Journal of Life Care Planning, Vol. 13, No. 4, (27-33)

2015 Life Care Planning Summit: Moving Forward and Looking Ahead

Cloie B. Johnson, M.Ed.

On September 18, 2015, the 2015 Life Care Planning Summit was held as a pre-conference to the International Symposium for Life Care Planners (ISLCP) conference in Scottsdale, Arizona. This Summit was sponsored by the International Association of Rehabilitation Professionals (IARP) and the Life Care Planning Section/International Academy of Life Care Planners (IALCP). I had the honor of chairing this Summit. My planning committee members were Patty Costantini, Jamie Gamez, and Debbe Marcinko. We also had a plethora of volunteers who were integral to the success of the Summit. On August 19, 2015, a Pre-Summit was held with the Facilitators and Recorders to allow them the opportunity to participate in both sessions and receive training on their duties during the Summit.

Background

The Life Care Planning Summit is a biennial event 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 and standards of practice have been established, consensus and unity in the field is a developmental process. Through Summits, participants have the opportunity to examine life care planning issues, contribute to the resolution of these issues, and be involved in the continued evolution of the field.

Since 2000, over 500 life care planners have taken 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. Life Care Planning Summits have been conducted in 2000, 2002, 2004, 2006, 2008, 2010, 2011 (Canada) and 2012. Consensus and majority statements affecting the practitioner have been published.

Historically, Letters of Endorsement of the Summits and/or Proceedings beginning in 2000 have been received from a multitude of organizations involved with the multidisciplinary specialty practice of Life Care Planning including:

- 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)

Past Summit locations and dates include:

- Dallas, TX – April 12, 2000
- Chicago, IL – May 18-19, 2002
- Atlanta, GA – April 24-25, 2004
- Chicago, IL – May 6-7, 2006
- Los Angeles, CA – May 15-16, 2008
- Atlanta, GA – April 17-18, 2010
- Toronto, ON – June 3-4 , 2011
- Dallas, TX – May 5-6, 2012

Since the last Summit held in Dallas in 2012, Karen Preston took the lead on a task force to review and revise the Standards of Practice with the aid of the community of life care planners. This was completed and published in the *Standards of Practice for Life Care Planners*, Third Edition. Through this process, new topics were identified which were focal to the 2015 Summit.

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 Statements serve as reinforcement for the work of the life care planner. Practitioners are on occasion asked about these statements in the litigation arena. Summit proceedings are developed by life care planners for life care planners about life care planning. Being familiar and aware of these statements is very important. At the 2015 Summit, additional consensus statements were developed.

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.

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 continues to look for more advanced educational opportunities along with ways to be involved in life care plan certification and research.

At the 2015 Summit, the group was assembled in a general session to explain the procedures and make brief opening statements that would serve to help focus attendees on the topics and issues.

Results of the *Life Care Plan Survey 2014: Business Practices and Protocols Survey*, conducted by Ann Neulicht and Susan Riddick-Grisham, with support from IARP, were presented as a precursor to the Best Practices in Business for Life Care Planners. The following are the results:

- A majority of respondents (55.6%) require a retainer before initiating work on a case. Retainer requests range from $500 to $10,000 (average, $2,500).
- Over 87% of respondents indicate that they routinely (greater than 75% of the time) include interview notes/forms and case-generated documents in their file.
- Over 90% of respondents include cost research, written correspondence to/from other professionals, a narrative report, and Life Care Plan in their case file.
- Respondents overwhelmingly bill by the hour (86.6%), although a majority (51.1%) do not charge a different fee for "rush" services (defined as 1 week or less to 12 weeks or less, with an average of 4 weeks or less).
- A range of 10 to 80 hours is reported for Life Care Plan completion (mean of 38.9 hours; median, 40 hours; mode, 50 hours).
- A majority of respondents (61.3%) charge a different rate for court/deposition appearance.
- While a majority of respondents also charge for court/deposition appearance travel (61.3%), a different rate is not charged for travel (79.3%), professional services when retained as a non-testifying consultant (96.5%), research assistance (80.5%), or administrative services (77.4%).
- Contacting the referral source is the most prevalent means for resolving non-payment of bills (58.5%).
- A majority of respondents (64.2%) keep closed case files in both paper and paperless formats, including generated work products (93.6%), interview notes (78%), expert's (own) deposition (59.6%), other expert reports (50.4%), and research notes (70.2%).
- Most of the respondents (40.1%) maintain closed files for 7 years.
- The primary health care-related professions of respondents are Rehabilitation Counseling (40.1%) and Nursing (34.5%).
- The primary certification is a CLCP (73.9%). A majority of respondents (60.6%) are owners of an independent practice with employees/subcontractors (75.8% rely on others to assist with cost research and 50.8% to assist with medical records review). Life Care Planning has been a part of most (58.87%) respondents' practices for 11 to 30 years.
- Respondents have completed 1 to 3,883 Life Care Plans; the mean number of plans completed by respondents is 334 (median/mode: 100).
- At least 144 respondents participated in the survey.

After the general session, numbers were assigned randomly to obtain an integrated mix of experience, training and knowledge. Every attendee rotated through both topic focus groups and participated in discussions on all topics.

The modified nominal group technique was used within each group 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, the 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 with the participants.

A working lunch then was held to include an Ethics Presentation by Dr. Christine Reid. She provided the following for this Summit write-up:

Goals of the working lunch focused on ethics included:

1) learning about developments related to the consensus statement focused on ethics from the last Summit, calling for organizations relevant to life care planning to come together and develop a unified code of ethics for life care planning practice, and

2) discussing (in small groups) ethical dilemmas that Summit participants have encountered in life care planning practice, framing the discussion in terms of the ethical

principles of Autonomy, Beneficence, Fidelity, Justice, and Nonmaleficence.

In the previous (2012) Summit, participants agreed on a consensus statement related to ethical practice in life care planning:

"Life Care Planners recommend the Life Care Planning Professional Associations and Life Care Planning certifying bodies, including but not limited to: IARP, IALCP, AANLCP, ICHCC, and CNLCP, jointly work toward a unified code of ethics for the practice of Life Care Planning." Since that time, there have been some conference calls among leaders of these organizations, but there has not been a commitment to collaborate on a unified code of ethics for life care planners. When committee members revising the Standards of Practice for Life Care Planners (3rd edition) engaged in an empirically-supported process of Standards revision, they determined that it was most appropriate to separate the Standards from the ethical guidelines portion of the previous Standards version, and to defer decisions focused on revisions of the ethical guidelines to a separate committee charged with developing an appropriate code of ethics. IARP has now begun the process of appointing a committee responsible for revising its code of ethics in a manner that could be applicable to all life care planners.

2015 Summit participants reviewed basic ethical principles that serve as the foundation for most professional codes of ethics. Descriptions of the principles of Autonomy, Beneficence, Fidelity, Justice, and Nonmaleficence were reviewed from the CDMS Code of Professional Conduct Preamble (http://www.cdms.org/uploads/files/CDMS_Code_of_Professional_Conduct.pdf) and the CRCC Code of Professional Ethics for Rehabilitation Counselors Preamble http://www.crccertification.com/filebin/pdf/CRCCodeOfEthics.pdf.

Participants reviewed how ethical dilemmas differ from clear ethical violations, because dilemmas have an element of "on the one hand..., but on the other hand . . . " when looking at what would be the "best" ethical decision. Participants then discussed how ethical dilemmas can often be described in terms of conflict between ethical principles. For example, if an evaluee desires one approach to service delivery, but the treating healthcare providers recommend another approach as "best" for this individual, that can be considered a conflict between the client's Autonomy (making one's own choices) and the healthcare providers' desire for Beneficence (what is likely to be "best" for the evaluee). Discussing the ethical principles related to an ethical dilemma can be a useful tool in ethical consultation.

Organizations and associations involved with life care planning were invited to present to the attendees. They provided a brief synopsis of their presentation for the purposes of these proceedings.

2015 Summit Remarks by Victoria Powell on behalf of the AANLCP

1. AANLCP is in the process of publishing our scope and standards of practice. Purchase of the nearly 300 page books will be available in January 2016.

2. AANLCP will hold its annual conference in San Antonio at the Hilton Palacio del Rio on February 5-8, 2016 (pre-conferences are on the 4th). The annual conference dates will be flexible, but the conference has officially moved from fall to late winter/early spring. The theme for this next conference is Blazin' the Trail: Addressing Sensory Disorders Across the Ages. Presentations will include topics such as cochlear implants, visual disturbances, Language Acquisition through Motor Planning, sexual dysfunction, the ACA, service animals, CRPS, and much more.

3. Our membership offerings have changed and we now offer tiered memberships which allow members to pick and choose from the benefits they most value. The membership levels are Basic, Deluxe, and Premier. Each tier includes different products, services, and discounts.

4. Membership is open to nurses as well as non-nurses. Non-nurses are encouraged to join as associate members. Associate members are now offered the option to select tiered memberships in order to take advantage of our purchasing power resulting in greater member discounts.

5. Member benefits now include coding and costing resources and more. EBSCO Nursing Reference Center, Find-A-Code, ASA Crosswalk, ODG, Medical Fees are offered as well as discounts to PMIC, AHD, and Word Rake. NANDA discounts are in the works.

6. We also offer a resource repository called Crash Cart. This platform allows members to search various topics to find forms, templates, letters, websites, databases, costing spreadsheets, and other useful information.

7. We have a mentorship program called Lifeline. This is free to our members and works to pair members together for mentoring in both situational and ongoing needs. Lifeline includes mentorship for business-related topics as well as life care planning practice-related topics.

8. AANLCP is now working at the policy level. We have joined National Quality Forums which is a non-profit, nonpartisan organization, whose members work to improve healthcare in both public and private sectors by developing consensus statements and convening various stakeholders to spur action and improvement.

9. AANLCP is also a member of the Nursing Organizations Alliance. This partnership allows us to identify, educate and collaborate with other nursing organizations to build on issues of common interest in order to advance the nursing profession. The focus is to address current and emerging nursing and health care issues.

10. The Journal of Nurse Life Care Planners has gotten a new facelift and layout. It is currently being indexed and full text articles are available on our website.

11. Our Core Curriculum is undergoing a revision. Lori

Dickson is the editor for the second edition. Expected publication date is late 2017/early 2018.

12. AANLCP offers several webinar educational series. We have a potpourri of topics available in our monthly #WebinarWednesday series. We also launched our Mastermind series this year which consists of four-week courses each made up of a webinar, weekly discussion groups, and an exam. Mastermind covers a variety of business-related topics such as strategic planning, financial health, marketing, testimony, subcontracting, report writing, and more. Mastermind 2016 will begin in February.

2015 Summit Remarks by Jan Roughan from the CNLCP

American Association of Nurse Life Care Planners (AANLCP) was founded in 1997.

The Association established the Certified Nurse Life Care Planning (CNLCP®) Certification Board as a separate non-profit entity in 2008.

The Certification Board develops criteria for, and oversees specialty nursing certification within the practice of nurse life care planning.

The Board, in an effort to be inclusive, has created several "pathways" to afford nurses practicing within the field of life care planning the opportunity to obtain specialty certification.

Of particular relevance to those nurses who already have their CLCP is a "reciprocity" pathway that allows an individual to apply for, and obtain the CNLCP®, without having to sit for the exam. The reciprocity criteria, along with the criteria for other expanded pathways that were created recently by the CNLCP® Certification Board, is contained in the CNLCP® Handbook published on AANLCP's website.

Two of the many goals of the CNLCP® Certification Board are:

- *establishment of a level of professionalism in life care planning that is backed by evidence-based determination of the treatment needs of the individual affected by illness/injury*
- *securing accreditation by the American Board of Nursing Specialties (ABNS), thereby recognizing nurse life care planning as an advanced practice within the nursing profession*

2015 Summit Remarks by Susan Grisham from the FLCPR

The Foundation for Life Care Planning Research was established in 2002 as a nonprofit research group, with a primary focus on research on the reliability and validity of the Life Care Planning process. Although that remains an important consideration for the Foundation, the Board has broadened the scope of the mission to consider any well-developed research design in Life Care Planning that advances the field and makes a significant contribution to the population of disabled individuals Life Care Planners seek to serve.

Publications are supported by research grant funding from FLCPR. The most recent research grant was awarded to Noel Ysasi, Ph.D., in 2014. His research involved the empirical analysis of 123 Physiatrists and 120 Life Care Planners (LCPs) regarding their professional opinions as to the prevalence and frequency of secondary complications (SCs) among persons with spinal cord injuries. Opinions were then compared with the empirical literature. Participants described how decisions were made and whether to include the costs of future SCs or not based on the possibility (less than 50%) versus probability (greater than 51%) of such complications occurring. Furthermore, this researcher surveyed both groups to assess for potential ethical concerns among persons operating as a LCP (provides expert testimony). This study was intended to provide LCPs with a guide as to whether or not particular SCs should be included within the life care plan, while gathering additional support from physiatrists as to whether the inclusion of a cost should be added for specific SCs. Publications will be forthcoming.

2015 Summit Remarks by Patricia Costantini from the IALCP

Patty Costantini, Life Care Planning Section – IALCP (International Academy of Life Care Planners) Past Chair, provided an update on IALCP's activities, which have included the items listed below.

- *The Journal of Life Care Planning was revived in 2015 under the leadership of Editor Dianne Simmons Grab. JLCP is on course to publish four issues by the end of the year.*
- *IALCP convened a meeting of life care planning industry leaders, which was held earlier that day (9/18/15). In attendance were representatives and staff from IALCP and IARP, the Foundation for Life Care Planning Research, the American Association of Nurse Life Care Planners (AANLCP), and the International Commission on Health Care Certification (ICHCC). The industry leaders agreed to identify common goals and interests and to continue to meet (preferably at life care planning conferences) intermittently to maintain open communication and collegiality.*
- *IALCP members have participated in IARP's educational endeavors by providing webinars relevant to life care planning practice. Additional webinars will be available in upcoming months.*
- *IALCP section is excited and well prepared to assist in the transition of the ISLCP (International Symposium for Life Care Planning) from the FLCPR to IARP. Current IALCP Chair, Debbe Marcinko, will be Co-Chair of the 2016 IARP conference, to be held in Pittsburgh, Pennsylvania.*
- *The IALCP board of directors continues to direct its efforts on updating and streamlining its strategic plan. Goals are focused on the overall advancement of the*

practice of life care planning.

2015 Summit Remarks by Evelyn Robert from the ICHCC

We submitted the application for accreditation and will know something by the end of the year and that we were very optimistic. The other announcement was that effective January 2016 the exam will be a two-prong exam which will include a life care plan written and based on a sample provided by the commission and the multiple choice exam.

Robert May also spoke. He went more into the accreditation and his thanks to Dr. Reid for all of her help with the application process.

2015 Summit Remarks by IARP Chief Staff Officer

IARP Executive Director Carl Wangman addressed the opening session of the 2015 Summit by quipping any association executive would welcome the opportunity to address more than 80% of the members of his or her association.

He paid tribute to the leadership of the Foundation for Life Planning Research Board and its decision to refocus on vitally needed original research for the community. He said IARP and its staff look forward to the opportunity to bring together the highly rated symposium and IARP annual meeting. The first joint meeting for the two organizations will be held in Pittsburgh, Pennsylvania, October 20-23, 2016. Evidence of the importance of life care planners to the Pittsburgh event is the choice of Debbe Marcinko, the current chair of the IARP Life Care Planning IALCP section, as the co-chair of the combined venture. The other chair is veteran IARP member Steve Shedlin, a past president of the international organization.

Mr. Wangman emphasized IARP's focus on the development of its ever-increasing student membership. There are currently over 700 student members in North America. He admitted a mistake had been made when the IARP staff and board assumed that graduates would shortly be employed after receiving their master's degree. He said the original steppingstone to professional individual members in the association is called professional candidate. The initial thinking was that professional candidate status would be available for one year. Now, the IARP board has determined a minimum of two years is more logical for a student to graduate, seek a job, and be employed. After the two-year period, the student is more likely to qualify as a regular member of the association. All students will be contacted with this new longer probationary period.

Another major change in IARP is this focus on the total career opportunities that exist for association members. Before July 1 of this year, members who were interested in more than one of the special interest sections were required to pay additional dues. As of July 1, all sections are now available to all members, with the only exception being that members of the Social Security Vocational Experts section must have a blanket purchase agreement number from the Social Security Administration as a prerequisite of their membership in that section. He said the association would create a separate discussion group for those interested in SSVE work, but have not yet received training.

IARP continues its outreach to new service areas. The new Vocational Rehabilitation Transition Services Section is an outgrowth of a special program conducted last spring as a part of the IARP Advanced Training Series. Highlighting federal action opening new practice opportunities, the pioneer IARP program conducted in Chicago over two and a half days featured Jim Boyd, Judy Drew, and Liz Watson as the faculty. The 40 attendees extolled the virtues of the program, and a companion discussion group for the attendees has been effective for the last six months. Liz Watson, who has been selected to the IARP Board of Directors to represent the new Vocational Rehabilitation Transition Services Section, will shortly establish a discussion group and outline of the objectives of the section.

The IARP executive also paid special tribute to Heidi Fawber, Patty Costantini, and Debbe Marcinko for their aggressive promotion of the Pittsburgh venue. He also saluted Susan Riddick-Grisham and her program committee for program excellence of the Symposium. He promised that IARP, in its management role for the 2016 event, would ensure the quality of the Symposium is maintained at its current high level.

After the working lunch with presentations on Ethics, and by the various organizations and associations affiliated with life care planning, attendees were re-assembled into one large group and the breakout group results were presented and summarized. Overall, a significant amount of consensus was reached on multiple topics. In other areas, there was a majority view. The entire group then participated in exploring whether or not these statements were in fact a Majority or Consensus view. Interestingly enough, despite great efforts by the facilitators and volunteers to identify and avoid already established majority and consensus statements, and/or already established Standards of Practice, some statements were found to be duplicative and therefore were rejected due to their redundancy.

Following the Summit, a draft of the proceedings was sent to all attendees. Corrections and clarification were obtained from the participants and incorporated as appropriate into these proceedings. 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.

Best Practices for Business and Best Practices for Transparency were the main topics for the 2015 Summit. This one-day Summit was a full day with a working lunch, including an Ethics Presentation by Dr. Christine Reid, followed by updates from the IALCP, Foundation of Life Care Planning Research (FLCPR), American Association of Nurse Life Care Planners (AANLCP), Certified Nurse Life

Care Planners (CNLCP) Certification Board, and the International Commission on Health Care Certification (ICHCC).

Topics discussed in the breakout sessions were: Best Practice in Business of Life Care Planners and Best Practice in Transparency for Life Care Planners.

Consensus Statements from the 2015 Life Care Planning Summit to be added to the prior 99 Consensus and Majority Statements from earlier Summits include:

100. Life Care Planners have the option to use support staff under their direction and guidance in completing life care plans.

101. Life Care Planners shall identify conflicts of interest.

102. Life Care Planners shall identify the sources of their recommendations.

The attendees were an integral part in the development and outcome for the field. Attendees are listed below:

Michele Albers
Dorajane Apuna
Mary Barros-Bailey
Debbie Berens
Harold Bialsky
Santo Steven Bifulco
Stephanie Birely
Marianne Boeing
Nancy Bond
Giovanna Boniface (Recorder)
Penelope Carragone
Anthony Choppa (Facilitator)
Nick Choppa
Lisa Clapp (Facilitator)
Michelle Clarence
Maryanne Cline
Denise Colingnon
Mariann Cosby
Patricia Costantini
Brian Daly
Kelly Dawson
Heidi Fawber
Brook Feerick (Recorder)
Nancy Forest
John Fountaine* (Recorder)
Cynthia Fricke
Jamie Gamez* (Recorder)
Reg Gibbs (Facilitator)
Shelene Giles (Recorder)
Bob Gisclair
Cathy Gragg
Gary Michael Graham
Cathy Gross
Susan Guth
Janice Haris
Camie Hawkins
Lois Hawkins
Stacey Helvin
Carolyn Higdon
Shanna Huber
Carol Hyland
Harvey Jacobs
Vicky Jensen (Recorder)
Amy Johnson Mackenzie
Alex Karras
Elizabeth Kattman
Anita Kelly
Charles Kincaid
Trudy Koslow (Recorder)
Susan LaFollette
Stony Landry
Joanne Latham
Sherry Latham* (Recorder)
Dirk Leverant
Ashley Literski
Paul Lukasik
Lisa Mancuso
Ann Maniha
Stephen Mann
Debbie Marcinko
Irmo Marini
Michael Martinez
Francine Mazone
Hector Miranda
Nancy Mitchell
Ann Neulicht
Michele Nielsen
Jodie Nolf
Erin O'Callaghan
Judith Parker (Recorder)
Gerri Pennachio
Regina Pepin
Kellie Poliseno
Victoria Powell
Karen Preston (Facilitator)
Edmond Provder
Christine Reid
Rhonda Renteria
Mary Sue Richards
Susan Riddick-Grisham
Evelyn Robert
Mary Rohrig
Jan Roughan
Anne Savage Veh* (Recorder)
Carla Seyler (Recorder)
Lisa Simeoni
Dianne Simmons Grab
Ron Smolarski
Geri Springston
Diane Steffy
Linda Stempel

Larry Stokes
Robert Taylor
Wendy Thomason
Karen Tobie Shearer
Kacy Turner
Carol Upman
Liz Vinton
Hope Wade
Heidee White
Lora White
Candace Winter
Daniel Wolstain
Helen Woodard
Laura Woodard
Steven Yuhas
Nancy Zangmeister

*Participated in Pre-Summit process which was included in general discussion.

About the Author

Cloie B. Johnson, M.Ed., is a Rehabilitation Counselor and Case Manager providing life care planning service at OSC Vocational Systems, Inc. in Bothell, Washington. Cloie has chaired or co-chaired the Summits in 2010, 2011, 2012 and 2015. She is also a past Chair of the IALCP.

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Consensus and Majority Statements Derived from Life Care Planning Summits Held in 2000, 2002, 2004, 2006, 2008, 2010, 2012 and 2015

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The following statements were created by Life Care Planners at various Summits between 2000 and 2015, and are relevant and applicable to all life care planners:

1. 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.

2. Life Care Planners shall seek out mentor relationships, educating students and unaffiliated professionals about life care planning training, education, experience, special knowledge and required credentials.

3. Life Care Planners shall disseminate information regarding their area of practice through electronic collaboration, Web sites, peer-reviewed journals, books, conferences and symposia and professional associations.

4. Life Care Planning research shall be reviewed by peers through an objective and "blind" process that addresses methodology.

5. Life Care Planners shall understand the definition of reliability and consistently practice in such a manner.

6. Life Care Planners shall explore markets for life care planning outside litigation.

7. Life Care Planners shall have knowledge of relevant laws and regulations as well as local and national care standards.

8. Life Care Planners shall understand optimal outcomes achievable for particular injuries.

9. 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.

10. Life Care Planners shall complete 120 hours of training including courses that focus on disability issues and is specific to life care planning.

11. Life Care Planning programs shall be based on the latest knowledge and practices.

12. Life Care Planning programs shall cover certification-preparation as well as advanced topics and complex issues.

13. Life Care Planning programs shall be promoted widely.

14. Life Care Planning programs shall be offered in accessible geographic locations and electronically.

15. Life Care Planning continuing education units shall be available at an increasing number of forums.

16. Life Care Planning continuing education units shall be available at forums that may not focus solely on life care planning.

17. Life Care Planners shall train themselves and recruit others to instruct educational programs.

18. Life Care Planner certification shall render its holder a qualified life care planner, provided that certification is maintained.

19. Life Care Planner certification shall be renewed every five years with the accumulation of 60 continuing education units.

20. Life Care Planners shall be licensed and/or certified in their professional discipline before being certified as a life care planner.

21. Life Care Planner certification standards shall be augmented.

22. The International Commission on Health Care Certification shall apply for National Commission for Certifying Agencies accreditation.

23. Life Care Planners shall hold a certification that has mechanism for complaints and resolution.

24. Life Care Planning certification shall flow from a

practitioner-created core curriculum.

25. The Life Care Planning certifying body shall not be proprietary.

26. The Life Care Planning certifying body shall manage and disclose ethical complaints and violations.

27. Life Care Planning certification exams shall be developed and maintained by an advisory group.

28. Life Care Planning certification exams shall be administered by an autonomous entity independent of any organization that provides life care planning training and/or education.

29. Standards of Practice terminology shall be reviewed.

30. Standards of Practice terminology shall be defined.

31. Standards of Practice shall delineate educational requirements for entry into the practice of life care planning.

32. Standards of Practice shall assert the role and accountability of life care planners.

33. Standards of Practice shall be based on a study defining the role and accountability of life care planners.

34. Standards of Practice shall allow for individual judgment and expertise.

35. Standards of Practice shall be utilized in the development of the practice of life care planning.

36. Standards of Practice shall be applicable to current practices.

37. Life Care Planners shall accept referrals only in their area of expertise.

38. Life Care Planners shall draft life care plans under supervision for one year.

39. Life Care Planners shall maintain objectivity.

40. Life Care Planners shall maintain strict adherence to confidentiality practices.

41. Life Care Planners shall renounce inappropriate, distorted or untrue comments about peers.

42. Life Care Planners shall renounce inappropriate processes and training.

43. Life Care Planners shall disclose and differentiate between the roles in which they may be called upon to act.

44. Life Care Planners shall avoid dual relationships when objectivity may be challenged.

45. Life Care Planners shall better define dual relationships.

46. Life Care Planners shall establish themselves within their primary field of practice.

47. Life Care Planners shall objectively place their client's interests before any personal or professional consideration.

48. Life Care Planners shall adhere to relevant Codes of Ethics.

49. Life Care Planners shall have access to recourse/corrective action process for Ethical violations.

50. Life Care Plans shall be individualized.

51. Life Care Plans shall be objective and consistent.

52. Life Care Plans shall be lifelong and flexible.

53. Life Care Plans shall be a clear, concise and user-friendly document.

54. Life Care Plans shall be comprehensive and based on multidisciplinary data.

55. Life Care Plans shall utilize research for recommendations.

56. Life Care Planners shall consider the integrity of data.

57. Life Care Planning shall depend on data collection, analysis and synthesis.

58. Life Care Planners may request additional data, testing and evaluation if required.

59. Life Care Planners shall research condition, resources, services and costs.

60. Life Care Plans shall utilize established procedures.

61. Life Care Planning procedures shall be peer or organizationally reviewed.

62. Life Care Plans shall be developed in the client's best

interest.

63. Life Care Plans shall include a basis for recommendations.

64. Life Care Planners shall utilize a reliable, consistent method for reaching conclusions.

65. Life Care Planners shall utilize adequate medical and other data for opinions.

66. Life Care Plans shall include an annotated list of requested and reviewed data/sources.

67. Life Care Planners shall utilize standardized procedures and tools for gathering and reporting information.

68. Life Care Plans shall feature standardized forms and formats.

69. Life Care Plans shall be consistent across similar cases.

70. Life Care Plans shall rely on medical/allied health professional opinions.

71. Life Care Plans shall be limited to the planner's expertise and scope of practice.

72. Life Care Planners shall methodically handle divergent opinions.

73. Life Care Planners shall properly inject personal expertise.

74. Life Care Planners shall utilize credible, evidence-based guidelines.

75. Life Care Planners shall conduct an in-person interview whenever permitted.

76. Life Care Planners shall utilize protocols for cost research.

77. Life Care Planners shall gather geographically relevant & representative prices.

78. Life Care Planners shall utilize protocols for using local versus national resources.

79. Life Care Planners shall follow generally accepted methodology.

80. Differences in clinical judgment can result in different recommendations.

81. Life Care Planning databases, templates and software shall have appropriate foundation.

82. Life Care Planning products and processes shall be transparent and consistent.

83. Life Care Planners shall be involved in research.

84. Life Care Planners shall include research in life care plans.

85. Life Care Planners shall study the reliability, validity and accuracy of life care plans.

86. Life Care Planners shall assess the reliability, validity and accuracy of data and methods.

87. Life Care Planners shall conduct longitudinal studies.

88. Life Care Planners shall evaluate the cost-effectiveness of life care plans.

89. Life Care Planners shall study the impact of life care plans upon quality-of-life.

90. Life Care Planners shall understand and explain research used in a life care plan.

91. Life Care Planners shall utilize research that is reasonable, relevant and appropriate.

92. Life Care Planners may independently make recommendations for care items/services that are within their scope of practice.

93. 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.

94. When the life care planner includes home care, both private-hire and agency-procured services are options to be considered.

95. The cost of private-hire home care includes care giver compensation and associated expenses.

96. Life Care Planners shall consider the impact of aging.

97. Review of evidence-based research, review of clinical practice guidelines, medical records, medical and multidisciplinary consultation, and evaluation/assessment of evaluee/family are recognized as best practice sources that provide foundation in Life Care Plans.

98. Best practices for identifying costs in Life Care Plans include:

- Verifiable data from appropriately referenced sources
- Costs identified are geographically specific when appropriate and available
- Non-discounted/market rate prices
- More than one cost estimate, when appropriate

99. Life Care Planners will define terminology of our work product(s).

100. Life Care Planners have the option to use support staff under their direction and guidance in completing life care plans.

101. Life Care Planners shall identify conflicts of interest.

102. Life Care Planners shall identify the sources of their recommendations.

References

Johnson, C. (at press) 2015 Life Care Planning Summit: Moving forward and looking ahead, *Journal of Life Care Planning*, *13*(4), 27-33.

Preston, K., & Johnson, C. (2012). Consensus and majority statements derived from Life Care Planning Summits held in 2000, 2002, 2004, 2006, 2008, 2010 and 2012. *Journal of Life Care Planning, 11*(2), 9-14.

About the Author

Cloie B. Johnson, M.Ed., is a Rehabilitation Counselor and Case Manager providing life care planning service at OSC Vocational Systems, Inc. in Bothell, Washington. Cloie has chaired or co-chaired the Summits in 2010, 2011, 2012 and 2015. She is also a past Chair of the IALCP.