THE AMERICAN ASSOCIATION OF NURSE LIFE CARE PLANNERS

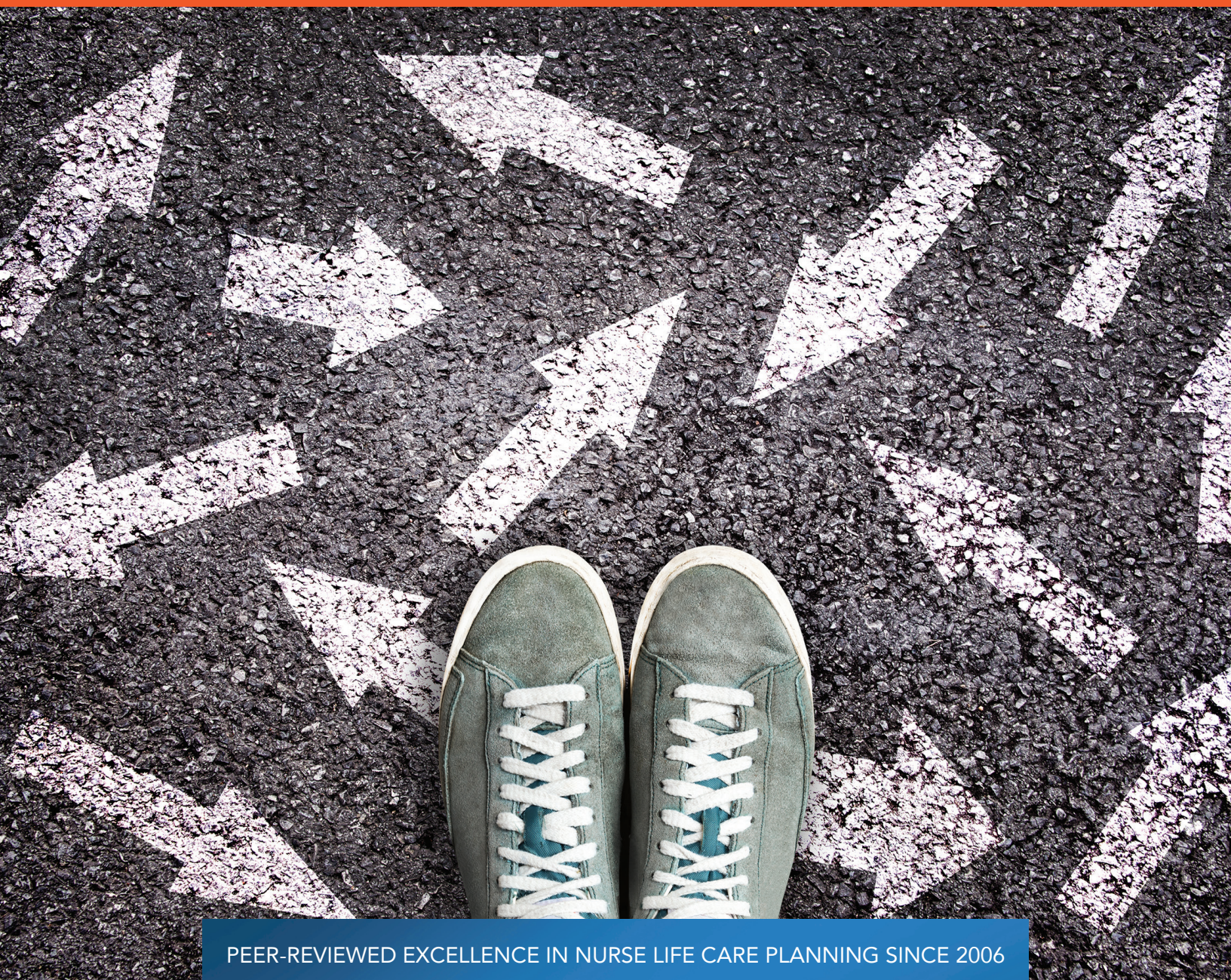
JOURNAL OF NURSE LIFE CARE PLANNING

aanlcp+

SPRING 2025

vol XXV, no. 2

New Directions in Homecare



PEER-REVIEWED EXCELLENCE IN NURSE LIFE CARE PLANNING SINCE 2006

aanlcp+
American Association of Nurse Lifecare Planners

SPRING 2025

JOURNAL OF NURSE LIFE CARE PLANNING

TABLE OF CONTENTS

DEPARTMENTS

A Message from the President

Dear AANLCP Members and Colleagues,

Spring 2025 has arrived, and we're thrilled to share that the 2025 Conference in Chandler/Phoenix was a tremendous success! We received overwhelmingly positive feedback about both the speakers and the venue, and we hope to return to this superb location in the future. A heartfelt thank you goes out to our incredible **Conference Committee** for their dedication and detailed planning. This year's schedule allowed for even more collaboration, networking, and reconnecting with colleagues—something we all value deeply.

The conference also sparked fresh ideas, inspired new attitudes, and encouraged increased learning among attendees. We saw renewed energy and innovation in our discussions, and we're excited to see how these insights and shared experiences will continue to shape the future of life care planning.

We proudly announce that Shirley Daugherty received the Denise Nelson Ambassador Award, recognizing her unwavering dedication to AANLCP, her many contributions, and her generous time commitment. Shirley is always ready to help, never hesitating to say "yes" when called upon.

We also congratulate **Shelley Kinney**, who was honoured with the Distinguished Service Award. Shelley continues volunteering countless hours to support AANLCP, always offering her knowledge and assistance with enthusiasm and grace.

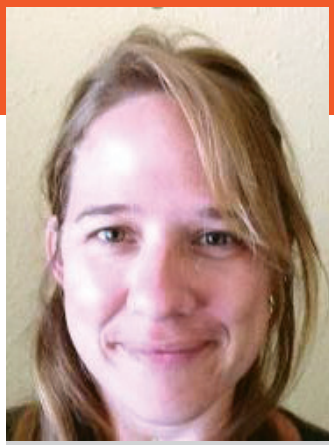
We are also pleased to share an exciting update from the 2025 Annual Meeting: The **Retired Membership category** was unanimously approved and is now available to our valued retired members.

Thank you all for being a part of such a vibrant and supportive community.

Warm regards,

Anne Gowing, RN, CRRN, CNLCP, and MSCC
President, AANLCP 2025 | president@aanlcp.org

From the Editor



Vanessa Richie
JNLCP Editor
journal@aanlcp.org

Good day, All,

With the world coming back to life, 2025 has gotten rather exciting. The 2025 Conference was fantastic, and it was great getting to meet some of you for the first time. Compliments to the Conference Committee for making the event such an outstanding experience. It seems to have inspired some wonderful new ideas for the year. Planning for the 2026 Conference is underway, and registration will begin this fall.

This issue is on a subject that definitely keeps inspiration flowing. With one of the few constants in the medical world being change, seeing the new tools, processes, and ideas being incorporated in some regions provides a new perspective on our own routines. Studies and research also provide a new look into some of the other new ideas that are likely to be incorporated at some point, too.

I hope you find something inspirational or informational in this quarterly issue.

Cheers,
Vanessa Richie, Editor

Information for Authors

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. Submitted material must be original. Manuscripts and queries may be addressed to the Editor. Authors should use the following guidelines for articles to be considered for publication. Please note capitalization of Nurse Life Care Plan, Planning, etc.

Text

- Manuscript length: 1500 – 3000 words
- Use Word© format (.doc, .docx) or Pages (.pages)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page
- Use APA style (Publication Manual of the American Psychological Assoc. current edition)

Art, Figures, Links

- All photos, figures, and artwork must be in JPG or PDF format (JPG preferred for photos).
- Line art must 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 must be submitted as a separate file, 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, 2019). Graphic elements embedded in a word processing document cannot be used.
- Live links are encouraged. Please include the full URL for each.

Editing and Permissions

- The author must accompany the submission with written release from:
- Any recognizable identified facility for the use of name or image
- Any recognizable person in a photograph, for unrestricted use of the image
- Any copyright holder, for copyrighted materials including illustrations, photographs, tables, etc. Note that images harvested online may be copyrighted.
- All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned in their work.
- All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission. The author, not the Journal, is responsible for the views and conclusions of a published manuscript.
- Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

All manuscripts published become the property of the Journal. Submission indicates that the author accepts these terms. Queries may be addressed to the care of the Editor at: journal@aanlcp.org

Manuscript Review Process

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and nursing. 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.

Journal of Nurse Life Care Planning is the official peer-reviewed publication of the American Association of Nurse Life Care Planners. Articles, statements, and opinions contained herein are those of the author(s) and are not necessarily the official policy of the AANLCP® or the editors, unless expressly stated as such. The Association reserves the right to accept, reject, or alter manuscripts or advertising material submitted for publication. The Journal of Nurse Life Care Planning is published quarterly in spring, summer, fall and winter. Members of AANLCP® receive the Journal subscription electronically as a membership benefit. Back issues are available in electronic (PDF) format on the association website. Journal contents are also indexed at the Cumulative Index of Nursing and Allied Health Literature (CINAHL) at ebscohost.com. Please forward all emailaddress changes to AANLCP® marked "Journal-Notice of Address Update." Contents and format copyright by the American Association of Nurse Life Care Planners. All rights reserved. For permission to reprint articles, graphics, or charts from this journal, please request to AANLCP® headed "Journal-Reprint Permissions" citing the volume number, article title, author and intended reprinting purpose. Neither the Journal nor the Association guarantees, warrants, or endorses any product or service advertised in this publication nor do they guarantee any claims made by any product or service representative. 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.

Contributors to this Issue

Linda Husted, MPH, RN, CNLCP®, LNCC, CCM, CDMS, CRC

Linda Husted is a certified nurse life care planner, legal nurse consultant, case manager, disability manager, and rehabilitation counselor. She provides legal nurse consulting, as well as pediatric and adult life care plans for the plaintiff and defense. She can be reached at RNzone.com

Barbara Bate, RN, CRRN, CCM, CMGT-BC, CNLCP®, CHLCP™, LNCC

Barbara Bate is Principal of Northeast Life Care Planning, Inc. (NLCP®), a nurse consulting company that provides a variety of services nationwide, including medical case management, medical cost analysis, Medicare set-aside allocations/conditional payment review, retrospective bill analysis, and life care plan development/review.

With over 41 years of experience as a registered nurse, Barbara holds certifications in Rehabilitation Nursing (CRRN®), Legal Nurse Consulting (LNCC®), Case Management (CCM, CMGT-BC), Life Care Planning (CNLCP®, CHLCP™), and Brain Injury (CBIS). She has provided medical case management services for patients with severe injuries such as traumatic brain injury, spinal cord injury, amputations, and orthopedic injuries since 1994, in addition to clinical work experience in the operating room, recovery room, pediatrics, and obstetrics. As a nurse life care planner, Barbara works with individuals diagnosed with multiple trauma, chronic pain, spinal cord injury, brain injury, birth injuries, burns, amputations, blindness, and chronic healthcare issues.

Barbara has been an active member of the American Association of Nurse Life Care Planners since 2004, serving as President in 2010. She, also, is a charter member of the National Alliance of Medicare Set-Aside Professionals (NAMSAP), now known as The National Medicare Secondary Payer Network, and a former member of NAMSAP's Board of Directors (2009 to May 2014).

In 2012, Barbara joined the Certified Nurse Life Care Planner (CNLCP®) Certification Board, now known as the Universal Life Care Planner Certification Board, and currently holds the position of Co-Chair.

Jan Roughan, BSN, RN, PHN, CRRN/ABSNC, CNLCP®, CHLCP™, CCM®, BRN Provider

Jan Roughan is a rehabilitation nurse specialist who functions in the capacity of case manager, life care planner, and expert witness. Her company, Roughan & Associates at LINC, Inc., is nationally recognized and provides Case Management and Medical/Legal Consulting services. It has been in existence since 1987, providing coordination of patient care; construction of Life Care Plans (LCP); LCP Critique; Medical Record Organization, Review, Summarization, and Analysis; Video Services, Reasonableness Analysis of Past Medical Billings; and consultative services to both the defense and plaintiff bar on simple and complex cases, ranging from infancy to the senior population. Diagnoses with which Roughan & Associates nurse specialists work include, but are not limited to, Neurological Injuries (Brain and Spinal Cord Injury), Burns, Orthopedic Injuries, Amputation, Chronic Pain, and Post Traumatic Stress Disorder.

Contributors to this Issue

Dr. Colarusso, DC, CLCP, CME, CICE, Designated Rating Physician, State of Nevada

Dr. Colarusso has been a dedicated Chiropractic Physician in Nevada since 1995, bringing decades of expertise to his practice. In 2017, he joined Claggett & Sykes Law Firm as the Client Advocate, where he oversees and reviews medical management for injured clients. His role ensures clients receive proper treatment to achieve the best and fastest recoveries possible.

Board-certified as an Independent Medical Examiner (ABIME) since 1998, Dr. Colarusso has served as a Designated Rating Physician for Nevada for over 25 years. He has conducted more than 1,000 Permanent Partial Disability (PPD) evaluations and Independent Medical Exams (IMEs) for injured individuals, underscoring his authority in the medical-legal field.

As a founding member and Chief Medical Strategist at Focus Graphics, Dr. Colarusso contributes to the legal community by creating demonstrative trial materials, including surgical animations, medical illustrations, and diagnostic imaging enhancements. These tools assist legal professionals in effectively presenting cases during mediation and trials.

In 2021, Dr. Colarusso expanded his impact by founding Focus Medical Consulting. As a Certified Life Care Planner (CLCP), he provides nationwide consulting services, leveraging his extensive medical-legal expertise to clarify injury causation, assess treatment needs, and quantify permanent injuries for clients.

A native of Las Vegas, Dr. Colarusso achieved All-American status in high school baseball and was drafted by the Philadelphia Phillies. Beyond his professional achievements, he is a dedicated family man, happily married with four children. In his free time, he enjoys coaching, traveling, and finding opportunities to relax.

Becky Czarnik, RN, MS, CNLCP, CMSP-F

Founder & Principal Nurse Life Care Planner, Sierra Nurse Consultants

Becky Czarnik brings over 40 years of nursing experience to her role as a Certified Nurse Life Care Planner and Certified Legal Nurse Consultant. As the founder and principal of Sierra Nurse Consultants, she leads a practice focused on life care planning, medical cost projections, and expert witness services in cases involving complex medical and legal issues.

With a BSN from St. Olaf College and a Master of Science from The Ohio State University, Ms. Czarnik's career has spanned intensive care, hospital leadership, home health, and community-based care in diverse settings across the country. This comprehensive background has given her a deep understanding of the full continuum of care—knowledge she now applies to developing future care plans that are both clinically accurate and legally sound.

As a mentor and educator, Becky is committed to supporting the next generation of nurse care planners. She currently serves as Education Chair for the American Association of Nurse Life Care Planners (AANLCP), where she contributes to curriculum development, national conference programming, and professional standards. She contributed to the AANLCP Scope and Standards of Practice and continues to publish and present on best practices in nurse consulting.

Becky encourages nurses to recognize the unique value of their clinical expertise in non-traditional roles. She believes that life care planning is not only a natural extension of nursing judgment and advocacy, but also a powerful opportunity to impact patients' futures beyond the bedside. Her work and mentorship aim to elevate the role of nurses in the legal arena and support colleagues transitioning into this specialized field.

Contributors to this Issue

Melinda Pearson, LMSW, CLCP

Melinda Pearson, LMSW, CLCP, brings over 25 years of experience in providing services to individuals with brain injuries and disabilities. She currently serves as the Director of Behavioral Services at Advocate Homecare, where she has been offering counseling and behavioral services since 2017. In addition, Melinda is a Certified Life Care Planner, specializing in Life Care Plans and Medical Cost Projections for catastrophic injury cases, working closely with attorneys. Her expertise is also reflected in her published articles in the Journal of Nurse Life Care Planning, and she is looking forward to presenting at the Brain Injury Association of New York's 2025 conference. Melinda holds board certification through the International Commission of Health Care Certification and is an active member of both the American Association of Nurse Life Care Planners (AANLCP) and the National Association of Social Workers (NASW).

Amanda Schmidt, BA

With nearly five years of experience in brain injury rehabilitation, Amanda is deeply committed to helping individuals with TBIs reach their full potential. She holds a Bachelor's in Communication Disorders, which equips her with the expertise to deliver person-centered, compassionate care. As a day program facilitator, independent living skills trainer, and behavioral specialist at Advocate Homecare, Amanda provides Behavior Support Plans that empower individuals to engage, grow, and succeed. Outside of work, she enjoys hiking with her dog, snowboarding, and camping with friends and family.

Catherine Latour, CRC, MSAP

Director of Vocational Services | Advocate Homecare

Catherine is the Director of Vocational Services for Advocate Homecare. She is a Certified Rehabilitation Counselor with an educational background in psychology and communication disorders and holds an MSAP in applied psychology. Catherine has worked in various industries, including retail, childcare, and social services, but has found her passion in providing vocational services to individuals with disabilities to help them reach their full potential and become active members of their communities.

In her free time, she enjoys taking care of her cat named Mango, getting stronger at CrossFit, being outside, running, reading, watching hockey, and occasionally staying horizontal on the couch for hours on end. She's also picked up a new hobby this year, crochet, and is working up to crocheting pillows!

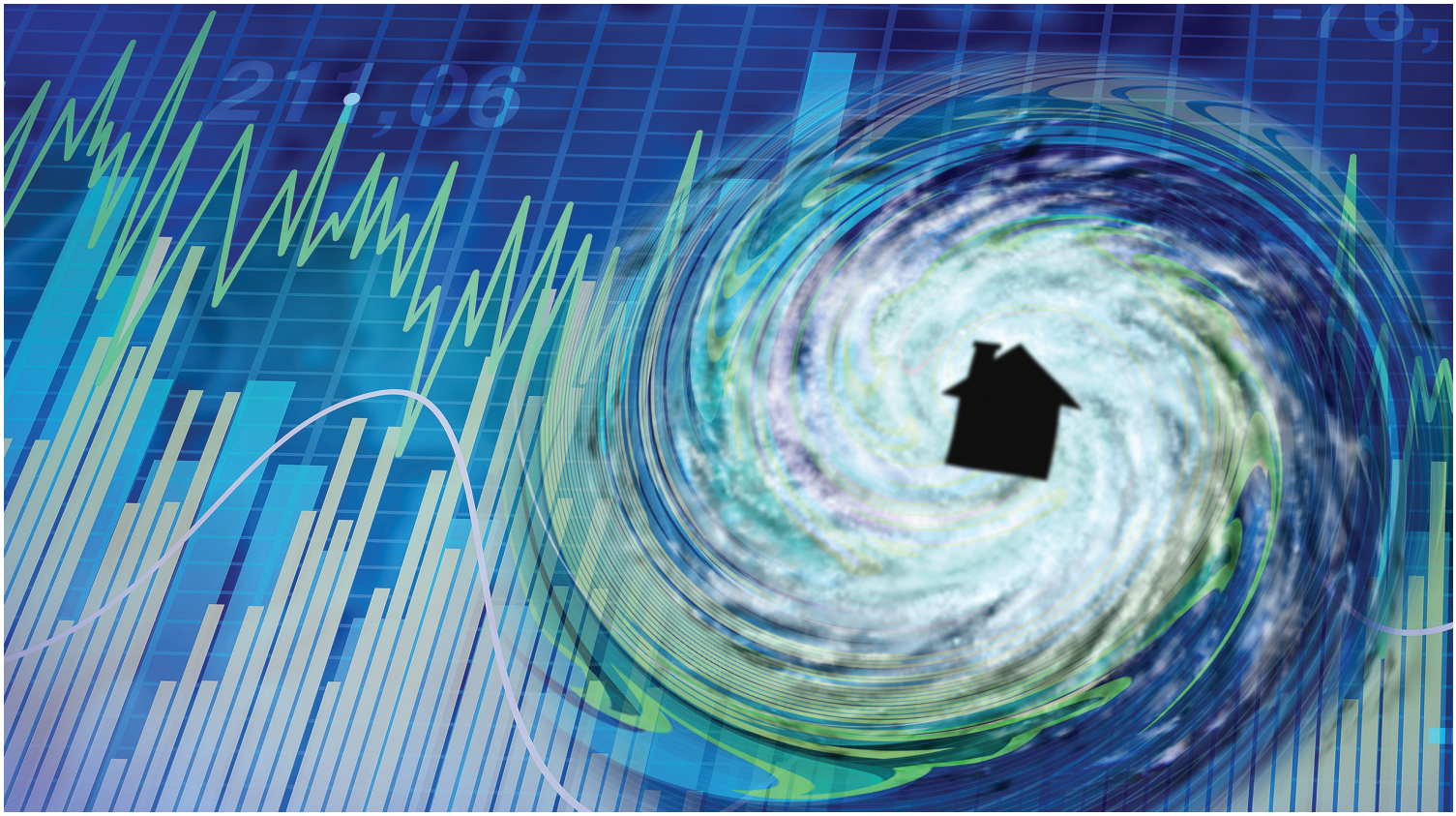
Christy Kniffen, BA, CBIS

With 20 years of experience in service coordination, Christy Kniffin is dedicated to improving the lives of individuals with traumatic brain injuries (TBI) and other disabilities. She specializes in individualized care planning, intensive case management, and ensuring access to medical, rehabilitation, and community-based services that promote well-being and independence. As a TBI Service Coordinator/NHTD for Advocate Homecare, Christy collaborates with individuals, families, and healthcare providers to navigate Medicaid eligibility, DSS systems, trust funds, and essential support services, ensuring that those on the TBI/NHTD Waiver receive the highest quality of care.

A strong advocate for the people she serves, Christy remains actively engaged in ongoing professional development to stay updated on best practices in brain injury rehabilitation and disability services. Her commitment to this field is both professional and personal, as she has firsthand experience as a parent and caregiver for individuals with disabilities. Christy is passionate about empowering individuals with TBI, equipping them with the tools and resources they need to regain independence and enhance their quality of life.

TURBULENCE ON THE HOME CARE FRONT: Implications for Life Care Planners

By Linda Husted, MPH, RN, CNLCP®, LNCC, CCM, CDMS, CRC



Keywords: 1) Home health care 2) Hospital-at-home 3) Care alternatives

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

Excessive caregiver burden: Overwhelming multidimensional strain when caring for a significant other.

Decreased self-care ability syndrome: Decline in independent performance of multiple daily living activities.

Ineffective health self-management: Unsatisfactory handling of symptoms, treatment regimen, and lifestyle changes associated with living with a chronic condition.

COVID-19 was a huge driver of change across numerous sectors of society, especially healthcare. In the U.S., the pandemic, coupled with several other significant issues (such as the demographic shifts with the ever-growing number of people over age 65, inflation with skyrocketing healthcare costs, and workforce shortages), formed what some would call a perfect storm. This created a confluence of problems that forced significant innovation and technological changes. The innovations that happened in home care included expanded roles and the implementation of additional models of healthcare delivery.

Telehealth services that provide remote medical care are not new, whether these services are delivered via synchronous technology, asynchronous or store-and-forward technology, remote patient monitoring (RPM), or mobile health (mHealth) (Mechanic et al., 2022). Although telehealth capabilities and hospital-at-home programs existed before COVID-19, they were underutilized and not integrated as an acceptable means of providing care until March 2020.

In March 2020, as hospitals faced extreme inpatient capacity challenges, the Centers for Medicare and Medicaid Services (CMS) launched the "Hospital Without Walls" initiative (CMS, 2020). New rules, including the promotion of telehealth services and waivers of federal requirements,

relaxed regulations to permit hospitals and healthcare systems to manage the flood of COVID-19 patients.

These evolving healthcare changes and rules also impact life care planning. Home care is often an important component of life care plans. Looking at what's new, expanding, or different on the home care front in 2025, it is helpful to briefly review the development of programs during the past five years, particularly emerging services. Costs of goods and services are non-discounted in life care plans, which aligns with best practices, as noted in Consensus and Majority Statements (Johnson et al., 2018). Although life care planners do not rely on Medicare, Medicaid, or private insurance, it is important to understand these as the major drivers of healthcare and costs in the U.S.

Acute Hospital Care at Home

As COVID-19 continued into November 2020, CMS announced a more comprehensive strategy allowing ambulatory surgical centers (ASCs) to provide greater patient care. CMS granted waivers allowing certain Medicare-certified hospitals to deliver acute care in the home, known as acute hospital care at home (AHCAH) (CMS, 2020). After the COVID-19 public health emergency ended, CMS reported that the Consolidated Appropriations Act, 2023, extended the AHCAH initiative to December 31, 2024 (CMS, 2024).

As of April 1, 2025, there were 398 facilities across 142 healthcare systems in 39 states approved by CMS to provide AHCAH programs, as reported by Quality Net Home (https://qualitynet.cms.gov/acute-hospital-care-at-home/resources). The American Relief Act 2025 extended authorization for both the telehealth waiver and the AHCAH waiver to March 31, 2025 (Vaidya, 2024). It is now up to the U.S. Congress to extend these programs beyond March 2025.

Not only have Medicare waivers demonstrated success in hospital-at-home programs, but commercial health insurance companies are also beginning to cover this model of care. For example, Virtua Health, the largest health care system in Southern New Jersey, announced that Horizon Blue Cross New Jersey now covers hospital-at-home care for eligible patients at Virtua (Virtua Health, 2024).

Mass General Brigham has the largest hospital-at-home program in the U.S. (Bruce, 2024). Becker's Hospital Review interviewed Stephen Dorner, MD, MPH, MSc, chief clinical and innovation officer of Mass General Brigham Healthcare at Home. Dorner discussed the program's success in treating an average of 50 to 60 people per day with inpatient-level care at home (Bruce, 2025). In 2025, Dorner predicts more advances in hospital-at-home technology and care coordination with the growth of medication dispensing and point-of-care lab testing in the home. He also anticipates that artificial intelligence (AI) will improve data analytics to help drive more predictive, proactive care in the home. He reported that improved data analytics will help identify patients who are clinically deteriorating and patients who are at increased risk for falls, to allow for proactive intervention.

Best Buy Health, a subsidiary of the technology retailer, partners with numerous large health systems to enable them to deliver care at home services, transitional care, and chronic care management (The John A. Hartford Foundation, 2024). The retailer's Geek Squad helps set up the hospital at home technologies, including real-time remote patient monitoring and telehealth.

Skilled Nursing at Home

Skilled Nursing at Home (SNF-at-Home) is another model of care providing higher intensity services than typical home care. In 2014, CMS provided the 3-day stay waiver allowing accountable care organizations to waive the 3-day rule for eligibility for admission to an SNF (CMS).

With proven success since the COVID-19 pandemic, the SNF-at-Home model has grown. For example, healthcare provider Compassus and its partners provide a successful SNF at Home program, touting a 44% reduction in hospitalization rates, a 45% reduction in discharge planning delays, and a 50% reduction in total cost of care (Compassus, 2025).

The SNF-at-Home model can offer short-term skilled care as well as rehabilitation services and behavioral health services. The 3-day stay waiver, if available in a particular state, can even allow a patient at home to become directly eligible for SNF-at-Home services.

Home and Community-Based Services

Depending on state policies, Medicaid can also offer SNF care at home coverage through the Home and Community Based Services (HCBS) waiver (CMS, 2014).

Waivers for ACHAH, SNF-at-Home, and HCBS have all proven successful. Following the public health emergency caused by the 2025 fires in Southern California, CMS offered a list of available waivers to provide help (CMS, 2025).

Lower costs, preference for receiving care at home, improved outcomes, and potential reductions in infection make the SNF-at-Home model an attractive option. Patients awaiting hospital discharge for a bed in an SNF, a rehabilitation center, or a behavioral health program may benefit from this model. By providing an alternative to both inpatient and SNF care, overall healthcare costs can be lower while freeing up inpatient beds for higher acuity patients. By providing points of care beyond the brick-and-mortar hospital, hospitals can care for the most complex patients.

Value-Based Care

Value-based care (VBC) is another model in the healthcare delivery system. In this model, providers are paid based on

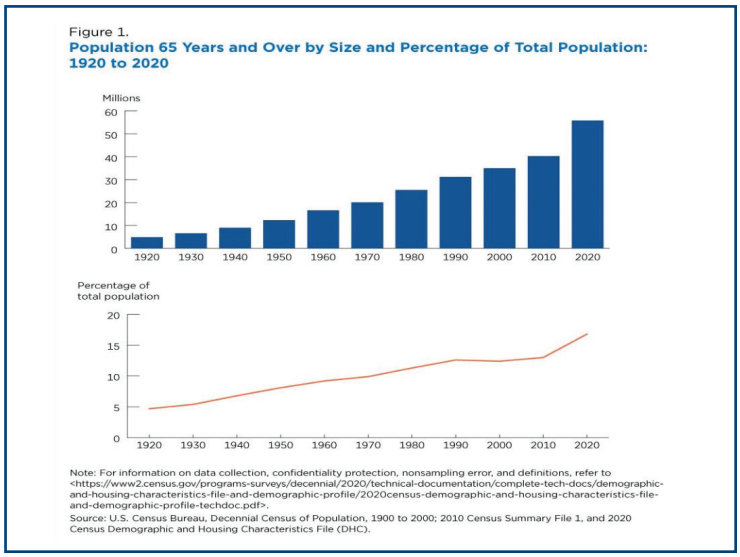
the quality of care they deliver and the health outcomes of their patients, rather than a fee-for-service with payment for the number of services performed. Refining VBC since 1945 to address cost and quality, Kaiser Permanente sees VBC as a model for the future of medicine in the U.S. (Permanente.org). According to Brian Fuller, Managing Director of ATI Advisory's Value-Based Care Design and Delivery practice, VBC will continue to accelerate in 2024 and beyond (Atiadvisory.com).

Home-Based Primary Care

Home-based primary care (HBPC) is a program providing primary, urgent, or palliative care to high-risk, medically vulnerable patients at home. The American Academy of Home Care Medicine has a house-call finder (https://www.aahcm.org/house-call-finder).

Looking forward from 2025, the pressure is on home health agencies to scale up services, both skilled and non-skilled, to meet the demand from hospitals and healthcare systems to provide these various models of care. With the increasing demand for skilled services for a large aging population with complex needs due to multiple comorbidities who prefer to receive care at home, providers on all fronts are beginning to look to the home to become the best point of care, whenever feasible.

As of 2020, one in 6 people in the U.S. were 65 and older, reaching 55.8 million according to the U.S. Census Bureau (Caplan, 2023).



Source: U.S. Census Bureau.gov

To improve outcomes and recipient satisfaction, providers consider Medicare Advantage Plan (MAP) beneficiaries as another patient population who could benefit from home care services (Remington, 2025). Nearly 33 million (or more than half of eligible Medicare recipients) were MAP beneficiaries in 2024, and some of their plans offer home care services (Freed et al., 2024).

The success of models of care (such as ACHAH, SNF-at-Home, VBC, and some HBPC programs) will depend on overcoming challenges, such as workforce shortages. These models depend on home health agencies at the end point of care and their ability to meet the staffing needs in the patient's home environment. Unless the home health agencies can staff the specific needs, the flow of transitions of care will be disrupted.

Workforce Shortages

Workforce shortages are a major challenge. There are strong headwinds along the entire continuum of care from hospital to skilled nursing facility care to home to provide quality, cost-effective care. According to the American Association of Colleges of Nursing Fact Sheet: Nursing Shortage, nursing schools across the U.S. are struggling to expand capacity to meet the rising demand for nursing care. The Fact Sheet also includes a blog by Health Affairs reporting that more than one million registered nurses will retire from the workforce by 2030 (American Association of Colleges of Nursing, 2024). Nursing programs are not meeting the demand for more nurses, and some nurses are either leaving nursing or retiring.

Joyce Famakinwa of Home Health Care News reported that the current industry-wide turnover rate in home care is 79.2% (Famakinwa, 2024). Turnover has increased 12% over the past two years, causing providers to turn away new clients.

The Home Care Association of America and the National Alliance for Care at Home (formerly the National Association for Home Care & Hospice) indicate that the shrinking home care workforce is reaching crisis proportions (The Home Care Workforce Crisis: An Industry Report and Call to Action, 2023). The report noted, "The need for more home care workers is on a direct collision course with the United States population demographics."

Brandi Kurtyka is the CEO of MissionCare Collective, the largest direct care worker community in the U.S. Kurtyka joined a HealthBiz podcast and reported that MissionCare Collective connects over 3 million caregivers with companies for work and training annually and services 8 thousand healthcare providers across the country (Williams, 2023). Addressing the caregiver workforce shortage, she explained that caregivers are going out the back door faster than those coming in the front door, finding better jobs with higher pay. She explained further that there are no federal regulations for the direct caregiver workforce. 53% live in poverty, are on some form of public assistance, and have no health insurance. They have to call out from work due to transportation and childcare issues. They are the lifeblood

of the care delivery system, yet they have low wages and, in some cases, are not guaranteed hours. MissionCare Collective and the National Association for Home Care & Hospice conducted a study of 67,000 direct care workers (such as CNAs, home health aides, and personal care workers) and found that many of these workers don't own a credit card (Howell, 2023).

Kurtyka also discussed findings in The Skilled Nursing Workforce 2025 Report. She relayed report findings that SNFs have an 82% turnover rate, with more than half of the facilities replacing over 50% of their staff annually (MissionCare Collective, 2024).

Artificial Intelligence (AI) is one way to improve efficiencies and help mitigate the workforce shortage. Looking at the impact of AI as a strategy in home care, Home Health Care News highlighted a survey in 2024, finding more than half of home-based care companies either plan to invest in AI over the next year or have already done so (Martin, 2024, December 13). Motivated primarily by staffing shortages, respondents at companies see AI optimizing workflow and operational efficiency and reducing staff burdens.

However, there is mixed support for using AI in health care. Home Health Care News reported that the union National Nurses United surveyed more than 2,300 registered nurses and members, finding that AI frequently contradicts and undermines nurses' clinical judgment (Martin, 2024). The same article reported that McKinsey & Company and the American Nurses Foundation surveyed 7,200 nurses, finding that 42% expressed hope that AI could enhance the quality of patient care, while 235 participants in the survey voiced concerns about the implications of this technology for patient safety.

Implications for Life Care Planners

Life care planners often include a home option for future support care in their plans. When the home option is no longer feasible, an alternative, such as skilled nursing facility care, is recommended. Life care planners propose care options in the individual's geographical area with providers that can offer both specific services required and services of high quality. It is also important to select providers who will continue to be available in the future. Since life care planners cannot predict when a provider might fall into hard times and go out of business, it is important to make the best choices by recommending providers who seem reliable and stable enough to be available for years to come. It is disconcerting to update a life care plan a year or more after submitting the original plan to learn that a home health agency or home care company is no longer an option.

Options for Identifying Home Health Care and Home Care Agencies

- There are many ways life care planners can identify quality agencies. For example, previous experience, consulting other planners, or evaluating the plan recipient's current provider. Here are a few other resources to identify support care options in life care plans, including home health care and home care companies:
- To address quality, life care planners can check the Medicare.gov site to identify ratings on skilled nursing homes at the Medicare Care Compare link: https://www.medicare.gov/care-compare/?providerType=NursingHome. CMS provides a 5-star rating system for health inspections, staffing, and quality measures. Results can be disappointing with low star ratings for staffing in many nursing homes. It is alarming to learn that low star ratings indicate high staff turnover (MissionCare Collective, 2024).
- Medicare.gov also provides a list of home health service companies per zip code with 1 to 5-star quality ratings at this link: https://www.medicare.gov/care-compare/?providerType=HomeHealth. Included under the quality rating for each agency is a patient survey rating ranging from 1 to 5 stars. While some home health agencies may report 4 or 5-star quality ratings, patient survey ratings may be only 1 or 2 stars. Finding agencies with aligned quality and patient ratings is difficult.
- The Department of Health in some states lists licensed health care service agencies and each agency includes the services offered.
- A web search can be conducted for agency names and reviews.
- An AI application, such as Perplexity or Perplexity Pro, can be used to identify certified home health agencies and licensed health care services agencies in a specific location.
- Home Care Association of America, representing nearly 4,500 home care agencies throughout the U.S., provides a resource to locate agencies at this link: https://web.hcaoa.org/directory.
- Assisted living facilities with aging-in-place programming and an enhanced license can offer varying levels of care.
- UltimateCare, a licensed home care agency in New York, has a comprehensive guide of tips on choosing a reputable agency covering topics such as licensing and accreditation, caregiver screening and supervision, emergency procedures, and quality measures. The guide can be found at this link: https://www.ultimatecareny.com/resources/how-to-evaluate-home-care-agencies-for-quality-services (Ultimatecareny.com, 2025).

Since home care can be the costliest component of a life care plan, life care planners need to ensure that the resources recommended in a plan are long-lasting. Private hire nursing and home care workers may, in some cases, be a better option than agency care. Having two or more agencies involved in covering necessary hours and filling in scheduling gaps may sometimes be necessary.

With more models of care, such as ACHAH or SNF-at-Home, now possible, life care planners may extend the years a plan recipient can live at home. This may be possible, depending upon family support. This can be burdensome for the family. If a family member is no longer available, nursing home care may be recommended as a backup option. If nursing home care is recommended, supplemental hours of personal care may be necessary to compensate for staffing shortages.

Conclusion

Times are fast-paced with evolving technologies and care, and there are many new directions to explore with those changes. The increasing demand to use the various models of care at home exerts pressure on home care companies. They need to implement digital strategies, telehealth, clinical supports, improved processes, and outcomes while managing the economic pressures of rising costs and the ever-increasing shortage of qualified workers. This can be a great opportunity for home care companies, but it makes for a very turbulent atmosphere.

This is a call to action for life care planners to brainstorm the best ways to select quality pediatric and adult home care providers, so that support care in plans remains valid, of excellent quality, and long-lasting!

REFERENCES

American Academy of Home Care Medicine. (2022). *HBPC Resources: A Tool Kit for Health Partners*. Accessed February 3, 2025, from https://www.aahcm.org/what_is_hbpc.

American Association of Colleges of Nursing. (2024). *Fact Sheet: Nursing Shortage*. www.aacnnursing.org. Accessed January 14, 2025, from https://www.aacnnursing.org/Portals/0/PDFs/Fact-Sheets/Nursing-Shortage-Factsheet.pdf.

Atiadvisory.com. (2024). Value-Based Care in 2024: *Anticipating Key Trends and Transformations*. Accessed January 24, 2025, from https://atiadvisory.com/resources/value-based-care-in-2024-anticipating-key-trends-and-transformations/.

Bruce, G. (10/30/2024). *How Mass General Brigham built the largest 'hospital at home.'* Accessed January 24, 2025, from https://www.beckershospitalreview.com/telehealth/how-mass-general-brigham-built-the-largest-hospital-at-home.html.

Bruce, G. (2025). *"Becker's Hospital Review 'Mass General Brigham's 2025 hospital-at-home plans."* January 8, 2025. Accessed January 24, 2025, from https://www.beckershospitalreview.com/telehealth/mass-general-brighams-2025-hospital-at-home-plans.html?origin=BHRSUN&oly_enc_id=7321H8657790D0B

Caplan, Z. (2023). *U.S. Older Population Grew From 2010 to 2020 at Fastest Rate Since 1880 to 1890*. Census.gov. Accessed February 1, 2025, https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html

CMS.gov/newsroom. *Additional Background Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge*. Added March 30, 2020. Accessed January 4, 2025. https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient

CMS.gov/newsroom. *CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge*. Added November 25, 2020. Added February 28, 2020. Accessed January 4, 2025, from https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge

CMS.gov/newsroom. *Acute Hospital Care at Home Data Release Fact Sheet*. Added January 16, 2024. Accessed January 4, 2025, from https://www.cms.gov/newsroom/fact-sheets/acute-hospital-care-home-data-release-fact-sheet.

CMS.gov. *Skilled Nursing Facility 3-day Waiver Analysis of Use in ACOs 2014 to 2019*. Accessed January 5, 2025, from https://www.cms.gov/priorities/innovation/data-and-reports/2023/snf-waiver-summary

CMS.gov. (2014). *Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule (CMS 2249-F/2296-F)*. Accessed January 5, 2025, from https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-fact-sheet_0.pdf

CMS.gov. (2025). *2025 Southern California Wildfires: Available Waivers in the State of California Health Care Providers*. Accessed January 4, 2025, from https://www.cms.gov/files/document/2025-southern-ca-wildfires-waiver-list-01-12-25.pdf

Compassus (2025). *Skilled Nursing Facility (SNF) at Home*. Accessed January 6, 2025, from https://www.compassus.com/snf-at-home/

REFERENCES

Famakinwa, J. (2024). *Home Care's Industry-Wide Turnover Rate Reaches Nearly 80%.* Homehealthcarenews.com. Accessed January 6, 2025 from https://homehealthcarenews.com/2024/07/home-cares-industry-wide-turnover-rate-reaches-nearly-80/

Freed, M., Fuglesten Biniek, J., Damico, A., & Neuman, T. (2024). *Medicare Advantage 2025 Spotlight: A First Look at Plan Premiums and Benefits.* KFF.org. Accessed January 24, 2025, from https://www.kff.org/medicare/issue-brief/medicare-advantage-2025-spotlight-a-first-look-at-plan-premiums-and-benefits/

Home Care Association of America and the National Alliance for Care at Home. (2023). *The Home Care Workforce Crisis An Industry Report and Call to Action.* Accessed January 24, 2025, from https://www.hcaoa.org/workforceaction.html

Howell, Jeff (Host). (2023, August 15). *Understanding caregiver personas: A look at the top 7.* Accessed January 29, 2025, from https://www.buzzsprout.com/1819085/episodes/13345740-understanding-caregiver-personas-a-look-at-the-top-7

Johnson, C. B., Pomeranz, J. L., & Stetten, N. E. (2018). *Consensus and Majority Statements derived from Life Care Planning Summits held in 2000, 2002, 2004, 2006, 2008, 2010, 2012, 2015 and 2017 and updated via Delphi study in 2018.* Journal of Life Care Planning. Accessed January 7, 2025, from https://rehabpro.org/global_engine/download.aspx?fileid=CF3E5F60-C18F-4C07-A8D6-D1F1291280B5&ext=pdf

Lightspring. Shutterstock illustration. *Real Estate Disaster and housing Turbulent Home buying market and mortgage Subprime lending financial turbulence and house debt crisis as an economic storm in a 3D illustration style.*

MissionCare Collective. (2024). *The Skilled Nursing Workforce 2025 Report.* Accessed January 3, 2025, from https://www.missioncare.com/hubfs/Skilled-Nursing-Workforce-Report.pdf

Martin, A. (2024). *The Buy-In: Striking The Right Chord With Home Health AI.* Homehealthcarenews.com. Accessed January 16, 2025, from https://homehealthcarenews.com/2024/12/the-buy-in-striking-the-right-cord-with-home-health-ai/

Martin, A. (2024, December 13). *More Than Half Of Home-Based Care Providers Are Investing In AI.* Homehealthcarenews.com. Accessed January 16, 2025, from https://homehealthcarenews.com/2024/12/more-than-half-of-home-based-care-providers-are-investing-in-ai/

Mechanic OJ, Persaud Y, Kimball AB. (2022 Sep 12). *"Telehealth Systems."* StatPearls, Treasure Island, FL: StatPearls Publishing 2025. Accessed April 16, 2025 at https://www.ncbi.nlm.nih.gov/books/NBK459384/.

Permanente.org. *Unlocking the potential of value-based care.* Permanente Medicine. Accessed January 24, 2025, from https://permanente.org/medical-excellence/unlocking-the-potential-of-value-based-care/

QualityNet.cms.gov. *Approved Facilities/Systems for Acute Hospital Care Home.* Updated February 21, 2025. Accessed February 22, 2025, from https://qualitynet.cms.gov/acute-hospital-care-at-home/resources

Remington, L. (2025). *Improving Outcomes Between Home Care and Medicare Advantage Plans.* Remington@RemingtonReport.com. Accessed January 26, 2025, from https://remingtonreport.com/intelligence-resources/futurefocus/improving-outcomes-between-home-care-and-medicare-advantage-plans/

The John A. Hartford Foundation. (2024). *Meeting the Growing Demand for Age-Friendly Care Health Care at the Crossroads.* Johnhartford.org. Accessed January 26, 2025, from https://www.johnahartford.org/images/uploads/resources/The_Growing_Demand_for_Age-Friendly_Care_Report_FINAL.pdf.

UltimateCare (2025). *How to Evaluate Home Care Agencies for Quality Services.* Ultimatecareny.com. Accessed January 26, 2025, from https://www.ultimatecareny.com/resources/how-to-evaluate-home-care-agencies-for-quality-services-0885f

Vaidya, A. (2024). *Telehealth, hospital-at-home waivers extended for 90 days.* Techtarget.com. Added November 7, 2024. Accessed January 25, 2025, from https://www.techtarget.com/virtualhealthcare/news/366617499/Telehealth-hospital-at-home-waiver-extended-for-90-days

Virtua Health. (2024). *"Virtua Health Secures Agreement with NJ's Largest Insurance Provider to Participate in 'Hospital at Home.'"* Accessed January 25, 2025, from https://www.virtua.org/news/virtua-health-secures-agreement-to-participate-in-hospital-at-home

Williams, D. E. (Host). (2023, September 14). *Interview with MissionCare Collective CEO Brandi Kurtyka.* Heathbusinessgroup.com. Accessed January 3, 2025, from https://www.healthbusinessgroup.com/blog/mission-care-brandi-kurtyka

Nurse Life Care Planning
PRACTICE & PROTOCOLS: 2024

By Barbara Bate, RN, CRRN, CCM, CMGT-BC, CNLCP®, CHLCP™, LNCC and
Jan Roughan, BSN, RN, PHN, CRRN/ABSNC, CNLCP®, CHLCP™, CCM®, BRN Provider

Keywords: 1) Job Task Analysis 2) Prevalent Practice Patterns/Protocols 3) Certification Validity 4) Psychometrically Sound Portfolio Exam

Life care planning is a specialty practice within the healthcare industry, particularly in nursing. It entails a specific process that includes analysis and arrival at a best estimate of an ill or injured individual's long-term treatment needs and associated costs. It is based on the initial elements of an illness or injury, the individual's recovery trajectory, the individual's current status, and the life care plan author's knowledge and experience with the needs of similar patient populations.

It is utilized in various venues (such as education, estate planning, special needs trust allocations, legal matters, insurance, National Vaccine Injury Compensation Program cases, etc.) and has become particularly important in the personal injury industry to assist the Trier of Fact/Jury in their arrival at a monetary award for the damages portion of cases.

Nurse life care planning, in particular, mimics key portions of the nursing process that provide the foundation for determining those services and supplies that will optimize the individual's outcome and minimize complications secondary to the index illness/injury.

The American Association of Nurse Life Care Planners (AANLCP) has established Standards of Practice to guide those working within the field of nurse life care planning. The Universal Life Care Planning Certification Board (ULCPCB™), an entity separate and distinct from the AANLCP, has developed criteria and psychometrically sound testing protocols to measure adherence to these standards and application of the nurse life care planning process to various case scenarios.

Based on the recommendation from the Accreditation Board of Specialty Nursing Certification (ABSNC), the ULCPCB™ has shifted from a multiple-choice exam to a portfolio-based assessment for the Certified Nurse Life Care Planner (CNLCP®) certification.

The CNLCP® Portfolio Examination was created in accordance with ABSNC's Accreditation Standards for Portfolio Assessment Certification Programs and officially launched in January 2025. The ULCPCB™ is permitted to apply for accreditation of the certification process once the program has at least 100 Certificants and/or has been active for one year (ABSNC, 2024).

Validity is a critical aspect of any certification process and a key consideration in the development and application of

portfolio assessment methods. It refers to the extent to which decisions made based on assessments are rational, sound, and aligned with the purpose of the portfolio. A passing score on a portfolio examination signifies that the nurse possesses the knowledge necessary to practice competently within the nursing specialty as assessed by the portfolio methods. Certification reflects a level of knowledge that exceeds the requirements for entry-level practice in nursing and serves as a measure of competence within a specialized nursing field (ABSNC, 2022).

In a recent (2024) effort to determine current practice trends and protocols, a Job Task Analysis (JTA) survey was undertaken by the ULCPCB™ with the assistance of Professional Testing Corporation (PTC). Also referred to as a practice analysis, job analysis, or role delineation survey, the JTA is a process that identifies the core tasks essential to the profession and the areas of knowledge required to perform those tasks. By defining those tasks and knowledge areas, JTAs can provide evidence of content validity for the certification program, ensuring that the exam effectively measures what it is intended to: a candidate's competence within the field (Sturges-Vera, 2024).

Job Task Analysis Study

In 2020, the ULCPCB™ established a geographically diverse Steering Committee consisting of life care planners who have been active in ULCPCB™ volunteer activities and who represented a variety of areas and levels of expertise and experience. The Steering Committee then appointed a Task Force composed of ten life care planners, who were also geographically diverse with a variety of areas of expertise and experience. Their goal was to delineate the tasks and knowledge areas, as well as the demographic questions to be used in a validation survey instrument. The Steering Committee, acting in an advisory capacity, provided general guidance to PTC and the Task Force. They reviewed the work of the Task Force and made recommendations regarding the proposed and completed elements of the study.

The Task Force began by reviewing the sections/domains, tasks, knowledge areas, and demographic questions developed in the previous certification board survey conducted in 2012. They were asked to compare them to current best practices. The task statements and knowledge areas that were deemed applicable to current practice were edited for clarity and completeness. The Task Force added new task statements and knowledge areas as deemed appropriate to accurately reflect current practice patterns in life care planning.

The Task Force set the scales for the survey as follows:

- Regularly (67-100% or daily)
- Frequently (34-66% or 2-4 times per week)
- Occasionally (1-33% or monthly, quarterly, or annually)
- Never (do not perform).

The importance scale was set at:

- Extremely Important/Essential
- Moderately Important
- Slightly Important/Useful
- Minimally/Not Important.

Once the Task Force drafted the preliminary lists, an independent review process was implemented so that subject matter experts who were not involved in the initial work could provide a fresh perspective on the project to date. The domains, task statements, knowledge areas, and demographic questions were then presented to a second panel of ten geographically diverse Independent Reviewers representing a variety of areas and levels of experience. The Independent Reviewers then provided feedback on completeness, clarity, consistency, and relevance of the proposed domains, tasks, knowledge areas, and demographic questions.

In December of 2023, the Steering Committee and two members of the Task Force reviewed comments from the Independent Reviewers who suggested only minor changes to task statements and demographic questions to enhance clarity. Modifications were made to the content, and redundant questions/tasks were identified and removed, all the while preserving the survey's integrity. The survey was then forwarded to the Task Force for review. The Task Force arrived at a consensus in regard to 160 task statements (organized into five domains), 36 knowledge areas, and 21 demographic questions that were included in the final survey.

The survey was distributed electronically to over 1,000 life care planners, including 438 registered nurses specializing in nurse life care planning. A total of 235 individuals accessed the link. At the beginning of the survey, a qualification question was posed: "Are you currently practicing as a life care planner? Yes, No." If a respondent answered "No," the following message appeared: "Your input is not needed at this time. Please look out for other ways you can become involved with ULCPCB™. Thank you," and the survey ended. A second qualification question asked, "What is your primary field of licensed professional practice?" If the respondent answered "RN," then they were considered qualified, and their responses were included in the analysis for the CNLCP® study. Of those who responded, 115 individuals were considered qualified and provided valid responses.

Respondents were asked to assess the frequency and importance of various tasks, the significance of knowledge areas, and the time spent on tasks in each domain. Additionally, they reviewed the eligibility and recertification criteria for the CNLCP® certification, providing feedback on appropriateness.

Results from this survey were used to develop the content specifications for the CNLCP® Portfolio Examination. The process described herein enhances the content validity of

the examination, improves the overall quality of the CNLCP® credentialing program, and supports the use of the nursing process in nurse life care planning. In fact, utilization of a professional process (e.g., nursing process [assessment, diagnosis, outcome identification, planning, implementation, evaluation]) scored 3.9 out of 4 for importance and frequency in three Domains (Patient/Evaluee Assessment, Collaboration with Others, and Life Care Plan Development).

Demographic Summary

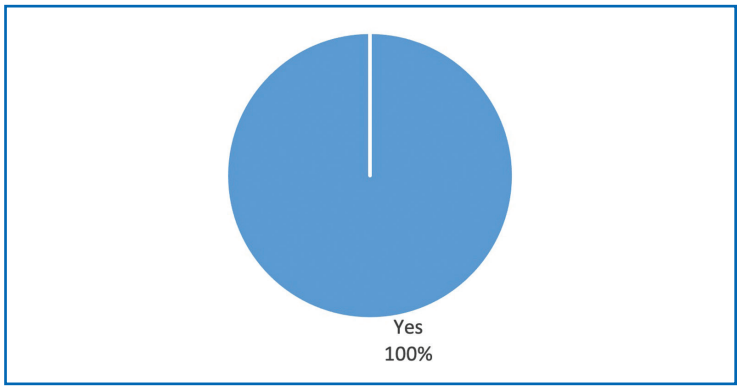
Survey Respondents

The data from 115 respondents were analyzed.

Distribution by Being a Licensed Healthcare Professional

Along with the qualification questions, respondents were asked to confirm whether they are licensed healthcare professionals (Figure 1). All 88 respondents who answered this question confirmed that they are licensed healthcare professionals.

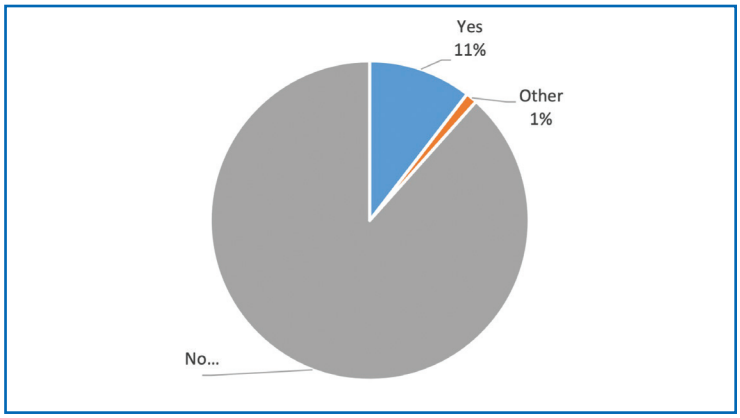
Figure 1: Are you a licensed healthcare professional? (N=88)



Distribution by Being a Rehabilitation Counselor

Respondents were asked to specify whether they are rehabilitation counselors (Figure 2). Just over 10% of respondents confirmed that they are rehabilitation counselors.

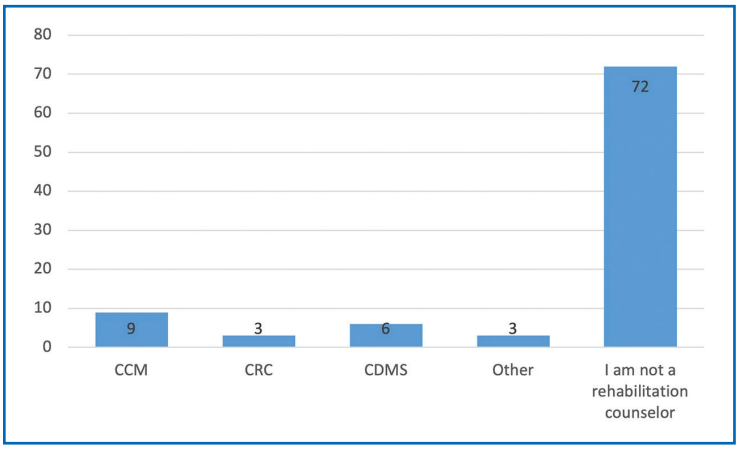
Figure 2: Are you a rehabilitation counselor? (N=86)



Distribution by Certifications as a Rehabilitation Counselor

Respondents were asked to indicate the certifications they hold if they are a rehabilitation counselor (Figure 3). They were able to select all that applied. The most common certifications selected were CCM and CDMS.

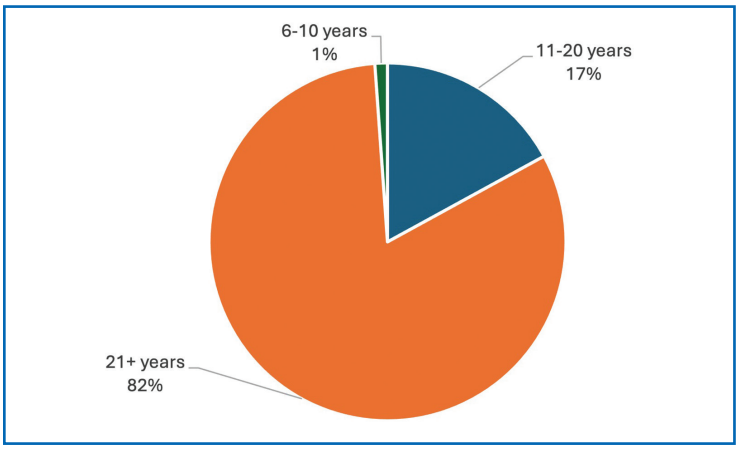
Figure 3: If you are a rehabilitation counselor, what certifications do you hold? Check all that apply. (N=85)



Distribution by Years Working in their Primary Profession

Respondents were asked to indicate how many years they have worked in their primary profession (Figure 4). Over three-quarters of respondents have worked as registered nurses for more than 20 years.

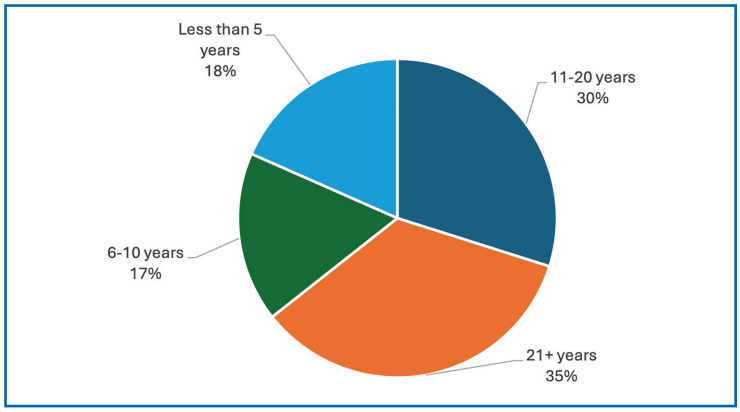
Figure 4: How many years have you worked in your primary profession? (N=88)



Distribution by Years Practicing as a Life Care Planner

Respondents were asked to indicate how many years they have been practicing as a life care planner (Figure 5). Close to two-thirds of respondents have been a life care planner for more than 10 years.

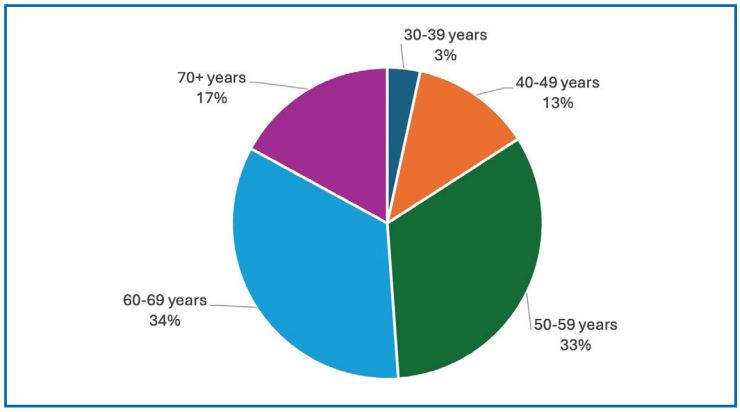
Figure 5: How long have you been practicing as a life care planner? (N=87)



Distribution by Age

Respondents were asked to indicate their age (Figure 6). Over half are 60 years old or older.

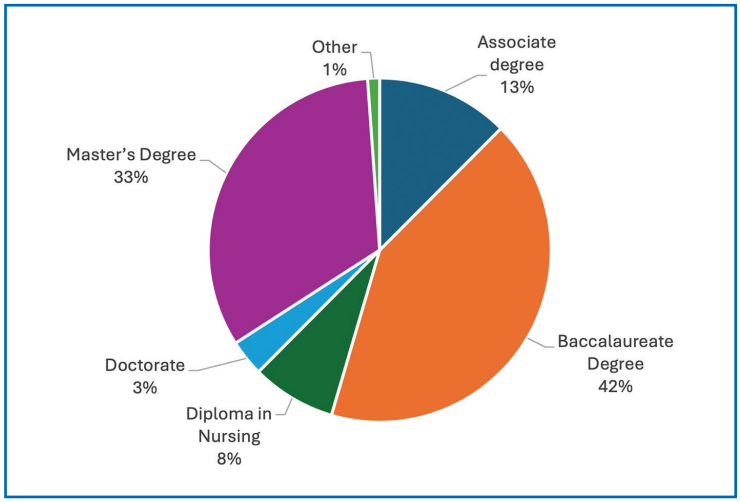
Figure 6: What is your age? (N=88)



Distribution by Highest Level of Education

Respondents were asked to indicate their highest level of education (Figure 7). The largest percentage of respondents have a bachelor's degree, followed by those with a master's degree or higher.

Figure 7: What is your highest level of education? (N=88)



Distribution by Geographic Location

Respondents were asked to indicate their current/primary region of practice (Table 1). The results are grouped into seven U.S. geographic regions, as well as Australia, Canada, and Other. All regions are represented, with the largest number of respondents from the Southeastern region, followed by the Western region. The fewest respondents in the U.S. are from the Midwestern region.

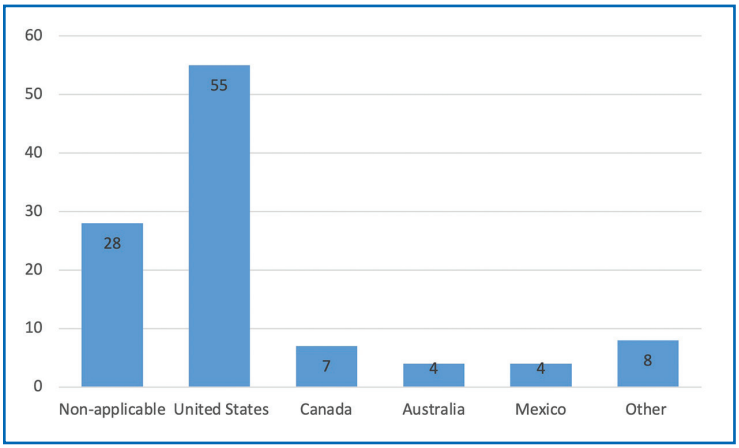
TABLE 1: Geographic Locations of Survey Respondents

Region	Number
United States	
Mid-Atlantic (DC, DE, MD, NJ, NY, PA, VA, WV)	13
Midwestern (IL, IN, MI, MN, OH WI)	4
Mountain & Prairie (CO, IA, KS, MO, MT, NE, ND, SD, UT, WY)	9
New England (CT, MA, ME, NH, RI, VT)	6
Southeastern (AL, FL, GA, KY, MS, NC, SC, TN)	22
Southwestern (AR, AZ, LA, NM, OK, TX)	12
Western (AK, CA, HI, ID, NV, OR, WA)	18
Australia	1
Canada	1
Other	2

Distribution by International Practice

Respondents were asked to indicate whether they practice internationally and, if so, where (Figure 8). They could select all applicable locations. Among those who chose a location outside the United States, some selected Canada, Mexico, Australia, and Other (mostly Europe and the UK).

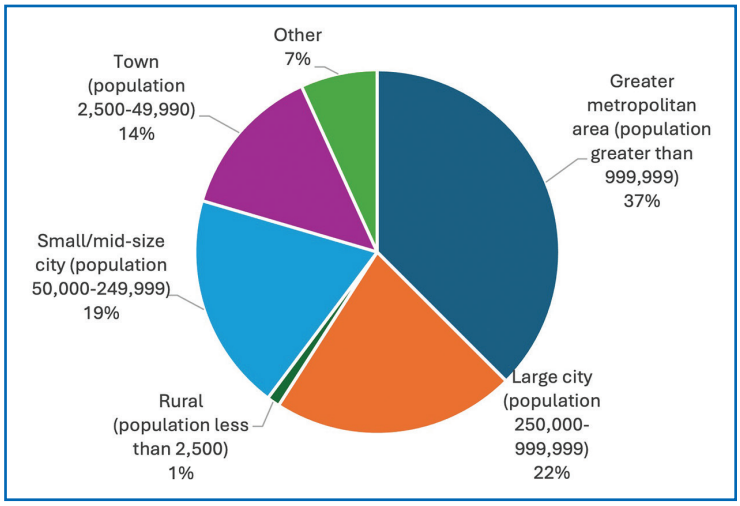
Figure 8: Do you practice internationally? Check all that apply (N=87)



Distribution by Primary Practice Location

Respondents were asked to indicate which type of geographic setting best describes their primary practice location in the last year (Figure 9). The largest percentage of respondents indicated a greater metropolitan area, followed by a large city. The smallest percentage of respondents indicated a rural location.

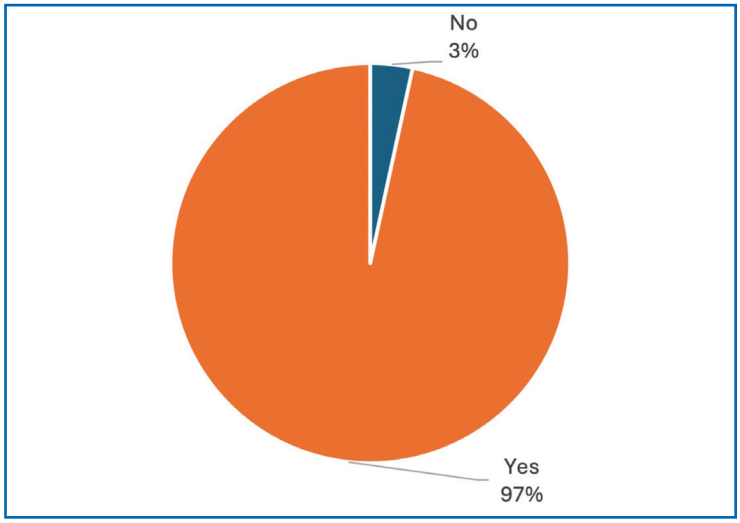
Figure 9: Which of the following best describes your primary practice location in the last year? (N=88)



Distribution by Having a Credential in Life Care Planning

Respondents were asked to indicate whether they currently hold a certification or certificate in life care planning (Figure 10). Almost all said they do have a credential in life care planning.

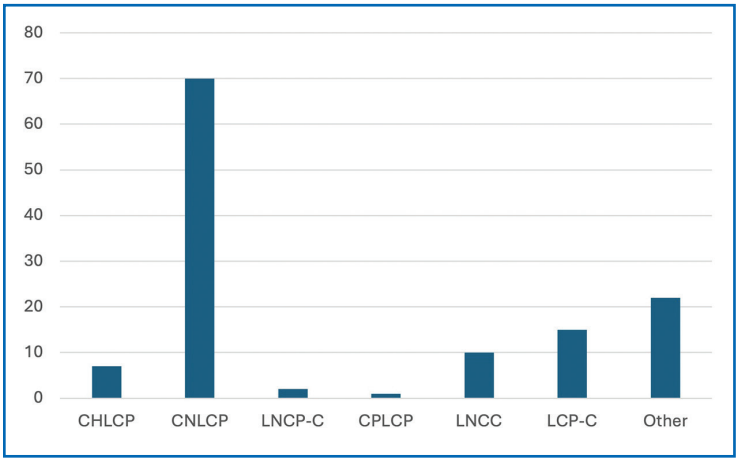
Figure 10: Do you have a current certification/certificate in life care planning? (N=88)



Distribution by Certification in Life Care Planning

Respondents were asked to indicate which certification or certificate in life care planning they hold (Figure 11). They were able to select all that apply. The largest number hold the CNLCP® credential, while a few hold LCP-C, LNCC, and CHLCP™. Most who selected Other indicated CLCP.

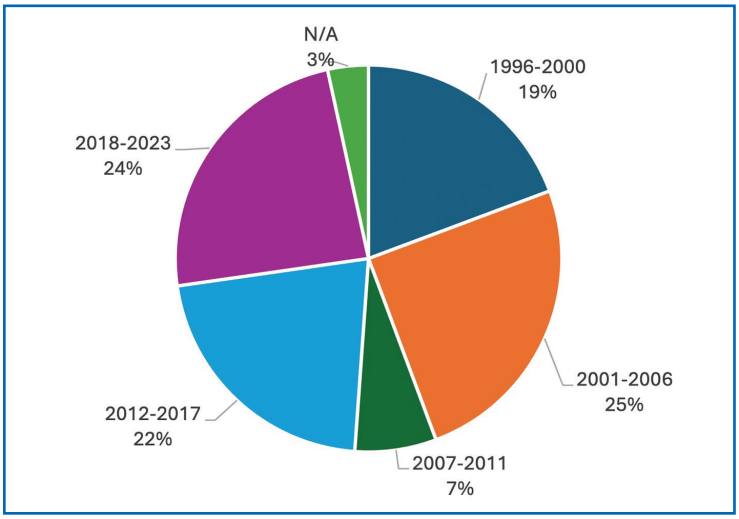
Figure 11: If yes, please identify all life care planning certifications/certificates. Check all that apply. (N=85)



Distribution by Year of Receiving First Life Care Planning Certification

Respondents were asked to indicate the year they received their first life care planning certification or certificate (Figure 12). Nearly half of the respondents earned their first certification between 2012 and 2023, while a quarter received their first certification between 2001 and 2006.

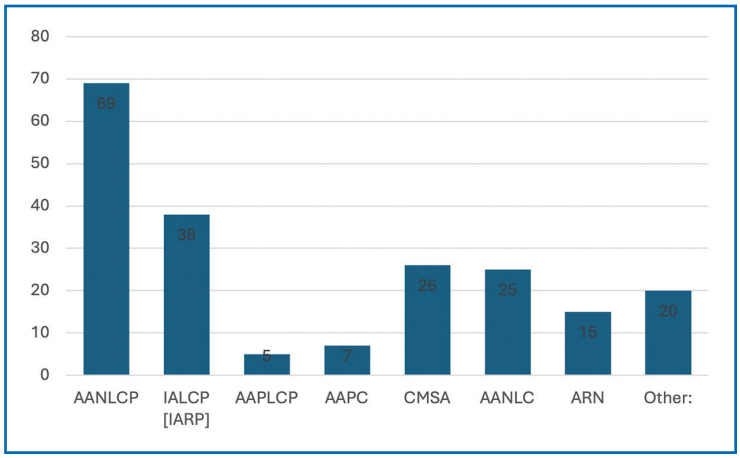
Figure 12: In what year did you receive your first life care planning certification/certificate? (N=88)



Distribution by Organization Membership

Respondents were asked to indicate all of the organizations they are currently a member of (Figure 13). The largest number are members of AANLCP, followed by IALCP/IARP, CMSA, and AANLC. Most of those who selected Other indicated ANA.

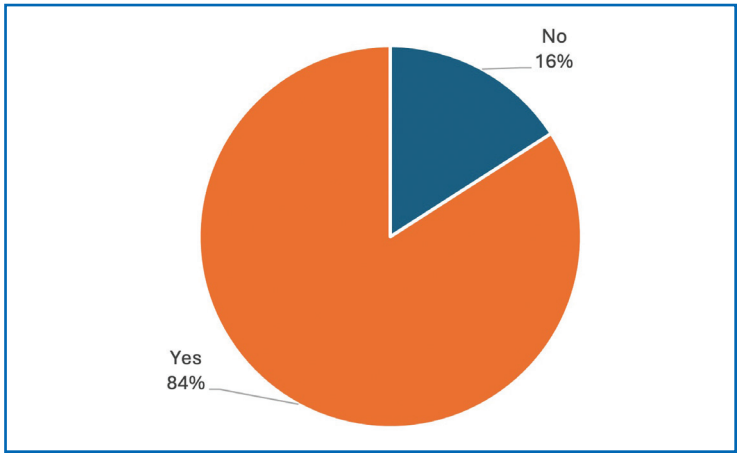
Figure 13: Identify all organizations that you are a current member of: (N=78)



Distribution by Attendance at Conferences

Respondents were asked to indicate whether they attend conferences offered by life care planning membership organizations (Figure 14). Over 80% indicated that they do attend conferences.

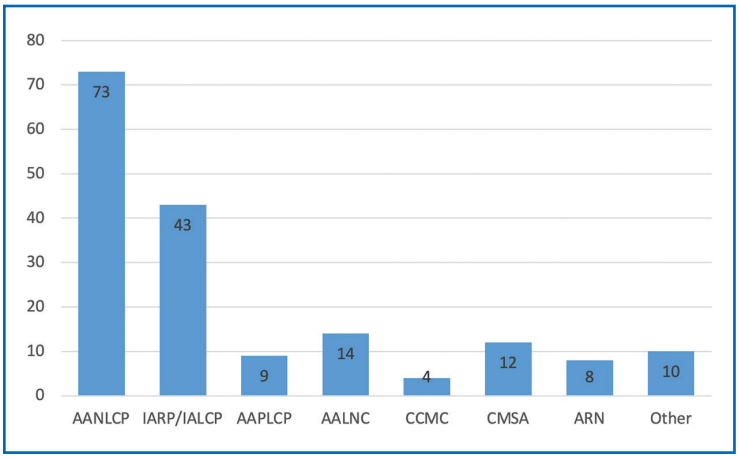
Figure 14: Do you attend conferences offered by life care planning membership organizations? (N=88)



Distribution by Conferences Attended in the Last Five Years

Respondents were asked to indicate all conferences they attended in the last five years (Figure 15). The largest number have attended AANCLP conferences, followed by IARP/IALCP.

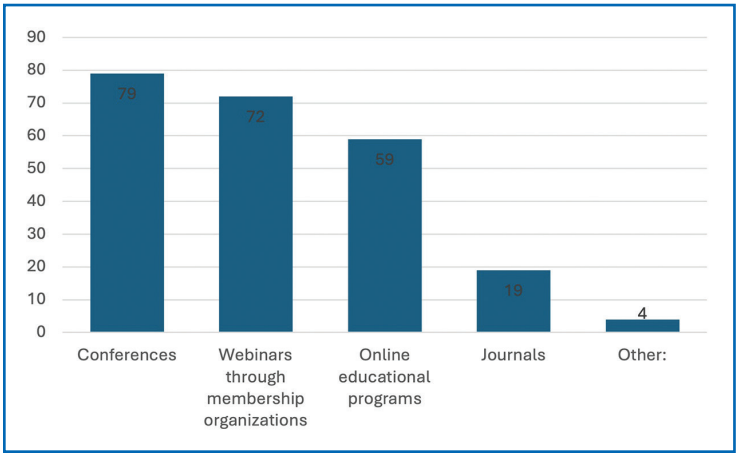
Figure 15: What conferences have you attended in the last five years? Please identify all (N=79)



Distribution by Sources of Continuing Education

Respondents were asked to indicate where they obtain their continuing education (CE) in life care planning (Figure 16). They were asked to select all that apply. The largest number obtain CE at conferences and by webinars through membership organizations.

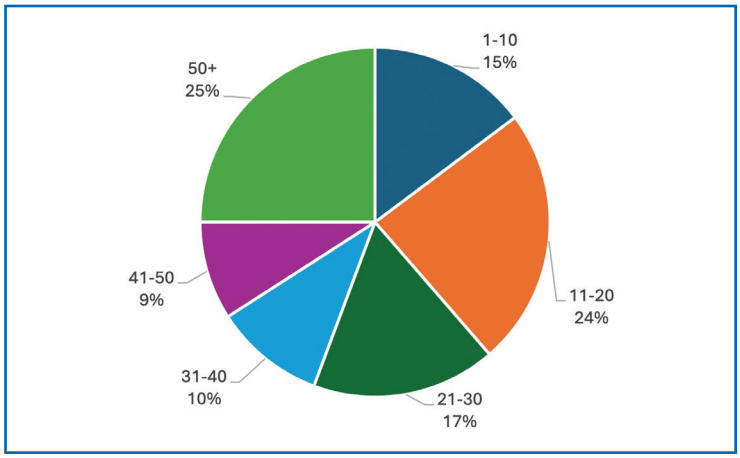
Figure 16: Where do you obtain continuing education in life care planning? Please identify all (N=88)



Distribution by Number of Life Care Plans per Year

Respondents were asked to indicate how many life care plans they develop or review per year (Figure 17). Almost 40% develop or review 20 or less life care plans, while over one-third develop or review 21-50 per year. A quarter develop or review more than 50 life care plans per year.

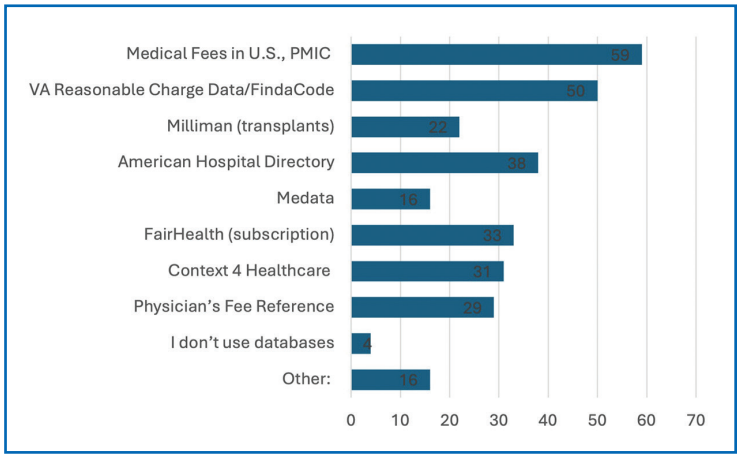
Figure 17: Approximately how many Life Care Plans do you develop/review per year? (N=88)



Distribution by National Databases for Pricing

Respondents were asked to indicate which national databases they use to obtain pricing (Figure 18). They were asked to select all that apply. The largest number use Medical Fees in the U.S., PMIC, followed by VA Reasonable Charge Data/FindaCode.

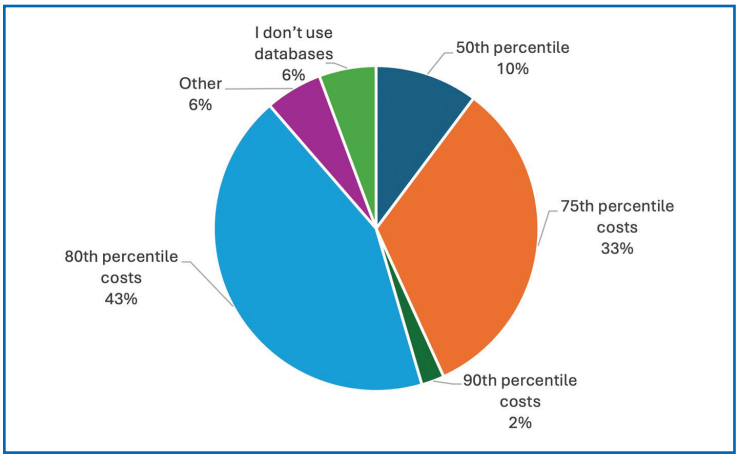
Figure 18: Which national databases do you use to obtain pricing? Check all that apply. (N=88)



Distribution by Percentile Used when Obtaining Pricing

Respondents were asked to indicate which percentile they use most often when obtaining pricing from a national database (Figure 19). The largest percentage uses the 80th percentile, followed by the 75th percentile. Less than a quarter of respondents use other percentiles.

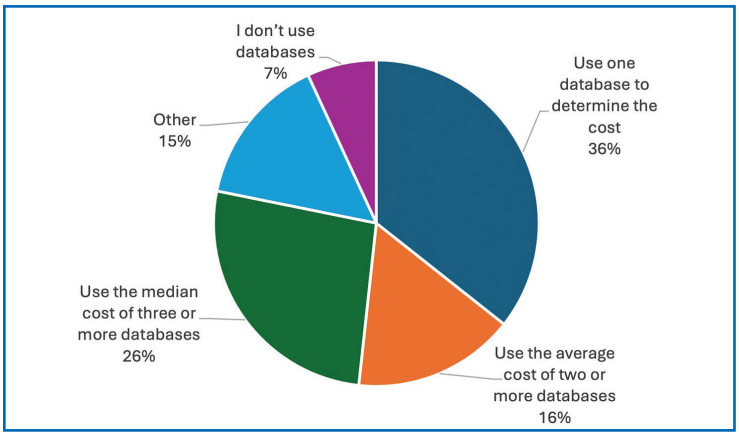
Figure 19: What percentile do you use most often when obtaining pricing from a national database? (N=88)



Distribution by Method to Determine Cost

Respondents were asked to indicate how they determine a cost when using national databases (Figure 20). Over a third use one database to determine cost, while over a quarter use the median of multiple databases. A couple of those who selected Other indicated that they use a range rather than a median.

Figure 20: What percentile do you use most often when obtaining pricing from a national database? (N=88)



The Task Force reviewed the responses to these demographic questions and concluded that the sample accurately reflects and is representative of the target population of nurse life care planners in the United States.

Task Statement Ratings

The survey included 160 tasks categorized into five domains (Table 2)

TABLE 2: Domains and Number of Associated Tasks

Domain	Number of Associated Tasks
I: Patient/Evaluee Assessment	48
II: Collaboration with Others	14
III: Life Care Plan Development	33
IV: Cost Research	18
V: Life Care Plan Report Construction	47

Each statement was rated based on both the frequency with which the task is performed and the importance of the task for competent performance. Frequency and Importance values are used because there may be tasks that are performed frequently but are not highly important for competent performance, while other tasks may be performed infrequently but are very important for competent performance. The rating scales were as follows:

Frequency Ratings	Importance Ratings
How often is the task performed as part of the job? 4 = Regularly (67-100% or daily) 3 = Frequently (34-66% or 2-4 times per week) 2 = Occasionally (1-33% or monthly, quarterly or annually) 1 = Never (do not perform)	How important is this task for competent performance? 4 = Extremely Important/ Essential 3 = Moderately Important 2 = Slightly Important/Useful 1 = Minimally/Not Important

Average Ratings

Based on the mean (i.e., weighted average) of the responses to each of the five domains (Table 3), Domain III: Life Care Plan Development received the highest rating for both frequency and importance, followed by Domain V: Life Care Plan Report construction, while Domain IV: Cost Research received the lowest ratings for both frequency and importance. A composite score [(mean frequency plus mean importance) divided by 2] reflected the same trend.

TABLE 3: Average Task Statement Ratings by Domain

Domain	Frequency	Importance	Composite (F+I)/2
I: Patient/Evaluee Assessment	3.4	3.4	3.4
II: Collaboration with Others	3.2	3.4	3.3
III: Life Care Plan Development	3.7	3.8	3.8
IV: Cost Research	2.6	2.8	2.7
V: Life Care Plan Report Construction	3.5	3.6	3.6

Most Frequently Performed and Most Important Tasks

Out of 160 tasks, 91 were rated to be high in frequency (>3.5). Of these, 25 tasks are in Domain I, three tasks in Domain II, 25 tasks in Domain III, five tasks in Domain IV, and 33 tasks in Domain V (Table 4).

Table 4: Tasks Rated High in Frequency (>3.5)

Task	Infrequently	Occasionally	Frequently	Regularly	Summary		
	%	%	%	%	N	Mean	SD
I. Patient/Evaluee Assessment							
1. Use your professional process (e.g., nursing process [assessment, diagnosis, outcome Identification, planning, implementation, evaluation], medical assessment/ diagnosis, psychological assessment/ diagnosis, vocational assessment, etc.)	1.7	0.9	5.2	92.2	115	3.9	0.5
2. Document date of birth	0	0	2.6	97.4	115	4.0	0.2
4. Document gender	3.5	6.1	8.7	81.7	115	3.7	0.7
5. Document current address	5.2	3.5	11.3	80.0	115	3.7	0.8
6. Document marital/relationship status	5.2	7.0	13.9	73.9	115	3.6	0.8
7. Documents date of injury/loss	0	0	3.5	96.5	115	4.0	0.2
8. Documents description of injury/loss	0.9	2.6	5.2	91.3	115	3.9	0.5
9. Document work/education status	0.9	10.4	18.3	70.4	115	3.6	0.7
15. Document daily or routine schedule	1.7	6.1	20.0	72.2	115	3.6	0.7
16. Document functional (ADL's and IADL's) abilities pre/post-incident	0	0.9	5.2	93.9	115	3.9	0.3
17. Document frequency, duration and vendor used for medical supplies/durable medical equipment	2.6	2.6	12.2	82.6	115	3.7	0.6
19. Document symptoms, limitations, and restrictions	0	0.9	3.5	95.7	115	3.9	0.3
22. Document psychosocial status and support system	0	3.5	12.2	84.4	115	3.8	0.5
23. Document medications (pre and post incident) including brand v. generic, dose, frequency, and average use if per diem	0	0	5.2	94.8	115	3.9	0.2
24. Document provider prescribing medications	0	11.3	13.0	75.7	115	3.6	0.7
25. Document mode of transportation	1.7	3.5	15.7	79.1	115	3.7	0.6
26. Document current living arrangement/environment	0	1.7	9.6	88.7	115	3.9	0.4
27. Document name and specialty of current treating providers	0	0	5.3	94.7	114	3.9	0.2
29. Document dates of last and next appointments with providers (or as needed follow up)	2.6	7.9	16.7	72.8	114	3.6	0.7
30. Document current status and treatment plan/patterns	0	1.8	7.0	91.2	114	3.9	0.4
31. Document current home health services	0	2.7	6.2	91.2	113	3.9	0.4
32. Document current durable medical equipment and supplies	0	0	4.4	95.6	113	4.0	0.2

Table 4: Tasks Rated High in Frequency (>3.5)

Task	Infrequently	Occasionally	Frequently	Regularly	Summary		
	%	%	%	%	N	Mean	SD
34. Confirm and document past medical/ surgical history and comorbidities	0	1.8	4.4	93.8	113	3.9	0.3
41. Consider individual and/or family preferences/goals in patient/evaluee assessment	2.7	8.9	15.0	73.5	113	3.6	0.8
42. Include home/environment evaluation/ description for functionality and safety in patient/evaluee assessment	2.7	5.3	12.4	79.7	113	3.7	0.7
II. Collaboration with Others							
1. Use your professional process (e.g., nursing process [assessment, diagnosis, outcome Identification, planning, implementation, evaluation], medical assessment/diagnosis, psychological assessment/diagnosis, vocational assessment, etc.)	1.9	0.9	2.8	94.4	108	3.9	0.5
2. Identify experts/ specialists for case needed for further evaluation	2.8	9.3	17.6	70.4	108	3.6	0.8
10. Rely upon medical records and/or expert reports in absence of physician or medical provider input	2.8	4.6	17.6	75.0	108	3.6	0.7
III. Life Care Plan Development							
63. Use your professional process (e.g., nursing process [assessment, diagnosis, outcome Identification, planning, implementation, evaluation], medical assessment/diagnosis, psychological assessment/diagnosis, vocational assessment, etc.)	2.0	0	4.0	94.0	100	3.9	0.5
64. Identify potential conflicts of interest with referral source	6.0	5.0	8.0	81.0	100	3.6	0.8
4. Review post-morbid medical records	0	2.0	5.0	93.0	100	3.9	0.4
6. Prepare a medical chronology	3.0	5.0	12.0	80.0	100	3.7	0.7
7. Request missing records	0	6.0	11.0	83.0	100	3.8	0.5
10. Review provider and/or expert reports	1.0	1.0	5.0	93.0	100	3.9	0.4
11. Review provider and/or expert depositions	2.0	11.0	10.0	77.0	100	3.6	0.8
12. Document pre-existing conditions	0	1.0	6.0	93.0	100	3.9	0.3
13. Research disease process, clinical practice guidelines, evidence-based resources	0	4.0	20.0	76.0	100	3.7	0.5
14. Determine practice/license specific diagnoses	6.0	6.0	11.0	77.0	100	3.6	0.9
16. Obtain medical experts and/or providers opinion/input regarding the interventions outlined in the Life Care Plan beyond your scope of practice	4.0	5.0	11.0	80.0	100	3.7	0.8

Table 4: Tasks Rated High in Frequency (>3.5)

Task	Infrequently	Occasionally	Frequently	Regularly	Summary		
	%	%	%	%	N	Mean	SD
17. Assess the need for Procedural/Surgical/ Intensive Intervention (e.g., emergency room visits, hospitalizations (non-surgical/surgical), pain management/functional restoration program, therapeutic pain injections, stage 1/stage 2 seizure work up, etc.) either independently or through collaboration with others	0	2.0	7.0	91.0	100	3.9	0.4
18. Assess the need for Home/Facility Care (e.g., attendant care for ADLs, assisted living, skilled nursing, nursing home, group home, etc.) either independently or through collaboration with others	1.0	0	7.0	92.0	100	3.9	0.4
19. Assess the need for Future Medical Care (including primary care, specialists, nutritionist/dietician, case management, dentist, prosthetist/orthotist, ophthalmologist, etc.) either independently or through collaboration with others	0	0	5.0	95.0	100	4.0	0.2
20. Assess the need for Diagnostic Testing (e.g., laboratory studies, imaging studies, etc.) either independently or through collaboration with others	0	1.0	7.0	92.0	100	3.9	0.3
21. Assess the need for Orthotics/Prosthetics (e.g., splints, braces, orthotics, prosthetics, etc.) either independently or through collaboration with others	0	2.0	7.0	91.0	100	3.9	0.4
22. Assess the need for Psychosocial Services (e.g., cognitive behavioral therapy, neurofeedback/biofeedback, etc.) either independently or through collaboration with others	0	2.0	7.0	91.0	100	3.9	0.4
23. Assess the need for Evaluations/ Treatment Sessions (including therapies, health and strength maintenance, inpatient/ outpatient rehabilitation, neuropsychological evaluation/testing, medically supervised weight loss program, community fitness program with/without pool, etc.) either independently or through collaboration with others	0	0	8.0	92.0	100	3.9	0.3

Table 4: Tasks Rated High in Frequency (>3.5)

Task	Infrequently	Occasionally	Frequently	Regularly	Summary		
	%	%	%	%	N	Mean	SD
25. Assess the need for Therapeutic Equipment Needs (including assistive technology, cane, walker, exercise equipment, mattress, safety items [shower bench/chair, raised toilet seat, grab bars, handheld shower head], palliative modalities [e.g., hot/cold wrap, wedge pillows], TENS unit/supplies, etc.) either independently or through collaboration with others	0	0	4.0	96.0	100	4.0	0.2
27. Assess the need for Aids for Independent Function (e.g., reachers/grabbers, adaptive utensils, items to assist with ADLs/IADLs, etc.) either independently or through collaboration with others	0	1.0	2.0	97.0	100	4.0	0.2
28. Assess the need for Drugs/Supplies (e.g., prescriptive and over the counter medications, lotions, bowel/ bladder supplies, etc.) either independently or through collaboration with others	0	0	2.0	98.0	100	4.0	0.1
30. Assess the need for Wheelchair Needs (e.g., wheelchair replacement, cushion replacement, cushion cover, maintenance, batteries, etc.) either independently or through collaboration with others	0	1.0	3.0	96.0	100	4.0	0.3
31. Assess the need for Architectural Renovations (e.g., widening doorways, ramps, roll-in shower, lower height of counters, etc.) either independently or through collaboration with others	3.0	2.0	11.0	84.0	100	3.8	0.6
32. Assess the need for home/Home Maintenance (e.g., lawn/garden care, exterior maintenance, snow removal, IADL Assistant, etc.) either independently or through collaboration with others	2.0	4.0	9.0	85.0	100	3.8	0.6
33. Assess the need for Transportation (e.g., wheelchair accessible vehicle w/conversion, hand controls, left accelerator, Handicap Placard, etc.) either independently or through collaboration with others	1.0	5.0	7.0	87.0	100	3.8	0.6
IV. Cost Research							
1. Obtain costs for items and services in a Life Care Plan using usual, customary, and reasonable/market value costs	1.0	1.0	6.3	91.7	96	3.9	0.4
2. Obtain costs for items and services in a Life Care Plan using standardized medical coding (e.g., CPT, Modifiers, HCPCS, DRG, ICD-10)	2.1	1.0	5.2	91.7	96	3.9	0.5
3. Obtain costs for items and services in a Life Care Plan using geographic specific pricing	1.0	1.0	6.3	91.7	96	3.9	0.4

Table 4: Tasks Rated High in Frequency (>3.5)

Task	Infrequently	Occasionally	Frequently	Regularly	Summary		
	%	%	%	%	N	Mean	SD
4. Obtain costs for items and services in a Life Care Plan using national databases (with geographic adjustment)	4.2	4.2	11.5	80.2	96	3.7	0.7
8. Obtain costs for items and services in a Life Care Plan using internet sources	0	6.3	27.1	66.7	96	3.6	0.6
V. Life Care Plan Report Construction							
1. Use categories/tables to list recommendations in the Life Care Plan for Procedural/Surgical/Intensive Intervention	4.4	2.2	6.7	86.7	90	3.8	0.7
2. Use categories/tables to list recommendations in the Life Care Plan for Home/Facility Care	2.2	1.1	5.6	91.1	90	3.9	0.5
3. Use categories/tables to list recommendations in the Life Care Plan for Future Medical Care	2.2	1.1	5.6	91.1	90	3.9	0.5
4. Use categories/tables to list recommendations in the Life Care Plan for Diagnostic testing	3.3	0	6.7	90.0	90	3.8	0.6
5. Use categories/tables to list recommendations in the Life Care Plan for Orthotics/Prosthetics	2.2	5.6	8.9	83.3	90	3.7	0.7
6. Use categories/tables to list recommendations in the Life Care Plan for Psychosocial Services	2.2	4.4	8.9	84.4	90	3.8	0.6
7. Use categories/tables to list recommendations in the Life Care Plan for Evaluations/Treatment Sessions	3.3	0	5.6	91.1	90	3.8	0.6
9. Use categories/tables to list recommendations in the Life Care Plan for Therapeutic Equipment Needs	2.2	0	4.4	93.3	90	3.9	0.5
11. Use categories/tables to list recommendations in the Life Care Plan for Aids for Independent Function	2.2	1.1	3.3	93.3	90	3.9	0.5
12. Use categories/tables to list recommendations in the Life Care Plan for Drugs/Supplies	2.2	0	2.2	95.6	90	3.9	0.5
13. Use categories/tables to list recommendations in the Life Care Plan for Personal Needs	6.7	4.4	6.7	82.2	90	3.6	0.9
14. Use categories/tables to list recommendations in the Life Care Plan for Wheelchair Needs	2.2	1.1	7.8	88.9	90	3.8	0.5
15. Use categories/tables to list recommendations in the Life Care Plan for Architectural Renovations	5.6	5.6	10.0	78.9	90	3.6	0.8
16. Use categories/tables to list recommendations in the Life Care Plan for Home/Home Maintenance	6.7	7.8	5.6	80.0	90	3.6	0.9

Table 4: Tasks Rated High in Frequency (>3.5)

Task	Infrequently	Occasionally	Frequently	Regularly	Summary		
	%	%	%	%	N	Mean	SD
17. Use categories/tables to list recommendations in the Life Care Plan for Transportation	4.4	5.6	7.8	82.2	90	3.7	0.8
18. Include Recommendation, Service Item, or Nursing Intervention in the Life Care Plan	2.2	4.4	6.7	86.7	90	3.8	0.6
20. Include Frequency/Duration in the Life Care Plan	0	1.1	1.1	97.8	90	4.0	0.2
21. Include Cost in the Life Care Plan	1.1	0	2.2	96.7	90	3.9	0.3
23. Include Source of costs in the Life Care Plan	0	2.2	5.6	92.2	90	3.9	0.4
24. Include medical diagnoses in the Life Care Plan and/or case file	0	1.1	6.7	92.2	90	3.9	0.3
26. Include psychiatric diagnoses (e.g., DSM) in the Life Care Plan and/or case file	4.4	8.9	12.2	74.4	90	3.6	0.8
27. Include surgical procedures, if applicable, in the Life Care Plan and/or case file	0	3.3	6.7	90.0	90	3.9	0.4
29. Include purpose of the life care plan in the Life Care Plan and/or case file	6.7	1.1	6.7	85.6	90	3.7	0.8
30. Include identification of professional process/methodology in the Life Care Plan and/or case file	6.7	2.2	6.7	84.4	90	3.7	0.8
31. Include list of records reviewed in the Life Care Plan and/or case file	0	2.2	5.6	92.2	90	3.9	0.4
32. Include medical timeline/chronology/summary in the Life Care Plan and/or case file	2.2	4.4	7.8	85.6	90	3.8	0.6
35. Include list of medical providers/professionals consulted/source of recommendations in the Life Care Plan and/or case file	2.2	1.1	10.0	86.7	90	3.8	0.6
36. Include foundation for opinions/rationale for recommendations in the Life Care Plan and/or case file	0	2.2	10.0	87.8	90	3.9	0.4
37. Include methodology utilized for costing in the Life Care Plan and/or case file	4.4	0	4.4	91.1	90	3.8	0.6
39. Include costs reflective usual, customary, and reasonable amounts; non-discounted/ non-inflated; known prevailing rates for geographic area in the Life Care Plan and/or case file	0	1.1	2.2	96.7	90	4.0	0.3
45. Include ADL/IADL narrative in the Life Care Plan and/or case file	4.4	3.3	7.8	84.4	90	3.7	0.7
46. Include symptoms, limitations, restrictions in the Life Care Plan and/or case file	0	0	5.6	94.4	90	3.9	0.2
47. Include life expectancy in the Life Care Plan and/or case file	5.6	5.6	4.4	84.4	90	3.7	0.8

Out of 160 tasks, 99 were rated to be high in importance (> 3.5). These include 23 tasks in Domain I, seven tasks in Domain II, 30 tasks in Domain III, five tasks in Domain IV, and 34 tasks in Domain V (Table 5).

Table 5: Tasks Rated High in Importance (>3.5)

Task	Not important	Slightly important	Moderately important	Extremely important	Summary		
	%	%	%	%	N	Mean	SD
I. Patient/Evaluee Assessment							
1. Use your professional process (e.g., nursing process [assessment, diagnosis, outcome Identification, planning, implementation, evaluation], medical assessment/diagnosis, psychological assessment/diagnosis, vocational assessment, etc.)	2.6	0	5.3	92.1	114	3.9	0.5
2. Document date of birth	0	1.8	3.5	94.7	114	3.9	0.3
5. Document current address	7.9	2.6	14.0	75.4	114	3.6	0.9
7. Documents date of injury/loss	0	0.9	1.8	97.4	114	4.0	0.2
8. Documents description of injury/loss	0.9	2.6	6.1	90.4	114	3.9	0.5
15. Document daily or routine schedule	2.6	4.4	22.8	70.2	114	3.6	0.7
16. Document functional (ADL's and IADL's) abilities pre/post-incident	0	0.9	0.9	98.3	114	4.0	0.2
17. Document frequency, duration and vendor used for medical supplies/durable medical equipment	2.6	2.6	10.5	84.2	114	3.8	0.6
18. Document functional assessment measures (% of each ADL and IADL person is able to perform)	6.1	5.3	11.4	77.2	114	3.6	0.8
19. Document symptoms, limitations, and restrictions	0	0.9	0.9	98.3	114	4.0	0.2
22. Document psychosocial status and support system	0	3.5	13.2	83.3	114	3.8	0.5
23. Document medications (pre and post incident) including brand v. generic, dose, frequency, and average use if per diem	0	0	3.5	96.5	114	4.0	0.2
24. Document provider prescribing medications	0	10.5	14.0	75.4	114	3.6	0.7
25. Document mode of transportation	1.8	3.5	15.8	79.0	114	3.7	0.6
26. Document current living arrangement/ environment	0	1.8	7.0	91.2	114	3.9	0.4
27. Document name and specialty of current treating providers	0	0	7.1	92.9	113	3.9	0.3
29. Document dates of last and next appointments with providers (or as needed follow up)	2.7	8.0	16.8	72.6	113	3.6	0.8
30. Document current status and treatment plan/patterns	0	0.9	4.4	94.7	113	3.9	0.3
31. Document current home health services	0	0.9	6.3	92.9	112	3.9	0.3
32. Document current durable medical equipment and supplies	0	0	3.6	96.4	112	4.0	0.2
34. Confirm and document past medical/ surgical history and comorbidities	0	1.8	6.3	92.0	112	3.9	0.4
41. Consider individual and/or family preferences/goals in patient/evaluee assessment	2.7	9.8	15.2	72.3	112	3.6	0.8

Table 5: Tasks Rated High in Importance (>3.5)

Task	Not important	Slightly important	Moderately important	Extremely important	Summary		
	%	%	%	%	N	Mean	SD
42. Include home/environment evaluation/ description for functionality and safety in patient/evaluee assessment	2.7	3.6	11.6	82.1	112	3.7	0.7
II. Collaboration with Others							
1. Use your professional process (e.g., nursing process [assessment, diagnosis, outcome Identification, planning, implementation, evaluation], medical assessment/diagnosis, psychological assessment/diagnosis, vocational assessment, etc.)	1.9	0.9	3.7	93.5	108	3.9	0.5
2. Identify experts/ specialists for case needed for further evaluation	2.8	5.6	15.7	75.9	108	3.6	0.7
3. Consult with experts/specialists on a case	4.6	0.9	18.5	75.9	108	3.7	0.7
5. Request information from and/or in consultation with treating providers (e.g., telephone calls, questionnaires)	3.7	5.6	17.6	73.2	108	3.6	0.8
9. Rely upon clinical practice or published standards of care guidelines in absence of physician or medical provider input	3.7	7.4	18.5	70.4	108	3.6	0.8
10. Rely upon medical records and/or expert reports in absence of physician or medical provider input	1.9	2.8	15.7	79.6	108	3.7	0.6
13. Rely upon professional education, training, and experience in absence of physician or medical provider input	0.9	6.5	15.7	76.9	108	3.7	0.6
III. Life Care Plan Development							
1. Use your professional process (e.g., nursing process [assessment, diagnosis, outcome Identification, planning, implementation, evaluation], medical assessment/diagnosis, psychological assessment/diagnosis, vocational assessment, etc.)	2.0	0	3.0	95.0	100	3.9	0.5
2. Identify potential conflicts of interest with referral source	4.0	0	9.0	87.0	100	3.8	0.6
3. Review pre-morbid medical records	0	10.0	16.0	74.0	100	3.6	0.7
4. Review post-morbid medical records	0	0	6.0	94.0	100	3.9	0.2
6. Prepare a medical chronology	3.0	3.0	14.0	80.0	100	3.7	0.7
7. Request missing records	0	1.0	9.0	90.0	100	3.9	0.3
8. Review academic records, including IEPs, 504s, etc. if pediatric case	5.0	8.0	14.0	73.0	100	3.6	0.8
9. Review additional information (e.g., interrogatories, depositions, declarations)	1.0	10.0	17.0	72.0	100	3.6	0.7
10. Review provider and/or expert reports	1.0	1.0	4.0	94.0	100	3.9	0.4
11. Review provider and/or expert depositions	2.0	4.0	14.0	80.0	100	3.7	0.6
12. Document pre-existing conditions	0	1.0	8.0	91.0	100	3.9	0.3

Table 5: Tasks Rated High in Importance (>3.5)

Task	Not important	Slightly important	Moderately important	Extremely important	Summary		
	%	%	%	%	N	Mean	SD
13. Research disease process, clinical practice guidelines, evidence-based resources	0	4.0	16.0	80.0	100	3.8	0.5
15. Identify expert/specialist/literature source(s) as basis for determination of life expectancy	9.0	6.0	5.0	80.0	100	3.6	1.0
16. Obtain medical experts and/or providers opinion/input regarding the interventions outlined in the Life Care Plan beyond your scope of practice	3.0	2.0	10.0	85.0	100	3.8	0.6
17. Assess the need for Procedural/Surgical/ Intensive Intervention (e.g., emergency room visits, hospitalizations (non-surgical/surgical), pain management/functional restoration program, therapeutic pain injections, stage 1/stage 2 seizure work up, etc.) either independently or through collaboration with others	0	1.0	7.0	92.0	100	3.9	0.3
18. Assess the need for Home/Facility Care (e.g., attendant care for ADLs, assisted living, skilled nursing, nursing home, group home, etc.) either independently or through collaboration with others	0	0	3.0	97.0	100	4.0	0.2
19. Assess the need for Future Medical Care (including primary care, specialists, nutritionist/dietician, case management, dentist, prosthetist/orthotist, ophthalmologist, etc.) either independently or through collaboration with others	0	0	2.0	98.0	100	4.0	0.1
20. Assess the need for Diagnostic Testing (e.g., laboratory studies, imaging studies, etc.) either independently or through collaboration with others	0	1.0	4.0	95.0	100	3.9	0.3
21. Assess the need for Orthotics/Prosthetics (e.g., splints, braces, orthotics, prosthetics, etc.) either independently or through collaboration with others	0	1.0	3.0	96.0	100	4.0	0.3
22. Assess the need for Psychosocial Services (e.g., cognitive behavioral therapy, neurofeedback/biofeedback, etc.) either independently or through collaboration with others	0	1.0	4.0	95.0	100	3.9	0.3

Table 5: Tasks Rated High in Importance (>3.5)

Task	Not important	Slightly important	Moderately important	Extremely important	Summary		
	%	%	%	%	N	Mean	SD
23. Assess the need for Evaluations/ Treatment Sessions (including therapies, health and strength maintenance, inpatient/outpatient rehabilitation, neuropsychological evaluation/testing, medically supervised weight loss program, community fitness program with/without pool, etc.) either independently or through collaboration with others	0	1.0	4.0	95.0	100	3.9	0.3
25. Assess the need for Therapeutic Equipment Needs (including assistive technology, cane, walker, exercise equipment, mattress, safety items [shower bench/chair, raised toilet seat, grab bars, handheld shower head], palliative modalities [e.g., hot/cold wrap, wedge pillows], TENS unit/supplies, etc.) either independently or through collaboration with others	0	0	2.0	98.0	100	4.0	0.1
26. Assess the need for Social/Leisure Needs (including membership in diagnosis related organizations/ magazine subscriptions, etc.) either independently or through collaboration with others	5.0	5.0	17.0	73.0	100	3.6	0.8
27. Assess the need for Aids for Independent Function (e.g., reachers/grabbers, adaptive utensils, items to assist with ADLs/IADLs, etc.) either independently or through collaboration with others	0	0	1.0	99.0	100	4.0	0.1
28. Assess the need for Drugs/Supplies (e.g., prescriptive and over the counter medications, lotions, bowel/ bladder supplies, etc.) either independently or through collaboration with others	0	0	1.0	99.0	100	4.0	0.1
29. Assess the need for Personal Needs (e.g., special needs trust, guardian) either independently or through collaboration with others	5.0	6.0	13.0	76.0	100	3.6	0.8
30. Assess the need for Wheelchair Needs (e.g., wheelchair replacement, cushion replacement, cushion cover, maintenance, batteries, etc.) either independently or through collaboration with others	0	0	2.0	98.0	100	4.0	0.1
31. Assess the need for Architectural Renovations (e.g., widening doorways, ramps, roll-in shower, lower height of counters, etc.) either independently or through collaboration with others	3.0	0	8.0	89.0	100	3.8	0.6

Table 5: Tasks Rated High in Importance (>3.5)

Task	Not important	Slightly important	Moderately important	Extremely important	Summary		
	%	%	%	%	N	Mean	SD
32. Assess the need for home/Home Maintenance (e.g., lawn/garden care, exterior maintenance, snow removal, IADL Assistant, etc.) either independently or through collaboration with others	3.0	2.0	5.0	90.0	100	3.8	0.6
33. Assess the need for Transportation (e.g., wheelchair accessible vehicle w/conversion, hand controls, left accelerator, Handicap Placard, etc.) either independently or through collaboration with others	1.0	1.0	6.0	92.0	100	3.9	0.4
IV. Cost Research							
1. Obtain costs for items and services in a Life Care Plan using usual, customary, and reasonable/market value costs	1.0	0	3.1	95.8	96	3.9	0.3
2. Obtain costs for items and services in a Life Care Plan using standardized medical coding (e.g., CPT, Modifiers, HCPCS, DRG, ICD-10)	2.1	0	3.1	94.8	96	3.9	0.5
3. Obtain costs for items and services in a Life Care Plan using geographic-specific pricing	1.0	2.1	3.1	93.8	96	3.9	0.4
4. Obtain costs for items and services in a Life Care Plan using national databases (with geographic adjustment)	4.2	2.1	10.4	83.3	96	3.7	0.7
8. Obtain costs for items and services in a Life Care Plan using internet sources	0	6.3	21.9	71.9	96	3.7	0.6
V. Life Care Plan Report Construction							
1. Use categories/tables to list recommendations in the Life Care Plan for Procedural/Surgical/Intensive Intervention	4.4	1.1	5.6	88.9	90	3.8	0.7
2. Use categories/tables to list recommendations in the Life Care Plan for Home/Facility Care	2.2	1.1	5.6	91.1	90	3.9	0.5
3. Use categories/tables to list recommendations in the Life Care Plan for Future Medical Care	2.2	0	6.7	91.1	90	3.9	0.5
4. Use categories/tables to list recommendations in the Life Care Plan for Diagnostic testing	3.3	0	6.7	90.0	90	3.8	0.6
5. Use categories/tables to list recommendations in the Life Care Plan for Orthotics/Prosthetics	2.2	0	7.8	90.0	90	3.9	0.5
6. Use categories/tables to list recommendations in the Life Care Plan for Psychosocial Services	2.2	0	8.9	88.9	90	3.8	0.5
7. Use categories/tables to list recommendations in the Life Care Plan for Evaluations/Treatment Sessions	3.3	0	6.7	90.0	90	3.8	0.6
9. Use categories/tables to list recommendations in the Life Care Plan for Therapeutic Equipment Needs	2.2	0	4.4	93.3	90	3.9	0.5

Table 5: Tasks Rated High in Importance (>3.5)

Task	Not important	Slightly important	Moderately important	Extremely important	Summary		
	%	%	%	%	N	Mean	SD
10. Use categories/tables to list recommendations in the Life Care Plan for Social/Leisure Needs	6.7	6.7	11.1	75.6	90	3.6	0.9
11. Use categories/tables to list recommendations in the Life Care Plan for Aids for Independent Function	2.2	0	3.3	94.4	90	3.9	0.5
12. Use categories/tables to list recommendations in the Life Care Plan for Drugs/Supplies	2.2	0	3.3	94.4	90	3.9	0.5
13. Use categories/tables to list recommendations in the Life Care Plan for Personal Needs	6.7	3.3	6.7	83.3	90	3.7	0.8
14. Use categories/tables to list recommendations in the Life Care Plan for Wheelchair Needs	2.2	0	5.6	92.2	90	3.9	0.5
15. Use categories/tables to list recommendations in the Life Care Plan for Architectural Renovations	4.4	2.2	5.6	87.8	90	3.8	0.7
16. Use categories/tables to list recommendations in the Life Care Plan for Home/Home Maintenance	5.6	3.3	5.6	85.6	90	3.7	0.8
17. Use categories/tables to list recommendations in the Life Care Plan for Transportation	4.4	4.4	3.3	87.8	90	3.7	0.7
18. Include Recommendation, Service Item, or Nursing Intervention in the Life Care Plan	1.1	3.3	4.4	91.1	90	3.9	0.5
20. Include Frequency/Duration in the Life Care Plan	0	0	0	100.0	90	4.0	0.0
21. Include Cost in the Life Care Plan	1.1	0	0	98.9	90	4.0	0.3
23. Include Source of costs in the Life Care Plan	0	2.2	2.2	95.6	90	3.9	0.3
24. Include medical diagnoses in the Life Care Plan and/or case file	0	1.1	5.6	93.3	90	3.9	0.3
26. Include psychiatric diagnoses (e.g., DSM) in the Life Care Plan and/or case file	4.4	1.1	8.9	85.6	90	3.8	0.7
27. Include surgical procedures, if applicable, in the Life Care Plan and/or case file	0	1.1	3.3	95.6	90	3.9	0.3
29. Include purpose of the life care plan in the Life Care Plan and/or case file	7.8	2.2	5.6	84.4	90	3.7	0.9
30. Include identification of professional process/methodology in the Life Care Plan and/or case file	6.7	3.3	6.7	83.3	90	3.7	0.8
31. Include list of records reviewed in the Life Care Plan and/or case file	1.1	1.1	5.6	92.2	90	3.9	0.4
32. Include medical timeline/chronology/ summary in the Life Care Plan and/or case file	2.2	3.3	13.3	81.1	90	3.7	0.6

Table 5: Tasks Rated High in Importance (>3.5)

Task	Not important	Slightly important	Moderately important	Extremely important	Summary		
	%	%	%	%	N	Mean	SD
35. Include list of medical providers/ professionals consulted/source of recommendations in the Life Care Plan and/or case file	2.2	0	7.8	90.0	90	3.9	0.5
36. Include foundation for opinions/rationale for recommendations in the Life Care Plan and/or case file	0	0	8.9	91.1	90	3.9	0.3
37. Include methodology utilized for costing in the Life Care Plan and/or case file	3.3	0	5.6	91.1	90	3.8	0.6
39. Include costs reflective usual, customary, and reasonable amounts; non-discounted/ non-inflated; known prevailing rates for geographic area in the Life Care Plan and/or case file	0	1.1	2.2	96.7	90	4.0	0.3
45. Include ADL/IADL narrative in the Life Care Plan and/or case file	3.3	4.4	5.6	86.7	90	3.8	0.7
46. Include symptoms, limitations, restrictions in the Life Care Plan and/or case file	0	1.1	4.4	94.4	90	3.9	0.3
47. Include life expectancy in the Life Care Plan and/or case file	6.7	4.4	4.4	84.4	90	3.7	0.8

Least Frequently Performed and Least Important Tasks

Seven tasks received low ratings (<2.0) for frequency (Table 6), and three tasks received low ratings (<2.0) for importance (Table 7).

Table 6: Tasks Rated Low in Frequency (<2.0)

Task	Infrequently	Occasionally	Frequently	Regularly	Summary		
	%	%	%	%	N	Mean	SD
I. Patient/Evaluee Assessment							
47. Include Day in the Life Video in patient/ evaluee assessment	46.0	34.5	7.1	12.4	113	1.9	1.0
48. Include Expert Evaluation Video in patient/evaluee assessment	66.4	16.8	7.1	9.7	113	1.6	1.0
IV. Cost Research							
15. Obtain costs for items and services in a Life Care Plan using the Medicare fee schedule	51.0	25.0	14.6	9.4	96	1.8	1.0
16. Obtain costs for items and services in a Life Care Plan using Medicaid/MediCal	70.8	16.7	7.3	5.2	96	1.5	0.8
17. Obtain costs for items and services in a Life Care Plan using private health insurance	77.1	12.5	5.2	5.2	96	1.4	0.8
V. Life Care Plan Report Construction							
41. Include photo of the patient/evaluee in the Life Care Plan and/or case file	53.3	21.1	11.1	14.4	90	1.9	1.1
42. Include video of the patient/evaluee in the Life Care Plan and/or case file	67.8	23.3	1.1	7.8	90	1.5	0.9

Table 7: Tasks Rated Low in Importance (<2.0)

Task	Not important	Slightly important	Moderately important	Extremely important	Summary		
	%	%	%	%	N	Mean	SD
IV. Cost Research							
16. Obtain costs for items and services in a Life Care Plan using Medicaid/MediCal	67.7	11.5	10.4	10.4	96	1.6	1.0
17. Obtain costs for items and services in a Life Care Plan using private health insurance	70.8	10.4	7.3	11.5	96	1.6	1.0
V. Life Care Plan Report Construction							
42. Include video of the patient/evaluee in the Life Care Plan and/or case file	53.3	25.6	7.8	13.3	90	1.8	1.1

The Task Force reviewed these tasks to assess their relevance for the CNLCP® portfolio examination. They commented that IV-16 and IV-17 are not considered best practice, and that V-42 is not done as often as a photo of the patient/evaluee. They therefore decided to remove these three tasks from the CNLCP® examination content outline, as they were rated as low (<2.0) in both frequency and importance.

Knowledge Areas

The respondents were asked to rate 36 knowledge areas as to how important each knowledge area is to competent performance as a nurse life care planner. The scale was the same as that used to rate the importance of tasks. All 36 knowledge areas were rated as high in importance (>3.5); therefore, none of the knowledge areas was rated low (<2.0) in importance.

Knowledge areas include:

General

1. Professional scope of practice
2. Professional process (e.g., nursing process [assessment, diagnosis, outcome Identification, planning, implementation, evaluation], medical assessment/ diagnosis, psychological assessment/diagnosis, vocational assessment, etc.)
3. Life care planning process/methodology
4. Illness/injury processes
5. Life care plan construction
6. Coding/Costing research

Illness/Injury Processes: Spinal Cord Injury, Burns and Amputations, Brain Injuries, Neonatal and Pediatric Injuries/ Illnesses, and Chronic Pain

1. Anatomy and pathophysiology
2. Common signs/symptoms/functional limitations
3. Actual/potential complications
4. Treatment/management (e.g., evaluations, testing, therapies, procedures [invasive and non-invasive], medications, injections/blocks, etc.)
5. Psychosocial aspects (e.g., patient/evaluee, family)
6. Typical or expected physiology of aging

Development of Test Specifications

The responses of the participants who completed the survey were tabulated, and cross-tabulations of the data according to several demographic variables were analyzed by PTC. The results suggested that the respondents were representative of the target population of nurse life care planners.

The Task Force reviewed and discussed the data results, including the highest and lowest ratings, for the task statements, knowledge areas, and domains. The method PTC used to calculate the weightings for the domains in the test specifications is based on the average task statement ratings for frequency and importance. The results are shown below

Proposed Test Specifications for the CNLCP® Certification Examination

Domain	Number of Associated Tasks	Sum of task frequency * task importance	Weighting (%)
I: Patient/Evaluee Assessment	48	11.3	19.6%
II: Collaboration with Others	14	11.0	19.1%
III: Life Care Plan Development	33	14.1	24.4%
IV: Cost Research	16	8.2	14.2%
V: Life Care Plan Report Construction	46	13.1	22.7%

The Task Force reviewed the results and came to a consensus that the weightings are appropriate for the CNLCP® Portfolio Examination. They recommended that the percentages be rounded to the nearest whole number. The Steering Committee accepted the recommendations of the Task Force. The results are shown below.

Test Specifications for the CNLCP® Certification Examination

Domain	Number of Associated Tasks	Sum of task frequency * task importance	Weighting (%)
I: Patient/Evaluee Assessment	48	11.3	20%
II: Collaboration with Others	14	11.0	19%
III: Life Care Plan Development	33	14.1	24%
IV: Cost Research	16	8.2	14%
V: Life Care Plan Report Construction	46	13.1	23%

The Content Outline of domains and tasks for the CNLCP® Portfolio Examination can be found in the CNLCP® Handbook for Candidates.

REFERENCES

Accreditation Board for Specialty Nursing Certification (2022). *Accreditation Standards for Portfolio Assessment Certification Programs*. Retrieved February 21, 2025, from https://absnc.org/certification/accreditation-standards-portfolio-assessment-certification

Accreditation Board for Specialty Nursing Certification (2024). *Accreditation Application Instructions*. Retrieved February 21, 2025, from https://absnc.org/certification/accreditation-application-instructions

Sturges-Vera, Karen. *Understanding the Job Task Analysis Process*. April 30, 2024. Retrieved February 21, 2025, from https://ptcny.com/understanding-job-task-analysis-process/

Universal Life Care Planner Certification Board Announces the Launch of the Certified Nurse Life Care Planner (CNLCP®) Portfolio Examination

[Concord, NH] – [January 13, 2025] – The Universal Life Care Planner Certification Board (ULCPCB™) is pleased to announce the launch of their psychometrically sound Certified Nurse Life Care Planner (CNLCP®) Portfolio Examination.

Certification through Portfolio Examination is designed to objectively assess the Candidate's ability to apply their specialized knowledge, understanding, and expertise in professional practice through review of an industry-relevant case scenario and arrival at supportable recommendations and a credible report.

Certification in Nurse Life Care Planning provides:

- Formal recognition of those individuals who have met the eligibility requirements determined by the Universal Life Care Planner Certification Board and passed the Certification Portfolio Examination for nurse life care planners, thereby permitting an RN to use the CNLCP® credential.
- Encouragement of continued personal and professional growth in the practice of nurse life care planning through certification maintenance requirements.
- Assurance to employers, the public, and members of the healthcare professions of the existence of a basic requisite level of knowledge in the specialty of nurse life care planning.

The Universal Life Care Planner Certification Board, statement:
"We are excited to introduce the CNLCP® Portfolio Examination as an innovative and rigorous tool for assessing the competencies of nurse life care planners. This updated approach to assessing one's knowledge ensures that certified nurses meet the highest standards of practice.

"The CNLCP® certification through portfolio examination represents a significant milestone in the specialty practice of nurse life care planning, highlighting the essential role that registered nurses play in creating comprehensive, long-term care plans."

About the Universal Life Care Planner Certification Board
The Universal Life Care Planner Certification Board (ULCPCB™) is a pivotal organization dedicated to promoting excellence in life care planning certification. Through certification, education, and professional development, the ULCPCB™ seeks to elevate the standards and practices of life care planning to ensure optimal outcomes for individuals with complex health needs.

For additional information, including exam requirements, registration details and resources, visit www.ulcpcb.org.
Contact:
Shirley Daugherty, MS, RN, FNP-C, CNLCP®, CHLCP™, MSCC
Secretary
Universal Life Care Planner Certification Board
shirley@daugherty-legalnurse.com

USING PERMANENT IMPAIRMENTS IN LIFE CARE PLANS

By Dr. Colarusso, DC, CLCP, CME, CICE, Designated Rating Physician, State of Nevada

Keywords: 1) Impairment Rating 2) Permanent Partial Disability (PPD) rating 3) Maximum Medical Improvement

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

Decreased activity tolerance
Chronic pain
Impaired physical mobility
Impaired Physical Mobility
Risk for Injury

Impairment ratings and support have long been used as a part of worker compensation cases. However, they are becoming increasingly common beyond workers' compensation, with their use in personal injury cases expected to grow. As Life Care Planners, we will encounter these expert reports more frequently, making understanding their purpose and application essential.

A life care plan provides a comprehensive roadmap for addressing an individual's future medical, rehabilitation, and support needs due to injury or illness. It considers critical factors such as the extent of the injury, pre-existing medical conditions, age, life expectancy, and the projected impact of the injury on the individual's overall health and daily life. This information enables life care planners to estimate the long-term costs of medical care and daily living support.

Injury as the Foundation of Life Care Plans

Every life care plan begins with an injury or illness. Legally, these conditions may also be classified as impairments, defined by the AMA Guides to the Evaluation of Permanent Impairment (commonly referred to as the "Guides") as a "loss of function, use, or derangement of a body part, organ system, or organ function" (AMA, 2002).

Life care plans primarily focus on permanent impairments or lifetime injuries. The Guides define a permanent impairment as one that has reached Maximum Medical Improvement (MMI)—a point where the condition is unlikely to improve significantly, even with further treatment. Consequently, life care plans inherently rely on the evaluation of permanent impairments.

The AMA Guides to the Evaluation of Permanent Impairment

The Guides, first published in 1971, have undergone six editions, evolving into a widely recognized framework. Today, 47 states either adopted or regularly consult the Guides to evaluate and quantify impairments resulting from workplace injuries or illnesses.

Impairment Evaluations

The following components must be completed as part of the impairment evaluation:

- Conducted by physicians specifically trained in the Guides.
- The physician must be independent and unaffiliated with either the plaintiff or the defendant to ensure impartiality.
- Evaluations include:
  - Comprehensive medical record review: Examines diagnostic tests and history.
  - Focused physical examination: Assesses the affected body part(s).
- The result is an impairment rating report quantifying:
  - The degree of long-term loss of function.
  - The impact on the individual's ability to perform Activities of Daily Living (ADLs).

The Gold Standard

The Guides establish a consistent, objective methodology for assessing permanent impairments, making impairment ratings the standard for determining fair compensation in work-related injury cases across most of the U.S.

Impairment Ratings in Personal Injury Cases

Impairment ratings have become invaluable tools in personal injury cases for pre-litigation negotiations, mediations, and trials. They provide an objective basis for resolving compensation and care needs disputes.

The following are the key advantages of impairment ratings

1. Unbiased Evaluations

- Performed by independent medical experts trained in the Guides.
- Comparable to an independent medical examination in its impartiality.

2. Quantified Impairment

- The injury's impact is expressed as a measurable percentage of whole-body impairment.
- The rating can support or contest financial awards or benefits to address medical costs and income loss.

3. Permanency

- Document long-term functional losses that will persist throughout the individual's lifetime.

4. Causation

- Links the impairment directly to a specific incident or event.

5. Impact on ADLs

- Evaluates how the impairment affects daily living, forming a basis for compensating reduced quality of life and independence.

Integration into Life Care Plans

Impairment ratings provide critical insights for life care planning, enabling accurate projections of future medical needs and costs. The results of an impairment rating can not only identify but also justify areas of future costs, procedures, and home health needs.

- Future Medical Costs: Justifies ongoing treatments, therapies, and interventions over the individual's lifetime.
- Home Health and Modifications: Quantifies the need for home care services and environmental adaptations based on impairment severity.
- Impact on ADLs: Informs the plan on the level of assistance required for everyday activities.
- Life Expectancy Consideration: Ensures the plan's provisions cover the individual's entire projected lifespan.

A common personal injury case may concern a client who was involved in a motor vehicle wreck. For example, let's say injuries were reported to his right shoulder and lower back. Lumbar MRI revealed multi-level disk protrusions. The shoulder MRI demonstrated a torn labrum and partial supraspinatus tear. The client received physical therapy to the shoulder for twelve weeks with marginal improvement in regard to pain and function. Physical therapy was also provided to the lumbar spine along with pain management, which included injections to the facet joints at multiple lumbar levels. Ultimately, shoulder surgery was performed, and the lumbar spine was recommended for radio frequency ablations (RFAs) for medial branch nerve irritation, which was causing continued pain and physical limitations.

The client was deemed at maximal medical improvement by his treating physicians after 12 weeks post shoulder surgery and RFAs to the lumbar spine. His law firm then ordered an independent medical evaluation, including a permanent impairment rating and life care plan.

The independent rating physician determined the client had suffered injuries causally associated with the motor

vehicle accident on record. Moreover, his injuries to the shoulder and lumbar spine had been appropriately treated, however, both body parts (shoulder and lumbar spine) continued to suffer from chronic and permanent impairments. The rating found a 10% whole-person impairment in the lumbar spine based on multiple-level involvement and muscle guarding. An additional 2% whole person impairment was added due to limitations upon the client's ADLs. The shoulder was found to have permanent loss of motion during flexion and abduction, which resulted in an 8% whole-person impairment based on the AMA Guides. A final whole person was determined by combining (not adding) the 10% lumbar spine impairment, 2% ADL impairment, along with the 8% shoulder impairment for a total of 19% impairment.

The independent impairment rating was then incorporated into a life care plan. The permanent injuries, including the continued limitations in ADLs, justified ongoing medical and rehabilitation needs.

The life care plan included:

- Annual Pain Management Appointments
- Annual Neurology Follow-ups for peripheral/spinal nerve assessment and NCV/EMG testing.
- Physical therapy sessions to manage pain and maintain mobility in the shoulder and spine 24 sessions every 3 years
- Diagnostic Testing: To monitor shoulder and lumbar spine conditions, periodic diagnostic tests will be necessary:
  - MRI (every 5 years): Shoulder, Lumbar Spine
  - X-rays (every 3 years): Shoulder, Lumbar Spine
- Interventional Procedures for Pain Management
  - Radiofrequency Ablation (RFA) for Chronic Pain Management (Lumbar Spine) (every 1-2 years)
- Assisted Living & Personal Care Needs: As Mr. Phillips ages, his pain and physical limitations will likely necessitate home assistance.
  - Housekeeping, cleaning, and ADL support (starting at age 70, 10 hours/week for 6 years)

This life care plan is structured to provide ongoing medical treatment, rehabilitation, and supportive care necessary for the client's recovery and long-term well-being. The impairment rating report serves as crucial medical evidence to project future costs and treatment needs, ensuring financial planning for his care is both comprehensive and realistic.

Impairment Report: Is It Valid?

As impairment reports become more common in life care planning, it raises a critical question: Is this impairment report valid?

For an impairment rating report to be valid, it must be authored by a formally trained physician (MD, DO, or DC) with expertise in The Guides. The physician must conduct a thorough medical records review, physically examine the injured party, and accurately calculate the permanent impairment percentage of the affected body part(s).

Lifecare planners who come across an impairment rating should verify the impairment percentage by enlisting another rating physician trained in the same edition of The Guides to confirm the validity of the whole-person impairment assessment. This process ensures an accurate representation of the individual's injuries and their lasting impact on ADLs.

The rating physician should always be independent of the provider creating the life care plan. This ensures an objective and unbiased application of an impairment rating when used in a life care plan.

Conclusion

Permanent impairments can help form the cornerstone of effective life care plans. By using the standardized methodology of the AMA Guides, impairment ratings ensure that plans are objective, comprehensive, and tailored to the unique needs of the injured individual. Impairment ratings bridge the gap between a person's catastrophic or non-catastrophic injury and the legal or financial decision-making, providing a reliable foundation for fair compensation and lifelong care.

REFERENCE

AMA. (2002). *AMA Guides® to the Evaluation of Permanent Impairment* (5th ed., 2nd printing). Accessed March 5, 2025, from https://www.ama-assn.org/delivering-care/ama-guides/ama-guides-evaluation-permanent-impairment-overview

Updated Diagnostic Criteria for mTBI

By Becky Czarnik, RN, MS, CNLCP, CMSP-F

Keywords: 1) Concussion 2) Mild traumatic brain injury 3) mTBI 4) PCSS 5) TBI 6) Neurological sequelae mTBI

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

Altered thought process

Impaired memory

Impaired mood regulation

Post Trauma syndrome

Neurobehavioral Responses, Ineffective Emotion Regulation (this might be an old diagnosis)

Disturbed sensory perception

The American Congress of Rehabilitation Medicine (ACRM) updated its 1993 diagnostic criteria for mild traumatic brain injury (mTBI) based on a few factors. The new definition was based on the following factors:

- Advances in neuroscience and diagnostic capabilities
- Inconsistencies across previous definitions
- The need for unified criteria usable across civilian, military, and sports settings

The Mild Traumatic Brain Injury Task Force of the American Congress of Rehabilitation Medicine Brain Injury Special Interest Group convened a Working Group of 17 members and an external interdisciplinary expert panel of 32 clinician-scientists. Public stakeholder feedback was analyzed from 68 individuals and 23 organizations. The new criteria were developed using evidence reviews and a Delphi expert consensus process, achieving over 90% agreement among international specialists.

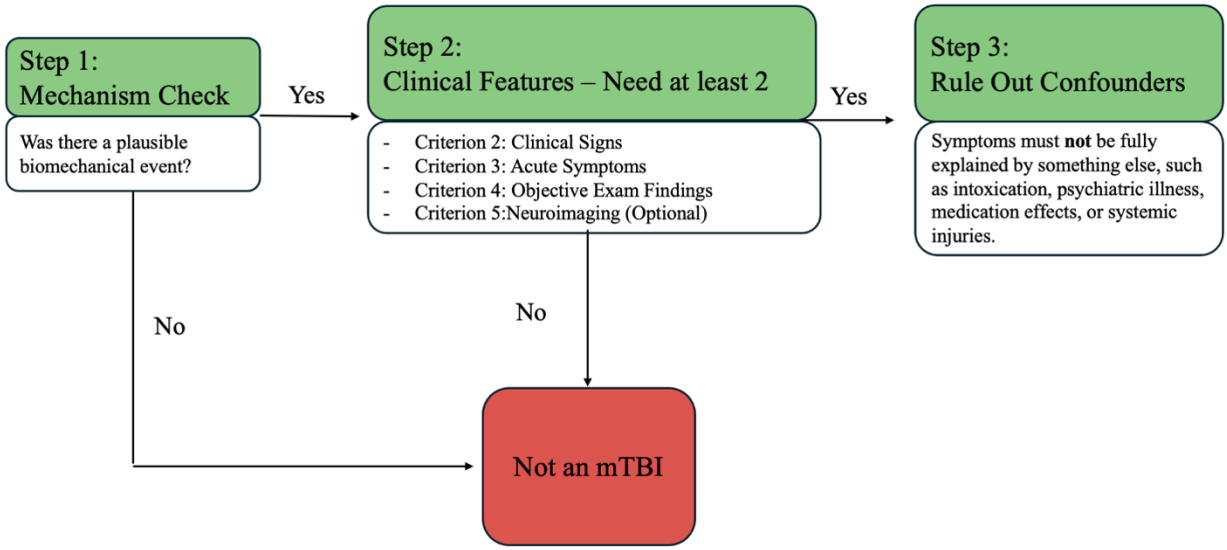
The updated report on the Diagnostic Criteria for Mild Traumatic Brain Injury was published in the Archives of Physical Medicine and Rehabilitation (Silverberg et al., 2023). This work was developed through an evidence review and expert consensus process. The goal of these updated diagnostic criteria for mTBI is to improve the quality and consistency of mTBI research and clinical care. The Brain Injury Association of America has also acknowledged some of the problems that arise when people fail to realize the potential problems that can arise when a person sustains a concussion.

Clinician-Friendly Summary: 2023 ACRM Diagnostic Criteria for mTBI

Definition of Mild Traumatic Brain Injury: mTBI is a traumatically induced disturbance of brain function caused by an external force, requiring a biomechanically plausible mechanism and supported by clinical evidence of acute brain dysfunction.

The following is a flowchart of the updated diagnoses and a more detailed look at each of the steps and criteria.

Summary of the 2023 ACRM Diagnostic Criteria for mTBI



Stepwise Diagnostic Checklist

1. Mechanism Check - Was there a plausible biomechanical event, such as a head strike, whiplash, or blast exposure?
   - If yes, continue to the next check.
   - If no, mTBI not diagnosed under the new ACRM criteria.

2. Clinical Features (Need ≥1)

Criterion 2: Clinical Signs

- Loss of consciousness (LOC < 30 mins)
- Post-traumatic amnesia (PTA < 24 hours)
- Altered mental status at time of injury, such as confused or dazed
- Neurological signs, such as seizures or balance issues

Criterion 3: Acute Symptoms (Need ≥2 within 72 hours)

- Headache
- Dizziness or balance problems
- Blurred vision
- Mental fog or concentration issues
- Sleep disturbance
- Emotional changes, such as irritability or anxiety

Criterion 4: Objective Exam Findings (Need ≥1)

- Cognitive impairment, such as poor memory or attention
- Balance or gait abnormalities
- Abnormal eye movements, such as saccades or convergence
- Blood-based biomarkers (if available), such as the i-Stat™ TBI Plasma blood test

Criterion 5: Neuroimaging (Optional)

- CT/MRI showing intracranial trauma, such as a small hemorrhage *(Still considered "mild" if LOC <30 mins, PTA <24 hours, and GCS ≥13)*
- 93.8% of the experts agreed that the terms Concussion and mTBI are interchangeable when neuroimaging is normal or not indicated.

3. Rule Out Confounders (Criterion 6)

- Symptoms must **not** be fully explained by something else, such as intoxication, psychiatric illness, medication effects, or systemic injuries.

Defining a Suspected mTBI

The experts recommended the new term, suspected mTBI. This new term will be introduced to manage diagnostic uncertainty when the data is incomplete or confounding factors are present. This emphasizes clinical judgement and a "when in doubt, treat it out" approach.

The significance of these updated criteria is to validate that a concussion is a form of brain injury caused by biomechanical force. By confirming that a concussion is a mild Traumatic Brain Injury, clinicians can reinforce the neurological seriousness of this condition, rather than minimizing it as a benign bump on the head. When an mTBI is minimized, individuals return to play, school, or work prematurely, which can lead to worsening symptoms, a prolonged recovery, or second impact syndrome (a second

concussion shortly after the first, that compounds the symptoms).

Risks Caused by Incorrectly Identifying mTBIs

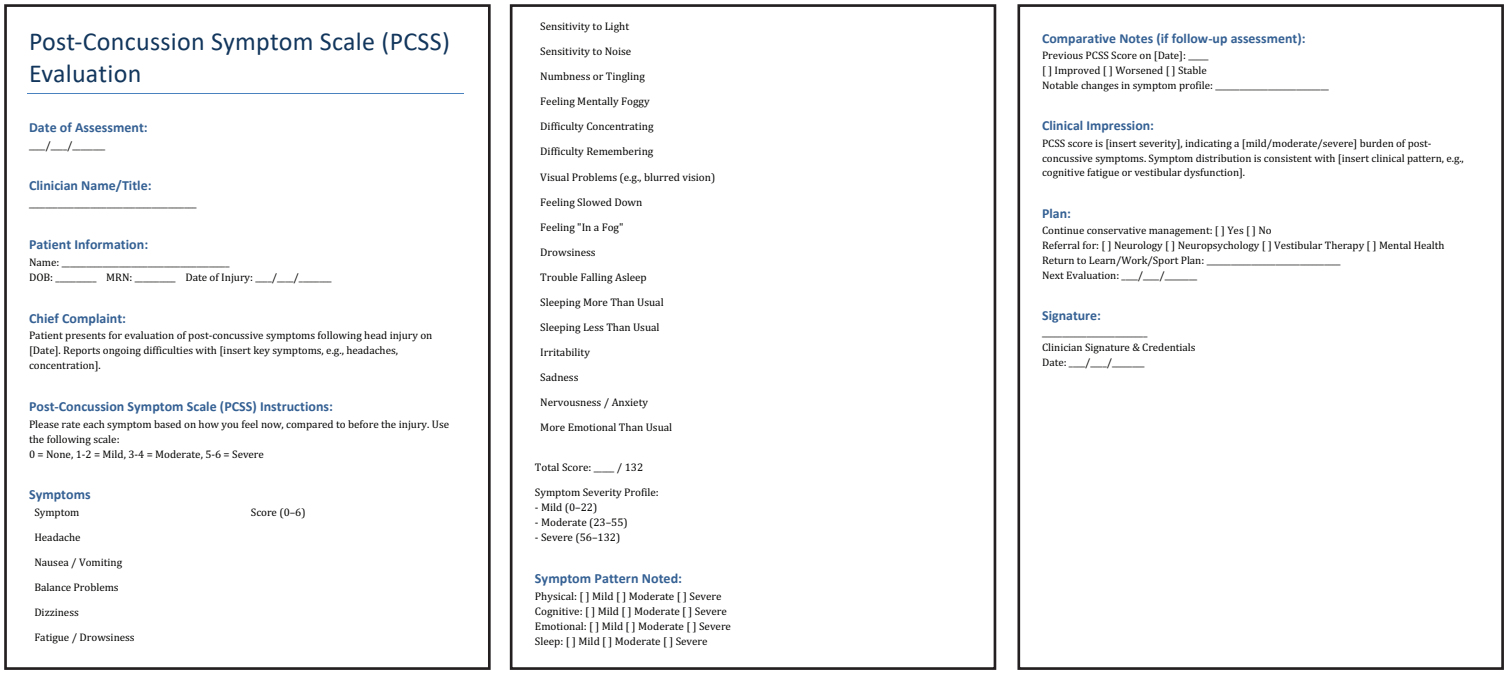
The risk of using the incorrect terminology or downplaying the significance of an mTBI may lead to a lack of recognition of delayed cognitive deficits. **There is an outdated timeline suggesting that most individuals with a concussion will recover within 7 to 10 days**. The Brain Injury Association of America conducted a survey that showed that 81% of American adults are unaware that concussions are a type of TBI. This can have serious repercussions, as they are more likely to ignore symptoms and issues that result from concussions, with roughly half of the participants misidentifying at least one symptom of concussions (BIAA, 2025).

According to a University of Michigan-led study, part of the NCAA-DoD Concussion Assessment, Research and Education Consortium (Broglio, 2022), represents the most extensive research on concussion recovery among collegiate athletes to date. The study advocates for a revised understanding that a 28-day recovery period is typical for most collegiate athletes. This adjustment aims to alleviate undue pressure on athletes to return to play prematurely and to normalize longer recovery durations. While most Life Care Plans are not written for collegiate athletes, it is important to recognize this new recovery time expectation and to evaluate the documentation of the lack of resolution of the post-concussion symptoms.

To properly address mTBIs, the Post Concussion Symptom Scale (PCSS) is widely recognized as a component of best clinical practice for the assessment and management of concussions, particularly in sports medicine, neurology, rehabilitation, and primary care settings (McCroy, et al, 2017; CDC; NCAA, Department of Veterans Affairs & Department of Defense, 2016). The use of the PCSS provides a quantifiable, structured format for monitoring symptom evolution and detecting prolonged recovery or complications like Post-Concussion Syndrome. It is an easy-to-use tool to administer and score, making it accessible for healthcare professionals of all experience levels. This also makes it easy for a diverse patient population who vary in levels of education, socioeconomic status, linguistic and cultural backgrounds, age, and disability. And it exerts a relatively low cognitive and physical demand on the individual when administered. The PCSS tool is globally recognized as a research-validated, accurate instrument for assessing post-concussion symptoms (Nelson, 2024).

The use of the PCSS scores provides objective and repeatable documentation of subjective complaints. The following are a sample of the PCSS evaluation and a sample of the PCSS symptom tracking.

PCSS Evaluation



Post-Concussion Symptom Scale (PCSS) Evaluation

Date of Assessment:
___/___/_____

Clinician Name/Title:
_____

Patient Information:
Name: _____
DOB: _____ MRN: _____ Date of Injury: ___/___/_____

Chief Complaint:
Patient presents for evaluation of post-concussive symptoms following head injury on [Date]. Reports ongoing difficulties with [insert key symptoms, e.g., headaches, concentration].

Post-Concussion Symptom Scale (PCSS) Instructions:
Please rate each symptom based on how you feel now, compared to before the injury. Use the following scale:
0 = None, 1-2 = Mild, 3-4 = Moderate, 5-6 = Severe

Symptoms

Symptom	Score (0–6)
Headache	
Nausea / Vomiting	
Balance Problems	
Dizziness	
Fatigue / Drowsiness	
Sensitivity to Light	
Sensitivity to Noise	
Numbness or Tingling	
Feeling Mentally Foggy	
Difficulty Concentrating	
Difficulty Remembering	
Visual Problems (e.g., blurred vision)	
Feeling Slowed Down	
Feeling "In a Fog"	
Drowsiness	
Trouble Falling Asleep	
Sleeping More Than Usual	
Sleeping Less Than Usual	
Irritability	
Sadness	
Nervousness / Anxiety	
More Emotional Than Usual	

Total Score: ____ / 132

Symptom Severity Profile:
- Mild (0–22)
- Moderate (23–55)
- Severe (56–132)

Symptom Pattern Noted:
Physical: [ ] Mild [ ] Moderate [ ] Severe
Cognitive: [ ] Mild [ ] Moderate [ ] Severe
Emotional: [ ] Mild [ ] Moderate [ ] Severe
Sleep: [ ] Mild [ ] Moderate [ ] Severe

Comparative Notes (if follow-up assessment):
Previous PCSS Score on [Date]: ____
[ ] Improved [ ] Worsened [ ] Stable
Notable changes in symptom profile: _____

Clinical Impression:
PCSS score is [insert severity], indicating a [mild/moderate/severe] burden of post-concussive symptoms. Symptom distribution is consistent with [insert clinical pattern, e.g., cognitive fatigue or vestibular dysfunction].

Plan:
Continue conservative management: [ ] Yes [ ] No
Referral for: [ ] Neurology [ ] Neuropsychology [ ] Vestibular Therapy [ ] Mental Health
Return to Learn/Work/Sport Plan: _____
Next Evaluation: ___/___/_____

Signature:
_____
Clinician Signature & Credentials
Date: ___/___/_____

PCSS Multi-day Tracking Template

Post Concussive Symptom Scale	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Symptoms							
Fatigue							
Trouble falling asleep							
Sleeping more than usual							
Sleeping less than usual							
Drowsiness							
Sensitivity to light							
Sensitivity to noise							
Irritability							
Sadness							
Nervousness or anxiety							
Feeling more emotional							
Numbness or tingling							
Feeling slowed down							
Feeling mentally 'foggy'							
Difficulty concentrating							
Difficulty remembering							
Visual problems (e.g., blurred or double vision)							
Total Score	0	0	0	0	0	0	0

Interpretation Guidelines
0–22: Minimal symptoms
23–44: Mild symptoms
45–88: Moderate symptoms
89–132: Severe symptoms (monitor closely)

Scale
0=None, 1-2=Mild, 3-4=Mod, 5-6=Severe

How the New Definition Helps Life Care Planners

As a Life Care Planner, it is important to use the correct terminology of mTBI. The term "mild" refers to the severity of the initial presentation of the injury, not the impact on the long-term function. The neurological sequelae of an mTBI may be subtle but persistent and can impact daily functioning. These deficits may include the following:

- Cognitive impairment, such as memory, attention, and executive function
- Emotional dysregulation, such as anxiety, depression, and irritability
- Sensory issues, such as light/noise sensitivity, and vision problems
- Persistent Post-Concussive Symptoms.

As a result of these neurological sequelae, an individual who has suffered an mTBI may require ongoing support services, such as the following:

- Neuropsychological evaluation
- Cognitive rehabilitation
- Occupational therapy services
- Visual rehabilitation
- Vocational retraining
- Behavioral health counseling
- Medication management.

It is important for Life Care Planners to use clinically accurate language when describing an mTBI. The updated mTBI classification and its implications are supported by clinical neuroscience, rehabilitation medicine, and evidence-

based practice standards. By compiling the serial PCSS scores from provider visits, or "translating" the patient's subjective complaints in the medical records into a PCSS score, the Life Care Planner can provide the documentation needed to demonstrate ongoing cognitive deficiencies. The use of the PCSS score permits the Life Care Planner to provide the documentation of subjective complaints in an objective format to demonstrate ongoing cognitive deficits. Reframing a concussion as an mTBI and using the PCSS ensures accurate communication of medical severity, rehabilitation, and long-term care needs, ongoing functional limitations, and resource justification in your Life Care Plan.

REFERENCES

Silverberg, N. D., Iverson, G. L., Cogan, A., Dams-O'Connor, K., Delmonico, R., Graf, M. J. P., Iaccarino, M. A., Kajankova, M., Kamins, J., McCulloch, K. L., McKinney, G., Nagele, D., Panenka, W. J., Rabinowitz, A. R., Reed, N., Wethe, J. V., Whitehair, V., & ACRM Mild TBI Diagnostic Criteria Expert Consensus Group. (2023). "The American Congress of Rehabilitation Medicine Diagnostic Criteria for Mild Traumatic Brain Injury." *Archives of Physical Medicine and Rehabilitation*, 104(7), 1343–1355. Retrieved April 16, 2025, from https://doi.org/10.1016/j.apmr.2023.03.036

Broglio, S. P., McAllister, T., Katz, B. P., McCrea, M., Harezlak, J., & CARE Consortium Investigators. (2022). "The natural history of sport-related concussion in collegiate athletes: Findings from the NCAA-DoD CARE Consortium." *Sports Medicine*, 52(2), 403–415. Retrieved April 16, 2025, from https://doi.org/10.1007/s40279-021-01553-2

McCrory, P., Meeuwisse, W., Dvorak, J., Aubry, M., Bailes, J., Broglio, S., Cantu, R. C., Cassidy, D., Echemendia, R. J., Castellani, R. J., Davis, G. A., Ellenbogen, R., Emery, C. A., Engebretsen, L., Feddermann-Demont, N., Giza, C. C., Herring, S., Iverson, G. L., Johnston, K. M., ... Vos, P. E. (2017).Consensus statement on concussion in sport—the 5th international conference on concussion in sport held in Berlin, October 2016. British Journal of Sports Medicine, 51(11), 838–847. Retrieved April 16, 2025, from https://doi.org/10.1136/bjsports-2017-097699

Centers for Disease Control and Prevention. (n.d.). *HEADS UP: Concussion and helmet safety*. U.S. Department of Health & Human Services. Retrieved April 16, 2025, from https://www.cdc.gov/headsup/index.html

National Collegiate Athletic Association. (n.d.). *Concussion safety protocol checklist*. Retrieved April 16, 2025, from https://ncaaorg.s3.amazonaws.com/ssi/concussion/SSI_ConcussionSafetyProtocolChecklist.pdf

Department of Veterans Affairs & Department of Defense. (2016). VA/DoD clinical practice guideline for the management of concussion-mild traumatic brain injury. Retrieved April 16, 2025, from https://www.healthquality.va.gov/guidelines/Rehab/mtbi/VADoDmTBICPGFinal508.pdf

Nelson, M. (2024)." The PCSS: When is it Concussion/PCS? Who's at Risk for Delayed Recovery?" *Complete Concussions*. Retrieved April 25, 2025, from https://completeconcussions.com/concussion-baseline-testing/the-pcss-when-is-it-concussion-pcs-whos-at-risk-for-delayed-recovery/

Brain Injury Association of America. (2025). *New National Survey Finds Most Americans Unaware Concussions Are Traumatic Brain Injuries*, March 6, 2025. Retrieved May 5, 2025, from https://biausa.org/public-affairs/public-awareness/news/new-national-survey-finds-most-americans-unaware-concussions-are-traumatic-brain-injuries

Brain Injury Community-Based Support Services:

A Case Study Demonstrating Supportive Services for People Living in the Community Independently

By Melinda Pearson, LMSW, CLCP; Amanda Schmidt, BA; Catherine Latour, CRC, MSAP; and Christy Kniffen, BA, CBIS

Keywords: 1) Life care planners 2) Traumatic brain injury 3) Home and community-based services 4) Assistive technology

This article highlights a successful community-based program that serves as a model for delivering comprehensive supportive services. The program illustrates the future needs of individuals with brain injuries who live independently in the community, whether at home with family or in their own residences with support from service providers assisting with daily tasks, behavioral intervention, counseling, and service coordination. A central feature of this case study is its integration of assistive and smart technologies, which play a pivotal role in enhancing autonomy, safety, and overall quality of life. From voice-activated home controls to remote monitoring systems and telehealth services, technology empowers individuals to manage their environments, communicate effectively, and access critical supports with greater ease. Although life care planners typically do not include collateral resources in formal life care plans, this article aims to showcase the types of services, including cutting-edge technological tools, that promote successful community integration for individuals with brain injuries.

This model is employed within New York State through the Traumatic Brain Injury (TBI) Medicaid Waiver Program. However, it is important to note that access to these services is not guaranteed, due to Medicaid eligibility and the waiver being a collateral funding source that could be defunded. This article presents the program as a model offering a valuable example of service structures that life care planners and other professionals may consider when identifying community supports necessary for individuals living with brain injuries.

A variety of supportive services are available within communities for individuals with TBI under the New York State TBI Medicaid Waiver Program, which provides

services designed to assist individuals in reintegrating into the community following catastrophic injuries (New York State Department of Health, 2009). Many U.S. states offer Home and Community-Based Services (HCBS) waivers to support individuals with brain injuries, helping them live more independently outside of institutional settings. HCBS waivers may provide services like personal care, supported employment, behavioral therapy, and respite care. Each state manages its own waiver programs with different eligibility criteria and available services.

Since it is not a medical model, the focus of this article will be on a case study highlighting the non-medical supportive services, assistive technology, and durable medical equipment. This provides a framework of support to better manage clients with TBI.

Brain Injury Program and Services

Survivors of TBI in New York State benefit from the Home and Community Support Medicaid TBI Brain Injury Support Program. The TBI Waiver Program is specifically designed to assist individuals in achieving independent living within their communities and in supporting person-centered goals.

This program offers a comprehensive range of services tailored to address the diverse needs of participants, promoting both autonomy and an enhanced quality of life. Participants are afforded the dignity of risk, which is the right to make their own choices even if those choices involve some level of risk, and the right to experience setbacks, as well as the freedom to choose their living arrangements, social circles, and personal goals and activities. These services aim to empower individuals, enhance their overall well-being, and facilitate greater independence within their communities (New York State Department of Health, 2009).

The participant's active engagement in these person-centered services is important to their integration process, as many individuals would otherwise remain at home or institutionalized with limited community engagement. It is important to recognize that many families are unable to

Table 1. Waiver Services Chart/A Representative Sample of the Services Offered in the TBI Waiver Program.

SERVICE	PURPOSE
Service Coordination	Assists participant to become a waiver participant and coordinates and monitors services in the service plan.
Community Integration Counseling	Counseling service to help participants cope with altered abilities and skills, revise long-term expectations, and changed roles in relation to significant others.
Positive Behavioral Interventions and Supports	Service provided to participants who have significant behavioral difficulties.
Independent Living Skill Trainer	Conducts functional assessment, training, supervision, assistance to individual issues and self-care in performing activities of daily living. Train formal and informal supports to provide the type and level of supports allowing the participant to become as independent as possible.
Structured Day Program	Outpatient congregate setting or the community to improve or maintain participants' skills and ability to live as independently as possible.
Waiver Transportation	Transportation for non-medical activities which support integration into the community.
Home and Community Support Services	Oversight and/or supervision. Assists with ADL's. Provided under the direction and supervision of a Registered Professional Nurse based on assessment of individual's needs and supported by physician orders.
Substance Abuse Program	Individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the participant.
Respite Care	Relieves informal non-paid supports who provide primary care and support to the participant.
Environmental Modifications Services	Internal and external physical adaptations to the home, including vehicle modifications. Ramps, lifts, widened doorways and hallways, handrails, grab bars, automatic or manual door openers and doorbells. Roll in showers, sinks, tubs, water faucet controls, plumbing adaptations, turnaround space, worktables, cabinet and shelving adaptations. Medically necessary heating/cooling, electrical wiring and plumbing systems, accessible living.
Assistive Technology Services	Supplements State Plan Medicaid Service for Durable Medical Equipment and Supplies.

provide long-term care and support for their loved ones throughout their recovery and beyond. The TBI waiver facilitates a participant's active involvement in the community, enhancing their well-being and overall quality of life. Research by Park et al. (2023) indicates that individuals with a diminished sense of community are more likely to experience higher levels of depression, anxiety, and stress. Conversely, those who feel a strong sense of belonging, support, and purpose within their communities tend to experience greater happiness and resilience (Park et al, 2023).

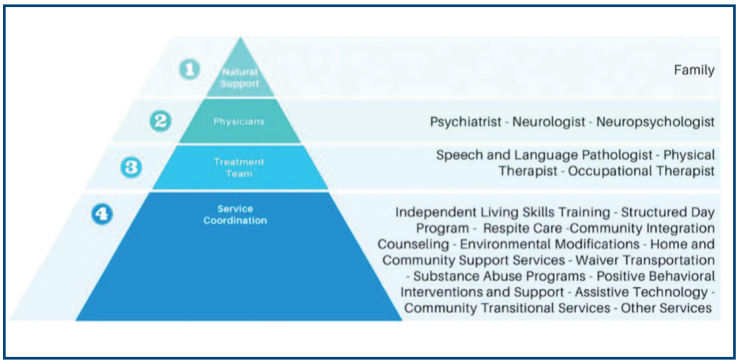
Best practices and collaboration are key to a successful team. The team may include several provider agencies because the program is person-centered, and the individual has the opportunity to choose providers and advocate for their needs, and each person has the right to fail.

The participant serves as the team leader, with the service coordinator ensuring all necessary services are in place. The coordinator is responsible for developing the service plan, which functions similarly to a life care plan by outlining the required services, treatment team, and physicians involved in the participant's care.

The hierarchy chart illustrates that the foundation for independence starts with waiver providers, followed by the treatment team, medical team, and natural supports.

Hierarchy of Treatment Team

Eligibility for the TBI waiver program is determined based on several key criteria. The individual must have a primary diagnosis of TBI or an acquired brain injury. Additionally, the individual must demonstrate a preference for community-based living rather than residing in an institutional setting, such as a nursing facility. Eligibility also requires a formal assessment confirming that the individual meets the level of care typically provided in a nursing facility.



The individual must be enrolled in the Medicaid program and be between the ages of 18 and 64, with the injury occurring after 18.

Many people do not qualify for Medicaid services, and there is no guarantee that a program like this can maintain funding. The programs are designed to be less costly than living in institutions. Although there are challenges with the program, it allows people to maximize their independence and live a meaningful life outside a nursing home.

Case Study

TF is a 40-year-old man who suffered a traumatic brain injury 20 years ago due to a motor vehicle accident. With his closest family member living 30 minutes from him, TF lives alone in his apartment as independently as possible with a team of providers. He relies on his team of providers to maintain safety in the community. TF's first month on the waiver began with 24-hour care to assess safety and service needs. TF experienced distress with constant supervision, and the team understood the challenges he was experiencing. The goal was to fade services out and use assistive technology to decrease person-to-person oversight and supervision.

Table 2. TF Services and Goals

SERVICE	PURPOSE
Service Coordination	• Live independently in the community • Maintain communication with his team • Maintain benefits • Monitor on-going medical care monthly to promote health and well-being
Community Integration Counseling	• Improve problem solving skills by 50 percent over the next 12 months • Each session, report successful utilization of coping mechanisms that improve anxiety
Positive Behavioral Interventions and Supports	• Decrease emotional reactivity • Decrease learned helplessness • Increase awareness of strengths and challenges
Independent Living Skill Trainer	• Provide verbal and visual prompts to schedule medical transportation • Provide verbal and visual prompts for planning grocery shopping • Provide verbal and visual prompts to maintain the apartment • Provide verbal and visual prompts to shop for groceries
Structured Day Program	• Lead meditation group 1 time per month • Identify 2 peers he considers friends • Improve socialization
Waiver Transportation	• Maintain safety in the community by providing oversight and supervision • Maintain safety while completing ADL's • Maintain compliance with medications

Team Collaboration: The Road to Autonomy

The Service Coordinator (SC) accompanied TF to the neurology assessments, ensuring accurate reporting and follow-through on critical recommendations. The neuropsychological report helped the team to understand the cognitive strengths and challenges, processing, speech, memory, attention, concentration, executive functioning, and emotional/behavioral considerations. With this information, they were better able to support TF by communicating in a way that was supportive of his processing strengths.

TF faced challenges with word organization and retrieval, reading comprehension, following directions, and memory retention. His Independent Living Skills Trainer (ILST) observed that these challenges hampered improvement in utilizing the interventions provided for his goals. A speech therapy evaluation was recommended, so the service coordinator arranged the evaluation and subsequent appointments.

TF was initially resistant to speech therapy because he felt self-conscious about his inadequacies. The behaviorist and counselor provided support by working with him to accept the help. In turn, the structured day program and the ILST continued to encourage a positive outlook and follow-through. TF agreed to the assessment, and the ILST attends appointments occasionally as a liaison between the speech therapist and the waiver team. The therapist recommended that TF journal a sentence daily and record important information when meeting with staff. The team ensured this occurred through prompting throughout the day. This support resulted in TF experiencing improvements in organizing his thoughts and following directions, highlighting the effectiveness of this team collaboration.

TF enjoyed walking in the community, but the treatment team observed that he had difficulty with endurance and tended to wander and get lost in town. Assisted technology and a physical therapy (PT) evaluation were recommended. Once PT was underway, TF was supported by the team through collaboration. They prompted TF to ensure that he adhered to the exercise routine at home. Regarding safety in the community and fall risk, the team recommended assistive technology to enhance his independence in the community. The team supported him by exploring a medical alert mobile system that would allow him to access the community safely.

His team, including the aides, observed that he struggled with ADLs in the house, putting his safety at risk. He would leave the oven or stove on, water running, heat or air conditioning set too high or low, and he would forget to take his medication or try to double up on dosage, not realizing he had taken it earlier. The participant, with his family's support, chose to invest in several different types of assistive technology.

1. Stove/Oven Monitor for Independent Living: Safety Features for People with Disabilities

A stove/oven monitor is a vital assistive technology that enhances safety and peace of mind for individuals with disabilities who are living independently. This device helps prevent kitchen fires, reduce injury risk, and provide support without removing autonomy. There are different brands with a variety of features, such as iGuardStove, CookStop, and HomeSense by FireAvert.

It offers the following key safety features:

- Automatic Shut-Off
  - Automatically turns off the stove or oven after a set period of inactivity or if a potential hazard is detected (e.g., smoke, lack of movement).
  - Protects individuals with memory challenges, such as those with brain injuries, dementia, or cognitive impairments.
- Motion Detection
  - Detects when the user is no longer in the kitchen and can prompt a warning or shut off the appliance.
  - Supports users who may become distracted or forget they are cooking.
- Heat and Smoke Sensors
  - Alerts the user—or an emergency contact—when unsafe levels of heat or smoke are detected.
  - Adds an extra layer of fire prevention beyond traditional smoke alarms.
- Mobile Alerts and Caregiver Notifications
  - Sends notifications to a smartphone or caregiver if unusual activity is detected or the oven is left on.
  - Allows remote support while respecting the person's independence.
- Voice Prompts and Audio Reminders
  - Provides friendly audio cues to remind the user that the stove or oven is on.
  - Adds another type of reminder that is ideal for users with visual impairments or memory issues.
- Large, Accessible Interface
  - Includes easy-to-read displays, tactile buttons, or compatibility with voice commands (like Alexa or Google Assistant).
  - Supports users with low vision, arthritis, or limited mobility.

- Customizable Settings
  - Allows caregivers or users to set time limits, sensitivity levels, and preferred alerts.
  - Tailors the device to specific needs and routines.

Some current examples of companies that offer these products are iguardfire.com, absoluteautomation.com/collections/cookstop, and fireavert.com.

2. Automatic Faucets

Automatic faucets (also known as touchless or sensor-activated faucets) are a simple yet powerful tool to support safe, independent living for individuals with physical, cognitive, or sensory disabilities. They help reduce water waste, improve hygiene, and remove barriers to daily routines.

It offers the following key safety and accessibility features:

- Motion Sensor Activation
  - Water turns on and off automatically by detecting hand movement.
  - Reduces physical strain for people with limited dexterity, arthritis, or mobility challenges since there are no twisting knobs or levers.
- Temperature Control Settings
  - Limits how hot the water can get or maintains a preset temperature.
  - Prevents burns or scalding, especially important for individuals with reduced sensation, visual impairments, or cognitive challenges.
- Timed Shut Off
  - The faucet turns off after a few seconds of inactivity.
  - Prevents flooding or excessive water usage for people who may forget to turn it off.
- Hygienic and Hands-Free
  - Does not require physical touch to operate.
  - Helps those with compromised immune systems, open wounds, or reduced hand control stay clean and safe.
- Easy-to-Install Retrofit Options
  - Many automatic faucet adapters can be added to existing sinks.
  - Increases accessibility without requiring full plumbing renovations—ideal for renters or those on a limited budget.
- Battery or Plug-In Power Options
  - Offers flexibility in powering the faucet without complicated wiring.
  - Makes it easier to install in various types of homes, including older buildings.

Automatic faucets not only support physical accessibility but also promote dignity and independence by removing common obstacles in personal hygiene and kitchen tasks. This technology helps make daily living easier, safer, and more efficient, without sacrificing the user's autonomy. Some current examples of companies that offer these products are moen.com, deltafaucet.com, and biobidet.com.

3. Medical Alert Mobile System.

A medical alert mobile system is a personal emergency response device designed to connect users to help instantly, no matter where they are. Unlike traditional home-based alert systems, mobile units use cellular and GPS technology, making them ideal for disabled individuals who are active or live alone.

It offers the following key features:

- One-Touch Emergency Button
  - Instantly connects the user to a 24/7 emergency monitoring center.
  - Critical for people with mobility challenges, chronic conditions, or a history of falls.
- GPS Location Tracking
  - Shares real-time location with emergency responders or family.
  - Ensures quick help even if the user can't speak or doesn't know their exact location—especially valuable for individuals with memory or communication impairments.
- Fall Detection
  - Automatically detects a hard fall and alerts the monitoring center—even if the user can't press the button.
  - Essential for users with balance issues, muscular disorders, or seizure conditions.
- Two-Way Communication
  - Built-in speaker and microphone allow the user to speak with a trained operator directly through the device.
  - No need to reach a phone—ideal for users with limited mobility or vision loss.
- Caregiver Notifications
  - Sends text or app alerts to designated caregivers if an emergency button is pressed or a fall is detected.
  - Keeps family or support staff informed in real time, offering peace of mind.
- Water-Resistant Design
  - Safe to wear in the shower or bath, where falls are common.
  - Supports safe hygiene routines without sacrificing emergency readiness.

- Long Battery Life and Charging Alerts
  - Devices often hold a charge for several days and notify users when recharging is needed.
  - Reduces maintenance burden, especially for users with cognitive impairments.

For people living with disabilities, medical alert mobile systems provide a lifeline to help, reduce fear of being alone, and support greater independence with confidence. Whether at home, in the community, or traveling, these systems remove barriers to safety while preserving autonomy. Some current examples of companies that offer these products are mobilehelp.com, medicalguardian.com, and lively.com.

4. Automated Medication Dispenser

An automated medication dispenser is an assistive device that helps individuals take their medications correctly, on time, and with minimal effort. These systems are especially beneficial for people with disabilities, cognitive impairments, or memory challenges, allowing them to live more independently while ensuring they stay on track with their treatment plans.

- Scheduled Medication Dispensing
  - Automatically dispenses the correct dose of medication at preset times.
  - Prevents missed doses or taking the wrong medication, which is particularly important for people with memory issues or those on complex medication regimens.
- Audible and Visual Alerts
  - Provides reminders through sound (alarm, voice prompts) and flashing lights when it's time to take medication.
  - Ensures that individuals with hearing or visual impairments can still be alerted to take their medications on time.
- Automatic Refills and Medication Inventory Tracking
  - Monitors medication levels and alerts the user or caregiver when it's time to refill or reorder medications.
  - Reduces the risk of running out of essential medications, which is vital for individuals managing chronic conditions.
- Multiple Medication Compartments
  - Stores different medications in separate compartments that are clearly labeled for specific times of day or days of the week.
  - Helps users stay organized and reduces the risk of mixing up medications, especially useful for individuals with cognitive impairments or complex medication schedules.
- Password Protection and Secure Access
  - Requires a PIN or password to access the medications, preventing unauthorized access.
  - Ensures medications are only dispensed to the right person, providing peace of mind for caregivers and families.
- Caregiver Notifications
  - Sends notifications to caregivers or family members when medications are missed or when refills are needed.
  - Provides an extra layer of support and monitoring without compromising independence.
- Portability and Compact Design
  - Many dispensers are compact and portable, allowing users to take them along when traveling or moving around the house.
  - Supports independent living by providing access to medications wherever the user goes, making it easier for those with mobility limitations.
- Emergency Override
  - In case of a malfunction or emergency, users can manually override the system to access their medications.
  - Ensures that users are not left without access to important medication in case of a technical failure.

For individuals living with disabilities, managing medications can be challenging. Automated medication dispensers provide a reliable solution that minimizes errors, reduces stress, and supports independence by offering timely reminders and secure dispensing. This technology ensures that people can stay on top of their health needs without relying entirely on external support.

5. A Plugin to Regulate the Temperature in the Apartment

Maintaining a safe and comfortable temperature in an apartment is crucial for people with disabilities, especially those with conditions that affect temperature sensitivity, mobility, or cognitive function. A plug-in temperature regulation device, such as a smart thermostat or a thermostat-controlled outlet, automates heating and cooling to ensure a stable and safe environment.

- Automatic Temperature Control
  - Maintains a set temperature range without requiring manual adjustment.
  - Prevents overheating or overcooling, which can be dangerous for people with conditions like multiple sclerosis, paralysis, or heart disease.

- Remote Access via Smartphone App
  - Users or caregivers can control and monitor the temperature from a smartphone.
  - Ideal for individuals with mobility limitations or for caregivers who want to check in from a distance.
- Voice Control Compatibility
  - Works with smart home assistants like Alexa or Google Assistant.
  - Allows hands-free adjustments for users with limited hand function or dexterity.
- Overheat Protection / Auto Shut Off
  - Some plug-in thermostats include built-in safety shut offs if the temperature exceeds safe limits.
  - Reduces the risk of fire or overheating in small spaces, which is critical for users who may not notice rising heat levels.
- Programmable Schedules
  - Allows users to preset heating or cooling cycles throughout the day.
  - Ensures comfort and safety during routine times like waking up or going to bed and helps conserve energy.
- Large, Easy-to-Read Displays
  - Displays temperature settings in large font and with backlighting.
  - Accessible for users with low vision or cognitive impairments who may struggle with small or complex controls.
- Battery Backup or Power Loss Alerts
  - Some smart plug-in units alert the user or caregiver if the power goes out or the system disconnects.
  - Ensures continuous temperature regulation even in case of outages or malfunctions.

For people with disabilities, environmental control is as much about health and safety as it is about comfort. A plug-in temperature regulation device provides greater independence, minimizes the risk of exposure to dangerous temperatures, and reduces the reliance on others for daily needs. Some current examples of companies that offer these products are store.google.com, bn-link.com, and inkbird.com.

6. Kitchen Appliances

To enhance kitchen safety, they opted for appliances such as an air fryer, rice cooker, and slow cooker, reducing the need to rely on the stove or oven. These assistive devices allowed for a reduction in hours with his aide from 90 hours per week to 28 hours per week. This reduction resulted in cutting future medical costs by nearly 50 percent, while offering TF autonomy and integration in the community.

Additional Services

In addition to support from the waiver team, TF received vocational services through the New York State Department of Education's Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR) Program. This vocational provider brought valuable expertise, having experience as both a TBI waiver provider and a vocational rehabilitation specialist. This unique perspective provides a comprehensive understanding of the interdisciplinary services TF received.

ACCES-VR has supported him in finding a job in the community over the past year. During the first three months, he was evaluated for job readiness through internships in a work setting with supportive services. After his successful internship, TF was hired part-time. He walks to his job 3 days per week. He works in an office as a janitor, and his coach supports him by visiting once per week and helping TF problem-solve issues, such as creating structure so that he can complete his work methodically from start to finish. Eventually, his coach will show up to check on TF monthly in the hopes of eventually fading as TF becomes successful.

Catherine Latour shared that she can see the benefits of team collaboration, both intra-agency and inter-agency. She stated, "TF provides a strong example of the significance of intra-agency collaboration. TF works with me through ACCES-VR for job training and placement services. TF's case is very complex, and he requires much more support and direction than he admits, so communication among service providers and across disciplines is crucial to TF's success" (Latour, 2025).

As the vocational counselor, Ms. Latour communicated regularly with TF's waiver team to ensure that she was aware of any changes, updates, and/or concerns the team may have to best support TF when he was training for work. These issues all had a direct impact on TF's ability to participate in vocational services and had long-term effects on his potential employment successes. "TF requires consistent encouragement and positive reinforcement, so I need to communicate with his PBIS and CIC specifically. Additionally, these are strategies that I can reinforce from those services as well during my time with TF vocationally to ensure consistency across the board" (Latour, 2025).

In addition to the communication with waiver services, Ms. Latour communicated with ACCES-VR to make service recommendations in line with TF's abilities and goals. While ACCES-VR was less directly involved, they required input and feedback regarding TF's abilities to ensure they authorized the appropriate services; "this feedback comes from not only myself as the vocational counselor but also TF's waiver team and TF himself. TF has had thoughts of terminating his services but with continued support and assistance from his providers he has been able to remain engaged in both TBI waiver services and ACCES-VR services. Collaboration among the team will be tantamount to TF's overall success" (Latour, 2025).

Eventually, the use of assistive technology will be considered for improved autonomy at work and job performance. Team collaboration and best practices ensure TF will meet his maximum potential. These providers in the community support services create a safety net for participants to succeed in living independently in the community. The use of assistive technology demonstrates cost-effective support that also enables the person's independence.

REFERENCES

Catherine Latour, February 13, 2025, personal communication.

National Association of State Head Injury Administrators. (n.d.) *About.* Retrieved April 25, 2025, from https://www.nashia.org/about

New York State Department of Health Traumatic Brain Injury Medicaid Waiver Program. (n.d.). *New York State Department of Health Traumatic Brain Injury Medicaid Waiver Program*. Retrieved February 21, 2025, from https://www.health.ny.gov/publications/1111.pdf

New York State Department of Health, Office of Long Term Care. (2009). *Home and Community-Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury Program Manual*.

Park, E. Y., Oliver, T. R., Peppard, P. E., and Malecki, K. C. (2023). "Sense of community and mental health: a cross-sectional analysis from a household survey in Wisconsin," *Family Medicine and Community Health*, 11(2), e001971. Retrieved February 21, 2025, from https://doi.org/10.1136/fmch-2022-001971

LOOKING AHEAD

2025

Summer: Psychology Complications

Autumn: Orthotics

2026

Winter: Methodology and Sandards

Spring: Elder Care

aanlcp
American Association of Nurse Lifecare Planners

Index of Past Issues

all past issues from 2009-present area available as PDFs for free download at **www.aanlcp.org**

2016

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

2017

XVII.1 Brain Injury
XVII.2 The Business of Life Care Planning
XVII.3 Back and Spine
XVII.4 Mobility and Extemity Function

2018

XVIII.1 Costing and Coding

2019

XIX.1 Presidents Issue
XIX.2 Licensure I Qualifications I Certifications
XIX.3 New Directions in Pain Management
XIX.4 Technology Updates

2020

XX.1 Spinal Cord Injury Updates
XX.2 Advances in Amputation
XX.3 Evidence Based Practice
XX.4 Durable Medical Equipment and NLCP

2021

XXI.1 Therapeutic Modalities
XXI.2 The Business of NLCP
XXI.3 Ages and Stages in Life Care Planning

2022

XXII.1 Expert Witnessing and Testimony
XXII.2 Pain Management Revisited
XXII.3 Orthopedics, Pain, and Research

2023

XXIII.1 Pediatrics
XXIII.2 Business of Life Care Planning
XXIII.3 Mental Health
XXIII.4 Interacting with Other Disciplines

2024

XXIV.1 Assistive & Durable Medical Equipment
XXIV.2 Nervous and Spinal Injury Considerations
XXIV.3 Ethics
XXIV.4 Delegation of Care and Caregivers

2025

XXV.1 Foundations in Life Care Planning
XXV.2 New Directions in Homecare