Journal of Life Care Planning, Vol. 1, No. 4, 239-264.
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An Educational Curriculum for Teaching Life Care Planning

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Abstract. Life care planning is a service offered by some rehabilitation consultants. However, few graduate rehabilitation counseling programs offer a course in life care planning. This article outlines the proposed content for a graduate level course in life care planning. The curriculum outlines the teaching content, resources, and teaching recommendations for 15 weeks of instruction. Relevant resources are included.

"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 (now known as the International Association of Rehabilitation Professionals) annual conference, Colorado Springs, CO, and agreed upon April 3, 1998 and cited in Weed, 1999.

Accordingly, the Life Care Plan is a comprehensive document that has been characterized as a "living document" that provides future care needs for those who have sustained a catastrophic injury. The Life Care Plan in and of itself is a case management tool, ideal for allowing those responsible for the care of persons with severe disability to guide and coordinate the delivery of necessary services and interventions throughout their life.

Week 1: A Historical Perspective

One of the most recent reviews of the history of Life Care Planning is found in the first chapter of Weed's *Life Care Planning and Case Management Handbook* (1998). Weed cites the origin of life care planning in the 1981 publication regarding determining damages in a civil litigation case by Deutsch and Raffa (1981). However, given the nature of case management involved in developing life care plans, educators may choose to begin the discussion much earlier than at the point cited in Weed's handbook. George N. Wright, in his text Total Rehabilitation (1980), provides some detail regarding the origins of "comprehensive rehabili-

tation planning". Comprehensive rehabilitation planning was originally mandated and defined in 1943 by the enactment of Public Law 78-113, the Barden-LaFollette Act. However, rehabilitation counselors have been providing comprehensive rehabilitation planning since 1918 when congress passed the Soldier's Rehabilitation Act, which provided for the vocational rehabilitation of disabled servicemen.

Specific to the growth of life care planning as a specialized field, however, Weed (1999) cites the first formalized training by Paul Deutsch in 1986. Deutsch and Sawyer's 1985 *A Guide to Rehabilitation* represented the first comprehensive "how to" book on the topic (May, 1998). Concerned that the industry was fragmenting and poorly standardized, five experts in 1992 developed eight life care planning training modules and established a life care planning training program, initially offered by the Rehabilitation Training Institute (RTI) and later through a private-public partnership between RTI and the University of Florida (UF). In 1996, Intelicus was formed in partnership with UF to continue the training of life care planners that previously had been provided by RTI and UF. Responding to a need for certification in the field of life care planning, the Commission on Disability Examiner Certification (CDEC) began efforts in 1994 to provide certification for life care planners and awarded its first certifications in 1996. In 2002, CDEC renamed its certifying body and is now known as the Commission on Health Care Certification (CHCC) and has awarded certifications to over 600 life care planners. The CHCC maintains the certification exam and renewal process. For more information on certification and the certification movement for life care planning, the reader is referred to May (1999) and CHCC's website at www.cdec1.com.

The Philosophy of Life Care Planning

General rehabilitation philosophy would suggest that the planning would facilitate the individual to become as independent as possible. Ideally, the individual will live in the least restrictive environment (one's own home vs. nursing home), and participate in society to the greatest extent possible. The individual's ability to work, their need for recreation, and other personal growth activities should be given equal consideration.

Marques Jaques, in her book, *Rehabilitation Counseling: Scope and Service* (1970), was the first in rehabilitation to utilize the "whole person" approach or the "holistic" concept in relation to dealing with people with disabilities. She pointed out that it is not possible to divide the person into parts. The acknowledgement of the parts creating the whole is fundamental in the area of life care planning.

In addition to the philosophical descriptions above, the second author of this article typically describes a major premise as conceptually restoring an individual to the type of lifestyle that he/she would have lived had the injury/disability not occurred. This concept is helpful in combating defense attorney arguments that some life care plans represent the most expensive of goods and services (i.e., recommending a moderately sized new accessible home as opposed to an apartment or trailer for someone whose pre-incident lifestyle and/or upbringing would have been as a homeowner).

Who is Qualified to Be a Life Care Planner

There continues to be on-going discussion regarding the "minimum" standard qualifications of who should be considered a "Life Care Planner." Historically, rehabilitation counselors have been performing the essence of the role and function of a life care planner for

decades. Some believe that nurses are ideally qualified to be life care planners; however, in reality, people from various professional backgrounds can qualify such as case managers, nurses, rehabilitation counselors, occupational therapists, physical therapists, speech and language therapists, and physicians (Weed, 1997).

Weed (1997, 1999), Deutsch (1994), and Blackwell (1994) agree that a rehabilitation professional trained as a rehabilitation counselor or nurse who has experience and specific knowledge regarding various disabilities may be excellent candidates to develop life care plans. Currently, there are several certifications that are relevant to life care planning, including the Certified Life Care Planner, the Certified Nurse Life Care Planner, the Certified Rehabilitation Counselor, the Certified Disability Management Specialist, the Certified Case Manager, and the Certified Rehabilitation Registered Nurse. These are but a few of the available certifications, with some having more relevance than others.

Teaching Suggestions for Week 1

Have students investigate the various certifications and certifying bodies to determine the level of relevance of the certification and the credibility of the certifying body, then compare and contrast what the students find. Provide a review of the Code of Ethics of each of the certifying bodies to examine the relevance and utility in working with clients in this venue. Have a life care planner or a small group of life care planners come speak about their education, training and professional experience. Stress the need for students to gain significant knowledge and experience in working with people with specific disabilities prior to initiating practice in life care planning.

Week 2: Overview of a Life Care Plan

Prior to beginning to delve into the individual components and intricacies involved in a life care plan, it is beneficial to provide students with a general overview of what a life care plan looks like and its component parts. Using an actual case study will be effective in educating students about the components of a plan as well as showing them an actual case. Although there are slightly different formats for composing a life care plan referenced in the literature (Blackwell, Krause, Winkler, & Steins, 2001; Deutsch & Sawyer, 1995; Weed, 1999), the content within each format is essentially the same and is typically broken down into two areas.

The first area is narrative and involves an integration of information generally gathered from a variety of sources including the clinical interview; review of medical and rehabilitation records; client earnings records (W-2s), if applicable; vocational and/or psychological or neuropsychological assessments, if applicable; depositions (video and/or written); school transcripts; and vendor prices for any purchased equipment, supplies or medications. This information generally conveys demographics about the client and their needs.

The second area of the life care plan includes the tables and addresses the types of services, supplies, equipment and adaptations being recommended for the client. This section also includes the expected cost for each item and replacement schedules, if required.

Section 1: Demographic Narrative

Gathering demographic information is very similar to a case management intake inter-

view. Blackwell et al., (2001) outlines a number of categorical information to be ascertained about the client including records reviewed, referral and background information, education and training, military service (if served), vocational history, pre-injury medical history, post-injury medical history, post-injury complications, functional abilities, activities of daily living, current management and care, current financial status, and conclusions. Similarly, Deutsch and Sawyer (1995), cite categories including client identifying information, chief complaints, physical limitations, additional data, current medical care, education and training, behavioral observations, test administration, medical summary, and conclusions. In cases of clients with an established work history, Deutsch and Sawyer (1995) include an additional section related solely to vocational history which addresses vocational handicaps, impact on placement, impact on range of job alternatives, rehabilitation plan, vocational development options pre- and post-injury, and pre- and post-accident vocational alternatives. In both instances, similar information is gathered to paint a clear picture of the client's pre- and post-injury circumstances. Educators should briefly define the type of information that is generally gathered in each category.

Section 2: Life Care Planning Tables

Deutsch and Sawyer (1995) identify a total of 18 different tables to be included in the life care plan; however, all tables rarely apply to any particular client's case. An overview of the tables should include general information regarding what types of components apply to each area. The tables include projected evaluations, projected therapeutic modalities, educational assessment/diagnostic testing, wheelchairs, wheelchair accessories and maintenance, home/facility care, transportation, drug and supply needs, home furnishings, aids for independent function, health maintenance, future medical care-routine, future medical care-aggressive treatment, complications, architectural renovations, prosthetics/orthotics, vocational/educational plan, and orthopedic equipment needs. For a brief description of each table, see the Life Care Plan Checklist in Weed, 1998 (p. 5).

Vocational Damages Assessment

In many cases there is the need for a vocational damages assessment as part of or in conjunction with the life care planning process. This section of the report is covered in detail in week ten of the course; however, it is important to educate students that many of the details regarding the extent of the damages and how the value of the damages is determined is discussed in the narrative report. While the cost of services and items in the rehabilitation plan is often found in the life care plan tables, the foundation or rationale and support for the proposed rehabilitation plan is found in the narrative report rather than in the tables.

Teaching Suggestions for Week 2

Educational strategies for this section may include having students review actual life care plans of several different types of injuries as homework assignments. Students can gain a better understanding of the consistency in reporting, noting, however, the distinct individual differences in plans (especially which charts to use) for various types of disabilities. In class discussion, students can be asked about the 18 tables and which ones may or may not be used in specific instances (e.g., a 70 y.o. client with a below the knee amputation would not require a table for

"vocational/educational plans").

Week 3: Building a Foundation - Data Collection

Requesting Records From the Referral Source

The first step in data collection involves letting the referral source know the type of information needed to build your report. A request for information form can be developed utilizing check boxes of which records are being requested from the referral source. Typical information to request includes all medical records, including rehabilitation and therapy evaluations and treatment; earnings and employment records, if applicable (generally for the last three years of full-time work); available depositions related to damages and/or future needs; school transcripts, if applicable; opposing side life care plan (if/when developed) if retained as a defense consultant; psychological or neuropsychological evaluations, if applicable; and vocational evaluation, if applicable (Deutsch and Sawyer, 1995). Often, information such as depositions and some evaluations have not taken place at the time of referral and are generally forwarded at a later date. The critical information to begin formulating the plan, however, is the medical records and earnings records. It would be useful for educators to provide examples to students pertaining to what a deposition looks like, neuropsychological report, vocational report, samples of medical records, and therapy evaluations (i.e. physical therapy, occupational therapy, speech therapy). Although some life care planners prefer to have this information in-hand prior to meeting the client in order to have a clearer picture and formulate additional questions, other planners prefer to complete the interview without any preconceptions of client function or status.

Conducting the Client Interview

The client interview is perhaps the most important component in gathering information about the client's mental and physiological functional status. The interview is conducted for several reasons. First is simply to meet and observe the client in person, preferably in his/her own living environment. This becomes important in establishing credibility of the planner in assessing the client's needs as opposed to developing a multi-million dollar life care plan for someone the planner has never met or seen. The second reason for the clinical interview is to solicit information from the client regarding the intricacies of what the disability imposes regarding everyday function. Related to this is the importance of interviewing the client in his/her home environment whenever feasible. Valuable information that generally is not found in the medical records includes the client's deficits in being able to carry-out activities of daily living due to physical limitations or environmental barriers. A third, but not exhaustive reason for the client interview is to attain his/her assistance in gathering information regarding their everyday needs as well as the costs. It is best to call the client prior to the interview and ask them to gather records to be provided to the planner at the interview relating to monthly costs of medications, supplies related to the disability, and any costs to providers or others. It is also important to explain to clients or legal guardians what the role of the life care planner is in the litigation process, why certain questions must be asked, and essentially any other issues important to providing full professional disclosure to clients.

As far as the actual interview itself, the multitude of questions to be covered is beyond the scope of this article. However, the major categories include client identifying information, family history, education/training, employment history, disability conditions, history of com-

plications, physical limitations, neurobehavioral limitations, environmental limitations, work situations/limitations, present medical treatment, adaptive equipment, supplies, activities of daily living, social activities, personal habits, financial status, agency involvement, available support to client, behavioral observations, tentative plan and impressions (Blackwell et al., 2001, p. 87). Educators and students are encouraged to review Blackwell et al., (2001) for more detailed information regarding the client interview.

Although some attorneys customarily hire other professionals to videotape a "day in the life" video of the client, in the author's experience, this also can fall under the purview of the life care planner. As an alternative, many life care planners take digital or still photographs of the client and his/her equipment, home environment, supplies, etc. Such visual representations become extremely effective tools in demonstrating to a jury what the client's actual needs, limitations and lifestyle are like with the disability. Professionally prepared "day in the life" videos are often several hours of material edited into 20-30 minutes showing key activities being performed during the day. Depending on the disability, these may include getting up/out of bed, ambulating, feeding, performing hygiene needs (e.g., brushing, grooming, bathing, etc.), communicating, and other key activities that demonstrate the client's level of functioning. For confidentiality reasons, educators need permission to show client videos and/or photographs to their students.

Clinical Interviews of Adults vs. Pediatric or Legal Guardian Cases

Clinical interviews for life care plans generally vary in length, but often average between three to five hours in the author's experience. Some life care planners mail out the interview questions in advance to the client, which can curtail some of this time. Interviews with adults who do not have a severe cognitive impairment are different from interviews regarding pediatric cases or adults with cognitive impairments. Essentially, interviews of adults without cognitive impairments who have the ability to be their own historian focus on obtaining information from the client as the primary source of information. Other individuals such as the spouse or primary caregiver also can be interviewed either with the client or separately; however, they should be viewed as the secondary source of information.

In pediatric or legal guardian cases, the client generally is not the primary source of information. In such cases, a parent (in pediatric and some legal guardian cases), spouse, or primary caregiver will provide information regarding the client's needs, functional limitations, and services/supplies/equipment. It is important for life care planners to observe the client and attempt some communication with him/her where relevant in order to gain an understanding of the extent of cognitive impairment (this of course precludes assumptions about infants) (Blackwell, Sluis-Powers, & Weed, 1994; Kitchen, Cody, & Deutsch, 1989). Planners in all clinical interviews also need to make behavioral observations of the family in order to note any adjustment problems that may need to be addressed.

Vocational Evaluation Clinical Interview

This component of the clinical interview focuses on the type of information that needs to be gathered regarding employment or potential future employment. In pediatric cases, the primary source of information will be from the parents and the planner must ascertain the parent's education, occupational history and earnings. Isom, Barton, and Holloway (2001) noted these to be the major predictors in establishing the probable future career path of the

child. Other researchers indicate it is also important to gain an even broader picture of an injured child's probable career path by considering sibling educational, vocational and earnings records (if relevant), as well as grandparents and aunts/uncles (Deutsch & Sawyer, 1995). The type of information planners need to gather during the interview may be found in Blackwell et al., (2001, p. 90), who notes specific types of questions to ask regarding past employment.

In obtaining information regarding clients with an established work history, key questions that must be answered include previous employers, job title and work responsibilities, hourly wage or salary, chronology of work history, why the person left the job, any past workers' compensation claims, and what skills might be transferable to other jobs. The planner also will need to gather documentation (i.e. W-2s) regarding annual earnings for at least the last three full years of work (Weed, 1999). Finally, it is important to ask the clients what their future vocational intentions and interests are regarding whether they believe they can work again, want to work again, go back to school, etc (Isom, 2001). This information, in part, ultimately assists the planner in establishing a vocational/educational plan for the client. Information on how the vocational assessment is derived is discussed in detail later in this article.

Teaching Suggestions for Week 3

Teaching strategies to ensure students understand the importance of the clinical interview as well as the type of information to be gathered can be used in several ways. For instance, students can be given the framework of the clinical interview and paired with one another; taking turns and interviewing each other and compiling a demographic report to turn in for a grade. Another assignment could be to have students again pair up and produce a 20-30 minute "day in the life" video of each other, having to decide what to video, and how long each segment/situation being videotaped should last.

Week 4: Building a Foundation - Interviewing Treators

Physicians

Following the interview of the client or family/guardian of the client, interviewing the various professionals who have treated the client is a fundamental aspect of building the life care plan (Weed, 1999). As indicated earlier the client may have been treated by a multitude of physicians, therapists, nurses, etc. and each specialty has very specific concerns regarding the client. Likewise, each treatment provider has very specific recommendations regarding the client's needs that are within their respective guidelines of treatment or standard of care.

Probably the best place to start is with the client's treating physician(s). The life care planner must determine what each physician's diagnosis (primary and secondary) is, prognosis for the patient, recommendations for future treatments, future medical exams, medications, tests/lab work, functional limitations, their opinion regarding ability to work, ability to live independently and associated costs, including their professional fees. These are but a few of the categories to be ascertained. Researching the disability prior to interviewing the treator is recommended depending on the level and currency of information the life care planner has regarding the client's illness or disability. Certainly, the life care

planner would want to have some idea of potential complications, general care issues and accommodation needs for individuals with the same or similar conditions prior to the interview (Kitchen, 2002). If the treator does not bring up these areas of concern, the life care planner should be in position to explore these issues with the treator.

Blackwell, Weed, et al, (1994), and Blackwell, Powers, et al, (1994) both have sample questions in their appendices which include questionnaires for the nurse, occupational therapist, physical therapist, speech and language therapist, mental health professionals, neuropsychologist, physicians, and vocational rehabilitation counselor and employer. Certainly, questions would vary depending on the nature of the disability, e.g., if the client has a spinal cord injury versus a head injury then the questions would inquire about different concerns relevant to the client. In the author's experience, it is useful for the life care planner to send the treator a copy of their questionnaire for review prior to the actual meeting or phone conference so that they may be more prepared on the types of topics to be discussed. Often the treator will submit a written response to the life care planner, then the life care planner will simply supplement the information outlined in the questionnaire with the actual conference, if needed.

Not only does the life care planner need to be sure to ask for specific information that would be important to the future care of the individual, but often the treator will add information that is essential to the future care needs of their patient. When interviewing multiple physicians, which is actually fairly common, each physician will recommend a course of medications or therapies for their client, some of which may be redundant and the life care planner needs to inform the physician of the schedules other physicians have already recommended. The life care planner should also inquire about the treator's costs.

Teaching Suggestions for Week 4

Students can be given a mock case with a specific disability. They can prepare a list of questions that they would use to interview a treating physician and various therapists referring to one or multiple resources to assist in building their questionnaire. Resources might include one of the following, however this list is by no means comprehensive:

Blackwell, T., Powers, A., & Weed, R. (1994). *Life care planning for traumatic brain injury: A resource manual for case managers*. Athens, GA: E & F, Inc.

Blackwell, T., Weed, R. & Powers, A. (1994). *Life care planning for spinal cord injury: A resource manual for case managers*. Athens, GA: E & F, Inc.

Consortium for Spinal Cord Medicine, Paralyzed Veterans of America. (1999). *Outcomes following traumatic spinal cord injury: Clinical practice guidelines for health care professionals*. Washington, D.C.: PVA.

Falvo, D.R., (1999). *Medical and psychosocial aspects of chronic illness and disability* (second edition). Gaithersburg, Maryland: Aspen Publications.

Reed, P. (2001). *The medical disability advisor*. Boulder, CO: Reed Group, Ltd.

Rosenthal, M., Griffith, E., Bond, M., & Miller, J. (Eds.). (1990). *Rehabilitation of the adult and child with traumatic brain injury* (second edition). Philadelphia: F.A. Davis Company.

Weed, R. (1999). *Life care planning: Past, present and future*. In R. Weed (Ed.). *Life care planning and case management handbook*. Boca Raton, FL: CRC Press.

Week 5: Building a Foundation - continued

Certainly, with the multitude of physicians treating an individual with catastrophic injury, the life care planner can spend a great deal of time trying to interview every provider involved. In such cases there is often a primary treator who can be relied upon to gain specific information regarding overall treatment. If the primary provider does not want or cannot address specific issues outside their area of specialty then the life care planner will have to interview an appropriate specialist who can provide input into those areas.

In some cases, the author has found it useful to identify an individual to serve as the primary physician or medical coordinating expert. Often this physician is a physiatrist or physical medicine and rehabilitation (PM&R) physician. Due to the nature of their specialty area, physiatrists can give information regarding the needs of the individual in a much more comprehensive manner, often reducing the need to seek multiple opinions from numerous specialists. The physiatrist will have information that concerns the whole person, future needs, and a much more functional prognosis regarding clients who have a physical disability. Conversely, clients with brain impairments may be best served by a neurologist and/or neuropsychologist who can address damage to the brain and functional consequences of the damage.

It is recommended the life care planner submit their plan to the primary physician or medical coordinating expert for their review and to gain the physician's signature on the life care plan due to the vast extent to which its foundations are based upon the physician's recommendations.

There is virtually unlimited opportunity to work with other treators and/or consultants in developing the life care plan. Psychologists, neuropsychologists, OTs/PTs, communications specialist, audiologists, neuro-optometrists, prosthesist, and orthotist are but a few of the possible ancillary professionals associated with any given case. These individuals contribute significant information to the current and future needs of the client and part of the life care planner's role is to identify and/or coordinate services across all the various specialty areas required for the client to receive optimum care and outcomes. The life care planner will have to identify specific information relevant to the specialty area when interviewing these various professionals.

Teaching Suggestions Week 5

Week five is simply an extension of week four. The instructor may want to invite a local physiatrist to speak to the class about his/her role and specialty. Using the mock case that was used in week 4, the students may want to identify various specialty areas that will likely be involved in the client's future care and then prepare a questionnaire relevant to the specialty area.

Week 6: Resources and Researching Costs

This aspect of developing life care plans is perhaps the most detailed and laborious and requires excellent organization skills. There are numerous sources of information; however, the best sources are the client (or significant other/caregiver) as well as the

treating medical professionals and those already involved in the client's care (Weed, 1999). Whenever treating professionals (i.e., physicians, therapists, nurses) are unable or unwilling to provide recommendations, a second alternative is to seek out professionals who may not have treated the client; however, agree to see and evaluate the client to provide future care recommendations. Finally, if neither of these options is feasible, a third option is to have a relevant medical professional review the client's medical records to provide prognostic recommendations for future care (Meier, 1999). Still, some planners find it just as useful and less time consuming to consult with only the treating physiatrist or appropriate specialist regarding all future medical care (i.e., therapies, physician visits, equipment needs).

Educators should provide to students copies of interview questions typically asked of each discipline. Weed's 1999 book, *Life Care Planning and Case Management Handbook*, offers excellent questions when consulting with physiatrists, nurse case managers, vocational counselors, psychologists, neuropsychologists, occupational therapists, physical therapists, speech language pathologist's, audiologists and economists. For example, treating occupational therapists will be in the best position to recommend devices and equipment such as wheelchairs, wrist splints, orthopedic equipment, and the numerous other devices which may assist the individual in functioning independently (McCaigue, 1999). Of course, specific and individualized questions relevant to the particular client will also need to be answered.

The client, who typically has had several months or years living at home by the time the life care planner interviews him/her, will also be an excellent source of information regarding personal needs. The client will often have an established record of specific needs such as ostomy and/or other equipment and supplies, where purchased, frequency of purchase, and at what price. Depending on treating physician recommendations, these records can often be integrated directly into the life care plan.

Finally, it is essential that life care planners be well versed in the medical implications of the specific disability of their client. Without a strong foundation of information regarding the medical aspects of specific disabilities, life care planners will simply not know the range of relevant questions to ask clients and treating medical professionals. Treating professionals do not generally focus on their clients' long-term needs, therefore, life care planners must know enough to prompt medical consultants with the right questions. Blackwell (1999) discusses ethics and life care planning and notes that it is unethical for life care planners to take on cases for which they are not otherwise qualified. As such, life care planners may obtain educational information regarding the medical aspects of specific disabilities by attending specific disability conferences, accessing library books and specific websites regarding the disability, accessing medical journals such as the Archives of Physical Medicine and Research and Journal of Trauma, checking Index Medicus for other related journals, or accessing computer databases such as MEDLINE and CINAHL (nursing and allied health database).

Pricing Out Costs: Local vs. National

Once all future care need recommendations have been gathered, the next critical step in developing the life care plan is to research costs for the goods and services recommended. Most life care planners agree that obtaining local prices for goods and services where the client resides is more relevant than obtaining national prices (Blackwell et al.,

2001; Deutsch & Sawyer, 1995; Weed, 1999). Kitchen (1999) outlines numerous resources for obtaining information and prices regarding various disabilities and services. Some services such as Acumyn™ have extensive databases on local goods and services as well as pricing information, almost providing life care planners with one-stop shopping for resource information (Kitchen, 1999, p. 461). The ability to ascertain costs for goods and services for the client becomes fairly easy when the life care planner resides in the same city as the client or has knowledge of local resources. Telephone, fax, e-mail or in-person visits all accomplish the same objective, however, life care planners must be careful to document who they spoke with, title, date, company name and what type of information was gathered.

Oftentimes, life care planner's clients are located in another city or state and gathering local resource information begins when the life care planner travels to conduct the clinical interview. The experienced life care planner will either have the client gather a list of applicable goods and services and provider contact information prior to the visit, or gather the information once there. Short of this, life care planners will need to access this information via the client by phone post-interview, or use the World Wide Web Yellow Pages or other resources to locate this information.

In addition to direct local resources for prices of goods and services, life care planners have other options available to them used in the author's experience. There are numerous resources available regarding equipment, supplies, orthotic devices, etc. found in disability-related magazines such as New Mobility, Paraplegia News, and Accent on Living. Company catalogs also are very useful in establishing pricing on a variety of goods such as CARE Catalog, Sammons-Preston, Abbey Medical, Home Health-Care Rehabilitation Products Directory and Resource Guide, and Maxiaids. In addition, numerous web sites such as www.invacare.com and www.theboulevard.com also provide information regarding costs for equipment and other supplies. In many instances, shopping directly from these resources is less expensive than going through local medical suppliers.

Assistive Technology

As stated at the beginning of this article, the majority of graduate rehabilitation counseling programs do not have a course on life care planning nor do they offer a course on assistive technology. As such, many life care planners are subsequently left to independently obtain information regarding the types and functions of numerous assistive or adaptive devices available on the market. Medical supply companies often have trade shows such as Medtrade, National Home Health-Care Expo, and Abilities Expo which brings together hundreds of vendors to not only promote their products, but also educate conferees on the product's functions, costs and warranty. Conferences and expositions that feature products such as standing frame wheelchairs, patient lifts, adaptable vans, self-turning air mattresses, ostomy supplies, etc. are an excellent source of information and education for the life care planner.

A second source of information on assistive technology would be to visit rehabilitation hospitals and meet with specialists who are up-to-date on assistive technology related to various disabilities. Additionally, visiting local medical suppliers and viewing the equipment, as well as observing demonstrations are equally effective.

Finally, in lieu of being able to access information on assistive technology by attend-

ing trade shows or visiting local rehabilitation hospitals or medical suppliers, life care planners may be able to obtain a working knowledge of assistive technologies through a combination of reading technology information in a supplier's brochure or on their website, then follow-up by discussing the equipment with the supplier. In follow-up discussions on assistive technology, life care planners must address the warranty and replacement components of the equipment as well as the cost of each. Although power wheelchairs are typically expected to last approximately five years with normal wear and tear, the batteries and tires/tubes wear out and need to be replaced on a more frequent basis according to the author's experience consulting with various vendors. The life care planner, therefore, must ascertain which components of the technology require preventative maintenance or require replacement on a regular basis.

Teaching Suggestions for Week 6

Educators may choose from a number of teaching alternatives related to resources and researching costs of goods and services. First, students must be knowledgeable about the medical aspects of the disability they are researching. One possible exercise is to give students as a homework assignment, a case study noting a relevant list of goods, assistive technology and supplies for which they must ascertain the costs. No specific directions on how to go about determining costs should be provided beyond the lecture content noted above. An adaptation of this assignment is to have students divide into groups of three and have one research answers to the assistive technology being prescribed, a second student research various supplies (i.e., ostomy, medications), and the third student research services such as the cost of therapies, home health care by an RN vs. a personal care attendant, and routine medical visits.

Another potential assignment would be to have students access website information to research and obtain information on assistive technology, its cost, and resource name, address and phone number. On a more local level, have students arrange to visit with occupational therapists or other specialists at a rehabilitation hospital or medical supply company, if feasible. University services for students with disabilities should also be able to provide a tour and demonstrate assistive technology (e.g., especially in the areas of blindness and deafness).

Finally, in a large group presentation, students can convey to other students what their findings were, their experiences contacting and consulting with medical professionals, and prepare handouts for other students regarding pricing information for goods and services. Through group discussion, students can learn from one another as to what type of information is available and how to go about obtaining the information.

Weeks 7, 8, & 9: Developing the Life Care Plan Tables

As indicated under Week 2, Deutsch and Sawyer (1995) identified a total of 18 different tables that might be appropriate for a given client. However, it is important to stress that different clients have different needs, resulting in different elements being included in the life care plan. Additionally, different life care planners may name their tables differently and may use a different format for outlining the information. There are guidelines published that the life care planner can follow. The established methods and

standards for life care planning (see Standards of Practice, Reavis, 2002) were published just for such purpose. The life care plan must include all tables relevant to the client and the thoroughness of each table in regard to the inclusion of all appropriate details that are recommended for the future care of the person with a disability.

Three predominant life care planners, Blackwell, Deutsch, and Weed, have utilized different components of the same table however, all three are very similar in substance. As an example, Deutsch utilizes the following column names in his Projected Evaluations table: Item/Service, Age/Year, Frequency/Replacement, Purpose, Cost (per unit & per year), Comment, and Recommended By (Kitchen, 2002). Blackwell utilizes the following columns in his Projected Evaluations table: Evaluation, Age/Year Initiated, Age/Year Suspended, Frequency, Base Cost, Growth Trend, and Recommended By (Blackwell, Powers, et al, 1994). Lastly, Weed utilizes the following columns in his Projected Evaluations table: Evaluation, Year at Which Initiated, Age/Year at Which Suspended, Per Year Frequency, Base Cost per Year, Growth Trend and Recommend By (Blackwell, Powers, et al, 1994).

Each table addresses the need to show a start date, end date (which may be the life expectancy of the client and would be stated as such), a base cost (either per unit or per year), and a column to indicate who recommended the evaluation. From this discussion, it is apparent that although the tables may vary slightly by title, all tables will have similar details.

Table 1

Element Title	Element Contents
Projected Evaluations	Allied health evaluations not performed by a physician.
Project Therapeutic Modalities	Treatments by allied health professionals.
Diagnostic Testing/Educational Assessment	Vocational Evaluations, psychological and/or neuropsychological evaluations, and other pertinent testing.
Wheelchair Needs	Wheelchair type and configuration, replacement schedule as required by client.
Wheelchair Accessories and Maintenance	Funds required to maintain the chair and associated components (including replacement schedule of components).
Aids for Independent Living	Items allowing for increased independence with living environment, ex. Environmental controls.
Prosthetics and Orthotics	Braces and body part (prosthesis) replacements, fitting, maintenance and replacement schedules and costs.
Home Furnishing and Accessories	Beds, ramps, and other home accessories needed for home living.

Drug and Supply needs (often two different tables)	Required Medications, dosages, supplies, and unit costs.
Home Care v. Facility Care	Specific needs of the client regarding assistance in activities of daily living and/or supervision. In-home care includes PCA, LPN, RN or Live-In Caregiver, homemaking assistance, yard care, etc. Facility care includes facility placement (e.g., residential brain injury program, assisted living facility, nursing home, etc.)
Future Medical Care—Routine	Future evaluations and treatments that are known that the client will require. Often the medical evaluations are broken out into a separate table due to costs differences in evaluations v. office visits.
Transportation	Specialized drivers training or adapted vehicles, including wheelchair lifts, hand controls, bumper mounts, tie-downs, etc. and replacement/maintenance schedules associated with the disability
Health and Strength Maintenance	Recreation and physical training needs, ex. Recumbent bicycle for blind client or “swim X indoor exercise pool” for brain injured client living in remote area.
Housing and/or Architectural	Specific requirements for the client depending on level of disability, living requirements, and/or renovations or

Renovations	modification costs of existing housing.
Future Medical Care: Aggressive Treatment or Surgery	Surgeries or other medical treatments that the client is likely to have to undergo with projected costs.
Orthopedic Equipment Needs	Walkers, canes, standing frames, and other "durable medical equipment" (which is often the title of this table).
Vocational/Educational Plan	Itemized parts of the vocational rehabilitation plan, including vocational evaluation, vocational counseling and guidance, training costs, rehabilitation technology, adapted work station, etc. as well as start and end dates and associated costs.
Potential Complications	Complications that individuals are likely to experience as a result of the disability, illness or injury.

Teaching Suggestions for Week 7, 8 & 9

With the conclusion of study of the various formats that have been used to outline the future care needs of the client; the class will start building tables. At the conclusion of week 7 the students will work on the first two tables. This work can be done independently or as a small group. At the start of week 8 the class will resume building tables with the goal to complete work on 8 more tables. In the last week, the class will complete building the remainder of the tables outlined above.

Week 10: Establishing Vocational Damages

Field (2002) indicated that vocational rehabilitation, in most cases, is an essential part of the life care plan. Assessing the vocational potential is uniquely to the professional domain of the Rehabilitation Counselor (Weed, 1997). This is a multi-step process that starts with deter-

mination if the client is employable after the injury or illness. If the client is employable, the next question is at what level? The counselor needs to determine if the client can return to work using their residual skills in their old occupation or related occupation with or without accommodations. If that is not possible, can the client be re-trained? If so, what level of employment will the client enjoy? Will there be a reduction in earnings from their prior or pre-morbid occupation? Once a vocational plan is developed, the counselor then determines the costs associated with services needed to accomplish vocational goals.

Secondary to the plan development and the cost of the plan is determination of the effects the injury/illness has on the client's earning capacity. Earning capacity evaluation has been reviewed and published in many places (Isom, 2001, Weed & Field, 2001, & Weed, 1999). Isom reviews the different methods and approaches to earning-capacity evaluations, chapter 11 of Weed & Field's *Rehabilitation Consultant's Handbook* analyzes and contrasts the different approaches to earning capacity loss evaluation and Weed deals with specifics of earning capacity evaluation within the role of a life care planner.

Ultimately, the rehabilitation counselor will determine what the client's pre-morbid earning capacity was, the cost of the mitigation of the effects of the injury/illness (the rehabilitation plan with associated costs), and the residual earning capacity. Within the context of the residual earning capacity, the rehabilitation counselor will explore the client's work life expectancy, access to the labor market pre- v. post-injury, and employability. If there is a loss, the rehabilitation counselor will document the amount of loss which could range anywhere up to a 100% loss. For cases in which a 100% loss is expected, the concept of "the odd-lot doctrine" should be reviewed (Weed, 1999). Typically, the rehabilitation counselor will defer to an economist to determine the present value of the loss, unless the counselor has some specific training that allows him/her to make this determination.

Teaching Suggestions for Week 10

Given the same mock client the students have been working with, determine what the client's pre-morbid earning capacity was. Determine the highest level of employment the client can reasonably expect to participate in and outline the rehabilitation plan that will achieve the desired goal with costs of the plan. Next, determine the post-injury or "residual earning capacity," the client's work-life expectancy and calculate the loss if such exists.

It may be helpful for the teacher to review a life care plan with a complex earning capacity evaluation and rehabilitation plan and discuss how the evaluation was performed as well as the concepts of reliability and validity with regards to the rehabilitation plan and the earning capacity loss evaluation.

Week 11: Completing the First Draft of a Life Care Plan

By this stage of the course, students should now be thoroughly familiar with the intricacies of developing a life care plan. Educators should stress that despite how comprehensive most life care planners can be in developing a plan, it is important, when feasible, to have the plan reviewed by the client (or legal guardian) as well as by the relevant treating professional(s). Both individuals will have ideally been involved in the building of the plan from the onset; therefore, there should be few surprises to both parties (Blackwell et al., 2001; Deutsch & Sawyer, 1995; Weed, 1999).

The client, or his or her legal guardian, should be asked to review the plan carefully for accuracy of demographic history and content of recommendations. Clients should also be advised not to become disheartened over some of the possible recommendations and opinions. For example, in order to avoid a vocational opinion of the client having the probability of being permanently unemployed become a self-fulfilling prophecy, life care planners need to counsel clients about the legal concepts of probability vs. possibility, and if clients so desire, they may well be able to work. Other components of the plan that may require explanation relate to some of the assistive technology, which may have been recommended based on the life care planner's experience, however, not previously discussed with the client. This occurrence should be rare, since it is highly recommended that life care planners consider technology recommendations with the consultation and mutual agreement of the client and his/her treatment providers.

In addition to the client's review of the plan, the treating specialist who provided recommendations into the client's future care needs should also receive a draft of the life care plan for review. Having the treating specialist's "stamp of approval" is critical to avoid potential surprises if the treating specialist does not agree with some of the recommendations or is of the opinion that more or different services should be included. Since life care planners often include recommendations in the plan that fall within their own area of expertise independent of treating specialist recommendations, they should be prepared to explain, justify and have the recommendations confirmed by the treating specialist. In some instances, planners may choose to remove items from the life care plan that the specialist does not support. Conversely, having a testifying treating specialist state that he/she has reviewed the life care plan and agrees with its recommendations greatly strengthens the plan's credibility and general acceptance of it.

Once the treating specialist and client have had a chance to provide feedback regarding the life care plan, the planner should integrate any relevant changes before submitting to the referral source. Some life care planners keep previous drafts of their plans which opposing attorneys can subpoena, while other life care planners choose to destroy first drafts once they have been updated and maintain only the most current plan in their records.

Teaching Suggestions for Week 11

Through class discussion, educators can begin this class by asking students to list why it is important for clients and the treating specialist to review the first draft of a life care plan. This can be followed up with presenting for class discussion, a case study (e.g., TBI) where a spouse represents his/her significant other. Students should be provided with a demographic history, and summary of the treating physician and legal guardian interview of the client to review prior to handing out a copy of the life care plan. Next, students should be provided with a copy of the life care plan for the client with a head injury and asked to review it for accuracy and content. The plan should deliberately be missing certain recommendations made by the treating specialist in the interview notes as well as reporting inaccuracies pertaining to the client's demographic history. Once students have been allotted ample time to review the plan, a discussion should ensue where the educator solicits student feedback regarding what is missing or inaccurate about the plan. This exercise additionally serves to have students review plans with a critical eye for detail.

Week 12: The Legal Arena

One cannot start this discussion without first talking about being qualified as an "expert." The whole discussion in Week 1 is driven by this topic. The legal system has determined how to qualify an individual as an expert. In 1923, the case Frye v. United States clarified who would be considered an expert (Isom, 2001). That decision was made in Federal Court; although many State courts still utilize Frye as the standard. In 1993, Daubert v. Merrill Dow Pharmaceuticals redefined for the federal court system who may be deemed a qualified expert. Currently 26 states have adopted Daubert as the standard (Field, 2000). In 1999, the debate that arouse from the Daubert decision was partially addressed in another court decision, Kumho Tire Co. v. Carmichael. A thorough review of these issues is provided by Tim Field in his *Resource Guide on the Daubert and Kumho rulings* (Field, 2000).

Secondary to the topic of who is an "expert" is the introduction to how the system works, legal terminology and the different perspectives of the plaintiff and the defense counsel (Isom 2001). There are hedonic damages, pain and suffering, punitive, and special damages which is the primary area of concern for the rehabilitation consultant. Special damages also are referred to as "compensatory damages" and determining the value of the compensatory damages is the reason why either the plaintiff counsel or defense counsel hires a rehabilitation consultant to prepare a life care plan and an earning capacity loss evaluation (Isom, 2001). For further discussion of these issues, the reader is referred to Weed & Field (2001), chapter on forensics. Additionally, in Weed's *Life Care Planning and Case Management Handbook* (1999), there is a thorough discussion regarding the role of the life care planner when working with the plaintiff and defense counsel, as well as an overview of the legal system in relation to life care planning.

Teaching Suggestions for Week 12

There are several ways the instructor may want to present this information in a meaningful way. One way might be to use a video-taped deposition of the plaintiff's expert that has been "reacted" followed by a discussion of the case and the students' opinions regarding the "expert's" opinions as they relate to the case. In essence, the students can be the jury. Additionally, if there is a day-in-the-life video available and a videotaped deposition of the defense expert, the students would be provided with ample information to make a somewhat informed decision, but more importantly they would see how the system works.

The second method would be to have a defense and plaintiff attorney present to the class and discuss their concerns and goals in relation to a specific injury case. Following their presentation, have an opportunity for the class to have an open discussion regarding the works of life care planners in general.

The last suggestion would be to have the class attend a trial where a life care plan is presented to the jury and then rebutted by the defense. This last suggestion would be highly instructive, but time-consuming and difficult to schedule. Certainly, anyone serious about working as an expert will want to attend a few trials on their own.

Week 13: The Deposition

The deposition is a process that many life care planners who practice in a forensic setting will be periodically exposed to. For some, the occasion is a terrifying experience likened to

studying for a comprehensive exam that they would rather avoid. Other life care planners thrive on the experience and the opportunity to test their skills and abilities. In either instance, most attorneys would agree that the deposition is an extremely important process that often determines whether a case will be settled before trial (Elliott, 1999).

Elliott (1999) describes two different types of depositions. The first is an "evidentiary" deposition, generally called by the retaining side when the attorney believes there is a good chance to settle the case or to videotape and present at trial if the life care planner will be unavailable. The second type of deposition is called a "discovery" deposition which the opposing attorney typically calls in an attempt to learn what the life care planner is expecting to say during trial as well as to observe the expert's demeanor and likely credibility with a jury. In both cases, testimony is recorded and may be read back or made known during the trial, especially in instances where an expert's opinions have changed. Students must be cautioned regarding the importance of consistency not only between deposition and trial appearances, but also in how he/she approaches each life care plan. It is not uncommon for attorneys to review a life care planner's past testimony for inconsistencies in reporting.

Ideally, prior to giving a deposition, the retaining attorney should meet with the life care planner to go over any perceived vague or weak areas in the plan. In addition, retaining attorney's can advise the life care planner as to any problem areas (i.e., differing opinions from treating physicians) that may need to be addressed. Finally, for those retaining attorneys who have worked with the opposing attorney before, the retaining attorney can advise the life care planner regarding the style or approach the opposing attorney typically takes in deposition. Students must also be made aware of the fact that the retaining attorney is not there to represent the life care planner, and that the expert is essentially on his/her own unless the opposing attorney asks inappropriate questions which, although may still have to be answered, they will later be decided upon for admissibility by a judge.

Procedurally, an evidentiary deposition will proceed much like a court trial. The retaining attorney will inquire about an expert's qualifications and proceed on to how the expert became involved in the case, what he/she was asked to do, what information was relied upon to develop opinions, and how he/she derived at his/her conclusions. Once done, the opposing attorney has the opportunity to cross-examine the expert and typically attempt to discredit either the expert's experience or qualifications, or discredit the expert's formed opinions in part or entirely (Deutsch & Sawyer, 1995). Several researchers have offered a list of "do's and don'ts" regarding deposing and testifying (Blackwell, 1992; Deutsch & Sawyer, 1995).

The discovery deposition, however, does not follow trial proceedings as closely as the evidentiary deposition. The opposing attorney will follow a very similar line of questioning that the retaining attorney will follow during an evidentiary deposition. The primary difference between the two is that the opposing attorney will be looking for areas of weakness in experience or developing the life care plan. He/she also will pursue certain lines of questioning in areas of the life care plan that seem unclear or not well established. It is important for the life care planner to keep his/her composure and once again remain consistent in their approach to develop life care plans. Once the opposing attorney has finished asking questions, the retaining attorney has an opportunity to carefully clear up any problem areas that occurred during the opposing attorneys questioning. A common trap some opposing attorneys attempt to catch experts in is having them admit certain recommendations in the plan are speculative and uncertain. Students must be educated on the concepts of probability vs. possibility, and that probability is defined as meaning something has a 51% or greater chance of occurring, whereas possibility simply means something is possible (i.e., elephants can fly) but not probable. Experts

must remain steadfast to their opinion that an occurrence is probable based on the client's medical condition, opinions of treating specialists, research or statistics concerning others with similar disabilities, etc.

Experts who give a deposition are asked by the court reporter whether or not they wish to read and sign their deposition. It is good practice to opt to do this in order to clear up any misinterpretation or typographical errors by the court reporter, clarify an opinion the expert gave during deposition which he/she did not have a chance to fully explain, and to begin preparation for trial as well as identify any areas of perceived weakness that came out during the deposition. Ideally, the retaining attorney and life care planner will have a post-deposition meeting to review any areas of weakness and attempt to clear these up before trial.

Teaching Suggestions for Week 13

Educators have several excellent strategies to further educate students about the deposition process. One strategy is to give each student a hardcopy of an example deposition (sanitized to remove all identifying information) the week prior to class to critically review, noting the order and type of questions asked as well as be prepared to discuss in class why certain questions were asked and answered (if readers have no example depositions or wish to obtain other copies, contact the authors). In other instances, educators may have videotaped depositions which can be an excellent learning tool for students. The instructor can pause/stop at certain predetermined points to discuss what is happening as well as to solicit questions from students. A third teaching strategy would be to set up a mock deposition in class by having students play certain roles and the instructor play the role of attorney. Students can prepare beforehand by having a case study to work from. The remaining class can observe and critique the student expert's testimony.

Week 14: Court Testimony

Trial testimony represents the climax or final process for the life care planner. Although the majority of cases settle out of court, many life care planners will likely have to testify at some point in their career. In preparing students on the finer points of testifying at trial, educators need to focus on several areas, including pretrial preparation, courtroom demeanor, testimony procedure and effectively presenting one's case. These areas are briefly discussed below.

Pretrial Preparation

As is the case in preparing for deposition, the life care planner and retaining attorney should meet to discuss how the life care planner's opinions will be most effectively presented at trial. The concepts of the "primacy effect" and "recency effect" relate to empirical research findings that a jury best remembers information presented at the beginning and at the end, therefore, it is often strategic for the life care planner to present his/her final conclusions at the beginning and summarize his/her findings at the end. Other reasons for a pretrial conference with the retaining attorney is to make sure no medical opinions have been changed or recently admitted, find out the jury makeup, the direction in which the trial is moving, and if there

are any pretrial stipulations (Blackwell, 1992; Deutsch & Sawyer, 1995).

Courtroom Demeanor

Educators are encouraged to review Blackwell (1992), Deutsch (1990), and Deutsch and Sawyer (1995) for more detailed information regarding courtroom demeanor and preparation. Important concepts to remember are that the life care planner is there to educate the jury and not advocate for the client. Although it may not always appear to be the case, the expert witness is ethically supposed to be an objective party who carries out an objective assessment. The life care planner also should dress professionally, remain composed at all times, maintain eye contact with the jurors, and not volunteer information that is not directly asked (Blackwell, 1992; Deutsch, 1985, 1990). Blackwell (1992) further gives pointers regarding liveliness of presentation and not sounding monotone, sounding natural and unrehearsed, tell the truth, avoid jargon, and to use analogies when appropriate (p. 35).

Testimony Procedure

Similar to an evidentiary deposition, the general order of testifying will include direct examination by the retaining attorney, cross-examination by the opposing attorney, re-direct examination by the retaining attorney, re-cross, etc. Blackwell (1992) cites essentially three phases of testifying: stating your qualifications, laying the foundation for your opinions, and giving your opinions. In educating the jury and having arranged how your testimony will unfold with the retaining attorney beforehand, presentations become much more effective with visuals such as PowerPoint presentations and/or overhead transparencies.

On cross-examination, opposing attorneys can essentially begin anywhere they want regarding challenging either your credentials and/or the life care plan. Life care planners need to again remember the differences between probability vs. possibility, pause and listen to the question before answering, remain composed and relaxed, and point out any misquoting or twisting of your findings. Experts should watch for catch phrases from opposing attorneys such as "Wouldn't you agree with me that…" and "Isn't it possible that…" which are designed to weaken the life care planner's prior opinions.

Educators should also explain to students what the life care planner's rights are while on the stand. Blackwell (1992) outlines six rights including asking the judge about how to answer a question, refusing to answer questions that you do not understand and/or asking for clarification, stating simply that you don't know the answer to a question rather than guessing or stepping out of your area of expertise, asking the judge if you can qualify an answer rather than giving a yes/no response, having the right to complete your answer if cut off, and feeling free to refer to your notes when needed (p. 40).

Finally, it is always important to request a post–trial conference with the retaining attorney to obtain feedback as to how you did. Ongoing feedback is important in refining your skills and determining how you can strengthen your presentation.

Teaching Suggestions for Week 14

Educators have a number of options available to them in preparing students for what is the concluding and climactic component of life care planning. One possible suggestion depends on whether the educator has access to videotaped court testimony to show in class with the

ability to pause/stop at important segments for class discussion. Short of this, but requiring some preparation, educators can prepare a mock trial assigning students the roles of opposing and retaining attorneys, life care planner, client, witnesses, jury and judge. Aside from learning courtroom procedure with this method, students can critique how a life care plan is presented, and the jury can critique the student life care planner's demeanor as well as quality of presentation. Finally, educators should also review, via class lecture, specific preparation strategies as well as key differences in an effective vs. ineffective trial testimony presentation.

Week 15: Refining Your Trade

Refining Your Skills

As in any profession, life care planners should strive to remain current and update their skills on a regular basis. Although certification is a voluntary, and not mandatory or state requirement for practice, belonging to a certifying organization that certifies life care planners becomes a prudent move for life care planners (May, 1999). Similar to other certification or licensure credentials, certification in life care planning requires 48 hours of continuing education within a three-year period or retake the exam to maintain certification. Life care planners can obtain continuing education from a number of relevant conferences, however, the University of Florida's Intelicus program offers ongoing annual training directly related to life care planning. In addition, in 2002, the first *Journal of Life Care Planning* was developed and plans to offer educational articles for continuing education credits. Prior to this, there was very little information on life care planning other than that consistently published by a small contingency of experts in the field (e.g., Blackwell et al., 2001; Deutsch & Sawyer, 1995; Weed, 1999).

With the field of life care planning continually expanding and becoming more complex, it is imperative that life care planners remain current regarding changes in the law as well as changes and/or innovations in practice.

Database Collection

As life care planners continue to build their library of resources related to the field, it behooves them to also build a database of contacts, pricing information and software available for case management (Thomas, 1999). TecSolutions Inc. has developed a life care planning database (LCPStat) which not only collects pricing information, but also generates the tables typically used for the life care plan. Life Care Creator by Objective Development Inc. is another program which generates reports (Retzlaff, 1996). If the life care planner does not desire to purchase such database and report generators, he/she can also contract these services from Acumyn™ described earlier (Kitchen, 1999). Short of this, some life care planners will simply maintain their own database on an Excel spreadsheet or in a word processing program.

Although maintaining a database of vendors and pricing information is somewhat rudimentary, maintaining empirical research information relevant to issues such as pediatric earning capacity, work life expectancy, life expectancy and utilization of goods and services among specific disability groups, requires scrutiny on the part of the life care planner as to its applicability to the individual client. Taking statistical information at face value without fully understanding how the data was gathered and interpreted may ultimately leave the life care planner in a vulnerable position if opposing counsel chooses to inquire about the reliability,

validity and limitations of such studies (Blackwell et al., 2001; Deutsch personal communication, Sept. 1997).

Networking with Experts

It is important to build and maintain relationships with other experts who are working as life care planners, economists, psychologists, etc. Lack of networking and collegial interaction creates the tendency to become isolated and somewhat behind on current issues, methodology, etc.

One of the best ways to establish and maintain relationships is by joining and actively participating in professional associations that are within your discipline. There is a Forensic section of The International Association of Rehabilitation Professionals (IARP) and other professional associations that cater to professional rehabilitation consultants serving as forensic experts. Any of the organizations will provide an opportunity for the emerging consultant to build and maintain relationships. IARP offers a list serv for its forensic members who choose to participate that allows for regular dialogue and discussion of pertinent issues to the rehabilitation consultant.

Building Your Vita

From the very first to the very last case the life care planner works within the forensic arena, a copy of one's curriculum vita will need to be provided. Often the first things an attorney will look for is a copy of the vita, often prior to even referring a case. It is very important to build a professional vita and then keep it updated. The life care planner needs to keep current on issues related to work and training and areas of competence. Certainly, work experience and educational background is prominently positioned in the vita.

If the life care planner intends to become a nationally or regionally recognized expert, it is not only important to study the right courses and have relevant work experience but it is important to give back to your profession through publication, presentation, and training. Each of these three areas should be addressed and the life care planner will want to publish in areas that relate to his/her intended field of practice or expertise. The same is true for making presentations at conferences and/or providing service or learning opportunities for other professionals. Publishing articles in peer reviewed journals directly related to one's consulting practice on relevant topics is an ideal way to establish a reputation.

Consistency in Testimony and Objectivity in Reporting

Many people do not realize that once you are deposed in a case it is a matter of public record and anyone can get a copy of your deposition and any attachments to it (i.e., your report that was submitted on the case). It is important that the life care planner remain objective and report findings based upon a consistent and reliable methodology.

Conversely, when testifying either in a deposition or trial, testimony needs to be consistent with the report, but also with reports and testimonies given on previous cases. In our electronic world, it is getting easier and easier for attorneys to get all previous testimonies for review prior to taking the life care planner's deposition. For example, if the life care planner said something on one case that is totally contrary to what is being said now, it could be prob-

lematic.

The way to make sure the life care planner stays out of trouble with "conflicting" reports and testimony is through using established and consistent methodologies, understanding the research behind the methods used, employing consistency in each evaluation, avoiding "flip-flop" on how a case is prepared, understanding other methodologies that are commonly used, and maybe, just as importantly, refraining from consulting until the planner has truly become an expert. In other words, know your field and areas of expertise.

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