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Editorial

It is an honor and a privilege to be the Guest Editor of this Special Issue on Summits for the *Journal of Life Care Planning*. This edition is unique in that it is a reflection and an opportunity; an educational tool and a reminder; a chorus and an instrument. Rather than pontificate on the meanings of the above commentary, I will briskly outline what this edition holds which when reviewed am hopeful the reader will draw the same conclusions. I encourage you to continue to be involved in the transdisciplinary practice.

This special issue of the *Journal of Life Care Planning* includes:

- The work of over 400 life care planners who took a vested interest in the future and participated in Summits to address cutting edge issues affecting Life Care Plans, Life Care Planning and Life Care Planners
- Proceedings of Life Care Planning Summits conducted in 2000, 2002, 2004, 2006, 2008, 2010 and 2011 (Canada) as well as the consensus and majority statements affecting the practitioner
- Letters of Endorsement of the Proceedings from a multitude of organizations involved with the multidisciplinary field of Life Care Planning include:
  - American Association of Nurse Life Care Planners (AANLCP),
  - American Association of Legal Nurse Consultants (AALNC),
  - Care Planner Network,
  - Commission on Disability Examiner Certification (CDEC),
  - Commission on Health Care Certification (CHCC, currently ICHCC),
  - Case Management Society of America (CMSA),
  - Foundation for Life Care Planning Research (FLCPR),
  - Georgia State University,
  - Intelicus,
  - International Academy of Life Care Planners (IALCP),
  - International Association of Rehabilitation Professionals (IARP),
  - IARP-Canada,
  - University of Florida,
  - Vocational Rehabilitation Association of Canada (VRA)

- A singular repository for all Majority and Consensus Statements created over the course of the 12 year history of the biennial Summits
- A source to understand the difference between a Summit and a Symposium/Conference
- Agenda for the 2012 Life Care Planning Summit on May 5 and 6, 2012 in Dallas, Texas
- Colleague and Association commentary on the 2012 Life Care Planning Summit.

I hope you take the time to reflect on the hard work of many, seize the opportunity to participate in the Summits, fully understand historical perspectives and impacts of the Summits and join other practitioners in sustaining our professionalism in this transdisciplinary practice. Looking forward to seeing you all in Dallas on May 5 and 6.

Cloie B. Johnson, MEd is the Past Chair of the International Academy of Life Care Planners, International Association of Rehabilitation Professionals and the Chair of the 2012 Life Care Planning Summit.

Editor's note: The following papers were reprinted from previously published articles in earlier issues of the journal. The following list of citations provide references to those papers:

Weed, R. & Berens, D. (2001). *Life Care Planning Summit 2000 Proceedings* Athens, GA: Elliott & fitzpatrick, Inc.
JCLP, 2(2), 57-101, 2002
JCLP, 3(2), 109-112, 2004
JCLP, 5(1-2), 25-26, 2006
JCLP, 5(3), 57-90, 2006
JCLP, 7(2), 49-60, 2008
JCLP, 9(2), 3-14, 2010
JCLP, 10(3), 25-28, 2011

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Special Issue of the Journal of Life Care Planning on Summits

Foreword by Roger Weed, PhD

This edition of the JLCP is essential reading for every life care planner. To be an effective and career-long practitioner, it is critical to understand not only how we became a specialty practice but the trends which have an effect on the contemporary life care planner as a result of changes in health care, current court decisions, and expanding practice horizons.

This special issue of the JLCP summarizes the results of the extraordinary efforts of our fellow life care planners over the past twelve years from various summits. Summits are designed to solicit the active participation of practicing professionals to help define ethics, methodology and standards of practice. (At most conferences the participants are listeners and the speakers impart information whereas at summits the leaders are listeners and the participants impart information.) Those who educate, research, certify and practice have routinely volunteered their time to collegially come together to look in the mirror at who we are, what we are doing, and where we are going. Attendees have efficiently and effectively helped guide and develop the future of life care planning. Looking at best practices, certifications, court decisions, ethics, methodology and standards of practice across our multidisciplinary practice, the participants have continued to chart the course to more fully understand the methodology and the reality of the consequences of court decisions and other factors derived from various jurisdictions and specialty practice areas.

I encourage you to read the past and present summit summary of proceedings reprinted in this edition of the JLCP and participate in the upcoming 2012 Summit in May in Dallas. The 2012 Summit planning committee, as usual, has attentively listened to practitioners and monitored various list serves to select topics of importance for summit participant discussion.

Summits ensure that we sustain our professionalism, confirming that we are not paint by number scribes. We have continued to follow the long-standing tenants and methodology consistent with the multidisciplinary aspect of life care planning. These have been reassuringly affirmed in court decisions across the country in both state and federal court jurisdictions as well as adopted by other venues (such as Medicare-Set-Aside, family planning, trusts, catastrophic healthcare reserves, workers' compensation claims, and others).

This special issue concisely provides a bird-eye view of what has historically been achieved in each of the biennial summits since 2000. In their reflection on the applicability of past developed consensus and majority statements, Karen Preston and Cloie Johnson have

continued to strive to ensure these statements maintain relevance, modified or are eliminated so as to maintain the credibility of the specialty practice, consistent with ongoing research and importantly affirmed by court decisions (for those practitioners who are involved in forensic rehabilitating). I commend them and look forward to the efforts of those attending the 2012 Summit in Dallas on May 5 & 6.

Thank you to Cloie Johnson for her editing assistance.

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Life Care Planning Summit 2000

Dallas, Texas
April 12, 2000

Introduction

On April 12, 2000, a conference was held specifically to address life care planning topics and issues with the goal of achieving consensus on five focus areas. The conference was sponsored by Intelicus/University of Florida in conjunction with the International Association of Rehabilitation Professionals (IARP), International Academy of Life Care Planners (IALCP), and the Commission on Disability Examiner Certification (CDEC). In addition, the American Association of Legal Nurse Consultants (AALNC) and the Case Management Society of America (CMSA) participated. Each organization was asked to identify a speaker/group facilitator to lead a small focus group.

In order to establish a consistent foundation, the definition of life care planning was distributed as follows:

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

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

1. **Professional preparation: Minimum qualifications Education**
   Experience
   Certifications
   Other credentials
2. **Basic tenets and procedures for completing life care plans**:
   Records review
   Medical foundation
   Expert witness v. consultant
   Reports and content
   Economic requirements
3. **Ethics**:
   Relevancy of ethics from certifications or licenses not specific to life care planning
   Maintaining files

Documenting contacts for Life Care Plan entries
Staying within area of expertise
Confidentiality
Objectivity

4. **Reliability and validity of the life care plan:**
   Based on adequate foundation
   Opinions referenced in life care planning by credentialed professionals
   Based on the industry requirements (e.g., personal injury, workers' comp., etc.) Research data

5. **Information dissemination:**
   How to make agreed upon standards and procedures readily available to public Publications, association, and certification board web sites
   Develop a reference list of life care planning and related publications

Method

Speakers

The participating organizations were asked to nominate a professional who was knowledgeable in the life care planning field who would offer comments to the group at the general session and would also act as facilitator in the focus groups. In addition, in order to achieve proper balance, physicians, plaintiff and defense attorneys, an economist, and other well known rehabilitation and life care planning professionals and authors were invited. The defense attorney and the CDEC Board representative were unable to attend due to poor weather which delayed their flights until too late to actively participate. However, the plaintiff attorney was able to talk with the defense attorney and relevant issues were included. In addition, the CDEC requirements and ethics were distributed to all speakers and attendees prior to the conference.

Participants

The attendees (limited to 100 attendees and the speakers) consisted of 102 professionals who were invited from lists of organizations known to include life care planners. Although attendees were generally self-selected, most had demonstrated experience in life care planning and 66 were Certified Life Care Planners (CLCP). Others were highly experienced and/or were actively obtaining training in life care planning. (Note: Although all available attendee reservations were sold, poor weather prevented a few from participation. The attendee list includes only professionals who actually were present for the summit.)

Procedures

Prior to the conference, all speakers and attendees were sent a binder which contained relevant information to help reduce the amount of time required to educate the audience. Included in the information was:

Definition of life care planning (see introduction).
Ethics and Professional Issues for the Life Care Planner developed by Dr. Roger Weed from a previous annual conference on life care planning.
General Considerations for Life Care Planners by Drs. Paul Deutsch and Chris Reid.
A Daubert Checklist for the Life Care Planner, by Tyron Elliot, Esq.
Daubert, The Emerging Profile, by Tyron Elliot, Esq.

Daubert and Kumho: Guidelines for the Rehabilitation Consultant, by Dr. Timothy Field.
A Rules and Guidelines Checklist by Dr. Randall Thomas.
The Commission on Disability Examiner Certification Standards and Examinations Guidelines, by Dr. Robert May.
Guidelines for Excellence in Life Care Planning, Draft #3, by Sharon Reavis, Karen Preston and Roger Weed and edited by Patricia McCollom.
NARPPS Standards and Ethics (now known as IARP).
Code of Ethics and Conduct, by American Association of Legal Nurse Consultants.
Miksis v. Howard, 106 F 3d 754 (1997).
Davis v. Ford Motor Company, 128 F 3d 631 (1997).

At the Summit, the group was assembled in a general session to explain the procedures and invite the speakers to make opening statements that would serve to help focus attendees on various topics and issues. The initial schedule was planned as follows:
Introduction and purpose — Roger Weed, Ph.D., CRC, CLCP, CCM, CDMS, LPC
Keynote speaker for the issues - Paul Deutsch, Ph.D., CRC, LMHC, CLCP
Plaintiff attorney perspective — Tyron Elliott, Esq.
Defense attorney perspective — Donald Lawson, Esq. (unable to attend due to weather)
Medical foundation issues — Richard Bonfiglio, MD and Terry Winkler, MD, CLCP
Economic foundation issues — Frederick Raffa, Ph.D.
Overview of effects on the industry based on legal research — Timothy Field, Ph.D.
Industry comments
CLCP Board perspective - Robert May, Rh.D., CRC (unable to attend due to weather)
IALCP perspective - Patricia McCollom, MS, RN, CRRN, CDMS, CCM, CLCP
NARPPS (now IARP) perspective — Ann Neulicht, Ph.D., CRC, CDMS, CVE, LPC, CLCP, DABVE
AALNC perspective — Patty Costantini, RN, M. Ed., CRC, CCM, CLCP, LNCC
CMSA perspective — Anne Llewellyn, RN.C., BPSHSA, CCM, CRRN, CEAC
Curriculum comments
Intelicus - Linda Shaw, Ph.D., CRC
University of Florida — Horace Sawyer, Ph.D., CRC

After the general session, numbers were assigned separately to each attendee within their professional discipline so that an integrated mix of experience, training and knowledge was assured. The initial small group session was 45 minutes and sessions thereafter were approximately 30 minutes. Every attendee rotated through all five focus groups and participated in discussions on all topics.

A modified nominal group technique was used within each focus group (except group 4) to gather information in an organized format and to reduce the influence of verbal or assertive participants on the outcome. A summary of the modified nominal group technique follows:

1. Ask the group members to write down their top 3 to 5 suggestions in order of priority
2. Use a flip chart to go around the group and write down suggestions
3. Combine suggestions when possible
4. After the issues are recorded, ask the attendees to "vote" on 3 to 5 of the suggestions listed
5. After the vote, group facilitator assigns 1 to the highest, 2 to the second highest, etc.
6. Facilitator adds up the score for each and the top scoring 3 to 5 recommendations represent the decisions for that group

7. When the large group reconvened, each small group contributed 3 to 5 recommendations. Theoretically, several overlapping recommendations should be made. Time was reserved at the end of the day for additional discussion by and to the panel members from the participants.

At the end of the conference day, attendees were re-assembled into one large group and the facilitators summarized the comments and consensus was noted. Overall, a significant amount of consensus was reached on multiple topics. In other areas, there was a majority view.

Following the Summit, a draft of the proceedings was sent to all attendees, speakers and participating organizations and their comments 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 which 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.

Results

The following sections represent a summary of the results of each focus group.

FOCUS TOPIC 1: PROFESSIONAL PREPARATION

Group Facilitator: Horace Sawyer, Ph.D., CRC
Recorder: Ann Wallace, MS, CRC, CDMS, MFCT

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 which is rare among service delivery strategies.

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

Qualification standards are needed that are professionally appropriate for life care planning without being exclusionary.

Priority Areas

Education

Majority View

Minimal level of education at the Bachelors Degree level (one group expressed concerns that a professional with a BA does not have the necessary skills)

If professional entry level is higher, i.e. Masters Degree, this higher level is required Professional degree above the bachelor level required if appropriate, i.e., physician

Experience

Majority View

Essential to have a combination of experience and education

Minimum of five years experience in a rehabilitation and health related field prior to being qualified for life care planning

Certification

Majority View

Eventual requirement for certification in an area related to life care planning to be recognized as a qualified life care planner

In addition, certified and/or licensed in own profession with established ethical standards

Professional Training

Majority View

Completion of professional training in life care planning and specific to the primary areas of developing, defending, and managing a life care plan

The present 120 hours of specialty training is acceptable

Additional Qualifications

Majority View

Completion of supervised period of time (internship, mentorship, practicum, etc.) under the supervision of a qualified life care planner required prior to being regarded qualified for life care planning

During this supervisory period, required completion of several life care plans, in

collaboration with supervisor/mentor, that would be peer-reviewed. (Editor's note: suggest minimum 5 life care plans).

FOCUS TOPIC 2: BASIC TENETS AND PROCEDURES

Group facilitators: Ann Neulicht, Ph.D., CRC, CDMS, CVE, LPC, CLCP, DABVE and Patty Costantini, RN, M.Ed., CCM, CRC, CLCP, LNCC (also recorder)

TENETS

Priority Areas

A Life Care Plan is Individualized to Reflect Specific Needs and Promote Optimal Health, Function and Autonomy

Consensus

Specific to an individual, disability, and geographic area

Promotes maximum function/optimizes residual functional capacity

Maximizes independence in a safe and least restrictive environment

Provides a framework/roadmap for implementation of optimal level of care

Includes proactive recommendations to prevent/decrease complications

Functional for the client

Reflects the whole person/client

Considers person/family-centered needs and preferences
Restores quality of life to pre-injury expectations as much as possible

A Life Care Plan is Objective and Consistent

Consensus

Opinions are supported by relevant, available data and research
Conclusions are based on medical, vocational and rehabilitation needs/case specific data
Recommendations are medically/vocationally reasonable and appropriate, probable, necessary and prudent
Utilizes unbiased and established procedures

A Life Care Plan is a Lifelong and Flexible Document

Consensus

A dynamic tool that changes with the client's needs (disability related and developmental)
Provides a logical/cyclic progression of services projected over the client's life expectancy
Reflects a work in progress (e.g. covers client's life span)
Usable (e.g. able to be implemented)

A Life Care Plan is Comprehensive and Based on Multidisciplinary Data

Consensus

Answers questions
Discusses consequences of a catastrophic impairment/disability
Provides collaborative recommendations to address medical, vocational, psychological, rehabilitation and education services as well as functional needs

PROCEDURES

Priority Areas

Completion of an Assessment that includes Collection, Analysis and Synthesis of all Available and Relevant Data

Consensus

To the fullest extent possible, conduct an inclusive data collection process to obtain available and relevant records (including those of the client, treating professionals and other relevant providers)
Conduct a comprehensive interview with the client, his/her family and/or significant other(s), if possible
Communicate with all relevant professionals/experts actively involved in client's care, if possible

Request Additional Testing, Evaluation, or Data, if Needed

Consensus

Address gaps in records and/or recommendations
Obtain recommendations that are within the expertise of the provider
Render opinions that are within the expertise of the life care planner

Research Medical Condition, Resources, and Services to Outline Reasonable and Appropriate Recommendations and Associated Costs

Consensus

Contact verifiable, reliable and credible sources

Review/utilize current literature, research and data to provide a foundation for opinions, conclusions and recommendations

Address reasonable desires/preferences of the client and/or family

Ask appropriate questions of all relevant providers

Assess relevant costs

Provide fair and representative costs relevant to the geographic area or region

Maintain Consistent System of Data Collection/Analysis, Record Keeping and Reporting

Consensus

Create a systematic diagnosis-based record keeping process for standardized data collection

Utilize a standardized format to insure a comprehensive and objective life care plan

Provide conclusions/recommendations supported by evidence within the life care plan and consistent with case records/documentation and other relevant information

FOCUS TOPIC 3: ETHICS

Group facilitators: Patricia McCollom, RN, MS, CRRN, CDMS, CCM, CLCP and Linda R. Shaw, Ph.D., CRC

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 nine (9) major themes were identified that encompass the majority of the comments. The consensus on these nine themes are described below and the general number of responses within each theme are shown in parentheses (totals do not correspond precisely to the number of total concerns identified as some may have been included within multiple themes):

Priority Areas

Competency (41)

Consensus

All life care planners must accept referrals only in the areas of their competency

All life care planners must be educated in the process of life care planning based on each industry's standards and published procedures

Aspiring life care planners with less than one year of experience should be supervised by life care planners with at least two years experience

Objectivity (43)

Consensus

Essential for life care planners to remain objective in their assessments and development

of life care plans despite pressures to construct a plan that is helpful to either plaintiff or defense legal positions

Need to adequately address objectivity in curriculum/training arenas

Life care planning industry needs to provide a mechanism for recourse and corrective action, possibly through a certification-related disciplinary process, when life care planners fail to exercise their obligation to professional objectivity

Life care planners must be certified or licensed in their area of expertise (not necessarily certified as a life care planner/CLCP) that provides a mechanism for ethics complaint resolution

Confidentiality Breaches (22)

Consensus

Life care planners must be educated about confidentiality requirements and legalities

Life care planners must adhere to confidentiality practices when providing services and maintaining records

Lack of Consistency in the Life Care Planning Process (12)

Consensus

Life care planners must use established procedures

"Enhancements" or significant changes in procedures should be subject to peer or organizational review by professionals who are experts in the field

Life care planners should belong to an organization that reviews life care planning topics and issues, as well as offers continuing education specifically related to the industry

Rules of Conduct Among Life Care Planners (11)

Consensus

Life care planners shall refrain from inappropriate, distorted or untrue comments about colleagues and/or the process or training programs available for life care planners

Lack of Research Basis for Recommendations/Conclusions (11) Consensus

It is essential for life care planners to remain objective in their assessments

Life care planners must be certified in their area of expertise that also provides a mechanism for ethics complaint resolution

Life care planners should belong to an organization that reviews life care planning topics and issues, as well as offers continuing education specifically related to the industry

Individualizing Life Care Plans to Patient/Family Issues (10)

Consensus

Life care plans are to be individualized to the client and his/her disability

Life care plans are to be developed in the client's best interest and have a foundation for inclusion of recommendations (i.e., medical foundation based on research and opinions of treating professionals within their own area of expertise v. own experience/opinions)

Lack of Consensus Regarding Life Care Planning Certification (8)

Consensus

Life care planners should belong to an organization and/or be certified in an area that incorporates ethics and procedures specific to life care planning

Dual Relationships (7)

Consensus

Life care planners who are qualified to provide a variety of services or act in several roles must disclose to the client and referral sources what role they are assuming and when/if roles shift

Life care planners must avoid dual relationships, including but not limited to, pre-existing personal relationships with clients, sexual contact with clients, accepting referrals from sources where objectivity can be challenged (such as dating or being married to the referral source), etc.

Summary of Ethics Discussions

Themes generally fell into three groups in the frequency with which they were voiced:

High Frequency Themes (41-43):	Competency
	Objectivity
Medium Frequency Themes (22):	Confidentiality Breaches
Lower Frequency Themes (7-12):	Lack of Consistency in Life Care Planning Process Rules of Conduct among Life Care Planners
	Lack of Research Basis for Recommendations/Conclusions Individualizing the Life Care Plan to Patient/Family
	Issues
	Lack of Consensus regarding Certification
	Dual Relationships

Breakdown of Participants' Comments Regarding Ethics

1. Persons without clinical skills (insufficient experience) competency, understanding the disability itself, practice with lack of experience (#34) **41**
2. Lack of research base **11**
3. Lack of consistency in process of doing LCP/procedures **12**
4. Need for emphasis on role of LCP/professional disclosure/role as educator **3**
5. Individual consensus re: standards, stakeholders (#6, 10, 29)
6. Lack of consensus regarding certification (#5, 10, 29) ****** holding out as "better than" uncertified, do we all need to be certified? **7**
7. Continuity among various standards/ethics **2**
8. Advocacy vs. reporter (#21) role clarified **2**
9. Pressures to "help the case"/OBJECTIVITY (#28) **43**
10. Need for all to "buy in" to one credentialing process (certification) (#5, 6, 29)
11. Lack of emphasis in university programs on LCP (competence) **2**
12. Need to operationalize ethical task standards—competency based terms **3**
13. Referencing no or non-existent databases/misrepresenting data
14. Not collecting sufficient data to form valid opinions **2**
15. Plans do not reflect consumer values/independent needs (#22) **3**
16. Rules of conduct among LCPlanners (e.g., not disparaging, objectivity) **11**
17. Consistency in maintaining files/disposing of files **4**
18. Confidentiality breaches, including contact with treating professionals without consent of person with disability or others (#33) **22**

19. Acceptable and published research procedures/validity/citing invalid research **3**
20. LCP individualized to patient/family needs/issues **8**
21. Dual relationship: e.g. LCP and case manager, impact on objectivity (#8) **7**
22. Medical necessity vs. quality of life (#15)
23. Infighting of organizations **3**
24. Equal access to data/information
25. Need to engage in interdisciplinary model while acting within scope of practice
26. Content of LCP must have defined outcome/rationale **2**
27. Must be valid basis for recommendations: fiscal responsibility **2**
28. Honest and competent evaluation — do not inflate/undershoot figures (#9) **5**
29. Raising the bar/setting agreed upon standards (#10, 6, 5) **3**
30. Consistency in standards across various practice arenas (e.g. litigation, w.c., etc.)
31. Business practices/accepting contingency payment/referral agreements, etc. **4**
32. Releasing notes/work product (#33)
33. Confidentiality of caseload/specific name in deposition/non-Federal Rule 26 (#18, 32)
34. Staying within your discipline's standards of practice (#1) **2**
35. Doing "canned" LCPs **3**
36. Untruthful/manipulating data
37. Confidentiality of names/sanitized LCPs
38. Reviewing value statement/CDEC
39. Qualifications to do plan
40. Conflict of interest identification **4**
41. Failure to give credit for research data
42. Comprehensive rather than selective approach
43. Discounting LCPs for reduced life expectancy

Note: Numbers in parentheses represent other items related to this item. Numbers within double asterisks (**) represent the number of participants who mentioned this concern. Those items for which there is no number in double asterisks were mentioned only once.

FOCUS TOPIC 4: RELIABILITY AND VALIDITY

Group facilitator: Tyron Elliott, Esq., with assistance from Richard Bonfiglio, MD; Paul Deutsch, Ph.D., CRC, LMHC, CLCP and Chris Reid, Ph.D., CRC, CLCP
Recorder: Mary Barros-Bailey, MA, CRC, CDMS, OWCP, NCC, CLCP

(Editor's note: This group was generally structured differently in that they did not hand out cards for each participant and instead brainstormed on applying the concepts to life care planning).

Priority Areas
Reliability
Consensus

Must use a reliable, dependable, and consistent method of drawing conclusions

Must have an adequate amount of medical and other data to form opinion(s)

Must include list of sources requested and a list of data reviewed

Must include list of responses received and date of response so an outside source can understand what questions were asked, how data was collected, date of response, and results

Need to know and understand the definition of reliability as related to opinions - Must utilize consistent and standardized procedures for completing life care plans

Standardized formats based upon published and generally accepted procedures are necessary (may include checklists and forms)

Appropriate to rely upon medical and allied health professional opinions in developing the life care plan

Must stay within life care planner's area of expertise

Although life care plans are individualized, it is important for the life care planner to be able to verify that he/she approaches each case similarly and that the plans for similar cases are relatively consistent

Validity

Consensus

When sufficient database is available, the life care planner will utilize existing research with regard to recommendations included in the plan. Examples may include life expectancy, need for therapies, treatment recommendations, replacement schedules of equipment, etc.

Justification for valid entries in a life care plan may vary from state to state and jurisdiction to jurisdiction. The life care planner must be knowledgeable with regard to legal rules.

Working definitions and guidelines

Face Validity: Explaining the logical basis of steps helps to document face validity.

a. Does the plan appear to be what it is?

b. Is there an "analytical fit" or "reasonable man, reasonable woman, or reasonable person" standard?

c. Does the plan look like it is doing what it is intended to do?

Content Validity: It is the life care planner's responsibility to make the content of the life care plan valid to the particular client.

a. Based on the legal standards for each case which may vary by state, the life care planner must insure that all relevant needs are included and eliminate all unnecessary items

b. Consideration of different ranges of care:

1. minimum care;
2. "reasonable person" care;
3. "Saks Fifth Avenue" care

c. Consideration of pre-existing factors:

1. How to account or not account for it?
2. How complete is the medical history?
3. How do you package the "whole person" in the life care plan (including pre-existing conditions)?
4. Determination may vary by jurisdiction

d. Consideration of conflicts of medical opinions

e. Awareness/knowledge about proper medical foundation and basis for plan and disability

f. Having appropriate opinions from appropriate disciplines is important

g. Valid data means having entire file/records and an adequate amount of baseline and medical data
h. Should know the disability sufficiently to understand what medical professionals and which disciplines are needed
i. Consideration of complications that are contingencies
j. Differentiating between what is probable v. what is possible
k. Provide medical foundation through physicians and/or research as the starting point, not the ending point
1. Cannot cost out future technology or "possibilities"
m. Revert back to the life care planner's role as educator
n. Be able to demonstrate on an item-by-item basis the rationale for each item and conclusion
o. Provide substantiation and documentation for each recommendation
p. Obtain physician approval of recommendations within their area of expertise (i.e., physician sign-off of plan v. own opinion). Federal rules do not require sign-off on every life care plan although this may be different from state to state.
q. Life care planner needs to be cognizant when something is outside his/her area of expertise

Criterion Validity: When the life care planner relies on an opinion, he/she adds criterion validity.

a. Concurrent Validity: Doing a research and literature review to determine appropriate information that exists in the current published literature

b. Predictive Validity: Providing opinions on individual caseload experience; being able to show follow-through; knowing follow up studies to look at basis over time

Process Validity: As a result of the life care planning process, the client more likely than not will ...

a. Achieve longer life
b. Achieve greater quality of life
c. Maximize functional capabilities
d. Minimize complications

FOCUS TOPIC 5: INFORMATION DISSEMINATION

Group Facilitators: Tim Field, Ph.D. and Anne Llewellyn, RN.C, BPSHSA, CCM, CRRN, CEAC

Priority Areas
Ways to Distribute and Disseminate Summit Information and/or Product Consensus

Activity/Method	Group 1	Group 2	Group 3	Group 4	Group 5
1. List Serve	10				
2. Info. Coord. Group	6				
3. Super Web/Net	15	17		13	11
4. Prof. Journals		19	10	11	15
5. Distance Learning		6			
6. Peer Reviews			8		
7. Manuals (updated)			8		
8. Book emails				10	
9. Member Organization					1

Summary in rank order of preference:

1. Super web/net (56)
2. Professional journals (55)
3. Member organizations (11)
4. List serves on the Internet (10)
5. Book emails (10)
6. Updated manuals (8)
7. Peer reviews (8)
8. Information coordination group (6)
9. Distance learning (6)
10. Develop Reference List of Appropriate and Peer-Reviewed Life Care Planning Publications

References on Topics Related to Life Care Planning

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INTELICUS
A University of Florida Partnership

October 25, 2000

Roger O. Weed, Ph.D.
Georgia State University
Department of Counseling and Psychological Services
9th Floor, college of Education
Atlanta, GA 30303-3083

Dear Dr. Weed:

On behalf of Intelicus, I would like to endorse the Proceedings of the Life Care Planning Summit, held in Dallas on April 12, 2000. We are pleased to have been a part of this important effort and hope that it will serve as a foundation document to guide the future development of Life Care Planning education, research and practice.

Sincerely,

Linda R. Shaw

Linda R. Shaw, Ph.D.
Life Care Planning Faculty and Curriculum Chair

IALCP

International Academy of Life Care Planners 114 N.W. 5th St. Ankeny, Ia. 50021 (800) 531-5146 Fax (515) 965-1286

October 5, 2000

TO: Roger Weed, PhD, CRC, CCM, CLCP

FROM: Patricia McCollom, RN, MS, CRRN, CDMS, CCM, CLCP
Chief Executive Officer
International Academy of Life Care Planners

RE: Proceedings of the Life Care Planning Summit 2000

The International Academy of Life Care Planners is grateful to have had the opportunity to participate in the sponsorship, development and presentation of the Life Care Planning Summit 2000.

The proceedings have been reviewed and input provided from the Academy members who attended. Further, initial findings were presented at the Academy's CMSA Pre-Conference Symposium, June 2000, and input was solicited from the more than 100 in attendance.

The outcome of the Life Care Planning Summit 2000 is one of challenge and excitement! Clearly those attending shared common concern for the professionalism, education, ethics and knowledge of life care planning practitioners. The proceedings offer to practitioners a foundation for future dialogue and a blueprint for education needs.

Let us go forward together with these proceedings, which support the IALCP's Standards of Practice for Life Care Planners, to promote ongoing discussion and advanced practice educational offerings.

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November 1, 2000

Roger Weed, Ph.D.
Georgia State University
Department of Counseling and Psychological Services
6th Floor, College of Education
Atlanta, GA 30303-3083

Dear Dr. Weed,

I recently had an opportunity to review the draft of the conference proceedings from the Life Care Planning Summit held in Dallas, Texas on April 12, 2000. As a representative of the University of Florida, I fully endorse the concept of developing the consensus of life care planners from various areas of the country. I anticipate that these proceedings will facilitate a more positive and collaborative approach to the practice of life care planning.

I am glad our University was actively involved in this important summit in life care planning and appreciate the collaboration with you, as well as your commitment to this effort.

Sincerely,

Horace W. Sawyer, Ed.D., CRC
Professor and Chair

American Association of Legal Nurse Consultants
4700 W. Lake Avenue, Glenview, IL 60025-1485
Toll free phone 877/402-2562 • Fax 877/734-8668

October 31, 2000

Roger Weed, PhD CRC CCM CLCP
Weed and Associates Inc.
PO Box 2133
Duluth, GA 30096

Dear Dr. Weed:

The American Association of Legal Nurse Consultants is grateful to have had the opportunity to participate in Life Care Planning Summit 2000.

We have reviewed the proceedings and are pleased to offer our endorsement. The proceedings represent a significant step in the evolution of the practice of Life Care Planning.

AALNC looks forward to ongoing dialog and future collaboration with other leaders in the field of Life Care Planning.

Sincerely,

Jeannie Autry, BS RN LNCC
President

cc: Patricia A. Costantini, MEd RN LNCC
Past President

International Association of Rehabilitation Professionals

October 23, 2000

On behalf of the International Association of Rehabilitation Professionals, I am pleased to write that IARP endorses the Life Care Planning Summit 2000 Proceedings without reservation. The Summit was a special opportunity for professionals in the field to discuss and delineate best practices for Life Care Planning. The Proceedings profile our high standards and effectively lay the groundwork for future deliberation of training and service delivery issues.

Roger and Debbie, we thank you for taking the lead in this historic endeavor, actively involving IARP in all phases of the Summit as well as pulling together the information in such a professional manner.

Best Regards,

Ann T. Neulicht

Ann T. Neulicht, PhD, CLCP, CRC, CVE, CDMS, LPC, DABVE
International Association of Rehabilitation Professionals Representative

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Commission on Disability Examiner Certification

V. Robert May III, Rh.D.
Administrator

November 28, 2000

Roger Weed, Ph.D.
Georgia State University
Department of Counseling and Psychological Services
6th Floor, College of Education
Atlanta, GA 30303-3083

Dear Dr. Weed:

I want to commend you on your efforts to establish practice standards in the specialty rehabilitation area of life care planning. There is no doubt that your efforts to organize and to provide structure to a multitude of professionals who have an interest in life care plan service delivery will only strengthen the quality of service and assist this Commission in regulating those who choose to become certified in life care planning. We fully endorse your leadership and we look forward to contributing to your efforts however you may wish our involvement to be.

Again, thank you for your kind consideration of this Commission and I look forward to working with you on this monumental project.

Sincerely yours,

V. Robert May III, Rh.D., CDE II
Executive Administrator

CDEC: 13325 Queensgate Road • Midlothian, Virginia 23113 • Phone (804) 272-9192

CMSA
CASE MANAGEMENT SOCIETY OF AMERICA
Advocacy • Integrity • Leadership • Professionalism

November 27, 2000

To: Roger Weed, PhD, CRC, CCM CLCP

From: Jeanne Boling, MSN, CRRN, CDMS, CCM
Executive Director
Case Management Society of America

Re: Proceedings of the Life Care Planning Summit 2000

Case Management Society of America is pleased to have been involved in the Life Care Planning Summit 2000 and to have been integral in the development of the consensus statements contained within the LCP Summit 2000 Proceedings. CMSA supports the process of peer review of the Proceedings content by the LCP Summit 2000 participants and others in pre-conference seminars at both CMSA's Annual Conference and the Medical Case Management Convention.

The building of significant dialogue among industry professionals toward consensus is a critical first step in the development of Life Care Planning. CMSA applauds the industry leaders spearheading this development and looks forward to continued efforts and discussion.

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Life Care Planning Summit 2002

Susan Riddick-Grisham, RN, CCM, CLCP
Program Chair

Introduction

Life care planning has become a valuable and necessary component of catastrophic case management and rehabilitation. Over the past 20 years, there has been significant growth in this transdisciplinary specialized field of practice. As the field has grown, professionals involved in the practice of life care planning have participated in the development of standards.

On April 12, 2000, life care planners from across the United States came together to participate in the first national life care planning summit. This professional summit provided a forum for in-depth discussion pertaining to five topic areas: Professional Preparation, Basic Tenets and Procedures for completing life care plans, Ethics, Reliability and Validity of the life care plan, and Information Dissemination. Out of this historic endeavor, a consensus document was published to guide the future development of life care planning, education, research and practice.

Continuing the ongoing progress in life care planning education, standards development, professionalism, and research, an online national survey of life care planners was conducted in November 2001. Results of the survey were peer-reviewed and published, along with the survey instrument, in an article titled Life Care Planning Survey 2001: Process, Methods and Protocols (*Journal of Life Care Planning*, 2002, 1(2), 97-148). The results specifically described the current state of life care planning practice along with

protocols/procedures used by life care planners.

On May 19, 2002, 120 life care planners came to together for the second national life care planning summit. Building on all of the significant accomplishments of the April 2000 meeting, Summit 2002 again created a forum for discussion among professionals about issues which impact the field of life care planning.

The Summit was sponsored by Intelicus/University of Florida in conjunction with the International Association of Rehabilitation Professionals (IARP), International Academy of Life Care Planners (IALCP), and the Commission on Health Care Certification (CHCC).

In preparation for this professional meeting, an educational committee worked to identify five focus areas to be addressed in the roundtable discussions. This committee consisted of Susan Riddick-Grisham, program Chair, Debbie Berens, Paul M. Deutsch, Tim Field, Patricia McCollom and Roger Weed.

The five topic areas and objectives included:

1. Life Care Plan Methodology/Functions - to explore life care plan methodology as outlined in the IALCP Standards of Practice and to determine if revisions are needed to better reflect changes in the field.
2. Professional Development - to explore professional development of the life care planner.
3. Scope of Practice/Specialty Skills - to explore the current requirements for becoming qualified and/or certified as a life care planner.

4. Ethics - to explore ethics involved in the practice of life care planning.
5. Future of Life Care Planning - to explore future developments, issues, and trends in life care planning.

Method

To better prepare attendees for the program, relevant materials were assembled and sent to all registered participants in advance of the Summit. Materials consisted of:

1. IALCP Standards of Practice
2. Code of Ethics for Rehabilitation Counselors
3. CHCC Guidelines

Facilitators and recorders for the roundtable discussions were identified by the program Chair. They consisted of qualified individuals from the supporting organizations as well as other experienced life care planning professionals. Due to the size of the number of participants, each topic area had two roundtables.

Prior to the Summit the attendees participated in a day long educational program focused on advanced practice issues. Presentations covered issues such as research methodology for life care planners, evidence-based guidelines, care management applications and factors in assessing medical equipment choices.

The Summit convened with a keynote presentation on the meaning and value of standards. In preparation for the roundtable discussions, each attendee was assigned a number within their professional discipline so that an integrated mix of experience, training and knowledge was assured. The small group sessions were 30 minutes each and every attendee participated in discussions on all topic areas. The method for soliciting information from the group was a modified nominal group technique.

At the end of the day, the attendees were reassembled into one large group. A brief summary of the results of each topic area was presented by one of the facilitators for each topic area.

A thorough analysis of the findings was later completed by each of the facilitators and provided to the program Chair. A comment noted by each of the facilitators, and many of the attendees, was the suggestion for the next Summit to either allow more time within the roundtables for greater substantive discussions or limit the size of the roundtable groups. Another observation made by some participants was the apparent variable application of the nominal group techniques by the roundtable facilitators. Understandably, these observations created the need for closer inspection of results published when analyzing data. Given these considerations, the summary of the results published on the following pages is accurate and adequately represents the views of the life care planning professionals who participated in Summit 2002.

After the Summit results were documented, a draft of the proceedings was developed and sent to key individuals within the sponsoring organizations and life care planning industry for review and comment. Based on feedback, the proceedings were revised as appropriate and the final step was to solicit endorsement of the proceedings from the sponsoring organizations as well as to ensure their support to the continued study, research and validation of life care planning.

Results

The following sections represent a summary of the results of the focus groups. For

purposes of this document, the following terms are defined:

1. Areas of Consensus means that all attendees present agreed to the areas as reported and associated with the bullet point.
2. Areas of Discussion means that an attendee or attendees present offered suggestions or recommendations that did not have unanimous support. In some cases, most attendees agreed and in others, the point could be an individual's suggestion with little group support.

FOCUS AREA:	**Life Care Plan Methodology/Functions**
Group Facilitators:	Terry Winkler, MD, CLCP
	Karen Preston, MS, RN, CRRN, PHN
Recorders:	Amy Sutton, RN, BSN, MA
	Lynn Esko, CRC, LMHC, CCM, CLCP

The charge given this group was to explore life care plan methodology as outlined in the IALCP Standards of Practice and to determine if revisions are needed to better reflect changes in the field. Scope of discussion would include areas relating to data collection, assessment, planning, plan research, facilitation, evaluation and testimony. Further, that the group, individually and collectively, establish priorities for these areas.

Overall Premises

Qualified life care planners must demonstrate a level of competence combining education, professional preparation, and experience. As this area of specialized practice grows it is essential that there is a consistency of practice across all disciplines entering the field. The IACLP Standards of Practice represent the parameters of responsibility for which life care planners are accountable.

Areas of Consensus

To create a foundation for life care plan content there needs to be:

1. Integrity of data- delineating what data was gathered, from what resources including research and literature.
2. A method to handle divergent opinions between experts or between experts and the literature.
3. A method to properly interject personal expertise.
4. Use of credible evidence-based guidelines.
5. Having access to conduct an in-person interview can enhance the life care planning process.
6. Standard tools for gathering and reporting information.
7. Protocols for doing cost research.
8. Protocols for handling "the impact of aging" aspects in a life care plan.
9. Guides outlining when to use local versus national resources.
10. Collaboration.

There needs to be a review of all terminology used to describe methodology of life care planning as stated in the IALCP Standards.

The life care planner should understand the difference between local standards for treatment and management of care versus the national standard (Centers of Excellence).

The life care planner should understand the optimal outcomes achievable to each injured person.

Priority Areas

Priority #1: Life Care Plan Methodology/ IALCP Standards Areas of Discussion:

1. Life care planners should utilize a peer review process.
2. Life care planners should seek other experts' input as needed or as appropriate to augment one's experience.
3. Should the life care plan include a section discussing the client's perspective?
4. The Standards do not reflect the value of doing a face-to-face interview with the client.
5. Further discussion needs to be conducted to evaluate the use of the words "thorough" and "complete" as stated in the IALCP Standards.
6. Standards should be general.
7. Need to differentiate between standards of practice and standards of methodology.
8. Need for total review and rewrite of the Standards.
9. The language in the Standards should be "request for" such items as medical records and in-person interview along with "seeks other experts' input as needed or as appropriate to augment one's experience."
10. Written standards should not be so narrow as to limit the life care planner's ability to practice.
11. Should there be standard templates for gathering data?
12. Indiscriminate use of medical literature with no understanding of its validity or applicability.
13. Should financial information be obtained from the client and then used in the life care plan?

Priority #2: Qualifications Areas of Discussion:

1. Re-evaluation of grandfathering (CHCC). (Editor's Note: CHCC does not allow grandfathering).
2. Review of existing requirements and raising standards for CHCC credentialing.
3. State licensure requirements for nurses doing life care plans.
4. Experience with collaborative teamwork. What should that include?
5. Five (5) years case management experience require for certification.
6. Bachelor of Science requirement for nurses and Masters degree for other health disciplines to qualify for training.
7. Ongoing peer review for maintenance of certification.
8. Active licensure and certification in primary field of practice.
9. Many life care planning training issues need to be addressed.

Priority #3: Life Care Plan Critique Areas of Discussion:

1. A critique should address the methodology of the life care planner.
2. A critique should be a professional review, based on objectivity.

FOCUS AREA:	**Professional Development**
Group Facilitators:	Paul Deutsch, Ph.D., CRC, LMHC, CLCP
	Tim Field, Ph.D
Recorders:	Dan Bagwell, RN, CLCP
	V. Robert May, Rh.D. CDE

The charge given this group was to explore professional development of the life care planner. Scope of discussion would include areas relating to training and education, certification and research. Further, that the group, individually and collectively, establish priorities for these areas.

Overall Premises

Professionals in various health care fields, including nursing, medicine, rehabilitation counseling, social work, physical and occupational therapy are involved in developing life care plans. As this specialized field of practice continues to grow and develop it is of specific purpose that a coordinated effort with standardized approaches be promoted. Education of new and experienced life care planners is an essential part of continuing professional development. The community of life care planners is now looking for more advanced educational opportunities along with ways to be involved in life care plan certification and research.

Priority Areas

Priority Area #1: CHCC compliance with or under accountability to the NCCA.

Areas of Consensus:

1. The field of life care planners should monitor the formal application to NCCA.
2. CHCC should be accountable to NCCA.

Priority Area #2: Advanced Training/Continuing Professional Education

Areas of Consensus:

1. Training needs to be focused on disability specific courses.
2. Programs covering advanced/complex issues are needed.
3. Regionally based offerings are needed.

Areas of Discussion:

1. Continuing education focused on clinical updates.
2. Continuing education focused on specialized areas of the life care plan.
3. Continuing education focused on changes in the legal field.
4. Continuing education focused on report writing.
5. Continuing education in non- traditional treatment of disease or disability states.
6. Need for new instructors.
7. Research-based continuing education.
8. Multiple forums to meet continuing education needs
9. Ethics continuing education as part of the CHCC re-certification requirements.
10. Education programs for life care planners in areas other than litigation.
11. Seminars with breakout sessions to give attendees more options.
12. Consider having certified instructors to provide on-going life care plan training.
13. Prep course for certification exam with study guide.

Priority Area #3: Development of a Peer Review Process

Areas of Consensus:

1. The field needs a formalized, blind peer review process that would be available to all life care planners.

Areas of Discussion:

1. Development of mentoring programs.
2. Availability of CEUs for individuals acting as mentors or peer reviewers.

Priority Area #4: Centralized Data/Information Repository

Areas of Discussion:

1. Development of a web site for life care planners.
2. Need to identify a way to communicate with all life care planners about national data.
3. Possible use of a listserv for life care planners.

Priority Area #5: Research

Areas of Consensus:

1. Life care planners must be involved in research.
2. Continuing education programs focused on demonstrating how to include research in the life care plan and how to present it.

FOCUS AREA: Scope of Practice/Specialty Skills

Group Facilitators: Ann Neulicht, Ph.D., CLCP, CRC, CVE, CDMS, LPC
Patricia McCollom, MS, RN, CRRN, CDMS, CCM, CLCP

Recorders: Patricia Costantini, RN, CRC, CCM, CLCP, LNCC
Steve Shedlin, MS, CRC

The charge given this group was to explore the current requirements for becoming qualified and/or certified as a life care planner. Scope of discussion would include CHCC requirements for certification and Scope of Practice definitions published by CHCC and IALCP. Further, that the group, individually and collectively, establish priorities for these areas.

Overall Premises

In light of the Scope of Practice definitions within the Standards of Practice published by the CHCC and IALCP, what do you believe are the qualifications to practice in the specialty area of life care planning? (question agreed upon by the facilitators, prior to the session)

Priority Areas

Priority Area #1: Qualifications/Education

Areas of Consensus:

1. Professional licensure and/or certification (in good standing) in primary field of practice.
2. Advanced education and health care/rehabilitation background.

Areas of Discussion:

1. No consensus about the definition of advanced education and rehabilitation background.
2. No agreement regarding minimum college degree needed.
3. Four year college degree for registered nurses and Masters for other health disciplines was discussed.

4. Active participation in professional organizations.

Priority Area #2: Qualifications/Work experience
Areas of Discussion:
1. Recent experience in catastrophic health/case management.
2. Experience in collaborative teamwork (rehabilitation based).
3. Five to six years of clinical experience was considered a minimum by some.

Priority Area #3: Certification by an Accredited Body
Areas of Discussion:
1. Certification should flow from a core curriculum created by practicing professionals.
2. Certifying body should not be proprietary.
3. Certifying body should be made up of practicing life care plan practitioners.
4. Re-evaluation of those "grandfathered" by CHCC. (Editor's Note: This has alreadybeen acted upon by CHCC).
5. CHCC should be in compliance with NCCA.
6. Additional research into the different life care planning certifications.
7. Raise the standard of the CLCP certification.
8. Should life care planners be certified in specialty areas?
9. Mentoring (after course work) should be required for certification.

Priority Area #4: Education and Training
Areas of Discussion:
1. Structured training classes specific to life care planning (minimum of 120 hrs).
2. Training in elements of life care plan development including report writing, health care reimbursements, statistics and evidence-based methodology.
3. Peer review.
4. Ongoing continuing education specific to life care planning.

FOCUS AREA:	**Ethics**
Group Facilitators:	Chris Reid, Ph.D
	Linda Shaw, Ph.D
Recorders:	Carol Hyland, CDMS, CLCP
	Dawn St. Clair, RN, CRRN, CDMS, CCM

The charge given this group was to explore ethics involved in the practice of life care planning. Scope of discussion would include areas relating to framework for an ethical practice, rules of professional conduct, avenues to resolve ethical conflicts and resources

Overall Premises

All qualified life care planners seek to develop an ethical practice to ensure acceptable professional conduct. Certified life care planners are held to the Code of Professional Ethics as outline by the CHCC.

Priority Areas

Priority Area #1: Framework for an Ethical Practice
Areas of Consensus:
1. Stay within one's primary field of practice.

2. Who is the actual client? Need to clearly define for whom the plan is being written and clearly communicate that to all parties involved.
3. Dual (or multiple) relationships should be better defined in the CHCC Code.
4. Conduct should be objective and unbiased regardless of who has hired you.
5. Need to understand and apply the rules of confidentiality.
6. Maintain current certifications and continuing education.
7. Life care planning is not an "industry" as listed in the CHCC Code; it is an area of professional practice.
8. Need to maintain competency related to one's caseload.
9. Need better definition in the CHCC Code about what creates a conflict of interest situation.

Areas of Discussion:

1. Need to ensure that all life care planners understand the ethical standards relevant to life care planning and the practitioner's own licensure/certification.
2. Need practice guidelines that are more specific regarding ethical rules.

Priority Area #2: Rules of Professional Conduct

Areas of Consensus:

1. Lack of CHCC accountability in determining management of ethical violations and complaints. Processes are not understood by individuals outside of CHCC and outcomes of the processes are not publicized.
2. Concern about AANLCP assertion that only nurses are qualified as life care planners.

Areas of Discussion:

1. There are many different professional disciplines practicing in life care planning, with separate ethical codes associated with each discipline. When practicing as a life care planner and there is a potential ethical code conflict, to which Code is one held? And does the Code consider the practice of life care planning?
2. Is there anonymity in reporting unethical behavior?
3. Can one be sued for reporting unethical behavior?
4. Life care planning training needs to include ethics.
5. Needs to be a clear definition of plagiarism in the field.
6. The life care plan report should include a list of medical records reviewed and vendors contacted.
7. Needs to be a way to unify life care planners.
8. Medical recommendations need to have an appropriate foundation.
9. What does a life care planner do when he/she disagrees with a physician recommendation?
10. In Canada, the life care plan certifications are not honored. What is the impact on practice standards?
11. To what ethical standard is someone who has not received life care planning training or certification held?
12. Life care planners are held to the ethical standards of the CHCC yet many feel they did not participate in the development of those standards.
13. How does one address an individual who is conducting himself or herself unethically?

14. Are there individuals who have been improperly certified, and if so, what can be done about this?
15. How do we develop plans for children without diminishing hope? Are we doing harm?
16. What are the guidelines regarding use of interpreters when obtaining consent releases from bilingual clients?
17. Are there mentors on ethical issues?
18. Do life care planners have a right to report unethical behavior to other certifying boards? Does this apply if the individual life care planner is not CHCC certified?

FOCUS AREA:	The Future of Life Care Planning
Group Facilitators:	Horace Sawyer, Ph.D., CRC
	Debbie Berens, MS, CRC, CCM, CLCP
Recorders:	Bill Goodrich, MA, CLCP, CRC, CCM, DABVE
	Terry Arnold, RN, CDMS, CRRN, CLCP

The charge given to this group was to explore future developments, issues, and trends in life care planning. Scope of discussion would include areas relating to professionals, markets, services, resources, etc. Further, that the group, individually and collectively, establish priorities for these qualifications.

Overall Premises

Qualified life care planners must demonstrate a level of competence combining education, professional preparation, and experience. Continuing education and professional training are essential. Future marketing will position life care planning at the next level of development. New markets and educating the public and other professionals are both important future dimensions. A mentoring process is needed, as well as an established peer review, with qualified professionals in life care planning.

Future research initiation and establishing a universal database will also be an important development for the successful future of life care planning. Accountability and compliance standards will facilitate a higher level of acceptance of life care plans in the future.

Priority Areas

Priority Area #1: Continuing Education and Professional Training in Life Care Planning

Areas of Discussion

1. More cost effective and more geographically accessible training opportunities for potential life care planners in addition to what is now available.
2. Offer distance learning formats and regional learning opportunities for life care planners.
3. Continuing education is essential for maintaining qualified life care planners.
4. Broader scope of training opportunities, i.e., ergonomics, vocational, economic issues, etc., to better prepare and qualify life care planners.
5. More applied, hands-on training needed.

Priority Area #2: Marketing Life Care Plans, Developing New Markets for Life Care Planning, and Educating the Public and Other Professionals

Areas of Discussion:

1. Develop marketing to attorneys and the public regarding the benefit and utilization of

life care plans as a case management tool in areas such as geriatric and elder care, Medicare trusts, individuals who are developmentally delayed, etc.
2. Develop new life care plan markets in patient advocacy to assist with planning for long term care, monitoring care on an ongoing basis, i.e. heart surgery or some acute illness, or long-term placement and/or finding alternatives for care, taking into consideration specific diseases or illnesses.
3. Explore new markets for life care plans outside the litigation arena.
4. Educate consumers on a national and international level.

Priority Area #3: Mentoring Life Care Planners and Peer Review

Areas of Discussion:

1. Develop and implement a formal mentoring program for development of new life care planners to include training of mentors, specifications/qualifications for mentors, determination of whether or not mentors could receive CEUs and development of a category for CEUs and establishment of fees for mentoring services.
2. Development of a list serve that would provide names of qualified and approved mentors.
3. Development of new leadership positions and recruit qualified life care planners to assume leadership roles and continue to promote the industry and ethical life care planning practices.
4. Initiate peer review/work product review to allow qualified life care planners to read and review life care plans, provide feedback and make comments/suggestions for improvements/enhancement.

Priority Area #4: Initiate Research and Universal Data Base

Areas of Discussion:

1. Continue research on reliability and validation of life care plans.
2. Initiate research on long term results of the life care plan, cost research, and consistency of life care plans.
3. Compile a universal database for resources and relevant life care planning articles with ability to have Internet availability to obtain actual articles.
4. Promote national organization specific to life care planning to serve as a national voice for life care planners to educate consumers, attorneys, legislators and professionals about life care planning and potentially serve as a universal database.

Priority Area #5: Accountability and Standards for Compliance

Areas of Discussion:

1. Develop more defined certification process including analysis of qualifications and experience as criteria for taking the certification test. Must have some experience in the field of life care planning prior to taking the certification exam.
2. Promote published standards of practice and ethics for life care planners.
3. Enforce standards of practice and ethics for life care planners.
4. Continually review standards of practice for development and implementation of higher standards and maintenance of standards.
5. Obtain national accreditation and oversight process for certification agency.

Note: Very little difference between Priorities 3, 4, and 5.

Other Areas of Priority Discussed:

1. National Organization for Life Care Planning (national voice for life care planners).
2. Collaboration and information-sharing between and among life care planners.
3.

Acknowledgements

I would like to acknowledge colleagues who participated in the Summit 2002 and thank Roger Weed, Ph.D and Paul Deutsch, Ph.D. for their pioneering leadership in the field of life care planning and education for life care planners. Special thanks to Sheri Jasper for her skill and efforts to make the conference a success.

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Georgia State University

March 14, 2003

Susan Grisham, RN, CCM, CLCP
Chair, 2002 Life Care Planning Summit
3126 West Cary Street, #137
Richmond, Virginia 23221

Re: Proceedings

Dear Ms. Grisham:

As the Georgia State University representative, I am pleased to endorse the proceedings of the 2002 Summit. Having the opportunity to participate with *the* leaders within the life care planning field was a distinct honor.

In addition, the professionals' ability within this specialized industry to direct their own destiny by forging collaboration with a wide range of organizations and professionals from various disciplines is commendable. Your capabilities as Chair was paramount to its success and the results demonstrate your leadership. I look forward to future Summits.

Sincerely,

Roger Weed, Ph.D., LPC, CRC, CDMS, CLCP, CCM, FIALCP
Professor and Coordinator Graduate Rehabilitation Counselor Training

INTELICUS
Knowledge That Earns

13 January 2003

Ms. Susan Riddick-Grisham
Chair, Life Care Planning Summit 2002
Life Care Manager, LLC
3126 West Cary Street, #137
Richmond, VA 23221

Dear Susan,

On behalf of Intelicus, I would like to fully endorse the Proceedings of the Life Care Planning Summit, held in Chicago on May 18-19, 2002. We are pleased and proud to have been a part of this important effort and hope that it will serve as a foundation document to guide the future development of Life Care Planning education, research and practice.

Sincerely,

Linda R. Shaw

Linda R. Shaw, Ph.D.
Life Care Planning Faculty & Curriculum Chair

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International Association of Rehabilitation Professionals

January 22, 2003

Susan Riddick-Grisham
3126 West Cary Street #137
Richmond, VA 23221

Dear Susan:

On behalf of the International Association of Rehabilitation Professionals, I am pleased to endorse, without reservation, the results/proceedings of the Life Care Planning Summit 2002.

The focus of this Summit, *Standards of Practice and Certification*, is timely as is the goal of providing a forum to discuss relevant issues, identify areas of consensus as well as needs for further discussion regarding scope of practice, methodology, ethics and the future of life care planning.

The proceedings reflect issues that are of concern to Life Care Planners. We encourage efforts to develop an action plan to address the recommendations of the Summit and look forward to ongoing dialogue/future collaboration in this endeavor.

Susan, thank you for your innovative energy, dedication, and ongoing commitment to practitioners in the field of life care planning!!

Best Regards,

Ann T. Neulicht

Ann T. Neulicht, PhD, CLCP, CRC, CVE, CDMS, LPC, D-ABVE
International Association of Rehabilitation Professionals Representative

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January 30, 2003

Ms. Susan Riddick-Grisham
Life Care Manager, L.L.C.
3126 West Cary St., #137
Richmond, Virginia 23221

Dear Ms. Riddick-Grisham,

On behalf of the University of Florida, we continue to fully support and endorse the efforts by professionals in life care planning to explore strategic focus areas and generate consensus outcomes. As these professionals represent various health care professions and areas of the country, the summits we have held are an important step in the future development of life care planning. I anticipate that these proceedings will facilitate a more positive and collaborative approach to the practice of life care planning.

Based on my experience at the Life Care Planning Summit held in Chicago on May 18-19, 2002, I would endorse the outcomes of this conference. It serves as a foundation for further direction of life care planning by professionals practicing this consultation specialty.

I would encourage other universities to become involved in curriculum and research development in life care planning and other areas of rehabilitation consultation. I appreciate your commitment and efforts in coordinating this important conference.

Sincerely,

Horace W. Sawyer, Ed.D.
Professor and Chair

Commission on Health Care Certification

Peter B. Lubinskas
Executive Director

Thursday, January 16, 2003

Susan Riddick-Grisham, RN, CCM, CLCP
Life Care Manager, LLC
3126 West Cary Street, Suite 317
Richmond, VA 23221

Re: 2002 Life Care Planning Summit

Dear Ms. Riddick-Grisham:

I want to thank you for summarizing the results of the 2002 Life Care Planning Summit held in Chicago, Illinois. While I was unable to attend, I understand the discussions were very productive. The Commission on Health Care Certification (CHCC) supports your efforts to organize and to provide input to the Commission on a variety of issues.

We thank all those who participated and look forward to future participation in life care planning summits.

Sincerely,

Peter B. Lubinskas
Director

CHCC: 13801 Village Mill Drive, Suite 204 • Midlothian, Virginia 23113 • Phone (804) 378-7273

AANLCP
American
Association
of Nurse
Life Care Planners

February 25, 2003

Susan Riddick-Grisham
Life Care Manager, L.L.C.
3126 West Cary St., #137
Richmond, VA 23221

Dear Susan:

The American Association of Nurse Life Care Planners, AANLCP, endorses the coming together of all Life Care Planners to address issues that impact the field. This opportunity affords Life Care Planners a voice in the future direction of Life Care Planning

Sincerely,

AANLCP Board

498 East Golden Pheasant Drive
Draper, Utah 84020
Phone (801) 816-0908
888-575-4047
Fax (801) 553-9931

IALCP

International Academy of Life Care Planners
114 N. W. Fifth Street, Suite 103, Ankeny, Iowa 50021

Tel: 800.531.5146
Fax: 515.965.1286
Email: IALCP@aol.com

January 29, 2003

Susan Riddick-Grisham
Life Care Manager, L.L.C.
3126 West Cary Street, #137
Richmond, Virginia 23221

Dear Susan:

I have reviewed your summarization of the outcomes of the Life Care Planning Summit 2002. The responses from participants demonstrate a unified desire to promote quality life care planning practice through education, standards and communication. The International Academy of Life Care Planners endorses the results of the Summit 2002. Thank you for your diligent work on this project.

Sincerely,

Patricia McCollom, MS, RN, CRRN, CDSM, CCM, CLCP
CEO

PM:sm

cc: Ann Neulicht

Journal of Life Care Planning, Vol. 11, No. 1, (50-52)

Life Care Planning Summit 2004
The Progress Continues

Debbie Berens, CRC, CCM, CLCP

Introduction

The Life Care Planning Summit 2004 was held April 24-25, 2004 in Atlanta, Georgia with nearly 100 professionals in attendance. Although this year marked the third Summit for life care planning professionals, for the first time the Summit was held over a two day period, allowing for more dialogue and in-depth discussion of pertinent issues, with less need to hustle through the roundtable groups. With the overriding theme of "Competence," the Summit focused on five (5) topics:

- Certification Process
- CLCP Examination and CEUs
- Future Research in life care planning
- CLCP Mentoring Program
- Standards of Practice for life care planners

Chaired by Dr. Paul Deutsch and sponsored by MediPro Seminars, LLC and the University of Florida, the Summit again drew support and participation from key professional organizations in life care planning including the International Academy of Life Care Planners (IALCP), International Association of Rehabilitation Professionals (IARP), Care Planner Network, Foundation for Life Care Planning Research, American Association of Legal Nurse Consultants (AALNC) and Commission on Health Care Certification (CHCC). Other highly qualified and experienced life care planners donated their time and dedication to the Summit as organizers, speakers, facilitators and recorders for the roundtable discussions.

Process

Following the structure of the previous two Summits, this year's Summit also utilized a modified nominal group technique in which a roundtable discussion group was held on each of the five topics listed above and attendees rotated through each of the roundtable discussions to provide input in the topic area. A group facilitator and recorder were assigned to each of the five discussion groups to assist the group through the process and record the comments and salient discussion points, with the goal of achieving consensus among the topics. Dr. Deutsch opened the session and Dr. Roger Weed provided an explanation of the modified nominal group technique to the entire audience. Introductory sessions were presented to the entire group to include a presentation by Dr. Weed and Susan Riddick-Grisham on Positive

Outcomes from Summits 1 & 2, an Update on the CHCC from CEO Bob May and executive director Linda McKinley, overview of the Development of Standards of Practice by Karen Preston, and Life Care Planning Mentoring Program by Patti McCollom. The large group, having previously been assigned into five smaller groups that provided a cross-representation within each group of the various backgrounds, education, training, experience and knowledge of the life care planning professionals who were present, was ready to begin the process.

Following a lunch break, participants separated into the five smaller groups and rotated through roundtable discussions on each of the five (5) topic areas over the remainder of the day on Saturday and throughout the morning on Sunday. Every participant rotated through the five roundtables and each roundtable, with the exception of the first roundtable, provided approximately one hour 15 minutes for participants to discuss the specific topic and generate comments and consensus areas. (The first roundtable was scheduled for one and one half hours to allow sufficient time to become familiar with the process). With approximately 15 participants assigned to each of the small groups, the size enabled individual participation from each member. At the beginning of each roundtable discussion, 3x5 index cards were given to the group members and participants were asked to write 3-5 suggestions in order of priority relevant to the particular topic of that roundtable. The facilitator then went around the room and asked each participant to state his/her suggestions, while writing the suggestions/comments on a flip chart, combining suggestions when possible. After the suggestions were recorded from each participant, the participants were asked to "vote" on the top 3-5 suggestions and prioritize the most important issues pertaining to the topic area. Consensus among the roundtables was then determined based on the priority order of the issues. At the completion of all roundtable discussions (5 total), over the 2 day period, the facilitator and recorder within each topic area culled the data and determined those areas in which consensus was reached or a high level of agreement was obtained among the participants within the particular topic. This information was then presented back to the entire large group in the afternoon session on Sunday so that participants could learn of the consensus or priority areas which grew out of the roundtable discussions, as well as areas in which no consensus was reached. Unedited raw data from the five roundtable discussions were made available to the participants via PowerPoint presentation during the concluding session on Sunday and also via email shortly following completion of the Summit 2004.

Summary

Although full proceedings and outcomes of the Life Care Planning Summit 2004, including consensus areas, will be published in the next few months, as well as presented at the International Conference on Life Care Planning on October 9 & 10, 2004 in New Orleans, Louisiana, some of the general consensus items identified by the participants and discussed in the large group session on Sunday, April 26, 2004, are summarized below:

- Terminology, including definition of "client," needs to be defined in the Standards of Practice and Standards of Practice should continue to delineate the qualifications to be a life care planner (endorsement of existing Statement 1.d), delineate educational requirements for entry into life care planning, and state the role and accountability of the life care planner.
- Urge CHCC to pursue certification by a respected and nationally recognized independent certifying agency that certifies certification bodies.
- Extend CLCP re-certification cycle to every 5 years consistent with many other certification renewals.
- Increase availability of advanced practice training in specialty areas.
- Ensure close monitoring of attendance at training programs that offer CLCP CEUs.
- The exam test body should be autonomous and separated from the training/educational group.
- Determine/verify need for mentoring program and agree on definition of mentoring

program as applied to life care planning.
- Determine qualifications of a mentor and standardize the mentoring process and relationship before implementation of mentoring program.
- Select common areas of concern or no consensus expressed by the group include:•
- Key ethical issues in the Standards of Practice.
- Legitimacy/general acceptance for the Standards of Practice and what recourse should be taken when life care planners do not follow the Standards.
- Definition and meaning/purpose of a mentoring program for life care planners.
- Full proceedings from the Summit 2004 will be published and a copy provided to each of the registered participants. Additional copies of the proceedings will be made available for sale to the general public.

Conclusion

True to the specialty practice of life care planning, participants at the Life Care Planning Summit 2004 were intellectually and philosophically "charged up" for the task and fully participated in the modified nominal group process. The Summit 2004 consisted of practitioners from a wide variety of life care planning practices both within the US and Canada who hold an incredible amount of knowledge and experience. Mixed in with the "seasoned" life care planners were newer life care planning practitioners and, for the first time, the Summit welcomed some students from the Kaplan College distance learning certificate program in life care planning. From an historical perspective, it is obvious that much has been accomplished as a result of the previous Life Care Planning Summits 1 & 2 and life care planning professionals who have participated in any or all of the Summits can be proud of the contributions they have made. The life care planners and their contributions, in turn, have helped shape our practice and determine the direction for our industry based on the collective input. Consistent throughout all the Summits is the apparent general consensus for collaboration among professionals and organizations that represent life care planners. The Summits have offered and been successful in providing a proactive approach by life care planners to establish consistency and collaboration among and within the practice of life care planning.

If the Summit 2004 sounds like a monumental task to accomplish in one weekend, it was. Similar to the previous Summits, life care planning pioneers Paul Deutsch and Roger Weed were found discussing, strategizing, planning, and shaping for the future of life care planning with movers and shakers and future leaders in the industry. The "electricity" and intellectual discussion generated by all participants and facilitated by the roundtable facilitators was outstanding! Please also read the Editorial at the beginning of this issue for further commentary on the "flavor" of the Life Care Planning Summit 2004.

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2006 Life Care Planning Summit/Town Hall Meeting:

A Celebration of Life Care Planning …10 Years Later

Debra E. Berens, CRC, CCM, CLCP

The 2006 Life Care Planning Summit and Town Hall Meeting was held May 6-7, 2006 in Chicago, Illinois with over 170 professionals in attendance. Although this year marked the fourth Summit for life care planning professionals, the format for the program was different from years past. By using a "town hall" meeting approach, participants were encouraged to engage in open dialogue about issues, challenges, and opportunities relevant to life care planners. The meeting offered the ability for participants to get answers to their questions, raise topics for discussion, and share successes (and a few horror stories) in a comfortable, professional, and energized meeting space with peers. According to the Summit manual, the "Rules of Play" included: Speak up, listen and pay attention, acknowledge success, identify solutions, do not interrupt, and the now famous saying, "What Happens in Chicago, Stays in Chicago."

The main format for the Summit were panel discussions, with a keynote address given by Dr. Jeffrey Kreutzer, Professor of Physical Medicine and Rehabilitation, Neurosurgery, and Psychiatry, at Virginia Commonwealth University Medical Center. Dr. Kreutzer's presentation was titled "How to Use Published Research to Develop Intelligent, Empirically-Based Life Care Plans." Over the course of two days, panel discussions covered such topics

Analysis of Future Needs
Forensic/Trial Experiences
Malpractice/Ethical Dilemmas
New Markets/Referral Sources for the Life Care Planner
Resources for the Life Care Planner
Future Trends/Expectations

Also new to this year's Summit was a pre-Summit review by the participants of 22 actual life care plans provided anonymously and voluntarily by life care planners across the United States and Canada. The idea was to have participants perform a critical review of the plans prior to coming to the Summit, then discuss the process and review the comments at the Summit. General themes and pros/cons of the various anonymous life care plans were generated at the Summit and CEUs were provided to those participants who completed all 22 reviews.

Chaired and moderated by Susan Riddick-Grisham and organized by MediPro Seminars, LLC, the 2006 Life Care Planning Summit was sponsored by The Care Planner Network and co-sponsored by Virginia Commonwealth University, University of Florida, Foundation for Life Care Planning Research, Commission on Health Care Certification, and International Association of Rehabilitation Professionals/International Academy of Life Care Planners. Other highly qualified and experienced life care planners donated their time and dedication to the Summit as planning committee members, organizers, speakers, and panel moderators/facilitators.

Full proceedings and outcomes of the 2006 Life Care Planning Summit are expected to be published in the next issue of the Journal of Life Care Planning as well as presented at the International Conference on Life Care Planning in Atlanta, Georgia on October 14 & 15, 2006.

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2006 Life Care Planning Summit Proceedings

Susan Riddick-Grisham, BA, RN, CCM, CLCP
Program Chair, 2006 Life Care Planning Summit

Editor's Note: The following proceedings were invited to be included in the Journal and represent the author's summary of the 2006 Life Care Planning Summit.

Introduction and Background

Networking with colleagues, celebrating individual and professional achievements, getting the latest on best practices, and hearing from panels of provocative, engaging and inspiring speakers, more than 150 life care planners gathered in Chicago, Illinois for the 2006 Life Care Planning Summit on May 6-7, 2006.

The organization of this year's Summit required some creative thinking on the part of the planning committee to be responsive to attendees' expectations while also be reflective of current life care planning practices and issues. Hopeful to step "outside the box" to view the complex situations and challenges faced by new and experienced life care planners, the 2006 meeting was, for the first time ever, conducted in a "town hall" style. Similar to previous Life Care Planning Summits, the purpose of this year's Summit was to demonstrate the continuation of the review of process and methodology for life care planning and the exploration of issues impacting the field. The town hall style was selected to provide an open forum for discussions in a relaxed, supportive environment. This style of meeting was in contrast to previous Summits where roundtable discussions about specific issues were focused on achievement of consensus from the field (Weed & Berens, 2001; Riddick-Grisham, 2003; Deutsch & Allison, 2004).

2006 Life Care Planning Summit Goals

Titled, "A Celebration of Life Care Planning…10 Years Later," the 2006 Life Care Planning Summit had many purposes and goals. Billed as a "town hall" meeting, the following message was disseminated to life care planners prior to the Summit and captures the essence of the meeting:

> Continuing education and professional development is part of the process of lifelong learning. Learning that occurs in the context of the daily workplace is far more likely to be relevant and reinforced, leading to better practice. As a profession we need to be self-confident enough to embrace a culture where continuing education

> and development, peer review, appraisal, and revalidation are not threatening concepts. Join us as we provide an open forum for experiential discussions about lessons learned by seasoned and new life care planners. Walk away with practical information that you can immediately apply to your practice setting (S. Grisham, personal communication, 2006).

One goal of the Summit was to share in a celebration of the growth in the field, specifically over the past 10 years, and its multiple accomplishments including:

- Development of professional organizations for life care planners.
- Publication of peer reviewed Standards of Practice.
- Development of a national examination leading to certification of life care planners.
- Development of a Code of Ethics for life care planners.
- Development and quarterly publication of the *Journal of Life Care Planning*.
- Successful completion of four Life Care Planning Summits which have allowed life care planning professionals an opportunity to discuss and debate issues in the field.
- Development of an annual international life care planning conference.
- Ongoing presentation of quality continuing education programs directed at expanding the application of comprehensive, clinically-based life care plans.
- Multiple publications specific to life care planning.
- Implementation of listservs allowing for the sharing of resources and a discussion forum on a daily basis.
- Creation of the Foundation for Life Care Planning Research (FLCPR).
- Publication of research specific to life care planning including: Cimino-Ferguson, 2005; Deutsch et al., 2003; Deutsch et al., 2005; Deutsch et al., 2006; Kendall & Deutsch, 2002; Kendall & Casuto, 2005; Marini & Harper, 2006; Pomeranz, 2005; Sutton et al., 2002, and many others).

A second goal of the Summit was to create a forum for sharing experiences, questions and challenges among life care planners and in a relaxed and supportive environment. A third goal was to share useful tools, tips, and ideas among attendees as a way to enhance the efficiency and effectiveness of life care planners in providing quality and sound life care planning services. By all accounts, these goals and others were achieved!

Additional announcements leading up to the conference proclaimed that the 2006 Summit would provide life care planners a platform upon which they could discuss the changing market place, explore new business opportunities, and share success stories. The discussions were expected to be full of candor, humility, and, perhaps, some braggadocio. And indeed they were!

Sample of Participant Comments

Evaluations completed by Summit participants have been received and reviewed. A sample of some of the positive comments generated by the 2006 Life Care Planning Summit are included below. For privacy and confidentiality purposes, the names of those making the comments have been removed.

- "This Summit brought 'real issues' to discuss and promoted 'fabulous' discussions between seasoned and newer Life Care Planners."
- "Best Summit yet! Good to see new faces in the presenters."
- "Really enjoyed the networking opportunities and I learned much from each of the sessions."
- "…lots of 'newbies'…great!"

Something New to Try

In advance of the 2006 Summit, attendees were offered the opportunity to participate in the first ever peer review of a sample of life care plans. According to the Standards of Practice for life care planners, "The Life Care Plan should be a working document that provides accurate and timely information which can be easily used by the client and interested parties. It should be a document that can be updated and serve as a lifelong guide to assist in the delivery of health care services in a managed format" (International Academy of Life Care Planners, Section II, 2006). What the Standards do not define is one single format for the presentation of the life care information. Instead, each life care planner decides on the report format that best allows him or her to relate pertinent information and the result has been a wide variety in report designs. The purpose of the Summit peer review process was to allow professionals who practice in the life care planning field a way to offer feedback regarding the strengths and weaknesses of the sample formats submitted by colleagues. The process also provided a framework for the reviewers to identify their own personal learning needs.

In total, twenty-two (22) sample life care plans were collected, sanitized, and sent to the registered program participants for review prior to the Summit. The samples showed wide variations in layout, organization, and the formatting of information. Summit participants were asked to review samples 1-11 using the "Comparison Matrix of Published Step-by-Step Procedures for Life Care Planning and Expert's Procedures" (see Appendix A, as cited in Weed, 2004) and samples 12-22 were reviewed using the Deutsch & Associates Critique Form (see Appendix B). Participants also were asked to review the "Checklist for Review of Life Care Plans (see Appendix C, as cited in Weed, 2004). Additionally, as part of the overall peer review process, participants were asked to provide feedback regarding the strength of the two review tools.

In addition to the field reviews by registered participants of the 2006 Summit, each of the 22 life care plans was reviewed by a panel of workers' compensation insurance professionals who offered feedback regarding the organization of the report form and the plan's ability to provide relevant information in an organized easy-to-read format. This first ever "customer" review process was designed to give life care planning professionals feedback to allow for a

better understanding of some customer needs as it pertains to the design format of the life care plan report. Insurance reviewers included:

- Kim Griffiths- Pinnacol Assurance
- Tom Klasnick- Broadspire Services, Inc., a third party administrator
- Chris Lemon- Broadspire Services, Inc., a third party administrator
- Karen Wilbanks- CNA Insurance

The results of the peer review activity were mixed. While many reviewers stated they found it to be a valuable experience, others stated they found the activity to be overwhelming and time consuming. Below is a sampling of some of the comments made, with reviewers' names removed to preserve their privacy:

- "This exercise helped me to see other organizational approaches."
- "A very time intensive project, but what an eye opener."
- "Yes it was great to see how others approach their plans."
- "The diversity of the plans was education in and of itself. I appreciate the different styles; however, the exercise had some challenges and perhaps I did not understand the directions clearly."

Currently, the reviews of each sample life care plan are being summarized and prepared for distribution to the Summit attendees at a later date. The preliminary results suggest that the preferred life care plan report format should include a narrative report which includes a comprehensive review of medical and psychosocial information, inclusion of references regarding medical foundation for the basis of conclusions contained within the report, the use of charts which clearly delineate the start/stop dates of usage, frequency of recommendation, annual costs, and lifetime totals. The insurance reviewers emphasized the usefulness of including annual and lifetime totals as part of the life care plan.

Overview of 2006 Summit Presentations

Day One of the two day Summit began with a presentation by Ann Neulicht and Carol Walker titled, The Life Care Plan RACE: Review, Analysis, Critique, Evaluation? The presentation focused on issues to consider in writing, reviewing, analyzing, critiquing and/or evaluating a plan. (Editor's Note: See article by the same name beginning on page 91 of this issue). The presentation was followed by a panel discussion, A Closer Look at Process/Methodology Issues, moderated by Karen Preston who guided the discussions covering sources influencing methodology and highlighting some of the methodology conflicts. One example cited was the use of an in-person interview versus a telephone interview to gather information for consideration of life care plan opinions. Questions arose about the use of Standards of Practice as a methodology guide allowing for individualized decision making based on unique case characteristics rather than a tool to lock the process into an "only one way avenue." Attendees also were provided an opportunity at the Summit to

conduct a peer review of the proposed revisions to the Standards of Practice and provide feedback into the revised Standards.

During this panel, a lengthy discussion was held regarding the importance of meeting the challenges of Daubert by utilizing a consistent methodology (Daubert, 1993). Dr. Paul Deutsch, long considered a leader in the field, offered his comments regarding the importance of creating a medical foundation for specific portions of the life care plan. He pointed out that the medical foundation can be created by collaboration with treating physicians or evaluators, and other clinical input. The use of evidenced-based Clinical Practice Guidelines such as those offered by the National Guideline Clearinghouse, http://www.guideline.gov/, can also offer the life care planner additional, relevant scientific literature on clinical and behavioral issues in a multitude of diagnostic conditions.

Two sessions of the Summit were devoted to interactive discussions regarding challenging issues faced by many life care planners, including the importance of obtaining reliable information. Opening the discussion, Ann Neulicht and Susan Riddick-Grisham explored the use of assessment tools as part of the information gathering phase of life care planning. Tools discussed included The Achenbach System for Empirically Based Assessment/ASEBA® (Achenbach, 2000), Behavior Rating Inventory of Executive Function/BRIEF™ (Gioia, Isquith, Guy, & Kenworthy, 1999), Judgment and Safety Screening Inventory (VCU/MCV, 2001), Disability Limitations Checklist (Reagles, 1997), Residential Accessibility Survey (Reagles, 2003), and the Community Integration Questionnaire/CIQ (Willer, 1993).

The speakers emphasized that many of these standardized assessment tools require specialized training and state licensure to administer and score, and the life care planner is advised to be aware of these requirements. The sessions resulted in an action plan to develop a comprehensive listing of assessment tools and instruments commonly used by life care planners when developing a life care plan. Summit participant and fellow life care planner, Joanne McDaniel, has offered and is in the process of compiling the list which will be available in the future on www.careplanners.net and possibly published in a future issue of the *Journal of Life Care Planning*.

Continuing the discussion among participants, the group explored issues pertaining to ways to efficiently work with clinical teams and the establishment of medical foundation for the medical entries of a life care plan. Suggestions included:

- At the time of referral, confirm with referral source what and which physician(s) will be utilized to support the medical foundation for relevant aspects of the life care plan
- Understand the limitations of each physician's specialty and area of expertise.
- Understand the specialized knowledge of the life care planner and his or her ability to provide the needed foundation for select portions of the life care plan.
- Acknowledge that there are differences in how life care planners approach

the clinical teams

- Acknowledge that life care planners come from a variety of professional and experiential backgrounds and typically will have varying credentials to offer the life care planning process.

As a new learning tool, the 2006 Summit provided attendees an opportunity to hear a brief presentation from Mary Anne Ehlert, CFP (certified financial planner). Ms. Ehlert, Founder of Protected Tomorrows, a company focused on helping families with special needs plan for the future, has successfully built a national network of Protected Tomorrows expert advisors, or "Advocates," who share her financial planning background and her dedication to serving the families of individuals with special needs. Ms. Ehlert reported that she has assisted over 3,000 families to develop financial plans. She shared her experiences in working with families as they make decisions in many of the areas that life care planners explore in the development of an individualized care plan. One excellent example that created a great deal of discussion was the issue of home care. It was noted that many life care planners may become challenged when trying to outline realistic home care scenarios. The shortage of nurses has resulted in many home care agencies refusing to guarantee the availability of services and life care planners are being forced to plan, consider or contemplate other options to meet the individual's need. One idea that generated useful discussions was the provision to privately hire caregivers. Attendees explored ways to thoroughly assess the complex issues involved in a private hire situation, including how to complete background checks, bonding, costing and long term management. Attendees agreed that this is an area of great interest and suggested that additional educational programs addressing home care would be useful for the field.

The afternoon of Day One brought a lively discussion by keynote speaker, Dr. Jeffrey Kreutzer, a widely known neuropsychologist who has worked with life care planners across the country. Dr. Kreutzer's presentation, *How to Use Research to Develop Intelligent, Empirically–Based Life Care Plans*, provided an overview of research regarding long-term neuropsychological problems following brain injury, post-brain injury driving, employment, productivity status and quality of life indicators. (Editor's Note: See reprint of one of Dr. Kreutzer's articles presented at the Summit beginning on page 99 in this issue.). The conclusion to Day One included three breakout sessions where each group was provided a sample life care plan for review and critique. The three sessions were led by three physicians experienced in life care planning: Dr. Terry Winkler, Dr. Richard Bonfiglio, and Dr. Robert Meier. The sessions allowed for group discussions regarding the assumptions and conclusions contained in each of the three sample life care plans.

Day Two of the Summit commenced with a panel discussion titled, "Best and Worst Trial Experiences" moderated by Bill Goodrich. This panel was designed to allow the participants to share real life deposition or trial experiences as a learning tool for future depositions or trials. Although this sometimes comical session was viewed by some as a "war story" session, many participants agreed that the power of interaction on this sensitive topic allowed for a great deal of individual learning and information exchange that helped to de-mystify the testimony experience.

The lively discussion continued into the next session, titled "Malpractice Concerns and Ethical Dilemmas" and moderated by Debbie Berens. Representing the Commission on Health Care Certification (CHCC), Evelyn Robert reviewed some ethical complaints submitted to the

CHCC which included:

- Misrepresentation of credential.
- Unqualified applicants with completed training from pre-approved training programs.
- Communication with opposing counsel who is counsel for retained certified life care planner (CLCP).
- Commissioner's review of life care plan of current seated commissioner.
- Certified life care planner's misrepresentation of employment status.
- File review of care plan to develop alternate care plan for opposing counsel – No injured party contact.
- Life care plan development without primary physician or rehabilitation team input.
- Development by CLCP of a Medicare Set Aside (MSA) document on a client whom the CLCP developed the life care plan.
- Disregard of conflicting file documents to life care plan goals.

Discussion focused on the possible perception of an ethical conflict involving a sole author of a life care plan and a MSA. The attendees requested additional feedback from the CHCC regarding future decisions pertaining to this dual role dilemma and requested an opportunity to offer field feedback before the CHCC made any final decision on the issue. Discussion also focused on the status of the CHCC's application for certification by a national certifying body. Questions on this topic were deferred to the CHCC chief executive officer.

Following the CHCC's report of ethical concerns brought before the Commission, Dr. Carol Walker initiated a lively discussion regarding professional licensure considerations when performing life care plan evaluations across state lines. Dr. Walker provided an overview of the mutual recognition model of nurse licensure that allows a nurse to have one license (in his or her state of residence) and to practice in other states (both physically and electronically), subject to each state's practice law and regulation. Under mutual recognition, a nurse may practice across state lines unless otherwise restricted. The attendees explored how this model applies to the other disciplines involved in the practice of life care planning.

Debbie Berens then presented an overview of actual ethics complaints submitted to the IALCP which included:

- Retaining attorney does not think life care plan is appropriate and refuses to pay for the life care planner's services leading up to and including development of the plan.
- Client/family disagrees with the life care plan and plan reportedly gives the appearance of inappropriate inclusion of some items and "over charging" of some items. Legal action reportedly is threatened against the life care planner.
- A life care planner retained by defense counsel contacts the client's treating physician without consent from the client or client's attorney.

Following the ethics session, the morning concluded with a panel discussion about "New Markets" in life care planning including trust case management or the implementation of life care plans as an expanding area of practice. Other new markets include life care planning/case management consultation to physicians and private life care planning consultation.

The afternoon session was opened by Leslie Watson and was titled "Work Smarter, Not Harder." Strategies to improve work productivity included the use of life care plan research assistants who can offer support by providing medical records review and summary and costing research. A comprehensive listing of research assistants can be found at http://www.careplanners.net/lcp_tools.asp. Resources for physician, lab, and medical facility fees were also outlined.

The 2006 Life Care Planning Summit concluded with a panel comprised of representatives of the IALCP, CHCC, and Foundation for Life Care Planning Research (FLCPR). The panel discussed trends and plans for the future of life care planning and each represented organization had an opportunity to offer suggestions. In addition to a membership drive, the IALCP offered the following plans:

- Complete transition to new organizational model, i.e., IARP.
- Increase IALCP visibility/awareness of our existence within the life care planning community.
- Increase membership in the Academy.
- Increase membership-driven services and programs.
- Increase education opportunities through a variety of venues/media/technologies.
- Develop long-range plans.

The CHCC proposed the following plans:

- Continued establishment of certifications:
  - Canadian Certified Life Care Planner (CCLCP)
  - Australia
  - Netherlands
  - China
  - Chinese Physical Therapists certified as Certified Disability Examiner (CDE)
- Additional development of certifications:
  - Certified Elder Care Specialist (CECS)
- Accreditation through National Commission for Certifying Agencies.
- Development of a review textbook for certification review course.
- Acceptance of CLCP qualifications by all pre-approved training programs.
- Continued academic research.

The Foundation for Life Care Planning Research proposed the following plans:

- Implementation of a Foundation fund raising project.

- Continued support of research projects addressing the reliability and validity of the life care planning process.
- Development of a Foundation newsletter.
- Scholarship support to students pursuing life care planning education.

Conclusion

In the opinion of this author, the 2006 Life Care Planning Summit was a great success and an enhancement to the field. As program chair, I was most pleased by the incredible amount of information sharing, professional support, and camaraderie that was displayed. There was an amazing amount of positive energy about where the practice is heading and what individual life care planners can contribute to the growth of the IALCP, FLCPR, and other entities focused on life care planning education and research. While the 2006 Life Care Planning Summit was not perfect (is that even possible?), much was learned from and about the process. Historically, each time a Life Care Planning Summit has been held, attempts are made to apply the lessons learned to the next Summit. Problems regarding the size and layout of the meeting room and technical problems with the microphones and audio-visual equipment will not be ignored as plans for the Summit 2008 get underway. Evaluations from the attendees have all been read and indicate that the "town hall" meeting format was an effective style. However, there were requests for a greater blend of panel presentations mixed with traditional lectures.

Looking forward to the 2008 Life Care Planning Summit, it is my hope that the specialty practice of life care planning will maintain the focus and energy generated thus far and that practitioners work together to build on all of the accomplishments of the past 25 years.

2006 Life Care Planning Summit Program Committee:

Barbara Armstrong
Bill Goodrich
Cindy Haseley
Ann Maniha
Ann Neulicht
Janice Nixon
Karen Preston
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Steve Yuhas
Carol Walker

Program Sponsors:

The Care Planner Network
Virginia Commonwealth University Medical Center
University of Florida
The Foundation for Life Care Planning Research (FLCPR)
Commission on Health Care Certification (CHCC)
International Association of Rehabilitation Professionals (IARP)/International Academy of Life Care Planners (IALCP)

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Appendix A, Comparison Matrix of Published Step-by-Step Procedures for Life Care Planning and Expert's Procedures

Published Step-by-Step Procedures for Life Care Planning

(Source: Step-by-Step Procedure for Life Care Planning, p. 624-625, in Weed. R. (Ed.). 2004. Life care planning and case management handbook. Boca Raton, FL: St. Lucie/CRC Press)

Case Intake:

1) When you talked with the referral source, did you record the basic referral information?

2) Time frames discussed?

3) Financial/billing agreement?

4) Retainer received (if appropriate)?

5) Arrange for information release?

Medical Records:

1) Did you request a **complete** copy of the medical records?

2) Nurses' notes?

3) Doctor's orders?

4) Ambulance report?

5) Emergency room records?

6) Consultants' reports?

7) Admission and discharge reports?

8) Lab/x-ray/etc.?

Supporting Documentation:

1) Are there depositions of client, family or treatment team that may be useful?

2) "Day in the life of" videotapes?

3) And if vocational issues to be included in report – school records (including test scores)?

4) Vocational and employment records?

5) Tax returns?

Initial Interview Arrangements:

1) Is the interview to be held at the client's residence?

2) Have you arranged for all appropriate people to attend the initial interview (spouse, parents, siblings)?

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LIFE CARE PLANNING SUMMIT 2008 PROCEEDINGS

by Summit 2008 Co-Chairs
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Introduction

The Life Care Planning Summit is a biennial event made up and attended by representatives from professional organizations and training programs, researchers, practitioners, and support service providers, to explore the current state and future directions of the specialty practice of life care planning. Although the process of life care planning standards has been established, consensus and unity in the field is a developmental process. Through a series of round table discussions, participants have the opportunity to examine life care planning issues, contribute to the resolutions of these issues, and be involved in the continued evolution of this specialty practice.

Consistent with previous Summits, the Life Care Planning Summit 2008 was designed to examine high priority issues in life care planning. At this point in time, a considerable amount of structure and process has been developed through training programs, professional associations, certifications, standards of practice, a professional literature base, and research programs. However, there are still differences in the methods by which individual life care planners practice, as well as varying opinions regarding continuing refinement of this practice area. Thus, the Life Care Planning Summit 2008 was intended to examine issues and provide direction at both the individual practitioner level and at the field level. Included at the end of this summary is a copy of the welcome letter to all attendees of the Summit.

In preparation for the Summit, discussion topics were selected by a planning committee who gathered ideas from life care planning practitioners in the field over a period of several months. The committee also reviewed topics discussed on various listservs relevant to life care planning. The process resulted in a lengthy list of topics that life care planners could address. The final selection was narrowed to cover topics that fit two categories:

1. Topics that were of the highest interest to individual practitioners, as demonstrated by frequency and duration of discussion.
2. Topics that were of priority to the field in terms of what would provide insight to organizations that support life care planners. This category included potential controversial topics that had not previously been discussed openly by practitioners and organizations.

The following six topics described below were selected as ones thought to be most relevant to the professional practice of life care planning. For each topic, questions were posed for discussion among the attendees. The topics, questions, and an explanation of the topic are discussed below. For each topic, dozens of ideas and comments were generated by the attendees. Using a group consensus technique outlined by Delbecq, Van de Ven, & Gustofson,

(1975), the priority ideas for each topic were identified, and consensus statements were written. These proceedings represent the agreed concepts arising from the Life Care Planning Summit 2008 process.

In addition to the agreed concepts, which are represented by consensus statements that were unanimously accepted by the attendees, there were several concepts where consensus was not reached. Many of these concepts are also included to illustrate topics where life care planners can continue dialog and field development. In particular, the areas where consensus was not reached provide a rich framework for future research, inclusion in education and training venues, and publication.

Note: Life care planners and professional organizations that provide support and services to life care planners are encouraged to use the results of the Summit to evaluate personal skills and practices, and to develop future services and programs for the life care planning community.

Topic One:

Visions for LCP Future: Identifying Controversial Aspects of Plans Created by Various Professional Disciplines.

Questions and Explanation:

1. What are the differences between life care plans created by practitioners of various backgrounds?
2. What are the strengths and challenges from these differences? Do they reflect "turf wars?"
3. What, if anything, do we need to do to address differences?

The rationale for these questions relate to the fact that life care plans are created by practitioners from many professional backgrounds. Differences in methodology among practicionerspractitioners from various backgrounds have been noted, such as performing independent testing and relying on personal opinions. There has been concern expressed about whether these "personalizations," or differences in methodology, undermine the overall life care planning process, and whether all life care planners should be follow the same methodology. Discussing this topic provided an opportunity to explore problems and advantages related to differences among professional backgrounds. Moreover, participants had the opportunity to discuss solutions to identified problems.

Discussion:

There were seven different professional backgrounds represented by the Summit participants, with rehabilitation counselors and nurses predominating. Differences were acknowledged, but not viewed as necessarily being negative. Acceptance of key principles and practices can prevent the life care plan from being undermined. Areas of discussion included perceptions that:

- There are inconsistencies in methodology.
- There are life care planners who seem to make recommendations outside their scope of practice.
- There is a need to understand one's own limitations and to end "turf wars."
- Some life care planners leave off recommendations and seem to have "tunnel vision,"

giving more weight to recommendations within the scope of their own discipline.

- There is a need for more consistent formatting across disciplines.

Consensus Statements (Unanimous Agreement):

1. Life care planners will follow generally accepted methodology.
2. Life care planners will adhere to relevant Codes of Ethics as applied to life care planning and based on their individual licensure, registration, and/or certification.
3. Life care planners will work within their scope of practice of their licensure, registration, and/or certification.
4. Life care planners will collaborate, as appropriate, between disciplines in plan preparation.
5. There is a need for life care planners across disciplines to utilize text, narrative, and rationales as a foundation for the process of life care planning.
6. There may be differences in clinical judgment that can result in different recommendations; this may be reasonable, but this difference may affect content and value.

Topic Two:

Developing Unity in the Field: Standards of Practice Shaping the Role and Function of Life Care Planning

Questions and Explanation:

1. For those who are Life Care Planners, is there anyone not familiar with the International Academy of Life Care Planning (IALCP) Standards of Practice?
2. Are the IALCP Standards of Practice still applicable today in your practice?

This topic was unique in that two purposes were established prior the Summit. The first purpose of this topic was to examine the evolution of life care planning practice role and function under the influence of standards of practice. The second purpose was to have participants review the first draft of an instrument developed to identify the roles and functions of life care planners.

Discussion:

All participants revealed that they were familiar with the Standards of Practice for Life Care Planners. All stated that they believed that the Standards are relevant. Discussion did not focus on any particular aspect of the Standards.

The purpose of a role and function study is to determine the status of what it means to be a life care planner and what a life care planner does. Comparison with prior studies shows the evolution of the professional practice of life care planning and provides opportunity for dialog about changes. The study is also important for education and certification programs to teach and measure relevant material. Summit participants were asked to review the role and function survey instrument developed for life care planners and provide written and verbal comments regarding the appropriateness and breadth of coverage of the items. Participants were asked to comment on the need for additional items as well as whether or not there were redundancies in the items listed on the instrument. Over 1000 written comments were provided by Summit the participants. The comments will be used to modify the instrument in preparation for the actual role and function study.

Consensus Statements (Unanimous Agreement):

1. All participants were familiar with the IALCP Standards of Practice.
2. The IALCP Standards of Practice are applicable to today's life care planning practice.
3. The following themes represent the comments for role and function study instrument development. Note that some comments pertain to issues broader than the study instrument.
    - The instrument is comprehensive, relevant, and useful.
    - Some questions are duplicative and there is repetition in concepts; some questions can be combined.
    - Items need to be regrouped items and reorganized.
    - The instrument is lengthy; some individual questions are too long.
    - There is need for term clarification, i.e., definitions or glossary; be aware of vague terminology; avoid use of undefined acronyms.
    - The definition of client needs to be clarified.
    - Questions should ask what IS done not what SHOULD BE done.
    - Some questions need an example to provide a frame of reference.
    - The choices of answers needs modifying; need to be able to indicate that the answer varies with various situations.
    - The instrument needs to be applicable and worded for Canadian life care planners planners.
    - Consider obtaining CEU credit for completing the survey as part of the role and function study.
    - There needs to be a definition of when a practitioner becomes a life care planner (consistent understanding is lacking).

Topic Three:

Best Practices: Methodology Issues in Data Collection

Questions and Explanation:

1. What methods are you using in data collection, including processes followed and use of tools?
2. Do these constitute the best practices for methodology?

In some ways, this revisited a topic that was discussed at the Life Care Planning Summit in 2000. During the 2000 Summit, consensus was reached by attendees on the need to utilize an inclusive data collection process in order to obtain available and relevant records including those of the client, treating professionals, and other relevant appropriate providers. After this was done, Summit 2000 attendees then agreed on the need for conducting of a comprehensive interview with the client and his/her family or other collaterals, if possible. The need to communicate, where possible, with all relevant professionals/experts who were involved in the client's care was also a consensus decision.

The foundation for addressing these questions during the 2008 Summit was related to the fact that as a field develops and the body of relevant research increases, there are often changes in what constitutes best practices in the methodologies to be employed. The goal of this

discussion was to determine the most consistent methodologies used by attendees and how these had either stood the test of time or evolved over time.

Discussion:

This was a very broad topic and many aspects were raised for discussion. There were many opinions about how data collection should be performed, yet consensus was only reached on a few broad statements, not on details. The areas discussed included:

- the reliability of telephone surveys for obtaining pricing.
- the use of checklists provided during the training sessions.
- the qualifications of research assistants.
- the lack of interview of plaintiff.
- the use of questionnaires for interview, establishment of a plan and standardized physician questionnaires.
- the use of discounted versus retail costs for items.
- the standardization of formats and what should be included in a standardized format.
- utilization of the actual provider of service to the injured person such as a primary care physician versus physicians from centers of excellence.
- use of historical data.
- differences between probable versus potential.
- contact with referral sources.
- the methodology of new treatments.
- contact with specialists in rehabilitation.
- equipment needs.
- accessibility needs.
- contact with other life care planners and clinicians.
- need for individualized case specific plans.
- understanding and researching the standards of practice of other disciplines as applicable to life care plan development.
- the use of research.
- diagnosis driven, evidence based practice utilizing clinical practice guidelines, and how to address life expectancy.

It is clear that there are also a number of areas where there are continuing questions regarding how the best practice for methodology might be achieved. These areas provide fertile territory not only for continued discussion in the field but also for developing research and educational projects to assess these areas.

Consensus Statements (Unanimous Agreement):

1. Life Care Planners will request and analyze relevant records, which may include, but are not limited to, medical, therapeutic, educational, vocational and billing records.
2. Life Care Planners will interview evaluees, seek input from family/caregivers, and

conduct an onsite evaluation when available or appropriate.
3. Life Care Planners will gather geographically relevant and representative pricing.
4. Life Care Planners will collaborate with relevant parties, including but not limited to, treating or consulting healthcare professionals and other disciplines as available or appropriate.

The following statement represents a large majority view, but was not unanimous:
- Life Care Planners may request/obtain assessments or perform testing evaluations (within their scope of practice) in the process of data collection.

Topic Four:
Best Practices: Methodology Iissues in Ccreating Aadmissible Llife Ccare Pplans

Questions and Explanation:
1. What practices increase or decrease the likelihood that a life care plan is vulnerable to exclusion by the courts?

This topic is covered in life care planning courses and has been a topic in articles and texts. However, the rules are different throughout the country and life care planners have had different experiences. This creates some complexity in adopting best practices for life care planners. The purpose of discussing this topic was to discover the experiences that life care planners have had, identify successes and areas of challenge, and identify strategies to prevent or salvage problem situations. There was opportunity to discuss how the "other side" finds ways to exclude a life care planner and a life care plan.

Discussion:
This topic generated much discussion and highlighted the regional differences experienced by life care planners. Issues discussed included:

- Whether life care planners should follow a particular training format.
- Whether there should be consistency in the format of the work product and in testimony.
- Whether the work product should be consistent regardless of the referral source and payment source.
- How to establish credibility and professional presence to communicate a strong presentation.
- How to determine adequate foundation for all areas.

The discussion overall showed the need for continued development in this area.

Consensus Statements (Unanimous Agreement):
1. Life care planners will educate all, including the trier of fact, about the life care planner's training, education, experience, specialized knowledge, and credentials as well as plan methodology and rationale.
2. Life care planners will use published methodology and standards of practice in developing the life care plan.
3. Life care planners will utilize adequate foundation for recommendations and opinions included in the life care plan.

Topic Five:

Research: Priorities, Needs, and Practical Applications in Day-to-Day Practice

Questions and Explanation:

1. List factors that make life care planners more or less likely to use research in life care planning.
2. What barriers are there to using research?
3. What is needed to make life care planners comfortable and competent using research?
4. What are the risks and benefits of using and citing research?

There is variability in actual practice about the use of research. The purpose of this topic was to gather information about current day-to-day practices and identify perceived needs related to research in life care planning.

Discussion:

Some participants responded that they do not conduct research by virtue of the fact that they develop life care plans in non-Daubert states and their life care plans are not challenged, or because they do not have a need to use research support. Identified advantages to using research were:

- Using research to clarify recommendations, treatment, patient history, etc.
- Using research as an educational tool.
- Using research to become familiar with the client's situation (diagnosis, population, culture, etc.), especially in rare and unusual cases.
- Using research to update current knowledge.

Barriers and concerns about using research included:

- Knowing how to ensure that research selected is valid and reliable.
- Determining if the research matches (or contradicts) the individual situation (diagnosis, needs, demographics, culture, etc.).
- Ability to conduct and bill for research time and resources.
- Determining whether the time and cost of doing research outweigh the usefulness to the case.
- Understanding research methodologies as applied to life care planning.
- Having the ability to appropriately analyze research studies.
- Ability to defend the use of research in a life care plan.
- Reluctance to use and rely on research that is outside the life care planners' scope of practice and/or level of expertise.

Consensus Statements (Unanimous Agreement):

1. Life care planners will be competent to understand and explain the research cited in the plan they authored.
2. Life care planners, when utilizing research to support the foundation for a life care plan recommendation, will endeavor to reference studies that are reasonable, relevant, and

appropriate to the intended purpose.

3. As appropriate, life care planners may utilize literature to become familiar with and update current knowledge on the evaluee's diagnosis, population, and cultural background.

Topic Six:

Professional Business Issues: Risks and Benefits of Databases, Templates, and Software

Questions and Explanation:

1. How do you evaluate a life care plan report in terms of readability, admissibility, consistency, standardization, accuracy, and the expense of preparation?

This topic was considered timely due to the increased use of technology in the development of life care plans. There are a number of databases available providing costs for services in life care plans (e.g. American Hospital Association and others) that are often used by life care planners. There are a number of software programs for use in creating life care plans. There are also checklists and forms (templates for gathering and organizing data) that have been utilized during the training programs in life care planning and continue to be used by life care planners.

The goals of the session were to acknowledge the growing availability of tools such as databases, templates, and software, and to explore whether these tools create benefits or challenges. Other goals were to examine issues related to individualized tailoring of a life care plan versus "cookie-cutter" plans in terms of efficiency, cost savings, and the credibility of the work product and ways to make work products easier for readers to understand and use. Also explored was the use of technology in terms of the potential erosion of the value of skilled life care planners through the utilization of more generic life care plans based on diagnosis and group data information.

Discussion:

Life care planners do use databases, software, and templates to create life care plans. There was acknowledgement that these tools vary in format and content, but there is not a desire to adopt standardized tools or to reject any particular tool. The impact of these tools creates efficiency, but tools are not viewed as a replacement for the professional judgment of the life care planner. Participants reinforced the need for appropriate foundation and methodology discussed during other topics, and that use of tools does not alter that need. Participants discussed these points:

- There is a place for databases, templates, and software; however, life care planning requires clinical knowledge and judgment as well as the ability to individualize the life care plan.
- The life care plan should be made cost efficient by reducing unnecessary information, educating the referral source regarding what services are needed, and preventing duplication of services.

Consensus Statements (Unanimous Agreement):

1. The life care plan is individualized, client specific, and should address issues associated with aging.
2. The life care plan will be a clear, concise, user-friendly document.

3. The use of databases, templates, and software will have an appropriate foundation.
4. There should be transparency and consistency in the life care plan product and process.

Summary

The 2008 Life Care Planning Summit 2008 provided life care planners with a valuable opportunity to address many important issues in the field of life care planning. With each Summit, life care planners continue to reach consensus on a number of areas as well as identify areas for continued growth. Consensus provides life care planners with information for comparing and improving their own practices. Areas where agreement is not achieved should cause life care planners to examine thoughtfully their practices, beliefs, and values. Life care planners need to determine whether differences of opinions are of consequence, and what efforts, if any, need to be made to reach consensus on an issue. In addition, the Summit provides organizations that provide services to life care planners with information that will enhance future programming. During the next two years, before Summit 2010, life care planners are encouraged to use this information to ensure that our field grows in relevance, credibility, marketability, and defensibility.

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.

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LIFE CARE PLANNING SUMMIT 2010 PROCEEDINGS

by Summit 2010 Co-Chairs
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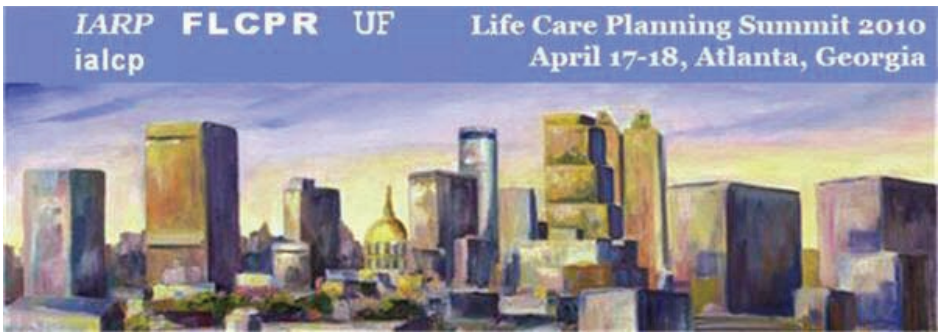

Introduction

The International Academy of Life Care Planners (IALCP), a section of the International Association of Rehabilitation Professionals (IARP), was honored to host the 2010 Life Care Planning Summit on April 17 and 18, 2010 in Atlanta, Georgia. The Summit was co-sponsored by the Foundation for Life Care Planning Research and the University of Florida.

This biennial 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 hot issues in the field while contributing to the continued evolution of life care planning.

Seventy-one representatives of life care planning training programs, certification programs, and professional associations joined with researchers, practitioners, and support service providers to explore the current state of the field and set future directions for life care planners. 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 are given to the following colleagues who volunteered to serve as panel members during the general session meetings on Saturday:

- Kathy Adams, RN, home health agency panelist
- Kathie Allison, LCP professionals panelist representing PT

- Huntly Chapman, LCP professionals panelist representing MD
- Carolyn Higdon, LCP professionals panelist representing SLP
- Nancy Mitchell, LCP professionals panelist representing OT
- Ann Neulicht, LCP professionals panelist representing rehab counseling
- Jan Roughan, LCP professionals panelist representing RN
- Carol Walker, LCP professionals panelist representing neuropsychology

Volunteers for the Case Management panel:

- LuRae Ahrendt
- Kathleen Kuntz
- Steve Yuhas

Volunteers who served as recorders during the Round Table discussions:

- Reg Gibbs
- Ann Neulicht
- Bob Taylor

In addition, we are grateful to the following guest panel participants who sacrificed their Saturday morning to provide us with valuable information:

- Matthew Allen (attorney, Hall, Booth, Smith, and Slover, PC)
- Harvey Spiegel (attorney, Henry, Spiegel, Milling, LLP)
- Bill Frazier (trust officer, Sun Trust Bank)
- Mamie Kneller (trust officer, Wells Fargo Bank)
- Samantha Renfro (mother of TBI survivor)

We are doubly grateful to the generous sponsors at Bright Sun Technologies, ABI Mentor, and Elliott & Fitzpatrick. Thank you very much!

Summit participants spent the two day event at nearby Georgia State University and, for the first time in Summit history, participants were introduced to cutting edge technology that tabulated participants' responses in real time by utilizing personal Audience Response Systems from Turning Technologies. Ron Rinaldi was the onsite technician who trained attendees and provided devices to record instant responses throughout the Summit. His assistance was invaluable and truly moved the Summit into the 21st century.

Theme and Goals of Life Care Planning Summit 2010

The broad goals of this year's Summit were to:

- Enable Life Care Planning practitioners to develop improved practice skills
- Establish best practices in the life care planning process
- Enable life care planning organizations to develop priorities for education, research, and services for Life Care Planning professionals

Methodology

This year's Summit integrated technology with the Modified Nominal Group Techniques General Instructions provided by Roger O. Weed, Ph.D. and based on the group consensus technique outlined by Delbecq, Van de Ven, and Gustofson (1975). As instructed, attendees were randomly sorted into three groups and participated through 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, speech/language pathologists, and many others).

As with previous Summits, each group had a facilitator (leader) and recorder who used a computer to summarize the data and assist in the utilization of the technology. The personal Audience Response Systems were utilized in the small groups as well as the large group consensus building session. Every attendee participated in discussions on all topic areas. 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 again utilized to record each attendee's "vote" in an effort to achieve consensus statements among the full group.

Threshold for Acceptance

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

- Unanimous consensus statements are those that were agreed upon by 100% of participants.
- Majority view statements are those that were agreed upon by 75-99% of participants.
- No consensus or majority views are those that did not reach agreement by at least 75% of participants; thereby indicating a need for more discussion and consideration by the group.

Participants

The Life Care Planning Summit 2010 had 71 attendees; however, due to early flight departures and other legitimate reasons, Sunday's final session was comprised of 59 participants (n=59). Demographics of the attendees for Sunday's consensus building group were:

Gender

Male	9
Female	50

Age

Less than 30 years old	1
Age 31 – 40	3
Age 41 – 50	14
Age 51 – 60	28
Age 61 – 70	12
Age 71 +	1

Professional Background

Rehabilitation Counselor	28
Registered Nurse	21
Occupational Therapist	4
Psychologist	3
Physical Therapist	1
Speech Language Pathologist	1
Physician	1

Years Experience as Life Care Planner

0 – 5 years	12
6 – 10 years	11
11 – 15 years	9
16 – 20 years	9
21 – 25 years	13
25 + years	5

Ten attendees reported not being a member of the International Academy of Life Care Planners (IALCP) and nine attendees were not a member of the International Association of Rehabilitation Professionals (IARP).

Topic 1: Best Practices for Establishing Foundation for Necessity: Boundaries for Decision Making

Purpose

Reach consensus on objective methodology for how decisions are made about care items included in a life care plan, focusing on what items a life care planner can put into the plan based on his/her scope of practice versus what items require consultation/recommendation from other experts.

Objectives

- Identify objective criteria and methodology for establishing the scope of practice boundaries for life care planners of various professional backgrounds.
- Understand boundaries for life care plan recommendations for self and other life care planning colleagues.
- Understand how using scope of practice boundaries affects the admissibility and usefulness of life care plans for end-users.

Background

Life care planners come from many disciplines, including registered nurses, rehabilitation counselors, physicians, psychologists, occupational therapists, physical therapists, and speech/language pathologists. Each discipline has its own scope of practice and professionals can recommend and provide certain kinds of treatment interventions based on his/her expertise and scope of practice. All life care planners have clinical practice limits and often must refer or defer to other qualified professionals for treatment interventions/recommendations outside their own discipline and expertise.

Providing a credible, defensible life care plan is vitally important to life care planners.

Topic One discussions were designed to explore the issue of establishing who is qualified to make care recommendations while ensuring that the life care plan is useable, credible, and defensible. The objectives for Topic One were to reach consensus on objective methodology for how decisions are made about care items included in a life care plan, focusing on what items a life care planner can put into the plan based on his/her scope of practice versus what items require consultation/recommendation from other experts.

Presentations

In exploring best practices for establishing foundation, Summit participants heard perspectives from two attorneys (one plaintiff attorney and one defense attorney) who practice in the area of catastrophic injury. Harvey Spiegel and Matthew Allen provided their insight and expertise as trial lawyers in discussing how "who" makes the recommendations in a Life Care Plan affects the admissibility/defensibility of the plan. The attorneys responded to questions regarding implications of a life care planner from a specific discipline making life care plan recommendations based on that discipline's scope of practice without consulting another professional. The attorneys also provided helpful information regarding their personal preferences and opinions based on their experience working with life care planners.

This general session was followed by a presentation by two trust fund managers who discussed their needs and requirements in using a Life Care Plan in non-litigation situations. Mamie Kneller from Wells Fargo and Bill Frazier from Sun Trust Bank answered questions and provided insight including: 1) What makes a life care plan credible and useable for their purposes; 2) What are the implications of a life care planner making life care plan recommendations outside the planner's scope of practice without consulting another professional, and 3) What are the underlying principles that should be followed by life care planners in determining whether to make independent recommendations or whether to seek other professional opinions. They also provided their personal preferences and opinions based on their experience working with life care planners.

The third presentation for Topic One included professional viewpoints from a panel of multi-disciplinary life care planners consisting of Kathie Allison (Physical Therapist), Huntly Chapman (Physician), Carolyn Higdon (Speech Language Pathologist), Nancy Mitchell (Occupational Therapist), Ann Neulicht (Rehabilitation Counselor), Jan Roughan (Registered Nurse), and Carol Walker (Psychologist), discussing what is within the scope of practice for his/her professional discipline including the content of their training, post-graduate education, clinical specialty, and/or professional experience as a practitioner that gives them the ability to accurately project and include life care planning recommendations. Documents such as practice acts (regulations), professional association scopes of practice, diagnoses manuals, and other authoritative sources that support their ability and their capacity to recommend all aspects of care (e.g., item, frequency, duration, timeframe) also were discussed.

Topic One Consensus Statements

Participants were asked to consider the following statements and to decide to accept, modify, or reject each statement:

1. Life care planners may independently make recommendations for care items that are within their scope of practice to order/prescribe when in clinical practice.
2. Life care planners should obtain recommendations from qualified professionals for care items that the life care planner could not independently order/prescribe in clinical practice.

3. There is not a universal set of recommendations that all life care planners may make; recommendations vary based on the scope of practice of the individual life care planner.
4. Recommendations for care that are included in a life care plan require the same criteria for inclusion regardless of how the life care plan will be used (i.e., litigation or non-litigation).

Of the four target statements for Topic One, the first and second statements reached majority view among the roundtable groups for modification. Shown below is the first target statement as suggested for modification by each of the three roundtable groups:

Suggested Modified Statement # 1

A- Life care planners may independently make recommendations for care items/services that are within their individual professional scope(s) of practice.

B- Life care planners may independently make recommendations for care items within the scope of their practice.

C- Life care planners may independently make recommendations for care items/services that are within their scope of practice.

The above majority view statements were reviewed and discussed by all participants once convened in the general consensus building group session and attendees reached 100% consensus on the statement, modified as follows:

- **Life care planners may independently make recommendations for care items/services that are within their scope of practice. (100% consensus)**

The second target statement also received sufficient input from the three roundtable groups to merit modification and general discussion. Once convened in the general consensus building group, a fourth statement also was added for consideration. The roundtable groups provided the following input:

Suggested Modified Statement # 2

A- Life care planners obtain recommendations from other qualified professionals for care items/services that are outside the scope of practice of the life care planner.

B- Life care planners should obtain recommendations when possible from qualified professionals for care items that are outside their individual professional scope(s) of practice.

C- Life care planners should seek recommendations from other qualified professionals and/or relevant sources for inclusion of care items outside of the life care planner's scope of practice.

D- Life care planners seek recommendations from other qualified professionals and/or relevant sources for inclusion of care items/services outside the individual life care planner's professional scope(s) of practice.

After review and discussion by all participants in the general consensus building group session, the following statement reached 100% consensus by the attendees with the following modification:

- **Life care planners seek recommendations from other qualified professionals and/or relevant sources for inclusion of care items/services outside the individual life care planner's professional scope(s) of practice. (100% consensus)**

The other two statements for Topic One did not reach consensus or a majority view among the attendees and were therefore deleted.

Topic Two: Best Practices for Determining Sources of Attendant Care in the Home

Purpose

Reach consensus on objective methodology for how decisions are made for recommendations about using attendants from agencies or private-hire for care at home.

Objectives

- Examine the variables that life care planners must consider when choosing agency-procured or private-hired attendants for home care.
- Understand the risks and benefits of choosing between agency-procured and private-hired attendants for home care.
- Identify objective methodology for making decisions about attendant care at home.

Background

Care at home is often the largest cost item in a life care plan. Therefore, arguments exist in favor of, and against, various home care options. Life care planners need a method to ensure that home care recommendations are credible, reasonable, logical, and defensible.

Presentations

In order to facilitate the discussion for Topic Two, Kathy Adams, RN and co-founder of Accord Services home health care agency, discussed agency considerations, such as regulations and private duty in-home care services for individuals with catastrophic injuries. Ms. Adams was joined by Dan Miears, Accord Services marketing director, and they discussed key national and state regulations that govern home health agency services, the various credentials and/or qualifications required for personal care attendants, knowledge of how state nursing care regulations affect private hire home health care, as well as the benefits of utilizing a home health agency vs. private hire, among other points related to agency care. An interesting comment made by the speakers is that agencies often cannot provide back-up care on short notice when that agency is not the primary provider of attendant care. This is due to the required process for opening a case to service the home health client and locating and training attendants specific to the patient's unique needs.

During the second session of Topic Two, Samantha Renfro, the mother of a 48 year old daughter who experienced traumatic brain injury at age 18, discussed her experience of over 30 years utilizing various home care options. Mrs. Renfro provided her personal experiences of the pros and cons of being a private hire employer versus seeking agency-based home care services from the real-world perspective of both a mother/caregiver/employer and from the experiences of her daughter as a patient/client. Considerations of becoming a private duty employer, providing a comprehensive overview of additional costs and factors, and discussion of responsibilities of being an employer were also paramount to the presentation.

The last session for Topic Two was a panel discussion by experienced case managers and life care planners, including Steve Yuhas, Kathleen Kuntz and LuRae Ahrendt. Each offered discussion as case managers and arrangers of attendant care services on the "Which is Better?" question and they debated and discussed the issue about whether attendants that are from an agency or are privately hired are more reliable, loyal, trustworthy, or a better provider of services for clients with catastrophic disability.

Topic Two Consensus Statements

Participants were asked to consider the following statements and to decide to accept, modify, or reject each statement:

1. Private-hire and agency-procured attendants for home care are both options to be evaluated in every case.

2. Life care planners agree that neither agency-procured attendants for home care nor private-hire attendants for home care are inherently better or worse.
3. Tools need to be developed that reliably screen for the ability to use home care attendants from agencies or private-hire.
4. Life care planners should use objective tools to determine the appropriateness and feasibility of using attendants from agencies or private-hire.
5. A White Paper should be written that provides a practice guideline for decision-making in selecting agency or private-hire home care attendants.
6. The criteria that need to be considered in determining whether to recommend agency or private-hire home care include:
    a. Cognitive abilities of the client/surrogate
    b. Willingness of the client/surrogate
    c. Complexity of tasks to be performed
    d. Predictability of outcome of tasks and need for decision-making by the attendant
    e. Risk to client if tasks are omitted or done incorrectly
    f. Availability of agency staff in the geographic area
    g. Availability of private-hire staff in the geographic area, including needed skill level
    h. Proximity to emergency care and ability of attendant to handle an emergency pending arrival of emergency care
7. Costs for private-hire home care should include all associated costs, which include:
    a. Federal and state taxes and insurances
    b. Workers' compensation or other insurance that covers caregiver injury
    c. Advertising and screening
    d. Case management services if indicated
    e. Room, board, and other incidental costs if indicated

Each break out session carefully reviewed each statement and provided input for acceptance or modification. The results were collected for general discussion on Sunday.

Of the seven (7) target consensus statements for Topic Two, the first statement had sufficient interest in modification within the roundtable groups that, once convened in the large consensus building group, participants discussed and worked to reach 100% consensus on the following statement:

- **When the life care planner includes home care, both private-hire and agency-procured services are options to be considered. (100% consensus)**

Original target statements #2, 3, and 4 were deleted based on results of the participants' voting. After much discussion among the large group, statement #5 was merged with statement #6 and then ultimately rejected by the entire group based on the group's consensus to delete the merged statement.

The remaining target Statement #7, sub-sections a. and b. were combined and modified to reach 100% consensus among the participants:

- **The cost of private hire home care includes care giver compensation and associated expenses. (100% consensus)**

Topic Three: Review of Consensus Statements, Majority-View Statements and Results of Life Care Planning Summits 2000 – 2008

Purpose

Review past consensus statements and majority-view statements for continued support,

modification, or deletion. Ensure that consensus statements and majority-view statements, which are published and form expectations for life care planning practice, are accurate, relevant, and appropriate. To require modification or deletion, the statement should:

- Require substantive change to stay within the originally intended meaning, or
- Be deleted if unable to be modified without substantially altering the meaning, or
- Be deleted if it is irrelevant and is no longer required

It was not the intent of the Summit 2010 to rework previous statements for the sake of unsubstantial word preferences if the understanding and meaning of the statement does not require change in order to remain accurate and relevant for today's life care planning practice.

Objectives

- Determine whether statements created at the Summits of 2000, 2002, 2004, 2006, and 2008 are still relevant and appropriate.
- Eliminate obsolete statements that are no longer relevant.
- Establish a process for modifying outdated statements that require change.

Background

Consensus statements, majority view statements and results of the previous decade of Life Care Planning Summits from 2000 – 2008 were reviewed for continued support, modification, or deletion. The task was to explore the current state of the field and set future directions by examining the previously developed consensus statements in the following areas:

- Professional Development
- Education
- Certification
- Standards of Practice
- Ethics
- Methodology and Research

For each statement from prior Summits, current Summit participants responded to the statements indicating Accept, Modify or Delete. To require modification or deletion, Summit participants were instructed that the statement should:

- Require substantive change to stay within the originally intended meaning, or
- Be deleted if unable to be modified without substantially altering the meaning, or
- Be deleted if it is irrelevant and is no longer required

Upon review of over 100 consensus statements from previous Summits, an analysis of the participants' voting was completed. Those items with 75% or greater for Accept were retained; those with 75% or greater for Delete were noted for deletion. Only one statement received 100% consensus as written:

- **Life Care Plans shall be individualized. (100% consensus)**

Further, one statement had a majority of votes to recommend deletion, i.e., “Some aspects of Standards of Practice are too detailed.” For purposes of these proceedings, only those statements that did not receive a majority vote to accept or delete are included below. Due to space limitations, the comprehensive list of all previous Summit statements, including those that were determined for acceptance or deletion, will not be listed here.

The following 43 statements did not receive a majority vote to accept or delete and have been identified by the Summit participants for review for modification. Statements are listed within their respective category:

Professional Development

- Life Care Planners may come from a variety of disciplines, provided they have qualifications including five years’ experience in a primary discipline, complete

supervised time under a qualified life care planner and belong to a life care planning professional association.
- Life Care Planners shall explore markets for life care planning outside litigation.
- Life Care Planners shall promote and participate in a national organization for life care planners that serve as a single voice for the practice of life care planning and as a single repository for life care planning resources.

Education
- Life Care Planning programs shall be promoted widely.
- Life Care Planners shall train themselves and recruit others to instruct educational programs.

Certification
- Life Care Planner certification shall render its holder a qualified life care planner, provided that certification is maintained.
- Life Care Planner certification standards shall be augmented.
- The International Commission on Health Care Certification shall apply for National Commission for Certifying Agencies (NCCA) accreditation.
- Life Care Planning certification shall flow from a practitioner-created core curriculum.
- The Life Care Planning certifying body shall not be proprietary.

Standards of Practice
- Standards of Practice terminology shall be reviewed.
- Standards of Practice shall be based on a study defining the role and accountability of life care planners.
- Some aspects of Standards of Practice are too detailed (2004).
- Standards of Practice shall be unitized in the development of the practice of life care planning.

Ethics
- Life Care Planners shall accept referrals only in their area of expertise.
- Life Care Planners shall draft life care plans under supervision for one year.
- Life Care Planners shall renounce inappropriate processes and training.
- Life Care Planners shall disclose and differentiate between the roles in which they may be called upon to act.
- Life Care Planners shall better define dual relationships.
- Life Care Planners shall establish themselves within their primary field of practice.
- Life Care Planners shall objectively place their client's interests before any personal or professional consideration.

Methodology
- Life Care Plans shall be lifelong and flexible.
- Life Care Plans shall utilize research for recommendations.
- Life Care Planning shall depend on data collection, analysis and synthesis.
- Life Care Plans shall be developed in the client's best interest.
- Life Care Plans shall include an annotated list of requested and reviewed data/sources.
- Life Care Plans shall feature standardized forms and formats.
- Life Care Plans shall be consistent across similar cases.
- Life Care Plans shall rely on medical/allied health professional opinions.
- Life Care Plans shall be limited to the planner's expertise and scope of practice.
- Life Care Planners shall methodically handle divergent opinions.
- Life Care Planners shall properly inject personal expertise.

- Life Care Planners shall utilize protocols for cost research.
- Life Care Planners shall utilize protocols for using local versus national resources.
- Life Care Planners shall utilize protocols for handling the impact of aging.
- Life Care Planning databases, templates and software shall have appropriate foundation.
- Life Care Planners shall be involved in research.
- Life Care Planners shall include research in life care plans.
- Life Care Planners shall study the reliability, validity and accuracy of life care plans.
- Life Care Planners shall assess the reliability, validity and accuracy of data and methods.
- Life Care Planners shall conduct longitudinal studies.
- Life Care Planners shall evaluate the cost-effectiveness of life care plans.
- Life Care Planners shall study the impact of life care plans upon quality-of-life.

Discussion

Following the presentation of consensus statements, Summit participants voted and a discussion ensued regarding not only the statements that require modifying, but what should be the process for modifying and updating them. The International Symposium of Life Care Planners (IALCP) has offered to lead the process of Summit statement modification. The ideas generated by the Summit attendees to modify the statements included forming a multidisciplinary task force and utilizing a work group at the upcoming International Symposium for Life Care Planning (ISLCP) in September 2010 to provide follow-through and continuity in the process. This work group would be charged with developing the process of analyzing the statements identified as needing modification during the Life Care Planning Summit 2010. The objective of the work group would be to review and understand the proceedings of the past five Life Care Planning Summits, the process utilized in the development of statements from the past five Summits, create a methodological design of the analysis of the relevancy of the Summit statements requiring modification as noted by the Life Care Planning Summit 2010, and present a plan of action to modify the statements as necessary by the Task Force.

Summary

The Life Care Planning Summit 2010 marked the culmination of a decade's worth of Summits spanning the years 2000-2010. This year's Summit provided a productive and positive experience with a lively, passionate, and energetic group of attendees. According to Summit participants, use of the personal Audience Response System technology made the process of consensus building easier and allowed the group to stay focused on the objectives. The use of this technology resulted in less time and frustration to work through the process of reviewing, developing, modifying, and reaching consensus among the participants. Another positive change for this year's Summit was the focus on two primary topics, which allowed greater time and more in-depth discussion and consideration of ideas before the consensus statements were developed. The result was that consensus statements were reached that addressed the topics. The changes that were incorporated into the format of the Life Care Planning Summit 2010 lay a foundation for stronger Summits in the future. Where will you be in 2012?

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.

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CANADIAN LIFE CARE PLANNING SUMMIT 2011 PROCEEDINGS

by Summit 2011 Co-Chairs
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With special contribution by Roger Weed, PhD

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 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.

LCP Attendees in 2000-2010

Lynn Abram
Kathy Adams
LuRae Ahrendt
Tracy Albee
Reg Albritton
Kathie Allison
Lori Allison
Lori Anderson
Dorajane Apuna
Donna Archer
Barbara Armstrong
Terry Arnold
Connie Averett
Karen Aznavoorian
Dan Bagwell
Daniel Baierl
Ellen Barker
Mary Barros-Bailey
Elizabeth Bauer
Becky Bellerive
Norbert Belz
Kathleen Benson Larson
Debra Berens
Tarri Blackwelder
Nancy Bond
Richard Bonfiglio
Patricia Bonner
Jack Bopp
Eva Bordeaux
Catherine Borowski
Paula Bowen
Barbara Bower Frew
Debra Bowman
Belinda Brice
Giles Bronson
Therese Bright
Ashley Bryars
Patricia Bulifant
Margot Burns Hammer
Rebecca Busch
Charlyne Butler
Judith Callery
Penelope Caragonne
Robynanne Cash-Howard
Deborah Caskey
Doreen Casuto
Huntly Chapman
Lessie Chapman
Anthony Choppa
Sheila Colon
Patricia Conway
Steve Cooley
Joseph Corcora
Mariann Cosby
Patricia Costantini
Anelle Covelle
Gace Cover
Cynthia Craig
Karen Crockett
Chris Daniel
Elizabeth Davis
Nancy Davis
Alisa Dayanim
Carolyn Degenhardt
Laura Deming
Deborah Determan
Paul Deutsch
Janet Dezenski
Linda Dielking
James Doherty
Orilla Driver
Nancy Dunlap Williams
Susan Dye
Wayne Eklund
Tyrone Elliott
Lynn Esko
Glenda Evans Shaw
Kristy Farnsworth
Judy Farrimond
Heidi Fawber
Shery Ficklin
Timothy Field
Donna Flannery
Sandra Fourqueen Beck
Wendy Garland
Linda Gartman
Paul Gianelli
Reg Gibbs
Shelene Giles
Joyce Gill
Bob Gisclair
Claire Giuseffe
Mary Glidden
Cynthia Glidewell
Joe G. Gonzalez
Woody Gonzalez
William Goodrich
Cornelius Gorman
David Goudelock
Doris Graessle
Debra Gross
Judy Guse Salah
Lisabeth Hall
Pamela Hanigosky
Cheryl Hansen
Walter Harrell
William Hartwick
Christopher Haskins
Cynthia Hassley
Camie Hawkins
Benson Hecker
Patricia Hedrick
Angela Heitzman
Stacey Helvin
Diana Herbst
Patricia Hicks
Carolyn Higdon
Lori Hinton
Debe Hodges
Liz Holakiewicz
Bonnie Hostettler
Mike Howerton
Beth Hoynik
Rita Hubbs
Darlene Humphrey
Carol Hyland
Kathy Jackson Smith
Ann Jaime
Sheri Jasper
Kent Jayne
Steve Johns
Cloie Johnson
Donna Johnson
Penny Johnson
Sharon Kaczkowski
Paul Keckley
Carol Kelly
Margaret Kelsay
Sherie Kendall

Joyce Kinnard
Susan Kirtley
Julie Kitchen
Diana Klein
Valerie Knafelc
Catherine Knebel
Patricia Knight
Judy Knouse
Lynda Kopishke
Trudy Koslow
Kathleen Kuntz
Daria Lasala
Sherry Latham
Norma LeClair
Nancy LeGasse
Kelly Lance
Janice Landy
Robert Lessne
Robert Lester
Dasha Little
Anne Llewellyn
Viola Lopez
Ann Lovegrove
Leslie Lovell
Sandra Lowery
Sarah Lustig
Janet Lynden
Lenora Maatouk
Ann Major
Ann Maniha
Debbe Marcinko
Terri Marshall-Gilfilan
Stefanie Martt
V. Robert May
Francine Mazone
Dennis McClellan
Patricia McCollom
Diana McCoy
Jo Anne McDaniel
Carol McDonald
Sarah McLain
Robert Meier
DeLeen Melton
Linda Michaels
Donna Micklow
Audrey Miller
Jeani Miller
Valerie Miller
Nancy Mitchell
Donna Moore
Rebecca Morgan
Elisa Morris
Janet Mott
Kirsten Mott
Carol Murphy
Ann Neulicht
Michele Nielsen
Janice Nixon
Alice Noe
Nancy Nusbaum
Marilyn Oakes
Barbara Orstein
Susan Orzolek
Carole Ostrowski
Lawrence Ostrowski
Tanya Owen
Christopher Owens
Valerie Parisi
Cameron Parker
Judith Parker
Lynn Parker
Dana Penilton
Geralyn Pennachio
Jeffrey J. Peterson
Audrius Plioplys
Jamie Pomeranz
Donna Pope
Lauri Postenrieder
Kathy Pouch
Peggy Powell
Victoria Powell
Brian Preston
Karen Preston
Edmond Provder
Fran Provenzano
Barbara Puryear
Carroll Ann Putzel
Fred Raffa
Sandra Ragsdale
Mary Sue Randolph
Kristen Rapp
Bonita Readie
Sharon Reavis
Larry Rechlin
Christine Reid
Kathy Reid
James Rice
Mary Sue Richards
Susan Riddick-Grisham
Evelyn Robert
Rick Robinson
Mary Ann Rohrig
Cy Rosenblatt
Jan Roughan
Paul Rudnick
Sandra Sager
Mary Salerno
Connie Salo
Kathleen Sampeck
Pam Sappington
Horace Sawyer
Julie Sawyer Little
Maria Scaringi
Mary Scheel
Barbara Scheffel
Karen Schultheis
Sandy Schultz
Leslie Schumacher
Kevin Schutz
Ursula Seelig
Carole Sellars
Gregory Sells
Melinda Sells
Timothy Sells
Susan Sereda
Sharon Servelle
Lyn Shade
Linda Shaw
Linda Shea
Steven Shedlin
Susan Sims
Myron Smith
Ron Smolarksi
Gayle Solk
Dawn St. Clair
Teresa St. Clair
Earlene Stanislaw
Diane Steffy
Ginny Stegent
Linda Stempel
David Stewart

Larry Stokes
Cindy Stowe
Norma Stricklin
Ruth Swiggum
Connie Sunday
Amy Sutton
Charles Szeg
Judith Szeg
Michele Tassin Gomez
Robert Taylor
Randall Thomas
Laurie Thornton
Karen Tobie
Robin Tomatz
Janey Toney
Gini Lee Toyne
Janet Troilo
Eugene Van de Bittner
Susan Van de Bittner
Maria Vargas
Cathlin Vinett
Elizabeth Vinton
Robert Voogt
Kim Wages
Carol Walker
Linda Walker
Ann Wallace
Alison Walmsley
Carolyn Watkins
Leslie Watson
Roger Weed
Susan Weintraub
Laura Weiss
Dana Weldon
Sandra Wells-Brown
Karen Wempen
Karen Wilbanks
Kathy Willard
Peggy Williams
Alex Willingham
Carla Willy
Tracy Wingate
Terry Winkler
Betty Wintroath
Susan Wirt
Helen Woodard
Susan Wright
Joni Yaeger-Powers
Mona Yudkoff
Steven Yuhas
David Zak
Paula Zinsmeister
Caren Zysk

Canadian LCP Attendees in 2011

Robin Kadanoff
Bonnie Koreen
Ann Krause
Tammy Kyle
Michel Lacerte
Ruth Leppard
Galit Liffshiz
Nancy Lok
Paul Lukasik
Sarah Macrae
Ann McFarlane
Mary Ellen Meyers
Cindy Miller
Dimple Mukherjee
Barbara Nagy
Elizabeth Parekunnel
Lynn Parker
Linda Petty
Yvonne Pollard
Elsa Poon
Janice Ray
Nancy Robinson
Rick Robinson
Joanne Romas
Jordan Roovers
Mathew Rose
Karen Rucas
Maria Scaringi
Anne Schneiderman
Susan Sereda
Francois Sestier
Reema Shafi
Linda Simmons
Lisa Simms
Debra Stoch
Susan Swanson
Victoria Sweetman
Evelyn tenCate
Edward Tenki
Sandra Vellone
Cheryl Verbeek
Roger Weed
Beverley Wilson
Kim Wilson Wiles
Steven Yuhas
Samera Zoberi

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Words from the field –

Various professionals and organizations share their thoughts on the significance of Summits.

Summits are an ideal way to look at our profession in a new light. We have covered some of the most basis topics that related to what we do as life care planners. We have wrestled with such topics as qualifications, standardized procedures, critiques by your peers of existing life care plans, how we grow as a profession and so many more really important aspects of what we do. Our discussions can be frank and soul searching. We have worked hard to come to a consensus regarding what we do as life care planners.

One of the most important aspects of the meetings involves listening to the voices of your peers. We are a composite of at least 4 major areas of health care – Medicine, Allied Health, Nursing, and Vocational Rehabilitation. Yes we are different but our goals are the surprisingly similar… to create a comprehensive defendable plan. I have been able to use this knowledge in my work and in deposition and trial testimony. I know the consensus surrounding many areas in our practice. I have been able to share my opinion with my colleagues.

I will continue to attend because I gain knowledge, improve my skills in formulating plans, and develop great friends that I can call on.

Kathie Allison, PT, MS, CLCP

The Summit is a time for the LCP profession to gather together and discuss/debate issues in the field. It brings together all the different professions that are doing life care planning—nurses, rehab counselors, OTs, PTs, etc. We break down into smaller groups for discussions. There will be a moderator, but it is not a lecture. This is our time to give our input into the direction of the field, develop consensus guidelines, etc. summit proceedings are recorded and published so we each have a record of what transpired. It's particularly beneficial when in deposition or court to say you've been involved with the Summit, and the Summit results back up/give foundation for what we do. I think it's pretty empowering.

I went the first year I was certified. I thought I might feel uncomfortable being a newbie with all of these seasoned LCPers but that was not the case. I learned a lot from the discussions and found I had a lot to offer as well. It's nothing like a conference, which is more didactic in nature; the Summit is participatory.

Angela M. Heitzman, MA, CRC, CLCP

The 2012 LCP Summit in Dallas is expected to become the pivot point for Life Care Planners in North America. The intense scrutiny given to Life Care Plans today mandate that an ethical client centre approach is met by a consensus. The 2011 Canadian Summit taught us what the strengths and weaknesses of Life Care Planning in Canada were and provided the catalyst to the current IARP Canada educational and policy development initiatives. Anyone interested in the healthy future of Life Care Planning is encouraged to attend at the rendezvous in Dallas and become a part of history.

Michel Lacerte MDCM MS FRCPC CCRC - IARP Canada Chapter

Participation in the 2012 Life Care Planning Summit at the Dallas/Ft Worth Airport on May 5th and 6th is on my calendar, and it should be on yours. The Summit is where we gather to define and refine the process of life care planning. The decisions that are made at the Summit are integral to the evolution of life care planning, and the process is open to all who attend.

In 2000, this group achieved consensus on a definition of life care planning, and it was not easy. Each subsequent Summit brings our focus to the methodology, standards of practice, and emerging topics regarding our work as life care planners. Include yourself in this process this year.

Judith Parker, M.Ed., CDMS, ABVE-D, CLCP

IARP/IALCP is proud of our active and principal role in the bi-annual Life Care Planning Summit. The next Summit will be held on May 5-6, 2012, at the Dallas Fort Worth Marriott Hotel North in beautiful Dallas, Texas.

As fellow Life Care Planners, it is imperative we come together to re-examine the standards of practice, address the prevailing issues, collaborate, and identify the areas of consensus among us.

In the past, the Summit has had a significant impact on the ongoing evolution of Life Care Planning and continues to encourage unity among its practitioners. Join us in supporting the continued growth of the Life Care Planning profession.

Elizabeth Davis, Chair
Steve Yuhas, Chair Elect
International Academy of Life Care Planners

The 2012 Life Care Planning Summit is set to provide the ultimate landscape of a “field united”. The ICHCC is committed to contributing to this year’s summit to address important issues affecting ALL Life Care Planners. As tough questions arise, inclusivity is of utmost importance. The ICHCC has elected to postpone the Congress of 2012 to focus on the tasks at hand of this year’s Summit. As the regulatory body, the ICHCC is obligated to Certified

Life Care Planners, (CLCPs), and ultimately what best represents the certification. The ICHCC Congress will be held in 2013 for all life care planners to attend, regardless of your certification status.

Life Care Planning continues to emerge as crucial for those with catastrophic injuries and/or non-catastrophic injuries resulting in chronic sequelae. As our role proliferates, it is our duty to provide consistent methodology maintaining balance, credibility and integrity of the field. Although we are a diversified group of professionals, coming from a multitude of health care related fields, our applied methodology should be consistent and held to the highest of health care service standards.

Your attendance for this year's Summit is vital to your life care planning practice and all life care planners should attend. Being involved in your professional community gives you a stronger voice in the decisions that will ultimately define what is expected from you as a practitioner. The responsibilities one accepts by practicing as a life care planner, certified or not, are somewhat daunting at times.

It is imperative we educate ourselves to the standards and ethics applicable as well as ongoing changes within the field that will affect our practices. It's equally important that the leaders in the field open their ears to issues, challenges and changes that are occurring. The ICHCC, IALCP and FLCPR are opening their ears in a town hall setting to hear those issues as well as update all of you on the issues, challenges and changes that are occurring within those associations. The planning committee anticipates this to be an informal process of sharing information as the associations open up to questions from the field.
The planning committee has also set up working groups for nominal processes to address and attempt to gain a consensus on some of the most requested topics from the field for discussion:
(1) Appropriate foundation for life care plans.
(2) Appropriate costing for life care plans.
(3) Ethics for the life care planning practitioner.
(4) Definitions of these different terms we are hearing: mini life care plan, minimum life care plan, cost projections, etc.

I look forward to seeing each one of you in Dallas and may you all have safe travels.

Sherry A. Latham--Life Care Planning Commissioner
International Commission on Health Care Certification (ICHCC)

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What Every Life Care Planner Should Know About the 2012 LCP Summit

Summary of the Webinar Presented by
Roger Weed, PhD
Cloie Johnson, MEd
Susan Riddick Grisham, RN
Steve Yuhas, MEd

There has been great confusion amongst some as to the difference between a Symposium, Seminar and Summit. This Webinar was presented to add clarity and provide education to enhance the profession and ensure all life care planners understand the impact and importance of the Life Care Planning Summit.

Educational Conferences vs. Summits

Educational conferences are typically held annually within ones professional association or by profit or non-profit organizations. There are typically attended in person. Other educational conferences becoming more traditional include Webinars and On-line seminars. Professional association conferences are typically more "cost effective" because speakers typically donate their time/services whereas other conference types typically pay speakers (speaking fees, transportation and other expenses). Leaders are selected to impart information to the attendees. The primary goal of an Educational Conference is to Impart information about ethics, standards of practice, clinical practices, disability education, products, supplies, etc to the masses. Educational conferences are designed so that leaders give information to the attendees.

Summits are held to set the stage for a professional practice. Summit attendees provide the information to the leadership. The goal is to develop ethics, standards of practice, standard of care, etc., specifically using the power of the group of attendees (grass roots). Summits are unique in that they are designed so that aggressive, forceful, or overbearing people have limited power. Summits are designed so that people, who are typically in the "background," quiet and less aggressive, have their voices heard. Summits use group dynamics and attempt to achieve consensus or near consensus. And most importantly, Summits typically set the very foundation for the specialty practice and often are the source for agreed upon standards of practice, standard of care, and ethics. Summit conferences are designed so that attendees give information to leaders

Historical Review of Past Summits

What is the Life Care Planning Summit?

The Life Care Planning Summit is a biennial meeting of practitioners and interested parties in the field of life care planning, with a limited number of attendees attending. The Summit explores important issues in the field, provides opportunity to reach consensus on issues, provides opportunity to identify and define areas of controversy, and provides direction

for future development and services

The first Life Care Planning Summit was held in Dallas, Texas on April 12, 2000, specifically to address life care planning topics and issues with the goal of achieving consensus on five focus areas:

1. Professional preparation
2. Basic tenets and procedures for completing life care plans
3. Ethics
4. Reliability and validity of the life care plan
5. Information dissemination

The Summit was sponsored by International Association of Rehabilitation Professionals (IARP), International Academy of Life Care Planners (IALCP), Intelicus/University of Florida and the Commission on Disability Examiner Certification (CDEC). In addition, the American Association of Legal Nurse Consultants (AALNC) and the Case Management Society of America (CMSA) participated.

The next Summit was held May 18 – 19, 2002 in Chicago, Illinois. The topic areas included:

1. Scope of practice; Skills
2. Ethics
3. Professional development
4. Methodology; functions
5. Future of LCP

On April 24 and 25, 2004, in Atlanta, Georgia, 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

The May 6 and 7, 2006 Summit in Chicago, Illinois occurred with a panel comprised of representatives of the IALCP, CHCC, and Foundation for Life Care Planning Research (FLCPR). The panel discussed trends and plans for the future of life care planning and each represented organization had an opportunity to offer suggestions.

IALCP offered the following plans:

1. Complete transition to new organizational model, i.e., IARP.
2. Increase IALCP visibility/awareness of our existence within the life care planning community
3. Increase membership in the Academy
4. Increase membership-driven services and programs
5. Increase education opportunities through a variety of venues/media/technologies.

The CHCC proposed the following plans:

1. Continued establishment of certifications: Canadian Certified Life Care Planner (CCLCP), Australia, Netherlands, China, Chinese Physical Therapists certified as Certified Disability Examiner (CDE)

2. Additional development of Certified Elder Care Specialist (CECS)
3. Accreditation through National Commission for Certifying Agencies
4. Development of a review textbook for certification review course
5. Acceptance of CLCP qualifications by all pre-approved training programs
6. Continued academic research

The Foundation for Life Care Planning Research proposed the following plans:

1. Implementation of a Foundation fund raising project
2. Continued support of research projects addressing the reliability and validity of the life care planning process
3. Development of a Foundation newsletter
4. Scholarship support to students pursuing life care planning education

The 2008 Summit was held May 15 and 16, 2008 in Los Angeles, California. This Summit was intended to examine issues and provide direction at both the individual practitioner level and at the field level. Specific areas included:

1. Visions for LCP Future: Identifying controversial aspects of plans created by various professional disciplines
2. Developing Unity in the Field: Standards of Practice shaping the role and function of life care planning
3. Best Practices: Methodology Issues in Data Collection
4. Best Practices: Methodology issues in creating admissible life care plans
5. Research: Priorities, needs, and practical applications in day-to-day practice
6. Professional business issues: Risks and benefits of databases, templates, software

On April 17 and 18, 2010 the Summit was held in Atlanta, Georgia. The Theme and Goals of Life Care Planning Summit 2010 were to:

1. Enable Life Care Planning practitioners to develop improved practice skills
2. Establish best practices in the life care planning process
3. Enable life care planning organizations to develop priorities for education, research, and services for Life Care Planning professionals

The topics were narrowed to the following:

Topic 1: Best Practices for Establishing Foundation for Necessity: Boundaries for Decision Making

Topic 2: Best Practices for Determining Sources of Attendant Care in the Home

Topic 3: Review of Consensus Statements, Majority-View Statements and Results of Life Care Planning Summits 2000 – 2008

On June 3 and 4, 2011, the Canadian Life Care Planning Summit 2011 was held in Toronto.

This Summit brought together leaders in life care planning from a variety of organizations with a goal of promoting unity within Canada. Through a series of round table discussions, life care planners had the opportunity to examine the hot issues in the field and contribute to the resolutions of these issues and to the continued evolution of the field. Representatives of life care planning training programs, certification programs, and professional associations joined with researchers, practitioners, and support service providers explored the current state of the field and set future directions. The topics discussed at this Summit reflected the changes and

maturation occurring in this dynamic field. Although the process of life care planning is not new, developing consensus and unity in the field in order to provide a credible, meaningful, marketable, and defensible service that reflects common principles and foundation among all life care planners will continue to be a work in progress.

The Summits have been an integral part of the development of the field and the practitioners in Life Care Planning. The IALCP has taken the leadership role in chairing the Summit with the collegial relationships of the various associations and organizations within the Life Care Planning community. Over time the Summit results have been published and relied upon by practitioners in their daily practice. The Best Practices and Consensus and Majority Statement serve as reinforcement for the work of the Life Care Planner. Practitioners are on occasion asked about these statements during depositions as well. Summit proceedings are developed by Life Care Planners for Life Care Planners about Life Care Planning. Being familiar and aware of these statements are very important.

In an effort to plan for the 2012 Summit, a survey was completed to obtain input from IALCP members on their needs and issues. Eight (8) questions were presented to the 498 members with 153 responding.

Questions and responses were on the following:

1. Have you ever attended a Summit sponsored by the IARP Life Care Planners Section?
   - 62.5% Yes
   - 37.5% No

2. How long have you been a member of the IARP Life Care Planners Section, including your time as a member of the International Academy of Life Care Planners (IALCP), which merged with IARP five years ago?
   - 25.0% More than 10 years
   - 34.9% 5 to 10 years
   - 40.1% 5 years or less

3. Should a Summit be planned for 2012?
   - 61.2% Yes
   - 17.8% No
   - 21.1% Other

4. Would you be willing to attend a Summit in person?
   - 78.8% Yes
   - 21.2% No

5. What locations would you suggest for holding the Summit?

Charleston, SC; Charlotte, NC; New York, NY; Atlanta, GA; Seattle, WA; Las Vegas, NV; Minneapolis, MN; Puerto Rico; St. Thomas, VI; Kansas City, KS; Chicago, IL; Washington, DC; New Orleans, LA; Denver, CO; Texas (Dallas, San Antonio); Tennessee, (Nashville, Memphis); Arizona (Tucson, Scottsdale, Phoenix); Florida (Orlando, Miami, Jacksonville, Tampa, Disney World); Pennsylvania (Pittsburg, Philadelphia); Boston, MA; California (La Jolla, Ventura, Los Angeles, San Francisco, San Diego, Palm Springs); Canada (Toronto, Montreal, Vancouver, Ontario, Quebec, British Columbia)

Other suggestions: Middle of the country, central, midwest, southwest, southeast, eastern, northeast, perhaps in conjunction with other meetings /Symposium, perhaps by web, west coast, anywhere that travel and lodging would be as cost-effective as possible, an interesting city, warm destination, major city for ease of travel, ease of access to airports,

6. Would you be willing to complete pre-summit assignments?

71.8% Yes
28.2% No

7. Would the days immediately following the annual September Symposium be an optimal time for the Summit to be held?

61.6% Yes
38.4% No

8. What issues should be addressed in a Summit for 2012?

Methodology research expert testimony
Ethics
Major issues raised on ListServ
Integrating Canadian LCP with US LCP
Clinical information with medical issues
Standards of care
Ethical issues, cost research
Seniors
Standards of practice
Starting a practice, malpractice insurance, networking
Specific for individual diseases
Certification and accreditation
Life Care Planning for children

Other issues suggested:

- Credentials, diversity, past consensus statements needing revision.
- Qualifications
- The need for credentialing (Canadian issue) review of practice guidelines for major impairment categories, e.g., spinal cord, brain injury.
- Advanced Techniques, Changes in Comp Law.
- LCP for Special Needs – Fiduciary – what are the funding sources, who is the client, how to locate referrals, who pays the life care planner?
- How to do all the work in an amount of time that makes the work more feasible to do and be paid for the time.
- Relevant issues and especially the proliferation of non-certified planners representing themselves to be competent.
- Costing Methodology (medications: generic v. name brand)
- Report formats.
- Life Care Planner ability to recommend services or items.
- Advanced practice issues related to cost research and methodology.
- Discussion regarding collateral sources and their appropriateness for LCP.
- How to obtain complication cost.

- Practical use of inexpensive software programs that can assist to obtain back-up for use of LCP items and cost.
- Identify the core components of consist life care planning.
- Define “mini life care plan” vs. cost projections.
- Clarify practice standards for those dedicated to plaintiff vs. defense work.
- The use of non-agency home care
- Cash discounts on medical bills
- Life care planners with 2 year degrees
- Medical summaries in life care plans
- Obtaining direct prices vs. use of data bases such as AHD, etc.
- The impact of insurers using MSA’s as a substitute for a life care plan, the use of some MSA companies of “Life Care Plan” for a section of their MSA
- Copyrighting the term “Life Care Plan” and its meaning, as traditionally defined by the Life Care Planning community.
- Each state’s/international specific laws concerning life care planning, i.e., courts expectations, lawyers’ expectations.
- Guardianship
- Instruction on critiquing peer’s LCP's…
- Steps to publishing in peer reviewed journal. Establishing and/or clarifying guidelines.
- Court challenges to our field; more on supporting custodial care hours
- Conflict of Interest
- Daubert and Life Care Planner testimony in trials
- Testifying in defense of a developed life care plan
- Evidence based practice.
- Attendant care consistency

It is highly recommended that practitioners take a vested interest in the future and participate in Summits to address cutting edge issues affecting Life Care Plans, Life Care Planning and Life Care Planners.

Journal of Life Care Planning, Vol. 11, No. 1, (119-126)

Welcome to the 2012 Summit for Life Care Planners

Dear Fellow Life Care Planning Professional:

The International Academy of Life Care Planners, a Section of IARP, is honored to host the 2012 Summit for Life Care Planners. This biennial event brings together leaders in life care planning from a variety of organizations with a goal of promoting unity. We have stepped Outside the Box this year to meet the various Hot Issues in Life Care Planning and to allow a voice to all.

We have a wonderful cross section of practitioners from all disciplines representing Rehabilitation Counselors, Nurses, Physical Therapists, Occupational Therapists, Physicians, Psychologists and other professionals within the Life Care Planning community.

The long-standing practice of having a biennial event including open collegial meetings and round table discussions, allows life care planners to have the opportunity to examine the hot issues and contribute to the resolutions of these issues and to the continued evolution of the specialty practice of life care planning.

Once again, representatives of life care planning training programs, certification programs, and professional associations will join with researchers, practitioners, and support service providers to explore the current state of the field and set future directions.

The topics to be discussed at this Summit reflect the changes and maturation occurring in this dynamic field. Although the process of life care planning is not new, developing consensus and unity in the field in order to provide a credible, meaningful, marketable, and defensible service that reflects common principles and foundation among all life care planners is still a work in progress.

A unique feature of the 2012 Summit is that an open Town Hall meeting will be held to allow the attendees to speak directly to the leadership of the International Academy of Life Care Planners, International Commission on Health Care Certification and the Foundation for Life Care Planning Research. This moderated town hall will provide feedback from the bottom up to enhance life care planning for all practitioners.

We will also have as usual round table discussions on additional hot topics including Costing, Foundation and Definitions.

On Sunday, attendees will spend the first half of the morning in a guided discussion on Ethics and their impact on the practitioners from differing backgrounds. The second portion of the morning will be the results of the round table discussions after the facilitators and records have compiled the data from Day One. There will also be a discussion of how to apply the results to personal development and to guide organizations in providing relevant services.

Open to life care planners at all levels of experience this is your opportunity to participate in the future development of your field. Participants will be listed in the published proceedings following the Summit. Welcome!

Cloie Johnson

Thank you, Thank you, Thank you

The 2012 Life Care Planning Summit would like to thank the numerous volunteers who provided sponsorship, support and endless volunteer hours in the coordination and implementation of this year's Summit.

Steve Cooley
Paul Deutsch
Heidi Fawber
Angie Heitzman
Patricia Hicks
Arlette Loeser
Lenora Maatouk
Bob May
Kathy Mundy
Lynn Pahl
Judith Parker
Evelyn Robert
Chris Reid
Bob Taylor

2012 SUMMIT PLANNING COMMITTEE

Cloie Johnson – *Chair*

Committee members:
Giovanna Boniface, Elizabeth Davis,
Brook Feerick, Susan Riddick Grisham,
Sherry Latham, Karen Preston,
Rick Robinson, Steve Yuhas

The 2012 LCP Summit is proudly
co-sponsored by the IALCP, IARP,
University of Florida, FLCPR and ICHCC

DRAFT AGENDA

Day 1 – May 5, 2012

8:00 a.m. – 8:30 a.m.	**Opening comments, intro**
8:30 a.m. – 10:30 a.m.	**Open Dialogue/Town Hall Meeting – IALCP, FLCPR, ICHCC**

Representatives -
Sherry Latham, Bob May - ICHCC
Paul Deutsch - FLCPR
Elizabeth Davis & Steve Yuhas - IALCP
Moderator - Cloie Johnson

10:30 a.m. – 10:45 a.m.	**Break**
10:45 a.m. – 12:15 p.m.	**Town Hall Debriefing** **Action Plan Discussion and Agreement**
12:15 a.m. – 1:30 p.m.	**Working Lunch - Past Consensus and Majority Statement Review of Pre-homework surveys and approval**
1:30 p.m. – 2:15 p.m.	**Nominal Group Process Instruction and Introduction of Topics**

2:15 p.m. – 3:00 p.m.	**Group rotation**
3:00 p.m. – 3:15 p.m.	**Break**
3:15 p.m. – 4:00 p.m.	**Group rotation**
4:00 p.m. – 4:45 p.m.	**Group rotation**
4:45 p.m. – 5:00 p.m.	**Wrap up**

Day 2 – May 6, 2012

8:00 a.m. – 8:15 a.m.	**Opening comments, intro**
8:15 a.m. – 9:45 a.m.	**Open Dialogue/Ethics - Development of Consensus/Majority Statements and Framework for the Practitioner**
Moderator - Christine Reid	
9:45 a.m. – 10:15 a.m.	**Results Topic 1 and vote on consensus**
10:15 a.m. – 10:30 a.m.	**Break**
10:30 a.m. – 11:15 a.m.	**Results Topic 2 and vote on consensus**
11:15 a.m. – 11:45 p.m.	**Results Topic 3 and vote on consensus**
11:45 a.m. – 12:00 p.m.	**Closing remarks and next steps**

Town Hall

A **town hall meeting** is used primarily to allow the members of a community to come together to discuss issues but not vote on any legislative or administrative action. Notably, the term is commonly used to describe forums at which participants can offer comment and can ask questions.

We are encouraged by the opportunity to come together and provide an open forum for the practitioners to speak to the leading associations. We appreciate the time of the FLCPR, IALCP and ICHCC to make this happen. The following is an outline to the session including protocol and format.

TOWN HALL MEETING PROTOCOL

Holding a town hall meeting is an efficient way to gather qualitative data through the use of a focused group discussion. The reward for this work is dynamic information not just about what people feel, but about *why* people feel the way they do about a particular subject or idea. Group discussions have the potential to provide both accurate and in-depth data.

The town hall meeting is intended as a complement to the rest of the needs assessment. What follows is a discussion of the general system for running a town hall meeting successfully.

The Moderator
Fundamental to the town hall meeting is a moderator who facilitates the discussion. This person will coordinate and manage the group, to make the participants feel comfortable in expressing themselves openly, while keeping the discussion on track.

Rules

Generally, rules include the following:
only one person talking at a time;
no side discussions among participants;
no members should be put down because of their opinions;
all thoughts and ideas are valued; and
there are no wrong or right answers.

Conducting the Discussion
The discussion itself should last between 1 and 2 hours and follow a structured format. The moderator should make every attempt to find a balance between keeping the group discussion on track and allowing it to flow naturally. In order to accomplish this, a "funnel" structure is often used. This approach is best outlined as a series of questions that move from general to specific.

FORMAT for the Town Hall Meeting

Opening (Moderator)

Welcome – outline of format and ground rules

Introductory Statement (REPRESENTATIVES)

This is a round robin question that everyone answers at the beginning of the meeting. It is designed to be answered quickly and to identify those characteristics that participants have in common. It should make everyone in the group feel more at ease.

Please provide a brief statement of the current state of your Association and your targeted goals for the foreseeable future (1, 5 and 10 years).
Audience Participation (AUDIENCE)

All participants are requested to provide statements (comments and concerns) as well as questions – attendees will be limited to 1 minute or provide your question in writing in advance.

Responses will also be 1 minute and may not require response but can be provided as feedback.

Representative Closing comments (REPRESENTATIVES)

Ending Summary (Moderator)

RECORDING AND USING THE INFORMATION

Every effort will be made to record the town hall meeting by having recorders. The information gathered from this meeting will be used to complement other quantitative work, using participant quotes and the grouping of ideas. The grouping of ideas refers to the categorizing of attitudes, feelings, or beliefs of the group toward the topic. This may simply involve discussions revolving around a single question. In other cases, this may involve outlining the major topics brought up by the group.

Topic 1
Best Practices for Establishing Foundation for Life Care Plans

Purpose

Reach consensus on objective resources included in a life care plan.

Objectives

Identify resources which the field of practitioners determines authoritative for establishing foundations in life care plans.
Understand limitations of such resources.
Identify ways to ensure life care plans have appropriate foundation.

Background

Life care planners come from many disciplines, including registered nurses, rehabilitation counselors, physicians, psychologists, occupational therapists, physical therapists, and speech/language pathologists. Each discipline has its own scope of practice and professionals can recommend and provide certain kinds of treatment interventions based on his/her expertise and scope of practice. All life care planners have clinical practice limits and often must refer or defer to other qualified professionals for treatment interventions/recommendations outside their own discipline and expertise. In 2010 the Summit reached consensus that "**Life care planners may independently make recommendations for care items/services that are within their scope of practice" and "Life care planners seek recommendations from other qualified professionals and/or relevant sources for inclusion of care items/services outside the individual life care planner's professional scope(s) of practice".** This does not include those items included beyond the practitioners scope of practice or those incorporated based on literature, experience or clinical judgment.

Providing a credible, defensible life care plan is vitally important to life care planners. Topic One discussions were designed to explore the issue of establishing what makes recommendations in the life care plan useable, credible, and defensible. The objectives for Topic One were to reach consensus on resources which the field of practitioners determines authoritative for establishing foundations in life care plans, understanding the limitations of such resources, and identifying ways to ensure life care plans have appropriate foundation.

Thought provoking questions to attendees –

What are acceptable resources and components included in a life care plan?
What are the limitations of such resources?
How can practitioners ensure life care plans have appropriate foundation?

Topic 2
Best Practices for Providing Costs within Life Care Plans

Purpose

Reach consensus on objective resources when placing costs in a life care plan.

Objectives:

Reach consensus on the various sources or methods for obtaining costs for life care plans.

Reach consensus on best practices for cost research and costs shown in life care plans.

Background:

Various methods are used by life care planners to obtain costs. Differences include local versus regional costs, use of online resources, use of actual treaters versus sampling of the local area, and use of reference texts. There are also differences in how recent the costs must be (i.e., obtained fresh each time or using previous research from a recent timeframe). There has not been in-depth discussion about which practices are acceptable for providing accurate and meaningful costs and whether the process can be different in various circumstances.

Thought provoking questions to attendees –

What are sources and methods for obtaining cost information?
How can practitioners ensure life care plans have appropriate costing foundation?
Can non-local area or non-provider costs be utilized within a life care plan?
If so, Why and what sources?
If not, Why?

Is there an expiration date for the validity of costs obtained by a life care planner to utilize in a life care plan?
Is there a minimum number of cost quotes required to provide a valid cost figure for life care plan items?

Topic 3
Definitions and Terms specific to Life Care Planning – Minimum Life Care Plan, Medical Cost Projections, Life Care Plans are these all the same?

Purpose

Reach consensus on acceptable terminology used to develop Life Care Plans.

Objectives

Identify the different types of Life Care Plans that are produced, including correct title and purpose for each type of report.

Establish guidelines for the purpose of a condensed report and define the different methodology used to formulate a Life Care Plan vs. Cost Projection vs. Mini Life Care Plan.

Determine if the different types of reports listed are all acceptable forms of Life Care Plans. Identify ways to define the above formally to better ensure consistency among the Life Care Planning group.

Background

Life Care Planners are being asked to produce a variety of reports recently. It has come to the attention of the community that there is different methodology and different terminologies being used. In order to maintain consistency within the practice of life care planning, the different types of reports should be defined and outlined.

Thought provoking questions to attendees –

What are the differences between the above named plans?
What are the limitations of each plan?
How can practitioners ensure consistency between these different types of plans across the spectrum of Life Care Planning?
Is it acceptable to term something a “Mini” or Minimum” Life Care Plan?
What constitutes a “Minimum” or “Mini” Life Care Plan? Are condensed reports appropriate for testimony?

Ethics Session

Moderator: Chris Reid
Recorders: Cloie Johnson & TBD

Purpose

Examine implications of different Codes of Ethics for practitioners in Life Care Planning.

Objectives

Explore various resources which provide ethical guidance for the transdisciplinary practitioners who prepare Life Care Plans.

Identify potential problems inherent in the diversity of Codes applicable to Life Care Planning.

Discuss options for enhancing the ethical conduct of all professionals who engage in Life Care Planning practice.

Background

Life Care Planners are expected to practice ethically. Life care planning is transdisciplinary with practitioners from various backgrounds all preparing Life Care Plans. In addition to the ethical standards outlined by the IALCP in the Standards of Practice, each credentialing body has its own code of ethics. In order to promote consistently ethical life care planning practice, implications of the diversity of relevant codes and options for enhancing overall ethical conduct should be discussed.

Thought provoking questions to attendees –

What kinds of differences between ethical codes could be problematic for ensuring consistency in ethical practice among life care planners?
What can be done to enhance the ethical conduct of all professionals who practice life care planning?

Guidelines for Authors

Purpose and Objectives

The *Journal of Life Care Planning* publishes refereed education and research materials relevant to the practice and processes of life care planning. The specific objectives of the Journal are as follows:

- Publish materials which will add to the growing literature base of the practice of life care planning.
- Provide the professional field with information regarding events and developments important to the practice of life care planning.
- Provide a forum for the debate and discussion of practice issues.
- Promote professional practice by addressing issues relevant to certification, ethics, standards of practice and research methodologies.
- Promote advanced practice through the publication of preapproved continuing education feature articles.

Manuscript Preparation

Submission of articles and manuscripts consistent with the objectives of the *Journal* are welcome. In the preparation of any submission to the *Journal*, please carefully consider the following:

1. The manuscript should be prepared in APA style. Refer to the *Publication Manual* of the American Psychological Association, Sixth Edition. Submit only original work that has not been previously published or copyrighted. Do not submit manuscripts that are under consideration at another source. Quoting from other sources is permissible, but only if carefully documented and referenced. Plagiarism in any form is considered unethical. Place identifying information (Name(s) of authors(s), addresses, employment, etc.) only on a cover page in order to facilitate the blind review process.
2. Manuscripts should be submitted to the *Journal* Editor via email (Preferred format: MSWord 2007 or earlier). It is expected that most manuscripts will need some revision or enhancement following the *Journal's* review process. The final draft of a revised manuscript should be resubmitted to the Editor via email.
3. Use proper language with regard to a person's sex and/or disabling condition.
4. All manuscripts, if published, become property of the *Journal*. Manuscripts that are not published will be returned to the author(s). However, the author(s), not the *Journal*, are responsible for the views and conclusions of a published manuscript.
5. The Editor, and the Editorial Board, have broad latitude in deciding the disposition of an article or manuscript. Issues of relevancy, quality of writing, and adherence to the guidelines for preparation are critical. Manuscripts may be returned without comment to the author, especially if no peer review is involved.
6. Submit articles and manuscripts to Irmo Marini, email at imarini@utpa.edu.

Subscriptions

Subscription Rates: Published quarterly (March, June, and September & December). Individual subscription is US $85.00; institutional rate is US $100.00. Rates subject to change without notice. Notify IARP immediately of any change of address.

Advertising: Submit ad copy to E & F, Inc. as a graphic file (tif or jpg) four weeks prior to a publication date. Rate is $150 for a full page ad; $85 for a half-page. With no exception, prepayment is required (Check, MC or VISA acceptable). Ad copy must be consistent with the stated objectives of the *Journal*, and may be refused at the discretion of the publisher. The *Journal*, E & F, Inc., or the staff, as a matter of policy, does not endorse in any way products or services that are advertised. All ad copy becomes the property of the *Journal.*

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