that patient-centeredness is very important as we look to building the trust and communication that we need to be able to best serve those who are uninsured.

Discrimination in the medical system really still exists. There is a recent study that looked at, for instance, medical record charts and looked at the pejorative words that were used to describe client behavior. Words like "noncompliant", words like "difficult", words like "noncooperative" and these tended to be used much more for African American clients than for white clients, showing again a very disproportionate interpretation of behavior, not finding out why you couldn't take your medicine, could you afford it, could you get to the pharmacy, were there reasons that you have a barrier to your medication. But instead describing the behavior as noncompliant or

even the nicer word, nonadherent. These are all pejorative terms and often times used to brand low-income people of color and other populations who really have those structural barriers or economical barriers that we talked about, and so don't make their appointments, so don't take their medications, so don't go to the specialists, and there are structural reasons often times that interfere in actually receiving those services. So, the more we can understand those, the more we can address them, the better we can serve this population, and the better relationships we'll have when things like the pandemic come along.

I'm going to look at two specific populations here to talk about this idea that acceptability and ensuring communication and trust. First is the homeless population who we have discussed a bit. Across the United States there is about 1.3 million people, and it is uncertain who exactly the count of adult homeless at any one time, who is sleeping in the outdoors, who is sleeping in shelters, who is sleeping in cars. All of these are really variables. All we know is that you just need to drive into downtown Nashville, you know that we have a homeless problem. The homeless crisis is an affordable housing crisis. We know this, we talk about this a lot, it's been very slow and difficult to address this.

For women, homelessness is often an issue of domestic violence. For incarcerated people, it's of course the release from jail and inability to support themselves in many ways because of the prejudice directed at prior incarcerated folks.

The tactics to manage homelessness are often more about ridding the communities of their visible presence, so criminalizing homelessness. So we see criminalizing public camping and removing public camps, as this is happening at Jefferson Street, happening in West Nashville… laws that prohibit people from living in vehicles, loitering, even handing out food, reducing public services such as restrooms and bathrooms which are purposely done to keep them invisible, and reluctance for them on their part therefore to access COVID-19 assistance and services because of the issue of autonomy versus restrictions. That is, you remember when the positives were held at the fairgrounds, and one "escaped" there was efforts to bring them back - we don't do that with adults who are COVID positive, but we do it with the homeless.

Lauren Caverly-Pratt: Dr. Bufwack, we've gone over a little bit of time, and I think that we have to - I'm so sorry to cut you off and interject in here, but I think we have to continue moving on with the remainder of our program today. Thank you so much for being here.

Dr. Mary Bufwack: Yeah, I hope folks will get these slides and look at the rest of the points made.

Lauren Caverly-Pratt: Yes, yes absolutely, we will be sure to send those out. Again, thank you so much for being here with us today.

THE LEGAL ROLE IN BUILDING SUSTAINABLE PUBLIC HEALTH

MEDICAL-LEGAL PARTNERSHIPS IN SMALLER COMMUNITIES

PANELISTS:
DOUG MEFFORD, *MANAGING COUNSEL OF HEALTHCARE TRANSACTIONS, VANDERBILT UNIVERSITY MEDICAL CENTER*
CHARLEYN REVIERE, *CHIEF LEGAL OFFICER/GENERAL COUNSEL VP, WEST TENNESSEE HEALTHCARE*
DAVID CLAY, *PARTNER, WALLER, LANSDEN, DORTCH, & DAVIS*

Moderated by Hailey Janeway, Associate, Waller, Lansden, Dortch, & Davis

[edited for reading]

FEBRUARY 18, 2022

Lauren Caverly-Pratt: Time for our first attorney panel of the day. On this panel, we have Doug Mefford, who is Managing Counsel of Healthcare Transactions at Vanderbilt University Medical Center; Charleyn Reviere, who is the Chief Legal Counsel at West Tennessee Healthcare; and David Clay, who is at Waller, Lansden, Dortch & Davis.

This panel will be moderated by Hailey Janeway, a proud alumnus of Belmont University College of Law. Hailey was on Law Review here, and she was also a member of the Health Law Transactional Moot Court team. She is an associate also at Waller, Lansden, Dortch & Davis in the corporate group where she focuses on mergers and acquisitions and other transactional work in the healthcare space.

With that, Hailey, it is good to see you. I am going to hand the reins over to you.

Hailey Janeway: Thank you. Alrighty. I think we will start with just letting each panelist introduce themselves and share a little bit about their background. So, if Doug Mefford wants to start.

Doug Mefford: Sure, I'd be glad to. Good morning, everybody. Thanks for the opportunity to be with you today. I am managing counsel at Vanderbilt University Medical Center. I've been at Vanderbilt since late 2013. My work is focused primarily on the transactional work that Vanderbilt is engaged in pretty much constantly. Prior to that, I was general counsel at a hospitalist provider company in Brentwood, and part of that I was with community health systems representing community hospitals in the western United States for several years. I started my career with a law firm here in Nashville, Bass, Berry, and Sims where I did corporate securities work for them. Most of my career has been in the healthcare sector from the transactional perspective. I tell folks I'm a corporate lawyer in a healthcare environment.

Hailey Janeway: Alright, Charleyn if you want to go next.

Charleyn Reviere: Good morning. First of all, I would like to say there is some construction going on behind me, so if you hear … and banging, that is what that is. I am general counsel for West Tennessee Healthcare. We are a large multisystem facility here in West Tennessee and have an 18-county service area. We are a nonprofit health system, so we take everyone regardless of their ability to pay. We have seven hospitals, a mental health facility, multiple physician clinics, you name it we do it in this area.

My background - I've been here for 17 years. Before that, I was in private practice. Between there I took twelve years off to raise my kids. I'm not sure which of those three has been the most challenging, but right now, I'm going to say it's been working in the hospital setting. I will say that for any of you who are in or are considering an in house career, do not make the naïve mistake that I did when I came here 17 years ago. I thought, this will be a narrow specialty, I will be able to just do healthcare, not really knowing what that meant, but I will be able to specialize. Then you come to work for a hospital, and it is like running a small town. You have, we have 7,200 employees, we have vehicles that go out and run into awning at the bank, we have ambulances that run off in ditches, we have malpractice cases, we have patients that fight in the hallway, and people who slip and fall, and then of course we have a multitude of compliance regulatory concerns that any healthcare institution has.

It is an interesting job; it is never dull. I am happy to be here throughout the day to talk about rural healthcare because that is vitally important in our area.

Hailey Janeway: Thank you. David, if you want to share.

David Clay: Yeah, David Clay here. Started my career at Waller in 2004 and have been here the whole time. I've been involved in healthcare transactions and healthcare securities work the entire time. Primarily I represent for-profit healthcare systems that are making investments in rural communities or smaller communities, whether through acquisitions, in and out of the market, partnerships, maybe a little bit about that and come at this more solely from an outside counsel perspective. I have not been in house in the healthcare system. When the time is right, I can talk about what I've seen from some of the for-profit players and look at those investments in communities.

I am happy to be here and enjoy working with Hailey, too. We get to work on some things together, and I am glad I get to be on this panel with her today.

Hailey Janeway: Thank you. Alright, so I don't think this has to be extremely structured. I know we have a list of questions that we can bounce around or go off the script if any of you have anything that you really want to talk about. I think I will just get started with the top of our list if that's alright with everyone. These questions are focused on the urban versus rural idea here. Number one, how does

merging with other healthcare providers contribute to a more sustainable public health system generally?
Anyone can jump in.

Doug Mefford: Okay, I'll jump in first. Let me say a bit of legalese, I am counsel for Vanderbilt University Medical Center, but I don't represent them in this context. My opinions and views are not attributable to them.

One thing I would point out initially is that consolidation, for consolidation sake, is not necessarily something that is going to make public healthcare more sustainable. I mean, there is a place for competition and diversification. But in the right combinations, there are a number of benefits to be achieved. You've got potentially, and hopefully, some kind of scale of cost reduction. In days past, that might have also included staffing reductions, but I don't think there are many hospitals out there anymore who would say they'd look at merger opportunities as a staff reduction opportunity. We are all desperately seeking additional staff for all of our facilities.

Certainly better bargaining positions with commercial payers, better access to capital for larger institutions for a number of the initiatives that hospitals just have to make these days in order to keep up.

Theoretically, you get better and more successful clinical recruitment. If you have a better and larger, more stable organization, that's attractive clinicians who are looking to move into a particular market or consider an offer from a healthcare provider.

Lastly, and probably most importantly, hopefully the transaction will translate into better quality of care for the patients and for that organization. That ultimately is the bottom line. All of the things that those of us in administration do are really worthless except to the extent that they translate into better bedside care for the patient. That's where the real work gets done. That should ultimately be the high objective in mergers and acquisitions that we do in the healthcare sector.

Hailey Janeway: Great. Anyone else have anything else to add?

David Clay: Yeah, I think all that Doug had said is exactly right. Of course, you're seeing a lot of government oversight in this area from an antitrust perspective. The government is not very keen on mergers and acquisitions in the healthcare space right now, maybe

not taking such a favorable view that they're going to improve access or healthcare, they have a very, maybe, skeptical view of the mergers and acquisitions that are occurring. That's one of the reasons why you're seeing fewer mergers right now that I think are what we'd call horizontal or system-to-system kind of things. I think you're seeing more acquisitions that are vertical in nature, and systems are trying to improve their continuum of care in the healthcare spectrum.

At the end of the day, I think it's access to capital that's a critical component. When I see our for-profit systems trying to get involved in local communities, usually the community is in the position that they don't have the capital or the operating revenue to keep the services that they want in the community. The for-profit system is able to provide something a little different in that regard.

Hailey Janeway: Makes sense. The next question we have is very much related to the first, but that is, what qualities in the mergers and acquisitions setting are very distinct in the rural setting versus the urban setting?

And then, follow up on that, are there any defining characteristics of the partnership between the two on paper on legal practice as opposed to other types of mergers?

Charleyn Reviere: I'd be happy to talk about that one. We've found that rural communities each have their own personalities. When you come into one, you need to be aware of that and use an individualized approach when working with those people.

I'll tell you a funny story. We have a small hospital in a county around here, and we were looking to consolidate three hospitals in a small county so that we could provide better service through one hospital. The people in the community were unhappy about one being closed, not because they utilized it, but because we were closing the cafeteria. No one cared about the hospital, but they were very, very upset about the cafeteria. So, once we figured that out, we offered to extend/expand the cafeteria services at the consolidated facility, and everyone was happy.

But, you do have to go in there and talk about what their community needs are and match those to the services that they will use. We use local advisory boards and retain those local advisory boards for those hospitals, because those are the people that live in that community area and are in touch with it.

We do have the ability to provide obviously some streamlined operations, policies, and compliance programs. We do find that in a smaller hospital, like in our main flagship hospital, we have a risk manager. But in our smaller hospital, we might have one person who wears that hat along with they are also HR Director and also managing all of the insurance and several other things. So we can bring that expertise to them and allow that person to continue to function in that role.

We want the rural community to have a sense of ownership of their facility while recognizing the benefits of the bigger operations.

Doug Mefford: Yeah, I would second the comments about the unique nature of rural hospitals and communities in which they operate. There is just a significant political overlay when you're doing a transaction with a rural community hospital.

Hospitals, community hospitals, rural hospitals, they represent a real sense of community pride for the locale. It's often one of the largest employers. It often is sort of a symbol of the strength and vitality of the community. Business leaders are often on their boards. It becomes a real, much more emotional and political issue for rural hospitals than you might find in some urban settings.

I think also the influence of the medical staff in keeping community hospital transactions is quite significant, probably more so than in urban hospital transactions just because they do have much more sway and control over how that hospital operates. They are very protective, rightly so, of their medical staff, and the providers that are given privileges at those hospitals… you really have to deal with all of those contingencies in a way that, maybe not quite so much in an urban environment.

I think one thing that has changed over time though, in those transactions, is that years and years ago, it might be much more common for a rural hospital to have much less sophisticated legal representation in their transaction than I think exists today. Even rural hospitals now have gotten much more sophisticated in how they approach these transactions and the representation that they secure to represent them in the transactions. It's not at all more so of the David and Goliath transaction that it maybe once was.

David Clay: I agree with Doug and Charleyn on that, and I was looking and thinking, all of the things that were mentioned are items

that get rattled off when you start the conversation with a local community hospital that is looking to acquire. It has questions about what investments are we going to make in the community, and what continuing over – you know there are covenants in your agreement about hospital operations that you're going to continue because the community wants to know you're not going to step in and just change everything, unless that's the deal.

You mention that local boards of trustees get set up, and so local community leaders' promises are made about how those are going to be structured and set up.

Indigent care policies – that you're going to keep the same indigent care policies in place or that you're going to convince them that your existing policies are strong, good. Those are all things that I think are very unique to rural areas, maybe a little bit different than the urban setting. Maybe there's not as much of a community affiliation to the hospital because of the urban nature.

But, the parallel I think between the two, and this is maybe only if you're dealing with your, maybe a county owned kind of hospital, or maybe a single not-for-profit that owns a facility route than something that's system based. All of those, whether in a rural or urban setting, you really get into interesting compliance issues when you start doing the due diligence because the compliance function for a single facility is just a little bit different than something that is within a system.

So even when they get sophisticated counsel, I agree with Doug on that, you're seeing that the due diligence ends up being kind of interesting, and there's a parallel I think even between rural and urban when you're looking at just a single facility where the compliance, as you get into diligence, may result in some voluntary self-disclosures and other things that a buyer is going to want to do. That's a parallel I see between urban and rural when you're talking about your smaller hospital settings rather than something that is a system and has a lot of support.

Hailey Janeway: Moving on to the next one, maybe we've touched on this a bit. Have you seen the urban and rural hospital groups doing anything to initiate a system in smaller communities, or what does that look like in your experience?

Doug Mefford: I'm happy to lead off on that one. In Vanderbilt's case, and I think in the case of many large urban hospital systems, there are a number of things that we are trying to do, and systems

are trying to do generally to bolster the care provided in regional and smaller community hospitals.

The real thrust of that is sometimes misunderstood in ways. Assistance provided from a large academic medical center, in Vanderbilt's case, for example, can sometimes be viewed with a bit of skepticism when we start to initiate activities in local communities because it's viewed sometimes as, oh here they come, trying to pull all the patients out of the community and drag them back to the mothership in Nashville. Frankly, that couldn't be further from the truth. We enjoy the benefit of being overcrowded all the time, so our objective really is to try to ensure that the right patient's in the right location, and that we are doing what we can to bolster the services in smaller communities so that patients will be comfortable staying there and so that we can provide additional resources there that perhaps the hospital hadn't had before.

A couple of the ways we do that specifically are, we developed I think ten years ago this year, the Vanderbilt Health Affiliated Network,[1] which is a clinically and financially integrated network of providers around not just Tennessee but surrounding states that help bring best practices to the network members. They are able to do some joint contracting together, and provide [group purchasing organization] services to some of the smaller hospitals to bolster their supply chain operations and reduce their cost… we try to have some alignment on clinic establishment in local communities where we could form clinics that would be complementary to the services that the local hospital has in place. In the prior presentation, telemedicine was a big topic. I think telemedicine is one of the most prolific and fastest growing service lines that larger systems can implement in smaller communities, and that's here to stay. I think early on there were some questions about if it would be long term accepted by payers, and clearly now I think the answer to that is yes. It has proven its effectiveness through the pandemic.

Lastly, there are the traditional professional services agreements, where larger hospitals may contract with smaller facilities that provide specialists or physician coverage in various respects. So, all of those are just some examples of the way that I think larger systems try to invest and partner with smaller community hospitals.

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[1] VANDERBILT HEALTH AFFILIATED NETWORK, https://www.vhan.com/ (last visited March 20, 2023).

Charleyn Reviere: Everything you said is the same thing we're experiencing. We, at one point during the pandemic, had the dubious honor of the most COVID patients in the state in our hospital. We had hospitals calling us from other states trying to transfer patients here, so I think everyone was in that same boat. But as part of that, and as an overall practice, we've established a regional transfer center, so that patients, so that we can see the beds that are available in facilities all around the west Tennessee area. The goal would be that if the patient lives in a county two counties away, if we can find a bed for them and provide the appropriate level of care in that community hospital, we want to do that for them. It's better for the patient, better for the family… And we're like you - we had the honor of being packed to the gills every day. So, to the extent that we can make quality care at the appropriate acuity level available to people in their own communities, that's what we want to be able to do.

We have established hospital call programs at all of our community hospitals so that the days when the physician came to the hospital to see the patient, we've seen a lot of that go away. Most family practices don't take calls at the hospital anymore. The hospital is practiced in the hospital, and that relationship exists where the family practice doctor refers the patient to the hospitals, and the hospitals take care of them during their acute stay, and then refers them back out to their family care provider.

Some of the things we've done to help that and facilitate that is that we are making sure that every patient, when they leave the facility, they have a follow up appointment with their primary care provider. If they don't have a primary care provider, we help them establish a relationship with someone.

Because we are nonprofit, we see a huge number of indigents, Medicare, Medicaid, TennCare patients here. We do run into some issues with private clinics not necessarily wanting to take those patients and have them be part of their practice. We have built up our own primary care practices so that we would have the ability to provide care.

Hailey Janeway: Thank you. I think just moving along, if anybody has anything they want to highlight, let me know. I'll kind of move into the more rural issues after this one. It would be interesting to know how large-scale mergers and acquisitions with other providers have impacted the urban providers of patient care and the rural providers of patient care.

Charleyn Reviere: It has increased the referrals back and forth, they have improved. Having those primary care rural providers aware of the specialists that are available at the flagship hospital, where often the rural community doesn't usually have the sub-specialists present. So being able to bounce those patients back and forth has been a good thing I think for both.

Doug Mefford: Yeah, I think when we talk about patient care you really have it sort of break that down to say what do you mean when you say patient care, and sort of in my mind, that's really at least three elements: it's certainly the quality of care, but it's also access, and it's also cost. All of those are impacted particularly through large scale system mergers.

David can probably speak better to some of the large system merger transactions that he's worked on. I think you may get different answers to that question depending on what contingency you're talking to. Physicians versus patients versus payers may have different perspectives on how mergers impacted patient care.

For large mergers, physicians may feel they have more autonomy perhaps than they may used to have in decision making. They may be feeling like they're more subject to corporate policy and directives than they were before. Patients might feel like there are more restrictions on their access to care. You hope, and we can talk about cost later, I think that's on the list, but the hope was that consolidation would bring lower patient cost. That was part of the Affordable Care Act, one of its objectives. I'm not sure that's proven to be the case.

But the success of the merger can have a big impact on a number of areas: systems integration, human integration, leadership alignment… All of those things play into whether or not a merger is successful and how that merger is then going to play out in terms of the patient care that is provided.

David Clay: Yeah, I don't know if I have much more to add to what Doug said there. Partly because, one of the interesting things you all will discover too, is that outside counsel – we help get a transaction done, and what it looks like operationally after that, I'm not going to get to see how it plays out.

Certainly, every one of my clients will expect that they're doing this transaction because they think it is going to be beneficial to the community and that it will improve patient care better, but doing the transaction and completing the merger is one thing.

Integrating it, getting the operations folks on board, and actually implementing your transaction is a different thing once the deal is closed.

Doug Mefford: Yeah, so I'll take that opening to just say one more thing about integration because I'm sort of passionate about that. Integration is just huge in terms of whether or not a transaction and a merger or an acquisition was successful across the metrics that you might use to ascribe success. Integration of these transactions really starts way before closing. It starts in the evaluation of whether or not you're going to do a transaction. There's so many things you have to think about in terms of philosophy toward patient care, philosophy toward indigent care, philosophy toward physician leadership, philosophy towards staffing. All of those things really have to be aligned on the front end between the two organizations particularly more in a merger of more equals.

Even on a true sort of winner – loser type acquisition where one system is getting consumed by another, for example, the winner or the buyer in that case has really got to be prepared to take the steps necessary to achieve that post-closing integration. If that doesn't happen, it ends up being worse for both organizations than if you had not done the merger or the acquisition at all.

Hailey Janeway: I think we have an audience question. This is coming from an attorney nurse who wants to know, how does the lack of Medicaid expansion in TN play into the issues we are discussing? Multiple rural hospitals are closing due to the lack of Medicaid coverage.

Doug Mefford: Well, I think there's probably not much question that the fact that there has not been Medicaid expansion in Tennessee has negatively impacted particularly smaller, rural providers in this state. The opportunity to provide them with more resources that would naturally occur because the reality is many of those hospitals do have a higher degree and a reliance on government beneficiary patients for their operations. The simple answer from my view of the world is, yeah, it has negatively impacted community providers to not have Medicaid expansion.

Charleyn Reviere: Yes, we've seen that play out in our system. We still provide them provide services; we just don't receive the reimbursement.

Hailey Janeway: Alright I think we can move into more specific rural issues. The first question would be, how can we attract a higher

volume of quality providers to smaller communities? And what do these kinds of partnerships and systems look like?

Charleyn Reviere: I can take that. We, in our hospital, we have a very active physician recruiting department. Part of what they focus on with physicians coming out of training today, is we find that they are very focused on the quality of life and work life balance.

In a smaller community, a smaller community can offer that in a way that larger communities can't sometimes. More time with family versus commuting in traffic, more opportunity to be involved in schools and also lower cost of living for a med student coming out with a lot of debt can be attractive. We have added with that some things that our keynote speaker mentioned. Our physicians can get public service loan forgiveness when working for us because of our status. So that's potentially a factor, too.

We don't find that any providers these days really want to come out of school and take on the risk of setting up their own practice. Employment does seem to be the model right now. We are also working toward establishing a rural track program through some expansion and residency funding. So, [University of Tennessee at] Martin ("UT Martin") is in our service area, and we have a family practice residency, a UT family practice residency that's centered here in Jackson. What we are looking at doing is having those residents come to Jackson for year one of that three year residency, and moving to UT Martin to complete years 2 and 3. Those years, we find, are generally the years in which they are getting married, starting a family, starting to put down roots, and the thought is if they can complete those 2 years of residency in that rural area, they might decide to remain there. So we're in the process of working with … to get that approved. We hope that will be something that will help providers move towards those areas.

Of course, we offer traditional recruiting incentives too, like loan repayment, sign on bonuses, we try to be competitive with those in those areas.

Hailey Janeway: Alright, something else that's interesting to think about is what kind of compliance issues do rural hospitals face the most? How are those different from urban hospital compliance issues?

Doug Mefford: David, do you want to jump in on that one?

David Clay: Yeah, I can. I don't know how you would characterize what they face the most, and some of that is for every transaction you look at - and I'm coming at this from more of a diligence standpoint, and I'm not a healthcare regulatory specialist, I've got colleagues that do sort of the fraud and kickback and Stark analysis,[2] but - that is what I think we would typically see, is that you've got a lot of things going on within smaller community hospitals that maybe don't have, and we mentioned before that, they're hiring more sophisticated counsel: a lot of times that's for the transaction that they maybe have not have sophisticated counsel day to day.

You're typically seeing Stark law compliance issues when it comes to, are agreements in writing? And how is compensation set up with the physicians? Things like that that are not intentional, they're just missteps and unfortunately Stark is a strict liability issue and is not intent-based, and so it results in a lot of items that get flagged.

Often you can come up with ways to build a, take a holistically, say oh yes this is compliant, maybe with pay stubs and other things. In other cases, you're going to end up having self-disclosure. Sometimes that is certainly going to be scary to a local system, but it's also very, very common.

Since the Affordable Care Act,[3] and sort of the CMS voluntary self-disclosure regimen, the settlements on those are very reasonable and it's really a way for a buyer to get a clean start on a facility, rather than having ongoing compliance issues.

I don't know if Doug or Charleyn have different thoughts on that. I don't know that I see different compliance issues between a rural or urban facility either.

Doug Mefford: Yeah, I agree with that. And to your point on Stark issues, I think that Stark issues, physician relationships, generally between physicians and hospitals, I think tend to crop up more just because you might have a much lower percentage of your medical staff as being employed by the hospital in a rural community and so anytime you're dealing with independent physician groups you've got a heightened Stark risk, and even for employee positions, the whole commercial reasonableness focus on compensation that didn't use to be as much in the limelight has certainly taken on a higher focus than it has in the past. Then you've just got the issues of fair

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[2] Stark Act, 42 U.S.C. § 1395nn (1989).

[3] The Patient Protection and Affordable Care Act, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

market value and payment of subsidies in some cases that small community hospitals have to pay in order to obtain fundamental services that they need to operate which don't exist as frequently in an urban environment.

Hailey Janeway: What do you perceive as the biggest problems facing rural communities in terms of healthcare outcomes?

Charleyn Reviere: I would say a lot of the things that Mary, the keynote speaker, mentioned and what we see here: access to care. One of the things that we've done that has been somewhat effective is, we used, since we are the destination hospital for all of these counties around us, we have used deidentified data from our patients' demographic data to determine if we have pockets of particular health issues in communities. For example, we had a community two counties over where we noticed we were getting a lot of patients who had uncontrolled diabetes that wasn't being controlled in any way. We were able to reach out to the providers there in that area and provide resources, education, put on a few clinics with the community, just to talk about how to manage diabetes and what supplies were available and make those available where we could. A couple of pharmacies partnered with us in that, so trying to do some targeted outreach like that for specific health conditions has had some positive effect. But that's one of the ways that we kind of impact that.

Doug Mefford: Yeah, I think recently now that Vanderbilt has gotten into acquiring a couple of smaller hospitals, one of the things we're seeing and we're hearing, certainly anecdotally, is as I mentioned earlier: staffing. It's just an issue for most all hospitals these days, and the ability to have adequate, particularly nursing, staff to provide the kind of care that you really want to provide for patients is a challenge. I have to think that's more acute even in smaller environments. The opioid crisis for small rural communities is a huge issue that just the degree of the number of patients that come through with drug related issues oftentimes perhaps uninsured patients it's just a real problem that small community hospitals struggle with I know on a day-to-day basis. Then last, I would just offer the lack of behavioral health services and psychiatric beds can be a real big challenge for smaller community hospitals, particularly, and that's largely in connection with the opioid crisis and drug issues and so forth. But just not having enough places to send patients who need that specialized care, I think it's going to, it continues to be a real challenge.

Hailey Janeway: And speaking to the staffing issues that people addressed, one of the issues addressed in Belmont's healthcare business and finance class is the necessity to maintain fair market value salaries and compensation for health care providers to maintain a tax-exempt status. How is this impacted your operations in a rural setting where there tend to be less providers?

Charleyn Reviere: From our standpoint, obviously, it's what David touched on earlier, it's Stark and Anti-Kickback.[4] It's not just the tax exempt, its Stark and anti-kickback rules as well that require us to pay fair market value to physicians that we obviously have to stay within that and sometimes we've found that to be a challenge. A market, you might not have anything comparable in the market to pay a specialist a certain number of dollars to go there, and yet we need that specialist to be there to provide care, so we have some other ways of looking at that to justify it. And given the need, we have a good community needs assessment that tells us the age of the physician population in the area, the number of patients they're carrying, the wait times for appointments and all those things help us justify rates that help us attract physicians to those communities, but sometimes even with all that we can't, we're not successful. With those limitations, I wish there was some more flexibility on those would be great.

Hailey Janeway: We have time for one last question, but you can wrap this up…

David Clay: Well, I was going to say when I saw that, when I saw that question my first thought was, I don't know if there was a difference between for profit and not for profit when it came to fair market value and other things, but I think that's a key issue for anybody. And then one thing I did think about from that nonprofit standpoint, it's not exactly on point for that question, but maybe along the lines; when you are doing an acquisition, for instance, maybe a for profit is acquiring a local hospital that has been a not-for-profit facility it's often going to implicate conversion statutes within the state. So, you're going to have to be able to show, that facility has to show as a not for profit to the attorney general, the state attorney general, hey this transaction is fair, the price being paid is fair market value, there's a reason why we're doing this deal and you're going to actually have to get approval from the state [attorney general] in order for the transaction to go through. That is something that is different when you're doing a transaction with a not for profit versus a for profit to for profit transaction, and in fact

[4] Anti-Kickback Statute (Anti-Kickback Statute), 42 U.S.C. § 1320a-7b (1994).

that gets implicated even when you're doing a long-term lease arrangement or something else that's not a pure acquisition.

Doug Mefford: So, I'll just offer it on the compensation fair market value front. Fair market value as an issue generally has spawned, not even a cottage industry, but an entire stable industry I think, of fair market value consultants who are working diligently to help facilities justify and validate prices they're paying, comp. they're paying, and so forth. It's evolved way beyond just saying well where do we follow the [Medical Group Management Association] scale[5] or the SullivanCotter scale,[6] right, I mean that's Charleyn's point, there are a lot of other factors that have to get factored into it these days.

Hailey Janeway: Alright Lauren, do we want to ask one more question or is that time for us?

Lauren Caverly-Pratt: I think we have time for one more question.

Hailey Janeway: OK, I have one for Charleyn, specifically, if she wants to close us out. As the leader of an entirely nonprofit hospital system, has the shift to value-based care driven the need to merge with other providers in your localities?

Charleyn Reviere: It has, it has led to the need to expand our primary care base and to create partnerships with [inaudible]. Value based care obviously goes beyond the walls of the hospital, so you're looking at the continuing care to that patient to reduce the admission rates and make sure that they have a positive health outcome, and so we've had to expand primary care significantly over the past several years to work towards that. Where sometimes our private clinics are not able to take on some of these patients, we also have a [federally qualified health center ("FQHC")] here in this community that we supported to help facilitate some of that that continuation of care. Telehealth has been a great help with that as it expands. I think telehealth will help us stay more in touch with patients and monitor them. We did a lot of remote monitoring during COVID which is great. We could send patients home, monitor them remotely so they didn't have to stay in the hospital, but yes, it's definitely going to lead to the need to not necessarily merge with other providers but at the very least establish partnerships and relationships with them that allow us to share data and work together to achieve positive outcomes.

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[5] MEDICAL GROUP MANAGEMENT ASSOCIATION (MGMA), https://www.mgma.com/ (last visited March 20, 2023).

[6] SULLIVANCOTTER, https://sullivancotter.com/ (last visited March 20, 2023).

Hailey Janeway: Thank you and I think that's time if Lauren wants to close us out.

Lauren Caverly-Pratt: Yes, thank you, thank you, thank you. Thank you so much David, Charleyn, Doug, and Hailey, it's been so great to have you here and all of your insights and thank you for sharing everything from your personal experiences.

THE LEGAL ROLE IN BUILDING SUSTAINABLE PUBLIC HEALTH

SPEAKER:
PROFESSOR JOANNA SAX, E. DONALD SHAPIRO
PROFESSOR OF LAW, CALIFORNIA WESTERN UNIVERSITY

[edited for reading]

FEBRUARY 18, 2022

Lauren Caverly-Pratt: We are now going to move into our speaker session. Our first academic speaker here is Professor Joanna Sax, the E. Donald Shapiro Professor of Law at California Western School of Law. Professor Sax earned her Juris Doctor from the University of Pennsylvania Carey Law School in addition to earning her PhD in cell and molecular biology from the University of Pennsylvania Perelman School of Medicine. Given this impressive background, it makes sense that her research sits at the intersection of law and science. She has a particular interest in how advances in science can translate into our everyday lives. As the slide says, she is widely recognized for her work on food policy in this vein, particularly FDA regulation of dietary supplements and genetically engineered food. She also really enjoys teaching, and in 2020 she was awarded the Professor of the Year award at California Western. Professor Sax, thank you so much for being here with us today.

Dr. Joanna Sax: Great, well thank you so much. I'll share my screen before I start talking. Let's just make sure that that works; if you could nod and let me know, can you see my slides? Yes, you can, ok great! Well, that's the first potential issue. Well, I just want to thank everyone so much for being here today and I want to thank Lauren, and the journal, and Professor Farringer for inviting me, and I hope this is the beginning of a relationship so I can get invited in person to Nashville. So, thank you so much for all your hard work behind the scenes to make this happen.

And to take a little bit of a left turn compared to the keynote speaker and the panels who have largely focused on health care delivery, which is very important, and I'm going to talk about another component of public health which is food. Which initially, you might not think that food is a public health issue, but it is, and we often think of food as a public health issue to the extent that we think of it that way with respect to our SNAP program or our school lunch program. But food overall is a public health issue, because of not only because of food security, but because of its intersection with climate change, and climate change is going to create a lot of public health issues. So, this talk will be a little bit different than the other one and I look forward to any questions at the end.

The overview of the talk is I'm going to say a little bit why food is a public health issue. I'm going to talk about why science matters and utilizing science to solve food as a public health issue, especially as it relates to sustainability and climate change. Then I'm going to talk a little bit about consumers' perception of risk and why consumers' perception, or really misperception, of risk created by

new scientific technologies, or even applying older scientific technologies, is misplaced, and we can actually kill technologies through the consumer component and then we don't have those technologies to solve our problems. I'm going to talk a little bit about why consumers might inappropriately assign risk to certain scientific applications and then ways that we might want to think about resolving that issue or closing the divide between consumer misperception of risk and evidence-based assessment of risk with possible interventions.

Food is a public health issue, malnutrition is the leading cause of death and disease worldwide, and climate change is an existential crisis, and that's actually a hard thing to say in the face of all of our other existential crises, including the pandemic which we're hopefully starting to come out of the pandemic mode. The climate change is going to significantly impact our food supply, and it's going to make malnutrition a worse problem even though malnutrition is currently the leading cause of death and disease worldwide. So, we need to talk about the relationship between agriculture, our food supply, and climate change. I'm going to focus on a sort of niche area in this, there's other areas in our food supply that certainly have a relationship to public health, there's other areas of our food supply that have relationships to climate change like transportation, for example, and so I'm really going to narrow down into just one of the issues that makes food a public health issue. My area is on genetically engineered food which is colloquially known as GMOs, and GMOs is sort of a subset of the genetically engineered food supply, and it's genetically engineered, broadly speaking, which is probably the more appropriate term, is the use of molecular techniques to alter seeds that are ultimately brought into crops and contribute to our food. I'm only going to focus on crops, you can have genetically engineered animals that raises different issues that I won't get into today, but I'd be happy to talk about it in the Q&A.

I think the biggest thing that consumers might misunderstand is that our entire food supply is genetically modified. We do not eat wild type varieties: corn, wheat we can't even self-propagate anymore, all of our major crops, strawberries, green peppers, these are not the wild type varieties. We humans have domesticated these crops over thousands of years, and the way that humans have domesticated these crops is through altering the DNA of the crops. Now thousands of years ago humans didn't even know that that's what they were doing, that they were causing molecular changes, that wouldn't come about until about the 1800s that we even understand that DNA, that traits were hereditable, I'll move on from that word, and sort of the techniques particularly in the 20th century

or the first half were these mass mutagenic techniques using chemicals, using radiation, treating seeds with these highly mutagenic techniques, growing the seeds up in the commercialization process, finding a better tasting strawberry, a better looking green pepper, a better yielding corn. And that those domesticated crops are our food supply, and through the commercialization process our food supply is very safe; so even organic farming which has sort of been disconnected from the GMO movement, all of the crops grown in organic farming are genetically modified. They are genetically modified through these mass mutagenic techniques, so organic farming does not mean that you're not eating genetically modified crops, that just means that you're not eating genetically engineered crops. Well, in the 1970s we started to learn more about the molecular basis within particularly mammalian cells, bacterial cells and this translated over into plant cells and over the next 50 years scientists figured out ways to do more precise genetic changes to crops, so instead of having to use the mass mutagenic techniques, radiation, chemical mutagenesis scientists were able to obtain desired crops through more precise mechanisms. That's the genetically engineered crops. The genetically engineered crops are utilizing advancements of science to make more precise genetic changes that are arguably more well understood, and the risk of an unsafe crop is likely less than that of the mass mutagenic techniques, and I should say the risk from the mass mutagenic techniques is also zero by the time the food gets through the commercialization process. But there's been a lot of misinformation about GMOs and genetically engineered crops which I'll talk about in a minute.

But, let me just talk about some of the things that genetic engineering techniques are able to do that we can't do with the traditional mass mutagenic techniques, and one example is golden rice. Rice is a staple crop in many areas of the world, and in some African nations there's a deficiency, a vitamin deficiency, where children at dusk can no longer see. They just they lose their sight at dusk, they need light to see, so they have to go into their homes and sort of their day ends at dusk, and golden rice is fortified genetically with the vitamin that creates this blindness, this night blindness, and it makes the rice a golden color. So, one idea is to use these genetic engineering techniques to supplement foods with nutrients that are severely missing that lead to malnutrition and disease, and there's a long political story behind golden rice. There's no safety issue, but there's a big political component. So, we can use these genetic engineering techniques used to make more nutritious food like golden rice.

Another example is the honey sweet plum. Plums are subject to viral infections; the honey sweet plum is genetically engineered to resist this virus that's carried by aphids which are like little bugs that will infest the plants. There's no safety issue, but our EPA requires that that be labeled as a pesticide, the fruit be labeled as a pesticide, which means that most consumers will not purchase fruit that is labeled as a pesticide. The other alternative is to treat plums with external application of pesticide, and in that way, it would not have to be labeled as a pesticide. The use of pesticides are an environmental issue and allow, and creating crops that are more pest resistant means that we use less external application of pesticides so that's another advantage.

Drought tolerant crops could be another example. Those are harder to create, but can we grow crops in a way with using less water and that's also going to be important as our climate changes. Some in the literature have called for the combination of organic farming techniques and genetically engineered crops, pest resistant crops, less pesticide which is an organic farming technique and many have called for that, but the organic farming industry sort of the big lobbying group has opposed those calls although organic farmers themselves may not share that position.

OK, so consumers are, we know that consumers are resisting genetically engineered crops and we see that through calls for labeling laws, and people we also know through studies that I've done[7] and others that consumers like the label natural, even though the label natural doesn't actually have a regulatory definition. But it's important to understand why people are rejecting using science to improve our food supply. I focus on multiple theories and I'm just going to talk about two today. I don't have a ton of time, but two theories that I've drawn from social science literature are affect and ambiguity. These are well studied theories for many decades, so my description of them in the next 30 seconds certainly does not do justice to the large amount of research, but affect which is a term pioneered by Paul Slovic says that emotion drives risk perception.[8] Fear and dread, if people experience feelings of fear or dread, they assign high risk and a low benefit regardless of the evidence based risk assessment that should make sense. People, for example, might be afraid of a plane crash so they're scared to fly, but the data says, the data tell us that the drive to the airport is actually more risky.

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[7] Joanna Sax & Neal Doran, *Food Labeling and Consumer Associations with Health, Safety, and Environment*, 44 J. L. MED. & ETHICS 630, 635 (2016).

[8] Paul Slovic & Ellen Peters, *Risk Perception and Affect*, 15 CURR. DIR. PSYCHOL. SCI. 322 (2006).

Ambiguity aversion, this is work by Daniel Ellsberg,[9] and many people since then that says that if people receive missing or conflicting information and they sort of can't separate out, if they received conflicting information, they sort of can't separate it out and they assign a high risk. We see this, for example on vaccine hesitancy, if people hear a link between vaccines and autism, to be clear, there is no link, they sort of can't forget that information. It becomes ambiguous to them, and they become hesitant to vaccinate.

I look at these theories to try to understand consumers' perception of risk, and I know I only have a couple minutes left, so I'm now going to speak super-fast, if you didn't think I was speaking too fast before, but this consumer misperception of risk matters because if we want to have regulatory structures that follow the science these are going to be rejected by consumers, that we're not going to have compliance with these policies. One example, of course, is vaccine mandates and the vaccine hesitancy, for example, to the COVID-19 vaccine was entirely predictable, we already knew that consumers were inappropriately assigning risk to vaccines and so we knew that there was going to be a problem with vaccine uptake and there really was not a lot done to deal with vaccine hesitancy. We know that consumers oppose genetically engineered foods, this is not as robust as the vaccine hesitancy group or even the anti-vaccine group, but it's predictable, and so we need to align consumers' perception of risk with evidence-based assessment of risk. It doesn't mean that consumers have to buy genetically engineered food, it doesn't mean that we have to tell them what food to buy, but they should at least have an appropriate risk assessment. I look a lot at, sort of, why this divide between consumer perception of risk and evidence-based assessment of risk is increasing and I look at it with food, and I look at it with vaccines, and fluoridated water, and other areas of scientific advancements and the three variables that I've been focusing on recently are individualism, the Internet, and economics.

Individualism refers to the sort of rise of the movement away from communities, or people realize, are sort of living in small knit communities into sort of more thinking about themselves and there's actually advantages to this, like in the 1950s these small knit communities just bred racism, sexism, bigotry and the movement away from that particularly in the 60s and 70s didn't solve those problems but it highlighted those problems. There's a lot of advantages to individualism, but there's some disadvantages too

[9] Daniel Ellsberg, *Risk, Ambiguity, and the Savage Axioms*, 75 Q. J. ECON. 643 (1961).

which is that people don't feel like they have to be part of community and make decisions based on the community.

The Internet, I hope I don't have to go into this too much, but of course there's a lot of misinformation on the Internet. People read this misinformation, they think it's real, it's presented very convincingly, it creates emotions, it creates ambiguity, and so this sort of feeds misinformation.

And then the economics, which is that there are groups and individuals who make a lot of money off of misinformation. We know like the anti-vaccine movement, a public figure Joseph Mercola, says you don't have to take vaccines here's this alternative herbal supplement and here's a natural way to build immunity and there really is no alternative to vaccines. So, there's a lot of money to be made to create this sort of schism with consumers.

My research is focused on well how do we close the divide between consumer misperception of risk and evidence based assessment of risk and there are ways to determine whether emotion or ambiguity aversion if we can, sort of, overcome these decision making theories to allow people, or utilize the decision making theories in a way that allows people to appropriately assign risk, and we can test these variables of individualism, Internet, and economics. You have to have some sort of intervention and maybe it's like social media, for example, or maybe it's a campaign by the CDC, and you sort of drive at people's emotions toying with this variable of individualism and you might see that you get some movement in consumer perception of risk, and you might find that with that same intervention using sort of correcting information on the Internet that you might get a more robust response, or under other scenarios that same targeted intervention wouldn't work as well sort of given the variables. This is a thought experiment; this last slide is a thought experiment in the sense of it's probably not just going to be one intervention. We're probably going to need to test and implement bold, simple interventions in order to figure out how to close the divide between consumers' misperception of risk and evidence-based assessment of risk so that consumers don't reject a technology to improve our food supply and lessen our impact on climate change. We can draw from another public health issue: smoking research, that would be another example, where interventions have been very effective and so we can draw on research from that area to see how we can close this divide.

So, that is 20 minutes which is what I was told, so I'll just say thank you.

Grace Benitone: Thank you so much for that 20 minutes. We do have time for a few questions if you are willing to answer them.

Dr. Joanna Sax: Absolutely!

Grace Benitone: One of our members of our health law journal is actually really interested in the role that marketing and law play in this issue, and you kind of touched on it a little bit at the end about social media and CDC campaigns, but, as well as the smoking research, are there any other examples of this emotional campaign that can help reduce the food insecurity issues that you may have seen?

Dr. Joanna Sax: Well, I've definitely seen sort of the opposite of your question, I've definitely seen marketing campaigns that create the fear, that create the dread. For example, there used to be this commercial where cows can be treated with this bovine growth hormone that they keep lactating and it's called RBST, and there's been no human health effect of it, I mean we can discuss the animal husbandry issue, but there's been no human health effect of eating dairy products from cows treated with RBST, and there was this commercial several years ago that portrayed RBST as this huge swamp monster coming after a child and was very terrifying, and then it was like: our products don't contain RBST. It was clearly a fear based, clearly fear based, and I've talked about in my research like: OK well we should use emotion to promote the correct facts, and sort of the problem with that is that it is very manipulative. I mean, they're manipulating the misinformation and then the question is do you want to be manipulative with the correct information, and so the answer is yes, you could do marketing techniques and utilize emotion and utilize the decision-making theories, and I would suggest that we do use emotion and we do consider ambiguity aversion, but we be honest about it. We're trying to get you emotionally, we're trying to resolve a conflict, so that it's not sort of secretly manipulative, it's perhaps openly manipulative.

Grace Benitone: Towards the end of your presentation as well you mentioned that there's a need to test different interventions. Do you have any ideas for what kinds of interventions or, yeah…?

Dr. Joanna Sax: Yeah, no that's the next area of my research. I've been trying to think about it. I think social media is a good intervention, because utilizing social media is a good intervention in the sense that people are on social media, and you can do like focus group studies or other survey studies where you give people an

intervention like a marketing, you know sort of how we were just talking about, you know where you sort of manipulate their emotions and you see if messages over social media can change people's perception of risk or allow them to appropriately assign risk. I think that's a place to start utilizing social media. Now, there's a problem with that because do you want the government sort of teaming up with social media to manipulate people? There's sort of an obvious externality there, so I think the research will go slow. Social media could be a way to start, but then you're going to run into sort of the relationship between the government and the private actors, so it's a good question. It's to be determined.

Grace Benitone: I'm looking forward to seeing that research play out, definitely interesting. I'll just ask this one last question. One of our members of our journal also was curious if you had any perspective on how climate change influences food security. If there's anything that you've noticed throughout your research that would play into that?

Dr. Joanna Sax: Well, it is. I mean it's actually; I mean how we grow our crops and where we can grow our crops is going to be significantly affected by climate change. It's not just that crops need certain temperatures and that's going to change. It's that we're going to have different pests, in different climates. So, just in terms of crops and agriculture, climate change, I mean, we could have significant food security problems particularly in poorer nations where there they have different pests all of a sudden and the crops have no innate ability because they've never been exposed to those pests before. I think climate changes is, and this is hard to say because we have a lot of problems, it's the thing that we need to be focused on because it's going to affect everything. Food is one component, but it's going to affect everything, and every public health issue is going to be driven by climate change. So, that's positive right, that's my positive end.

Grace Benitone: Yeah, I'm actually going to ask one more question as well. We had a student wondering if the current law stands more on, or leans towards, creating security or sustainability of food, and if you want to speak to perhaps the difference of those as well, I'm sure some audience members would be interested in that.

Dr. Joanna Sax: Yeah, well, if I just think about the U.S., so the U.S. if we think about sort of our SNAP program and our school lunch program, it's trying to go for food security, but the problem is that the food's extremely unhealthy, that the most inexpensive food has very little nutritional value. I would say that the government

likely thinks, our government likely thinks that it's addressing food security but it's doing so at the expense of other public health issues: obesity, diabetes, actually you can be overweight and malnourished at the same time. I think, and also, we have significantly subsidized you know corn, wheat sort of our commodity crops. I don't think our government thinks it's dealing with food security, but I would argue that it's inadequately dealing with that, and I don't think our government does a lot, I mean the EPA because it regulates pesticides, that I would say that that agency would likely say that it's interested in climate change, and some of its policies are, some of its policies are not, so also sort of an unsatisfying answer as well but a good question.

Grace Benitone: Great. Well thank you so much, it's very interesting and I think I'm going to go ahead and hand it back to Lauren, she'll go ahead and move us forward with the day but thanks so much for chatting with us.

Dr. Joanna Sax: Thank you for having me. I really appreciate it.

Lauren Caverly-Pratt: Thank you, Grace, and again, thank you Professor Sax. Like Grace said, that was so interesting. I would honestly love to hear you speak a little bit more on the topic but unfortunately, we do have to keep moving along with our day. Thank you for being here with us virtually and I hope that we'll be able to get you out to Nashville someday in the future in person.

THE LEGAL ROLE IN BUILDING SUSTAINABLE PUBLIC HEALTH

SPEAKER:
PROFESSOR JESSICA MANTEL, PROFESSOR AND CO-DIRECTOR OF THE HEALTH LAW & POLICY INSTITUTE,
UNIVERSITY OF HOUSTON LAW CENTER

[edited for reading]

FEBRUARY 18, 2022

Lauren Caverly-Pratt: Up next, we have Professor Jessica Mantel. Professor Mantel is a professor of law and co-director of the Health Law and Policy Institute at the University of Houston Law Center. She comes with considerable experience, previously working as a senior attorney in the Office of General Counsel for the Department of Health and Human Services. In this position, she advised the Center for Medicare and Medicaid services on a wide variety of Medicare matters, and she also worked as a health policy analyst in the Government Accountability Office evaluating Medicaid, Medicare payment issues. Professor Mantel's research centers on trends in health care delivery systems and the allocation of limited resources. She received both her Juris Doctor and a Masters of Public Policy from the University of Michigan, so go blue. Professor Mantel it is so great to have you here with us today.

Professor Jessica Mantel: Great. Thank you so much. So, thank you to the Belmont Health Law Journal for inviting me here today. I want to talk about the research that I've been doing on team-based care models that address the needs of low-income populations.

As we've seen with COVID, no one is immune to the disease, but it's not been an equal opportunity disease. It obviously has had especially devastating impact on racial and ethnic minorities, as well as just lower income populations. And so, addressing the needs of vulnerable populations during COVID has understandably been a priority of many local public health departments; but these efforts have often been hampered by limited resources, limited data, as well as just fragmentation in our healthcare system where we have different agencies and different players working in silos. And we have also seen some mistrust between the public sector and the private sector.

All of this has created some significant challenges in coordinating public health response efforts and particularly efforts to address the needs of more vulnerable populations. But some communities have been more successful than others, and today I want to focus on a particular example of this, and these are communities where they've been able to leverage the resources of what I call community-based integrated health teams. So, let me just say a little bit about that – this is a term that some colleagues and I came up with, so it's not very well known or used in the healthcare world, but we use it to refer to health teams who manage patients' health-related needs across various providers and systems of care; so they're managing both individuals' medical needs, but also looking at the social determinants of health. So, things like substandard housing and food insecurity, which obviously have an

adverse impact on individuals' health. And the patients that are served by these teams typically are those with significant health issues, so those that have multiple chronic conditions or repeat visits to the emergency room, with these patient health care issues being complicated by complex social, financial, and behavioral health needs. So, these health teams are interprofessional and they often will include a physician or a nurse, behavioral health provider or social worker, community health worker, or other health related professionals. Together, these professionals will jointly focus on the well-being of the whole person.

What I mean by that is that they're going beyond the traditional focus on patients' medical needs, and they're trying to address the full spectrum of circumstances that adversely impact individuals' health. They'll do things like assess the patients' not just medical needs, but non-medical needs such as food insecurity, and they'll do care coordination across different settings; so they'll help patients navigate health care system or help them navigate the network of social service agencies out there. They also will provide intensive case management and will connect individuals to community resources that can address some of their health care needs. Another thing these teams do is provide patient education or health coaching. So, examples of these teams can be found throughout the healthcare system; they're often embedded within the primary care setting. So, you might see a large physician practice, primary care practice, or community health clinic will have one of these interdisciplinary teams that works with some of these more vulnerable patients. But sometimes it can be established or funded within a local public health department, or there might be just an independent community-based organization operating one team.

There's emerging evidence that these community integrated health teams can improve the health of vulnerable populations when we're not in a public health crisis. But COVID has given an opportunity for these teams to play more expansive role, and specifically the, I think they're uniquely positioned to help support some efforts to address the needs of vulnerable populations during a public health emergency. And on the PowerPoint slide I have an overview of different ways that they do so, and I'll go into more detail in a minute about each of those. But generally speaking, COVID we have vulnerable individuals who may be at higher risk of getting COVID, or suffering complications that land them in the hospital, and so any sort of effective public health response needs to identify high risk individuals that are directly impacted by the public health emergency, or at high risk of suffering serious health complications; and we need to educate those individuals about the

risks, as well as resources that are available to help them mitigate their risk and provide supporting services that help them mitigate the risks that they face. In addition, we need to address any health or social needs that arise during a public health emergency, in order to help these individuals reduce the risk of getting sick, or otherwise having their health decline during the public health crisis. And community integrated health teams are positioned to do all of these things. So beyond, in addition, beyond helping individuals at the individual level, they're also well-positioned to support public health activities at the population level. So this would include supporting cross sector initiatives that address communities' health needs at that population level during a public health crisis; they also can help support sharing of data across different entities involved in responding to a public health crisis, and share their frontline observations with public health officials or other key actors, as well as support contact-tracing efforts.

Let me start with one of the key things, the first thing that a community health team can do: is to quickly identify high risk individuals. As I mentioned, it is very important because we want to be able to target some of our public health intervention to those that are most vulnerable from getting seriously ill, and this requires a lot of data and data analytics capability, and some community integrated health teams do have this capacity; many maintain databases where they compile data from multiple sources, so they have health information about individuals coming from multiple providers. They may have claims data from Medicaid or other payors like Medicare, managed care plans, and often they will collect data as well from social services agencies through shared common dashboards, so they might have information, for example, from homeless agencies or agencies working with those that are suffering food insecurity.

In addition, these teams often have data analytics expertise, so they know how to review all this data to identify high-risk individuals and some of the more sophisticated community integrated health teams can even kind of mine the data to create predictive models of individuals' health risk. And so, during a public health emergency, this data and expertise can be repurposed to identify specifically individuals at high risk during a public health emergency, like COVID. So, for example some CIH teams, they developed a COVID specific [inaudible] index based on algorithms from mining this data. And one example of this is in California, the Contra Costa Health Service System, which is a county-based health system that serves Medicaid beneficiaries; they used all that data they had to identify individuals in their community that they felt

were at high risk for COVID complications, so a high likelihood of ending up in the hospital, and then they reached out to those individuals specifically to help support their taking preventive measures.

Which brings me really to the second thing that community-based integrated health teams can do, and that's outreach to high-risk individuals. So, preventing the spread of a disease like COVID requires effective public health messaging; and community integrated health teams are well-positioned to do this. So, in my research I've seen several examples of these teams that helped their individual patients better understand COVID; so, they educated patients on preventative steps they can take to reduce their risk, they educated patients about symptoms of COVID that they should watch for, all of which obviously is vital information for individuals who are at high risk. And importantly, I think these teams are well-positioned to counter a lot of the misinformation that we see out there during a public health crisis. So obviously with COVID, with widespread mistrust of public health authorities and media and healthcare providers, it's been difficult to counter a lot of the misinformation about COVID that's out there. And these teams often have pre-existing relationship with patients, and they've been able to then, over time build these relationships and they're viewed as credible sources of information. And in addition, a lot of the professionals on these teams receive training on how to convey information in a culturally sensitive manner; and so, this makes them often very effective messengers of public health information. And so, teams have reported that they've had some success with their patients, but not just educating about COVID, but importantly countering misinformation out there, and in some cases are overcoming vaccine hesitancy.

And, in particular, the team members that are probably best positioned to do this are community health workers; and a lot of these community-based integrated health teams include community health workers. I don't know how familiar all of you are with these professionals, but these are individuals whose, one of the primary role is to just be a bridge between patients and the healthcare system, so when we're not in a public health crisis they help patients make their appointments, maybe go to them with to a doctor's appointments, help them understand the information that they're receiving from their providers, and importantly, community health members typically are members of the communities they serve; so they're often from minority communities and have a history of mistrust in institutions and the healthcare system. And because these community health workers are coming from the communities they

serve, they're often able to breakdown those walls of mistrust. One good example of this comes from the Navajo Nation, where their community health workers were often effective in combatting a lot of the misinformation out there regarding COVID; and that's because these community health workers are among the most trusted members of the Navajo Nation community, and that meant they were very effective messengers when it came to public health information related to COVID. I think as important these community health workers are to Navajo Nation, because they often were talking one-on-one with individuals, and there was that relationship of trust, those individuals would open up to these community health workers, and that allowed the community health workers to identify specific gaps that individuals had in their knowledge about COVID, so they were really well-positioned to address some of these COVID myths and conspiracies that are out there.

Another thing, kind of related to this outreach, is that these community integrated health teams will just, really what they do every day is they screen patients for unmet medical and social needs that are adversely impacting their health. And during COVID, we've seen these teams expand that screening to include COVID related questions, so really assessing individuals' risk for getting COVID, and whether there are barriers to their adopting preventive measures. So, for example, does as an individual face challenges to sheltering in place if they need to self-quarantine? They can also, through these screening measures, just monitor whether an individual is experiencing a decline in their physical or mental health, something that we saw a lot during COVID, as well as identify any social risk factors that have been exacerbated by COVID – difficulty accessing food because they're self-isolating, or they had to discontinue their home health services and so, that we did a lot early on in COVID, or are they facing financial distress from losing a job.

Having identified these high-risk patients and screening them for unmet medical and social needs related to COVID, these teams are then well-positioned to address some of those needs. First, they can help individuals just navigate the medical and social service system, really important during a public health crisis, where there can be barriers to accessing needed health care. We saw early on in COVID that providers shifted from in-person visits to telehealth, and telehealth was a challenge for a lot of populations that weren't familiar with that, and so teams were often helping individuals schedule telehealth appointments and importantly helping them with their technology needs. One of the teams that I interviewed, they

actually provided tablets to their patient clients so that they were able to continue to meet with their physicians via telehealth.

Another thing these teams can do is just to ensure that an individual's basic needs are being met - they can arrange for home delivery of prescriptions or food to individuals who are self-isolating, and then some of the teams we talked to said they provided masks or other hygiene kits to individuals, and then several teams set up vaccine events as well.

Another thing these teams do is health coaching. So they can support individuals adhering to medical recommendations, and that's something we saw that really was a struggle for many people during COVID, but because they have these preexisting relationships with these teams and the team members are trained in communicating health information in a culturally sensitive way, they're well-positioned to have some success with that health coaching to help support people continue to comply with medical recommendations.

Yet another thing these teams do is that they will frequently check in with their patients, and that can help lessen social isolation. There's a lot of research out there suggesting that social isolation can contribute to physical and mental decline in individuals, and in talking with these community integrated health teams, a lot of them mentioned how they were, the clients that they regularly were checking in with during COVID were just so thankful to know that there was someone there checking on them and that there's just someone who cared. So, I think that's really important function of these teams can serve. And in addition, some members of teams, some community health workers, social workers have training in basic mental health services, so they can address patients' just basic mental health needs, and as we saw during COVID, we, there was just a big increase obviously in anxiety and depression and some community integrated health teams reported that they coached patients on skills to help them manage that anxiety or to lessen their depression. Another example was a team that just set up support groups via Zoom for their patients, right, to address both the social isolation and some of those mental health needs.

Finally, related to mental health needs, these teams have great connections or just a network of behavioral health providers that they work with and they're able to then connect individuals who are having mental health issues during a crisis like COVID with behavioral health professionals. And then finally they can connect individuals to community services, so connect them to food banks,

or connect them to utility financial assistance programs if they've lost their jobs during COVID, or help them understand the eviction moratorium, or what other emergency aid or relief may be out there. So, one example of this is a community team out in California, they identified high-risk individuals among the homeless population, and then helped them locate and secure temporary COVID housing which was, which California did in various hotels that were not being occupied otherwise during COVID. So they supported high-risk homeless individuals being able to self-isolate.

Turning away from not just helping individuals, but to looking to what these teams can do at a population level, I think it's important to note that a lot of the problems that afflict vulnerable populations are very complex and multifaceted and they require a system-level intervention, and no one organization can do that on their own. What we really need often is a coordinated response across the public health sector, health care providers, and social service agencies. But forming these cross-sector partnerships is not easy, and it's almost impossible to do in the midst of a public health crisis. But a lot of these community integrated health teams can support a coordinated public health response because they often already have preexisting relationships with entities across these various sectors, and they've developed shared processes and infrastructure.

One of the key things that a lot of these teams have done is built up data sharing capacity. Coordinating public health responses requires a lot of sharing of data. You need that data, for example, to have a fuller picture of patients and what their health and social needs are during a public health emergency. It could help support tracking of a disease or mitigating a virus's spread, and as I mentioned before, a lot of these community integrated health teams have in place data sharing infrastructure. One example is Alameda Care Connection, another example from California, but they leveraged their health information exchange to coordinate outreach to homeless individuals - so they flagged homeless individuals in their health information exchange system, they flagged individuals who were eligible for these isolation and quarantine hotels that we saw in California, and so this allowed a treating provider to inform an individual of their eligibility for this when they showed up a medical care and then arrange transportation for that individual to the, an isolation quarantine hotel.

In addition, when these individuals did go into these isolation quarantine hotels, the health information system would then notify automatically housing managers and health providers,

who could then reach out to these individuals to provide additional services. And then a lot of the teams I've interviewed talked about how they used their shared data system during COVID to disseminate up-to-date information among different participating organizations; so notifying providers which patients are considered high-risk, keeping just the community organizations' health care providers up-to-date about when a social service agency reopened for in-person services, or any sort of special or new COVID related services that they're providing. Also, we've heard that some of these community integrated health teams, which share the frontline observations they have under one-on-one interaction patients, they would share those with public health officials so that they had a better understanding of what was happening among vulnerable populations.

Going back to the Navajo Nation, the community health workers that were meeting one-on-one with individuals in the community gained a lot of insight at what the community specific needs were, and they shared those with the leaders in the Navajo Nation. Those leaders could use that information to guide the purchase of food and supplies during COVID so they could better meet the community's needs. So also leveraging just these existing cross-sector relationships can support coordinated action, specifically developing some more systemic solutions to challenges that arise during a public health emergency. So when we have different organizations unfamiliar with another, really hard to identify who does what, and what their respective competencies are, there can be a lack of trust in others organization that can hinder collaboration; but with these teams they already have these cross-sector partnerships, already know who does what, who has what resources, and they can build on that to develop more population level interventions to address challenges during a public health emergency. One example was a team that, through the screening they were doing with patients, they realized that many of them, many of the non-[inaudible] patients lacked food delivery options that would help them self-isolate; so they built on their existing relationship with food banks, local transit agencies to quickly establish food delivery services in the community. Finally, we've seen a lot of the professionals on these teams, be sort of enlisted to help with contact tracing efforts, sometimes they would also train the other people contact tracing.

Why do I think it's important to talk about the ways these community integrated health teams can help during a public health crisis? We've seen some states like California and Vermont investing in these community integrated health teams, but generally

across the country there's just not that many of these teams in existence, and that's largely due to lack of funding. And so it may be that, as we hopefully will soon emerge from COVID, will start to have more publicly available funding to build out our public health infrastructure and I want to suggest that supporting community integrated health teams should be a part of those efforts, as I hope I've convinced you all they can play enough effective role in supporting the public health response during an emergency situation. But also, it would just be an efficient use of public funds to help develop these teams because when we're not the middle of a public health crisis, these teams are just very effective of addressing the needs of vulnerable populations. So, for any of you that want to learn more about this, I have up the PowerPoint slides an article[10] that I published on this, and I'll conclude my remarks there, I just think five minutes or so for questions, but I hope that I can answer any questions that you have.

Grace Benitone: Alright Jessica, thanks so much for that presentation. We do have some questions. One of which is, you discussed the CIHTs in the positive role that they played in the pandemic - going forward, are there any gaps that you've identified or any improvements you think that could be made for CIHTs going forward?

Dr. Jessica Mantel: So, one thing that we've heard in our conversations with them is how important data is. And as I said, many of them have developed comprehensive data, but there's limits to that. They may not have data from all the healthcare providers in the community, they may not have data from social service agencies, and a lot of them would welcome public support in developing more comprehensive data, that just, data platforms that bring together all this information that they can then access in supporting the services that they provide to patients.

Grace Benitone: Awesome. You also touched on the preexisting relationships being very important to having that trust with the community-based health teams. How do these community-based health teams get these relationships in the first place, and how can how can they create more relationships going forward?

Dr. Jessica Mantel: Teams have different methods for selecting the individuals that they're going to help, but once they've done that

[10] Jessica Mantel, LEVERAGING COMMUNITY-BASED INTEGRATED HEALTH TEAMS TO MEET THE NEEDS OF VULNERABLE POPULATIONS IN TIMES OF CRISIS, 30 ANNALS HEALTH LAW 133 (2021), https://lawecommons.luc.edu/annals/vol30/iss2/4.

selection process right, they reach out to the individual and sometimes the individual may have been referred to them by health care provider or it's a team embedded in the health care provider, so there already is a preexisting relationship; and usually there's a single person, like a social worker, community health worker, who's really the key point of contact, who will reach out to that individual and will do that fairly frequently, particularly in the beginning, and they have sometimes a questionnaire with the screening that they do to just identify individuals' needs, but often they'll do just a more open conversation like, "Mrs. Jones you know what's going on, what are your concerns, what would you like our help with," and that just helps over time build trust. And prior to COVID too, many of these teams, those individuals like community health workers and social workers, would actually go visit the individuals in their home, which can be a more comfortable setting for helping to build that relationship. Obviously with COVID, but you know they're not doing that so much, but they probably will return to that shortly. And so that's sort of another way that they can build trust, and as I mentioned, community health workers in particular are well-positioned to build that trust because they often are members of that community, and so they just, they understand better what individuals are with, dealing with, and they just had a little bit of an easier time building that trust.

Grace Benitone: We hear a lot about there being a shortage of social workers or not enough resources. How is that play into the community-based health teams as well, that there's not a not enough per se?

Dr. Jessica Mantel: Yeah, for a lot of reasons, we need to have more social workers, and particularly social workers that have some training in that health issues because this is a population that has a lot of mental health issues. And as I said, the social workers who have that training are well-positioned to provide at least some basic mental health services and support. With community health workers, there is a growing push to the state level to certify community health workers to kind of make their development a little more professional to make sure their training conforms with kind of best practices. In some states, they're waiving those, any fees that you would normally have when you apply for the license or state certification. And they might also, the state may be supporting programs that train community health workers, so we're starting to see movement in that direction. I'm also noticing, there seems to be more grant funding coming from the federal government to support community health worker programs, so their training and their expansion, so I think people are really starting to figure out that

social workers and community health workers have an important role to play, and hopefully as a society we'll kind of continue to at the state level and federal level push the development of those two professionals.

Grace Benitone: Alright that's super encouraging. Thanks so much, Jessica. I think, again, it's another interesting presentation and definitely we could probably spend a lot more time talking about it because it's such a huge initiative.

Dr. Jessica Mantel: Thank you.

THE LEGAL ROLE IN BUILDING SUSTAINABLE PUBLIC HEALTH

NEW PAYMENT MODELS AND DELIVERY SYSTEMS

PANELISTS:

DAKASHA WINTON, SENIOR VP & CHIEF GOVERNMENT RELATIONS OFFICERS, BLUE CROSS BLUE SHIELD TENNESSEE
MARK ISON, MEMBER, SHERRARD, ROE, VOIGT, HARBISON
BETH SWENSON DEWEESE, EPISODES OF CARE STRATEGY SPECIALIST, STRATEGIC PLANNING AND INNOVATION, TENNCARE

Moderated by Ashley Gholston Fowler, Bass, Berry & Sims

FEBRUARY 18, 2022

Lauren Caverly-Pratt: We're going to come back together for our final attorney panel of the day. I'm just going to give everyone a second to hop back on. Like I said, yes, this is our final attorney panel of the day, our final official section of programming. On this panel today we have Dakasha Winton, who is the Senior Vice President and Chief Government Relations Officer at Blue Cross Blue Shield of Tennessee, Mark Ison, a member at Sherrard, Roe, Voigt, and Harbison, and also Beth Swensen DeWeese, Episodes of Care Strategy Specialist at TennCare. This panel is going to be moderated by Ashley Gholston Fowler, another proud alumnus of Belmont Law. Ashley is an associate in the healthcare space and health care practice group at Bass, Berry and Sims. Like I mentioned, Ashley earned her law degree with a health law certificate at Belmont and a BS in Biology from the University of Alabama at Birmingham. After completing her undergrad studies, Fowler attended medical school for several years and also directed an after-school program at the PENCIL foundation. Ashley it is so great to see you again; I'm going to hand the reins over to you.

Ashley Gholston Fowler: Thanks, Lauren. It's always great to be at Belmont, albeit virtually today, but happy to be here, thanks for having me.

Lauren Caverly-Pratt: Thanks for being here.

Ashley Gholston Fowler: And, before I get to these questions about new payment and delivery systems, I wanted to get each of the panelists to talk a little bit about their background and their practice areas to illuminate some of the different perspectives we have today. So, I'll start off with Mark.

Mark Ison: OK thank you, Ashley. Thanks for the opportunity to join this panel today, all of you wonderful folks at Belmont. I have been practicing I think seventeen going on eighteen years, have been at Sherrard, Roe, Voigt, and Harbison the entire time, have practiced primarily in healthcare transactional work, regulatory fraud and abuse, operational matters, healthcare transactions - certainly not litigation and happy to keep it that way. And, in a small firm like ours things have kind of developed organically over the years and I'm aware that I sort of combine practice areas that a lot of larger firms would split apart, but I think it's, you know it's been a fun ride so far.

Ashley Gholston Fowler: Thanks Mark. Next, I'll ask Dakasha a bit about her practice.

Dakasha Winton: Well, hi everyone, and I echo Marks's comments in the sense of thank you for having me and also, I'm very happy to not be a litigation attorney as well. I have been with Blue Cross now for thirteen years in a few roles, but primarily I work with the Tennessee General Assembly as well as members of Congress and some local members as well in trying to develop policy issues, which is the perspective that I'll try to come from. I don't really do a lot of payment delivery stuff, but our payment delivery guy is on vacation, so you're stuck with me. So, I will hopefully give you some insight from the policymaking perspective, in addition to the perspective of what we do here at Blue Cross. And so, thank you again for having me.

Ashley Gholston Fowler: Thanks. And Beth, you want to talk a bit about your practice?

Beth Swenson DeWeese: Hi good morning, thank you for having me. I'm also really excited to be back at Belmont. I'm member of the, or I graduated from the charter class of 2014 from Belmont Law. I'm an Episode Strategy Specialist at TennCare. I've been with the agency for about four years now and I use my legal background to design and evolve new and innovative payment models. I mostly focus on the Episodes of Care Program, which is our acute and specialty payment reform initiative, but I also work on a bunch of other things within the strategic planning and innovation division here at TennCare. And also excited or glad not to be a litigation attorney as well.

Ashley Gholston Fowler: Me too. Alright so I'll open it up, I'll ask you what are the trends that you all are now seeing in new payment models and deliveries?

Mark Ison: Who would you like to start Ashley?

Ashley Gholston Fowler: We can start with you Mark.

Mark Ison: Well, and I will say, my perspective on these it's not a policy perspective, it's very much a, bottom up perspective working with physicians primarily who have been asked to participate in these models, and so most of what I think I've been seeing lately is, you know TennCare has a number of episodes of care, in particular, I've had some dealings with the perinatal episode of care with TennCare, with the Medicare, of course the accountable care

organizations,[11] the joint replacement bundle payments,[12] some things like that, and patient centered medical homes.[13] So, seeing models that are driving in many cases physicians who are not in the same practice or driving physicians together with hospitals or physicians across different related specialties together to care for people either in a specific condition, something like a joint replacement episode or a perinatal episode or just covered lives more generally and, of course linking them together, either through payment incentives or in some cases putting them at risk, I mean that's a really high overview and I know we're going to talk about all of those things more over the next hour but you kind of asked what are we seeing, those are the types of things that I'm seeing on a pretty regular basis.

Ashley Gholston Fowler: And I guess to take us back, why are the current payment models unsatisfactory and what's the core issue with the way we're currently doing things? And anyone can jump in and answer.

Mark Ison: Why don't one of you two more on the payor side start there, I have some thoughts on it, but I'll wait.

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[11] An Accountable Care Organizations (ACOs) are defined as "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program." CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/medicare/medicare-fee-for-service-payment/aco (last visited March 20, 2023); Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 3022.

[12] Payment bundling is "[a] payment structure in which different health care providers who are treating [a patient] for the same or related conditions are paid an overall sum for taking care of [their] condition rather than being paid for each individual treatment, test, or procedure." HEALTHCARE.GOV, https://www.healthcare.gov/glossary/payment-bundling/#:~:text=A%20payment%20structure%20in%20which,treatment%2C%20test%2C%20or%20procedure (last visited March 20, 2023); Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 3201.

[13] A patient-centered medical home (PCMH) is "a model of care in which patients are engaged in a direct relationship with a chosen provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and advocates and arranges appropriate care with other qualified providers and community resources as needed." ASSOCIATION OF CLINICIANS FOR THE UNDERSERVED, https://clinicians.org/programs/programs-resource-archive/patient-centered-medical-home/ (last visited March 20, 2023); Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 3201(b)(2)(B)(i).

Ashley Gholston Fowler: Dakasha?

Dakasha Winton: Yeah, I'll jump in there. I think one of the initial issues is just the trust that's required to share the data. What the last panelists talked about how important it is for data sharing in order for us to work through the process, and as a health plan we obviously have a lot of data, and so it's really taking advantage of the opportunity for health plans and physicians and hospitals, everybody to work together. I think that's what we are seeing and trying to figure out a way to make things consistent, so that you can actually do the measurements and also recognizing that everyone, they are subjected to different things so it's kind of hard to create a completely objective approach and also try to deal with people on an objective basis in regards to their health care.

Beth Swenson DeWeese: And I'll jump in here sort of with the TennCare perspective, which of course one of the challenges I think we face is a lot of the incentives that exist in the private sector for both providers to sort of be voluntary programs to opt in, a lot of those and especially with our member base we don't have the ability to say, oh let's just wave copays, for example, if you opt into our centers of excellence program for example. That's a challenge that we have to, that's kind of unique to TennCare, that we have to incentivize providers and we also have to incentivize our members to engage in a value-based payment program and to really make it successful and we don't have necessarily the same levers that the public sector would have or the private sector. And I also think a lot of the work that TennCare does to innovate in the payment reform sphere is, it's interesting because we go beyond just having purely voluntary programs but that also, when you introduce downside risk or when you introduce programs that are maybe not as voluntary, then I think you have to really work extra hard to get the providers to buy into the program. I think it's extra challenging to really get everybody sort of aligned and wanting to work with the incentives and the program and I think that's a unique challenge that that we face, and I think it's also something that programs, I think that's the, I do think a little bit to your first question, I mean I do think that there's a trend towards having more downside risk and introduced into payment reform models, but I think that also comes a lot of challenges as well.

Mark Ison: If I could take my physician hat off for a moment and talk from more of a policy perspective, I think you asked what might be wrong with current payment models, and when you say current a lot of payments now are being delivered in a value-based way, but if we're thinking back five years or ten years a lot of what is wrong

with the system now is frankly you get what you pay for. If what you're paying for is fee for service care, if you're paying for procedures, if you're paying for visits, if you're paying for drugs, if you're paying for surgeries that's what you're going to get. What you're not going to necessarily get is health. You're not going to get population health. You're not going to get so many of the other things that some of the other speakers have been talking about. We're paying for the wrong things in the more traditional models, and you know it's very difficult to combat that mentality: among patients, among physicians, among insurance companies' health systems. To move away from that and toward a more outcomes-based or value-based, or quality-based whatever you want to call it something other than just stamping widgets and getting paid by the widget. Taking two steps back that is sort of, how, what I thought of when I heard your question initially.

Ashley Gholston Fowler: Okay, are there any efficiency problems that might be associated with changing current payment models?

Mark Ison: Well from the provider side, if everything is set up to do a more fee for service model, any movement to new payment initiatives is going to require new training, new staff, maybe new computer systems. We've already seen this with [electronic medical records ("EMR")], interoperability, and certification. Twenty years ago, there were really no EMRs, and then there were some EMRs, and they didn't have the right types of functionality. Some were nothing more than pdf and medical records.

Now we've moved all the way through to where we have rules now on interoperability and information blocking and all of that which are moving us toward a more functional standard of efficiency, but it's been a long road to get there, and I think practices from the provider side spend a lot of money at each step of the way. A lot of times, I think a lot of providers would say learning new tricks, implementing new infrastructure, dealing with the amount of data that has to be collected to make these types of payment models work.

Ashley Gholston Fowler: A follow up to that are there any structures input to help providers afford some of these new healthcare technologies or whatever else needed to keep up these new models?

Dakasha Winton: I think I'll chime in here, and I'll echo Mark's point from the last question because one of the things that we see is there are lots of restrictions around what data that you can share and

how you actually share that data. Not only do you have health plans seeking data; you also have other third party vendors seeking data as well, to how do we report that out to physician groups, how do they receive that data, and we tend to have some compliance issues, and then there's some increased risks there's anytime you talk to anyone in IT they're going to say it's not a matter of if your system has a breach, it's a matter of when. Trying to protect that data and ensuring that you are sharing it in a way that is appropriate that absolutely creates some barriers in how we administer these types of programs.

Beth Swenson DeWeese: I'll jump in again with a little bit of a different perspective because I'm on the government side. We're very aware of whenever we are developing a new payment reform, an initiative, or a payment model, we have to think about the additional administrative burden on providers, and we strive to work very hard on avoiding adding any new barriers, or any new systems, or requiring a new technology because that is a very real challenge.

We are certainly sensitive to the fact that providers have a lot thrown at them in terms of these administrative burdens. So, specifically with the episodes of care program, we deliver our, or our managed care organizations, deliver performance reports to providers. It's just in a pdf, you know, there's no additional platform or system or EMR that's required to read it. Our reports, we really designed them for episodes of care to pull in a lot of data sources or claims that individual providers in their own practice aren't going to have access to see, and it helps give a lot of insight that on the provider level, you wouldn't be able to get those claims of information pulled together and track multiple patients all in the same report, but we try to do that. Because as the government and, again with our managed care organizations, we're uniquely positioned to offer that sort of 30,000-foot view without the administrative burdens, without introducing a new technology. There's not a new platform, and I think that's where you know TennCare really adds a lot of value in the space because we do have that position to be able to do that, whereas an individual health care system, hospital system, or a large provider, that would just be a huge burden on them to develop that on their own.

Ashley Gholston Fowler: Shifting gears a little bit, how have you all seen that COVID-19 has impacted this space? Has it created any additional hurdles, has it proved to be a catalyst to get more people to change to payment models, what have you seen?

Dakasha Winton: I think you know a lot of the provider systems were...I think there are lots of things that they were doing to try to implement and address the issues that came about, but I don't know if the resources were available to extend for developing new payment models other than there's been a lot of discussion about telehealth and providing telemedicine, which was absolutely invaluable, but you had a lot of the smaller providers that actually didn't have the resources available to do that.

So, in terms of development of payment models I certainly believe that the providers who had payment models already in place where they were able to provide real quality care from the outset, they fared better than those entities that did not have payment models in place, pre and post COVID, well not quite post because we're still in it, but it's definitely one of those situations where those who could really focus on the quality of care were providing versus the dollar or the number, they were able to really enhance the services that they were providing because they had the discipline to do that already.

Mark Ison: I think a lot of the practices I worked with, I haven't worked with I mean, they've been in survival mode, not so much more recently, but certainly in the beginning, and it has taken a lot of them, I think of it as kind of a hierarchy of needs, and if your hierarchy of needs is number one you've got to have enough money coming in the door to keep your employees, to keep the lights on, to keep, and then you've got to keep your patients safe, your employees safe you're worrying about all those sorts of things. There was no money. There was no bandwidth to do new thing, and I agree with Dakasha to the extent that there was a practice that was already well set up to do things. I mean yes, telehealth fine, great some people have used that better than others, but advanced payment models, alternative payment models are a lot more than just telehealth, and telehealth may be a piece of that, but it's not even a necessary piece of a lot of it. I think COVID has been a completely different focus for a lot of providers that has probably retarded their ability in a large degree to think about engaging in some of these additional payment models. They just haven't had the bandwidth for it.

Ashley Gholston Fowler: Okay, so, if you could provide one piece of advice to an organization working with a new payment model what would it be?

Beth Swenson DeWeese: I'll start this one off, just because we love our providers, and we love our providers more specifically when they really engage with us. A lot of TennCare's programs, I'm

thinking especially episodes of care, we see the best outcomes for providers and for ultimately for patients and for our members when the providers really engage with the program. They talk, they answer the call when their MCO rep calls, they talk to the state when they have feedback.

I think a lot of these programs, these payment models seem theoretical when you read them on paper, when they're maybe first presented to you, but the rubber meets the road when you talk to the people that are helping to implement, when you're really engaging, you're providing feedback it's a dialogue. We do many things to foster provider and stakeholder feedback, and we put a lot of effort into incorporating changes into the program based on that feedback. It certainly takes effort. These payment models don't just happen; they don't just fall out at a tree and conk you on the head, and say "okay, well we've now reformed your payment, and you're good to go call it a day." It very much takes teamwork, and our [managed care organization ("MCO")] partners especially blue cross blue shield, we love working with you, and I think you do a lot of work. All three of our MCOs do a lot of work in the provider engagement area. I think that is something that is an area of focus, an area of a lot of resources and putting intentionality into engaging providers is very important on our side of the.

Then, to your point to your question about advice for the provider: engage back with us. We reach out to you, please reach back out to us and answer the call and have the meeting because I think that really gets the best results in the payment model. Ultimately, that improves quality for the patient and that improves outcomes, and I think that's my one piece of advice.

Dakasha Winton: Yeah, and from the payer perspective, I'd echo that with multiple claps if I had multiple hands to do that. The key is just really developing those trusting relationships between the payors and the providers and then ensuring that the providers are included in the design process. It's so important for us to hear back from the providers. We created back, I think, in 2014 a physician advisory council so that we could talk through new payment models, and we continue to have that conversation. I think the best piece of advice that I would give is just collaboration: collaboration and share your insight because ultimately as a payor we're not the ones that are in the room with the patients, the provider is. So, having their insight and their perspective that's the most critical thing that we can get when we're establishing these processes.

Mark Ison: Did you want me to comment? Thank you both for that because as someone who works with providers that's actually very helpful. I was going to suggest something like that, which is to say, don't wait until the last minute and think you're going to wing it. Reach out to the payor. Reach out to the to the people in charge. Find out what the goals are and work toward those goals. Don't fight the system. Work within it to meet the goals.

I have so many providers that come to me and say a payment model is not working, and they're not working toward the same goal. They're not trying to, for whatever reason. They they've got their back up, and they want to fight against it. They want to complain about it instead of saying, "okay, look, this is a fact, we've got to retool the way we're thinking about treating these patients, or this condition, or whatever to work toward this." They may or may not be successful, but you know it has to start there. So, thank you both for that. I thought that was good advice.

Ashley Gholston Fowler: I think you all have touched on incentivizing positions. Have you seen a change in mentality among providers now that they are provided with incentive payments for the quality care that they're providing?

Beth Swenson DeWeese: I'll jump in here, to build off the comments on the last question. There's always a little bit of a growing pain when you roll out a new program, and I don't care how great the program is, I don't care how great the physicians or how willing they are, change is hard and that's huge. I think that's a human universal, and people don't like having to adapt to change. After you get over the initial newness of it, of new payment models in general and value-based payment is now; it's the newness is off of the concept. There are still new programs, right? There's always something innovative, but as a concept, we've all been living with it for a while, and it's no longer a foreign territory. It's something that because it is well on the road to being most people by and large, I'm talking broad strokes here, by and large most providers see that this is the way of the future. This is not going anywhere. This is not a niche novelty that hey we're trying it, and maybe in 10 years it won't be here. It's here to stay, and there's been a change in providers that have sort of come to sort of accept that and once you get over that initial, oh it's different it's new, there's a lot of value and benefit.

I appreciate Dakasha's comments about data sharing earlier in the panel. I think that's very true; people are initially scared of data sometimes. What are you going to find when you start looking

at my data? What are you going to do with my data once you get it? But I think again these payment models, certainly the designs change, and there's always something new. It's no longer new enough that people… it's we're getting to where they're accepting it, and now we're talking about accepting nuances, and we're getting down into details, and it's not something that is a fad. It's here to stay and generally providers I've seen, they accept it even with episodes of care. We are a mature program now.

We have been around since 2015. So, at this point everyone's involved, nobody's in the first year of being in episodes of care at least for TennCare. So, we find that there's a lot more just acceptance even if you don't have feedback and even if you don't like a certain element, you kind of reckon we're here to stay. We've had proven success. We've had positive results. So, we're not just going to dissolve tomorrow because a few people don't like it, and I think that's really helped acceptance. I think you know my last comment about working with us really helped a lot of folks to say, well if we can't beat them join them, and there's been this slow evolution. We're just going to work with the system because the system is here to stay, whatever that may be: episodes of care, whatever payment model you're talking about

Dakasha Winton: I think certainly we've had the exact same experience, and maybe with the larger practices and hospitals, many of them have organized themselves to be successful in the value-based reimbursement environment. So, they're actively seeking opportunities to engage in new reimbursement models. It's no longer what is this going to look like; it's how can we show you that we can add value, and this is the ways that we can provide this model. So, we've been super encouraged by the adoption of models by our health care providers and partners in the providing of care for Tennesseans.

Ashley Gholston Fowler: Dakasha, I know earlier you spoke a little bit about compliance issues that arise if we could elaborate and discuss what are some other compliance issues that may come about with these new payments?

Dakasha Winton: Like I mentioned, when you have a data breach, that's a significant issue if you've experienced it, and we've gone through that. Back in 2009 it was not a pleasant experience and so hopefully, we won't have another one for quite some time. I'm going to probably knock on wood because somebody will call me next in the next 10 minutes like, "oh my god! what have you done," but I think certainly in terms of when we think about the regulatory

process and how government is engaging in a lot of the health care issues unfortunately, health care is probably and education are two of the most politicized issues that you could possibly think of. So whenever you have the government engaging and you have lawmakers and policy makers saying, "oh, well I think we need to do this [or] we need to adjust that," that's the one of the compliance areas wherein there's constant change. We had a pretty significant change within 2020 with the adoption of the consolidated appropriations act, and with all of that: How do we deliver information to individuals? How much information does a hospital have to provide? How much does an insurer have to provide? So, those challenges of keeping up with all of the changes and laws and regulations is probably my big compliance area that I've mentioned

Beth Swenson DeWeese: I know with my work at TennCare, one of the things that's kind of interesting, and I think is really fun is we touch on some anti-trust laws just because we are 100% managed care which means TennCare has three managed care organizations that sort of administer the bulk of our programs and so a lot of my work is actually with each MCO, each managed care organization and working with them, and we have to make sure for developing a new, especially if it's a pilot, program. So, [if] we're trying to develop a new payment model, antitrust is something that we have to keep in the forefront of our minds, and also, a little bit related one of the things I like about the government practice side of things is working with other organizations, but I'm not always working with the lawyers of those organizations, and this is a practice tip I have for government lawyers: always keep in mind who your client is. For me, my client is TennCare. So, I'm going to pick on Blue Cross just because you're on the call, but I was recently working on a project for piloting a new program, a new payment reform program, and I was reviewing documents that we received from the MCOs. Some of those ideas they were great, and I was like, "wow, this is really cool! But wait a minute, I don't think the business folks talk to the lawyers right." I could tell they talked to the clinical folks; I could tell they talked to the provider contracting; I mean these are some great ideas, but…

Dakasha Winton: they probably try to avoid it honestly…

Beth Swenson DeWesee: and yeah, I can understand the struggle, but again going back to my point you know Blue Care, for example, I'm reading their document, Blue Care is not my client so I can't say, "oh you need to look at this statute, or have you checked out this sub paragraph 2b on your proposal to look at?" No, I just have to say, "that's really interesting and creative. Have you talked to

legal? Have you conferred with your attorneys because I think you might want to," and you have to be careful because I can't provide them legal advice, and I don't want to say anything that could be misconstrued as legal advice.

But Blue Cross and all of our MCOs are very large organizations. Even the most integrated organization, you're still going to have a certain degree of silos, and you've just got to really make sure that the clinical folks, the business folks, the contracting folks aren't coming at this from a way that's not compliant with the laws. The Anti-kickback Statute[14] is a complex law and that kicks in places that a lot of business folks just don't see or they don't anticipate. Again, I can't say that's going to violate the anti-kickback statute, I just have to flag it for them in a way that they can then take it back and just making sure that when we get a new idea everything's, everyone's talked to everybody. I find that sometimes those are the more fun calls that I have with the MCOs and just always keep in mind who's your client and keep that forefront as you're interacting with your counterparts and other organizations.

Mark Ison: Yeah, and I will say I would agree with that that the fraud and abuse side of this, I mean with these models a lot of times there's here's a pot of money to be distributed, shared in some way. In many cases between hospitals and physicians or you know some other group of people who refer to another group of people, and it it's amazing to me, and thankfully now with the recent changes to the anti-kickback statute and the Stark Law, the exceptions, safe harbors for value-based payment, value-based arrangements are helpful. I think practitioners are getting used to those and what's going to be the scope of those exceptions. I think they're intended to be very broad, but we'll see, but before, with each time one of these programs would come out it had to have its own regulatory sub guidance, its own waivers, its own how does this comply with the Stark Law, the Anti-kickback statute?

War story really quick. I was working with a small surgical practice. He was contracting with a, not a rural hospital but it certainly wasn't an urban hospital, smaller hospital to do one of these CMS bundles and the hospital's attorney was not really a fraud and abuse attorney. The practice had asked me to look at it. They were headed into a really bad place. They were going to end up on paper, at least, violating any number of fraud and abuse laws based on the way they were going to do it. You had to prepare these incredibly intricate documents. There were restrictions on how the money could be distributed even once it got into the physician

[14] AntiKickback Statute (Anti-Kickback Statute), 42 U.S.C. § 1320a-7b (1994).

practice, and so those types of things are a little scary. They were forced into this. They didn't necessarily want to do it. I think it worked out pretty well for them eventually to the point of our other panelists here, but at first they could have been forced into fraud and abuse violation that they really didn't choose for themselves, and so I think as these programs become more and more prevalent it's just going to be more and more important to make sure that the rest of the law is keeping up with them so that they're not having to call and pay someone thousands of dollars to nitpick inter-party documents in an arrangement like this because "oh my goodness we didn't have this safeguard on the way the money would flow, now we violated the Stark Law[15] or something else," and so you know that to me is also happening a little bit where you have these entrepreneurs frankly who are coming up with new payment models. Then they're going to someone like TennCare. They're doing this a lot at the state level and saying pay me to manage this condition this disease state through this program.

Sometimes they come to us to help them structure those programs, and we're looking at the laws in that state or even federal laws and saying well, yes, I see what you're doing and the intent is pure as the driven snow, but actually technically you're violating this handful of things here, and you can take the Uber approach and move into a market and just do it and hope that the law catches up. And you can fight your way out with litigation but not everybody's Uber and this is healthcare and the penalties can be very severe. So, it's, there is a tension between innovation and, in particular, fraud and abuse and reimbursement. Reimbursement would be the other piece of this how are they actually going to get paid to do this. So, I would say that that's the number one concern and struggle I see with these as they roll new ones out constantly.

Ashley Gholston Fowler: So, we talked a little bit about the provider perspective and payor perspective, but as far as long-term goals go, what are the benefits and detriments to patient care that you may have seen as we shift to these new models?

Dakasha Winton: Well, I'll start here. In terms of benefits, I think you have a greater emphasis on outcomes and quality, you're better able to differentiate between providers in terms of how they provide quality and outcomes and patient practice patterns et cetera, relative to their peers. Financially, for providers, it makes a pretty big difference too. Detriments, I would say outside of the control of everybody here but, care, the cost of care is still continuing to increase in price too quickly year over year relative to income

[15] Stark Act, 42 U.S.C. § 1395nn (1989).

growth and inflation. The other detriment that I would say it is much harder to be a provider today: clinicians that have been practicing before and during this change they've had much higher professional frustration and then the burnout rates have been much higher because they've had to deal with not only the new payment models and trying to keep up with all of those things but they're also dealing with you know different type of commercial segments. So, they've historically dealt with Medicaid and Medicare. Now you have the health insurance marketplaces and what does that reimbursement look like? And so you're adding multiple things and just expected to be much smarter about a lot of things. Trying to juggle all of that is it's just complex and so I think that that's what I would say would be the detriments from the perspective that we see.

Beth Swenson DeWeese: I'll say from the 10,000-foot perspective for the state side of things TennCare is roughly about a third of Tennessee's budget. The state budget, right, we're huge, and Dakasha is absolutely right, the cost of health care is just rising and rising very quickly. If we are not able to be financially sound and well managed, and if we can't do our best at addressing those rising costs of health care then we're taking money out of the pot for other Tennessee agencies, and we're taking that money from department of ed, I mean the list goes on. We are such a huge part of our budget there's just no option to fail at this. I think it's just vital for the state, and when you think about what levers can TennCare as an agency, what can we pull, what can we do to sort of manage those costs and sort of cap the rising costs of health care, we really, you more or less have three options: we can, the lever we can pull, is the number of members that we cover, how many services we cover for those members, and what our providers get paid. I mean those are our three, again 10,000 feet, those are our core levers. Value-based payment and innovative payment models, that is critical to our ability to pull those levers and adjust…keep our costs and manage our program and incentivize our providers. And align incentives so that we can keep a dull roar on the chaos of rising health care costs

The downside if we don't do that, the margin of error is multiplied times a third of the budget. We're talking billions of dollars. So, if we don't get it right, it's a big mess, and I think that's important for us too. Value-based payment is a really big part of how we manage and how we address the rising costs when we look at especially episodes of care program, when we look at cost charts and year over year and you see the projection and then you see what episodes of care has done. We sort of bent the curve, and we've either maintained or we've lowered costs, we've increased or maintained quality that is essential to our mission and those payment

reforms have helped us optimize the money that we get and use and cover. That helps the state; that helps Tennesseans. So, I think that's how I approach it from the from the TennCare side is we just, we just can't fail. This is just too vital. We can't let the downside get us.

Mark Ison: From the provider side, I would say this is a little tricky because doctors realize like the rest of us, I mean they're taxpayers as well, that that health care costs are perhaps too high based on what we're getting for it or we're getting the wrong things for it. So, initiatives that are aimed at making health care more efficient, more effective at improving health, improving quality I think it's very hard to argue against. Those initiatives that simply tried to constrain a budget, as you might expect, are a little less popular with the people who are being reimbursed for healthcare and also initiatives that make it harder in terms of administrative costs, or other effort that has to go into treating a patient and also into reporting the metrics or whatever it has to be that make it harder to receive that reimbursement are also pretty unpopular.

I think a balance has to be struck. You asked for, okay what's a downside or a detriment: you cannot cut your way to more and more efficiency to lower and lower costs you can't keep moving the baseline. Eventually you're going to get to a point where it costs what it costs, and we're not really, the physician practice has to stay in business too. The surgery center has to stay in business too. I'm not trying to cry [wolf or] to [bad] mouth anybody here there are so many practices and providers who are very successful, but I think we have to be careful in in talking about quality and health and efficiency all of which I think most of us, all of us probably, can get behind, and just talking about whose pocket the money is going to go into, and for instance with [accountable care organizations ("ACOs")], with some of these models I've always looked at them and chuckled a little bit to myself. All these people piling in to do it it's like you realize you're just lowering your own reimbursement; you're lowering the baseline. It's getting harder and harder to make the same amount of money and a lot of people do see that, but it's so…maybe it's survival of the fittest, survival of the most efficient, survival of the smartest, but the truth is we need a lot more providers. We need especially doctors and providers in primary care in rural areas. We need innovative approaches to serving the needs of different communities. We just got to be careful that we're not taking away the money that's going to be needed to succeed in in doing that.

Ashley Gholston Fowler: Okay thanks, and as we wind down, I think this may be my last question for you all but something that [we heard] earlier about these models or have been around for a while and they're here to stay so what does this look like what do you think the reimbursement scheme will look like 10 years from now? How quickly or slowly might we actually rethink payment models?

Mark Ison: I mean as one of you said, it's here to stay right? This isn't new. It's not going away. I think at some point, maybe it already is, but I think it's a lagging indicator medical education is going to have to take this into account. How do we treat patients? How do we address the health of a patient population? And that's going to have to start way before somebody actually gets into delivering health care services. It's going to be part of training and just the philosophy of health care, and I think we're headed that direction. Where is it in 10 years? I would hope, you know it's difficult when you talk about outcomes based payments or value based payments quality, every patient is an individual and every patient brings a unique set of complications, and they don't fall necessarily into buckets all the time, and maybe AI computer technology, maybe there's hope there, I'm not someone who you know believes that we're all going to end up plugged into the meta matrix, but perhaps there will be innovations in technology that allow us to better measure baselines and improvements in ways that that more closely track the actual results that we're getting so that we can reward quality, we can reward outcomes, and at the same time doing that in a way that's taking into account the individuality of each patient. I'm hopeful that we'll get there.

Teachers always say, "how can you grade us on the performance of our students? We can't correct everything that's wrong in their lives. Every student is individual. They have other issues that may not have anything to do with our teaching, that may cause them to succeed or not succeed in school." Patients are the same way. So we we've got to figure that out if we're going to pay for outcomes in health.

Beth Swenson DeWeese: Mark's comment on every patient is individual, and I think that is something that if I had to like read the tea leaves [as to] where this is going I think getting patients involved more in the payment I think that's something that is a trend I don't want to put a five or ten year tag on it. A lot, at least on the TennCare side, a lot of our payment models, they're for the provider. So, if you're a TennCare member, you have no idea you just had an episode of care or you're not maybe aware that you are in a patient-centered medical home. You might have some understanding of the

provider type but you're not necessarily feeling that you're in a new you know innovative payment model.

I think that there's been recent regulation on patient engagement incentives that came out I believe[16] last year; the rule was finally finalized and I think that that really is a signal that there's support even at the CMS level to for these plans, these payment models to really get the patient involved and get the patient to have some, you know, I hesitate to say, skin in the game because it feels a little bit, I don't know, vulgar to say, but to get the patient incentivized. A lot of payment models talk about aligning incentives that's something we talk about at least at TennCare quite a bit, like let's get all the incentives aligned so that everyone's working towards the same goal. I see in the future, I see getting patients and getting our members also one of those incentives that's aligned that's something that's a growing trend and just getting them involved, getting them motivated. I said there's some signals from CMS that they're supportive of that. That's sort of my guess, my prediction on where this is going.

Dakasha Winton: I'll just echo their comments. I think Beth and Mark both aligned exactly what it's going to have to be. There's going, right now you have the collaboration between the health plans and the providers, but you absolutely have to have the patients become more actively involved in the care that they receive and also being accountable for that care that they receive. So, if they miss an appointment and what does that look like and how do those things occur and certainly technology is going to help those things. I think that as we continue to evolve and the data that we continue to climb through artificial intelligence all the things it is going to continue to have a significant impact on how we deliver that care. In my mind, I for one would think after being in healthcare for almost 20 years now it's just kind of like has it really changed that much? It's changed some, but in my mind it's going to happen much quicker than maybe it will happen in real life, but we'll see.

Ashley Gholston Fowler: Okay well thank you all. I think we're about out of time. So, I'll turn it back over to Lauren.

Lauren Caverly-Pratt: Thanks Ashley and thank you so much Dakasha, Mark, Beth, and also you Ashley. We thought that was really another really fascinating discussion, and I wish we could

[16] State of Tennessee: The Budget fiscal year 2021-2022, TN.GOV (2021), https://www.tn.gov/content/dam/tn/finance/budget/documents/2022BudgetDocumentVol1.pdf (last visited Mar 15, 2022).

listen to all of you talk a little bit more, but unfortunately, we can't just keep everybody here all day. We really appreciate you taking the time out of your day to chat with us and be here with us at our symposium. So, thank you all.

This concludes our scheduled programming for the day.

Thank you again everyone for attending and thank you especially to all of our speakers and panelists. It was so great to have you here with us today, lots of very fascinating discussions, and I'm going to hand it over briefly to Dean Deborah Farringer, our faculty advisor for a couple of her closing remarks.

Dean Deborah Farringer: I just wanted to thank everyone for coming. Thank you to all our attendees today, we're really grateful for your support and your involvement in the [*Belmont*] *Health Law Journal*, and we hope you can continue to join us for other events and hopefully the next ones will be in person, we can bring you back to school. So, we're hoping for that for the coming year. I also wanted to thank our speakers and panelists today for taking time and being willing to just serve as experts and help provide information to all of our attendees. I certainly learned a lot, and I think it was a good, really broad base of all of the various issues that that create sustainability in our healthcare system and all the various things that we need to think about. Lastly, I really just wanted to thank our journal members; they have worked really, really hard and tirelessly. There's their picture there in front of the law school. It takes a lot of effort to coordinate an event like this, even a virtual event, and I just wanted to thank them. I especially want to thank our Symposium Director who is labeled here as Belmont College of Law Grace Benitone, who I know has worked so, so hard over the last year doing both this fall panel and the Spring Symposium. She's doing an excellent job as our event planner and has just done an amazing work this year. And, I also just wanted to thank Lauren Pratt, our Editor-in-Chief. We could not do this without her. She keeps us all on our toes and going and keeps the train moving. I'm really excited about improvements and ways that she's improved the journal this year and we can just expect better things to come. So, thank you everyone for coming. We're so appreciative of your support and we hope we will see all of you soon.

WHY A SUSTAINABLE PUBLIC HEALTH SYSTEM NEEDS COMMUNITY-BASED INTEGRATED HEALTH TEAMS

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I. INTRODUCTION

At the outset of the COVID-19 pandemic, expressions of solidarity by politicians, celebrities, and Facebook posters were seemingly everywhere, encapsulated in the catchphrase "We're all in this together." But while all of us have been affected by COVID-19, its impact has been anything but equal. In particular, existing inequities in income, employment, safe housing, transportation, and, most crucially, in health care have contributed to socioeconomically disadvantaged groups experiencing higher rates of COVID-19 infections, hospitalizations, and death.
[1] Given the link between these pre-existing inequities and COVID-19 health disparities, the pandemic has revealed the necessity of building a more sustainable public health system that better meets the needs of economically and socially marginalized populations. This Article describes one approach for doing so ─ leveraging the skills and resources of community-based integrated health teams (CIHTs) to support public health emergency responses that coordinate medical, behavioral health, and social services.

CIHTs are multi-disciplinary teams that help provide or coordinate medical, behavioral health, and social services for socioeconomically disadvantaged individuals with complex healthcare needs.[2] In recognition that these patients often have

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[1] *See Health Equity Considerations and Racial and Ethnic Minority Groups*, CTRS. FOR DISEASE CONTROL & PREVENTION ("CDC") (Feb. 12, 2021), https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html (summarizing the evidence that some racial and ethnic minority groups are being disproportionately affected by COVID-19 and listing contributing factors); Vida Abedi *et al.*, *Racial, Economic, and Health Inequality and COVID-19 Infection in the United States*, J. RACIAL & ETHNIC HEALTH DISPARITIES (epub ahead of print) (epub at 1), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7462354/ (finding counties with higher poverty experiencing higher COVID-19 death rates); Rebekah L. Rollston & Sandro Galea, *The Coronavirus Does Discriminate: How Social Conditions are Shaping the COVID-19 Pandemic*, CTR. FOR PRIMARY CARE: HARV. MED. SCH. (May 5, 2020), http://info.primarycare.hms.harvard.edu/blog/social-conditions-shapecovid (discussing socioeconomic conditions that influence the risk of contracting COVID19). *See generally* ORG. FOR ECON. CO-OPERATION & DEV., OECD POLICY RESPONSES TO CORONAVIRUS (COVID-19), COVID-19: PROTECTING PEOPLE AND SOCIETIES 1–34 (2020), https://read.oecd-ilibrary.org/view/?ref=126_126985-nv145m3l96&title=COVID-19- Protecting-people-and-societies (describing generally the challenges facing vulnerable populations living in OECD nations).

[2] Jessica Mantel, *Leveraging Community-Based Integrated Health Teams to Meet the Needs of Vulnerable Populations in Times of Crisis*, 30 ANNALS OF HEALTH L. & LIFE SCI. 133, 134 (2021). *See also* Mary Takach & Jason Buxbaum, CARE MANAGEMENT FOR MEDICAID ENROLLEES THROUGH COMMUNITY HEALTH TEAMS 7, 11 (The Commonwealth Fund, 2013), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publicati

chronic health conditions that are further complicated by social, financial, and behavioral health needs, CIHTs take a holistic view of an individuals' health and address the full continuum of patient's health-related needs. Specifically, they offer these patients intensive case management services and coordinate care across the health care, public health, and social services sectors.[3] While the composition of each CIHT's team varies, they may include physicians, nurses, nurse practitioners, behavioral health specialists, community health workers (CHWs),[4] and social workers.[5]

One of us (Prof. Mantel) previously conducted a literature review of published articles and blog postings discussing how CIHTs can repurpose their resources to help communities meet the health needs of economically and socially marginalized populations during a public health emergency. This research found that CIHTs are well-positioned to quickly and effectively respond to the challenges that disadvantaged groups face during a public health crisis, both on an individual level and community level. As summarized in a previously published article reporting the findings of this research, during a public health crisis, CIHTs can conduct outreach to high-risk individuals and educate them about their health risks, provide individuals with material resources and emotional support, and connect them to health care providers and available community resources.[6] CIHTs also can support system-level interventions designed to meet a community's needs during a public

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ons_fund_report_2013_may_1690_takach_care_mgmt_medicaid_enrollees_co mmunity_hlt _teams_520.pdf (describing the activities of community health teams); CTR. FOR HEALTH CARE STRATEGIES & ST. HEALTH ACCESS DATA ASSISTANCE CTR., COMMUNITY CARE TEAMS: AN OVERVIEW OF STATE APPROACHES 2 (2016), https://www.chcs.org/ resource/community-care-teams-overview-state-approaches/.

[3] Takach & Buxbaum, *supra* note 2, at 11 (describing the activities of community health teams); CTR. FOR HEALTH CARE STRATEGIES & ST. HEALTH ACCESS DATA ASSISTANCE CTR., *supra* note 2, at 2.

[4] The literature has not yet settled on a consistent definition of the term "community health worker," but this Article uses the terms as follows: "[a] community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." *Community Health Workers*, AM. PUB. HEALTH ASS'N, https://www.apha.org/apha-communities/member-sections/community-health-workers (last visited Apr. 24, 2021).

[5] Takach & Buxbaum, *supra* note 2, at 7; CTR. FOR HEALTH CARE STRATEGIES & ST. HEALTH ACCESS DATA ASSISTANCE CTR., *supra* note 2, at 2; Glenn Landers *et al.*, *Finding Innovation and Resilience During the COVID-19 Pandemic: Cross-Sector Alignment and the Response to COVID-19*, GA. ST. UNIV.: GA. HEALTH POL'Y CTR. (Aug. 7, 2020), https://ghpc.gsu.edu/2020/08/07/cross sector-alignment-and-the-response-to-covid-19/.

[6] Mantel, *supra* note 2 , at 136-44.

health emergency, such as public health education campaigns and coordinated, cross-sector initiatives.[7]

This Article builds upon this prior research by describing specific examples of how CIHTs have supported their community's COVID-19 public health response that were shared with the authors during qualitative interviews with CIHTs. To determine whether and how CIHTs support local public health emergency response efforts, we interviewed team members from different CIHTs about their COVID-related efforts. Although the responses during the interviews did not confirm every type of COVID-related activity by CIHTs described in the literature, the CIHTs participating in our study have supported COVID-19 response efforts in a variety of ways. Specifically, the CIHTs we interviewed provided assistance to high-risk individuals and supported system-level interventions.

This Article proceeds in three parts. Part I describes the research study we conducted, including who we interviewed, descriptions of the types of CIHTs we included, and the topics about which we inquired. Part II describes how CIHTs can provide assistance to individual patients during a public health crisis. Part III is the system-level counterpart of Part II and describes how CIHTs can leverage their capabilities to support public health interventions targeting specific populations. Part IV concludes by confirming that CIHTs can quickly and effectively respond to the complex challenges facing disadvantaged populations during a public health crisis, and that allocating public health funds in support of CIHTs would support a more sustainable and effective U.S. public health system.

II. THE RESEARCH STUDY

Between the spring and fall of 2021, we conducted virtual interviews with twenty-nine professionals who were members of CIHTs.[8] These professionals included physicians, registered nurses, nurse practitioners, a pharmacist, behavioral health specialists, social workers, CHWs, housing coordinators, and program administrators. Interviewees represented a diverse group of CIHTs from multiple regions of the United States. The CIHTs operated in large cities as well as in rural communities, and primarily served populations that are economically and socially marginalized. Some CIHTs focused on seniors, others focused primarily on the homeless, and some others focused on low-income or uninsured individuals. Some CIHTs had flexibility in choosing their target populations while others were limited to specific populations. Most,

[7] *Id.* at 144-50.

[8] This research was done with approval from the University of Houston Institutional Review Board.

however, targeted patients who frequent emergency departments or inpatient facilities and/or suffer from multiple chronic conditions.

Given the wide range of CIHTs included in the study, there were several differences among them. Some CIHTs were embedded in primary care practices, hospitals, health care systems, or local public health departments. Meanwhile, others were unaffiliated with a health care provider or public health department and were operated by independent community-based organizations. CIHTs also varied in how they financed their operations. Many CIHTs relied in whole or in part on grant funding, and some CIHTs received funding from the state. Provider-based CIHTs often were financed in whole or in part by their organization's general operating budget, while some CIHTs operated by community-based organizations had contracts with local hospitals or health care systems. Some CIHTs also had contracts with managed care organizations.

Regardless of these differences, all CIHTs conducted some type of social determinant of health screening and helped enroll patients in public assistance programs, connected patients with community resources, or assisted patients with their unmet social needs in other ways. All CIHTs also provided care coordination, helped patients navigate the health care system, and coached patients on healthy behaviors. Most importantly, all of the CIHTs in the study assisted with local COVID-19 responses in some capacity.

Our interviews explored multiple aspects of CIHTs' COVID-related activities. During the interviews, we asked interviewees how COVID-19 affected the populations served by their CIHT. We also asked interviewees how their respective CIHTs modified their operations in response to COVID-19. In addition, we asked interviewees what services their CIHTs provided to their individual patients to help combat the effects of COVID-19, and whether their CIHT participated in system-level interventions to address the pandemic's effects.

Because CIHTs were, and still are, occupied with COVID-19 response efforts, our sample size was small. Thus, the CIHTs we interviewed may not be representative of the full range of CIHTs currently operating in the United States. Despite this limitation, our study offers useful insights into how CIHTs can repurpose their expertise and resources to support public health efforts to meet the needs of economically and socially marginalized populations during a public health emergency.

III. ASSISTING VULNERABLE INDIVIDUALS

Prior to the pandemic, financial, social, and environmental inequities put disadvantaged groups at greater risk of poor health.[9] COVID-19 has compounded these health disparities.[10]

During the pandemic, many members of economically and socially disadvantaged populations could not effectively self-isolate given their lack of resources, their living in crowded households, or their working in settings with greater risk of exposure.[11] In addition, these populations experienced higher rates of job loss and decreased income, which put them at greater risk for food insecurity, loss of employer-sponsored health insurance, unfulfilled prescriptions, and delays in seeking medical care.[12] The pandemic's mental health burden also has been greater for economically and socially marginalized groups relative to the general population.[13] Moreover,

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[9] *See generally* Sravani Singu *et al*., *Impact of Social Determinants of Health on the Emerging COVID-19 Pandemic in the United States*, 8 FRONTIERS PUB. HEALTH 1, 2–3 (2020) (explaining how the social determinants of health adversely impact the health of disadvantaged populations).

[10] *See id.* at 6–7; Leo Lopez III *et al*., *Racial and Ethnic Health Disparities Related to COVID-19*, 325 JAMA 719, 719 (2021) ("Disparities in socioeconomic conditions across racial lines have been exacerbated during the COVID-19 pandemic.").

[11] *See* sources cited *supra* note 1. Vulnerable populations may have difficulty self-isolating or self-quarantining because they often lack basic resources such as food, household products, and health supplies, or may require support services such as childcare and food delivery. *See COVID-19: Support Services*, CDC (June 1, 2020), https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/support-services.html.

[12] *See* Sameed Ahmed M. Khatana & Peter W. Groeneveld, *Health Disparities and the Coronavirus Disease (COVID-19) Pandemic in the USA*, 35 J. GEN. INTERNAL MED. 2431, 2431–32 (2020) (stating that COVID-19-related job losses will increase the number of uninsured due to the loss of employer-sponsored health insurance); Singu *et al*., *supra* note 9 (discussing how the adverse economic impact of COVID-19 has disproportionately affected minorities and lower-income groups and led to the loss of employer-sponsored health insurance, and how the loss of health insurance can lead to lower use of health care resources); FEEDING AM., THE IMPACT OF THE CORONAVIRUS ON FOOD INSECURITY IN 2020 2 (2020), https://www.feedingamerica.org/sites/default/files/2020-10/Brief_Local%20Impact_10.2020_0.pdf (discussing increases in food insecurity as a result of COVID-19); *see* Amy Kennedy, *COVID-19 Pandemic and Adherence to Therapy: What Can Pharmacists Do?*, PHARMACY TIMES (July 14, 2020), https://www.pharmacytimes.com/news/covid-19-pandemic-and-adherence-to-therapy-what-can-pharmacists-do (commenting that higher rates of unemployment and the loss of health insurance will reduce medication adherence).

[13] One possible explanation for the pandemic's disproportionate impact on mental health is that social distancing measures were more likely to reduce access to mental health services and informal mental support mechanisms for socioeconomically disadvantaged individuals relative to other individuals. In addition, pre-existing mental health conditions, which can increase COVID-19's mental health consequences, are more prevalent among socioeconomically

given the link between poor mental health and physical health,[14] this increased mental health burden among disadvantaged individuals may have contributed to greater declines in their physical health.

Because CIHTs understand the interplay between these social, financial, and health-related factors, they are well-positioned to mitigate their impact on disadvantaged populations during a public health crisis. Our interviews with CIHT professionals confirmed this assumption. Below we describe the ways the CIHTs in our study supported their patients during the COVID-19 pandemic.

A. CIHT's Data-Related Capabilities

Many CIHTs maintain databases with extensive information on the populations they serve. These databases incorporate data from multiple sources, including the patient's clinical records, demographic information, and social determinants of health data.[15] CIHTs also are skilled at analyzing this data to identify high-risk individuals or those most likely to benefit from a CIHT's services.[16]

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disadvantaged groups. Mental health providers' switch to telepsychotherapy and telepsychiatry also raised access barriers for disadvantaged individuals who lack the requisite technology, stable internet connections, or digital literacy. *See* F. Marijn Stok, *et al*., *Social Inequality and Solidarity in Times of COVID-19*, 18 INT'L J. OF ENVTL. RES. & PUB. HEALTH 6339, 6343 (2021),https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8296166/pdf/ijerph-18-06339.pdf.

[14] *See* Joseph Firth, *et al*., *The Lancet Psychiatry Commission: a blueprint for protecting physician health in people with mental illness*, 6 LANCET PSYCHIATRY 674, 675-681 (2019) (summarizing evidence showing physical health disparities for people with mental illness).

[15] *See* Rajiv Leventhal, *Medical Home Network Uses AI to Identify High-Risk COVID-19 Patients*, HEALTHCARE INNOVATION (Mar. 18, 2020), https://www.hcinnovationgroup.com/ covid-19/news/21130199/medical-home-network-uses-ai-to-identify-highrisk-covid19- patients (describing the data collected by Medical Home Network for its Medicaid patients); *see* Amanda L. Brewster *et al*., *Community Resilience for COVID-19 and Beyond: Leveraging A System for Health Care and Social Services Integration*, HEALTH AFFS. BLOG (Aug. 12, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200807.222833/full/ (stating that Contra Costa Health Services maintains a countywide data warehouse integrating Medicaid claims, electronic health records, homeless services data, and other records).

[16] *See, e.g*., C. Annette DuBard & Carlos T. Jackson, *Active Redesign of a Medicaid Care Management Strategy for Greater Return on Investment: Predicting Impracticability*, 2 POPULATION HEALTH MGMT. 102, 102–06 (2018) (describing how Community Care of North Carolina uses data analytics to develop an impracticability score predicting which Medicaid beneficiaries are more likely to benefit from participating in their program and generate savings for the Medicare program); CTR. FOR HEALTH CARE STRATEGIES & ST. HEALTH ACCESS DATA ASSISTANCE CTR., *supra* note 2, at 11 (describing how the Montana

During a public health emergency, CIHTs can repurpose their data and data analytics skills to identify those individuals at highest-risk for pandemic-related complications, patients at-risk for receiving inadequate clinical care, and patients likely to benefit from CIHTs' other public health emergency response activities.[17]

The CIHTs participating in our study confirmed that they collect and maintain data about their patient populations, and that pre-COVID-19, they used this data to identify high-risk individuals and those likely to benefit from a CIHT's services. For example, one interviewee stated that her CIHT has created a data-sharing platform that aggregates information from multiple organizations in the community, including local hospitals, and that her organization analyzes this data to identify vulnerable individuals:

> [Our platform] gets daily admit data transfer feeds from local hospitals…. We [analyze] the records and find folks who are in the local hospitals who…have this medical complexity and recent utilization and social vulnerability…It's hospitals, as well as primary care providers, also the local jail feeds into that [database]…. We use it to, as you said, identify people. [18]

Another interviewee explained that her CIHT obtains data from approximately 300 local agencies which the organization then "aggregate[s] it down to a patient level, to see what resources are being used, either by a particular patient or by a particular service agency."[19] The interviewee further stated that her CIHT uses this data to assess the community's needs and then address those needs as required by their contracting organization.[20] In addition to collecting data from providers and other organizations, CIHTs gather data from the patients themselves by inquiring into their physical and mental health needs and their financial and social

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Health Improvement Program uses predictive modeling software to identify the most at-risk Medicaid beneficiaries).

[17] *See generally* Mantel, *supra* note 2.

[18] Interview with program administrator (on file with authors).

[19] Interview with program administrator (on file with authors).

[20] Interview with program administrator ("Then we have different contracts. We have a contract right now with [county health organization]. They're working with substance use disorder, and we're helping them…identify what areas of [county] have the largest substance use disorder population within a geographical code.") (on file with authors).

circumstances.[21] Some CIHTs regularly conduct repeat patient assessments in order to track patients' progress over time.[22]

With the pandemic's onset, many CIHTs used their data to support their communities' public health response. As seen during the COVID-19 pandemic, some individuals are at greater risk of hospitalization or death given their prior health conditions and social and material circumstances.[23] An effective public health response must quickly identify these high-risk individuals and provide them with health education and preventive services.[24] CIHTs can aid these efforts by using their data to identify individuals who, during a pandemic, face an elevated risk of complications should they contract the disease.[25] For example, one CIHT in our study used its database to identify individuals at high-risk for COVID-19 complications and worked with those individuals to support their getting vaccinated.[26] More generally, some interviewees commented that *all* of the patients served by their CIHT are high-

[21] Multiple CIHTs we interviewed commented that they gave their patients a questionnaire to assess their social determinants of health. Some used a questionnaire they created themselves, while others used standard assessments from Centers for Medicare and Medicaid Services (CMS). Other CIHTs use less formal methods such as an unstructured conversations about self-sufficiency. Though CIHTs employed different methods for assessing patients' individual circumstances, the vast majority inquired into patients' access to transportation, their nutrition, their insurance status, and their mental health.

[22] Interview with licensed social worker (noting that her CIHT conducts an initial screening to create an initial care plan with the patient and then repeats the screening "mostly every couple of months" to update the care plan) (on file with authors); interview with program administrator (when asked about how often her CIHT conducted a repeat assessment of social determinants of health, stating stated "[w]e really formalize it every six months…but informally, I think it happens every single [visit with patient]") (on file with authors).

[23] *See* sources cited *supra* note 1. *See also* Donald J. Alcendor, *Racial Disparities-Associated COVID-19 Mortality Among Minority Populations in the U.S.*, 9 J. CLINICAL MED. 2442, 2445 (2020) (discussing the factors contributing to higher rates of COVID-19 mortality among racial minorities, including higher rates of clinical risk factors such as diabetes, hypertension, cardiovascular disease, smoking, and chronic obstructive pulmonary disease).

[24] Mantel, *supra* note 2, at 137; Madeleine Ballard *et al*., *Prioritizing the Role of Community Health Workers In the COVID-19 Response*, 5 BMJ GLOBAL HEALTH 1, 6 (2020) (explaining that community health workers can support effective outbreak control by identifying and educating at-risk populations in order to reduce their exposure to COVID-19).

[25] *See generally* Mantel, *supra* note 2, at 137-38.

[26] Interview with program physician ("Understand we had a high-risk group and, when it came time for vaccination, we definitely made an effort to identify our folks who were most at need and help facilitate vaccination for them. That's still an ongoing effort but I think we probably have…50% of our population vaccinated now.") (on file with authors).

risk, but that their CIHTs analyze data in order to identify the high-risk patients most in need of their services.[27]

CIHTs that maintain shared databases with local hospitals and other providers can identify patients who, during a pandemic, contract the virus and are in need of follow-up care or support. For example, one of the CIHTs in our study maintained a shared data system with other local organizations that collected data on the local homeless population. During the COVID-19 pandemic, the CIHT used its shared data system to identify homeless individuals who tested positive for COVID-19 and then moved those individuals out of crowded homeless encampments into isolation hotels or hospitals.[28] Another CIHT in our study similarly flagged their patients who were hospitalized with COVID-19 and followed-up with these individuals to assess their health status and needs.[29]

Finally, CIHTs can use their data to identify individuals who are at-risk of their health care needs going unmet during a public health crisis. For example, during the COVID-19 pandemic one of the CIHTs in our study flagged its patients who use oxygen and worked closely with these patients and their durable medical equipment suppliers to ensure that the patients continued to receive their oxygen supplies.[30]

B. Addressing Individuals' Unmet Health Needs During a Public Health Emergency

As discussed above, CIHTs screen their patients for unmet medical and behavioral health needs and for social determinants that

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[27] *See generally supra* notes 18-20 and accompanying text (describing CIHTs' use of data to identify high-risk patients). *See also* interview with program physician (noting that "over 80% of the patients in our clinic are African American or patients of color...they are at a high risk...they [have] multiple comorbidities.") (on file with authors); interview with program administrator ("[A]ll of our patients are medically complex, so all of them are at a high risk for contracting COVID, for having COVID-19 exacerbate their other underlying health issues."; interview with program nurse practitioner ("All of our patients are high risk, and that's why we did the weekly phone calls.") (on file with authors).

[28] Interview with program administrator (commenting that her CIHT was "well-positioned to help support [program which housed COVID-19 positive individuals a space to safely self-isolate] because [it] had a shared data system to find these individuals," and that the CIHT "knew where [those individuals] were staying in encampments [and it] could quickly triage and get them either to the hospital if they were exposed or to [isolation space]") (on file with authors).

[29] Interview with program administrator (on file with authors) ("We had the case managers and the team members following-up closely with the patients who had been reported to have COVID-19 when they were in the hospital.").

[30] Interview with program physician ("So I think with those patients that I help that are now on oxygen, definitely just working really closely with them and their medical equipment companies to make sure we're getting them the oxygen that they need.") (on file with authors).

adversely impact their health.[31] They then seek to address these health-related needs by helping their patients navigate the health care and social services systems and by connecting patients to available resources, such as food or transportation assistance.[32] During a public health crisis, CIHTs can use these capabilities to timely address the heightened medical, behavioral health, and social needs often experienced by disadvantaged individuals.[33]

In ordinary times, CIHTs address patients' unmet medical needs by connecting patients with primary care physicians and specialists, including helping patients schedule needed appointments.[34] CIHTs also serve as a bridge between patients and their health care providers by updating a physician on changes in a patient's health status or attending doctor appointments with a patient in order to facilitate better communication between the patient and their physician.[35] With the onset of COVID-19, the

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[31] *See supra* note 15 and accompanying text; *see also* Kate LaForge *et al*., *How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care*, 41 J. AMBULATORY CARE MGMT. 2, 8 (2018) (profiling the screening process at multiple community-based organizations).

[32] *See* Nancy Carter *et al.*, *Navigation Delivery Models and Roles of Navigators: A Scoping Literature Review*, 18 BMC HEALTH SERV. RES. 96, 96–97 (2018) (discussing teams of health professionals that provided patient navigation services in the primary care setting); *Community Health Workers Toolkit: Member of Care Delivery Team Model*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/toolkits/community-health-workers/2/team (describing how community health workers can work on a care team and provide patient navigation services that increase access to healthcare); Brewster *et al*., *supra* note 15 (describing how during the COVID-19 crisis an accountable care organization's care coordination programs and outreach is providing linkages to services such as food and housing); CTR. FOR HEALTH CARE STRATEGIES & ST. HEALTH ACCESS DATA ASSISTANCE CTR., *supra* note 2, at 2 (noting that "core features" of community teams include team members who routinely connect patients with relevant community-based resources); ACL BUSINESS ACUMEN ROUNDTABLE WORK GROUP, COMMUNITY INTEGRATED HEALTH NETWORKS: AN ORGANIZING MODEL CONNECTING HEALTH CARE & SOCIAL SERVICES 6, https://acl.gov/sites/default/files/common/BA_roundtable_workgroup_paper_2020-03-01-v3.pdf (noting that community integrated health networks may offer nutritional assistance, delivery, and transportation assistance).

[33] Mantel, *supra* note 2, at 141-44.

[34] Interview with licensed social worker ("Well, our initial goal usually is to do care coordination with the patients for their medical stabilization. So working to find out if people are connected to primary care, and then also specialty care, coordinating all of that.") (on file with authors); interview with registered nurse (commenting that the CIHT connects patients to primary care doctors and, if needed, available specialists) (on file with authors); interview with nurse practitioner ("So we work on medical issues, patients that just need some follow-up, they haven't been able to make it to the cardiologist to their CHF. So patient care navigators help them schedule their appointments.") (on file with authors).

[35] One interviewee noted:

> [A]nother key core component of the coach model is we do what's called accompaniment. So, when we get people connected to their primary care provider, our staff member accompanies them to that

CIHTs in our study expanded these efforts to address the new obstacles facing their patients, including physicians converting from in-person visits to telemedicine visits, government-imposed restrictions on nonessential medical services, and patients foregoing care in an effort to limit their COVID-19 exposure.[36]

Not surprisingly, the CIHT professionals we interviewed reported that the health care system's shift to telemedicine created access barriers for their patient populations. One interviewee noted that many disadvantaged patients lack access to the technology needed for telemedicine appointments: "Where we might be able to have a Zoom meeting, the patient is only telephonic,…[o]r they might not even have a phone, or their phone might not have minutes on it."[37] A program administrator whose CIHT serves the homeless population similarly commented on increased patient "fall off" because of "practical barriers" to telemedicine, including that many homeless patients lack a place where they can charge their phones.[38]

Several of the CIHTs in our study helped patients stay connected with their providers by addressing some of these barriers to telemedicine. One CIHT provided patients with tablets that they could use for telemedicine visits,[39] as well as taught patients how to access and navigate the virtual health care system.[40] A program administrator for a different CIHT similarly stated that her CIHT "did a lot of things around virtual visits," including providing patients with phone card minutes to prevent patients from losing contact with their providers and the CIHT when the patient's cell phone runs out of minutes.[41]

The COVID-19 pandemic also limited patients' access to their health care providers due to restrictions on non-essential medical services and patients delaying in-person care in an effort to

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> appointment to ensure that we're both advocating with them, for them. That the doctor is aware of what the patient told us were their goals, and how the doctor can help us and the patient achieve them together.

Interview with program administrator (on file with authors).

[36] *See* Ateev Mehrotra, *et al*., *The Impact of the COVID-19 Pandemic on Outpatient Visits: A Rebound Emerges* (May 19, 2020), available at https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits.

[37] Interview with licensed social worker (on file with authors).

[38] Interview with program administrator (on file with authors).

[39] Interview with program physician ("Even now, now that our patients and our navigators are doing visits, they take the iPad out. They drive out to the house. They send them the iPad, we have a telemedicine visit for some patients who can't get in and that's worked well.") (on file with authors).

[40] Interview with program administrator (describing the steps her CIHT took to support patients' access to telemedicine, noting that these supporting efforts were "a huge benefit not only for [the patients'] care, but then of course, whenever [the patients] had to see anybody else…for special appointments") (on file with authors).

[41] Interview with program administrator (on file with authors).

limit their COVID-19 exposure. This delay or avoidance of care created missed opportunities for managing patients' chronic conditions, providing preventive services such as routine vaccinations, and early detection of worsening or new conditions.[42] CIHTs, however, can serve as a bridge between patients and their health care providers when a public health emergency restricts access to routine care. For example, one interviewee reported that her CIHT played this role during the COVID-19 pandemic:

> I personally did a ton of outreach when it came to just connecting with individuals and asking, 'Hey, how're you doing?' As well as my social worker and even our collaborative care nurses, just really checking in with patients on a weekly, monthly or bimonthly basis, to see how they're doing and to see if they had any concerns that needed to be brought to the attention of any of us or to their primary care physician. And we have sort of that... built that rapport, maybe they're not seeing their primary care physician for another three or six months. And they feel comfortable and safe to sort of say, "Hey, this is what's going on. Do you mind sending this along to my primary care physician or whomever?[43]

In acting as a liaison between patients and their providers, CIHTs helped providers stay abreast of any changes in their patients' health care status and to intervene as appropriate.

The populations served by CIHTs also commonly face a range of mental health challenges,[44] which one of our interviewees described as "a fairly significant burden" in ordinary times.[45] Published reports suggest that COVID-19 exacerbated these mental

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[42] *See* Mark E. Csiesler, *et al.*, *Delay of Avoidance of Medicare Care Because of COVID-19-Related Concerns—United States, June 2020*, 69 WEEKLY I 1250 (2020), available at https://www.cdc.gov/mmwr/volumes/69/wr/mm6936a4.htm. As explained by an interviewee:

> One thing we saw, they were choosing not to navigate the healthcare system and such as health maintenance things went undone. They weren't caring for themselves. So they weren't keeping up with their healthcare. We weren't getting immunizations as they were supposed to be and whatnot, and follow up just wasn't as good. So, the concern was once we started back, a lot of people came in and ended up coming to the ER because they were behind in their healthcare, and now we had to catch up. And unfortunately, we had an exacerbation occur during that time.

Interview with nurse practitioner (on file with authors).

[43] Interview with community health worker (on file with authors).

[44] *See* Anna Macintyre, *et al.*, *What has economics got to do with it? The impact of socioeconomic factors on mental health and the case for collective action*, 4:10 PALGRAVE COMM. (2018) (summarizing evidence on the link between socioeconomic factors and mental health).

[45] Interview with program manager (on file with authors).

health challenges,[46] and our interviewees similarly observed an increase in anxiety and depression among their patient populations during the pandemic.[47] Most of the CIHTs participating in our study took steps to address their patients' heightened mental health issues caused by the pandemic.

Many CIHTs reported that they increased their outreach to patients to help combat the mental effects of isolation and loneliness, particularly through more frequent telephonic engagement.[48] One interviewee stated that his CIHT "increased [its] visit volume just by doing a lot of phone visits and just check-ins."[49] Another interviewee stated that she stayed connected with patients by driving around their apartment complexes, "and if [she] saw somebody, [she] would just yell out" and ask "how things are going?"[50] Importantly, regular outreach by the CIHT members reminded patients that they were not alone and that the CIHT was there to help them. As explained by one interviewee, "[p]eople saw that, that [sic] we were fully engaged and they knew that we were able to connect with, you know, they could get us by phone, but they could still see us out in the community."[51] CIHTs also utilized their behavioral health referral networks to connect patients with mental health services, including virtual therapy programs,[52] and some

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[46] *See* Stok *et al*., *supra* note 13.

[47] Interview with licensed social worker ("There's been a lot of, I would say, well, as a mental health provider, there's been a lot of anxiety and uncertainty about the virus, about people that are already medically complex, where patients are telling me, 'I'm not letting anyone in the apartment.'") (on file with authors). Another interviewee noted:

> So in the behavioral health side, we noticed increased anxiety, increased depression, significant amount of losses, and or, fear in anticipation of loss because there had family members that were ill in isolation. They couldn't do their church activities and some of them that's their social time. So we noticed the decline in their emotional state as COVID progressed as we started being home longer.

Interview with licensed clinical social worker (on file with authors).

[48] Interview with program administrator ("One of the biggest things that our patients struggled with was really the social isolation, not having social programs, not being able to go to church, not being able to see family. We really increased our contact.") (on file with authors).

[49] Interview with physician (on file with authors).

[50] Interview with community care coordinator (on file with authors).

[51] Interview with community care coordinator (on file with authors).

[52] As an interviewee noted:

> And so, a lot of it was just communicating with our clients to let them know that we were there and that we would assist them with whatever they were needing to have some things done. If they needed a mental health session, we were giving them the tools they needed to have, to have that done by way of Zoom giving them the contact numbers.

Interview with registered nurse (on file with authors). Another interviewee stated:

> One of the benefits to this time though, was the new availability of some of the more intensive mental health programs, like intensive outpatient,

CIHTs taught patients coping mechanisms to better manage their anxiety over the COVID-19 pandemic.[53] As described by one interviewee:

> A lot of our patients were stuck at home, weren't seeing anyone; couldn't see their grandchildren, couldn't see other people just because they were so high-risk and that took a huge toll on their mental health. The [CIHT] behavioral health team helped out in a huge way with the patients that were willing in helping them find resources or other ways that they can help improve their moods and their outlook on everything.[54]

In addition to helping patients with their medical and mental health needs, CIHTs are experts in addressing the social and material challenges faced by socioeconomically disadvantaged populations. As noted above, for many individuals, the pandemic amplified these challenges.[55] CIHT professionals have extensive referrals networks, and during the pandemic many of the CIHTs participating in our study utilized these connections to link patients to community resources. For example, two CIHTs helped move COVID-positive homeless individuals to temporary housing where they could safely self-isolate from others.[56] Another interviewee stated that her CIHT provided patients with a list of every local food pantry and their operating hours so that patients would have access to food during the initial COVID-19 lockdown.[57] In addition, many

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> or partial hospitalization programs… . If you can sit at home and do a virtual therapy program six hours a day from home, it's much more manageable. That was actually an unexpected benefit that we were able to align a lot of our patients with.

Interview with program administrator (on file with authors).

[53] *See* interview with primary care physician ("Especially with COVID, we've seen a lot of rise in anxiety and depression throughout the country. And so, it's been a blessing to have their [CIHT's licensed clinical social workers'] support in helping patients get through this challenging and confusing time.") (on file with authors).

[54] Interview with pharmacist (on file with authors).

[55] *See supra* note 12.

[56] *See* interview with program physician (noting that her CIHT, which was part of a local health system, worked with the health system to provide hotel rooms for some of their COVID-positive patients who could not quarantine after hospitalization or an emergency department visit) (on file with authors). Another interviewee stated:

> We helped link people to the hotel too because we had [a local program] here. Our team had a role that was the COVID response. Anybody in the homeless population who tested positive for COVID, we would get a call so that we could help the transition from the hospital into the hotel, and make sure that they had everything that they needed.

Interview with housing coordinator (on file with authors).

[57] The interviewee stated:

> We created a spreadsheet of every food pantry, every doctor's office, every organization that could... DMV, City Hall, Social Security, every

CIHTs provided necessary resources directly to patients during lockdown periods or when self-isolating, including delivering food, diapers, and other necessities.[58] Some CIHTs also reported giving personal protective equipment (PPE) or hygiene kits to their high-risk patients,[59] while others distributed PPE to residents in poorer neighborhoods.[60]

C. **Effective Public Health Messaging**

Unfortunately, the COVID-19 pandemic has made evident many individuals' mistrust in the government, media, and health care system,[61] with large numbers rejecting public health recommendations regarding social distancing, mask wearing, and COVID-19 vaccination.[62] But where these institutions have been

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> adult day program, pharmacy, transportation, we generated a list where we update it in real time. If someone could have access to it, that particular organization if that particular organization was closed, if they were operating on limited hours, so our team just put that structure in place within I want to say 48 hours of the office shutting down. And that was something that people, it wasn't just limited to [organization], it was people throughout [county] were able to use it.

Interview with program nurse (on file with authors).

[58] One interviewee noted:

> I think with our clients that had issues with let's say they had issues with running out of food or... Because we have a gift-in-kind closet as well and some mothers who have young babies had issues buying diapers or whatever. So, we would meet them here at the office or what we would do is just give them the package. They weren't coming in the office, but we would package everything and make sure they had what they needed for their children.

Interview with registered nurse (on file with authors); interview with program administrator ("The other thing I would say is that there were a whole lot of food drops, so even if I can't hang out with you, there were a lot of supplies places or trying to bring things to you so you shelter in place.").

[59] Interview with program administrator ("And we gave everybody PPE. We're drowning in PPE. We have so much. We have 5,000 masks. We just got worried initially. We got an extra bid. It was like, "'Great, masks for everybody.'") (on file with authors).

[60] Interview with housing coordinator ("We went out…into the encampments. We brought people hand sanitizer, soap, gave them pamphlets on COVID and how to protect themselves. We gave out masks.") (on file with authors).

[61] *See* Mark John, *Public Trust Crumbles Amid COVID, Fake News-survey*, REUTERS, (Jan. 13, 2021), https://www.reuters.com/article/health-coronavirus-global-trust/public-trustcrumbles-amid-covid-fake-news-survey-idUSL8N2JM2V9 (reporting widespread mistrust in governments and media across the globe, including only fifty-three percent of survey participants saying they have confidence in the institution of government and fifty-three percent reporting trust in traditional media outlets, with only twenty-one percent of voters for Donald Trump reporting trust in journalists).

[62] *See* Alicia Best *et al*., *Institutional Distrust Among African Americans and Buildings Trustworthiness in the COVID-19 Response: Implication for Ethical Public Health Practice*, 32 J. HEALTH CARE POOR UNDERSERVED 90, 94 (2021)

unsuccessful public health messengers, CIHTs may succeed. Because CIHTs often form trusting relationships with patients, their patients generally view CIHTs as credible sources of information.[63] This may be especially true for members of a CIHT team who themselves come from the communities they serve, such as community health workers.[64] In addition, many CIHT professionals receive training on conveying health information in a culturally sensitive manner.[65]

Several interviewees in our study generally highlighted the value of their CIHTs building trust with their patients. One interviewee in particular noted that because community health workers typically are members of the community they serve, their relationship with patients has "a component of that kind of peer support" which is "of great value to the client."[66] Another interviewee identified CIHTs' ability to build trust with patients as one of the biggest strengths of the CIHT model because this trust

("Research indicates a strong association between institutional distrust and nonadherence to health-related recommendations.").

[63] Mantel, *supra* note 2, at 140. *See also* Leventhal, *supra* note 15 (stating that patients identified by CIHT as high-risk are contacted by care teams based in primary care practices that "have built trusted relationships with patients"); Rob Waters, *Community Workers Lend Human Connection to COVID-19 Response*, 39 HEALTH AFFS. 1112, 1116 (2020), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00836 (commenting on how the rapport and trust between community health workers and patients is vital to the success of community health workers' efforts to support patients during the COVID-19 pandemic).

[64] *See* Sarah R. Arvey & Maria E. Fernandez, *Identifying the Core Elements of Effective Community Health Worker Programs: A Research Agenda*, 102 AM. J. PUB. HEALTH 1633, 1633 (2012) ("[B]ecause most [community health workers] are members of the communities within which they work, they are assumed to delivery health messages in a culturally relevant manner."); Denise O. Smith & Ashley Wennerstrom, *To Strengthen the Public Health Response to COVID-19 We Need Community Health Workers*, HEALTH AFFS. BLOG (May 6, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200504.336184/full/ (stating that community health workers can "serve as community messengers for critical public health and social service information"); Shreya Kangovi, *Want to Help Battle COVID-19? Bring in More Community Health Workers*, ASS'N AM. MED. COLLS. (June 9, 2020), https://www.aamc.org/news-insights/want-help-battle-covid-19-bring-more-communityhealth-workers (explaining that community health workers can prevent the spread of COVID-19 through efforts such as public health messaging).

[65] *See* Richard C. Boldt & Eleanor T. Chung, *Community Health Workers and Behavioral Health Care*, 23 J. HEALTH CARE L. & POL'Y 1, 1 (2020) ("Community health workers are community members trained to facilitate interactions between the health care system, individual patients, and the communities in which they are situated."); Jayshree S. Jani *et al*., *Cultural Competence and Social Work Education: Moving Toward Assessment of Practice Behaviors*, 52 J. SOC. WORK EDUC. 311, 311 (2016) (noting that social work education seeks to teach students to be culturally competent).

[66] Interview with patient care navigator (on file with authors).

allows the CIHT to guide patients toward behaviors which ultimately can improve their lives.[67]

As part of their outreach efforts during the pandemic, the CIHTs in our study sought to educate patients about the COVID-19 virus and coached them on preventive practices that reduced their risk of exposure.[68] Although our interviewees did not specifically highlight the role patient trust played in their COVID-19 outreach efforts, several interviewees reported success in persuading patients to get vaccinated. For example, a licensed social worker commented that many of her CIHT's patients were hesitant or resistant to getting vaccinated for COVID-19, but that by working with these patients the CIHT was successful in vaccinating some of its vaccine-hesitant population.[69] Another interviewee similarly noted that through persistent outreach and education about the COVID-19 vaccine, his CIHT overcame many patients' initial resistance to the vaccine.[70]

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[67] As one interviewee stated:

> Forming authentic healing relationships with people makes it easier for them to trust us and share things with us that they might not otherwise share. And then to be able to use that, to help them go from a place of strength, of being able to then work on things that they need to work on to live better lives…

Interview with program medical director (on file with authors).

[68] As explained by one interviewee:

> So, we take care of a vulnerable population anyway, and we have folks that have been vaccine-hesitant, and so requiring a whole lot of outreach and a whole lot of education to get them vaccinated, now that we're post-COVID. During the surge and during the outbreak and our resurges, our last surge, the mortality that impacted our clinic was pretty high, and so we were [inaudible] losing a patient a week. So, we, again, had to continue to educate people again and again about the virus was real, that the folks that were saying it wasn't real, "Yeah, it's real. You're at risk." Over 80% of the patients in our clinic are African American or patients of color, and that they are at a high-risk group, they had multiple comorbidities, and so trying to educate them about staying in, that we weren't trying not to see you in clinic, that we're calling you up because we want to keep you safe.

Interview with physician (on file with authors). *See also* interview with program nurse ("Because we have nurses, we're able to go out and provide some education, and it's just been a tremendous help to the city, because it's needed.") (on file with authors). Another interviewee stated:

> I definitely reached out, provided them with different resources that they may need or may not need when COVID came around. I didn't wait for them to ask me what they needed I provided them with a detailed list so they can have it. Then I definitely went over safety protocol and just making sure you was [sic]... When we was [sic] at the stay at home order, making sure quarantine was at the top of the list.

Interview with medical social worker (on file with authors); interview with program administrator (commenting that all of their patients are medically complex and therefore high-risk, and that her CIHT therefore provided their patients with a lot of information about COVID-19) (on file with authors).

[69] Interview with licensed social worker (on file with authors).

[70] Interview with program physician (on file with authors).

These success stories suggest that CIHTs can play an important role in support of more effective public health messaging to economically and socially disadvantaged populations during a public health crisis.

IV. SUPPORTING SYSTEM-LEVEL INTERVENTIONS

Although CIHTs provide invaluable assistance to individual patients, many of the challenges facing economically and socioeconomically disadvantaged populations require cross-sector collaborations and population-level programs.[71] With their deep understanding of their communities' health-related needs, multidisciplinary expertise, and working relationships across the health and social services sectors, CIHTs regularly engage in coordinated, system-level interventions.[72] During a public health crisis, CIHTs can leverage these existing capabilities in support of emergency response efforts broadly targeting disadvantaged populations.[73] Many of the CIHTs participating in our study described various ways in which they provided coordinated, population-level assistance during the COVID-19 pandemic, which we describe below.

A. Data-Sharing During a Public Health Emergency

The COVID-19 pandemic underlined the need for data-sharing infrastructure that can support rapid information sharing across different organizations.[74] During a public health emergency, a comprehensive data-sharing infrastructure allows various organizations to exchange and aggregate their health-related data in order to gain insight into the community's health needs, track and mitigate a virus's spread, and coordinate public health response efforts.[75] Building shared data-platforms and negotiating data-

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[71] Mantel, *supra* note 2, at 144-45.
[72] *Id*.
[73] *Id*.
[74] *See* Nadereh Pourat *et al*., *How California Counties' COVID-19 Response Benefited from the "Whole Person Care" Program*, HEALTH AFFS. BLOG (Apr. 28, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200427.341123/full/ ("The challenges to such emergency responses are well documented elsewhere and include the need for . . . rapid and effective information sharing.").
[75] *See* Landers *et al*., *supra* note 5 ("Efforts to track and trace the virus can be supported with data-sharing infrastructure."); Pourat *et al*., *supra* note 74 (stating that rapid and effective information sharing "is necessary to raise awareness of priorities and implement a coordinated response across all sectors that provide essential health and human services."); ROBERT WOOD JOHNSON FOUND., SENTINEL COMMUNITIES INSIGHTS, COLLABORATION IN

sharing agreements are time-consuming and resource intensive activities, however, and cannot be accomplished belatedly during a public health emergency.[76] But as noted above in Part II.A, many CIHTs already participate in or maintain data-sharing platforms.

Some of the CIHTs participating in our study shared examples of how they and partner organizations utilized their data-sharing systems during the COVID-19 pandemic. As mentioned previously, some CIHTs used data-sharing systems to identify COVID-positive homeless individuals who were then moved to temporary housing where they could self-isolate,[77] while one CIHT used its data-sharing system to flag patients hospitalized with COVID-19 who were then contacted for follow-up care post-discharge.[78] Another CIHT relied on a partner organization's algorithm to identify patients at high-risk for COVID-related complications, with the CIHT then conducting outreach to these individuals and educating them about COVID-19 risks and preventive measures.[79] Finally, one interviewee commented that her CIHT shared its patient data with a partner community organization focused on providing care to immigrants who lacked adequate health care given their citizenship status.[80] Specifically, the CIHT provided the partner organization with information about immigrants who were not receiving adequate care during the pandemic as part of a coordinated effort to ensure that "whole communities survive COVID."[81]

B. Coordinated Public Health Responses

Many of the problems affecting socioeconomically disadvantaged populations are complex and multifaceted, and therefore are best addressed through multiple organizations pooling

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COMMUNITIES TO ADDRESS COVID-19 6 (2020) (reporting that "easy availability of useful data" has facilitated more effective responses to COVID-19); *Whole Person Care Lays Groundwork for Quick COVID-19 Response*, CAL. ASS'N PUB. HOSPS. & HEALTH SYS. (Aug. 31, 2020), https://caph.org/2020/08/31/whole-personcare-lays-groundwork-for-quick-covid-19-response/ (stating that every California Whole Person Pilot profiled by the authors "pointed to the importance of data sharing to rapidly disseminate information and reach those most in need during the public health emergency").

[76] *See* Landers *et al.*, *supra* note 5 ("Building collaborative data infrastructure often takes time and can be highly resource intensive.").

[77] *See* Interviews with program physician and housing coordinator, *supra* note 56.

[78] *See* Interview with program administrator, *supra* note 29 ("We had the case managers and the team members following-up closely with the patients who had been reported to have COVID when they were in the hospital.").

[79] Interview with program administrator (on file with authors).

[80] Interview with licensed master social worker (on file with authors).

[81] Interview with licensed master social worker (on file with authors).

their collective expertise and resources.[82] Developing these collaborative initiatives is no simple task as it requires that the participating organizations identify potential stakeholders, foster familiarity and trust across their organizations, and create shared processes and infrastructure.[83] Building these partnerships during a public health crisis can be difficult,[84] and communities therefore often must rely on pre-existing collaborations.[85] CIHTs are well-positioned to support a coordinated public health emergency response, as they not only can contribute their expertise in meeting

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[82] *See* Arleen F. Brown *et al*., *Structural Interventions to Reduce and Eliminate Health Disparities*, 109 AM. J PUB. HEALTH S72, S72-S73 (2019) (calling for multisectoral collaborations to address health disparities because minority populations often face "multiple levels of mutually reinforcing structural disadvantage that contribute to poor health," interventions that focus primarily on behavior change at the individual and interpersonal levels have limited long-term impact). As the authors argue, "[t]ake, for example, the case of obesity disparities: interventions that improve nutrition and physical activity at the individual level are unlikely to succeed when the food and social environments (e.g., unsafe and limited recreational space, ready access to low-cost, calorie-dense food options) and high rates of poverty present severe barriers to maintaining healthy diets and active lifestyles." *See id*.

[83] *See generally* Lee M. Johnson & Diane T. Finegood, *Cross-Sector Partnerships and Public Health: Challenges and Opportunities for Addressing Obesity and Noncommunicable Diseases Through Engagement with the Private Sector*, 36 ANN. REV. PUB. HEALTH 255, 258–62 (2015) (discussing challenges to forming cross-sector partnerships, including lack of appreciation for each other's roles, goal alignment, and power struggles); RUBEN AMARASINGHAM ET AL., USING COMMUNITY PARTNERSHIPS TO INTEGRATE HEALTH AND SOCIAL SERVICES FOR HIGH-NEED, HIGH-COST PATIENTS 4 (2018) (identifying common challenges to cross-sector partnerships, including lack of expertise to support data integration); ASTHO, ASTHO- CDC-HUD CONVENING MEETING NOTES: CROSS-SECTOR PARTNERSHIP MODELS TO IMPROVE HEALTH AND HOUSING OUTCOMES NOVEMBER 29TH–30TH 9–10 (discussing barriers to cross-sector collaborations, including competing priorities, insufficient data infrastructure and data sharing challenges).

[84] *See* Brian C. Castrucci *et al*., *Misunderstood: How Public Health's Inability to Communicate Keeps Communities Unhealthy*, HEALTH AFFS. BLOG (Oct. 8, 2020), https://www.healthaffairs.org/do/10.1377/hblog20201006.514216/full/ (noting the difficulty of establishing deep collaborations belatedly in times of crisis); Matt Craven *et al*., *Not the Last Pandemic: Investing Now to Reimagine Public-Health Systems*, MCKINSEY & CO., 1, 3 (July 2020), https://www.mckinsey.com/~/media/McKinsey/Industries/Public%20and%20Social%20Sector/Our%20Insights/Not%20the%20last%20pandemic%20Investing%20now%20to%20reimagine%20public%20health%20systems/Not-the-last-pandemicInvesting-now-to-reimagine-public-health-systems-F.pdf (commenting that forming cross-sector partnerships "becomes much more challenging during a crisis").

[85] *See* Castrucci *et al*., *supra* note 84 ("The pandemic is showing us just how critically important these cross-sector relationships are. Times of crisis are when we need to rely on these relationships rather than try to establish them belatedly . . . "); Landers *et al.*, *supra* note 5 ("By having the core elements of cross-sector alignment in place, local and regional systems possess greater capacity to address the social and economic effects of COVID-19.").

the health-related needs of socioeconomically disadvantaged populations, but they also have existing partnerships across the health care and social services sectors.[86]

Interviewees shared several ways in which their CIHTs supported their community's public health response during the COVID-19 pandemic. As previously noted, two CIHTs in our study coordinated with other local organizations to transition COVID-positive homeless individuals to temporary housing.[87] Another interviewee discussed her participation on an inter-agency team that jointly conducted outreach in homeless encampments.[88] Some CIHTs partnered with other organizations to develop clinical programs to meet pandemic-related health needs. For example, one CIHT partnered with a local government agency to operate vaccine clinics,[89] while another CIHT helped a local hospital system to set-up a respiratory clinic for those affected by COVID-19.[90] Another CIHT utilized its extensive referral network to create a publicly available resource with information about local organizations' operations, such as which food banks were still in operation.[91]

C. Lending Expertise and Resources to Emergency Public Health Efforts

In addition to participating in data-sharing arrangements and other collaborative activities, CIHTs can support public health emergency responses by lending their expertise, personnel, and other resources to local relief efforts. In some communities, local

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[86] *See* Mantel, *supra* note 2, at 149. For example, one of the program administrators we interviewed commented that her CIHT devoted a specific team member to maintaining relationships with other organizations. She elaborated that this was necessary because "so much of [their] work is about relationships… so, having a specific go-to person at the board of social services or at the transportation center, for example, someone needs to hold those relationships and help be the linkage for everybody." Interview with program administrator (on file with authors).

[87] *See* Interviews with program physician and housing coordinator, *supra* note 56.

[88] Interview with housing coordinator ("We went out with law enforcement and went out into the encampments. We brought people hand sanitizer, soap, gave them pamphlets on COVID and how to protect themselves. We gave out masks. We also gave out the…phone number to anybody who wanted to seek shelter or any other services.") (on file with authors).

[89] Interview with program administrator ("our operational leadership had partnered with [city] and we did vaccination clinics, not only for our population) (on file with authors).

[90] Interview with program administrator (on file with authors); interview with caseworker ("[The CIHT team] actually did outreach through [the program] and did chart reviews to make sure that patients were being seen and they weren't being dropped. That was a lot, I think we called over 200 patients.") (on file with authors).

[91] Interview with program nurse, *supra* note 57.

public health agencies contracted with CIHTs to perform specific emergency response activities. For example, a local county contracted with one of the CIHTs in our study to identify and provide care coordination services to homeless individuals who tested positive for COVID-19.[92] The county selected the CIHT to perform this important function in recognition of the CIHT's sophisticated data-sharing infrastructure and its expertise in assisting the homeless population with their health-related needs.

CIHTs also can re-assign personnel on a full-time or part-time basis to local emergency response efforts. During the pandemic's onset, the CIHT in our study that helped establish an emergency respiratory clinic also assigned its nurses to clinic, where they performed health assessments of patients suspected of having contracted COVID-19.[93] Another CIHT's personnel participated in its local public health department's contact tracing efforts[94] and educational outreach to people who themselves or whose close contacts tested positive for COVID-19.[95]

V. CONCLUSION

Long before the COVID-19 pandemic hit America's shores, there was ample evidence that a person's socioeconomic status affects their health. Economically and socially disadvantaged populations face more barriers to affordable, high quality care than other populations, as well as live, work and play in conditions that often adversely impact their health. The COVID-19 virus has only heightened these health inequities, with disadvantaged groups disproportionately experiencing the pandemic's negative effects.[96] A public health system that neglects these economic and social differences across different populations risks repeating the failures of the COVID-19 pandemic, with the next public health crisis only further deepening existing health disparities. A sustainable public health system therefore must have the capacity to address the complex, multifaceted needs of disadvantaged populations during public health emergencies. With their proficiency in coordinating a broad range of health and social services at both the individual and population level, CIHTs can provide invaluable assistance to these efforts.

The published literature highlights various ways in which CIHTs can leverage their expertise and resources to support the needs of economically and socially disadvantaged populations

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[92] Interview with program administrator (on file with authors).
[93] Interview with program administrator (on file with authors).
[94] Interview with program social worker (on file with authors).
[95] Interview with program administrator (on file with authors).
[96] *See supra* note 10 and accompanying text.

during a public health emergency. Specifically, during a public health crisis CIHTs can utilize their data collection and analytics capability to identify high-risk individuals, conduct outreach to and connect with available resources individuals adversely impacted by the public health crisis, ensure that individuals' medical and mental health needs are met, and support coordinated, cross-sector responses to the crisis.[97] The CIHTs that participated in our qualitative study confirmed that, during the COVID-19 pandemic, they supported their local public health efforts in these various ways.

In addition to the important role CIHTs can play during a public health crisis, research has shown that during ordinary times CIHTs can both improve the health of economically and socially disadvantaged individuals and lower health care spending.[98] All of the CIHTs participating in our study similarly reported success on either health outcome and efficiency metrics such as reducing emergency room visits, or offered anecdotes of how they were increasing patients' overall wellness or social circumstances.[99] Yet

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[97] *See* Mantel, *supra* note 2, at 136-44.

[98] *See, e.g.*, C. Annette DuBard, SAVINGS IMPACT OF COMMUNITY CARE OF NORTH CAROLINA: A REVIEW OF THE EVIDENCE, COMMUNITY CARE OF NORTH CAROLINA DATA BRIEF 11, at 1–2 (2017), https://www.communitycarenc.org/media/files/data-brief-11-savings-impact-ccnc.pdf (among patients participating in Community Care of North Carolina, finding substantial reductions in inpatient utilization and annualized per-beneficiary net savings for Medicare and Medicaid of approximately $3 for every $1 invested); Craig Jones *et al.*, *Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care*, 19 POPULATION HEALTH MGMT 196, 196 (2016) (reporting a reduction in health care expenditures and utilization and improved outcomes for participants in Vermont's patient-centered medical home program); Nadereh Pourat *et al.*, INTERIM EVALUATION OF CALIFORNIA'S WHOLE PERSON CARE (WPC) PROGRAM 27–34 (2019), https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/wholepersoncare-report-jan2020.pdf (finding that California's Whole Person Care program improved care coordination, care processes, and some health outcomes). *But see* Caroline Fichtenberg *et al.*, *Health and Human Services Integration: Generating Sustained Health and Equity Improvements*, 39 HEALTH AFFS. 567, 569 (2020) (summarizing the evidence on impacts of integrating health and human services and stating that although "[s]ome studies have documented improved health outcomes and cost reductions, but other studies did not find anticipated health or health care benefits").

[99] Some interviewees cited data demonstrating the effectiveness of their CIHTs' intervention. For example, one interviewee whose CIHT collected data stated the following:

> We did demonstrate that if people were engaged in the clinic within the first year, we're able to reduce their ED visits by about 58%, and be able to reduce their hospitalizations by 40%, which then translates into more cost-effective care, and then demonstrate that we had patients with improved control of their blood pressures and improved control to their diabetes.

Interview with program physician (on file with authors). Similarly, another interviewee whose CIHT was involved in a randomized control trial stated that

despite their promise for reducing health care inequities and spending, the CIHT model has not been widely adopted.[100] One obstacle to CIHTs is the substantial up-front costs required to start a CIHT, as well as uncertainty about securing sustainable financing remain.[101] Our interviewees similarly commented that funding remains an ongoing challenge for their CIHTs and hinders their success.[102]

"patients enrolled with [the CIHT] were way more likely to be connected to a community resource, access to food assistance programs. A lot of [the CIHT's] folks were connected to that." Interview with medical director (on file with authors).

Other interviewees provided anecdotes in support of their CIHTs' success in improving patient health and lowering health care costs. For example, one interviewee stated:

> [W]e have some patients that go into the emergency room because they are hungry, and they know they can get a meal. So then we'll help them get a SNAP application or a TANIF application. We have a relationship with the food bank so we'll help them get immediate needs met and then we help them try to figure out how we can get their needs met in the longer run.

Interview with program administrator (on file with authors). *See also* interview with program administrator ("I remember this one patient... Five ED admissions in six months prior to being with the [CIHT], and have no ED admissions after being with the [CIHT].") (on file with authors). Another interviewee stated:

> I'll give you, again, the pharmacists' viewpoint. There has been so many times where I have called a patient and notice that their blood sugars are dropping too low, and that can be very dangerous and that can be a trip to the hospital, put a patient in coma, that can be very expensive. So, with the closer monitoring that they get these kinds of clinics versus other clinics, by pharmacists, by care coaches, I want to say we do have a much fewer readmits or hospital admissions for those reasons.

Interview with pharmacist (on file with authors).

[100] *See* Brewster *et al.*, *supra* note 15 (stating that few communities have integrated public health, health care delivery, and social services functions).

[101] *See* Pourat *et al.*, *supra* note 74 (noting that a developing the infrastructure and partnerships to support system-wide integration "required considerable upfront investment" by the pilot sites participating in California's Whole Person Care program); Pourat *et al.*, *supra* note 98, at 267 (discussing concerns about the Whole Person Care pilots regarding the "uncertainty around future funding to support [Whole Person Care] infrastructure and activities"); Fichtenberg *et al.*, *supra* note 98, at 569–70 ("Another consistent challenge to integrated health and human services is financial sustainability."); Elise Miller *et al.*, PARTNERSHIP FOR HEALTHY OUTCOMES, WORKING TOGETHER TOWARD BETTER HEALTH OUTCOMES 9–14 (2017), https://www.chcs.org/media/Working-Together-Toward-BetterHealth-Outcomes.pdf (discussing the challenges cross-sector partnerships face in "covering their full, ongoing costs").

[102] For example, one interviewee explained her CIHT's ongoing funding challenge as follows:

> I think what hinders our work right now is that frankly, figuring out the balance of how do we make sure we're funded to do the work that we want to be doing, and straddling this line of being... When we're a nonprofit, we're a little more... Understandably, we need to be a little more nimble and receptive to funding opportunities. Whereas, bigger

The COVID-19 pandemic has highlighted that importance of investing in CIHTs as part of building a sustainable public health system that can quickly and effectively respond to the complex challenges facing disadvantaged populations during a public health crisis. Investing in CIHTs also provides the added benefit of strengthening ongoing efforts to reduce health inequities. As policymakers consider how to best spend future public health dollars, allocating a portion of this funding to the expansion of CIHTs across the country would support a more sustainable and effective U.S. public health system.

> health systems, and CEOs making their own complex care planning, they can probably just be straight up innovative, and they know they have the dollars to back it. We are super innovative, tons of ideas, but finding someone to pay for it becomes a little more challenging. And so, that hinders that, and that hinders staff, and that ultimately can hinder patients.

Interview with program administrator (on file with authors). Similarly, another interviewee whose CIHT is funded solely by contracts noted that a hindrance to her CIHT's success is that the CIHT is "at the mercy of whatever [the] contractor wants [it] to do." Interview with program administrator (on file with authors). A third interview stated that factors that hinder her CIHT's success and that she wishes she could change are "money and staff." Interview with patient care navigator (on file with authors).

IF YOU CAN'T STOP THEM, PROTECT THEM: THE LEGAL TETHERS FOR BRINGING FULLY COMPREHENSIVE SEXUAL EDUCATION POLICY TO TENNESSEE

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I. INTRODUCTION

In a nationwide debate, Americans are fighting over how to teach sexual education, if at all, in public schools. Currently, 38 states and the District of Columbia have sexual education requirements.[1] Statistics show that on the world health stage, the United States is lacking in sexual health education. For example, Switzerland and the Netherlands boast impressive teen pregnancy statistics, with only 8 in 1000 teens and 14 per 1000 teens becoming pregnant respectively, while the US averages 57 in 1000 teens.[2] While teen pregnancy is not the only indicator of sexual health, this statistic shows a large gap between the US and countries that adopt more comprehensive sexual education policies. Switzerland and the Netherlands start sexual education during early adolescence, offer low-cost emergency contraception, and expect sexually active teens to use contraception.[3]

These countries' approaches to sexual education are reflective of the United Nations Educational, Scientific and Cultural Organization and the World Health Organization recommendations.[4] Using science-backed data, the United Nations Educational, Scientific and Cultural Organization and the World Health Organization published the International Technical Guidance on Sexuality Education ("ITGSE").[5] This guide takes an evidence-informed approach to sexual education and, when compared to state policy throughout the US, exposes major differences.[6]

In an effort to promote public health, all states alike need to adopt comprehensive sexual education programs that encourage safe sex practices, promote healthy relationships, and acquire medically accurate knowledge surrounding sex. Recently, the

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[1] *Sex and HIV Education*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education (last visited November 4, 2021).
[2] *Teen Pregnancy Rates Declined In Many Countries Between The Mid 1990s and 2011*, GUTTMACHER INST. (Jan. 23, 2015), https://www.guttmacher.org/news-release/2015/teen-pregnancy-rates-declined-many-countries-between-mid-1990s-and-2011.
[3] *Id.*
[4] *International Technical Guidance on Sexuality Education: An Evidence-informed Approach* (Revised ed. 2018), UNITED NATIONS POPULATION FUND, https://www.unfpa.org/sites/default/files/pub-pdf/ITGSE.pdf.
[5] *Id.*
[6] *Id.*

Tennessee Family Life Curriculum (the "Curriculum") has been updated to include a more comprehensive approach to sexual education.[7] This plan, while more inclusive than the previous sexual education curriculum, still neglects to include critical subjects. The Curriculum needs another revamp to fully address all sexual health topics, as presented in the ITGSE.

This Note explores why Tennessee needs a comprehensive sexual education curriculum, how Tennessee can get it, and what should be included in the Curriculum. For the purposes of this Note, a comprehensive sexual education curriculum is scientifically-based, age appropriate, incremental, and inclusive of all sexual identities and genders.[8] The Curriculum needs to cover an array of subjects including, but not limited to, sexual and reproductive issues, contraception, sexuality, human rights, violence, consent, relationships, and non-discrimination.[9] While Tennessee expanded its Curriculum to include information on HIV, STDs, and to permit contraception to be taught, the Curriculum remains abstinence-based. By neglecting to require lessons about contraception, safe sex practices, abortion, and consent, Tennessee, along with dozens of other states, are leaving their youth uneducated while actively feeding into public health issues.

The Part II of this Note provides background on sexual health in the United States. Particularly, this section includes statistics surrounding STDs and teen pregnancy, the current sexual health policy in Tennessee, and examples of different sexual education curriculums currently being used throughout the United States.

Part III of this Note analyzes legal tethers that can help attain comprehensive sexual education in Tennessee including the Mature Minor Doctrine,[10] Freedom of Religion,[11] the Fourteenth Amendment Liberty Interest,[12] Title IX,[13] and Title V.[14] These analyses show arguments for comprehensive education and how to overcome the opposition of comprehensive education.

Finally, this Note concludes with suggested improvements to Tennessee's Family Life Curriculum policy based off the World Health Organizations International Technical Guidance on Sexual

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[7] Tenn. Code Ann. § 49-6-1301–8 (2021).
[8] UNITED NATIONS POPULATION FUND, *supra* note 4.
[9] *Id.*
[10] TN Dept. of Health, *Mature Minor Doctrine*, https://www.tn.gov/content/dam/tn/health/documents/MatureMinor_Doctrine.pdf (last visited November 3, 2021).
[11] U.S. CONST. amend. X.
[12] U.S. CONST. amend. IV.
[13] Education Amendments Act of 1972, 20 U.S.C. §§1681–1688 (2018). Title IX (2018).
[14] The Social Security Laws, 42 U.S.C. §701-710, subchapter V.

Education and successful comprehensive sexual health curriculums currently being applied in the US.

II. BACKGROUND

The need for sexual education is rooted in its impact on public health. One can look to policies and statistics from other states and countries to see how sexual education policy can impact sexual health. Looking to STD rates, teen pregnancy rates, and current forms of sexual education helps reveal what is needed from Tennessee's Family Life Curriculum today.

A. Sexual Health Statistics

The United States is plagued by sexual health endemics that touch millions of Americans every year, from STD infections[15] to teen pregnancy.[16] The US continues to funnel billions of dollars into direct medical costs for STD treatment,[17] yet remains a world leader for teen pregnancy.[18]

i. STDs

On any given day in 2018, one fifth of the US population had an STD, totaling nearly 68 million infections that year alone.[19] Of these cases, 26 million are new STD cases, and nearly half of these new cases are individuals between the ages of 15 to 24.[20] STDs can cause long term health problems including pelvic inflammatory disease, infertility, tubal or ectopic pregnancy, cervical cancer, and perinatal or congenital infections in infants born to infected mothers.[21] If the serious health concerns surrounding STDs and

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[15] Ctrs. For Disease Control and Prevention, *Sexually Transmitted Infections Prevalence, Incidence, and Cost Estimates in the United States*, https://www.cdc.gov/std/statistics/prevalence-2020-at-a-glance.htm (last visited November 3, 2021).

[16] Isaac Maddow-Zimet, *Pregnancies, Births and Abortions in the United States, 1973-2017: National and States Trends by Age*, GUTTMACHER INST., https://www.guttmacher.org/report/pregnancies-births-abortions-in-united-states-1973-2017 (last visited November 3, 2021).

[17] *Key Statistics from the National Survey of Family Growth – P Listing*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/nchs/nsfg/key_statistics/p.htm (last visited November 3, 2021).

[18] Kathrin F. Stanger-Hall et al, *Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S.*, 6 PLOS ONE (2011). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3194801/

[19] CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra*, note 15.

[20] CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra*, note 17.

[21] Nat'l Inst. of Allergy and Infectious Disease, *Sexually Transmitted Diseases* (August 6, 2015), https://www.niaid.nih.gov/diseases-conditions/sexually-

infections were not enough, there is also an astounding economic impact rooted in the spread of STDs. In 2018, new STDs throughout the US resulted in $16 billion in direct medical costs, with 26% of that going towards treating 15-24-year-olds with STDs.[22]

ii. Teen Pregnancy

The US continues to have one of the highest teen pregnancy rates out of all developed countries.[23] In 2017, there were 14 pregnancies per 1,000 women aged 15–17 and 57 pregnancies per 1,000 women aged 18–19.[24] While statistics show that there is a decline in teenage pregnancy, evidence shows there is a correlation between that decrease and an increase in teenage use of contraception and practice of abstinence.[25]

Teen pregnancy has an immediate impact on the education of girls. Only 40% of teen moms finish high school and only 2% of teen moms finish college by the age of 30.[26] There is a clear correlation between teen birth rates and national graduation rates.[27] This lack of education also impacts the mother's earning potential and overall family income. Nationwide, nearly half of teen mothers live with incomes below the poverty line.[28] The Brookings Institution released a study that children of teen mothers without a high school diploma have family incomes of around $50,000 by age 29, while their counterparts who delay their first birth by just two years and receive a high school diploma have yearly incomes that are nearly $6,600 higher.[29]

Teen pregnancies do not only affect the mother; their children also suffer consequences. Children of teenage mothers are more likely to drop out of high school, have health problems, be incarcerated during adolescence, become a teen parent themselves,

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transmitted-diseases#:~:text=In%20addition%2C%20STDs%20can%20cause,infants%20born%20to%20infected%20mothers.

[22] CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra*, note 17.

[23] Stranger-Hall, *supra* note 18.

[24] Maddow-Zimet, *supra* note16.

[25] *Id*.

[26] *Why It Matters*, POWER TO DECIDE, https://powertodecide.org/what-we-do/information/why-it-matters (last visited November 3, 2021)

[27] *Id*.

[28] Nat'l Conference of State Legislatures, *Oklahoma: Teen Pregnancy- Impact on Education and the Economy* (April 2015) https://www.ncsl.org/documents/health/TPreOKEducation415.pdf.

[29] Emily Cuddy and Richard Reeves, *Teen Moms: The Difference Two Years and a Diploma Make*, BROOKINGS (August 18, 2014), https://www.brookings.edu/blog/social-mobility-memos/2014/08/18/teen-moms-the-difference-two-years-and-a-diploma-make/#:~:text=Whereas%20children%20of%20teen%20mothers,that%20are%20nearly%20%246%2C600%20higher.

and face unemployment.[30] Aside from the direct impact on the family, there is a nationwide economic impact. Between 1991 and 2015, the teen birth rate dropped 64%, which resulted in $4.4 billion in public savings in 2015 alone.[31]

B. Sexual Education Policy Survey

i. Tennessee

The 2021-2022 school year marked the beginning of Tennessee's new Family Life Education Curriculum. The new curriculum scraps the previous policy that only required counties that have a teen pregnancy rate over 19.5 out of 1,000 girls aging 15 to 17 to have sexual education in schools.[32] Now, each Local Education Agency ("LEA") must adopt a Family Life Curriculum that complies with the newly adopted statutory requirements.[33]

As explained in Tenn. Code Ann. § 49-6-1304, the Curriculum has 13 requirements, as well as 4 topics that are forbidden.[34] The first requirement of the Curriculum calls for "emphatically promot[ing] only sexual risk avoidance through abstinence, regardless of a students' current or prior sexual experience."[35] Under the umbrella of promoting abstinence before marriage,[36] the Curriculum requires educators to explain "the physical, social, emotional, psychological, economic and educational consequences of nonmarital sexual activity,"[37] assist students in practicing refusal skills to resist sexual activity,[38] address the benefits of raising children in a marital relationship,[39] and teach the social science research support benefits of "reserving the expression of human sexual activity for marriage."[40]

In addition to abstinence, the Curriculum calls for information to be factually and medically accurate,[41] encourages communication with parents or other trusted adults about sex,[42] discusses the interrelationship of teen sexual activity and exposure to other risk behaviors like drinking and smoking,[43] educates on

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[30] *Id.*
[31] Maddow-Zimet, *supra* note16.
[32] Tenn. Code Ann. § 49-6-1302 (2020).
[33] Tenn. Code Ann. § 49-6-1302 (2021).
[34] Tenn. Code Ann. § 49-6-1304 (2021).
[35] Tenn. Code Ann. § 49-6-1304(a)(1) (2021).
[36] Tenn. Code Ann. § 49-6-1304(a)(3) (2021).
[37] Tenn. Code Ann. § 49-6-1304(a)(2) (2021).
[38] Tenn. Code Ann. § 49-6-1304(a)(7) (2021).
[39] Tenn. Code Ann. § 49-6-1304(a)(8) (2021).
[40] Tenn. Code Ann. § 49-6-1304(a)(3) (2021).
[41] Tenn. Code Ann. § 49-6-1304(a)(4) (2021).
[42] Tenn. Code Ann. § 49-6-1304(a)(6) (2021).
[43] Tenn. Code Ann. § 49-6-1304(a)(9) (2021).

consent, puberty, pregnancy, child birth, and STDs including but not limited to HIV/AIDS,[44] teaches students how to identify healthy and unhealthy relationships,[45] informs about adoption,[46] and provides instruction on detection and prevention of child sex abuse,[47] human trafficking,[48] and dating violence[49].

However, the Curriculum forbids promoting any gateway sexual activity[50] (which is defined in section 1301 as "encouraging, advocating, urging or condoning gateway sexual activities"[51]), providing or distributing materials on school grounds that condone, encourage, or promote student sexual activity among unmarried students,[52] and distributing contraception on school property.[53] Schools may, but do not have to, provide medically accurate information about contraception and condoms that is consistent with public policy and presented in a manner that emphasizes only abstinence removes all risk.[54] The statute allows parents to opt their student out of the lesson without penalty.[55] Tennessee's approach to sexual education is representative of a middle ground in the US when compared to states like Mississippi and Vermont, that employ sexual education programs that are not fully abstinence based, but also not a fully comprehensive approach.

ii. Mississippi

Mississippi's current sexual education program is essentially an "abstinence-only education." The statute calls for every public-school district to adopt either an abstinence only or abstinence-plus education model.[56]

Under the statute, the curriculum must teach the gains of abstaining from sexual activity and the negative effects of not abstaining;[57] the harmful consequences to a child, the child's parents, and society when a child is born out of wedlock;[58] that abstinence before marriage and fidelity within marriage is the only certain way to avoid out of wedlock pregnancy, STDs and related

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[44] Tenn. Code Ann. § 49-6-1304(a)(10) (2021).
[45] Tenn. Code Ann. § 49-6-1304(a)(11) (2021).
[46] Tenn. Code Ann. § 49-6-1304(a)(12) (2021).
[47] Tenn. Code Ann. § 49-6-1304(a)(13)(A) (2021).
[48] Tenn. Code Ann. § 49-6-1304(a)(13)(B) (2021).
[49] Tenn. Code Ann. § 49-6-1304(a)(14) (2021).
[50] Tenn. Code Ann. § 49-6-1304(b)(1) (2021).
[51] Tenn. Code Ann. § 49-6-1301(7) (2021).
[52] Tenn. Code Ann. § 49-6-1304(b)(2) (2021).
[53] Tenn. Code Ann. § 49-6-1304(b)(4) (2021).
[54] Tenn. Code Ann. § 49-6-1304(b)(4)(A) (2021).
[55] Tenn. Code Ann. § 49-6-1305(b) (2021).
[56] Miss. Code Ann. § 37-13-171(1) (2021).
[57] Miss. Code Ann. § 37-13-171(2)(a) (2021).
[58] Miss. Code Ann. § 37-13-171(2)(b) (2021).

health problems;[59] the current law of rape, paternity, child support, and homosexual activity;[60] and that a mutually faithful, monogamous marriage is the only appropriate setting for sex.[61]

In addition, schools may elect to have a discussion on condoms or contraceptives but there may not be a demonstration of how to use them.[62] HIV may be discussed but it is not required under the statute.[63] The curriculums cannot teach about abortion.[64]

iii. Vermont

Vermont is an exemplar of comprehensive health education in the US. Its comprehensive health program occurs throughout elementary and secondary education and covers an array of topics from sexual health to pollution to disaster relief.[65] Within the education system, Vermont requires family and mental health education which covers decision making about sexual activity, parent and student interaction, family life guidance, and signs of suicide.[66]

Vermont also has a human growth and development requirement which calls for instruction on understanding the physical, emotional, and social elements of development and interpersonal relationships, possible outcomes of premature sexual activity, contraceptives, adolescent pregnancy, childbirth, and abortion.[67] Vermont has further instruction on utilizing health services, recognizing and preventing sexual abuse and violence, and instruction on parenting styles and methods.[68] Vermont schools may also include a module focusing on cervical cancer and the human papillomavirus (HPV).[69] Vermont also requires all public school districts to make condoms available for their students, free of charge.[70]

iv. Comparison

Of the three varying approaches to sexual education, Vermont is representative of a comprehensive sexual education

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[59] Miss. Code Ann. § 37-13-171(2)(d) (2021).
[60] Miss. Code Ann. § 37-13-171(2)(e) (2021).
[61] Miss. Code Ann. § 37-13-171(2)(f) (2021).
[62] Miss. Code Ann. § 37-13-171(3) (2021).
[63] *Id.*
[64] Miss. Code Ann. § 37-13-171(6) (2021).
[65] 16 V.S.A. § 131 (2021).
[66] 16 V.S.A. § 131(5) (2021).
[67] 16 V.S.A. § 131(8) (2021).
[68] 16 V.S.A. § 131(11) (2021).
[69] 16 V.S.A. § 133(c) (2021).
[70] 16 V.S.A. § 132 (2021).

program, while Mississippi falls on the opposite end of the scale, reflecting the policies of abstinence-only education. Tennessee's family life curriculum falls somewhere near the middle, but still leans toward the abstinence-only side of the policy scale.

Currently, only 39 states in the US require sexual education, with all 39 states requiring provision of information on abstinence and only 20 states requiring provision of information on contraception.[71] There is strong data that shows a correlation between a state's approach to sexual education policy and its STD and teen pregnancy rates,[72] however, this is not the only basis for sexual health.[73]

v. STDs, Teen Pregnancy Rates, and Sexual Education Styles

When broken down on a state-by-state basis, sexual health crisis statistics tend to correlate with the sexual education program adopted by the state.[74] Additionally, there is strong connection between race, geography, and socio-economic factors and STD and teen pregnancy rates.[75] The spread of STDs can be tied to numerous social, economic, and behavioral factors.[76] Racial groups including African Americans, Hispanics, and Native Americans have higher rates of contracting STDs.[77] Those suffering from poverty and substance abuse are also more at risk of STDs.[78] Access to health care is crucial for early detection and reducing the spread of STDs.[79] Socially, negative stigma and discomfort surrounding STDs are one of the biggest differences between the US and other developed countries with low STD rates.[80]

As previously mentioned, Mississippi is representative of an abstinence-based approach, Vermont is representative of a

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[71] GUTTMACHER INST., *supra* note 1.
[72] Erin Blakemore, *Teens aren't receiving enough sex education, study says,* THE WASHINGTON POST (Nov. 28, 2021 at 9:00 a.m. EST) https://www.washingtonpost.com/health/sex-education-teens/2021/11/26/c005d154-4c98-11ec-b73b-a00d6e559a6e_story.html.
[73] STD and teen pregnancy rates are not the only basis for sexual health.
[74] *Id.*
[75] *Sexually Transmitted Diseases,* OFF. OF DISEASE PREVENTION AND HEALTH PROMOTION, https://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases#five (last visited January 4, 2022).
[76] *Id.* (These factors are known to contribute to the vulnerability of populations and should be kept in mind when looking at the analysis below. This note does not account for the social differences between the states, just the types of sexual education).
[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Id.*

comprehensive approach, and Tennessee is representative of a middle point leaning towards the abstinence-based side. Mississippi consistently is in the top three states for rates of sexual health crises. In 2019, Mississippi had the highest Gonorrhea rate with an average of 404.1 out of 100,000 people,[81] the second highest Chlamydia rate with an average of 847.2 out of 100,000 people,[82] and the third highest Syphilis rate in the US.[83] Conversely, Vermont is consistently in the bottom two states for sexual health crises rates. In 2019, Vermont had the lowest Gonorrhea rate with 27.9 out of 100,000 in 2019,[84] the lowest Syphilis rate in the country at 1.8 out of 100,000 in 2019,[85] and the second lowest Chlamydia rate with 274.3 out of 100,000.[86]

In 2019, Tennessee had the 12th highest rate for chlamydia,[87] 10th highest for Gonorrhea,[88] and 21st highest for syphilis.[89] While not as egregious as Mississippi, Tennessee has never come close to competing with Vermont's low rates.

In terms of teen birth rates, the states follow a similar trend. Mississippi has the second highest in the country with 29.1 out of 1,000 teens, Tennessee has a rate of 23.7 out of 1,000, and Vermont has a rate of 7.6 out of 1,000 teens.[90]

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[81] *Table 13. Gonorrhea – Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2019*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/std/statistics/2019/tables/13.htm (last visited November 3, 2021).

[82] *Table 2. Chlamydia – Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2019*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/std/statistics/2019/tables/2.htm (last visited November 3, 2021).

[83] *Table 26. Primary and Secondary Syphilis – Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2019*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/std/statistics/2019/tables/26.htm (last visited November 3, 2021).

[84] CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 81.

[85] CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 83.

[86] CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 82.

[87] *Id*.

[88] CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 81.

[89] *Table 26. Primary and Secondary Syphilis – Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2019*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/std/statistics/2019/tables/26.htm (last visited November 3, 2021).

[90] *Teen Birth Rate by State*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/nchs/pressroom/sosmap/teen-births/teenbirths.htm (last visited November 3, 2021).

III. ISSUE

As shown above, the US continues to be plagued by sexual health crises. To combat these issues, international organizations recommend comprehensive curriculums. The ITGSE breaks their ideal curriculum down into 8 key concepts: relationships; values, rights, culture, and sexuality; understanding gender; violence and staying safe; skills for health and well-being; the human body and development; sexuality and sexual behavior; and sexual reproductive health.[91] In addition to these 8 concepts, they further break down their guidance into 4 different age groups: 5-8 years, 9-12 years, 12-15 years, and 15-18+ years.[92] Within those age groups they have learning objectives applicable to each of the 8 Key Concepts.[93]

Opposers of comprehensive sexual education argue that sexual education should teach abstinence, often basing their preferences on religious beliefs and reaching to legal arguments to support them. Tennessee's abstinence-based approach to sexual education continues to be detrimental to the state's overall sexual health because it does not cover necessary topics that are included in a more comprehensive sexual education policy.

IV. LEGAL TETHERS

Under the Tenth Amendment, every state has the power to create and enforce its own educational requirements, because it is not otherwise mentioned in the US Constitution.[94] Every state is required by its own state constitution to provide education.[95] For example, under Art. XI Section 12 of Tennessee's constitution, the state "recognizes the inherent value of education and encourages its support" and "(t)he General Assembly shall provide for the maintenance, support and eligibility standards of a system of free public schools."[96] However, not all states require sexual education as a requirement to providing education.[97]

The debate over sexual education is often value-based. These value-based arguments are rooted within the United States

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[91] UNITED NATIONS POPULATION FUND, *supra* note 4.
[92] *Id.* at 34.
[93] *Id.* at 35.
[94] U.S. CONST. amend. X.
[95] *Education*, LEGAL INFO. INSTITUTE, https://www.law.cornell.edu/wex/education#:~:text=Each%20state%20is%20required%20by,children%20may%20receive%20an%20education.&text=The%20Equal%20Education%20Opportunities%20Act,%2C%20sex%2C%20or%20national%20origin. (last visited January 4, 2022).
[96] TENN. CONST. Art. XI, § 12.
[97] GUTTMACHER INSTITUTE, *supra* note 1.

Constitution via the First Amendment's Freedom of Religion Clause,[98] and the Fourteenth Amendment's Liberty Interest.[99] Other legal arguments made concerning sexual education include minors' ability to make health-related decisions,[100] and discrimination against women and members of the LGBTQ+ community.[101] This section of the note analyzes various legal tethers and explains how the law supports an argument for a comprehensive sexual education.

A. Mature Minor Doctrine

Tennessee has a common law doctrine that allows minors to consent to medical treatment, known as the Mature Minor Doctrine.[102] The Mature Minor Doctrine follows the Rule of Sevens: under the age of 7 parental consent is required due to a lack of capacity, unless a statutory exception applies; between the ages of 7 and 14 there is a rebuttable presumption that the child lacks capacity, so parental consent is generally necessary; and when treating minors ages 14 to 18, there is a rebuttable presumption of capacity, so physicians can treat the minor without parental consent unless they believe the minor lacks the capacity to make their own health care decisions.[103]

In addition to the general doctrine discussed above, Tennessee has codified certain conditions[104] that allow minors to be treated without parental consent including treatment for drug abuse, STDs, emergency situations, provision of contraception, and provision of prenatal care.[105]

Decker v. Carrol Academy addresses various challenges surrounding the Mature Minor Doctrine and challenges the constitutionality of the doctrine specifically concerning contraceptives for minors.[106] Carrol School officials referred Decker's daughter to a public health clinic, and that public health clinic then distributed birth control to Decker's daughter without parental consent.[107] Decker contended that the distribution of birth

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[98] U.S. CONST. amend. X.
[99] U.S. CONST. amend. IV.
[100] *Mature Minor Doctrine, supra* note 10.
[101] Education Amendments Act of 1972, 20 U.S.C. §§1681–1688 (2018). Title IX (2018).
[102] *Mature Minor Doctrine, supra* note 10.
[103] *Id.*, *see also* Cardwell v. Bechtol, 724 S.W.2d. 739 (Tenn. 1987).
[104] In the argument here, the relevant Tennessee statutes are Tenn. Code Ann. § 68-10-104(c) concerning STD treatment for minors, Tenn. Code. Ann. § 68-34-107 Concerning contraceptives for minors, and Tenn. Code Ann. § 63-6-223 concerning prenatal care for minors.
[105] *Mature Minor Doctrine, supra* note 10.
[106] Decker v. Carroll Academy, 1999 Tenn. App. LEXIS 336 (Tenn. Ct. App. May 26, 1999).
[107] *Id.*

control violated her parental rights under the First Amendment.[108] The Court sided with Carrol Academy, granting a motion to dismiss because Decker failed to rebut the presumption that her 14-year-old daughter had the capacity to consent to the medical treatment administered.[109]

Informing mature minors about their sexual health allows them to make informed decisions about their own health. There is a rebuttable presumption that minors over the age of 14 have the capacity to make medical decisions concerning contraception and treatment of STDs.[110] However, having the capacity to decide does not necessarily mean that a minor will be educated enough to understand all potential ramifications of their decisions. By providing comprehensive sexual education, minors will be better situated to make educated decisions regarding their health that they may otherwise not have as an uneducated minor.

B. Freedom of Religion

Both sides of the debate on sexual education root their arguments within the First Amendment's Freedom of Religion Clause. The first sixteen words of the First Amendment read: "Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof."[111] Often intertwined, the first clause is the Establishment Clause, while the second clause is known as the Free Exercise Clause.

i. Establishment Clause

The Curriculum violates the Establishment Clause because it is coercive. The Establishment Clause prohibits the government from making any law respecting an establishment of religion.[112] Put simply, the government cannot make a law that favors one religion over another. Unfortunately, it is not that simple. The Establishment Clause, and its related tests, is a contentious subject amongst legal scholars and Justices alike. Previously, the test most associated with the Establishment Clause was the *Lemon* Test.[113] Under *Lemon v. Kurtzman*, the Supreme Court established a three-prong test to determine whether a law violates the Establishment Clause known

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[108] *Id.*
[109] *Id.*
[110] *Mature Minor Doctrine*, *supra* note 10.
[111] U.S. CONST. amend. X.
[112] Stephen J. Shapiro, *Freedom Of Religion*, UNIV. OF BALTIMORE, https://home.ubalt.edu/shapiro/rights_course/Chapter5text.htm (last visited November 3, 2021).
[113] Lemon v. Kurtzman, 403 U.S. 602, 612 (1971).

as the "*Lemon* Test".[114] Under this test, first, the law must have a secular purpose.[115] Second, the laws primary effect must not be to advance or inhibit religion.[116] Third, it must not foster an excessive entanglement between government and religion.[117]

Under the *Lemon* Test, The Curriculum violates the Establishment Clause because it does not pass the first prong of the *Lemon* Test, as it lacks a secular purpose.[118] The secular purpose prong requires the government's actions to be justified by a primary, genuine, secular purpose.[119] Different cases use the secular purpose prong differently.[120] In *Edwards v. Aguillard*, the Court looked to the actual purpose and required it to be clear and not merely a sham.[121]

The Curriculum currently leans towards abstinence and rejects comprehensive policy. In order to have a secular purpose, and survive the *Lemon* Test, Tennessee must show that the primary purpose behind the Curriculum is advancing a legitimate, secular state interest and not a religious ideal.

The Curriculum's promotion of abstinence, banning of contraception distribution, and non-requirement of contraception education is more representative of a religious belief, not American values. For example, despite 64.9% of women in the US aged 15 to 49 using contraception,[122] the Curriculum still claims the lack of contraception education is based on American values. However, this viewpoint is more like the Roman-Catholic belief that contraception should be banned because it is a sin against nature.[123] Other religions, including some Protestant denominations, some forms of

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[114] *Id*.
[115] *Id.*
[116] *Id.*
[117] *Id.*
[118] *See* Wallace v. Jaffree, 472 U.S. 38 (1985) (deciding that if there is no obvious secular purpose, the court does not need to examine the other two prongs of the *Lemon* Test).
[119] *Lemon*, 403 U.S. at 612-14.
[120] *Compare* Edwards v. Aguillard, 482 U.S. 578 (1987) *with* Lynch v. Donnelly, 465 U.S. 668, 679 (1984) (requiring that the statute must be wholly motivated by religious motivations in order to be invalidated by the establishment clause).
[121] *Edwards*, 482 U.S. at 578.
[122] Kimberly Daniels, Ph.D., and Joyce C. Abma, Ph.D., *Current Contraceptive Status Among Women Aged 15-49: United States, 2015-2017*, NCHS DATA BRIEF NO. 327 (December 2018) https://www.cdc.gov/nchs/products/databriefs/db327.htm#:~:text=In%202015%E2%80%932017%2C%2064.9%25%E2%80%94or%2046.9%20million%20of,among%20women%20aged%2040%E2%80%9349.
[123] J G Schenker and V Rabenou, *Contraception: traditional and religious attitudes*, 49 EUR. J. OBSTET. GYNECOL. REPROD. BIOL. (1993). https://pubmed.ncbi.nlm.nih.gov/8365507/#:~:text=The%20Roman%20Catholic%20church%20forbids,denominations%20have%20allowed%20contraceptive%20use.

Islam, Hinduism, and Buddhism allow for couples to prevent pregnancy.[124] As a result, the Curriculum should fail the first prong of the *Lemon* Test, because without a sincere intent, the Curriculum lacks a secular purpose.

Even if the intent behind the Curriculum is to promote sexual health and lower rates of STDs and teen pregnancy, it still fails the first prong of the *Lemon* Test. As a recipient of federal Title V funding,[125] Tennessee is adhering to a series of requirements that are not proven to help combat current sexual health crises.[126] One 2011 survey of sexual health programs revealed that the level of abstinence promoted in a curriculum positively correlated with teen pregnancy, meaning that teens in states that prescribe more abstinence education are more likely to get pregnant.[127] A congressionally mandated 2007 study additionally revealed that Title V programs had no beneficial impact on teen sexual behavior.[128] A proven rate of failure associated with the strategies utilized in the Curriculum shows that the government is electing to use policies that are not aligned with their intent.[129] This again causes the intent of the Curriculum to fall into the "sham" category because the state is not taking steps to ensure the outcome is achieving the intent of the policy, and ultimately fails the *Lemon* Test for lack of a secular purpose.

Although the Curriculum fails under the *Lemon* Test, this long-maligned test has now been abandoned, requiring a new analysis. In *Kennedy v Bremerton School District*, the Court abandoned the *Lemon* Test and in its place instructed that the Establishment Clause is to be interpreted by reference to historical practices and understandings.[130] Citing to cases including *Town of Greece v. Galloway* and *American Legion,* the Justices call upon the courts to draw a line "between the permissible and impermissible" reflecting the "understanding of the Founding Fathers."[131] While it is outside of the scope of this note to fully interpret this change in law, this note acknowledges how the Curriculum may still violate the Establishment Clause without fully interpreting this new rule.

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[124] *Id*.

[125] Ass'n of Maternal & Child Health Programs, *AMCHP State Profile: Tennessee*, http://www.amchp.org/Policy-Advocacy/MCHAdvocacy/2021%20State%20Profiles/Tennessee%202021%20FINAL.pdf (last visited November 4, 2021).

[126] Stanger-Hall, *supra* note 18.

[127] *Id*.

[128] *A History of Abstinence-Only Funding in the U.S.*, SEXUALITY INFO. AND EDUC. COUNCIL FOR THE U.S., https://siecus.org/wp-content/uploads/2018/07/4-A-Brief-History-of-AOUM-Funding.pdf (last visited November 3, 2021).

[129] *Id.*

[130] *Id*. at 2428.

[131] *Id*.; *see* Town of Greece v. Galloway, 572 U.S. 565 at 576; *see also* Am. Legion v. Am. Humanist Ass'n, 139 S. Ct. 2067 (2019).

As part of this new test, the ruling in *Kennedy* explained that the government cannot coerce people to observe religious practices.[132] In *Kennedy,* the Court decided that a public high school football coach praying at the 50-yard line after football games was not coercive behavior.[133] In turn, the justices ruled that firing the coach for praying on the 50-yard line violated the Establishment Clause.[134]

Unlike praying on the 50-yard line, an abstinence-based sexual education policy is likely coercive. The Curriculum limits access to comprehensive sexual education and presents a limited view reflective of Roman-Catholic beliefs. This format does not give students the opportunity to access comprehensive education and ultimately coerces them into learning an abstinence-based view of sexual education.

Overall, it is unclear how the new test for the Establishment Clause will be applied to sexual education. Whether the Curriculum is in line with the historical practices and understanding is a question for a later date. However, there is a strong argument that the Curriculum violates the Establishment Clause because it is coercive and forces students to learn the Roman-Catholic approach to sexual education, not a science-backed, religion-neutral approach. As a result, the Curriculum interferes with freedom of religion rights for students and their parents within public schools. Tennessee needs to adopt a curriculum that survives the Establishment Clause by not being coercive.

ii. Free Exercise Clause

Others who oppose comprehensive sexual education argue that it violates their religious rights under the Free Exercise Clause. Under the Free Exercise Clause, all individuals have the absolute right to hold any religious belief without interference by the government.[135]

In *Citizens for Parental Rights v. San Mateo County Bd. Of Education,*[136] California parents challenged the implementation of family life and sex education programs by the school board.[137] The parents brought a slew of accusations including that the program interfered with the parents' and students' free exercise of religion

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[132] Kennedy v. Bremerton Sch. Dist., 142 S. Ct. 2407, 2430 (2022).
[133] *Id*. at 2429
[134] *Id*. at 2431
[135] Stephen J. Shapiro, *Freedom of Religion*, UNIV. OF BALTIMORE, https://home.ubalt.edu/shapiro/rights_course/Chapter5text.htm (last visited November 3, 2021).
[136] This case is not binding precedent in Tennessee.
[137] Citizens for Parental Rights v. San Mateo Cnty. Bd. of Educ., 51 Cal. App. 3d 1, 4 (1975).

and that a statutory system of excusal from participation in the program would be unconstitutional.[138] The Superior Court dismissed the complaint and the Court of Appeals affirmed, finding the program to be constitutional because of the state's excusal program.[139]

The court went on to apply the three-step analysis from *Sherbert v. Verner.*[140] This three-prong analysis determines whether a regulation of conduct based on a religious belief can be upheld by the court.[141] First, the court assesses whether the regulation directly threatens the public safety, peace, or order.[142] Second, it looks to whether the disqualification from receipt of benefits burdens the free exercise of the petitioner's religion in any way.[143] Third, if there is any incidental burden, the court determines whether it was justified by a compelling state interest.[144]

In this case, the court found that it was apparent that the parents' refusal to send their kids to the program did not threaten public safety,[145] the election not to participate and the informal pressure surrounding it was not unduly burdening on the petitioner,[146] and there is a compelling state interest in education.[147] As a result, the court found that since the program was not compulsory, it did not violate the Free Exercise Clause.[148] Additionally, the court noted that "[a]bsent some serious contention of harm to the mental or physical health of the children of this state or to the public safety, peace, order or welfare, a mere personal difference of opinion as to the curriculum which is taught in our public school system does not give rise to a constitutional right in the private citizen to control exposure to knowledge."[149]

Free Exercise jurisprudence has since changed since *Citizens.* The decision in *Employment Division, Dept. of Human Resources of Oregon v. Smith* altered Free Exercise law by refusing to grant religious exceptions from neutral, generally applicable criminal laws.[150] In *Employment Division, Dept. of Human Resources of Oregon v. Smith*, the plaintiffs were fired from their jobs after taking peyote for religious purposes, which violate Oregon's state law banning the use of controlled substances for non-

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[138] *Id*. at 5.
[139] *Id.* at 5–6.
[140] *Id.* at 16; Sherbert v. Verner, 374 U.S. 398 (1963).
[141] *Citizens,* 51 Cal. App. 3d at 16.
[142] *Id.*
[143] *Id.*
[144] *Id.*
[145] *Id.*
[146] *Id.* at 17.
[147] *Id*. at 19.
[148] *Id.*
[149] *Id.* at 18.
[150] Emp't Div. v. Smith, 494 U.S. 872, 879 (1990).

medicinal purposes.[151] The plaintiffs were denied unemployment benefits because of their "workplace misconduct" and challenged the decision in court.[152] Ultimately, the Court found that the Free Exercise Clause of the First Amendment permits the state of Oregon to criminalize religious practices that violate generally applicable laws.[153] Within the *Employment Division* decision, the Court explains that, along with other methods of suppressing religious liberty, the government may not compel affirmation of religious belief or lend its power to support one side of a religious argument.[154]

Applying the *Citizens* test, along with the changes in *Employment Division,* to the issue at hand, a comprehensive sexual education program that provides an opt-out provision would not violate the free exercise clause. Currently, the Curriculum includes a provision under Tenn. Code Ann. § 49-6-1305 that requires notification of the parents prior to the commencement of the instruction of the Curriculum and allows for parents to submit requests for their child to be excused.[155] This is an example of a suitable optout provision.

C. Fourteenth Amendment Liberty Interest

The right of parents to decide how to raise their children is rooted within the Fourteenth Amendment of the Constitution. This Amendment states, "nor shall any State deprive any person of life, liberty or property . . ."[156] Under the liberty clause, the Supreme Court has identified unenumerated rights, including the right to marry,[157] establish a home,[158] and bring up children[159] through a series of cases. The unenumerated right most commonly included in sexual education arguments is the right to bring up children as the parents see fit.

Supporters of comprehensive sexual education look to *Meyers v. Nebraska*[160] and *Pierce v. Soc'y of Sisters.*[161] In *Meyers v. Nebraska,* the Supreme Court struck down a Nebraska law that criminalized teaching a foreign language to any student that had yet

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[151] *Id.* at 874.
[152] *Id.*
[153] *Id.* at 890.
[154] *Id.* at 877.
[155] Tenn. Code Ann. § 49-6-1305(b) (2021).
[156] U.S. CONST. amend. IV.
[157] *See* Loving v. Virginia, 388 U.S. 1 (1967).
[158] *See* Moore v. East Cleveland, 431 U.S. 494 (1977).
[159] *See* Meyer v. Nebraska, 262 U.S. 390 (1923); *See also* Pierce v. Soc'y of Sisters, 268 U.S. 510 (1924).
[160] *Meyer,* 262 U.S. 390.
[161] *Pierce,* 268 U.S. 510.

to complete the eighth grade.[162] The law was enacted following WWI as a reflection of the growing hostility towards German culture.[163] Here, Meyers was a parochial schoolteacher who was convicted of teaching German to a ten-year-old student.[164] The Court found that prohibiting the teaching of German interfered with the parents' desire to educate their children without a legitimate state interest, which falls under the parents' right to control and educate their children.[165]

Similarly, in *Pierce v. Soc'y of Sisters*, the Court found that requiring children to attend public school violates the Fourteenth Amendment under the parents' right to bring up their children.[166] In this case, Oregon enacted the Compulsory Education Act that mandated children to attend public school, reasoning that the state's interest in overseeing the education of citizens was greater than the right to choose.[167] Two private educators sued to enjoin the Act. As a result, the Court found in favor of the educators, concluding that there was not a strong enough government interest in requiring public school education to infringe on parental rights.[168]

Based on these two cases, some parents argue that by providing comprehensive sexual education, the government is interfering with their right to control and educate their children. Precedent shows that when a conflict about content of education arises, the decision-making power falls to the parents absent a strong government interest.[169] However, by providing an opt-out provision, as Tennessee already does, the parents still have control over their child's education. Should this not be enough, sexual health is a stronger government interest than hostility towards German culture or wanting kids to go to public school, so it may overcome the balancing test if necessary.

This liberty interest argument is a double-edged sword. While some parents argue that providing comprehensive sexual education violates their rights, others argue that not providing it will also violate their rights. By refusing to teach comprehensive sexual education, the government is placing the burden on the parents (a burden most parents may not be fit to carry). The government

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[162] *Id.* at 396.
[163] *Id.* at 402.
[164] *Id.* at 396.
[165] *Id.* at 401.
[166] *Pierce*, 268 U.S. 510.
[167] *Id.* at 530.
[168] *Id.* at 535-536.
[169] Jesse R. Mirriam, *Why Don't More Public Schools Teach Sex education? A Constitutional Explanation and Critique,* 13 WM. & MARY J. WOMEN & L. 539 (2007), https://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=1082&context=wmjowl.

interest for not providing sexual education also is not very strong, giving the approach a chance to succeed.

For a curriculum to survive both sides of a potential Fourteenth Amendment liberty interest challenge, the government needs to show a strong government interest and allow for an opt-out provision.

D. Title IX

Title IX is a federal civil rights law that protects people from sex discrimination within educational institutions that receive federal funding.[170] Title IX of the Education Amendments of 1972 states, "[n]o Person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving federal funding."[171] Under Title IX, institutions that receive federal financial assistance, including schools, must operate their programs in a nondiscriminatory manner.[172] Key areas that Title IX is usually applied to include admissions, athletics, sexual harassment, treatment of LGBTQI+ students, and single-sex education.[173]

While there is not extensive case law covering the subject, sexual education curriculums may be violating Title IX.[174] For example, schools in Tennessee receive funding through Title V Abstinence education programs.[175] By receiving Title V funding, the Curriculum undoubtedly passes the first qualification of Title IX: it is an educational program that receives federal funding.[176] The more difficult point to prove is that individuals are being discriminated against on the basis of sex. Two arguments can be made that incompetent sexual education curriculums violate Title IX. The first argument is rooted in the gendered effects of inadequate sexual education. When a school neglects to adequately inform their students about use of birth control, girls' education will suffer the consequences more than the boys' education.

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[170] Off. For Civil Rights, *Title IX and Sex Discrimination*, U.S. DEP'T OF EDUC. (Aug. 2021) https://www2.ed.gov/about/offices/list/ocr/docs/tix_dis.html.
[171] *Id.* (quoting Education Amendments Act of 1972, 20 U.S.C. §§1681–1688 (2018). Title IX (2018)).
[172] U.S. DEP'T OF EDUC., *supra* note 170.
[173] *Id*.
[174] Danny Morano, *Let's Talk About Sex Ed, Baby: Sexual Education Programs and Curricular Exclusions Under Title IX*, 88 U. CHI. L. REV. ONLINE 1 (2021).
[175] Ass'n of Maternal & Child Health Programs, *supra* note 125.
[176] Education Amendments Act of 1972, 20 U.S.C. §§1681–1688 (2018). Title IX (2018).

Teen pregnancy is the primary reason that girls drop out of school.[177] According to the CDC, only 50% of teen mothers receive a high school diploma before the age of 22, while 90% of women who are not teen mothers graduate high school.[178] Researchers from the University of Washington found that teens who receive comprehensive sex education are less likely to become pregnant than teens who receive abstinence-only-until-marriage or no formal sex education.[179] Researchers found that teens who received comprehensive education were 60% less likely to become pregnant or impregnate someone than those who did not receive sexual education.[180]

Aside from direct impacts of teen pregnancy, lack of sexual education can still negatively impact a woman's overall educational experience. In the US, dysmenorrhea is the leading cause of short-term absenteeism among adolescent girls.[181] Dysmenorrhea causes severe and frequent cramps and pain during periods.[182] One study revealed that 38% of girls missed school days within the past 3 months because of dysmenorrhea, while 59% had difficulty focusing in class because of it.[183] Symptoms may include pain and cramping in the lower abdomen and back, nausea, vomiting, diarrhea, headache, and fatigue.[184] Both NSAIDs and oral contraceptives can be used to manage symptoms of dysmenorrhea.[185] However, a study revealed that only 54% of white American adolescents know about this therapeutic treatment.[186] By limiting the instruction surrounding contraceptives, schools are not

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[177] *About Teen Pregnancy*, CTRS. FOR DISEASE CONTROL AND PREVENTION, (last updated Sep. 3,2021) https://www.cdc.gov/teenpregnancy/about/index.htm.
[178] *Id.*
[179] Marshall Bright, *Study Finds that Comprehensive Sex Education Reduces Teen Pregnancy*, AM. CIVIL LIBERTIES UNION (Mar. 28, 2008, 4:53 PM) https://www.aclu.org/blog/reproductive-freedom/study-finds-comprehensive-sex-education-reduces-teen-pregnancy.
[180] Health Behavior News Services, *Comprehensive Sex Education Might Reduce Teen Pregnancies*, NEWSWISE (Mar. 13, 2008) https://www.newswise.com/articles/comprehensive-sex-education-might-reduce-teen-pregnancies.
[181] Chantay Banikarim et al, *Prevalence and Impact of Dysmenorrhea of Hispanic Female Adolescents*, ARCH. PEDIATR. ADOLSEC. MED. 2000 (Dec. 2000) https://jamanetwork.com/journals/jamapediatrics/fullarticle/352652#:~:text=In%20the%20United%20States%2C%20dysmenorrhea,of%20short%2Dterm%20school%20absenteeism.&text=Several%20studies%20have%20shown%20that,the%20availability%20of%20effective%20medications.
[182] *Dysmenorrhea*, JOHNS HOPKINS MED., HTTPS://WWW.HOPKINSMEDICINE.ORG/HEALTH/CONDITIONS-AND-DISEASES/DYSMENORRHEA (last visited November 4, 2021).
[183] *Id.*
[184] *Id.*
[185] *Id.*
[186] Banikarim, *supra* note 181.

informing females about uses for birth control other than avoiding pregnancy.[187] Male students do not suffer from dysmenorrhea, and therefore are not as severely impacted by the lack of information regarding contraceptives.[188]

Furthermore, a lack of comprehensive education can also impact the LGBTQI+ community. In 2019, men who identify as gay or bisexual accounted for 70% of new HIV infections within the US, making them a particularly vulnerable portion of the population.[189] Anal sex is the riskiest type of sex for transmission of HIV, but the risk can be mitigated by using a condom or preventative medicine.[190] Additionally, lack of inclusion of LGBTQI+ information in sexual education curriculums can contribute to hostile school environments, including bullying.[191] The Curriculum does not currently require LGBTQI+ materials to be taught during sexual education.[192] Not only does a lack of conversation about sexual identity create an increasingly hostile environment,[193] but also the lack of condom education can put LGBTQI+ students at greater physical risk.[194]

By failing to adopt a fully comprehensive sexual health curriculum, girls, and members of the LGBTQI+ community, are being denied the full benefits of a sexual education, and there is a discriminatory impact. Females are more at risk of dropping out of school, having increased absentee rates, and lower success rates when faced with challenges that could be prevented through proper

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[187] *Id.*

[188] JOHNS HOPKINS MED., *supra* note 182.

[189] *HIV Incidence*, CTRS. FOR DISEASE CONTROL AND PREVENTION, (last updated Sept. 16, 2021) https://www.cdc.gov/hiv/group/msm/msm-content/incidence.html.

[190] *HIV*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/hiv/group/msm/msm-content/prevention-challenges.html (last visited Jan. 4, 2022).

[191] *A Call to Action: LGBTQ Youth Need Inclusive Sex Education*, THE HUM. RIGHTS CAMPAIGN, https://www.hrc.org/resources/a-call-to-action-lgbtq-youth-need-inclusive-sex-education (last visited Jan. 4, 2022).

[192] Kaia Hubbard, *Few States Require LGBTQ-Inclusive Sex Education, Report Finds*, U.S. NEWS (May 26, 2021) https://www.usnews.com/news/best-states/articles/2021-05-26/few-states-require-lgbtq-inclusive-sex-education (According to US News, California, Colorado, New Jersey, Oregon, Rhode Island, Washington, and the District of Columbia require LGBTQ+-inclusive sex education. Delaware, Iowa, Massachusetts, South Carolina and Wisconsin require that if sexual education is taught, it does not affirm or discriminate against LGBTQ+ students. On the opposite end of the spectrum, Florida, Illinois, Louisiana, Mississippi, North Carolina, Oklahoma, and Texas have ban sexual education promoting of a homosexual lifestyle and focus on "monogamous, heterosexual marriage").

[193] *Id.*

[194] *HIV Prevention*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/hiv/group/msm/msm-content/hiv-prevention.html (last visited Jan. 4, 2022).

education.[195] Members of the LGBTQI+ community are also faced with discrimination, as the education focused on the risks and protections are focused on heterosexual individuals and do not cover some risks that members of the LGBTQI+ community may face.[196] Without a fully comprehensive sexual education program, Tennessee schools are risking liability by violating Title IX.

E. Title V

While there is no federal law that dictates what sexual education curriculums in schools must entail, the government uses federal funding to control how the programs approach the topic.[197] Currently there are no federal programs that fund access to comprehensive sexual education.

Title V, Section 510(b) of the Social Security Act sets up federal grants for state abstinence-only-until-marriage programs.[198] The intent of this program was "to align Congress with the social tradition . . . that sex should be confined to married couples."[199] Within this statute, the federal government defined the meaning of abstinence education, stating "its exclusive purpose [is to] teach[] the social, psychological, and health gains to be realized by abstaining from sexual activity."[200] Under this program, for every $1 the federal government allocates, the state must provide $3.[201] These funds go to a variety of other causes within the sphere of maternal and child health.[202]

While all states except for California have accepted Title V funding in the past, many states began to decline funding in the early 2000s when studies showed that there was no statistically significant beneficial impact on young people's sexual behavior as a result of the initiative.[203] However, Tennessee continues to receive funding from Title V.[204] In 2019 alone, Tennessee received $11,875,637 in MCH Block Grant Funds.[205] The allotment of these funds is reflective of a series of factors, including the number of low-income children in the state.[206] These funds, distributed over a multitude of causes, also contribute to Tennessee's "Adolescent Pregnancy

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[195] *About Teen Pregnancy*, *supra* note 177.
[196] THE HUM. RIGHTS CAMPAIGN, *supra* note 191.
[197] SEXUALITY INFO. AND EDUC. COUNCIL FOR THE U.S., *supra* note 128.
[198] *Id.*
[199] *Id.*
[200] *Id.*
[201] *Id.*
[202] Ass'n of Maternal & Child Health Programs, *supra* note 125.
[203] SEXUALITY INFO. AND EDUC. COUNCIL FOR THE U.S., *supra* note 128.
[204] Ass'n of Maternal & Child Health Programs, *supra* note 125.
[205] *Id.*
[206] *Id.*

Prevention Program" where health educators provide information on healthy relationships, adolescent health, and positive youth development.[207]

This poses a challenge to establishing a comprehensive sexual education program in Tennessee because it must abide by the requirements of Title V. For example, Section 510(b)(4) forbids certain forms of education including demonstrations, simulations, or distribution of contraceptive devices.[208] While this may pose issues, Tennessee may opt out of funding from Title V for their Curriculum, while still accepting funding for all the other important initiatives that Title V covers. For example, Vermont still receives Title V for a multitude of programs including newborn screening, oral health, and palliative care services, but does not apply it towards their sexual health programing.[209] As a result, they are able to shape their programming without the limitations under Title V.[210]

V. RECOMMENDED POLICY CHANGES FOR TENNESSEE

When crafting the new Curriculum for Tennessee, legislators should look to established sexual education programs and scientifically backed recommendations to shape new policy. States including Vermont,[211] California,[212] and the District of Columbia[213] are making strides towards fully comprehensive sexual education programs. Other countries like the Netherlands and Switzerland are active examples of using education to lower negative statistics. Organizations like the World Health Organization[214] and The Guttmacher Institute[215] continue to publish scientifically backed strategy guides on comprehensive sexual education that can provide guidance and act as templates. Tennessee legislators should also look to states like Mississippi, to see what their policies are and how they are yielding negative results, in order to find similar flaws in Tennessee's policy.

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[207] *Id.*

[208] Social Security Act §510, 42 U.S.C. 710 (2002). https://www.ssa.gov/OP_Home/ssact/title05/0510.htm.

[209] Ass'n of Maternal & Child Health Programs, *AMCHP State Profile: Vermont*, amchp.org http://www.amchp.org/Policy-Advocacy/MCHAdvocacy/2021%20State%20Profiles/Vermont%202021%20FINAL.pdf.

[210] *Id.*

[211] 16 V.S.A. § 131 (2021).

[212] Cal. Ed. Code § 51931-9 (2021).

[213] CDCR 5-E2305.

[214] UNITED NATIONS POPULATION FUND, *supra* note 4.

[215] A Definition of Comprehensive Sexuality Education, GUTTMACHER INSTITUTE, https://www.guttmacher.org/sites/default/files/report_downloads/demystifying-data-handouts_0.pdf.

What sets comprehensive curriculums like Vermont's and the program outlined in ITGSE apart from other programs, such as those in Mississippi and Tennessee, is their in-depth coverage of a wide variety of topics. The ITGSE is based on the idea that sexual education can be used to help with public health crises like HIV, AIDS, and teen pregnancy, as well as social concerns like gender-based violence, human rights, and sexuality acceptance.[216] Meanwhile, The Guttmacher Institute takes a rights-based approach to sexual education that recognizes that all people are sexual beings and goes beyond merely covering disease prevention; all of these programs focus on adapting the information to be age appropriate, some starting as young as age four.[217]

To keep the policy guidance relevant to this Note, this section of the Note focuses on the 15-18-year age group presented in the International Technical Guidance and their 8 Key Concepts:[218] relationships; values, rights, culture, and sexuality; understanding gender; violence and staying safe; skills for health and well-being; the human body and development; sexuality and sexual behavior; and sexual reproductive health.[219] The 15-18-year age group falls into the "presumed capacity" category of the Mature Minor Doctrine in Tennessee.[220] Despite overlooking the younger age group in these recommendations, Tennessee should adopt curriculum for all age groups in order to reflect the recommendations in the ITGSE.

The seventh and eighth concepts are the most relevant. Covering sexuality, sexual behavior, sexual health, and reproductive health,[221] these topics are most closely tied to the public health statistics mentioned in the first section of this Note. The seventh concept covers sexuality and sexual behavior.[222] Not only should the Curriculum cover what sex is, but it should also cover sexual feelings, the biological, social, psychological, spiritual, ethical, and cultural dimensions within it.[223] In addition, this section covers sexual pleasure and the associated responsibilities.[224] Covering risk reduction strategies, other than abstinence, needs to be mandatory in Tennessee's curriculum. By providing these risk reduction

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[216] UNITED NATIONS POPULATION FUND, *supra* note 4.
[217] GUTTMACHER INSTITUTE, *supra* note 215.
[218] These ideals are similar to the recommendations of many other respected institutions. Prior to initiating new policy, Tennessee and other policy makers should consult other sources including The Guttmacher Institutes Information Handout on Comprehensive Sexuality Education mentioned in the footnote above.
[219] UNITED NATIONS POPULATION FUND, *supra* note 4.
[220] *Mature Minor Doctrine*, *supra* note 10.
[221] UNITED NATIONS POPULATION FUND, *supra* note 4 at 69-80.
[222] *Id.* at 69.
[223] *Id.* at 70.
[224] *Id.* at 72.

strategies, individuals will be informed on how to protect themselves if they choose to be sexually active and will be aware of the risks associated with sex. Explaining that the use of condoms and contraceptives can reduce unintended consequences of sex and that there are dangers of non-penetrative sex is recommended by the ITGSE.[225]

The eighth concept covers sexual and reproductive health.[226] This topic, again, stresses the importance of teaching about contraception including effectiveness, side effects and benefits of abstinence, condoms, and other forms of contraception.[227] This will help minors make educated choices regarding their sexual health. In addition, covering the benefits of contraception will highlight uses like dealing with dysmenorrhea, which can prevent absenteeism of girls in school.[228] Finally, understanding how to access health services relating to STDs, HIV, and unintended pregnancy will help diminish the negative consequences of sexual activity. The Curriculum needs to include a complete and clear presentation of abstinence, condoms, and other contraception to fully educate minors on their sexual health options. In addition, Tennessee should learn from Vermont's practices[229] and provide condoms to prevent lack of access. Educating minors about different forms of contraception will help them understand the necessity of utilizing at least one of the methods, whether it be abstinence or not, and how it can impact their health in other ways.

Within the first concept, relationships, Tennessee has already checked off a number of boxes, including forming and identifying healthy relationships, explaining the consequences of sexual activity on relationships, confiding in trusted adults, and the challenges of having a child before marriage along with the benefits of raising children within marriage.[230] However, there are a number of ways the Curriculum can improve to provide better education surrounding relationships. For one, the Curriculum should include how forced marriages can also lead to negative social consequences that are similar to unintended pregnancy. By overlooking issues that can occur within marriage, the Curriculum would continue to blindly support the institution of marriage reflected in religion that is not a current American reality. The Curriculum should also explore the stigma and discrimination surrounding health statuses, sexual orientation, and gender. Addressing the stigma and discrimination surrounding these topics uses education to shift from

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[225] *Id.*
[226] *Id.* at 73.
[227] *Id.* at 75.
[228] JOHNS HOPKINS MED., *supra* note 182.
[229] 16 V.S.A. § 132 (2021).
[230] UNITED NATIONS POPULATION FUND, *supra* note 4 at 37-47.

an automatically negative perspective to an informed perspective on the subject. This allows people to see statuses from a neutral, informed stance before forming their own opinions. Finally, the Curriculum should identify support systems, not only trusted adults but also community resources. Providing minors with trusted resources allows them to seek guidance from trustworthy sources when making decisions that they do not fully understand.

The second recommended concept covers values, rights, culture, and sexuality.[231] For one, this section emphasizes the importance of one's own values when making decisions surrounding sexual behavior.[232] This step allows students to identify their values, commonly in line with their religion, and explore how it will impact their decision making, without the teachers emphasizing one religion over another. Additionally, this section should address rights and laws surrounding reproductive health, including what health services they have at their disposal and how cultural and social norms play a role.

Understanding gender is the third concept that needs to be covered.[233] Tennessee's curriculum currently overlooks the role of gender entirely. The new curriculum should include acknowledging gender roles and biases and how they impact individuals including people with "nontraditional" gender identities. Gender roles and identities are rapidly evolving, and education is playing a part in that change. New norms are forming around respecting nontraditional gender identities; thus, it is necessary to provide the information to minors to be aware of these different points of view. This section also includes gender equality, and how contraception and life planning can have different gendered effects. Finally, this section should cover gender-based violence, something that Tennessee already does. Overall, this gender-based section is crucial for meeting the requirements of Title IX, as it provides an opportunity for all genders and gender identities to be seen as equal. It provides an opportunity for acknowledgment as how girls and members of the LGBTQI+ community may have different needs or issues than boys surrounding relationships and sexual health.

Violence and safety are further explored in the fourth concept.[234] Tennessee already covers child sexual abuse, human trafficking, and consent. To expand on this solid foundation, all types of sexual abuse should be covered and the dangers of sexual media along with the role of internet in relationships should be covered.

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[231] *Id.* at 45–48.
[232] *Id.*
[233] *Id.* at 49–52.
[234] *Id.* at 53–57.

The fifth concept covers skills for health and well-being, including decision making, peer influence, and communication in relationships.[235] While Tennessee currently addresses decision making and how to say no to sexual activity, it is critical to talk about decision making if an individual chooses not to practice abstinence. This method, while not promoting "saying yes to sex" informs individuals on what can impact rational decision making and the possible consequences. By talking about decision making, minors are equipped with tools for having safe and consensual relationships.

The sixth concept, the human body and development,[236] is mainly covered by the human growth and development curriculum. Referring to this section of the ITGSE when developing the human growth and development curriculum would be beneficial to ensure Tennessee's current curriculum covers all of the important aspects of the human growth and development cycle in an age-appropriate manner.

No matter the information presented, it is critical that the Curriculum still provides an opt-out provision. This opt-out provision will continue to protect the Curriculum from freedom of religion claims along with Fourteenth amendment liberty interest challenges.

VI. CONCLUSION

The United States has a sexual health crisis. Teen pregnancy rates continue to be the highest in the industrialized world. One fourth of the US population has an STD. Economically, the country is funneling billions of dollars into remedying these unintentional consequences of sexual activity, when sexual education programs could be preventing them. Tennessee needs a LGBTQI+ friendly, comprehensive sexual education program that teaches about the uses of contraception, condoms, and abstinence to prevent STDs and teen pregnancy that includes an opt-out provision. The Curriculum will overcome Freedom of Religion and Liberty Interest hurdles, adhere to Title IX expectations, and provide minors with a suitable level of knowledge to safely utilize the Mature Minor Doctrine.

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[235] *Id.* at 58–63.
[236] *Id.* at 64–68.

THE HIDDEN ENEMY ON THE FRONTLINE: WHEN MEDICAL PROFESSIONALS CHOOSE THEIR PROFESSION OVER THEIR LIFE

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I. INTRODUCTION

Every year a staggering 400 doctors die by suicide in the United States.[1] On April 26, 2020, in New York City, Dr. Lorna Breen tragically became part of this astounding statistic.[2] Dr. Breen was passionate about her job and strived her entire life to build a career around helping others.[3] As her family describes it, "she always knew she was going to be a doctor."[4] Dr. Breen was headstrong and "unflappable"; she once was so determined to finish her half-marathon that she did so before immediately taking herself to the hospital to diagnose herself with a pulmonary emboli.[5] So dedicated to maintaining her personal health and well-being that friends describe Dr. Breen skipping activities even on vacation if it meant she would not receive the adequate eight hours of rest that night.[6] When she was not caring for her patients, Dr. Breen loved to travel, played cello, joined a ski club, and salsa danced, on top of being the "cool aunt" to all eight of her nieces and nephews.[7]

When the COVID-19 pandemic hit New York City, Dr. Breen, an assistant professor of emergency medicine at Columbia University, was also working as head of the Emergency Department of the New York Presbyterian Allen Hospital.[8] Soon, Dr. Breen found herself battling an overflowing department full of COVID-19 patients with limited personal protective equipment, not enough bed space, and not enough oxygen for her patients.[9] Dr. Breen and her colleagues routinely found themselves sleeping in the hallways of the hospital and fighting this new pandemic eighteen hours a day.[10] On top of this, shortly after the pandemic hit New York City, Dr.

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[1] Pamela Wible, *When Doctors Commit Suicide, It's Often Hushed Up*, WASH. POST (July 14, 2014), https://www.washingtonpost.com/national/health-science/when-doctors-commit-suicide-its-often-hushed-up/2014/07/14/d8f6eda8-e0fb-11e3-9743-bb9b59cde7b9_story.html.

[2] DR. LORNA BREEN HEROES' FOUNDATION, https://drlornabreen.org/about-lorna/ (last visited Jan. 8, 2022).

[3] *Id.*

[4] Corina Knoll, Ali Watkins & Michael Rothfeld, *'I Couldn't Do Anything': The Virus and an E.R. Doctor's Suicide*, NEW YORK TIMES, (July 11, 2020), https://www.nytimes.com/2020/07/11/nyregion/lorna-breen-suicide-coronavirus.html.

[5] Knoll *et al.*, *supra* note 4.

[6] *Id.*

[7] Breen, *supra* note 2.; Knoll *et al. supra* note 4.

[8] *Lorna Breen and the Toll of COVID-19*, COLUMBIA UNIV. IRVING MED. CTR. (April 29,2020), https://www.cuimc.columbia.edu/news/lorna-breen.

[9] Breen, *supra* note 2.

[10] Taylor Romine, *An ER Doctor who Continued to Treat Patients After She Recovered From COVID-19 has Died by Suicide*, CNN (April 28, 2020), https://www.cnn.com/2020/04/28/us/er-doctor-coronavirus-help-death-by-suicide-trnd/index.html.

Breen contracted COVID-19 herself.[11] Having only taken a week and a half off to recover, Dr Breen found that she could only continue to fight twelve-hours a day for her patients, but never wanted to give up on her patients and her colleagues.[12] Dr. Breen returned to work on April 1, returning to hallways clogged with stretchers where patients lay in their last moments alone "waiting to be saved."[13] Dr. Breen described herself as "baffled and overwhelmed," "drowning" while facing the "hardest time of [her] life."[14]

On April 9, 2020, Dr. Breen could not even get up from her chair, she had not slept in a week, and found herself exhausted working the front lines of the pandemic with meager resources; on one occasion she was working two emergency departments on the same shift, five miles apart.[15] When Dr. Breen found herself beyond exhaustion, her primary concern was for her job.[16] She was terrified to seek help, to reach out for resources because doing so would risk what she loved most in the entire world: her career.[17] After speaking with her supervisor, Angela Mills for an hour and half, Ms. Mills noted Dr. Breen was not herself and indicated she wanted to hurt herself.[18] Dr. Breen's friend, who is a psychiatrist came to pick Dr. Breen up that night and told her that she needed to go to the hospital.[19] Dr. Breen spent eleven days in an inpatient psychiatric ward, but she was certain her "career would not survive."[20] Her younger sister, Jennifer Feist said Dr. Breen was so embarrassed and that she thought everyone knew she was struggling.[21] In her last conversation with her friend Anna Ochoa, Dr. Breen was stuck on the idea that she had somehow failed, she kept stating "I couldn't help anyone. I couldn't do anything, I just wanted to help people, and I couldn't do anything."[22]

Dr. Breen committed suicide on April 26, 2020, in Charlottesville, Virginia.[23] Dr. Breen most definitely answered the

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[11] *Id.*
[12] *Id.*
[13] Knoll *et al.*, *supra* note 4.
[14] *Id.*
[15] Breen, *supra* note 2.
[16] *Id.*
[17] *Id.*
[18] Knoll *et al.*, *supra* note 4.
[19] *Id.*
[20] Knoll *et al.*, *supra* note 4.
[21] *Id.*
[22] Knoll *et al.*, *supra* note 4.
[23] Romine, *supra* note 10; This note will not discuss post-COVID syndrome, and its potential long-term effects on mental and physical health. For a greater in-depth examination of the effects, please see: Sher L, "*Post-COVID Syndrome and Suicide Risk.*" 114 QJM: AN INT'L J. OF MED. 2, 95-98 (2021), *available at* DOI: 10.1093/qjmed/hcab007 https://pubmed.ncbi.nlm.nih.gov/33486531/.

call to serve her community and country during the most dire circumstances, but the system certainly failed her in the process.[24] Dr. Breen's family has since established a fund to help support mental health among medical professionals.[25] But there is more that needs to be done, and the responsibility to help those who put their lives on the line and risk infection should not be borne alone by the families of those who have died. As Ms. Feist noted, "If the culture had been different, that thought would have never even occurred to her, which is why. . . [w]e need to change it. Like, as of today."[26] Not only is seeking mental health treatment viewed as weak amongst those within the medical community, but many licensure boards throughout the country require doctors to disclose any current or past mental health treatment.[27]

Medical professionals are often unwilling to seek mental health treatment largely due to concerns over the impact it would have on their licensing.[28] As Dr. Liselotte Dyrbye, a professor of medicine and medical education at the Mayo Clinic in Minnesota describes, "The medical license application questions are getting in the way of very treatable mental health disorders and probably contributing to the high rates of suicide among physicians."[29] And yet, while The Federation of State Medical Boards (FSMB) urges state medical licensure boards not to ask about mental health history and stresses this practice may violate the Americans with Disabilities Act of 1990 ("ADA"),[30] the legal community has done little to actually protect medical professionals and more needs to be done to provide protections pursuant to the ADA. It is time for Congress to push states to take action regarding a rewriting of their licensure questions and for Congress to supply funding to create a national and confidential treatment space for physicians where they can seek treatment without fear of major repercussions.

Part II of this Note will discuss the disturbing mental health crisis in the medical community and how the COVID-19 pandemic has only exacerbated this issue. Part III of this Note will discuss why licensure questions regarding mental health contribute and lead to a stigmatization of mental health treatment and unwillingness of both medical school students and practicing physicians from seeking treatment. Next this Note will discuss how similar law licensure

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[24] Breen, *supra* note 2.
[25] Knoll *et al.*, *supra* note 4.
[26] *Id.*
[27] *Id.*
[28] Ronnie Cohen, *Doctors May Fear Losing Their License for Seeking Mental Health Care*, REUTERS (Oct. 10, 2017), https://www.reuters.com/article/us-health-mentalhealth-physician-licensu/doctors-may-fear-losing-their-license-for-seeking-mental-health-care-idUSKBN1CF2N9.
[29] *Id.*
[30] *Id.*

questions have been outlawed after litigation, yet similar progress has not been shown in medical licensure. Next this Note will discuss The Dr. Lorna Breen Health Care Provider Protection Act. Finally, in part IV, this note will advance two potential ways Congress can address this issue (1) urging states to change their licensure questionnaires, thus helping alleviate the fear amongst the medical community and (2) providing funding for a confidential mental health treatment program available to any medical professional who can thus seek treatment without fear and embarrassment.

II. SUICIDE IN THE HEALTHCARE PROFESSION

Unfortunately, the tragic story of Dr. Breen is not an unusual or rare one. Even prior to the COVID-19 pandemic, every year in the United States 400 doctors and medical professionals commit suicide.[31] On average, a doctor sees 2,300 patients, meaning roughly a million patients lose their doctor to suicide every year.[32] For white females, the profession of medicine puts them the most at risk to commit suicide (2.78 times higher than the average suicide rate for white females).[33] For white males, being a doctor is the second most suicidal profession they can choose.[34] While being a doctor certainly increases stress levels, the prevalent rates of depression and suicidal ideations start long before doctors start to treat patients. In fact, 27.2% of medical school students report depression or depressive symptoms and 11.1% report suicidal ideation.[35] Medical students are three times more likely to commit suicide than other people of their age.[36] These symptoms carry over into their residency programs, with some programs reporting that 75% of their residency interns meet the criteria for major depression.[37]

Recently, this issue has only been exacerbated by the COVID-19 pandemic. While fighting the COVID-19 pandemic, 38% of doctors report anxiety or depression, 43% of doctors report suffering from work overload, and 49% report professional burnout

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[31] Wible, *supra* note 1.
[32] *Id.*
[33] Gus Lubin, *The 19 Jobs Where You're Most Likely To Kill Yourself*, BUS. INSIDER (Oct. 18, 2011), https://www.washingtonpost.com/national/health-science/when-doctors-commit-suicide-its-often-hushed-up/2014/07/14/d8f6eda8-e0fb-11e3-9743-bb9b59cde7b9_story.html.
[34] *Id.*
[35] Lisa S. Rotenstein, *Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students: A Systematic Review and Meta-Analysis.*" 316 JAMA 21, 2214-2236 (2016), *available at* doi:10.1001/jama.2016.17324 https://pubmed.ncbi.nlm.nih.gov/27923088/.
[36] *Id.*; Wible, *supra* note 1.
[37] Rotenstein, *supra* note 35.

during this time.[38] This is disproportionally affecting women, Black, and Latinx health professions.[39] 39.3% of women reported anxiety and depression while only 26.4% of men did; additionally, 70.1% of Black and 74.4% of Latinx health workers experienced fear of exposure while only 56% of white workers reported this.[40] While it is easy to write this off as a short-term issue, not in need of long-term solutions, the issue is not with the long hours, sick patients, or simply one of limited issue only during a global pandemic, this is an issue of ongoing stigma and fear of mental health treatment stemming from licensure requirements in the medical field.

III. HOW LICENSURE CONTRIBUTES TO HIGH SUICIDE RATES

In order to practice medicine, every doctor must meet the requirements set forth by each individual state in which they want to practice.[41] Each state sets their own standards, questionnaires and requirements, often leading to a complex and varied system with which physicians must navigate.[42] In order to grant licensure, many states seek information regarding the candidate's mental health status, with many of those states seeking information regarding a candidate's complete mental health history, not merely any current mental health conditions that may affect their ability to perform a job.[43] Despite this practice potentially violating the ADA,[44] many states still ask questions that are invasive and discriminatory in nature.[45] Even in record-keeping, both medical and licensure boards violate the requirements of the ADA by not asking mental health related questions on a separate form, which could expose an

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[38] Sara Berg, *Half of Health Workers Report Burnout Amid COVID-19*, AMER. MED. ASS'N (July 20, 2021), https://www.ama-assn.org/practice-management/physician-health/half-health-workers-report-burnout-amid-covid-19.

[39] *Id.*

[40] *Id.*

[41] *Navigating State Medical Licensure*, AMERICAN MEDICAL ASSOCIATION, https://www.ama-assn.org/residents-students/career-planning-resource/navigating-state-medical-licensure (last visited Jan. 8, 2022).

[42] *Id.*

[43] Phyllis Coleman et al., *Ask About Conduct, Not Mental Illness: A Proposal For Bar Examiners And Medical Boards To Comply With the ADA And Constitution*, 20 J. LEGIS. 147, 177 (1994).

[44] Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12101-12213; Coleman, *supra* note 43.

[45] James Jones, "*Medical Licensure Questions About Mental Illness and Compliance with the Americans with Disabilities Act*." 46 J. AM. ACAD. PSYCHIATRY LAW, 458-71, 469 (2018), available at DOI:10.29158/JAAPL.003789-18 http://jaapl.org/content/jaapl/46/4/458.full.pdf.

applicant's private medical history to anyone who views the application.[46]

Among the chief reasons, medical students and doctors fear seeking treatment for any mental health condition due to stigma and fear of being denied a license to practice medicine.[47] Fear of stigma alone prevents 30% of depressed first- and second-year medical students from seeking help.[48] Among those few medical students and doctors who do seek help, many pay cash for those services to avoid having a record of their treatment appear in any insurance paperwork.[49] Medical students who do seek mental health treatment have reduced chances of procuring a residency placement.[50]According to one consensus statement written by a team of fifteen experts in this field, "Practicing physicians with histories of psychiatric disorders or counseling for psychosocial difficulties encounter discrimination in hospital privileges, health insurance, and malpractice insurance."[51] The stigma and disparate treatment of those who seek mental health treatment is much more actualized for people regarding medical licensure requirements. It is certainly true that state medical licensing boards need to ensure all applicants are fit to serve as doctors within their state, however, asking questions about past mental health impairments does little to show if someone is fit to be a doctor now, the "real issue is conduct not illness."[52] Physicians working in states where medical licensure questions ask "broadly about current or past diagnosis or treatment of a mental health condition, past impairment from a mental health condition, or presence of a mental health condition that could affect competency were 21% to 22% more likely to be reluctant to seek help."[53] Conversely, doctors working in states that do not seek any mental health information for licensure or only inquire about current impairments are less likely to be reluctant to seek care when needed.[54] It is evident that having minimal or no inquiries into a medical professional's mental health allows a physician to seek help

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[46] Coleman, *supra* note 43.
[47] Jones, *supra* note 45, at 459.
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] *Id.* (citing to Center C, Davis M, Detre T, "*Confronting Depression and Suicide in Physicians: A Consensus Statement*." 289 JAMA, 3161–66 (2003)).
[52] Coleman, *supra* note 43; For an in-dept analysis of each states' medical licensure questions about mental health illness, view *Medical Licensure Questions About Mental Health Illness and Compliance with the Americans with Disabilities Act*, available at http://jaapl.org/content/jaapl/46/4/458.full.pdf.
[53] Liselotte Dyrbye, "*Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions."* 92 Mayo Clinic Proceedings 1486 (2017), *available at* DOI: 10.1016/j.mayocp.2017.06.020 https://pubmed.ncbi.nlm.nih.gov/28982484/.
[54] *Id.*

if needed, rather than refuse treatment over fear of stigma and losing their license.

Despite increased mental health awareness as a society, over the last few decades, medical professionals have seen an increase in discrimination towards those with a history of mental health issues.[55] In 1993, 75% of medical licensing boards asked about mental health history of applicants.[56] By 2013, that number had increased to 84%.[57] This line of questioning is directly contrary to the views of the American Psychiatric Association ("APA"), which states that a history of mental health condition is "not an accurate predictor for mental fitness," thus, those questions are "irrelevant" as to current mental impairments.[58]

Additionally, the AMA has advocated for licensing boards not to ask questions regarding mental health history because these questions deter medical students and professionals from seeking help.[59] Even after the initial licensing process, the fear of repercussions permeates the medical field as medical licensure boards can discipline doctors for mental health diagnoses, regardless of whether or not this diagnosis actually impacts the doctor's ability to perform their job proficiently.[60] In 2007, the Journal of Medical Licensure and Discipline surveyed all state medical boards licensure applications and found:

> Of the 35 state medical boards that responded, 37% indicated that diagnosis of mental illness by itself was sufficient to merit sanctioning a physician. The study also found that 40% of the responding state medical boards considered a diagnosis of substance abuse as sufficient for sanctioning a physician. Potential sanctions include the revocation or restriction of a physician's license, probation, or satisfactory completion of a treatment program.[61]

As this study shows, almost half of all states would punish an applicant or physician for a mere diagnosis of a mental health condition alone.[62] This is a very troubling statistic considering that

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[55] *Id.* at 460.
[56] *Id.*
[57] KJ Gold, *Do US Medical Licensing Applications Treat Mental and Physical Illness Equivalently?*, 49 FAM. MED. 6,464–67 (2017), *available at* https://pubmed.ncbi.nlm.nih.gov/28633174/.
[58] *Id.*
[59] M. Moran, *AMA To State Medical Boards: Don't Ask About Past Mental Illness*, PSYCHIATRIC NEWS (Dec. 9, 2016), http://psychnews.psychiatryonline.org/doi/full/10.1176%2 Fappi.pn.2016.12b6.
[60] Julianne Story, *Barriers to Mental Illness and Substance Abuse Treatment Among Physicians and the Impact on Patient Care*, 114 MO. MED. 91 (2017).
[61] *Id.* (citing to H. Hendin, *Licensing and Physician Mental Health: Problems and Possibilities*, 93 J. MED. LICENSURE AND DISCIPLINE, 6–11 (2007)).
[62] *Id.*

nearly one in every five Americans live with a mental health condition (around 51.5 million Americans in 2019) according to the National Institute of Mental Health.[63] The issue of licensure penalties can be even more concerning for females, as the prevalence of Any Mental Illness (AMI) is 24.5% for females, while only 16.3% for males.[64] Additionally, AMI affects individuals who report being of two or more races (37.7%) rather than white adults (22.2%).[65] Because mental health affects women and minorities in substantially higher numbers than it does men and white individuals, women and minorities can be at greater risk of suffering negative consequences by licensing boards.

The root of the fear among doctors comes from questions asked by licensure boards in regard to past mental health treatment or diagnosis.[66] According to one study conducted in 2014,"Nearly 40% of physicians (2325 of 5829) reported that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure."[67] In a nation-wide study of nearly all medical licensure board questionnaires, only one-third of states had questions that conformed with the APA, AMA, and FSMB policies and recommendations, or are clearly compliant with the Americans with Disabilities Act of 1990.[68]

According to one study, only thirteen states ask no questions or minimally invasive questions regarding an applicant's mental health.[69] Among these "Grade A" states, four states do not ask any mental health related questions and some such as Wyoming merely ask, "Does the applicant's health allow for the safe and competent practice of medicine?" Compare this in sharp contrast to Montana's question which asks, "*Have you ever* been diagnosed with a physical condition or *mental health disorder* involving potential health risk to the public? Have you [had] any physical or mental condition(s) which may have or had adversely affected your ability to practice this profession, included but not limited to a contagious or infectious disease involving risk to the public? If yes, attach a detailed

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[63] *Mental Health Information - Statistics*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/mental-illness (last visited Jan. 8, 2022).
[64] *Id.*
[65] *Id.*
[66] Hannah Lehmann, *Stay Out of My Mind: Privacy of Physician Mental Health Treatment in Licensing Applications*, 28 ANN. HEALTH L. ADVANCE DIRECTIVE 101, (2019).
[67] Dyrbye, *supra* note 53.
[68] *Id.*
[69] Pamela Wible, *Physician-Friendly States for Mental Health: A Review of Medical Boards*, IDEAL MEDICAL CARE (Aug. 22, 2019), https://www.idealmedicalcare.org/physician-friendly-states-for-mental-health-a-review-of-medical-boards/.

explanation."[70] This question makes an applicant disclose any and all mental health conditions. For example, if a medical student sought mental health treatment due to the stress of school and was diagnosed with *any* condition, they would now be forced to disclose that and fear not receiving their medical license, simply because they sought help. This reinforces and discourages any kind of mental health treatment. Additionally, New Hampshire poses the question, "*Have you ever* had any physical, *emotional, or mental illness* which has impaired or would be likely to impair your ability to practice medicine?"[71] As the study notes, a doctor applying for licensure who may have experienced postpartum depression decades ago must answer yes to this question when it has no current implication as to their ability to practice medicine.[72]

Even worse, certain states referred to as "Grade F" states seek highly invasive and unrelated information into an applicant's mental health or "emotional" history.[73] For example, Mississippi forces all applicants to waive their privacy rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and forces the applicant to pay for and consent to a mental examination.[74] Mississippi's licensure questions states:

> The submission of an application for licensing to the Board shall constitute and operate as an authorization by the applicant to. . . each physician or other health care practitioner whom the applicant has consulted or seen for diagnosis or treatment. . . disclose and release to the Board any and all information and documentation concerning the applicant which the Board deems material to consideration of the application. . . and as a waiver by the applicant of any privilege or right of confidentiality which the applicant would otherwise posses with respect thereto.[75]

Additionally, any applicant consents to a mental examination and "waive[s] all objections as to the admissibility or disclosure of findings, reports or recommendations. . . [t]he expense of such examination shall be borne by the applicant."[76] Alaska asks applicants twenty five questions relating to mental health, with many being "unlinked to current impairment."[77] Among these is a question that asks, "Have you *ever* been diagnosed with, treated for,

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[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.*

or do you currently have: followed by a list of 14 mental health conditions including depression, seasonal affective disorder, and any condition requiring chronic medical or behavioral treatment."[78] Considering around 10% of Alaskans meet the requirements for seasonal affective disorder, which affects women more often than men, this line of questioning exposes a significant amount of the Alaskan applicants to the risk of not getting licensed.[79] Like previous examples, it provides applicants with few alternatives than not seeking treatment.

FSMB is a national organization that supports state medical licensing boards in their goals and provides "initiatives that promote patient safety, quality health care and regulatory best practices."[80] This organization has urged state medical boards to "review their medical licensure (and renewal) applications and evaluate whether it is necessary to include probing questions about a physician applicant's mental health."[81] Additionally the FSMB stresses that under the ADA they cannot seek information that may have been in the past and should limit their time frame into two years or less, but preferably will focus more on the present.[82] Furthermore, FSMB has urged an acceptance of "safe-haven non-reporting" where applicants and physicians can seek treatment within a Physician Health Program ("PHP") and as long as they are in good standing with the program they are able to seek confidential treatment without having to disclose their treatment or diagnosis to the state licensure boards.[83]

A similar program to the "safe-haven" program that FSMB advocates for has had great success in the United Kingdom. Medical professionals in the UK often suffer the same reality of long work hours, unpredictable schedules, increased fear of potential litigation, and lack of resources that doctors face here in the United States.[84] This has led to a similar increased suicide rate among those within the medical profession in the UK. In the UK, the suicide rate for doctors is two to five times higher than the suicide rate among the

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[78] *Id.*

[79] J. M. Booker, *Prevalence of Seasonal Affective Disorder in Alaska*. 149 AM. J. PSYCHIATRY 9, 1176-82 (1992), *available at* DOI:10.1176/ajp.149.9.1176 https://pubmed.ncbi.nlm.nih.gov/1503129/.

[80] *About FSMB*, FEDERATION OF STATE MEDICAL BOARDS, https://www.fsmb.org/about-fsmb/ (last visited Jan. 8, 2022).

[81] *Physician Wellness and Burnout*, FEDERATION OF STATE MEDICAL BOARDS, https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf (last visited Jan. 8, 2022).

[82] *Id.* at 13.

[83] *Id.*

[84] Clare Gerada, *Doctors and Mental Health*, 67 OCCUPATIONAL MED. 9, 660-61 (2017), *available at* DOI: 10.1093/occmed/kqx090, https://academic.oup.com/occmed/article/67/9/660/4782192.

general population.[85] Similarly, doctors in the UK face "personal, professional and institutional stigma."[86] One study described how "doctors feel a dreadful sense of personal failure and inadequacy if they struggle to keep working and despair can be sudden and overwhelming. The researchers describe an overwhelming stigmatization. . . which left them isolated and sad. Some sick doctors deliberately concealed their problems, and this resonates with doctors attending PHP who will pretend to go to work each day rather than admit to their families that they are unwell."[87] One doctor who was brave enough to openly blog about her mental health struggles as a physician, Dr. Wendy Potts, hung herself after her practice suspended her when a patient reported her after reading her blog.[88]

The General Medical Council has recognized and responded to the hidden enemy of mental health stigma by changing its stance regarding physicians suffering with mental health whereby they will only have concerns about the mental health of a physician where the condition has "affected your ability to practice or perform your duties on clinical placement…Even if your health condition is serious, it doesn't necessarily mean that you can't practice safely."[89] In an effort to confront the pandemic of mental health within the medical profession, in 2008 the United Kingdom established the confidential NHS Practitioner Health Programme ("PHP").[90]

The purpose of this program is to address the pervasive problem of mental health among practitioners, and it provides confidential treatment by various psychiatrists, nurses, and therapists.[91] PHP uses a nation-wide network of therapists to provide either in-person or web-based therapy and group sessions for patients.[92] While originally started just to serve doctors and dentists practicing in London, this service has been expanded to cover all general practitioners and trainees in all of England.[93] The program has seen resounding success, just four months after expanding services across all of England: by May 2017, there were 3,000

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[85] Clare Gerada, *Doctors, Suicide, and Mental Illness*, 42 BJ PSYCH BULL. 4, 165-68 (2018), *available at* DOI: 10.1192/bjb.2018.11, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6436060/.
[86] *Id*.
[87] Max Henderson et al., *Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study*, BMJ Open. 2(5) (2012).
[88] Gerada, *supra* note 85.
[89] *Managing Health Concerns*, GEN. MED. COUNCIL (Dec. 3, 2020), https://www.gmc-uk.org/registration-and-licensing/join-the-register/what-to-tell-us-when-you-apply-guide/managing-health-concerns.
[90] Gerada, *supra* note 74.
[91] *Id*.
[92] *Id*.
[93] *Id*.

doctors who had sought help by the PHP.[94] Not only do a high number of doctors report for confidential treatment, but a high number of these doctors see positive results.[95]

Physicians who have sought treatment through PHP report they feel "happier, more relaxed, more self-confident, and emotionally stronger," with several others stating they were able to "rebuil[d] their self-respect and. . . improve[] their relationships with family members and colleagues."[96] One physician reported that PHP led them to "[abandon] the idea of committing suicide."[97] Even in areas of substance abuse, the program has seen amazing success. 80% of doctors who reported to PHP with substance abuse have been able to remain abstinent from substance use after the conclusion of treatment; only 6% of patients treated by PHP relapsed.[98]

A. Litigation Regarding Similar Licensure Questions on Law Licensure Applications

The position of the APA and other organizations is supported by litigation dealing with similar law licensure questionnaires. Like the medical licensure process, each state sets forth its own requirements and creates its own questionnaires that potential lawyers must fill out in order to be considered by that particular state for licensure. States have required applicants to fill out similar questions regarding their mental health both past and present. As evidence by the case of *Clark v. Virginia Board of Bar Examiners*, a similar question was raised concerning the legality of these questions under the ADA when a law licensure applicant refused to answer the questions on the application.[99] The specific questions at issue on Virginia's law licensure applicated asked:

> 20. (b) Have you within the past five (5) years, been treated or counselled for a mental, emotional or nervous disorder?
>
> * * *
>
> 21. If your answer to question 20 (a), (b) or (c) is yes, complete the following that apply:
>
> (a) Dates of treatment or counseling;
>
> (b) Name, address and telephone number of attending physician or counselor or other health care provider;

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[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] *Id.*
[98] *Id.*
[99] Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430 (E.D. Va. 1995).

> (c) Name, address and telephone number of hospital or institution;
> (d) Describe completely the diagnosis and treatment and the prognosis and provide any other relevant facts. You may attach letters from your treating health professionals if you believe this would be helpful.[100]

The Board refused to grant the applicant her law license until she answered these questions regarding her mental health, forcing her to disclose her entire treatment and diagnoses, regardless of whether she was currently affected or not.[101] The Board contended that these questions were vital to ensuring an applicants' fitness. According to testimony, however, "approximately twenty percent of the population suffers from some form of mental or emotional disorder at any given time," but the Board had only received forty-seven affirmative answers to these mental health questions in the past five years despite receiving 2,000 applications per year.[102] The Board further stated that it had never denied a license based on answering these questions in the affirmative. The court thus concluded that these questions were ineffective at identifying applicants suffering from mental health issues and that the Board failed to prove how the questions served their purported purpose of "preventing the licensure of applicants lacking the fitness to practice law."[103] This case demonstrates that because licensure boards do not use questions concerning mental health to actually deny licenses, these questions are ineffective and irrelevant to determining who amongst the applicants is unfit to practice based on their previous or current mental health status. These questions serve no other purpose than to strictly deter applicants from seeking help out of fear that they will have a license denied because they have to answer these questions.

In addition to being ineffective, these questions tend to deter potential licensees from seeking treatment they might need and from which they may benefit.[104] Following *Clark*, eight states amended their mental health questions as a result of actual or potential lawsuits.[105] The court concluded that despite failing to answer the questions, the plaintiff met all the requirements for admission to the bar and question 20(b) violated the ADA by subjecting those with mental disabilities to further scrutiny thereby "discriminat[ing] against those with mental disabilities."[106] While the Board has

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[100] *Id.* at 433.
[101] *Id.*
[102] *Id.* at 437.
[103] *Id.*
[104] *Id.*
[105] *Id.* at 440.
[106] *Id.* at 442.

"broad authority to set licensing qualifications" within its state, the Board failed to show this question is necessary to its licensing function, thus the court required the Board to change its question to align with the ADA.[107] Many other courts have found similar questions violate the ADA.[108, 109]

B. Lack of Similar Protections Regarding Medical Licensure

Certainly, more work needs to be done advocating on behalf of the medical community to ensure state medical licensure boards are not violating the ADA standards. Quite ironically, the fear of stigma and career repercussions associated with the medical licensure requirements leave a significant number of medical professionals with untreated mental health conditions who can, in turn, be a danger to their patients.[110] Nearly 100,000 preventable medical errors occur each year in the United States alone, and recent studies have suggested that between 210,000 and 400,000 deaths each year are attributed to preventable harm.[111] Much of these preventable harms are related to medical professionals experiencing burnout from excessive caseloads, negative work environments, or poor work-life balance.[112] Physicians experiencing professional burnout are likely to experience fatigue, loss of empathy, detachment, depression, and suicidal ideation.[113] Medical boards have a duty to protect the public health and safety by regulating physicians; however, by delving deep into unnecessary mental health treatments and diagnosis, many are harming the public health more than they may realize by discouraging physicians from seeking needed care.

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[107] *Id.* at 443-46.
[108] *See generally* Ellen S. v. Fla. Bd. of Bar Exam'rs, 859 F. Supp. 1489 (S.D. Fla. 1994); In re Underwood, Docket No. BAR-93-21, 1993 Me. LEXIS 267 (Dec. 7, 1993).
[109] For a more complete review of law licensure questions surrounding the character and fitness requirements, and more specifically mental health questions, see Michelina Lucia, *Trial by Surprise: When Character and Fitness Investigations Violate the ADA and Create Dangerous Lawyers*, 38 LAW & INEQ. 205 (2020).
[110] Stephanie Denzel, *Second-class Licensure: The Use of Conditional Admission Programs for Bar Applicants with Mental Health and Substance Abuse Histories*, 43 CONN. L. REV. 889 (2011); Jon Bauer, *The Character of the Questions and the Fitness of the Process: Mental Health, Bar Admissions and the Americans with Disabilities Act*, 49 UCLA L. REV. 93 (2001).
[111] FSMB, *supra* note 70.
[112] *Id.* at 4.
[113] *Id.* at 5.

C. The Dr. Lorna Breen Health Care Provider Protection Act

In the wake of the ongoing COVID-19 pandemic and Dr. Lorna Breen's tragic death, many have started to take note of this issue plaguing the medical profession. On August 6, 2021, the United States Senate unanimously passed the Dr. Lorna Breen Health Care Provider Protection Act.[114] While this bill hopefully will garner enough support to pass through both chambers of Congress and eventually make its way onto President Biden's desk, as of the writing of this note the bill has stalled out in the House of Representatives.[115] This bill certainly presents a renewed hope that policy makers have finally realized the severity of the issue, but the proposed legislation does too little to address the root of the issue – stigma and licensing. The American College of Emergency Physicians ("ACEP") strongly supports the passage of the legislation and notes that this bill will "create behavioral health and well-being training programs and a national campaign to encourage health care professionals to seek support and treatment. . . [in addition to] initiat[ing] a federal study into health care professional mental health and burnout and provide grants to establish and expand mental health support services to those providing care to COVID-19 patients."[116] However, funding a study, when so many studies point to the same issue, and providing mental health services to only those physicians who treat COVID-19 patients is not nearly enough. Without doing more for these professionals, the legal system is failing the very people who dedicate their lives to saving the public at a profound level.

While the legislation has admirable goals to "reduce and prevent suicide, burnout, and mental and behavioral health conditions among health care professionals," it does little to change state medical licensing questionnaires.[117] This act establishes: (1) grants for training medical students, residents and professionals in ways to prevent suicide, burnout, substance abuse disorders and other mental health issues, (2) a national campaign encouraging medical professional to seek mental health treatment, (3) grants for

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[114] *Senate Passes Dr. Lorna Breen Health Care Provider Protection Act*, AMERICAN HOSPITAL ASSOCIATION (Aug. 6, 2021), https://www.aha.org/news/headline/2021-08-06-senate-passes-dr-lorna-breen-health-care-provider-protection-act.

[115] *Id.*

[116] *Dr. Lorna Breen Health Care Provider Protection Act Introduced in Senate*, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (June 1, 2021), https://www.acep.org/corona/COVID-19-alert/covid-19-articles/dr.-lorna-breen-health-care-provider-protection-act-introduced-in-senate/.

[117] DR. LORNA BREEN HEROES' FOUNDATION, https://drlornabreen.org/about-the-legislation/ (last visited Jan. 8, 2022).

education, peer-support groups, and lastly, (4) a comprehensive study of mental health burnout, including the impact of COVID-19 here. While this is undoubtably a noble task, more needs to be done to eliminate the states' powers in asking invasive questions about a candidate's mental health history for these professionals to feel comfortable seeking treatment.

IV. HOW TO OVERCOME STIGMATIZATION AND UNFAIR LICENSURE PRACTICES

In considering ways to approach this issue, this Note will suggest two areas in which the law can improve to help the medical field overcome issues of stigmatization and overzealous licensure practices. First, this Note will urge Congress to put forth a model regulatory questionnaire as a model for state medical licensure boards to adopt questions that do not violate the ADA and do not deter professionals or medical students from seeking help. Additionally, this Note will argue that the Dr. Lorna Breen Healthcare Protection Act should be expanded to include a nationwide program for medical professionals and medical students to seek confidential mental health treatment modeled after the successful program implemented in the United Kingdom.

A. Model Regulatory Questionnaires as a Model for State Medical Licensure Boards to Adopt

The Tenth Amendment provides that "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."[118] This directly effects the licensure process and regulation of medicine by states, rather than the federal government, who lack direct control. As noted by one scholar: "the practice of medicine for many years has been regulated by the states; this policy will not change since the federal government cannot assume this function without an amendment to the Constitution."[119] While this Note will not discuss in depth the constitutional ramifications of national medical licensure requirements, Congress can certainly advocate and put forth model questions for states to follow in their licensure applications that do not violate the ADA.

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[118] U.S. CONST. amend, X.

[119] Blake T. Maresh, MPA, *The Interstate Medical Licensure Compact: Making the Business Case,* 100 J. MED. REG. 2, 8-27 (2014), *available at* https://doi.org/10.30770/2572-1852-100.2.8 (citing to Derbyshire, R; *Medical Licensure and Discipline in the United States*; The Johns Hopkins Press, 18 (1969)).

The APA has developed and recommended specific questions for state licensing boards to use on their applications.[120] Importantly, this language focuses on the current state of the physician's well-being and not on the past. The APA recommends this phrasing:

> Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No).[121]

This question "encourages physicians to consider any physical or mental health issue that could impair their performance and helps to destigmatize mental illness."[122]

Yet, these questions prove insufficient as a metric for determining who is fit to practice medicine and who is not. According to one study done across all fifty states, "By the age of 65 years, 75% of physicians in low-risk specialties and 99% of those in high-risk specialties were projected to face a claim."[123]

Additionally, more specific and targeted questions would be a better gauge of an applicant's fitness to serve as a licensed medical professional. Certainly, a physician's mental health illness would not pose a risk to their patients unless the illness causes problematic and harmful behaviors; thus, conduct is what licensure boards should seek to inquire about rather than generalized mental health.[124] Two professors have suggested a myriad of questions more likely to enable licensing boards to flush out candidates who could potentially pose a great risk to their potential future patients based on their actions rather than simply a mental health illness:

1. Have you ever been expelled, suspended from, or had disciplinary action taken against you by any educational institution? If so, explain the circumstances.

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[120] *Id. See also* Brendan Murphy, *Medical Boards Must Avoid Contributing to Mental Health Stigma*, AMER. MED. ASS'N (June 13, 2018), https://www.ama-assn.org/residents-students/transition-practice/medical-boards-must-avoid-contributing-mental-health-stigma.

[121] *Id.*

[122] *Id.*

[123] Anupam B. Jena, *Malpractice Risk According to Physician Specialty*, 365 N. ENGL. J. MED., 629-636 (2011) available at https://www.nejm.org/doi/full/10.1056/NEJMsa1012370.

[124] Phyllis Coleman et al., *Ask About Conduct, Not Mental Illness: A Proposal For Bar Examiners And Medical Boards To Comply With the ADA And Constitution*, 20 J. LEGIS. 147, 177 (1994).

2. Has your grade point average ever varied by half a letter grade or more between two terms? If so, explain the circumstances.

3. Have you ever been absent from school or a job for more than 30 consecutive days? If so, explain the circumstances.

4. Have you ever been fired from, asked to leave, or had disciplinary action taken against you in any job? If so, explain the circumstances.

5. Have you ever been evicted or asked to vacate a place in which you lived? If so, explain the circumstances.

6. Have you ever been arrested for D.U.I.? If so, explain the circumstances, including the outcome of the incident.

7. Have you had any blackouts or periods of intoxication associated with alcohol or any other drug within the past six months? If so, explain the circumstances.[125]

The staggering wide range of mental health questions persists and creates uncertainty amongst medical students and professionals who fear seeking treatment. The Dr. Lorna Breen Health Care Provider Protection Act does nothing to combat this issue. In line with what the FSMB and APA recommend, Congress should amend this Act to place significant weight on states to adopt a more uniform policy that not only aligns with ADA requirements, but also would encourage applicants to seek mental health treatment. This Act should put forth a model questionnaire that states can rely on to conform to ADA standards and to enable states to ensure that they are protecting the public and ensuring that only doctors who *currently* suffer from mental impairment or engage in risky and harmful behavior that may affect their job are denied licensure or examined more closely.

B. Establishing a Nationwide Program Providing Confidential Mental Health Treatment Modeled After the Successful Program Implemented in the UK

Lastly, Congress should expand the Dr. Lorna Breen Healthcare Protection Act to include a program by which doctors

[125] *Id.*

can seek confidential mental health counseling without risk to their license and model this program after the successful program that the United Kingdom has enacted.

While Congress may not be able to police what and how questions are asked by applicants to state medical licensure boards,[126] Congress can establish a program modeled after the PHP in the UK. The UK has faced similar issues with doctors feeling the stigmatization and lack of resources for mental health and their confidential services have proven effective at treating physicians' mental health needs with a high success rate.

The FSMB has already urged states to create "safe-haven non-reporting" where applicants and physicians can seek treatment within a PHP and as long as they are in good standing with the program, they are able to seek confidential treatment without having to disclose their treatment or diagnosis to the state licensure boards.[127] It is evident that states are refusing to address this issue, however, and Congress needs to take action. Many states have not altered their state licensure questionnaires to comply with the ADA regulations and have not created a safe, confidential service where medical professionals can seek needed help. The Dr. Lorna Breen Health Care Provider Protection Act provides a great first step that addresses the silent pandemic of mental health crises medical professionals face by establishing grants to help fund mental health services for frontline workers. But this does little to address the fear of licensing repercussions such that a confidential program would do. Additionally, while COVID-19 has certainly exacerbated mental health among frontline workers, the mental health struggles that medical professionals face are not new, and certainly not solely caused by the pandemic. Resources need to be made available to all physicians.

V. CONCLUSION

Mental health issues plague the medical field, from medical students to long-standing, successful doctors. More needs to be done to safeguard these individuals' right to access necessary mental health services without the stigma and fear of loss of licensure. Dr. Lorna Breen should never have felt "embarrassed" by her mental health issues in light of being massively overworked to the point of pure exhaustion. She should never have been made to feel as if her career could never recover from this. Stigmatization of mental health treatment and diagnosis is a deadly issue that needs to be combated.

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[126] *Supra* note 107.
[127] FSMB, *supra* note 70.

It is clear little is being done within the states to help medical professionals seek mental health treatment without the fear of losing their livelihood. The Dr. Lorna Breen Healthcare Protection Act needs to be expanded to include model licensure questions for states to follow that not only conform with the requirements of the ADA, but also do not stigmatize mental health. These questions should be limited to current impairment, as shown it is not a reliable indicator to ask about past treatments or diagnosis in determining whether an applicant is qualified to practice medicine. As shown above, there are various ways states can reform their questions to be less stigmatizing: (1) through the APA's suggestion of asking only about any current impairments or (2) by asking questions specific to *conduct* rather than illness. Additionally, this Act should be expanded to establish a nationwide, confidential service, modeled after the successful UK program which encourages medical professionals to seek necessary care. By changing the culture surrounding mental health treatment and diagnosis in the medical field, we will help save the lives of medical professionals and improve the services that they are providing to their patients.

ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE? WHERE AMERICAN WORKERS' COMPENSATION LAW CURRENTLY STANDS AND WHERE IT SHOULD GO IN PREPARING FOR PANDEMICS

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I. INTRODUCTION

It is May 2020, and Sara arrives at the hospital to begin her night shift as a respiratory therapist in a newly created unit. This unit is dedicated to treating patients with a highly contagious, but not yet well understood, virus that is wreaking havoc on the world. She suits up in the available personal protective equipment (PPE), including the same N-95 mask that she has been wearing all week. During her shift, many of the patients she intubates are coughing aggressively, and Sara can see the droplets accumulate on her face shield. She does not think much about this because the same thing has been happening for weeks, and it is her job to care for these patients. A few days later, Sara wakes up feeling miserable. Her chest hurts, her head hurts, and she can barely catch her breath between coughing fits. She immediately calls her supervisor and informs her that she suspects she has been infected with the disease they have now named COVID-19. Her supervisor encourages her to get tested.

Sara's test comes back positive for COVID-19, and her condition deteriorates rapidly. Soon, she requires the care she provided to others. She misses weeks of work, and ultimately, the physical and mental toll the virus took leaves her unable to return to her job as a respiratory therapist. Additionally, she has amassed significant medical debt. She knows she contracted COVID-19 at work because it was the only place that she was exposed to the virus. She did not go out to eat or to the grocery store during the time she was working on the COVID-19 unit, and there was no community transmission in her town during this time. Sara wonders if she can receive workers' compensation to help with her medical bills. Had she contracted a disease like Hepatitis B or HIV, her chances of receiving worker's compensation benefits for these medical conditions would be high. Similarly, had she aggravated her degenerative disk disease or required rotator cuff repair or knee arthroscopy after lifting a patient, her injuries would likely be covered by the worker's compensation statute. However, contracting COVID-19 in the workplace is uncharted territory for workers' compensation laws.

The threat of unknown infectious diseases causing pandemics is a threat well anticipated by microbiologists and epidemiologists globally.[1] For decades, governmental agencies like

[1] Tom Frieden, *Dr. Tom Frieden: Protecting the World from the Next Pandemic*, GE REPORTS: BREAKTHROUGH (Oct. 29, 2015), https://www.ge.com/news/reports/dr-tom-frieden-protecting-the-world-from-the-next-pandemic.

the World Health Organization[2] and the Centers for Disease Control and Prevention[3] have worked to prepare the healthcare field for outbreaks with unknown origins, with a primary focus on influenza spillover events. In 2020, while scientists and physicians worked to rein in the COVID-19 pandemic, it became clear that the law was not prepared for the drastic effects a pandemic would have on well-established legal concepts ranging from federalism to workers' compensation. This Note, using the COVID-19 pandemic as a guiding example, explains why proactively adopting workers' compensation statutes that provide for compensation caused by infectious diseases in any pandemic emergency is vital to a functioning workers' compensation statutory scheme.

Section I of this Note will introduce the basics of workers' compensation law, including the history of infectious diseases as compensable workplace injuries in the field of American workers' compensation law. Section II explains the fundamentals of both the occupational disease theory and accidental injury theory as a means for recovery when an infectious disease is contracted in the workplace. This section further explores how both theories, in their current state, fail to adequately protect employees in a pandemic emergency. Finally, Section III of this Note provides guidance on how state legislatures may proactively amend their workers' compensation schemes to better protect employees and why these proactive measures are vital to furthering the purpose of workers' compensation laws.

II. BACKGROUND OF WORKERS' COMPENSATION AND INFECTIOUS DISEASES

Originating out of the industrial revolution, workers' compensation has a long and complicated history in the United States.[4] States began enacting forms of workers' compensation statutes in the early twentieth century. From their inception, workers' compensation laws have varied from state to state.[5] At the heart of workers' compensation law is the idea that some injury or disease must "arise out of and in the course of employment."[6] This idea is broken down into two parts: the "arising out of" component and the "in the course of" component. The "arising out of" component generally relates to the causal connection between employment and injury; some aspect of the employee's job must

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[2] TRAINING FOR EMERGENCIES, https://www.who.int/emergencies/training (Last visited Nov. 2, 2021).

[3] NATIONAL PANDEMIC STRATEGY, https://www.cdc.gov/flu/pandemic-resources/national-strategy/index.html (Last visited Nov. 2, 2021).

[4] 1 LARSON'S WORKERS' COMP. LAW § 2.07 (2021).

[5] *Id.*

[6] 1 LARSON'S WORKERS' COMP. LAW § 1.01 (2021).

have been the cause or exacerbation of the injury.[7] The "in the course of" component generally relates to the time and place of the injury; the injury must occur during the hours in which the employee usually works and in the location in which the employee usually works.[8] An employee must fulfill both requirements in order to receive compensation for their injuries.[9]

Early workers' compensation laws excluded occupational diseases from coverage, focusing instead on compensation for accidental injuries. Over time, compensation laws evolved and coverage for workplace diseases became more common.[10] States vary tremendously, however, in how they classify workplace diseases and compensate them. Some states view infectious disease as accidental in nature and, therefore, treat such diseases as compensable accidental injuries.[11] Other states include infectious diseases in occupational disease statutes that apply only in circumstances where a specific accident or exposure cannot be identified.[12]

In states that compensate employees for infectious diseases under an accidental injury theory, the infection must have been caused by some unexpected event or unusual exposure.[13] Accidental injuries in workers' compensation are generally characterized by their unexpected nature and the ability to trace the injury to a reasonably specific time, place, or cause.[14] Infections caused by microorganisms entering the skin through a scratch or by handling colonized materials can constitute unexpected events for which compensation is granted.[15] Unexpected and unforeseen exposures to known allergens may also be considered accidental.[16] Unusual exposures include contracting an infectious disease while caring for patients in a hospital ward dedicated specifically to that disease.[17] In these cases, the accidental nature of the injury stems from the

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[7] Harold J. Fisher, *Injuries Arising Out of and in the Course of Employment*, 26 MO. L. REV. 278, 282 (1961).
[8] *Id*. at 283.
[9] *Id*. at 280.
[10] 1 LARSON'S WORKERS' COMP. LAW § 2.08 (2021).
[11] 4 LARSON'S WORKERS' COMP. LAW § 51.01 (2021).
[12] 4 LARSON'S WORKERS' COMP. LAW § 52.03[1] (2021).
[13] 4 LARSON'S WORKERS' COMP. LAW Chap. 51.syn (2021).
[14] 3 LARSON'S WORKERS' COMP. LAW § 42.02 (2021).
[15] 4 LARSON'S WORKERS' COMP. LAW § 51.02-03 (2021).
[16] Lorentzen v. Industrial Comm'n, 790 P.2d 765, 767-68 (Ariz. Ct. App. 1990) (a teacher's allergic reaction to a pesticide exposure was deemed to be accidental because, while the teacher knew of her allergy, she did not expect to be exposed to the substance in the course of her employment).
[17] 4 LARSON'S WORKERS' COMP. LAW § 51.05; *see* Gaites v. Soc'y for Prevention of Cruelty to Children, 251 A.D. 761, 762 (N.Y. App. Div. 1937); Industrial Com. v. Corwin Hospital, 250 P.2d 135, 136-7 (Colo. 1952).

unusualness of the exposure.[18] In some states, an injured worker can only be compensated for an infectious disease if that infection resulted from some traumatic injury.[19]

A majority of states have enacted occupational disease statutes within their workers' compensation schemes. These statutes provide compensation for diseases that cannot be traced to a specific exposure or traumatic accident.[20] Additionally, these statutes allow compensation for infectious diseases when the infection does not fulfill the statutory requirements of an accidental injury.[21] In contrast with the more concrete and definite elements of accidental injuries, occupational disease statutes generally require the disease to be "peculiar to the calling" and one in which the employee is exposed to "hazards greater than those involved in ordinary living."[22] Occupational disease statutes, by their nature, allow for a broader range of compensable injuries. For example, these statutes may reach musculoskeletal issues like herniated discs and carpal tunnel syndrome, as well as diseases that are infectious in nature like tuberculosis and hepatitis.[23] Because occupational diseases necessarily lack a specific exposure, proof of causation rests on circumstantial evidence.[24] This evidence includes both the extent of exposure, during employment and outside employment, and absence of the disease in the individual prior to the work-related exposure.[25]

During the first two years of the COVID-19 pandemic, states across the country implemented measures to account for the unique nature of COVID-19 in workers' compensation law.[26] Governors used executive orders to create a presumption of compensability for certain employees, namely healthcare workers and first responders in some states.[27] In other states, the legislatures amended workers' compensation laws in order to provide a presumption of

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[18] *Id*.
[19] 4 LARSON'S WORKERS' COMP. LAW § 51.04; *see* Hoffman v. Consumers Water Co., 99 P.2d 919, 920-21 (Idaho 1940); Mills v. Columbia Gas Const. Co., 55 S.W.2d 394, 396 (Ky. Ct. App. 1932).
[20] 4 LARSON'S WORKERS' COMP. LAW § 52.03[1] (2021).
[21] *Id*.
[22] Grain Handling Co. v. Sweeney, 102 F.2d 464, 465 (2d Cir. 1939).
[23] 4 LARSON'S WORKERS' COMP. LAW § 52.04 (2021); *see* Ross v. Kollsman Instrument Corp., 24 A.D.2d 670, 671 (N.Y. App. Div. 1965); Kinney v. Tupperware Co., 792 P.2d 330, 333 (Idaho 1990); Quallenberg v. Union Health Center, 280 A.D. 1029 (N.Y. App. Div. 1952); Jeannette Dist. Mem'l Hosp. v. Workmen's Comp. Appeal Bd. (Mesich), 668 A.2d 249, 251 (Pa. Commw. Ct.1995).
[24] Booker v. Duke Med. Ctr., 256 S.E.2d 189, 200 (N.C. 1979).
[25] *Id*.
[26] 4 LARSON'S WORKERS' COMP. LAW § 51.06[2] (2021).
[27] *Id.*; California, Connecticut, Kentucky, Michigan, Missouri, New Hampshire, New Mexico and North Dakota created a presumption of compensability through executive order.

compensability.[28] In some other states, governors signed executive orders that indicated support for first responders but did not create a form of rebuttable presumption for them.[29] A majority of these executive orders and amendments contain sunset provisions establishing set dates of expiration.[30] These piecemeal amendments and executive orders indicate that most state governments want employees to recover for COVID-19 infections contracted in the workplace; however, as explained below, more detailed and permanent codification is required to fully provide for injured employees.

III. CURRENT STATUTORY SCHEMES ARE INSUFFICIENT TO CLASSIFY PANDEMIC DISEASES AS COMPENSABLE INJURIES.

There are two major categories of compensable injuries in American workers' compensation law: occupational diseases and accidental injuries. Currently, both categories are flawed in relation to pandemic diseases, leaving many employees without redress should they contract such a disease in the workplace.

A. Occupational disease statutes preclude pandemic diseases.

Multiple issues arise when attempting to classify an infectious disease as an occupational disease under the majority of states' occupational disease statutes. The disease must be both peculiar to the calling and it must not be an ordinary disease of life.[31] These causation requirements may fit an infectious disease like COVID-19 in certain contexts, but in most employment contexts these diseases would be excluded.

What constitutes a disease "peculiar to the calling" is not well defined statutorily and derives its meaning mostly from common law decisions. A disease may be peculiar to the calling when the risk of contracting or developing the disease is present to a greater degree than is found in employment and living conditions

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[28] *Id*.; Alaska, Illinois, Minnesota, New Jersey, Utah, Vermont, Virginia, Wyoming, and the District of Columbia amended their workers' compensation schemes to include a presumption of compensability.

[29] *Id*.; Arkansas and Washington did not create a presumption of compensability.

[30] A.C.A § 11-9-601 extends coverage until May 1, 2023; Cal Lab Code § 3212.86 extended coverage until January 1, 2023; 820 ILCS 310/1 extended coverage to cases of COVID-19 contracted prior to June 30, 2021; Utah Code Ann. § 34A-3-203 extended coverage to cases of COVID-19 contracted prior to June 1, 2021; Va. Code Ann. § 65.2-402.1 extended coverage to cases of COVID-19 contracted prior to Dec. 31, 2021; Wyo. Stat. § 27-14-102 extended coverage until March 31, 2022.

[31] 4 LARSON'S WORKERS' COMP. LAW § 51.01 (2021).

in general.[32] This increased risk is not meant to be interpreted as the risk associated with all employees in a particular field, but rather for the specific individual seeking compensation.[33] This individual evaluation should primarily focus on the risk associated with the nature of the individual's employment and not some singular condition present at the individual's workplace.[34] Further, a disease that arises from an unavoidable risk of the employment itself or is inherent to the nature of the employment may be peculiar to the calling.[35] Interpreting the peculiar to the calling requirement too narrowly, however, may lead to the exclusion of diseases that, while present in the general population, are more commonly found in specific industries and workplaces.[36] For example, consider an employee who contracts a disease like Serum Hepatitis in the course of their employment via some action unique to their job, such as handling infected materials as a lab technician; an employer cannot exclude this employee from receiving compensation simply because the general population could also contract the disease.[37]

Diseases that are ordinary to everyday life are also defined by common law rather than by statute. The distinction between what is and is not an ordinary disease of life relies on the likelihood of contracting or developing the disease at work versus the likelihood of contracting or developing the disease anywhere outside of work.[38] It is important to note that under this framework, diseases that exist in the general population are not diseases of ordinary life when the manner in which the general public is exposed is less likely to cause disease than the manner in which an employee in a specific profession is exposed.[39] For example, even where Tuberculosis may be present in the general population, an employee working in close proximity to Tuberculosis patients for an extended period of time is more likely to contract Tuberculosis than a person who does not work in the same role and who is only incidentally exposed to Tuberculosis.[40] Because it is difficult to find specific factors that cause disease, whether it be repetitive motion or bacteria, that are not present in everyday life, employers cannot limit compensation to only those diseases that arise from the specific type of

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[32] Aleutian Homes v. Fischer, 418 P.2d 769, 777 (Alaska 1966).
[33] Patterson v. Connor, 484 N.E.2d 240, 242 (Ohio Ct. App. 1984).
[34] In re Claim of Leventer, 257 A.D.2d 903, 904 (N.Y. App. Div. 1999).
[35] McCreary v. Industrial Comm'n, 835 P.2d 469, 475 (Ariz. Ct. App. 1992); *see also* Perron's Case, 88 N.E.2d 637, 639 (Mass. 1949) (inherent danger exists when the likelihood of contracting a disease is "so essentially characteristic of the employment.").
[36] Bowman v. Twin Falls Const. Co., Inc., 581 P.2d 770, 781 (Idaho 1978).
[37] *Booker*, 256 S.E.2d at 200.
[38] 4 LARSON'S WORKERS' COMP. LAW § 52.03[1] (2021).
[39] Mills v. Detroit Tuberculosis Sanitarium, 35 N.W.2d 239, 241 (Mich. 1948).
[40] *Id*.

employment.[41] Ultimately, where an employee is exposed to the disease causing factors in a greater degree and in a different manner than the general public, employees can receive compensation for otherwise ordinary diseases of life.[42]

This begs the question of whether infectious diseases qualify as occupational diseases. There are no simple answers to this question even for existing diseases such as Hepatitis and Tuberculosis. Specifically, courts in states with occupational disease statutes have taken many different positions relating to three common infectious diseases: Hepatitis B, Hepatitis C, and Tuberculosis. For instance, Pennsylvania's workers' compensation scheme creates a rebuttable presumption that a disease arose out of and in the course of employment if the disease is a hazard in certain occupations, including infectious Hepatitis for healthcare workers.[43] By comparison, the Georgia Court of Appeals has held that Hepatitis B is an ordinary disease of life that an employee, even in the healthcare setting, has the same chance of contracting outside of work.[44] In Virginia, for Tuberculosis to be considered an occupational disease, it must be contracted while working in a specialized Tuberculosis unit. Otherwise, Tuberculosis is considered an ordinary disease of life even where an employee can show a potential increased risk for contracting the disease in their employment.[45] Tuberculosis is an ordinary disease of life in Florida; for an employee to be compensated for contracting Tuberculosis, there must be concrete evidence that there is some increased risk or opportunity for infection in the employee's occupational setting.[46] While this is not an exhaustive list of state views on infectious diseases as occupational diseases, these examples demonstrate that COVID-19, or any other airborne disease that has pandemic-level spread, does not fit squarely within the existing occupational disease statutes.

While scientists have not yet labeled COVID-19 as endemic, it is hard to see COVID-19 as anything other than an ordinary disease of life. Indeed, many leading scientists do believe that the disease will become endemic across the globe, similar to the

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[41] 4 LARSON'S WORKERS' COMP. LAW § 52.03[3][b] (2021); *see* Louisville v. Laun, 580 S.W.2d 232, 234 (Ky. Ct. App. 1979); Roettinger v. Great Atl. & Pac. Tea Co., 17 A.d.2d 76, 80-1 (N.Y. App. Div. 1962).

[42] Adams v. Hygrade Food Prods. Corp., 82 N.W.2d 871, 872 (Mich. 1957).

[43] *Jeannette Dist. Mem'l Hosp.*, 668 A.2d at 251 (Pennsylvania workers' compensation law lists enumerated occupational diseases for which a rebuttable presumption exists that the injury arose out of and in the course of employment); *see also* 77 P.S. § 27.1.

[44] Fulton-Dekalb Hosp. Auth. v. Bishop, 365 S.E.2d 549, 550 (Ga. Ct. App. 1988).

[45] Van Geuder v. Commonwealth, 65 S.E.2d 565 (Va. 1951); Lindenfeld v. City of Richmond Sheriff's Off., 492 S.E.2d 506, 510 (Va. Ct. App. 1997).

[46] Fla. State Hosp. v. Potter, 391 So. 2d 322, 323 (Fla. Dist. Ct. App. 1980).

common cold and flu.[47] In the United States, community spread of the disease is high.[48] Community spread usually relates to the amount of infected persons in the community who cannot identify the source of their infection.[49] It is highly likely that, in most occupations, the chance of contracting COVID-19 at work is the same or less than in the community at large, especially when factoring in social distancing, mask wearing, and remote work opportunities. It is also hard to see how COVID-19 would be considered "peculiar to the calling" in most occupations. For employees outside the healthcare sector, COVID-19 is likely neither an unavoidable risk of employment nor a risk inherent to employment. This precludes teachers, factory workers, and "essential" employees like grocery store clerks and restaurant waiters and waitresses from recovering for COVID-19 infections contracted at work. While state governments have implemented changes to their workers' compensation schemes that may allow for compensation in these occupations, these amendments relate solely to COVID-19, and most amendments expired during 2021.

B. Accidental injury statutes currently preclude pandemic diseases.

Pandemic-causing infectious diseases are not well encompassed by accidental injury statutes. Most accidental injury statutes require an infectious disease to arise out of an unexpected event or unusual exposure.[50] In order to qualify as an accident, the disease must have some factor of unexpectedness and must be traceable to some definite time, place, and cause within reasonable limits.[51] Like occupational disease statutes, pandemic diseases like COVID-19 may fall under these statutes in specific contexts.

Unexpected events were the starting point for infectious diseases as accidental injuries, and unexpected events can include

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[47] Kelly Servick, *Is it Time to Live With COVID-19? Some Scientists Warn of Endemic Delusion*, SCIENCE (Feb 15, 2022); Nicky Phillips, *The Coronavirus is Here to Stay – Here's What That Means*, NATURE (Feb. 16, 2021) https://www.nature.com/articles/d41586-021-00396-2; Ingrid Torjesen, *Covid-19 Will Become Endemic but With Decreased Potency Over Time, Scientists Believe*, BMJ (Feb. 18, 2021), https://www.bmj.com/content/372/bmj.n494; Jesse T. Jacob et al., *Risk Factors Associated with SARS-CoV-2 Seropositivity Among U.S. Healthcare Personnel*, 4 JAMA NETW. OPEN, 7 (March 10, 2021).

[48] COVID DATA TRACKER, https://covid.cdc.gov/covid-data-tracker/#datatracker-home (Last visited Nov. 2, 2021).

[49] COVID-19 FREQUENTLY ASKED QUESTIONS, https://www.cdc.gov/coronavirus/2019-ncov/faq.html#:~:text=Community%20spread%20means%20people%20have,health%20department's%20website.%E2%80%8B (Last visited Nov. 2, 2021).

[50] 4 LARSON'S WORKERS' COMP. LAW Chap. 51.syn (2021).

[51] 4 LARSON'S WORKERS' COMP. LAW § 51.01 (2021).

entry of pathogens into the body by either abnormal or normal methods.[52] Infectious diseases that are caused by abnormal entry of pathogens tend to arise when pathogens or poisons enter the body due to some accident that occurred during employment.[53] Allowing compensation for infectious diseases caused by an unexpected event seems to stem from the idea that the unexpected event is the accident, not the contraction of a disease. More clearly stated, a scrape,[54] an insect bite,[55] or an exposure to bodily fluids[56] qualifies as the accident, and the disabling infection contracted from it is the injury.

Infectious diseases caused by the normal entry of pathogens are diseases that arise out contaminated food or water or otherwise inadequately kept employment conditions.[57] Here, unlike abnormal entry of pathogens, the infection itself is the accident.[58] Contracting a disease after consuming contaminated food and beverages is considered an accident in these cases because of the truly unexpected nature of the infection, and no specific instance of violence or trauma to the body is required.[59] A fundamental difference in cases related to normal entry of pathogens is the added element of the employer's failure to use due care in maintaining a clean and safe working environment.[60] Finally, in cases of normal entry of pathogens causing infectious diseases, an important consideration is state statutes that limit compensation to infections

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[52] 4 LARSON'S WORKERS' COMP. LAW § 51.02-03 (2021).

[53] Connelly v. Hunt Furniture Co., 147 N.E. 366, 367 (N.Y. 1925).

[54] In re Worker's Comp. Claim of Vinson, 473 P.3d 299, 311 (Wyo. 2020) (noting a situation in which an employee scraped his hand on a work locker and later developed a Streptococcus A infection, the scrape was the accident, and the infection was a compensable subsequent condition).

[55] Oalmann v. Brock & Blevins Co., 428 So. 2d 892, 896 (La. Ct. App. 1983) (noting a situation in which an employee was bitten by fleas and later developed Typhoid Fever, the flea bites were considered the accident and the infection was considered to be causally related to those bites).

[56] Ky. Emplrs. Safety Ass'n v. Lexington Diagnostic Ctr., 291 S.W.3d 683, 685 (Ky. 2009) (noting a situation in which an employee was splashed by another's bodily fluids, the splash was considered an accident and any subsequent preventative measures and treatment were considered causally related to the splash).

[57] 4 LARSON'S WORKERS' COMP. LAW § 51.03 (2021); *see* Vennen v. New Dells Lumber Co., 154 N.W. 640, 642 (Wis. 1915).

[58] Victory Sparkler & Specialty Co. v. Francks, 128 A. 635, 639 (Md. Ct. App. 1925) (while this case is not an infectious disease related ruling, the general rule that some unexpected foreign substance entered the body through normal employment activities applies in the same manner to infectious disease cases); *see* Union Mining Co. v. Blank, 28 A.2d 568, 576 (Md. Ct. App. 1942).

[59] *Union Mining Co.*, 28 A.2d at 576.

[60] 4 LARSON'S WORKERS' COMP. LAW § 51.03 (2021); *see also Victory Sparkler & Specialty Co.*, 128 A. at 640.

and other injuries that result directly from violence or trauma to the body.[61]

Unusual exposures to pathogens differ from unexpected events in that the exposure to the pathogen is the accident.[62] These exposures are unusual precisely because they arise from circumstances that are outside of the general expectation of the public. Thus, these exposures are unexpected. These cases encapsulate the field of infectious diseases caused by working directly with sick patients in specific units in the hospital,[63] but also reach classrooms[64] and daycare facilities.[65] It is more difficult to identify the time, place, and cause of an unexpected exposure in cases of unexpected events. Unusual exposure cases usually stem from a collection of exposures over a short period of time, and the traceability element requires only that the time, place, and cause be determined within reasonable limits.[66] As such, if a disease can be reasonably traced to a time and place where the cause existed, an employee is likely to recover as long as there is no evidence that the employee was exposed to the same disease outside of work.

The issue is whether infectious diseases qualify as accidental injuries. The answer, while not certain, is that infectious diseases are more likely to qualify as accidental injuries than they are as occupational diseases. There are a wider variety of cases where employees have received compensation for injuries and disabilities caused by infectious diseases when classified as accidental injuries as opposed to occupational diseases. For instance, employees have been compensated for diseases caused by infectious agents such as *Neisseria meningitides*,[67] Poliovirus,[68] *Histoplasma capsualatum*,[69] *Salmonella typhi*,[70] and *Bacillus anthracis*.[71] Some of these cases were traced to a specific exposure, while others simply required

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[61] Buchanan v. Maryland Casualty Co., 288 S.W. 116, 118 (Tex. 1926); *Hoffman*, 99 P.2d at 920-21; Loudon v. H. W. Shaull & Sons, 13 A.2d 129, 131 (Pa. Super. Ct. 1940); *Mills*, 55 S.W.2d at 396.

[62] 4 LARSON'S WORKERS' COMP. LAW § 51.05

[63] *Industrial Com.*, 250 P.2d at 136-7 (noting a nurse's polio infection after working in a polio specific ward at the hospital was found to be accidental).

[64] McDonough v. Whitney Point Cent. Sch., 222 N.Y.S.2d 678, 679-80 (N.Y. App. Div. 1961) (noting that a teacher's mumps infection during an outbreak at her school found to be accidental); *see also Lorentzen*, 790 P.2d at 767-68.

[65] Portman v. Camelot Care Ctrs., 2000 Tenn. LEXIS 96 at *4 (Tenn. Special Workers' Comp. App. Panel Mar. 2, 2000) (noting that a daycare worker's herpes infection after being spit at was found to be accidental).

[66] 3 LARSON'S WORKERS' COMP. LAW § 42.02 (2021).

[67] Omron Elecs v. Ill. Workers' Comp. Comm'n, 21 N.E.3d 1245, 1255 (Ill. App. Ct. 2014); New Castle v. Workmen's Comp. Appeal Bd. (Sallie), 546 A.2d 132, 137 (Pa. Commw. Ct. 1988).

[68] *Industrial Com.*, 250 P.2d at 138.

[69] City of Nichols Hills v. Hill, 534 P.2d 931, 955 (Okla. 1975).

[70] Scott & Howe Lumber Co. v. Indus. Com., 199 N.W. 159 (Wis. 1924).

[71] McCauley v. Imperial Woolen Co., 104 A. 617, 622-23 (Pa. 1918).

testimony that the disease was contracted through employment. Additionally, some courts have found that an infectious disease that does not satisfy the occupational disease elements may be considered an accidental injury for which the employee could recover.[72] Again, while every state does not view infectious diseases as accidental injuries, it is much easier to see how COVID-19 or other emerging infectious diseases would fit under these requirements.

Not every person who contracted COVID-19 knew with certainty where they were exposed.[73] However, accidental injury statutes do not require complete certainty so long as an exposure can be connected with employment within reasonable limits.[74] For most employees that worked full time in person during the COVID-19 pandemic, their place of employment was most likely the place of exposure.[75] This includes healthcare workers[76] and first responders,[77] but may also include grocery store workers,[78]

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[72] Baldwin v. Jensen-Salsbery Laboratories, 708 P.2d 556, 558 (Kan. Ct. App. 1985) (noting that an employee filed workers' compensation occupational disease claim for injuries caused by brucellosis infection, court found the infection to be accidental injury); Mid-South Packers, Inc. v. Hanson, 178 So. 2d 689, 691 (Miss. 1965) (employee's brucellosis infection held to be accidental injury as opposed to occupational disease); Wheaton v. City of Tulsa Fire Dep't, 970 P.2d 194, 196 (Okla. Civ. App. 1998) (employee's Hepatitis C was not an occupational disease as defined by state statute, case was remanded for determination of whether the infection could be considered an accidental injury).

[73] *Supra* note 49.

[74] 4 LARSON'S WORKERS' COMP. LAW § 51.01 (2021).

[75] Jay Barmann, *How Many Essential Workers Died in California During the Pandemic?* SFIST, August 6, 2021, https://sfist.com/2021/08/06/how-many-essential-workers-died-in-california-during-the-pandemic/.

[76] Soumya Karlamangla, *A Nurse Without N95 Mask Raced in to Treat a Code Blue Patient. She Died 14 Days Later*, LOS ANGELES TIMES, May 10, 2020, https://www.latimes.com/california/story/2020-05-10/nurse-death-n95-covid-19-patients-coronavirus-hollywood-presbyterian.

[77] Jace Harper and Dane Kelly, *DeWitt Township First Responder Dies of COVID Caught on the Job*, NEWS 10 WILX, Dec. 28, 2021, https://www.wilx.com/2021/12/29/dewitt-township-first-responder-dies-covid-caught-job/.

[78] Leticia Miranda, *Grocery Workers Died Feeding the Nation. Now, Their Families are Left to Pick Up the Pieces*, NBC NEWS, April 12, 2021, https://www.nbcnews.com/business/business-news/grocery-workers-died-feeding-nation-now-their-families-are-left-n1263693.

restaurant workers,[79] factory workers,[80] and teachers.[81] As stated earlier in this note, employees are likely unable to recover compensation under occupational disease statutory schemes. Employees working in spaces where there is limited social distancing, poor ventilation, minimal personal protective equipment, and high levels of exposure to the public are subject to exposures of the disease in an unexpected or unusual manner. An unmasked infected customer having a coughing fit or screaming at an employee may be considered an accident which caused the disease.[82] In the same way, a nurse or respiratory therapist being splattered with saliva while caring for an infected patient could be said to have experienced an accidental injury should the nurse or respiratory therapist become infected with COVID-19. However, these specific instances of causation are not explicitly required so long as there is a "causal connection between the conditions under which the work is required to be performed and the resulting injury" and that the connection is "apparent to the rational mind."[83]

C. Ultimately, accidental injury statutes are the best way to classify pandemic diseases.

Accidental disease statutes provide employees with a broader range of protections for infectious diseases like COVID-19. Employees need only show that contracting the disease was unexpected and that there is a reasonable traceability between employment and contracting the disease. Employees should, however, be cautious of statutes that require infectious diseases to be directly caused by a traumatic or violent injury.

On the other hand, occupational disease statutes make recovering for workplace infections with COVID-19 difficult for employees that work in occupations that are not directly associated with an increased risk of contracting COVID-19. Additionally, in

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[79] Naomi Knowles, *A Beloit Restaurant Worker Died in a Covid-19 Outbreak. Throughout the Pandemic, Worker Protections Often Left Behind*, NEWS 3 WISC-TV, Feb. 8, 2021, https://www.channel3000.com/unprotected-a-news-3-investigation-sunday-at-10/.

[80] Josh Funk, *Report: At Least 59,000 Meat Workers Caught COVID, 269 Died*, ASSOCIATED PRESS, Oct. 27, 2021, https://apnews.com/article/coronavirus-pandemic-business-health-pandemics-congress-72e766be17083ad819ea3ac26cb7fb76.

[81] Mye Owens, *More Than 20 Tennessee School Staff Members Have Died From COVID-19*, WKRN NEWS 2, Oct. 13, 2021, https://www.wkrn.com/news/more-than-20-tennessee-school-staff-members-have-died-from-covid-19/.

[82] MacRae v. Unemployment Comp. Com., 9 S.E.2d 595, 600(N.C. 1940) (an employee's award for compensation for Tuberculosis was affirmed on the grounds that being exposed to Tuberculosis by a coughing coworker constitutes an accidental injury).

[83] *Industrial Com.*, 250 P.2d at 137.

some states, it may be difficult to recover unless the employee works in a unit dedicated solely to caring for COVID-19 patients.

In sum, emerging pandemic diseases do not clearly fall under occupational disease statutes and may be covered by accidental injury statutes. With this in mind, state lawmakers should better prepare for future pandemics by explicitly providing compensation for employees that contract these diseases under the accidental injury theory.

IV. PREPARING FOR FUTURE PANDEMICS REQUIRES CODIFYING COMPENSATION UNDER ACCIDENTAL INJURY STATUTES AND CONSIDERING OTHER FACTORS THAT MAY MAKE COMPENSATION FOR THESE DISEASES DIFFICULT.

The lack of consistent nationwide guidance on how to classify and compensate workers injured by COVID-19 indicates that drafters of workers' compensation statutes did not anticipate the effect a pandemic would have on the workforce. While there is no fault to be associated with this unforeseen unpreparedness, now is the time to prepare for a future where both employees and employers know their rights. As they stand today, neither traditional occupational disease statutes nor traditional accidental injury statutes completely encompass a disease like COVID-19 for all employees.

A. Emerging infectious diseases and pandemic-causing diseases should be classified as accidental injuries for workers' compensation purposes.

When viewing infectious diseases from an epidemiological standpoint, the connection between infectious diseases and accidental injuries is clear. Boiled down to the simplest terms, infectious disease epidemiology is identifying a specific source (a time, place, and cause, *per se*) of an exposure to an infectious disease (usually, an exposure that is unexpected or unusual to the sick individual).[84] Just as employees may not be able to identify the specific date and method of their exposure, epidemiologists cannot always identify exactly how every infected individual contracted their disease. That fact does not prevent epidemiologists from identifying potential sources of disease when the source can be found within reasonable limits. Thus, it should not preclude employees from recovering when they are exposed to a disease that can reasonably be traced to their employment.

[84] U.S. DEP'T OF HEALTH AND HUM. SRVS., PRINCIPLES OF EPIDEMIOLOGY IN PUBLIC HEALTH PRACTICE (3d ed. 2012).

Bloodborne infectious diseases like Hepatitis and HIV, while sometimes compensable as accidental injuries, are more often considered occupational diseases.[85] The common cold and the flu, which are caused by airborne pathogens similar to the one that causes COVID-19, have traditionally been viewed as non-compensable injuries,[86] whereas Tuberculosis, which is caused by a different airborne pathogen, is often considered compensable either as an accidental injury or occupational disease.[87] While there is limited scholarship specifically related to classifying COVID-19, most articles take the view that these infections should be classified as occupational diseases and investigate how that classification applies in a single state.[88] These discussions point out that classifying COVID-19 as an occupational disease is not without its issues and spend little to no time reviewing accidental injury coverage in depth.[89] Classifying these infections as accidental injuries provides an opportunity for more types of employees to recover for the severe injuries that COVID-19, or other diseases like it, may cause.

For example, if Sara, the respiratory therapist from the introductory story, lived in a state that compensated infectious diseases under a theory of occupational disease, she would likely receive compensation. In any pandemic emergency, it is likely that her role as a respiratory therapist in a specific ward of the hospital dedicated to treating patients suffering from the disease in an early phase of the pandemic would qualify her illness as a disease that was

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[85] Nikita Williams, *HIV as an Occupational Disease: Expanding Traditional Workers' Compensation Coverage*, 59 VAND. L. REV. 937, 943-948 (2006).

[86] Dealers Transport Co. v. Thompson, 593 S.W.2d 84, 91 (Ky. Ct. App. 1979) (noting here that a common cold alone would not be compensable, but the employee may have a better chance at recovering workers' compensation were the cold exacerbated by employment to the point of severe injury or death).

[87] *MacRae*, 9 S.E.2d at 600 (treating exposure to tuberculosis as an accident); *Lindenfeld*, 492 S.E.2d at 510 (treating Tuberculosis as an occupational disease).

[88] Kate E. Britt, *Libraries and Legal Research: Workers' Comp and Contagious Disease: History and Future*, 100 MI BAR JNL. 42, 43-44 (2021), investigates COVID-19 as a compensable disease in Michigan and focuses solely on occupational diseases; Stephen D. Palmer, *The Compensability of COVID-19 in Workers' Compensation Cases – A General Analytical Roadmap*, 44 AM. J. TRIAL ADVOC. 367, 371-379 (2021), investigates COVID-19 as a compensable disease in Alabama and points out that COVID-19 may not be an accidental injury under Alabama law; Glenn W. Garcia, *A Novel Virus Brings Novel Issue in the Area of Workers' Compensation: Addressing COVID-19 Injury Claims Faced by Workers on the Frontlines*, 7 ST. THOMAS J. COMPLEX LITIG. 46, 50-58 (2021), focuses on Florida's presumption of compensability and how it affects COVID-19 as an occupational disease; Creola Johnson, *Crushed by COVID-19 Medical Bills, Coronavirus Victims Need Debt Relief Under the Bankruptcy Code and Workers' Compensation Laws*, 125 PENN. ST. L. REV. 453, 490-493 (2021), promotes changes to workers' compensation laws to include COVID-19 as an occupational disease to help mitigate costs incurred while hospitalized with the disease.

[89] *Id.*

peculiar to the calling. Sara's job put her at an inherent risk of contracting the disease. Further, in early stages of a pandemic before community transmission became widespread, the disease would likely not be considered a disease of ordinary life. Sara's risk of contracting the disease at work is higher than it would be in the general public. If Sara contracted the disease later in the pandemic when community transmission peaked, Sara's risk is likely still greater in her role working directly with patients infected with disease than outside of work.

In contrast, compare Sara's story to that of an employee in a meat packing factory, a grocery store, or even a school. These employees work in roles where contracting an airborne infectious disease is not inherent to their employment. They do not work in roles where they are directly and purposefully exposed to infected individuals, and it cannot be said that their jobs specifically create a risk of disease that is more than the risk of living in general. Further, even in the early days of the pandemic, their roles did not expose them to the disease in a manner different than the general public, which would make proving that the disease was not a disease of ordinary life difficult.

In a post-COVID-19 pandemic world, proving that COVID-19 is not a disease of ordinary life for these employees is almost impossible; the chances of contracting COVID-19 at work is likely the same as it would be outside of work. [90] As such, occupational disease statutes do not help those employees who work in roles that are not associated with the direct care of COVID-19 patients.

Industrial Commission v. Corwin Hospital is a useful parallel in evaluating pandemic diseases as accidental injuries. In this case, a nurse working in a polio ward during an outbreak contracted polio and the court concluded that the nurse's disease was an accident. In coming to the conclusion that the nurse's disease was an accident, the court considered factors including the nurse's role working exclusively in a polio ward, extreme working conditions that included fatigue and overworking, and that the personal protective equipment may not be satisfactory to protect from the disease.[91] The court in this case emphasized that these factors increase the likelihood of contracting polio. Further, the court determined that contracting polio in these conditions, specifically the fatigue felt by the nurse and the inadequacy of available PPE, led to the type of unexpected result that indicates an accidental injury. Those factors, utilized by the Supreme Court of Colorado in 1952, are relevant nationwide, now and in the future, for courts reviewing cases of employees contracting emerging infectious diseases at work.

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[90] Jacob et al., *supra* note 47, at 11.
[91] *Industrial Com.*, 250 P.2d at 138.

When applying accidental disease statutes to Sara's story and those of the factory and grocery store workers and teachers, they all are likely to receive compensation. The only required elements are for the exposure to have some level of unexpectedness and that the exposure be reasonably traceable to some time, place, and cause. For Sara, her exposure is clearly unusual as most people do not regularly experience such close contact with individuals infected with deadly diseases. Additionally, her exposure can be reasonably traced to her employment because she is working in a role that exclusively deals with infected patients.

When evaluating the claims for workers' compensation made by essential workers using the factors from *Corwin*, it becomes clear that contracting a pandemic-causing emerging infectious disease at work is an accidental injury. Contracting these types of diseases at their place of employment is unexpected; there is no expectation that they will contract the disease as part of their job. However, the traceability of the exposure is a trickier element to meet. But again, as the court in *Corwin* provided, there need only be a causal connection between the work environment and the resulting injury.[92] In a factory, where employees are working in close contact with coworkers for long hours and where PPE may not be sufficient, the causal connection is apparent to the rational mind. Additionally, for the grocery store worker who is working in a space where he or she is not adequately protected against the general public and are subject to outbursts by customers who may or may not be wearing PPE, the causal connection is apparent to the rational mind. Finally, for the teacher who is working with children who struggle with personal space and mask-wearing in a small classroom with little ventilation, the causal connection is apparent to the rational mind. Additionally, fatigue is likely high in all of these occupations, as more employees are required to work longer hours to meet the demand caused by a lack of adequate labor. It is important to emphasize that all of the different factors applied to the different employees may be present or not present for each or all of those employees, and each case must be evaluated on the merits.

After reviewing a variety of hypothetical situations involving pandemic diseases under both disease theories of workers' compensation law, it is clear that utilizing an accidental injury theory of disease during pandemics is vital to furthering the purpose of workers' compensation laws: to provide for employees when they are injured while working.[93] Requiring most employees to meet an almost impossible standard during a time of uncertainty regarding the disease and its spread goes directly against this purpose. States that have already amended their workers' compensation legislation

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[92] *Id.*

[93] 1 LARSON'S WORKERS' COMP. LAW § 1.03[2] (2021).

to include cases of COVID-19 should be commended. However, these amendments do not go far enough to protect workers.

The amendments to workers' compensation schemes vary widely from state to state. Some create a rebuttable presumption of compensability for all or most employees.[94] Others create a rebuttable presumption for healthcare workers and first responders.[95] There are amendments that only create a presumption for first responders.[96] There are amendments that create a presumption for healthcare workers, first responders, and essential workers.[97] There are some amendments that create no presumption of compensability.[98] Additionally, all of the amendments provide specific dates at which the coverage ends. Although Florida has not made any amendments, there is some indication that teachers may be able to recover after contracting COVID-19 in the workplace.[99] The variety in these amendments indicate that building piecemeal legislation to address specific needs in workers' compensation schemes is not the best way to address emerging infectious diseases because the laws will not provide for employees in accordance with the purpose of workers' compensation law. As the amendments reach their expiration dates, lawmakers must meet and decide to extend the coverage of the laws both in scope and in time. When state governments disagree on the cause and severity of a pandemic-causing disease, coming to agreement on terms for the scope and length of compensation may be difficult. Ultimately, lawmakers should make specific provisions for infectious diseases in their accidental injury statutes that will apply prospectively in times of pandemic.

These laws should apply to all workers, regardless of "essential" status. This will prevent lawmakers from showing favor to certain occupations, such as: allowing a grocery store clerk and a teacher, who contract the disease in a similar manner to recover despite only one being considered an essential worker under most current amendments. These laws should also not provide for any specific method of transmission. Where pandemics of unknown origin are likely, there is no guarantee that the method of

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[94] 4 LARSON'S WORKERS' COMP. LAW § 51.06[2] (2021); California and Wyoming created rebuttable presumptions for nearly all employees.

[95] *Id*.; Alaska and Virginia created rebuttable presumptions for health care workers and first responders.

[96] *Id*.; Missouri, New Hampshire and Wisconsin protect only public facing first responders.

[97] *Id*.; Kentucky protects grocery clerks but not pharmacy clerks; Illinois; New Jersey.

[98] *Id*.; Arkansas and Washington have no presumption of compensability for COVID-19 related claims.

[99] Fla. Educ. Ass'n v. Desantis, 2020 Fla. Cir. LEXIS 2693 at *20 (2d. Cir. Fl. 2020).

transmission can be predicted. Restricting these laws to a specific method, whether it be airborne, fecal-oral, vector borne, etc., prevents these provisions from being applicable to a range of potential emerging infectious diseases. Finally, these laws should not require that the disease arise from some violence or trauma to the body. While the states that have this requirement are in the minority,[100] this requirement in relation to pandemic preparedness precludes the ability to recover from contracting a disease that was unquestionably related to employment.

The most pressing concern relating to enacting these types of provisions is the most fundamental judicial concern: will the floodgates open to unending legislation relating to everyday infections like the common cold or seasonal flu? This concern is understandable, but misplaced, and does not stand under either the occupational disease or accidental injury theory.

This concern has been addressed in multiple cases across the country.[101] First, common infectious diseases like the common cold or flu are undoubtedly diseases of ordinary life and are peculiar to no calling. These diseases are so prevalent in society that the risk of contracting them at work are equal to the risk of contracting them outside of work. Next, and most pertinent for the purposes of this Note, diseases like the common cold and flu are not likely to meet the requirements of accidental injury. The prevalence of these diseases, coupled with the understanding that they are a part of life, takes away the unexpectedness of their development. Further, the inability to accurately test for the common cold specifically makes it difficult to trace to employment because it cannot be diagnosed with certainty. Regardless of their classification, these diseases, while severe in a small number of cases, are not likely to cause significant time off from work or costly medical bills and life changing disability.

B. Classifying pandemic diseases as accidental injuries provides a solution to additional issues in preparing workers' compensation schemes for pandemics.

There are two significant areas of concern when considering coverage for pandemic diseases: the unforeseen and unknown long-term impacts these diseases may have on employees and the exclusivity associated with workers' compensation claims.

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[100] 4 LARSON'S WORKERS' COMP. LAW § 51.04.

[101] *Loudon*, 13 A.2d at 114–15; In *New Castle*, 546 A.2d at 137, the court refused to consider under circumstances that the disease at issue was rare; View taken by the Dissent in *MacRae*, 9 S.E.2d at 605.

i. Post-COVID Conditions

The injuries caused by pandemic diseases like COVID-19 vary from individual to individual, and for some employees, the only impact on work would be the days taken off to quarantine from a known exposure or to recover from a mild case at home. For other employees, an infection may result in long stints in the hospital, periods of time on a ventilator, and even death. It is highly likely that where these diseases would be considered a compensable injury, there would be no issue with granting lost wages, medical costs, or death benefits for the immediate aftermath of an infection. Where the diseases cause long-term effects; however, is where the issue arises.

In the United States, there are generally two types of benefits covered by workers' compensation laws: wage loss and medical expenses.[102] These benefits are paid to disabled employees as defined by state workers' compensation statutes, but those disability definitions often vary from state to state and usually require some disruption in the ability to work. For example, in states like Idaho[103] and New Mexico,[104] for an injury or disease to be a disability, the employee must be totally incapacitated and thus no longer able to perform the job at which they were injured. In Oregon, an infectious disease simply must interfere with the employee's ability to work to be considered a disability.[105] These disability requirements imply that someone suffering from long-term effects of a pandemic disease must prove that the symptoms they experience have a significant effect on their work, and not just in their everyday life. The Department of Health and Human Services (HHS) recently classified long-term effects of COVID-19 as a disability under certain provisions of the Americans with Disabilities Act (ADA),[106] and this provides important context for the severity and nature of these long-term effects.[107] This decision provides that where long-term symptoms impose limitations on major life activities, including work, an individual can be considered disabled.[108] While the ADA is not the reference for which injuries or diseases constitute

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[102] 6 LARSON'S WORKERS' COMP. LAW § 80.02 (2021).
[103] Jones v. Morrison-Knudsen Co., 567 P.2d 3, 7 (Idaho 1977).
[104] Herrera v. Fluor Utah, 550 P.2d 144, 146-47 (N.M. Ct. App. 1976).
[105] Beaudry v. Winchester Plywood Co., 469 P.2d 25, 29 (Or. 1970).
[106] 42 U.S.C. § 12102.
[107] *Guidance of "Long COVID" as a Disability Under the ADA, Section 504, and Section 1557*, DEP'T OF HEALTH AND HUM. SRVS., https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/guidance-long-covid-disability/index.html#footnote10_0ac8mdc (last visited Nov. 2, 2021).
[108] *Id*.

compensable workplace injuries, the importance of long-term effects of a disease like COVID-19 being categorized as a legal disability cannot be overstated.

Additionally, the long-term effects of a pandemic disease may not be clearly diagnosable for workers' compensation purposes. For example, some individuals who have contracted COVID-19 experience symptoms related to the disease for weeks or months following infection.[109] These impacts are generally referred to as "post-COVID conditions" or more colloquially as "long-COVID." These symptoms vary in each patient and can range in severity from things like a cough or headache to heart palpitations and organ system inflammation.[110] Post-COVID conditions further muddy the waters because not all individuals that contract COVID-19 experience these long-term effects, and these long term effects may or may not have significant impacts on an individual's ability to work.[111] Drafters of workers' compensation laws must consider whether long-COVID is compensable as a separate disease from COVID-19 or compensable due to its connection with the initial infection.

Should post-COVID conditions be categorized as a separate compensable injury, employees may have difficulty recovering in states that would classify COVID-19 as an occupational disease. Employees in these states may be able to recover for costs associated with their initial infection if that infection is found to satisfy the occupational disease elements, but where the long-term effects are considered a separate disease, the evaluation may not even reach the elements. In some states, if an employee cannot be diagnosed with a specific disease, they are unlikely to recover. [112] Some states take an alternative approach, however, and allow recovery even where there is no identifiable disease.[113] Thus, the issue arises of whether post-COVID conditions are a diagnosable disease. Employees suffering from post-COVID conditions may fare better in states that view COVID-19 as an accidental injury. Even if post-COVID conditions were viewed as a separate injury, employees would likely still be able to satisfy the unexpectedness and traceability requirements.

Where post-COVID conditions are considered part of the initial COVID-19 infection, employees have a better chance of

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[109] *Post-COVID Conditions*, CTRS. FOR DISEASE CONTROL, https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html (last visited Nov. 2, 2021).

[110] *Id*.

[111] *Id*.

[112] Peer v. MFA Milling Co., 578 S.W.2d 291, 296 (Mo. Ct. App. 1979) (noting that where a disease is not identified, there can be no recovery).

[113] Armstrong v. City of Wichita, 907 P.2d 923; 927 (Kan. Ct. App. 1995) (noting that a disease does not have to be identified to be compensable).

recovering in states that apply either theory of recovery. Occupational disease states would likely view long-term effects as part of the disease itself. Similarly, accidental injury states would likely view the effects as symptoms arising out of the accidental injury itself.

Codifying pandemic diseases under accidental injury statutes would prevent these diagnosability issues. Accidental injury statutes would make associating long-COVID with the initial infection easier under the theory that all injuries arising out of an accident are compensable. Additionally, these statutes do not require a specific diagnosis for compensability like many occupational disease statutes require, therefore making the difficulty in properly diagnosing long-COVID irrelevant.

ii. Workers' Compensation Exclusivity

Workers' compensation statutes nationwide generally restrict employees from recovering under both a workers' compensation theory and under a tort theory like negligence.[114] This exclusivity rests on the idea that where employers may be held liable for injuries due to no fault of their own, there must be some limit on how much injured employees can recover.[115] Applying the exclusivity doctrine to cases of pandemic disease like COVID-19 can be tricky and ultimately may preclude recovery altogether.

The idea that exclusivity provisions may prevent employees from recovering for injuries associated with contracting COVID-19 in the workplace has been explored previously through a lens viewing COVID-19 as an occupational disease.[116] Essentially, employees may not recover for a disease that does not fit the statutory definition of an occupational disease, but employees cannot use traditional tort theories to sue their employers for injuries sustained at work in place of a workers' compensation claim.[117] These provisions effectively leave employees suffering from the medical effects and faced with exorbitant medical bills with no means of redress.

Exclusivity provisions have already influenced COVID-19 tort lawsuits against employers. In New York, for example, an employee's public nuisance claim for failure to maintain a safe work environment was denied for a variety of reasons, one being the exclusivity provision in New York's workers' compensation law.[118]

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[114] 9 LARSON'S WORKERS' COMP. LAW § 100.01 (2021).
[115] *Id*.
[116] Michael C. Duff, *Pandemic Mini-Symposium: Can Workers' Compensation "Work" In A Mega-Risk World? The Covid-19 Experiment*, 35 ABA JOURNAL LAB. & EMP. LAW 17, 20 (2020).
[117] *Id*.
[118] Palmer v. Amazon.com, Inc., 498 F. Supp. 3d 359, 374-75 (E.D.N.Y. 2020).

The court indicated that allowing the employee to recover under the tort claim violated the premise that employees should not be allowed to recover for workplace injuries twice.[119] Additionally, in California, an employee sued her employer for the wrongful death of her husband after he contracted COVID-19 from his wife who contracted COVID-19 at work.[120] The employer moved to have the case dismissed on the grounds that the husband's death was derivative of the wife's workplace injury and, therefore, the wrongful death action was excluded under California workers' compensation law; the court denied the motion.[121]

While exclusivity provisions are a cornerstone of American workers' compensation law and generally provide adequate relief to employees without unduly burdening employers, it is clear that in times of pandemics, these provisions may provide a workaround for employers. In occupational disease jurisdictions, employers could defend against tort actions using workers' compensation exclusivity and employees would be left to the mercy of the court to find that the disease was not ordinary to everyday life and peculiar to the calling. Additionally, employers may create their own policies for emerging infectious diseases that exclude employees from receiving workers' compensation benefits regardless of what the law requires.[122]

Codifying pandemic diseases under accidental injury statutes would prevent these exclusivity issues. Accidental injury statutes would provide clear guidance to employees that pandemic-related claims are compensable rather than leaving employees to guess as to whether they could file a claim. Additionally, the statutes would provide a greater chance of recovery so that employees would not have to rely on tort claims by requiring the employee to prove that the disease was unexpected and traceable, as opposed to proving the disease was peculiar to the calling and not ordinary to everyday life.

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[119] *Id*.

[120] See's Candies v. Superior Court of Cal. for L.A., 2021 Cal. App. LEXIS 1076 at *14–16 (Cal. Ct. App. 2021).

[121] *Id*.

[122] Barnes v. Vanderbilt Univ. Med. Ctr., 2021 TN Wrk. Comp. LEXIS 92 at *3, 9 2021 TN WRK. COMP. LEXIS 92 (Tenn. Ct. of Workers' Comp. Cl. September 21, 2021) (noting a worker who was denied workers' compensation benefits at a preliminary hearing after his employer treated his COVID-19 symptoms through its occupational health clinic rather than through a workers' compensation claim, and once the workers' compensation claim was brought, the employee was no longer considered disabled, and causation could not be proven at the hearing).

V. CONCLUSION

Considering the nationwide impact of COVID-19, the optimal time to prepare for pandemics is before they happen. Although the distinction between accidental injuries and occupational diseases may be blurred in many areas of infectious diseases, lawmakers should provide clear rules for emerging pandemic diseases. Both employers and employees suffer when there is no guidance on how best to handle workers' compensation claims. In order to better serve both employers and employees and promote the goal of workers' compensation laws, state lawmakers should enact proactive legislation that would become effective in times of pandemics and provide compensation for pandemic diseases as accidental injuries.