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The Journal of Nurse Life Care Planning is published quarterly in spring, summer, winter, and fall. Members of AANLCP® receive the Journal subscription electronically as a membership benefit. Back issues are available in electronic (PDF) format on the association website. Journal contents are also indexed at the Cumulative Index of Nursing and Allied Health Literature (CINAHL) at ebscohost.com.

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In order to make safe and effective judgments using NANDA-I nursing diagnoses it is essential that nurses refer to the definitions and defining characteristics of the diagnoses listed in this work.
It was a short eight years ago that my first copy of the JNLCP came to my mailbox—and that's a paper copy at the post office. I wrote a snappy note to the head of the editorial committee, Kathy Pouch, volunteering my services and before I knew it I was doing rewrites and general editing. Your Journal then wasn't quite what it is now—published in hard copy, in black and white, no art, irregularly delivered maybe two or three times a year, and often containing three articles that said pretty much the same thing. I thought—hoped—that we could do better, so I put in my name for the job as editor at Kathy's urging. It took about five months for that to go through channels (full disclosure: there were no other candidates) and I found myself with a guarantee of editorial independence and a mandate to generally liven up the thing. I promised we'd publish a topical, lively, accessible quarterly journal blessedly low on eye-glazing academic language with no loss of useful content, electronically so we could have pretty much zero publication costs.

There was some gnashing of teeth about the electronic part. Those who were around then will remember the argument that went something like this: "It's a membership benefit so we should keep it all to ourselves!" Some cynics pointed out that it was just about our only membership benefit at that point, and they weren't far wrong. But calmer heads prevailed, recognizing the senselessness of keeping nurse life care planning's light hidden from others. My first issue as Editor, produced on my desktop Macintosh using Pages, went out in PDF by email to the entire membership of about 100 in March 2009.

They say that a lighthouse doesn't go running all over an island looking for boats to save, it stands there shining. Our light, thus freed up, started attracting some measure of attention, that's for sure. It didn't take too long for the JNLCP page to collect the most names at our annual conference committee roundups; once I actually got asked not to take them all because the other committees needed more help. But how could I turn anybody away who wanted to work? We heard from the grapevine that life care planners of all stripes were reading it. Membership surveys told us that 80% of you sent copies of individual articles or entire issues to clients, colleagues, and patients. Many more remembered specific articles or issues of particular value in their practices. We got requests for reprints. We got paeans from far and wide. Coincidentally, our association membership began to increase.

A few years ago AANLCP undertook a wholesale rebranding, with new fonts and mandated color palette for the Association's print and online presence. That also meant a Journal redesign, with production transitioning from my Macintosh and going to a pro designer. Our current designer is professional and thorough (though I've still done the covers).

It hasn't all been smooth sailing, of course. There was the time I learned that material we used had appeared in another journal a few years earlier; because it came to me anonymously I had no record of who submitted it. I printed an apology, the original author was gracious, and we moved on. There were other occasions for humility to come, but none so painful. Plenty of nights I would sweat bullets getting the thing together to make deadline. Every issue I said to myself, “Good grief, I'm not sure this issue will be very good,” and every issue people have been generous with their praise. I am grateful that our light still shines.

Your Journal is the product of the best committee an editor could wish for. I can’t overstate the debt we owe to the people who came to the meetings ready to brainstorm, found authors with something to say, wrote thoughtful and constructive reviews, and fulfilled their commitments year in and year out. Thank you all so much for your dedication to the cause. Your names are in every issue and in my heart. Do stay in touch.

Now the new lamplighters will take over, Mariann Cosby and Laura Stadjuhar. I wish them all the luck in the world.

Wendie A. Howland
Editor, JNLCP
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AANLCP® invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning within the medical-legal community. Submitted material must be original. Manuscripts and queries may be addressed to the Editorial Committee. Authors should use the following guidelines for articles to be considered for publication. Please note capitalization of Nurse Life Care Plan, Planning, etc.

**Text**

Manuscript length: 1500 – 3000 words
- Use Word® format (.doc, .docx) or Pages (.pages)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Use Times, Times New Roman, or Arial font, 12 point
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for editorial review
- Use APA style (Publication Manual of the American Psychological Association)

**Art, Figures, Links**

All photos, figures, and artwork should be in JPG or PDF format (JPG preferred for photos). Line art should have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi. Each table, figure, photo, or art should be on a separate page, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003) Live links are encouraged. Please include the full URL for each.

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Manuscripts not published will be returned to the author. Queries may be addressed to the care of the Editor at: whowland@howlandhealthconsulting.com

**Manuscript Review Process**

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and the nursing profession. Acceptance is based on manuscript content, originality, suitability for the intended audience, relevance to Nurse Life Care Planning, and quality of the submitted material. If you would like to review articles for this journal, please contact the Editor.

**AANLCP® Journal Reviewers for this issue**

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American Association of Nurse Life Care Planners

Dorajane Apuna-Grummer
Wendie A. Howland
Editors
By the time you read this message many things will be decided, making this is a difficult message to write. Publishing deadlines for this September issue require me to complete my message to you in July and we have several irons in the fire. With your vote in August, you elected incoming officers to join the 2017 Executive Board. You have all received, commented on and voted on the proposal to increase our membership dues. So here I sit writing and wishing I had a crystal ball. I received many phone calls and emails in response to the dues situation. We have a lot of work yet to do. I want to thank you for sharing your creative ideas and support. Your response was overwhelmingly positive. In the words of Henry Ford, “Coming together is a beginning; keeping together is progress; working together is success.”

AANLCP® celebrates its 20th Birthday in 2017. AANLCP® was founded in 1997. The life care planning industry was forever changed when Kelly Lance MSN, APRN, FNP-C, LNCP-C recognized the nursing process as a novel life care planning methodology. I don’t image those early days were easy. It takes a tremendous amount of time and dedication to bring ideas to reality. For that Ms. Lance will always have my appreciation and respect.

I have spent countless hours these past months thinking about where we came from and where we’re going. Our futures are rich with opportunity. As nurses we are critical thinkers and quick to adapt. We know the importance of holistic care and plan along the full spectrum of the care continuum.

Nurse life care planners come from diverse backgrounds, with years of education, experience, professional standards, scope of practice and unique skill set. We collaborate; before we were nurse life care planners we developed and implemented care plans for our patients with other nurses. Now, thanks to Ms. Lance, we write plans of care for lifetimes.

In the words of Dr. T. Heather Herdman, Executive Director of NANDA International, “A medical diagnosis deals with disease or medical condition. A nursing diagnosis deals with human response to actual or potential health problems and life processes. For example, a medical diagnosis of Cerebrovascular Attack (CVA or Stroke) provides information about the patient’s pathology. The complimentary nursing diagnoses of Impaired verbal communication, risk for falls, interrupted family processes and powerlessness provide a more holistic understanding of the impact of that stroke on this particular patient and his family – they also direct nursing interventions to obtain patient-specific outcomes. (©NANDA International, Inc., www.kb.nanda.org)

There are other professions that write life care plans. Each brings its unique methodology and perspective. I’m not sure that’s a bad thing. Each brings something to the table. All well-written, objective plans share a common thread: providing evidence for individualized current and future care to protect, promote, and optimize the health and ability of individuals and families affected by catastrophic injury and complex/chronic health conditions.

But as in so many other areas in life, there’s just something about … nursing. Please join me in celebrating our unique abilities as we face the future, whatever it brings. We make a difference.
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To contribute, contact
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 Contributors to this issue

MARIANN F. COSBY
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PENELOPE CARAGONNE
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("Life Care Planning in Mexico and Latin America") has served persons with multiple disabilities for over 36 years. She has lectured extensively on long-term planning and case management as a model for comprehensive service delivery both within and outside a litigation context. She also provides long-term case management services to individuals with catastrophic injuries, assistive technology assessment, prescription, installation, training and repair services. Her company offers job site modification, educational access services, and forensic assessment, consultation, and testimony. She has served as Vice President of External Affairs, American Rehabilitation Economics Association, book review editor of The Earnings Analyst, Director of Research, International Association of Rehabilitation Professionals in the private sector and has authored multiple articles for the rehabilitation and forensic economics literature.

KATHLEEN PHILLIPS
("A Comparison of Canadian and US Life Care Planning") is a Canadian Registered Nurse who has been a member of AANLCP since 2009 and Certified since 2011. She completed her master’s degree in Edinburgh, Scotland. She has had a varied nursing career over 40 years as a critical care staff nurse, nurse manager, nurse educator and administrator/owner of a private home care company. She currently is semiretired and lives in British Columbia. She can be contacted at kplegalnurseconsultant@gmail.com

Members of the AANLCP Journal Committee would like to thank Outgoing Editor Wendie A. Howland MN RN-BC CRRN CCM CNLCP LNCC for all of her contributions to help make our journal what it is today, a digital, freely-available, peer-reviewed nursing journal. Digital issues are archived dating back to March 2009 at www.aanlcp.org.

We appreciate Wendie Howland’s outstanding service and wish to extend our best wishes to Incoming Editor Mariann F. Cosby, DNP, MPA, RN, PHN, CEN, NE-BC, LNCC, CLCP, CCM, MSCC.
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Considering and including cultural preferences, beliefs, and spiritual and health practices in plans of care is part of professional nursing standard of practice (American Nurses Association [ANA], 2015). Cultural aspects of care are assuming greater prominence in individual plans of care (ANA, 2015) and standards of practice (Douglas, et al., 2011; Expert Panel for Global Nursing and Health, 2010). As cultural diversity continues to evolve and grow, nurses and other life care planning professionals may find Purnell’s (2013) fourth edition of Transcultural Health Care: A Culturally Competent Approach helpful. This text contains information that the life care planner can use to close any personal cultural knowledge gap and aid in life care plan development.

Purnell (2013) identifies spirituality as one of the twelve domains of culture. Hence spirituality is an important element for the health practitioner and life care planner to keep in mind when caring for patients or developing life care plans for clients. Health beliefs and practices are often rooted in spirituality as religious traditions (Ehman, 2012). The following excerpts adapted from Ehman’s (2012) publication provide some practical points to consider when developing care plans for Buddhist, Catholic, Hindu, Jehovah’s Witness, Jewish, Muslim, and Pentecostal individuals, families, communities, or populations.
**Buddhist**
- Strong sense of modesty, reluctant to receive treatment by someone of the opposite sex.
- Some groups do not allow touching the head (where the soul resides) unless medically imperative.
- Strict vegetarian diet is common, may refuse to take food or medication that is produced using animals or animal by-products.
- Repetitive chanting, prayer beads, burning incense or candles may be part of rituals.
- Strong emphasis on mindfulness. May need peaceful and quiet place to meditate.
- May refuse analgesia due to desire to achieve greater mental alertness and mindfulness. Consider non-pharmacological pain management options.
- Ethical pain management plan should include end-of-life care strategies that safeguard the need for mental alertness.
- Death process includes minimizing actions that might disturb meditation, and keeping the body still after death for the purpose of religious rites keeping the spirit intact.

**Catholic**
- Sacraments and blessings such as Confession, Holy Communion; and when near death, the Last Rites/Sacrament of the Sick should be considered.
- Religious practices such as regular attendance at Mass or special religious holidays should be considered and integrated.
- Religious objects such as a rosary, crucifix, or religious medal are often important to be kept on person or available.
- Extraordinary measures regarding life-sustaining treatment may provoke some moral questions or issues associated with religious teachings.
- Non-meal diets during certain times of year are often requested to correspond with Lent/Easter.

**Hindu**
- Modesty concerns are strong and include reluctance of receiving treatment by someone of the opposite sex. Issues with genital and urinary systems are not discussed in the presence of the spouse.
- Strict vegetarian diet is common, may refuse to consume food and medications that are produced using animals or animal by-products such as gelatin or some calcium preparations.
- Fasting in common and should be considered when planning medical/dietary needs
- Washing hands after eating and implicating of norm of right hand for clean tasks, left hand for unclean tasks such as toileting should be considered.
- Jewelry or other adornments with strong cultural and religious meaning are common.
- Death process includes transition period with karmic implications; family involvement and attendance at all times.

**Jehovah’s Witness**
- Strict prohibition against receiving blood; some blood fractions such as albumin, immunoglobulin and hemophiliac preparations may be accepted, guided by conscience.
- Some sects refuse autotransfusion for surgery, including reinfusion technology
- Use microtechnique for lab studies to minimize blood loss for testing.
- Organ donation and transplantation is allowed, guided by conscience.
- May seek all possible treatment options that do not conflict with religious-based directives for treatment without blood.

**Jewish**
- Some (Orthodox Judaism) observe strict rule to not work in the Sabbath: from sundown on Friday until sundown on Saturday. This includes prohibition of using certain tools and electrical devices such as motorized bed, or other patient care items that use the flow of electricity.
- Jewish holidays are significant such as Passover, Rosh Hashanah, and Yom Kippur; may affect scheduling of medical procedures or dietary changes for special food or fasting.
- May keep kosher in accordance with religious laws requiring special methods of preparation of certain foods.
- Modesty concerns may be an issue with someone of the opposite sex.
- Value of saving a life is held in extremely high regard. As a result exception of religious laws may be made.
- Withholding or withdrawing life-sustaining therapy is deeply debated with rabbi input.
- Skull cap (yarmulke or kippah) or prayer shawls are common as are use of small boxes (phylacteries) with scriptures (males)
- A Jewish person may be non-religious and observe Jewish religious traditions for cultural reasons.
- Use caution with the term Jew, which can carry complex historical connotations.
- Burial within a day of death, unless far-away immediate relatives cannot arrive in time or Shabbat or a holiday prevent preparations. No autopsy unless lawfully required. Family involvement and attendance with the body at all times.
Muslim

- Modesty concerns are strong and include reluctance of receiving treatment by someone of the opposite sex. Women may need to cover body completely; request a family member's presence during an exam or request to keep clothes on during an exam. Often avoid eye-contact as a function of modesty; do not shake hands
- Diet is in accordance with religious laws for halal food, or opt for vegetarian diet. May refrain from food and drink during 30-day month of Ramadan, which shifts according to lunar calendar
- Dietary regulation can affect medications that have porcine origins or contain gelatin derived from animal sources or alcohol
- Washing with running water before and after meals is required
- Prayers and conducted five times a day; kneeling and bending to the floor
- May be hesitant to express need for pain medication; may experience the pain to be spiritually enriching
- Generally discourage the withholding or withdrawing of life-sustaining therapy.
- In death, family requests to be present to whisper a proclamation of faith; burial done as soon as possible; autopsy rarely allowed unless legally required.

Pentecostal

- May pray exuberantly by speaking in tongues that are seemingly unintelligible
- Request large numbers of people be allowed around the patient
- Belief in miraculous healing.

This is not intended to be an exhaustive reference, but a selection of examples to prompt the thoughtful nurse life care planner to enquire carefully about similar issues when appropriate. Note that there are many other cultural traditions with particular needs regarding diet, consent, modesty, touching, death, organ transplantation, and other aspects of care. The following references will offer a good place to start. In addition, the JNLCP would welcome anecdotes and insights from our readership on this far-ranging topic.

REFERENCES


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- Dataflow between LCP, MSA, MCP
- Customize templates by injury for future files
- Set page breaks or change page orientation
- Customize Narrative headings or use default
- Create “options” in LCP, MSA or MCP
- Upload files into template
- Submitter cover letter for MSA
- Calculates “Seed” money
- MSA template for WC and Liability files
- Limited use “User” available for certain sections
- LCP Narrative Section
- LCP Tables Section
- Customize Cover Pages
- Customize Company Logo or Customer Logo
- Footer information
- Admin. section to assign users
- Group files by customer on “Dashboard”
- Custom Data Lists reduces data entry
- Screen lock on “non-usage” for security
- Calculates age
- Calculates life expectancy
- Inflation factor built into template tables
- Calculates tables
- Customize table headings
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LIFE CARE PLANNING IN MEXICO AND LATIN AMERICA

PENELlope Caragonne PhD

Introduction
Developing a Life Care Plan (LCP) internationally requires all the abilities, skills, and knowledge you need to complete plans in your home country. However, to be valid and truly useful post litigation, a plan must exactly fit the cultural and healthcare infrastructure of the country where it will be used. Culture, attitudes toward health and disability, relative wealth and even spiritual and religious attitudes will affect the plan outcome.

For example, I recently developed life care plans in the United States, Mexico and Honduras involving the need for narcotic analgesics. I was struck by the difference in availability of these drugs. As you would expect, availability is greatest in the United States, followed by Mexico with about half as much, and then Honduras with about half as much as Mexico. Obviously, I wasn’t able to translate recommendations directly, and had to consult health professionals in the countries where the plans were set to determine appropriate alternatives and substitutions.

Getting information and opinions from medical professionals can be a very different process in Mexico and other countries in Latin America. The issue of cultural differences is complex; entire books have been written about this. Searching Amazon.com for books using the term “cultural differences” yields 127,829 returns. For this reason and since a brief review can often lapse into a recitation of cultural stereotypes, exploring this topic is beyond the scope of this paper.

However, whether buying a liter of milk from a local tienda or discussing a medical procedure and the cost with a physician, in Latin America, business should only be conducted after the parties establish a relationship.

Formality and what Americans might consider courtly manners are the standard for this. To Americans, particularly those who live in big cities, new interactions will seem like everything is being discussed except the business at hand. The directness that we value so much will seem brutal, maybe even rude, or make the person being direct seem untrustworthy. Keep this in mind when making any contact. A few minutes talking about the other person, work, family, or even the weather will lead naturally to a discussion about the presenting business.

Stages of International Life Care Planning
Many of the usual standard components for LCP will apply, including the responsibility for ethical practice. Some have sub-steps with different requirements depending upon the country. However, as you might imagine, there are some additional stages needed.
STAGE 1
Initial Request for Work: Determinations to make
There are few differences compared to a plan based in the United States. The single most frequent difference is a request for currency conversion. This requires a number of steps but it does not entail changing the cost of items from US Dollars (USD) using the current bank exchange rate. The cost of every item will be different in another country, even if it is imported from the United States. You have not created an international LCP by simply changing the cost to another currency. Proffering a cost-converted LCP for services based in another country is a sure path to an exclusionary hearing -- and the expense and work involved in trying to prevent an exclusionary ruling.

STAGE 2
Plan Translations
Having a LCP in English and the home country language is critically important. A LCP is a “roadmap” to services, not just for the court but for the disabled individual who needs to be able to read it. When costing, the researcher must know the name of the item and its particulars in both languages. For this reason, have a good working knowledge of the language in question and a full translation of the resource names and particulars before beginning to research costs. Engage a certified translator if necessary. A certified medical translator should translate medical records to prevent misunderstandings.

STAGE 3
Planner and Subject Safety
Safety is more likely to be an issue when creating a plan in Latin America. Analyze precautions that might be needed both for the planner doing on-site data collection and for the individual returning home with a disability and possibly a settlement that could be large by local standards. Google as the best source for current information; in today’s world these issues can change overnight. Look for local newspapers and other sources. If you are not fluent in the language, most browsers offer translation plug-ins to allow you to read them. Remember, what is relevant today may become outdated suddenly; books may not be as useful as periodicals and even internet forums.

STAGE 4
Plan Research
This is where native language proficiency is most crucial. However, don’t expect a United States level of Internet development to help you search for reliable contact information, or even to find an actual vendor site with products, descriptions, and costs. Business websites are rare. Be prepared for phone numbers to be out of service, websites to contain inaccurate information, or companies to be out of business. Finding that first usable phone number may be the hardest part. Your only recourse may be to ask that person about other resources or perhaps a better time to call.

Most of the items for a catastrophic injury will be available in most countries; however, locating sources may resemble a detective story. Some items will require a substitute, and in some cases (e.g., pharmaceuticals), you may have to use a local physician to identify a commonly-used substitute and equivalent dose.

Some rural small towns may be nearly inaccessible. In one of my cases, I have to time deliveries so supplies can be shipped before the roads wash out during rainy season and then after they’ve been repaired. Basing medical services in the closest large city is sometimes the only choice, but you’ll have to factor in suitable transportation.

STAGE 5
Skills and Familiarity in Equipment and Services for Disability
Having a working knowledge and “hands-on” experience in goods and equipment selection, purchase, repair, use, and adaptation for effective use in rural vs urban areas is critical. This will avoid costly future purchases of devices incompatible with a rural environment or repair needs. For example, a sip-and-puff motorized wheelchair that’s optimal for personal independence in the United States may prove to be an expensive hindrance in many parts of Latin America.

STAGE 6
Plan Documentation and Transparency
Getting hard copy proof of a quotation is more difficult in Latin America. Sometimes all you will have is the contact person’s name, phone number, and organization. That person may not have an email address, a fax machine, or other methods to give you information. Documenting the contact date and information may have to suffice.

A relatively new method to get supporting documentation uses a cell phone and an application called WhatsApp. This is a messaging app that allows text, voice, files, and pictures to be sent over an Internet or data connection. Most cell phone users in Latin America pay per message for regular SMS, but WhatsApp uses minimal data to send photos of equipment or even possible homes for sale. You can paste all of this into a report.

Be careful to use the appropriate rate of exchange when converting to USD. Published exchange rates generally represent the cost of money used between banks. These rates are not available to an individual and are therefore inappropriate to use in a LCP. Checking with exchange houses to determine the consumer exchange rate. For example, in Mexico the bank exchange rate is $20.00 MXN (Mexican pesos) per USD (U.S. dollar) and the consumer rate is $19.70 MXN per USD.

Each country develops their own life expectancy tables. It is neither appropriate nor accurate to use a US table, and nor does a US table’s category “Hispanic” apply to an individual living at home in
Latin America. Go to the source for that county or seek values from the country-specific World Health Organization tables.

**STAGE 7**

**Physician, Nursing, and Paraprofessional Validation**

Identifying a skilled physician of good reputation may be even more difficult. Oversight of professionals who may misrepresent their skills and qualifications seems to be much less thorough. Sometimes I have researched the licensure of every doctor in a specialty listed in the yellow pages. In Mexico, this licensure is called a cedula, and is a government issued license showing successful graduation from University in an area of expertise. A physician who then completed education to become a physiatrist would have two cedulas—the first for the medical license and the second for physiatry.

Typically, most listings are for physicians without a cedula in the advertised specialization. This lack of credentialing is likely to be even more common for nurses and other paraprofessionals. A recent article announcing the opening of a new school for nursing quoted the Governor of the State of Jalisco as saying that the majority of nurses in Jalisco have had no formal training. Take care before including someone as a resource.

**STAGE 8**

**Researching Quantitative Data Bases**

You can get information about labor, salary, life expectancy, central banking, medication, and other issues for any country. The World Health Organization, the United Nations, and other international membership organizations usually have databases on country-based websites and sometimes under the membership organization website. These are generally not easy to use as they were developed for professionals such as economists. The learning curve can be steep. Just knowing what data member countries must supply will help when searching for information about a member country.

**STAGE 9**

**Representing Services Available Through Federal Health Systems**

Most of Latin America relies on a dynamic and ever-changing constellation patchwork of private, public, and charity medical care. Cities may have better and more comprehensive services; rural areas are either surprisingly well-served or neglected entirely.

Mandatory services may be available without cost but may have a two-year wait for pre-existing conditions. Finding specific and accurate information can be difficult and may require painstaking research through federal and state government proceedings records. There probably won’t be just one place to find clear information. Sometimes it is easier to identify an expert in the country who will be able to obtain the information required. These experts can sometimes be found on Internet forums as individuals, usually attorneys, whose clients are United States or Canada citizens relocating for work or retirement.

**Summary**

I have sought to summarize the most pertinent issues to consider when doing life care planning internationally. First, establish relationships with the individuals providing information. Incorporate the cultural differences so that the plan can actually be used in the country in question. Obtain accurate translations if you are not fluent in the language. Take the time to learn about resources, caregiver qualifications and availability, and the regulatory structure for services.

**REFERENCE:**


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**PENELOPE CARAGONNE PHD**

has served persons with multiple disabilities for over 36 years. She has lectured extensively on long-term planning and case management as a model for comprehensive service delivery both within and outside a litigation context. She also provides long-term case management services to individuals with catastrophic injuries, assistive technology assessment, prescription, installation, training and repair services. Her company offers job site modification, educational access services, and forensic assessment, consultation, and testimony. She has served as Vice President of External Affairs, American Rehabilitation Economics Association, book review editor of The Earnings Analyst, Director of Research, International Association of Rehabilitation Professionals in the private sector and has authored multiple articles for the rehabilitation and forensic economics literature.
To: Our Dedicated Membership  
From: CNLCP® Certification Board  
Subject: AANLCP® Proposed Dues Increase  

We, the Chairman, Co-Chairman, Officers and Directors of the CNLCP® Certification Board applaud your current support of our esteemed organization.  

As a professional entity, the members of AANLCP® practice in a sub-specialty of nursing practice that entails application of an advanced degree of knowledge, expertise and experience. Your membership in the AANLCP® organization provides you with several benefits, including dedication to furthering your presence, as well as professionalism, within the Life Care Planning Community.  

As the majority of you are aware, your Certification Board has embarked upon a path toward obtaining recognition of our unique nursing practice in the form of accreditation by the Accreditation Board for Specialty Nursing Certification (formerly ABNS) so that we can become accredited as well as certified. However, towards that end, it is critical that the Association remain viable; and, that we all vote in support of the proposed dues increase to maintain that viability.  

Please, then, join us in voting "yes" on the proposed increase by logging in to www.AANLCP.org and navigating to the following between 8/30/16 and 9/13/16:  

Membership -> Members Only -> Dues Increase Vote  

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A Comparison of Canadian and US Life Care Planning

KATHLEEN PHILLIPS RN, BSN, M.SC.N.ED, LNC, CM, CNLCP

Introduction

After participating in numerous American Association of Nurse Life Care Planners Educational Conferences, I have obtained some informal knowledge from American colleagues as well as personal knowledge and research and documents about some of the main differences between life care planning in Canada and the United States (US).

There is little or no research in the literature regarding life care planning in Canada. There also appears to be a lack of research in the US about life care planning.

“Life care plans are generally commissioned by third-party payers in order to set aside adequate reserves for the future costs or to negotiate a settlement.” (Klinger, Baptiste, and Adams, 2004). As in the US, often these are medicolegal documents to outline damages for individuals catastrophically injured due to liability or medical malpractice.

The average health professional in Canada does not know what a life care plan is. Typically in Canada, life care planning (formerly called cost of future care) has been the domain of occupational therapists. The term “life care plan” is not as widely used as it is in the US, with many Canadian attorneys still requesting Cost of Future Care reports. (Walker, 2006)

Other professionals in Canada who prepare life care plans include, but are not limited to:

- registered nurses, usually with extensive nursing knowledge and advanced degrees
- case managers
There is no requirement at this time that the professional preparing a life care plan be certified. The majority of life care plans appear to be prepared by occupational therapists, but there is a growing movement for registered nurses to become involved with legal nurse consulting, including life care planning. The Canadian Nurse Journal has advertisements from more than one company offering legal nurse consulting courses for Canadian nurses. There are also private educational, occupational, and health care companies that offer some life care planning courses and training.

The US has taken the lead in this area of nursing. Canada lags behind in recognizing life care planning as a nursing specialty.

Legal Considerations

In Canada there are 10 provinces and 3 territories, each with their own laws. “Each province and territory has a provincial/territorial court and hears cases involving either federal or provincial/territorial laws” (Department of Justice, n.d.). Therefore, as in the US, the life care planner must be knowledgeable of any differences between the jurisdictions in which claims are filed and adhere to applicable laws and procedures.

Most lawsuits in US courts involve a jury (Matheson, 2007). In most Canadian lawsuits involving medical malpractice and personal injury claims, there is no jury; a judge presides over bench trial.

One of the main differences in life care plans between the US and Canada is that American life care planners must take into account all future medical and surgical needs of a client and cost out individual treatments. They also often use Common Procedural Codes (CPT) for items listed in their plans. There are no such codes in Canada.

Most notably, there is no requirement in Canada to cost out future medical expenses in a life care plan, because all medical care including physician visits, x-rays and laboratory tests and hospital related expenses including surgeries, are part of Canada’s universal health care. All home care costs are also covered within some provincial plans as well; in others there may be daily fees for home care, based on income. While in some provinces persons pay a monthly fee to access health care services, no one is denied access. The Canadian life care planner is likely to identify what potential surgeries may be required in the future; however, the only costs included in the plan would be for any added related short term medications, equipment, and therapies.

As in the US, some Canadians may have extended health care benefits through an employer or a private insurance company to cover many health care needs not covered by provincial or territorial plans. Often, there is a yearly benefit cap. These benefits likely include therapies that are not typically covered by most provincial or territorial medical plans, such as physiotherapy, occupational therapy, speech therapy, massage therapy and chiropractic, medications, and psychological counseling. Generally there are no impediments, such as a court-awarded settlement, that would deny any individual access to extended health care benefits. Unlike in the US, these benefits should be accounted for within the life care plan.

In the US, the Medicare Modernization Act (2003) requires that Medicare remain the secondary payer whenever possible. As a result, nurse life care planners with expertise in Medicare guidelines are in high demand to assess expected care needs in workers’ compensation cases and develop plans that protect Medicare’s interests (Medicare set-asides, MSAs) in settlements (AANLCP, 2013). There is no such requirement in Canada.

Government social assistance and health programs may not be accessible to Canadians who receive a court-awarded settlement for cost of future care needs; often what has been paid to date is repaid out of the court settlement (subrogated interest). While everyone still has access to all health care despite income and assets, for some benefits, income is considered before approval.

Although mandatory certification in both countries is not universal, it seems generally accepted that the courts do place some weight on the evidence of experienced certified life care planners.

In the US, depositions are taken before trial. In Canada there is no such process; there is usually a discovery prior to trial. Typically, opposing lawyers cannot cross-examine any expert witnesses, such as life care planners, until the matter reaches the court procedure. In most Canadian provinces there is, however, a mechanism to examine experts in advance of trial. For example, in the province of Alberta, Rule 5.37 states:

Questioning experts before trial:

5.37(1) The parties may agree, or in exceptional circumstances the Court may direct, that an expert be questioned by any party adverse in interest to the parting proposing to call the expert witness at a trial.

(2) The questioning must be limited to the expert’s report.

(3) The Court may impose conditions about questioning with respect to all or any of the following:

(a) limiting the length of questioning

(b) specifying where the questioning is to take place

(c) directing payment costs incurred

(d) any other matter concerning the questioning

(4) Evidence of an expert under this Division is to be treated as if it were evidence of an employee of the party who intends to rely on the expert’s report.

(Alberta Rules of Court, 2010)

Canadian life care planners should be aware that their entire files could be accessed by opposing counsel.

Educational and Certification

Professionals can obtain Canadian certification in life care planning through the International Commission on Health...
Care Certification (ICHCC). According to their website, to be eligible to qualify for this certification one must meet the definition of a “Qualified Healthcare Professional” and have the appropriate education and experience. “Additionally, this credential is designed to offer Canadian health care providers access to certification in life care planning through ICHCC on the same level of competency as required of their United States CLCP peers (International Commission on Health Care Certification, n.d.).”

In the past, Canadian professionals who desired training leading to certification as life care planners could take a program through the Department of Behavioral Science and Community Health at the University of Florida. This program recently transferred to the Institute of Rehabilitation Education and Training. There is Canadian content that meets the needs of the Canadian professionals and are then eligible for certification by the International Commission on Health Care Certification. The designation is Canadian Certified Life Care Planner (CCLCP). There is no Canadian governing body or association for Canadian Certified Life Care Planners.

There are some private Canadian companies, such as Roy Matheson, who offer some life care planning courses that do not lead directly to Canadian certification, but that are accepted as prerequisites by ICHCC for the certification course. There is no specific life care planning program in Canada designed exclusively for Canadian registered nurses.

The American Association of Nurse Life Care Planners has a Core Curriculum in Nurse Life Care Planning as a reference to help aspiring nurse life care planners prepare for the Certified Nurse Life Care Planner (CNLCP) certification examination, most often in conjunction with educational courses offered by private companies. There are other university programs and private companies who offer similar education to prepare nurses and others for certification examination as a Certified Life Care Planner (CLCP) in the United States.

Both credentials require certified members to meet continuing education requirements to recertify. Contact the respective organizations for requirements.

Cultural Considerations

While both the US and Canada have diverse populations of many different cultures, there are some differences to be noted.

In the US there is a large Latino/Hispanic speaking population. In Canada there is large French speaking population as well as First Nations, Inuit, and Métis. Canada also has large South Asian and East Asian populations. Cultural differences should be addressed within the life care plan.

According to Health Canada, cultural safety requires health care providers to be respectful of many beliefs. Provinces and territories are responsible for delivering health care services, guided by the provisions of the Canada Health Act. Health care services include insured hospital and primary health care, including physicians and other health professional services. Like other citizens, First Nations people and Inuit access these insured services through provincial and territorial governments (National Aboriginal Health Organization, 2009).

There is a federal program called Non-Insured Health Benefits for First Nations and Inuit to help these groups achieve an overall health status comparable with other Canadians (Non-Insured Health Benefits Canada, n.d.). This program covers health benefits not covered by provincial plans and includes specific drugs, dental and vision care, medical supplies and equipment, mental health counseling and medical transportation for eligible First Nations and Inuit citizen who prove financial need. There does not appear to be an equivalent federally funded benefit program for Native American people in the United States, although those covered under the Indian Health Service have special access to provisions in the Affordable Care Act and other funded programs (HealthCare.gov, 2016).

The Métis Health Benefits Program is sponsored by the Government of The Northwest Territories and is administered by Alberta Blue Cross on their behalf. Currently, Métis living in each province receive health care benefits through the provincial plans (Métis Health Benefits, n.d.). Although the Métis played a singular role in Canada’s early history, their status in the country’s legal framework has been a decades-long controversy. Federal and provincial governments have argued back and forth for years about who is responsible for providing programs, services and benefits to the Métis – a Western-based nation descended from the offspring of European traders and First Nations women. A recent Supreme Court ruling makes it clear the Métis are a federal responsibility (Galloway, 2014).

The life care planner must be knowledgeable about the application of different laws and programs. If a client is First Nations, Inuit, or Métis, eligibility for Non-Insured Benefits and any additional future care needs outside of the Non-Insured Benefits program, should be addressed in the life care plan. If the life care plan is commissioned in the province of Quebec, (Canada's predominantly French population), then it likely must be prepared in the French language.

A Final Note

Both countries lack a body of research about life care planning, particularly outcomes: Was the life care plan implemented as presented and what was its effect on quality of life?

Differences between Canadian and US life care planning are outweighed by the similarities. Both countries require adherence to standards of care and practice, privacy protection, and knowledge of the laws of the land to ensure that individuals receive the most appropriate life care plans to meet future needs.

Disclaimer:

The opinions expressed are solely those of the writer. The writer does not profess to have wide expertise in discussing the differences between the two countries and there is likely more information that is not readily available to review. Life care planners should consult with local experts for more information if needed.
### Comparative Table for quick reference

<table>
<thead>
<tr>
<th>Legal</th>
<th>Canadian LCP</th>
<th>American LCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judge presides over most medical malpractice/personal injury trials</td>
<td>Knowledge of provincial, territorial, and federal law</td>
<td>Knowledge of state and federal law</td>
</tr>
<tr>
<td>Universal healthcare, therefore no requirement to cost future medical care</td>
<td>Universal Health Care</td>
<td>Jury trials</td>
</tr>
<tr>
<td>No funding codes in Canada</td>
<td>Discovery before trial/no deposition</td>
<td>Identify and cost all future medical procedures</td>
</tr>
<tr>
<td>Use of CPT (not mandatory)</td>
<td>Use of CPT (not mandatory)</td>
<td>Knowledge of Medicare guidelines for MSA for some cases</td>
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<tr>
<td>Knowledge of Medicare guidelines for MSA for some cases</td>
<td>Deposition and discovery before trial</td>
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| Education                                                             |                                                                 |                                                                 |
|----------------------------------------------------------------------|                                                                 |                                                                 |
| Formalized training for LCP is not university based                  | University, college based programs                                       |                                                                 |
| Private company training programs                                     | Private company education/training                                        |                                                                 |
| No RN based education programs for LCP                               | AANLCP core curriculum for RNs                                            |                                                                 |
| Certification through ICHCC                                          | Certification through AANLCP and/or ICHCC                                |                                                                 |
| CEU to recertify                                                     | CEU to recertify                                                         | Same                                                                       |
| No mandatory requirement to be certified LCP                         | Same                                                                       | Same                                                                       |

| Cultural                                                             |                                                                 |                                                                 |
|----------------------------------------------------------------------|                                                                 |                                                                 |
| French speaking population                                           | Hispanic population                                                      |                                                                 |
| South Asian and East Asian populations                               | Not as large as in Canada                                                 |                                                                 |
| First Nations, Inuit, and Métis benefit programs                     | Indian Health Service, ACA provisions for access                        |                                                                 |
KATHLEEN PHILLIPS is a Canadian Registered Nurse who has been a member of AANLCP since 2009 and Certified since 2011. She completed her master’s degree in Edinburgh, Scotland. She has had a varied nursing career over 40 years as a critical care staff nurse, nurse manager, nurse educator and administrator/owner of a private home care company. She currently is semiretired and lives in British Columbia. She can be contacted at kplegalnurseconsultant@gmail.com

REFERENCES:
American Association of Nurse Life Care Planners (AANLCP) (2013). A Core Curriculum for Nurse Life Care Planning. DJ Apuna-Grummer and WA Howland, editors. AANLCP, Salt Lake City UT
Gibson, Kim Occupational Therapist, Enigma Consulting, Abbotsford, BC Canada; professional telephone consultation 2/6/2016
Wintermute, Leah D. Partner, Field Law LLP, Edmonton, Alberta, Canada; professional email consultation 5/29/2016
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~ Colleen Manzetti, DNP, RN, CNLCP, CNE
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Life care planning in Latin America
1. Plan outcome can depend on cultural attitudes about all of these except
   a) congenital disability
   b) judicial privilege
   c) spiritual practices
   d) wealth

2. Which of the following is unacceptable and would put an international plan at risk for challenge in litigation?
   a) Applying official bank exchange rates to US cost
   b) Considering financial risks to patient safety
   c) Consulting Internet sources for DME purchases
   d) Using WhatsApp for supporting documentation

3. A completed life care plan should be translated into the patient’s native language
   a) because medications have different names.
   b) for the court to be able to judge its provisions.
   c) so local workers can maintain and repair DME.
   d) to explain safety needs to local security forces.

4. Information about life expectancy for an international plan can be best obtained from
   a) A Federal health system database
   b) An Internet forum for new arrivals in the country
   c) A local physician with a cedula in the specialty
   d) A World Health Organization website

A Comparison of Canadian and US Life Care Planning
1. Life care planning in Canada is regulated by:
   a) The federal government
   b) Individual territorial / provincial governments
   c) The International Commission on Health Care Certification
   d) No regulating body addresses life care planning

2. First Nations, Inuit, and Métis citizens’ health care costs are covered by the
   a) Canada Health Act
   b) HealthCanada
   c) National Aboriginal Health Organization
   d) Provincial / territorial health plans

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Becky Czarnik MS RN CLNC, LNCP-C
Education Committee Chair, AANLCP
2012
XII.1 Coding and Costing
XII.2 Electrical Stimulation Technology
XII.3 Preconference / Brain Injury
XII. 4 Veterans Administration

2013
XIII.1 LCP for Motor and Developmental Disorders
XIII.2 Ethical Topics in LCP
XIII.3 Preconference / Exemplars in NLCP
XIII.4 Home Modifications

2014
XIV.1 Technology Updates

2015
XV.1 Topics in Transplantation
XV.2 Updates in Spinal Cord Injury
XV.3 Burns
XV.4 Perinatal / Childhood

2016
XVI.1 Pain
XVI.2 GI issues
XVI.3 International LCP
XVI.4 Home Care

XIV.2 LCP Across All Ages
XIV.3 Psych topics in LCP
XIV.4 LCP and the ACA