

Results of the 2021 Survey of Remote Life Care Planning Practice: Pandemic Edition

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Abstract

There is no research on how life care planners adopted or changed their delivery of remote services during the 2020-2021 pandemic or the permanency of any these changes. The purpose of this study is to: 1) collect data on the impact of the COVID-19 pandemic on remote life care planning practice; 2) capture remote assessment practices and develop Best Practice recommendations for contemporary delivery of services at a distance; and 3) obtain stimulus qualitative data to develop close-ended questions as a basis for future longitudinal studies on remote life care planning.

Review of the Literature

For over two decades, researchers have attempted to capture how life care planners practice (Neulicht et al., 2002; Neulicht et al., 2010) and the emerging professionalization of the individual scope of practice held by a growing number of medical, allied health, and rehabilitation professionals. Unlike any other public health event in the lifetime of anyone writing or reading this article, what the World Health Organization (World Health Organization, 2022a) calls SARVS-CoV-2 (the virus) and COVID-19 (the disease) has likely affected life across the globe for every 7.87 billion world citizens (World Health Organization, 2022b). The disruption and adaptation to a unique way of living and working under and after a world pandemic required professionals – including life care planners – to analyze what they do, how they do it, whether they want to continue to do it the same way, or how to adapt to or adopt new systems, processes, or technologies – and act and react very quickly!

A few months after the onset of COVID-19, (LaBerge et al., 2020) reported on a survey of nearly 900 corporate executives and managers about changes in business practices, and the accelerated adoption of new practices by several years. For instance, they found that

while – before the pandemic – employers anticipated it would take an average of 454 days to increase remote working and collaboration, the average rate of adoption of this practice was 10.5 days after the start of the pandemic. Furthermore, while corporate leaders expected it would take 672 days, on average, to increase the use of advanced technologies in operations and 547 days to increase migration of assets to the cloud, after the start of SARVS-CoV-2, these activities were operationalized in 26.5 and 23.2 days, respectively. Technology behavior and adoption is one of the most documented changes to practice. However, attitudes towards how work is done by those referring, performing, or receiving services is also demonstrating a substantial impact. The same survey found that for those using their services, while it had been projected that it would take an average of 511 days for changes in customer needs or expectations, the average was actually 21.3 days for those changes.

Researchers in all aspects of society are attempting to measure the effects of the pandemic, even as it continues to rage into its third year, although weakened in its impact on health and death of those infected. It is still too early to understand what permanent effects SARVS-CoV-2 has had on human behavior until its effects become human history, rather than another emerging variant and response to infections or reinfections impacting our home and business lives. The same perspective is true about research regarding current professional practice in the field of life care planning, particularly as a committee gathered to update and launch the 2022 life care plan decennial survey to capture current and emerging trends in the process, methods, and protocols of practitioners. The literature about remote life care planning practice or use of technology is scant. Past articles about technology in life care planning practice include:

- assistive technology (Bate, 2011; Mayer, 2011; Powell, 2011; Sofka, 2011a, 2011b, 2012a, 2012b; Sofka & Caragonne, 2012b, 2013; Whiting-Madison et al., 2017);
- legislative tracking (Dawson & Stolte Upman, 2011);
- transportation or housing (King, 2018; Sofka, 2013, 2014); and
- impact on various medical conditions (Deutsch et al., 2005; Kreimer, 2019, 2020; Page, 2013; Sofka & Caragonne, 2012a; Wiles Higdon, 2015) (Deutsch et al., 2006; Kreimer, 2019, 2020; Page, 2013; Sofka & Caragonne, 2012a; Wiles Higdon, 2015).

In 2020, Rutherford Owen et al. (2021) conducted a brief survey of life care planners (N=100) to investigate the use of technology. The practice they reported as constituting the most significant use by most of the respondents in 2020 were virtual interviewing/home visits (72%). Their survey identified the following technologies or online sources used by life care planners in practice (not necessarily because of the pandemic): clinical practice guidelines, custom templates, databases (academic, costing, facility, etc.), government websites, software (life care planning, spreadsheet, word processing, etc.), video conferencing, and voice activation.

Due to the impact of COVID-19 on society as to potentially skew the results of the decennial survey regarding life care planning practice, the 2022 decennial Life Care Planning Survey committee sought to capture some of the behaviors resulting from the effect of the pandemic through this initial supplemental study projected to be repeated at more frequent intervals than the decennial survey to measure and assess technological and other changes

to life care planning practice. This article outlines the results of the preliminary study regarding the effects of the SARVS-CoV-2 pandemic on life care planning practice, implications of its findings, and recommendations for best practices and future research.

Procedures

A review of the items on the instrument for the decennial life care plan study by the eight -subject matter expert (SME) committee members formed the foundational document, to identify the areas of practice where information about the impact of the pandemic might be relevant. This research is considered an exploratory survey on the topic, thus necessitating a broad qualitative data approach, to minimize the introduction of bias through predetermined response categories, and to maximize the empirical development of those categories for follow up surveys.

A subcommittee of two SMEs from the decennial survey group developed the initial questionnaire, which was reviewed and refined by the overall SME panel and piloted in September 2021 among 13 volunteer life care planners in the United States and Canada. The data were collected through a finalized instrument developed on the SurveyMonkey online platform survey, with an initial invitation followed by two reminders, disseminated through the listservs or mailings lists of the following organizations: American Association of Nurse Life Care Planners (AANLCP), International Academy of Life Care Planners (IALCP), International Commission on Health Care Certification (ICHCC), and Nurse Life Care Planner Certification Board (NLCP); in November and December 2021. Physician Life Care Planning (PLCP) leadership declined to participate in the decennial, and subsequently, the pandemic survey.

Data Analysis

Quantitative and qualitative data was collected by the study as appropriate given the purpose and design of the study.

Quantitative Data Analysis

Quantitative data analysis was limited to those questions whose responses naturally resulted in numerical data, such as demographic variables and questions, or other quantifiable responses as the best method to derive meaning from the data. The quantitative data was analyzed by various members of the decennial committee and described narratively.

Qualitative Data Analysis

Several questions did not lend themselves to quantification of the answers. Instead, a qualitative content analysis of the survey responses was performed by designated committee members who examined and coded the responses and derived subsequent meaning.

Results

A total of 207 responses were received to the survey in November/December 2021 taking an average of 9:44 minutes to complete. Respondents had the option to skip a question; therefore, not all respondents answered each question. Because the population of life care

planners is unknown, and there is overlap between life care planners who hold membership or credentials by the various organizations through which the survey was disseminated, a response rate could not be calculated. Following are the results of the survey questions, starting with a description of those who answered the anonymous survey.

Demographics of the Sample

Most life care planners answering the survey (83.12%) practiced in the United States; the balance of respondents practiced in Canada. Over three-quarters (76%) of all states were represented in the survey with the greatest number of respondents coming from California (11.54%) and Florida (10.77%). Almost all Canadian respondents were from Ontario; one life care planner was based in British Columbia. Of 147 life care planners answering the questions, the largest number (40.14%) came from the nursing profession. In descending order, other professions identified include: rehabilitation counselors, 30.61%; occupational therapists, 12.24%; counselors, 5.44%; physicians, 4.76%; and psychologists, 3.40%. Representing less than 2% each were life care planners, whose primary professions were physical therapy (1.35%), social work (1.36%), and speech therapy (0.68%). Regardless of profession or location, a clear majority respondents (65.56%) of the 151 respondents to the educational degree question were educated at least at the graduate level (50.33% master's; 15.23% doctoral or professional degree). Just over a quarter of life care planners (26.49%) held a baccalaureate degree. Less than 10% of life care planners held a diploma (4.64%) or a sub-baccalaureate degree in nursing (3.31%). While education levels possessed by life care planners was skewed towards higher levels, the age range of respondents spanned nearly 50 years, and two-thirds of respondents were between the ages of 56 and 75 years. There was only one survey participant 35 or younger. The remaining 152 respondents (99.25%) were all between 36 and 75 years of age, with the highest number of respondents in the 56-65 year old range (38.56%). Interestingly, the next highest age range was not lower in age, but higher, with respondents between the ages of 66 and 75 representing an additional 28.10% of the sample.

The respondent group demonstrated a strong alliance towards credentialing in life care planning as follows:

- Certified Life Care Planner™ (72.19%)
- Certified Case Manager (37.9%)
- Certified Life Care Planner™ (72.19%)
- Certified Rehabilitation Counselor (32.45%)
- Certified Nurse Life Care Planner™ (18.54%)
- Canadian Certified Life Care Planner™ (14.57%)
- Certified Disability Management Specialist (11.92%)
- Medicare Set-aside Certified Consultant™ (10.60%)
- American Board of Vocational Expert (9.27%)

- Critical Care Registered Nurse (7.95%)
- Certified Vocational Expert (7.95%)
- Legal Nurse Consultants-Certified (7.28%)
- Certified Physician Life Care Planner (1.32%)
- Certified Medical Coder (2.65%)
- National Certified Counselor (1.32%)
- Certificate of Clinical Competence in Speech Language Pathology (0.66%)

None of the respondents claimed to hold the American Board of Professional Psychology or the Academy of Certified Social Worker credentials.

Of the 156 respondents reporting active membership in life care planning organizations, nearly four out of five (79.49%) identified membership in the International Association of Rehabilitation Professionals/International Academy of Life Care Planning. The next highest life care planning organization identified was the American Association of Nurse Life Care Planners, identified by 30.13% of respondents. These findings are interesting in that the largest percentage of respondents by primary occupation was nursing. Just 5.13% of respondents reported belonging to the Physician Life Care Planners organization. Surprisingly, despite the requirement for life care planners to hold professional licensure or certification as a "Qualified Healthcare Professional," (International Commission for Health Care Certification, 2022), 7% of the sample reported holding no active membership in any life care planning professional organization.

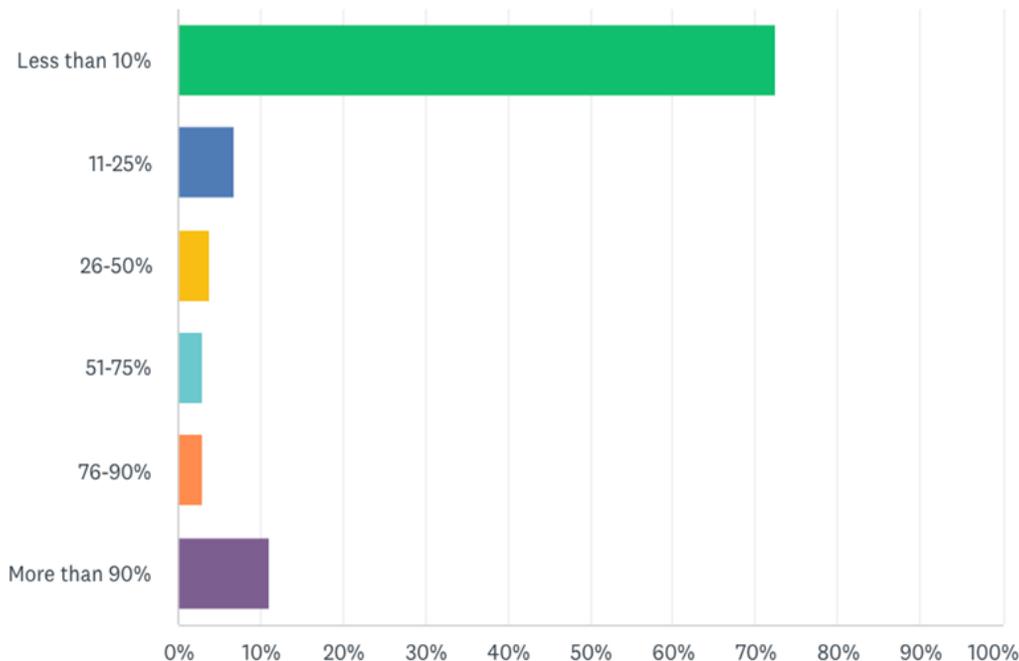
Adoption of Remote Life Care Planning Practices Due to the SARVS-CoV-2

The pandemic survey asked about current or anticipated future professional behavior in practice specific to the areas of assessment, testimony, fees, and termination. Findings are categorized by question. To examine the overall impact on life care planning assessment, the committee used two questions covering pre-and post-pandemic periods until December 2021, as well as two reflection questions, to capture outlooks about the changes. The experiences of life care planners between these two time periods were vast as summarized by their responses to the questions. Likewise, their comments, reflections, and surprises about the changes were insightful.

Question 1: In What Percentage of Your Cases Before 2020 Did You Perform Remote Life Care Planning Assessments?

Figure 1 provides a quick visual illustration as to what life care planners reported was their usual practice with remote assessments before 2020.

Prior to 2020, most life care planners (72.46%, n=207) who answered the survey had performed a remote life care plan assessment less than 10% of the time, while just over 10% of life care planners made it their practice to perform life care planning assessments remotely most of the time (>90%). The remaining group of life care planners (16.43%) had performed remote life care planning assessments from 11-90% of the time, with the lower

Figure 1*Life Care Planners Pre-Pandemic Use of Remote Assessments*

end of the range being favored. Overall, 83.08% of life care planners reported that they had not performed a life care plan assessment online before 2020 in half or less of their cases.

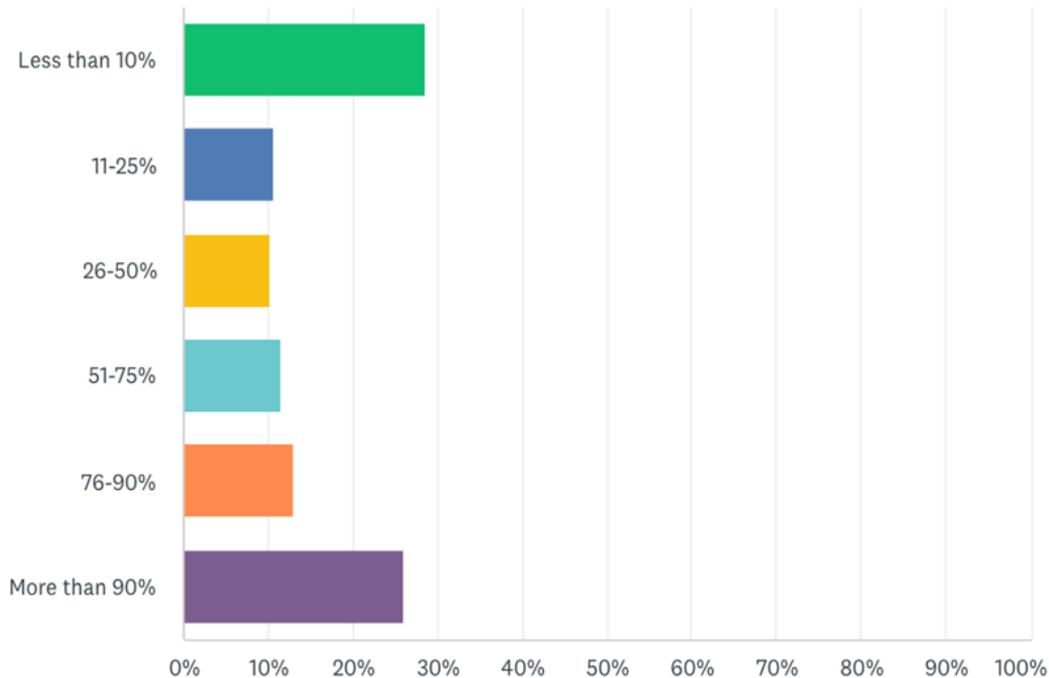
Question 2: Today, in What Percentage of Your Cases do You Perform Remote Life Care Planning Assessments?

As in the pre-pandemic question, Figure 2 provides a sketch of the overall impact of remote life care planning involving assessments.

While this survey was performed about 21 months after the official start of the pandemic in North America, when a lot of jurisdictions, government entities, private practices, and other practice settings were no longer on lock down, data suggests that about half (50.72%) of life care planners continued to perform life care planning assessments remotely at least half of the time. Of those who had not performed a remote assessment before 2020, only 28.5% reported they still had not performed a remote assessment, a change approaching half of life care planners (43.96%). Of significance is that about a third of life care planners shifted from never having performed a remote assessment to now having had the experience.

Question 3: Comments About Changes in the Frequency of Your Remote Life Care Planning Assessments Before 2020 and Now?

As one would expect, there is a range of experiences reported across the 112 comments provided to the request for additional comments, including: strongly preferring and

Figure 2*Life Care Planners Post-Pandemic Use of Remote Assessments*

only completing in-person assessments; completing both remote and in-person assessments dependent on circumstances; developing hybrid assessment processes comprised of both remote and in-person portions; and those completing remote assessments only. Three-quarters of respondents reported an increased use of remote assessments, and/or stated an intent to continue using remote assessments in the long term. A minority of respondents commented that there was either no change in their use of remote assessments compared to pre-COVID-19 (17.9%), they had returned to completing only in-person assessments (3.6%) or retired/closed their business (2%), or had no comments (2%).

Comments focused on the increased awareness of, and increased positive perceptions of the utility, effectiveness, and acceptability of remote assessments to assessors, evaluatees, and referral sources. For example, one respondent reflected, “previously, it was not acceptable to provide a thorough assessment remotely. However, in adapting through COVID, I have developed techniques to ensure I am able to obtain all of the information I need” Further, while 9% of respondents provided comments stating that remote assessments were effective, just 2% suggesting remote assessments were “inadequate” or that they “despised” using remote platforms, expressing opinions such as “vital to perform in person assessments for accuracy and completeness.”

Approximately 60% of respondents indicated completing both remote and in-person assessments, to varying degrees. Most often, respondents indicated examining referrals on case-by-case basis to determine whether to proceed with a remote or in-person assessment

process (14.3%), citing factors including: evaluatee diagnosis and level of impairment; health status/fragility, vaccination status, and potential harms related to exposure; necessity of in-person evaluation of the home environment; existence of a suitable/safe in-person meeting location; client/referral source preferences for remote assessment; facility restrictions for outside visitors, and if air travel was required to assess the client in-person. About 8% of life care planners indicated adopting a hybrid assessment process for all clients, completing the intake/interview remotely to reduce the time, travel, and/or exposures associated with in-person assessments for the minimum required content and/or time (“I do the initial assessment remotely and then meet them briefly or do a tour of the home if it is absolutely necessary”). Just 6.3% stated they now complete all assessments remotely.

Regarding perceived acceptability for remote assessments, client preferences were infrequently noted, with 3.6% stating that their clients prefer using Zoom. Alternately, <2% stated concerns that evaluatees had difficulty using/accessing technology for remote assessments, and <1% stating clients preferred meeting in-person. About 4.5% commented that referral sources now specifically request remote assessments to save expenses and/or time, with no negative perceptions by referral sources noted. Respondents were worried about returning to in-person assessments due to personal safety/exposure (4.5%), with a small number (<1%) of respondents indicating they would not complete an assessment that required air travel to access or noting they want to permanently conduct all assessments remotely. Altogether, responses noted a trend towards supporting the feasibility and acceptability of remote assessments, and highlight the range of client needs and factors that may influence whether to complete remote, hybrid, or online assessments now or in the future, and that additional guidance and streamlining of best practices is warranted, as outlined by one respondent, “When the dust settles, I will probably ultimately be doing remote assessments 25%-35% of the time and have to develop a set of decisions-making criteria of the circumstances where I would do one kind of assessment over another. It would be helpful if the professional/ credentialing organizations assisted in developing best practice criteria in this regard.”

Question 4: What Has Surprised You Most in Doing Remote Life Care Planning?

About one in eight life care planners stated that nothing surprised them about doing life care planning remotely. A handful of respondents added that they had been doing remote life care planning before 2020, so nothing had changed in their practice. It was unclear if the others were unsurprised because they were not engaging in remote life care planning (only 2% of the sample stated not having performed any remote work) or, if like their peers, they had been engaging in the practice previous to the pandemic.

Seven percent of the 148 responses to this question could not be classified due to the ambiguity of the response. Other responses fell from positive, negative, or mixed into the following themes: assessment, business practices, technology, testimony, and business practices for the evaluatee, the life care planner, or others.

Specific to assessment, although a couple of respondents felt that remote assessment was “much harder;” especially for those who were using technology that did not allow them to have “eyes on the client,” the predominant theme was that life care planners were surprised how effective using remote methods could be to their life care planning practices. Summative comments were “... it became the norm and most clients were fine with it” and “... it has

become ‘normalized’ for our practice,” or “How much I can do remotely and how easy of a transition it was to doing remote and digital nomad work in my practice.” Many respondents were more specific about their surprises:

- the convenience, ease, flexibility, efficiency, or effectiveness of the remote assessment process;
- their or their staff’s comfort with remote evaluations;
- the ability to form rapport online with greater evaluatee participation, or “ease of interaction; and
- how remote assessment creates less stress and greater comfort for evaluatees.

Very few respondents noted either apprehension by evaluatees or referral sources in engaging in remote assessment or difficulty in establish rapport in the interview process.

While the predominant theme was positive as to data collection through remote assessment, three exceptions were noted: 1) increased difficulty of capturing data about evaluatees or their location because of the small image being reduced to a screen (“... I did not capture the person fully because I was not in their space”; “inability to do physical exam”) thus fear about such impact when testifying; 2) performing home evaluations “... how disorienting it can be touring a home through a camera ... great thing is it can be recorded”; and 3) gathering data from individuals with more complex disabilities (“... not a good approach for complicated cases”), which requires greater skill and clarification by the life care planner to inquire about care not evident within the headshot or puts a greater burden on the evaluatee to provide documents or information to the life care planner.

The overall surprises involving technology is summed up with this statement: “I’m surprised how quickly people can adapt to technology.” This sentiment was expressed to both life care planning practitioners, as well as evaluatees, although there were a few exceptions as to some evaluatees not having hardware, internet, or skill access to connect with the evaluator or the unpredictability of online access. This comment by a life care planner is indicative of the theme arising from responses to this question, “... how easily the legal world has embraced it.” One respondent was surprised that remote assessment was “accepted in the courts as effective.” All responses involving testimony described the use of videoconferencing for depositions, in a favorable light as being less stressful, more casual, even disinhibited (“Opposing counsel ... wearing tank top and boxer shorts ... started deposition with baby goat ... [and] ended wearing stuffed turkey hat”).

Business practices surprises were evenly mixed between some life care planners who continued to get work and others who got little or no work, or having problems with collections. One respondent was surprised over the ability to launch a private practice.

Finally, one life care planner was surprised about how evaluatees were unable to obtain treatment while another was surprised about the inability to obtain information from providers, although business circumstances were beginning to change.

Practical Impacts Regarding Adoption of Remote Life Care Planning

Understanding adverse and constructive aspects of the pandemic on life care planning practice was important for the researchers to understand. Therefore, two questions

addressed the negatives and the positives.

Question 1: What are the three most negative impacts of the pandemic on your life care planning practice?

Seven percent of the 151 respondents to this question did not believe there were any negative impacts of the pandemic on their practice, while 4% answered “N/A,” which was difficult to interpret. Thematically, the areas that were identified as the most negative fell into the following categories: assessments; courts and testimony; interaction with the healthcare system and providers; business practices; interaction with colleagues; and personal impacts.

By far, the biggest downside declared by over 35% of respondents was the inability to meet with evaluatees in person or to do home assessments, which challenged the life care planner’s collection of observational data, to observe the existence and use of durable medical equipment, build rapport, include family input, and feel as if respondents were able to gather the same kind of data as they did before 2020. One life care planner stated a radical decision to “... not take referrals ... it is essential to meet with clients.” Difficulties were also found in communication with the use of personal protective equipment and the need to quarantine five days between home visits, while other life care planners lamented the inability to perform a physical examination or collect psychometric testing data. Particularly problematic to the respondents was obtaining information from evaluatees who had difficulty accessing technology, resulting in the need of using a telephone to perform an interview rather than more interactive means of communication.

The off-again, on-again closing and opening of court systems was noted by 27.8% of life care planners to result in various negative impacts, such as reduced referrals during times of closure and requests for rush cases when courts reopened (“... flooded with cases” ... “... crunch time after things began to open up”). Another 7% of respondents indicated this inconsistent activity by the courts resulted in reduced income or slower payment of invoices, and one mentioned the closure of their practice due to lack of work. Five life care planners (3.3%), expressed having too many depositions, not liking these on Zoom, or the difficulty of testifying remotely in a trial setting. One life care planner indicated that attorneys were less willing to hire their mentees who had no experience testifying.

Dealing with the healthcare systems and treatment providers was challenging for a small number of life care planners (under 5%). Connecting with healthcare providers and attending medical appointments with the evaluatee to gather information from providers was mentioned by 9.3% of life care planners as being a greater challenge. Further, 6% of life care providers specifically mentioned that the reduced or lack of medical care received by evaluatees during the pandemic was problematic because evaluatees were in worse medical condition than anticipated or providers were concerned about providing projective care need opinions because of not having treated the evaluatee in a while, thus life care planners were uneasy about the optics of the reduced frequency of care vis-à-vis their opinions as to future frequency and duration needs for the life care plan. There were concerns about the evaluatee developing long COVID or a secondary mental health (e.g., anxiety) condition as comorbid to the medical or psychological conditions associated with the condition(s) evaluated for the life care plan.

Another theme identified by life care planners was the impact of the pandemic on business practices. Transition and adjustment to a contemporary style of work involving

electronic modes of practice and the difficulty in getting work done was identified as general business topics requiring greater planning. Three life care planners specifically identified having children at home due to school closures or a spouse moving their office home, while themselves setting up their practices or working from home, as factors impacting productivity. Others complained about communication between staff members or the blurring of “lines between work, personal, and pleasure.” Time and financial costs of moving employees remotely, its impact on productivity, and costs associated with having the office closed, were cited by a handful of life care planners as negative impacts of the pandemic, while one respondent complained that employees did not want to return to the office, where it was felt that there was greater productivity. One life care planner expressed the inability to expand their business, while others lamented the reduced ability to network and market. A few respondents found greater difficulty in performing practical and essential tasks, such as getting release forms signed, obtaining medical records, or researching codes or costs.

From a personal and social perspective, 4.6% of life care planners expressed their increased stress or anxiety – or that of their evaluatees – over fear of contracting COVID-19. About 9.9% felt isolated and missed networking with their colleagues in person or attending conferences.

Question 2: What are the three most positive impacts of the pandemic on your life care planning practice?

A total of 147 respondents replied to this question, with 84% of respondents identifying positive impacts on their life care planning practice arising from the pandemic. Just 12% of respondents indicated that there were no positives arising from their professional experiences during the pandemic, and about 5% responded “N/A” and were, thus, unable to be categorized.

Fifty-nine percent of respondents indicated that the integration of video/virtual participation in any mode was a positive development. Specifically, using video conferencing platforms for assessments (22%) and for depositions (16%) were frequently cited as positive experiences, along with improved perceived acceptability of remote assessments by life care planners and attorneys (7%). Positive effects were also noted for use of video conferencing for meetings (7%), conferences (3%), or “typical” use (5%).

Fifty-two percent of respondents indicated some positives arising from personal experiences of their work. Positives included enjoying working from home (11%), experiencing improved work-life balance (8%), being “forced” to implement changes to their practice that they had previously wanted to implement, but had been unable to previously enact (5%), re-imagining their practice workflow to improve processes/procedures (5%), or improving safety of themselves and others (4%). Respondents noted enjoying the new learning, creativity, and variety of workload that arose during the pandemic (6%), along with having more flexible work demands (4%), taking time to reflect on personal goals and needs as it related to work, keeping their job through tough times or being able to raise fees (1-2% each).

Forty percent of respondents indicated that less travel was a positive of the pandemic. Reasons varied and included less stress associated with travel (5%), and/or fewer business expenses (10%) resulting in less costly reports to customers, and fewer personal expenses (e.g., travel, vehicle maintenance, business clothing). Less travel was also cited along with

the areas of improved work efficiency and work-life balance. Almost one-quarter of respondents indicated that the changes to practice in the pandemic resulted in improved efficiency and more time to complete their work tasks – life care plans as well as catching up on other work-related tasks that were historically lower priority for them. Similarly, 8% of respondents noted that it was easier to connect with others due to scheduling and availability.

Workload changes of any sort were noted by 13% of respondents. As practice goals vary, so too did perceived positive impacts of the pandemic. Respondents indicated that positive impacts on workload included: having more work (7%), remote assessment procedures enabling a referrals from a wider geographical range (3%), the ability to maintain referrals at baseline level (1%), or the opportunity to reduce workload to suit their preferences or retirement transition goals (1%). While less frequently cited, positive social impacts were also reported, including perceiving others in the field of being more understanding and flexible, appreciating in-person contacts more when they occurred, or feeling their credentials were more valued (1% each).

Technologies in Remote Life Care Planning

Question 1: Describe up to five technologies (e.g., videoconferencing platforms, apps, software) you have adopted to do remote life care planning.

Respondents were asked to describe technologies, apps or software adopted to complete life care planning remotely. A total of 73.6% of the survey respondents (n=151) completed this question, with eight providing a response that was unable to be classified (e.g., N/A). While 4.0% (n=6) respondents did not adopt any recent technology for remote life care planning during the pandemic, most respondents stated adoption of one or more technologies in the realm of video conferencing, hardware/networking, software/apps, online resources, and/or leveraging existing technologies and supports in new ways.

The most frequently cited technology adopted was video conferencing software, with 131 respondents (86.1%) identifying one or more video conferencing platforms. Responses were split with 63 (41.7%) respondents reporting just one video conferencing platform, while 67 respondents (44.4%) using between 2-5 platforms. The most cited platform was Zoom, with 70.9% respondents, followed by Microsoft Teams (20.5%), FaceTime (19.2%), and general video conferencing without a specific provider (13.9%). Other platforms were used by 5% or fewer respondents included: Blue Jeans, Citrix, Doximity, Doxy, Google Duo, Google Meet/Hangout, GoToMeeting, Lifesize App, Meetings.com, Planet Depo (using Zoom), Skype, WebEx, and WhatsApp.

Furthermore, 23.8% of respondents (n=36) reported increasing use of software and applications to enable working from home, team coordination and project management, and data security. In this domain, 6.6% of respondents (n=10) reported using cloud-based documents for team coordination (e.g., Google Docs, Microsoft Online, Microsoft Teams); 5.3% of respondents (n=8) adopted use of cloud-based file storage (e.g., SharePoint, Dropbox, Google Drive), or especially secure file sharing systems (e.g., ShareFile, Hightail). While noteworthy, less than 5% of respondents indicated adopting other specialized software and apps, such as for dictation, scanning, electronic signatures, invoicing, task management, electronic medical records, home care coordination, and multi-factor authentication for data security.

Web-based resources were noted to increase also, with 5.3% of respondents indicating

adopting online standardized testing (e.g., PariConnet, Pearson Q-Global, Cambridge Brain Sciences) as well as professional networking (e.g., LinkedIn), or increased use of online costing databases.

Investments in hardware and computer networking were less frequently reported, with just 2.6% of respondents indicating purchasing new computers to enable video conferencing, creating custom internal networking portal, or implementing computer networking systems.

Increased use of existing technologies, such as phone calls, texts, emails, telephone calls, or faxes were reported by 10.6% of respondents. Finally, 2% of respondents reported modifying testing procedures to have evaluatee family members, or an on-site aide, take photos or complete functional testing in lieu of the life care planner's physical attendance, and submit these via email or video.

Overall, a focus on use of video conferencing software was in line with the desire to replicate in-person meetings to enhance the ability of the life care planner to observe the evaluatee, their family and living environment despite restrictions on in-person assessments and meetings. Such focus on communication technologies, software and apps, online resources and standardized testing, computer/network hardware and leveraging use of existing technologies serves to enable team collaboration, communication, and data security when working remotely. Such technologies may continue to support life care planners in the present circumstances, but enable flexible and adaptable procedures into the future.

Informed Consent and Report Disclosures

Typically, informed consent is the process whereby life care planners establish the standard of care with evaluatees and outline exceptions and limitations, while the report is where some of those exceptions and processes are documented.

Question 1: How has your disclosure and informed consent process changed as a result of the pandemic?

As a result of the pandemic, the disclosure and informed consent process has changed for 71% of the survey respondents (n=147) with thirteen responses unable to be classified (e.g., "N/A") and three "Yes" responses without any explanation or detail. One respondent wrote that they could not speak to this as 2020 was the first year of getting cases and another explained that the process is "in development." Of the open-ended responses that were coded (n=129), a majority (53.1%, n=69) indicated that there is no change in their process, although one respondent added "Should I?" and five responded "Not much" or "Not really." The most consistent change was in technology (24%, n=31) with electronic submission/e-signature the most frequently cited change (13.1%, n=17), followed by use of a virtual/remote platform (8.5%; n=11), and increased security (2.3%, n=3). Respondents also indicated that the process is slower and/or more complicated, most often due to technology (8.5%, n=11). A change in business practices is cited by 10.8% (n=14) of the respondents. Examples of business practice changes include:

- adding a video authorization/remote disclosure
- asking who is in the room not (virtually) visible

- disclosure that the meeting would not be recorded either through visual or auditory means
- sending forms prior to an interview, using more email communication, and relying on attorneys/referral sources for forms

The pandemic has also brought about changes in communication (10.8%, n =14), such as delineation of specific protocols (6.9%, n=9) and the need for additional explanation, including limitations (3.8%, n=5).

Question 2: How has your disclaimer about precautions taken in the assessment process or the limitations of your assessment changed in your written reports as a result of the pandemic?

Respondents were asked to describe how their disclaimer about precautions taken in the assessment process, or the limitations of their assessment, has changed in written reports because of the pandemic. Out of the 146 responses, 10 were unable to be classified (e.g., “N/A”) and six respondents answered “Yes” without any explanation or detail. Out of the 130 coded responses, 57 (43.8%) indicated that their disclaimer has not changed (including one respondent that indicated “Not much/not really” and one who responded, “Somewhat”). Again, one respondent answered “No, Should I?” Use of a remote platform was the primary pandemic change (23%, n=30) with one respondent who cited increased office cyber security to protect electronic documents. Additional communication included added explanation (13%, n=19), assessment limitations (10.3%, n=15), and protocols (9.6%, n=14). Explanations in reports included:

- an additional statement that if unable to complete physical assessment/addendums would be completed, if required, once able to do a physical assessment
- disclosure whether a client was seen in-person or via other methods
- effects of the pandemic on the patient and treatment
- other steps to get information if not comfortable about videoconferences
- wording added regarding how the process was different than before (e.g., mechanisms used in the assessment process; testing may or may not have to be completed online; assessment for the vocational rehabilitation section was more impacted)

Examples of limitations include:

- assessment limited due to need for video conference
- change in (virtual/remote assessment) recommendations if an in-person assessment completed; cite areas of concern for information that may need to be obtained once able to visit in-person
- documentation/disclosure of reasons for limitations/relationship (directly or indirectly) to pandemic

- how consent was obtained; how the assessment was conducted; failure for in-person assessment explained
- how the pandemic and/or contact has been problematic and/or impossible (when an in-person assessment was not feasible/recommended)
- no access to client for in-person assessment (including home and facility environment); examination changed to observations (unclear of meaning); scope of report
- notation that clients were seen via videoconference (or by phone if no capacity for video) and will be seen in person when the situation permits
- noted when proctoring was done or unable to be done or that certain assessments were not done due to circumstances
- perceived limitations of remote assessment

Cited protocols included remote interviews, masking, distancing (if possible, outside), cleaning/sanitizing, requirement that evaluatee be vaccinated (if not, risks of in-person assessment were weighed and noted in report), and increased risk of exposure if in-person assessment was conducted.

Impacts on Access to Other Professionals

Life care planners do not typically work in a vacuum but coordinate with others on the transdisciplinary team. The committee was interested in knowing any impact of the pandemic or access to other members of such team.

How has the pandemic impacted your access to physicians, other consulting health professionals, or vendors?

A total of 149 respondents provided information as to how the pandemic impacted access to physicians, health professionals, or vendors. Of these, 3.5% indicated “N/A” and their response could not be categorized, while others provided generic responses of “Yes” (2.0%) or Minimal (4.7%), but did not provide further explanation.

The most frequent response was that there was no impact on this aspect of life care planning (30.2%), with the next most frequent response indicating greater difficulty with communicating with physicians, healthcare providers, and vendors (17.4%). While 9.4% of respondents stated they had increased access to physicians or healthcare providers due to the ability to attend virtual appointments or video conference meetings, and just 4.7% indicated an overall improvement in all areas of provider/vendor communication with 4.0% indicated initial difficulties/delays but returning to baseline at the time of the survey.

For those providing detailed responses outlining challenges they experienced, the primary areas of concern included: it was harder to get information from providers (15.4%), increased efforts were required and there were general delays in the process or communications (9.4%), difficulty reaching a “real” person due to teleworking (8.7%), difficulty obtaining in-person assessments (8.7%), appointments being delayed/postponed (5.4%), or doctors being too busy, or harder to reach than usual (6.0%). Some concerns were identified with the

quality of information provided by physicians/healthcare providers, with perceived decreased detail/depth which respondents attributed to limited access to in-person assessments (3.4%), or lack of access to in-person assessments resulting in those physicians being unwilling to complete forms for the patient due to lack of in person assessment (1.3%).

Just 10.7% of respondents commented on vendor communication, noting concerns with difficulty obtaining costs due to vendors closing during shutdowns or going out of business altogether (4.7%), or otherwise having difficulty reaching those who complete billing to obtain costs (1.3%). Minor concerns were noted with volatile pricing or delays in shipping (0.7% each).

Impacts on Testimony

Testimony in a variety of jurisdictions is a typical role and function of a life care planner; therefore, we sought information regarding how such testimony was impacted by the pandemic.

How has your testifying changed since early 2020?

Of the 152 respondents providing a response regarding changes to testimony since early 2020, 69.1% endorsed changes providing information as to how this had changed, and just 8.6% indicated no change to testifying since early 2020. The remaining respondents indicated: "N/A" (9.2%) such that these responses could not be categorized, and 3.9% reported that testifying had changed but did not describe how. Finally, 9.2% of respondents indicated that they had not testified at all since March 2020, though did not indicate whether this was a change from their usual pace of testimony.

The most frequently cited change to testimony was moving to remote testimony via video conferencing software, with either all testimony (28.3%) or most testimony (25.7%) delivered remotely (more than half of respondents). Several respondents further indicated finding testimony remotely less stressful, more enjoyable, and more helpful for all parties involved (5%, n=8), with rare instances of technical issues (1%), or difficulty seeing jurors/counsel (1%) hampering the experience.

Experiences differed between depositions and trials, with trials more likely to be noted as not occurring at all (3%), not having in-person trials until very recent to the survey (3%), many cases being continued/rescheduled (9%, n=14), more frequently settling before trial (2.6%), or always settling before trial (2.0%). In terms of volume of testimony (deposition or trial), respondents rarely indicated more testimony (2.0%), less testimony (8.6%), or variable testifying frequency— with a group stating that there was a large decrease in testimony initially and at the time of the survey it was rebounding to pre-pandemic baselines or greater (4.6%).

Just 2.3% of respondents indicating completing all testimony in person, and just 5.3% indicating testifying in-person occasionally with varying COVID-19-related protocols such as masking, testifying in a plexi-glass shielded area, or with jurors spread out around the room.

Impacts on Income

Understanding if and how life care planner income was impacted was of interest to the researchers.

How has your income been impacted as a result of the pandemic?

A total of 149 respondents (87.1%) completed the question regarding the impact of the pandemic on income. The greatest number of respondents identified no impact on their income (n=53, 35.6%), with income going down for almost one quarter (n=36, 24.2%) of life care planners, going up to one in six (n=23, 15.4%), it being variable (n=16, 10.7%), reporting minimal impact (n=6, 4.0%), or indicating that their income was impacted but not specifying the nature of the change (n=7, 4.7%). Nine respondents (6%) indicated other (e.g., "N/A") and, thus, could not be classified.

Of the respondents reporting that their income dropped, there was a range of reasons provided. While 22.2% of respondents (n=8) did not offer an explanation as to the extent or reasons for the decrease, most respondents (n=28, 77.8%) offered details to characterize the extent of this loss, or explain the reasons. Of concern, 27.8% of respondents reported income loss (n=10) and used descriptors such as: company closure, crippling, dramatic, job loss, major, significant, terrible, or tremendous reported. Reported reasons for income loss, if provided, included less work available/more competition for work (n=6, 16.7%), less travel reimbursements (n=5, 13.9%), reduced hours due to family care needs (n=3, 8.3%), decreased desire to work from home, or deciding to retire (n=2, 5.6%). Less frequently respondents cited launching a company concurrent to the pandemic, and not accepting referrals unless in-person assessment was possible (n=1 each, 2.8%).

Of life care planners citing increased income (n=23, 15.3% of all respondents), most did not specify the nature of the increase (n=15, 65.2%). Major increases in income, business volume, or expansion were reported (n=6, 26.1%) and moderate gains due to more working hours or referrals were expressed by others (n=2, 8.7%).

Finally, respondents reporting variable income over the course of the pandemic (n=16, 10.7%) consistently reported that there had been a major decrease early in the pandemic due to initial closures, but that income had recovered to baseline and, in some instances, increased beyond baseline with an increased numbers of referrals. Logistical issues pertaining to slower turnaround on invoice payments or staffing logistics were also noted.

Overall, a range of respondent experiences were given pertaining to income throughout the pandemic. Further exploration of demographics (e.g., age, gender, discipline, geographic location) may shed additional light as to whether other trends may differentiate between those more likely to have positive or negative impacts. It is encouraging that several respondents who experienced significant decreases early in the pandemic were seeing recovery towards or exceeding baseline, with characterizations of increased referrals due to the pandemic creating a bottleneck or backlog in the system.

Impacts on Professional Development

Because the vast majority of life care planners are credentialed, where continued education and networking advances practice, we asked life care planners about their experiences in this regard.

How has the pandemic changed your willingness to travel to attend in-person continuing education events?

Although this item was designed to capture the quality of any change, many of the 151 respondents seemed to replace the “how” with a “did” at the beginning of the question. About 19% of the responses were ambiguous with the majority simply said “Yes,” a handful saying “No,” and one “N/A.”

The remaining responses were along a continuum of those strongly advocating for future training only through virtual delivery and the other extreme, only through in-person delivery. However, the advocates who were absolutists in either direction were a small minority and most responses fell into the grey band between these anchors of the range of opinions with those preferring remote training (39%) being almost equal to those who preferred in-person training face-to-face (36%).

Beginning with the life care planners who preferred remote training, some of these preferences were due to convenience or cost (“too difficult and expensive to travel”; “I really like the option of participating in conferences from my office”), effectiveness or efficiency (“... have been pleasantly surprised how effective and easy to manage remote conferences have been”; “... increased my willingness to pay for and participate in events, if I can do so without travel”), and personal choice (“I will travel to court or for an IME, but it is not necessary to travel for continuing education”). Qualifiers in these responses fell into those who had a change of mindset and preference when the pandemic forced a new professional development experience while other responses seemed to focus on the range of choices being reduced to online training. Having a greater range of offerings in the online environment drove one life care planner to comment, “... I know several life care planners that have never attended the annual conference or symposium prior to the virtual conference last year. That’s a huge bonus for our field.” Overall, the respondents who advocated more for remote training can be summed up by this response, “I expect this to be a long term thing for me. It is so expensive in both time and money to travel across the country for a conference. I will think long and hard before I do this again ...”

On the other extreme were the life care planners who advocated for in-person training, due to the advantages of network with colleagues and other social interaction (“I am really eager to see colleagues”) or learning style (“I am tired of remote learning ... will only attend conferences in person as I don’t learn much during virtual conferences”). About one in eight life care planners expressed a potential interest in returning to in-person training if they felt safe and there was an effort to protect attendees with recommended public health protocols or in locations where the population had a higher rate of vaccination or personal protective device practices, while a couple respondents mentioned that they had contracted COVID-19 at conferences although they were vaccinated and boosted and were less willing to participate in the future. The sentiment of this group of in-person proponents is illustrated by the following: “I see more value in web based continuing education sessions; however, I believe in person conferences are beneficial for interacting with other life care planners and professionals to share experiences, debate best practices, and network.”

Overall, the following life care planner best voiced the general breathe of life care planner comments regarding attendance at remote or in-person training, “I want to see people for some events, but not each one. I like that there is a virtual option.” For individuals

or organizations organizing and delivering training for life care planners, understanding the exposure to alternative delivery of training changed the willingness of some practitioners to return to training as was normal before 2020. Therefore, a continued focus on learning options virtually and in-person will result in inclusive and accessible training, and help increase attendance.

Impacts on Retirement

The Great Resignation has become synonymous with labor force participation and attrition during the pandemic. We want to put our finger on the pulse of this phenomenon within life care planning.

Question 1: Has the pandemic impacted your retirement plans? And, Question 2: If so, how has the pandemic impacted your retirement plans?

A total of 154 life care planners responded to this question. Slightly more than 70% of respondents (n=108) reported that the pandemic has had no impact on their retirement plans. However, 29.87% of those completing the survey reported their plans have been affected. For respondents (n=46) who provided comments, equal numbers reported the pandemic had delayed their retirement plans as those who reported a hastened retirement plan. Those deciding to work longer did so primarily for financial reasons and noted lost life care planning work hours or decreased family income as factors impacting their decision. Delayed scheduling of trials and the associated commitments also impacted the ability to retire in the timeframe previously planned. Pandemic benefits were also reported. A few respondents (n=3) noted they enjoyed their work more and had a better work/life balance with less travel requirements and thus planned to work longer. Those who reported plans to retire earlier noted less referrals as well as more unpleasant and aggressive interactions with attorneys as factors impacting their decision.

Projections for Future Remote Life Care Planning Practice

Now that the vast social impact of the pandemic has washed over the globe touching all aspects of life, we were deeply interested in knowing what new or adopted practices life care planners anticipate keeping in their practice in the future.

Question 1: How do you think the pandemic will change your life care planning practice into the future?

Of the 149 respondents who answered this question, 74.5% indicated at least one aspect in which the pandemic would change their future practice. Just 12.1% (n=18) reported they did not think this experience would change their future practice, or hoped practice would fully return "back to normal" per the pre-pandemic era. Another 11.4% (n=17) were unsure if there would be any impact on their practice, and 2.0% indicating no opinion.

Notably, general adoption of videoconferencing or online technologies in a variety of domains was central. About 23.5% of respondents indicated a preference for interviews and evaluations to be entirely or majority online (n=35), using a hybrid online-in person approach based on evaluating the "need" for an in-person assessment based on unique client

needs/circumstances and only attending in-person if required (14.1%, n=21). A minority of respondents hoped to fully resume in-person only assessments (5.4%, n=8). Notably, a few respondents indicated increasing acceptance of online evaluations within the field and anticipating that referral sources will indicate a preference for virtual assessments where possible to decrease costs associated with travel. For example, one respondent stated, “more remote evaluations are here to stay I think. Especially for cases where the environment is not as important for the life care plan, less complex cases, no cognitive issues,” while another stated “I have realized that while in-person assessments are valuable, an effective and comprehensive life care plan CAN be done in a remote situation. Therefore, I am more willing to conduct remote assessments to save the client time/money.” A third life care planner added, “I think the remote assessment will change the LCP practice and hopefully will be more acceptable as in-home assessment sometimes may not be feasible at all times due to certain circumstances such as bad weather, unsafe place, unwillingness of the retaining attorney to pay for the travel expenses or unwillingness of the individual and family to have a stranger come to their home ...”

Beyond client evaluations, respondents indicated a strong preference to continue with remote depositions/testimony (14.1%, n=21), widespread use of videoconferencing and online technologies (13.4%, n=20), and specifically noted use for meetings (4.0%, n=6) and conferences (2.7%, n=4). Several respondents reported having had interactions with attorneys and other professionals as to the mutual preference for virtual testimony citing the ease of use, efficiency, and cost savings, and included statements such as, “Many attorneys say that they never want to go back to in person depositions” highlighting perceived benefits within the legal community.

This preference for virtual assessments, meetings, and depositions was noted with several spin-off benefits to the evaluatee, as well as the life care planner. For example, 14.1% (n=21) of respondents hoped not only for less travel and associated expenses for the evaluatee, but also to improve the life care planners’ work-life balance, stress levels, and environmental impact of travel. Respondents also indicated an increased focus on employee health and safety via endeavoring to decrease exposures (4.0%, n=6), ongoing use of personal protective equipment during in-person interactions (4.0%, n=6), and choosing to take on fewer cases or be more selective of cases to reduce stress and improve work-life balance (2.0%, n=3). Finally, it is notable that several respondents (n=8, 5.4%) stated pursuing retirement now, or earlier than anticipated because of the pandemic.

Question 2: Add additional comments you would like to make.

Additional comments were provided by 37 respondents. Primary themes involved respondents reflecting on COVID-19 pandemic changing the nature of their work setup, via, considering permanent restructuring of how one conducts their business operations; changes to networking and advertising; and changes to life care planning practices for both remote and in-person assessments.

Respondents describing the changing nature of their business operations considered the structure their home and/or physical office spaces and computer networking to allow working from home on a permanent basis as a flexible option. Rationale for permanent changes included enjoying working from home, reduced environmental impact via less travel, as well as reduced stress and health risks. Respondents noted challenges with com-

munication: with colleagues within and outside of their organization; changes to networking/advertising due to lack of in-person connections; and evaluatees reporting burnout with video conferencing due to receiving many services and assessments virtually. Interestingly, the process and benefit of pausing to reflect on changes to life care planning practice were noted by multiple respondents not only on their own work, but also on how this experience may influence future recommendations for work structure for evaluatees requiring work accommodations to work from home, given that evaluatees facing additional barriers.

Multiple respondents reflected on the long-term impact that COVID-19 pandemic will have on the life care planning profession, and the need for the profession to be able to quickly shift to meet the current (and future) realities to retain life care planners, as well as to consider long-term implications on how acceptable, suitable, reliable remote life care planning is, and whether any liability implications may arise. Several respondents called for the development of procedures and protocols to support best practice for remote life care planning as a viable option (versus returning to only in-person assessments), however noting that the flexibility and burden of such procedures should not increase burden on the life care planner. Tied to a call for the development of remote best practice standards, however, were also fears of the unknown - whether in the future remote life care planning would face legal criticism or be accepted as an equivalent approach.

Finally, in-person assessment procedures and practices may need to be evaluated going forward, to identify suitability of an in-person assessment rather than accepting this as the standard (e.g., greater consideration of evaluatee health and/or vaccination status, physical attributes of the assessment location to identify any potential health risks) to ensure health and safety for the evaluatee and the life care planner.

Implications

The results of this study have potentially some implications for life care planning. Demographically, as a group, life care planners are aging and some were driven to retirement due to the significant changes of practice put in place by the pandemic. Bringing new professionals into the practice who are well trained through various programs, mentorship opportunities, and who could continue to elevate the professional bar should be priority for the field. The mix of disciplines engaged in life care planning may change as those entering the field may come in greater numbers from disciplines that have been traditionally under-represented. Younger entrants into life care planning may bring with them greater ease with technology that could further enhance remote life care planning practices spurred by the pandemic.

Because of the expansive adoption of new practices, technologies, and practice methods to which life care planners have been exposed and a clear majority have adopted, some of these new practices may not go away. That is, the future of life care planning may remain remote for some, in-person for others, but hybrid for the majority of those in the field.

Practical and ethical methods of professional and business practices could be a challenge for life care planners before COVID-19. If practice remains more remote or hybrid permanently, the importance of providing training to life care planners practicing in the new environment should be front and center in educational training programs and professional development in such areas as disclosure and informed consent, effective methods of remote interviewing and data collection, report disclaimers, secure and efficient use of technologies,

etc. For those organizations or individuals providing training or continuing education opportunities, although there may be some bounce back from life care planners tired of remote education, there may be life care planners who seek to continue receiving their education remotely, but want to engage in and access the same training as those who attend in person. Therefore, having a remote attendance option is likely an important consideration in conference or other training planning and development.

While the pandemic affected every professional or profession in some way, not all disciplines were likely affected the same way. Another implication for practice is understanding and adapting to the changes of the pandemic to adjunct fields, such as healthcare or the legal profession, and realigning life care planning practice to continue to provide excellent evaluative, research, and other services.

Implications for life care planner's income were varied, but generally suggest that the pandemic has had a net positive affect on such income due to decreased costs, increased work efficiencies, and perhaps even increased referrals or life care planning opportunities.

Recommendations for Best Practices

The results of the life care planning pandemic survey may not be surprising to life care planners who have continued to practice since 2020. The sustainability of some or all practices into the future is yet to be determined with additional research. Through adoption of technologies or practices of their use, life care planners have been exposed to new tools or to features of existing digital tools they previously had not used or harnessed full capacities. That is, life care planners have moved as an aggregate into the world of professionals who think digitally. Dr. Tsedal Neeley who wrote *The Digital Mindset* (Kostopoulos, 2022)(Kostopoulos, 2022), stated:

When we enter the digital mindset arena, we have to change how we frame everything we do. It's a process of changing how we think – how we think about collaboration, how we think about computation, and how we think about change. When you put all those through the lens of the digital mindset, you're operating differently . . . (para. 9). Neeley adds, "The digital mindset is not just about technical skills . . . it's also a way of thinking . . . about data, devices, and technologies as well as how we operate . . ." (para. 10).

By practicing through the pandemic, most life care planners have entered the digital mindset. Remaining in the digital mindset may take the life care planner, and the field of life care planning, into a mindful effort to sustain a productive and ethical remote practice.

It is not surprising that one of the greatest adoptions of life care planners in practice, whether for collecting data from evaluatees and their families, from their service providers, or in testifying about their opinions, are tools for video conferencing. This is consistent with the increase in the use of telemedicine that has an estimated growth of 38x since the start of the pandemic (Bestsenny et al., 2021). It is unlikely that once the pandemic becomes endemic, the use of video conferencing will bounce back to pre-pandemic use. Therefore, life care planners could benefit from recommendations from professional organizations providing sources for best practices around the issue of security and privacy such as (Wheeler, 2022, p. 9):

- ensure that any telehealth platforms that you use meet current federal and state[/provincial] privacy and security standards.
- use data encryption that is compliant with current HIPAA[/PIPEDA] security standards.
- back up your IT [(information technology)] system on a regular basis.
- ensure that security software is current and that firewalls are working.
- keep blank drives available to retain copies of encrypted systems so you have a backup if your electronic health records are held for ransom, despite reasonable precautions you have taken.
- maintain a separate, secure address file for all clients so you are prepared to carry out required breach notifications, as may be required by federal or state[/provincial] privacy, security[,], and breach notification laws.
- consider using some of the free cybersecurity services available through [the Cybersecurity and Infrastructure Security Agency,] CISA (see cisa.gov/free-cybersecurity-services-and-tools).

Recommendations for Future Research

Although the basics of survey research were used in the development and implementation of this study (Cobern & ADAMS, 2020)(Cobern & Adams, 2020), the need for data to make practice decisions in a dynamic environment to help ease the impact of substantial changes in that practice, necessitate short-period samples during a prolonged period of constant changes (Ulrich, 2020)(Kohler, 2020). Nonetheless, capturing fluctuations to practice can help identify the transitional or permanent nature of professional behavior after the environment settles to a more average cadence.

This first 2021 survey of remote life care planning practice was an exploratory study. Typically, to avoid the introduction of bias through pre-determined categories selected by a small group of subject matter experts, qualitative data is collected to survey questions and quantified, if appropriate. That was the case with this study. Except for the demographic items that were aligned with the decennial survey to allow benchmarking, all other questions of this initial survey allowed for qualitative responses. It is recommended that future studies on remote life care planning practice use the empirically derived categories resulting from this study's outcomes, with "Other" options. In addition, where appropriate, researchers may consider analyzing response differences between disciplines to clarify needs for training and practice development.

Furthermore, we recommend that the remote assessment supplement to the decennial survey of life care planning practice be administered with greater frequency, perhaps every 2-3 years. This accelerated frequency could help capture emerging and permanent practices by life care planners and the environments in which they practice not only emerging because of the pandemic, but also potentially other future movements impacting remote life care planning.

Lastly, life care planners en masse have been exposed to the practice of remote practice and at least half of the professionals suggest maintaining remote practice as part of their practice. To respond to this massive shift in practice, we recommend the development of best practice guidelines for life care planners to maintain the benefits of the hybrid model of remote and in-person work while reducing potential disadvantages.

Summary and Conclusions

Results of this study clearly indicate that the pandemic has had a dramatic impact on life care planners and the practice of life care planning – in both positive and negative ways. Respondents report multiple changes such as remote business practices and service delivery. Testimony, adoption of technologies, modifications for disclosures/assessment, willingness to travel (to conferences, evaluate evaluations, and courts) as well as retirement planning. Remote practices have enhanced the work-life balance for some as well as created issues for evaluatees/life care planners who are not digitally savvy. Life care planning is likely forever changed by the COVID-19 pandemic; future research is needed to document the course of these changes and best practices (including training) that will facilitate service delivery.

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