Volume 33
Number 2
Summer 2022

THE JOURNAL OF Legal Nurse Consulting



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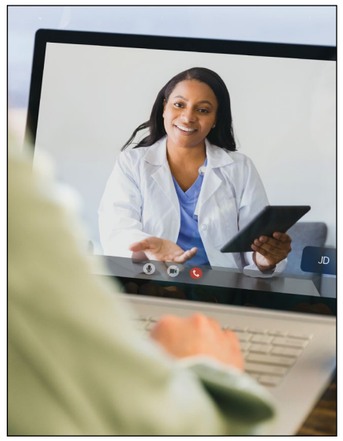

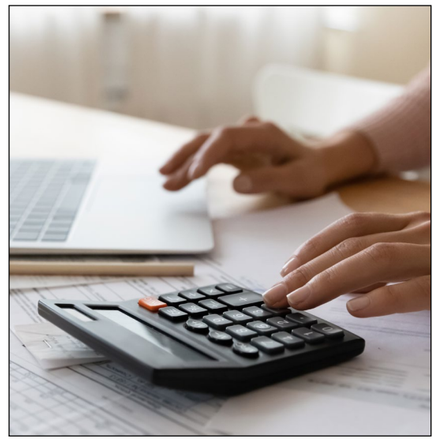

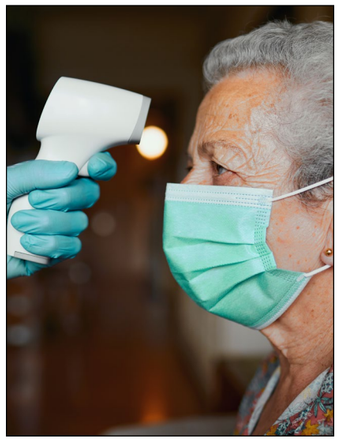

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The purpose of the *Journal* is to promote legal nurse consulting within the medicallegal community; to provide novice and experienced legal nurse consultants (LNCs) with a quality professional publication; and to teach and inform LNCs about clinical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

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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. Please see the next page for Information for Authors before submitting.

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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.

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- 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
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- Include a 100-word abstract and keywords on the first page
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Lisa Mancuso,
BSN, RN, CCRN, CLCP, LNCC

President, AALNC

President's Update

Dear members and readers,

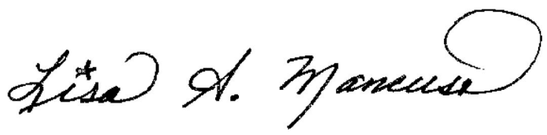
I am writing this letter on April 18, 2022, just ten short days before our Annual Forum 2022. I am not quite the President of AALNC, and yet I am writing this President's Letter in anticipation of a great Forum and an exciting year for our organization.

You will be reading this approximately 6 weeks after the Forum. I hope that attending Forum 2022 helped you plan your year ahead. Did you connect with in-house LNCs who love their jobs? Did you have coffee with an independent LNC who would not change a thing? Did you share a snack with a life care planner, and you had no idea there was such a thing? Legal nurse consulting is multi-faceted. There are so many ways to bring your skills to the table.

I hope when you attended Forum you engaged with our vendors. Did you learn about new products? Did you find something that could help you be more productive? If you have a need that was not met at the Forum, we want to know about it. One goal as an organization is to provide you with as many tools as possible to help you be successful. Let us know what we can do better.

I always leave Forum feeling energized. I've found, over the years, that the trip home from Forum is a good time to set new goals. AALNC helps me meet my professional goals while the education inspires me to be flexible about my methods for reaching those goals. Networking has shown me there are so many ways to achievement!

AALNC is known as the "professional home for LNCs." I hope at Forum, you found your "family." After I attended my first Forum in 2011, I was motivated to become more involved in AALNC. Volunteering was a new process for me. It helped me learn how our organization functions "behind the scenes." The relationships I made through volunteering steered my success and those relationships are now, indeed, family to me. As Susan Carleo said in 2016, "I volunteered my way up the chain of command." I am delighted to be the 2022-2023 AALNC President and I look forward to working with all of you during the next year. Please feel free to contact me at any time.



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Editor's Note

Dear readers and colleagues,

Looking back to the pandemic's beginning in early 2020, it was hard to imagine that we would still be hearing about COVID-19 a year or two later. Fast forward to today, and not many lives have gone unscathed by the novel coronavirus. Our legal systems are no different as cases have been put on pause while the legal world tried to navigate virtual court hearings across the United States and adopt ways to keep those working in the legal system safe.

The number of COVID litigation cases has continued to rise, including everything from wrongful death to worker's compensation and even mask mandates. For those of you involved in COVID litigation, there are several COVID litigation trackers available through a quick internet search. These trackers look at a variety of subjects, including employment litigation, complaint tracking, labor and employment litigation, current court rulings, case trackers, workplace, and so on.

The Supreme Court of the United States had a groundbreaking ruling in January of 2022, putting healthcare at the forefront of mandated vaccines for many healthcare workers while allowing big employers to be off the hook in a manner of speaking. Many large (and small) employers continue to require the vaccine for their employees, while the Occupational Safety and Health Administration (OSHA) does not. The challenges healthcare is currently experiencing have been unprecedented in healthcare history as workers continue to be stressed with mass shortages, mass exits, and mass burnout. These "perfect storm" type issues mean the courts will be rife with litigation for several years to come.

The legal nurse consultant (LNC) is invaluable in these cases. As our manuscripts for our summer publication highlight, understanding when various regulations and mandates were put in force or in effect will be critical to determining the merit of cases along with compliance issued by governing bodies.

With our Annual Forum just wrapping up, our attendees recognize the American Association of Legal Nurse Consultants (AALNC) is our resource to help you network and prepare to be involved in these cases. Our journal committee is pleased to bring you our second COVID-related journal since the beginning of the pandemic. Inside the journal are CEs to help keep your certifications and licenses up to date. This is a member-only benefit from the AALNC.

I wish you all the success in your role as an LNC. If you are an experienced LNC, please consider mentoring the LNCs that are just learning to embrace their new role. If you are just learning to embrace your new role as an LNC, don't be afraid to network, reach out, and ask questions of the more seasoned crew. Most of us welcome the opportunity to mentor and share experiences. If you have not made the commitment to attend the Forum, please mark it down to attend this coming year. The experiences, education, and networking are invaluable.

May your summer be blessed with laughter, trips, and the joy of bonfires or other outdoor activities!

Sincerely,

Martha R. Kelso, RN, HBOT

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RN, HBOT

Editor, JLNC

COVID-19:

A Catalyst for Telemedicine

Allison Thorn, MHA, MSN, FNP-BC

Keywords: COVID-19, pandemic, telemedicine, telehealth, virtual health, virtual visits, growth of telemedicine

COVID-19 turned the world upside down, but nowhere more significantly than in healthcare. Providers, patients, payors, and health systems were forced to adapt to a relatively unfamiliar form of patient access quickly-telemedicine. Although telemedicine was not new to the healthcare systems in the United States, it was underutilized until the pandemic hit. The COVID-19 crisis rapidly escalated telemedicine to a new "normal" mode of healthcare and was widely embraced. Telemedicine is here to stay and will only continue to expand its use and capabilities.

INTRODUCTION

On March 11, 2020, the COVID-19 virus was declared a pandemic by the World Health Organization ([WHO], 2020). This novel virus affected every country in the world in numerous ways, including hospitals at capacity with severely ill patients, dramatic loss of human lives, businesses temporarily or permanently closed, an increase in the unemployment rate, a disruption in the supply chains for goods and services, and an overall negative impact on the economy, among other examples. However, not everything associated with the COVID-19 pandemic has been bleak. One positive aspect has been the explosive growth in telemedicine usage by healthcare professionals and patients. With social distancing and other safety measures in place, addressing the population's continuing healthcare needs was a challenge at first. Still, soon, telemedicine became the lifeline for many during the pandemic and has become vital for access and medicine's future.

DEFINITIONS

"Tele" literally means distance. Telemedicine, the WHO's preferred name, is a term coined in the 1970s that means "healing at a distance" (WHO, 2010). Telemedicine and telehealth are often used interchangeably, but they have variations. Gogia (2020) states that telehealth and telemedicine are used when delivering healthcare services where there is a physical separation between the provider and the patient. "It is about transmitting voice, data, images and information rather than moving care recipients, healthcare professionals or educators. It encompasses diagnosis, treatment, preventive (educational) and curative aspects of healthcare services…" (Gogia, 2020). According to the American Academy of Family Physicians ([AAFP], 2021) and Gogia (2020), telemedicine is the practice of medicine using technology to deliver care from a distance, explicitly referring to providing remote clinical services, while telehealth is a broader term, referring to electronic and telecommunication technologies and services used to provide care from a distance and includes non-clinical services such as administration and education. Fatehi et al. (2020) inspected 1,527 medical records in their quest to define telemedicine specifically and analyzed 95 unique definitions for telehealth, from scholarly to available sources. A few of the more common names include digital health, virtual health, eHealth (electronic health used for when any form of electronics is used), and mHealth (mobile health used for when electronic health services are operated through a mobile device). A unified definition needs to be standardized for telemedicine.

A BRIEF HISTORY OF TELEMEDICINE

Telemedicine is not novel to the U.S. healthcare systems. Telecommunications as we know them today started during the American Civil War (1861-1865), in which telegraphs were used to deliver mortality lists and medical care to soldiers. Alexander Graham Bell in 1876 has been attributed to the first telehealth encounter when he called for help for his assistant after spilling acid on his trousers. The Lancet medical journal in 1879 described a doctor's first diagnosis of a child over the telephone in the middle of the night. The concept of telemedicine evolved more in 1905 with a Dutch physiologist who utilized the telephone to transmit and monitor cardiac sounds and rhythms. Formal recognition of the term telemedicine started in the 1920s when two-way television and radio signals were used to communicate. In Pennsylvania in the 1940s, a transmission of radiography was done through telephone circuits between cities 20 miles apart. In the 1950s-1960s, telemedicine transmitted video, images, and complex medical data. The University of Nebraska used interactive television in 1959 to transmit neurological exams and was widely considered the first case of real-time video telemedicine consultation. Telepsychiatry through remote counseling followed. Then, when NASA began plans to send astronauts to space, the need for remote monitoring was a must, building telemedicine capabilities into their spacesuits. Electrocardiogram (ECG) wireless transmissions were first established in India in 1975. Radiology was the first specialty to fully embrace telemedicine in the 1980s, allowing radiologists to report from home. Now they can report from anywhere in the world, as can many other healthcare providers (Gogia, 2020).

Today, there are four main types of telemedicine:

1. Store and forward, also known as asynchronous, uses software to store patient data that can be viewed later by a healthcare professional.
2. Remote patient monitoring (RPM), also called self-monitoring or telemonitoring, relies on patients to test and monitor themselves with various medical devices and other technologies. The data is transmitted back to the main telemedicine system for a medical professional to view.
3. Real-time interactive services, also called virtual visits, use the real-time phone or video for a patient and healthcare professional to connect simultaneously and conduct a visit.
4. Stored interactive is a relatively new form of telemedicine and combines the store and forward with real-time interactive services. This type allows patients to record messages and videos and send them to a healthcare professional to view later (Healthchat, 2022).

HOW COVID-19 ADVANCED TELEMEDICINE

Initially, the objective of modern telemedicine was to save costs and time for patients and healthcare providers. Still, due to the internet, the scope has widened to a range of telehealth solutions, some of which were never imagined before COVID-19. "Like the TV remote, it is increasingly more than just a convenience. Many patients are hooked onto telemedicine now" (Gogia, 2020). Early in the pandemic, the Centers for Disease Control and Prevention (CDC) analyzed visit data from four of the largest U.S. telehealth providers that offer services in all states to examine changes in the frequency of use of telehealth due to the pandemic. During the first quarter of 2020, at the outset of the pandemic in the U.S, telemedicine volume increased 50%, compared to the same time in 2019, with a 154% increase in the last week of March 2020 alone. The study also showed a significant increase in telemedicine visits among adults (18-49 years) from 66% to 73% in 2019. And 69% of patients who had a telehealth encounter during the early pandemic in 2020 were managed at home (Koonin

The Centers for Medicare & Medicaid Services (CMS) made five critical changes in telehealth opportunities so accessibility could increase during the current pandemic.

et al., 2020). Similarly, as published in Modern Healthcare, from February through April 2020, the U.S., telemedicine grew from less than 1% of primary care visits to 43.5% of visits (VirtualMed Staff, 2020).

In February 2019, The American Medical Association (AMA) concluded that only 28% of its members were currently using telemedicine as a part of their healthcare delivery. Since the beginning of COVID-19, usage has grown tremendously, with an estimated 60-90% of AMA physicians using telemedicine, with about half of those using telemedicine for the first time, according to Meg Barron, AMA's Vice President of Digital Innovation (Zarefsky, 2020).

Due to telemedicine's convenience, one analysis found that the average patient spent approximately two hours for a provider's visit (including travel, wait times, and the visit itself). In contrast, they spent about 20 minutes on a virtual visit. They also found that patients were 30% more likely to attend telemedicine visits than in person (Marin, 2020). In addition to timesaving, telemedicine provides a massive advantage to high-risk populations, including seniors, the disabled, and those with chronic health conditions, by removing the need for transportation (Marin, 2020) and possible exposure to other illnesses.

While many state legislatures adjourned or postponed their session in March 2020, almost every state took action to advance telehealth through gubernatorial executive orders, insurance regulation and directives, and Medicaid. The Centers for Medicare & Medicaid Services (CMS) made five critical changes in telehealth opportunities so accessibility could increase during the current pandemic. Those changes were:

1. Medicare will pay physicians the same rate for telehealth services as in-person visits for all diagnoses, not just those related to COVID-19, throughout the national public health emergency.
2. Patients can be in their home or any other setting to receive telehealth services.
3. Patients do not need to have an existing relationship with the physician providing telehealth assistance.
4. Physicians can waive or reduce cost-sharing (for example, copays) for telehealth visits.
5. Physicians licensed in one state can see a patient in a different state (Zarefsky, 2020).

A retrospective review of the progress of telehealth since the initial COVID-19 spike in the U.S. as published by McKinsey & Company (Bestsennyy et al., 2021), revealed some intriguing information. First, telehealth utilization has stabilized 38 times higher than before the pandemic, ranging from 13- 17% of visits across all specialties. Second, consumer and provider attitudes towards telehealth are more favorable than before the pandemic. Third, some temporary regulatory changes that facilitated the expanded use of telehealth have become permanent, for example, the CMS expansion of reimbursable telehealth codes for the 2021 physician fee schedule; however, it is uncertain if all the waivers will become permanent. Fourth, investments in telehealth have catapulted, fueling more innovation with three times the level of venture capitalist investment in 2020 than in 2017. Lastly, virtual healthcare and business models are evolving to include other telehealth virtual solutions such as more access to specialists, integration with other telehealth services, and improving customer experience, convenience, access, outcomes, and affordability.

In addition to telehealth adoption of primary care visits, there has been an increase in specialty visits, with the highest growth in psychiatry at 50% and substance abuse treatment at 30% (Bestsennyy et al., 2021). Furthermore, today mobile usage for healthcare or health-related information has surged due to COVID-19 demands. There are over 325,000 smartphone apps for patients to use for any number of medical services. The apps range from patient reminders, transmitting health information, providing health education, daily fitness trackers, bio-health monitors such as pacemakers, glucose checks, and patient portals to access all their health information. Various software, hardware, and attachments can turn an ordinary mobile phone into a stethoscope, pulse ox, heart monitor, slit lamp, microscope, and more (Gogia, 2020).

BARRIERS AND LEGAL IMPLICATIONS TO TELEMEDICINE

As innovative as the evolving world of telemedicine is, some barriers must be overcome for telemedicine to reach its full potential. These barriers can also be the basis for medical negligence or malpractice lawsuits. As discussed, the foundational issue regarding the lack of a unified definition of telemedicine hinders further growth and opens the doors for medical malpractice. The fact that telemedicine means different things to different people creates confusion. Additionally, many states still have not established a standard of care for telemedicine, so it can be problematic if the patient claims they were not treated according to a certain standard (Panter, 2021).

A critical concern for telemedicine is the legal hurdles to patient privacy and security as well as data sharing, such as data breaches or other unauthorized disclosure of confidential patient information (Panter, 2021). As Nittari et al. (2020) state, "Today, an electronic medical record can hold more intimate details of an individual than any single document. This magnifies the issues related to patient privacy." There is also the potential for fraud and abuse. "Telemedicine providers can be held liable under state and federal false claims acts, anti-kickback statutes, and self-referral laws" (Panter, 2021). Providers crossing jurisdictional boundaries to provide care can raise legal concerns, too. Failure of providers to follow the state laws and regulations of where the provider and patient are located, which vary, could lead to significant liability. Moreover, patients should be diligent with verifying any providers' credentials before a telemedicine visit. Due to the vague definition of virtual abuse, it can be difficult for a legal team to determine whether the patient was a victim of medical abuse over technology (Panter, 2021).

According to the AAFP, other barriers include that reimbursement for telemedicine varies widely by state and payer. For example, 10 states require Medicare coverage of telemedicine, 43 states require Medicaid coverage for some services, 18 states require private payer coverage, and 14 states have legislation pending. One of the most prevalent issues is the licensure of out-of-state providers. Sandy Marks, AMA Senior Assistant Director of Federal Affairs, cautioned that telehealth services had been a critical tool during COVID-19. Still, unless Congress acts on more permanent legislation, they will return to only being available to Medicare patients in rural areas and will not be available in the home after the public health emergency (Strazewski, 2020).

Modern technology can also be challenging to access or navigate for a portion of the population (older, less tech-savvy, disabled, rural, or low-income patients). Many older, experienced clinicians have not historically supported telehealth for several reasons. It requires a change in their habits and practice from how medicine has always been done and involves additional learning, time to adapt and become proficient, and increased expenses for updated equipment, programs, and maintenance. Also, there is the inability to touch the patient, which to them feels like the interaction is less than ideal and that the consultation is incomplete and provides less quality. This could potentially lead to a misdiagnosis, especially if the quality of the video or phone connection is poor. Even though some providers are not on board with this newer technology, due to the COVID-19 pandemic, their patients are more enthusiastic about telemedicine, with 76% now preferring telehealth over in-person care, up from 11% in 2019 (Gogia, 2020).

THE FUTURE

VirtualMed Staff (2020) highlights five predictions for the future of telemedicine:

1. Telemedicine will be the standard service offered across all care settings. Patients have become accustomed to the level of access telemedicine provides, and a common thread will be easy access to healthcare, which will generate confidence and drive growth.
2. Patients will choose providers, health systems, and hospitals based on telemedicine capabilities/access. Telemedicine will redefine patient expectations in all facets of healthcare.
3. Medical facilities that embrace telemedicine will see increased growth in the business (and revenue). At the beginning of COVID-19, hospitals and medical offices saw decreased volume and revenue. Telemedicine is now a revenue source that can safeguard against future troughs in healthcare.
4. Telemedicine will become an efficient and cost-effective means of providing preventative medicine services. According to the CDC, chronic illnesses avoidable through preventive care services account for 75% of the nation's healthcare spending. By offering more convenient access to follow-up care, specialists, and telemedicine treatment, hospitals will have fewer readmissions, patients will have fewer complica-

Telemedicine, in its primitive form, has been around since the middle 1800s and has steadily grown over the past decade, but the pandemic blew the doors wide open for its adoption.

tions, inpatient stays, and reduced cost of treatments and services. Meg Barron stated, "All signs point to more health at home and determining how to optimize in person and virtual care" (Strazewski, 2020).

5. Access to specialists will increase substantially, benefitting hospitals and Emergency Departments' (EDs) with shorter wait times and improving patient satisfaction and health.

Bestsennyy et al. (2021) believe that as the pandemic eventually wanes, essential factors to sustaining and growing consumer usage of virtual health are creating a seamless consumer interface, breaking down silos in healthcare provision (across virtual and in-person care) with improved data integration, and a fostering consumer engagement.

SUMMARY

Telemedicine, in its primitive form, has been around since the middle 1800s and has steadily grown over the past decade, but the pandemic blew the doors wide open for its adoption. Despite some healthcare providers' resistance to telemedicine, the COVID-19 pandemic forced providers and healthcare systems to quickly adapt to this style of healthcare access to meet patients' needs and stay in business. With a newer tech-savvy generation of providers and consumers, the demand for telemedicine and its growth will continue to be expected as part of a comprehensive healthcare system. As technology and innovation progress, the barriers to providing telehealth must be resolved and legal pitfalls overcome to meet the needs and wants of those seeking healthcare.

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COVID-Related Skin Manifestations:

A Medical-Legal Perspective

Martha R Kelso, RN, HBOT

Keywords: COVID, COVID-19, skin disorders, wounds, atypical wounds, wrong diagnosis, care plan, cytokine storm, long-hauler, super-spreader, COVID toes, COVID-19 skin disorders, 2019-nCOV, maculopapular, chilblain-like, proning

With the arrival of the novel coronavirus, otherwise known as COVID-19, the world as we knew it changed. The human race and medical field had to adapt to the unprecedented assault this virus launched on the human body and on humanity. Various terminology like cytokine storm, long-hauler, super-spreader, and COVID toes became prevalent on social media, news outlets, and amongst healthcare personnel. Additionally, various skin and wound disorders were observed and reported by members of the wound community, which were not readily recognized by the members of the medical community lacking training in skin and wound care. This lack of recognition can result in an incorrect understanding of the skin disorders and tissue failure resulting in wound disorders caused by COVID-19, thus leading to wrong diagnosis and the ripple effect beyond.

According to the Centers for Disease Control and Prevention's (CDC) COVID-19 Timeline, January 17, 2020, the first reported case of 2019-nCOV occurred in the United States. On January 18, 2020, samples were taken, and COVID was confirmed by a lab on January 20, 2020, in Washington state (CDC, 2022). By the end of 2020, approximately 20,000,000 total cumulative cases were confirmed in the United States, and more than 54,000,000 confirmed cumulative cases by the end of 2021 (CDC, 2020). Additionally, the CDC reported a total of 862,494 COVID-related deaths as of January 23, 2022 (CDC, 2020).

As COVID unfolded and mutated, more information became known about its devastating effects on the human body. However, the effects of COVID vary from individual to individual, and can be dependent on comorbid medical conditions, the severity of the disease, and many other factors. Risk factors for developing severe symptoms of COVID-19 can include those with heart and lung conditions, obesity, advanced age, diabetes, weakened immune system, brain disorders, nervous system disorders, cancer, kidney disorders, and Down Syndrome, just to name a few (Mayo Foundation for Medical Education and Research [MFMER], 2022).

As the pandemic rages on, COVID-related skin manifestations have been noted and documented in COVID-positive patients of all ages, including children. The skin manifestations range from rashes to blisters and even full-thickness tissue breakdown, including destruction down to the bone. Skin manifestations have been reported in upwards of 20% of COVID cases. Descriptors of the cutaneous manifestations include terminology like "maculopapular, chilblain-like, urticarial, vesicular, livedoid, and petechial lesions" (Singh et al., 2021, p. 51). Although the exact pathogenesis of the skin eruptions and breakdown is unknown at this time, angiotensin-converting enzyme 2 (ACE2) has been isolated in the skin and adipose tissue at higher expression levels than other human organs. ACE2 expression was significantly higher in fibroblasts and melanocytes, two important cellular compartments in skin tissue (Singh et al., 2021, p. 51).

Various medical personnel reported and evaluated ulcers not consistent with pressure throughout the pandemic. The ulcerations can have borders described as a purpuric plaque with retiform or livedoid edges. Pathology reports of biopsies revealed underlying thrombogenic vasculopathy most likely secondary to COVID, versus frank necrosis typically observed from pressure-related injuries (Young & Fernandez, 2020) (National Pressure Injury Advisory Panel [NPIAP], 2020). In some reported cases, skin manifestations were present before symptoms of COVID appeared (Singh et al., 2021).

According to the Centers for Medicare and Medicaid Services (CMS), as published in the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, "a pressure ulcer/injury is localized injury to the skin and/or underlying tissue…as a result of intense and/or prolonged pressure or pressure in combination with shear" (Centers for Medicare and Medicaid Services [CMS], 2019). Of note, pressure ulcer/injury definitions may be similar across the healthcare continuum but are not universal.

With COVID-related skin manifestations, many times the skin breakdown occurs where there is an absence of pressure. For example, purpuric discoloration may occur on the buttock area, however, the COVID patient may have been positioned prone for many hours a day. The prone position may be used in a compromised COVID-19 patient to allow "for better expansion of the dorsal (back) lung regions, improved body movement and enhanced removal of secretions which may ultimately lead to advances in oxygenation (breathing)" (McCabe, 2020). When prone, no pressure is exerted on the buttock region, therefore making it nearly impossible for pressure to have causation for skin breakdown.

Additionally, the skin and tissue breakdown can be quite severe due to vasculopathy issues forming systemic coagulopathy in the tissue. Vasculopathy is most likely caused by the cytokine storm possibly resulting in "complications due to hypercoagulation and microvascular occlusion" involving the skin and tissue. With ACE2 receptors being a source of entry for COVID-19 and those receptors being expressed in vascular endothelium, accelerated and extensive clotting has been documented with COVID-19 infections (NPIAP, 2020).

Biopsies submitted for pathology were able to document the thrombogenic vasculopathy in COVID-19 positive patients with purpuric skin lesions and microvascular occlusion of vessels in the skin versus histologic specimens of deep tissue pressure injuries showing "frank necrosis of skin, fat, and muscle". For "purple areas

This activity is designed to increase understanding that COVID-19 infections can result in COVID-Related Skin Manifestations and understand how skin and underlying tissue behave during the illness to determine if a breach in care existed and what possible treatments or interventions were put in place and if treatments were appropriate.

Upon completion of the learning activity the learner will be able to:

a. Identify risk factors for developing severe symptoms of COVID-19 and skin manifestations and descriptors used in COVID-related skin manifestations.
b. Recognize the process for skin breakdown that occurs in the absence of pressure in COVID-19 patients and how vasculopathy issues are involved in skin and tissue breakdown.
c. Identify the importance of how the LNC must review records to determine proper assessment and work-up of wound etiology with diagnosis and treatments to determine if a breach in care existed.

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until July 1, 2025.

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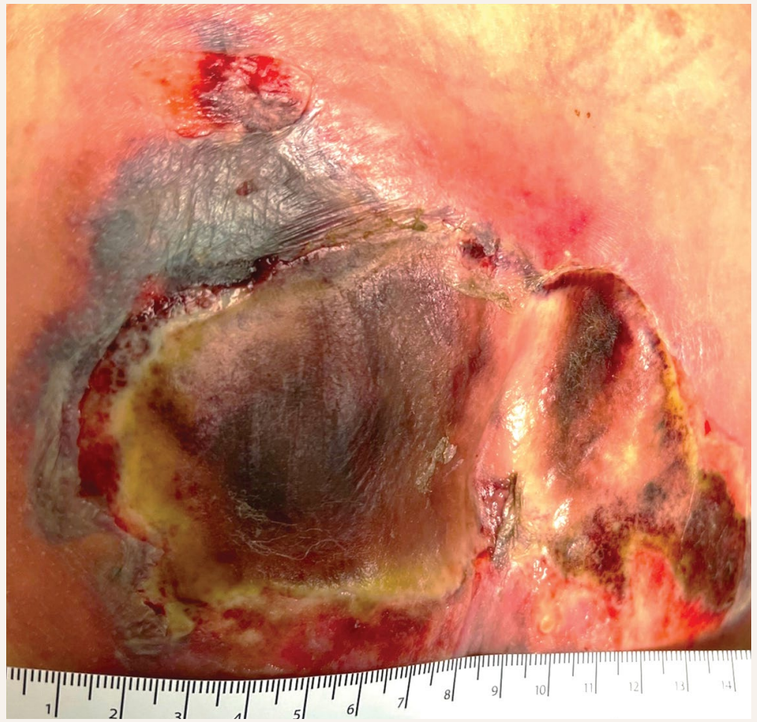

on non-pressure loaded surfaces" these areas should not be classified as pressure injuries and for purple areas where pressure is a component, further investigation is required before determining primary etiology as pressure versus COVID-related skin manifestations since skin and tissue was more susceptible to breakdown due to vasculopathy or other COVID manifestations (NPIAP, 2020).

As legal nurse consultants (LNCs), record review to determine proper assessment and work-up of wound etiology are paramount. The wrong diagnosis can have a very real ripple effect that is profound and can be catastrophic. The wrong diagnosis can lead to the wrong care plan, wrong interventions, wrong treatment, delay of appropriate referrals, wrong goals, and wrong ICD-10 diagnosis codes transmitted to payors asking for payment.

As an example, a diagnosis of a wound or skin lesion as a venous wound, usually means some form of compression would be appropriate to assist in healing. Ongoing lifetime compression is usually prescribed to prevent further venous ulcerations from developing as a standard of care. A goal of healing and preventing future wounds is reasonable if no other co-morbid medical conditions are a factor. However, if the ulcers are not venous and in fact some form of cancer, the goal would change, as would the interventions and reasonable expectation for healing. An incorrect diagnosis could delay the treatment of cancer and could have catastrophic results in the lower extremity.

An assumption by some healthcare professionals is that if a wound is over bone, it must be pressure, is an inaccurate assumption. CMS has stated for healthcare professionals to "determine that the lesion being assessed is primary related to pressure and that other conditions have been ruled out". The examples cited by CMS include arterial ulcers which "may be over the ankle or bony areas of the foot" and venous ulcers often occur in the lower leg around the "medial ankle" (Centers for Medicare and Medicaid Services [CMS], 2017).

It empowers the LNC involved in a legal case to be intimate with the regulations encompassing and governing the specific site of care. For example, the staging criteria and terminology in an acute care hospital vary compared to the staging criteria and terminology in the post-acute care setting. Much like the pressure ulcer/injury definition, the staging criteria are also not universal. The staging criteria for the practice setting may not match the ICD-10 definitions either, so understanding which criteria were utilized and if this was appropriate is also important.

Another criterion put forth by CMS in long-term care discusses understanding various skin ulcerations. CMS mandates "at the time of the assessment and diagnosis of a skin ulcer/wound, the clinician… (physicians, advance practice nurses, physician assistants, and certified wound care specialists, etc.) …is expected to document the clinical basis which permit differentiating the ulcer type, especially if the ulcer has characteristics consistent with a pressure ulcer, but is determined not to be one" (CMS, 2017). For example, did the nurse or other staff member witness pressure at the site of ulceration, or did the staff assume the spot was caused by pressure without an investigation or thorough assessment? Understanding the basic principles of pressure ulcer/injury assessment and development can assist the LNC in record review to determine if proper clinical assessments were completed at the time etiology was determined.

COVID-related skin manifestations can be catastrophic and extensive often resulting in a full-thickness wound that can extend to muscle or bone. Listing the wound as pressure, when in fact the wound may be caused by COVID, may not change the outcome of the wound, but it could change the understanding of the patient or family. Being informed of the correct diagnosis means the patient or family can make informed decisions surrounding the diagnosis. Wrong information means the patient and family are not making fully informed decisions on care. Additionally, healthcare professionals may inaccurately list the wound goal as healable, when it may be a palliative wound due to COVID. The goals of the care plan often change the interventions.

In conclusion, understanding that COVID-19 infections can result in COVID-related skin manifestations is a good place to start in understanding how skin and underlying tissue behave during the illness. This understanding can assist the LNC in determining if a breach in care existed and what possible treatments or interventions were put in place, and if treatments were appropriate. COVID changed the landscape of healthcare and the landscape of wound litigation, perhaps forever.

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COVID-19:

Updates of Infection Control Regulations for Long-Term Care Facilities

Ethel Wills, BSN, MSN, ALNC

Keywords: COVID-19, CFR §483.80 updates, Code of Federal Regulations, infection control, LTC, regulations, Center for Disease Control and Prevention, CDC, World Health Organization, WHO, Centers for Medicare and Medicaid Services, CMS, Public Health Emergency of International Concern, PHEIC, PPE, Infection Prevention and Control Program, IPCP, Infection Preventionist, IP, pandemic, HHS, Department of Health and Human Services

The Centers for Medicare & Medicaid Services (CMS) promulgates regulations that long-term care (LTC) facilities must meet to participate in Medicare and Medicaid programs. These regulations are in the Code of Federal Regulations (CFR) 42 Subpart B. The rules about infection control are in § 483.80 of the LTC regulations. This article discusses changes to 42 CFR § 483.80 due to the COVID-19 pandemic and its implications for LNCs when reviewing legal claims about COVID-19 in LTC facilities. COVID-19 continues to threaten the lives of LTC residents.

INTRODUCTION

On January 20, 2020, the Centers for Disease Control and Prevention (CDC) officially acknowledged COVID-19 in the United States (U.S.) when the first case was confirmed within the country (CDC, 2022a). Less than 10 days later, the World Health Organization's (WHO) International Health Regulations (2005) Emergency Committee declared the COVID-19 outbreak a Public Health Emergency of International Concern (PHEIC) (WHO, 2020a), which was further highlighted with the first death occurring on February 29, 2020 (CDC, 2020). The WHO updated this "concern" and publicly declared COVID-19 as a pandemic on March 11, 2020 (WHO, 2020b). Unfortunately, the WHO's declaration was not met with readiness by healthcare entities. The scarcity of healthcare supplies including face masks, personal protective equipment (PPE), ventilators, alcohol-based hand rubs (ABHRs), and personal care items for the public, emphasized the magnitude of the health crisis and highlighted the lack of emergency preparedness of the country. On March 13, 2020, the U.S. President declared the COVID–19 pandemic a national emergency (Federal Register, 2020).

COVID-19 hit the elderly population particularly hard. Frailty, co-morbidities, and congregate living caused those in nursing homes to be particularly vulnerable to respiratory infection. It has had varying effects on the world, and now, more than two years later, it continues to do so.

CODE OF FEDERAL REGULATIONS

Long-term care facilities must adhere to specific requirements to operate as skilled nursing facilities and to receive payments from the Medicare and the Medicaid programs. There are more than 20 regulations affecting care in long-term care facilities, that equate to hundreds of pages of instructions. Title 42 of the US Code of Federal Regulations (CFR) addresses public health and welfare, with Chapter IV Part 483 Subpart B of the CFR addressing the requirements for long-term care facilities.

Infection control (CFR §483.80) and updates have been relevant to COVID-19. The goal of CFR §483.80 is to ensure that facilities develop and implement infection control and prevention programs to recognize and control the spread of infection.

CFR §483.80 INFECTION CONTROL

Excerpts from the regulation, as noted in the *State Operations Manual Appendix PP Guidance to Surveyors for Long Term Care Facilities Rev. 11-22-2017* were as follows:

The Infection Prevention and Control Program (IPCP) must include, at a minimum, the following elements:

- (a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment.
- (a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
  - A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility

This activity is designed to provide an overview of the Infection Control regulation for long-term care facilities relevant to the COVID-19 pandemic.

Upon completion of the learning activity the learner will be able to:

a. Identify updates of 42 CFR § 483.80
b. Understand and identify timelines of the updates
c. Increase awareness of impact of the updates for the LNC

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until July 1, 2025.

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COVID-19 hit the elderly population particularly hard. Frailty, co-morbidities, and congregate living caused those in nursing homes to be particularly vulnerable to respiratory infection.

Establishing an IPCP to prevent the development and transmission of communicable diseases has long been a requirement for nursing home facilities. To enhance service and care delivery, the CFR §483.80 was updated to require an Infection Preventionist (IP) to oversee the IPCP.

- When and to whom possible incidents of communicable disease or infections should be reported
- Standard and transmission-based precautions to be followed to prevent the spread of infections
- When and how isolation should be used for a resident; including but not limited to:
  - The type and duration of the isolation, depending upon the infectious agent or organism involved
  - A requirement that the isolation should be the least restrictive possible for the resident under the circumstances

(CMS, 2017, CFR §483.80(a), Para 1-2, p.54).

TIMELINE

Establishing an IPCP to prevent the development and transmission of communicable diseases has long been a requirement for nursing home facilities. To enhance service and care delivery, the CFR §483.80 was updated to require an Infection Preventionist (IP) to oversee the IPCP. By November 28, 2019, facilities were required to designate one or more individuals as an IP. The responsibilities of the IP included overseeing the IPCP and participating in and reporting to the Quality Assessment and Assurance Committee of the facility (CMS, 2017, CFR §483.80(b), p.54).

February 6, 2020

The Department of Health and Human Services (HHS) in concert with CMS sent a memorandum to healthcare facilities concerning the 2019 Novel Coronavirus Illness to take action to prepare as the virus can rapidly spread. Facilities were urged to review the CDC's recommendations. It encouraged facilities to examine their infection prevention and control policies and practices and review the use and availability of PPEs (Department of Health and Human Services/Centers for Medicare and Medicaid Services (HHS & CMS, 2020a).

March 2020

HHS & CMS provided additional guidance about infection control and prevention practices for nursing home facilities in a memorandum. Facilities were advised to regularly screen patients and staff for COVID-19 symptoms and restrict visitors who displayed signs of respiratory illnesses and traveled out of the country within the previous 14 days. Additionally, facilities that experienced increased respiratory illnesses (regardless of suspected etiology) among patients/residents or healthcare personnel were to immediately contact their respective local or state health departments for further guidance (HHS & CMS, 2020b).

In a memorandum on March 13, 2020, facilities were instructed to restrict all visitors and non-essential health care personnel and cancel communal dining and group activities. Additionally, all residents and staff were screened for possible COVID-19 symptoms. Staff that worked at multiple facilities were to be actively screened and restricted to reduce the risk to others of COVID-19. Additionally, they were given admission guidelines for ill residents (HHS & CMS, 2020c).

Due to the known scarcity of certain supplies such as masks, PPE, and ABHRs, state and federal surveyors were to refrain from issuing citations to facilities for the absence of supplies. Facilities were instructed to notify their public health agencies of the shortages, follow national guidelines for optimizing their current supply, or identify the next best option to care for residents. However, the "next best option" was not explicitly communicated, leaving opportunities for action open for interpretation (HHS & CMS, 2020d).

May 2020

Beginning May 8, 2020, the Patient Protection and Affordable Care Act required nursing home facilities that participated in the Medicare and Medicaid programs to report resident and staff infections, potential infections, and deaths related to COVID-19. Facilities were required to electronically report information about the virus in a standardized format to the CDC's National Healthcare Safety Network at least weekly. CFR §483.80(g) was added to the regulation, which specified the reporting to include the following:

- Suspected and confirmed COVID -19 infections among residents and staff
- Residents previously treated for COVID -19 infections
- Total deaths and COVID -19 deaths (resident and staff)
- PPE
- Hand hygiene supplies in the facility
- Ventilator capacity and supplies
- Resident beds and census
- COVID-19 testing access
- Staffing shortages

(HHS & CMS, 2020e)

Additionally, CFR §483.80(g) paragraph 3 was added. It required facilities to keep residents, their representatives, and their families informed of the following:

- The occurrence of either a single confirmed infection of COVID-19 or three or more residents or staff with new onset of respiratory symptoms that occur within 72 hours of each other. They were to be notified no later than 5 PM the next day.
- Actions implemented to mitigate, prevent, or reduce the spread of the infection along with any changes in regular operation

(HHS & CMS, 2020e).

After facilities began adhering to reporting requirements, the gravity of the pandemic's effect on nursing homes could be seen in a more accurate light. By May 24, 2020, there were 60,439 COVID-19 cases reported countrywide in nursing homes, and 25,923 nursing home resident deaths were reported due to COVID-19. The number of staff reported with COVID-19 was 34,442, with staff deaths reported as 449 (CMS, 2022).

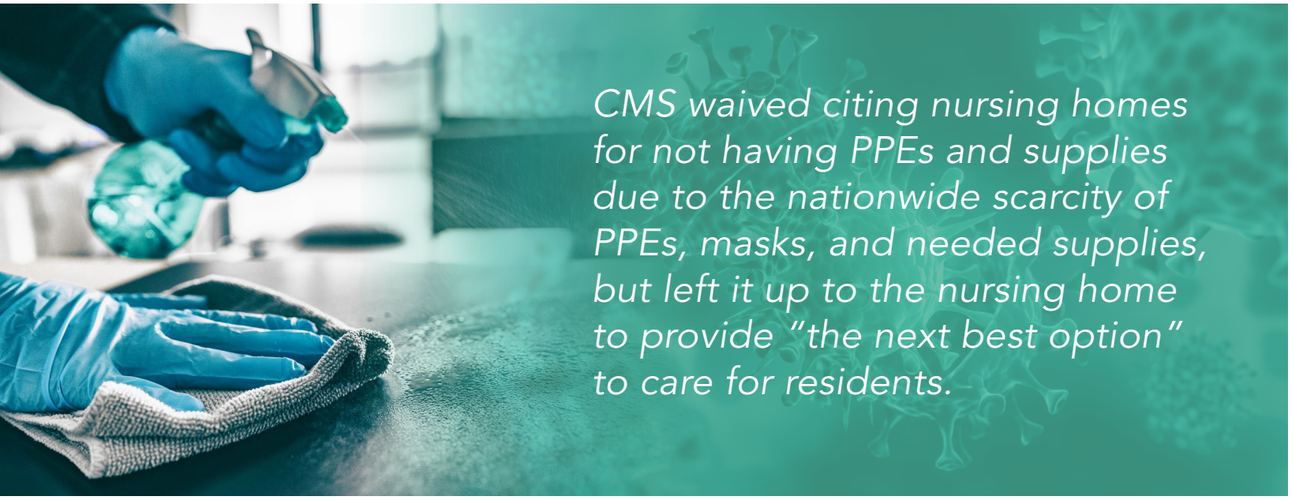
Additionally, the subsequent impact of COVID-19 on staffing in nursing home facilities shortages could not be overlooked. Although staffing shortages have long been an issue in nursing homes, COVID-19 enhanced the deficit. A CMS survey of self-reported information on staff shortages, resident and staff exposure to COVID-19, and PPE availability in 11,920 nursing homes found 15.9%, 18.4%, 2.5%, and 9.8% reported shortages of licensed nurses, nurse aides, clinical staff, and other staff, respectively. Georgia and Minnesota said their highest rates of shortages were in licensed nurses and nurse aides. The shortages were directly related to COVID-19 factors (Xu et al., 2020).

August 2020

The availability of COVID-19 tests enabled staff and residents to be tested for the virus. On August 25, 2020, CMS established LTC Facility Testing Requirements for staff and residents. CFR §483.80 was updated to require facilities to test all residents and staff for COVID-19. CFR § 483.80(h) COVID-19 testing was added to the regulation (HHS & CMS, 2020g). On September 2, 2020, 42 CFR 483.80(h) was added to the infection control regulation (HHS & CMS, 2020h)

November 5, 2021

With the approval of the vaccines to combat the COVID-19 virus, COVID-19 immunization was added



CMS waived citing nursing homes for not having PPEs and supplies due to the nationwide scarcity of PPEs, masks, and needed supplies, but left it up to the nursing home to provide "the next best option" to care for residents.

to 42 CFR §483.80(d). The facilities developed policies and procedures to ensure each resident and staff member was offered the COVID-19 vaccine and received education on the benefits, risks, and potential side effects. It also provides that each resident or representative can accept or refuse a COVID-19 vaccine and change their decision. Documentation related to staff COVID-19 vaccination was to be maintained. A contingency plan for the staff who were not fully vaccinated for COVID-19 was also to be included in the policy and procedures (HHS & CMS, 2021).

After months of restrictions, CMS removed the restrictions on visitors to the LTC facilities on November 12, 2021. This was a long-anticipated welcoming for families and residents (HHS & CMS, 2021b).

January 2022

CFR §483.80(g) was updated to extend the weekly reporting requirements to December 31, 2024. All the previous items remained a part of the reporting requirements. Added to the list were:

- COVID-19 vaccine status of residents and staff, including total numbers of residents and staff, numbers of residents and staff vaccinated, numbers of each dose of COVID-19 vaccines received, and COVID-19 adverse events
- Therapeutics administered to residents for treatment of COVID-19

(HHS & CMS, 2022)

THE IMPACT OF CFR §483.80 UPDATES

Infection Prevention and Control have been among the requirements for nursing home facilities to operate and receive funding from Medicare and Medicaid services for several years. The COVID-19 outbreak caused the implementation of some much-needed additions. One would expect that the knowledge of facilities' bed capacity, census, and available staff to provide care would drive federal mandates to implement staffing requirements and offer financial resources to impact securing and retaining staff. In a recent report of a nursing home in North Carolina, three staff, composed of a licensed practical nurse and two certified nursing assistants, were reported to be providing care for 98 residents (Reynolds et al., 2022). Questions for consideration (1) were accurate reports of bed capacity, census, staffing counts, etc., being reported as required by CFR §483.80, and (2) what assistance, if any, was being provided by CMS?

LTC facilities must report information weekly to the CDC's National Healthcare Safety Network related to COVID-19, and as of this article, they are required to do so until 2024 (HHS & CMS, 2022). The information gathered is valuable and needed data: availability of PPE, immunizations, ongoing COVID-19 infections, number of deaths, etc. Will the collected data be used for future care delivery and care improvement? Facilities are cited for lack of compliance and face loss of reimbursements if there is a failure to comply with guidelines. A question to consider for CMS is whether the fines and citations are deterrents, or do they foster the likelihood of falsifying reported data? CMS waived citing nursing homes for not having PPEs and supplies due to the nationwide scarcity of PPEs, masks, and needed supplies, but left it up to the nursing home to provide "the next best option" to care for residents. Quality care and its delivery to this vulnerable population are necessary and moral responsibilities. COVID-19 exposed the deficiencies and the need for improvement.

The changes in CFR §483.80 highlights the requirements of the IPCP regulation impacted by the COVID-19 outbreak. When evaluating COVID-related claims against LTC, the dates of the amendments to CFR §483.80 must be considered.

As COVID-19 continues to impact the world, there will likely be additional or amended federal regulations addressing infection control and prevention in LTC facilities. The LNC reviewing potential COVID-19 claims arising out of care and treatment in such facilities should be aware of the regulations at the time of the incident.

COVID-19 LITIGATION IN LTC CASE REPORTS AND IMPLICATIONS FOR LNC MERIT SCREENING

On March 16, 2020, CMS inspected Life Care Center of Kirkland in Kirkland, Washington after an outbreak of "respiratory illness". The inspection found that the facility failed to identify and manage residents with respiratory illness timely, was unable to notify the Washington State Department of Social Health Services (DSHS) of the outbreak and failed to provide an alternative care plan when the primary clinician fell ill (*Deborah de Los Angeles, individually and as Daughter and Personal Representative of the Estate of Twilla June Morin v. Life Care Centers of America, Inc d/b/a Life Care Center of Kirkland, a foreign corporation; Lake Vue Operations, LLC, a foreign limited liability company; Ellie Basham, individually; Todd Fletcher, individually; and Unknown John and Jane Does*, 2020).

It is noteworthy that the first COVID-19 case, and the first death reported due to COVID-19 were in a neighboring county to Kirkland, Washington, in January 2020 and February 2020, respectively.

A wrongful death and fraud lawsuit was filed on April 10, 2020 against Life Care Center of Kirkland and other defendants by Deborah de Los Angeles, whose mother died on March 4, 2020 at the facility from the virus. The complaint alleged that the facility discouraged visitors on February 10, 2020 due to a spike in illness which they assumed to be seasonal influenza. However, the Quality Assurance and Performance Improvement (QAPI) meeting minutes of February 19, 2020, did not address any concerns. It was not until February 27, 2020, that Life Care Center of Kirkland reported the increase in respiratory illnesses to the King County Health Department (*Deborah de Los Angeles, individually and as Daughter and Personal Representative of the Estate of Twilla June Morin v. Life Care Centers of America, Inc d/b/a Life Care Center of Kirkland, a foreign corporation; Lake Vue Operations, LLC, a foreign limited liability company; Ellie Basham, individually; Todd Fletcher, individually; and Unknown John and Jane Does*, 2020).

Pertinent evidence:

- COVID-19 was a novel virus to the U.S. (CDC, 2022a)
- CMS urged LTC facilities to review the CDC recommendations for healthcare facilities (HHS & CMS, 2020a)
- COVID-19 was reported to be active in their region (first active case and death reported)
- CMS encouraged LTC facilities to review their infection control and prevention policies and procedures (HHS & CMS, 2020a)
- CMS informed LTC facilities to notify local or state health departments of the increased number of respiratory illnesses (regardless of suspected etiology) among residents or staff (HHS & CMS, 2020b)
- All nursing home facilities are required to establish and maintain an IPCP (CMS, 2017)
- CMS requires nursing home facilities to have an IP to oversee its IPCP and participate in the QAPI process and program (CMS, 2017)

INFECTION CONTROL FAILURE IN NEW JERSEY NURSING HOME

In 2020, 119 residents died of COVID-19 in two state-run New Jersey nursing home veterans' facilities. Families of the residents accused the nursing homes of gross negligence. The allegations were failure to meet standards of care, failure to follow infection control measures, including not wearing gloves and masks, and allowing residents to gather in common areas even after new infections were detected. A $53 million settlement was reached on January 10, 2022 (Jackson, 2022). In early March 2020, CMS instructed LTC facilities

A wrongful death and fraud lawsuit was filed on April 10, 2020 against Life Care Center of Kirkland and other defendants by Deborah de Los Angeles, whose mother died on March 4, 2020 at the facility from the virus.

to discontinue communal dining and group activities as infection control and prevention measures.

IMMUNITY FROM LIABILITY CONSIDERATION FOR NEW JERSEY NURSING HOMES

In April 2020, four families filed a lawsuit against Andover Subacute and Rehabilitation Center I and II in Andover, New Jersey facilities related to the death of their loved ones to COVID-19 at the facilities. It was alleged that the facilities failed to take precautions to prevent the spread of the virus. To be shielded by the Public Readiness and Emergency Preparedness (PREP) Act, which grants immunity from lawsuits to those fighting the pandemic, the facilities appealed to have the case heard in federal court to get a favorable outcome. The nursing homes lost the appeal; the federal appeals court ruled that the case should proceed to state court (Hals, 2021). On March 3, 2022, Attorney Phillip Giordano of Gordon, Fournaris & Mammarella (a plaintiff firm involved in the case) shared that the case was active, and several motions have been filed since their firm won that appeal (*Verbal discussion with Phillip Giordana, March 3, 2022*)).

CONSIDERATIONS FOR THE LNC

COVID-19 has been devastating to residents and staff of nursing homes due partly to the vulnerability of the residents. There were 38,061 COVID-19 cases confirmed and 1433 deaths reported among U.S. nursing home residents for the week ending January 30, 2022 (CDC, 2022b). By February 20, 2022, there had been 994,923 COVID-19 cases confirmed among residents of nursing homes and 150,843 reported deaths from COVID-19 (CMS, 2020).

COVID-19 illness and death in these facilities have resulted in negligence and wrongful death lawsuits which include, among others, the following claims:

- Lack of preparedness
- Failure to implement recommended safety protocols
- Failure to adequately screen staff
- Failure to adequately and timely screen residents
- Failure to timely quarantine
- Lack of adequate personal protective equipment items
- Failure to follow the infection control protocol of CMS
- Failure to recognize a significant change in condition
- Failure to perform COVID-19 testing of resident when signs and symptoms
- Failure to inform residents, representatives, and families of COVID-19 cases within the facility

THE ROLE OF THE LNC

LNCs involved in COVID-19 cases should be aware of the dates of the regulatory changes affecting nursing homes and the active regulation at the time of the allegation. Timelines of changes in regulations and COVID-19 outbreaks in the geographical region of the case and within the LTC facility would be beneficial when reviewing COVID cases. In addition to the medical records, the LNC should consider requesting the below for review:

- State surveys for historical relevant information
- Index of the policy and procedure manual to ensure desired content is obtained as titles may differ among facilities
- Infection Control Policy
- Policy and procedure for cleaning of resident's living quarters
- Isolation procedure
- Employee education and training logs and updates
- Screening and testing logs of the facility
- QAPI meeting schedule and minutes

CONCLUSION

The scope of this article has been around CFR §483.80 and its updates relevant to COVID-19. The lack of adequate infection prevention and control will likely be included in allegations against LTC facilities involving COVID-19. Research regarding CFR §483.80 regulations since the onset of the pandemic is essential to evaluate merit in these claims.

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Resources for LNC Success:

WVUOV Chapter's Advisor Program

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Keywords: mentor, mentoring, LNC mentor, advisor, LNC advisor, WVUOV mentor, WVUOV, start-up, chapter, AALNC

Nurses are generally not business-minded so getting started in Legal Nurse Consulting (LNC) work can be daunting. This line of non-clinical practice does not come easy and those willing to mentor can be few and far between or can cost a significant amount. There is a plethora of courses online but with a finite budget, these can get costly for start-ups and rarely offer true mentoring to guide you down your path. The West Virginia Upper Ohio Valley (WVUOV) Chapter of the American Association of Legal Nurse Consultants (AALNC) has launched a solution that is included in chapter membership at no extra cost.

Supporting membership is a hallmark of the WVUOV original online Chapter of AALNC. In response to questions from new LNC members about various aspects of the business, the Chapter started the LNC Advisor program in 2020 as a better way to offer dedicated mentoring as a benefit.

The WVUOV LNC Advisor program is innovative in that it shifts the focus from what other LNC "training" offers, which can be a laundry list of services, and instead focuses on individualized LNC needs. All Participants in the program have a one-on-one introductory phone call with an Advisor. Participants have tremendous experience in at least one area of clinical expertise. The program's goal is to help them focus on their personal skills and experience. They then set business goals and develop a plan to incorporate those skills to strategize for success.

The first contact is all about the start-up LNC - not recommended templates, work product samples, or forms that might be useful. The conversation centers around how to approach attorneys by ascertaining their needs and those of the case. At the end of the first call, Participants have an actionable plan while setting realistic goals to accomplish prior to the next conversation with the Advisor. These goals are varied depending on the Participant's needs and desires. Goals may be small, such as reading certain materials on business development, or larger, such as getting a website up and running. The Advisor will guide to ensure goals are achievable.

Some Participants have been asked by attorneys to do casework not taught in "traditional" LNC courses and they need guidance from the Advisor about how to proceed. None of them have had to turn down work just because it seems like something they cannot do. Nurses have many skills that are easily applied to an LNC business, and the program helps put this interaction with attorneys into a "doable" project.

No two Participants have the same business plan and the Advisors have learned from them, too. Sometimes one Participant's approach to a project can be adapted to fit another Participant's attorney-client needs. Networking and sharing ideas to advance their business practices are encouraged during virtual sessions. All Participants are welcome to attend networking sessions according to their schedule and needs. Participants can give permission to share email addresses for further networking and business exposure.

FINDING A "NICHE"

A niche is a particular service need that develops from discussions with attorney-clients; it is not a Participant's specialty clinical area. Some start-up LNCs have already considered a niche they are interested in pursuing; others are already wisely working with an advisor from SCORE (Service Core of Retired Executives), a government program that is free to new small business owners. Brainstorming with SCORE gives a business perspective outside nursing and helps Participants see the bigger picture when it comes to marketing their skills as an LNC. This has helped Participants see the possibilities of educating attorneys, paralegals, and/or the community in LNC services. For instance, does the public know when they consult an attorney about possible medical malpractice, they should ask if an LNC is going to help with their case by reviewing their medical records? Attorneys know the law; nurses know the medicine.

So how can LNCs let the public know about their business? Can YOU see the possibilities to be explored?

Other ways Participants strategize their business are:

- Serving as testifying experts
- Taking on leadership roles in the Chapter
- Initiating an Independent Medical Examination (IME) or Defense Medical Examination (DME) service in their community, and educating attorneys and paralegals about this service
- Publishing articles in the Chapter newsletter and *Journal of Legal Nurse Consulting*
- Meeting with reporters from the local newspaper
- Creating sample work products if needed
- Participating in listservs in a professional manner
- Getting involved in networking groups

The virtual landscape in networking and LNC education today lends itself well to the development of a thriving LNC business.

CONCLUSION

Becoming a Participant in the WVUOV LNC Advisor program is an avenue to success not previously explored by other AALNC Chapters. The virtual landscape in networking and LNC education today lends itself well to the development of a thriving LNC business. This avenue was not available to LNCs throughout the US in the recent past. WVUOV wants to assist you in rising to the challenge by joining the business community today with your own LNC practice.

To become a Participant in the Advisor program, you must be a member of AALNC in good standing (www.AALNC.org). You are then eligible to join the WVUOV Chapter. The Advisor program is a free benefit for Chapter members. Visit the website at https://WVUOV-AALNC.com. We look forward to you joining our program.

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Joanne's interest in nursing research and evidence-based practice has developed over her career, both in the OR and as an LNC. Her goals are to de-mystify medical jargon for attorney-clients, promote the profile of LNCs in the community, and mentor newer LNCs to find resources for business success. Joanne is a member of several professional organizations, keeping up to date in clinical advances to retain her RN license and assist her clients with their research needs.

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Questions?

For more details, please contact our Sales and Partnership Manger, Kris King, at **kking@aalnc.org** or (312) 673-5505.