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CANADIAN LIFE CARE PLANNING SUMMIT 2011 PROCEEDINGS

by Summit 2011 Co-Chairs
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Introduction

On June 3 and 4, 2011, a conference was held specifically to address life care planning topics and issues in Canada with the goal of achieving consensus on five focus areas. This event was coordinated by the International Academy of Life Care Planners (IALCP), a section of the International Association of Rehabilitation Professionals (IARP), IARP Canadian Chapter, and the University of Western Ontario. The conference, held in Toronto, Ontario, was supported by the Foundation for Life Care Planning Research (FLCPR), the Care Planner Network, International Commission on Health Care Certification (ICHCC), Canadian Society of Medical Evaluators (CSME), Vocational Rehabilitation Association (VRA) of Canada, and the College of Vocational Rehabilitation Professionals (CVRP).

In order to establish a consistent foundation, the Summit Proceedings from the first Life Care Planning Summit held in Dallas Texas in 2000, and Consensus Statements derived from the Summits subsequently held in 2002, 2004, 2006, 2008 and 2010 were supplied to the participants.

At the Canadian Life Care Planning Summit 2011, Canadian life care planners were invited to participate in the development of consensus statements for the practice of Life Care Planning in Canada. Leaders in the field of Life Care Planning research, teaching, practice and policy were in attendance at this first Canadian Summit.

This event brought together leaders in life care planning from a variety of organizations with a goal of promoting unity. Through a series of round table discussions, life care planners had the opportunity to examine and identify resolutions for issues in the field, while contributing to the continued evolution of life care planning.

Seventy-one participants representing a diversity of disciplines and backgrounds in life care planning, life care planning training, and professional associations met to explore the current state of the field and set future directions for life care planners in Canada. The topics discussed at this Summit reflect the changes and maturation occurring in this dynamic field. Although the process of life care planning is not new, a common principle and foundation among all life care planners is to determine consensus and unity in the field, thus leading to the provision of a credible, meaningful, marketable, and defensible service.

Our thanks and appreciation is given to the following colleagues who participated as speakers, facilitators and recorders during this Summit: Carol Bierbrier, Talaal Bond, Giovanna Boniface, Deborah Carter, Evie Cowitz, Tony Choppa, Evelyn ten Cate, Pierre Côté, Reg Gibbs, Lynn Parker, Janice Ray, Rick Robinson, Karen Rucas, Victoria Sweetman, and Steve Yuhas.

We are also recognize with gratitude the generous sponsors: Invacare Canada - Vince Morelli, Theracare Marketing Network - Erica Regular, and IARP - Victoria Sweetman. Thank you very much!

Summit Focus Areas

For purposes of the Canadian Summit, topics and issues were sorted into five focus areas which include:

1. Professional preparation:
   i. Minimum Education qualifications
   ii. Experience
   iii. Certifications
   iv. Other credentials
   v. Continuing Education
   vi. Mentoring
   vii. Standards of Practice
   viii. Resource Development
   ix. Writing skills
2. Basic tenets and procedures for completing life care plans:
   i. Records review
   ii. Medical foundation
   iii. Expert witness v. consultant
   iv. Reports and content
   v. Economic requirements
3. Ethics:
   i. Relevancy of ethics from certifications or licenses not specific to life care planning
   ii. Maintaining files
   iii. Documenting contacts for Life Care Plan entries
   iv. Staying within area of expertise
   v. Confidentiality
   vi. Objectivity
4. Reliability and validity of the life care plan:
   i. Based on adequate foundation
   ii. Opinions referenced in life care planning by credentialed professionals
   iii. Based on the industry requirements (e.g., personal injury, workers' comp., etc.)
   iv. Research data
5. Information dissemination:
   i. How to disseminate the Summit proceedings

Summit participants attended the two day event in Toronto and utilized the same technology introduced in the 2010 Life Care Planning Summit in Atlanta, GA that tabulated participants' responses in real time by utilizing personal Audience Response Systems from Turning Technologies. Jason Eadie, whose assistance was invaluable, was the onsite technician

who trained attendees and provided devices to record instant responses throughout the Summit.

Methodology

The Canadian Life Care Planning Summit integrated technology with the Modified Nominal Group Techniques General Instructions provided by Roger O. Weed, Ph.D. and based on the group consensus techniques outlined by Delbecq, Van de Ven, and Gustofson (1975). As instructed, attendees were sorted into five groups and participated in each of the focus group topics. Groups were assigned so that an integrated mix of experience, training and knowledge was assured (nurses, rehabilitation counselors, physicians, occupational therapists, physical therapists, kinesiologists, and speech/language pathologists. One economist participated in one round on the topic of validity and reliability, and two lawyers participated in the Ethics and Tenets and Procedures topics, one of whom stayed for the entire conference.).

As with previous Summits, each group had a facilitator (leader) and recorder who used an easel and marker to summarize the data and assist in the group process. Every attendee participated in each round table session. The attendees then re-convened into one large group and the facilitators summarized the comments and noted consensus statements among the groups where applicable. For those topics where consensus was not reached among the roundtable groups, participants had time for additional discussion and the technology was utilized to record each attendee's "vote" in an effort to achieve consensus statements among the full group.

All Facilitators and Recorders were provided the group technique general instructions prior to the Summit as well as two training sessions (one by conference call and another in person the morning of the conference). All participants were emailed written instructions prior to the conference and, as a prelude to the beginning of the groups, were given verbal directions as well as comments on the value of achieving consensus statements. The Facilitators who did not vote, were all Americans, had participated in at least one previous Summit, and were familiar with the process.

Following the Summit, a draft of the proceedings was sent to all attendees, speakers and participating organizations and their comments were solicited. Corrections and clarification were obtained from the participants and incorporated as appropriate into the proceedings.

Finally, a second "prepublication draft" incorporating the second edited version that represented consensus and majority views was distributed to participating organizations for endorsement and final comment. This document is a culmination of the efforts of many individuals and representative organizations that have contributed and endorsed the contents contained in this report.

Threshold for Acceptance

For purposes of the Summit, the following thresholds were established prior to the Summit to determine levels for consensus and majority view statements among the participants:

1. Unanimous consensus statements were those agreed upon by 100% of participants.
2. Majority view statements were those agreed upon by a majority of participants, thereby indicating a need for more discussion and consideration by the group in an effort to obtain consensus.
3. Near consensus statements were those receiving 90 % or more votes.
4. Minority view statements were those where a majority could not be reached, but where strong feeling/opinion was held by the minority.

Participants

The Canadian Life Care Planning Summit 2011 had 71 attendees; however, due to early flight departures and other legitimate reasons, the final session had slightly less numbers as noted below.

The large group attendees proceeded to attempt to reach consensus and ultimately achieved consensus on 33 statements. An additional 18 statements achieved majority view with a threshold of 90% or greater.

Demographics of the attendees in the large group session held on Day 2 indicated the group was comprised of 58 participants (n=58) through large group discussion of Topic 2, 51 participants through Topic 3, and 47 participants through review and discussion of Topic 5:

Gender	
Male	7 %
Female	93 %

Age	
Less than 30 years old	2%
Age 31 – 40	21%
Age 41 – 50	33%
Age 51 – 60	43%
Age 61 – 70	2%
Age 71 +	0

Practice Location	
Ontario	91%
Quebec	0
PE, Nova Scotia, NB, NL	2%
Manitoba, Saskatchewan	0
Alberta, British Columbia	5%
Northeast USA (practicing Life Care Planning in Canada)	2%
NW, SE, SW USA	1%

Professional Background	
Rehabilitation Counselor	31%
Nurse	7%
Occupational Therapist	47%
Physical Therapist	9%
Speech Language Pathologist	2%
Physician	2%
Kinesiologist	3%

Also in attendance were two lawyers and one economist, who commented when asked although they did not vote.

Years Experience as Life Care Planner

0 – 5 years	28%
6 – 10 years	34%
11 – 15 years	14%
16 – 20 years	21%
21 – 25 years	2%
25 years	2%

Note: The number of years in the attendee's respective professions was not asked.

Association Memberships

IARP	50%
IALCP	43%
VRA	33%
ICHCC – CLCP/CCLCP	33%

One half (50%) of the attendees held membership with the International Association of Rehabilitation Professionals (IARP), 43% were a member of the International Academy of Life Care Planners (IALCP), and 33% were a member of the Vocational Rehabilitation Association (VRA). One third (33%) of the attendees held the CCLCP/CLCP Certification from the ICHCC.

RESULTS

The following sections represent a summary of the results of each focus group. Observations were solicited from the facilitators and their input is noted before the actual round table consensus and majority view outcome statements.

FOCUS TOPIC 1: PROFESSIONAL PREPARATION

Group Facilitator: Tony Choppa Recorder: Lynn Parker

Overall Observations

Qualified life care planners must demonstrate a level of competence combining education, professional preparation, and experience. The greatest strength and primary challenge of life care planning is the interdisciplinary nature of service delivery and qualified professionals preparing life care plans from different disciplines.

In life care planning, certification came before standards of practice and this is rare among service delivery strategies.

Life care planning is not a profession, but is comprised of different qualified professionals providing the same specific area of expertise and consultation (i.e., specialty within a profession). This is a strength of this specialty practice area.

Standards are needed that are professionally appropriate for life care planning without being exclusionary and that acknowledge the diversity of the practitioners' backgrounds.

Results for Topic 1

In the large group, the following statements were voted on using the audience response system.

Total Group Consensus Statement:

Similar to the 2000 Life Care Planning Summit in Dallas, TX, there were no statements that received consensus.

Total Group Majority Statement:

The following statements resulted in a majority view:

Education:

- Minimum bachelor's degree in a health or rehab field
- Minimum of 5 years clinical experience in health related field
- Bachelors and or licensure as a health care professional
- Beginning in 2011, minimum of bachelors degree in a health and allied health or rehab field

Experience

- 5 years in a vocational and/or health setting or clinical practice
- Minimum of 5 years clinical experience in a rehab and/or health related field

Individual Group Outcomes

Group 1

Critical issues in professional preparation:

Relevant Education
Experience
Certification
Continuing Education
Mentoring
Standards of Practice
Resource Development

Consensus was reached on the following statement:

Education

Minimum bachelor's degree with the following specializations; Voc, SLP, OT, PT, Kin, RN

Group 2

Critical issues in professional preparation:

Education
Experience
Formal training in life care planning
Certification
Mentoring

Consensus was reached on the following statements:

Education

Minimum bachelor's degree in a health or rehab field

Experience

Minimum of 5 years clinical experience in health related field

Group 3

Critical issues in professional preparation:

Formal Education
Experience
Life care education
Certification
Continuing education
Mentoring

No Consensus was reached, however the following statements were developed.

Education

Minimum bachelor's degree in an allied health or related field - Majority (8-3)

Experience

5 years clinical experience in a multi-disciplinary setting - Minority (6 against-5 for)

Group 4

Critical issues in professional preparation:
Education
Experience
Certification
Mentor
Writing skills

Consensus was reached on the following statements:

Education

Bachelors and/or licensure as a health care professional

Experience

5 years in a vocational and/or health setting or clinical practice

Group 5

Critical issues in professional preparation:
Education
Experience
Life care planning training
Certification

The following statements were developed.

Education – consensus

Beginning in 2011, minimum of bachelors degree in a health and allied health or rehab field

Experience – Majority (8 for and 1 against)

Minimum of 5 years clinical experience in a rehab and/or health related field

Experience – Minority (1 for and 8 against)

Minimum of 2000 clinical hours over 5 years in a rehab and/or health related field

FOCUS TOPIC 2: BASIC TENETS AND PROCEDURES

Group Facilitator: Rick Robinson Recorder: Karen Rucas

Overall Observations

Basic tenets and procedures of life care planning serve as the basic core beliefs and procedures upon which the life care plan is developed. Tenets and procedures directly impact the entire process of life care planning from initial referral to final consultation with parties involved in the matter.

Overall, input from each of the five (5) groups was generally consistent. Following group input, each item was rated by the group according to importance, each item was then rank ordered by the facilitator. Although many items were identified as basic tenets and procedures, certain items received no "votes" in terms of the importance of the item as a basic tenet or procedure. Item input by the group is described below:

Results for Topic 2

Following small group discussion, each item was brought to the large group for further consensus development.

Total Group Consensus Statements:

In the large group discussion, the following statements reached full consensus:

- The Life Care Plan should be objective.
- The Life Care Plan should be consistent in methodology.
- The Life Care Plan should be unbiased.
- The Life Care Plan should be based on peer-reviewed evidence.
- The Life Care Plan should be individualized to the person and his/her specific needs.

Total Group Majority Statements:

The following item was accepted as reaching majority view:

- The Life Care Plan should be client centered and one that restores maximum functioning and quality of life while considering individual needs.

Individual Group Outcomes

Group 1

TENETS

Individualized to person
Objective and consistent
Flexible , dynamic and lifelong
Comprehensive and based on multidisciplinary data
Promote and/or maximize function
Implementable

PROCEDURES

Comprehensive and objective assessment
Maintain consistent system of data collection
Research medical condition and resources
Interview Individual and family
Review, do analysis and synthesize data
Request additional testing and/or medical documentation or consultation
Consistent record keeping and recording

Group 2

TENETS

Client centered that restores maximum functioning and quality of life while considering individual needs
Objective, consistent and unbiased
A dynamic plan to optimize care including comprehensive medical, vocational, etc. information deemed appropriate, necessary and reasonable

Evidence based practice and peer reviewed
Promotes maximum functioning and increased residual capacity
Dynamic tool related to both disability and development, and updated throughout the life cycle
Specific to the individual and geographic area
Information regarding medical, vocation, etc. is comprehensive
Recommendations are medically and vocationally reasonable, necessary and appropriate
Opinions are medical and professionally supported

PROCEDURES

Communicate to/with the client, family and medical providers
Comprehensive data collection and review of records
Address gaps in records
Use standardized format
Research medical conditions or disability
Render opinions within scope of practice
Research items and costs in geographical area
Consistent system of data collection and records
Comprehensive file review
Ask appropriate questions of medical providers
Communicate with all relevant, reliable and credible professionals involved
Accept referral based on knowledge base

Group 3
TENETS

Individualized to specific needs
Objectivity in the development of the plan
Comprehensive and based on multidisciplinary data
Includes future health related needs
Blueprint of lifetime rehab and medical needs
Includes costs for health related needs
Usable
Dynamic document
Has a consistent foundation
Restores quality of life
Inclusive data collection

PROCEDURES

Conducting comprehensive assessment and interview with client and significant others
Comprehensive review of medical records and documentation
Consistent process of data collection and compilation
Based on medical, vocational and rehab needs with case specific data
Research of the medical condition
Request for medical information and/or assessments to fill in gaps
Standardized record keeping and recording
Verifiable, reliable and credible sources

Group 4
TENETS

Individualized needs and promote optimal health, function and autonomy
Plan is lifelong, flexible, dynamic and changes with the client's needs
Restores as much as possible quality of life and lifestyle to person
Defining rehabilitation as ability, autonomy and social reintegration
Conclusions are based on relevant professional opinions from multi-disciplinary practitioners with appropriate expertise
Plan is consistent with acceptable standards of care and research
Plan is based on reliable data and data collection
Plan is objective, unbiased and planner is not an advocate
Integrates multiple sources of data
Plan is all encompassing
Plan is holistic and client centered
Plan is clear, concise and reader-friendly

PROCEDURES

Do a comprehensive assessment and research of analysis
Biomedical research to support recommendations
Data must be reviewed and critically appraised
Review medical records and fill in the gaps
Consult with medical and rehab team, relevant to their practice
Involve the client in the process including interview with client and family without a cultural context
Reasonable recommendations
Assumptions must be stated
Research available programs and services within a geographical area
Establish reasonable outcomes

Group 5
TENETS

Objectivity and consistency
Individualized to reflect individual needs and maximum health functioning
To return client to previous life to the extent possible
Backed by research and relevant data to include medical, vocational and functional data and opinions
Specific to whole person, disability and geographical region
Recommendations are reasonable and logical
Lifelong, flexible and dynamic tool
Restore quality of life
Holistic
Comprehensive and multidisciplinary

PROCEDURES

Full and comprehensive assessment to include client interview
Collaborative approach to reflect consultation with medical and rehab professionals where possible
Follow consistent methodology

Consider all data accepted and rejected and close the gap by requesting additional testing and data as required and when possible
Review medical records
Development of adequate and appropriate recommendations
Research medical condition
Research professional literature
Research appropriate and current costs

FOCUS TOPIC 3: ETHICS

Group Facilitator: Steve Yuhas Recorder: Janice Ray

Overall Observations

As the professional specialization of life care planning has evolved, the need to promote ethical practice among life care planners has taken on increasing prominence. Participants were grouped together and major themes were identified that encompass the majority of the comments. The consensuses on these themes are described below

Results for Topic 3

Total Group Consensus Statement:

In the large group, the following became consensus statements:

- Life Care Planners must be impartial.
- Life Care Planners must be objective.
- Life Care Planners should be knowledgeable about the client's condition.
- Life Care Planners must exhibit integrity.
- Life Care Planners must maintain confidentiality.
- Life Care Planners must demonstrate integrity and honesty.
- The Life Care Plan must include professional disclosure.
- Life Care Planners must maintain Professional Boundaries.
- Life Care Planners must adhere to their relevant professional Code of Ethics and Rules of Conduct.
- Life Care Planners must comply with the Rules of Privacy regarding information and confidentiality.

Total Group Majority Statement:

- Life Care Planners must be competent.
- Life Care Planners must obtain Informed Consent when required.
- Life Care Planners must provide/demonstrate sound foundations for recommendations.
- The Life Care Plan must include a professional disclosure.

Individual Group Outcomes

Group 1

Impartial/Objective/Independent
Competency & knowledgeable about the client's condition – education/training
Intellectual Honesty and Integrity
Confidentiality – disclosure
Informed Consent – client education; information without consent; transparency
Accountability - disciplinary measures
Dual Relationships; professional boundaries; dual roles/conflict of interest

Ethics of conduct/empathy
Consistency
Business Practices – fees; referral fees; 'who is the client'
Reconcile client needs/wants
Use of alternate non-traditional treatment
Aware of inherent biases
Constraints of system
Research literature

Consensus was reached on the following statements:
Life Care Planners must be Impartial/Objective /Independent
Life Care Planners demonstrate competency and are knowledgeable about the client's condition – education/training
Life Care Planners must exhibit intellectual honesty and integrity
Life Care Planners must maintain confidentiality – disclosure of information
Life Care Planners must execute Informed Consent – client education; refrain from obtaining information without consent; transparency

Group 2:
Objective
Competency
Foundations for recommendations
Education
Confidentiality
Adhere to established procedures
Certified/License in area of expertise
Individualized Life Care Plan
Scope of Practice
Supervision/Mentoring new Life Care Plan
Client's Best Interest
Association affiliation & CEU's
Life Care Plan is peer reviewed

Consensus was reached on the following statements:
Life Care Planners must be objective
Life Care Planners must demonstrate competency
Life Care Planners must provide/demonstrate sound foundations for recommendations
Education
Life Care Planners must maintain confidentiality

Group 3:
Competency
Objectivity
Confidentiality
Individualized Life Care Plan
Consistency
Standards of Practice
Certification Required

Rules of Conduct
Supervision/Mentoring
Research
Without Bias/Prejudice

Consensus was reached on the following statements:
Competency
Objectivity
Confidentiality
Individualized Life Care Plan
Consistency

Group 4:
Competency
Objectivity – Equality
Integrity and Honesty
Transparency – Clarity of Role/Scope of Request
Maintain Professional Boundaries
Scope of practice
Conflict of Interest
Individualized to Client Needs – based on pre-existing status
Valid basis for Recommendations – valid data
Confidentiality
Dual Roles

Consensus was reached on the following statements:
Life Care Planners must demonstrate competency
Life Care Planners must demonstrate objectivity – equality
Life Care Planners must demonstrate integrity and honesty
Life Care Planners must exercise transparency – clarity of role/scope of request
Life Care Planners must maintain professional boundaries

Group 5:
Objective unbiased assessment and development of Life Care Plans
Life Care Plan Code of Ethics and Rules of Conduct
Rules of Privacy re: information & confidentiality
Expertise and experience in client's disability
Transparency of Life Care Planner's role/referral source
Consistent methodology and practices
Respectful of individuals and families
Responsibility to client
Consider client's preference/lifestyle and cultural differences
Obtain certification
Practice within area of expertise
Belong to a Professional Association

Consensus was reached on the following statements:
Life Care Planners must provide objective unbiased assessments for the development of

Life Care Plan
Life Care Planners must adhere to the Life Care Plan Code of Ethics and Rules of Conduct
Life Care Planners must comply with the Rules of Privacy re: information & confidentiality
Life Care Planners must demonstrate expertise and experience in client's disability
Life Care Planners must be transparent in their Life Care Planning role to the referral source

FOCUS TOPIC 4: RELIABILITY AND VALIDITY

Group Facilitator: Reg Gibbs Recorder: Giovanna Boniface

Overall Observations

What makes a life care plan reliable and valid? This is the challenge every life care planner faces each time a plan is written. In order for a life care plan to be reliable and valid, the author must use a standardized and dependable methodology, an approach that is consistent with the individual's injury/disability, and be based on current research and professional opinion.

Results for Topic 4

Total Group Consensus Statement:

In the large group discussion, the following statement reached full consensus:

- Life Care Planners must utilize a Consistent Methodology

Total Group Majority Statement:

- Life Care Planners should use reliable, consistent, dependable, standardized methods for drawing conclusions.
- Life Care Plans should include research/literature or medical foundation for recommendations.
- Life Care Plans should rely upon opinions of medical/rehabilitation professionals.

Individual Group Outcomes

Group 1

Consistent Methodology
Content Validity-use of reliable data, individualized to the client
Face Validity-include research to validate recommendations
Stay within scope of practice/expertise
Reasonable and Justifiable

Consensus was reached on the following:

Consistent Methodology

Group 2

Reliable, consistent, dependable, standardized method for drawing conclusions
Reliance on file review as well as pertinent medical and allied health professional opinion
Probability v. possibility
Individualized life care plan content
Standard methodology

Maintenance of own file/records
Knowledge of legal issues
Review of entire records
Sources of information referenced

Consensus was reached on the following:
Reliable, consistent, dependable, standardized method for drawing conclusions

Group 3
Standardized process of assessment
Use of current research for foundation
Awareness of medical foundation
Accurate item costs and sources of information
Individualized plan
Probable v. possible
Reasonableness
Filling gaps for medical information
Stay within Scope of practice
Lack of medical opinion
Consider pre-existing conditions
Accounting for aging process
Peer evaluation
Consistent documentation/maintenance of file
Conflicting medical opinions
Evaluation of life care plan as a discipline
Relying on treatment providers opinions for recommendations
Life Care Planner knowledge of interpretation of research methods

No consensus was reached within this group.

Group 4
Consistent methodology
Use of existing research
Relevant professional opinion
Accurate and standardized and sufficient data/documentation
Foundational data/literature
Method with predictive validity
Stay in your field
Plain language
Stay within expertise area/stay in your field
Appropriate opinions/discussion
Absent data/ no validity
Current resource database
How function has impacted disability
Standard report format
Relevant purposeful plan
Individualized plan
Reliable data

Template for cost table
Standard interview process (could be linked to consistent methodology)
Consistent with published standards/research
Supportive documentation for research
Validate recommendations

Group 5

Consistent methodology
Research/literature or medical foundation for recommendations
Reliance/use of opinions of medical/rehab professionals
Does Life Care Plan make sense
Individualized (lifestyle of client)
Effective Life Care Plan
Include relevant information; eliminate irrelevant
Content validity
Costs are referenced
Probability v. possibility
Life Care Planners and medical/health professionals stay within scope of practice

Consensus was reached on the following:

Consistent methodology
Research/literature or medical foundation for recommendations

FOCUS TOPIC 5: INFORMATION DISSEMINATION

Group Facilitator: Cloie Johnson Recorder: Carol Bierbrier

Overall Observations

Each round table group was requested to identify means in which Summit proceedings should be disseminated; ways to distribute and disseminate Summit information and/or product. With great consistency, each group identified similar avenues.

Results of Topic 5

Total Group Consensus Statements:

The large group reached consensus on the following statements:

- Life Care Planning Summit Proceedings should be disseminated through Peer Reviewed Journal
- Life Care Planning Summit Proceedings should be disseminated through Journal of Life Care Planning
- Life Care Planning Summit Proceedings should be disseminated through Professional Associations
- Life Care Planning Summit Proceedings should be disseminated through Professional Association Websites
- Life Care Planning Summit Proceedings should be disseminated through Professional Association Conferences
- Life Care Planning Summit Proceedings should be disseminated through Webinars
- Life Care Planning Summit Proceedings should be disseminated through CCLCP Course
- Life Care Planning Summit Proceedings should be disseminated through ISLCP

- Life Care Planning Summit Proceedings should be disseminated through LCP curriculum
- Life Care Planning Summit Proceedings should be disseminated through Manuals
- Life Care Planning Summit Proceedings should be disseminated through E-mail
- Life Care Planning Summit Proceedings should be disseminated through In Service
- Life Care Planning Summit Proceedings should be disseminated through Distance Learning
- Life Care Planning Summit Proceedings should be disseminated through Conference
- Life Care Planning Summit Proceedings should be disseminated through Websites on the Internet

Total Group Majority Statements:
They indicated the following as Majority Statements:

- Life Care Planning Summit Proceedings should be disseminated through Other Stakeholders Group Conferences-
- Life Care Planning Summit Proceedings should be disseminated through Newsletters
- Life Care Planning Summit Proceedings should be disseminated through the Regulatory College
- Life Care Planning Summit Proceedings should be disseminated through ICHCC Website
- Life Care Planning Summit Proceedings should be disseminated through a Canadian Website
- Life Care Planning Summit Proceedings should be disseminated through Stakeholders websites
- Life Care Planning Summit Proceedings should be disseminated through Manuals-Stand Alone
- Life Care Planning Summit Proceedings should be disseminated through Word of Mouth

Individual Group Outcomes
Group 1

Publication/journals
E-mail
Professional association's weblinks
Conferences
Website
Webinar
Professional Associations
Medical Legal Societies
Mailing
Universities/Training
Paper copy
Conferences for life care planning/IARP
E-mail to referral sources and colleagues
Journal of Life Care Planning
Word of mouth
In service
List Serves

Manuals

Consensus was reached on the following ways:

Publication/Journal
E-mail
Websites
Professional Association Web links
Conferences
Webinar
University Training-majority

Group 2

Web
Journal Peer Reviewed
Professional Associations
Newsletter
Regulatory College
Special Interest Groups
CCLCP Course
IBC/IIC
Network of Educational Influential
Webinar
E-mail
Meeting-Peer
National Judicial Institutions
Book-Printed
Speakers Bureau
Professional Assoc Web
Library
List Serves
Monkey Survey Newspaper
Newspaper

Consensus was reached on the following ways:

Web
Journal Peer Review
Professional Association
Other Stakeholders Group Conferences-IBC/IIC/NJI/consumer/legal
Newsletter
Regulatory College
Webinar
CCLCP Course

Group 3

Website
Journal of Life Care Planning
Professional Associations members
Journals (Professional)

International Symposium of Life Care Planning
Professional Colleges
International Association of Rehabilitation Professionals/International Academy of Life Care Planners website
ICHCC website
Canadian Website
Stakeholder Associations
Life Care Planning curriculum
List Serves
One on One education
In-service to professionals
Google

Consensus was reached on the following ways:
Website
Journal of Life Care Planning
Professional Associations
Professional Journals
ISLCP
Regulatory College/IALCP

Majority was reached on the following ways:
ICHCC Website
A Canadian Website
Life Care Planning curriculum

Group 4
Website-Professional Associations
Professional Journals
Internet
Electronic Manual-Hardcopy
E-mail
In-service
Distance Learning
Conferences
List Services

Consensus was reached on the following ways:
Website Professional Associations
Professional Journals
Electronic Manual-Hardcopy
E-mail
In Service
Distance Learning
Conferences
Internet

Group 5

Website
Internet
Journal (Peer reviewed)
Webinar
Professional Organizations
List Serves
Manuals-Hard copy/Electronic
Word of Mouth
Stakeholder's websites

Consensus was reached on the following ways:

Website/Internet/Search Optimized
Journal
Webinar
Professional Organization
List Serves
Stakeholder's websites
Manuals-Stand Alone
Word of Mouth

Summary

The Canadian Life Care Planning Summit 2011 was on many levels a success and indicative of the diversity of the professionals in Canada, not unlike the diversity of Life Care Planners in the United States and elsewhere. There was a consistent replication of results from the Summits of 2000, 2002, 2004, 2006, 2008 and 2010. The initial work by the community in 2000 was mimicked by the attendees in Canada. The Summit proves once again to be an avenue of contribution by the practitioners to the field. We look forward to the work of the Canadians to utilize this process for ongoing success of Life Care Planners. Additionally, it is hoped that all Life Care Planners will take an active role in the growth and development of the field showing unity and collegiality.

Reference

Delbecq, A.L., Van de Ven, A.H., & Gustafson, D.H. (1975). *Group techniques for program planning: A guide to nominal and Delphi processes.* Glenview, IL: Scott Foresman and Company.

Canadian Life Care Planning Summit 2011 Attendees:

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SUMMARY OF TOTAL GROUP RESULTS FOR CANADIAN LIFE CARE PLANNING SUMMIT 2011

Editor's Note: The following summary is intended to provide an "at-a-glance" summary of the Consensus and Majority View Statements reached during the inaugural Canadian Life Care Planning Summit held in June 2011 in Toronto, Canada in the five topic areas.

Results for Topic 1

In the large group, the following statements were voted on using the audience response system.

Total Group Consensus statement:

Similar to the 2000 Life Care Planning Summit in Dallas, TX, there were no statements that received consensus.

Total Group Majority Statement:

The following statements resulted in a majority view:

Education:

- Minimum bachelor's degree in a health or rehab field
- Minimum of 5 years clinical experience in health related field
- Bachelors and or licensure as a health care professional
- Beginning in 2011, minimum of bachelors degree in a health and allied health or rehab field

Experience

- 5 years in a vocational and/or health setting or clinical practice
- Minimum of 5 years clinical experience in a rehab and/or health related field

Results for Topic 2

Following small group discussion, each item was brought to the large group for further consensus development.

Total Group Consensus Statements:

In the large group discussion, the following statements reached full consensus:

- The Life Care Plan should be objective
- The Life Care Plan should be consistent in methodology.
- The Life Care Plan should be unbiased.
- The Life Care Plan should be based on peer-reviewed evidence.
- The Life Care Plan should be individualized to the person and his/her specific needs.

Total Group Majority Statements:

The following item was accepted as reaching majority view:

- The Life Care Plan should be client centered and one that restores maximum functioning

and quality of life while considering individual needs.

Results for Topic 3
Total Group Consensus Statement:
In the large group, the following became consensus statements:

- Life Care Planners must be impartial.
- Life Care Planners must be objective.
- Life Care Planners should be knowledgeable about the client's condition.
- Life Care Planners must exhibit integrity.
- Life Care Planners must maintain confidentiality.
- Life Care Planners must demonstrate integrity and honesty.
- The Life Care Plan must include professional disclosure.
- Life Care Planners must maintain Professional Boundaries.
- Life Care Planners must adhere to their relevant professional Code of Ethics and Rules of Conduct.
- Life Care Planners must comply with the Rules of Privacy regarding information and confidentiality.

Total Group Majority Statement:

- Life Care Planners must be competent.
- Life Care Planners must obtain Informed Consent when required.
- Life Care Planners must provide/demonstrate sound foundations for recommendations.
- The Life Care Plan must include a professional disclosure.

Results for Topic 4
Total Group Consensus Statement:
In the large group discussion, the following statement reached full consensus:

- Life Care Planners must utilize a Consistent Methodology

Total Group Majority Statement:

- Life Care Planners should use reliable, consistent, dependable, standardized methods for drawing conclusions.
- Life Care Plans should include research/literature or medical foundation for recommendations.
- Life Care Plans should rely upon opinions of medical/rehabilitation professionals.

Results of Topic 5
Total Group Consensus Statements:
The large group reached consensus on the following statements:

- LCP Summit Proceedings should be disseminated through Peer Reviewed Journal
- Life Care Planning Summit Proceedings should be disseminated through Journal of Life Care Planning
- Life Care Planning Summit Proceedings should be disseminated through Professional Associations
- Life Care Planning Summit Proceedings should be disseminated through Professional Association Websites
- Life Care Planning Summit Proceedings should be disseminated through Professional Association Conferences

- Life Care Planning Summit Proceedings should be disseminated through Webinars
- Life Care Planning Summit Proceedings should be disseminated through CCLCP Course
- Life Care Planning Summit Proceedings should be disseminated through ISLCP
- Life Care Planning Summit Proceedings should be disseminated through LCP curriculum
- Life Care Planning Summit Proceedings should be disseminated through Manuals
- Life Care Planning Summit Proceedings should be disseminated through E-mail
- Life Care Planning Summit Proceedings should be disseminated through In Service
- Life Care Planning Summit Proceedings should be disseminated through Distance Learning
- Life Care Planning Summit Proceedings should be disseminated through Conference
- Life Care Planning Summit Proceedings should be disseminated through Websites on the Internet

Total Group Majority Statements:
They indicated the following as Majority Statements:

- Life Care Planning Summit Proceedings should be disseminated through Other Stakeholders Group Conferences-
- Life Care Planning Summit Proceedings should be disseminated through Newsletters
- Life Care Planning Summit Proceedings should be disseminated through the Regulatory College
- Life Care Planning Summit Proceedings should be disseminated through ICHCC Website
- Life Care Planning Summit Proceedings should be disseminated through a Canadian Website
- Life Care Planning Summit Proceedings should be disseminated through Stakeholders websites
- Life Care Planning Summit Proceedings should be disseminated through Manuals-Stand Alone
- Life Care Planning Summit Proceedings should be disseminated through Word of Mouth