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EDITORIAL

Life Care Planning Summit III: Progress in Action

It was the third Life Care Planning Summit. Again, professionals engaged in the specialty practice came together to dialogue about this unique process, which continues to grow in importance in the health care arena. There were those who had come together before and those who came to the audience for the first time. All seemed to have a common goal: to work together to promote excellence in practice! Reflection on the two-day event reveals three outstanding outcomes – beyond consensus items…

- The willingness to share professional beliefs and values was universal.
- The desire to improve education and communication among practitioners was without dissent.
- The support for cohesiveness and <u>professional</u> practice was constant.

Professional beliefs and values were discussed in each of the groups. Clearly, the practice has expanded beyond litigation support, and the field welcomes this transition. Life care planners discussed with one another how to integrate various professional codes of ethics into every day meaning and support for practice. They passionately described their desire for a mechanism to deal with unethical practice and for unity regarding definitions of ethical practice in life care planning. It was an interesting evolution to observe. The practice appears to have advanced from beginning ethical competency – the "I" stages – to the advanced competency level: what must we do together, and how will it impact the whole?

Education and communication were key discussion points. Again, the evolution of the practice was apparent. Comments noted need for evidence based practice and research creating foundation for recommendations. Topics recommended for future programming reached beyond "current treatment topics" to determination of best practices and the relationship of clinical practice guidelines to testimony. Again, in reflection, we have progressed to the need for multi-levels of education: the beginners who must learn the basics and have mentoring; the experienced professionals who require more to challenge them, to promote critical thinking and to help them move forward, together, to define and strengthen life care planning as a specialty practice.

Never before, in prior Summits, had the desire to promote cohesiveness been so evident. While opposing points of view were presented, participants questioned one another to learn the rationale for their thoughts and comments, rather than appearing confrontational. There were points, such as mentoring, where no consensus was reached, yet the respect for varying views was consistent and unwavering. It was striking to hear one participant state, "I understand your position, and appreciate your position, however have you considered…" That statement is in striking contrast to many heard in dialogues in Summits 1 and 2.

As professionals, in transdisciplinary practice, we now stand together to share, to communicate, and to evaluate our positions from differing perspectives. The journey continues and the path may narrow, but the third Life Care Planning Summit demonstrates that we are maturing and indeed how far we have traveled!

Patricia McCollom, *Editor*

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An Overview of the RAPEL Methodology for Life Care Planners in Tort Cases

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Abstract. *Personal injury litigation is intended to compensate victims for damages when a party is found liable. Included in the reparation are costs associated with future medical care, lost earnings capacity, and other quantifiable damages. This article reviews the elements for expert opinions utilizing the RAPEL mnemonic, or memory prompt, for recollection of relevant elements, and offers suggestions for effective and reasonable opinions for tort cases. Although this article is most useful for life care planners who also are vocational experts, there are many areas of importance for professionals who act solely as a life care planner.*

This article discusses the topics and issues associated with offering expert testimony in forensic rehabilitation, in particular, personal injury litigation. According to Black's Law Dictionary (1999), forensics is defined as "used in or suitable for courts" (p. 660). Dorland's Medical Dictionary defines rehabilitation as "restoration of normal form and function following injury or illness" or "restoring … to gainful employment" (Friel, 1981, p. 1140). For pediatrics, the term "habilitation" is often used since the child is not necessarily being restored to a prior level of functioning and therefore not being "re"habilitated. However, for purposes of this article, the term forensic rehabilitation will be used to convey the principles associated with the specialized practice of offering expert opinions in civil litigation. This article will also outline the relationship between the rehabilitation expert and the courtroom, including selected terms that may be important to the rehabilitation consultant who is involved as an expert witness in the legal system.

Historically, rehabilitation consultants/counselors, particularly in the vocational arena, have been employed in various aspects of disability programs since the 1920s (Snow & Weed, 1998; Weed, 2000; Weed, 2004; Weed & Field, 2001). Over the years, it became evident that rehabilitation consultants would be a valued addition to assisting people with disabilities in physical restoration plans (i.e., rehabilitation plans) leading to work-related goals. The Veterans Administration first employed rehabilitation consultants to assist with vocational education training and then expanded services to include rehabilitation counseling. The federal government also used rehabilitation consultants to assist in the work efforts of United States citizens through the state-based rehabilitation services programs. The first organized attempt at returning people to work in the private sector was realized in workers' compensation insurance in the late 1960s when the International Rehabilitation Associates (IRA), now Intracorp, utilized nurses to facilitate return to work efforts for individuals injured on the job. By the 1990s, private sector rehabilitation had extended into most areas of disability care, including State and Federal workers' compensation, long-term disability, Social Security Disability Insurance (SSDI), health insurance, railroad injuries, longshore workers and employees who work at sea, and personal injury litigation (Weed, 1994; Weed, 1990; Weed & Field, 2001).

Most states require "qualified" experts (licensed or certified) to work with people receiving workers' compensation, and state rehabilitation programs now require qualified rehabilitation professionals to work with clients seeking assistance under the state-federal program. Counselors working as vocational experts in the Social Security system must submit credentials and be approved. However, in the personal injury litigation arena, this is not necessarily true. According to Kim Manufacturing, Inc. vs. Superior Metal Treating, Inc. (1976, p. 455), an expert witness is one "who by reason of education or specialized experience, possesses superior knowledge respecting a subject about which persons having no particular training, are incapable of performing an accurate opinion, or deducing correct conclusions." The inference is that in personal injury litigation, it is possible that an individual offered by an attorney as an "expert" in the area of rehabilitation would not be qualified in many other jurisdictions or industries based on credentials and certifications. Although most attorneys, in this author's experience, are conscientious about offering experts who are highly credentialed, there have been occasions where poorly qualified or prepared experts have participated in litigation as expert witnesses (for example, Elcock v. Kmart Corporation, 2000). Indeed, in a recent personal injury case, the vocational "expert" when challenged on his credentials, revealed no certification, no license nor graduate training specific to rehabilitation, no record of continuing education (though the general counseling degree was 20 years prior), and no professional organization memberships (stating that "I am not a joiner").

Selected Litigation-Related Terms

In litigation, an attorney first evaluates the liability of a claim, which will determine if the person who would be the targeted defendant in the lawsuit has liability (Taylor, 1997). Moreover, liability must be to the extent that some action in which the individual engaged was the approximate cause of the injury that has economic consequences. If this is the case, the attorney will begin to assess damages. First, it should be noted that jurisdictions throughout the United States are different. Federal cases, although commonly using similar rules, can have differences in the evidence rules based on interpretation by judges. In addition, each state may have their own rules and regulations with regard to what the requirements are to pursue a personal injury legal case. However, what is consistent is that the rehabilitation consultant's role is to identify damages.

Damages represent the economic consequences associated with a liable event (Elliott, 2004). Although there are many different types of damages, the most commonly encountered for life care planning experts are the following (see Table 1). General damages represent "presumed" costs associated with an injury but which are difficult to identify in a precise manner. An adult who is still able to work and earn at the wage level of pre-incident, but no longer has much choice about which jobs he or she can choose (say, loss of 90 percent of the personal labor market access), is an example. A person with a back injury who is in daily pain, although can still work, is another example. Another controversial element is hedonic damages introduced in the literature by Brookshire and Smith (1990), which many states reportedly have excluded. This approach relates to assessing the effect of an injury on one's

Table 1: Damages, selected definitions

- General damages presumed to follow from a wrong, but do not need to be actual losses
    - Lost opportunity
    - Pain and suffering
    - Hedonic damages refers to the loss of pleasures of life
    - Many states have significant limitations on hedonic and pain and suffering damages
- Special damages includes actual losses and must be claimed and proved - e.g., medical costs and lost capacity to earn.
- Punitive damages (also known as "added damages")

Source: http://dictionary.law.com/

pleasures of life. In general, the vocational expert can offer opinions about some of the characteristics associated with placement difficulties but it is difficult to assign "hard" costs to hedonic issues (see the "A" in RAPEL below).

The area of most important focus for the life care planning expert is related to special damages. One who is a qualified expert in both future medical care and vocational losses is in a position to "pull together" most of the "hard costs" associated with an injury. Identified and quantifiable losses can include not only costs associated with future medical needs and services, but also the impairment of earnings capacity as well as the cost of vocational re-training, counseling, and other costs associated with future allowable care. Note: Many, if not most, rehabilitation experts are not qualified to offer opinions to both life care planning and vocational damages and there may be two experts who are needed to coordinate efforts to provide a comprehensive damages analysis.

Punitive damages refer to egregious behavior on the part of a defendant where a pattern of deceitful conduct is uncovered. For example, in 1981 the Ford Motor Company was hit with a jury award of $125 million in punitive damages when Richard Grimshaw was severely burned from injuries incurred when, in his 1971 Pinto, he was struck at 28 mph (however, the court eventually reduced the award to $3.5 million). Ford apparently had internal memos that revealed that they knew about the design problems but chose to go ahead with production anyway (Grimshaw v. Ford, 1981).

Although an overview of various damages is provided for background information, the focus of this article is on special damages. Often, rehabilitation or life care plans are used to identify and mitigate damages from a permanent injury by offering recommendations to restore a client medically and vocationally.

Unlike criminal law where a jury must determine guilt beyond a reasonable doubt, the test in personal injury litigation is that the preponderance of evidence supports the contention by the plaintiff regarding liability and damages (Elliott, 2004; Taylor, 1997). Both sides, plaintiff and defense, may retain their own experts who can be referred to as testifying experts or consulting experts. In many cases, the defense retains consultants who are not disclosed (i.e., consulting experts) and who provide consultation and education to the attorney on relevant issues and perhaps even help develop questions to be used at deposition and/or trial. The testifying expert is one who is expected to appear at trial and is “disclosed” to the other side. These experts are exposed to justifying their opinions to an opposing attorney or several attorneys. For example, medical malpractice cases may have many defendants (e.g., hospital, nurses, and doctors) and each defendant will have their own attorney who may ask questions during a deposition.

There typically is a basic philosophical struggle for the testifying expert. Lawyers are trained to be advocates for whichever side they are retained (plaintiff or defense). Therefore, the attorney, whether plaintiff or defense, is charged to present the best stance for the case to “win.” In contrast, the rehabilitation expert’s role is to represent the rehabilitation profession and offer a professional and objective opinion (Berens & Weed, 2001; Weed, Berens, & Pataky, 2003; Weed & Field, 2001). This is more difficult than it may appear, for two reasons. One is that some experts can become “caught up” in the legal arguments that the retaining attorney is offering and, therefore, appear to lose their objectivity in favor of the side of the retaining attorney. The other is that it is possible the retaining attorney is “feeding” information to the expert that supports a particular position, and withholding other information that may be relevant to the case. The rehabilitation expert must be vigilant to maximize the chances of reasonable, legitimate, and objective opinions that are defensible.

The first instrumental concept for life care planners to comprehend is to identify future care damages. It is assumed that the reader is familiar with the basic life care plan entries which cover both medical and non-medical care. Based on the author’s experience, one overlooked detail seems to be the inclusion of needs that are not related to the injury. For example, clients with pre-existing hypertension that was controlled with medication typically should not have the cost of blood pressure medication included in the life care plan unless there is a causal relationship between the continued need for blood pressure medication post-incident and the incident itself. Another overlooked detail is the deduction or reduction in costs included in a life care plan for items commonly used by the general population or required by the individual prior to the incident or if the incident had not occurred (assuming the client is compensated for earnings capacity). Such items include routine medical and dental care recommended for the general population (i.e., annual physical examination, twice per year dental cleaning and exam), routine eye care (applicable in cases where eye or vision impairments are evident), and even such common items as a cell phone or personal computer. Bigger ticket costs that should also be deducted from the life care plan include the average cost of a standard home (in cases where a wheelchair accessible home is recommended), the average cost of a vehicle (in cases where a customized or wheelchair accessible van is recommended) and the cost of food and housing associated with facility based care.

Another instrumental concept that life care planners need to understand is the notion of lost earnings capacity (Weed, 1995; Weed, 1996; Weed, 2004; Weed & Field, 2001). In adult cases, many rehabilitation experts confuse lost earnings with capacity to earn. In the legal literature, it is clear that people who have no work history, such as children and homemakers, may still have a capacity to earn either when they become adults or if they were to choose to enter the workforce. Therefore, it is unreasonable to assume that an injured homemaker who is unable to go to work and was not earning an income prior to injury, has no loss of capacity to earn an income. In Rodriques vs. McDonnell Douglas (1978), it is noted that earnings capacity includes the capacity to learn or to be trained. In Klingman vs. Kruschke (1983), it is determined that a person does not have to show wage reduction to have a loss of earnings capacity. Indeed, an adult may be able to return to work at an income consistent with what was earned at the time of the injury, but which does not represent his or her capacity to earn. An example to illustrate this point is a third year law student who is close to graduation but is severely injured while delivering pizzas. The part-time income that he earned obviously does not represent his capacity to earn once he graduates from law school. Therefore, he is compensated at the expected loss of income capacity of an attorney, rather than what he was earning at the time of injury as a pizza deliverer. Although earnings capacity involves the potential to earn, or the potential that the person might attain, these opinions cannot be "rank speculation" (Riles vs. Home Insurance Co., 1982). Methods and procedures subjected to peer review and replication by other professionals are important for establishing a solid foundation for expert opinions.

Consistent with some legal case precedents, there are certain elements that are necessary for personal injury litigation when assessing damages for individuals with a disability. In previous publications, the RAPEL method has introduced these elements (Deutsch & Sawyer, 2003; Dillman, 1987; Dillman, 1998; Weed, 1994; Weed, 1995; Weed; 1996; Weed, 2004; Weed, 2000; Weed & Field, 2001) and an overview will be provided in this article.

RAPEL Elements

RAPEL is a mnemonic that is intended to prompt consultants to readily recall which relevant topics for damages in personal injury litigation should be included (see Table 2). As noted above, special damages fall within the purview of rehabilitation consultants. In this author's experience, it is common to observe missing "data" in reports and RAPEL is a tool intended to help forensic experts remember to include all relevant information in their reports.

Table 2 RAPEL Explanation (Reprinted from Weed & Field, 1994)

The **RAPEL** Method:
A Common Sense Approach To
FUTURE CARE AND EARNINGS CAPACITY ANALYSIS

***R*EHABILITATION PLAN**: Determine the rehabilitation plan based on the client's vocational and functional limitations, vocational strengths, emotional functioning, and cognitive capabilities. This may include testing, counseling, training fees, rehabilitation technology, job analysis, job coaching, placement, and other needs for increasing employment potential. Also consider reasonable accommodation. A life care plan may be needed for catastrophic injuries.

***A*CCESS TO THE LABOR MARKET**: Determine the client's access to the labor market. Methods include transferability of computer programs, transferability of skills (or worker trait) analysis, disability statistics, and experience. This may also represent the client's loss of choice and is particularly relevant if earnings potential is based on very few positions.

PLACEABILITY: This represents the likelihood that the client could be successfully placed in a job. This is where the "rubber meets the road." Consider the employment statistics for people with disabilities, employment data for the specific medical condition (if available), economic situation of the community (may include a labor market survey), availability (not just existence) of jobs in chosen occupations. Note that the client's attitude, personality, and other factors will influence the ultimate outcome.

EARNINGS CAPACITY: Based on the above, what is the pre-incident capacity to earn compared to the post-incident capacity to earn? Methods include analysis of the specific job titles or class of jobs that a person could have engaged in pre- vs. post-incident, the ability to be educated (sometimes useful for people with acquired brain injury), family history for pediatric injuries, and LMA92 computer analysis based on the individual's worker traits.

Special consideration applies to children, women with limited or no work history, people who choose to work below their capacity (e.g., highly educated who are farmers), and military trained.

LABOR FORCE PARTICIPATION: This represents the client's work life expectancy. Determine the amount of time that is lost, if any, from the labor force as a result of the disability. Issues include longer time to find employment, part-time vs. full-time employment, medical treatment or follow-up, earlier retirement, etc. Display data using specific dates or percentages. For example, working an average of four hours a day may represent a 50% loss.

Rehabilitation Plan

The “R” in RAPEL refers to a rehabilitation plan which is expected to improve or maintain the client’s functioning, as well as limit or mitigate damages sustained in personal injury. A life care plan may be offered to enhance the client’s medical prognosis and living circumstances. Items in the future care plan may include direct medical care from physicians and therapists or ancillary recommendations, such as architectural barrier removal, transportation needs, specialized recreational equipment specific to the disability, home furnishings and accessories, among others. To prepare a comprehensive plan, see Deutsch and Sawyer (2003), Weed (2004), and Weed and Field (2001). If a child or adult has the potential to be educated or trained, the life care plan should include educational support, vocational assessments, guidance and counseling, job analyses, labor market surveys, and other vocationally relevant services. A rehabilitation plan may include vocational assistance with regard to evaluation, counseling, job coaching, tuition, fees, books and supplies, as well as rehabilitation technology equipment and supplies (as appropriate). If the life care planner does not have the credentials to offer vocational opinions, then it is expected that recommendations will be solicited from a qualified vocational expert in the same manner as medical and psychology recommendations are solicited from relevant experts

Access to the Labor Market

This section typically will not be a part of the life care plan report. The “A” in RAPEL refers to access to the labor market which is based somewhat on the SSDI concept of “employability.” In determining access to the labor market, the intention is to identify the number of jobs which an individual might have access to based on a worker trait profile utilizing the U.S. Department of Labor functional categories, without regard to whether the jobs are available (Field & Field, 1992, 2004). Through the use of specialty computer programs, it is possible to determine the worker trait profile of a particular client. For a child, adjustment for expected improvement with growth and aging regarding the physical, mental, and cognitive capabilities that the child might achieve as an adult is considered. By searching the databases on various traits (which can be accomplished through several computer programs such as Skilltran [www.skilltran.com], OASYS [www.vertekinc.com], and the McCroskey Vocational Quotient System [www.vocationology.com]), it is possible to identify which job titles from the *Dictionary of Occupational Titles* (DOT) (U.S. Department of Labor, 1991), that the individual would have access to pre- versus post-injury. In addition, some computer programs are able to cross reference to census codes which will provide the number of jobs that would be available pre- versus post-injury. Next, it is possible to cross reference to the U.S. Bureau of Labor Statistics to identify the median weekly wages associated with each of the census codes in an attempt to assess the economic consequences related to loss of or reduced access to employment. (Note: The Census code arrangement has been substantially modified so some older software programs may not correctly cross-walk to economic data.)

Another scenario is that a client may have a substantial reduction in the number of jobs available, but not have a significant loss of ability to earn an income. The value of the labor market access approach is, in part, to assess the potential for actual placement in a job. For example, if the person has a large loss of access to the labor market, it is reasonable to expect s/he will be harder to place in a job and have fewer opportunities to change jobs or move up the occupational ladder when compared to the average person without a disability.

Placeability

The “P” in RAPEL refers to placeability. The determination of ease of one’s vocational placement is expected to flow from access to the labor market analysis previously described. Essentially, what is the potential for the client’s successful placement in a particular industry or job? Earnings capacity may or may not be affected. However, in the concept of the age earning cycle, it is possible that an individual who may have an equal expected entry-level income will have a reduced ability to “climb the ladder” and have a lower earnings ceiling than would have been expected absent the injury. Further, it is expected that easily placed people need fewer services, on average, than people who are more difficult to place. That is, individuals who have lost access to 95% of their personal labor market can be expected to require substantial services and perhaps retraining to be able to locate suitable employment.

For purposes of this article, suitable employment is defined in the following legal citations. "Employment or self-employment which is reasonably attainable in light of the individual's age, education, previous occupation, and injury, and which offers an opportunity to restore the individual as soon as practical and nearly as possible to (his or her) average weekly earnings at the time of injury" (Workers' Compensation Law Bulletin, 1992). Some clients have successfully challenged the assumption that because they are able to perform the physical functions and they possess the aptitude to perform some occupations that it constitutes suitable employment. One case demonstrates the issue: A licensed practical nurse was injured on the job. The employer offered her a clerical position at the hospital which she eventually turned down. Although the clerical job was within her physical limitations, it was not considered "suitable employment" because "Woods is a nurse and she never expressed any interest in doing clerical work" (Workers' Compensation Law Bulletin, 1992, p. 7).

Maryland similarly defines suitable, gainful employment as "... employment, excluding self-employment that restores the disabled covered employee, to the extent possible, to the level of support at the time that the disability occurred" (Workers' Comp Law, LE, 9-670, p. 212). The law further states that in determining whether employment is suitable gainful employment, the following shall be considered: (1) the qualifications, interests, incentives, pre-disability earnings, and future earnings capacity of the covered employee; (2) the nature and extent of disability of the covered employee; and (3) the current and future conditions of the labor market. Other states including Oregon, California, and Minnesota, also have adopted guidelines which include personality and interest factors that are often over looked in vocational evaluations (sources: Oregon's Code OAR 436-120-005 [6]; California Workers' Compensation Code L.C. 4635 [f]; Minnesota MS 176.102 [13]).

Another element related to placeability is the potential of an individual to secure only one or two jobs, particularly one that has been customized to meet his or her particular functional limitations. In this situation, if the individual loses the employment, then placement in another job is difficult, if not impossible. This is known in the workers' compensation and personal injury arenas as "odd lot doctrine." Under the odd lot doctrine, any work that the client might be able to do would be of limited quality, dependability, or quantity, and there is no reasonably stable market for his or her labor activities (Gilcrease vs. J. A. Jones Construction, 1982; Loprinzo vs. Mald, Corp., 1983; Spring v. Department of Labor and Industries of State of Washington, 1982; Haynes v. State Accident Insurance Fund, 1976).

Although on the surface it may appear that a life care planner, who is not also a vocational expert, does not need to address vocational issues. However, placeability opinions may have an effect on the life care plan such that the plan may not adequately include all relevant services. In one case, a life care planer assumed the client to be completely vocationally disabled (unable to work) and provided for 24 hour care while the vocational expert retained on the same case opined the client could work at least part-time and did not need attendants 24 hours per day.

Earnings Capacity

The "E" in RAPEL refers to earnings capacity and is based on one's capability to earn an income. This differs from the concept of lost earnings because the person's actual income at the time of injury may not reflect what she or he could have achieved if an injury had not occurred (see information regarding the pizza delivery driver earlier in this article). In general, the earnings capacity of an individual is that which reasonably can be attained and held (Deutsch & Sawyer, 2003; Weed & Field, 2001). To elucidate further on earnings versus earnings capacity, refer to Figure 1, which is based on economic data compiled from noted economist, Everett Dillman (1987, 1998). This information shows that the percent relevancy for the actual earnings as the estimate for expected earnings capacity does not relate at all to expected earnings until after age 20 (Weed & Field, 2001). Generally, by the time an individual turns 35 to 40 years of age, the earnings history may represent the person's capacity to earn a living. However, each client must be evaluated individually. For example, workers who have low intelligence and work as laborers in the construction industry may very well have reached their capacity to earn by the time they reach their 20s. However, professionals, such as attorneys, may not have reached their maximum capacity to earn until the age of 50 or 60.

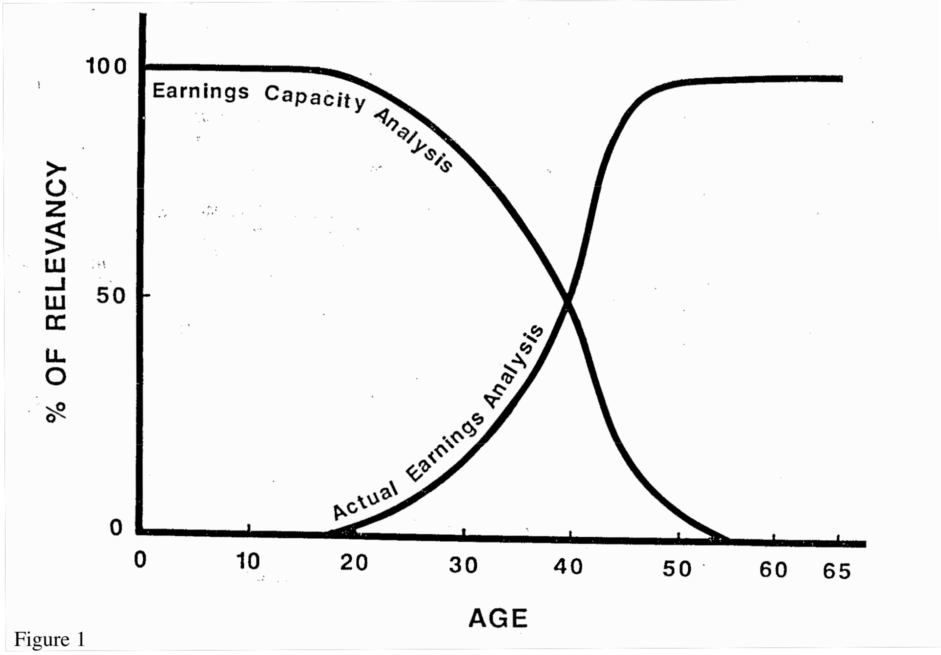

Figure 1
Earnings vs. Earning Capacity
(Reprinted from Weed & Field, 1994, 2001)

Based on a rehabilitation plan, access to the labor market and placeability factors, the individual may or may not be employable. If employable, an estimate of the person's earnings potential can be displayed in various ways. Earnings potential for children can be determined by identifying jobs or job categories similar to the child's parents and/or older siblings, or assessing the educational potential of the child pre-versus post-injury, or identifying census codes for the job titles and cross-referencing the codes to wage data from the U.S. Bureau of Labor Statistics (updated yearly) to obtain median weekly wages of jobs based on worker traits. For children and adults, another option is to manually, or via a computer program, estimate worker traits and skills to sort through vocational options (Bast, Williams & Dunn, 2002; Dunn & Kontosh, 2002; Gibson, Earhart & Lento, 2002; Field, 2002; Weed & Field, 2001; Weed, 2002). McCroskey (2003) asserts statistical support for using a computer to arrive at an opinion about expected job outcomes.

Other considerations include analyzing the job category for elements specific to the industry or employment option. For example, construction labor, landscaping, fishing, tourism, sports-related occupations, and the like are often seasonal in nature. Union-related occupations may have clear patterns of promotion (e.g., apprentice, journeyman, master, and foreman). Also, homemakers may have chosen to stay home with children, but still have a capacity to earn. A "stay-at-home" mother (or father) with a master's degree in education certainly has the potential to earn an income and, if injured, the earnings capacity would be based on what employment opportunities would be pre- vs. post-incident.

Labor Force Participation

The "L" in RAPEL refers to the labor force participation, or worklife expectancy of the client. Although an individual with a permanent disability may not experience a loss of work life expectancy, it is more common for a person with a disability to take longer to find a job, or enter the labor market at a later date than if the injury had not occurred (U.S. Department of Commerce, 1989). Also, this person may experience more time lost between jobs because of greater difficulty to find employment, or may need to take regular time off for medical treatment (e.g., an individual with an amputated limb who requires routine prosthesis maintenance/adjustments and replacement). Additionally, it is not uncommon for people with disabilities, particularly with brain injuries, to have fatigue which may be a reason for working part-time. There also is potential for earlier retirement or difficulty in keeping a job. In general, each of these factors can be economically determined. To illustrate, assume an individual worked an average of 40 hours per week prior to injury and sustained brain damage such that the evidence demonstrates that a reasonable expectation would be to work four hours per day on average, or 20 hours per week. This would translate to a 50% loss of work life expectancy, without consideration of other factors.

Education plays a significant role with regard to work life expectancy. Under the work life estimates published by the U. S. Department of Labor (1986) and the works of Ciecka, Donley and Goldman (1995), an individual with a high school education may enter the work force at an earlier age, but an individual with a college degree will actually spend more time in the labor market, even though the college graduate generally enters the work force four years later than someone with a high school diploma. This is a result of the types of jobs that a high school graduate may obtain. As an example, construction work may very well be seasonable in nature, or there may be minor injuries that require time off, or strikes that would contribute to a loss of time in the labor market. Furthermore, the physical demands of construction work may necessitate an earlier exit from the job market than a job that is light or sedentary within an indoor or protected environment.

Life care planners need to be aware of work life expectancy opinions in cases where additional attendant care or other relevant services may be needed either as a result of part-time work or early retirement.

General Vocationally-Related Considerations

It is important to note that various statistics and research articles are available to the rehabilitation consultant to help support one's expert opinion. For instance, according to the U.S. Census Bureau (as cited in Farley, 1996), about 67% of people with disabilities, who claim that they want to work, are unable to obtain suitable employment. Correspondingly, according to the Harris Poll (1994), the Americans with Disabilities Act has not significantly enhanced the potential of a person with a disability to return to employment. On the other hand, it is noted that public accommodations, including transportation and education, have improved. One way to ameliorate some effects of disability on employment potential is through effective rehabilitation and professional help for placement of people with disabilities. However, the vocational expert is cautioned to use statistics to support one's opinion, not the other way around. That is, just because one has a disability does not automatically mean they are expected to be unemployable or unplaceable. Each client's circumstances must be individually evaluated and, although the data suggests that the majority of individuals with disabilities do not work, that does not preclude the reasonable opinion that some individuals with a disability, if given proper support and services as outlined in a life care or rehabilitation plan, can be expected to "beat the odds" and become employed as an individual with a disability.

Other considerations for expert opinion relate to:

- Education and earnings (Ezell, 1997; Farley, 1996; Weed, Baird, Dunlap, & Lewis, 1999),
- Full-time vs. part-time work and earnings ratio, since more people with disabilities work proportionally part-time, as well as age at the time of injury and minority status (U.S. Department of Commerce, 1989),
- Differences between women and men with disabilities (Nosek, 1996),
- Job tenure based on education and age (Ezell, 1993; U. S. Bureau of Labor Statistics, 1998),
- Appearance (Hamermesh & Biddle, 1993; Johnson, Ley & Benshoof, 1993; Rubin & Rossler, 2001). (Also see Veterans Administration, 1991; & Elias v. Ford Motor Co., No. 82-1587L, Ist Cit. 1983 for a successful use of this concept in personal injury litigation),
- Height (Judge & Cable, in press),
- Educational achievement for pediatric cases (Elias, 1997; Hout, 1998; Martin, 1998; Toppino, Reed, & Agrusa, 1998; U.S. Bureau of Census, 1996; U. S. Department of Labor, as cited in Yearwood, 1999), and
- Family influences on children (Farley, 1996; Hout, 1984; Joesch & Smith, 1987; Laband &
- Lentz, 1983; McLanahan, 1997; Potok, 1995).

For general details about the references listed above, refer to the article by Weed (2000).

Another factor is the concept of "regression toward the mean" for statistical extremes (Tabachnick & Fidell, 1996). This concept is established in basic statistics where a "normal population" exists. Extremes, when repeated, positive and negative, can be expected to "regress" or return to some degree toward the mean or average. Practically speaking, this will be demonstrated in the following example. Assume a child is the result of a union between two parents, both of whom tested at the 99th percentile of intelligence. It is statistically likely that the child will be *somewhat* more toward the average than his or her parents, i.e., regress toward the mean.

Basic Testimony Issues: Daubert and Kumho Tire Rulings

Historically, experts have been allowed to testify if the person offering an opinion has knowledge and experiences that would assist the jury in determining liability and damages. Initially, the "general acceptance theory" was offered which indicates that scientific evidence should be based on evidence generally accepted in the specific field of knowledge (Frye v. United States, 1923). In 1993, the Daubert decision provided an "enhancement" of the Frye decision as it encourages the judge to become a "gatekeeper" so that court time will not be wasted on "junk science." Under Daubert (Daubert v. Merrell Dow, 1993), the expert's opinion needs to be based on scientific or valid evidence which has been subjected to peer review and publication. However, Daubert also recognized that some propositions are too particular, too new, or of limited interest to be published. Therefore, the specific requirements include (1) whether the method consists of a testable hypothesis, (2) whether the method has been subject to peer review, (3) known or potential rate of error, (4) existence and maintenance of standards controlling technique's operation, (5) whether the method is generally accepted, (6) relationship of technique to methods which have been established to be reliable, (7) qualifications of expert witness testifying based on methodology, and (8) non-judicial uses to which the method has been put. However, the list is non-exclusive, and each factor need not be applied in every case (also see Federal Rules of Evidence Rule 702, 28, U.S.C.A.). The ruling underscored the need for "valid" scientific evidence.

In 1999, the Kumho Tire ruling extended this to non-scientific experts (Kumho Tire v. Patrick Carmichael, 1999). Under Kumho Tire, an individual was offered as an expert on defective tires. The individual's testimony was disallowed by the trial judge in part because he was unable to cite literature that would demonstrate that he used a generally accepted method. Also, he could not identify any peer who agreed that his method was valid or reliable. The reader who has more interest in this topic is referred to the legal cases cited in this article, as well as to an article by Feldbaum (1997) on the Daubert decision and its interaction with the federal rules and, specific to the life care planner, the article titled The Life Care Planner, the Judge and Mr. Daubert (Countiss & Deutsch, 2002).

It is clear that experts need to utilize data and published methods to support their opinions. In this author's view, the days are numbered for rehabilitation experts who simply attempt to justify opinions based on "my education and experience" without having supporting documentation or substantial clinical experience. Clearly, transferable skills analysis and life care planning procedures have been published in many forums, and the professional is advised to use available resources (Bast, et al., 2002; Dunn & Kontosh, 2002; Gibson, Earhart & Lento, 2002; Field, 2002; Field & Weed, 1988; Weed & Field, 2001; Weed, 2002; Weed, 2004).

Ethical Considerations

In recent years, ethics have taken the forefront in most certifications related to rehabilitation, for example, the Code of Professional Ethics for Rehabilitation Counselors doubled in size with the new Code revisions effective 2001, and increased emphasis on ethical standards in forensic settings are included in the revised document (Weed & Berens, 2003). Many ethics guidelines across various certifications seem to overlap with each other while others have significant differences in detail. However, there are several concepts that appear to apply across the board. According to Banja (1994), Blackwell (1999), and Weed and Berens (2004) the four commonalities are:

1. **Autonomy**. This refers to the client's right to information and voluntary decision making. The rehabilitation consultant should respect the client's right to choose. However, when a lawsuit is filed, clients have generally waived their rights to confidentiality. Experts need to make clear their role (through Professional Disclosure) when conducting interviews to reduce or eliminate the potential for misunderstandings or miscommunications.

2. **Nonmaleficience**. This concept refers to the client's right not to be harmed. The most common way to harm a client in human services is to engage in sexual relations (Weed, et al., 2003). In personal injury cases, the likelihood that the consultant would be in a position to "harm" a client in this way is rare.

3. **Beneficence**. This concept presumes that clients receive appropriate care or services. This issue is specifically relevant for professionals who have trouble maintaining professional competence. Life care plans and vocational opinions must be based on existing standards of practice, comprehensive and appropriate.

4. **Justice**. This details the client's right to receive unbiased and nonprejudicial treatment. This issue is the one that is most suspect since, in personal injury litigation, the general perception (real or not) is that consultants are commonly biased toward the side that has retained them. For example, one vocational rehabilitation "professional" offered opinions regarding loss of earnings without regard to the affects of a rehabilitation plan. When asked "why?" on deposition, he reported that he was not asked to do so by the attorney even though this is considered standard practice for vocational experts.

Ethics statements of most professional organizations are lengthy and are not reproduced in this article. In addition, the reader may be a nurse, case manager, vocational expert, life care planner, or psychologist, and ethical issues are different for each. To be properly educated in this area, readers are referred to the various ethics requirements that are relevant to their particular certifications/licenses depending on which role is assumed. This may include review of documents from professional associations, certification boards, and licensure requirements.

Conclusion

Life care planning and vocational rehabilitation professionals are important adjuncts to the settlement of a personal injury case and, as a testifying expert, to educate a jury regarding the effects of an injury on a client's medical and other future care needs as well as earnings capacity. Included in the analysis may be a rehabilitation plan to increase the client's function or to mitigate some of the vocational damages, and a life care plan for enhancing the client's medical outcome (Note: The published format for life care plans includes the elements for a

Vocational/Educational Plan). Many court cases clearly have established the efficacy and the need for knowledgeable experts to offer opinions in this area. Experts interested in this arena are urged to become educated with regard to available practice guidelines, and government and other research data on which to support their opinions. Options include attending conferences such as the annual International Conference on Life Care Planning typically held in October of each year (contact www.mediproseminars.com for details and to register). Experts also are urged to be ethical and conduct their practice in an ethical manner by adhering to the applicable codes of ethics that govern their area of expertise. Further, experts are urged to follow published standards of practice and provide objective and professional services to avoid being "caught up" in the litigation process by "taking sides." If life care planning and rehabilitation experts utilize published standards and are reasonable and appropriate in their opinions, then the perceived value of experts in the courtroom will continue to be enhanced.

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Outcome Measurement in Life Care Planning: One Company's Approach

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Editor's Note: This article presents the concept of outcome measurement in life care planning and encourages others to develop and use standardized tools for evaluating quality and satisfaction. The survey instruments referenced in the article have not been peer-reviewed and only one of six questionnaires is printed in its entirety.

Abstract. *The purpose of this article is to identify and discuss the development of an outcome measurement system for the evaluation of the life care planning process. A literature review conducted by the authors did not reveal published standardized tools for evaluating life care planning services. In the authors' view, the importance of outcome data to substantiate the value of a service is important and one sample instrument used by the authors is offered as a model.*

Introduction

Outcome measurement is a process by which a professional or organization uses an evaluation tool to quantitatively measure customer satisfaction and identify benefits with services provided. It is this ongoing collection of feedback which promotes adjustment, evaluation, and fine tuning of the service that allows for service improvement.

The importance and value of outcome measurement has become most evident across all spectrums of professional organizations within the last decade (Matthews, 2000). A comprehensive literature review reveals that there is some method and level of outcome measurement, management, and evaluation in all professional sectors; most evident is the presence of outcome measurement systems in the health care industry. According to one source, "Outcome management increases the potential of organizations to achieve competitive leverage, quality patient care, and efficient operations through effectively collecting and interpreting information. This ability will become increasingly important in the future as the cost of care will certainly rise and the competition for revenues increase." (Matthews, 2000, p. 55).

Organizations use outcomes management, data collection tools, and data resources to gather precise information to be able to validate the importance of a particular service or program. Outcome measurement provides a wealth of knowledge that should ultimately feed valuable information back into the program or service in order to provide continuous improvement and increased effectiveness of the service or product. While outcome evaluation analyzes the effectiveness of an activity or process, it also can improve delivery mechanisms by making them more efficient and less costly. Outcome evaluation is also a measurement tool which allows a user to identify strengths and weaknesses, produce data, and verify results. These data may then be used for public relations and promoting services. A professional might also employ the data to compare programs to decide which should be retained and to identify effective programs for duplication elsewhere.

It is important to recognize the value of the research, support, and organizational commitment required to plan and implement an effective outcomes management program. To facilitate progression towards an integrated outcomes information management system, one must be aware of emerging outcomes measurement; be proactive in integrating existing measurements with new measurements; and be sure that the information is precise, accurate, valid, and relevant to the organization's operations. In order for any business or organization to remain successful within our current high tech, information-seeking society, the business/organization must be able to clearly identify and document the value of the service or product which they provide.

Toward this end, the authors conducted a literature review and discovered that no standardized tool for businesses to evaluate life care plans was revealed. Two published studies indicated that life care plans are reliable over time when established procedures are followed (McCollom & Crane, 2001; Sutton, Deutsch, Weed & Berens, 2002). However, survey forms soliciting feedback from various people who may be involved in the life care planning process was not found.

Outcome Measurement and Rehabilitation

Rehabilitation nursing continues to evolve as a specialty practice within the nursing profession. In the authors' opinion, one particular role or niche that is a perfect match to the unique skills and knowledge of the rehabilitation nurse is that of the Rehabilitation Consultant/Life Care Planner. Rehabilitation nurses have traditionally played a fundamental role in identifying appropriate services and resources for individuals with disabilities and/or chronic illnesses. The identification of appropriate resources and coordination of care for the individual with a disability is paramount in facilitating an improved quality of life. Within all areas of health care, particularly within rehabilitation, the importance of tracking vital patient information for outcomes measurement continues to influence the delivery of care and services. The same should be true for the service of life care planning.

Within the specialized practice of life care planning, there is a definitive process which guides the development of the life care plan (LCP) and this process begins with general discussion regarding the nature of the disability or chronic illness of the individual for whom the LCP is intended. All pertinent medical, academic and/or vocational records are reviewed and incorporated within the LCP and a comprehensive evaluation of the individual's status according to NANDA (North American Nursing Diagnosis Association) approved nursing diagnoses is then completed. Communication (written and/or verbal) with all treating professionals is attempted in an effort to ascertain recommendations in relation to their area of specialty. The patient information and components of the life care plan are thoroughly evaluated to ensure focus on prevention of disability complications and outline expectations of disability management over the life span. Throughout the development of the life care plan, identifying the need for other professional evaluations and/or referrals for services, accessing equipment, and outlining appropriate costs contributes to greater quality and satisfaction. This comprehensive approach in preparation of the LCP yields benefit to the client, the recipient of the LCP, and the rehabilitation professional. At the completion of the LCP process, the client is requested to complete the outcome measurement tool which accompanies the report and a self-addressed stamped envelope is included with the survey for the client's convenience in returning the form. In addition, the client is again contacted by telephone in an effort to determine if the LCP has met their needs. This provides additional opportunity for open discussion regarding questions or concerns in relation to the LCP.

Over the past six years, the authors have developed an outcome measurement system for evaluation of the life care planning process within their company. Consultants in the company use the system to elicit feedback from those for whom the life care plan was prepared and from third parties including the client's legal representative and insurance company. The outcome measurement system developed by the company is used to gather input on a regular basis through the use of customer satisfaction surveys, questionnaires, ongoing informal inquiry, and other forms of communication. The collection of this information is vital to evaluating and insuring that services are meeting the needs and expectations of clients and their families. Consumers have a definitive role in the planning, development, delivery, and evaluation of the services received and responses from the outcome surveys are incorporated into the authors' practice. The information obtained through the use of this process can be a prime consideration in the ongoing strategic planning process which guides any life care planning practice.

Based on the authors' experience, including preparation of 50-70 new LCPs annually, revision of an equal quantity, and preparation of petitions of care for special needs trusts, the outcome measurement surveys help to assess the effectiveness of LCPs, timeliness to complete LCPs, and overall satisfaction with the end product for it's intended purpose. Once the LCP is implemented and service coordination has been initiated, a survey is taken after six months to determine patient and/or family satisfaction with services provided. In addition, an annual satisfaction survey is taken on each case while services are being provided, duration of which varies from case to case. Currently, average utilization of services per case is 6 years with the longest case being 13 years.

As previously stated, a literature search revealed that there presently are no standardized outcome measurement systems available specifically for the life care planning process. As noted above, research reveals that studies have been done to measure the reliability of life care plan recommendations over time, with results showing that life care plans overall are reliable and accurate in outlining future care needs (McCollom & Crane, 2001; Sutton, Deutsch, Weed, & Berens, 2002). Questionnaires used by the authors are specifically designed to evaluate whether the life care planning process is meeting the needs of clients (defined here as the person with the disability). The advantages of questionnaires are that they can be non-threatening, completely anonymous, inexpensive to administer, and easy to compare and analyze. The disadvantage to questionnaires is that they can be impersonal and can be set aside and not returned. Additionally, the life care planner should be aware that questionnaires in and of themselves may present reliability problems, poor return rates, and accuracy problems in relying on self-reports. For these reasons, efforts should be made to minimize any potential effect of these problems on the results.

With the objective of the questionnaire to gather information to evaluate the strengths and weaknesses of the services provided, quantitative (ratings, rankings) and qualitative (written commentary) information is obtained. The results are then tabulated, included in a report for internal use to develop program recommendations, and shared with different groups including present and future clients.

Tips for the Life Care Planner

When developing a survey for outcomes measurement, life care planning professionals should be clear of what input is being requested and how that information will be utilized. This will provide focus on what information will be needed and will help determine what questions will be asked. Avoid wording that may influence the respondent to answer a certain way so as to avoid biased responses. Surveys need to include a brief explanation of the purpose of the questionnaire, clear explanation of how to complete the questionnaire, and directions about where and how to return the completed questionnaire. Avoid including too many questions as this may discourage potential respondents from completing the questionnaire. Checklists can lessen the time required to complete the survey but must be carefully phrased to elicit the information required. An example of one of the surveys used by the authors is included later in this article.

Purpose of an Outcome Measurement System for Life Care Planning

1. Provide opportunity for clients and families to communicate concerns.
2. Provide clients and families with comprehensive care and control over life care management experiences.
3. Ensure services provided are meeting the needs of all involved, including external parties, officers of the court, trustees and insurers.
4. Provide an opportunity for evaluation of the efficiency/effectiveness/progress performance through the eyes of its consumers.
5. Improve the quality of life for clients and families.
6. Communicate to internal staff, clients and families in a format that recognizes the value of input.
7. Encourage continued participation and incorporate outcome data in a strategic plan.
8. Monitor internal organization efficiency measures.

Survey Procedure Process

1. Surveys sent to the requester with the final copy of the LCP.
2. Surveys sent to families receiving case management or care coordination services on an annual basis.
3. Survey sent annually to the individual with the fiduciary responsibility.
4. Survey format and content reviewed annually for relevancy/need for addition/deletion of measurements based on input from staff and clients and families.
5. Organizational efficiency measures monitored quarterly to provide data for strategic planning.
6. Life care coordinator is responsible to communicate to administrative assistant the frequency of survey distribution based on acuity of clients and families, frequency of treatments, team meetings and identified family needs.
7. Progress measures documented for clients and families who receive services within program for six months or when approval from funding is secured on a semiannual basis.
8. Goals reviewed on a semiannual basis for active life care management cases; revised

goals are identified if indicated by documentation.

Evaluation of Completed Surveys

1. Returned surveys are reviewed and shared with the life care planning staff on a periodic basis.
2. Data from the surveys is analyzed utilizing the outcome measurement report tool.
3. Data from the organizational efficiency measures are analyzed utilizing the outcome measurement tool.
4. Corrective action plans are formulated as needed. Outcome data/corrective action plans are incorporated into strategic planning process.
6. Information is shared with consumers through publication of an annual report/newsletter.

Survey Examples

The authors have developed six different survey forms to measure satisfaction outcomes. Below is one full example of a survey as well as sample questions associated with the other surveys.

Survey #1, Family (full survey) (Reprinted with permission. Copyright retained by the authors.)

Favorable Unfavorable

Did goal setting at team meetings address relevant issues?

Did you have sufficient opportunities to participate in decision making of health care related issues of yourself/your family member?

Was you/your family member's quality of life improved?

Have team meetings and communication from life care planning coordination been timely?

Was the life care coordinator responsive to your needs?

Does the homecare program meet you/your family member's needs?

Do you view the services provided as increasing the independence/quality of life for you/your family member?

Does the life care coordinator provide sufficient opportunity for your suggestions?

Are your suggestions incorporated into you/your family member's program?

Thank you.

Comments:

The following are excerpts from other survey forms:

Survey #2, Life Care Plan
This survey requests information on performance in the area of life care planning.
Some examples are:

- Was the report useful for settlement negotiation, trial and/or arbitration?
- Did the clinical referral to physician, therapists and/or academic personnel contribute to the preparation of your case?
- Did the report address future life care needs, costs and/or nursing practice issues required for litigation?

Survey #3, Settlement/Arbitration
This survey requests information on abilities to convey the essence of the client's health care needs. Some examples are:

- Was the life care plan assistive in defining the parameters of long term care needs?
- Did the life care plan clearly itemize future care and costs for the client?
- Was the life care plan easy to follow, thereby contributing to the presentation of the case?

Survey #4, Testimony
This survey requests information related to testimony in court, depositions, guardianship, orphan's court and specialized hearings. Some examples are:

- Presentation of life care plan and related information.
- Accessibility for preparation and testimony.
- Helpfulness during case preparation.

Survey #5, Families

- Was your child's and family's quality of life improved?
- Does the home care program meet your needs?

- Are your suggestions incorporated into your child's program?

Survey #6, Case Management/Life Care Coordinator Funders

- Are the Life Care Coordination reports useful for maintaining a clear understanding of case status and effectiveness of recommended services?
- Has communication regarding status of the case been provided in an ongoing timely manner?
- Has resource material/information regarding case services been provided when indicated?

Summary

In summary, it is the authors' view that any professional or organization should monitor the quality of their service or product through the use of an appropriate outcome measurement process/system. This article offers some initial suggestions which the authors believe address life care planning outcomes. Quality is an individual, subjective perception of a service or product, and attempts to assess and improve the quality of a service implies the ability to be able to identify quality and recognize variations in it. In order to remain successful and continue to thrive, it is again the authors' view that an organization should be able to collect, organize, analyze, and appropriately utilize information specific to their service. To quote from one source, "You can't equate information with knowledge. Information is simply a group of facts. Turn information into knowledge by analyzing the data, identifying patterns and relationships, and working to gain insight into what the information implies" (Alfaro-LeFevre, 1999, p. 156).

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Aging with Cerebral Palsy, Spinal Cord Injury and Amputation: Implications for Life Care Planners

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Editor's Note: For more information on this topic, the reader may want to refer to a just released book that appears to be a good resource for life care planners. Look to the next issue of the *Journal of Life Care Planning* for a full review of this new resource.

Kemp, B. & Mosqueda, L. (2004). *Aging with disability: What the clinician needs to know.* Baltimore, MD: Johns Hopkins Press. (410) 516-6900.

Abstract. *People with disabilities commonly have aging related complications that occur at an earlier age than their peers without disabilities. These complications can lead to a cascade of difficulties which can negatively affect the level of the individual's independence and can impact many components of the life care plan. As a life care planner, it is critical to understand the effects of early aging complications and their potential impact on the life care plan. This article addresses some of the aging implications for individuals with cerebral palsy, spinal cord injury, and amputation.*

Introduction

For people who have a significant physical disability from a young age, aging related complications come early. Kemp (1996) reported that twenty to twenty-five years after the onset of a disability, most people with significant physical disabilities experience a decline in abilities, early onset of age-related secondary conditions such as arthritis or cardiovascular disease, and resulting emotional, relationship, vocational, and quality of life related issues. Some studies (e.g., Crewe, 1990; Kemp, 1992) have concluded that musculoskeletal issues which include pain, weakness, fatigue, and a subsequent decline in endurance and functional abilities are common complaints across disabilities studied.

The known problems associated with aging with a disability are fairly recent phenomena. Because of medical advances, people with significant disabilities are now living life spans longer than those who lived a generation ago (Crewe, 1990; Kemp, 1996). While life expectancy of all Americans, including people with disabilities, is increasing, Bryan Kemp, director of the Rehabilitation Research and Training Center on Aging with a Disability, has said, "The increase in life expectancy of the disabled isn't accompanied by necessarily good health or good quality of life" (personal communication, Bryan Kemp, American Society on Aging annual meeting, San Diego, CA, March 25, 2000). The fact that most people with even severe disabilities are now living nearly normal life spans has left them, and their health care professionals, poorly prepared to deal with the accompanying problems of aging with disabilities (Crewe, 1990; Kemp, 1996; Turk & Weber, 1998). Education of people with disabilities, their caregivers, and the health care professionals who serve them, is a critical need. The lack of knowledgeable health care providers and programs offering care across the lifespan, as well as the difficulty of transition from pediatric to adult care, have contributed to discontinuity and even to a lack of care for adults with longstanding disabilities (Crewe, 1990; Currie, Gershkoff, & Cifu, 1993; Kemp, 1996; Sowell, 2000; Turk & Weber, 1998). Historically, children with disabilities such as cerebral palsy and spina bifida, for example, and their parents were educated that their conditions were non-progressive (Turk, Scandale, Rosenbaum, & Weber, 2001; Turk & Weber, 1998). This information has interfered with the implementation of strategies to prevent or lessen the negative effects of early aging for people with disabilities. It also has implied the lack of need for specialized care specific to each disability throughout life. These are important issues for life care planners.

Life care planners have a charge to establish the needed care and costs associated with a person's disability across their lifetime and often a life care plan is developed for a child or young adult. While many conditions seen by life care planners are non-progressive in and of themselves, it is critical that the life care planner have knowledge of what it means to age with a specific disability and the impact of those changes on the life care plan. Research on this topic is more plentiful for some specific disabilities and difficult, if not impossible, to find in others. This article will focus on implications of aging for disability groups most likely in need of a life care plan, including individuals with cerebral palsy, spinal cord injury, and amputations.

Cerebral Palsy

Murphy, Molnar, and Lankasky (1995) found that of 101 adults with cerebral palsy recruited from the United Cerebral Palsy Association, more than 90 percent were not having regular health examinations. The same percentage of female participants with cerebral palsy was reported as not having periodic breast or pelvic examinations, mammograms, and papanicolaou (PAP) smear testing. The extra time, expertise, and equipment needed for such exams were seen as barriers to providing this basic level of care. In contrast, Turk, Geremski, and Rosenbaum (2001) reported that 67 percent of women without disabilities receive a pelvic exam on a yearly basis. Murphy, et al. (1995) also found that 90 percent of the male participants reported a lack of prostate examination. Similar lack of care was found in routine testing and follow-up for hypertension, hyperlipidemia, electrocardiogram, and elevated blood sugar. Eighty percent of these 101 adults with cerebral palsy reported a concern that their physicians did not know enough about their disease (Murphy, Molnar, & Lankasky, 2000).

While life spans for people with disabilities have grown longer, for some with cerebral palsy, excessive mortality continues to be a problem, in part, because of a lack of normal preventative medicine. Strauss, Cable, and Shavelle (1999) reviewed the medical records of 45,292 individuals with cerebral palsy and cited death from breast cancer in adult women with cerebral palsy as nearly three times that of the normal population. They suggested that this population had different and fewer preventative measures or treatment. The study also reported more deaths than would be expected from cerebrovascular and ischemic heart disease, which suggests a lack of preventative care and monitoring for these conditions. They found that heart disease is the primary cause of death in people with cerebral palsy, and pulmonary disease is the second most common cause of death. The Report from the

Roundtable on Aging and Cerebral Palsy (1997) has identified needed areas of research and proposed changes in interventions to improve the process of aging with cerebral palsy with an emphasis on exercise, wellness, and health promotion.

Inadequate dental care and dental treatment for children with cerebral palsy also is reported and often leads to significant dental problems as adults. Seizure medications and difficulty with positioning and cooperation for hygiene were noted as contributing factors (Murphy, et al., 1995; Report from the Roundtable on Aging and Cerebral Palsy, 1997). While the literature did not address the physical difficulty of brushing and flossing teeth for individuals with severe cerebral palsy, the problems in performing good oral care presumably also contribute to dental problems among individuals with cerebral palsy.

Another potential area for problems in adults with cerebral palsy are musculoskeletal pain complaints, typically beginning in the fourth or fifth decade of life (Andersson & Mattsson, 2001; Arcand, 2000; Crawford, 1996; Murphy, et al., 1995; Rapp & Torres, 2000; Report from the Roundtable on Aging and Cerebral Palsy, 1997). Turk & Weber (1998) revealed the incidence of pain in women with cerebral palsy to be as high as 84 percent. This pain can lead to multiple problems including decreased flexibility, increased fatigue, lessened stamina, decreased functional abilities, and depression (Arcand, 2000).

Turk, Geremski, and Rosenbaum (1997) studied the health and function of people with cerebral palsy. Of the 125 participants, 44 percent were residents of a residential facility and the others were recruited from the community. The findings came from an extensive data collection including physical examination, health interview, physical therapy assessment, nutritional habits, and a survey of activities of daily living. Medical records also were reviewed. One fourth to one third of the group studied had an increased need for assistance with activities of daily living (ADL) skills after the age of twenty, depending on the specific ADL. People with less severe disability from cerebral palsy had more pain, particularly in the ambulatory group (Turk, et al., 1997).

Murphy, et al. (1995) reported that many individuals with cerebral palsy who previously walked had stopped walking by the age of 25 because of fatigue and efficiency issues. Another group of ambulators reportedly stopped walking in their forties because of pain complaints. However, the percentage of participants who lost ability to ambulate was not clear from this study. Another study of 72 adults with cerebral palsy, average age of 33, indicated that walking was lost to about 25 percent of participants and for those who continued to walk, distance was compromised (Bottos, Feliciangeli, Sciuto, Gericke, & Vianello, 2001).

Several health challenges increase in frequency as individuals with cerebral palsy age, including contractures (Andersson & Mattson, 2001; Murphy, et al., 1995), bowel and bladder complaints (Arcand, 2000; Murphy, et al., 1995; Rapp & Torres, 2000; Report from the Roundtable on Aging and Cerebral Palsy, 1997) and fractures (Arcand, 2000; Crawford, 1996; Murphy, et al., 1995; Rapp & Torres, 2000; Report from the Roundtable on Aging and Cerebral Palsy, 1997). Andersson and Mattsson (2001), Arcand (2000), Murphy, et al. (1995), and the Report from the Roundtable on Aging and Cerebral Palsy (1997), all cited overuse of joints or physiological burn-out for people with cerebral palsy.

Depression is another reported complaint in this disability cohort. Kemp (1996) reported a relationship between disability and depression and noted that people who were depressed needed more help than those who were not. The impact of the loss of functional abilities and the increased need for assistance as people with cerebral palsy age may contribute to depression and further functional declines.

Based on a review of literature and the clinical experience of the author, implications of aging with cerebral palsy for the life care plan include:

- Case management is an important consideration for the person with cerebral palsy and case management assistance may be critical even for individuals with normal cognition. For individuals with cerebral palsy, it may be difficult to find or access specialized care and the necessary time and equipment needed for regular preventative care may not be readily available. Case management can provide assistance in these areas.
- Specialized dentistry may be needed lifelong. Special equipment for oral care may be needed.

- Consultation with a dietician at regular intervals will be helpful with problems associated with weight management (over and under weight), which is common in this disability group. According to Amy Johnson, registered dietician at Region's Hospital in St. Paul, Minnesota, individuals with cerebral palsy who are tube fed or have ongoing problems with pressure sores need a nutritional evaluation on an annual basis. Individuals that take more than one hour to feed also need annual assessment. Further, individuals more than 18 years old need nutritional assessments when there has been a greater than 10 percent unplanned loss or gain in weight in one year. Conversely, children with cerebral palsy need dietary/nutritional assessments when they experience a 5 percent loss in weight or show significant changes in their patterns on the growth chart. These children typically are seen yearly until their growth stabilizes (personal communication, Amy Johnson, RD, June 16, 2004).

- Alternative means of mobility should be an early consideration for individuals with any ambulation impairment. Powered mobility may be an important consideration for distance mobility.

- A lifelong fitness routine is critical in maintaining strength, flexibility, endurance, and independence for individuals with cerebral palsy; however, a physical trainer may not have the needed expertise to meet the specialized needs of this population. It is this author's opinion that physical or occupational therapy evaluations every 2-3 years over one's lifetime may be a more appropriate choice.

- Annual assessments by occupational and physical therapy for range of motion measurements and home program updates for individuals with cerebral palsy who have a 20 degree or more joint contracture. These evaluations may be combined with fitness or equipment assessments depending on the therapist or facility.

- Consider increased care needs as the person ages. An increase in assistance with self care after high school was reported in a study of 215 people with cerebral palsy (Turk & Weber, 1998). However, household chores and community daily living tasks were not discussed. In one small study, it was reported that over 83.7 percent of individuals with cerebral palsy age 65 and older needed help with shopping, meal preparation, household chores, finances, and personal cares compared to 65.6 percent of individuals aged 15 to 34 (Crawford, 1996).

- Assistive technology needs can change over time (example: a normal bed may work well in youth but a bed transfer assistive device or hospital bed may be needed in later decades).

- An ergonomically correct environment in both the home and work setting is critical in preventing injury and ergonomic assessments at life phase changes may be appropriate.

- Pain management, while not needed in childhood, may well become important as a person ages.

- Yearly screening for depression or cognitive decline as part of the physical examination by a family physician beginning in the mid 40s, and yearly psychological assessments are recommended if problems are noted. Previous history of depression will indicate added vigilance (personal communication, M. Suzanne Wright, PhD., ABBP, clinical psychologist, Gillette Lifetime Specialty Care, June 18, 2004).

- Potential aging related complications such as overuse syndrome and potential for falls should also be addressed.

Spinal Cord Injury

The life expectancy of individuals with spinal cord injury is increasing (National Spinal Cord Injury Statistical Center, 2003). However, aging with a spinal cord injury brings an increased risk of cardiovascular disease, diabetes, hyperlipidemia (Bauman & Spungen, 1994; McGlinchey-Berroth, Morrow, Ahlquist, Sarkarati, & Minaker, 1995), and hypertension (McGlinchey-Berroth, et al., 1995; Thompson, 1999; Thompson & Yakura, 2001). In a study by examination of 144 people with spinal cord injury, Garland (2001) found increased incidence of osteoporosis which leads to increased risk of fracture. Groah, Weitzenkamp, Lammertse, Whiteneck, and Lezotte (2002) completed a chart review of 3,670 people with spinal cord injury and found significantly increased risk and mortality from bladder cancer. McGlinchey-Berroth, et al. (1995) cited carpal tunnel syndrome, chronic obstructive pulmonary disease, and kidney stones as prevalent in their study of 510 people with a mean age of 50 who had spinal cord injuries.

Thompson (1999) conducted a study of 150 people with spinal cord injury as part of a larger cross-sectional study of the effects of aging the by Rancho Los Amigos National Rehabilitation Center, a leader in the study of aging with a disability. The participants were patients at the Center's outpatient clinic. When interviewed, individuals in their middle 40s and early 50s reported increased need in assistance with bathing, transfers, dressing, and household chores. An 18-20 year average time since injury correlated with this need for more assistance and the older the person was at the time of their injury, the shorter the duration of time before more assistance was needed. Thompson (1999) also found that individuals with tetraplegia needed more assistance at an earlier age than those with paraplegia. In another study of 150 individuals with spinal cord injury, Thompson and Yakura (2001) found that aging related changes of pain, fatigue, decreased muscle strength, weight gain, and an increased incidence of urinary tract infections and pressure sores make performing ADLs more difficult.

Aging related changes in patients with spinal cord injury were found by Thompson and Yakura (2001) to have occurred 15-20 years earlier than those expected of persons without a disability. They proposed that these changes occurred at a younger age because, on a daily basis, the person is working at full capacity and this leaves them with little reserve. Regular physical assessments may allow for interventions to slow or prevent functional changes.

The older age of the individual and the longer the time post-injury was found to be predictive of increased care needs (Charlifue, Weitzenkamp, & Whiteneck, 1999; DeVivo, Shewchuk, Stover, Black, & Go, 1992; Gerhart, Bergstrom, Charlifue, Menter, & Whiteneck, 1993; Thompson, 1999; Thompson & Yakura, 2001). The research by Charlifue, et al. (1999) was helpful in that it studied 439 individuals through the use of a questionnaire and physical examination at five, ten, and fifteen years after the time of injury. The study demonstrated that increased age was associated with the need for more physical assistance. The exact nature of the increased need for assistance was not specified in the study but was measured by use of the Functional Independence Measure (FIM). The study by DeVivo, et al. (1992), with a large sample of 11,117 participants with spinal cord injury, was less significant to the author of this article because participants were, on average, less than five years post injury. In another study of individuals with spinal cord injury who had an average of 13 years from the time of injury, nearly two thirds of the 150 participants who have had these functional changes also reported decreased social activities (Thompson & Yakura, 2001).

Petland and Twomey (1994) found that of 52 individuals studied with long term paraplegia and manual wheelchair use, mean age of 44 years, arm pain was noted as a common problem and there were consequent functional declines that affected the individuals' abilities to perform daily living tasks. Individuals with spinal cord injury who use their shoulders and upper extremities for transfers and bed mobility are typically unable to adequately rest injured/overused arms and shoulders and this can lead to chronic problems. In another study by Gellman, Sie, and Waters (1988), almost 68 percent of 84 people with paraplegia reported pain in their upper extremities and pain complaints increased with length of time since injury. These participants were seen when receiving routine follow-up care at least one year after injury. The prevalence of pain complaints highlights the need for fitness, adaptive equipment, and prevention of unusual stresses, weight control, and an appropriate ergonomic environment for individuals with spinal cord injury.

Gerhart, et al. (1993) conducted a study of 279 people with long term spinal cord injury. The participants were long established patients receiving follow-up care for their injuries and were more likely to have appropriate equipment and care than their counterparts who did not receive such follow-up for their disability. These individuals with spinal cord injury had been discharged from rehabilitation and functioned independently in all ADLs, but showed an increased need for attendant care as they aged. The individuals who needed additional help had a lower perceived quality of life (Gerhart, et al., 1993).

In a study conducted by Thompson and Yakura (2001) of 150 participants with spinal cord injury, assistive technology could have reduced the functional losses of persons with spinal cord injury due to aging but only ten percent of the 150 participants could identify this need themselves. When seen by a physical therapist, 78 percent of the participants needed new equipment and Thompson and Yakura (2001) reported an increased need for equipment over time. This underscores the need for regular and long term follow-up for individuals with spinal cord injury.

Based on a review of literature and the clinical experience of the author, implications of aging for individuals with spinal cord injury for the life care plan will vary by level of injury but generally include:

- Periodic assessments with a dietician may be important for weight control and frequency will depend on genetic predisposition to weight problems, activity level, level of injury, and potential to be active. Amy Johnson, registered dietician, indicated annual nutritional assessments for individuals experiencing a 10 percent weight gain in one year are recommended until the issues with excessive weight are managed or stabilized (personal communication, Amy Johnson, RD, June 16, 2004).

- Yearly screen for depression as part of physical examination by family physician beginning on average twenty years after injury with yearly psychological assessments if problems are noted. Previous history of depression will indicate added vigilance (personal communication, M. Suzanne Wright, PhD., ABBP, clinical psychologist, Gillette Lifetime Specialty Care, June 18, 2004).

- Powered mobility should be considered for individuals with paraplegia for use on prolonged or extended community outings and/or to travel on uneven ground even when the individual is proficient in maneuvering a manual wheelchair. Based on this author's experience, manual assist wheelchairs should be introduced 10-15 years after injury and powered wheelchairs for clients with spinal cord injury using manual wheelchairs 20 years after injury.

- Assistive technology needs are likely to change over time and occupational and physical therapy evaluations to assess assistive technology are recommended.

- An ergonomically correct environment in the home and work site will minimize injury risk. Period ergonomic assessments at life phase changes may be indicated.

- A lifelong fitness routine is critical in maintaining strength, flexibility, endurance, and independence for individuals with spinal cord injury; however, a physical trainer may not have the needed expertise to meet the specialized needs of this population. The author recommends physical or occupational therapy evaluations every 2-3 years over lifetime may well be a more appropriate choice.

- The life care plan should address the potential need for increased assistance with ADLs and household chores as the person ages and consider the possible psychological impact of increased dependency.

Amputation

There is relatively little research about the long term effects of living with an amputated limb. Studies reviewed had generally small sample sizes and no statistics were found on children and young adults with congenital or acquired limb loss. The research available regarding aging issues for individuals with amputation indicated an early onset of pain and arthritis symptoms in the non-amputated limb due to overuse and stress of the normal extremity. For example, Lemaire and Fisher (1994) reported a significant increase in osteoarthritis in the non-amputated leg of twelve individuals with lower extremity amputation with an average age of 71.8 years. This is thought to be due to an increase of workload to the normal leg when compared to individuals without leg amputations.

Not surprisingly, a study of 11 individuals without amputations found that there was better symmetry of gait compared to those with below knee amputations (Hurley, McKenney, Robinson, Zadravee, & Pierrynowski, 1990). Gait analysis in the study was done but over half of the subjects were young and not long term prosthetic users. An asymmetrical gait over a long period of time is likely to lead to wear and tear injury, pain, and potentially greater disability.

Individuals with upper extremity amputation experience similar overuse problems and Jones and Davidson (1999) noted that 50 percent of 46 upper extremity amputees had problems such as pain, arthritis, shoulder impingement, and epicondylitis. The location of the injuries varied and seemed to be dependent on vocational and lifestyle activities. Although the time since amputation was difficult to determine from the study results, this factor is important because upper extremity amputations tend to occur at younger ages than lower extremity amputations (Dillingham, Pezzin, & MacKenzie, 2002). The long term impact of overuse of the intact limb is the prime issue in aging in this disability group.

Based on a review of literature, the author suggests that the life care plan for an individual with amputation includes:

- An ergonomically correct environment in the home and work site will minimize injury risk. Ergonomic assessments at life phase changes may be helpful.

- Weight control is important for prosthetic fit and to help from over-stressing joints. Periodic assessments with a dietician for those with a potential for weight control difficulties are recommended.

- A fitness program is essential to minimize injuries related to overuse. Input from therapists or a personal trainer may be a benefit to this disability group.

- Alternative mobility may be needed for those with lower extremity amputations. Age and mobility environment will need to be considered.

- Pain management, other than for phantom pain, may not be a concern early in the disability for the individual with amputation. However, it can become a problem as the person ages because of problems associated with overuse.

Conclusions

Individuals with childhood and young adult onset disabilities are living significantly longer and, along with that, a new set of potential obstacles has been discovered. More literature about aging with a disability is available for some diagnoses and sorely lacking in others. In the literature reviewed, there is a common theme of pain, fatigue, and potential for overuse injuries across disabilities. This can lead to weakness, decreased endurance, and an overall decline in functional abilities. For individuals who have worked hard to be as independent as possible in their lives, this is a difficult discovery. For life care planners, this can mean a change in projections for care and assistive technology as a person ages. It is important for life care planners to utilize practice guidelines and obtain input from physicians with disability specific expertise when possible.

It is clear that aging with a disability is significantly more difficult than it is for the general public population. Individuals with disabilities themselves are learning the hard way about what it means to grow older. In many instances, they have been told that their disabilities were static but in fact, new problems occur as their body's age and there is need for education and ongoing specialized care. Concrete preventative measures need to be planned to maximize independence when aging with a disability and the life care planner is in a unique position to identify those measures for inclusion in the life care plan.

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About the Author

Nancy Mitchell, MA, OTR/L, CLCP, ATP, is an occupational therapist with 30 years of experience. She became a certified life care planner in 1998. In addition to her continued clinical practice, she owns Mitchell Disability Assessments & Life Care Planning. Ms. Mitchell completed a master's degree in gerontology with an emphasis on aging with a disability and was a founding team member of a clinic developed for adults with early onset disabilities.

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News Update…

Nevada Amicus Brief and Impact on Life Care Planners

Robert H. Taylor, MA, CRC, CDMS, CPC (AZ), CLCP

Editor's Note: The following news article is provided as a general topic of interest and relevance to life care planners and has not been peer reviewed.

In August 2003, the International Association of Rehabilitation Professionals (IARP) retained counsel to file an Amicus Curiae brief with the Nevada Supreme Court to support that vocational rehabilitation experts retained by defendants be permitted to interview plaintiffs and administer vocational tests as part of their evaluation.

In the case, *Jeffrey A. Feldman & Penny I. Feldman vs. The Second Judicial District of the State of Nevada*, In and For The County of Washoe, and the Honorable Janet J. Berry, District Judge, Respondents and Demaris Jane-Kay Gullekson, Real Party in Interest, Supreme Court of Nevada Case Number 41560, Filed Feb. 11, 2004 (Nevada Supreme Court case cite provided), the District Court in Washoe County, NV had ordered the plaintiff to present for a vocational rehabilitation evaluation with a vocational rehabilitation expert retained by the defendant. Plaintiff's counsel objected and requested relief from the Nevada Supreme Court, the only appellate court in the state. Counsel for the plaintiff and defendant filed briefs in support of their positions. The IARP Forensic Section created a committee, composed of Steve Bast and John Williams of Florida, John Meltzer of Wisconsin, Nancy Hughes of Tennessee, and Robert Taylor of Arizona. This committee wrote the technical language in support of a vocational rehabilitation expert personally meeting with the subject of the analysis in order to evaluate their claims for damages related to lost wages and diminished earning capacity in the most accurate way possible.

The Nevada Supreme Court granted IARP standing and permitted the filing of the Amicus Curiae brief. In its decision issued on Feb. 11, 2004, plaintiff was denied their request for relief, thereby upholding the District Court in its decision allowing the defense expert to conduct an in-person interview with the plaintiff. More notable was the Court's language which took notice of the role that vocational rehabilitation experts play in evaluation of lost wages and diminished earning capacity.

The decision of the Nevada Supreme Court has (indirect) impact on life care planners as well, although life care planning was not specifically addressed in Feldman. What was significant was the Court's willingness to accept the role of vocational rehabilitation experts in assessing damages in civil litigation cases and the importance of allowing defendants to evaluate plaintiff's damages claims through the same approach taken by the plaintiff. Recognizing the importance of personal contact with the plaintiff and not simply relying on a review of records or other experts for guidance, the Court did not block the defense expert's access to the plaintiff, thus placing the defendant on “equal footing” with the plaintiff’s vocational rehabilitation expert.

Life care planners retained by defendants are at times faced with similar barriers imposed on them by plaintiff’s counsel, case law and/or local court rules. In many jurisdictions, case law and/or local rules do not allow defense life care planners to personally interview plaintiffs. It is, thus, difficult for a life care planner retained by the defendant to obtain first-hand information regarding the content of a life care plan (LCP). Records relied upon by a defense expert may not be current. Physicians performing independent medical evaluations (IMEs) at the request of a defendant may not have access to the information required by a life care planner. Without the benefit of a personal interview with the plaintiff, a defense life care planner may have difficulty obtaining the information necessary to develop a LCP according to life care planning standards of practice and codes of ethics related to credentials held by the life care planner.

With the Nevada Supreme Court recognizing the role played by vocational rehabilitation experts in evaluating claims for damages made by plaintiffs in civil cases, the next step for life care planners to take in enhancing their professional identity is for the appropriate professional association(s) to act as IARP did should the opportunity arise in the future. Although the Archer vs. Warren case in Texas attempted to carve out a stronger identity for life care planners, the facts of that case were such that the issues in Feldman, as discussed above, were not placed before the appellate court to address. For specific information regarding the Amicus brief in the Archer vs. Warren case, please refer to the *Journal of Life Care Planning, 1* (1), 15-33.

A significant component of LCP development is a meeting with the person (and family in some cases) for whom the life care plan is being prepared. While not always possible in cases involving civil litigation, it would behoove life care planners retained by defendants to ask for the opportunity to interview the individual, or their parent or guardian, in the case of a minor. Defense counsel should be encouraged to ask the trial court to intervene in cases where a plaintiff attorney refuses to allow this meeting. Should the trial court deny the defendant relief, the life care planner should discuss with defense counsel the wisdom of seeking relief in the appellate court. If a defense attorney is willing to take such action, the opportunity would thus arise for writing and filing an Amicus Curiae brief as occurred in the Feldman case in Nevada.

Life care planners retained as experts in civil litigation cases must first gain awareness and understanding of the appellate process and know where to turn should this issue arise. The life care planning community must then be prepared to take the necessary steps to help address the issue and enhance the role of life care planners involved in such cases. Such action would include identifying the entities or professional associations that might be given standing with an appellate court and allowed to file an Amicus Curiae brief, conducting fund raising if necessary to pay legal fees, gathering data pertaining to life care planning methodology and process and writing the technical language to be included in the Amicus Curiae brief.

For life care planning to continue to be recognized by the courts as a credible specialty practice requiring advance skills, with a distinct role in the measurement of damages related to the need and cost of future care, it will be necessary to tackle these issues as they arise. Life care planners must accept the primary responsibility to see that these issues are addressed, but they must also have awareness of the means at their disposal to do so. This awareness may not exist at the present time. A professional association, such as IARP, whose members include vocational rehabilitation experts, life care planners, case managers and other professionals involved in disability management, might be able to take the lead here, perhaps working jointly with the International Academy of Life Care Planners (IALCP). Whatever association ultimately becomes involved, life care planners will reap the benefits as we gain additional credibility and recognition in the eyes of attorneys and the courts.

About the Author

Robert H. Taylor is Director and Chief Executive Officer of Vocational Diagnostics, Inc., a private firm based in Phoenix, AZ. Mr. Taylor's practice is nationwide and includes catastrophic case evaluation and management, life care planning, vocational rehabilitation and economics. Mr. Taylor is currently the Vice-President of the International Association of Rehabilitation Professionals (IARP) and will become its President for a two-year term in May 2005. Mr. Taylor is a recognized speaker in the areas of life care planning and life care planning ethics and has presented at numerous conferences and professional programs at the regional and national level.

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Life Care Planning Summit 2004
The Progress Continues

Debbie Berens, CRC, CCM, CLCP

Introduction

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

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

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

Process

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

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

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

Summary

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

- Terminology, including definition of "client," needs to be defined in the Standards of Practice and Standards of Practice should continue to delineate the qualifications to be a life care planner (endorsement of existing Statement 1.d), delineate educational requirements for entry into life care planning, and state the role and accountability of the life care planner.

- Urge CHCC to pursue certification by a respected and nationally recognized independent certifying agency that certifies certification bodies.

- Extend CLCP re-certification cycle to every 5 years consistent with many other certification renewals.
- Increase availability of advanced practice training in specialty areas.
- Ensure close monitoring of attendance at training programs that offer CLCP CEUs.
- The exam test body should be autonomous and separated from the training/educational group.
- Determine/verify need for mentoring program and agree on definition of mentoring program as applied to life care planning.
- Determine qualifications of a mentor and standardize the mentoring process and relationship before implementation of mentoring program.

Select common areas of concern or no consensus expressed by the group include:

- Key ethical issues in the Standards of Practice.
- Legitimacy/general acceptance for the Standards of Practice and what recourse should be taken when life care planners do not follow the Standards.
- Definition and meaning/purpose of a mentoring program for life care planners.

Full proceedings from the Summit 2004 will be published and a copy provided to each of the registered participants. Additional copies of the proceedings will be made available for sale to the general public.

Conclusion

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

Summits have offered and been successful in providing a proactive approach by life care planners to establish consistency and collaboration among and within the practice of life care planning.

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

About the Author

Debbie Berens, MS, CRC, CCM, CLCP, has attended each of the Life Care Planning Summits in the role of participant, organizer, and/or facilitator. She has been active in the life care planning community for the past 15 years and has conducted various training seminars and presented at conferences as well as contributed over the years to writings and publications in the field of rehabilitation and life care planning. She currently serves as Associate Editor of the *Journal of Life Care Planning* in addition to her nationwide life care planning practice based in Atlanta, Georgia.

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A Dialogue with…
Linda Shaw, Ph.D.

By Debbie Berens, Associate Editor

1. JLCP: Linda, you are well-known for your leadership with curriculum development for life care planning training. What is your professional background and how has your career led you in this direction?

I always find these kinds of questions interesting because they presuppose that there is some kind of logical orderly process by which one's career develops. In my case, I've always felt that I just happened to be at the right place at the right time and lucked out!! In any case, I am a rehabilitation counselor by training and have worked with quite a number of populations in many different settings, including individuals with spinal cord injury, brain injury, and mental health problems. While working in brain injury rehabilitation, I worked at and became the director of several different programs that covered the entire rehabilitation spectrum, from coma management programs to outpatient rehab. I probably had my first major exposure to life care planning while I was running an outpatient brain injury rehabilitation facility in Chicago. Many of our clients were in our facility on liens and/or had litigation in process. My medical and therapy staff and I interacted with of attorneys and life care planners, and we often had videographers doing "A Day In the Life" videos at our facility. After I completed my Ph.D. in Counseling Psychology and Human Systems with a major emphasis in Rehabilitation Counseling, I accepted a faculty position at the University of Florida. Dr. Horace Sawyer was my Department Chair and he and I developed a close working relationship. Being a lowly underpaid assistant professor, I was happy to put my knowledge of rehabilitation, and particularly brain injury rehabilitation, to work for me, and I agreed to consult on a couple of cases where individuals with brain injuries needed life care plans. I was fortunate to have Dr. Sawyer nearby for mentoring and I enjoyed the process. As the relationship between the University of Florida and Intelicus developed, I became involved, along with Dr. Sawyer, in developing and monitoring the curriculum and the faculty of the program. We were fortunate to be able to work with Sheri Jasper and she handled all of the "logistics" of the program. It has been a fascinating process, watching the program evolve from those very early days to the well-established MediPro Seminars, LLC program that serves as the bedrock for quality training in life care planning today. After I adopted my children, I cut way back on my outside consulting, but have been fortunate to continue my involvement with life care planning through the MediPro Seminars, LLC program and through participation in such events as the Life Care Planning Summits, which I consider to constitute some of the profession's seminal and defining moments.

2. JLCP: Your involvement with life care planning training as well as having served as Commissioner, Vice-Chair, and Ethics Committee Chair of the Commission on Rehabilitation Counselor Certification (CRCC) has made you aware that some life care planners assert that they do not need to be certified as a life care planner because they are already certified in other areas, such as certified rehabilitation counselor. First, what in the CRC Code of Professional Ethics and scope of practice relate directly to life care planning? Second, is the CRC a sufficient credential for life care planners or is specific certification as a life care planner needed?

I do not agree with the position that the CLCP is an optional credential for practicing life care planners. Other certifications, such as CRC, CCM and CRRN provide a measure of assurance to clients that the professional possesses a minimal set of skills and knowledge areas that are required in the practice of the individual's profession. Life care planning, while based on these same knowledge areas, is a specialty practice area and requires a very specific set of skills and advanced knowledge about very specific disabilities, legal processes, and ethical considerations that are unique to the practice of life care planning.

It is important to remember the real reason for certification. It is not designed to impress attorneys or insurance companies or juries, although it may, indeed, have that effect. Certification's very reason for being is to ensure clients that the professional practitioner has demonstrated that he/she possesses the minimum competencies necessary to perform his/her job competently, professionally, and ethically. It ensures that the individual has demonstrated that he/she has the ability to do the job, and provides a set of standards to which that individual is held accountable.

The CRCC Code of Professional Ethics is similar to other codes of the professions involved in the practice of life care planning, in that it addresses a range of ethical behaviors that are critical to the profession in general. All Codes struggle to balance the need for specific guidance for specific circumstances, with the understanding that one cannot possibly address every possible ethical problem or dilemma that might arise in the practice of one's profession. When the CRCC Ethics Committee published the most recent (2001) revision of the Code, they specifically attempted to provide additional guidance to individuals working in forensic settings and specifically addressed issues related to the provision of "indirect services." Consequently, there are now specific references to the fact that those providing indirect services are still covered by the Code, and several new rules now address such issues as objectivity, the need to generate written reports, and others that are particularly useful for life care planners. But the specificity of guidance the Code can provide in any one area is limited because of the breadth of the profession's scope of practice. If the Code provides several pages of rules specific to the needs of life care planners, and then gives equal consideration to the needs of personal adjustment counselors, insurance case managers, substance abuse specialists, vocational evaluators, and additionally addresses the issues unique to all of their different practice settings, the Code would far outweigh the New York City phone directory and be difficult to access and use. Consequently, although the Code addresses many issues that can be applied to life care planners, it is, understandably, somewhat lacking in specific guidance for the daily ethical issues that CRCs practicing in this specialized area are most likely to encounter. For this reason, it is imperative that the specialty area of life care planning provides its own ethical guidelines and standards of practice, geared to the real, daily problems encountered by life care planners, and that it holds practitioners accountable to those standards as well.

3. JLCP: You have published and presented widely on the topic of ethics. What are some areas of professional ethics that life care planners face today?

Anyone active in the life care planning community knows of some of the most common “sticky” ethical issues. Because we work in an adversarial environment, and because our opinion can “help” or “hurt” a case, there are constant pressures to bias one’s opinion in the direction favored by the attorney or referral source that has retained our services. Resisting these pressures becomes easier when life care planners develop a clear understanding of their role, i.e. to objectively assess the client’s needs and render a careful, responsible plan that flows directly from the facts of the case. Our opinions need to flow from the needs of the client, not from any external influences. Qualified and responsible life care planners would readily agree that life care plans should be unbiased and independent from any influences from either the defense or plaintiff’s attorneys. As is usually the case however, the devil is in the details. Where does our responsibility end? If two wheelchairs of different price ranges will satisfy the client’s needs, is there any harm in choosing the one that will raise or lower the plan’s costs, dependent upon whether one has been retained by the defense or plaintiff? Is it appropriate to discuss our opinion with the attorney who has retained us without putting anything down in writing? And on and on and on.

A second general area of concern is the need to fully inform the client about one’s role and deviations from what the client might ordinarily expect from a particular type of professional. Clients who are being evaluated by life care planners who are rehabilitation counselors or psychologists by training, for example, might ordinarily expect that the counselor will act as an advocate for them and that they can expect strict confidentiality. Because neither of these conditions generally hold true in life care planning, the counselor needs to be especially careful to fully explain his/her role and the limits on confidentiality at the outset of the relationship with the client. Furthermore, the counselor must take steps to ensure that the client understands the implications of such role restrictions or limitations to confidentiality. Over the five years that I served on the CRCC Ethics Committee, we unfortunately saw many cases where rehabilitation counselors had been acting in capacities that were somewhat nontraditional and had never fully informed the client of the specific job duties they had been hired to perform. When the client then realized that the counselor had included information in a report that they perceived as harmful in some way, the counselor found him/herself facing an ethics charge. A CRCC-sponsored study recently completed found that many individuals do not do an adequate job of professional disclosure and either fail to include critical information or fail to inform the client of important information at the outset of the professional relationship.

The adversarial nature of our work is a factor in another area of concern for most life care planners at some point or another. Sooner or later, most of us will be on the opposite side of a case where another life care planner appears to be acting unethically. He/she may appear to be incompetent in that the plan that was developed reveals a poor understanding of the needs associated with a particular disability; perhaps the work was sloppy; or perhaps it appeared to be strongly biased in a particular direction. Perhaps that individual has attacked your work, and has said things about you, either on or off the record, that might damage your own reputation. It is critical that life care planners develop the appropriate competencies and exercise due care to ensure quality work. Additionally, professional behavior is always required and disparaging or harmful remarks are completely inappropriate. At the same time, it is not appropriate to ignore unethical behavior. Most of the professional codes of ethics include provisions for reporting unethical behavior and it is critical that responsible life care planners familiarize themselves with the appropriate requirements under their respective Codes.

I could probably go on and on with this question, as it is a topic of great importance to every life care planner. We could all recount many specific ethical dilemmas and challenges too lengthy to reprint here. It may be more appropriate to simply note that our decisions must always be guided by the five ethical principles that should determine all of our actions: autonomy, beneficence, nonmaleficence, justice, and fidelity. Life care planners who feel at all insecure about the meaning and significance of any of these or about how to resolve ethical dilemmas in which one or more of the principles may be violated should seek out additional training in the area of professional ethics. As life care planners, our integrity is our most valuable asset and it should be guarded and nurtured throughout our professional lives.

4. JLCP: From a training or curriculum perspective, what areas of change or growth do you foresee in life care planning?

Actually, I think this is a very exciting time, educationally, for life care planners. As the pool of qualified life care planners has expanded, there is a burgeoning need for advanced training. As practicing life care planners gain experience and develop their own knowledge related to life care plans, they appear more than willing to share their expertise. Programs like the planned mentoring program are very exciting and can only improve the quality of the life care planning process. Life care planning requires awareness of the latest and greatest technologies, medical procedures, medications, and legal trends. Given the rapid pace at which all of those areas are developing, it is critical that the life care planner find ways to stay up-to-date. Educational providers also need to continuously update their curricula. The faculty of MediPro Seminars, LLC works diligently to ensure that the certificate program and advance training reflect the state of the art. We have also responded to life care planners' needs to diversify their practices and develop related product lines, resulting in our Medicare Set-Aside (MSA) training and our new ElderCare Management certificate program. Over the past several years, we have seen a number of new "players" entering the marketplace providing both basic and advanced training of interest to life care planners. While it is a good thing to have an increased number of programs from which to choose, it becomes increasingly important to carefully evaluate the quality and reputation of the trainers and the companies/organizations sponsoring the training.

For the future, I expect training to follow the direction of the evolution of life care planning. The use of life care plans for non-litigation purposes will probably continue and training in specialized applications will evolve. We can probably expect to continue the trend toward distance learning, as it appeals to small independent firms and practitioners due to minimization of lost billable hours. At the same time, however, I have experienced an increase in the tendency for life care planners to want to reach out to others and to profit from the development of a professional "community." We tend to be "people" persons, and it goes against our nature to isolate ourselves at a computer terminal. I continue to get feedback from our students that one of the most valuable aspects of their training was the networking they did and that they continue to support and be supported by the individuals with whom they formed lasting professional relationships during their training. Consequently, I believe that a balance of distance and in-person education is optimal for most people.

5. JLCP: Given your active involvement in life care planning curriculum development for the past 14 years, what suggestions or insight can you offer life care planners related to training and professional development?

When selecting a training activity, ask around! Who has heard this presenter? Does the company providing the training have a good reputation? Do sponsoring groups share your philosophical approach to the practice of life care planning training? Is the training format compatible with your learning style?

Sometimes you are aware of your training needs and sometimes a really good training program can make you aware that you have needs that you were not even aware you had. If you perceive a need for training, either for you personally, or for the field at large, voice your thoughts to the organizations responsible for training. You would be amazed at how many of our programs and presentations started from a casual mention from somebody that they really needed to know more about a particular topic and had noticed that there did not seem to be much “out there.”

Finally, do not overlook the wonderful resources that are out there ready for the taking. There are several books and journals that relate either directly or indirectly to life care planning. Listserves have begun to proliferate and I am amazed at the collective knowledge of the participants, as well as their generosity and helpfulness in sharing with each other what they know. The Journal of Life Care Planning plans to start providing CEUs for reading their articles and for those of you who have not yet signed on, the articles tend to be excellent, practical pieces, written by fellow practitioners. For those of you who have something to share - - share it!! Write an article. Submit a poster presentation to the annual life care planning conference. Post a comment on the listserve. We all grow when we freely share our expertise and insights with one another.

Finally, the best advice I can give to anyone is to make a solid commitment to your own professional development. Budget whatever time and dollars that you reasonably can afford and understand that training has a way of affecting your bottom line in profitable ways. You stay fresh, motivated, and on top of your game when you stretch your mind and your perspective.

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Certification for the CHCC CLCP Certification?

Linda McKinley, BSN, RN, CDMS, CCM, CLCP

Introduction

The topic of certification for the Commission on Health Care Certification (CHCC) has repeatedly come up at conferences, most recently at the Life Care Planning Summit 2004. I would like to take this opportunity to provide information about the certifying agency that is available to certify CHCC and a basic understanding of the process.

NOCA / NCCA Background

NOCA, the National Organization for Competency Assurance, was established in 1977 and has emerged as a leader in quality standards for credentialing organizations. NCCA, the National Commission for Certifying Agencies, is the accreditation body of NOCA and was established in 1989. NCCA was designed to promote and ensure the professional competency of certification organizations by using a peer review process to establish standards, evaluate compliance with those standards, provide recognition, and serve as a resource for a wide range of professions and occupations.

The NCCA standards are the only national and voluntary standards for certifying agencies. NCCA is an independent resource and authority on accreditation using objective benchmarks for the operation of certifying organizations. The Commission's effort and emphasis is on the concept of "competence" and results. This includes performing accurate work, making sound judgments, and effective interaction with other professionals, which is demonstrated and maintained throughout one's practice. NCCA is headquartered in Washington, DC, and as of May 2004, there were 56 NCCA accredited certification organizations.

Implications for Applicants

The purpose of a certification organization is to evaluate individuals who wish to enter, continue, and/or advance in their discipline through certification and obtaining a credential demonstrating a required level of competence. The benefit of NCCA certification not only includes recognition that standards were met, but defends the integrity and enhances the credibility of the organization.

Programs must be non-governmental, national, not-for-profit, and must have had at least two examination administrations to meet eligibility requirements in addition to the specific standards briefly outlined below.

Structure and Development of Standards

The first Standards were issued in the late 1970s. Revised Standards were approved in 2002, effective January 1, 2003. To earn or maintain accreditation by NCCA, the certification program must meet all Standards and provide evidence of compliance. The Standards focus on five areas:

Purpose, Governance and Resources
Standards 1-5 (10 essential elements)

> Includes purpose of certification program, structure, policies, autonomy and decision making, organization, governing committee, public member, financial resources, staff.

Responsibilities to Stakeholders
Standards 6 – 9 (8 essential elements)

> Includes published documents, policies and procedures, eligibility criteria, assessment instruments, statistics, appeals, confidentiality, discipline.

Assessment Instruments
Standards 10 – 18 (19 essential elements)

> Includes published performance domains, assessment content versus practice analysis review process, cut score, psychometric procedures.

Re-certification
Standards 19 – 20 (4 essential elements)

> Includes establish and publish policies and procedures for re-certification, consequences if requirements are not met.

Maintaining Accreditation
Standard 21 (5 essential elements)

> Includes required reporting to NCCA.

A complete copy of the Standards for the Accreditation of Certification Programs can be downloaded from the NOCA website (www.NOCA.org).

The Certification Process

The NCCA “Applicant Checklist” has 31 criteria areas where documentation of compliance must be provided. According to NCCA, rare approval is granted initially. Most groups have to make some changes in order to meet the standards. That requires a review of bylaws, operations, procedures, and publications. Nine (9) copies must be submitted for the preliminary review. NCCA staff then determines if the application is complete.

There is a *formal review* of applications only at regular NCCA meetings. Denials and deficiencies are notified in writing. There is an opportunity (within a specific timeframe) for reconsideration and formal appeal.

Conclusion

Implications for the certified life care planning community are undeniable. However, the feasibility for CHCC to successfully undertake this enormous project (both administratively and financially) is still in question. This is a great starting point and I am energized by the numerous CLCPs who have stepped up and offered their assistance for the various task forces and committees that would be needed to accomplish this. Updated information on certification status will be posted on the CHCC website (www.chcc1@aol.com).

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Announcements and Educational Opportunities For Your LEARNING Pleasure

Note: The following list is not all inclusive. The JLCP does not support or endorse the educational opportunities listed below and provides this information solely as a service to our readers and in support of continuing education for all rehabilitation professionals. While we make every effort to publish accurate information, we cannot assume liability for errors in these listings and suggest that you verify all pertinent meeting details with the sponsoring organization BEFORE making your travel plans or other arrangements.

July

American Psychological Association Annual Meeting
July 28-August 1, 2004
Hawaii Convention Center, Hilton Hawaiian Village Beach Resort and Spa, and Sheraton Waikiki Hotel, Honolulu, HI

For more information, www.apa.org.

August

14th Florida International Medical Expo
August 18-19, 2004
Miami Beach Convention Center, Miami Beach, FL

For more information, www.fimeshow.com or 941/366-2554.

September

American Congress of Rehabilitation Medicine, 2004 Joint ACRM-ASNR Conference, "Evidence-Based Rehabilitation: Linking Science, Practice and Policy"
September 9-12, 2004
Sawgrass Marriott Resort, Ponte Vedra Beach, FL

For more information, www.acrm.org or 317/915-2250.

25th Annual Neurorehabilitation Conference on Traumatic Brain Injury and Stroke
September 13-14, 2004

Boston Marriott, Cambridge, Massachusetts

For more information, www.braintreehospital.org or (781) 348-2113, Donna Carr.

Life Care Planning Training, Module 1 & 2
MediPro Seminars, LLC
September 16-19, 2004
Marriott Suites Hotel, Las Vegas, NV

For more information, www.mediproseminars.com or 866/633-4776.

The Annual Conference on Legal Issues in Brain Injury
September 18-20, 2004
Ritz Carlton, Bachelor Gulch, Colorado

For more information, www.nabis.org or 703/683-8400.

The Pacific Coast Brain Injury Conference
September 23-25, 2004
Vancouver, BC, Canada

For more information, www.pcbic.org or 604/944-2652.

American Academy for Cerebral Palsy & Developmental Medicine
58th Annual Meeting
September 29-October 2, 2004
Los Angeles, CA

For more information, www.aacpdm.org and www.acpoc.org or 847/698-1635.

MCMC 16th Annual Medical Case Management Conference "Health and Humanity in an Election Year"
September 30-October 3, 2004
Marriott Wardman Park Hotel, Washington, DC

For more information, www.mosby.com/MCMC

Looking Ahead

October

129th American Neurological Association Annual Meeting
October 3-6, 2004
Sheraton Hotel, Toronto, Ontario, Canada

For more information: 952/545-6284.

American Academy of Physical Medicine & Rehabilitation (AAPM&R) 65th Annual Assembly & Technical Exhibition
October 7–10, 2004
Phoenix Civic Center Plaza, Phoenix, AZ

For more information, www.aapmr.org or 312/464-9700.

MediPro Seminars Life Care Planning Training
Medicare Set-Aside Program
Advanced Solid Organ Transplant
Advanced Mild TBI
Advanced Pediatrics
Advanced Chronic Pain Management
October 7-8, 2004
JW Marriott Hotel, New Orleans, LA

For more information, www.mediproseminars.com or 866/633-4776.

World Congress & Exposition on Disabilities
"Making a Difference in the World of Disabilities"
October 7-9, 2004
Orange County Convention Center, Orlando, FL

"The world's leading disability event is committed to improving the lives of those with disabilities, their families and caregivers, physicians, direct support professionals, allied healthcare professionals, educators and adapted physical education specialists and everyone working within the disability community."

For more information, www.wcdexpo.com or 201/226-1446.
The 5th Annual Conference on Brain Injury
"Managing Challenging Situations in Brain Injury Care"
October 8, 2004
Bethesda Rehabilitation Hospital, Bethesda, MD

For more information 651/232-2725, Lia Christiansen.

2nd Annual International Conference on Life Care Planning (ICLCP)

October 9-10, 2004
JW Marriott Hotel, New Orleans, LA

For more information, www.mediproseminars.com or 866/633-4776.

National Case Management Week
"Case Management…The Passion, Power, and Promise of Healthcare"
October 10-16, 2004

Promoted by the Case Management Society of America (CMSA), "this weeklong celebration serves to recognize case managers, to educate the public about case management, and to increase recognition of the significant contribution of case managers to quality healthcare for the patient, healthcare provider and payor."

For more information, www.cmsa.org/CMWeek/.

Medtrade 2004 Exposition
October 26-28, 2004 (Pre-exposition session on "Continuum of Care" presented by American Association for Homecare, October 25, 2004)
Orange County Convention Center, Orlando, FL

Medtrade is the largest international exposition dedicated to the home health care industry and offers an excellent venue for seeing, touching, and talking with specialists with regard to the latest technological advances in home health care.

For more information, www.medtrade.com.

Academy of Certified Case Managers (ACCM)
"Forum for Advanced Practice"
October 27-28, 2004
Orange County Convention Center, Orlando, FL

For more information, www.academyccm.org or 203/454-1333 x 2.

November

National Business Group on Health and Integrated Benefits Institute
"Maximizing Human Capital in a Changing Economy"
November 9-11, 2004
Wyndham Palace Hotel, Orlando, FL

For more information, www.businessgrouphealth.org or www.ibiweb.org or 202/624-1763.

IARP Forensic Section Conference
“Fine Tuning the Forensic Rehabilitation Practice”
November 11-13, 2004
Sheraton Gunter Hotel, San Antonio, TX

For more information, www.rehabpro.org.

MediPro Seminars Life Care Planning Training
Module 5: LCP: Pulling it All Together
Module 6: Forensic Rehabilitation
Medicare Set-Aside Program
KAPLAN College Site Program
CLCP Review & Certification Exam
November 11-15, 2004
Renaissance Grand Hotel, St. Louis, MO

For more information, www.mediproseminars.com or 866/633-4776.

25th Annual Neurorehabilitation Conference on Traumatic Brain Injury and Stroke
November 13-14, 2004
www.jhcenter.com John Hancock Conference Center at Copley Square, Boston, Massachusetts

For more information, www.braintreehospital.org or 781/348-2113, Donna Carr.

24th Annual Conference of the National Academy of Neuropsychology
November 17-20, 2004
Westin Seattle Hotel, Seattle, Washington

For more information, www.nanonline.org or 303/691-3694.

Toronto ABI Network Conference
“Exploring the Spectrum of Brain Injury: Sharing the Tools of the Trade”
November 18-19, 2004
Toronto Hilton (downtown), Toronto, Ontario

For more information, www.abinetwork.ca or 416/597-3422 x 3961.

American Speech-Language-Hearing Association (ASHA) Convention
November 18-20, 2004
Pennsylvania Convention Center, Philadelphia, PA

For more information, www.asha.org or 800/638-8255.