Journal of Life Care Planning, Vol. 3, No. 3, 193-202

Proceedings of the Life Care Planning Summit 2004 Atlanta, GA April 24-25, 2004

Edited by
Paul M. Deutsch, Ph.D., CRC, CCM, CLCP, FIALCP
and
Lori Allison, MA, CLCP

Written by:
Lori Allison, MA, CLCP
Debbie Berens, MS, CRC, CCM, CLCP
Joseph R. Corcoran, MA, CRRN, CCM, CLCP
Bob Gisclair, MS, CRC, CDMS, CCM, LPC, CLCP
Linda McKinley, BSN, RN, CLCP, CDMS, CCM
Ann T. Neulicht, Ph.D, CLCP, CRC, CVE, CDMS, LPC, D-ABVE
Karen Preston, PHN, MS, CRRN, FIALCP
Linda Shaw, Ph.D., CRC
Amy Sutton, RN, BSN, MA, CLCP
Susan Wirt, RN, CCM, CLCP, CRP, CRRN
Steve Yuhas, CRC, CCM, CLCP, NCC

For an excellent overview of the *Life Care Planning Summit 2004* and description of the modified nominal group technique, refer to Debbie Berens' article which was published in the Journal of Life Care Planning, Volume 3, Number 2, (2004). All Summit attendees participated in all groups.

The theme of the Summit was "Competence" and included the following focus areas:

1. The Certification Process
2. CLCP Examination and CEU Credits
3. Future Research in Life Care Planning
4. CLCP Mentoring Program
5. Standards of Practice for Life Care Planners

In their group, Future Research in Life Care Planning, Ann Neulicht and Linda McKinley

collected demographic information from Summit participants. Seventy five registrants for the 2004 Summit included individuals from all time zones (Eastern: 41, Central: 17; Mountain: 4; Pacific: 9) as well as Hawaii (1) and Canada (3). Fifty one individuals indicated that they were Certified Life Care Planners (CLCPs). There were 25 Certified Rehabilitation Counselors (CRCs), one Registered Nurse/Certified Rehabilitation Counselor (RN/CRC), one Occupational Therapist/Certified Rehabilitation Counselor (OT/CRC), one Occupational Therapist (OT), 2 Certified Case Managers (CCMs) and two Registered Rehabilitation Professionals (RRPs) listed on the registration list. As indicated by information provided by group participants (N'51), Nurses and Rehabilitation Counselors comprise a majority of the 2004 Summit. Details regarding educational status are found in Figure 1.

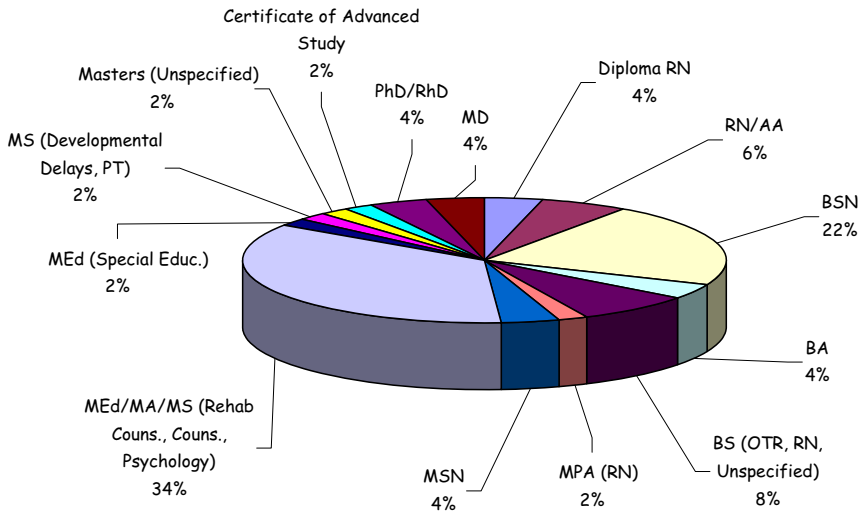

Figure 1: Educational Status of Summit 2004 Participants

Participants have practiced in their specialty area for 10 – 44 years, with an average of 25.52 (mean) to 26 (median) years. The most frequently cited number of years of experience is 18 (mode). Although one participant has been certified/practiced as a LCPer for 4 months, experience as a LCPer (following an established, standardized methodology for LCP) generally ranges from 1 – 29 years with a mean of 10 years, median of 8.75 years and mode of 8 years (i.e., 1996, the first year of formal certification). Forty-one participants are currently CLCPs, 2 had pending applications and one is a current student. This is a first summit for 33 individuals. Thirteen participants attended the 2000 Summit and 9 attended the 2002 Summit. Data is not available regarding individuals who have attended all three Summits.

Focus Area 1: The Certification Process

Group Facilitator: Debbie Berens, MS, CRC, CCM, CLCP
Recorders: Steve Yuhas, CRC, CCM, CLCP, NCC, and Amy Sutton, RN, BSN, MA, CLCP

General Purpose and Issues Contemplated by the Group

The charge given to this group was to analyze the following issues:

1. Examine the current certification and renewal requirements and provide suggestions for modification (i.e., maintain, revise, amend, add, remove.) Participants were referred to pages 9-10 of the CHCC Standards and Examination Guidelines reprinted in the Summit manual to review existing criteria to sit for certification and page 17 of the Guidelines for criteria for certification maintenance and renewal.
2. Consider whether or not CHCC should pursue certification by an independent certifying agency.

Group Consensus Statements

1. Urge CHCC to pursue certification by a respected and nationally recognized independent certifying agency.*
2. Refine experience requirements to sit for the CLCP exam.*
3. Increase the required number of years of professional work experience within the primary discipline (Majority recommended five years of required experience).

**Denotes consensus across all groups.*

Majority View

1. Pursue the non-profit status of CHCC.
2. Require a minimum of a Bachelor's degree as criteria to become certified (Discussion included instituting a "grandfather clause" for those who are already certified, but do not have a Bachelor's degree).
3. Increase the required number of onsite training hours, though the number of hours was unspecified.

Minority View

1. Mandate certification in LCP in order to practice. This was a majority view represented by one (1) group. In the large group discussion, no consensus was reached.

Areas of Discussion/Concern Unique to the Group

There was overwhelming consensus for CHCC to continue to pursue certification by NCCA or other respected and recognized independent certifying agency. Realizing that this will not be accomplished without assistance from certificants and other interested parties, there was discussion regarding the steps required to continue to pursue this option. Many attendees offered their administrative and financial support in order to achieve this goal.

The majority of participants supported increasing the number of onsite training hours required for certification. Participants noted that the current certification process requires significantly fewer onsite training hours when compared to the earlier process in which all 160 hours were onsite. Consensus regarding this issue was not achieved. Although a few participants suggested that the certification process should be revised to require that 100% of the certification hours occur exclusively onsite, the majority endorsed increasing the number (unspecified) of onsite training hours between what was previously required and what is currently required. Discussion clarified that the decision to reduce number of onsite training

hours was in response to practitioners who are unable to attend a certification program that requires onsite training, exclusively.

Focus Area 2: CLCP Examination and CEU Credits
Group Facilitator: Linda Shaw, Ph.D., CRC
Recorder: Bob Gisclair, MS, CRC, CDMS, CCM, LPC, CLCP

General Purpose and Issues Contemplated by the Group
Participants were asked to focus on issues related to the:

1. CLCP Exam.
2. Acquisition of continuing education units (CEUs) for certification maintenance.

Group Consensus Statements
Regarding the CLCP exam:

1. Change the renewal period to 5 years and increase the CEU requirement (60 credits per 5 years).
2. Validity and reliability of exam items should be established before being used in scoring.
3. Develop the item writing process using experienced and trained LCPers.
4. Maintain an Advisory Group to evaluate and update the exam and to examine and publish information about the exam.

Regarding CEUs:

5. Increase the availability of more specific training in specialty areas such as burn injuries, complex trauma, collateral resources and expert testimony.
6. Increase the awareness of other professional associations of the existence of the CLCP credential in order to promote availability of their training programs for CLCP CEUs.
7. Establish a bulletin board with upcoming LCP training opportunities and hot topics.
8. Allow relevant training to be applied without pre-approval (consider reciprocity).
9. Ensure close monitoring of attendance.
10. The testing body should be autonomous and separated from training/educational group (i.e., CHCC should not provide training).

Majority View
Regarding the CLCP exam:

1. Require a minimum number of hours in basic LCP concepts (methodology) for initial certification.
2. The passing cut-off score of the CLCP exam should be defined and made public.
3. Develop a standardized scoring process for all exam takers; not normed to the group taking the exam during each testing session.
4. Add an oral exam, in addition to the written exam, that consists of a presentation and defense of a LCP.
5. CHCC should provide specific feedback on exam results by content area.

Regarding CEUs:

6. Make CEUs available for mentoring, supervision, and LCP critiquing.

Minority View

Regarding the CLCP exam:

1. Revisit the quantity and specificity of vocational content included in the exam, given that many nurses refer this analysis to vocational professionals.
2. Ensure that the preparatory course continues to be broad in content, rather than specific to the exam questions.
3. Increase the accessibility of the preparatory course by offering it in additional geographic areas and in distance and/or online formats.
4. Provide easier access to those taking the CLCP exam (consider multiple sites and/or computer administration).
5. Increase the number of items on the exam.
6. Establish regional representatives for critiques.
7. Allow only two opportunities to pass the exam and notify applicants that non-certified individuals should be discouraged from writing plans.
8. Include more questions about ethics and case law.
9. Utilize consultants with expertise in test development and validation in the CLCP exam development process.

Regarding CEUs:

10. Require a minimum number of CEUs to be in-person training.
11. Inform certificants, upon passing exam, of appropriate CEU providers.
12. Improve the availability of practicum/interactive learning opportunities.
13. Provide the accrediting body with requested data on the exam.
14. Consider raising the minimum number of CEUs required.
15. Ensure that links to CEU offerings on websites are focusing on training applicable to LCP.
16. Require submission of a LCP and provide feedback for renewal of certification.
17. Improve the process for obtaining CEU approval for inservice training.
18. Provide CEU training regarding how to be an effective mentor.
19. Stratify CEU requirements across topical areas.

Areas of Discussion/Concern Unique to the Group

Discussion generally focused more heavily on CEUs than the on the CLCP exam. There was significant discussion about the need to access quality advanced training that was specifically targeted to LCPs. Additionally, the group was concerned that training or professional activities that already exist and are relevant to LCP be easily utilized to meet their CLCP CEU requirements. For example, the group felt strongly that we need to increase awareness among related professional groups so that relevant training will be pre-approved for CLCP CEUs.

Regarding the CLCP exam, there was great concern that the exam development and scoring process should be scrutinized for validity and reliability and that high standards should be maintained. The groups were divided with respect to the amount of vocational information that should be included in the exam, with nurses often preferring less content than other participants. There also was some acknowledgement that, although some items regarding the exam would be desirable, the costs and complexities of addressing the issues would make them difficult to implement. In some cases, such as the desire to extend the renewal period, participants were almost unanimous in asserting that they would be willing to pay more for their certification and renewals if necessary. In others, such as requiring an oral exam, there were quite a number of participants who felt that the logistics and expense would not make this course advisable.

Focus Area 3: Future Research in Life Care Planning
Group Facilitator: Ann T. Neulicht, Ph.D, CLCP, CRC, CVE, CDMS, LPC, D-ABVE
Recorder: Linda McKinley, BSN, RN, CLCP, CDMS, CCM

General Purpose and Issues Contemplated by the Group
Each group was introduced to the topic by highlighting two primary purposes of research:

1. To identify what variables are related, how they are related, the nature of the specific mechanisms or processes that are involved, and the extent to which relationships can be generalized across populations.
2. To provide the best available approximation of the truth or falsity of propositions.

Majority View

1. Analyze LCP validity and reliability.
2. Study of the percentage of plans that are implemented.
3. Assess the accuracy and durability of LCPs.
4. Analyze whether cost projections are sufficient.
5. Conduct longitudinal studies (e.g., aging and disability).
6. Identify specific clinical research related to LCP recommendations (e.g., home supervision/DME).
7. Assess life expectancy accuracy.
8. Study the relationship of LCP implementation to quality of life.
9. Evaluate the cost effectiveness of LCPs.

Minority View

1. Analyze the comprehension and detail of LCPs.
2. Conduct quality outcome comparisons between certified and non-certified providers.
3. Specify "Top 5" reasons a certified LCP vs. non-certified LCPer is/would be disqualified.
4. Explore the relationship between geographic location and cultural diversity of LCPers and clients.
5. Compare LCP projections, demand, award and actual cost.

6. Assess patient compliance with a LCP.
7. Analyze the frequency of updates (especially pediatric plans).
8. Compare LCP and treatment provider recommendations.
9. Identify basic standards of care by diagnosis.
10. Assess the cost of care by diagnosis.
11. Evaluate referral reasons for LCP.
12. Explore the relationship between referral source, purpose of a LCP, and outcome.
13. Investigate the outcome of children with cerebral palsy as a function of school therapy vs. private care.
14. Analyze adherence to LCP standards.
15. Explore the relationship between date of injury, referral and discovery deadline (e.g., timeframe).
16. Identify LCP report formats (including research).
17. Assess the effect of case management on implementation and satisfaction with a LCP.
18. Explore the relationship/effect of certification on job satisfaction.
19. Development of a caregiver/family competency (patient understanding) assessment tool.
20. Study the effects of client characteristics on the LCP process.
21. Identify the effects of advancing technology on LCP.
22. Research the impact of LCP on case resolution.
23. Explore the impact of the LCP to decision making by the trier of fact; in other words, did the LCP assist in this process?
24. Assess the role of a LCPer.
25. Study unpaid caregiver services over time.
26. Define "least restrictive" research by state; in other words, how it is done and what it is called?
27. Explore the relationship between finances/support and return to work.

Areas of Discussion/Concern Unique to the Group

Research ideas that were proposed, and discussed, but did not receive a vote for inclusion in the top five priorities (by any group):

1. Impact of the funding source on LCP totals (e.g., Workers' Compensation vs. "other").
2. Outcome of mentoring vs. non-mentoring on LCP quality.
3. Use of urgent care vs. ER services in a LCP.
4. Ethical dilemmas in LCP.
5. Impact of case manager, court, and/or family coordination on LCP implementation.
6. Impact/importance of family wishes (and cultural beliefs) on the LCP.
7. Establishment of a clearinghouse for LCP research.
8. Clarification of scope of practice.

9. Comparison of plaintiff vs. defense LCP reviews.
10. Demographic information on LCP use (national and international).

Focus Area 4: CLCP Mentoring Program
Group Facilitator: Lori A. Allison, MA, CLCP
Recorder: Joseph R. Corcoran, MA, CRRN, CCM, CLCP

General Purpose and Issues Contemplated by the Group
Roundtable groups were asked to identify the primary considerations to be addressed prior to and/or during the process of developing a formal mentoring program.

Group Consensus Statements
1. First, arrive upon a definition of both the mentoring process and the mentoring relationship and then,
2. Consider the following issues:
    - The necessity of such a program
    - Minimum qualifications of the mentor
    - Assurance of access and equal opportunity for participation
    - Standardization of the mentoring process
    - Standardization of the mentoring relationship
    - Identification of incentives for participation in such a program
    - Legal and liability issues associated with the mentoring process
    - Administrative oversight of the mentoring program

Majority View
There were no majority view statements reached within this focus area.

Minority View
Small group discussions generated the following questions that should be resolved prior to and/or during the process of developing a formal mentoring program:

1. Who is qualified to be a mentor?
2. Should mentors undergo a peer-review process?
3. How can all interested parties participate?
4. How does the mentoring process differ from other forms of collaboration and/or conferring with other practitioners in the field?
5. Does the mentor become a co-author of the mentee's plans?
6. What are the goals of the mentoring program? What is the expected end product?
7. Should mentors undergo a formal training process?
8. How can consistency among mentors be maintained?
9. Should mentors be compensated?
10. Can mentors and mentees earn CEU or "Points for Credit"?
11. Does the mentor assume any liability for plans developed by the mentee?
12. Can the anonymity of the patient/client be preserved?
13. How can potential conflicts of interest be identified?

Areas of Discussion/Concern Unique to the Group

Although the development of a formal mentoring program was suggested during the Summit 2000 (Weed & Berens, 2001) and Summit 2002 (Riddick-Grisham, 2003) proceedings, there was considerable discussion regarding the nature of and necessity for such a program. For this reason, participants arrived upon only consensus and minority views.

Focus Area 5: Standards of Practice for Life Care Planners
Group Facilitator: Karen Preston, PHN, MS, CRRN, FIALCP
Recorder: Susan Wirt, RN, CCM, CLCP, CRP, CRRN

General Purpose and Issues Contemplated by the Group

Discussion focused upon issues related to the current Standards of Practice published in 2000. The development of the 2000 Standards was coordinated by a committee from the International Academy of Life Care Planners (IALCP) and reviewed by the LCP community at large through dissemination of drafts and discussions at national meetings. As the field of LCP has continued to evolve and mature, internal and external forces combine to influence the practice. The focus of discussion was examining what aspects of the Standards need to be retained and what aspects need to be revised to meet current state-of-the-art.

The discussion was very lively and thorough, revealing areas where LCPers share views regarding Standards of Practice and areas where there was considerable lack of clarity and consensus. Consensus and/or majority viewpoint was reached on several important points. We were also able to articulate critical areas that need further examination and discussion in an effort to eventually reach consensus.

Group Consensus Statements

1. The term "client" shall be defined in Standards of Practice for LCPers.
2. Terminology used in the Standards of Practice needs to be defined.
3. Standards of Practice will continue to delineate the qualifications to be a LCPer (endorsement of existing Standard statement 1.d).
4. Standards of Practice state/delineate educational requirements for entry into LCP.
5. Standards of Practice shall state the role and accountability of the LCPer.
6. A study defining the role and accountability of the LCPer should be the basis for defining them in the Standards of Practice, when available.
7. Standards of Practice should be written in a way to allow the individual LCPer to utilize his/her professional judgment and experience (i.e., they should not be written to tie the hands of the LCPer).
8. Some aspects of the Standards of Practice are too detailed.

Majority View

1. Standards should state that the client is the injured or disabled party. Dissenting minority opinion was that the client is the referral or payer source.

Minority View

1. There was disagreement regarding key ethical issues, including:
   - Whether dual roles/relationships can be appropriate (such as being the case manager and LCPer concurrently or sequentially, or whether a LCPer can also have any kind of relationship with the injured/disabled party).
   - The extent the LCPer can let the referral source or payer source influence the contents of the LCP to maintain satisfactory business relationships.
2. There needs to be an understanding of whether LCP Standards of Practice are different from, yet compatible with, Standards created for the various professions who are practicing LCPers.
3. There needs to be a way to reach a common set of LCP Standards of Practice so that LCPers are not held to Standards promulgated by multiple LCP entities, especially if the various Standards are not consistent. This includes understanding what creates legitimacy of the Standards and gaining acceptance throughout the industry.
4. LCPers are concerned about what should happen when LCPers do not follow Standards of Practice.

Areas of Discussion/Concern Unique to the Group

Throughout the course of discussion, there was recognition that Standards of Practice create a powerful influence on the role of LCP and how LCPs are constructed and used. The discussion was positive in the desire to ensure that Standards are reasonable, provide protection for the LCPer and users of the plans, and contribute to the integrity of the LCP process. Clearly, there are critical areas that require further development as LCP continues to evolve.

References

Berens, D. (2004). Life care planning summit 2004. *Journal of Life Care Planning, 3*(2), 109-112.

Riddick-Grisham, S. (2003). Life care planning summit 2002. *Journal of Life Care Planning, 2*(2), 57-101.

Weed, R. & Berens, D. (2001). *Life care planning summit 2000 proceedings*. Athens, GA: Elliott & Fitzpatrick, Inc.