the Quarterly Dose

Your Health Care Litigation Prescription

MARSHALL DENNEHEY

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Welcome to the first issue of *The Quarterly Dose*, Marshall Dennehey's first newsletter exclusively devoted to health care litigation issues and topics that matter to you. Our intention is to provide quarterly updates on new law in the jurisdictions where we practice and insight into trends we are seeing in the industry.

Our health care medical malpractice team handles litigation in seven states (Pennsylvania, New Jersey, Delaware, New York, Florida, Ohio and Connecticut) and has an active case list which well exceeds 2,500 files at just about any given time. Last year, our team tried more than 30 cases and arbitrated, mediated or settled countless others. Information sharing is one of the keys to success in our industry and this publication allows us to share with you what we've learned from our successes and how it can be applied to help you overcome the challenges in your world.

Thank you for entrusting us with your litigation. With this publication, we are raising the bar to exceed your expectations.

Enjoy your first dose!

Special thanks to Megan Nelson, associate in our Orlando, Florida office, for her creativity in developing the publication's name.

INSIDE THIS ISSUE

Managing Risks in ER Psychiatric and Behavioral Health Treatment

By: Jason W. Bialker, Esq. and Adam J. Fulginiti, Esq.

As mental and behavioral health care grows more universal, and the delivery of healthcare services becomes more diverse, providers must be prepared to account for shifting landscapes regarding the standard of care. Given new trends emerging within this field, there are best practices providers can utilize to manage and mitigate risk in the emergency room setting.

Vetting and Training Personnel

Within the context of behavioral health emergency room treatment, vetting and training of personnel constitutes a key factor in litigation which often manifests in corporate negligence claims. Institutional providers may face exposure not only for the actions of their staff related to the patient, but also the operation of the facility itself. This includes factors such as the hiring and retaining of personnel, the adequacy of policies and procedures, adequacy of facilities and equipment, and notably, training and oversight of staff.

While all licensed providers in the ER should ideally be proficient in handling behavioral health patients, treatment of these patients should be assigned to providers with relevant experience, given the unique challenges these patients present. Providers should be proficient in modalities germane to behavioral health, which include screening tools regarding depression, violent ideations, trauma, and substance abuse. They should also be competent in the performance of safety checks regarding risks for ligature, suffocation, and/or items that can be thrown, broken, or otherwise used to harm the patient or others. Proficiency should be demonstrated by physicians, nurses and other mid-level providers, as well as other "ancillary staff." Behavioral health settings often include a safety observer and security personnel who can also be utilized in crisis cases involving agitation or risk/history of violence/self harm. Social workers and other crisis specialists may also be employed. Regardless of the role of the personnel involved, providers interacting with behavioral health patients in the ER should be proficient in observation, communication, and engagement.

In addition to ensuring proper vetting and training of ER staff, documentation of these processes should be created and maintained in credentialing and/or personnel files. Examples of relevant materials include initial training/orientation, acknowledgment of receipt related to policies and procedures, and ongoing education and training.

Telemedicine in the Behavioral Health ER

Logistically, telemedicine can and often is utilized to supplement staffing and maintain continuity of services. For larger institutions, daytime and evening shifts may employ in-person coverage but for overnight hours, psychiatric telemedicine services may be utilized. Smaller institutions, which typically have less access to in-person staff, may utilize psychiatric telemedicine with greater frequency. In either scenario, psychiatric telemedicine enhances the ability of healthcare institutions to service and treat a broader array of patients, irrespective of the staff physically present.

While the benefits of psychiatric telemedicine may be obvious, they come at a cost, as the risks and exposure common to all telemedicine practice exist and, in fact, may be enhanced, within the setting of ER behavioral health treatment. This primarily derives from the lack of in-person contact, the quintessential element of telemedicine. Generally speaking, the inability of a provider to be physically present with a patient can impact the therapeutic dynamic. This "disconnect" between in-person care and telemedicine can be pronounced in the context of behavioral health treatment, where factors such as body language, eye contact, and other manifestations may be more difficult to appreciate. Lack of in-person contact may also impact the provider's rapport with the patient, potentially limiting the patient's trust. This may affect the patient's candor with the provider, which may in turn diminish the provider's ability to generate a properly-informed diagnosis and treatment plan.

In light of these challenges, institutions should ensure telemedicine providers involved with behavioral health patients are proficient with this type of practice. Tactics such as maintaining patient engagement, conducting objective screening, and obtaining as detailed a history as possible are key to mitigating potential adverse outcomes. The institution should also maintain up-to-date telemedicine-related technology to minimize challenges associated with behavioral health telemedicine in the ER. In the event the telemedicine provider determines in-person care or admission is necessary, institutions must be prepared to handle such a recommendation, be it through on-site treatment or the facilitation of transfer to another facility.

Subcontracted Services

Larger healthcare institutions, especially those in an academic setting, maintain their own psychiatric medicine service, which is flush with attending physicians, fellows, residents, and other mid-level providers. Consequently, the need to subcontract outside providers to assist with behavioral health treatment in the ER is typically unnecessary. However, smaller healthcare institutions may not have access to in-house psychiatric services, or, may have limited access throughout a 24-hour time period. Smaller institutions may therefore need to subcontract with an outside psychiatric provider in order to furnish or supplement in-house psychiatric services.

Additionally, the need for security services in the ER has been on the rise. In a 2022 American College of Emergency Physicians survey, 85% of those surveyed expressed that the rate of violence experienced in emergency departments has increased over the past five years. In this regard, 55% said they had been physically assaulted, almost all by patients, with a third of those resulting in injuries. Notwithstanding the societal stigma imposed upon psychiatric patients and those struggling with addiction, these same physicians reported that psychiatric patients, along with those seeking drugs or under the influence of drugs or alcohol, comprised over 80% of the assaults experienced. Given the increasing risk that ER providers face, institutions may opt to retain and/or increase their security staff and technology, often through subcontracting with a third party.

The importance of delineating parameters of the subcontractor relationship, particularly responsibility for certain tasks, is key. To the extent such companies are enlisted to provide services, institutions should understand what

services these entities are obliged to perform and what they are not. This typically can be addressed through service agreements or similar contracts, which provide guidance regarding the apportionment of responsibilities. Within these contracts, indemnity provisions are critical to identifying exposure in the event of an adverse outcome and potential litigation.

For example, when contracting with an outside provider to provide in-house psychiatry services, the parties must have a clear understanding of their respective roles in the hiring, orientation and training, credentialing, supervision, and control over the provider. The contract should clearly layout each party's responsibilities. Such contracts typically require outside vendors to hire the provider and to ensure they are qualified for the proposed role in the ER. At the same time, the contract may significantly limit the vendor's role regarding supervision/control over the care furnished by the provider. The hospital typically has responsibility for the orientation and credentialing of the provider, as well as supervision of their work pursuant to hospital/ER policies and procedures. The contract should address other issues such as scheduling, disciplinary action, removal or termination of the provider, and, of course, indemnity and contribution.

For security staff, many of the same issues exist. There must be a clear delineation of responsibility for vetting and hiring the security staff, and responsibility for ensuring they are qualified and receive the proper and necessary training. The ability to discipline and/or terminate security staff should also be clearly stated. As for behavioral health, depending on the ratio of behavioral health patients in the ER, a healthcare provider should consider providing security staff with advanced training on how to manage patients with behavioral health issues, including those actively in crisis. Either way, the ER should have a sufficient number of properly trained security staff present at all hours to effectively manage a typical shift's behavioral health caseload.

Crisis Management and Facilities

Behavioral health patients come with their own unique challenges, especially those who present tothe ER in active crisis. Proper screening and assessment of patients in crisis is necessary to not only protect the patient and provide them with the proper treatment, but also to protect others. In addition to vetting and training personnel, the use of telemedicine, and the decision to subcontract certain functions, the ER must have comprehensive policies and procedures regarding provision of care to behavioral health patients. For patients in crisis, policies and procedures should include where the crisis patient should be located in the ER, the protocol for monitoring/surveillance, and the protocol for security (often dependent on the presence, or lack thereof, of a history of violence or indication of potential violence).

If possible, a specific number of treatment rooms should be set up for patients in crisis, with all potentially harmful objects removed from the room. These rooms should be located in an area of the ER where security can be effectively provided and which do not allow easy access to exit points. Consideration should be given to security cameras to assist with monitoring, as surveillance footage may be pertinent in the event of an incident and potential, future litigation. If there are crisis intervention specialists in the ER, these specialists must be able to appropriately monitor and access patients in order to facilitate safety and treatment needs. If specific rooms cannot be designated for crisis patients, then the ER should have a plan for what to do when a crisis patient arrives in the building. This includes accounting for where patients are screened and assessed, where they are located, how they are monitored, how to make their environment safe and keep them safe, and how to protect the safety of others. ◆

ALL RISE

Recent Victories and Success Stories

David Tomeo, **Victoria Pepe** and **Karen Kankula** (all of Roseland, NJ) obtained a dismissal in the Superior Court of New Jersey on personal jurisdiction grounds of a multi-count complaint brought by a New Jersey-based medical laboratory against our client, an Arizona company which provides both medical services and health insurance to Arizona residents. The plaintiff argued that our client was amenable to suit in this state, asserting that our client had business interactions with the laboratory in New Jersey. In opposition, we were able to establish that not only was such assertion untrue, but also that any claims sent by the plaintiff to our client for testing services would have been processed in Arizona and that our client did not have any contacts—much less the constitutionally mandated minimum contacts—necessary for personal jurisdiction in New Jersey. In addition, finding that the plaintiff did not conduct any due diligence before filing suit, and did not make any attempt to take jurisdictional discovery while the motion was pending, the court dismissed the action with prejudice in New Jersey, despite the plaintiff's argument that a dismissal without prejudice was appropriate, thus leaving to the courts of Arizona the question of whether such a dismissal has preclusive effect in any suit brought there under these facts.

Lynne Nahmani and **Jessica Wachstein** (both of Mount Laurel, NJ) successfully defended a chiropractor with a directed verdict on informed consent and a no cause, 7-0, on standard of care. The plaintiff claimed the defendant was negligent in failing to obtain an MRI before adjusting the lumbar spine with a differential diagnosis, which included a herniated or bulging disc. The plaintiff claimed increased risk of harm for foot drop, surgery, pain and suffering, and alteration in work and life enjoyment.

Suzanne Utke (Philadelphia, PA) won a summary judgment motion in a failure to diagnose breast cancer case on behalf of an imaging company. The plaintiff had four mammograms between July 2011 and January 2015, all of which read as negative for abnormalities by four radiologists, who were all named defendants and were alleged to be employed by the insured imaging company. In October 2015, after a fall that led to an urgent care visit and a MRI, a metastatic lesion was seen on the plaintiff's hip. She was subsequently diagnosed with Stage IV metastatic breast cancer. Suit was filed for a missed diagnosis of breast lesions allegedly appearing on each of the four prior mammograms. The imaging company was named for theories of corporate and vicarious liability. After multiple mergers, acquisitions, and contractual relationships with all of the corporate co-defendants, the non-involvement of the imaging company was hotly contested and a stipulated dismissal could not be secured. After complex discovery, the motion for summary judgment was finally granted, with prejudice, for our client. ◆

Florida Tort Reform: The Impact of House Bill 837 on Health Care Litigation

By: Megan J. Nelson, Esq.

On March 24, 2023, Florida Governor Ron DeSantis signed House Bill 837 into law. Also known as the "Civil Remedies" or "Tort Reform" law, HB 837 has changed civil litigation in Florida, including providing a uniform standard for calculating the accurate value of past and future medical expenses in personal injury or wrongful death actions. Florida Statute 768.0427 now defines how past and future medical expenses may be entered into evidence at trial and how letters of protection are admission as to medical expenses and discovery related to the treating provider and a plaintiff's attorney's relationship.

House Bill 837 changes how cases will be evaluated for settlement negotiations and potentially increases the ability to reasonably settle claims before trial. It is important to note that these changes apply to causes of action filed after the effective date of March 24, 2023. However, if a complaint was filed before March 24, 2023, but is amended after March 24, 2023, there may be an argument that the changes from HB 837 should apply to the amended complaint.

If you find yourself wondering why these changes matter, it's because a plaintiff's damages are evaluated based on multiple factors, including past and future medical expenses. For example, if the medical bills are $100,000 but the amount paid is $10,000, a plaintiff should not be able to assert $100,000 in medical expenses. Knowing what can be presented to a jury will help to provide a better evaluation and strategy for settlement negotiations.

Before the new law, a plaintiff was permitted to board the full amount of medical bills charged for services rendered, with the exception of services paid by Medicare or Medicaid. Evidence of adjustments, reductions and setoffs could not be entered into evidence, unless paid by Medicare or Medicaid. Now, under HB 837, the evidence offered to prove the amount of damages related to medical expenses for past medical bills is limited to what was actually paid, regardless of the source of payment.

Example: If the medical bill is $1,000 but the contractual reimbursement rate (private insurance, Medicare, Medicaid) is $450 and the plaintiff's co-pay is $50, then the amount paid for the bill can be presented to the jury as $500, not the $1,000 billed.

For any unpaid medical bills (past and future), the claim can only be for an amount deemed necessary and reasonable. The amount that may be presented will depend on whether the plaintiff has health care coverage. If a plaintiff has Medicare, Medicaid or no coverage, the amount that may be offered into evidence is 120% of the Medicare reimbursement rate in effect on the date of the medical treatment or service obtained. For

future medical expenses, the amount would be the reimbursement rate in effect on the date of trial.

Example: If the medical bill is $1,000 but the Medicare reimbursement rate is $400, then the reasonable value of the unpaid services would be $480.

If there is no Medicare rate for a service, then the amount that may be offered into evidence is 170% of the applicable state Medicaid rate in effect on the date of the medical treatment or service obtained. For future medical expenses, the amount would be the reimbursement rate in effect on the date of trial.

Example: If the medical bill is $1,000 but the state Medicaid reimbursement rate is $400, then the reasonable value of the unpaid services would be $680.

New Definition for Letters of Protection

Florida Statute 768.0427 now defines a letter of protection as "any arrangement by which a health care provider renders treatment in exchange for a promise of payment for the claimant's medical expenses from any judgment or settlement of a personal injury or wrongful death action. The term includes any such arrangement, regardless of whether referred to as a letter of protection." This means any document showing an agreement for services can be called a "Letter of Protection," "LOP," or anything else. If there is an agreement to provide medical services to a plaintiff and not to charge the insurance carrier, it falls under the definition of a letter of protection.

If a plaintiff has health coverage (private insurance, Medicare, Medicaid) but does not submit the medical treatment or services to the insurance carrier (i.e., treating under a letter of protection), the amount that may be offered into evidence is limited to what the insurance carrier would have paid plus the plaintiff's co-pay.

Example: If the medical bill is $1,000 but the contractual reimbursement rate (private insurance, Medicare, Medicaid) is $450 and the plaintiff's co-pay is $50, then the amount paid for the bill can be presented to the jury as $500, not the $1,000 billed.

If the letter of protection is subsequently transferred to a third party, the amount that may be offered into evidence is limited to the amount the third party paid or agreed to pay in exchange for the right to receive payment pursuant to the letter of protection.

Example: If the medical bill is $1,000 but a third party bought the letter of protection for $700, then the amount paid for the letter of protection can be presented to the jury as $700, not the $1,000 billed.

The law also places new obligations on a plaintiff to disclose information related to the letter of protection, including identifying whether the plaintiff was referred for treatment and the identity of the person who made the referral. If the referral is made by the plaintiff's attorney, disclosure of the referral is permitted, and evidence of such referral is admissible, notwithstanding attorney client privilege. Moreover, in such situations, the financial relationship between a law firm and a medical provider, including the number of referrals, frequency and financial benefit obtained, is relevant to the issue of the bias of the testifying medical provider. This effectively overturns the Florida Supreme Court's decision in *Worley v. Central Florida Young Men's Christian Ass'n, Inc.*, 228 So. 2d 185 (2017).

As the new law allows evidence of reasonable amounts for necessary treatments, it is important to be aware that a doctor may claim that their bills are reasonable and medically necessary due to the limited availability of doctors willing to treat patients under a letter of protection. However, a

proactive defense that actively pursues what the reasonable and customary cost is for the medical treatment and services received, is likely the best course of action. Florida has implemented price transparency related to minimizing the surprise bills that arrive after medical treatment and services have been provided by hospitals. This price transparency allows the defense to argue what constitutes a reasonable and customary value. ◆

SIDEBAR

News and Happenings

Alyson J. Kirleis joined our Pittsburgh office as a shareholder in the Health Care Department. A highly accomplished medical malpractice litigator, Alyson has 35+ years of experience defending physicians, nurses and dentists, hospitals and long-term care facilities when claims and lawsuits are brought against them. An experienced litigator, she has successfully handled hundreds of matters which have included trials, mediations and appeals throughout western Pennsylvania in both state and federal courts. She additionally represents health care professionals before various licensing boards. Please join us in welcoming Alyson to the team!

We are also pleased to welcome two new associates to our New Jersey Health Care team: **David Drake** in our Mount Laurel office and **Nicole Geraci** in our Roseland office.

Heading to the American Hospital Leadership Summit in July? Make plans to attend an exciting presentation hosted by **Matthew Keris**, shareholder in our Scranton office, and Susan Boisvert, senior patient safety risk manager at The Doctors Company. With projected spending on the use of AI in health care to dramatically increase in the very near future, health care professionals need to prepare themselves now for the medicolegal issues they will soon face. Explore the transformative potential of AI in areas such as diagnostics, personalized medicine and operational efficiency. Also gain insights into the role that governing boards play in assessing and addressing the potential risks and operational impacts of integrating AI into workflows, including medical professional liability and discovery issues. **Learn more here.**

Happy retirement to **Janice Merrill** and **Kevin Osborne**! We applaud their remarkable accomplishments during their careers at Marshall Dennehey, and we wish them all the best as they begin this next chapter! ◆

LEGAL ROUNDUP

Case Law Updates

New Jersey

By: Victoria L. Pepe, Esq.

An "almost perfect storm of events" warranted additional time to file an Affidavit of Merit

Gonzalez v. Maher Ibrahim, et al., No. A-3719-22, 2024 WL 649332 (N.J. App. Div. Feb. 16, 2024) (approved for publication)

The plaintiff and her husband, by way of a *per quod* claim, initiated a medical malpractice action against the defendants for, among other things, their alleged failure to administer pain injections at the correct vertebrae of the plaintiff's spine. The trial court entered an order waiving the affidavit of merit (AOM) requirement, finding that the causes of action alleged in the original complaint were within the common knowledge doctrine.

The plaintiff then filed an amended complaint, naming P. Loesberg, M.D. as a defendant. Dr. Loesberg was alleged to have administered anesthesia to the plaintiff. In his answer, the doctor demanded the plaintiff serve an affidavit of merit. The trial court did not schedule a Ferreira conference to address the timely filing of an AOM regarding the plaintiff's claims against the doctor. About 134 days after he filed his answer, Dr. Loesberg moved to dismiss the plaintiff's complaint for failure to provide an AOM.

The trial court denied Dr. Loesberg's motion and scheduled a Ferreira conference to address the AOM issue. At the Ferreira conference, the judge rejected the doctor's contention that it was too late for the plaintiff to submit an AOM, reasoning that additional time was warranted for the plaintiff to produce an AOM because Dr. Loesberg was not a named party in the action when the initial Ferreira conference was conducted (thus, the need for an AOM regarding any allegations against him were not discussed at that time). Additionally, once the amended complaint added Dr. Loesberg as a party, no follow-up Ferreira conference was scheduled until after the 120-day AOM filing period against him had expired.

After the Ferreira conference, the judge entered an order requiring the plaintiff to file an AOM by a designated time, with which the plaintiff complied. Dr. Loesberg then filed a second motion to dismiss the plaintiff's complaint, chiefly arguing that no extraordinary circumstances existed that would allow for additional time to file an AOM. However, the trial judge denied the doctor's second motion to dismiss, finding that extraordinary circumstances were present. Dr. Loesberg appealed.

On appeal, the Appellate Division held that extraordinary circumstances existed here for the following reasons: (1) the trial court entered an AOM waiver order prior to the filing of the plaintiff's amended complaint asserting medical malpractice claims against Dr. Loesberg; (2) the doctor did not assert the plaintiff's lack of filing an AOM as a defense in response to the plaintiff's discovery requests; and (3) the lack of a Ferreira conference after Dr. Loesberg filed his answer (which the court noted is not an extraordinary circumstance on its own but is, rather, one consideration of the entire fact-sensitive inquiry). ◆

LEGAL ROUNDUP

Case Law Updates (cont.)

Pennsylvania

By: Kevin M. Majernik, Esq.

Pennsylvania Superior Court holds that trial court correctly entered nonsuit on plaintiff's corporate negligence claim for failing to show actual or constructive knowledge

Corey v. Wilkes-Barre Hosp. Co., LLC, 2023 PA Super 262, 307 A.3d 701 (Pa. Super. 2023)

The trial court entered nonsuit on the plaintiff's corporate negligence claim as the case did not involve any kind of systemic negligence on the part of the hospital. The trial court found that the plaintiff's sole expert gave only generalized, non-specific terms of what the expert believed "they" should have done, but failed to identify who was "they." The plaintiff's expert was only critical of "they," which the court could only assume was the nurse and the attending emergency room physician, not the defendant hospital. Even assuming arguendo that "they" referred to the defendant hospital, the only testimony concerning knowledge for corporate negligence concerned issues with alarms on monitoring equipment, which fell well short of what is required for actual or constructive knowledge necessary for a claim of corporate negligence. Accordingly, the court found that there was no testimony and/or evidence demonstrating actual or constructive knowledge. This is beneficial to support arguments made in preliminary objections, judgment on the pleadings, summary judgment and nonsuit for corporate negligence claims where a plaintiff fails to allege or sufficiently allege actual or constructive knowledge.

Pennsylvania Superior Court holds that, under Section 311 of MCARE, matters reviewed do not require a document be specifically reviewed by a patient safety committee

Lahr v. Lehigh Valley Hosp., Inc., 2023 WL 8665017 (Pa. Super. Dec. 15, 2023)

The trial court had ordered production of patient safety reports which were (i) prepared in accordance with MCARE, (ii) intended to be confidential, and (iii) contained information identical to that conveyed to the Pennsylvania Patient Safety Authority protected by Section 311(d) of MCARE. The defendant-hospital claimed that the documents were privileged pursuant to MCARE, as they were patient safety event reports created in accordance with an adopted patient safety plan created in accordance with MCARE.

The Superior Court, on appeal, reversed the trial court's determination, finding that "matters reviewed," as stated in Section 311(a) of MCARE, do not require the purportedly privileged document under Section 311(a) if they have been reviewed by a patient safety committee or governing board in order to establish protection. Rather, at a minimum, based on the statutory interpretation of Section 311 of MCARE, a party only needs to demonstrate that the document "arose out of matters reviewed by a patient safety committee or a governing board pursuant to their Section 311(b) responsibilities." While this decision is unreported, it will still be beneficial in

asserting patient safety privileges under Section 311 of MCARE.

Pennsylvania Supreme Court holds that No Felony Conviction Recovery Rule barred medical malpractice and indemnification claims

Dinardo v. Kohler, 304 A.3d 1187 (Pa. 2023)

Both the trial court and the Superior Court found that the plaintiff's claims were barred by the No Felony Conviction Recovery Rule. The plaintiff filed a medical malpractice suit against his prior treating psychiatrist and health care providers, claiming that his criminal conduct—murdering four individuals—was a result of their gross negligence and sought compensatory damages and indemnification against judgments by the families of the four victims. The Pennsylvania Supreme Court found that any recovery was barred by the No Felony Conviction Recovery Rule as the plaintiff was barred from profiting and/or beneficiating via civil laws off of his own criminal conduct. Specifically, the Pennsylvania Supreme Court found that the complaint, when read as a whole, sought damages that flowed from his own homicidal conduct.

This is a major application of the No Felony Conviction Recovery Rule in the medical malpractice realm and can serve as a basis for further preliminary objections or dispositive motions wherein a plaintiff's claims stem from criminal conduct. ◆

Make plans to attend our
"Trends in Health Care and Health Law Seminar"
on **May 9** at the Union League Liberty Hill in Lafayette Hill, Pennsylvania.

Attendees will hear from a dynamic lineup of speakers about hot topics impacting the health care industry, including the use of AI in medicine, the impact of nuclear verdicts and damages, and a Pennsylvania medical malpractice law update.

Special guest speaker Dr. Huntley Taylor, CEO of Taylor Trial Consulting, will discuss the application of the Story Model of Juror Decision Making to civil litigation.

To register, click **here**.

Volunteer of the Year Award

Melissa Choma, RN, LNCC, a nurse legal analyst in our Pittsburgh office, received the 2023–24 **Volunteer of the Year Award** at the annual meeting of the American Association of Legal Nurse Consultants, held April 18–20 at the Omni William Penn in Pittsburgh. Melissa has been a member of the AALNC since 2015, and has since held several leadership positions, including Director-at-Large in 2020, President-Elect in 2021, and President in 2022. In 2023, she volunteered to step back in for a second term as President of the organization.