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Life Care Planning Report Writing Foundations, Standards, Methods, and Ethics: Development of a Checklist

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Abstract

For about two decades, life care planning practice literature has broached the idea of developing report-writing guidelines. The literature implies that resistance to such guidelines derive from a perception that they could impede a life care planner's report design, organization, or content. As clinical practice guidelines provide leeway to the individualized need of a case so, too, can life care planning report-writing guidelines allow for individualized styles within professional frameworks. This article rests upon a content review of all available report-writing literature in life care planning and introduces a checklist to serve as a tool for new and veteran life care planners, as well as life care planning educators or trainers. Therefore, the checklist is not intended to be an end-all, be-all. Life care planners must understand the jurisdictions or countries in which they practice, individualized needs of those whom they evaluate, and their own styles to tailor the Life Care Plan (LCP) Report Checklist© and author their reports accordingly. It is predicted that, over time, this first attempt to provide a tool for report-writing may evolve along with the practice of life care planning itself.

Keywords: Life Care Planning, Report Writing Foundations, Report Writing Standards, Report Writing Methods, Report Writing Ethics, Professional Report Writing, Forensic Report Writing

The Function of the Report in Life Care Planning

Miller (2008) states that the life care plan report "… identifies the client's medical, rehabilitation[,] and social needs and provides a current dollar amount to each of the recommended goods and services" (p. 21). Miller adds, "The foundation and rationale for the service needs to be detailed as well as the costs and availability of services specific to the client's geographic location should be included in the report" (p. 21). From an attorney's perspective, Fick (2003) states, "The Life Care Plan must follow the process published and accepted in peer review journals, describing information regarding recommendations, purpose, frequency, and cost" (p. 165). The Weed and Grisham *Step-by-Step Procedures for Life Care Planning* (as published in Weed, 2018, p. 17) is one such process. All these references to what should go into a life care plan report seem straightforward. Yet, a review of the life care planning literature finds no focused discussion on the guidelines for report writing.

The Purpose of a Report in Life Care Planning

The purpose and function of the life care planning report is to be the transparent descriptive and summative presentation of qualitative and quantitative primary and secondary evidence in a case (Barros-Bailey, 2018). While it is possible that there may have been a presentation or two on this subject that did not reach print in the general literature of the specialty, this article appears to be the first in the life care planning literature that explores the foundation, standards, methods, and ethics of life care planning reporting and introduces a checklist guiding life care planners towards accomplishing the specialty's expectations. While procedural checklists (e.g., Weed & Grisham) exist in the field that help guide life care planners as to the steps to consider in developing a life care plan, these are different than a report-writing guideline that subsume what was done in the life care planning process and how to communicate it in a transparent manner. Procedural checklists ***direct*** what and how to do something. Writing guidelines help clearly ***tell*** what and how it was done in a manner an audience can access the information. The LCP Report Checklist© tool introduced in this article adds to the existing literature because it combines, categorizes, and sequences the literature in the field, common checklists, consensus statements, role and function studies, standards, and surveys of best practices.

Foundations, Standards, and Methods

A foundation is "a basis (such as a tenet, principle, or axiom) upon which something stands …" ("Foundation," n.d.). Upon it rests standards that are defined as "something established by authority, custom, and/or general consent as a model or example" ("Standard," n.d.). And, how one delivers upon the standards that rest on foundations are methods that are further defined as an "orderly arrangement, development, or classification" ("Method," n.d.). Now, we will cover the background in life care planning that resulted in the tenets inherent to reporting the convergence of various data results, and the consequent findings, conclusions, and opinions.

Foundations: Life Care Planning Summits

Historically, there has been a long-standing desire for life care plan reporting guidelines. Two decades ago, leaders in the field as well as institutions representing life care planners gathered to start developing specialty-wide statements of consensus to guide practice though biannual meetings that came to be known as life care planning

summits. As early as the first life care planning summits held in the United States in 2000 and 2002, professionals called for broad agreement on reports, their contents, and "continuing education focused on report writing" (Riddick-Grisham, 2018a, p. 78). In 2004, some life care planners called for the identification of report formats, although this was a minority opinion and not formally adopted in the consensus statements (Deutsch et al., 2004). By 2006, summit discussions focused on the autonomy of the life care planner in deciding what format, organization, and design to choose (Riddick-Grisham, 2018b). A few years later, the first Canadian life care planning summit included consideration of reports and their contents as part of the basic tenets and procedures for completing life care plans (Johnson, et al., 2011). Neither in the United States nor in Canada, however, did the introduced topics on report-writing rise to the level of consensus statements. By 2018, there was majority acceptance for the following revised statement, "Life care planners shall utilize standardized procedures and tools for gathering and reporting information and feature standardized forms and formats" (Johnson et al., 2018, p. 7). Thus, in nearly two decades of LCP summits trying to reach specialty-wide consensus on reports, no specific guidelines arose to define basic foundations, standards, or methods of reporting. While report writing rose as an area of consideration at various times in life care planning summit process recognizing it as a valuable area of practice, until now there was no action to provide report guidelines.

Other than in summit proceedings, in 2002 grant research funds were provided by the organization now known as the International Commission of Health Care Certification (ICHCC), for a doctoral student to study and establish report-writing standards for life care planning reports (May, 2002). The ICHCC held "that life care planner credibility and competency are judged through the final product: *the report*" (May, 2002, p. 210). The results of the funded research are unknown, and not found in the life care planning or academic literature or through an all-database search of EBSCO and Google Scholar.

Standards of Practice and Methods

Life care planning standards suggest the importance of the final product of a life care planning evaluation, the report, but do not supply specific guidelines. McCollom (2005) reported on the revision of the initial *Standards of Practice for Life Care Planners* originally developed in 2001 stating that the life care planner was to follow "a consistent method of organizing data, creating a narrative Life Care Plan report[,] and cost projections" (p. 71). Similarly, measurement criteria for the standard of whether the life care planner uses a planning process in the current *Standards of Practice for Life Care Planners* (International Academy of Life Care Planners [IALCP], 2015) states, "the life care planner 'Follows a consistent method for organizing data, creating a narrative life care plan report, and projected costs' and 'Develops and uses written documentation tools for reports and cost projections'" (IALCP, 2015, p. 9). Likewise, the *Standards of Practice for Life Care Planners* (IALCP, 2015) set the measurement criteria on the assessment process by noting that any potential gap in the data needed for an assessment, such as inability to interview the evaluee or missing records, should be noted in the report.

Finally, role and function studies performed in life care planning (American Association of Nurse Life Care Planners [AANLCP], 2015c; ICHCC, 2018; Pomeranz et al., 2010) name several factors and subfactors associated with report-writing. In 2010, Pomeranz et al. posited considerations such as the assignment of needs and services for best outcomes to charts and the narrative report and correlating headings on the narrative report with charts. The Certified Nurse Life Care Planner (CNLCP) organization noted content areas to be included in the report (e.g., projected evaluations, medical providers, medical and nursing diagnoses, recommendations, costs) as well as format (e.g., tables, narrative, resources/bibliography (AANLCP, 2015a). The most recent professional job analysis in the profession by ICHCC (2018) provides the greatest detail on report writing to date. Subfactor 4 (Report Writing) within Factor 1 (Care Plan Development) of the study makes up 27 functions that fall into pre-report (e.g., timekeeping), report (e.g., calculations), and post-report (e.g., billing) phases. Factor 6 (Marketing), Subfactor 1 (Report Writing), Factor 8 (Data Collection), Factor 9 (Report Preparation), and Factor 12 (Report Writing) specify report contents.

For new entrants into the field, the literature states that life care planning training should include "elements of life care plan development and report writing …" (Riddick-Grisham, 2018a, p. 58). For experienced life care planners, the AANLCP (2015c) *Standards of Practice* provide guidance in Standard 14 when it suggests that practitioners perform self-evaluations and act to achieve resulting goals, such as revising report formats. Yet, there is still no comprehensive collection of guidelines to support such report writing training to new entrants to the field of life care planning or others who have many years of practice who are re-examining their report-writing practice.

Ethics

The ICHCC's *Code of Professional Ethics* (2015) was found to be the only ethical code in the specialty that addresses report writing in Principles 3, 4, and 7. The Rules for these Principles are summarized below as:

- R.3.1: … ICHCC [C]ertificants shall further use [their] specialized knowledge and skills to do no harm to the "disabled" [sic] individual with regards to the summary and conclusions of reporting, regardless of the referral source (p. 30).
- R.4.1: ICHCC Certificants shall ensure that there is a mutual understanding of the evaluation report by all parties involved.

- R.4.2: ICHCC Certificants shall collaborate as a team with allied professionals in formulating reports when applicable.
- R.4.3: ICHCC Certificants shall not commit the recipient of the case to any prescribed course(s) of action which [sic] may be specified in the report.
- R.4.4: ICHCC Certificants shall obtain from other professionals essential medical records and evaluations for report development or evaluating function and impairment (p. 31).
- R.7.3: ICHCC Certificants shall administer tests under the same conditions established in their standardization. Any modifications to standardized testing protocol must be documented in report (p. 33).

Whether procedural or methodological, these rules define the ethical approach of credentialed life care planners towards reporting and assume behaviors in the reporting process that were considered in the development of the LCP Report Checklist©.

Life Care Planning Report = Narrative + Tables/Charts

Is the life care plan report mostly narrative descriptions or a series of items totaled in a tabular or chart format? Based on guidelines for writing about quantitative and quantitative information to make it most transparent to the reader, the report should have a blend of both. This balance is supported in the life care planning literature (IALCP, 2015; McCollom, 2005). As part of the proceedings for the 2006 Summit, Riddick-Grisham (2018b) states,

> … 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 recommendations, annual costs, and lifetime totals. (p. 100)

A list for the review of a life care plan resulting for that summit has as its first item, "Did narrative report accompany LCP?" (Riddick-Grisham, 2018b, p. 128) with the last item stating, "Consistency between narrative report, records[,] and plan entries" (Riddick-Grisham, 2018b, p. 129). These report-writing expectations align with the mainstream literature for all disciplines of how to represent information that is both qualitative and quantitative, as is the case in a life care plan evaluation.

The Publication Manual of the American Psychological Association (7th ed.) ([APA7], 2020) identifies the difference and importance of each type of data in report writing. APA7 notes there are seven types of writings (annotated bibliographies, cause-and-effect, comparative, expository, narrative, persuasive, précis, and response/reaction). Life care planners may be exposed to cause and effect reports by forensic experts like accident reconstructionists who may be hired for the liability end of a case; however, it is not very common that a life care planner may write a cause-and-effect report. For life care planners serving as expert witnesses where ethical and legal standards call for objectivity, expository or persuasive reports are not supported. Rather, narrative reports that "convey a story from a clear point of view and include a beginning, middle, and end … [and] should have a clearly defined purpose and focus and include concise, evocative language" (p. 10) predominate. Complementing the narrative report, APA7 promotes the use of tables "to present a large amount of information efficiently and to make their data more comprehensive. Tables usually show numerical values … or textual information … arranged in an orderly display of columns and rows … to facilitate readers' understanding of the work …" (p. 195).

In short, a life care plan report without a narrative is like reading *Moby Dick* (Melville, 1851) through a series of tables or charts that summarize how many crew members died, over what duration Ahab was obsessed with the whale, and how frequently he pursued the whale. There is a lot depth and understanding that is missing from the story that brings it to life through the eyes of the author. Likewise, to read a life care plan only through a narrative section without charts is dense; it can be confusing and tedious as it becomes exceedingly difficult to understand how items sum up into totals individually or in sections. Tables and charts "make it much easier to understand … data under analysis and to promote accurate communication" (Duquia et al., 2014, p. 280). Because information collected in life care plans is descriptive and numerical, both ways of summarizing that type of data in a report format is necessary for the intended audience to easily understand it.

Life care plans have both kinds of observation (narrative) and summarized (tabular) data appropriate for each section in a report. Meta-analytical review of each type of data found that neither narrative nor tabular sections trumps the other, and both can be vital depending on the audience (Reinhart, 2006). Isom and Marini (2003) summarize the best presentation of both forms of communication when they state, "While the cost of services and items in the rehabilitation plan is often found in the life care plan tables, the foundation and rationale and support for the proposed rehabilitation plan is in the narrative report rather than in the tables" (p. 242). David Ball, a trial consultant, recommended that "for each item or category of items on your list, in your report you show why it is needed, what happens in terms of care, safety, comfort particularly the safety and well-being of the client [sic]" (p. 12).

In practice, in the second survey of life care planning practices (Neulicht, et al., 2010), the majority of respondents included data in their reports that can easily be identified as being narrative or tabular in scope, or sometimes both (Table 1):

Table 1

Neulicht, et al. (2010) List of Areas Included in Reports by Majority of Life Care Planners

Classified by Narrative and Tabular Types

Item	Narrative	Tabular
Beginning/Ending Dates for Items/Services		√
Daily Routine/Schedule	√	
Date of First Contact	√	√
Date of Life Care Plan (LCP)	√	√
Durable Medical Equipment List		√
Evaluations Requested	√	√
Frequency/Replacement Schedules		√
Functional Abilities	√	
LCP Tables/Charts Including Beginning/Ending Dates for Items/Services		√
Location of Interview	√	
Medical Diagnoses	√	
Medical Summary/Chronology	√	
Medication Regimen	√	√
Narrative Report	√	
Other Records Requested	√	
Providers/Professional Consulted	√	
Psychosocial/Psychiatric Diagnosis	√	
Rational/Purpose for Recommendations	√	√
Reason for Referral	√	
Recommendations for Source		√
Records Received/Reviewed	√	
Referral Source	√	
Social/Environmental Profile	√	
Summary of Total Costs (Annual and/or Lifetime)		√
Supply Consumption		√
Vendor List		√
Vocational/Educational Profile	√	

Neulicht et al. (2010) reported that the items that were not typically included in reports were "a bibliography, clinical practice guidelines, collateral sources, date of referral, financial profile, nursing diagnosis, pictures, [and] research articles" (p. 148). Both the 2015 CNLCP content areas and the 2018 ICHCC role and function study note that a function of the work of a life care planner involves including a bibliography in the written report. The updated literature in life care planning, along with calls for evidence-based life care planning practice, and the advent of easier forms of photography through smartphone technology since the 2009 survey, suggest there may be significantly higher number of life care planners now including bibliographies, clinical practice guidelines, pictures, and research articles in their reports.

The Life Care Plan (LCP) Report Checklist©

Heeding the calls in life care planning practice for life care plan reporting guidelines, the author performed a content analysis of available literature on report writing and developed a checklist including all recommendations (Isom & Marini, 2003; Riddick-Grisham & Deming, 2011; Weed & Berens, 2018), ethical standards (AANLCP, 2015b; American Academy of Physician Life Care Planners, 2015; IALCP, 2015; ICHCC, 2015), best practice surveys (Neulicht, et al., 2010), role and function studies and content areas (CNLCP, 2015; ICHCC, 2018; Pomeranz et al., 2010), professionals standards (AANLCP, 2015c; IALCP, 2015), and summits (Deutsch et al., 2004; Johnson et al., 2011; Riddick-Grisham, 2018a, 2018b). See Table 2. As outlined in the ICHCC (2018), the LCP Report Checklist© has three major phases – pre-report, report, and post-report – each detailed here.

Table 2

Life Care Plan (LCP) Report Checklist© (Barros-Bailey, 2020)

	✓
PRE-REPORT	
Determine report format, contents, and style based on standard practices and regulations (Content areas, charts, appendices, guidelines on reporting on people with disabilities, style for cites/references, etc.)	
REPORT	
I. IDENTIFYING INFORMATION	
A. LIFE CARE PLANNER	
Name	
Company	
Contact Information	
Credentials	
B. EVALUEE	
Name	
Date of Birth	
Date of Incident/Loss	
Location/Address	
C. CASE	
Date of Life Care Plan	
Referral Source	
Name/Jurisdiction	
II. INTRODUCTION AND HISTORY	
A. CASE	
Purpose (e.g., life care plan evaluation and recommendations, peer-review/rebuttal of a life care plan)	
Date of First Contact	
Methodology (Reliable, dependable, consistent, and standardized)	
Disclosure/Informed Consent	
B. EVALUEE HISTORY (pre/post continuum)	
Social (Identified gender, relationship status, family, cultural, geographic, social/environmental profile, etc.)	
Physical, Mental, and Cognitive Chronology and Status	
Physical, Mental, and Cognitive Functioning and Status	
Pre/comorbid Conditions	
Treatment and Interventions	
Daily/Routine Schedule	
Educational History and Status	
Vocational History and Status	
Avocational/Extracurricular History and Status	
III. EVIDENCE, FINDINGS, CASE FORMULATION/DIAGNOSIS(ES)	
A. EVIDENCE/FINDINGS	
1. *Primary* (Information collected by the life care planner)	
▪ Interview(s) (Evaluee, family, treatment/evaluative professionals/team members, data sources, etc.)	
▪ Observation(s) (Information heard, seen, etc. through informal and formal assessment/testing processes)	
▪ Participant-Observation(s) (Information heard, seen, etc. through informal and formal assessment/testing processes where the life care planner participates in the assessment itself – such as a hands-on assessment)	
2. ***Secondary*** (Information collected by someone other than the life care planner or his/her staff)	
▪ Documents (Referral materials, expert reports, depositions, peer-reviewed or authoritative literature, professional peer-reviewed literature and guidelines, medical chronology, answers to interrogatories, etc.)	

	✓
▪ Archival (Government or raw data: vital records, government database collections, raw data from a study, etc.)	
▪ Physical Artifact(s) (Assistive technology, durable medical equipment, day-in-the-life video, pictures of evaluee, etc.)	
B. CASE FORMULATION/DIAGNOSIS(ES)	
Diagnosis(es)/Presenting Condition(s)	
Synthesis and Prioritization of Needs	
IV. RESEARCH AND OPINIONS	
A. METRICS, MEASURES, & CLASSIFICATIONS	
Life Expectancy	
Classification Codes (CPT, HCPCS, ICD-9/10, DSM-V, ICF, etc.)	
Frequencies and Durations of Items/Replacement Schedules	
B. NARRATIVE & CHART TOPIC AREAS	
Projected Evaluations (Medical, mental health, therapeutic, allied health, architectural, etc.)	
Projected Therapeutic Modalities (Medical, mental health, therapeutic, allied health, etc.)	
Diagnostic Testing (Imaging, laboratory, etc.)	
Educational/Vocational/Avocational Evaluations (Testing, assistive technology, adapted recreation, etc.)	
Mobility (Wheelchair, cane, walker, etc.)	
Mobility Accessories, and Maintenance (Wheelchair maintenance, cane replacement tips, etc.)	
Orthotics/Prosthetics and Orthopedic Equipment (Artificial limbs/supports, splints, braces, etc.)	
Durable Medical Equipment (Commode/shower chair, hospital bed, lifts, nebulizers, suction machine, etc.)	
Home Furnishings/Accessories (Therapy table, walk-in bathtub, stair lift, etc.)	
Aids for Independent Function (Grabbers, assistive utensils, service animals, support boards, etc.)	
Medications (Prescription, over-the-counter, etc.)	
Nutritional Needs (TPN, protein, etc.)	
Supplies (Incontinence, nutritional, wound, etc.)	
Attendant/Facility Care (Home/facility, private/service)	
Case Management (Medical, vocational, conservatorship, guardianship, etc.)	
Future Medical Care/Routine (Physiatry, pediatrics, etc.)	
Surgical Intervention or Aggressive Treatment/Acute Medical Intervention	
Vocational/Educational Plan (Adapted learning/working environments, educational/work accommodations, direct placement/training needs, etc.)	
Health and Strength Maintenance (Club memberships, group activities, etc.)	
Leisure and Recreation (Adapted sports lessons, special needs camps, etc.)	
Transportation (Private, public, services, etc.)	
Home/Architectural Modifications/Renovations (Ramps, retrofitted bathroom/kitchen, etc.)	
C. SUPPORT FOR NARRATIVE & CHART TOPIC AREAS	
List of Records Received/Reviewed	
Medical Summary/Chronology	
Rational/Purpose for Recommendations	
Sources/Vendors	
Professional Literature and Clinical Practice Guidelines	
Bibliography/References	
D. CALCULATIONS	
Item/Annual costs	
E. POTENTIAL COMPLICATIONS	
V. OTHER (IF APPLICABLE TO CASE/JURISDICTION/INDIVIDUAL SCOPE OF PRACTICE)	
Rule 26: *CV*, List of Cases Testified, Fees	
Collateral Sources	
Nursing Diagnosis	

	✓
Pictures	
Gap in Records and/or Life Care Plan Recommendations	
Proof Report (Formatting, calculations, spell/grammar, link between primary and secondary data, readability, etc.)	
POST-REPORT	
Professional Review (if applicable) (Physician, neuropsychologist, therapists, etc.)	
Secure Document (.docx, PDF, etc.) with Passwords Against Change or to Open	
Itemized Bill of Time/Mileage for Service	
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Step 1: Pre-Report Phase

In this section of the LCP Report Checklist©, the life care planner finds the major contents areas of the report that are relevant to the evaluee as well as the layout of the narrative and tabular content. For the seasoned life care planner, this section of the LCP Report Checklist© intermingles writing style with personal preference that may long have been established through the development of a template; such template may be updated periodically, as recommended by AANLCP self-evaluation standards (2015c). Other areas of consideration may include appendices or personal tastes for the design or layout of the report.

Stylistically, there are two areas of writing that merit a more comprehensive review in the pre-report phase: 1) writing about people with disabilities and 2) writing style for citing and referencing secondary data sources, particularly those from the published literature. All major writing styles in the United States caution writers about using bias-free language; this caution includes professional report writing (Schneider et al., 2018). Because life care planners deal with individuals with functional differences that may be physical, mental, or cognitive, it becomes imperative the life care planner use bias-free language. For example, for most disability types, when referring to someone with a diagnosis or functional difference, the person is recognized first with the impairment being only a part of who the person is, not defining the individual. The evaluee is not a disabled person, but a person first who happens to have a disability. The writing standard is to use "people-first" language. There are a variety of resources available to life care planners who many not be aware or fully versed on how to deal with person-first written or oral reports, such as the *Guidelines for Writing About People with Disabilities* (ADA National Network, 2015), or other sources that could be found through a search engine. Because most literature in life care planning uses the writing standards of APA7, adhering to these guidelines of how to address bias-free language (disability, age, gender, sexual orientation, racial and ethnic identity, etc. available at https://apastyle.apa.org/style-grammar-guidelines/bias-free-language) is an excellent writing skill for a life care planner to develop. There are cultural differences of how to refer to people with disabilities. Life care planners must become aware of their audience and change the writing style specific to national, disability population, or cultural norms thereby showing the life care planner is educated about the specific group from which the evaluee derives.

If the life care planner provides services in a forensic setting, how the person being evaluated is referred to can imply the intended relationship and avoid confusion regarding the life care planner's standard of care. In the forensic context, the life care planner as a retained expert witness has a standard of care that is evaluative, not clinical. That is, there is no client-counselor/therapist, patient-nurse/physician, or other clinical relationship (Barros-Bailey et al., 2008). Therefore, using descriptive terms indicative of that relationship such as evaluee, examinee, or plaintiff instead of client, patient, or another term that is typical of settings where delivery of clinical services is expected, can help to protect the life care planner if there is a question as to the scope of the standard of care established with the person being evaluated. Exploring the circumstance where life care planners may play dual roles and where they risk conflicting standards of care that may come into play in a negligence lawsuit is beyond the scope of this article.

The American Psychological Association's writing style is often referred to as APA. In the review of the literature about emerging best practices in life care planning, the inclusion of references or bibliographies as part of the professional report is becoming part of regular practice (CNLCP, 2015; ICHCC, 2018). For practitioners who have not been in a formal academic setting for a long time or may be new to APA, knowing how to accurately develop a reference list (one that includes only those materials cited in the report) or a bibliography (a list that goes beyond a reference list and includes publications on broader topics) may be intimidating. Fortunately, there are a variety of options available to life care planners to help the task of developing these lists. The most direct APA source guide is

apastyle.apa.org to learn how to reference distinct types of publications and the various nuances of the writing style. Online or software sources, such as Citation Machine found at https://www.citationmachine.net/apa help the writer to generate references per a variety of styles, including APA7. On Citation Machine, the user completes the various cells on the online tools, and it generates the APA reference. A word of caution when including references or bibliographies with professional reports: if the reader of the report wants a copy of the publication listed, the author can only provide such a copy if it is not copyrighted. If the publication is copyrighted, the party requesting the document must obtain a copy of the publication themself from the publisher unless the expert witness is served with a court order (not a subpoena) to provide such information (Mitchell, et al., 2016). Otherwise, the life care planner may be engaging in copyright law violation if copying and sending a copy of copyrighted materials without obtaining permission from the copyright holder (Mitchell, et al., 2016).

Step 2: Report Phase

This section of the LCP Report Checklist© holds all the areas found in life care planning literature that make up part of the report. These components include: a) Identifying Information; b) Introduction and History; c) Evidence, Findings, Case Formulations/Diagnoses; d) Research and Opinions; and, e) Other Applicable Information. Before covering each general content area, it bears emphasis that ***what*** and ***how*** the information is represented in the report, apart from having both narrative and tabular sections, can be contingent on the needs of the evaluee, the jurisdiction, the country, or the life care planner's organizational or presentation style and design.

Identifying Information

This part of the report is very direct; it has identifying information about the life care planner, the evaluee, and the case. If the life care planner uses standard letterhead, this information may be automatically contained and does not need to be updated for each report. The depth and breadth of identifying information can vary per life care planner or jurisdiction.

Introduction and History

Information about the purpose of the evaluation, dates of contact with the evaluee, methods used, and disclosure and informed consent procedures are typically contained in this section. Was the life care planner referred the case under a reduced scope such as performing a medical cost projection assessment for purposes of mediation, focusing narrowly on attendant care needs, performing a peer review and rebuttal report, or another task that involves a subset of the tasks generally expected in life care plan methodology? Are there factors that are unknown making it a preliminary report contingent upon further information? Noting these kinds of deviations from the standard helps guide the reader to understand the rest of the report.

This is typically the section where the purpose of the referral is identified, and language is included to demonstrate the dynamic nature of a life care plan. Some life care planners may include some of this language in other parts of the reports, such as in a closing paragraph. Whatever the style, the purpose of the evaluation section provides a type of roadmap to the rest of the report including when the life care planner started the process, how they went about doing the work (methodology and procedures), and the limits of their role thereby establishing the standard of care (disclosure and informed consent).

Evidence, Findings, Case Formulations/Diagnoses

This third section of the report, and the fourth section that follows, are typically what many readers may associate with the life care planning report itself. It contains information that the life care planner collected (called primary data) from interviews of the evaluee, their family, treatment team, or other individuals; observations, including informal and formal testing (e.g., psychometrics); or, hands-on observations (Barros-Bailey, 2018). Depending on the circumstance, the life care planner may not have the opportunity to collect primary data and may only have the ability to review reports, depositions, pictures, videos, or other information collected by other people to develop opinions. In this case, the life care planner is performing an evaluation just using secondary data (Barros-Bailey, 2018), which also includes review of items like general practice guidelines, government or research databases, or scholarly or professional literature. Any of the data that the life care planner relies upon, either primary or secondary, is defined as evidence (Yin, 2018). Often, whether using primary or secondary data, or both, there are data points that converge between and within both types of information. The more data and evidence that converges, the greater the internal validity of the life care plan (Yin, 2018). Including such convergence of data in the report provides the life care planner with a roadmap to the validity of their analysis, findings, opinions, and recommendations.

Based upon all the evidence the life care planner has available from all sources relevant to the case, they develop a concept about the needs of the evaluee. In academic research terms, this is called case formulation or conceptualization, and in some instances can include establishing diagnoses. Note that the case conceptualization process is often iterative and can happen concurrently or at any point along data collection and review, not necessarily after every single bit of information has been gathered or reviewed.

Research and Opinions

The heart of the report typically rests upon the research and opinions section that includes the metrics, the story of the

client told in the narrative, and the numerical factors tied to the needs in tabular form along a variety of different categories and calculations. Opinions rest upon the particulars of the case based on life care planner certainty and potential complications that do not rise to the level of probability at the writing of the report. Babinsky and Mangraviti (2003) describe in the legal context that opinions need to be offered "to a reasonable degree of probability" (p. 366). Specifically, they say,

> How sure is the expert? Does the expert merely have a hunch? Generally, a reasonable degree of certainty is what is required. Experts should express their opinions "to a reasonable degree of … certainty" (p. 200) … There normally is no need for an expert to offer any standard higher than a reasonable degree of scientific certainty (p. 315).

Metrics, measures, and classifications may include life expectancies, classification codes (e.g., CPT, DSM-V, HCPCS, ICF), frequencies, and durations upon which each item's annual and/or lifetime costs are calculated. For the narrative and table categories, these were found to be clustered in slightly different ways by various authors (AANLCP, 2015c; CNLCP, 2015; Deutsch & Sawyer, 1995; Isom & Marini, 2002; Neulicht et al., 2010; Riddick-Grisham & Deming, 2011; Weed & Berens, 2018). From a construct perspective, the categories are materially the same and can be tailored to case-specific needs and the style of the planner. Some life care planners may list all of the categories of their template in a report, even if they do not apply to a particular evaluee, noting "N/A" to demonstrate they have considered the services but they do not apply. Other life care planners eliminate a category if it does not apply to the case. There is no universal agreement in the field as to either approach.

What becomes most significant in tailoring these categories to the case is understanding that in the hand-off of the life care plan to other members of the damages team, particularly the forensic economist, certain types of items must be clustered together to facilitate the application of different growth factors and arrive at accurate calculation of the life care plan to present value. That is, the rate of inflation of the items in a life care plan may differ. Clustering together like items allows for greater validity of the pricing of the life care plan. Therefore, putting the apples in the same bin, eggs in the same flat, and oranges in the same crate is critical. Specifically, Dillman (2018), a forensic economist, outlines the clustering of like items as follows:

- *Medical Services – Professional and Hospital Services* (physicians, psychologists, nurse practitioners, therapists, other professionals; impatient stays, pharmacy, diagnostics, emergency care, convalescent care, etc.)
- *Medical Commodities* (prescription and nonprescription medications, supplies, dressings, general use or convalescent equipment, hearing aids, etc.)
- *Non-Medical Services* (housing, transportation, specialty foods, adaptive sports equipment, etc.)

For the tabular display of information, Dillman (2018) also recommends including marginal costs, value of the items, and the delivery amount, frequency, and duration of each recommendation.

In providing calculations, the literature listed at minimum the inclusion of the item and annual costs. Whether to include lifetime costs or future value totals varies (unless the life care planner is qualified to calculate these to present value). Dillman (2018), for example, urges life care planners not to include lifetime costs because juries often do not understand the difference between future value costs the life care planner supplies and the present value numbers the forensic economist gives. Therefore, there is no consistency in whether to include calculations at the level of lifetime costs or to leave this part of the analysis for the forensic economist.

Support for the opinions included in the life care plan, such as a list of records received and reviewed, a medical cost summary or chronology, rational/purpose for the recommendations, sources/vendors used, and support in clinical practice guidelines or in the literature have become part and parcel of life care planning practice (CNLCP, 2015; ICHCC, 2018). How the life care planner includes this information, such as part of the report or in appendices, varies based on different report writing and presentation styles.

Methodologically, complications may become problematic for the evaluee in the future. However, whether complications *will likely* become problematic and at what cost may be unknown; therefore, the type of complication is typically noted because it may be possible but may not rise to the level of probability (certainty), but the potential costs may be impossible to accurately assess. An example is an evaluee who has a greater fall risk as the result of an incident. Whether future falls could result in the need for ice, a Band-Aid, casting of broken bones, hospitalization, invasive procedures, or death may be impossible to predict, or to accurately include the costs of such a risk in a section other than in complications.

Other Applicable Information

The life care planner may include in the life care plan report other information, such as the planner's qualifications, fees, and past testimony under Rule 26 of the *Federal Rules of Civil Procedure* (The National Court Rules Committee, 2020), collateral sources (depending on the jurisdiction or scope of the referral), pictures, noted gaps in available records, or other relevant information. It is essential to proofread the report and perform a spell and grammar check of its contents before sending it.

Step 3: Post-Report Phase

After completing the report, some actions may or may not accompany its remittal. If applicable, the life care planner may have the party/parties providing foundation to different

sections of the life care plan review it to ascertain the opinions outside the life care planner's scope of practice are accurately represented. This step is highly contingent on a variety of factors and may not be part of all life care plan reports.

Securing the report through encryption, in whatever format (word processing, PDF, RTF, etc.), against changes and modifications should be a regular practice prior to its electronic remittal. The author is aware of several cases where the receiving source changed part or a sizable part of the professional report because the document was not protected against those changes. Just because a document has been converted from a word processing format to a PDF does not secure it against changes. The PDF can easily be converted back into the word processing format, changes made to it, and placed back into a PDF. Learning how to password protect a document takes less than five minutes while browsing a search engine or viewing a YouTube tutorial. The best time to learn about the value of encrypting a report against changes is now, not when sitting in a deposition or on the witness stand and learning that someone along the process changed your life care plan to reflect opinions you do not hold.

Lastly, sometimes included with the report, but not as part of the report itself, is the itemized bill of time and expenses incurred by the life care planner. There are many applications and techniques available to maintain such information, but those business processes are beyond the scope of this article.

Conclusions, Implications, and Future Research

Whether someone is new to life care planning or has authored many life care plans, a writing guideline for different phases in the development of narrative and tabular reports can be helpful. This LCP Report Checklist© derives from the foundations, standards, methods, and ethics found in the literature of life care planning literature. The specialty has changed since its start about four decades ago and is as dynamic as the definition we use for a life care plan. Therefore, the LCP Report Checklist© is not an end-all, be-all for report writing in the specialty. Rather, it is a starting point where emerging practices in life care planning could change its content or organization over time. The LCP Report Checklist© was developed with the understanding that, depending on the particular style of the life care planner, the jurisdiction or the country in which they practice, or the evaluee, some aspects of the checklist may not apply, or other categories or components may be relevant. The LCP Report Checklist© may be helpful to researchers considering roles and functions of life care planners or best practices, or to life care planning educators developing assignment rubrics. The intent of the LCP Report Checklist©, however, is to provide the practicing life care planner with a practical and comprehensive tool based on years of literature in the field to guide report writing.

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