

Volume 28

Number 4

Winter 2017

THE JOURNAL OF  
**Legal Nurse**  
*Consulting*



EMPLOYMENT LAW AND  
NEW AUTHOR SUPPLEMENT

AALNC

AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS

AALNC  
AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS

2018

ANNUAL FORUM



**APRIL 13-14**

**CLEARWATER, FL**  
Hilton Clearwater Beach  
Pre-Forum April 12



**10**  
**THE ENHANCED NURSING COMPACT AND ITS IMPLICATIONS**

*Michael Loughran, President, Nurses Service Organization*

**14**  
**Q&A: BOARD OF NURSING**

*Elizabeth Murray BSN, RN, LNCC*

**17**  
**INVESTIGATING ALLEGED MALPRACTICE FOR EVIDENCE OF EMPLOYMENT RETALIATION: A CASE STUDY**

*Wendie Howland MN, RN-BC, CRRN, CCM, CNLCP, LNCC*

**19**  
**ARE NURSING BOARD ACTIONS PERMANENT PUBLIC RECORDS?**

*Lorie A. Brown, RN, MN, JD*

**21**  
**BURNOUT AND PATIENT SAFETY**

*Minda Lee Lockeretz BSN RN LNC*

**22**  
**ADA CASE REVIEW: A NEW NICHE FOR LNCS**

*Regina Jackson, RN, BS, CCM, LNCC*

**26**  
**ANATOMY OF A WORKERS' COMPENSATION CASE**

*Gina T. Crawford, LCR*

**32**  
**CHANGING THE PARADIGM: COLLABORATIVE LAW**

*Bartina L. Edwards, J.D.*

**38**  
**DID YOUR CLIENT WITH MEDICARE REPORT HIS SETTLEMENT AND AWARD TO MEDICARE?**

*James Hanus, RN, BSN, OCN, MHA*

**40**  
**CREATIVE WAYS TO GET YOUR FOOT IN THE DOOR: A STEP BY STEP LNC MARKETING GUIDE**

*Erin OConnell MSN, MBA, RN-BC, CNL, CNLCP*

**45**  
**GUIDE TO THE EMS WORLD**

*Michael J. Curran, RN, BSN, EMT-P, NHDP-BC*



- 02 Manuscript Review Process
- 03 Article Submission Guidelines
- 04 From the President
- 05 From the Editor
- 07 Letters to the Editor
- 09 Test Your Screening Skills

# AALNC

AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS

## American Association of Legal Nurse Consultants

330 North Wabash Ave.  
Suite 2000  
Chicago, IL 60611  
877/402-2562  
312/321-5177  
Fax: 312/673-6655  
E-mail: [info@aalnc.org](mailto:info@aalnc.org)  
Web site: [www.aalnc.org](http://www.aalnc.org)

### BOARD OF DIRECTORS

#### President

Debbie Pritts RN LNCC

#### President-Elect

Kimberly Beladi NS RN LNCC

#### Past President

Susan Carleo RN, CAPA, LNCC

#### Secretary/Treasurer

Laura Nissim MS RN CNS LNCC

#### Directors at Large

Elizabeth Murray BSN RN LNCC  
Erin Gollogly BSN RN  
Mary Flanagan

### THE JOURNAL OF LEGAL NURSE CONSULTING

#### Editor

Wendie A. Howland, MN, RN-BC,  
CRRN, CCM, CNLCP, LNCP-C, LNCC

#### Editorial Committee For This Issue:

Britney Anderson DNP, RN, CPNP  
Kathleen Ashton, PhD, RN, ACNS-BC  
Randall Clarke, BSN, RN  
Rebecca E Czarnik, MS, RN, CLNC,  
LNCP-C

Lauren Danahy, BS, RN, MBA, CCM,  
LNCC, CCHP

Cheryl Gatti, BSN, RN, LNCC, CCRN-R

Stormy Green Wan, RN, BSHS, RNFA

James Hanus, BSN, RN, OCN, MHA

Elizabeth Hill, PhD, RN

Regina Jackson, BS, RN, CCM, LNCC

Minda Lee Lockeretz BSN, RN, LNC

Elizabeth Murray, BSN, RN, LNCC

Ann Peterson, EdD, MSN, RN, FNP-  
BC, LNCC

Deborah S. (Susie) White, BSN, RN,  
LNCC

Debbie Tipton Winters, RN, MSN,  
MSS

Elizabeth Zorn, BSN, RN, LNCC

## PURPOSE

The purpose of The Journal is to promote legal nurse consulting within the medicallegal community; to provide novice and experienced legal nurse consultants (LNCs) with a quality professional publication; and to teach and inform LNCs about clinical practice, current legal issues, and professional development.

## MANUSCRIPT SUBMISSION

The Journal accepts original articles, case studies, letters, and research. Query letters are welcomed but not required. Material must be original and never published before. A manuscript should be submitted with the understanding that it is not being sent to any other journal simultaneously. Manuscripts should be addressed to [JLNC@aalnc.org](mailto:JLNC@aalnc.org). Please see the next page for Information for Authors before submitting.

## MANUSCRIPT REVIEW PROCESS

We send all submissions blinded to peer reviewers and return their blinded suggestions to the author. The final version may have minor editing for form and authors will have final approval before publication. Acceptance is based on the quality of the material and its importance to the audience.

The *Journal of Legal Nurse Consulting* is the official publication of the American Association of Legal Nurse Consultants (AALNC) and is a refereed journal. Journal articles express the authors' views only and are not necessarily the official policy of AALNC or the editors of the journal. The association reserves the right to accept, reject or alter all editorial and advertising material submitted for publication.

The content of this publication is for informational purposes only. Neither the Publisher nor AALNC assumes any responsibility for any injury and/or damage to persons or property arising out of any claim, including but not limited to product liability and/or negligence, arising out of the use, performance or operation of any methods, products, instructions, or ideas contained in the material herein. The reader shall assume all risks in connection with his/her use of any of the information contained in this journal. Neither the Publisher nor AALNC shall be held responsible for errors, omissions in medical information given nor liable for any special, consequential, or exemplary damages resulting, in whole or in part, from any reader's use of or reliance on this material.

The appearance of advertising in the *The Journal of Legal Nurse Consulting* does not constitute a guarantee or endorsement of the quality or value of such product or of the claims made for it by its manufacturer. The fact that a product, service, or company is advertised in *The Journal of Legal Nurse Consulting* shall not be referred to by the manufacturer in collateral advertising. For advertising information, contact [JLNC@aalnc.org](mailto:JLNC@aalnc.org) or call 877/402-2562.

Copyright ©2017 by the American Association of Legal Nurse Consultants. All rights reserved. For permission to reprint articles or charts from this journal, please send a written request noting the title of the article, the year of publication, the volume number, and the page number to Permissions, *Journal of Legal Nurse Consulting*, 330 North Wabash Ave., Suite 2000, Chicago, IL 60611; [JLNC@aalnc.org](mailto:JLNC@aalnc.org). Permission to reprint will not be unreasonably withheld.

*Journal of Legal Nurse Consulting* (ISSN 2470-6248) is published digitally by the American Association of Legal Nurse Consultants, 330 North Wabash Ave., Suite 2000, Chicago, IL 60611, 877/402-2562. Members of the American Association of Legal Nurse Consultants receive a subscription to *Journal of Legal Nurse Consulting* as a benefit of membership. Subscriptions are available to non-members for \$165 per year. Back issues are available for free download for members at the Association website and \$40 per copy for non-members subject to availability; prices are subject to change without notice. Back issues more than a year old can be obtained through the Cumulative Index to Nursing & Allied Health Literature (CINAHL). CINAHL's customer service number is 818/409-8005. Address all subscriptions correspondence to Circulation Department, *Journal of Legal Nurse Consulting*, 330 North Wabash Ave., Suite 2000, Chicago, IL 60611. Include the old and new address on change requests and allow 6 weeks for the change.

## ARTICLE SUBMISSION

*The Journal of Legal Nurse Consulting* (JLNC), a refereed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). We invite interested nurses and allied professionals to submit article queries or manuscripts that educate and inform our readership about current practice methods, professional development, and the promotion of legal nurse consulting within the medical-legal community. Manuscript submissions are peer-reviewed by professional LNCs with diverse professional backgrounds. The JLNC follows the ethical guidelines of COPE, the Committee on Publication Ethics, which may be reviewed at: <http://publicationethics.org/resources/code-conduct>.

We particularly encourage first-time authors to submit manuscripts. The editor will provide writing and conceptual assistance as needed. Please follow this checklist for articles submitted for consideration.

## INSTRUCTIONS FOR TEXT

- Manuscript length: 1500 – 4000 words
- Use Word® format only (.doc or .docx)
- Submit only original manuscript not under consideration by other publications
- Put title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for peer review
- Text: Use APA style (Publication Manual of the American Psychological Association, 6th edition) (<https://owl.english.purdue.edu/owl/resource/560/01/>)
- Legal citations: Use The Bluebook: A Uniform System of Citation (15th ed.), Cambridge, MA: The Harvard Law Review Association
- Live links are encouraged. Please include the full URL for each. Be careful that any automatic formatting does not break links and that they are all fully functional.
- Note current retrieval date for all online references.
- Include a 100-word abstract and keywords on the first page
- Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

## INSTRUCTIONS FOR ART, FIGURES, TABLES, LINKS

- All photos, figures, and artwork should be in JPG or PDF format (JPG preferred for photos). Line art should have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.
- Each table, figure, photo, or art should be submitted as a separate file attachment, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003)

## INSTRUCTIONS FOR PERMISSIONS

The author must accompany the submission with written release from:

- Any recognizable identified facility or patient/client, for the use of their name or image
- Any recognizable person in a photograph, for unrestricted use of the image
- Any copyright holder, for copyrighted materials including illustrations, photographs, tables, etc.
- All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned

## GENERAL INFORMATION

Acceptance will be based on the importance of the material for the audience and the quality of the material, and cannot be guaranteed. All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission.

The author, not the Journal, is responsible for the views and conclusions of a published manuscript. The author will assign copyright to JLNC upon acceptance of the article. Permission for reprints or reproduction must be obtained from AALNC and will not be unreasonably withheld.



**Debbie Pritts**  
RN, LNCC

President, AALNC

## Share Your Knowledge!

**W**ell, I am halfway through my term and I can't believe how fast time flies. I am running past yet another deadline and pondering what message can I impart. I am thankful to continue to meet so many fascinating and successful LNCs through our association. I am also trying my darnedest to reach out to as many new and experienced LNCs as I can, so that together we continue to build our membership and share the knowledge and awesomeness I uncover every day.

The AALNC continues to offer the highest quality of education for all levels of LNCs because continuous learning is vital to maintain a competitive advantage. I invite you to explore our website, [www.aalnc.org](http://www.aalnc.org), check out the educational opportunities we offer, then see how they would match your needs and interests. Whether you are new to legal nurse consulting, have mid-level experience, or are well-seasoned, once you discover how we can best meet your needs, take action!

You don't have to be a new LNC to reap the benefits of one module, or two, or more from our AALNC Legal Nurse Consulting Professional Course: Building Skills, Building Careers. We offer the LNCC Review Course to help you prepare for the LNCC® exam. What better way to promote your expertise and professionalism as an LNC than by becoming board certified, the one and only legal nurse consulting certification accredited by the Accreditation Board for Specialty Nursing Certification (ABSNC).

AALNC offers a great selection of dynamic live and on-demand webinars presented by prominent professionals. Browse the online bookstore and check out our series of laminated reference cards by the Products & Services Committee.

And save the date April 13-14, 2018, for the AALNC Annual Educational and Networking Forum in the beautiful, sunny, white sands of Clearwater Beach, Florida! The Forum Committee has been busy selecting the speakers and preparing to make this year's forum another very worthwhile experience. I'm planning a fabulous, fun networking event to make the most of the natural setting of the Gulf coast: think palm trees, white sand, tiki torches, and treasure hunts. You get the picture!

In September 2018, the AALNC held our first-ever live mock trial in partnership with the John Marshall Law School in Chicago, IL. Our members once again volunteered their time and expertise for a successful learning experience. Our attendees told us that the mock trial exceeded their high expectations. We also enjoyed it as a great networking opportunity.

I have met so many LNCs recently who are looking for ways to become successful. You all have a ginormous load of experience, your brains are bursting with knowledge, and the AALNC wants you to share! Joining our professional association is definitely a good first step towards success, and continuous learning is fundamental to maintaining that competitive edge. Contributing your professionalism and leadership in the LNC world is a proven way to give your career that boost you're looking for. Commit yourself to sharing your knowledge by presenting a webinar or a forum session, writing for the JLNC, or serving on a committee.

Commit to being a lifelong learner. Commit to being a leader and mentor. Pursue your goals with passion. Your success comes from your persistence as you strive to be your best.

*Debbie Pritts RN, LNCC*

Debbie Pritts, RN, LNCC

# The Work of Nursing

**G**reetings and welcome to the December 2017 JLNC. We're looking at various aspects of employment, from the ADA to Workers' Compensation (OK, so we didn't come up with a Z). We have several articles pertaining specifically to nursing work and licensure here, and to an interesting niche role an LNC can play in collaborative law. You'll also find our first New Nurse Authors Supplement, with two articles from first-time RN authors. We intend to make this a regular annual feature, so don't be shy! AALNC President Debbie Pritts has some suggestions for boosting your LNC credibility and practice— and one is publishing an article in a professional journal. And here we are, ready to hand, with yet another way to enrich your life.

Lately I've been interested in a few cases in which RNs were harassed and, in one case, assaulted for doing their jobs. Two are in active litigation, so I will change their details in our interview ([page 17](#)); the other drew national attention in September after video of an incident several weeks earlier went viral.

The case of Alex Wubbels RN, a former Olympic athlete and charge nurse in a critical care unit in Utah, captured national attention after she informed a police detective of her hospital's policy preventing that police officer/phlebotomist from drawing blood from an unconscious patient in the absence of an arrest, a warrant, or patient consent. The patient, an off-duty reserve officer from another jurisdiction, was injured when his vehicle was hit by a suspect engaged in a high-speed chase with police; the suspect died. The detective became enraged at her refusal and despite being cautioned by a fellow officer he threatened Ms. Wubbels, seized her bodily, dragged her out of the building, handcuffed her, and put her in a car. She was eventually released and was never charged; she received an apology from the police chief and the mayor only when the video was released weeks later. The officers have been relieved from duty; the detective also lost his second job with an ambulance company after the video captured him saying that after this incident, he would take all the people with insurance to other hospitals and all the drunks and homeless to this one.

Reaction from nurses across the country was strong and swift. Copies of notes I received included comments like,

*"... the hospital security guard – who is supposedly there to protect staff in the ED – is not only talking on his cell phone, but is actually opening the door for the rogue policeman as he man-handles the nurse out the door! What have you done about the security staff? Can your professional nursing staff rely on their help in a crisis? Although you are the interim CEO, it is clear that the buck stops with you and the organizational culture you set for staff who choose to work there."*

*"Assertions to the contrary by the second officer notwithstanding, it is not true that Nurse Wubbels would have no consequences if she provided the officer illegal access to the patient and the officer was later found to have acted wrongly. The Boards of Registration in Nursing that I know would take a dim view of an RN failing to protect her patient regardless. "Just following orders" is no excuse for wrong behavior or substandard patient protection in nursing, and hasn't been for a long, long time. I suspect Nurse Wubbels knows this already, and I was proud to see her act as she did."*



**Wendie Howland**  
MN, RN-BC, CRRN,  
CNLCP, LNCC

Editor, JLNC



I also received the following:

*What is a nurse or other medical provider in North Carolina to do when a law enforcement officer demands the withdrawal of blood from an unconscious patient? North Carolina General Statute § 20-139.1(c) answers this question. The nurse does not need to evaluate the circumstances to determine the legal propriety, nor must the nurse demand a warrant. The nurse need only determine that the blood draw may be done safely.*

*North Carolina General Statute § 20-139.1 provides:*

*•A physician, registered nurse, EMT or other qualified person shall withdraw the blood sample or urine test as specified by a law enforcement officer, and no further authorization or approval is required;*

*Thus, North Carolina law requires a nurse to comply with the directive of a law enforcement officer to withdraw blood from an unconscious patient, unless the nurse determines that the withdrawal will endanger the safety of either the nurse or the*

*patient. If the courts later determine that the withdrawal was unjustified or illegal, the results of the blood draw may be excluded from evidence; however, the nurse, hospital and/or practice that employs the nurse may not be held criminally or civilly liable for following the officer's directive, complying with the statute, and withdrawing blood using the applicable standard of care.*

*The same rules apply even when the patient is conscious and actively refusing to submit to a blood draw. See N.C. Gen. Stat. § 20-139.1(d2).*

I'd be very interested in what the ANA or the NC BoN has to say about this. It appears to require the nurse to put the state's needs ahead of the patient's, and that's pretty much anathema. What's your thinking on this issue? We'll publish the best answers we get in a later issue, anonymously if requested. Stay tuned.

Late update, 11/1/2017. There has been a settlement in Nurse Wubbels' favor. The settlement covers all possible defendants in a lawsuit, including individual police officers and hospital security officers, and the payout will be divided among the city and the University of Utah.

*Wendie A. Howland*

Wendie A. Howland MN RN-BC CRRN CCM CNLCP LNCC



## CONCUSSION CONFLICT

I have had an opportunity to read the most recently published fall issue of the JLNC. Some great articles with information that served as a nice review as well as some new information that I will file in my gray matter for use when I work on various PI cases.

I had a concern, however, about conflicting information presented by different authors in back-to-back articles.

In Concussion--The Invisible Injury by Tong and Almquist, both concussion experts, appears the following:

*Prescribed rest for longer than 1-2 days is no longer considered correct, as patients reported persistent symptoms with longer periods of complete rest. Patients showed better improvement with early modified re-engagement with daily physical and mental activity (Thomson et al., 2015).*

*Clinicians no longer recommend complete removal from work or school until symptoms resolve, increased stress related to schedules, income loss, responsibilities in a company or keeping up with curriculum is not helpful.*

*The goal is to keep an individual in his normal routine with normal sensory experiences the brain can use to re-train itself.*

The following article by M. Bengston, PhD, Concussion--Helping Your Loved One Heal is in direct conflict with the above:

*It is crucial that your loved one not be allowed to return to normal work activities or spend time on electronic devices that stimulate the brain including television, computers, tablets, phones. Most important in the first month following injury but should actually apply until all symptoms have disappeared.*

I feel these conflicts (obviously speaking to sensory stimulation after concussion and not participation in sports or aggressive activity) should be addressed as the article by Ms. Tong and Mr. Almquist appear to be a reflection of the current recommendations whereas the article by Michelle Bengston appears to be the old school of thought in treating those in a state of post-concussion syndrome.

I would prefer to remain anonymous if this is published but it may help to answer other's similar concerns.

**Anonymous NLCP, LNC**

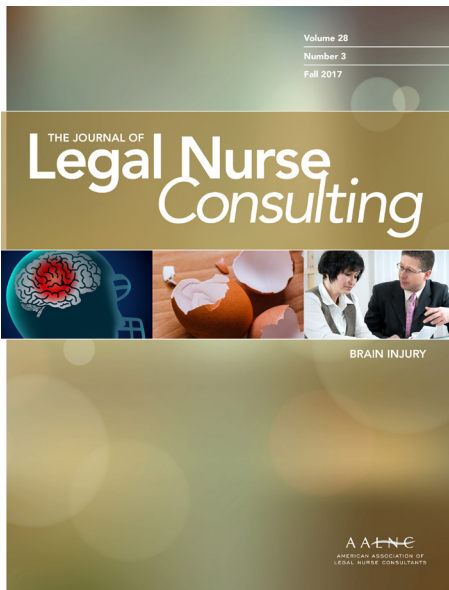


### Dear Anonymous:

Thank you very much for writing. Concussion is a rapidly-evolving field. We included this psychologist's submission as an opinion piece; your mileage may vary.

One of the JLNC's challenges is treading the fine line between being another strictly clinical journal, and meeting needs and expectations of our (primarily LNC) readership to be aware of what's out there that might affect their assessments of current guidelines, research, and client/family knowledge to apply in LNC work. We encourage all LNCs to look at the most up-to-date literature, discuss with practicing clinicians whenever possible, and proceed based on what's best for the case at hand. On this particular point, as it happens, I agree with you. In my practice, I would offer patient teaching handouts, when indicated, from or in collaboration with a treating team member. ~

Ed.



## SEPTEMBER 2017 ISSUE

*Excellent publication once again (posted to LNCExchange).  
I highly recommend it to all LNCs.  
You don't get free education like this by anyone else in our profession.*

**Kathy Ferrell BS RN LNCC**

## REBUTTING DAUBERT CHALLENGE

*Kudos to the authors for the AALNC Fall 2017 Journal article about rebutting a Daubert challenge to NLCP testimony. Please correct the article reference for the CNLCP Role & Function Study: This study was conducted by the CNLCP® Certification Board.*

**Janice Skiljo Haris, RN MSN CNLCP® MSCC  
MEDLink San Francisco Office**

## UPDATES

### **New England Compounding Center trials:**

NECC co-owner and head Barry Cadden was found not guilty of 25 counts of second-degree murder and guilty of a wide range of other charges including racketeering and fraud, and sentenced to nine years in prison. Just before we went to press, chief pharmacist Glenn Adams Chin, who was apprehended about to board a plane to China, was also found not guilty of second degree murder, but also guilty of racketeering and fraud. Sentencing will be in December. So far seventy-six people have died and many hundreds more are ill after receiving epidural and intraarticular injections of NECC steroids contaminated with a variety of molds and fungi.

### **Researching your references:**

A NY Times report on the burgeoning practice of academics publishing in worthless journals.  
<https://nyti.ms/2yXxy90>

# Test Your Case Screening Skills

## CASE #1

Molly Jones calling re: her husband Sam Jones. December 2010 had hernia operation - now has nerve damage, probably permanent. Second surgery to try and correct it at General Hospital – found nerve that was stitched which he relieved. Also trimmed mesh and cut nerve to try and numb area. Was employed before surgery, is now unemployed. Worked for a trucking company-driving tractor trailer. At this point the doctors are unsure if he will be able to return to work. Is in constant burning, pain, shooting pain down his thigh into his right testicle. Feels like a hot iron on his skin. Cannot sit or stand for a long time, sleeps only 3-4 hours at a time. Takes Vicodin for the pain.

### Test Your Case Screening Skills

You decide: reject, or investigate?

## CASE #2

John had c/o a lump on the right side of his neck to his ENT, Dr. Wolff, retired in 2009. Drained it three times and sent to pathology (June, 2009) which was negative but the report suggested a Pet Scan which was never relayed to Daniel. He has his medical records from Dr. Wolff and it's mentioned in his file. Has a new ENT, Dr. Hanks, who suggested removal after John started to have pain up into his ear - checked for infection or lock jaw - negative. His hearing aid was intact. On 4/20/11 he had surgery with Dr. Hanks and he had to remove two lymph nodes and found throat cancer. On his Pet Scan the only thing that lit up was his R tonsil. On 5.11.11 he had his R tonsil out at which time Dr. Hanks found that the whole bottom part of his tonsil was full of cancer (underwent radical tonsillectomy). He will need 33 radiation treatments and 6 chemo treatments. Never smoked.

Check your answers on [page 31](#).



# The Enhanced Nursing Compact and Its Implications

Michael Loughran, President, Nurses Service Organization

Keywords: nurses, telehealth, state licensing, malpractice, insurance

*Nurses most often provide direct patient care in the nurse's state of residence and licensure. The delivery of healthcare services is changing, and expansion of telehealth services has resulted in nurses providing services beyond their residential state boundaries. Here is the challenge: nurses must be licensed in the states where they practice. But what if they are providing professional services in more than one state? This has broad licensure and legal implications for nurses nationwide.*

## INTRODUCTION

Nurses most often provide direct care in the nurse's state of residence and licensure. A nurse would usually obtain a license from another state if moving to another state or taking a position in a neighboring state (example: a nurse lives in Philadelphia and works across the river in Camden, NJ). Telehealth has resulted in nurses and other healthcare

professionals providing services beyond their state boundaries. This includes working in virtual ICUs or hospitals, remote patient monitoring units, healthcare call centers, case management from home offices, and more. Legal nurse consultants (LNCs) should understand the continued telehealth expansion, the variety of healthcare settings that deliver services in a more efficient manner using

telehealth, professions providing these services, standards, and potential implications for licensure.

Typically, nurses are only licensed in the state where they provide professional services. Although the states in the US have fairly uniform criteria determining entry to practice, there is no agreement in the nursing community

about measuring continued competence. Therefore, states have different requirements for license renewal and what registered nurses must know in the provisions of their respective Nurse Practice Acts. So if a nurse lives and is licensed in Pennsylvania and monitors a patient in Florida, then the nurse not only must be licensed in Florida but should also be knowledgeable of the Florida Nurse Practice Act and how it differs from Pennsylvania's.

The risk is two-fold: nurses must be appropriately licensed in every state where they provide professional services and be knowledgeable of practice differences in policies and procedures, as well as conventional differences, in them. Failure in either of these could result in licensure and legal challenges.

## THE eNLC

In 2015, National Council of State Boards of Nursing (NCSBN) proposed a modern-day licensure solution with the Enhanced Nurse Licensure Compact (eNLC). The basic principle of the eNLC, which is an updated version of the current Nurse Licensure Compact (NLC), would allow registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) to have single multistate licenses, with the ability to practice in both their home states and other NLC states (NCSBN, 2016a). This enhanced Compact is intended to replace the NLC and is advancing through state legislatures and governors' offices now. This newer version includes a required criminal background check, restriction from acquiring a multistate license if ever convicted of a felony, and consistent standards for initial endorsement, renewal, and reinstatement licensure (ANA, 2016).

These will help facilitate nurse mobility across state borders, which then increases access to care for patients while maintaining public protection, as nurses would still be subject to each

state's practice laws. There are currently 25 states in the NLC (NCSBN, 2015). However, as of July 20, 2017, 26 states have enacted legislation to make the eNLC effective. The list of participating states and information on eNLC implementation date, January 19, 2018, is available at <https://www.ncsbn.org/enhanced-nlc-implementation.htm>. (NCSBN, 2017)

## ARGUMENTS FOR THE eNLC

The Compact offers a good option for nurses whose practices cross state borders, such as case management, transport nursing, nurses who live on state borders and, of course, telehealth. It would also benefit communities with a shortage of qualified nurses, such as school nurses and home health, where help could be just over a state line. Nurses with eNLC licenses can easily respond to a disaster or supply vital services at national events, regardless of state licensure, and it helps highly mobile registered nurses, such as military spouses who relocate often, or travel nurses. A multistate license facilitates both work environment and work/life scenarios.

The eNLC also appears to be cost-effective. It eliminates the need for nurses to pay each state's individual licensing fee, and it is designed to make the process easier and faster than current protocols (NCSBN, 2016a). It's also estimated that less than one percent of U.S. nurses ever are ever subject to discipline by a board of nursing (NCSBN, 2016a). All of this suggests the eNLC would also be low-risk for patients and advantageous for employers – increasing the pool of potential candidates and reducing the costs of licensure.

## IMPLICATIONS

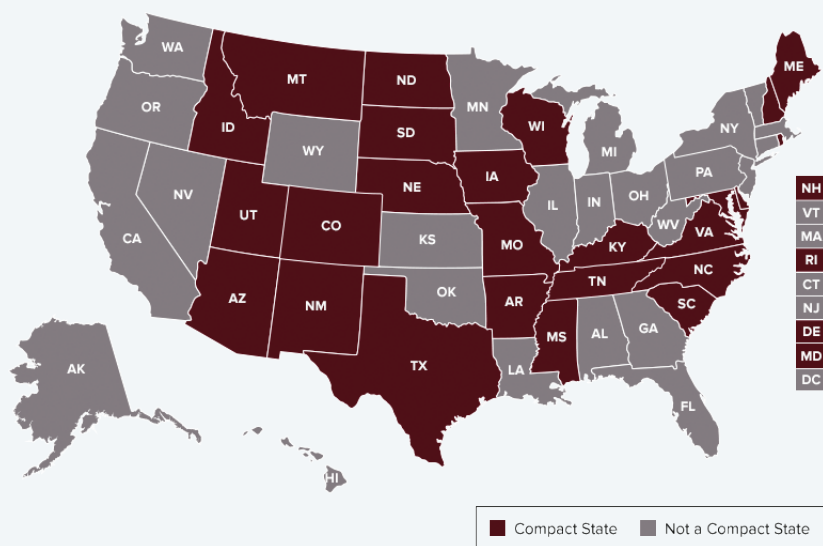
So what's the problem? Or rather, the bigger question at hand for the industry is, do we really have one? Most nurses

hold only one license and work only in their state of residence (ANA, 2015). Do we really need to invest the time, money and energy into creating a new licensure model for a fraction of the nursing population? Do we need to re-invent a 100-year-old model that meets the needs of the vast majority of nursing professionals? The eNLC is a solution that is created for only a few practicing nurses but affects many. There may be simpler solutions, such as endorsing a nurse's license to authorize practice via technology in other states. And in the context of telehealth, does it truly make sense that the nurses must be licensed in patients' states? Or is it sufficient that they be licensed in the states where the nurses are?

From a licensure perspective, the eNLC raises other risk concerns. How does discipline in a Compact state affect a license in a home state? Would a nurse be subject to discipline in more than one state for the same incident (Compact and home state)? Could a nurse's license be revoked, suspended, or limited? If so, how does this affect the nurse's ability to work, both in the immediate future and long-term? State legislatures and Boards of Nursing must consider how to address these risks for a wide range of nurses to maximize the promise of the Compact.

Another factor would be how to allocate fees to the BONs. Presently, a license for a nurse residing in and licensed in a Compact state is honored in all Compact states. However, many nurses residing in nonCompact states pay out of pocket for all other state licenses required by their employment, unless their employers will. It's not clear how many nurses need to do this, to what extent, or how much money is involved.

License-related actions typically begin with a complaint to the board of nursing (BON) in the state where the RN practices. Sources of complaints include clients, client families, colleagues, or employers. A state BON may be



As of July 2017, the following states participated in the Nurse Licensure Compact.

\* Indicates pending legislation

- Arizona
- Arkansas
- Colorado
- Delaware
- Georgia \*
- Idaho
- Illinois\*
- Iowa
- Kentucky
- Maine
- Maryland
- Massachusetts\*
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada\*
- New Hampshire
- New Jersey\*
- New Mexico
- North Carolina
- North Dakota
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Virginia
- West Virginia
- Wisconsin
- Wyoming

notified by another state BON, another agency, or law enforcement of action taken against a licensed nurse. Allegations include unprofessional conduct (e.g., privacy violations, lapses in moral character) or more serious crimes. A BON may also take action related to disciplinary action taken in another state. How might these processes change with nationwide eNLC?

These are the uncontested basic assumptions:

- + Technology will continue to drive evolution in healthcare delivery
- + Nurses are integral to healthcare and optimal patient outcomes
- + Nurses must be able to practice across state lines without undue burden or cost

Considering a nursing shortage affecting both urban and rural communities (AACN, 2014), it's apparent that healthcare delivery must develop new ways to meet patient needs and foster positive healthcare outcomes. Telehealth

uses technology for this and relies on nurses to do it. Telehealth's inherent flexibility allows healthcare entities and providers to meet patient expectations more effectively, regardless of geography. The better informed all nurses, including legal nurse consultants, are on critically-important current and emerging practices in telehealth, nursing licensure, standards, and healthcare overall, the more valuable they will be to clients grappling with these issues.

As of July 2016, 10 states had enacted the eNLC: Arizona, Florida, Idaho, Missouri, New Hampshire, South Dakota, Oklahoma, Tennessee, Virginia and Wyoming; this number rose to 26 by July 2017 (NCSBN, 2916b, 2017).

## SUMMARY

Nurses must be aware of risks and exposures in a multistate practice, because practicing in multiple states makes the nurse subject to the laws and regulations of each of them. The nurse bears the burden to be current on updates to Nurse Practice Acts from state to state. A perceived deviation from scope of practice can result in a complaint to the regulatory authorities in both the Compact state and the nurse's home state. The complexity and burden of managing multiple administrative processes will continue to be a challenge. If a state perceives a nurse was practicing outside scope for that state, the remote state can take action on the so-called Privilege to Practice (NCSBN, 2013). The implications can be far-reaching.

The American Nurses Association affirms that "any modification to a licensure law to improve portability must ensure health care consumer/patient safety first, consistent with nursing's code of ethics" (ANA, 2013). The association also encourages nurses "to engage in the effort to ensure that changes in licensure policy reflect

the profession's needs, values, and commitment to healthcare consumer/patient safety" (ANA, 2013).

The eNLC will have to have processes in place to ensure those standards are met to achieve acceptance, not only from states but also from nursing professionals.

## REFERENCES

(retrieved April 2017 except as noted)

American Association of the Colleges of Nurses. (2014). Nursing Shortage Indicators. Retrieved from <http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-shortage>

American Nurses Association. (1999). Legislative and Policy Issues Related to Interstate Practice. Online Journal of Issues in Nursing. Retrieved from <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/Columns/Legislative/NCSBNLetter.aspx>

American Nurses Association. (2013). ANA Issue Brief – Nursing Licensure Portability. Retrieved from <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/Issue-Briefs/Nursing-Licensure-Portability.pdf>

American Nurses Association. (2016). Interstate Nurse Licensure Compact. Retrieved from <http://www.nursingworld.org/State-Licensure-Compact.aspx>

National Council of State Boards of Nursing. (2013). Employers Fact Sheet. Retrieved from [https://www.ncsbn.org/NLCA\\_Employers\\_Fact\\_Sheet.pdf](https://www.ncsbn.org/NLCA_Employers_Fact_Sheet.pdf)

\_\_\_\_\_. (2015). 25 Nurse Licensure Compact (NLC) States. Retrieved from [https://www.ncsbn.org/NLC\\_Implementation\\_2015.pdf](https://www.ncsbn.org/NLC_Implementation_2015.pdf)

\_\_\_\_\_. (2016a). Enhanced Nurse Licensure Compact Facts. Retrieved from [https://www.nursecompact.com/privateFiles/NLC\\_Facts.pdf](https://www.nursecompact.com/privateFiles/NLC_Facts.pdf)

\_\_\_\_\_. (2016b). Missouri Enacts Enhanced Nursing Licensure Compact. Retrieved from <https://www.ncsbn.org/9642.htm>

\_\_\_\_\_. (2017) Enhanced Nurse Licensure Compact (eNLC) Implementation. Retrieved 10/2/2017 from <https://www.ncsbn.org/enhanced-nlc-implementation.htm>



**Michael Loughran** is president of the Nurses Service Organization and the Health Care Division of Aon's Affinity Insurance Services Inc. NSO is the

nation's largest provider of nurses professional liability insurance coverage, with more than 550,000 nursing professionals insured in the program today. Over his 30-year career in the insurance industry, Michael has held leadership roles spanning marketing, underwriting and business development. He received his Bachelor of Arts degree in Philosophy from St. Charles Borromeo and holds his property and casualty insurance licenses on a national basis. He may be contacted at [michael.loughran@aon.com](mailto:michael.loughran@aon.com).

## EARN up to \$250 PER HOUR & SET YOUR OWN SCHEDULE

## GET PAID WHAT YOU ARE WORTH



**KELYNGO**  
Life Changing, Life Care Planning

Whether you are in business for yourself or working for a company, **Nurse Life Care Planning** offers you the opportunity to enter the ranks of the highest paid nurses in the country!

Enroll now in the courses that will change your life while you continue to do what you love. Kelyngo's **Setting the Standards in Nurse Life Care Planning® Course** will prepare you for certification in your new career. All courses are taught by the founder of the American Association of Nurse Life Care Planning, Kelly Lance, MSN, APRN, FNP-C.

- Courses are approved by ANCC & ICHCC for 120 contact hours
- Kelyngo is the only program taught using the nursing process at its core
- Totally Online and Totally Convenient!
- 4 Live Webinars are added to the the course to help you with your studies

### Kelyngo courses offer career options:

- Nurse Life Care Planning
- Medicare Set-Asides

**Mention this ad and receive the Medicare Set-Aside Course FREE with your course registration of Life Care Planning!**

[www.kelyngo.com](http://www.kelyngo.com)



## Q&A: Board of Nursing Actions

Elizabeth Murray BSN, RN, LNCC interviews Ottamissiah Moore BS, LPN, WCC, DWC, CHPLN, CSD-LTC

According to the National Council of State Boards of Nursing (NCSBN), boards of nursing (BONs) protect public health and welfare by outlining the standards for safe and competent care and issuing licenses to practice. (NCSBN, 2017) Each state determines how its BON will execute this mission, and BONs report to one of the following: the state governor, a state agency, both the governor and an agency, or another state official or organization. State law dictates the authority and composition of the board. (NCSBN, 2017) A legal nurse consultant (LNC) involved in a BON action should be aware of the BON's scope and responsibility, regulatory requirements, and its state nurse practice act. In this question and answer session Missy Moore, a member of the District of Columbia (DC) Board of Nursing since 2005, sheds light on how the BON runs in DC.

### OVERVIEW

The type of cases involved in BON action in the US, involving less than one percent of licenses, usually fall into the following categories (NCSBN, 2017):

- Practice-related: breach in standard of care
- Drug-related
- Boundary violations: overreaching the therapeutic relationship by accepting gifts or money, or establishing inappropriate relationships for gain
- Sexual misconduct
- Abuse
- Fraud
- Positive criminal background checks

As a Legal Nurse Consultant, you may need to verify nurse licensure from time to time for a client. A website database "[nursys.com](http://nursys.com)" provides license verification including disciplinary actions for members of the NCSBN,



and for jurisdictions participating in the Nurse Licensure Compact (NLC). As of publication time, only Pennsylvania, Alabama, Hawaii, Oklahoma, and California did not participate in the database. Fifty-one BONs currently participate, including America Samoa, Guam, and the U.S. Virgin Islands. Data is submitted monthly, not instantaneously with disciplinary actions, so the verifier should keep that in mind when searching for disciplinary actions.

**EM: What are the most common complaints against nurses? Where do they come from?**

**OM:** A good amount of the complaints come from health care facilities of all kinds. DC mandates facilities to report nurses who were fired because of practice issues. Because the DC BON is under the DC Department of Health, complaints may also come from the surveyors of hospitals, nursing homes, home health companies, and the Department of Health itself. Complaints can also come from consumers and other nurses.

Common complaints include:

- + medication errors, with or without injury
- + failure to assess or to notify the provider
- + submitting fraudulent documentation for payment
- + failures to conform to standards of acceptable conduct and prevailing practice within a health profession
- + medication diversion
- + ethical issues

**EM: How is the District of Columbia Board of Nursing comprised?**

**OM:** The Board consists of eleven DC residents: Seven RNs, two LPNs, and two consumer members appointed by the Mayor, with the advice and consent of the DC Council.

*Interestingly, about 25% of the nurses who receive a notice do not respond until some action is taken on their licenses.*

**EM: How does the DC BON respond to a hospital report? What percentage of complaints do they decline to investigate, and why?**

**OM:** First, the nurse consultant and attorney review all complaints. Then discipline committee staff ensure that all needed case information is available for review with the discipline committee; the BON may request an investigation if they need more.

About 50% of cases are not investigated because the initial report includes all needed information. If there is an investigation, the BON visits the facility, interviews staff, and obtains policies and procedures; they may interview or ask for a reply in writing to the complaint from the nurse. Interestingly, about 25% of the nurses who receive a notice do not respond until some action is taken on their licenses.

The length of time to resolve a complaint or action varies by state, board, and politics. Most of our complaints are handled within a few months; however, it depends on the origin of the complaint. A complaint from a hospital or consumer may settle more quickly than a complaint from the survey team.

**EM: How many nurses are exonerated by an investigation? How many are exonerated after litigation?**

**OM:** Many nurses do not have issues with their licenses. If the nurse agrees to a negotiated settlement, the nurse must adhere to the BON's discipline specified in it. This is not reportable to the database. Sometimes a nurse may get a letter of concern or letter of reprimand. These are not reported to the database.

We have very little litigation on our board. Less than 10% of the nurses have an attorney when they appear before us.

**EM: How are standards of practice invoked in defense?**

**OM:** For a standard of care issue, we review the policy and procedure of the facility or organization, possibly the job description, the documentation, and sequence of events.

**WRAP-UP: WHAT DOES THIS MEAN FOR THE LNC?**

As Ms. Moore outlined, every BON is unique. A nurse would be uniquely suited to help a legal team defend a nurse. LNCs can contribute to the legal team by obtaining and explaining the applicable Standard of Care, and by reviewing applicable medical records or policies and procedures. The LNC can also help prepare the defendant for testimony.

**THE IMPLICATIONS FOR MULTI-STATE NURSE COMPACT LICENSURE**

The NCSBN publishes resources and tools that LNCs can use to support the defense in a BON action. Their website, [www.ncsbn.org](http://www.ncsbn.org), also has a graphic of the process from complaint to resolution and reporting. It is important to find the resources to reference in each state, or when there is a compact licensure involved. A new Enhanced Nursing Licensure Compact (eNLC) will be implemented on January 19, 2018 (<https://www.ncsbn.org/enhanced-nlc-implementation.htm>). These new licenses make it easier for nurses to practice across state lines in

telehealth and disaster relief, and to take advantage of online education. For nurses with compact licenses, if discipline by a BON is required, the BON of the state where the nurse is licensed or the state where the nurse practices rules, depending on the situation, and both may take action if the nurse is licensed in one state and practices in another under the multi-state licensure compact. The disciplinary action is then placed into the national licensure database: [nursys.com](http://nursys.com).

The various state's BON confidentiality requirements vary. In some states the defendant pay not know the source of the complaint. Also, BON's do not have jurisdiction in matters of medical malpractice compensation. However, a medical malpractice case and a complaint to the BON can both be made in the same matter. Knowing the state nurse practice act(s) where you practice is imperative for any nurse. If

you don't know details about the BON in your state, take the time to look up the information today.

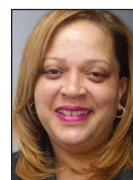
## REFERENCES

NCSBN. (2017, 08 03). National Council of State Boards of Nursing. Retrieved from <https://www.ncsbn.org/boards.htm>



**Elizabeth Murray BSN, RN, LNCC** is an independent legal nurse consultant with and owner of Elizabeth Murray Consulting, LLC a consulting firm in the

Northern Virginia/Washington DC area, primarily consulting on defense cases in Long Term Care and Medical Malpractice. Elizabeth is a former US Army Captain, and has extensive experience in adult and pediatric Critical Care and Emergency nursing. She has been working in the legal nurse consulting field for thirteen years and currently serves as a Director at Large on the board of the American Association of Legal Nurse Consultants (AALNC).



**Ottamissiah "Missy" Moore BS, LPN, WCC, DWC, CHPLN, CSD-LTC** is the Staff Development Specialist for a 296-bed long-term care facility in

Washington, DC. She is the immediate past president of the National Federation of Licensed Practical Nurses, 2008-2012. She has served as a board member for the District of Columbia State Board of Nursing since 2005. In 2011, she was a member on the PN NCLEX Item Selection Committee of the National Council of State Boards of Nursing. She was appointed to the LPN Standards Committee of the Commission of Graduates of Foreign Nursing Schools and to the National League for Nursing Licensed Practical Nurse Ad Hoc Committee. Missy is a Lifetime Member of the National Black Nurses Association, where she also actively serves on numerous committees.

**FIGeducation.com**

# Grow your career with FIG

**Learning & Mentorship**

- Life Care Planning
- Medicare Set-Asides
- Medical Cost Projections

**Shelene Giles, FIG Founder**  
MS, BSN, BA, RN, CRC, CNLCP, CLCP, MSCC, LNCC

**FIGeducation.com**



# Investigating Alleged Malpractice for Evidence of Employment Retaliation: A Case Study

Wendie Howland MN, RN-BC, CRRN, CCM, CNLCP, LNCC

## INTRODUCTION

Legal nurse consultants may find themselves working on surprising issues. This is a brief case study of LNC work on a case of alleged retaliation in employment. Details have been extensively changed to protect the innocent.

## WHAT HAPPENED?

Mercy Community Hospital employed Nurse Backus for about thirteen years, giving her regular raises and promotions— and no disciplinary actions, not even a verbal counseling — as she progressed from CNA to LVN to RN relief charge in a critical care unit. So

why would I get a call from an employment attorney asking if I could help him with the hospital's sudden actions against his nurse client, including suspension and firing, for allegations of dangerous practice errors?

I went through the long, detailed complaint to correlate its specific allegations with patient medical records. Then I recommended that the attorney request quite a few other critical documents: policies and procedures, disciplinary records for other nurses receiving other actions such as written warnings or suspensions, missing pages of heavily redacted logs, missing EKGs and other

patient data, Pyxis reports and drug audits, missing and whited-out nurses' notes, and missing and whited-out physician and ancillary staff documentation. The hospital resisted but finally responded to a court order — for most of it. The hospital found no evidence of drug diversion in their audits. This is significant.

So, what prompted this cascade of unhappy events? Short answer: Nurse Backus had become active in the nursing union, off duty on her own time, working to call public attention to short staffing's effects on care. Within months she was suspended and fired.



In Nurse Backus' midwest state, a hospital who fires a nurse alleging a patient care-related cause reports the nurse to the Board of Nursing (BoN); the BoN makes a required referral to a 90-day recovery and monitoring program on the automatic assumption of substance abuse. Nurse Backus denied this strenuously but cooperated fully with the program requirements. She had a hair test to look for past evidence of drug use and daily observed voiding for urinalyses for drug and alcohol screens for months. All were negative. She underwent mandatory psychological/psychiatric evaluations and bi-weekly group therapy meetings with other nurses in the diversion program; no psychopathology was ever identified. The program recommended that the BoN discharge her with a clean bill of health, weeks before the end of the 90-day period. They did.

Although Nurse Backus knew she was innocent, this whole process was a terrible blow to her self-confidence; she was accused of being an addict; she lost friends and family members who wouldn't look her in the eye; she lost her job. By law now she must declare that she was fired and participated in this program for drug diversion whenever she looks for work. And she has been ... for more than a year, so she may have lost her livelihood, too. She recently discovered that the hospital sent a

report of all this to at least one local HR department where she applied, unrequested. That looks vindictive.

### DIGGING FOR GOLD

Those disciplinary records, policies, and patient records were a goldmine. I made brief salient chronologies for each of the patients whose care was allegedly compromised by her negligence, because she was accused of overmedicating some of them or giving medications outside of parameters. Best practices from the Institute for Safe Medication practices (ISMP, 2011), her state nurse practice act, studies on barcode technology and safety (Poon et al., 2010), and some basic demonstrative material on EKG rhythm strips were helpful, too. Finally, I made an index of similar or identical errors committed by others I found in the charts. I included corresponding disciplinary records, if any; they were few and far between.

I found that Nurse Backus was cited for violating policies that did not exist or were contradictory. She was accused of dangerous practices that were routinely practiced by nearly all nurses in the records, including at least a few supervisors, and that were not dangerous. She was accused of omitting charting that appeared contemporaneously in other places in the record, in the same way many other staffers charted. She was accused of not responding to emergent

patient situations that weren't remotely emergent, including for baseline arrhythmias in a patient who had a physician-signed Do Not Resuscitate form and went home on hospice. Interestingly, I also learned that she was alleged to have signed a document acknowledging faults, except she had never seen it and the signature was not her own.

Long story made short, there was nothing—nothing—out of the ordinary for a busy, chronically understaffed unit, inconsistent electronic charting systems, and no clear policies. In the end, I found no evidence whatsoever that Nurse Backus made dangerous practice errors. And that was without the exculpatory white-outs and missing pages that never appeared.

### CONCLUSION

Knowing all that, it was hard not to conclude that the hospital intentionally triggered the mandatory BoN protocols to retaliate against her and, by extension, to intimidate other nurses in the union. Litigation is still in progress. It will be interesting to see what the jury says about that. Stay tuned.

### REFERENCES

- Institute for Safe Medication Practices (2011) Guidelines for timely medication administration; response to the CMS "30 minute" rule. ISMP. <https://www.ismp.org/newsletters/acutecare/articles/20110113.asp> Retrieved 8/2/2016
- Poon EG, Keohane CA, Yoon CS et al. (2010) Effect of bar-code technology on the safety of medication administration. *N Engl J Med* 2010; 362: 1698-707



**Wendie Howland MN, RN-BC, CRRN, CCM, CNLCP, LNCC** is the owner

of an independent consulting business providing life care planning and legal nurse consulting to plaintiff and defense firms nationwide. She serves as the Editor of the JLNC and has spoken and published on life care planning and legal nurse consulting in many settings. She can be contacted at [whowland@howlandhealthconsulting.com](mailto:whowland@howlandhealthconsulting.com).



## Are Nursing Board Actions Permanent Public Records?

Lorie A. Brown, RN, MN, JD

**U**nfortunately, there are only a few states that allow expungement of Nursing Board records and only under very limited circumstances. Kentucky is one of those states but, again, only if certain circumstances are present.

Once you have a formal complaint or discipline taken against your nursing license, it does become public record.

The theory is that the public has the right to know if health care providers have had any action(s) against their licenses. It is even publicly available on [www.nursys.com](http://www.nursys.com).

Many states now allow expungement of criminal records after a certain period of time. If your criminal record is contained in the Nursing Board record and

your criminal matter is expunged, then why should it still be public record in the Nursing Board files?

Or, what if a nurse was reprimanded early in her career then goes on to have an exemplary career for 15 years? The nurse has a perfect record but for that one blemish early on that is no longer meaningful. Is it “promoting the integri-



## Many states now allow expungement of criminal records after a certain period of time.

ty of the profession” by stigmatizing that nurse’s record for an error that occurred 15 years before, and that no longer represents his or her current practice?

### Here is Kentucky’s statute 201 KAR 20:410. Expungement of records:

Section 1. Definition. “Expungement” means that all affected records shall be sealed and that the proceedings to which they refer shall be deemed never to have occurred.

Section 2. A nurse whose record has been

expunged may properly reply that disciplinary records do not exist upon inquiry.

Section 3. Upon a request from a nurse against whom disciplinary action has been taken, the board shall expunge records relating to the following categories of disciplinary action:

- (1) Consent decrees that are at least five (5) years old if all the terms of the consent decree have been met.
- (2) Agreed orders and decisions that are at least ten (10) years old and which

concern one (1) or more of the following categories, if there has not been subsequent disciplinary action and all of the terms of the agreed order or decision have been met:

- (a) Failed to timely obtain continuing education or AIDS education hours;
  - (b) Paid fees that were returned unpaid by the bank; or
  - (c) Practiced as a nurse or advanced practice registered nurse without a current license, provisional license, or temporary work permit.
- (3) Agreed orders and decisions that are at least ten (10) years old and which resulted in a reprimand, if there has not been subsequent disciplinary action and all of the terms of the agreed order or decision have been met.
- (4) Agreed orders and decisions that are at least twenty (20) years old, if there has not been subsequent disciplinary action and all of the terms of the agreed order or decision have been met.

For those who have had a Nursing Board action and want that matter removed from public records, I would strongly suggest that you contact your legislature to get this changed. It is unfair that a one-time isolated event is forever on a nurse’s record or that a criminal matter remains public on the Nursing Board record after it is otherwise expunged.

Do you believe that Nursing Board records should be removed after a certain time? What circumstances would you propose?



**Lorie A. Brown RN, MN, JD** is a registered nurse and attorney. Brown Law Office is a national law firm with its principal office in Indianapolis, Indiana, and has

relationships with nurse attorneys and other attorneys throughout the country. She can be contacted at [lorie@brownlaw1.com](mailto:lorie@brownlaw1.com).



# Burnout and Patient Safety

Minda Lee Lockeretz BSN RN LNC

Keywords: burnout, patient safety, quality care, nurse burnout, healthcare provider burnout, burnout and patient safety

The JLNC editorial committee had a discussion on nursing burnout and its alleged relevance to decline in patient safety as a possible article topic, as many people assume that caregiver burnout increases nursing errors. I reviewed preliminary peer-reviewed research on this topic. I found that while there are many published articles proposing correlations between nurse poor well-being and/or burnout increasing patient care errors, there does not appear to be conclusive evidence to support this claim.

Measurement of actual patient care errors is often subjective (Hall, Johnson, Watt, et al., 2016). In their meta-analysis of 46 previous studies, Hall and colleagues found a lack of prospective studies that could help identify a direct causal relationship. They found different types of scales used to measure well-being/burnout, objective vs. subjective reporting of errors, and lack

of consistency in the way patient safety is measured, amongst others factors mitigating against solid conclusions.

- ✦ Subjective reporting can lead to significant bias, because healthcare workers who self-identify as “burned out” are less likely to report errors or near-misses than workers who describe themselves as happy or content at work (Salyers, Fukui, Rollins, et al., 2015).
- ✦ A positive safety culture (happy, well-supported, engaged staff, and self-reporting of errors and near-misses without fear of blame or retribution) is critical for increased patient safety and ultimately lowers risk of staff burnout (Vifladdt, Simonsen, Lydersen, et al., 2016). However, this does not lead to the conclusion that burnout causes more errors and decreased patient safety across the board.

Further research is certainly warranted in today’s health care culture of cost-containment while promoting and providing increased patient safety.

## REFERENCES

- Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O’Connor, D. B. (2016). Healthcare Staff Well-being, Burnout, and Patient Safety: A Systematic Review. *Public Library of Science ONE*, 11(7). <http://doi.org/10.1371/journal.pone.0159015>
- Salyers, M. P., Fukui, S., Rollins, A. L., Firmin, R., Gearhart, T., Noll, J. P., ... Davis, C. J. . (2015). Burnout and self-reported quality of care in community mental health. *Administration and Policy in Mental Health*, 42(1), 61-69. <http://doi.org/10.1007/s10488-014-0544-6>
- Vifladdt, A., Simonsen, B., Lydersen, S., Farup, P. (2016, October). The association between patient safety culture and burnout and sense of coherence: A cross-sectional study in restructured and not restructured intensive care units. *Intensive and Critical Care Nursing*, 36, 26-34. <http://dx.doi.org/10.1016/j.iccn.2016.03.004>



# ADA Case Review: A New Niche for LNCs

*Regina Jackson, RN, BS, CCM, LNCC*

## BACKGROUND

The Americans with Disabilities Act (ADA) of 1990 was amended in 2008, and is now called the Americans with Disabilities Act Amendments Act (ADAAA). The ADAAA became effective on January 1, 2009 and made significant changes to the ADA's definition of "disability" that broadens the scope of coverage under the ADAAA. The Equal Employment Opportunity Commission's (EEOC) guidance under the ADAAA directs employers to focus on "reasonable accommodations" rather than the issue of whether the individual is disabled. Prior to the amended act, employers were focused on determining

if an employee had a disability. Due to the broader definition of disability, employers now have a higher obligation to reasonably accommodate employee's requests for workplace accommodations. ("The ADA Amendments Act of 2008," n.d.)

The ADAAA protects otherwise qualified individuals with a disability who are able to perform the essential functions of the job with or without reasonable accommodations. Disability is an impairment that substantially limits one or more major life activities, e.g., sleeping and eating. A major life activity also includes the operation of a major bodily function, including but not limit-

ed to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. Certain ADAAA protections are also applicable to United States applicants; from applying for a position through the interview process. ("The ADA Amendments Act of 2008," n.d.)

## JOB DESCRIPTION/ ANALYSIS

A job description should have a descriptive title, job purpose, duties, and essential responsibilities. It also establishes expectations for potential



employees of the criteria that will be used for hiring and to evaluate future job performance. Analyzing and sorting out essential from nonessential job functions with a thorough and well-written job analysis is critical. (ADA Information and Technical Assistance, n.d.)

## ESSENTIAL JOB FUNCTIONS

Essential job functions are the fundamental duties of a position: the things a person holding the job absolutely must be able to do. Essential job functions are used to determine the rights of an employee with a disability under the ADAAA. An employee who cannot perform the essential job functions, even with a reasonable accommodation, is not considered qualified for the job and is not protected from discrimination (Guerin, 2017).

- Essential job functions are the reason the job exists.
- They are the primary tasks that must be performed and cannot be delegated to others.
- Well-written job descriptions are key in outlining an employee's essential functions.
- If a worker is not able to perform the essential functions of a job even with accommodations, there is no obligation for the employer to accommodate.

An employee who is otherwise qualified (for example, because the employee has the degrees, license, and experience required for the position) is protected from disability discrimination if he or she can perform the essential job functions. It doesn't matter if the employee requires an accommodation from the employer to do so: As long as the employee can perform the essential functions of the job, with or without a reasonable accommodation, the employee is protected from discrimination by the ADAAA.

## Analyzing and sorting out essential from nonessential job functions with a thorough and well-written job analysis is critical.

This is why the labeling of job functions as "essential" or "nonessential" is so important. If a function is truly essential, and an applicant or employee cannot perform it even with a reasonable accommodation, then that person is not qualified for the job. (Guerin, 2017)

Furthermore, an employer is obliged to engage in an interactive process and to provide reasonable accommodations.

The interactive process is an employer talking with the employee to understand the difficulties preventing the employee from performing an essential job function and requiring accommodation. Management should know how much time the employee spends performing a specific task. If it's less than 50 percent of the time, it may not be a core function.

This conversation need not be formal. It includes working together to identify effective solutions that would allow the employee to perform the job successfully. ("Accommodation and Compliance Series," n.d.)

A reasonable accommodation is any modification or adjustment to the job or worksite that allows the employee to perform essential job functions and enjoy the same benefits and privileges of employment as all other employees. Common workplace accommodations are:

- Equipment or assistive technology / changes to worksite or work station
- Shift changes
- Extra training
- Removal of non-essential functions
- Reassignment to open positions
- Allowing assistive animals in the workplace

- Allowing work from home
- Allowing paid or unpaid leave

## ADAAA FILE REVIEW

When reviewing a case, it is critical for the LNC to determine if an employer was compliant with the ADA interactive process. The six review steps are:

### 1. Recognizing an Accommodation Request

The employee does not need to use key words like "ADAAA" or "reasonable accommodation." Whenever an employee indicates difficulty performing job duties due to a medical condition or impairment, the employer should consider and recognize whether the employee is making a request for accommodation under the ADAAA. ("Accommodation and Compliance Series," n.d.)

*Note: Once an accommodation request is identified, the employer should respond immediately – unnecessary delays in processing an accommodation request can be a violation of the ADAAA process. ("Accommodation and Compliance Series," n.d.)*

### 2. Gathering Information

Under the ADAAA, the employer can request medical substantiation of disability if the disability or need for accommodations is not obvious. This will give information on how to proceed to process the request. However, employers only need to understand an employee's impairments and the related accommodations. They are not entitled to personal medical details or a specific diagnosis.

In some cases, the disability and need for accommodation are obvious. For



example, if an employee who recently started using a wheelchair needs a ramp to enter the workplace, no medical substantiation is needed. (“Accommodation and Compliance Series,” n.d.)

### 3. Exploring Accommodation Options

During this step, the LNC would analyze if the employer invited the employee to share any accommodation ideas. This is also where the LNC would note if the employer encouraged the employee to see a medical provider for options or recommendations.

The LNC should evaluate whether the employer consulted with appropriate external resources, e.g., the Job Accommodation Network (JAN), a free, national resource for employers seeking help with accommodation ideas; an industrial hygienist for indoor air quality concerns; or an ergonomist to ensure appropriate use of office equipment and set-up.

*Note: The medical provider may be unfamiliar with the worksite and so not be able*

*to suggest accommodation ideas. However, the provider may be able to offer insight as to whether any ideas under consideration will be helpful. (“Accommodation and Compliance Series,” n.d.)*

### 4. Choosing an Accommodation

The employer has the right to choose the most effective accommodation option at the lowest cost. The employer may opt to trial it for effectiveness before full implementation.

The LNC should determine if the employer documented:

- the terms of the trial in advance
- that the employee understood that a trial is temporary
- specified trial period duration
- next steps if the accommodation proved ineffective
- clear communication of the above to the employee

Although not required by ADA, when possible the employer should choose the

accommodation the employee prefers. (“Accommodation and Compliance Series,” n.d.)

### 5. Implementation

The LNC needs to determine whether:

- the employer ensured equipment was properly installed and the employee trained on its use
- management was aware of a schedule change or a policy modification and implemented it effectively
- the employee was allowed time to acclimate to a job reassignment

*Note: Reassignment is the accommodation of last resort, to be implemented only if*

- *there are no effective accommodations for the current position, or*
- *there is no comparable position, or*
- *all other accommodations would impose an undue hardship*

*The employee cannot opt for a reassignment program. It is an outcome to the accommodation process. The employee is entitled to an open, vacant position if*

- *minimally qualified*
- *satisfies the requisite skill, experience, education, other job-related requirements of the position*
- *can perform the essential functions of the new position, with or without accommodation. (“Accommodation and Compliance Series,” n.d.)*

### 6. Monitoring/ Evaluation

This step is often forgotten. In some cases, an accommodation stops being effective for various reasons, e.g., the employee’s limitations change, workplace equipment changes, the job duties change, the workplace itself changes, or the accommodation becomes an undue hardship for the employer. (“Accommodation and Compliance Series,” n.d.)

During a review, the LNC should check to see if the employer confirmed with the employee that no other accommoda-

tions are needed. Did the employer send notice of case closure to the employee or provide a point of contact if the employee needs to reopen a case?

Employers must demonstrate engagement in the interactive process and exhaustive efforts to try to accommodate an employee with a disability effectively.

## SUMMARY FOR THE LNC'S NARRATIVE REPORT

- Does the employee have a disability or impairment?
- What did the employee tell the employer about the impairment?
- Did the employee notify the employer of a need for accommodation to do the job?
- Did the employer act timely in relation to the accommodation request?
- What steps (if any) did the employer take to engage with the employee and appropriate parties related to a request for an accommodation?
- Did the employee mention ability or inability to perform essential job functions?
- If so, did the employer complete a thorough job analysis review?
- Did the employer engage in the interactive ADAAA process?
- Did the employer continuously monitor accommodation effectiveness?
- Did the employer communicate with the employee and provide a contact should the employee need further accommodation assistance?

## CASE STUDIES

**Wells Fargo:** In 2011 the Division entered into a comprehensive settlement agreement with Wells Fargo & Company, which owns or operates almost 10,000 retail stores and 12,000 ATMs throughout the United States. The complaint alleged that Wells Fargo would not do business with people with hearing and speech disabilities over the phone using

## *Employers must demonstrate engagement in the interactive process and exhaustive efforts to try to accommodate an employee with a disability effectively.*

a telecommunications relay service. Instead, the individuals were directed to call a TTY/TDD line that asked them to leave a message, which frequently went unanswered. The Division also found that Wells Fargo failed to provide financial documents in alternate formats, such as Braille or large print, to people who are blind or have low vision; failed to provide appropriate auxiliary aids and services for in-person meetings with individuals who are deaf; and failed to remove barriers to access for individuals with mobility disabilities. Under the agreement, Wells Fargo will pay up to \$16 million to compensate individuals who experienced discrimination, as well as \$1 million in charitable donations to non-profit organizations that will assist veterans with disabilities. ("Accommodation Case Study," n.d.)

**Ventura County, California:** In July 2010, the Division entered into an agreement with Ventura County, California, resolving a lawsuit alleging that the county had discriminated against a woman who applied for a position as a children's social service worker. Because the woman is deaf, Ventura County did not believe that she was qualified for this position, even though she had been successfully working as a children's social worker in Los Angeles County for 10 years. Under the terms of the agreement, the county adopted an employment policy prohibiting discrimination and explicitly acknowledging that reasonable accommodations for an employee may include providing a qualified sign language interpreter. The county also paid the victim \$45,000 in compensatory damages. ("Equal Opportunity Case Study," n.d.)

## REFERENCES

- Accommodation and Compliance Series. (n.d.). Retrieved August 9, 2017, from [www.askjan.org](http://www.askjan.org)
- Americans with Disability Act of 1990, as amended. (n.d.). Retrieved August 2, 2017, from [www.ada.gov](http://www.ada.gov)
- Eliminating barriers to places of public accommodations for people with disabilities. (n.d.). Retrieved September 3, 2017, from [https://www.justice.gov/crt/us-department-justice-civil-rights-division-accomplishments-2009-2012#\\_Expanding\\_Opportunity\\_in\\_1](https://www.justice.gov/crt/us-department-justice-civil-rights-division-accomplishments-2009-2012#_Expanding_Opportunity_in_1)
- Ensuring equal opportunities for workers and applicants with disabilities. (n.d.). Retrieved September 3, 2017, from [https://www.justice.gov/crt/us-department-justice-civil-rights-division-accomplishments-2009-2012#\\_Expanding\\_Opportunity\\_in\\_1](https://www.justice.gov/crt/us-department-justice-civil-rights-division-accomplishments-2009-2012#_Expanding_Opportunity_in_1)
- Guerin, L. (2017). Essential job functions under ADA. Retrieved from [www.nolo.com/legal-encyclopedia/essential-job-functions-under-the-ada.html](http://www.nolo.com/legal-encyclopedia/essential-job-functions-under-the-ada.html)



**Regina Jackson, RN, BS, CCM, LNCC** is a Board Certified Legal Nurse Consultant and Medical Case Manager with a rich and diverse professional career that spans over 35 years.

Ms. Jackson has expertise in occupational health, workers' compensation, and OSHA recordkeeping, and previously held a position as a Senior ADA Case Manager Specialist for the Intel Corporation.

Ms. Jackson is currently employed by a private entity serving on a specialized team that provides in-depth systematic review of complex federal workers' compensation cases for the U.S. Department of Labor. She can be contacted at [reginahilljackson@gmail.com](mailto:reginahilljackson@gmail.com)



# Anatomy of a Workers' Compensation Case

Gina T. Crawford, LCR

## WHO AM I?

Before I discuss the intricacies of a workers' compensation (WC) case, let me tell you about myself. I do so because I am a bit of an anomaly as a non-lawyer in the legal world.

I am a New York State Licensed WC Representative (LCR). I earned the LCR by passing a rigorous written examination and otherwise demonstrating my proficiency in WC and related laws. I am one of fewer than 50 people in New York State (NYS) who have

earned this license. Before I assumed my present role, I earned a Bachelor of Arts degree in political science/pre-law. I now have more than 20 years of experience in the legal field at two prominent law firms.

NYS created this license because many attorneys declined to practice WC law due to limited fees; fewer attorneys meant fewer opportunities for injured workers to have effective representation. To safeguard them, NYS required non-lawyer applicants to pass a strin-

gent written examination and otherwise demonstrate a depth of knowledge in WC and related laws. LCR practice is strictly and regularly monitored by the NYS WC Board (WCB) and must be renewed every two years.

The LCR license authorizes me to represent injured workers before the WCB in the same way as an attorney. I counsel and represent injured workers in all aspects of a case including proffering lay and medical testimony, conducting depositions, cross-examining lay and

medical witnesses, performing legal and medical research, preparing memoranda of law, negotiating settlements and handling appeals before the WCB.

This article will address the anatomy of a WC case and give insight into how LNCs can work in this arena. Although my experience is in NYS, the concepts and processes can be similar in other jurisdictions.

## WHAT IS WORKERS' COMPENSATION?

Each state has a WC system, essentially no-fault (i.e., the injured worker is entitled to lost income and medical benefits regardless of who was at fault for the injury). Before states codified WC systems, a work injury was handled like any other personal injury: the injured worker had to prove the employer was negligent to recover damages. Employers raised typical defenses (e.g., contributory negligence, assumption of risk or negligence caused by a third party) which resulted in little, delayed, or no benefit to the injured worker. As a result, many injured workers had to seek public assistance from the government for income and medical care. This caused court dockets to swell and put businesses at risk (in cases with large verdicts), threatening the economic stability of the country.

The primary goal for the WC system was twofold: to create a social benefit structure providing injured workers with adequate lost wage benefits and prompt medical treatment regardless of fault; and to relieve employers from the risk and expense of personal injury lawsuits.

Ironically, the WC system itself does not address workplace safety. Private sector workplaces are regulated by the US Occupational Safety and Health Administration (OSHA). The WC system does not retrain injured workers who are unable to return to their prior employment or who lost their jobs due to their injury.

*Before states codified WC systems, a work injury was handled like any other personal injury: the injured worker had to prove the employer was negligent to recover damages.*

An injured worker covered by WC cannot sue the employer for negligence, and there is no payment for pain and suffering. These are some of the most frustrating aspects of the WC system for injured workers and their families, especially when, for example, an employer removes safety equipment from a machine to save money, causing serious injury or death. Unless there is a negligent third party, other than the employer, who caused the injury, the worker's only recourse is often limited. There are two types of WC benefits: part of the wages lost due to the injury, and medical treatment.

The most common injuries are:

- **Accident:** a specific event. For example, if a worker trips and breaks a leg at work, that may be deemed a WC accident.
- **Occupational disease:** caused by the nature of the work. For example, carpal tunnel syndrome after years of working as a sheet metal fabricator or jackhammering may be deemed an occupational disease. Other common occupational conditions are lung diseases from some exposures and hearing loss.
- **Consequential injury:** arising from either of the above. For example, a right leg fracture puts more weight on the left leg during recovery. If a problem with the left leg develops as a result, this may be deemed a consequential injury. Another typical consequential injury is depression with anxiety from the stressors

associated with chronic pain, loss of livelihood and financial strain after a WC injury.

Medical evidence is critical. Regardless of whether the claim is related to accident, occupational disease, or consequential injury, starting and pursuing a claim requires prima facie medical evidence (PFME) from an authorized physician who opines specifically that the event is causally related to the employment. Medical providers must have and document the full and complete history of the accident/injury and the injured worker's medical history, particularly with respect to any pre-existing injuries of related body parts.

## WHO ARE THE PARTIES INVOLVED IN A WORKERS' COMPENSATION CASE?

- **Claimant/Injured Worker**
- **Claimant's Legal Representation**  
Claimants in New York are not required to have legal representation, although it is highly recommended
- **Employer** of record when the injury was sustained
- **WC insurance carrier** who represents the interests of the employer and is responsible for paying required benefits. Some employers are self-insured or use a third-party administrator (TPA) for these functions.
- **Defense attorney/carrier's legal representation**, often a local defense firm hired to defend any issues. Some carriers have in-house counsel or

licensed representatives or authorized individuals who can also appear before the Board on the carrier's behalf.

- **Administrative law judge (ALJ)** presides over the WC case. Administrative law regulates the operation and procedures of government agencies. WC laws are administrative laws.
- **Workers' Compensation Board/Commission/Agency**, the governing agency administratively handling all aspects of a case. Each state has its own.

### WHY MIGHT A WORKERS' COMPENSATION CLAIM BE DENIED?

Not every injury sustained in employment is covered. Depending on circumstances, a carrier might deny or dispute a claim for:

- Mental health/stress
- Heart attack/stroke
- Death
- Unwitnessed accidents
- Idiopathic injuries
- Significant pre-existing conditions
- Repetitive/occupational injuries
- Assault
- An incident involving drugs or alcohol
- "Horseplay"
- Accidents that occur
  - "off the clock"
  - during lunch breaks
  - traveling to and from work
  - in employee parking lots
  - during business trips
- A party with credibility issues

When the carrier denies a claim, the parties litigate the issues for compensability. Whether a case will be considered compensable is often fact-specific and subject to the relevant state statute and case law, which is ever-changing and often inconsistent.

### WHAT BENEFITS ARE AVAILABLE TO AN INJURED WORKER?

When a case is determined to be compensable, the injured worker is entitled to **lost wage** and **medical benefits**.

Typically, WC pays only a portion of wages lost. States have statutes that set maximum and minimum lost wage benefit rates. There are a few exceptions, e.g., police officers or firefighters injured in the line of duty may receive full lost wages.

Injured workers are entitled to medical treatment only for the work-related injuries. Such treatment often requires prior authorization. Some states, including New York, have very strict guidelines, rules, and processes that medical providers must follow to be paid.

Heirs or family of a worker who dies may be entitled to lost wage benefits.

### WHAT ABOUT PERMANENT INJURY?

Once an injured worker's condition reaches maximum medical improvement (MMI), determination of permanency is required. This can happen as early as six months after the accident or may be later. Many states have associated required forms. Some, like New York, handle permanent extremity impairments differently than those for the neck or back.

States usually have detailed medical impairment guidelines for this. They often resemble those in the *American Medical Association Guide to Evaluation of Permanent Impairment* (American Medical Association, 2008).

In New York there are two sets of guidelines: *the Medical Impairment Guidelines* [June, 1996] and the *NYS Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity* [December, 2012]. The 2012 *Guidelines* do not universally supersede

the 1996 *Guidelines*; for certain older claims the 1996 *Guidelines* still apply. Both *Guidelines* can be found directly at <http://www.wcb.ny.gov>.

New York has recently passed legislation to update the permanent impairment guidelines to incorporate medical advances that result in better healing and outcome, effective 01/02/2018. However, the proposed changes are not yet available for review. Publication is expected after consultation with labor, business, medical providers, insurance carriers and self-insured employers.

Pain is not factored into permanency evaluation. If there is no permanent injury, no additional lost wage benefits will be owed to the injured worker.

The treating physician and the carrier's consultant often have different opinions on the nature and extent of the permanent impairment. When the parties disagree, the issue will be litigated and resolved by the ALJ.

### BONES OF A WORKERS' COMPENSATION CASE

Although no-fault WC cases are not personal injury cases, many of the issues and the medical management are very similar. WC cases are less formal but faster-paced. Many personal injury lawyers refer to WC cases as the "wild, wild west."

### PRIMA FACIE MEDICAL EVIDENCE ("PFME")

It is important to identify specific injuries by obtaining and reviewing thoroughly all relevant past and present medical records, and determining whether documented findings and diagnosis are consistent with the history and injury claimed. The case cannot move forward without sufficient evidence.

- Is there a complete history of the accident/event?



- Is there a pre-existing injury? If so, what is the nature and extent?
- Did the injured worker disclose the pre-existing injury? Failing to do so could be considered fraud (which can result in suspension of benefits, fines and criminal charges).
- What are the complaints/symptoms?
- What are the physician's physical findings?
- Are there any diagnostic tests?
- What is the final diagnosis?
- Does the medical provider give a statement of causal relationship? If so, is it supported by a rational basis and a reasonable degree of medical certainty?
- Is treatment requested (physical therapy, diagnostic, chiropractic care, pain management, medications, etc.)?

If so, is there a statement of medical necessity for the treatment and is prior approval required for the treatment?

If the carrier accepts the injury, medical treatment can proceed. If the carrier disputes the injury, they may have the worker examined by their medical consultant (MC). If the MC disagrees on causal relationship, the issue will be litigated and resolved by the ALJ. See Litigation, below.

### **MEDICAL ASPECTS OF A CASE**

Once a case is accepted, medical case management can continue for the life of the injured worker if it does not settle. This often entails:

- Ongoing review of the medical records from all providers and consultants
- Monitoring treatment requested for medical necessity and Guidelines compliance, and assisting with authorization if needed
- Monitoring work or retraining capacity
- Monitoring percentage/degree of disability, as the amount of lost wage benefits may depend on this
- Coordinating treatment with multiple providers
- Coordinating medication authorizations
- Addressing long-term opioid usage and/or associated weaning issues
- Coordinating home modifications and home care

- Addressing reimbursement for out-of-pocket medical expenses
- Conducting research
- Projecting anticipated future care
- Communicating with medical providers for clarification as needed

## LITIGATION

The most common issues litigated are:

- degree of disability
- need for treatment
- extent of permanent injury
- causal relationship of injuries
- prescription medication management

Medical providers testify under oath. In New York, this is done by telephone depositions. Most depositions are less than one hour; this is very difficult in more complicated cases. The medical providers are paid a nominal fee. Thus, they typically agree to be deposed only at the beginning of the work day, during the lunch break, or at the end of the day. It can be difficult to dig further into disputed issues.

New York has strict rules that prohibit legal professionals from communicating directly with a medical provider to influence their testimony or opinion. Thus, most communications with medical providers are carefully and neutrally written with copies to all parties involved. This typically means that there are no meetings or conference calls with a doctor before testimony. A provider may not even know the reason for the deposition. There is an element of surprise and uncertainty inherent in this process, especially if the provider has not reviewed the medical records in advance or does not provide proper support for written opinions and reports.

## OUTCOME OF LITIGATION

The ALJ does not attend or supervise these depositions. Once the record is closed, the ALJ receives the transcripts

and Memorandum of Law and the deposition transcripts from the parties and makes a decision. Those dissatisfied with the ALJ's decision have rights of appeal.

## IS THERE A ROLE FOR LNCs IN WC CASES?

Yes, definitely. Most of my time is spent addressing ongoing medical issues. Few firms use LNCs. This does not mean, however, that they should not consider it, especially for larger firms with a very high case volume.

## WHAT COULD AN LNC DO FOR THE WC PLAINTIFF ATTORNEY?

The sky's the limit. This list will be familiar to most LNCs:

- Medical record requests and reviews on all associated issues
- Medical records organization and summary
- Medical research
- Analyzing the injury, monitoring treatment
- Attending MC examinations
- Assisting with deposition preparation
- Researching opposing medical experts
- Drafting medical portion of legal documents (e.g., Memoranda of Law, Appeal);
- Drafting correspondence to medical provider
- Communicating with carrier on treatment issues
- Identifying authorized medical providers and coordinating appointments
- Addressing treatment guideline issues
- Assisting in and reviewing Medicare set-aside arrangement (MSA)
- Addressing medical necessity of home modifications and durable medical equipment
- Assisting with prescription medication authorization, medical

necessity, Guideline compliance, and weaning issues

## WHAT CAN AN LNC DO FOR A WC INSURANCE CARRIER?

Nurse case managers (NCM) are LNCs. They often work for carriers or TPAs. Their role includes:

- Requesting and reviewing all medical records to identify any issues of concern (causal relationship, PFME, pre-existing injuries, malingering concerns, medication addiction, new injuries, etc.)
- Coordinating and monitoring medical treatment to ensure compliance with the applicable treatment guidelines and standards
- Reviewing and responding to authorization requests for treatment, prescription medications, and equipment;
- Identifying and coordinating appropriate medical consultant examinations, and attending them if permission is given by claimant attorney
- Communicating with treating providers and medical consultants
- Maintaining an ongoing medical summary
- Strategizing to reduce medical costs
- Facilitating return to work, modified duty, or retraining
- Communicating with claimant if unrepresented or permitted
- Attending medical appointments with claimant if unrepresented or permitted
- Assisting in and reviewing Medicare set-aside arrangement (MSA) if settlement anticipated
- Coordinating care and admission with medical facilities, e.g., hospitals, nursing homes, rehabilitation centers, mental health centers, pain management centers, home health care or addiction centers



- Coordinating and communicating with hospital medical staff and social workers if claimant is admitted
- Coordinating and assisting with home modifications and durable medical equipment needs
- Communicating with claimant's legal representative

In cases involving complicated injuries and care, I welcome carrier NCM involvement to assist in securing necessary treatment. Savvy NCMs can reduce costs of medical treatment by monitoring ongoing need for medical treatment and medications, particularly physical therapy, chiropractic, pain management, and medications. However, I am cautious if NCMs become overbearing or overstep their job scope with the claimant or providers.

## WHAT CAN AN LNC DO FOR A STATE WC GOVERNING AGENCY?

Every state has a unique WC agency. In New York, the Medical Director's office is dedicated to:

- Granting licenses to medical providers and consultants to handle WC cases and monitoring their compliance
- Creating and implementing medical forms for WC cases
- Addressing medical fee schedule issues
- Creating and monitoring medical treatment and permanent impairment guidelines
- Communicating with and guiding authorized providers
- Communicating with and guiding claimants and their legal representatives
- Developing medical portal system to streamline the medical authorization process and eliminate forms and confusion
- Outreach/education on any medical issues

- Strategizing to create a better system for all
- Publishing on relevant medical issues

## SUMMARY

Although my experience is limited to New York, each state has a system designed to provide basic lost wage and medical benefits to injured workers in exchange for immunity for the employer from a lawsuit. The benefit rate, benefit caps, covered injuries/conditions, treatment and permanency guidelines, procedures, statutes, coverage requirements, how premiums are calculated, and appeals processes may vary. Medical case management, however, is very similar. LNCs can find or develop niche roles in many sectors of the WC gestalt, for the benefit of claimants, carriers, and employers.

## REFERENCE

Rondinelli, R (ed.) (2008) Guides to the Evaluation of Permanent Impairment (6th ed.). American Medical Association.



**Gina T. Crawford, LCR** has worked in the legal field since 1999 in Rochester NY (Nixon Peabody, LLP & Faraci Lange, LLP) before joining the Modica Law Firm 2010. She earned her license as a New York State Workers Compensation Licensed Representative in 2005 allowing her to appear at hearings and represent injured workers before the New York State Workers' Compensation Board in the full and same capacity of a lawyer. She is a member of the Monroe County Bar Association in Rochester, New York. Gina works closely with prominent personal injury attorneys to address the complex interplay between WC and related personal injury cases. Modica Law Firm is based in Rochester, New York and concentrates its practice in labor and employment law, whistleblower claims, Social Security Disability (and other disability benefits), workplace accidents, personal injury cases and workers' compensation claims.

## Check Your Answers

## Test Your Case Screening Skills Page 9

**Case #1:**  
Investigated due to "stitched" nerve.

**Expert review:** the expert does not believe that Sam's pain was caused by a stitch involving the ilioinguinal nerve, but rather by the mesh plug. Among the reasons for the expert's belief is that Sam had no pain for the first few days after the first surgery, which the expert feels would not make sense if the nerve had been stitched during the surgery. In addition, the expert feels that if an entrapped ilioinguinal nerve was the problem, after it was intentionally severed in the second surgery, he would have expected any pain caused by it to stop, which has not been the case.

**Disposition:** reject after expert review.

**Case #2:**  
Investigated

\* Obtained records and sent out for expert review

**Disposition:** Rejected after expert review – clear liability (CT scan results in 2009 mandated PET scan) but delay in diagnosis and treatment did not change the outcome, either with respect to treatment options or prognosis, which is good.



# Changing The Paradigm: Collaborative Law

*Bartina L. Edwards, J.D.*

Keywords: collaborative law, dispute resolution, legal nurse consulting, conflict resolution, employment law, culture of retaliation

Collaborative law is a tool that can change the paradigm for how we approach conflict and disputes, and interact with each other in employment spaces, medical spaces and anywhere there is an opportunity to dialogue, communicate and collaborate. This can ultimately transform workplaces, work cultures, and environments for physicians, patients, advocates, employees, employers, attorneys, and legal nurse consultants. This article describes how the unique role of a neutral offers an opportunity for legal nurse consultants to be a part of a niche market that is ripe for change. It describes collaborative law's process, benefits, and hallmarks, emphasizing interests rather than adversarial positions. This makes collaborative law ideal for employment, business, medical and other civil disputes. Collaborative law skills can be invaluable to any legal nurse consultant (LNC) to assist a legal team to influence the outcome of a dispute without litigation, through listening, collaboration, research, review, and medical evaluation skills.

## INTRODUCTION

A paradigm can be defined as a shared cognitive framework or set of beliefs and practices people apply in a situation. Paradigm change means transforming how we work with each other and resolve disputes in both the physical and the mental space. However, this requires a shift in consciousness, interruption of norms, education, questioning, and reframing. Collaborative law exemplifies a paradigm shift.

The beginning of collaborative law (CL) has its roots in a model created by Stuart ("Stu") Webb, a Minnesota attorney, who in 1989 created a model designed to resolve legal cases outside of the courts. Collaborative law is now recognized and practiced in over 20 countries and throughout the United States.

While not new, CL is a transformative tool that changes how we approach conflict and interact with each other. Anyone -- doctors, patients, employees, employers, attorneys and legal nurse consultants (LNCs)—anywhere, can apply CL wherever there is an opportunity to dialogue, communicate, and collaborate.

## WHY CL?

Litigation is necessary and appropriate in some cases. Participants must identify key results, implement strategies and manage costs to achieve results. I call this *positional risk management*. The current legal system focuses on winning and managing litigation, not problem-solving and preventing litigation. And while litigation can be cooperative, it remains adversarial; even if cooperative, the traditional *results-oriented* approach is not

## Collaborative law is now recognized and practiced in over 20 countries and throughout the United States.

the same as a collaborative *interest-based* approach. As defined by the IACP, the collaborative law process or collaborative law is "a voluntary dispute resolution process in which parties settle without resort to litigation."<sup>1</sup> CL looks at issues as problems to be solved rather than cases to be "won" or "lost."

The CL process maintains privacy, since there is no litigation.<sup>2</sup> There is no proceeding and no public record.

Each party's collaborative attorney has equal footing to negotiate on common interests, the crux of disputes for true agreement. Position-based negotiations often do not delve into the real issues that prevent agreement, lead to impasse and compromise. However, the collaborative law model allows for better results. Attorneys may still advocate zealously for their own clients, but they also work collaboratively towards settlement that actually meets both parties' needs.

The collaborative process (CP) can benefit from an interdisciplinary approach where neutrals and collaborative professionals are added to the team. Based on research commissioned by the International Academy of Collaborative Professionals (IACP), with or without the neutrals, "the overall settlement rate of cases

reported by clients was 90%, with 10% of cases terminating prior to settlement of all issues. While adding value in other ways, clients' retention or lack thereof of a financial professional or one or more mental health professionals did not alter the settlement rate."<sup>3</sup>

For further confirmation that CL warrants attention,

"readers are directed to the 1976 Pound Conference convened by the American Bar Association which examined concerns about the efficiency and fairness of the courts systems. Following the Pound Conference, Derek Bok, the former Dean of Harvard Law School and former President of Harvard University reflected on the significant events of the conference and opined, 'Over the next generation, I predict, society's greatest opportunities will lie in tapping human inclinations towards collaboration and compromise rather than stirring our proclivities for competition and rivalry. If lawyers are not the leaders in marshaling cooperation and designing mechanisms that allow it to flourish, they will not be at the center of the most creative social experiments of our time.'"<sup>4</sup>

1. IACP (n.d.) What is collaborative practice? <https://www.collaborativepractice.com/public/about/about-collaborative-practice/what-is-collaborative-practice.aspx> retrieved 10/10/2017

2. The parties do not completely lose the right to litigate. However, if the parties decide to litigate, they cannot use anything that was discussed in the CP, and the collaborative lawyers must withdraw from the case. Both parties must secure new trial counsel for purposes of moving forward with litigation.

3. Wray, Linda K., on behalf of the IACP Research Committee, (July 6, 2010), What Clients Say about their Satisfaction with Collaborative Professionals, [www.collaborativepractice.com/professional/resources/research-articles.aspx](http://www.collaborativepractice.com/professional/resources/research-articles.aspx);

4. Solovay, Norman., Jr., Maxwell, Lawrence R. (Spring 2009, Vol.2, No. 1 edition), New York Dispute Resolution Lawyer, retrieved from <https://apps.americanbar.org/dch/committee.cfm?com=DR035000>.

And in 1984, in his speech on "The State of Justice," Chief Justice Warren Burger stated,

"the entire legal profession has become so mesmerized with the stimulation of the courtroom contest, that we tend to forget that we ought to be healers of conflict... trial by adversarial contest must in time go the way of the ancient trial by battle and blood...our system has become too costly, too painful, too destructive, too inefficient for truly civilized people."

### CASE OPPORTUNITIES AND THE LNC

We have seen an increase in employment-related lawsuits. Sexual harassment claims, negligent or intentional infliction of emotional distress claims and medically-based leave claims require medical information. FMLA (Family Medical Leave Act) and ADA (Americans with Disabilities Act) claims are commonplace. Workers' compensation and retaliation claims are often linked, when the employer retaliates against the injured employee who files a workers' compensation claim. These claims that revolve around unfair labor practices and inequitable treatment of employees require access to and interpretation of medical-related records.

Many claims are filed administratively before proceeding to litigation; in 2016, 45.9 % of all EEOC charges were on the basis of some form of legal retaliation (i.e. Title VII, ADA, etc.) compared to 22.6% in 1997. When grouped together, retaliation comprises the highest number of all claims and is growing. This number is 47.5 % for North Carolina.<sup>5</sup>

When segregated, 36.2 % of all EEOC charges filed are retaliation on the basis of Title VII, only, still the highest number of all individual-based claims, followed closely by race. Sex-based charges have held pretty steady around 30% with a slight decrease, but in 2013 harassment cost U.S. companies more than \$97 million, an all-time record at the time. The old human resource rules for preventing and confronting harassment and workplace violations began to change;<sup>6</sup> and while the number of ADA cases is down, total ADA claims are up 12.0% from one year ago, seeing the largest increase. These claims are at 30.7% of total charges filed.<sup>7</sup>

Medical case statistics are startlingly similar. Employment law cases often result in summary judgment in favor of the defendants, and 80% of medical malpractice cases nationwide that go to trial result in defense verdicts.<sup>8</sup>

Many employment law cases have a medical-related component, which make employment lawyers a good prospect for the LNC. The LNC has a unique opportunity as the medical connector to a legal team. Generally, among other duties, the LNC can

- serve as a medical expert
- assist attorneys and others by connecting to other medical professionals
- interpret medical records, charts, and research findings
- consult on medical-related topics

Historically, this has translated to damages. However, in CL, it translates to a more effective resolution without litigation. While the approach and the language are very different, remedies and effective resolution are not necessarily mutually exclusive.

### CL IN PRACTICE

Using the CL process, the expert is referred to as a *neutral*. The collaboratively-trained LNC adds value in this role, collecting, reviewing, and analyzing information and data from *both* parties. This allows the LNC to have a greater effect on resolution, leading to sustainable change without focusing on liability and blame. The LNC is also exposed to both parties in a transparent non-adversarial way that could present additional business opportunities without a conflict of interest.

There are structured meetings known as four-way conferences, because the two parties and their collaborative trained attorneys meet to discuss needs, interests, objectives, goals, and issues and set an agenda. If there are additional members, then it could become a six-way conference. This team approach may include collaborative professionals and/or neutrals (*experts*). This team, as applicable, works together to find a customized resolution. There may be several meetings but they take less time than litigation.

The CL process requires that all participants:

1. sign a collaborative written participation agreement that must meet certain criteria
2. voluntarily disclose all relevant and material information applying to the matter that must be decided
3. agree to use good faith efforts in their negotiations to reach a mutually acceptable settlement
4. must each be represented by a collaboratively-trained lawyer whose

5. <https://www.eeoc.gov/eeoc/statistics/enforcement/charges.cfm>

6. <https://www.eeoc.gov/eeoc/statistics/enforcement/index.cfm>

7. EEOC 2016 Charge Statistics, <https://www.eeoc.gov/eeoc/statistics/enforcement/charges.cfm>; [https://www.eeoc.gov/eeoc/litigation/selected/ada\\_litigation\\_facts.cfm](https://www.eeoc.gov/eeoc/litigation/selected/ada_litigation_facts.cfm).

8. Statement of the Physician Insurers Association of America Presented by Lawrence E. Smarr, President, Physician Insurers Association of America before a joint hearing of the United States Senate Judiciary Committee and Health, Education, Labor and Pensions Committee Regarding: Patient Access Crisis: The Role of Medical Litigation, February 11, 2003 ([www.thepiaa.org/pdf-files/February\\_11\\_testimony.pdf](http://www.thepiaa.org/pdf-files/February_11_testimony.pdf)).

## TOWARD A HIGHER, DEEPER DISPUTED RESOLUTION

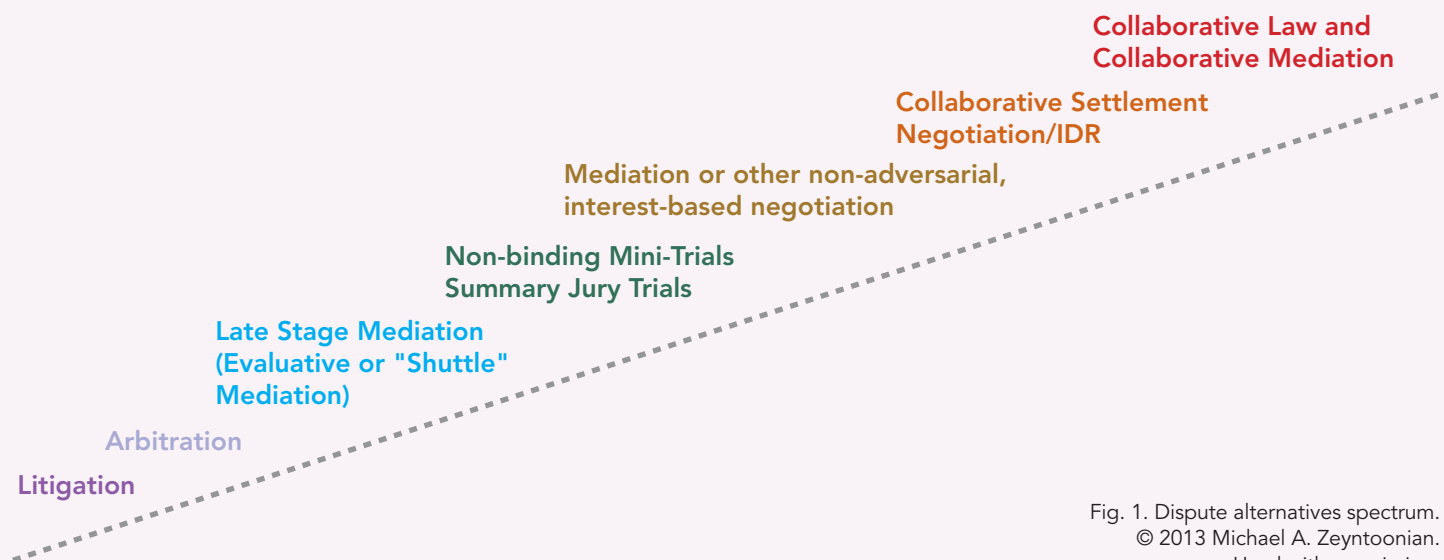


Fig. 1. Dispute alternatives spectrum.  
© 2013 Michael A. Zeytoonian.  
Used with permission.

representation terminates upon the undertaking of any contested court proceeding

5. may engage mental health, financial or other professionals whose engagement terminates upon the undertaking of any contested court proceeding
6. may jointly engage other neutrals (i.e., experts) as needed.<sup>9</sup>

The process works best when the parties have an interest in repairing, preserving, and transforming relationships between them. On a spectrum where preventive training and counsel is the least disruptive and litigation is the most disruptive, CP is almost in the middle. And when looking at a spectrum of dispute alternatives, the spectrum as designed by Michael A. Zeytoonian<sup>10</sup> tends to look more like Fig. 1, above.

### ISN'T CL LIKE MEDIATION?

No. Although often included in litigation, most mediation does not encourage dialogue and exchange, but works like settlement negotiations; the mediator works with the parties' positions, carrying information and numbers back and forth between them. This is often referred to as a "shuttle" mediation.

Instead of reaching common interests, often mediation occurs in between discovery or post-discovery and involves jockeying numbers. There is little problem-solving, preservation of relationships, or meeting of the minds. It is positional and compromising. Attorneys have been trained to continue litigation, get past summary judgment, and focus on trial if the case does not settle in mediation. Collaborative law removes the focus from litigation and puts it

exclusively on resolution. It empowers the parties, rather than the lawyers, arbiters, and mediators.

### BEST USE OF CL

The ABA states,

As mentioned, not all cases are suited for litigation and not all cases are suited for Collaborative Law. However, Collaborative Law will be tremendously advantageous to injured parties with legitimate claims who otherwise will likely go unrepresented. There are specific reasons for the failure of some would-be plaintiffs to secure legal representation. It is often not economically feasible for an attorney to take the case; the claim is too small; the injured party is too angry or just seeking revenge; or the claim is too difficult or too complicated to prove.

9. IACP (n.d.) <https://www.collaborativepractice.com/public/about/about-collaborative-practice/what-is-collaborative-practice.aspx>.

10. Michael A. Zeytoonian, <https://www.disputeresolutioncounsel.com/category/collaborative-processes/> (retrieved December 2016); The Dispute Spectrum is portrayed in various forms to reflect the levels of dispute and their corresponding dispute alternatives.

*For over 20 years, legal nurse consultants have acted as collaborators and strategists, offering support in medically-related litigation and other medical-legal matters.*

It is particularly difficult for young or elderly plaintiffs to find attorneys because it is difficult, if not impossible, to prove economic damages; this difficulty is compounded in states that have caps on non-economic damages. In a situation in which an injured party sues and the process becomes too daunting, expensive or time- and emotion-consuming, the injured party (and her/his attorney) could move into a collaborative process, in the hope that an interest-based, face to-face process would bring a reasonably speedy resolution to the matter. These situations require a case-by-case analysis by the attorney and client to determine if the collaborative law process is useful and appropriate. This requirement, often referred to as the 'collaborative commitment', is intended to ensure that the attorneys, as well as the parties, are fully committed to the collaborative process.<sup>11</sup>

Moreover, with medical claims,

physicians are often prohibited by their liability insurance carriers from speaking with patients after

an adverse event. This prohibition seems to make litigation almost inevitable, when the intent of the carrier is just the opposite.<sup>12</sup>

Yet, the Report of the Harvard Medical Practice Study to the State of New York concluded that only twenty-seven percent (27%) of adverse events that occur during hospitalization were due to actual negligence on the part of a health-care provider.<sup>13</sup> The study reports the incidence of adverse events for hospitalizations is 3.7% and, of these, 1.1% are due to negligence. Although it is generally envisioned as the logical next step after a medical error, as previously noted, the statistics regarding successful litigation in medical malpractice cases are abysmal. Collaborative law in potential medical claims and disputes has the potential to be very effective because it contains a safe container in which the stakeholders to any resolution of medical error can collaborate to provide a fair process to the injured party. The stakeholders include the patient, the patient's attorney, the physician, and the phy-

sician's attorney. From time to time, depending on the circumstances, others may be required, such as the physician's insurer, hospital administrators/risk managers, or counsel for the hospital. This process gives the injured party/family members the immediate support and advice of a collaborative attorney. It is particularly important because, unlike the traditional malpractice method, the collaborative support and advice offered by the attorneys takes place in a situation in which the injured party is less likely to be at a disadvantage. Most face-to-face meetings between an injured party and a physician(s) and other health care providers are marked by inequality of bargaining power; lack of control over the process; difficulties insuring a full and fair opportunity to be heard, to ask questions and have them answered; and little chance for smaller claims, which wouldn't be taken on a contingency basis, to be heard and resolved. The peace of mind that comes from taking a case out of the win-or-lose litigation process into a non-adversarial, compassionate process is empowering to all participants.<sup>14</sup>

This also creates additional opportunity for the LNC, as a collaborative member of the legal team or as a neutral.

## **EMPLOYMENT AND BUSINESS LAW**

Collaborative law processes are widely used in family law. However, CL is

11. Clark, Kathleen, The Use of Collaborative Law in Medical Error Situations, <https://apps.americanbar.org/dch/committee.cfm?com=DR035000>.

12. Id.

13. Id. FN See Barry r. Furrow, Thomas I. Greeney, Sandra JH. Johnson, Timothy C. Jost and Robert L. Schwartz, Health Law Cases, Materials and Problems, 3rd Edition, West Publishing (1997) at p.32 (excerpt from Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York – the Report of the Harvard Medical Practice Study to the State of New York (1990).

14. Id. See Carol B. Liebman and Chris Sterns Hyman, Medical Error Disclosure, Mediation Skills, and Malpractice Litigation: The Project on Medical Liability in Pennsylvania, available at [www.medliabilitypa.org](http://www.medliabilitypa.org). Copyright 2005 Carol B. Liebman & Chris Stern Hyman; But see Jill Schachner Chanen, A Warning To Collaborators, ABA Journal.com, Tuesday, May 8, 2007 (from the May ABA Journal National Pulse), addressing the Colorado Bar Association's ethics committee's opinion regarding collaborative law. Colorado's bar association is the sixth state bar association to address the ethics of collaborative law and the only one to suggest that it is unethical. However, the Colorado opinion suggests that it is appropriate for the parties to sign a participation agreement and for the attorneys to limit the scope of their engagement to negotiation. The other state bar associations, including those of Kentucky, North Carolina, New Jersey, Pennsylvania and Minnesota, all approve of it.

gaining recognition as an efficient and cost-effective method in employment and business disputes.

Business practices, the economy, the political environment, and other factors influence employment and business disputes. Notwithstanding claims that revolve around unfair labor practices and inequitable treatment of employees, many employment law cases require access to and interpretation of medical-related records. This makes employment lawyers a good prospect for the LNC.

In employment situations, CL is a good fit for organizations that want to do more than try to find work-life balance for their employees. Offering diversity programs and annual training as a tick mark isn't enough. While bases for claims may be debatable, retaliation claims represent 45.9% of claims that employees advance and employers have to defend, and without change, it is likely this trend will continue.<sup>15</sup> Almost all retaliation claims involve at least one of the following:

- + miscommunication
- + inadequate training
- + unfair discipline
- + suspicious timing of events
- + policy abuse
- + whitewashed internal investigations

Organizations can change the paradigm to embody equity and integrity by dismantling the culture of retaliation creating a culture that promotes alignment of purpose and avoidance of lawsuits, integrating human resources, employees, and lawyers into the organization's business

Misconduct arises when individuals compromise their values in order to gain



something and are willing to deviate from the rules to manipulate the process in order to advance, or facilitate the advancement of certain individuals, while denying that same opportunity to others in the company.<sup>16</sup> A culture of retaliation is a key indicator of misconduct.

## CONCLUSION

The opportunity for LNCs lies in adding a unique skill to their practices. Once trained, the LNC can act as a neutral and be part of a process that yields faster, less costly, improved results for the parties. As indicated by the American Association of Legal Nursing Consultants, "for over 20 years, legal nurse consultants have acted as collaborators and strategists, offering support in medically-related litigation and other medical-legal matters."

Recommending this option to attorneys and colleagues adds value to an LNC's position as a team member and change agent. Research shows those who

have used CL favor it over litigation, resulting in the settlement of 90% of all cases reported.<sup>17</sup> Promoting this process expands, rather than narrows, the field of case opportunities while shifting the collective legal consciousness towards effective and sustainable change.

There is no better time than the present to embody those principles by adding collaborative law to the LNC's toolbox.

For more information on collaborative law in the workplace, visit [www.collaborativepractice.com](http://www.collaborativepractice.com) to learn how to help change dispute resolution by becoming a "paradigm shift catalyst."



**Bartina L. Edwards, J.D.**

practices in business, HR consulting, and labor/employment law for companies, firms, businesses, and individuals

in Charlotte NC. She can be reached at [bedwards@blelaw.com](mailto:bedwards@blelaw.com).

15. <https://www.eeoc.gov/eeoc/statistics/enforcement/charges.cfm>.

16. [http://www.corporate-ethics.org/pdf/Business\\_compliance\\_and\\_ethics\\_forum\\_2009.pdf](http://www.corporate-ethics.org/pdf/Business_compliance_and_ethics_forum_2009.pdf).

17. Wray, Linda K., on behalf of the IACP Research Committee, (July 6, 2010), What Clients Say about their Satisfaction with Collaborative Professionals, [www.collaborativepractice.com/professional/resources/research-articles.aspx](http://www.collaborativepractice.com/professional/resources/research-articles.aspx).



# Did Your Client with Medicare Report His Settlement and Award to Medicare?

James Hanus, RN, BSN, OCN, MHA

Keywords: CMS, Medicare, award, settlement

*The Centers for Medicare and Medicaid Services (CMS) has established under federal law a mandatory requirement for Medicare beneficiaries to report settlements and awards that they receive from legal activities, where Medicare paid for some or all of their medical costs related to the reason(s) for the legal action. But are the beneficiaries and their legal counsel aware of this reporting requirement?*



**O**n December 12, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a Technical Alert <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/Alert-2017-Smart-Act-Threshold-.pdf> which made a significant change in the reporting requirements for Medicare beneficiaries for settlements and awards from liability insurance (includes self-insurance), mass tort settlements, physical trauma liability-based incidents, and workers' compensation as of January 1, 2017.

Under Section 111 of the Medicare Medicaid and SCHIP Extension Act of 2007 (MMSEA) at 42 U.S.C. 1395y(b)(7) and (b)(8) requires that Medicare beneficiaries who receive liability insurance coverage (including self-insurance) settlements and awards must report them to CMS. This will then allow CMS to recover any payments related to the settlement/award where CMS paid for services under any of the Medicare programs (Part A, Part B, etc.). The CMS recovery is reduced by any attorney fees and costs associated with the settlement/award.

Section 111 also requires that liability insurers, no-fault insurers and workers' compensation insurers must also report payments for Medicare beneficiaries to CMS. If insurers have questions about reporting to CMS they can email [PL110-173SEC111-comments@cms.hhs.gov](mailto:PL110-173SEC111-comments@cms.hhs.gov).

Section 202 of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act) added paragraph(viii) to Section 1862(b)(2)(B) of the Social Security Act requires CMS to calculate

*LNCs should also be aware of the extant requirement for each such case to have a Medicare Set-aside Arrangement (MSA) on file to document how Medicare's interests will be protected vis-à-vis future medical expenses related to the compensable condition.*

and publish no later than November 15th of each year a single threshold for settlements and awards. The CMS calculation resulted in the Technical Alert.

Among the changes made by the Alert, the threshold for reporting worker's compensation settlements went from \$300 to \$750; for liability insurance, mass tort, physical trauma and self-insurance, the threshold went from \$1,000 to \$750.

While the Medicare beneficiary is responsible under the MMSEA, is your client aware of this obligation and have you or your firm made him aware of the requirement once a settlement or award is made to the Medicare beneficiary?

*Editor's note: LNCs should also be aware of the extant requirement for each such case to have a Medicare Set-aside Arrangement (MSA) on file to document how Medicare's interests will be protected vis-à-vis future medical expenses related to the compensable condition. This applies whether or not the beneficiary was on Medicare at the time of the injury or award. Many attorneys are not familiar with this requirement for all such settlements, especially in states where related medicals remain open (i.e., paid by a*

*workers' compensation insurance carrier) for the life of the claimant.*

*LNCs can help clients avoid serious consequences by alerting their attorney clients about this requirement. While CMS does not require any certification for anyone to prepare or submit an MSA, it would be prudent to consult someone with training and expertise in current MSA requirements and formats when anticipating a settlement in a liability case.*



**James Hanus, RN, BSN, OCN, MHA** is a Clinical Appeals Specialist, leading a team that defends oncology clinics in over 30 states against denied

government and commercial insurance claims with an average success rate of 91% over the past 8 years. He has clinical experience in telemetry and the past 15 years has also worked in oncology in radiation and clinical research. Before nursing school he received a BA in Business Administration-Hospital Administration and a Master's Degree in Health Administration, served in the U.S. Air Force (active duty and reserve), and served in multiple healthcare management positions and retired as a Lt. Col. He is also a member of the Editorial Board for JLNC. He may be contacted at [Jihanus11@gmail.com](mailto:Jihanus11@gmail.com).



# Creative Ways to Get Your Foot in the Door: A Step by Step LNC Marketing Guide

Erin OConnell MSN, MBA, RN-BC, CNL, CNLCP

Keywords: LNC, marketing, communication, public speaking, networking, creating a brand

*Marketing is a nine-letter word that makes nurses shudder. Marketing is foreign to nurses because we have spent most of our careers taking care of patients and not selling our services. Now we are looking to change our career paths, but we're not quite sure how to develop client relationships through a cohesive business and marketing plan. How do we even start? Where do we look for advice? Marketing starts with a plan – a solid business plan, followed by a marketing plan; practice presenting, building a brand, and being creative. The ultimate goal of your successful LNC marketing plan will not only get your name out to numerous attorney clients, but it will also keep your name on their minds.*

## INTRODUCTION

Marketing: A nine-letter word that makes legal nurse consultants panic. Most LNCs (especially new ones—myself included) clam up, shake, and break into a sweat. Truthfully, I hate marketing; however, it is a necessary evil to gain and maintain clients. To be a successful legal nurse consultant, you have to be an effective marketer. So I have to put my fears aside and make connections. Marketing, when done properly, increases clientele, which increases your caseload and ultimately leads to a thriving business. Although marketing isn't my favorite part of legal nurse consulting, there are some easy, creative ways that have proven successful for me.

## SKILLS 101: CONTACTS, PRESENTATION

When I first started my LNC business, I was confident in my medical knowledge and nursing abilities, but I had no experience with business practices. How will I attract clients? How do I get myself out there to attorneys and fellow LNCs to let them know I'm interested in their business? After reading a plethora of books, articles, websites, and blogs, I realized the answer to those questions was ... marketing.

But what in the world is marketing? As a nurse, I never needed to sell my services. Patients came to the hospital for care and I was there to do my job. There was no solicitation involved. No matter what facility I worked in, I never needed to stand on the street corner and beg them to let me heal their wounds or ease their pain. As a legal nurse consultant, my clients are no longer patients; they are attorneys and nurses, which means I have to seek them out for business.

My first experience with actually "marketing" myself was joining my local AALNC chapter. I went to my first local chapter meeting as a guest.

## *To be a successful legal nurse consultant, you have to be an effective marketer.*

My blood was pumping, and I was super excited. Now what? I've joined this organization filled with valuable contacts. I have all of this nursing knowledge oozing out of every pore. Who wants it? Who knows that I have all this knowledge that I am eager to share? It was disheartening to realize that although I took the first step by joining an organization filled with potential business prospects, I was still virtually invisible to them.

So, I went back to reading. Everything I read said I needed to make my presence known by talking to people, introducing myself, and giving presentations. Presentations? Oh goodness, what have I gotten myself into? I hate talking in front of people, especially attorneys because they (gasp) know the law, and I am just starting my legal nurse journey. On top of that I am not comfortable selling my skills. How do I make myself stand out? Standing out is something I have always avoided and now I have to do it on purpose?! But then I realized one crucial point: they want my nursing expertise, and I am more than excited to show them what I know.

To get used to speaking in front of attorneys, other LNCs, and even courtrooms comfortably and professionally, I signed up for Toastmasters, an organization focused on improving presentation skills. The constructive feedback from others helped me recognize my strengths and weaknesses and even got me to eliminate the "umm" out of my vocabulary. I recorded my presentations so that I could critique myself. When I gave a deposition or testified in court, I requested the transcripts so I could look over the flow of my communication. Join a Toastmasters group that

is legal-based and you can use this as an opportunity to improve your presentation skills and market. (<https://www.toastmasters.org>)

## BRANDING

Next I began to focus on how to sell my skills and stand out from the rest of the crowd. Perhaps the best way to stand out is to create your own personal brand. Creating a brand gives you a business identity. The cornerstone of any brand is a business name and slogan that will catch everyone's eye. The name must be unique and not already in use, so I checked availability of the domain name and other social media accounts. The business name also has to hint at how I will help someone solve his or her problem. The name should also spark curiosity about your business. I looked at other LNC's business names and slogans. What makes them stand out?

When choosing a business name, it's important to leave room for growth. You don't want a name so specific that your business won't be able to expand in the future. Keep the name simple so it is easy for your client to remember. If your client can't spell or remember your name, how will they remember your website or know how to contact you? Ask for feedback from fellow LNCs, friends, and family. It's always good to get different perspectives. Although the decision is ultimately yours, having other opinions may make you see drawbacks you wouldn't otherwise notice. Finally, register the company by forming a legal business entity.

After my business name was established, I realized I needed to introduce myself not only by my name, but by my business name as well. My name and

my business's name needed to become synonymous. The best way to merge the two, and promote your business for next to nothing, is to create business cards. Your business card should convey your brand quickly. The color, font, and images should coordinate with your other materials or website. I invested in high quality business cards (i.e., handmade, textured), but you can even get 250 of these for only a few dollars. Keep the card simple by limiting the amount of information, images, and color schemes. Choose a readable font, 12 point or larger (we're not getting any younger). Use the back of the business card to include more details about your business (e.g., if you specialize, what services you offer).

## BUSINESS PLAN

My final step was to create a business plan. I was able to receive help from a local university's small business development center. They provide consulting for companies of all sizes, from startups to seasoned professionals. If you can't get help from a local university, you can create a business plan on your own. Sit down with a pen and paper and brainstorm. What is unique about you? What are your professional strengths? What do you do best? What are your goals? Where do you see yourself in 2 months? 6 months? How about a year? The business plan will help you focus on your strengths. Review it monthly, and list important dates. Those dates will include what you want to accomplish in a specific timeframe. List your short- and long-term goals. Now that I have my business plan, I feel organized. I have deadlines for my goals, and I review them monthly.

## GETTING EXPERIENCE, LEARNING FROM THE COMPETITION

Now that you have a brand, business cards to market yourself, and a business plan with attainable goals, the next obstacle you'll face with marketing is

how to compete and continue to market in a competitive field. The legal nursing field can be intimidating, to say the least. There are some LNCs who have been doing this for years. I listen to them talk and try to absorb every word they say, take notes, and ask questions. Writing down general ideas that I take away from a conversation gives me a jumping-off point that I can further research in the privacy of my own office space. A good place to start for me was getting some subcontracting jobs from more seasoned LNCs. Subcontracting gives you the opportunity to get your work critiqued, further developing your skills and then increasing your confidence.

Another way to stand out is to put yourself out there. Volunteer, get involved, and get noticed. I jumped at every volunteer opportunity presented to me. I became a board member for my local AALNC chapter, I got involved on the national level, and I got involved with the individual members through subcontracting for them. I introduced myself and spoke with everyone at my local chapter meetings; I gave presentations and wrote articles for my local chapter. These opportunities got my name out into the LNC community and gave me practice in communicating with clients and peers. Each experience improved my ability to tell individuals about my brand and my skills—to sell my business.

## MAKE A MARKETING PLAN

I was marketing, but realized my efforts were kind of haphazard. Although I had an overall business plan, I didn't have a marketing plan. While the business plan focuses on overall business goals, the marketing plan should focus specifically on how you need to work on building client relationships. When I developed my plan I figured out which areas were my best shot; I planned what I would do each week in order to market. I searched for opportunities to meet new attorneys and marked those dates in my

calendar. The opportunities included attending attorney conferences and joining associations that attract attorneys with whom I wanted to start a working relationship. See if there are trial lawyers' and defense lawyers' associations in your area. Another way to meet attorneys is to hang out at the courthouse or stop in during a court proceeding and talk with the attorney after the proceeding.

I marketed everywhere I went and always had business cards with me. I have marketed in an elevator and while sitting next to an attorney on a bench; I have even marketed while waiting to go into traffic court. Never fail to jump at any opportunity you have to speak with an attorney, paralegal, or law office secretary. I find presenting a nice gift to the secretary, paralegal, or attorney during my visits makes them remember me (it also comes in handy to get past the gatekeeper) and I always include my business card. Giving a re-orderable gift nudges the potential client to contact you again to re-order their supply. I made appointments and scheduled coffee, lunches, and dinners with attorneys and paralegals.

When you meet new attorneys or potential contacts, ask for their business cards. After finishing the conversation, jot down key points on the business cards so you can reach out to them later. Send a hand-written note reminding them of your conversations and including their personal detail.

## BUILD AND NOURISH RELATIONSHIPS

Speaking of handwritten notes, I send handwritten cards or a note card for every occasion (e.g., holidays, Attorney Day, Paralegal Day, birthdays, when they win cases). I also send handwritten thank you cards for cases or referrals. This shows your client (or potential client) that you care enough to actually write a personalized note. These people are not just potential paychecks; you're

building relationships. Whenever new potential clients call, always ask how they got your contact information. If they were referred, I would send the referring individual (e.g., attorneys, LNCs, paralegals) a thank you card with a small token. The small tokens could be anything you think the person would enjoy (e.g., gift cards, snack baskets). When sending gift cards, make sure they're usable nearby. If you plan to send holiday-themed gifts, plan ahead for the holiday next year and you will be able to purchase things at a discount at the end of this year's holiday season.

While working as a clinical nurse I always appreciated a family member who brought us gifts, especially food. Show up unannounced and provide a current client with a gift basket of fruit, cookies, or your homemade specialty. Make sure when you leave your gift you leave your business card and poke your head into the office. Showing up when no one expects it lets the clients know that you're thinking about them. It makes them feel important and brings your name to the foreground. Bringing a gift allows you the opportunity to have exposure and move behind the gate-keeper. Tuesdays through Thursdays are the best days to try to catch someone in the office, but do not go during lunch-time, as you will likely miss running into your potential client.

## MARKETING PACKAGE

Develop a marketing package. Include your business card and an explanation of your business. You could include a section of services you offer. You can include redacted samples of your work. In addition, you can incorporate information on how you can help the attorneys and what value you will add. Explain how you will save them time and money. Your marketing package can be anything you feel is important for the attorneys to know about you and your business. Find a mentor or a nearby LNC and ask for feedback. Show your



marketing packet to the small business association and get their feedback. Ask your attorney clients what they would like to see in a marketing package.

## PRESENTATIONS

Presenting is a way to communicate with multiple attorneys at once. While presenting you show the attorneys your strong points and that you are an expert in the area and create credibility. All attorneys have to acquire so many CLE's (continuing legal education) per timeframe. Talk with the individuals in your area who are in charge of the CLE and let them know that you would like to present. This would be a good time to give your presentation to the "Toastmasters" so that you can perfect your presentation and receive feedback before going in front of the attorneys.

Exhibiting can be expensive but it is a great way to market to a large number of attorneys at once. Before paying for your exhibit fees find out how many LNCs and lawyers will be present. If there are a small number of attorneys attending the conference this might not be money well spent. Before the conference, see if you can have a list of attendees and send them a post card stating, "I look forward to seeing you at the conference. I will be exhibiting. I have this prize I am giving away."

Another way to entice attorneys to visit your booth is to call each of them before

the conference and tell them you are taking a survey and ask what they would like to receive as a giveaway at the conference. This provides the opportunity to talk with previous clients, get their feedback, and make a follow-up call telling them the results of your survey. Also, if you are a testifying expert for ICU and you have a fellow LNC who is a testifying expert for OB the two of you could split the table. During exhibiting, bring take home items that create a buzz and will be used after the conference.

Cold calling is another way to establish relationships. You can get names from internet searches or from watching the news. Before you make calls, do research on the attorneys you want to contact. Create a list of contacts for that day and create a follow up folder for each. Find out what areas of law they practice and if they have won recent settlements. This is a way to break the ice, and gives you an opener. If you cannot break your way past the secretary, stop by the office and bring a gift. Be persistent, but there are limits before you become annoying.

Calling after hours and on weekends is an opportunity to talk with the attorney you are trying to reach. Some attorneys work long hours and weekends when support staff has gone home. Just think: if he were using your services he might be enjoying the bright sunny day outside.

## PUBLISH!

Now is the time to start writing. In most businesses, if you write about a subject continuously you will eventually be seen as an “expert” in that field. You can write white papers, set up a blog, and join forums where you can interact with your peers and potential clients. While answering forum questions you are exhibiting your knowledge and getting your name recognized.

## NETWORKING AND ADVERTISING

One way to gain referrals is to ask existing clients for new contacts. If you are talking with an attorney and he/she does not currently have a case for you, ask if he knows of any colleagues in need. If he says “yes” and gives you names, ask if you can use his name when you call that potential client.

Attend law conferences, bar association functions, trial lawyer association functions, and legal seminars. This is a great way to have the opportunity to talk with attorneys and develop a relationship. Start with small talk and ask questions about their practice. Ask for a business card so that you can follow up with them after the conference. Develop an elevator speech and let them know that you are a nurse who enjoys reading medical records.

Attending conferences is a great way to market. You can contact the conference organizers and see if you can donate items for goodie bags. When you sponsor (or co-sponsor) the conference books, the organization will put your name in it. You can volunteer to give a presentation or co-present with another LNC in your area of expertise. When you attend a conference, you are there to market so you should start with small talk. You should be ready to explain your area of specialty and the value you can bring to an attorney or LNC client. Ask questions, because you will always

learn something. Remember to collect business cards and jot down personal details about the potential client. If the conference is associated with one of your forums, take note of the seasoned LNCs and look for them at the conference. Make sure to introduce yourself and compliment them on their contribution to the forum. You can never have too many friends in the business!

There are many options for advertising. You can advertise at nursing conferences or advertise in the classifieds of the Bar Association or the Defense or Plaintiffs Lawyers Association. Develop a printed and electronic newsletter and send it out on a regular basis. This newsletter will create an opportunity to remind the attorneys that you are available and knowledgeable.

If you are looking to create a marketing tool, look for items on Etsy or Pinterest. Purchase M&M or candy jars for the firms or the attorney’s desks, and you will have the opportunity to stop by in order to refill them. Make arrangements with a local bakery to purchase their cookies at a discount price. Tell them you plan on purchasing so many per week or month. Sponsor a firm’s lunch by calling the secretary or attorney the day before and letting them know you will be there at a certain time and will have lunch.

Once you develop a comfort with marketing it can be fun. Just remember to establish a budget and develop inexpensive ways to draw attention to your services. The more you talk, the easier it will become. The more you present, the easier presenting will become. Develop a plan and set your goals. Sit down and make sure you have a road map – your business and marketing plan – so that you can continue down the best path for your business. Always listen to information presented and ask questions. Develop your own way to keep your name on the front burner and always remind the attorneys or LNC that you are there waiting patiently.

Continuously think outside the box to create new and exciting ways to attract new clients. Marketing will no longer be a panic-producing nine-letter word!

## REFERENCES

Beesley, C. (2012, September 29). Your business, your brand- 7 simple brand identity tips.

Retrieved January 18, 2017 from the U.S. Small Business Administration: <https://www.sba.gov/blogs/your-business-your-brand-7-simple-brand-identity-tips>

Beesley, C. (2016, June 24). 8 ways to boost sales of your small business services. Retrieved

November 11, 2014 from the U.S. Small Business Administration: <https://www.sba.gov/blogs/8-ways-boost-sales-your-small-business-services>

Berry, T. (2010, May 26). 6 easy steps to a simple practical business plan. Retrieved

January 18, 2017 from the U.S. Small Business Administration: [www.sba.gov/blogs/6-easy-steps-simple-practical-business-plan](http://www.sba.gov/blogs/6-easy-steps-simple-practical-business-plan)

Carbajo, M. (2013, July 10). How to choose a business name that helps you-Not hurts you.

Retrieved: January 18, 2017 from the U.S. Small Business Administration: <https://www.sba.gov/blogs/how-choose-business-name-helps-you-not-hurts-you>

Joos, B., & Joos, J. (2000). Marketing for the legal nurse consultant: A guide to getting all the clients you can handle using proven, low cost strategies. Sautee, Ga: Sky Lake Publishing.

Weston Pollock, B. (2014, November 6). Business plan insight from SCORE mentors.

Retrieved January 18, 2017 from the U.S. Small Business Administration: <https://www.sba.gov/blogs/business-plan-insights-score-mentors>



**Erin O'Connell, MSN, MBA, BSN, RN-BC, CNL, CNLCP** has over a decade of clinical nursing experience in ICU, Telemetry, the ER, Long-term Care, Rehabilitation, and Same-day/PACU. She currently works as the Clinical Nurse Leader in LTC. She currently serves on the AANLCP's research committee, helping to enrich resources for Nurse Life Care Planners, and is the WV/UOV AALNC Webinar Committee Chair. She can be contacted at [Erin@OConnellAndAssociates.net](mailto:Erin@OConnellAndAssociates.net).



# Guide to the EMS World

Michael J. Curran, RN, BSN, EMT-P, NHDP-BC

## INTRODUCTION

Understanding the origins and current state of prehospital emergency care can be vital for the LNC whose case includes those elements.

In his article in the *American Journal of Public Health*, Manish N. Shah, MD accurately described the slow evolution of the Emergency Medical Services (EMS) System. “Modern” EMS started with Jean Dominique Larrey, Napoleon’s chief physician, who organized a system to treat and transport injured French soldiers” (Shah, 2006). Although the Civil War, World War I, World War II, and the Korean War saw advances in removing injured soldiers, EMS had few major changes until the 1960s. By

the 1960s, EMS systems were a “patchwork of unregulated systems” (Shah, 2006). In some areas, physicians staffed ambulances. In others, the ambulances were staffed by “minimally trained or untrained personnel” (Shah, 2006).

Currently recognizable EMS began a little more than fifty years ago. The 1966 white paper *Accidental Death and Disability: The Neglected Disease of Modern Society*, by the Committee on Trauma and the Committee on Shock of the National Academy of Sciences – National Research Council, gave impetus for the development of EMS. The Highway Safety Act of 1966 established the Department of Transportation (DOT), with authority to improve pre-hospital care throughout the country.

The National Registry of Emergency Medical Technicians (NREMT), 1970, established a national standard for pre-hospital care training. The National Association of Emergency Medical Technicians (NAEMT) began in 1975 with the support of the NREMT, to educate EMS personnel. Today it is the largest US professional association for EMS professionals.

The NREMT provides national EMS certification, “which is a validated and legally defensible attestation of competency” (nremt.org, n.d.). This certification is recognized in every state, and nearly all states use it as the basis for licensure.

## *The NREMT provides national EMS certification, “which is a validated and legally defensible attestation of competency”*

### RESEARCHING A CASE?

For research on a case involving EMS personnel, NREMT and NAEMT materials are an excellent place to start. Their website, [nremt.org](http://nremt.org), is a treasure trove of information on the different levels of Emergency Medical Technicians (EMT). There are links to the individual state EMS agencies' EMS standards of practice, training, and professional responsibilities.

The NAEMT, [naemt.org](http://naemt.org), is mostly an advocacy association for EMS personnel. NAEMT supports finding funding to improve the training in areas with limited resources, and develops courses such as Advanced Medical Life Support, Pre-Hospital Trauma Life Support, Tactical Emergency Casualty Care, and the Department of Defense's Tactical Combat Casualty Care. Most importantly, NAEMT advocates for its members in areas such as personal safety, so personnel may do their job more effectively.

### TRAINING HIERARCHY

**Emergency Medical Responders (EMR)** are the foundation and most basic type of pre-hospital professional care. They provide immediate life support to patients in the field, e.g., cardiopulmonary resuscitation (CPR), automated external defibrillation (AED), oxygen by non-rebreather mask, and wound control. Many fire departments use EMRs as initial providers until an ambulance or rescue unit can arrive. EMRs are also found in many rural search and rescue units to begin care before a victim can be moved.

**Emergency Medical Technicians (EMT)** add more basic skills for emergent and non-emergent care and transport. These include CPR, AED, spinal immobilization, fracture stabilization, bleeding control and shock management, upper airway adjuncts and suctioning, and a variety of oxygen delivery methods. EMTs make up the largest proportion of allied health professionals in pre-hospital care.

**Advanced Emergency Medical Technicians (AEMT)** incorporate all the skills of EMTs with limited advanced skills such as placing intravenous access and giving bolus medications. AEMTs provide an important bridge between EMTs and Paramedics for many departments or agencies.

**Paramedics** are allied health professionals who provide advanced emergency care (Advanced Life Support, ALS) to critical and emergent patients. Paramedics can be found on mobile critical care units, and medical helicopters or fixed-wing transport units for longer transportation times or difficult evacuations. Paramedics provide advanced airway management (intubation and others), intravenous and intraosseous access, giving bolus medication, defibrillation, and cardiac pacing, among others. They often work in non-ideal settings with limited resources. Paramedics also give some of the critical care provided in many hospital and emergency rooms.

### SUPERVISION AND REGULATION

To describe how EMS personnel are supervised and what the hierarchy from the state to the local level looks like, I

will describe practice in the Commonwealth of Kentucky, where I currently live, and in the State of Illinois, where I used to live.

The Board of Emergency Medical Services (KBEMS), <https://kbems.kctcs.edu/> is set up within the Kentucky Community & Technical College System (KCTCS). At their website, you will find information regarding contacts, required forms, deadlines, state policies, and more. KBEMS is responsible for entry, exit, and disciplinary actions for field personnel. KBEMS establishes and enforces the state standards for EMS care, and the consequences for not meeting them.

This Board also establishes the requirements for medical directors who supervise EMS at the local level. Medical directors specify whether the agency/department personnel must meet minimal state level standards, or exceed them. The medical directors establish standard operating guidelines and protocols for field personnel to be allowed to practice under medical supervision. The EMS personnel become an extension of the medical director in the field.

The Illinois Department of Public Health (IDPH) breaks down EMS into twelve regional EMS Systems (EMSS), each with its own medical director. For example, during the ten years that I practiced as an Illinois paramedic, I needed to meet licensing requirements through IDPH, then I also had to meet and be interviewed by the medical director of the regional system where I hoped to practice.

### PROFESSIONAL JUDGMENT AND DOCUMENTATION

Knowing the standards of care provided outside of the hospital, the LNC should know what leeway the professional has in unique situations. Can EMS use “professional judgment” when caring for a patient?



Maggiore's Journal of Emergency Medical Services (JEMS) article (2006) referenced the testimony of a medical director of the Kalamazoo County Medical Control Authority in a Michigan Appellate court case. Dr. William Fales testified that "the protocol is simply a guideline, and that paramedics are not expected to follow the protocols verbatim, or in any sequential order. ... The paramedics are not only permitted, but encouraged, to use professional judgment in determining how to proceed." EMS is messy at times because of the nature of the work. We don't have control over our work environment. We must be able to adapt to conditions and render care wherever we find the patient.

That said, Chris Kaiser (2010) reminds pre-hospital professionals, through his blog *Life Under the Lights*, to make a reasonable effort to "do a thorough assessment every time, kick the decision up to the physician, and document, document, document." Covering the dicey subject of AMA refusals, Kaiser notes that patients have every right to refuse care, "even if they're being stupid." EMS professionals must gather all the facts from the tools and equipment (including their knowledge and experience) that they bring to the patient, present those facts to the patient to allow them to make a decision, and, if necessary, involve medical control in the conversation. EMS personnel are in a unique position as an extension of hospital care, and they are also the patient's voice when medical control can only "see" what EMS communicates by radio, bedside, or written report. Careful documentation is the best defense when things don't go as planned -- and protects both patient and EMS.

The Legal Nurse Consultant (LNC) will want to request and review the EMS run report to discover the relevant who, what, when, why, and how regarding prehospital contact with the patient. Focus on the time log, patient

assessment, treatments, and the narrative. Together these explain who sent the crew to the scene and why, what they found on arrival, what care they offered and delivered, where they took the patient (if anywhere), to whom they handed off the patient, and the timeline for all of these steps until the crew reported clear for another call. This record can be correlated with the emergency department nursing and medical records, and sometimes billing.

Another useful form documents patient refusal of service. This covers why EMS were called to the patient, what conditions they found, how they advised the patient of the risks of refusing their services, and that in spite of this, the patient still refused care and transport. This should be signed by the patient if possible, or refusal to sign documented, preferably by two crew member signatures.

## SUMMARY

Out-of-hospital care records can give the LNC eyes and ears in unfamiliar territory. Knowing EMS personnel's roles, capabilities, and responsibilities can help give perspective and clarity to understanding prehospital care that can be critical to issues in a case.

## REFERENCES

- Illinois Department of Public Health. (n.d.) EMS System Listing. Retrieved July 17, 2017, from [http://dph.illinois.gov/topics-services/emergency-preparedness-response/ems/res\\_sysListing](http://dph.illinois.gov/topics-services/emergency-preparedness-response/ems/res_sysListing).
- Kaiser, Chris. (2010) EMS Case Law? AMA Refusals, Death and Documentation. *Life Under the Lights*. Retrieved July 29, 2017, from <http://www.lifeunderthelights.com/2010/09/27/ems-case-law-ama-refusals-death-and-documentation/#sthash.hyl1qgf1.dpbs>.
- Kentucky Board of Emergency Medical Services. (n.d.) About KBEMS. Retrieved July 17, 2017, from <https://kbems.kctcs.edu/About/>.
- Maggiore, W. Ann. (2006) The 'gross negligence' standard and EMS. *Journal of Emergency Medical Services*. Retrieved July 29, 2017, from <http://www.jems.com/articles/2006/08/gross-negligence-standard-and.html>.

National Association of Emergency Medical Technicians. (n.d.) EMS: A historical perspective. Retrieved July 17, 2017, from [http://www.naemt.org/docs/default-source/about-ems/history-of-ems/EMS\\_Historical\\_Perspective.pdf?sfvrsn=0](http://www.naemt.org/docs/default-source/about-ems/history-of-ems/EMS_Historical_Perspective.pdf?sfvrsn=0).

National Association of Emergency Medical Technicians. (n.d.) History of EMS: Where we've been and where we're going. Retrieved July 17, 2017, from [http://www.naemt.org/docs/default-source/about-ems/history-of-ems/History\\_of\\_EMS.pdf?sfvrsn=0](http://www.naemt.org/docs/default-source/about-ems/history-of-ems/History_of_EMS.pdf?sfvrsn=0).

National Registry of Emergency Medical Technicians. (n.d.) Advanced Emergency Medical Technicians. Retrieved July 17, 2017, from <https://www.nremt.org/rwd/public/document/advancedemt>.

National Registry of Emergency Medical Technicians. (n.d.) The History of the NREMT and EMS in the United States. Retrieved July 17, 2017, from <https://www.nremt.org/rwd/public/document/history>.

National Registry of Emergency Medical Technicians. (n.d.) Emergency Medical Responders. Retrieved July 17, 2017, from <https://www.nremt.org/rwd/public/document/emr>.

National Registry of Emergency Medical Technicians. (n.d.) Emergency Medical Technicians. Retrieved July 17, 2017, from <https://www.nremt.org/rwd/public/document/emt>.

National Registry of Emergency Medical Technicians. (n.d.) National Registered Paramedics. Retrieved July 17, 2017, from <https://www.nremt.org/rwd/public/document/paramedic>.

Shah, M.N. (2006). The Formation of the Emergency Medical Services System. *American Journal of Public Health*, 96(3), 414-423. <http://doi.org/10.2105/AJPH.2004.048793>



**Michael Curran, BSN, RN, EMT-P, NHDP-BC** has been a licensed paramedic for 18 years and a registered nurse since 2012. His background is in private ambulance services, contract paramedic services, hospital-based services, and municipal services. Currently, he is focused on healthcare disaster preparedness as a member of the KY-1 Disaster Medical Assistance Team, as part of the federal response. He testifies as an expert witness in cases involving EMTs and paramedics. He can be contacted at [mcurrans@mac.com](mailto:mcurrans@mac.com).

THE JOURNAL OF  
**Legal Nurse  
Consulting**

## Looking Ahead...

**XXVIX.1, March 2018** — Product Liability, Medical  
Devices, FDA, Toxic Tort

**XXVIX.2, June 2018** — EHR Revisited

**XXVIX.3, September 2018** — Trials

**XXVIX.4, December 2018** — Pediatrics and New Nurse  
Author Supplement

**AALNC**  
AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS