Life care planning is an advanced collaborative case management specialty practice focused on assessing, evaluating, coordinating, consulting, planning for, and monitoring necessary services for individuals with complex medical care needs over their lifetime. This handbook provides a comprehensive resource for all people involved with catastrophic impairments and chronic medical care case management.

The Life Care Planning and Case Management Handbook, Fourth Edition, begins by defining the roles played by each of the key team members working with the life care planner. It provides planners with insights critical to successful interactions with medical and health-related professionals as well as the team members they are most likely to encounter as they work to build an accurate and reliable life care plan. Next, the text offers up-to-date information on the disabilities most frequently encountered by the life care planner. The contributors, who are recognized experts in their disciplines, also address issues in forensic settings, ethics, standards, research, and credentials.

The fourth edition includes numerous chapters on general issues, as well as updated standards of practice from the International Academy of Life Care Planners (IALCP), Life Care Planning Consensus Statements, and Valuable step-by-step charts and checklists. Completely updated and expanded, this revised handbook now includes new chapters on multicultural considerations in life care planning, admissibility of life care plans in U.S. Courts, and Canadian life care planning practice. Additionally, infused in other chapters is new information on medical coding and costing for life care planners, life care planning in non-litigated contexts, as well as research and education within life care planning.
Life Care Planning and Case Management Handbook
Fourth Edition

Edited by
Roger O. Weed
Debra E. Berens
Contents

Foreword........................................................................................................................................ix
Acknowledgments and Tributes...............................................................................................xi
Editors .........................................................................................................................................xv
Contributors .............................................................................................................................xvii

SECTION I THE ROLES OF LIFE CARE PLAN TEAM MEMBERS

1 Life Care Planning: Past, Present, and Future.................................................................3
   Roger O. Weed
2 The Role of the Physiatrist in Life Care Planning.........................................................21
   Richard Paul Bonfiglio
3 The Role of the Rehabilitation Nurse in Life Care Planning .........................................29
   Amy M. Sutton
4 The Role of the Vocational Rehabilitation Counselor in Life Care Planning ...........41
   Debra E. Berens and Roger O. Weed
5 The Role of the Psychologist in Life Care Planning.....................................................61
   Harvey E. Jacobs
6 The Role of the Neuropsychologist in Life Care Planning...........................................79
   Carol Walker
7 The Role of the Occupational Therapist in Life Care Planning..................................105
   Nancy L. Mitchell and Courtney V. Mitchell
8 The Role of the Physical Therapist in Life Care Planning...........................................135
   Kathie Allison and Kirsten Potter
9 The Role of the SLP and Assistive Technology in Life Care Planning......................149
   Carolyn Wiles Higdon
10 The Role of the Audiologist in Life Care Planning.....................................................255
    William D. Mustain and Carolyn Wiles Higdon
11 The Role of the Economist in Life Care Planning.......................................................317
    Everett G. Dillman
SECTION II SELECTED DISABILITIES: TOPICS AND ISSUES

12 Life Care Planning for the Amputee ................................................................. 335
   Robert H. Meier, III

13 Life Care Planning for Acquired Brain Injury ............................................... 367
   David L. Ripley and Roger O. Weed

14 Life Care Planning for the Burn Patient ....................................................... 401
   Ruth B. Rimmer and Kevin N. Foster

15 Life Care Planning for Depressive Disorders, Obsessive-Compulsive Disorder,
   and Schizophrenia ..................................................................................... 443
   Nicole M. Wolf

16 Life Care Planning for People with Chronic Pain ......................................... 469
   Denise D. Lester

17 Life Care Planning for Spinal Cord Injury ..................................................... 497
   David J. Altman and Dan M. Bagwell

18 Life Care Planning for Organ Transplantation ............................................. 533
   Dan M. Bagwell and Lisa Norris

19 Life Care Planning for the Visually Impaired ................................................. 571
   Roger O. Weed and Rasheeda Wilkins

20 Elder Care Management Life Care Planning Principles ................................ 591
   Dorothy J. Zydowicz-Vierling

SECTION III FORENSIC CONSIDERATIONS

21 Forensic Issues for Life Care Planners ......................................................... 609
   Roger O. Weed

22 A Personal Perspective of Life Care Planning .............................................. 631
   Raymond L. Arrona, and Mamie Walters, as told to Anna N. Herrington

23 A Plaintiff’s Attorney’s Perspective on Life Care Planning ............................ 641
   Katherine A. Brown-Henry

24 A Defense Attorney’s Perspective on Life Care Planning ............................. 655
   Tracy Raffles Gunn

25 Life Care Planning and the Elder Law Attorney .......................................... 669
   Terry C. Cox and F. Auston Wortman, III

26 Day-in-the-Life Video Production in Life Care Planning .............................. 681
   J. Mat Hunt, Jr.

27 Ethical Issues for the Life Care Planner ....................................................... 691
   Debra E. Berens and Roger O. Weed
SECTION IV   GENERAL ISSUES

28  Reliability of Life Care Plans: A Comparison of Original and Updated Plans........703
    Amy M. Sutton, Paul M. Deutsch, Roger O. Weed, and Debra E. Berens

29  Americans with Disabilities Act (ADA): From Case Law to Case Management
    and Life Care Planning Practice ..............................................................711
    Lewis E. Vierling

30  Life Care Planning Resources ........................................................................729
    Ann Maniha and Leslie L. Watson

31  Medical Equipment Choices and the Role of the Rehab Equipment Specialist
    in Life Care Planning ..............................................................................759
    Paul Amsterdam

32  Home Assessment in Life Care Planning ......................................................787
    Jim Karl and Roger O. Weed

33  Vehicle Modifications: Useful Considerations for Life Care Planners ..........799
    C. Dan Allison, Jr.

34  Credentialing and Other Issues in Life Care Planning ................................813
    Debra E. Berens and Roger O. Weed

35  Admissibility Considerations in Life Care Planning ....................................819
    Timothy F. Field

36  Cultural Considerations for Life Care Planning .........................................833
    Mary Barros-Bailey

37  Life Care Planning in Canada .....................................................................843
    Dana M. Weldon

Appendix I: Standards of Practice for Life Care Planners, 3rd Edition..............865

Appendix II: Consensus and Majority Statements Derived from Life
    and 2015 ....................................................................................................875

Appendix III: Journal of Life Care Planning Title Index ..................................879

Author Index ..................................................................................................897

Subject Index .................................................................................................909
This 2018 edition of the *Life Care Planning and Case Management Handbook* represents the fourth edition of one of the pillars of reference texts in the practice of life care planning. In the Foreword for the 2010 edition, I indicated that a number of important and valuable contributors within the practice of life care planning had been brought together to advance this practice specialty. Co-editors Dr. Weed and Dr. Berens have accomplished no less a feat for this current edition in bringing together specialists in their practice areas to present readers with the most important updates to aid in plan development and case management. Perhaps the most important change for the fourth edition is the addition of several relevant and contemporary chapters that make this text a timely and necessary contribution to the ongoing practice of life care planning.

From an historical perspective, Dr. Weed and I first met in 1984. This was approximately 8 years after I had begun working on the development of the basic tenets, methodologies, and principles of life care planning and 3 years after the publication of *Damages in Tort Actions*. No one to that point in time had come to life care planning with greater enthusiasm or interest. Since that time, no one has proven to share my vision for life care planning with greater dedication and effort. Dr. Weed has been a dedicated colleague, researcher, writer, lecturer, teacher, and a tremendous overall contributor to the advanced practice of life care planning. In recognition of his work, he was invited to participate in *A Guide to Rehabilitation* (Deutsch & Sawyer, 1985–2007, AHAB Press, White Plains, New York). That text was retired in 2007 and the *Life Care Planning and Case Management Handbook*, along with Susan Riddick Grisham’s *Pediatric Life Care Planning and Case Management* text (2010), represent the two most comprehensive texts on the topics of Life Care Planning and Case Management currently on the market. Dr. Weed has, without question, been a major moving force in the advancement of life care planning for the past two and one half decades. He has done this by always remaining a team player who stays focused on what is good for life care planning and the practitioners as a whole. We have always shared a philosophy of openly contributing in our lectures and our texts all of the latest information and research we have available. Dr. Weed never holds anything back, and, even in his retirement today, this latest text continues to hold to that philosophy.

The 2018 edition of the *Life Care Planning and Case Management Handbook* will continue to be a necessary desktop reference for every advanced practitioner of life care planning. New chapters included in the fourth edition are on topics such as Admissibility Considerations Life Care Planning, Cultural Considerations for Life Care Planning, and Life Care Planning in Canada, and these will prove to be exceptionally important and relevant to today’s practitioner. The reader will also find that chapters upon which they have depended in the past have been carefully reviewed and updated to reflect present day or contemporary issues in life care planning. In some cases, past contributors have aptly fulfilled this role, but in other instances new contributors with proven,
specialized skills and insights have been tapped to provide their insights to completely rewrite or update some of the chapters.

What is most important for readers such as myself is we can still find what we have so come to rely on in past editions. For example:

In the opening 10 chapters, the text continues to define the roles played by each of the key team members working with the life care planner, with a completely revised chapter on the nursing role. It provides life care planners with the insights critical to successful interaction with medical, health-related professionals, and economic team members they are most likely to encounter as they work to build a successful and accurate life care plan.

In the next nine chapters, the book provides up-to-date information on the disabilities most frequently encountered by the life care planner. Most importantly, we are not just lecturing on current information, but we are providing critical resources for being able to bring ourselves up to date on a day-to-day and case-by-case basis. This is what makes this book a critical desktop reference.

The Handbook then moves on to address issues typically left out of similar texts—issues made critical by Daubert v. Merrell Dow in the forensic setting and issues that should be critical even in the nonforensic setting. I refer to ethics, standards, research, credentials, and a review of litigation-related case law, all of which are thoroughly and professionally addressed within these pages. In addition, the text includes a chapter on updated and present day resources used most commonly by life care planning practitioners in conducting their work, followed by separate chapters that address medical equipment, home assessments, and vehicle modifications.

It is easy to see that this text continues to illustrate the progression of a career, in which Drs. Weed and Berens have both written and edited many other books, chapters, and articles. With a combined career of 70 years in the field of rehabilitation, this text has been instrumental in not only helping to develop and advance the specialized practice of life care planning but also helping to develop the market for the work product we produce. Once again, I extend my congratulations to co-editors Dr. Weed and Dr. Berens, and all of the contributors on an excellent work. I also continue to congratulate those with the insight to be working with a copy of this text on their desktops.

Paul M. Deutsch, PhD, CRC, CCM, CLCP, FIALCP

Past Chair: Foundation for Life Care Planning Research

(Editor’s note: Dr. Deutsch is founder of the Life Care Planning movement)
Acknowledgments and Tributes

There are a number of people who have contributed to helping this fourth edition become a reality. First to be recognized is Dr. Paul Deutsch, acknowledged as the father of life care planning, who, although now retired, has for many years maintained strong support for our work in this field. We are truly honored to have him write the Foreword to this edition. His lifelong dedication of promoting and enhancing the specialty practice is unmatched. He has been a prolific author, generous sharer of practice details through numerous presentations, the founder of the Foundation for Life Care Planning Research, and all-around powerhouse for developing established protocol and methodology of life care planning practice. Furthermore, there are numerous contributors to this text who represent a major powerhouse of knowledgeable movers and shakers in the life care planning specialty practice from a wide range of specialties.

In addition, there are some former contributors who sadly are no longer with us. As we go to print with the fourth edition of the Life Care Planning and Case Management Handbook, we want to make a special tribute to these authors. Since publishing the first edition of the Life Care Planning and Case Management Handbook in 1999, several superb contributors have passed on, but their legacies and contributions not only to the Handbook but to the life care planning community continue. The following is intended to thank these extraordinary professionals, once again, for their contributions to the promotion of life care planning. All are greatly missed!

Paul Amsterdam was a Nationally Certified Assistive Technology Professional (ATP) who specialized in wheelchair mobility and adaptation. With more than 35 years of experience in the medical equipment industry, Paul specialized in complex rehabilitation diagnoses and served as an expert in wheelchair mobility and adaptive seating as well as consulted with life care planners to ensure the equipment and technology recommendations in their plan were appropriate and well-supported. In addition to his full-time medical equipment work, Paul helped to create more than 100 wheelchair clinics and volunteered his time to raise funds and awareness of people with disabilities, including awareness for wheelchair sports. However, he is perhaps most known within the life care planning community for his knowledge about purchase, modification, maintenance, repair, and life expectancy of rehabilitation-related equipment. He contributed to all editions of this text, authored several articles and chapters, and freely agreed to speak at many life care planning and rehabilitation organization conferences. Most recently, Paul contributed a standing column to the Journal of Life Care Planning titled “The Medical Equipment Corner.”

Tyron C. Elliott, JD, was primarily a practicing plaintiff’s trial lawyer where he focused on the area of neurolaw, which emphasized brain and spinal cord injuries. He was an adjunct professor
at Emory University School of Medicine in Atlanta, where he lectured on legal-medical issues. He was also a popular speaker on litigation-related topics and presented at numerous life care planning conferences. Tyron was the executive editor of the *Neurolaw Letter* and contributed several articles on brain injury and related litigation. Tyron filled a unique niche in the life care planning community as attorney and a true “counselor” of the law. He contributed the former chapter on A Plaintiff’s Attorney’s Perspective on Life Care Planning. (From Roger: I enjoyed consulting with Tyron for many years but finally decided that I valued him as my own personal attorney, thus we agreed that I would no longer provide expert witness services for his clientele.)

**Randall W. Evans, PhD, ABPP,** was president and CEO of Learning Services Corporation, a national provider of neurorehabilitation and supported living services. A practicing neuropsychologist, Dr. Evans published extensively in the areas of neuropsychology, neuropharmacology, and neurorehabilitation. Randy was a surveyor for the Commission on Accreditation of Rehabilitation Facilities and also served as a clinical associate professor of psychiatry at the University of North Carolina School of Medicine at Chapel Hill. He was one of the first rehabilitation professionals in the United States to receive Diplomate status from the American Board of Rehabilitation Psychology. Randy contributed the initial chapter on The Role of the Neuropsychologist in Life Care Planning.

**Patricia McCollom, RN, MS, CRRN, CDMS, CCM, CLCP,** was president and nurse consultant for LifeCare Economics, LTD, Management Consulting & Rehabilitation Services, Inc., and was the founding CEO of the American Academy of Nurse Life Care Planners and the International Academy of Life Care Planners. She was past national president of the Association of Rehabilitation Nurses, former chair of the National Task Force on Case Management, and past chair of the Commission for Case Manager Certification. At the national level, she taught case management practice and life care planning. She was vice president of the Board of Directors of the Foundation for Life Care Planning Research. The author of many articles on rehabilitation, case management, and life care planning, she was one of three principle developers of the certificate course in Life Care Planning, to be initiated by Kaplan College. In recognition of her visionary talents she was the first editor of the *Journal of Life Care Planning*. She also was a life care planning lifetime achievement award winner and, in honor of her dedication to research and education, the Patti McCollom Research Award (which included cash) was created and continues to be awarded by the Foundation for Life Care Planning Research. Patti contributed the original chapter on Elder Care Management.

**Terry Winkler, MD, CLCP,** was a Board Certified Physiatrist (PM&R) physician and, due to his popularity as a speaker and charming personality, he was one of the first physician repeat educators for the National Life Care Planning training program. He was past medical director of Cox Hospital Rehabilitation Programs and medical director of Springfield Park Care Sub-Acute Rehabilitation Program and Curative Rehabilitation Center. Terry contributed numerous life care planning publications. As an active practicing physician he specialized in traumatic/acquired brain injury, spinal cord injury, amputations, and life care planning consulting. Terry was also Clinical Associate Faculty at the University of Florida, Gainesville and LSU Medical Center, Department of Rehabilitation, New Orleans. Past honors included a Lifetime Achievement Award for life care planning, the America Award, Alumnus of the Year at Louisiana Tech University, and the Jean Claude Belot Award for Academic Achievement from Harvard University. Terry contributed the chapters on Spinal Cord Injury and Visual Impairment in life care planning.
Sheri Jasper was not a direct contributor to this publication but contributed to the specialty practice of life care planning in many other ways. Those of us who have participated in or even just explored life care planning training programs probably encountered her at some point in the process. Her professional background was centered around sales, customer service, and operational management, and she was hired as the contact point person at the beginning of the nationwide life care planning training in the early 1990s. Sheri initially worked for the Rehabilitation Training Institute, Intelicus, and later Medipro Seminars, all providers of the first nationwide life care planning training program that led to certification in Life Care Planning. An absolute joy to work with, Sheri was always exuberant and helpful and could be found coordinating and implementing the initial on-site training programs and conferences. She was the first contact for professionals seeking training and the heartbeat of life care planning training behind the scenes. When she lost her battle with cancer, the Sheri Jasper Award was created to honor others who embodied her spirit of positive, supportive, friendly, and encouraging attitude toward colleagues and exemplified a willingness to go the extra mile with good humor and perseverance.

As life care planning practitioners, we are eternally grateful for the contributions of the above-mentioned authors (and Sheri) who laid the foundation for what was to come.

We also think it is valuable to recognize others who have been instrumental in our careers.

From Roger: My parents have primary credit for urging me to break the mold of local tradition by continuing my education. I was raised in a very small town where high school graduates commonly went to work in the timber industry. In fact, one of my peers could not understand why I would go to college when I could make almost as much money as a college graduate right out of high school. At the time, I did not have a good answer for him. However, the last time I saw him, now years ago, he was chronically “between jobs” due to the massive turndown in the local economy, which is based almost entirely on wood products and logging.

Dr. Timothy Field, who in 1984 was a professor at the University of Georgia, agreed to be my PhD major advisor after a few years of mentoring and advising me in my professional life. I can truly convey that Dr. Field has been a major positive factor in my professional life. He has opened many doors, been supportive beyond the call of duty, and shown me new horizons. As mentioned above, Dr. Paul Deutsch has also been very supportive in my professional career by including me in his life care planning training, writing, and volunteer-related activities as well as being available for consultation. Julie Kitchen, who retired from life care planning within the past year, has also been available for an enormous number of contacts for information and was always a pleasure to work with. I also acknowledge my co-editor, Debbie Berens, who at the time of this edition has, for close to 30 years, been a major cheerleader, editor, organizer, co-author, and overall superb and talented colleague.

Last, but certainly not least, my wife, Paula, has always encouraged me to pursue professionally whatever I wanted. This support resulted in many moves and job changes for her, and she has never wavered. Now that I am enjoying retirement, looking back over an amazing career of teaching and consulting reminds me that what unfolded surpassed all expectations. All in all, I believe that many people have observed more capability in me than I saw in myself. Through good fortune, outstanding resources, and a lot of assistance, this fourth edition text has come to fruition.

From Debbie: It is thrilling to realize that for almost 30 years I have had the incredible experience of mentorship from co-editor, Roger Weed, even as he has retired from his academic career and active life care planning and consulting practice and is enjoying his “second career” as an avid
traveler and forever champion of the rehabilitation profession. Roger continues to be the epitome of a mentor, colleague, professional confidante, sounding board, motivator, and friend. And although he is now retired, I hope for many continued years of professional association.

Another major driving force in my life for over 30 years has been Mark, my husband, who gets the most credit for endurance and perseverance throughout my professional career. His unflinching belief in me and unwavering support of all my activities has allowed me to take risks and to grow in professional ways that I would have never imagined. And for our two sons, Matt and Jacob, whose strength and constant love and support, even as they enjoy their college years, is the backbone of who I am. Every step on the journey to bring this text together has been made with each of them by my side and in my heart.

For my extended family, Mom and Dad, who have been there at all the right times throughout my life as only parents know how to do, and to my sisters and their families who shower me with support from across the miles, my world is so much better with each of you in it.

With appreciation, we recognize that this book is the culmination of many contributors within the specialty practice of life care planning who have given of their valuable time, energy, and expertise to write a chapter. In our daily practices, we are continuously reminded of the good that goes on in life care planning and the collective energy of life care planning professionals who produce quality work and are committed to advancing the practice. It is hoped that this book will play a small part in continuing the life care planning and case management momentum.

Roger O. Weed
Debra E. Berens
Editors

Roger O. Weed, PhD, CRC/R, LPC/Ret, CCM/R, CDMS/R, CLCP/R, FNRCA, FIALCP/R, Professor Emeritus, is retired as professor and graduate rehabilitation counseling coordinator at Georgia State University. He also held doctoral student graduate faculty status in Counseling Psychology as well as Counselor Education and Practice doctoral programs. He has authored or co-authored about 150 books, reviews, articles, and book chapters, approximately 80 of which were specific to life care planning.

During his more than 42 years in the profession, Dr. Weed was honored several times for his work including the 2006 Distinguished Professor Award from Georgia State University’s Alumni Association (sole recipient), the 2011 Lifetime Appreciation Award from the International Commission on Health Care Certification, the 2009 Larry Huggins Lifetime Achievement Award from the Private Rehabilitation Specialists of Georgia, the 2005 Lifetime Achievement Award from the sponsors of the International Life Care Planning Conference, the 2004 Lifetime Achievement Award from the International Association of Rehabilitation Professionals (as well as recognition in 1997 and 1991 as the Outstanding Educator), the 1993 National Professional Services Award from the American Rehabilitation Counseling Association, and the 2003 Research Excellence Award from the College of Education at Georgia State University.

Dr. Weed is one of the five founders of the original, nationwide training program leading to Life Care Planning certification. He is also past chair of the Georgia State Licensing Board for professional counselors, marriage and family therapists, and social workers, as well as past president of the International Association of Rehabilitation Professionals.

Debra E. Berens, PhD, CRC, CCM, CLCP, maintains a nationwide consulting practice specializing in life care planning for children and adults with catastrophic injuries, disabilities, or chronic medical conditions since 1989. She has authored/co-authored more than 40 articles/chapters and given more than 50 presentations on topics of life care planning, rehabilitation consulting, and case management, and served for 16 years as moderator of the International Symposium for Life Care Planning. Dr. Berens also is a clinical assistant professor in the Clinical Rehabilitation Counseling graduate program at Georgia State University and is recipient of industry awards including the 2010 Faculty Excellence Award by Georgia State University College of Education, the 2010 Outstanding Life Care Planning Educator, and the 2013 Lifetime Achievement Award in Life Care Planning.
Contributors

Kathie Allison, PT, MS, CLCP, obtained her BS in physical therapy from the University of Kansas in 1972 and her MS in education from the University of Kansas in perceptual motor development in 1979. She was certified as a Life Care Planner in 2000. She worked as a physical therapy clinician for 35 years. She was on faculty at the University of Kansas from 1979–1986 where she taught in the Physical Therapy Education program. Her emphasis was on clinical techniques and cardiopulmonary physical therapy. From 1986–1993, she was in health care management. She started her independent practice of life care planning in 1993. She has presented at both the IALCP and AALNCP conferences and has written chapters for the AALNC Journal. Her area of specialty is transplantation.

C. Dan Allison, Jr., MS, OTR/L, ATP, CDRS, is an occupational therapist with a certification in Driving Rehabilitation, as well as assistive technology. He is currently employed in Atlanta, Georgia, at the Shepherd Center, a rehabilitation hospital specializing in medical treatment, research, and rehabilitation for people with spinal cord injury and brain injury, where he works full time in the driving program. Prior to that, he was a research associate at the T.K. Martin Center for Technology and Disability of Mississippi State University. Allison received his BS degree in supervision from Purdue University, and a MSc degree in occupational therapy from Western Michigan University, with an emphasis on disabled driver rehabilitation. He is currently president of the Association for Driver Rehabilitation Specialists (ADED), with memberships in the American Occupational Therapy Association (AOTA), the GA Occupational Therapy Association, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA), and the National Mobility Equipment Dealers Association (NMEDA).

David J. Altman, MD, CLCP, is a physician specializing in neurology with an active clinical practice in San Antonio, Texas. Dr. Altman completed his undergraduate training at Brandeis University in 1992, after which he attended medical school at the University of Connecticut, receiving his medical degree in 1996. After completing his internship at Hartford Hospital in 1997, Dr. Altman completed his neurology residency at the University of Texas Health Science Center in San Antonio in 2000. He also completed a fellowship in clinical neurophysiology at Brown University in 2001 before returning to San Antonio to begin his clinical practice in neurology. Dr. Altman provides inpatient clinical services as a neuro-hospitalist for the Methodist Healthcare System. In this capacity, he provides neurology consultation services for diagnosis, emergency management, and follow-up inpatient care of patients who have suffered stroke, brain injury, spinal cord injury, peripheral nerve injury, and other neurologic injuries or diseases in all departments at this Level I Trauma Center and Joint Commission Certified Stroke Center, as well as other hospitals within this system of care throughout South Texas. He has taken an active role
in developing and building the stroke program for the Methodist Healthcare System. Dr. Altman serves as the regional neurology advisor for the Warm Springs Healthcare System in San Antonio. He has also served as the medical director for Global Rehabilitation Hospital in San Antonio and partnered with the Neurology Center of San Antonio, as well as the neurology director of Access Quality Therapy Services. In addition to his clinical neurology practice, Dr. Altman is a Certified Life Care Planner and provides life care planning services as a consultant with Rehabilitation Professional Consultants, Inc. in San Antonio.

Paul Amsterdam, ATS, was a specialist in the field of rehabilitation medical equipment. He comes from a family of three generations in this industry, starting in 1929 with the founding of Amsterdam Bros., one of the country’s first orthotic and surgical supply stores. Amsterdam was a Nationally Certified Assistive Technology Specialist. He helped to create and participated in more than 100 wheelchair clinics in rehabilitation hospitals, developmental centers, and schools for people with disabilities throughout the New York–New Jersey metropolitan area. He was been a featured columnist for *Case Manager* magazine and other publications for more than 5 years. Amsterdam was considered an expert in wheelchair mobility and adaptive seating. He made full assessments of functional needs, designed custom positioning seating systems, and offered alternatives in decubitus prevention as well as manual and power mobility options. As a nationwide consultant he provided complete evaluations for both adults and pediatrics with a wide range of physical disabilities.

Raymond L. Arrona began his career in 1967 as an independent contractor with Wear-Ever Aluminum, Inc., Alcoa Aluminum’s first subsidiary, which marketed Wear-Ever Cookware and Cutco Cutlery. He quickly achieved one of the company’s coveted positions as division manager and relocated from Arizona to Georgia in 1976 where he was president and CEO until 1997 of RASAR Management Services, Inc./dba Vector Marketing, which represents the Cutco Cutlery product. He also operated as Vector’s southern zone division manager for the states of Georgia and South Carolina. In late 1997, he joined a start-up company, QuestCom, which develops websites for businesses. Since the publication of the first edition of this book, he has relocated with his daughter, Anita (now deceased), to Mesa, Arizona, where he owns Pride of the Valley, an upscale shared direct mail card deck, an affiliate of Pride of the City. Arrona experienced every father’s nightmare when his daughter, Anita, was tragically injured in an accident caused by a drunk driver. “The impact of Anita’s accident has been far reaching in all areas of my family’s life, including the personal, financial, spiritual, educational, judicial, professional, and friendship levels. No emotion has been immune from the effects of that tragic day. It is my wish that by telling Anita’s story, it will in some way help others through similar situations, or assist in allowing life care planners to gain insight into our family as we continue to deal with this life-changing event.”

Dan M. Bagwell, BSN, RN, CLCP, CCM, CDMS, is chief executive officer of Rehabilitation Professional Consultants, Inc. and president of Dan Bagwell & Associates, both of which are located in San Antonio, Texas. Bagwell is a registered nurse, licensed to practice in the State of Texas. He received a bachelor of science in nursing in 1978 from the University of Mississippi School of Nursing. He is a Certified Life Care Planner, Certified Case Manager, and Certified Disability Management Specialist. Bagwell provides adult and pediatric catastrophic case management and life care planning services for individuals in Texas and many other states throughout the country. His clinical nursing experience spans nearly four decades, with the
majority of his professional services dedicated to medical case management, professional consultation in health care, and life care planning services involving litigated and non-litigated matters. His clinical experience has included critical care nursing and service as an officer in the United States Air Force Nurse Corps and medical crew director in Tactical Aeromedical Evacuation with the USAF Reserves. Bagwell previously served as president and co-founder of Life Care Personal Living Centers and co-founder and vice president of MediSys Rehabilitation, Inc. He has given numerous presentations, lectures, and symposiums concerning life care planning at regional, national, and international conferences, and he has authored peer-reviewed journal articles and textbook chapters on life care planning.

Mary Barros-Bailey, PhD, CRC, CLCP, is a Spanish- and Portuguese-speaking life care planner and vocational expert. Her caseload often includes multicultural and international cases. She has presented on a variety of professional topics throughout the country and on three continents. Beyond her forensic and clinical practice and professional publishing, presenting, and research, Dr. Barros-Bailey is adjunct teaching and clinical faculty with the University of Idaho’s rehabilitation counseling program and teaches a global child advocacy class at Winona State University. She holds dual citizenship in the United States and the European Union and has traveled to every continent, including Antarctica.

Debra E. Berens, PhD, CRC, CCM, CLCP, maintains a nationwide consulting practice specializing in life care planning for children and adults with catastrophic injuries, disabilities, or chronic medical conditions since 1989. She has authored/co-authored more than 40 articles/chapters and given more than 50 presentations on topics of life care planning, rehabilitation consulting, and case management, and served for 16 years as Moderator of the International Symposium for Life Care Planning. Dr. Berens also is a Clinical Assistant Professor in the Clinical Rehabilitation Counseling graduate program at Georgia State University and is recipient of industry awards including the 2010 Faculty Excellence Award by Georgia State University College of Education, 2010 Outstanding Life Care Planning Educator, and 2013 Lifetime Achievement Award in Life Care Planning.

Richard Paul Bonfiglio, MD, is board certified by the American Board of Physical Medicine and Rehabilitation. Dr. Bonfiglio has previously served as the medical director of several nationally recognized rehabilitation facilities, including the Lake Erie Institute of Rehabilitation and the Bryn Mawr Rehabilitation Hospital. He has also maintained close academic ties, including having served as residency program director at the Schwab Rehabilitation Center. He is an adjunct faculty member at Lake Erie College of Osteopathic Medicine. Dr. Bonfiglio’s clinical practice within the field of physical medicine and rehabilitation has included providing care to children and adults with traumatic brain injuries, spinal cord injuries, amputations, and acute and chronic pain problems. He is an internationally recognized speaker on rehabilitation topics. Dr. Bonfiglio has been involved for years in the review and critical analysis of life care plans. His interests include the development of a strong medical foundation to enhance the accuracy and reliability of these plans. He is also an expert in life expectancy determinations for individuals following catastrophic illnesses and injuries. He has been on the faculty of the Rehabilitation Training Institute and MediPro Seminars for life care planning. Dr. Bonfiglio has sustained a strong clinical practice within the field of physical medicine and rehabilitation, providing care to children with a variety of physical and cognitive impairments, and children and adults with traumatic brain injuries, spinal cord injuries, amputations, and acute and chronic pain problems.
Contributors

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Paul M. Deutsch, PhD, LMHC, CRC, CLCP, retired, is a licensed mental health counselor with a PhD in rehabilitation counseling and counseling psychology. He specialized in working with catastrophic disabilities resulting from either birth or a trauma. Dr. Deutsch is best known for having developed the basic tenets, methodologies, and processes of life care planning. He first published on life care planning as a fundamental tool of case management in his 1981 text (Damages in Tort Actions, Deutsch and Raffa). Dr. Deutsch has authored or co-authored 12 volumes and more than 50 peer-reviewed journal articles and chapters. Dr. Deutsch has taught as an adjunct professor at several universities and lectured widely through the United States and Europe. In the 1980s and early 1990s, he worked extensively in the former Soviet Union with colleagues of Alexander Romanovich Luria. He has worked extensively in brain injury and spinal cord injury rehabilitation, among other areas. His experience includes co-ownership and directorship of a brain injury rehabilitation center in the 1980s and later ownership and management of a long-term residential and supported work program for severe brain injury patients. He remained active in research efforts until retirement and helped to spearhead the formation of the Foundation for Life Care Planning Research along with Dr. Roger Weed, Dr. Christine Reid, Patricia McCollom, MS, RN, and Susan Riddick, RN. The primary work of this foundation is research on the reliability and validity of the life care planning process. Related areas of research may include life expectancy as it is influenced by effective life care planning, as well as case management and all appropriate related life care planning research. The foundation has forged multiple university relationships and developed successful fundraising efforts. Funding has allowed the foundation to support several doctoral dissertation projects, other research efforts, and offer recognition awards to professionals who contribute to the advancement of life care planning. Dr. Deutsch also was a prime author of the core materials for the profession’s amicus curiae brief that was filed in the Texas Seventh District Court of Appeals which became a major foundation for the specialty practice of life care planning. He also was instrumental in establishing ongoing education (Kaplan online, University of Florida, and others), training, and certification (certificate #1) for Life Care Planners.
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Contributors

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Mamie Walters, CNHP, pursued a career in music theory and composition until 1981 when she became co-owner and successfully operated a cutlery distributorship for 6 years. During this period, she met Ray Arrona, who was with Vector Marketing Corporation. Her business acumen led to a national promotion as senior assistant to the executive vice president of sales and marketing for the southern zone with Vector. In March 1994, this position ended and Walters pursued
Contributors

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THE ROLES OF LIFE CARE PLAN TEAM MEMBERS
Chapter 1

Life Care Planning: Past, Present, and Future

Roger O. Weed

Contents

Introduction ................................................................................................................................. 3
The Past ................................................................................................................................. 4
The Present ............................................................................................................................ 6
Step-by-Step Procedures ...................................................................................................... 9
The Future ............................................................................................................................ 13
Conclusion ............................................................................................................................ 15
Appendix: Life Care Planner: Secretary, Know-It-All, or General Contractor? One Person's Perspective .............................................................................................................................. 15
Two Apparent Self-Serving Views ........................................................................................ 16
A Critical Review of Educational Requirements .............................................................. 16
A Third View—By Analogy .................................................................................................. 18
Conclusion ............................................................................................................................ 19
References ............................................................................................................................. 19

Introduction

In the previous editions of this text, I wrote that life care planning has become a major buzzword in the field of professional rehabilitation. Many people who have little knowledge about published concepts in life care planning continue to use the term life care plans to generate business. Several years ago, I recall reading a deposition from a PhD-level “life care planner” who, when asked by the opposing attorney about resources in life care planning, revealed that it was his opinion there were no written resources or training programs in life care planning. This discourse occurred in 1996, after there already existed a national certification in life care planning. It was repeated in 2003 by two “experts,” one of whom claimed there were no training programs but also claimed to be one of the founders of the life care planning practice. Since the second edition, there have been fewer similar occasions, suggesting, in this author’s opinion, that life care planning has become
mainstream underscored by references in the legal literature (Field & Weed, 2015). Although more professionals are aware of the life care planning concepts, many life care planners have faced deposition and courtroom challenges in personal injury litigation, which have further refined the requirements for successful presentation of information (for more information see Weed & Johnson, 2006, as well as the forensics chapter in this text).

Clearly, life care planning continues to be the standard by which other plans are to be measured with regard to the management of catastrophic impairments, complex health care needs, or opinions for various litigation venues. The published methods, concepts, and procedures are an effective means to determine the road map of care as well as to identify reasonable needs and costs associated with an impairment (as an example, see Deutsch et al. 1989a). However, not everyone is demonstrating quality practice; many do not know of existing standards of practice (IALCP, 2015), and many professionals are resisting standardization of the concept. As with previous editions, it is helpful to review the specialty practice of life care planning as a foundation for this book.

The Past

The original issuance of life care plans appeared in a legal publication, Damages in Tort Actions (Deutsch & Raffa, 1981), which established the guidelines for determining damages in civil litigation cases. By 1985, the life care plan was introduced to the health care industry in the Guide to Rehabilitation (Deutsch & Sawyer, 1985). One of the first nationwide rehabilitation professional training programs was organized by Dr. Paul Deutsch and offered on September 16–17, 1986, in Hilton Head, South Carolina, where more than 100 rehabilitation professionals from throughout the United States assembled to begin the process of learning about life care plans. Initially the training comprised approximately 2 days to introduce rehabilitation professionals to the overall concepts and the format that was published in the Guide to Rehabilitation. It also became evident that many people were practicing life care planning in a variety of ways, some of which appeared to be contrary to the intended goals and purposes of ethical rehabilitation practices (Weed, 1995b). In addition, as previously mentioned, many people were using the term life care planning as it became more popular, but had little or no awareness of the appropriate uses or practices associated with this emerging industry.

In the fall of 1992, five rehabilitation professionals, Richard Bonfiglio, MD; Paul Deutsch, PhD; Julie Kitchen, CDMS; Susan Riddick, BS, RN; and Roger Weed, PhD, met to discuss the apparent problems associated with the life care planning practices. Concerned that fragmentation and poor standardization would result in the overall decline of the specialty practice, they decided to develop a concentrated training program consisting of eight 2-day modules representing the various aspects of life care planning.

Module I was a basic overview of life care planning process methods, standards, and formats. Module II was designed to include the vocational aspects of clients whose life care plans appropriately included work-related opinions. Module III addressed effective case management strategies within the complex medical environment. Module IV outlined the various forensic rehabilitation issues to which many rehabilitation professionals, willingly or unwillingly, are subjected. Module V focused specifically on spinal cord injury issues, and Module VI identified brain injury issues. Module VII was an overview of the long-term care issues for other physical and emotional disabilities as well as some disease processes. Module VIII focused more explicitly on business and ethical practices, including the use of technology in life care planning.

Following this process, a management company (Rehabilitation Training Institute) was contracted to set up training programs throughout the United States. Before the first flyers
were fully distributed, the first of the organized modules (scheduled for November 1993) was filled. Two introductory courses were developed: one on the West Coast and the other on the East Coast. It became obvious that there were a number of rehabilitation professionals who were interested in pursuing continuing education related to life care planning, and several participants requested official recognition for their educational efforts. Dr. Horace Sawyer of the University of Florida was approached, and he agreed to pursue an official certificate of completion through the University of Florida's Continuing Education Department. A private-public partnership between the Rehabilitation Training Institute and the University of Florida was formed and named Intelicus. The five founders donated the program content to Intelicus, which was purchased by Medipro Seminars in 2003. However, Medipro has since ceased operations. Most of the founders continue to donate time and services in support of online training through the University of Florida and the annual life care planning symposium (visit the website for the International Academy of Life Care Planners—https://connect.rehabpro.org/lcp/home—for the current schedule).

Although an initial description of life care planning was offered by Drs. Deutsch and Raffa in *Damages in Tort Action*, collaboration with leaders and organizations resulted in an agreed upon definition:

A *Life Care Plan* is a dynamic document based upon published standards of practice, comprehensive assessment, data analysis, and research, which provides an organized concise plan for current and future needs with associated costs, for individuals who have experienced catastrophic injury or have chronic health care needs. [Combined definition of the University of Florida and Intelicus Annual Life Care Planning Conference and the American Academy of Nurse Life Care Planners (now known as the International Academy of Life Care Planners) presented at the Forensic Section meeting, NARPPS annual conference, Colorado Springs, Colorado, and agreed upon April 3, 1998.]

Although the certificate of completion from such programs as the University of Florida and Kaplan University underscored the value of obtaining education specific to this specialized profession, it did not provide the assurance of ethical practice or the professional identity that was desired by people who had invested thousands of dollars and much of their time in the training process. Several certification boards were contacted, with three indicating an interest in leading the way to certification. Eventually the Commission on Disability Examiner Certification (now known as the International Commission on Health Care Certification, or ICHCC) based in Midlothian, Virginia, and owned by V. Robert May, RhD, assumed the responsibility, and the first certifications were offered in the spring of 1996. Although the ICHCC also certifies nurses, for nurses who wish to affiliate with an organization that only certifies nurses, the American Association of Nurse Life Care Planners was formed.

Occasionally, there are questions about who did what first. The chronology below is intended to “lay out” the development of the specialty practice of life care planning as it is known today. As noted previously, Paul Deutsch, in the mid-1980s, was the first rehabilitation professional to formally teach “life care planning” concepts, methodology, and such. He is considered the “founder” of the life care planning process and was the first one to publish on the topic in the rehabilitation literature (with Fred Raffa) in 1981 (*Damages in Tort Action*).

Susan Riddick-Grisham was the first nurse to formally teach other nurses an organized series of life care planning classes when she was hired by Crawford & Company in the early 1990s to educate their consultants nationwide. It may be obvious, but she underwent specific life care planning training prior to teaching the methodology to others. She was also the only nurse to help develop the original nationwide training program curriculum launched by the Rehabilitation
Training Institute (which later became Intelicus and, through the years, has been reformatted to be today’s life care planning certificate training program offered by the University of Florida).

Patti McCollom was the first nurse to start an organization specifically for nurses and life care planning in the mid-1990s when she founded the American Academy of Nurse Life Care Planners. Under Patti’s direction and at the urging of others, the organization was expanded to include life care planners from disciplines including and outside of nursing (i.e., multidisciplinary) and is now known as the International Academy of Life Care Planners (IALCP), a section of the International Association of Rehabilitation Professionals (IARP). Later, there was another “nurse only” group founded by Kelly Lance, known as the American Association of Nurse Life Care Planners (AANLCP).

Finally, life care plans have historically been subject to intense scrutiny in a variety of rehabilitation fields, including managed care, workers’ compensation claims, civil litigation, mediation, reserve setting for insurance companies, and federal vaccine injury fund cases.

The Present

At present, the life care planning specialty practice continues to grow, change, and modify the scope of practice associated with catastrophic case management. The International Academy of Life Care Planners is well established and has published the third edition of basic standards of practice (IALCP, 2015). The Journal of Life Care Planning was launched in 2002. Kaplan University, Capital Law School’s paralegal program, and the University of Florida’s Distance Education program offered online training programs leading to certification. At the time of this publication, Kaplan University has discontinued training and the University of Florida’s Distance Education program transferred ownership of their Life Care Planning Pre-Certification Program to the Institute of Rehabilitation Education and Training (IRET) which continues to offer online life care planning training programs. Also new since the third edition is the American Academy of Physician Life Care Planners (AAPLCP), founded in 2013, which held their inaugural conference in San Antonio in April 2016 chaired by Joe Gonzales, MD (aaplcp.org, 2016). Reportedly, this physician focused group is a professional organization of board certified physicians and other qualified clinical and forensic professionals dedicated to the practice and advancement of life care planning. According to the website, only life care planning certified physicians (CPLCP™) will be members with the “Fellow” designation. Qualified physicians and nonphysicians may join as a “member,” “associate member,” or “resident member” (see website for criteria). Although there may be other purported credentials for life care planning, “exams,” if any, may not be based on reliable/valid data, backed by legitimate role and functions studies, and an exam administered by a well-known organization does not constitute due diligence for a valid credential. An additional training program is FIG Services, independently owned and established in 2005 to provide education in Nurse Life Care Planning, Life Care Planning, and Medicare Set-Asides (FIG Services, 2017).

In addition to training programs, the Foundation for Life Care Planning Research (FLCPR), established in 2002, is a nonprofit research group that supports graduate students and other qualified research efforts in life care planning, including reliability and validity studies. The Foundation has held national Life Care Planning Summits on a biennial basis since 2002 with representation and endorsements from multiple life care planning and related organizations. Outcomes from the Summits have led to transdisciplinary and transorganizational consensus and majority views on more than 100 statements relevant to important topics and issues within life care planning (Johnson, 2015). At the time of this edition, the primary task of organizing the Summits has been assumed by the IALCP.
Although life care planning principles can be used in almost any aspect of care management, they are particularly useful in complex medical cases because the principles and methods that have been developed:

- Provide for needed quality care
- Reduce errors and omissions
- Allow fewer clients to drop through the cracks
- Reduce the failure to consider various aspects that can influence the ultimate outcome of the client’s medical care (Weed & Riddick, 1992; Weed, 1995a)

Complex case management has become a specialty area, and, indeed, the Certified Case Manager (CCM) designation became established in 1993. Good case managers—professionals who are able to work consistently in a complex and often adversarial system—are very valuable professionals.

Since the third edition of this textbook, certification continues to attract a variety of health care professionals, and there are now certified life care planners in Canada and most of the United States. Sometimes arguments continue to be raised that life care planners should be people with nursing backgrounds only (Weed, 1989 as cited in Weed & Berens, 2010). In addition, one article proposed that only professionals with at least a doctorate should be considered qualified to develop life care plans (Weed, 1997). However, in the view of many practicing life care planners as well as the organizers of the initial national life care planning training program, it is the expectation that various professionals are qualified to practice in areas of their knowledge, skills, and abilities. For example, a rehabilitation nurse who has recently graduated from nursing school is ill prepared to effectively manage catastrophic cases. On the other hand, a master’s-level vocational counselor who has spent several years working specifically in spinal cord injury rehabilitation may be extremely qualified to develop life care plans for that population. In addition, it is expected that life care planning members are part of a team, and it is further expected that team members will practice within their knowledge area. Historically, it has been common for vocational counselors and rehabilitation nurses to work together to develop vocational and medical rehabilitation plans (Riddick & Weed, 1996). Occasionally, nurses who author life care plans have been at a disadvantage since they are not educated or trained in vocational planning aspects. For helpful hints, see the chapter regarding the Role of the Rehabilitation Nurse in Life Care Planning where a checklist is available on questions the life care planner should ask the vocational expert.

In current practice, many organizations and hospitals have adopted life care planning procedures for discharge planning (Weed & Riddick, 1992; Riddick & Weed, 1996; Weed & Field, 2012). There are also health care professionals (such as physiatrists/physicians, occupational therapists, physical therapists, speech/language pathologists, nurses, dietitians, counselors, psychologists, audiologists, etc.) who develop projected care based on the published formats used in life care planning. Although it is important that the various participants in the training have a rehabilitation education and relevant certification in their area of specialty before engaging in the life care planning process, this by itself is certainly not enough; additional education and experience specific to life care planning are necessary (Weed, 1989, 1997). To identify some of the basic methodologies used in the profession and to underscore the relevance of the chapters included in this book, a review of the peer-reviewed current standards, developed in 2001, revised in 2006 and 2015, is appropriate (IALCP, 2015). Additionally, life care planning includes various topics that assure the effectiveness of the overall plan. Items included are listed in Table 1.1.
### Table 1.1 Life Care Plan Checklist

<table>
<thead>
<tr>
<th>Category</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Projected Evaluations</strong></td>
<td>Have you planned for different types of nonphysician evaluations (e.g., physical therapy, speech therapy, recreational therapy, occupational therapy, music therapy, dietary assessment, audiology, vision screening, swallow studies, etc.)?</td>
</tr>
<tr>
<td><strong>Projected Therapeutic Modalities</strong></td>
<td>What therapies will be needed (based on the previous evaluations)? Will a case manager help control costs and reduce complications? Is a behavior management or rehab psychologist, pastoral counseling, or family education appropriate?</td>
</tr>
<tr>
<td><strong>Diagnostic Testing/Educational Assessment</strong></td>
<td>What testing is necessary and at what ages? Vocational evaluation? Neuropsychological? Educational levels? Educational consultant to maximize PL 94–142 and/or Individuals with Disabilities Education Act (IDEA)?</td>
</tr>
<tr>
<td><strong>Wheelchair Accessories and Maintenance</strong></td>
<td>Has each chair been listed separately for maintenance and accessories (bags, cushions, trays, etc.)? Have you considered the client’s activity level?</td>
</tr>
<tr>
<td><strong>Aids for Independent Functioning</strong></td>
<td>What can this individual use to help himself or herself? Environmental controls? Adaptive aids? Omni-reachers?</td>
</tr>
<tr>
<td><strong>Orthotics/Prosthetics</strong></td>
<td>Will the client need braces? Have you planned for replacement and maintenance?</td>
</tr>
<tr>
<td><strong>Home Furnishings and Accessories</strong></td>
<td>Will the client need a specialty bed? Portable ramps? Hoyer or other lift?</td>
</tr>
<tr>
<td><strong>Drug/Supply Needs</strong></td>
<td>Have prescription and nonprescription drugs been listed, including size, quantity, and rate at which to be consumed? All supplies such as bladder and bowel program, skin care, etc.?</td>
</tr>
<tr>
<td><strong>Home Care/Facility Care</strong></td>
<td>Is it reasonable for the client to live at home? How about specialty programs such as yearly camps? What level of care will he or she require?</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td>Are hand controls sufficient or is a specialty van needed? Can local transportation companies be used?</td>
</tr>
<tr>
<td><strong>Health and Strength Maintenance</strong></td>
<td>What specialty recreation is needed? Blow darts? Adapted games? Row cycle? Annual dues for specialty magazines? (Specialty wheelchairs should be placed on wheelchair page.)</td>
</tr>
<tr>
<td><strong>Architectural Renovations</strong></td>
<td>Have you considered ramps, hallways, kitchen, fire protection, alternative heating/cooling, floor coverings, bath, attendant room, equipment storage, etc.?</td>
</tr>
<tr>
<td><strong>Potential Complications</strong></td>
<td>Have you included a list of potential complications likely to occur such as skin breakdown, infections, psychological trauma, contractures, etc.?</td>
</tr>
<tr>
<td><strong>Future Medical Care/Surgical Intervention or Aggressive Treatment</strong></td>
<td>Are there plans for aggressive treatment? Or additional surgeries such as plastic surgery?</td>
</tr>
<tr>
<td><strong>Orthopedic Equipment Needs</strong></td>
<td>Are walkers, standing tables, tilt tables, and/or body support equipment needed?</td>
</tr>
<tr>
<td><strong>Vocational/Educational Plan</strong></td>
<td>What are the costs of vocational counseling, job coaching, tuition, fees, books, supplies, technology, etc.?</td>
</tr>
</tbody>
</table>
After it is determined that a life care plan is appropriate, locating a qualified life care planner is necessary. Certainly, individuals who have completed the programs through the American Association of Nurse Life Care Planners, IRET, IARP, and others who have achieved the national board certified life care planner designation should be qualified, and visiting the certification boards’ websites (www.ichcc.org/clcp.html and www.aanlcp.org) will provide a list of certified individuals. The person seeking a qualified life care planning professional should inquire as to the source of the credential, the published peer reviewed research foundation for establishing the criteria, and whether the organization is recognized by credible overseers such as the National Commission for Certifying Agencies (see www.credentialingexcellence.org/ncca, 2016). Alternatively, there are other people who have been practicing in their respective fields for decades and have extensive experience that may supplant the need for a designated or certified life care planner (such as a fellow of the International Academy of Life Care Planners or those with extensive experience). Questions regarding the planner’s qualifications, which include education, work experience, life care planning experience, research knowledge and experience, certifications in legitimate rehabilitation areas, and, in the area of civil litigation, forensic experience, would be relevant (Table 1.2). It may also be important to determine the consultant’s awareness of life care planning with regard to his or her expertise or knowledge about the methodology of life care planning, courses completed on life care planning, references and publications relevant to life care planning, and knowledge of professionals who have been movers and shakers in the life care planning field.

It is also relevant to determine the consultant’s commitment to the profession by inquiring into which organizations he or she participates in. Many professionals pay monetary dues to associations but do not participate in professional development, committee work, or other profession-enhancing activities. It is pertinent to determine if the professional has contributed time and effort by either volunteering to work with clients, speaking on relevant issues, holding office within professional organizations, or writing for relevant publications. Receiving awards, honors, or peer recognition is also pertinent.

Other questions to ask may include the consultant’s jurisdictional experience. If the practitioner is expected to work in personal injury litigation, then experience in this arena seems appropriate. Other specialty practices exist and the rules differ, such that it is often extremely important to ensure that the practitioner’s experience covers these specialized fields (Weed, 1994, 1996; Weed & Field, 2012).

Reviewing a sample life care plan may be appropriate to determine if the prospective professional establishes a generally accepted foundation for his or her opinions and uses checklists and forms for other health professionals in their specific area of expertise. In general, it is expected that a physician be involved in the plan’s medical opinions, although there are many ways to establish a medical foundation for diagnosis and treatment if a qualified physician is not available. Other types of miscellaneous information may help determine if the consultant has a current vita that outlines his or her experiences, as well as any history of ethics or malpractice complaints.

**Step-by-Step Procedures**

Assuming that the rehabilitation professional is qualified to assess and project a lifetime care plan for a client and is knowledgeable in the topics to be covered, the next step is to begin the process of the life care plan (Table 1.3). First, of course, the referral must be made to the life care planner and basic information, including time frames, billing agreements, retainer information, and information release topics, must be discussed (Weed & Field, 2012). Second, it is important to obtain as complete a copy of the medical records as possible, including nurses’ notes, physicians’
Table 1.2 Checklist for Selecting a Life Care Planner

**Professional’s Qualifications**

- **Education**, including degrees and continuing education? If doctorate, was the university accredited? (Some have mail-order graduate degrees or diplomas from universities that are less than stellar.)
- **Work** experience?
- **Life care planning** experience?
- **Research** knowledge and experience?
- **Certifications or licenses**? Generally accepted rehabilitation certifications include **CLCP** (certified life care planner), **CRC** (certified rehabilitation counselor), **CDMS** (certified disability management specialist), **CVE** (certified vocational evaluator), **CRRN** (certified rehabilitation registered nurse), **CCM** (certified case manager), diplomat, or fellow **ABVE** (American Board of Vocational Experts).
- **Forensic experience** (if appropriate)? Familiar with the rules pertaining to experts? Have they testified? Do they have a list of cases in which they testified at deposition or trial for the previous 4 years? Plaintiff/defense ratio?

**Prospective consultant’s awareness of life care planning**

- Are they a board **certified** or qualified life care planner?
- Have they achieved the **certificate** in life care planning offered through one of the recognized training programs?
- Have they completed **courses** offered by a noted program on life care planning? (e.g., Kaplan University, Intelicus if previous to the 3rd edition of this text, University of Florida, International Association of Rehabilitation Professionals, AANLCP, et al.)
- Can they cite life care planning **references**?
- Do they subscribe to the **Journal of Life Care Planning**?
- Do they know some of the **professionals** associated with life care planning publications and training (e.g., Dr. Debbie Berens, Dr. Terry Blackwell, Dr. Richard Bonfiglio, Dr. Paul Deutsch, Julie Kitchen, Dr. Robert Meier, Dr. Ann Neulicht, Karen Preston, Dr. Fred Raffa, Susan Riddick-Grisham, Dr. Horace Sawyer, Dr. Randall Thomas, Dr. Roger Weed, Dr. Terry Winkler)?

**Commitment to the profession**

- Are they a member of the International Academy of Life Care Planners? What professional and disability-specific **organization(s)** do they belong to? (Are these legitimate or fringe organizations such as a for-profit owned by an individual or group with little recognition or substance?)
- Do they **participate** in professional development?
- Have they **contributed** their time and effort by volunteering services to clients in need, speaking, holding office with professional organizations, writing articles, chapters, or books?
- Have they received **awards, honors, and/or peer recognition**?

**Specialty practice experience?**

- Workers’ compensation or federal Office of Workers’ Compensation Programs?
- Personal injury?
- Social Security?
- State rehabilitation?
- Longshore workers?
- Jones Act?
- Federal Employees Liability Act (FELA)?
- Long-term and short-term disability?
- Specialize in a particular disability?

(Continued)
orders, ambulance reports, emergency records, consultants’ reports, admission and discharge reports, and laboratory and radiographic reports.

It is also useful to obtain additional information from the client or family in the form of depositions, interrogatories, or other records. Employment records, tax records, and school records are usually helpful if there are vocational issues to be included in the report. If the client is a young child with no educational or medical history, then it would be of value to survey in extensive detail the family history, including mother and father, aunts and uncles, and grandparents (Weed, 1996, 2000). In some situations, siblings may have school and other history that may be useful. Occasionally, videotapes of the client prior to the injury or day-in-the-life videos may be compiled by the attorney and can be useful, particularly in civil litigation defense cases or insurance consulting where the client is not readily accessible to the consultant.

An initial interview should occur at the client’s residence if possible (whether facility or home), and appropriate people should be invited to the interview, which may include parents, spouse, siblings, or caregivers. In general, initial interviews will last from 3 to 5 hours. When the professional attends the interview, it is important to use interview forms or checklists that will help structure the interview and ensure that topics appropriate to be discussed are encompassed. There may be supplemental forms for pediatric cases, brain injury, assistive technology, Activities of Daily Living, and others. It is useful to obtain a copy of the life care plan checklist (see Table 1.1) to educate the client and family members as to the purpose of the life care plan and the general components that make up the care plan. It is also recommended that a camera or video recorder be used to record the living situation, medications, supplies, and equipment used for the client. For example, a home may need to be modified and photographs are beneficial for documentation.

In general, it is valuable to consult with the therapeutic team members, if possible. As noted previously, there may be personal injury litigation defense cases or insurance consulting where this is not possible. It is also reasonable to retain the services of a physician or other individuals as appropriate when treatment team members are not available to discuss the case or the caregivers are not specialized. Also, some treating physicians are not experts in the particular disability or are reluctant to provide recommendations, in which case it may be appropriate to arrange for specialty evaluations by other qualified medical professionals.

There is a special note that should be made with regard to medical foundation for cases that have some or many medically based needs. There are people who are not physicians who claim that they need not have any more medical foundation than their own experience. There are others who

<table>
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<tr>
<th>Table 1.2 (Continued)</th>
<th>Checklist for Selecting a Life Care Planner Professional’s Qualifications</th>
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<tbody>
<tr>
<td><strong>Medical foundation for opinions established</strong></td>
<td>• Use established published checklists and forms?</td>
</tr>
<tr>
<td></td>
<td>• Routinely consult with a physician as part of the team and/or use clinical practice guidelines, medical records, medical depositions, or other recognized sources?</td>
</tr>
<tr>
<td></td>
<td>• Include other health professionals as appropriate (e.g., OT, PT, SLT, RT, audiology, neuropsych, etc.)?</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>• What and how do they bill for their services? Do they charge different rates for interview, records review, deposition, or trial?</td>
</tr>
<tr>
<td></td>
<td>• Do they have a current curriculum vita?</td>
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<tr>
<td></td>
<td>• History of ethics complaints or arrests?</td>
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assert they merely are administratively writing down the notes dictated to them by physicians and are not making independent judgments about the efficacy of recommendations. In this author’s opinion, a qualified life care planner must be a collaborator, participant, and author of the life care plan. For a detailed review of this issue, see the Appendix at the end of this chapter entitled “The Life Care Planner: Secretary, Know-It-All, or General Contractor? One Person’s Perspective” (Weed, 2002a), as well as additional comments made in the forensic chapter later in this book.

Table 1.3 Step-by-Step Procedure for Life Care Planning

1. **Case Intake:** When you talked with the referral source, did you record the basic referral information? Time frames discussed? Financial/billing agreement? Retainer received (if appropriate)? Arrange for information release?


3. **Supporting Documentation:** Are there depositions of the client, family, or treatment team that may be useful? Day-in-the-life videotapes? And if vocational issues are to be included in report, school records (including test scores), vocational and employment records, tax returns?

4. **Initial Interview Arrangements:** Is the interview to be held at the client’s residence? Have you arranged for all appropriate people to attend the initial interview (spouse, parents, siblings)? Did you allow 3 to 5 hours for the initial interview? (Some consultants or defense experts may not be permitted direct access to the client or treating health care professionals.)

5. **Initial Interview Materials:** Do you have the initial interview form for each topic to be covered? Supplemental form for pediatric cases, CP, traumatic brain injury (TBI), spinal cord injury (SCI) as needed? Do you have a copy of the life care plan checklist? Example plan to show the client? Camera or camcorder to record living situation, medications, supplies, equipment, and other documentation useful for developing a plan?

6. **Consulting with Therapeutic Team Members:** Have you consulted with and solicited treatment recommendations from appropriate therapeutic team members (if appropriate or able to do so)?

7. **Preparing Preliminary Life Care Plan Opinions:** Do you have information that can be used to project future care costs? Frequency of service or treatment? Duration? Base cost? Source of information? Vendors?

8. **Filling in the Holes:** Do you need additional medical or other evaluations to complete the plan? Have you obtained the approval to retain services of additional sources from the referral source? Have you composed a letter outlining the right questions to assure you are soliciting the needed information, as appropriate?

9. **Researching Costs and Sources:** Have you contacted local sources for costs of treatment, medications, supplies, equipment? Or do you have catalogs or flyers? For children, are there services that might be covered, in part, through the school system?

10. **Finalizing the Life Care Plan:** Did you confirm your projections with the client and family (if appropriate)? Treatment team members (if appropriate)? Can the economist project the costs based on the plan if one is used? Do you need to coordinate with a vocational expert?

11. **Last But Not Least:** Have you distributed the plan to all appropriate parties (client, if appropriate, referral source, attorney, economist, if there is one)?

Source: Roger O. Weed and Susan Grisham. Handout at various professional training sessions.
After preliminary life care plan needs are assessed, information should include frequency of the service or treatment, duration of the treatment, cost, source of information, and perhaps vendors for the services or products listed.

It is not uncommon for basic evaluations to reveal various holes that may require additional medical or other evaluations to be appropriate. For example, a neuropsychologist may be required in brain injury cases. It is important that the consultant compose a list of questions that will assist the evaluator in addressing questions that are specific to the life care plan (Blackwell et al., 1994a, 1994b; Weed & Field, 2012). For example, neuropsychologists may perform an outstanding job in writing reports and listing the results of tests but may be less than adequate in identifying functional limitations that result from the disability, as well as revealing specific treatment options with costs so that a projection of its estimated value can be determined.

After a life care plan has been completed, it is common for the planner to research the costs of treatment, medications, supplies, and equipment. There are occasions when catalogs will provide the necessary resource, particularly for products that are commonly available through mail order or for remote locations where the services or products are limited. In some states, depending on the jurisdiction (e.g., civil litigation, workers’ compensation, long-term disability, etc.), there may be a need to identify collateral sources. A common collateral source is a “free and appropriate education” often offered through the public school system for eligible students with a qualified disability under the federal Individuals with Disabilities Education Act (IDEA). There may also be special rules regarding the costs associated with products. One state, California, for example, proposes linking products and services for workers’ compensation insurance cases to Medicare/Medicaid reimbursement schedules.

As the life care plan is approaching finalization, it may be appropriate to consult with the client and family to determine that historical information is accurate and that the topics included in the life care plan are suitable and reasonable in accordance with the rules of the jurisdiction. Once the life care plan is complete, it is the responsibility of the life care planner to distribute the life care plan to appropriate resources. The life care planner should be mindful of the rules within the jurisdiction to avoid distribution of a plan to inappropriate sources. In the case of civil litigation, the attorney who retains the consultant’s service typically determines the appropriate recipient(s).

One more contemporary task in which some life care planners who are retained by plaintiff’s attorneys in civil litigation participate is to help develop day-in-the-life videos in support of settlement or trial exhibits. In recognition of this growing opportunity, a chapter on this topic has been added to this edition.

The Future

Life care planning continues to realize new horizons. Since the life care plan first emerged in the rehabilitation literature in the 1980s, the concept has grown immensely to represent the most effective case management method within the specialty practice, particularly with regard to complex medically challenging cases (Deutsch et al., 1989b; Kitchen et al., 1989; Weed & Sluis, 1990, Blackwell et al., 1997; Weed, 2007). As this book goes to press, many of the topics that were considered the future of life care planning just a few years ago have already become the present (Deutsch, 1994). Life care planning in the areas of reserve setting for insurance companies, managed care organizations, workers’ compensation, personal injury, facility discharge planning, and government-funded vaccine injury programs have strongly endorsed the concept. In civil injury litigation, the Daubert (1993) and Kumho rulings (see the new Chapter 36 on Admissibility as well as Weed & Johnson, 2006) will continue to affect how some professionals develop life care plans.
by encouraging the practice of using consistent, researched, and critiqued methods of developing
opinions (see chapters on forensics and perspectives by defense and plaintiff attorneys for more
information).

It was predicted that areas of mental health (especially serious lifelong psychiatric illness such
as schizophrenia), geriatrics, mediation, facility-based life care planning, special needs trusts for
children, divorce cases, and assisting families with financial and estate planning will increase.
However, there is more room for growth in all of these areas. An example was a divorce case
where the settlement was based somewhat on the cost of a persistent vegetative-state client living
at home; the soon-to-be ex-wife was aware that the child’s father planned to place the client in a
facility because it was less expensive and therefore would reduce his obligation for child support.
The care planner was initially asked to identify a reasonable care plan. Another example is that
attorneys who identify themselves as elder care lawyers are now practicing a recognized specialty
(see Chapter 25, Life Care Planning and the Elder Law Attorney, as well as the new chapter on
Elder Care Management Life Care Planning Principles in this book).

In addition, based on participants in recent training programs, experts from a variety of
health care–related occupations (physicians, neuropsychologists, occupational therapists, physical
therapists, and speech and language pathologists) will participate individually as life care planners
and as members of a team. Furthermore, life care planners are participating in training programs
and certification specific to the development of Medicare set-aside plans used primarily in the
workers’ compensation arena (ICHCC, 2016). Gaining knowledge and expertise in medical coding
procedures for determining medical charges for various services included in a life care plan also
appears to be an emerging area. Health maintenance organizations will use this methodology to
assist with the projection of costs for their catastrophically impaired patient population. Managed
care is a current phenomenon that has special application to life care planning. If the goal is
to manage care, then using life care planning procedures is a viable option. The design is an
excellent method to avoid errors and omissions. Unfortunately, the term managed care often really
means managed costs. If health maintenance organizations truly wish to enhance care outcomes
for their patients, then we will observe many case management professionals involved in training
programs focused on life care planning. At least one nationwide case management firm (General RE
Corporation) has adopted the basic life care planning procedure to work with insurance companies
for catastrophic injuries in an attempt to assist them with overall rehabilitation planning and
projection of costs. Structured settlement companies use the life care plan to develop proposals for
settlements and estate planning. Facility and hospital discharge planners will use the method for
more effective patient and family education as well as for assurance of comprehensive care. Another
area that appears on the horizon but is slow to catch on is provision for the care of children who have
complex health care needs and who are in the foster care system or are adopted (Buckles et al., 2008).

Another exceptionally relevant specialty area has to do with the care of wounded warriors. One
source estimates more than 35,000 injured military personnel, with substantial numbers requiring
long-term medical care (Leskin et al., 2007). However, it appears that veterans’ specific life care
planning has been slow to “catch on.” Several life care planners have also become a person’s case
manager and end-of-life and hospice choices training and education may be another emerging
need.

With the Affordable Care Act, many life care planners in litigation venues have been challenged
to consider the collateral source and financially offset appropriate categories (Field & Weed, 2015).
With the changing and undetermined future of health care insurance in the United States, life
care planning professionals should be prepared to answer challenging questions regarding cost of
future care needs.
Additionally, life care planning research already completed (Sutton et al., 2002, and reprinted in this text), has and will continue to increase in number and sophistication with an eye toward underscoring reliability and validity criteria, as well as enhancing the standards of practice. At the time this book went to press, the most comprehensive role and function study of life care planning was being updated and was in the data collection stage with results expected to be published in the Journal of Life Care Planning. For a current list of research projects completed or underway, visit the FLCPR website at http://www.flcpr.org/research.html.

Conclusion

Life care planning has emerged as an effective method for identifying and outlining future care needs and costs. The specialty practice continues to grow and develop new horizons. It is of specific importance that a coordinated effort with standardized approaches be promoted so that the practice as a whole progresses and becomes more useful in an ever-increasing number of venues. As more professionals, including allied health professionals, become involved in this process, the specialty practice will mature and develop more effective outcome measurements. Some universities are developing doctoral programs to endorse or encompass life care planning procedures and methods. A 2003 unpublished study of accredited graduate rehabilitation counselor training programs revealed that two-thirds offer training in life care planning (Isom et al., 2003). Indeed, beginning with its exam administration in October 2017, the Commission on Rehabilitation Counselor Certification has included life care planning as one of its knowledge domain areas under the category of Community Resources and Partnerships for which applicants will be tested (Commission on Rehabilitation Counselor Certification, 2017; see Section 11: The Certification Examination, https://www.crccertification.com/filebin/pdf/CRCCertificationGuide102017.pdf). In civil litigation, both plaintiff and defense attorneys have increasingly turned to rehabilitation professionals to consult on life care planning issues. It is incumbent upon the life care planning professional to assure that services offered are consistent with the standards of the profession and the methodologies that have been endorsed by practitioners. Building on the work of others, rather than reinventing the wheel, will assist in achieving this goal.

Appendix: Life Care Planner: Secretary, Know-It-All, or General Contractor? One Person’s Perspective

Some professionals have criticized life care planners for the way in which they conduct the process of accumulating the data required for projecting future care of clients. For consistency in this appendix, the life care plan definition is as follows: A Life Care Plan is a dynamic document based upon published standards of practice, comprehensive assessment, data analysis, and research, which provides an organized concise plan for current and future needs, with associated costs, for individuals who have experienced catastrophic injury or have chronic health care needs. Source: Combined definition of the University of Florida and Intelicus annual life care planning conference and the American Academy of Nurse Life Care Planners (now known as the International Academy of Life Care Planners) presented at the Forensic Section meeting, NARPPS annual conference, Colorado Springs and agreed upon April 3, 1998 and cited in Weed, 1999; available at www.internationalacademyoflifecareplanners.com. Consistent with the definition of life care planning, standards of practice, ethics, and procedures have been developed over the years to assure effective...
elucidation of client needs and published in peer-reviewed journals (McCollom & Weed, 2002; Weed 2002b). How one accomplishes this task has been refined to the extent that certified life care planners (CLCP) have been trained to review medical records, depositions, and all other available information, conduct interviews where possible, contact treating professionals when accessible, or otherwise obtain a foundation for the entries in the plan (such as hiring consultants to provide recommendations within their scope of practice and expertise or relying upon research). It is recognized that many life care planners are consultants in litigation, assist insurance companies to set reserves in workers’ compensation or health insurance cases, or work in other settings where they may not have access (either direct or indirect) to the treating professionals involved in the client’s care, and alternative approaches have been developed to assure accurate assessment of client needs. For purposes of this appendix, the focus will be on litigation-related plans.

**Two Apparent Self-Serving Views**

Varying criticism has been launched by some with regard to procedures used by life care planners for obtaining recommendations. This appendix is intended to address two well-known criticisms. The first is the rehabilitation consultant who stated in testimony that the life care planner’s role is essentially one of a “secretary.” The professional meets with the doctor or others and simply writes down their opinions, researches costs, and then publishes a report with the entries. The person presenting this assertion portrays the life care planner as merely a conduit for information. (It should be noted that the individual making this assertion is not a CLCP but was criticizing a life care plan—not this author’s, by the way. Reportedly, at least one CLCP has also presented this opinion.)

The second argument is by the professional who has “been there, done that” and based on his/her experience expresses that they do not need to consult anyone about projected needs. These individuals contend that a review of the records and perhaps an interview is all that is necessary to develop a comprehensive and accurate care plan for an individual with a catastrophic injury. Within this argument, several depositions reviewed reveal that these individuals believe their nursing degree uniquely qualifies him/her, or the CRC credential or PhD degree is adequate for him/her to complete a life care plan. Conferring with physicians or treating professionals (if available) is deemed unnecessary because, at least implicitly, “they know it all” or, alternatively, *ipse dixit* (loosely interpreted as “I said it so it must be true”). Also, the representation that one group of health care professionals is superior or more “uniquely qualified” to develop life care plans (assuming they have the credentials to seek certification) smacks of prejudice which sets up a foundation for conflict and strife (not unlike diversity bias). In fact, rehabilitation practice is built upon the foundation of teamwork to maximize outcomes.

**A Critical Review of Educational Requirements**

After reviewing various cases in litigation, workers’ compensation, and other disability related treatment venues, there seems to be a rather clear picture of what is acceptable with regard to developing an expert opinion that is “valid.” The “secretary” view can be easily dismissed since it is incumbent upon the qualified life care planner to:

- Know and understand medical terminology, basic anatomy, physiology, and the functional meaning of a diagnosis.
- Know what questions need to be asked of providers in order to get appropriate information regarding future needs.
Know how to work within the medical system and access the needed information.

Know which specialties and specialists should be included in care plans.

Know how to conduct relevant research about medical conditions and costs.

Be able to critically analyze and synthesize information from a variety of sources.

Know when information received is not credible or the professionals providing the information are not adequate.

Know when consultation by a specialist or specialists is indicated.

Know how to identify qualified specialists and coordinate the consultation.

Offer opinions within his/her professional expertise as a part of the overall plan.

Other… (Updated resources: For more information on role and function studies for life care planners, see https://www.ichcc.org/certified-life-care-planner-clcp.html and https://connect.rehabpro.org/lcp/home).

Like a secretary, life care planners use the telephone and often the computer to author letters and reports. However, “secretarial” work is a minor part of the process. Indeed, master’s degree students in rehabilitation counseling at Georgia State University must develop a comprehensive rehabilitation plan with a “real” client as part of their program. Even with specialized instruction, it is rare that a student can offer a professional quality product until they have gained real-world experience. In fact, students have available to them example projects as well as a textbook with step-by-step procedures yet most need “hand-holding” throughout the semester in order to complete the project. The point to the above is to underscore that the job of accumulating future care data for a person with a catastrophic injury or complex health problems cannot be delegated to someone who does not have specialized knowledge and training.

With regard to the “know-it-all” professional, in this author’s experience the individual commonly is not a CLCP. Two recent depositions reviewed were by nurses who admitted in deposition to never having any training in life care planning but, nonetheless, offered opinions for the plaintiff without the benefit of physician or therapist participation or endorsement of recommendations. The nurses claimed that their nursing education and experience was sufficient as the foundation for opinions. Three others, two of whom held doctorates and one master’s level CRC, opined that his/her experience was adequate to express opinions, with one stating that his/her rehabilitation counselor training was essentially equivalent to the CLCP. In an attempt to survey these assertions more closely, the accreditation agencies for nursing (National League for Nursing Accreditation Commission, www.nlnac.org) and rehabilitation counselor training (Council on Rehabilitation Education, www.core-rehab.org) were contacted. First, according to a survey of accredited rehabilitation counselor master’s degree programs, 54 percent offer some training specifically in life care planning and all are required to offer training in case management skills (Countiss & Deutsch, 2002). Other required curricula include medical aspects of disability (including anatomy and physiology), psychosocial aspects of disability, functional capabilities of people with disabilities, assistive technology, counseling and helping skills, vocational and career development, assessment, job development, research, and foundations of rehabilitation counseling. Nursing programs require education in anatomy and physiology, theoretical and clinical applications, nursing theory, nursing process, critical thinking, health assessment, technical skills, health promotion/disease prevention, concepts of illness and disease management, nursing research, nursing role, leadership/management, health systems and policy, and trends and issues in community based, acute care, and long-term care settings. A baccalaureate nursing curriculum typically includes courses on medical surgical nursing, obstetrics/women’s health, pediatrics, gerontology, psychiatry, and community health. There are other liberal arts courses with an emphasis in the sciences included, which is similar
to the baccalaureate programs the rehabilitation counselors must accomplish before embarking on a graduate degree. The bottom line: Although both education curricula include a foundation for working within the medical system, both have strengths and weaknesses. Nurses generally have more in-depth medical education than most rehabilitation counselors and may have some case management training but certainly are not trained as physicians or therapists. Rehabilitation counselors generally have more education and a broader perspective with medical case management, rehabilitation planning, and vocational planning training but likewise are not trained as physicians or therapists either. In addition, rehabilitation counselors with doctorates have more than twice the higher education than nurses and have additional specific rehabilitation training with a heavy emphasis on research. In this author’s view, all life care planners must have an adequate foundation for expressing medical or other expert opinions and just knowing what degree they possess is not enough. Indeed, many physicians will defer to other physicians when opinions are outside of his/her specialty area, so the nonphysician offering recommendations that are, in effect, prescriptions seems well outside his/her scope of practice. It should be recognized that this appendix does not address the training of the many other health care–related professionals who author life care plans, but many of the points are relevant to them as well.

In summary, the life care planner who portrays him- or herself as able to identify the details of lifetime needs of clients who require a physiatrist, neurologist, orthopedist, gastroenterologist, ophthalmologist, internist, neuropsychologist, occupational therapist, physical therapist, speech/language therapist, as well as nursing care, diagnostic studies, vocational needs, case management, and so on, is not credible. Even if the life care planner is a physician, he or she is not qualified to address many of the areas listed above (for example, case management and vocational needs) (Deutsch, 2002). The punch line of this discussion is that in order for the life care planner, retained as an expert witness, to offer a well-founded plan, he/she must rely upon many sources (medical records, literature, as well as solicited medical recommendations) for his/her opinions.

A Third View—By Analogy

An alternative comparison might be encapsulated in the analogy of the general contractor. In this author’s experience, general contractors come from a wide variety of educational and experiential backgrounds. The range of training includes engineering and architecture, as well as the person with a GED who worked up through the ranks by building homes. However, it is a rare person who knows every specialty. Think about some of the tasks that go into building a quality home: Architectural design, drafting, site preparation, foundation planning and forming, framing, electrical, plumbing, sheet rock, roofing, security systems, cabinetry, tile, bricklaying, wallpapering, flooring, painting, heating/air conditioning, landscaping, irrigation planning and installation, deck building, budgeting, and facilitating the permit process. The experienced general contractor probably has a “good idea” of what is involved in building a home but rarely knows all of the details especially when it involves troubleshooting, anticipating problem areas, or knowing the latest in building techniques and materials in all subspecialty areas. Likely, the general contractor will rely upon the opinions of experts within the various specialties to attend to those details which he/she is not qualified to do. In commercial construction where a bid is required, the general contractor will usually solicit bids from subcontractors and then compile the estimates into a proposal. The competent contractor knows who to hire or how to locate an expert in order to end up with a product that can be sold. However, we all know stories of failures in this industry where housing is not according to code or is substandard—not unlike some life care plans.
Conclusion

The qualified life care planner is neither a secretary nor all-knowing. He or she is more akin to a general contractor who has much to offer the health care industry in many settings. Like a general contractor, most states allow life care planners to hang out their shingle without anything other than a business license. However, most competent general contractors who build homes will join a local chapter of the Home Builders Association and agree to a set of ethics which adds a measure of comfort for the customer. Likewise, the foundation of a qualified life care planner is embedded in the individual professional’s education, related experience, and personal history. Receiving training specific to life care planning, joining an organization specific to life care planning, and achieving CLCP certification where standards and ethics are specific to the profession further supports that foundation and is the beginning to enhancing a valued profession. Since qualified life care planners are more alike than different and must rely on other professionals within his/her respective areas of expertise in developing a solid plan, it is incumbent upon all life care planning professionals to work together in this coordinated effort and to build consensus for uniformly accepted standards, ethics, and purposes.

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