Journal of Nurse Life Care Planning

Veterans Administration and LCP
Introduction to the Veterans Administration
Shelly Kinney MN RN CCM CNLCP

Tips for Obtaining Information from a VAMC
Shelly Kinney MN RN CCM CNLCP

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Keith Sofka ATP (retired)
Penelope Caragonne MSW Ph.D CLCP

Nurse Life Care Planning: Licensure, Specialty Designation, Certification, and Accreditation
Kertrina Miller BSN RN CCRN CPAN

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. Other diagnoses may be relevant depending on patient needs.
Editor’s Note

Welcome to the Winter 2012 Journal of Nurse Life Care Planning, with Contributing Editor Shelly Kinney MSN RN CCM CNLCP and Lt Col (ret) USAF. We are delighted to have articles focusing on the US Veterans Administration with contributions reflecting many aspects of veterans’ care that will be useful to the nurse life care planner, from state-of-the-art prostheses to sexual trauma to help with the ever-challenging question, “How do I get costs from the VA?”

As I write this, we have just returned home from an outstanding conference, one that is sure to have lasting effects on our work. After thoughtful, challenging presentations by the ANA and your peers who wrote the current Scope and Standards of Practice for nurse life care planning, the hallways and meeting areas were a-buzz with the sound of professional excitement and debate. It’s thrilling to be involved with this process knowing that we are developing the future of nurse life care planning now, today. Please do your part by filling out the job analysis survey and forwarding it to every nurse life care planner you know, regardless of certification or practice setting. We need only ninety more respondents to complete work on this vital project. Deadline is December 15! Follow this link: http://www.ptcny.net/clients/CNLCP/2012rdsurvey/

Have a wonderful holiday season! Use the Amazon link at our website bookstore for gifts of all kinds! And please remember to help those less fortunate living where disaster has hit so hard this year.

Cordially,
Wendie Howland
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Information for Authors

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.

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Manuscript length: 1500 – 3000 words
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- 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)

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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)

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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.

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Contributing To this Issue

Penelope Caragonne PhD (“Technology Corner: Environmental Control Units”) 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.

Shelly Kinney (“Introduction to the Veterans Administration”) has over 20 years of experience in critical care and rehabilitation nursing, case management, and Life Care Planning. Lt. Col (ret) Kinney is a veteran of Desert Storm and OIF/OEF and is accustomed to working with government programs. She has special expertise working with individuals who have traumatic brain injury or chronic pain. Through her independent consulting company, Kinney Consulting, Inc., she provides Life Care Planning services across the country and case management services in Nebraska and surrounding states. She is the chair of the Editorial Committee for the American Association of Nurse Life Care Planners and frequently speaks at conferences for Life Care Planners, case managers, and vocational specialists on Life Care Planning and long term needs of individuals who have experienced traumatic illness or injury.

D. Ryan Hixenbaugh (“Personal Bionics”) is the Senior Marketing Strategist for iWalk. He has been published and spoken on personal bionics to payers, case managers, physicians and prosthetists since before the technology was commercially launched. Hixenbaugh has worked with product development and launches for a variety orthopedic and prosthetic medical devices since 1996. He currently resides in Seattle, Washington.

Ginny Lee (“The Invisible War”) enlisted in the U.S. Army directly out of high school. Upon discharge, she obtained her nursing degree in 1996 as a registered nurse. She started her training at Ben Taub Hospital in Houston, TX in the Medical and Surgical ICU and Neuro ICU. She earned a bachelor’s in business, and double master’s degrees in nursing and administration with an emphasis on healthcare management. She has worked in home health, developing cardiac and stroke protocols to decrease acute care hospitalizations. She worked with soldiers coming home from Iraq and Afghanistan as a case manager and to assist reintegration. She has assisted attorneys and life care planners with various cases from personal injury to medical malpractice. Currently, she spends most of her time volunteering with Veterans and Veterans Advocacy groups and victims of crime, such as rape, domestic violence, and child molestation. She is married with one stepdaughter and resides in Hot Springs, AR.

Kertrina Miller (“News from the Certification Board”) received her degree in nursing from Montana State University and has been a registered nurse for 20 years. She started her nursing career in an open heart intensive care unit. Later her nursing career moved to the medical/surgical/pediatric intensive care unit, recovery room, emergency room, physician office, and hospital management. She is an active member in AACN, ASPAN, and AANLCP and is certified in critical care (1997-present), perianesthesia care (2000-present), and life care planning (2005 to present). She is owner of Rocky Mountain Life Care Planning, LLC. She has served on the CNLCP® Certification Board since 2010. She volunteers in Gallatin County as a Guardian ad Litem. She presented “Asbestos disease and the life care plan” at the 2009 AANLCP conference, and co-authored “The Value of the Life Care Plan” in the quarterly Montana Trial Trends.
Keith Sofka ("Technology Corner: Environmental Control Units") is a principal of Caragonne and Associates, Ajijic, Jalisco, MX. He has practiced the provision of assistive technology services for the past 30 years. Mr. Sofka provides consultation to hundreds of companies, schools, Government Agencies and individuals. A major focus of Mr. Sofka's work has been to provide recommendations for and implementation of school and workplace reasonable accommodation recommendations for individuals and organizations. This work typically includes housing and commercial building access as well as transportation, mobility and completion of daily living needs as well as modifications to the individual worksite. He has also taken training and practiced in other areas of assistive technology including custom seating and positioning for individuals with severe orthopedic involvement. His work has always been focused on ways to use technology to increase the independence of the individual.

Letters to the Editor

New CNLCPs

We are pleased to announce that the following nurses have completed the requirements for the CNLCP credential. Thank you for printing this in the Journal of Nurse Life Care Planning.

Glenda Evans-Shaw BSN RN-BC PHN CCM CNLCP
CNLCP Certification Board
glenda@suttercreek.com

Please join us in offering congratulations to the new CNLCP Class of 2012 and to recertifying CNLCPs! For information on obtaining certification by examination or reciprocity, please go to the Certified Nurse Life Care Planner Certification Board website at http://www.cnlep.org/page5.asp

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Kelly West
This issue was created in response to requests for resources and direction to life care planners dealing with veterans with access to benefits from the Veterans Administration (VA).

The VA as we know it today is a constantly-changing organization. Some of this information is summarized from VA History in Brief, a historical summary published by the VA. (Department of the VA, 2005) The full document can be found at http://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf

We usually associate hospitals and clinics with VA benefits, but other VA benefits and services are available. Many veterans are not aware of all their current entitlements, e.g., vocational rehabilitation programs, medical equipment, financing and grants for home renovations, disability income, low-interest home loans with no down payment or private mortgage insurance, community mental health clinics, education and support through the Disabled American Veterans (DAV) and other veterans organizations, help for homeless veterans, and more.

Life care planners are often faced with cases that will take a long time to resolve. A veteran may have immediate access to healthcare services and programs for that interim period before a settlement is reached. If the client does not prevail, having this assistance in place may prevent financial ruin or medical complications. Some nurse life care planners are involved in work where collateral resources must be considered and thus must determine if the recommendations in the life care plan can be fulfilled through VA benefits.

History

In 1776 the Continental Congress created the nation’s first pension plan to encourage enlistments and curtail desertion of soldiers. It granted half pay for life in cases of limb loss or other serious

Shelly Kinney has over 20 years of experience in a variety of health care settings, nurse case management, and life care planning. Lt. Col (ret) Kinney is a veteran of Desert Storm and OIF/OEF and is accustomed to working with government programs. She has special expertise working with individuals who have traumatic brain injury or chronic pain and provides Life Care Planning services across the country and case management services in Nebraska and surrounding states. She can be contacted at 402-637-0143 or srkinney@cox.net
disability. Unfortunately, the Continental Congress had neither authority nor funds to make payments, so financial responsibilities were left to the individual states. In the end, at most only 3,000 veterans of the War for Independence ever drew a pension. Later, grants of public land were made to those who served to the end of the war.

Over the next 30 years, various government departments were charged with benefits administration to disabled veterans and families of deceased soldiers. The 1818 Service Pension Law provided a fixed pension for life to every person who had served in the War for Independence and was in need of assistance. Officers received $20 a month; enlisted men, $8 a month. This was the real beginning of veterans benefits.

From 1816 to 1820, the number of pensioners increased from 2,200 to 17,730, and the cost to the United States government for pensions rose from $120,000 to $1.4 million.

The first national effort to provide medical care for disabled veterans in the United States was the Naval Home, established in Philadelphia in 1812 to care for remaining veterans of the War for Independence and those injured during the War of 1812. This was followed by two facilities in Washington, D.C., the Soldiers’ Home (1853) and St. Elizabeth’s Hospital (1855). In 1865, after the Civil War, Congress authorized the National Asylum for Disabled Volunteer Soldiers.

These homes, called branches, provided room and board, and gave incidental medical care to disabled and indigent veterans, regardless of whether their disabilities were service-related.

In the years that followed, national homes cared for veterans of the Mexican, Civil, Indian and Spanish-American Wars, and for noncombat veterans as well.

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By the late 1920s, these homes provided hospital level of medical care.

**Among the provisions of the War Risk Insurance Act Amendments of 1917** was the authority to establish rehabilitation and vocational training for veterans with dismemberment, vision loss, hearing loss, and other permanent disabilities. The program retained injured persons in service by training them for new jobs. Eligibility for vocational rehabilitation and other benefits under the new law was retroactive to April 6, 1917, the date the United States entered World War I.

**A 1919 law** gave responsibility for medical care of veterans to the Public Health Service, put a number of military hospitals under control of the Public Health Service, and authorized new hospitals. This effort could not keep up with the growing workload; contracts were awarded to private hospitals to help ease the burden.

**In 1924,** Brig. Gen. Frank T. Hines reorganized the Veterans Bureau into six services: Medical and Rehabilitation, Claims and Insurance, Finance, Supply, Planning, and Control. This resulted in 73 subdistrict offices responsible for dealing with beneficiaries and claimants, supervising vocation training, administering outpatient medical care and giving physical examinations.

**In 1944, Congress passed the GI Bill of Rights,** in reaction to WWI veterans who marched on Washington, D.C to protest the financial devastation that welcomed them back from the war. The GI Bill of Rights was a comprehensive benefits package to aid the transition of 16 million veterans returning from World War II. There were three main provisions of the first GI Bill – tuition assistance, guaranteed home loans, and unemployment compensation. These benefits were the forerunners of the veteran benefits and civilian worker’s compensation benefits available today.

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Amputees returning from World War II had difficulty obtaining artificial limbs. In reaction, Congress authorized the VA to fill this need. The VA’s experience in assisting thousands of veterans led it to becoming a world leader in the development of prosthetic devices. This is one example of how each war leads to advances in medical science. After WWII, the VA hospitals made affiliation agreements with medical schools, and VA hospital-based research began.

Benefits for veterans of the Korean and Vietnam Wars were adjusted in response to the country’s economic status at the time and the increasing number of veterans being served by the VA. Additional hospitals were built, Veteran’s Centers were opened to provide outpatient mental health services, and pensions were adjusted to a sliding scale based on the veteran’s other sources of income. Interdisciplinary treatment teams were created to address needs of the growing population of aging vets. Geriatric Research, Education and Clinical Centers (GRECCs) were created to coordinate in the field of geriatric medicine.

Late in the 1980s, the VA dedicated resources to serving homeless veterans and those with chronic mental illness. It responded to the growing numbers of patients with HIV/AIDS with special treatment units and special training for treatment teams. The Montgomery GI Bill, very similar to the current 9/11 GI Bill, was adopted to provide 36 months of educational benefits in return for three years of military service and agreement to pay $100 per month in to the system for the first 12 months of service. Eligibility for VA pensions was changed to include only those deemed “totally disabled” and unemployable.

Congress established income-based eligibility assessment procedures to determine whether vet-

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Veterans were eligible for free medical care. Those not eligible for free care now pay for services on a sliding scale based on income.

The Persian Gulf War, which began in August 1990 as Operation Desert Shield and became Operation Desert Storm in January 1991, saw U.S. society becoming increasingly favorable to military personnel and veterans benefits. As of July 1, 1992, there were 664,000 Persian Gulf War veterans, not including Reservists called up for active duty. Of these, 88,000, or 13.2 percent, were women. Even before the hostilities ended, Gulf War veterans began complaining of symptoms with no readily identifiable cause. The symptoms included fatigue, skin rash, headache, muscle and joint pain, memory loss and difficulty concentrating, shortness of breath, sleep problems, gastrointestinal problems and chest pain.

VA began a Persian Gulf registry, which is a voluntary health assessment offered at all VA Medical Centers. Veterans are interviewed about their medical history for the registry and their possible exposure to environmental hazards. The results of these examinations are given to the veterans and are analyzed for use in research. In 1993 Congress authorized medical care for Gulf War veterans for conditions possibly related to exposure to toxic substances or environmental hazards.

The Center for Minority Veterans was authorized by Congress in 1994 to promote the use of existing programs by minority veterans and proposes new programs, benefits and services to meet the specific needs of minority veterans. VA’s Center for Women Veterans was established in November 1994 with a mission to ensure women veterans the same access to VA benefits and services as males, to make VA programs responsive to gender-specific needs of women veterans, to improve women veterans’ awareness of services, benefits and eligibility criteria, and to ensure that women veterans are treated with dignity and respect.

In 1997 VA established eight Comprehensive Women’s Health Centers and four Stress Disorder Treatment Centers.

The VA system was originally designed and built for America’s veteran population of the mid-20th century, when long admissions for diagnosis and treatment were the rule. In 1995, the VA began to bring service continued next page
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delivery more in line with that in the community at large. VA hospitals were grouped into 22 Veterans Integrated Service Networks (VISNs). Critical elements of this transformation included population-based planning, decentralization, universal primary care, a shift to outpatient care, and an emphasis on measuring performance on the patient outcomes. By 2005, the VA had 157 medical centers and more than 850 community-based outpatient clinics.

The VA today

As of July, 2012 the VA had 152 Medical Centers and 812 CBOCs throughout the United States and its territories.

Since 1998, veterans who served in a combat zone or comparable hostilities have been eligible for free VA hospital care, outpatient services, and nursing home care for two years after leaving active duty for illnesses and injuries that may be the result of their military service. Extended services depend on approval of medical review board and release from active duty service commitments. Other veterans are eligible based upon their income.

Women

Gone are the days when the VA cared only for aging male veterans. During Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF) from 2003-2010 and Operation New Dawn (OND) from 2010-2011 the U.S. military had record numbers of women airmen, Marines, sailors, and soldiers.

Women are the fastest-growing group within the veteran population, now at 8% of the total, and are 11.6% of OEF/OIF/OND vets (US Department of Veterans Affairs 2012). Women’s health services are no longer

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provided in an exam room with the foot of the exam
table facing the doorway. Each VA Medical Center
now has a Women Veteran Program Manager to coordi-
nate everything from primary care to mental health
and sexual abuse counseling. Gender-specific care is
the goal of every VA facility.

**Outpatient Clinics** Many veterans must travel great
distances to access VA health care services. In re-
response to this, Community Based Outpatient Clinics
(CBOCs) have been expanded to improve primary
care access. Veterans must still travel or work with the
VA to seek payment approval for providers in their
community. To locate the nearest clinics, veteran cen-
ters, regional offices or cemeteries, a search engine is
available using zip codes on the VA website at

**Burial benefits** All veterans who were discharged
under conditions other than dishonorable, their
spouses, and eligible dependent children can be buried
in a VA national cemetery. All veterans, regardless of
where they are buried, are eligible for a burial flag,
Presidential Memorial Certificate, and government
headstone, and a grave marker or medallion. There is a
new movement to open additional national cemeteries
or designate a portion of existing cemeteries as na-
tional cemeteries so that more veterans and their fami-
lies have access to free cemetery plots. (Dept. of Vet-


**Homelessness initiatives** Veterans are at in-
creased risk for homelessness due to mental illness,
health problems, limb loss, job loss

after returning from deployment, or the current econ-
omy in general. “According to HUD’s latest estimates,
there are 636,000 homeless people in the United
States, and more than 67,000 of them (14 percent) are
military veterans.” (Trautman, 2012)

In 2010 the VA and Housing and Urban Development
initiated a joint project, supported by President Obama
and VA Secretary Shinseki, to end veteran homeles-

ness by 2015. Case managers in the VA Medical Cen-
ters and outpatient clinics are available to pair veterans
who are homeless or at risk of homelessness with
available resources in their communities. In the first
year of the program, homelessness among veterans
decreased by 12%. There is a toll free number to refer
a veteran to the program – (877) 424-3838. Referrals
may also be made by calling the nearest CBOC or VA
Medical Center.

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Home modifications  “Veterans or service members who have specific service-connected disabilities may be entitled to a grant from the Department of Veterans Affairs (VA) for the purpose of constructing an adapted home or modifying an existing home to meet their adaptive needs. The goal of the Specially Adapted Housing (SAH) Grant Program is to provide a barrier-free living environment that affords the veterans or service members a level of independent living he or she may not normally enjoy.” (Department of Veterans Affairs, 2012)

Caregivers  The VA and Easter Seals have teamed up to provide caregiver training for family caregivers of veterans. A Caregiver Support Coordinator is available at each VA Medical Center. Additional services available include Adult Day Care; home based primary care (physician house calls) for homebound veterans or those for whom leaving home is difficult; drop in home health care services including skilled nursing, home health aide, and therapies; home telehealth; respite care; and home hospice services.

To find out what is available in a veteran’s area, contact the Caregiver Support Coordinator at the local VA Medical Center or call the national VA Caregiver Support Line - 855-260-3274. Additional services and financial compensation are available for family caregivers of post 9/11 veterans and service members.

Summary  In his second inaugural address in 1865, President Lincoln called upon Congress “to care for him who shall have borne the battle and for his widow, and his orphan.” This phrase was adopted as the VA’s motto. There are many more programs and services available to veterans and their families. The VA relies on their website www.va.gov, veterans organizations such as the DAV and American Legion, and word of mouth to inform veterans of new programs.

Rapid change makes it difficult to get the word out. If you are working with veterans, you can help ensure they are aware of their entitlements by researching the VA website or setting up a meeting with a case manager/ service coordinator at the facility nearest them.

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Please refer to other articles in this issue for additional resources.

References


Trautman T. Heyman Medal finalists at HUD and VA are getting veterans off the streets. The Washington Post. 7/25/12. Retrieved online 8/12/12.
Tips for Obtaining Information from a VAMC

Shelly Kinney MN RN CCM CNLCP

Obtaining information from government health care facilities can be a long and frustrating process. It begins with a phone call resulting in access to a phone bank. The automatic answerer provides myriad button-pushing options that direct you to more options. If you reach the correct department, a person will likely answer, and on a lucky day that person will have the pay grade to answer questions about benefits, cost, and medical information. Other times, you may be transferred to a supervisor’s voice mail and only hope to have the call returned later.

The focus of this article is obtaining medical and cost information from the Veteran’s Affairs medical system. The goal is to provide you with a process to succeed in obtaining medical records for an individual with previous military service and/or access to the VA medical system. A process to obtain costs for care at these facilities is explained.

Acronyms play a big role in military organizations and the VA is no exception. Acronyms are spelled out whenever they are recognized. In this article, “VA” refers to any part of the Veterans Affairs organization including medical centers, clinics, and contracted organizations.

Obtaining Medical Records

Where to ask? It is very likely that a veteran receives primary care at a CBOC, but for complex testing (CT, MRI, and invasive procedures) travels to a regional VA Medical Center. Because VA medical records are maintained at the facility or facilities where care is provided, not necessarily at any central file, you will likely need to contact each facility where care or diagnostics were performed to request a copy of any medical records from that facility. Requests for records must be in writing and should indicate what records you are requesting, why you are requesting them, and to whom they are to be released. The addresses for all VA facilities can be found at http://www2.va.gov/directory/guide/home.asp?isflash=1

What form do I need? You can use any HIPAA-compliant medical record request form. Some sensitive information, such as AIDS and hepatitis testing and treatment, cannot be released unless it is specifically requested.

The Freedom of Information Act gives veterans the right to access all of their own medical records. Re-
quests for medical records can be expedited if the veteran requests them in person using the VA’s Medical Record Request Form VA 10-5345, available at http://www.va.gov/vaforms/medical/pdf/vha-10-5345-fill.pdf. The form can be filled out electronically and printed, or printed out and completed by hand.

How long will it take? Federal policy mandates a maximum twenty day turnaround; many VA facilities have shorter times. In general, when a request meets all HIPAA guidelines, is signed by the veteran, and includes specifics regarding all records required and to whom they are to be released, the records will be available in twenty days or less.

Can I get records from periods of active duty? The Official Military Personnel Files (OMPF), held at the National Personnel Records Center (NPRC), are administrative records containing information about the subject's military service history. Many OMPFs contain both personnel and former active duty health records, but the service branches discontinued retiring the health record portion to the NPRC in the 1990s. In 1992, the Army began divesting itself of most of its former members' health records, sending them to the Department of Veterans Affairs. Over the next six years, the other services followed suit. The Department of Veterans Affairs Records Management Center, in St. Louis, MO, became responsible for maintaining active duty health records and managing their whereabouts.

Call the VA toll free number at 1-800-827-1000 to identify the current location of specific health records and to find out how to obtain releasable documents or information. (National Archives, 2012)

In comparison, hospital inpatient records were generated when active duty members were hospitalized while in the service. Typically, these records are not filed with the health records but have generally been sent to the NPRC by the facility which created them.

Records before 1973 may not be available at all. Many were destroyed in a 1973 fire at the NPRC in St. Louis, MO. There are no back-up copies. However, hospitals with Clinical Record Libraries typically maintained records longer than hospitals without such libraries. Patients treated at military hospitals with such libraries (as early as 1951 for Air Force hospitals and 1957 for Army hospitals) may have clinical records that were not filed in the OMPF. Records for Army and Air Force hospitals that fall within that time frame may still be available, even if the service member's OMPF was destroyed in the NPRC 1973 fire. Click on Clinical Record Libraries, http://www.archives.gov/st-louis/military-personnel/clinical-record-libraries.html for a list of these Army and Air Force facilities.

Summary
In summary, the best practice process for obtaining VA medical records is the following:

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• Obtain the VA medical record request form.
• Review the form with the veteran to ensure all necessary boxes are checked and information regarding to whom the records are to be released is correct.
• Request the veteran visit the medical records department at each facility where they are provided medical care and submit the form in person.

When medical records from a period of active military service are required, first ask the veteran if they have a copy of their medical record. If not, refer the veteran to their VA Regional office for assistance. The appropriate regional office can be located on the VA website at http://www.vba.va.gov/VBA/benefits/offices.asp

The process should become much more streamlined in the near future. In 2011, “Congressional lawmakers approved $100 million to fund Veterans Affairs and Defense efforts to jointly develop a digital medical record system.” (Lipowicz, 2011) This system will electronically link the medical record systems at all VA clinics and hospitals.

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**Obtaining costs from the VA**

*How do I get costs from the VA?* Life care planners will find it difficult to get cost information from the VA. To understand why, it is important to review how VA services are funded and a bit more about the organizational structure. The VA provides health care at little or no charge to more than 5 million veterans annually. Medical services are provided through the inpatient and outpatient facilities run by the Veterans Health Administration. Those services include routine health assessments, readjustment counseling, surgery, hospitalization, and nursing home care. (Golding, 2010)

Eligibility for health care services provided by the VA is based on length of military service and percentage of service-connected disability. Generally, veterans of the active military must have served 24 continuous months on active duty and been discharged under other than dishonorable conditions. Reservists and National Guard members who were called to active duty under a federal order also qualify for health care benefits if they completed the term for which they were called and were granted an other than dishonorable discharge.

Those broad criteria, however, do not necessarily translate into access to medical treatment. VA funding and access depends on annual appropriation acts of Con-

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gress, so enrollment varies from year to year according to the resources available. Instead of raising the cost for services, restrictions are tightened or relaxed to maintain the budget. *Eligibility and costs can - and often do - change every year.*

**Priority levels determine care access** Ambulatory visits, inpatient services, and prescription medications are provided at no charge to many veterans, including those who have service-connected disabilities rated 50 percent or greater and those seeking treatment for a service-connected condition. Service access depends on how the veteran is categorized according to 8 levels of priority (P1-8) (Figure 1, next page).

Veterans who are not eligible for free services may still have access to care. Copayments apply to veterans in P7 and P8 for care that is not related to a service-connected condition and may also apply to veterans in P2 through P6. (Table 1)

The priority levels also apply to priority for appointment scheduling. A P7 or P8 veteran may wait many months to gain an appointment for an elective evaluation or procedure. Therefore, for a life care plan that considers offsets or collateral resources, it may not be feasible to include the VA as a resource unless either the veteran is a category P1 or all care is 100% service-connected.

The Congressional Budget Office reports that annual VA resources averaged about $5,600 per enrollee for 2009, an inflation-adjusted increase of 9 percent from $5,100 in 2008. Funds are managed per enrolled veteran, and cost containment is addressed by limiting or expanding the number of those eligible for care. *Because total funds are averaged over all eligible veterans, VA has no need to cost out each test, procedure and hospital stay.*

**Does VA get reimbursed by insurance? Can I learn that amount?** The VA Health Resource Center has been seeking reimbursement for services provided to veterans with health insurance since 1989. *They do not seek reimbursement from Medicare, Medicaid, or HMO health plans.* Billing is not handled by individual hospitals and clinics and billing offices are grouped by region. This explains why costs cannot be obtained by contacting the patient billing at individual facilities.

If you call a VA facility and ask for the billing office, you will be transferred to the national call center in Kansas City, KS. This office handles billing of copayments only. The offices that bill medical insurance are

**Table 1. Copayments (2012)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit</td>
<td>$15</td>
</tr>
<tr>
<td>Specialty care visit</td>
<td>$50</td>
</tr>
<tr>
<td>Medications, 30-day supply</td>
<td>$9</td>
</tr>
<tr>
<td>Hospitalization (each)</td>
<td>$1156</td>
</tr>
<tr>
<td>Hospitalization (per diem)</td>
<td>$10</td>
</tr>
</tbody>
</table>

Note: Continued on page 713
### Enrollment Priority Groups

<table>
<thead>
<tr>
<th>Priority Group</th>
<th>Definition</th>
</tr>
</thead>
</table>
| 1             | Veterans with VA-rated service-connected disabilities 50% or more disabling  
               | Veterans determined by VA to be unemployable due to service-connected conditions |
| 2             | Veterans with VA-rated service-connected disabilities 30% or 40% disabling |
| 3             | Veterans who are Former Prisoners of War (POWs)  
               | Veterans awarded a Purple Heart medal  
               | Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty  
               | Veterans with VA-rated service-connected disabilities 10% or 20% disabling  
               | Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, “benefits for individuals disabled by treatment or vocational rehabilitation”  
               | Veterans awarded the Medal Of Honor (MOH) |
| 4             | Veterans who are receiving aid and attendance or housebound benefits from VA  
               | Veterans who have been determined by VA to be catastrophically disabled |
| 5             | Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income and/or net worth below the VA national income threshold and geographically-adjusted income threshold for their resident location  
               | Veterans receiving VA pension benefits  
               | Veterans eligible for Medicaid programs |
| 6             | World War I veterans  
               | Compensable 0% service-connected veterans  
               | Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki  
               | Project 112/SHAD participants  
               | Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975  
               | Veterans of the Persian Gulf War that served between August 2, 1990 and November 11, 1998  
               | Veterans who served in a theater of combat operations after November 11, 1998 as follows:  
               | Currently enrolled Veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for 5 years post discharge |

**Note:** At the end of this enhanced enrollment priority group placement time period Veterans will be assigned to the highest Priority Group their unique eligibility status at that time qualifies for.

<table>
<thead>
<tr>
<th>Priority Group</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Veterans with gross household income below the geographically-adjusted income threshold (GMT) for their resident location and who agree to pay copays</td>
</tr>
</tbody>
</table>
| 8             | Veterans with gross household income above the VA national income threshold and the geographically-adjusted income threshold for their resident location and who agree to pay copays  
               **Veterans eligible for enrollment:** Noncompensable 0% service-connected and:  
               o Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status  
               o Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less  
               **Veterans eligible for enrollment:** Nonservice-connected and:  
               o Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status  
               o Subpriority d: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less  
               **Veterans not eligible for enrollment:** Veterans not meeting the criteria above:  
               o Subpriority e: Noncompensable 0% service-connected  
               o Subpriority g: Nonservice-connected |

*Figure 1. VA Fact Sheet. Department of Veterans Affairs, 2011*
not accessible by phone for questions, and the locations are not published. They are secure facilities and handle claims paperwork only. Insurance companies are billed based on usual and customary charges for service in the area where medical services are provided.

Your question, “How can I obtain the cost of a procedure done at the VA?” has still not been fully answered. However, the steps to take to find a cost for services are now clear:

- Determine the veteran’s priority category for copayment status.
- All veterans should know their category; it affects appointment availability. If they do not know if they are P1 or P2, the disability exam in the VA medical record gives their percentage of disability. P1 veterans receive services without copayments. All others have a sliding scale copayment for services and because their category may periodically change, your best bet is to utilize the highest copay amount (Table 1).
- Determine the usual and customary (U&C) charge for necessary services using common resources.

How do I find U&C? Usual and customary charges for any case can be found in several different ways. For example:

- **Medical Fees in the United States**, PMIC. ($149) [www.pmiconline.com](http://www.pmiconline.com) or via your favorite online bookseller.
- Contact 2-3 providers in the appropriate geographical area and request the cost for the services or procedures.

- **Agency for Healthcare Research and Quality – Healthcare Utilization Project (HCUP)**. Free online resource for hospital costs nationally or by state. Gives a good ballpark figure based on the ICD-9 Procedure Codes. These codes can be found using a search engine (Google, Bing, etc.) by searching “ICD-9 xxx,” where “xxx” is the desired procedure. [http://hcupnet.ahrq.gov/](http://hcupnet.ahrq.gov/)
- **American Hospital Directory**. Online subscription resource for hospital charges. ($355) [www.ahd.com](http://www.ahd.com)

There are other benefits available for category P1 and P2 veterans that may impact the life care plan including wage compensation, vocational rehabilitation, housing grants, and allowances for transportation and clothing. Additional information on these programs can be found at [http://www.va.gov/opa/publications/benefits_book/benefits_chap02.asp](http://www.va.gov/opa/publications/benefits_book/benefits_chap02.asp)

*continued next page*
Obtaining information from government resources can be a long, frustrating process. With a few tips and tricks to help you follow their rules and guidelines, you can have quick access to the information necessary in a limited amount of time.

References
http://www.archives.gov/veterans/military-service-records/medical-records.html
“The Invisible War” has been opening up in theaters across the country since its debut at the 2012 Sundance Film Festival, having won the Audience Award: U.S. Documentary, directed by Kirby Dick. “The Invisible War” was described in the 2012 Sundance Film Festival press release of awards as, “An investigative and powerfully emotional examination of the epidemic of rape of soldiers within the U.S. military, the institutions that cover up its existence, and the profound personal and social consequences that arise from it.” (Sundance Institute, 2012) “The Invisible War” contends that there is, and has been, an epidemic of military sexual trauma in the greatest and strongest military force in the world, the United States Military.

The term “military sexual trauma” (MST) didn’t appear in military vocabulary until the 1991 Tailhook Scandal at a convention in Las Vegas, where multiple women were sexually assaulted. In 2003, Congress addressed another scandal at the Air Force Academy in Colorado involving multiple reports of harassment and sexual assaults of cadets.

In the summer of 2012, more than 30 recruits reported being sexually harassed, accosted, assaulted, and raped by Drill Instructors. What is different is that now predators are being formally charged and sentenced in courts martial.

These events, among others, have attracted the attention of researchers around the globe. They have compared the incidence of sexual assault in both the military and VA percentages to that of the civilian population, “with 18% to 25% of American women reporting experiencing either an attempted or completed rape in their lifetime; and 3% to 4% of American men reporting an attempted or completed rape during their adulthood.” (Turchik & Wilson, 2010)

Ginny Lee enlisted in the U.S. Army directly out of high school. Upon discharge, she obtained her nursing degree in 1996 and worked in Medical and Surgical ICU and Neuro ICU. She earned a bachelors in business, and double masters degrees in nursing and administration with an emphasis on healthcare management. She worked with soldiers coming home from Iraq and Afghanistan as a case manager and to assist reintegration. She spends most of her time volunteering with Veterans and Veterans Advocacy groups and victims of crime, such as rape, domestic violence, and child molestation. She can be contacted at 501-326-4247, ginnylourn@gmail.com.
In the military and veteran groups, the percentages equal or exceed the civilian rate, with 9.5% to 33% of women reporting either attempted or completed rape while serving in the military. (Turchik & Wilson, 2010)

If the definition of military sexual trauma includes sexual harassment with other forms of sexual assault (unwanted oral, anal, or vaginal sex), “the rates of reported sexual assault during military service by women range from 22% to 84%, and the rate of men reporting some form of sexual assault while in the military is 36% to 74%.” (Turchik & Wilson, 2010)

Department of Defense studies are more difficult to assess; they look only at incidents that were reported and recorded through the chain of command. It is well-known that many victims do not report attempted or completed sexual assault. Fear of retaliation is the most significant reason for failure to report in both civilian and military populations.

I served in the United States Army from 1986 to 1990. I was assaulted in basic training by a Drill Instructor. As a result of the assault, I was medically discharged (honorable with medals and commendations) with a permanent sternoclavicular dislocation with occasional airway compromise and an unstable right shoulder joint with multiple spontaneous dislocations. As a veteran and a nurse, I was aware of the strict unwritten rule NOT to talk about the incident. In one way, I think this is how I survived the last 20 years. I trained myself into thinking that if I didn’t talk about, it didn’t happen. I felt permanently stuck in a classic grieving cycle of denial.

I have been a patient in the VA medical system since 1991. In 1991, there were few providers for OB/GYN care. There were very limited mental health services available for MST and associated symptoms, what I call “side effects of MST,” now called “non-combat-related post-traumatic stress disorder (PTSD).” Because of the limited services for veteran women, up to 2004 my primary needs were met in the civilian world.

In 2004, I had decided that it was time to get back into the VA system, as complications from the assault were becoming a life complication. This time, a Women’s Clinic allowed quicker access and enrollment into the system. 2004 was also the year that I became professionally involved with the VA as a registered nurse.
As a registered nurse, I have worked and taught within the VA healthcare system, as well as assisted in life care plans on patients involved in medical malpractice cases involving the VA. I have also worked with the VA as a civilian case manager for the Department of the Army, coordinating care for Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) soldiers who were injured but did not meet the criteria for hospitalization at a Military Treatment Facility (MTF).

The Turchik and Wilson study is similar to one conducted at the Portland VA Hospital in 2004. Participants, of which I was one, were asked to fill out various surveys regarding symptoms, adjustment complications, and coping mechanisms. We were also asked what therapies seem to be working at the time, and what we felt would benefit other survivors. This experience inspired me to become more involved in veterans’ issues and an advocate for MST survivors.

At the same time the VA was dealing with the Air Force Academy cadet victims of MST and the scandalous conditions at Walter Reed (Priest and Hull, 2007), they were also faced with increasing reports of MST in active-duty and veteran victims and the marked increase in suicides, peaking in 2012. This led to the development and use of the Post Deployment Health Assessment (PDHA), completed by each soldier in four intervals: pre-deployment, before leaving the post-deployment facility, entrance into the military treatment facility, and 18-30 months after transition. Case managers also complete a health risk assessment and a mental health assessment. (Department of Defense, The Office of Deputy Assistant Secretary of Defense)

These assessments were developed to help address all issues for returning soldiers, provide documentation for ongoing care, and help estimate future VA healthcare system needs. Despite the availability and use of these forms, the VA found that veterans were reluctant to report MST. They do, however, report and seek assistance through other avenues of care within the VA. For example, the VA started offering Women’s Services in 1988. Women veterans of OEF/OIF are encouraged to use the case management services of Women’s Services and the treatment modalities of the Federal Recovery Teams. The National Center for PTSD is also available for women and men to report and receive treatment for MST.

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VA facilities have inpatient programs for both male and female veterans, with specific focuses on combat- and noncombat-related PTSD. PTSD, by far, is the mental health departments’ greatest challenge. PTSD care is individualized. No one specific medication treats PTSD, yet drugs do treat the symptoms of depression, anxiety, panic attacks, hypervigilance, intrusive nightmares, substance and alcohol abuse, social and personal relationship complications, and inability to adjust to the home environment. PTSD also puts individuals at high risk for legal issues. PTSD related to MST also causes self-blame, shame, and sexual inhibitions, among others. Male victims of MST can struggle with sexual identity, masculinity, and homophobia if the perpetrator was a man. (Turchik & Wilson, 2010)

**New therapies**

New therapy modalities include cognitive behavioral therapy (CBT), eye movement desensitization and reprocessing EMDR), prolonged exposure therapy (PET, the most effective treatment and which will be implemented throughout the VA system), stress inoculation therapy (SIT), and relaxation and breathing exercises including yoga. Not all of these therapies are available at every VA hospital.

**CBT** is the most widely used to date, usually provided over 12-14 weeks, depending on the needs of the veteran and the progression of treatment. CBT concentrates on changing negative thought processes direct resulting from any serious trauma. Initial appointments are one-to-one; the veteran turns in homework to a therapist, a licensed social worker, nurse practitioner, or psychologist every week.

**EMDR** is a specialized treatment originally developed Francine Shapiro, Ph.D. As she walked one day, she noted that when she thought about disturbing images, her eye movement would change as she processed this memory. When she redirected her thoughts back to those disturbing images, her physical and emotional response was not as strong or relevant. (Tartakosky, 2012)

EMDR is an eight-phase program that helps the individual become desensitized to negative memories and associated negative responses, both physical and emotional, replacing them with positive responses and decreasing the physical responses. EMDR is not talk therapy; the veteran provides no details of the trauma. (EMDR International, n.d.)

**Prolonged exposure therapy** can be used with other therapies and with pharmacological agents like paroxetine (Paxil). Prolonged exposure therapy involves the veteran recounting the traumatic event over and over to a therapist. The veteran then takes the recording of the session home, and as homework, listens to the recording repeatedly. Prolonged exposure in vivo requires the veteran to enter or expose himself to a place or sound that is safe, but that he would otherwise avoid. For example, the therapist continued next page
may have the veteran who reacts to the sound of thunder as if it were mortar fire listen to a recording of a thunderstorm.

The military treatment facility in San Antonio found that video prolonged exposure therapy has also had an impact on desensitization. The Computerized Assisted Rehabilitation Environment, or CAREN, is a large dome with a 300º 3-D screen. The soldier is immersed in a scene that is similar to the environment where the trauma occurred. When the outcomes to this exposure produced positive outcomes with PTSD, clinicians decided to conduct further studies using CAREN. This led to Virtual Iraq, a VR head-mounted display that projects graphic scenarios including “ambushes, improvised explosive devices, dead or wounded soldiers, including sights, sounds, and smells.” (Greenyer, 2010)

The VA also provides both inpatient and out-patient programs for alcohol and substance abuse, common in all PTSD survivors. Unfortunately, the outcome of these issues can be detrimental, especially if it involves the law. Some states have set up Veterans Court. Veterans Court looks at the crime committed and the circumstances behind the crime. In most cases, the outcome is to get the veteran to mandatory treatment.

A disturbing trend is the growing rate of homelessness among women veterans. Women’s shelters, non-profit organizations like Women’s Dress for Success provide opportunities for women veterans get back up on their feet and find employment, and once employed, network with other women who provide tools and advice for the working women. The VA has networked with civilian employers to “Hire Our Heroes” and Monster.com has jumped in to assist resulting in many veterans obtaining employment.

The VA’s proactive approach to MST and any form of PTSD has been astounding, in the very least. In many ways, it is transforming my life from one of a life filled with hopelessness, to one with a sense of hope that includes laughter and a light flickering in a very dark tunnel. I do consider myself one of the lucky ones even though my injuries have progressed enough to prevent me from doing bedside nursing and my PTSD makes employment a challenge. I am now considered 100% disabled, but I still have a working mind, empathy for veterans, and a passion to spread the word about MST in the mili-

continued next page
tary. “The Invisible War” has finally provided me what I needed; it’s empowering to know that I am not invisible and that I am not alone.

References

Nursing Diagnoses to Consider

- Ineffective Self-Health Management (Domain 1, Health Promotion; Class 2, Health Management)
- Readiness for Enhanced Knowledge (Domain 5, Perception/Cognition; Class 4: Cognition)
- Risk for Compromised Human Dignity (Domain 6, Self-Perception; Class 1: Self-Concept)
- Disturbed Personal Identity (Domain 6, Self-Perception; Class 1: Self-Concept)
- Chronic Low Self-Esteem (Domain 6, Self-Perception; Class 2: Self-Esteem)
- Impaired Social Interaction (Domain 7, Role Relationships; Class 3, Role Performance)
- Interrupted Family Processes (Domain 7, Role Relationships; Class 2: Family Relationships)
- Sexual Dysfunction (Domain 8, Sexuality; Class 2, Sexual Function)
- Ineffective Sexuality Pattern (Domain 8, Sexuality; Class 2, Sexual Function)
- Post-Trauma Syndrome (Domain 9, Coping/Stress Tolerance; Class 1: Post Trauma Responses)
- Rape-Trauma Syndrome (Domain 9, Coping/Stress Tolerance; Class 1: Post Trauma Responses)
- Ineffective Coping (Domain 9, Coping/Stress Tolerance; Class 2, Coping Responses)
- Readiness for Enhanced Coping (Domain 9, Coping / Stress Tolerance; Class 2, Coping Responses)
Throughout United States history, significant research has been invested during wartime to advance technologies designed to improve the function of impaired or amputated limbs. These expenditures, their rationale, and purpose should come as no surprise. Beginning with the more than 21,000 combat-related amputations suffered by the Union Army during the Civil War, traumatic limb loss has long plagued U.S. service men and women during wartime. (Siggford, 2010) As of 2011, the trend has persisted, with more than 1,100 combat-related major limb amputations reported during the recent conflicts in Iraq and Afghanistan. (Kirk, Jones et al., 2011)

Since 2003, the U.S. government has committed tens of millions of research dollars to visionaries, universities, and manufacturers to ensure that our wounded soldiers receive the best technology available. These investments have resulted in the development and commercialization of personal bionics, a new class of technology that enables normal, natural, and more personalized movements for individuals with limb loss or impairments.

Nurse life care planners now have access to a number of these new solutions that normalize function, improve overall quality of life, and reduce the total lifetime cost of care. Personal bionics, originally funded by the U.S. Department of Veterans Affairs, is dramatically changing the life of amputees and reducing the complexity of their life care planning. The technology helps reduce the overall cost of care and enables people to return to work and other important daily activities faster and more easily than ever before.

D. Ryan Hixenbaugh is the Senior Marketing Strategist for iWalk. He has been published and spoken on personal bionics to payers, case managers, physicians and prosthettists since before the technology was commercially launched. Hixenbaugh has worked with product development and launches for orthopedic and prosthetic medical devices since 1996. He can be contacted at iWalk, 4 Crosby Drive, Bedford MA 01730, 206-310-5144.
The following examination will describe personal bionics in more detail and explain how this emerging technology needs to be part of the healthcare road-map for all amputees.

**History**

This innovation began in the halls of the Massachusetts Institute of Technology. Hugh Herr, Ph.D. and director of biomechatronics at MIT, is a double amputee who lost both of his legs following a disastrous mountain climbing expedition on Mt. Washington in 1982. Since then, Dr. Herr has been on a quest to help others with limb pathology and to transcend the concept of disability for amputees across the country.

With funding provided by the U.S. Department of Veterans Affairs and the Army’s Telemedicine and Advanced Technology Research Center (TATRC), Dr. Herr and his collaborators established the Powered Human Augmentation project and applied bionic technology to develop, in 2006, the first device that powers movement and enhances mobility.

The culmination of Dr. Herr’s research, engineering and clinical testing is the BiOM Ankle System, the first personal bionic intervention that enables natural movement for lower-limb amputees. Today the BiOM is the only bionic ankle system that has been clinically shown to reach human normalization, allowing amputees to walk with a normal gait. (Herr and Grabowski, 2011)

Personal bionic fittings first began in 2010 at facilities such as The Center for the Intrepid (CFI) at Brooke Army Medical Center. Here, veterans were exposed to the BiOM for the first time and CFI officials released preliminary results from their fittings that indicated that the BiOM “allows leg amputees to walk at normal metabolic cost thus allowing an amputee to walk normally.”

Dr. Jason Wilken, the Director of the Military Performance Laboratory at the CFI elaborated by stating that personal bionics offers promising results that indicate “the bionic lower leg system is able to match the intact human limb, allowing for greater walking efficiency and reduced stress on the rest of the body.” (Personal communication, 2011)

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Currently, the technology has already been adopted by more than 40 VA Medical Centers and the major Department of Defense sites across the country to serve people with both below knee or above knee amputations. As of June 2012, several hundred people with below-the-knee amputations currently wear the BiOM Ankle System, including William Gadsby, a 34-year-old veteran who wears both the BiOM ankle and a microprocessor knee. Gadsby, a former Marine who was severely injured by an IED while on patrol in Al Anbar Province, Iraq, notes immediate and significant improvements to his quality of life. “This device is literally a miracle,” said Gadsby. “A few months ago I was walking at nighttime and had my hands in my pockets. For the first time in four years I was able to look up at the stars without stopping to balance myself. I’ve been able to walk up steep hills and stairs. I can walk down steep grades, and have been able to do some yoga stances. Just walking—in and of itself—is awesome.” (Department of Veterans Affairs, 2012)

The BiOM performance and immediate improvement in function has similarly improved the health of many other veterans, both younger and older than Marine Gadsby. This includes Ed Lastowski, a Vietnam veteran who received 39 surgeries over the span of 30 years to try to preserve his natural leg following an accident overseas. Following elective surgery in 2010, Lastowski finally consented to amputation and struggled through an assortment of crutches, wheelchairs, and prosthetic devices. While these preserved his stability, they drastically limited his mobility, forcing extreme energy output and fatigue, and an altered gait cycle that led to persistent knee, hip, and back pain. Once fitted with personal bionics, Lastowski’s life changed again, providing him with an experience unlike any conventional prosthesis. “The BiOM Ankle System isn’t just another prosthetic. It is personal bionics. You have more energy, mobility, stability and less pain. I can walk normally now, which is something I hadn’t done in three decades,” Lastowski said.

The BiOM Ankle System is the first in a series of new personal bionics products that will emulate or augment physiological function through electromechanical replacement.

continued next page
Personal Bionics is Changing the Standard of Care

Amputees using the previous standard of care—personal energy storing and returning (ESR) and passive-elastic prosthetics—face three clinical issues that challenge their return to work and daily activities:

They walk with an altered gait. Traditional prosthetics are unresponsive. Without the triceps surae (Fig. 1), it is up to the user to figure out how to move the device through the swing phase of the gait cycle. Altering the gait cycle to swing the leg accelerates wear on the joints and causes chronic knee, hip, and back pain. This often leads to an extended reliance on pain medications, osteoarthritis, and eventually joint replacement or even joint fusion.

They use more energy. Prosthetics are heavy. It takes significant energy and effort to walk with a prosthetic device. As a result, people who wear the devices tend to walk more slowly and get tired quickly.

They feel unstable. Prosthetic feet are fixed at a 90° angle. The ankle is also fixed and provides little or no flexion to roll with or adapt to the ground.

People lose the sense that their feet are “feeling” the earth. It is estimated that people on prosthetics fall down about once every 10,000 steps.

Personal Bionics Simplifies Process

This new technology transcends the limitations of traditional prosthetics by delivering normalized function, which is defined as the ability to restore natural movement and personal mobility to individuals who wear prosthetics. True normalized function was impossible with previous prosthetic technologies.

Every BiOM customer is fitted using Personal Bionic Tuning, which compares their gait to a performance curve for non-amputees. While the person walks on the BiOM Ankle System, the clinician uses Android operating system technology to adjust the device to fit within the curve of normative gait characteristics for non-amputees. Once the person’s gait is tuned to a natural level of performance, it is further adjusted to fit personal preference.

With traditional prosthetics, amputees experience persistent pain. The literature has well established the ongoing pain people with amputations experience in their knees, hips and backs on both the affected and sound side. (Table 1)

Studies have also been conducted through Veterans Administration Patient Treatment and Outpatient Care files that specifically link knee pain and symptomatic knee osteoarthritis, a second disability, to the

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Figure 1. Triceps surae muscle group.
veteran amputee population when compared to non-amputees. (Norvell, Czerniecki, et al. 2005)

By normalizing function, personal bionics reduces aches and pains, relieves stress on the joints that is typically caused by deviations in the gait, increases stability, and enables people to return to work and other important daily activities faster and more easily than ever before.

### Personal Bionics Comparative Effectiveness Research

The BiOM is already one of the most-studied prosthetic devices on the market. Several publications have compared the performance of this technology with capabilities of traditional ESR and passive elastic prostheses designs. These studies demonstrate the BiOM’s ability to resolve major clinical issues affecting amputee mobility by enabling:

**Natural gait** People wearing prosthetics voiced a preference for the higher power contribution of the BiOM powered plantar flexion. (Ferris and Aldridge et al., 2011)

**Normal metabolic energy exertion** The metabolic energy required for ankle mechanics and push-off work for an amputee wearing the BiOM is comparable to the energy expended by a non-amputee. (Herr and Grabowski, 2011)

**Ability to walk at a natural speed** People wearing the BiOM settled on walking velocities that were 23% faster than the speeds they chose wearing traditional prosthetics, a walking velocity equivalent to the natural walking speed of participating non-amputees. (Herr and Grabowski, 2011)

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**Table 1. Pain characteristics of people with amputations of at least five years.**

*Streuf, van Heugten et al., 2009; **Gailey et al., 2008.

<table>
<thead>
<tr>
<th>Pain</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfemoral amputation knee pain</td>
<td>75% **</td>
</tr>
<tr>
<td>Transtibial amputation knee pain</td>
<td>46% **</td>
</tr>
<tr>
<td>OA knee pain</td>
<td>27% *</td>
</tr>
<tr>
<td>OA hip pain</td>
<td>14% *</td>
</tr>
<tr>
<td>Knee and hip OA pain</td>
<td>16.3% *</td>
</tr>
<tr>
<td>Knee pain on intact side</td>
<td>41% *</td>
</tr>
<tr>
<td>Hip pain on affected side</td>
<td>23% **</td>
</tr>
<tr>
<td>Hip pain on intact side</td>
<td>55% **</td>
</tr>
<tr>
<td>Moderate-severe back pain</td>
<td>63% **</td>
</tr>
<tr>
<td>Back pain due to scoliosis</td>
<td>43% **</td>
</tr>
<tr>
<td>Pain in stump</td>
<td>46% *</td>
</tr>
<tr>
<td>Phantom limb pain</td>
<td>47% *</td>
</tr>
</tbody>
</table>

Ability to easily change speeds The BiOM was able to decrease the leading (biological) leg effort by 10% across multiple walking velocities. (Herr and Grabowski, 2011)

Ability to safely walk on different terrains and stairs In comparative stair-climb testing, participants wearing the BiOM experienced a 167% increase in involved side ankle push–off power compared to ESR feet that rely on deformation of a carbon fiber keel. (Ferris and Aldridge et al., 2011)

Reduced chronic or acute pain Restoring normal ankle motion and peak plantar flexion power may alleviate comorbidities associated with transtibial amputation, including lower back pain. (Herr and Grabowski, 2011)

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As many as 80% of all amputees experience back pain. (National Limb Loss Information Center, 2006) According to survey comments from users, the BiOM reduces the pain and dependence on pain medications associated with traditional prosthetics. Additional studies will attempt to quantify these comments from people wearing the device.

The BiOM Ankle System empowers amputees to do the things they want at their chosen speed. For Ed Lastowski, these benefits were critical: “My pain medication has been cut by a third since wearing the BiOM system. I no longer have the pain and pressure in my knee, shoulders, and hips.”

Planning for a Veteran’s Future

The increase in numbers of amputees has resulted in a backlog of claims at the VA. In turn, nurse life care planners are increasingly being called upon to help these veterans. The right plan can lead to a healthier patient, one who faces a decreased risk of comorbidities, possesses confidence, suffers less from depression, and is better prepared to function in military or employed life again.

While interpreting the VA coding system can be a confusing process, it is becoming easier to identify the scenarios that make the most sense for each patient. (See also Tips for Obtaining Information from a VAMC, page 708, Ed.) The following checklist allows Life Care Planners to make the most educated decision about care for veterans with lower-limb loss. (Some information provided by the National Limb Loss Information Center.)

Simplifying the Nurse Life Care Planner Checklist

Gather key information, including cause and time of onset of injury, employment history, family gross income, monthly expenses, health insurance information, and additional funding sources, if any.

Determine eligibility for VA healthcare. To qualify, a veteran must have:

continued next page
• Been discharged from active military service under honorable conditions.
• Served a minimum of two years if discharged after September 7, 1980 (prior to this date, there is no time limit).
• Served as a National Guard member or reservist for the entire period for which he or she was called to active duty, other than for training purposes only.
• Prepare a justification statement. Some funding sources, particularly government programs, require the applicant to prepare a justification statement before funds are actually appropriated.
• Review function level criteria (Table 1) with the patient. Criteria considered for assessing the functional level include the patient's history, current condition, nature of other medical problems, and the patient's desire to ambulate.

Personal bionics makes it easier for patients to ambulate. For example, the metabolic energy required for ankle mechanics and push-off work for a K3 amputee wearing the BiOM is comparable to the energy expended by a non-amputee. (Herr and Grabowski, 2011)

Discuss pain management, levels of pain, and types of medications being used. Consider that the BiOM reduces aches and pains associated with a deviated or abnormal gait.

Discuss the patient’s current health, quality of life, and physical activities, as well as his or her long-term needs. Estimate treatment costs for potential future conditions such as obesity, diabetes, and joint pain for patients predisposed to acquiring these conditions due to lack of mobility.

Studies have shown the average lifetime healthcare costs for amputees surpasses $500,000. (Mackenzie, Jones, et al., 2007)

Because of its ability to normalize function, the BiOM has been demonstrated to reduce comorbidities, such as obesity, diabetes, depression, back injuries, joint deterioration, and sleep issues.

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**Table 1. Functional levels**

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<th>Level</th>
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<td>K0 (Level 0)</td>
<td>No ability or potential to ambulate or transfer safely with or without assistance; prosthesis does not enhance the quality of life or mobility.</td>
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<tr>
<td>K1 (Level 1)</td>
<td>Ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence—typical of the limited and unlimited household walker.</td>
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<tr>
<td>K2 (Level 2)</td>
<td>Ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs, or uneven surfaces—typical of the limited community walker.</td>
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<tr>
<td>K3 (Level 3)</td>
<td>Ability or potential for walking with variable cadence—typical of the community walker able to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic use beyond simple walking.</td>
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<tr>
<td>K4 (Level 4)</td>
<td>Ability or potential for prosthetic use that exceeds basic walking skills, exhibiting high impact, stress, or energy levels.</td>
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Estimate the initial and lifetime cost of the BiOM system, and budget for the number of devices needed over the patient’s lifetime.

The BiOM may be replaced about every five years and costs between $50,000 and $70,000 for a single system depending upon the patient’s fitting requirements. The BiOM also comes with a 2-year limited warranty. During the warranty period, maintenance costs are covered.

The BiOM prevents typical future conditions and allows for normalized function, while other prosthetic devices cause escalating comorbidities, medication needs, and mental health issues. Life care planners will begin seeing more patients outside the military as the product becomes more popular for workers compensation and private insurers.

Walking Tall with Personal Bionics

For veterans returning home from the trauma of war, living an active, healthy life is sometimes more of a dream than reality. Unemployment is higher among veterans than the rest of the population. According to the Associated Press, 45% of the 1.6 million Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans are now filing for disability claims for service-related injuries, significantly more than for previous wars.

Former Marine William Gadsby is one of a growing number of veterans with above-the-knee amputations who now walk naturally due to personal bionic technology. The personal bionic experience and powered plantar flexion capabilities makes walking feel more stable and secure on uneven terrain. “I

continued next page
recently took my family to the Outer Banks in North Carolina. I was able to walk up the sand dunes with no problem,” Gadsby says, “In fact, I kept shouting to my wife and my 3-year-old son to keep up with me! I also went hiking in the Shenandoah Valley area of Virginia with a 50-pound pack. I was going up some pretty steep trails, and I wasn’t getting tired.”

Gadsby has recognized a huge change in his mindset as well. “I am a cranky guy normally,” he admits. “But my wife has noticed a major psychological change in me. Before the BiOM, my body was more worn out with pain and I was always dead tired when going somewhere. Now I’ve got zero back pain. I’m active from the time I wake up until the time I fall asleep. My depression has largely receded. I’m more confident and feel closer to how I felt before I was wounded. I feel like a normal person again.”

The promise and potential of personal bionics exceeds the expectations of even Dr. Hugh Herr. “I predict a bionics revolution,” says Herr. "We're entering a bionic era where we actually are beginning to see technology that's sophisticated enough to emulate key physiological functions." (Lee, 2012)

While Herr continues to set his sights on continued advancement and long-term personal bionics innovation, the health benefits and cost savings are already palpable for current providers of the BiOM, includ-

Nursing Diagnoses to Consider

- **Activity Intolerance:** Insufficient physiological or psychological energy to endure complete required or desired daily activities (Domain 4 Activity/Rest, Class 4: Cardiovascular/Pulmonary Responses)
- **Impaired Physical Mobility** Limitation in independent purposeful physical movement of one or more extremities (Domain 4, Activity/Rest; Class 2: Activity/Exercise)
- **Impaired Walking:** Limitation of independent movement within the environment on foot (Domain 4, Activity/Rest; Class 2: Activity/Exercise)
- **Fatigue:** An overwhelming sense of exhaustion and decreased capacity for physical and mental work at the usual level (Domain 4, Activity/Rest; Class 3: Energy Balance)
- **Chronic Pain:** Unpleasant sensory or emotional experience arising from actual or potential tissue damage or described in terms of such damage (International Association for the Study of Pain); sudden or slow onset of any intensity from mild to severe without anticipated or predictable end and a duration of greater than 6 months (Domain 12: Comfort, Class 1: Physical comfort)
ing the Department of Veteran’s Affairs. According to Cezette Leopold, a VA prosthetics representative based at the VA Medical Center in Richmond, Virginia, “The real payoff is better health. Amputees outfitted with this technology will be healthier because they can lead much more active lives.” Furthermore, Leopold adds, “Healthier amputees equate to a significant reduction in health care costs. Amputees who have less exhaustion and less pain tend to move around a lot more. They lose weight. They reduce their reliance on pain medications. They even return to work.” (Department of Veterans Affairs, 2012)

For the veterans and amputees around the country who have already received access to the BiOM, the revolution began with just a few simple, normal steps.

To learn more about transitioning from prosthetics to personal bionics, visit: www.iwalk.com and www.va.gov.

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http://www.va.gov/health/NewsFeatures/20120719a.asp


Environmental Control Units (ECU) in Life Care Planning (part 1)

Keith Sofka ATP (retired) and Penelope Caragonne MSW Ph.D CLCP

We’ve been asked to provide basic information necessary to understand and include an ECU in a Life Care Plan. Part 1, in this issue, covers four areas:

- Factors to consider when evaluating an individual for use of an ECU
- Basic purposes of ECUs
- Issues to be addressed during the prescriptive process
- Types of user interfaces that are available

Part 2, in the next issue, will include examples of ECU applications and features of specific ECU models, how they are used, and their manufacturers.

Developing a proper prescription for an individual’s ECU is a complex process: there are so many user variables to identify and specify. Fitting an individual’s ECU should be unique. Five types of information are critical:

- Specific needs and tasks that the individual wants to address through use of an ECU
- Abilities and aptitudes
- Functions that the ECU needs to perform
- The interface to be used by the individual
- Type of ECU required

Without all of this information, the ECU cannot be tailored to the individual’s unique needs, and its long-term utility will be compromised.

Without learning what specific tasks the individual wants to perform, “under-prescription” occurs: tasks that could have been automated may be neglected. Without an in-depth understanding of the individual’s abilities and aptitudes, “over-prescription” can happen: tasks which could be performed independently may be included as part of the ECU’s function. Functional use of ECU is designed to increase, not reduce, an individual’s independence. A comprehensive assistive technology evaluation will ensure that

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the ECU is fitted specifically to the individual. Since ECUs can increase the independence of a disabled individual, it may sometimes be possible to decrease the hours of attendant care required.

ECUs assist individuals to access and use devices to perform tasks. Examples of these tasks are:

- placing and receiving telephone calls
- opening doors
- controlling lights
- controlling room/house temperature
- operating an intercom
- paging an attendant
- controlling a hospital bed
- operating a patient lift
- controlling entertainment systems including television, radio, CD player, and satellite dishes

**Types available** There are two kinds of ECUs. The first is the all-in-one unit with a single user interface modified to the requirements of the user. A second type is a series of discrete devices, one for each device to be controlled. I have installed and supported both types.

I have a clear preference, however, for the discrete type for two reasons. The first is cost. The cost for discrete devices is generally far lower than for the all-in-one unit. Second, when a breakdown to a discrete unit occurs, only access to the broken device is lost. With the all-in-one ECU’s, when a breakdown occurs, access to all adapted devices is lost. Loss of access to a relied-upon ECU device can cause serious problems for the disabled individual, resulting in loss of access to the environment until it is repaired or replaced. Always ask a vendor about repair time and availability before purchase. Sometimes a loaner ECU is available during extended repair periods.

*continued next page*
However, if not, increased attendant care might be needed.

**Individual factors** Consider factors which contribute to long-term use of the device. Having asked focus groups of technology consumers, we have learned that device abandonment is a critical issue with any type of assistive technology. If a person can’t or won’t use a device, it can’t be helpful.

The primary issue to be addressed when planning ECU implementation is individual tolerance for technology. Is this person an experienced computer user who enjoys learning new technologies? It is very reasonable to provide for periodic reevaluation in a life care plan, since the individual’s adjustment and interests may change over time.

A person must be reasonably accommodated to their disability. Those who are newly injured may find it difficult to accept the need for help at first. It may take time and encouragement to help them accept an ECU as a major enhancement for quality of life.

Cognitive issues are critical. Using an ECU requires some training and the individual must have the ability to learn and integrate new information.

**User interface** Once the preferences for task automation are determined, the individual’s abilities identified, the tasks requiring automation defined, and the device functions known, selecting the user interface is the next step. This should be based upon the individual’s abilities, personal preferences, and tolerance for technology.

The simplest, least complex interface that permits full access is usually the best choice. Sometimes a trial of a week to a month can reassure all concerned that the correct interface has been selected. There are several different kinds available. (Table 1)

**Table 1. Types of ECU interfaces**

- **Switch or multi-switch scanning system, a variety (switch types depending upon the individual’s abilities)**
- **Sip and puff interface (a variation of the switch)**
- **Voice control (speech recognition)**
- **Mouth stick interface**
- **Eye-tracking and other types of mouse control**

**Tasks** Most people like to have access to some lights, a telephone, the television, a CD player or other means of playing music. Generally, even individuals who have full-time attendant care appreciate independent access to these types of devices.

*continued next page*
Control location  Will these devices need to be controlled from the individual’s wheelchair? At the point of use, or from a single place such as the living room or bedroom?

Many times, telephone access can be accomplished simply by using a mouth stick placed next to the telephone in a holder. Lights can be controlled with motion detectors that turn on the light when the room is entered. If less automatic operation is desired, a wireless on-off switch can be placed either on the wheelchair or some other convenient location near the point of use.

The next column will explore the range of specific devices available. Descriptions of actual installations will be provided to illustrate the benefits, costs and long-term utility deriving from the use of an ECU for the individual with a disability. If you have specific questions, please forward them to the editor and I will attempt to address them.

Nursing Diagnoses to Consider

‣ **Activity Intolerance:** Insufficient physiological or psychological energy to endure complete required or desired daily activities (Domain 4 Activity/Rest, Class 4: Cardiovascular/Pulmonary Responses)

‣ **Impaired Physical Mobility**  Limitation in independent purposeful physical movement of one or more extremities (Domain 4, Activity/Rest; Class 2: Activity/Exercise)

‣ **Readiness for Enhanced Coping:** A pattern of cognitive and behavioral efforts to manage demands that is sufficient for well-being and can be strengthened (Domain 9, Coping/Stress Tolerance; Class 2, Coping responses)

‣ **Impaired Comfort:** Perceived lack of ease, relief, and transcendence in physical, psychosocial, environmental, cultural, and social dimensions (Domain 12: Comfort, Class 2: Environmental comfort)
This brief review will help you understand the important ideas involved in obtaining ANA recognition for nurse life care planning as a nursing specialty and ABNSC accreditation for the Certified Nurse Life Care Planner (CNLCP) credential.

**Licensure**
Individual state Registered Nurse (RN) professional licensure is the minimum credential for and provides the legal authority to practice nursing. The NCLEX examination, taken after graduation from an approved program, measures entry-level competence.

**Certification**
Certification is formal recognition that validates the knowledge, skills, and experience of a nursing specialty. Therefore, it recognizes achievement of a higher professional practice standard beyond basic licensure.

The Certified Nurse Life Care Planner (CNLCP®) Certification Board independently facilitates consumer health and safety by maintaining a comprehensive qualified certification program for nurse life care planners.

Certification in nurse life care planning, CNLCP, indicates that a nurse is licensed to practice and has met specified rigorous requirements.

Periodic recertification assures the public that the RN has participated in educational and other activities to maintain knowledge and competence.

**Accreditation**
A nursing specialty certification board validates the quality of its certification program by obtaining and maintaining accreditation from a national certifying.

Kertrina Miller has been a registered nurse for 20 years. She is an active member in AACN, ASPAN, and AANLCP and is certified in critical care, perianesthesia care, and life care planning. She is owner of Rocky Mountain Life Care Planning, LLC. She has served on the CNLCP® Certification Board since 2010. She volunteers in Gallatin County as a guardian ad litem. She can be reached at kertrina@rmlcp.com, 406-556-1907.
agency such as the Accreditation Board for Specialty Nursing Certification (ABSNC), formerly known as the ABNS Accreditation Council. Just as JCAHO serves as an advocate for consumer protection by establishing and maintaining standards for hospital certification, so ABSNC serves as an advocate for consumer protection by establishing and maintaining standards for professional specialty nursing certification. Participation in either organization's certification process is voluntary.

Obtaining ABSNC accreditation requires a specialty certification board to document compliance with specific standards to demonstrate that it has a mechanism in place to respond to issues of discrimination, test security, confidentiality, appeals, and non-compliance. ABNSC also requires documentation that the candidate certification examination construction, evaluation, and passing score criteria are developed using psychometrically sound and fair methods. To review the complete list of standards necessary to meet accreditation requirements please see: www.nursingcertification.org/accreditation-standards.html.

By obtaining an external accreditation of our certification program we will demonstrate to the public that we provide a high-quality certification program with a psychometrically-sound and legally-defensible examination. Achieving ABNSC accreditation will mean that the CNLCP credential will become, and remain, nationally recognized as a high-quality specialty nursing certification.

Nursing specialty recognition
Nursing specialty designation demonstrates to the public a distinct, well-defined field of nursing practice, based on a related scientific body of knowledge, with nationally-consistent scope and standards of practice.

Obtaining formal recognition as a nursing specialty by the American Nurses Association (ANA) is a rigorous process that requires the completion of fourteen specialty recognition criteria. To review the process and requirements to meet ANA specialty recognition requirements please see: www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NursingStandards/3-s-Booklet.aspx.

What’s the difference?
Although ANA specialty recognition and ABSNC accreditation have some overlapping criteria, their goals are distinctly different. ABSNC accreditation ensures the certification exam meets national credentialing standards. ANA specialty recognition establishes a nursing specialty as a unique nursing practice that requires knowledge, skills and experience beyond basic licensure.

Both the accreditation of the certification examination by ABSNC and the recognition of nurse life care planning by ANA are crucial and monumental steps for credibility in the field of nurse life care planning.

continued next page
What about that job analysis?
A critical requirement for ABSNC accreditation is a completed comprehensive job analysis of nurse life care planning practice to ensure that the certification examination measures what is pertinent to the practice of nurse life care planning. The survey group must be representative of current nurse life care planning throughout the United States. The job analysis identifies important nursing actions, practices, and responsibilities in the specialty of nurse life care planning.

The Certification Board uses practice areas identified by the survey to develop examination specifications and content and provide a framework for candidate study.

In addition to the examination, several other ABNSC requirements are based on the data obtained from the job analysis survey.

A complete survey is necessary in both the accreditation process and the establishment of nurse life care planning as a specialty of nursing. We need another 93 responses to have a valid, acceptable sample.

Please do your part for our profession by taking a few minutes to tell the ABNSC what we do. Respondents will be anonymous and do not need to be CNLCP or CLCP certified to participate in this study. Please forward this link to any RN you know who does life care planning of any kind. Our deadline is December 15, so do it now!

To get started, go to:
http://www.ptcny.net/clients/CNLCP/2012rdsurvey/

Sedona AZ
Shelly Kinney
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