

RESEARCH ARTICLES

A Comparison of the Steps, Processes and Considerations Involved in Developing a Life Care Plan in the United States and Canada

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Keywords: Canadian life care planning, American life care planning, Life care planning methodology

<https://doi.org/10.70385/001c.138605>

Journal of Life Care Planning

Vol. 23, Issue 2, 2025

Using as structure the phases of the life care planning method outlined in chapter two by Barros-Bailey, Rutherford-Owen, and Preston (2024), this article will present a comparison of American and Canadian considerations in the steps and processes of developing a life care plan. This includes a detailed analysis of both the common practices and nuanced differences in the operationalization of each phase of life care plan development. The methodologies and considerations presented are not inclusive of all American or Canadian life care planners. Rather, the authors respectfully recognize variability between individual practitioners, American jurisdictions, Canadian provinces and their associated public health care systems and offerings, as well as practice settings. For demonstrative purposes, a sample evaluatee will be presented to exemplify similarities and practical life care planning approaches taken by life care planners in Canada and the United States.

Sample Case Study

Mr. John Smith is a 26-year-old, African American male who sustained a gun shot wound with retained bullet fragments. He was diagnosed with a C5 ASIA A spinal cord injury. This diagnosis implies no sensory or motor function preserved below the level of injury (Physiopedia, 2025). Associated with Mr. Smith's diagnosis was a neurogenic bladder, neurogenic bowel, neuropathic pain, and spasticity. Mr. Smith spent 11 days in acute care followed by 20 days in inpatient rehabilitation in a spinal cord injury model system. Treatment providers included a physiatrist, urologist, orthopaedist, primary care physician, occupational therapist, and physiotherapist, as well as an activity-based therapy provider. Mr. Smith is married with three children all under the age of five years. The life care plan was finalized 15 months after the date of injury.

The Life Care Plan

Barros-Bailey, Rutherford-Owen & Preston (2024) identified a six-phase life care plan method. A more fulsome description of each phase can be found in the primary reference. In the following sections, each phase of the six-phase methodology in life care plan preparation will be presented, accompanied by a brief summative description. While there are many

similarities in the steps and processes involved in life care planning in the United States and Canada, there are some critical differences. In each phase, the similarities between the two nations will be presented followed by a review of any salient differences considering the American versus Canadian context.

Phase 1– Determining the Purpose

Setting the stage for the life care plan, this step involves identifying the purpose of the plan (e.g., a comprehensive life care plan in comparison to another form of report). This foundational step informs the decisions and actions to be taken throughout the life care planning process. In this phase, the life care planner confirms the nature of the loss, as well as intended purpose and use for the plan. In both countries, the most common causes of injury are motor vehicle collisions, professional malpractice (e.g., birth injuries, diagnosis delay/error, surgical outcomes, drug dosage or dispensing error), slip and falls, and assaults. Although the comprehensive process is similar, it is well-established that the process is to be individualized to the specific characteristics and needs of the case. Retainer agreements vary among life care planners.

Country	Differences in Application
United States	Plaintiff and defense attorneys, liability insurance carriers or self-insureds, and other entities may request life care plans, usually for cases of injury requiring long-term or lifetime care. In the case of Mr. Smith, a plaintiff attorney retained the life care planner for a personal injury lawsuit.
Canada	Referrals are most frequently received from plaintiff attorneys, defense attorneys, and sometimes insurers. Infrequently, life care plans are used outside of personal injury litigation (e.g., family law).

Phase 2 – Review Evidence and Conceptualize Case

Before meeting with the evaluatee (the person who is the subject of the life care plan), a detailed and comprehensive review of the secondary data is undertaken. Secondary data is data collected by someone else but reviewed by the life care planner to inform the foundation to the life care plan (Barros-Bailey, 2018). This is most often provided by the retaining referral source, and includes documentation authored by primary and specialist physicians, allied health professionals, emergency services, as well as legal, educational, and vocational sources. Documentation can be extensive, including data on pre-existing and concurrent issues. The life care planner identifies any data gaps and discusses with the referral source how to remedy the identified gaps.

A detailed review and analysis lead to a case conceptualization, which is innately informed by the scope of professional practice of the life care planner. Each life care planner has a professional scope of practice to which they must adhere throughout the life care planning process (International Academy of Life Care Planners (IALCP), The Life Care Planning Section of The International Association of Rehabilitation Professionals, 2022). The life care planner's scope of practice, experience, and skills inform a worldview or lens through which they conceptualize the case. The case conceptualization will include delineation of the index injury within the context of the evaluatee's

comorbidities, documented professional diagnoses and prognoses, impairments and strengths, environmental considerations (e.g., physical home structure, social supports), and current recommendations for care. Based upon the developed case conceptualization and the life care planner's scope of practice, the life care planner develops their scope-specific individual assessment protocol to inform the future steps of the process.

For Mr. Smith, documentation review was undertaken of the secondary data provided by the referral source, which included emergency response documentation, hospital and medical records, allied health and counseling records as well as deposition transcripts. The developed case conceptualization included a defined understanding of the nature of the injury, documented diagnoses and prognoses, impairments and strengths, environmental considerations, and the current required level of care. An assessment protocol was developed based upon the life care planner's scope of practice, with specific consideration of the case conceptualization. The intended assessment instruments were organized for the assessment with the evaluatee. Consent and release forms were developed to permit both the required assessment as well as the subsequent collaborations and investigations critical to the life care plan development. This process would similarly occur in both the United States and Canada.

Country	Differences in Application
United States	In the United States, life care planners may be nurses, occupational or physical therapists, physicians, psychologists, social workers, rehabilitation counselors, or other licensed specialists.
Canada	Canadian life care planners are most often occupational therapists. Other professional disciplines include vocational or rehabilitation counsellors, nurses, and other allied health professionals. Physicians may be asked to opine on life care plans (e.g., support a plaintiff-retained life care plan, act as a defense expert by opining on a plaintiff life care plan) but in Canada, physicians very rarely author life care plans. In Canada, life care planners commonly receive referrals long after the original event, perhaps even years post-injury, with the individual approaching or having already reached maximum medical recovery. As a result, the provided secondary data/documentation can be voluminous. Family physician clinical records are often provided by the referral source, as well as any other relevant data reviewing pre-existing or concurrent issues to be carefully considered. The analysis of the lengthy documentation summary informs the case conceptualization, assessment protocol, and plan for life care plan development.

Phase 3– Collect Primary Data

Phase three is informed by the active and strategized primary data collection by the life care planner. Primary data is data that is collected by the life care planner (Barros-Bailey, 2018). This includes the data collected from the evaluatee (e.g., subjective and objective data) via interview and implementation of the assessment protocol. Primary data is also collected via surveys, interviews, and collaboration with others, family members, members of the treatment team, assessors, and any other relevant collaborative sources.

Akin to what occurred with Mr. Smith, there are considerable similarities across the two countries in this phase. A formal interview is conducted with the evaluatee. During this interview, the life care planner explores the evaluatee's first-person, lived experience of their injury, recovery, function, and needs. While there are specific circumstances that may restrict the evaluation

to occurring virtually, an in-person evaluation is most common. Such an evaluation allows for observations of the evaluatee performing functional activities within their specific environment and administration of assessment protocols. An evaluatee's environment is informed by characteristics (e.g., physical, social, financial, institution or societal policies) that may facilitate or restrict functional participation. These characteristics of the environment can become more evident during in situ observation of functional performance. The observations and outcomes from the assessment protocol may inform the content of collaborative inquiries and recommendations to be included in the life care plan.

As relevant to the impairment and context, individual instruments (e.g., Bathel index, Disability Index, PHQ-9) can be completed by the evaluatee. Whether during the same interview with the evaluatee, or occurring at a separate time, a family member or close friend may be interviewed as to their observations of the evaluatee's status, needs, pre- to post-injury changes, etc. This third-party observation of changes in the evaluatee over time can be helpful. Such individuals may also be asked to complete selected instruments (e.g., Modified Caregiver Strain Index, WHO Disability Assessment Schedule). The descriptions from the evaluatee and their family member(s), the results from their completed instruments, and the life care planner's objective observations, both naturally as well as from the assessment protocol, are then triangulated. Any inconsistencies with the secondary data are explored and reconciled to develop a cohesive understanding.

With the evaluatee's consent, the life care planner will then determine the method they will use to collaborate with others related to the evaluatee's current and future causally related needs. These collaborations most often include medical and professional treatment providers. With catastrophically injured individuals, there are commonly large teams of professionals, necessitating numerous physician and allied health collaborations. In the case of Mr. Smith, this included his physiatrist, occupational therapist, and physiotherapist. Reiteration letters are commonly created following each collaboration and returned to the professional for review and authentication.

Country	Differences in Application
Canada	While practices vary among life care planners, Canadian physicians appear to prefer completing surveys rather than interviews. This is perhaps attributable to the limited number of physicians available in Canada and their resultant time restrictions. Canadian physicians tend to strictly adhere to their own scope of practice with the evaluatee (e.g., family medicine), and refer the life care planner to other physicians (e.g., specialists) for questions outside of that scope. For example, a family physician or physiatrist may identify the need for a urologist's involvement with the evaluatee given a neurogenic bladder due to the subject spinal cord injury, but customarily the family physician or physiatrist would defer to the urologist regarding the nature and frequency of urological intervention and related investigations. In Canada, the importance of these individual medical and allied health collaborations is further underscored by a lack of specialty programs such as an annual multi-day outpatient spinal cord injury assessment at a spinal cord injury rehabilitation centre, as was recommended for Mr. Smith. Specialists (e.g., physiatrists, orthopaedists, psychiatrists) are in short supply in Canada. Furthermore, there appears to be more reluctance among Canadian treatment providers to engage in medical-legal issues. It is not uncommon for treating specialists' responses to be quite delayed, resulting in a bottleneck for completion of the life care plan. This routinely results in careful consideration of the data available via the secondary sources. At times, referral sources will fund independent assessments (e.g., by a medical expert) to opine on a variety of matters (e.g., causally-related diagnoses and impairments, current and future needs, severity of impairment),

Country	Differences in Application
	which may be a more accessible means for the life care planner to collect required data. Collaborative interviews, rather than surveys, tend to occur with allied health providers and collateral information sources. These collaborations allow for an expansion upon the information available in the secondary data as specifically required for the life care plan (e.g., treatment objectives, anticipated outcomes, treatment anticipated until discharge from active intervention, intervention thereafter over lifetime, collateral recommendations, etc.). A summary of the collaborative interview is most often created by the life care planner and returned to the professional for review and authentication.

Phase 4— Research and Data Analysis

Phase four, typically the most time-consuming phase, involves applying the identified needs to appropriate life care plan categories. Categories represent a clustering of similar needs (e.g., treatment, personal care, equipment). Careful needs appraisal with associated researched costs is critical to developing a valid and reliable life care plan that meets standards of practice (IALCP, 2022). The planner substantiates the needs within the case-specific primary and secondary source data, clinical practice guidelines, and evidence-based practice literature. Clear grounding of the needs within the evidence enhances the internal and external consistency, as well as the validity of the life care plan.

Across both countries, and akin to the process used with Mr. Smith, this step involves researching the costs for the evaluatee's needs using a consistent, valid, and reliable approach (IALCP, 2022). Costs are to be verifiable, geographically relevant, and representative of the services available to address this specific evaluatee's needs (IALCP, 2022). Non-discounted/market rates are to be reflected. More than one cost estimate shall be considered, when appropriate (Johnson et al., 2018).

Overview of Contextual Differences in Phase 4

While costing data contained in a Canadian life care plan is derived through valid and reliable methods, the approach taken to obtain the data is quite different from the United States. This difference is approach is due to the structure of the Canadian health care system, access to stable and long-term public programs that the Canadian judiciary considers in their decisions, different regulations regarding collateral funding sources, and the lack of Canadian geographically based databases of reasonably available sources.

There are strengths and limitations inherent to Canada's public health care system. While there is equitable access to required medical care, there can be long wait lists (Moir & Barua, 2024). Additionally, there is a shortage of physicians in Canada. For example, the Canadian Institute of Health Information (2024) indicated that 5.4 million adult Canadians, representative of approximately 17% of the population, do not have access to a regular primary health care provider. There are some private diagnostic services (e.g., MRIs) available in some jurisdictions of Canada but private medicine remains rare.

In contrast, the American health care system operates through a complex blend of private and public financing, with most individuals covered through employer-sponsored insurance, while others rely on government programs such as Medicare and Medicaid. The United States spends more per capita on health care than any other country (Gunja et al., 2023) and leads in medical innovation, offering patients access to advanced technology, specialized providers, and cutting-edge treatments. The American health care system is plagued by high costs, administrative inefficiencies, and significant disparities in access and outcomes. Preventive care is underutilized, and major public health indicators such as life expectancy and maternal mortality rank below those of peer nations. The fragmented nature of care delivery often undermines coordination and drives up costs, without corresponding improvements in health outcomes (Gunja et al., 2023).

In the United States, the collateral source rule is a common law doctrine that prevents a defendant from reducing liability by the amount of compensation a plaintiff receives from independent sources, such as health insurance. This has obvious implications for life care planning. The rule aims to ensure full accountability for tortfeasors and to avoid penalizing injured parties for having secured benefits through foresight or employment. However, many states have modified or abolished the rule in certain tort contexts, leading to variation in its application (Atchity, 2021; Stern & Rutherford-Owen, 2022).

In 2002, Dr. Paul Deutsch, who is considered to be the founder of life care planning (Bonfiglio & Marcinko, 2024), wrote the following related to the Individuals with Disabilities Education Act (IDEA), a law that makes available a free appropriate public education to eligible children with disabilities throughout the United States:

...IDEA is viewed as one of the most stable collateral sources available for children with disabilities. Services provided to school children with disabilities under the IDEA or Section 504 of the Rehabilitation Act of 1973 are stable, time tested and reliable and funding for continued services under these programs has been a government priority that is expected to continue (Deutsch & Sawyer, 2002, as cited in Neulicht & Berens, 2011, p. 294).

Although IDEA was established in 1975, several authors in the most recent life care planning handbook continue to reference IDEA as a resource for educationally necessary needs in pediatric life care plans in the United States (Bagnell & Moberg-Wolff, 2024; Berens & Neulicht, 2024; Sutton, 2024).

Similarly, in Canada, there are longstanding, publicly funded programs, such as the Ontario Drug Benefit and the Assistive Devices Program of Ontario. The Ontario Drug Benefit Act was introduced in 1990 and an act of parliament would be required to change it. The Assistive Devices Program of Ontario came into existence in 1982. Both programs are long-established

government programs that have endured for at least 35 years. They have clearly established standards for entitlement and quantum of benefit. To avoid duplication within the life care plan (i.e., applying a cost for a need that will be funded by a public program), non-discretionary, longstanding public programs that have clearly established entitlement criteria and established quantum of benefit bear consideration in a Canadian life care plan.

Country	Differences in Application
United States	Life care planners commonly use a combination of national databases that allow for geographic adjustment, internet research, and personal contacts (i.e., calls, emails, etc.) to obtain costs for items included in the plan.
Canada	The socialized Canadian health care system ensures universal coverage for medically necessary health care services that are provided on the basis of need rather than the ability to pay (Government of Canada, 2024). Canada is composed of 10 provinces as well as three territories located in the far north. Approximately 90 percent of Canadians live within 160 km of the border with the United States, with a tendency to congregate in urban centres (O'Neill, 2025). Given that Canada is the second largest land mass in the world, this reflects a concentration of the population in the southern third of the country's geography. The greatest population density is found between Quebec City, Quebec, and Windsor, Ontario. Specialized medical and rehabilitation services are located in large urban centres, which can be long distances from some evaluatees' homes. The federal government transfers funding (collected through taxation) to the provinces and territories, who are responsible for delivering health care to its citizens. To receive the Canada Health Transfer from the federal government, the provinces and territories must fulfill five key principles as stipulated by the Canada Health Act (Government of Canada, 2025): 1. Public administration: The health care insurance must be administered and operated on a non-profit basis by a public authority. 2. Comprehensive: The health care insurance plan must insure all health services provided by hospitals, medical practitioners (and some dentists), and similar, additional services rendered by other health care practitioners (e.g., nurses, acute care allied health professionals). 3. Universality: The health insurance plan must uniformly entitle all insured persons of the province to insured health services. 4. Portability: Outside of a minimum waiting period of three months, the health care insurance plan must not impose any other waiting periods as citizens relocate between provinces. 5. Accessibility: The health insurance plan must provide insured health services on uniform terms and conditions that provide reasonable access to services. Provinces and territories are not permitted to extra-bill or apply user charges for insured health services. Generally, inpatient services delivered in a hospital such as physician and nursing services, diagnostics, acute allied health services, as well as meals and lodging are funded by the provincial health care insurance programs. Outpatient diagnostics and laboratory services, as well as primary care (e.g., family physician, nurse practitioner), are commonly funded by the public health system. Services not funded by the public health care insurance system (e.g., allied health, mental health counselling, dental care) must be funded privately. Each province or territory, often in consultation with physician regulatory colleges or groups, determines the realm of services deemed to be "medically necessary". Once a service is deemed to be medically necessary, the full cost of the service must be covered by the public health insurance plan to in compliance with the Canada Health Act. In sum, while there are significant commonalities between the provinces, there are some differences and nuanced characteristics between the 13 regional public health insurance systems in Canada. Akin to life care plans developed in the United States, Canadian life care planners outline the relevant medical needs in a life care plan. However, in Canadian plans, the evaluatee's needs are itemized but identified as covered under the provincial health care insurance plan. No cost for the medical service is applied given the statutory legislation governing public funding for medically necessary care. As travel costs are routinely included in Canadian life care plans, the accurate quantification and likely provider of the service is relevant. Furthermore, though funding of medical care may be publicly available, detailing the anticipated medical needs is critical to the philosophy of life care planning (IALCP, 2022, p. 4): A life care plan is a document that provides accurate and timely information which can be followed by the evaluatee (the person who is the subject of the life care plan) and relevant parties. It is a detailed document that can serve as a lifelong guide to assist in the delivery of health care services. In addition to the medically necessary services, which are statutorily safeguarded by legislation, provinces and territories offer supplementary publicly funded health benefits to specified groups (e.g., individuals with disabilities, children, seniors). These programs are offered at variable degrees of funding (e.g., complete funding, a portion of funding) to address needs such as medications, mobility devices, medical equipment, hearing care, vision care, and dental care. These programs are not always statutorily safeguarded but many have been in existence for decades with some periodic revisions.

Country	Differences in Application
	Canadian life care planners shall consider non-discretionary, longstanding, public programs with clearly established entitlement criteria and quantum of benefit. These programs are periodically revised. While the life care planner may detail such potential for change, the trier of fact should be aware of their existence for appropriate consideration. Furthermore, considering the philosophical overview outlined in the Standards of Practice for Life Care Planners (cited above), inclusion of these programs in the life care plan serves as a source of information to the evaluatee. Considering the lifelong potential of the plan, the evaluatee will benefit from knowledge of these programs for their future access. As one example, consider the Ontario Drug Benefit (Ministry of Health of Ontario, 2025). Ontarians who qualify for this program include: • Ontarians 24 years of age or younger who are not covered by a private insurance plan (e.g., through their parents' collateral benefits) • All Ontarians once they turn 65 years of age • Low income seniors can have their deductible waived • For other seniors (variable with their level of income), there are deductibles (e.g., \$100/year) and minimal co-payment funding requirements (e.g., \$4-6/prescription refill) for other seniors. • Ontarians living in a long-term care home, home for special care, or Community Home for opportunity • Ontarians receiving professional home and community care services • Ontarians who are receiving social assistance through either Ontario Works or Ontario Disability Support Program • Ontarians enrolled in the Trillium Drug Program There is a published formulary (https://www.formulary.health.gov.on.ca/formulary/) that allows confirmation of coverage via the Ontario Drug Benefit program, which covers approximately 5000 prescription medications (Ministry of Health of Ontario, 2024). In Canada, an evaluatee's access to collateral benefits (e.g., through their employer or their spouse's employer) should similarly be outlined, along with any limitations, for the trier of fact to consider. Not considering these public programs and collateral sources risks the application of duplications to the life care plan. A comprehensive life care plan would reasonably be expected to include different models presenting available support versus the out-of-pocket, extraordinary costs to the evaluatee: Model 1: Collateral Benefits Current collateral benefits, such as that available through the evaluatee's employer, or a parent's or spouse's employer • The funding level available should be detailed as well as any deductibles payable by the evaluatee, confirmable via pharmacy records. Details of any limitations such as a maximum allowance or effect of retirement shall be presented. Model 2: Public Funding If the evaluatee is eligible, either now or in the future, to receive medication funding through the Ontario Drug Benefit, the funding parameters, deductibles, and co-payments should be outlined. Model 3: Private Funding Out-of-pocket, extraordinary costs to the evaluatee in the absence of collateral benefits and public funding should be presented. The development and presentation of the details (e.g., level of current available funding, deductibles and co-payments, limitations of funding, susceptibility to a loss of coverage) inherent to the three models of care eliminates duplication and allows the trier of fact to consider the options available to the evaluatee. A further consideration of funding relates to the nature of the loss and the sources of funding that may be inherent to that event in question. A significant proportion of the referrals received by life care planners in Canada relate to motor vehicle collisions. There are different forms of motor vehicle insurance determined in each province and territory. Some provinces have government-funded insurance programs, whereas other provinces have private insurers delivering insurance that is overseen by a government ministry. Some jurisdictions have optional levels of coverage for motorists to purchase. Ontario, the most populous province of Canada, has a no-fault, private insurer system that is overseen by the Financial Services Regulatory Authority (FSRA) of Ontario. The Statutory Accident Benefits Schedule is enshrined in legislation in the Ontario Insurance Act (Government of Ontario, 2025). The available benefits have been revised over the years. There are different levels of coverage available to insureds based upon the nature of their injury (i.e., non-catastrophic versus catastrophic). Changes in statutory coverage have occurred over time. Coverage is mapped to the date of loss. Currently, if an insured experiences a catastrophic injury today, there is combined maximum of \$1 million available for medical and rehabilitation benefits, as well as attendant care benefits. In addition, there are other available benefits (e.g., income replacement benefits, housekeeping and home maintenance benefits, education, and visitor's allowance). While these benefits are substantial, they are often exhausted by an individual with catastrophic impairments. Thus, it is necessary for supplementary funding sources to be examined. The result is that Canadian life care planners may in fact be costing the needs outlined in their life care plan in more than one full set of tables: one set considering the funding and parameters specific to the available insurance coverage and a second set of tables considering private market rates for needs that fall in excess to the insurance funding. There are no known commercial costing databases available to Canadian life care planners. Thus, each life care planner/organization tends to maintain their own repository of information. This repository may be built (and maintained for currency) most often via internet research and direct

Country	Differences in Application
	inquiries with geographically relevant providers, as recommended by the life care planning literature, such as Consensus Statement #85 (Johnson et al., 2018).

Phase 5 – Report Findings

As was developed for Mr. Smith, a life care plan includes a narrative report that describes and grounds the outlined needs within the presented primary and secondary data as well as evidence-based literature. The narrative should clearly present the information from the referral, the secondary data documentation analysis and case conceptualization, the assessment findings, collected primary data, and finally, the identified needs. The narrative should be clearly written, organized, demonstrate consistency, and present the evaluatee's needs in a well-reasoned manner. Narrative formats vary between life care planners and some referral sources may have a preferred format. Life care planners will quantify the needs and related costs in tables either embedded within the narrative or appended to the narrative. This is well described in the Standards of Practice #15 & #16 (IALCP, 2022) and is consistently present in life care plans authored both in the United States and Canada. Given that Canadian life care plans can be initiated later than those in the United States and thus involve more extensive documentation review, some Canadian life care planners will include a lengthy documentation summary and analysis as an appendix to enhance the readability of the remainder of the life care plan.

Country	Differences in Application
United States	In the United States, depositions of life care planners are very common in personal injury, medical malpractice, product liability, and other complex litigation cases. Life care planners are not deposed in all jurisdictions; however, it is common in most circuit, state, and federal courts. Therefore, American life care planners should anticipate giving sworn testimony and defending their opinions at some point on any given case and plan accordingly from case inception. Robinson (2024) provides a description of the American legal system and the procedures and requirements of the system as it relates to a life care planner working in a forensic milieu.
Canada	With variability among practitioners, it is not uncommon to find the signed surveys and summaries of the collaborations enclosed with the life care plan as appendices. This is intended to enhance the transparency of the life care plan and allow a reviewer to audit the completeness as well as the internal and external consistency of the life care plan. Some life care planners will transparently represent their costing research (i.e., specific provider and cost) whereas others may simply reference the providers they sampled in their costing research. A point of significant contrast arises in providing sworn evidence. Very few (e.g., 2%) of Canadian tort cases reach a court room (Government of Canada, 2021). Depositions do not exist. Thus, Canadian life care planners do not routinely have a vast amount of experience providing expert testimony. Given Canada's less litigious society, physicians are less experienced than their American counterparts in medical-legal issues. Canadian physicians appear to be reluctant to get involved in opining outside of their scope of practice and most are not familiar with the practice of life care planning. Treating physicians are infrequently involved in reviewing life care plans.

Phase 6 – Re-Evaluation

In practice, the process of life care planning is iterative. That is, through data collection and analysis, there may be a need to return to previous phases to ensure that the needs outlined in the life care plan are grounded in substantive and defensible data. A life care plan is most commonly defined as follows:

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. (International Conference on Life Care Planning, 1998, emphasis added).

This reflects the understanding that needs change over time. Even the most rigorously developed, valid, and reliable life care plan may be periodically re-evaluated, due to individual or contextual changes. This may prompt renewed collaboration and a revised treatment plan. At the request of the referral source, a life care planner may prepare an addendum to the original report, detailing any changes since the time of the original report with an explanation of how the changes impact the previous recommendations. Alternatively, a more fulsome updated report may be indicated. Further consultation or collaboration may be indicated with treatment providers followed by the previously outlined steps and details. This process would be common across both the United States and Canada.

Upon reading the physiatrist's deposition testimony related to Mr. Smith, the life care planner learned of possible updated recommendations pertaining to antispasmodic agent frequency and neurogenic bladder management. Consequently, a follow-up phone conference with the physician resulted in new recommendations, and an updated plan was submitted to the referral source.

Conclusion

Based upon the above analysis, there are clearly high degrees of similarities in the steps and processes involved in life care planning in the United States and Canada. However, due to identified societal differences in healthcare delivery including the availability of healthcare providers and the legal systems of Canada and the United States, and their accompanying practices, there are noteworthy differences in the life care plans prepared in each country. This article has detailed salient differences in the operationalization of each phase of life care plan development. Specific differences were discussed including the requirement to consider the socialized medical system of Canada and stable, enduring publicly funded healthcare delivery programs, and the lack of available databases for Canadian life care planners.

Published: July 22, 2025 CDT.



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