

# Journal of Life Care Planning



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### Purpose and Objectives

The Journal of Life Care Planning publishes refereed education and research materials relevant to the practice and processes of life care planning. The specific objectives of the Journal are as follows:

- Publish materials which will add to the growing literature base of the practice of life care planning.
- Provide the professional field with information regarding events and developments important to the practice of life care planning.
- Provide a forum for the debate and discussion of practice issues.
- Promote professional practice by addressing issues relevant to certification, ethics, standards of practice and research methodologies.
- Promote advanced practice through the publication of preapproved continuing education feature articles.

### Publication Guidelines

*Journal of Life Care Planning* (JLCP) is a quarterly publication of the International Association of Rehabilitation Professionals (IARP). The articles are written with the rehabilitation professional in mind. Articles are suggested for, but not limited to, the following tracks: case management, rehabilitation education, ethics, vocational rehabilitation, disability management, forensic/life care planning, and practice management.

Author(s) should follow the 7th edition of the *Publication Manual of the American Psychological Association*. Articles should be in Microsoft Word format, using Times Roman font, and be double-spaced. Do not use the tab key or spaces to align text. Only one space should follow any punctuation. Do not include additional spaces at the end of the paragraph.

Tables need not be camera ready since they are reset to match the style of the journal. Tables should be located at the end of the document. Graphs, photographs, and figures should be included as separate files and be in a graphic format, e.g., JPG, TIF, BMP, PNG. Indicate correct location of tables and figures in text, enclosed in angle brackets.

Authors should use acceptable language, which respects individuals.

Abstracts of no more than 250 words each should be included. The abstract should include a brief summary of the content of the article. Author notes should conform to current APA 7th edition format.

The name and mailing address of the lead author should be provided to Editor in order that a complimentary copy of the journal can be sent in appreciation.

The articles are reviewed by the Editor and by members of the *JLCP* editorial board. There is no guaranteed publication date for an accepted article. Articles should be sent to the Managing Editor as an email attachment.

Upon review, an article is either accepted or rejected. Accepted articles often require editing for spelling and grammar. These are done without contacting the authors. Authors will be contacted, however, if there are questions about the meaning of the content or if significant changes are needed to syntax. Articles are generally published in the order received.

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**Editor's Message***Aaron Mertes PhD, CRC, PCLC*

There are a lot of people who have moved science forward, but perhaps the most well-known figure is Charles Darwin. In thinking about his work, the hallmark of his discoveries is the adaptation of a species, not out of individual effort, but collective survival. Adaptation is a collective change of accumulated power that outlasts, persists, or overcomes adversity.

As I am thinking through the content of this issue, these principles come to mind. COVID-19 happens forcing the community to change its practices to remote evaluations, virtual depositions, and online conferences. Life care planners adapted. How exactly? Well this issue has an article describing the data of just what those changes meant to the community.

Another life care planning summit happened, but not like the others. The issue of how life care planners come up with their cost numbers has been in the process of getting more complicated with the advent of the internet, online marketplaces, access to providers, large data-sets, and other factors. Technology has provided opportunity to life care planners with new tools to innovate with. However, adherence to consistent and lasting protocols resists innovation. So, the community must make choices. This issue has an article about the choices and outcomes of those efforts to establish new ways of working.

In the spirit of learning something new, there is also an article about the process of life care planning from referral of a case to testimony. For those newer to the practice who have perhaps not seen the entire process through from start to finish, this is a guide to help understand it. It is as if to say, "if the community will survive, it must prepare a new generation." This is a welcomed addition to the library of resources for new professionals.

This issue also contains an addition to the literature on amputations and a book review of other writings contributing to the body of work in the field. These efforts represent scholarly development, a sharing of information that contributes to the resources of the practice.

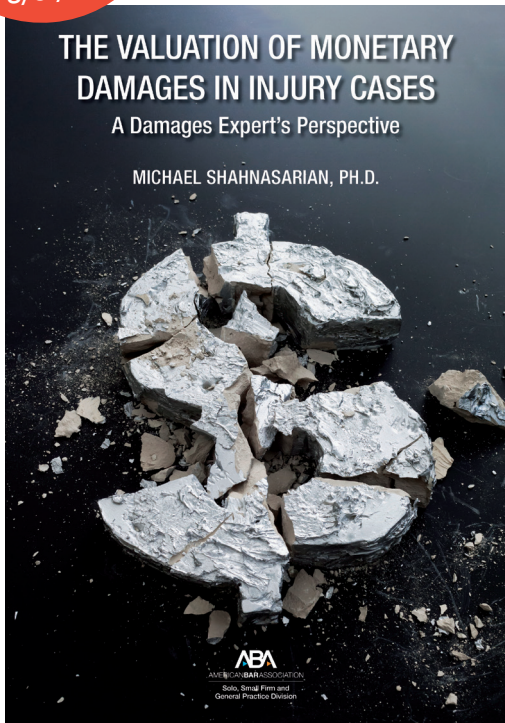
What these contributions represent, then, is a well-round example of the diverse work going on in different areas of the practice. It demonstrates the consistent efforts by dedicated people who see the need to focus on contribution to the collective well-being of the community at a time when change challenges the practices of the community. In short, we adapt.

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# “Must Reading” for Vocational Experts and Life Care Planners

**ABA**  
AMERICAN BAR ASSOCIATION

Solo, Small Firm and  
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August 2022, 502 pages, 7x10  
Product code: 5150530

## The Valuation of Monetary Damages in Injury Cases A Damages Expert's Perspective

By Michael Shahnasarian, Ph.D.

Cited as “must-reading for trial lawyers” for its “invaluable expertise,” a new book from damages expert **Michael Shahnasarian, Ph.D.**, is earning advance praise from top plaintiff and defense lawyers nationwide. Published by the **American Bar Association**, the book brings a fresh perspective to this complex area of litigation, using case studies and models helpful to veterans and students alike.

Dr. Shahnasarian, a nationally and internationally recognized expert in forensic vocational, rehabilitation, and life care planning who has reviewed evidence in thousands of cases, says: “Assessing the true monetary damages resulting from an injury case—whether an automobile or industrial accident or a medical procedure gone awry—is a complex process. The key to neither overvaluing nor undervaluing damages lies in carefully and methodically scrutinizing case-specific, technically relevant facts and the nuances of them in a scientifically accepted manner.”

*The Valuation of Monetary Damages in Injury Cases* provides a step-by-step guide to arriving at a sound damages assessment. It helps attorneys, judges, insurance adjusters, litigation experts, law students, law professors, vocational experts, life-care plan professionals, and even sophisticated plaintiffs gain a strong understanding of how to conduct and value an assessment of a damages claim—and be able to defend the underlying methodology.

*“Dr. Shahnasarian’s book will become a significant contribution to the literature on evaluating and presenting damages in injury cases.”*

—Timothy F. Field, Ph.D., Rehabilitation Consultant, Elliott & Fitzpatrick, Inc.

*“Dr. Michael Shahnasarian’s new book is must-reading for trial lawyers, young and old, in a broad spectrum of cases requiring the valuation of monetary damages, whether involving bodily injury, employment termination, retaliation for whistle blowing, or other life-altering events. The author has unrivaled expertise, insight, and wisdom in these areas from many disciplines, including psychology, vocational rehabilitation, life care planning, and economics.”*

—Michael A. Schlanger, Esquire, Covington & Burlington (Retired Partner)  
Defense Bar Trial Lawyer

*“His book reflects invaluable expertise and provides a very understandable guide to this critical area of litigation. Dr. Shahnasarian’s detailed, intelligible approach makes it a great read for any trial lawyer, regardless of experience.”*

—C. Steven Yerrid, Esquire, The Yerrid Law Firm, Plaintiff’s Bar Trial Lawyer

*“[The book’s] life care planning section is spot on. The inclusion of Standards of Practice for Life Care Planners as a foundation, as well as numerous case examples of varying complexity and instruction on common litigation pitfalls, will certainly assist aspiring experts with providing valuable litigation-related services.”*

—Roger O. Weed, Ph.D., Professor Emeritus, Georgia State University  
Fellow Emeritus, International Academy of Life Care Planners  
Board Emeritus, Foundation for Life Care Planning Research

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

Mary Barros-Bailey<sup>1</sup>, Melissa Knott<sup>2</sup>, Ann T. Neulicht<sup>3</sup>, Nancy Mitchell<sup>4</sup>, Tracy Albee<sup>5</sup>, Rick Robinson<sup>6</sup>, Susan Riddick-Grisham<sup>7</sup>, and Debbe Marcinko<sup>8</sup>

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## Abstract

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

## Review of the Literature

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

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

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

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

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

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

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



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

### **Procedures**

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

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

### **Data Analysis**

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

#### **Quantitative Data Analysis**

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

#### **Qualitative Data Analysis**

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

### **Results**

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

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

### **Demographics of the Sample**

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

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

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

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

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

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

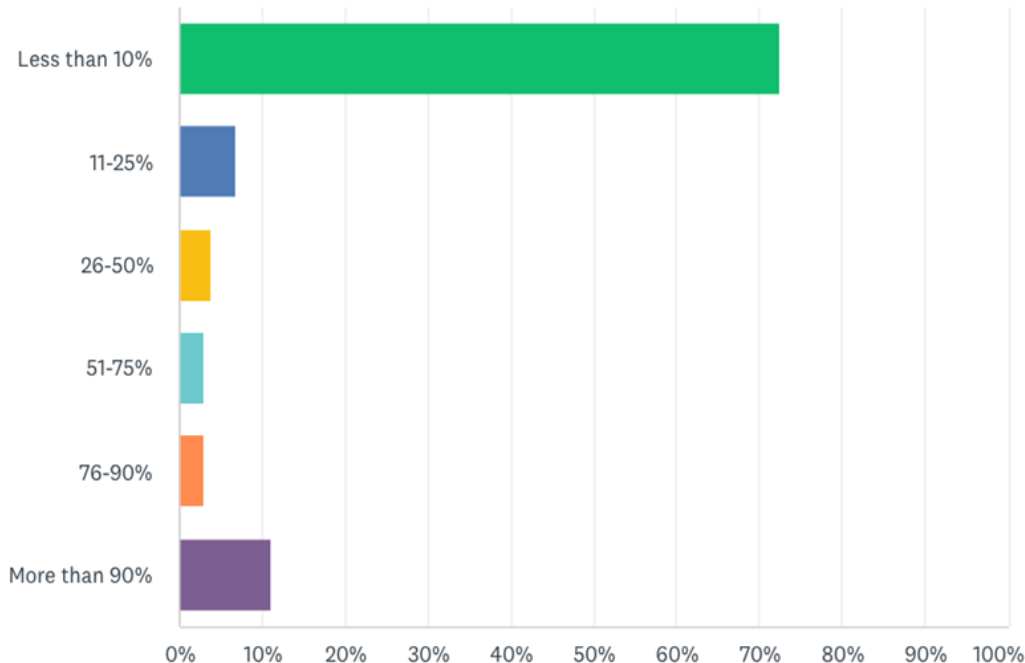
### **Adoption of Remote Life Care Planning Practices Due to the SARVS-CoV-2**

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

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

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

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

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

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

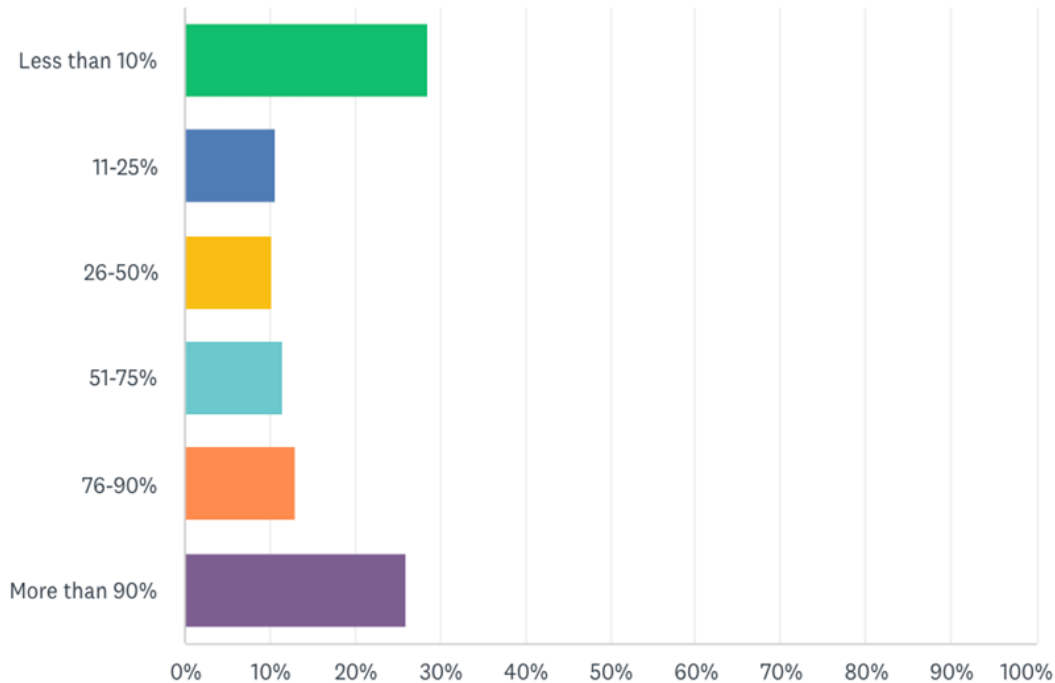
### **Question 2: Today, in What Percentage of Your Cases do You Perform Remote Life Care Planning Assessments?**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Practical Impacts Regarding Adoption of Remote Life Care Planning**

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

addressed the negatives and the positives.

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

### **Technologies in Remote Life Care Planning**

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

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

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

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

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

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

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

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

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

### **Informed Consent and Report Disclosures**

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

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

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

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

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

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

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

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

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

Examples of limitations include:

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

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

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

### **Impacts on Access to Other Professionals**

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

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

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

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

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

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

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

### **Impacts on Testimony**

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

#### **How has your testifying changed since early 2020?**

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

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

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

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

### **Impacts on Income**

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

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

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

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

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

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

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

**Impacts on Professional Development**

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

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

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

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

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

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

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



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

### **Impacts on Retirement**

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

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

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

### **Projections for Future Remote Life Care Planning Practice**

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Implications**

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

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

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

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

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

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

### **Recommendations for Best Practices**

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

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

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

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

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

### **Recommendations for Future Research**

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

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

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

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

### Summary and Conclusions

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

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# 2022 Life Care Planning Summit: Costing Techniques, Survey Results and Development of a Costing Framework in Support of the Life Care Planning Specialty

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## Abstract

This paper will outline the history of Summits leading to the task at hand, the future development of a costing framework through deeper understanding of the evolution of the process. Leaders within the specialty practice came together to address this evolving issue and bring together life care planners to take the next steps. This article will retrace the historic outcomes of the Life Care Planning Summits since 2000, present the diverse costing approaches and techniques in life care planning, and set the stage for the future.

## Introduction

For over 22 years, life care planners have led the specialty practice of life care planning through routine collaboration and discussion at the Life Care Planning Summits chaired by the International Academy of Life Care Planners (IALCP), which is the Life Care Planning Section of the International Association of Rehabilitation Professionals (IARP). Five years ago, at the May 2017 Life Care Planning Summit, an agreement was reached by the attendees that “life care planners shall develop a position statement (white paper) regarding the presentation of charges and/or costs presented in the life care plan” (Albee et al., 2017, p. 26). It was further agreed that this document would provide “guidance to life care planners for the variety of uses and jurisdictional requirements encountered by life care planners” (Albee et al., 2017, p. 26). A committee was developed to achieve this goal and this process evolved from a survey to a summit to a formal costing framework committee. This paper will outline the history of Summits leading to the task at hand, the evolution of the process, and what is expected into the future.

### **The History of the Life Care Planning Summit**

The Life Care Planning Summit began as a biennial meeting of practitioners and interested parties in the specialty practice of life care planning to explore important issues. Historically, the Life Care Planning Summit has provided an opportunity to reach consensus on issues, identify and define areas of controversy, and give direction for future development and services. Summits are held to set the stage for a professional practice. The goal for the specialty practice of life care planning is to develop ethics, standards of practice, standard of care, etc., specifically using the power of the group of attendees (grass roots). Summits are designed to give all practitioners a forum to voice opinions. Summits use group dynamics and traditionally attempt to achieve consensus or near consensus, through majority opinion. And most importantly, Summits typically set the very foundation for the specialty practice and often are the source for agreed upon standards of practice, standard of care, and ethics. Summit conferences are designed so that attendees give information to leaders, associations and other life care planners.

Over time, the Life Care Planning Summit results have been published and relied upon by practitioners in their daily practice. The published outcomes have culminated into the Consensus and Majority Statements which have been updated routinely and published in the *Journal of Life Care Planning*. Johnson and Preston (2015), Johnson (2015), Johnson et al. (2018) have historically served as guiding principles for the work of the life care planner. Practitioners are on occasion asked about these statements in the litigation arena. Life Care Planning Summit proceedings are developed by life care planners for life care planners about life care planning. Being familiar with and aware of the results of these Summits and these majority and consensus statements is very important.

It has routinely been recommended that practitioners take a vested interest in the future of life care planning and participate in Summits to address cutting edge issues affecting life care plans, life care planning and life care planners. Costing has emerged since the 2012 Summit as an ongoing and evolving issue relevant to life care planners.

Since 2000, there have been 11 life care planning Summits throughout the United States and Canada. A brief history is summarized below in Table A.

**Table 1***Credentialed Analysis*

Year	Date	Location	Focus	Comment
2000	April 12	Dallas, TX	Professional preparation; Basic tenets and procedures for completing life care plans; Ethics; Reliability and validity of the life care plan; Information dissemination.	The first Summit was sponsored by the International Association of Rehabilitation Professionals (IARP), the International Academy of Life Care Planners (IALCP), Intelicor/University of Florida and the Commission on Disability Examiner Certification (CDEC). In addition, the American Association of Legal Nurse Consultants (AALNC) and the Case Management Society of America (CMSA) participated.
2002	May 18 and 19	Chicago, IL	Scope of practice; Skills; Ethics; Professional development; Methodology; Functions; Future of life care planning.	
2004	April 24 and 25	Atlanta, GA	Certification Process; CLCP examination and continuing education credits; Future research in life care planning; CLCP mentoring program; Standards of practice for life care planners.	
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Table 1 – continued from previous page

Year	Date	Location	Focus	Comment
2006	May 6 and 7	Chicago, IL	A panel of representatives of the IALCP, CHCC, and the Foundation for Life Care Planning Research (FLCPR) discussed trends and plans for the future of life care planning and each represented organization had an opportunity to provide input.	First Panel (Town Hall) Approach
2008	May 15 and 16	Los Angeles, CA	<p>Visions for the future of life care planning: Identifying controversial aspects of plans created by various professional disciplines; Developing unity in the specialty practice: Standards of practice shaping the role and function of life care planning;</p> <p>Best practices: Methodology issues in data collection; Best practices: Methodology issues in creating admissible life care plans; Research: Priorities, needs, and practical applications in day-to-day practice; Professional business issues: Risks and benefits of databases, templates, and software.</p>	
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**Table 1 – continued from previous page**

Year	Date	Location	Focus	Comment
2010	April 17 and 18	Atlanta, GA	Topic 1: Best Practices for Establishing Foundation for Necessity: Boundaries for Decision Making; Topic 2: Best Practices for Determining Sources of Attendant Care in the Home; Topic 3: Review of Consensus Statements, Majority-View Statements and Results of Life Care Planning Summits 2000 – 2008.	Technology was first utilized to gather input from attendees.
2011	June 3 and 4	Toronto, Canada	This was a replication of the first Summit to ensure the specialty practice was consistent internationally although jurisdictional requirements may change.	
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Year	Date	Location	Focus	Comment
2012	May 5 and 6	Dallas, TX	This Summit brought together the IALCP, the Foundation for Life Care Planning Research (FLCPR), the International Commission on Healthcare Certification (ICHCC) and the American Association of Nurse Life Care Planners (AANLCP) to begin a collegial dialogue between the various entities promoting life care planning. Additionally, the topics of ethics and costing were further explored.	The Summit in 2012 provided the 98th and 99th Consensus and Majority Statements as summarized in the Journal of Life Care Planning (JLCP) Volume 11, No. 1 (Preston and Johnson, 2012). Following the 2012 summit, Karen Preston chaired a task force which reviewed and revised the Standards of Practice with the aid of the community of life care planners. This was completed and published in the Standards of Practice for Life Care Planners, Third Edition.
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Year	Date	Location	Focus	Comment
2015	September 18	Scottsdale, AZ	Best Practices for Business and Best Practices for Transparency were the main topics for the 2015 Summit. Consensus Statements from the 2015 Life Care Planning Summit to be added to the prior 99 Consensus and Majority Statements from earlier Summits include: 100. Life Care Planners have the option to use support staff under their direction and guidance in completing life care plans. 101. Life Care Planners shall identify conflict of interest. 102. Life Care Planners shall identify the sources of their recommendations (Johnson, 2015).	This one-day Summit was a full day with a working lunch, including an ethics presentation by Dr. Christine Reid, followed by updates from the IALCP, FLCPR, American Association of Nurse Life Care Planners (AANLCP), Certified Nurse Life Care Planners (CNLCP) Certification Board, and the International Commission on Health Care Certification (ICHCC).
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Year	Date	Location	Focus	Comment
2017	May 19 and 20	Denver, CO	The goal was to further define “associated costs” with education and discussion on how costs are derived and appropriate ways to determine and utilize collateral sources.	<p>As a group, attendees compiled 29 different venues in which a life care plan may be utilized.</p> <p>Additional consensus: A comprehensive and systematic review of the existing 102 statements through a multi-association process to determine if they are still appropriate and relevant is needed.</p> <p>Life care planners shall develop a position statement (white paper) regarding the presentation of charges and/or costs presented in the life care plan that provides guidance to life care planners for the variety of uses and jurisdictional requirements encountered by life care planners. The paper must take into consideration that “associated costs” are referenced in the definition of a life care plan, and ensure the current geographically relevant monetary charges for a good and service in the life care plan.</p> <p>There was a consensus to reaffirm other past consensus and majority statements: #98, #86, #82 and #79 were all reaffirmed by the 2017 Summit proceedings.</p> <p>In the future review of the statements, it will be necessary to look closely at #56 and consider the definition of “integrity” (applicability, relevance and the obligation of the life care planner to know the integrity of our data versus only the sources of data).</p>

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**Table 1 – continued from previous page**

Year	Date	Location	Focus	Comment
2022	May 13 and 14	Dallas, TX	Topic of Summit: Costing techniques, survey results and development of a framework in support of the life care planning specialty.	Utilization of TopHat technology.

Summits have ensured that we sustain our professionalism, and confirm that we are not paint by number scribes. We have continued to follow the long-standing tenets and methodology consistent with the multidisciplinary aspect of life care planning. These have been reassuringly affirmed in court decisions across the country in both state and federal court jurisdictions as well as adopted by other venues (such as Medicare-Set-Aside, family planning, trusts, catastrophic healthcare reserves, workers' compensation claims, and others).

### **Development of the 2022 Summit**

Beginning in April 2020, IALCP Chair Aaron Mertes solicited volunteers to work on the Summit Planning Committee. Dr. Aaron Mertes, Cloie Johnson, Susan Grisham, Dr. Elizabeth Davis, Kirsten Thomas, Dana Penilton, Laura Woodard and Carol Fricks began the process of developing an agenda. The first meeting was held on April 24, 2020, and meetings continued at least monthly until the Summit occurred in May of 2022. Two years of discussion, debate and dialogue explored topics, formats, issues and ideas to ensure the Summit was relevant to life care planners. The Summit committee developed a life care planning costing technique survey to guide discussion at the Summit and data was collected from November 9, 2021 to December 21, 2021. During the interim Dr. Mertes stepped off the committee and Evelyn Robert, Reg Gibbs and Jamie Pomeranz joined the group.

### **Goal for the 2022 Summit**

In July 2020, a survey titled "Summit Topic Input" was sent to life care planners through the various life care planning associations. Additionally, the 2020 Post-Symposium Survey completed in November 2020 was reviewed. The results of both surveys dovetailed with the call from the 2017 Summit attendees for life care planners to develop a position paper regarding the presentation of charges and/or costs in a life care plan. Based on the 2017 Summit call for action and the results of the two surveys, a goal evolved around the topic of life care plan costing, specifically costing techniques, survey results and development of a framework in support of the life care planning specialty. Ultimately, objectives were formed including helping life care planners identify costing techniques used by life care planners internationally and discussion regarding determination of UCR, fee schedule, jurisdictional differences and why life care planners use their specific costing techniques.

### **2022 Summit Objectives**

Chairs Evelyn Robert and Dr. Elizabeth Davis led the development of this forward thinking agenda. The 2022 Summit topics included: review of the history of costing techniques; evolving issues addressing methodology, reliability, and techniques, including but not limited to sources, jurisdictional issues, and the impact of case law; and identify approaches for costing techniques used by the life care planning specialty by presenting survey results at the Summit.

Summit participants would be presented factors that influence the ways in which life care planners present costs in life care plans. Attendees would participate in working groups to identify techniques used for life care plan costs; discuss methods, reliability and validity of each costing technique (i.e. databases, correspondence via phone calls, emails and

letter); discuss how to report costs (range, average, percentile, etc.); and move towards the development of a peer reviewed publication of the Summit results with attendee recognition. Top Hat technology was presented by Dr. Jamie Pomeranz and Dr. Nami Yu to the committee to allow all participants to have a voice, outside of the previously used modified nominal group technique.

### **Life Care Planning Costing Technique Survey**

The first step in collecting data regarding costing techniques used by the community of life care planners was the dissemination of a survey to life care planners. Data was collected through SurveyMonkey® from November 9, 2021 to December 21, 2021. There were 264 responses and a completion rate of 80%. The survey contained the following instructions:

At the May 2017 Life Care Planning Summit an agreement was reached that “life care planners shall develop a position statement (white paper) regarding the presentation of charges and/or costs presented in the life care plan.” It was further agreed that this document would provide “guidance to life care planners for the variety of uses and jurisdictional requirements encountered by life care planners.

You can contribute to this effort by completing the survey on the link below. The answers that you provide will be used to determine trends regarding one of the most basic components of life care planning-the techniques that we use to determine costs. Your responses will inform topics of discussion at the Life Care Planning Summit to be held in Dallas on May 13 and 14, 2022.

Key questions in the survey included the following:

- For what percentage of life care plans that you write do you contact providers and vendors by telephone to ask for actual fees and prices in the evaluatee’s geographic area?
- Do you consider telephone calls to specific providers and vendors a valid method of determining the costs of services and products in a specific geographic area?
- For what percentage of the life care plans that you write do you e-mail providers to ask for actual fees for services?
- Do you consider e-mail correspondence with specific providers a valid method of determining the cost of services in a specific geographic area?
- For what percentage of the life care plans that you write do you use a database to determine the costs of products and services recommended?
- For what percentage of the life care plans that you write do you use a combination of sources to determine the costs of products and services recommended?

### **2022 Life Care Planning Summit**

The IALCP 2022 Summit was held from May 13 and 14, 2022 at the Dallas Fort Worth Airport Hyatt Hotel and was attended by 161 people. Cloie Johnson and Laura Woodard began with the history of life care planning and the evolution of cost techniques. This presentation was published in the *Journal of Life Care Planning* (Johnson & Woodard, 2022).

Attendees were then provided with presentations including a statistical primer by Matthew Sprong, PhD, a discussion of Fair Health data by Allison Schnieders, a presentation on Usual, Customary, and Reasonable (UCR) as a costing technique by Rebecca Busch, a Discussion of VA Reasonable Charges Data Tables/Find-A-Code data by Valerie Parisi; a discussion of Context4Healthcare data by John Danza, an attorney's perspective on life care plan costing by Adam Snyder, Esquire, and a presentation on recent case law in California related to life care plan costing and what this may foreshadow in other states by Eustace de Saint Phalle, Esquire, Sarah Madan, Esquire, and Jan Roughan, RN.

Dr. Pomeranz and Dr. Yu introduced Top Hat technology which would serve as the foundation for the focus group. The following morning the attendees were provided an explanation of the Costing Survey administered the prior fall and there was a presentation of the survey results and a discussion of the focus group topics on Costing Techniques.

### **Costing Survey**

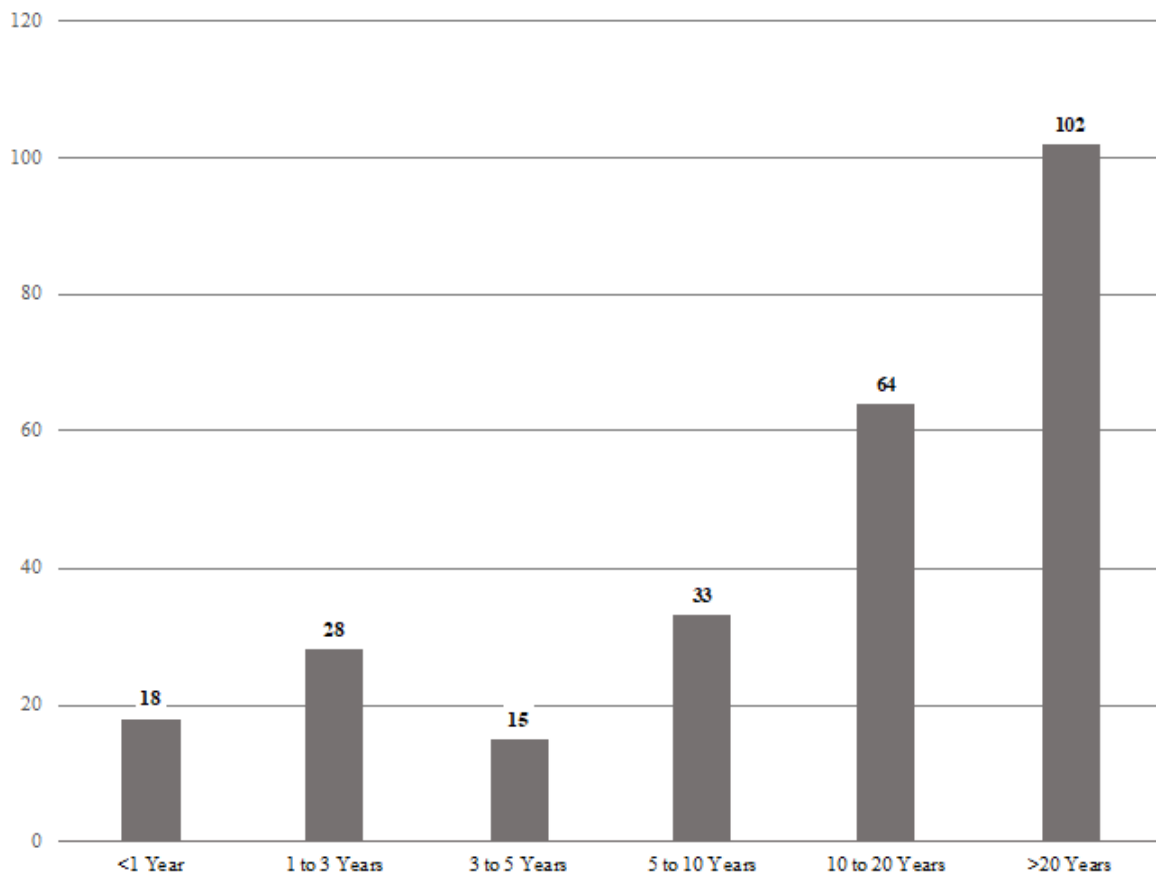
Survey results are provided as separate tables. Highlights of significance include: length of time writing plans, experience prior to writing plans, certification, use of research assistants, geographic location where plans are written, training for cost research, cost gathering techniques used, and cost reporting techniques used. Specific questions and results are as follows.

- More than 39% of life care planners have been writing plans for over 20 years; 64% for over 10 years.
- Over 70% of life care planners had more than 10 years of experience in their primary discipline before writing life care plans
- 64% of the sample reported CLCP as the primary certification related to life care planning; CNLCP 22%, CRC 21% and CCM 18%.
- In the last 12 months, 44% of life care plans were developed without the help of a research assistant to determine costs and 23% used research assistants 81% to 100% of the time.
- Approximately 37% have submitted plans in Florida, and 35% have submitted plans in Texas. All 50 states, D.C., Canada and US District courts were all noted.
- About 44% of life care planners learned how to research costs for services and products through a formal training program, the remaining learned on the job, from a mentor or other non-formal training.
- 42% of life care planners obtain fees and prices by telephone 81% to 100% of the time.

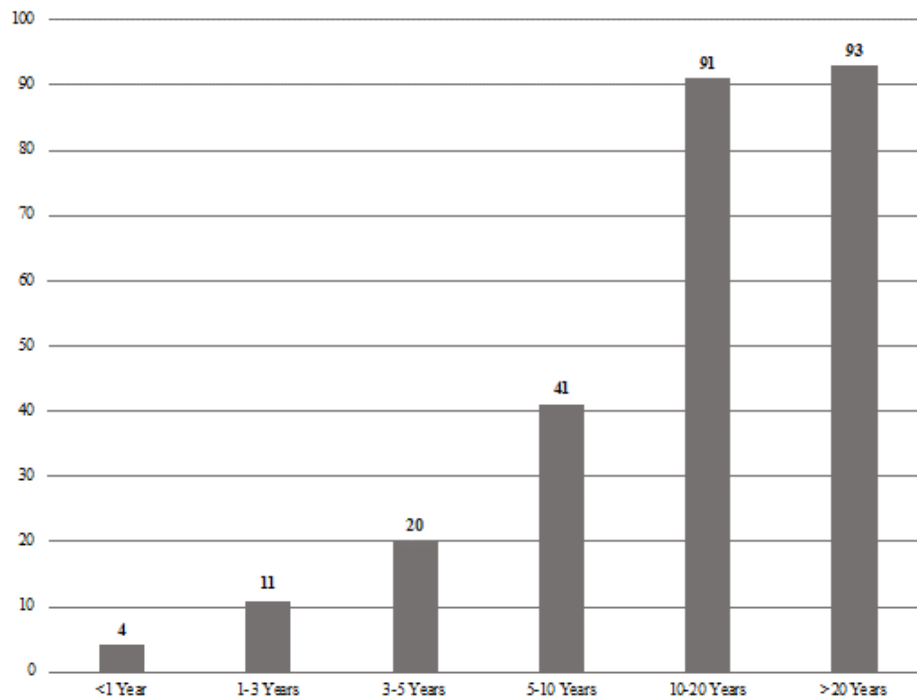
- 6% of life care planners obtain fees and prices by email 81% to 100% of the time.
- 62% life care planners use a database to determine costs 81% to 100% of the time
- Many life care planners (81%) use a combination of sources to determine costs 81% to 100% of the time.
- 93% life care planners identify the sources of the costs in their plans 80% to 100% of the time.
- 43% of life care planners who use databases for costs report 75th percentiles; 22% report the 80th percentile.
- 64% of plans do not rely on Medicare fee schedules to determine costs.
- 51% of life care planners consider prices less than 12 months old to be valid.

Specific questions and results are reported below.

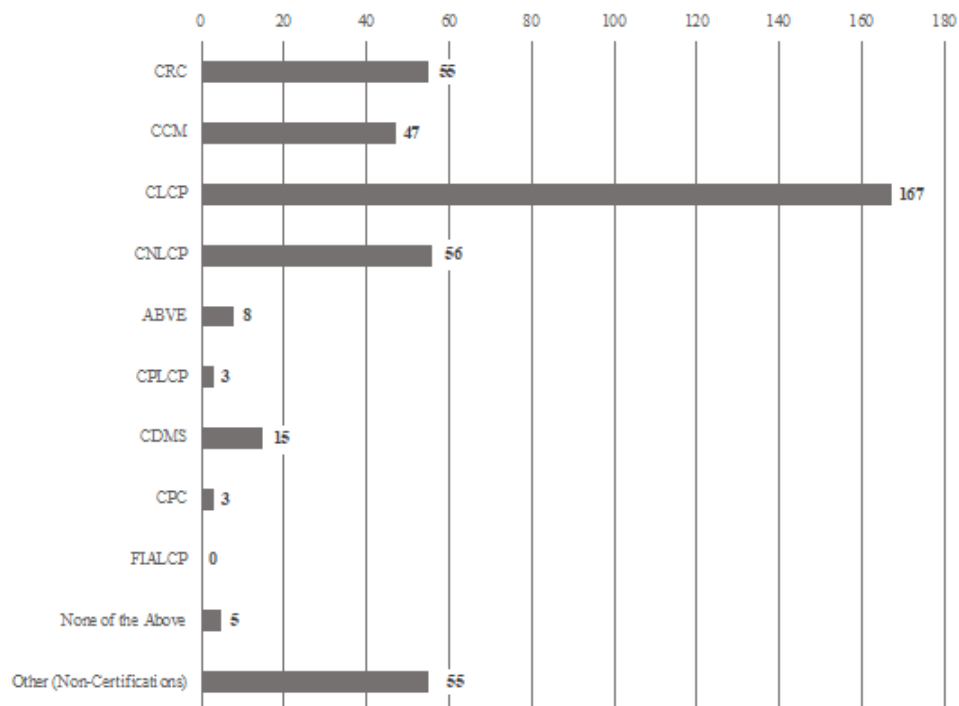
*For how long have you been writing life care plans? (n = 260)*



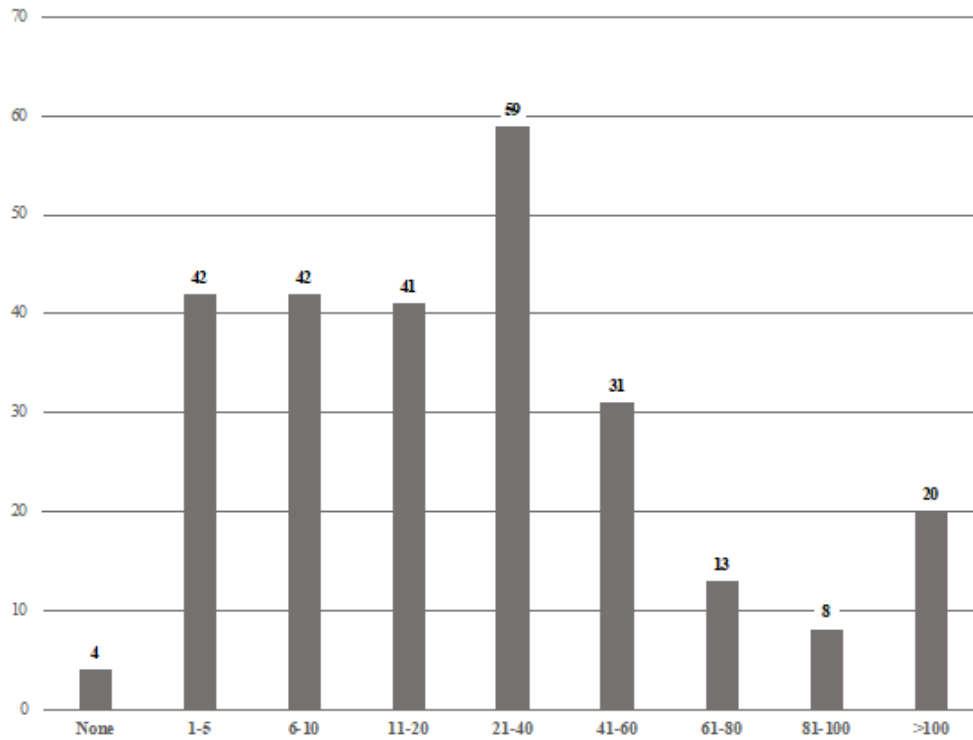
*How many years of experience did you have in your primary discipline before you began writing LCPs? (n = 260)*



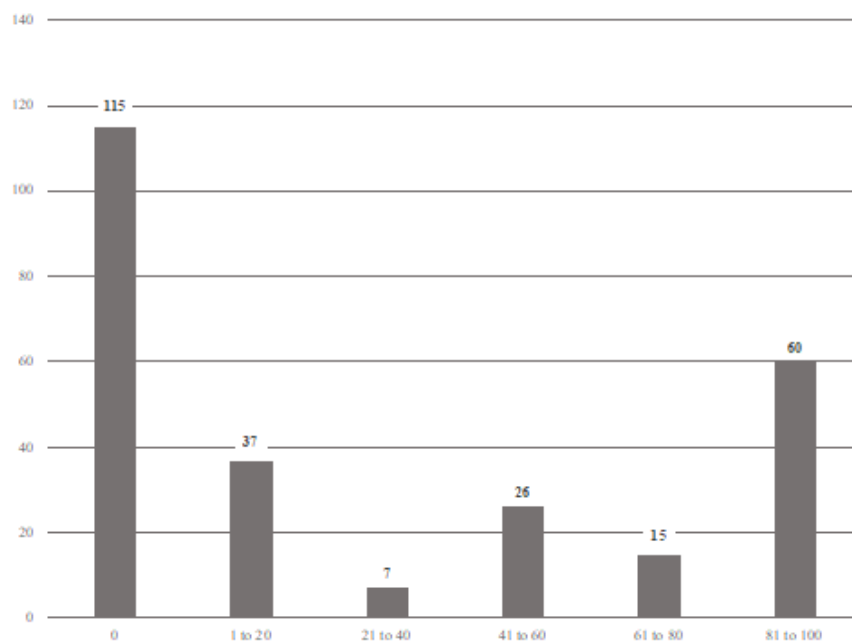
*Primary certification related to life care planning. (n = 260)*



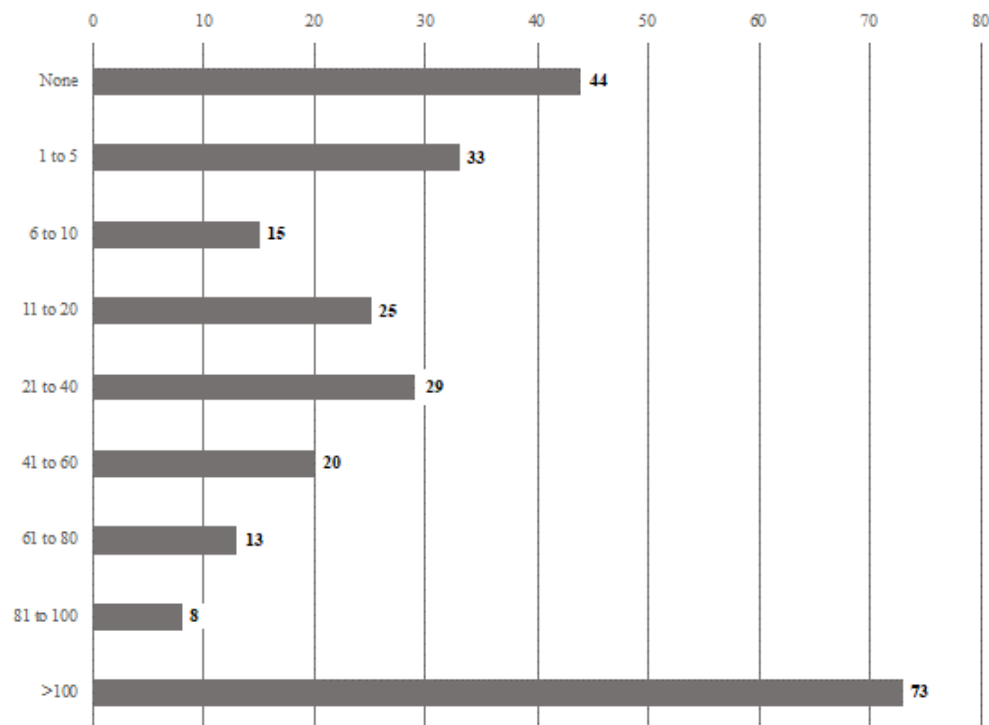
*How many LCPs do you write each year? (n = 260)*



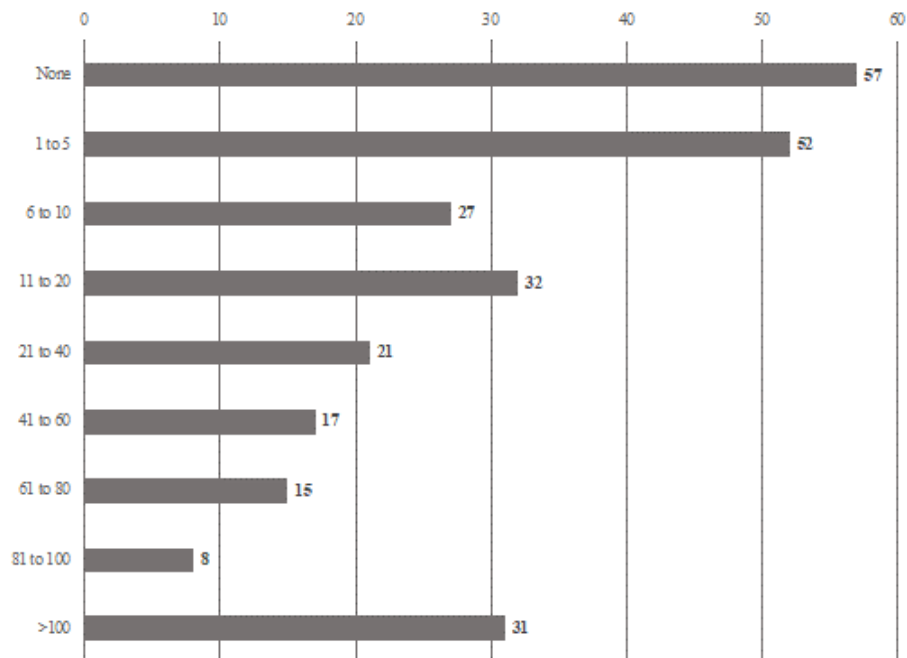
*For what % of the LCPs that you have written in the last 12 months have you enlisted the help of a research assistant to determine costs? (n = 260)*



*How many times have you testified in a deposition? (n = 260)*

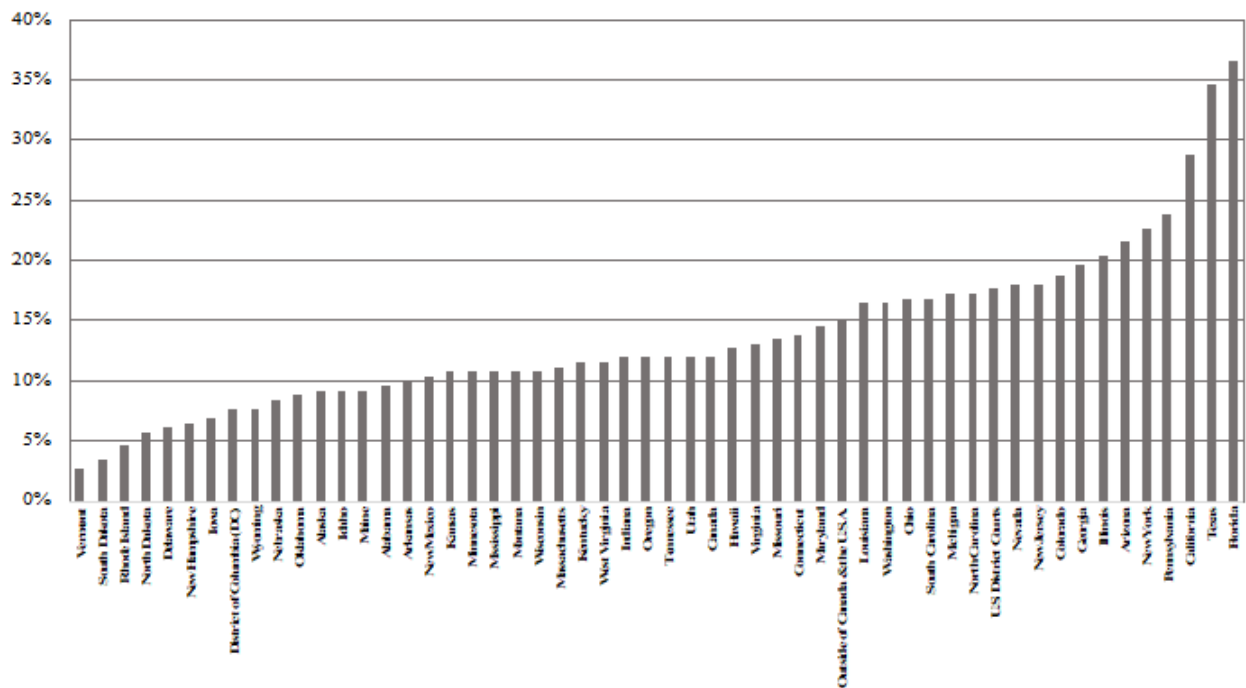


*How many times have you testified in a trial? (n = 260)*

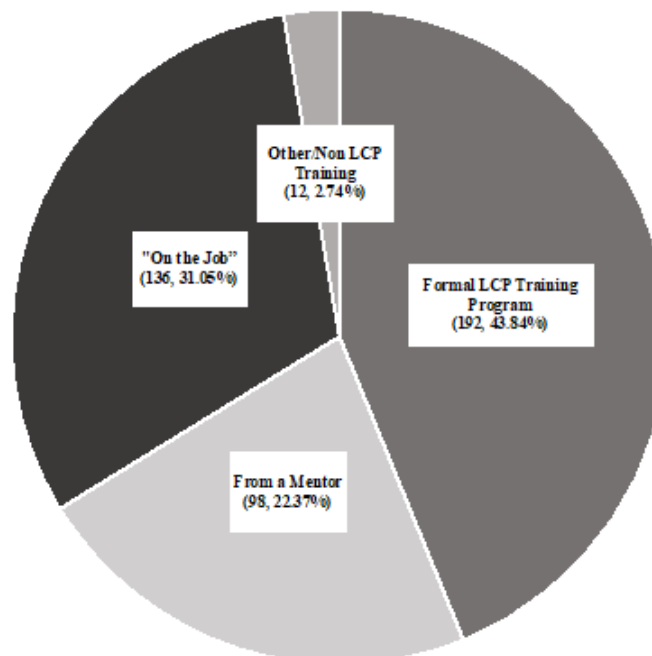




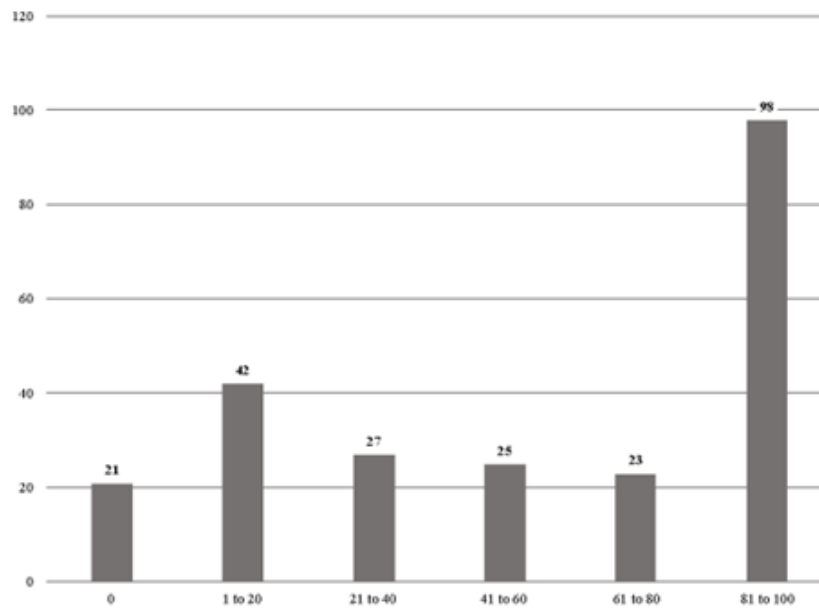
*In which of these jurisdictions have you submitted LCPs? (n = 260)*



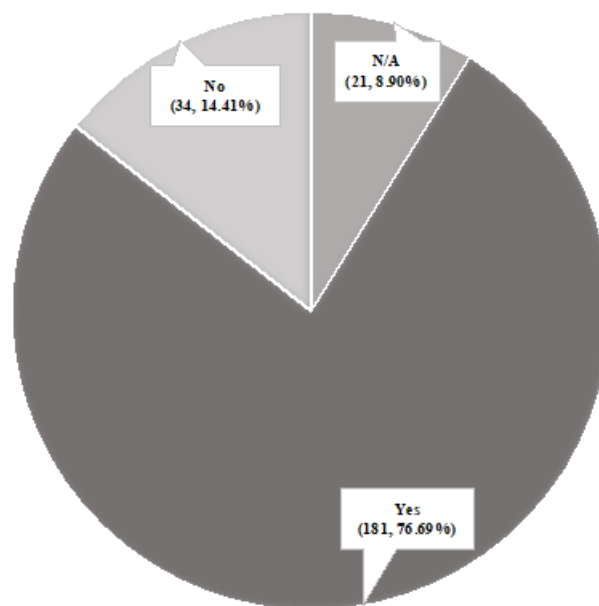
*How did you learn how to research costs for services and products recommended in a LCP? (n = 438)*



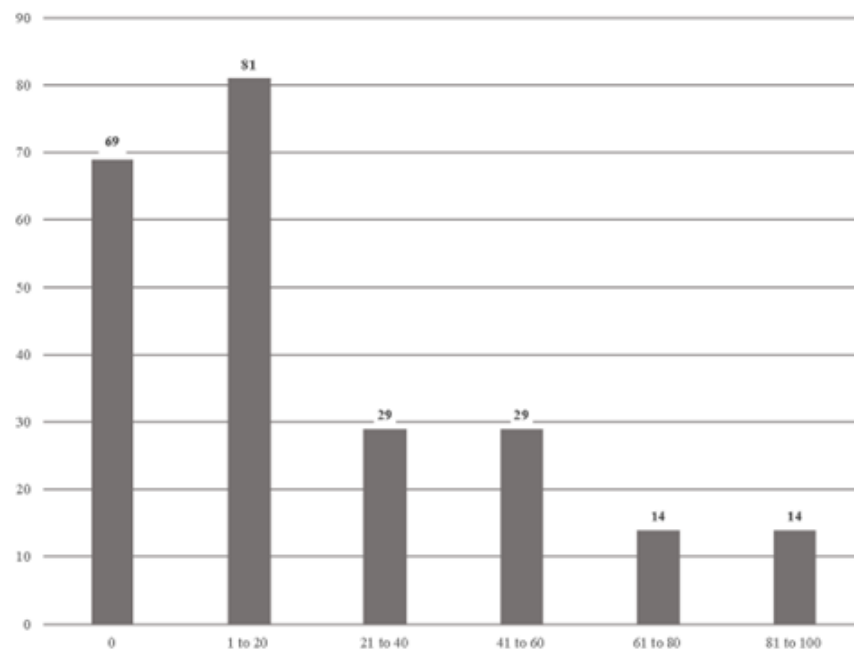
*For what percentage of the LCPs that you write do you e-mail providers to ask for actual fees for services? (n = 236)*



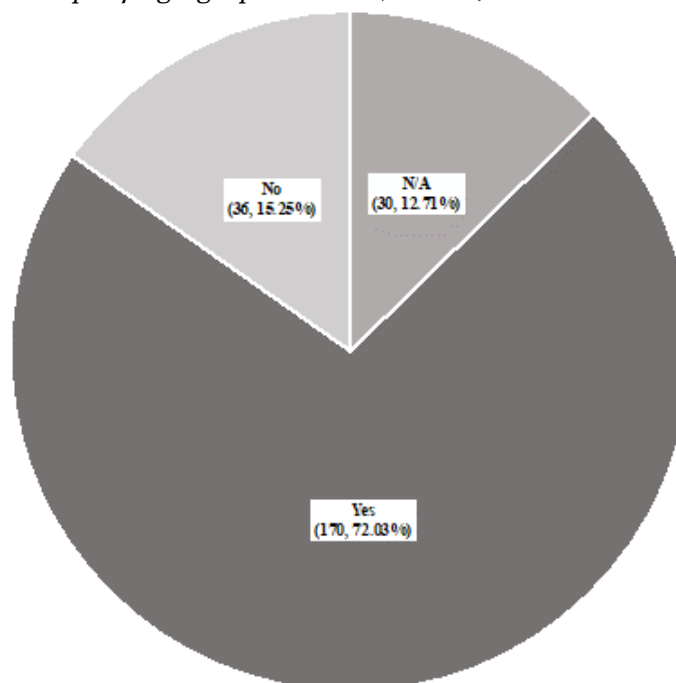
*Do you consider telephone calls to specific providers & vendors a valid method of determining the costs of services & products in a specific geographic area? (n = 236)*



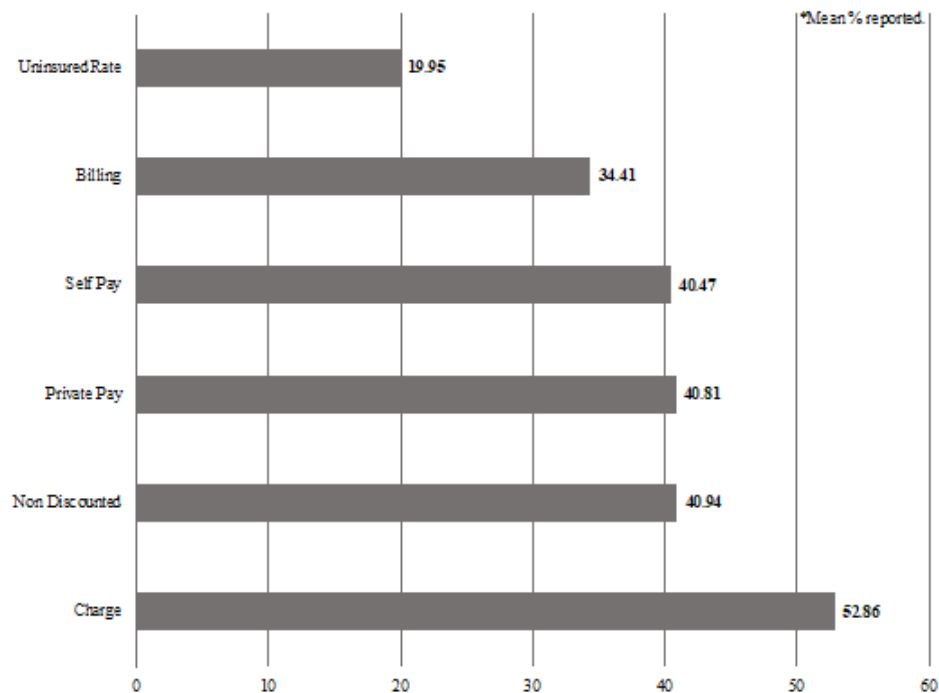
*For what percentage of the LCPs that you write do you e-mail providers to ask for actual fees for services? (n = 236)*



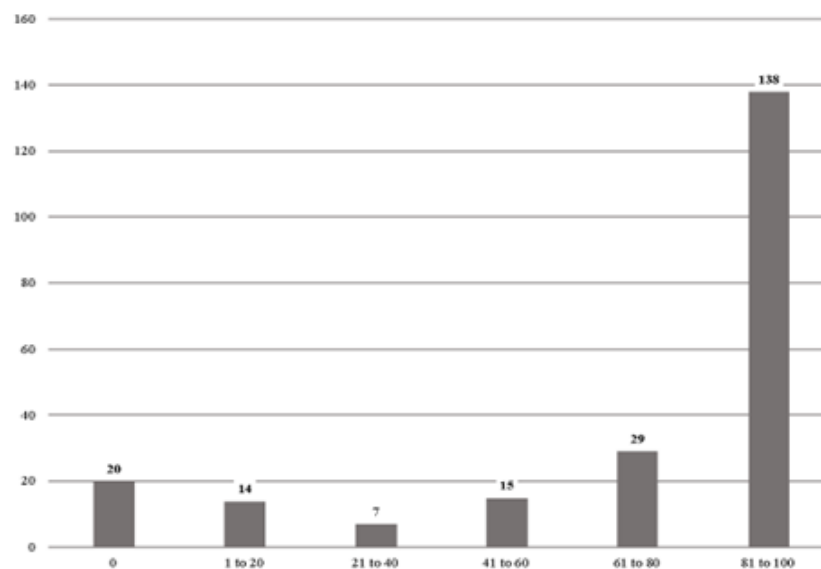
*Do you consider e-mail correspondence with specific providers a valid method of determining the cost of services in a specific geographic area? (n = 236)*



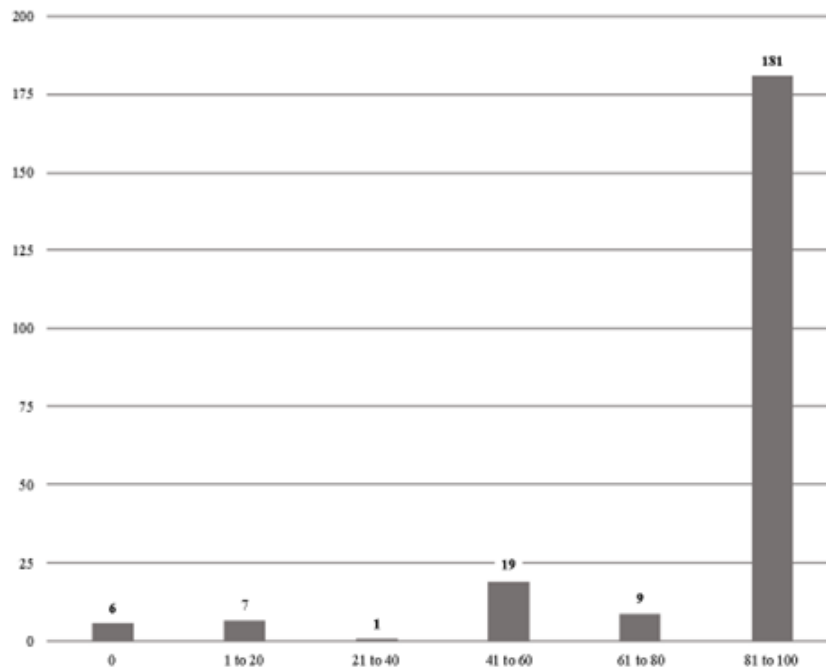
*For those who make telephone calls/write e-mail letters to providers to determine costs for medical services: For what % of the LCPs that you write do you use the term [x] when requesting information?*



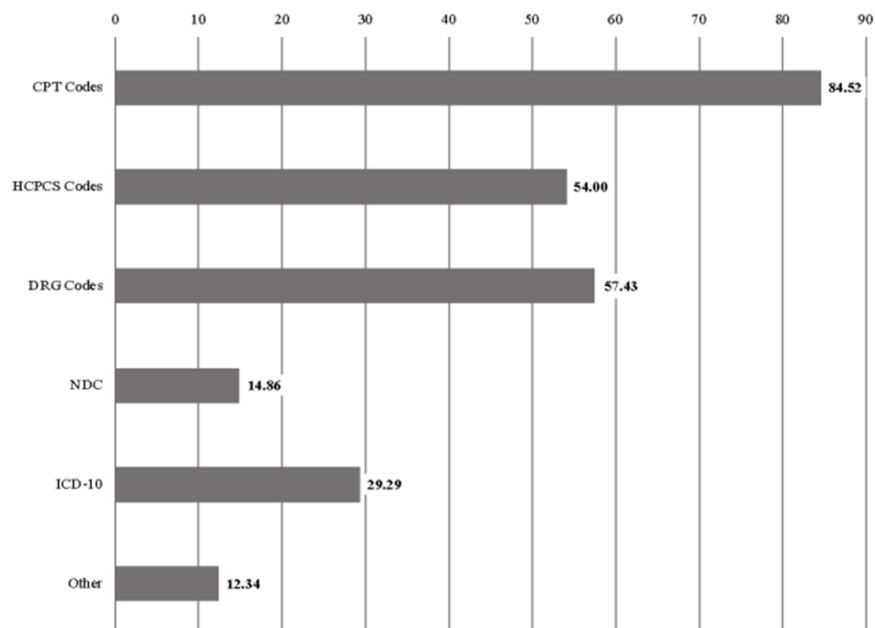
*For what % of the LCPs that you write do you use a database to determine the costs of products and services recommended? (n = 223)*



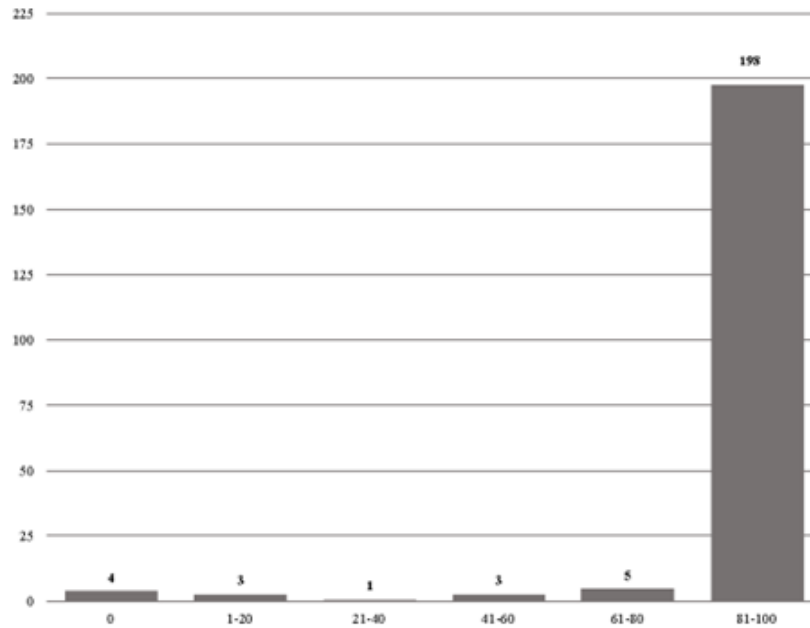
*For what % of the LCPs that you write do you use a combination of sources to determine the costs of products & services recommended? (n = 223)*



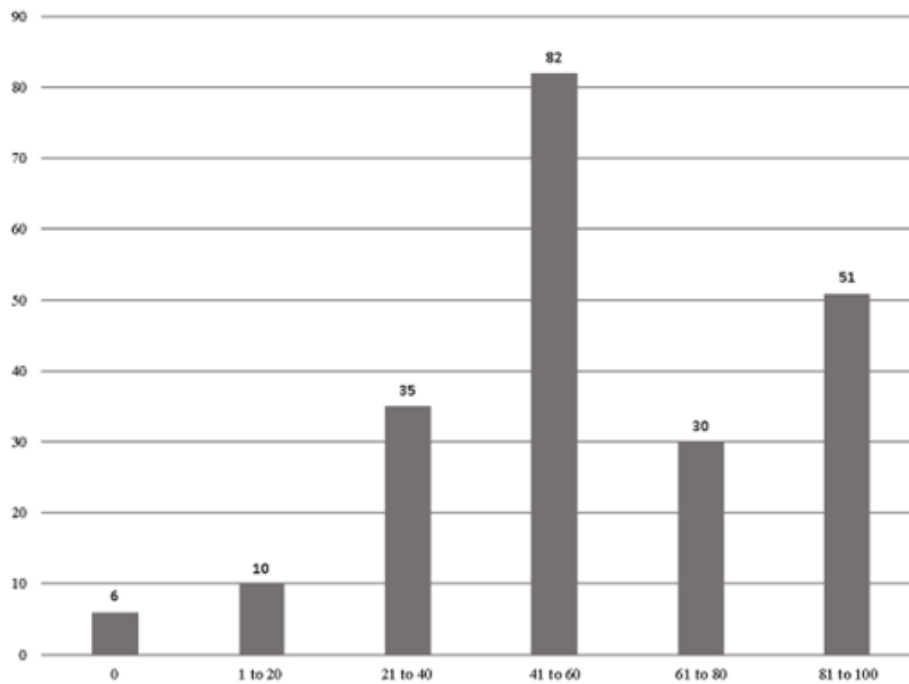
*Of the LCPs that you write in which medical, surgical, or diagnostic procedures are recommended, for what % do you use [x] to research costs? [Note: When researching medical, surgical, or diagnostic procedure costs, about 85% use CPT codes.]*



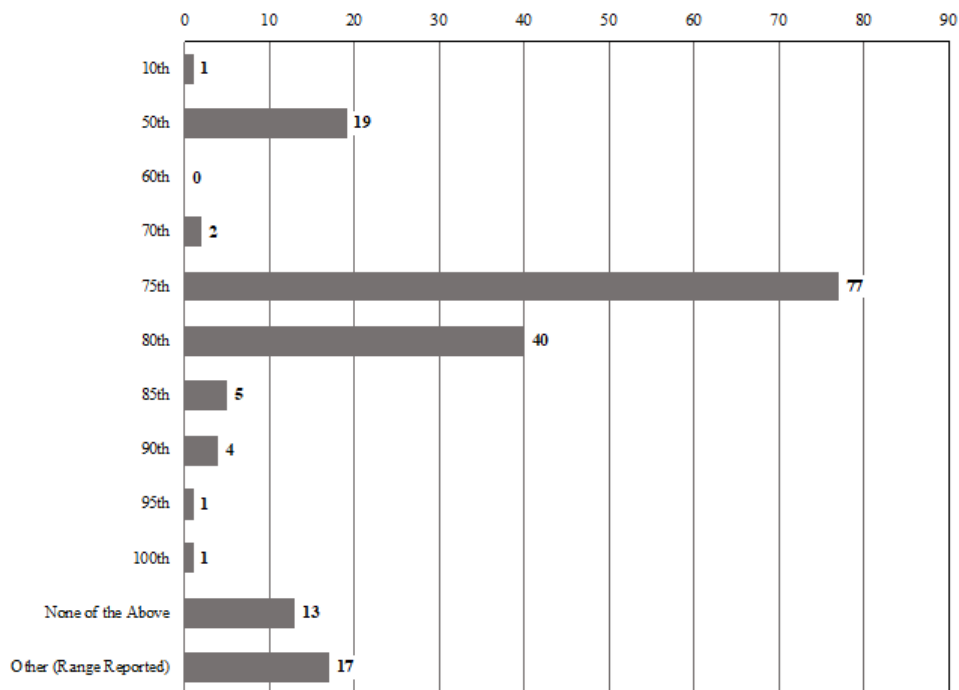
*In what % of the LCPs that you write do you identify the sources of the costs presented in your plan? (n = 214)*



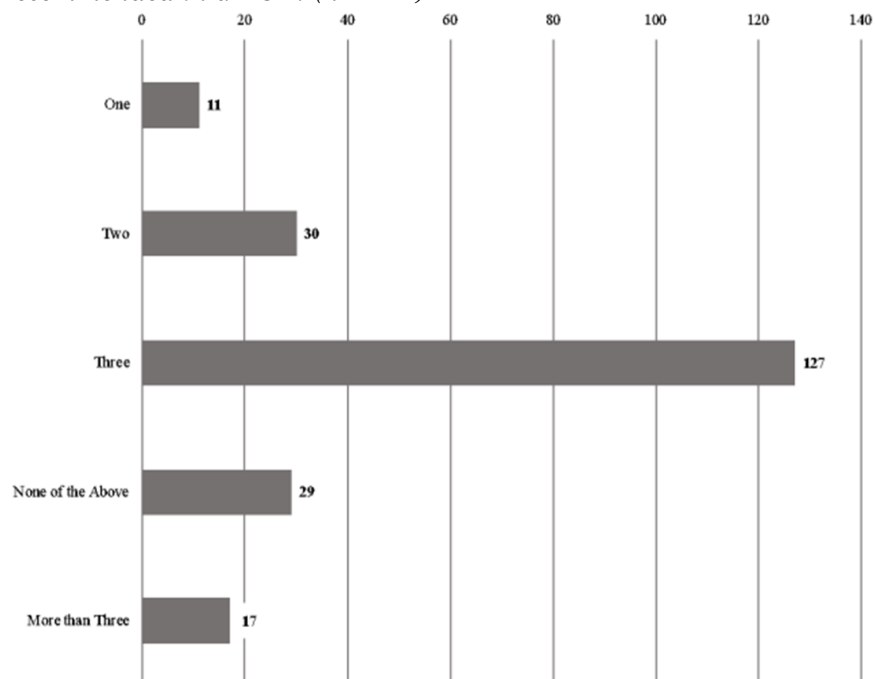
*In what % of LCPs written by others that you review can costs be verified with the information provided? (n = 214)*



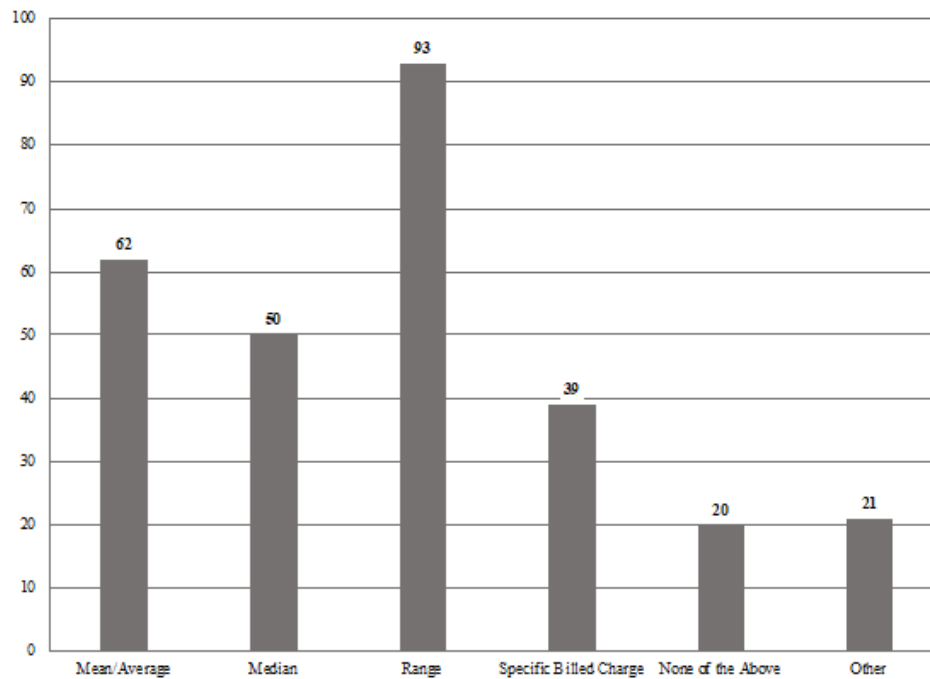
*This question is for those who use a database as a source of cost information for their LCPs. Which percentile do you use to represent costs? (n = 180)*



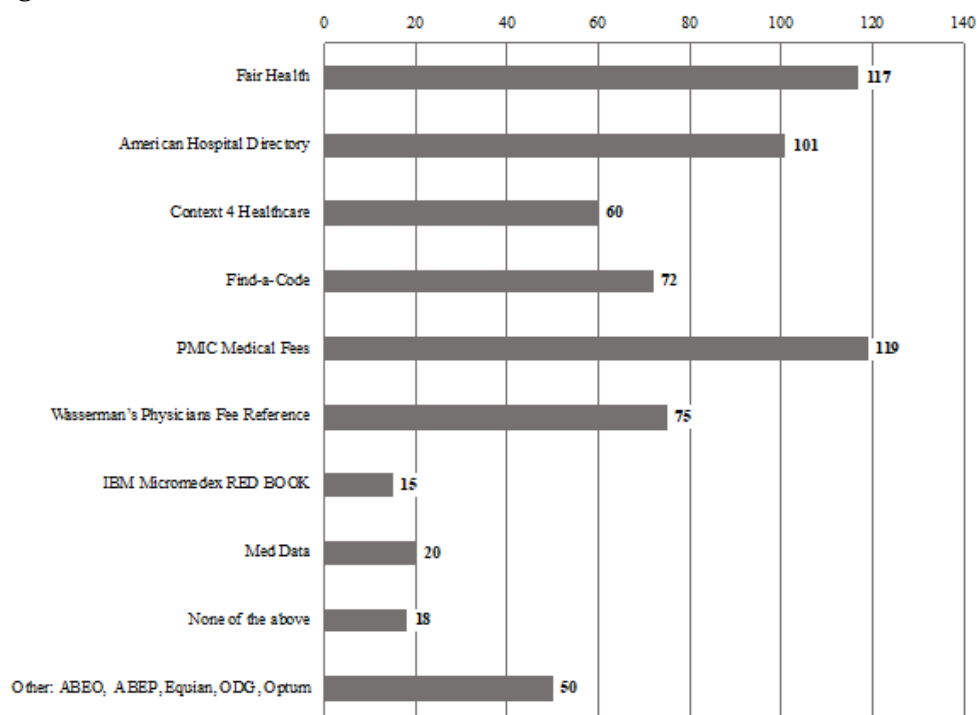
*If you do not use a database, how many cost sources do you generally obtain for a specific service or product recommended in a LCP? (n = 214)*



*If you do not use a database, which of the following do you use to represent costs of specific services and products? (n = 211)*

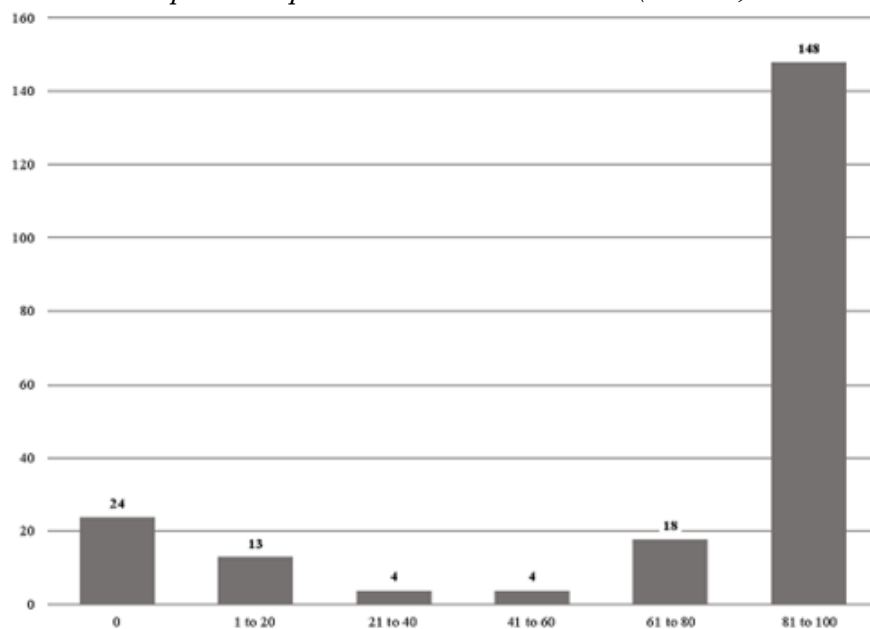


*Please indicate if you have current paid subscriptions to, or have paid to download, any of the following databases: (n = 212)*

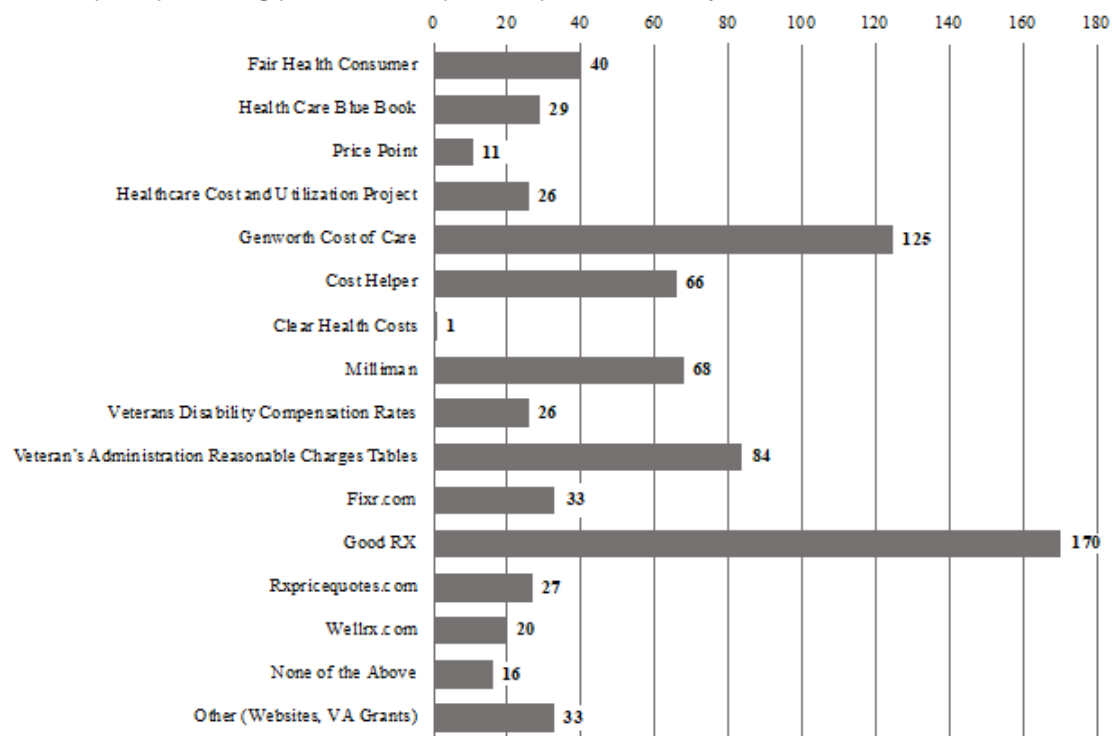




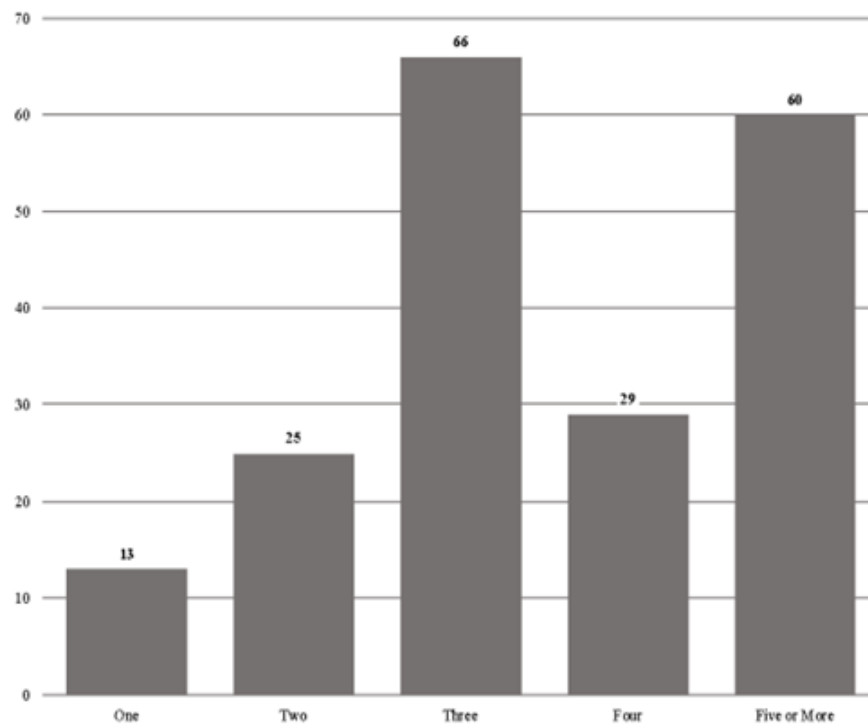
*For what % of the LCPs that you have written in the last 12 months have you used any of the databases mentioned in previous question to determine costs? (n = 211)*



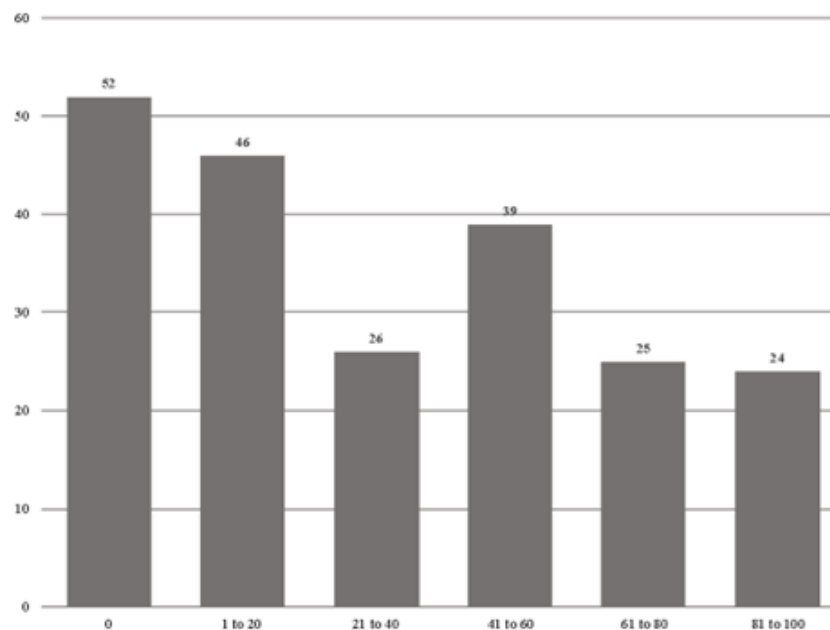
*Which of the following free sources of cost information do you use? (n = 212)*



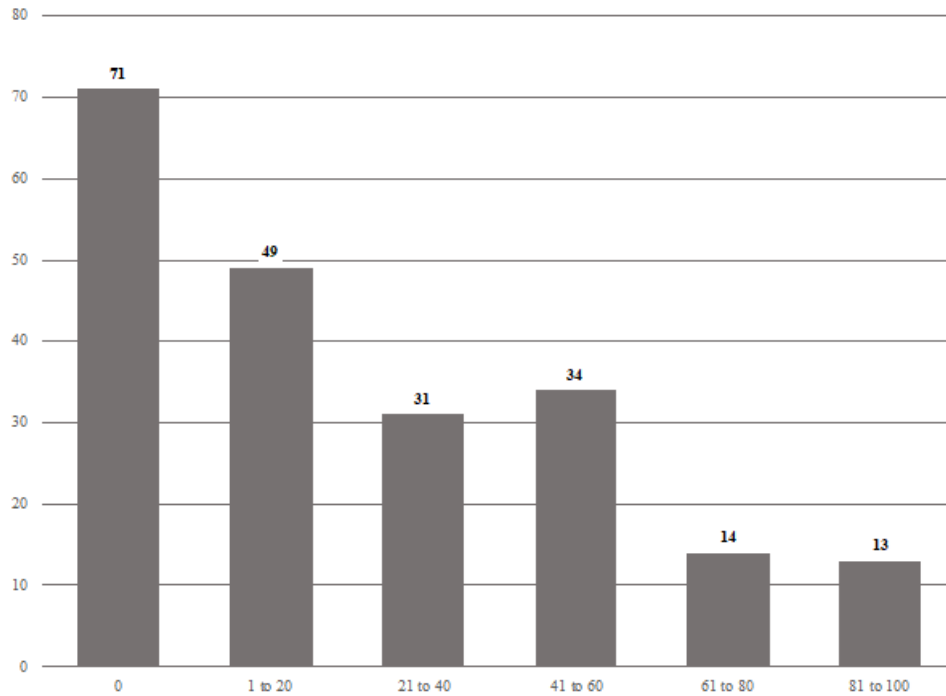
*Generally speaking, how many databases, free & subscription, do you consult for cost information when writing a LCP? (n = 212)*



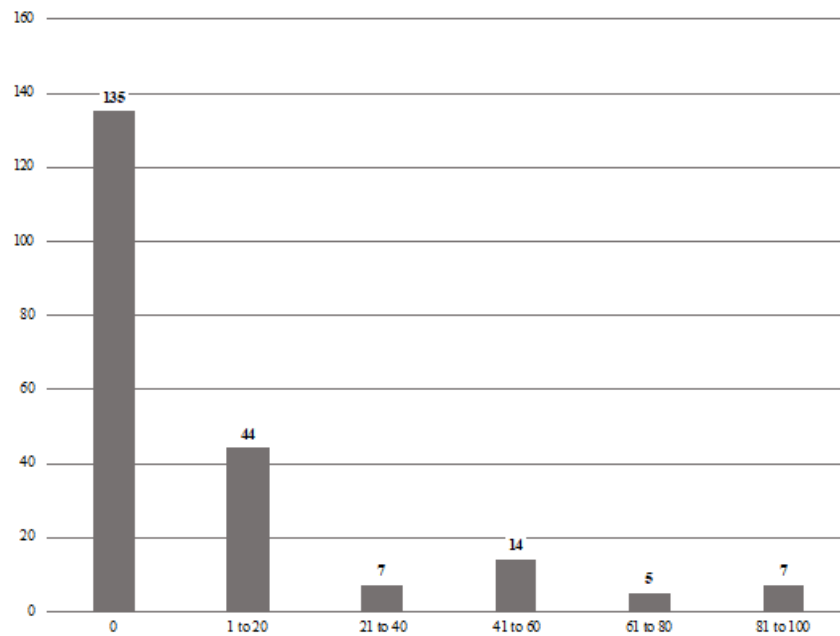
*For what % of the LCPs that you write do you rely on medical bills to determine costs? (n = 212)*



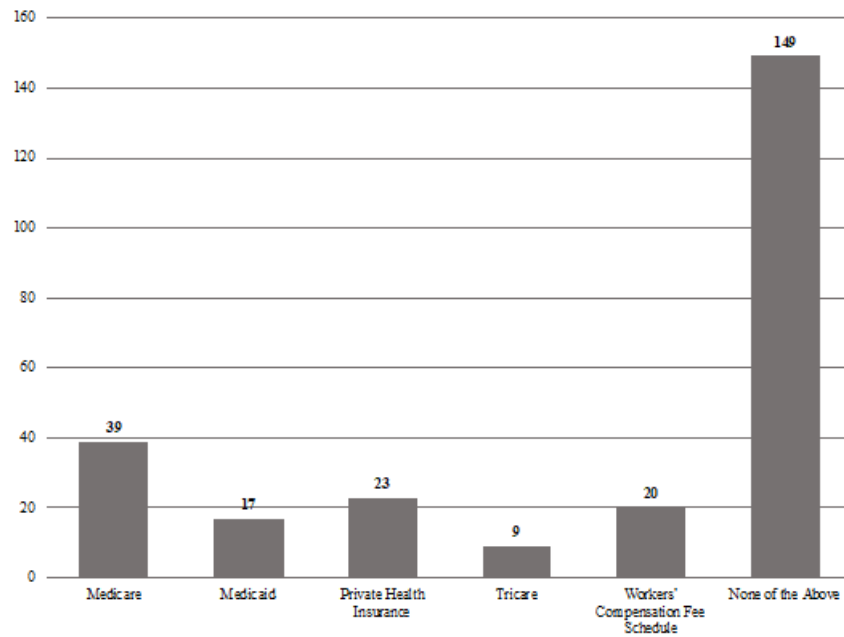
*For what % of the LCPs that you write do you rely on a hospital chargemaster or on prices published on hospital websites to determine costs? (n = 212)*



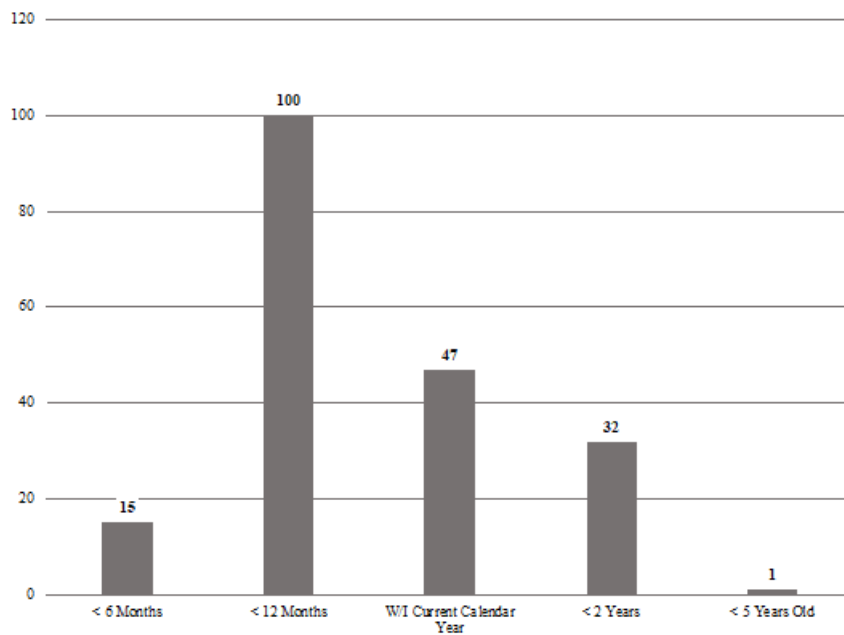
*For what % of the LCPs that you write do you rely on Medicare fee schedules to determine costs? (n = 212)*



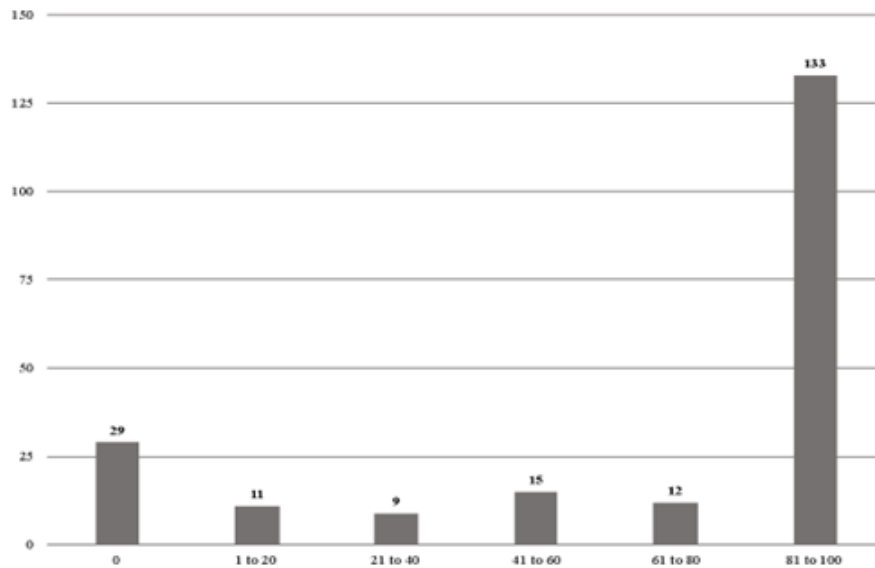
*On which of the following collateral sources of funding do you rely to determine costs for a LCP? (n = 212)*



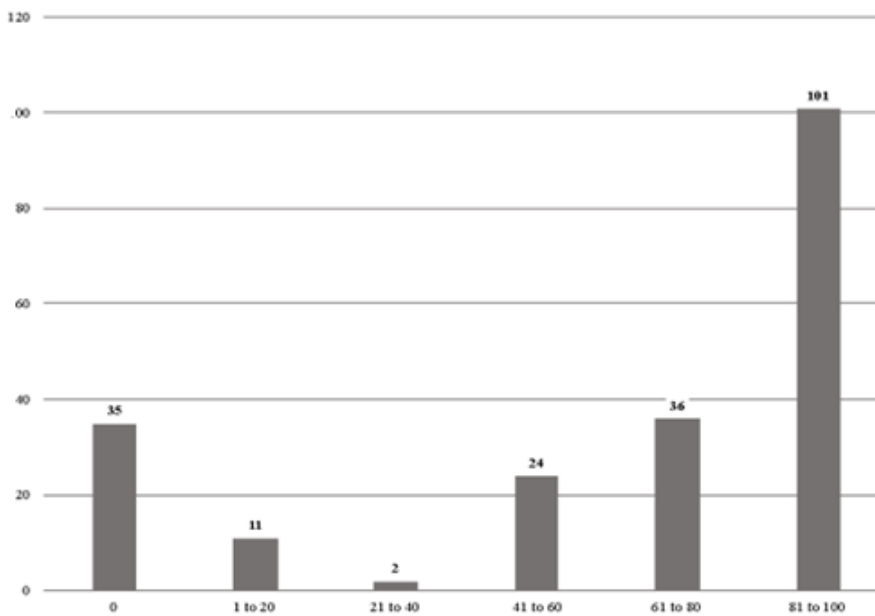
*How current do prices need to be for you to consider them valid? (n = 195)*



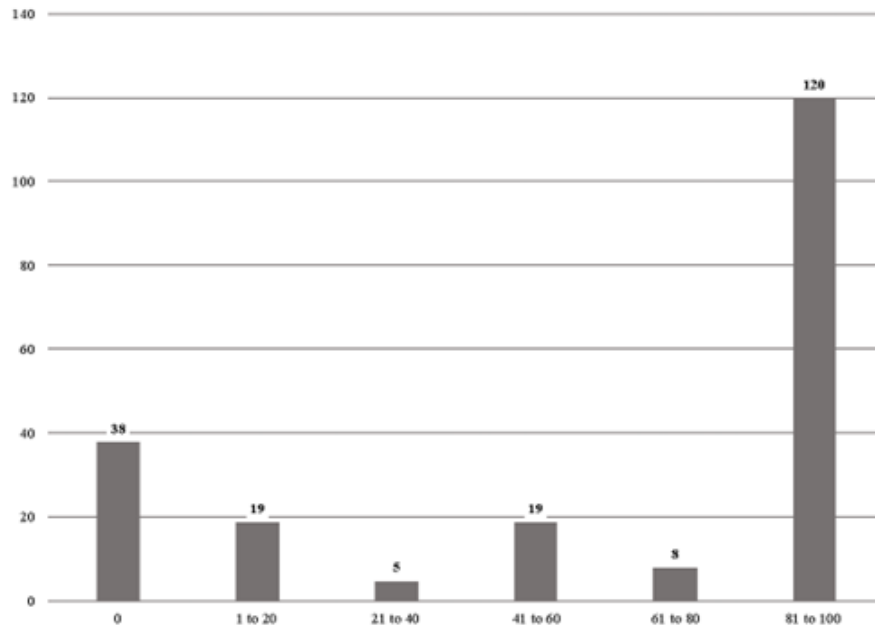
*In what % of the depositions in which you have testified have you been asked to discuss costs appearing in a LCP that you have written? (n = 209)*



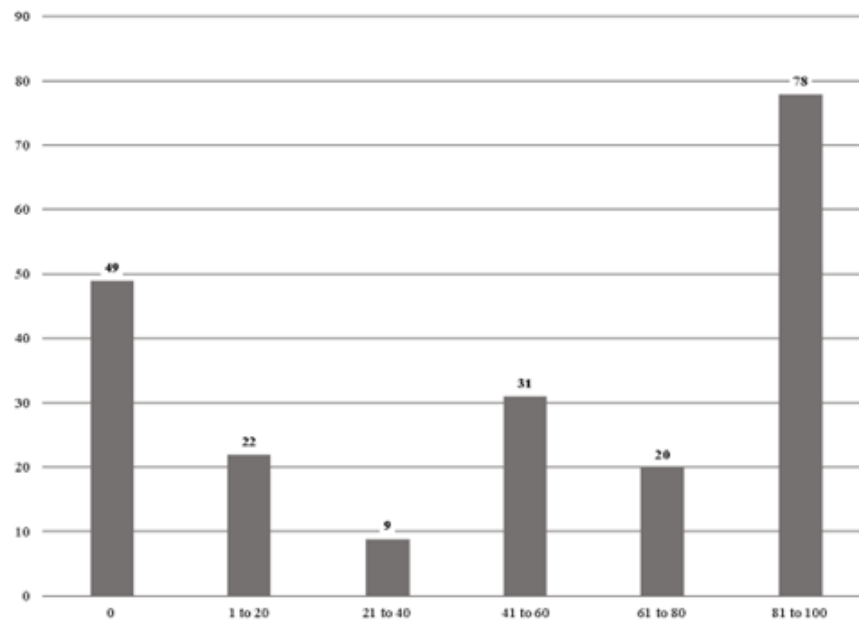
*In what % of the depositions in which you have testified have you been asked to discuss the sources of costs appearing in a LCP that you have written? (n = 209)*



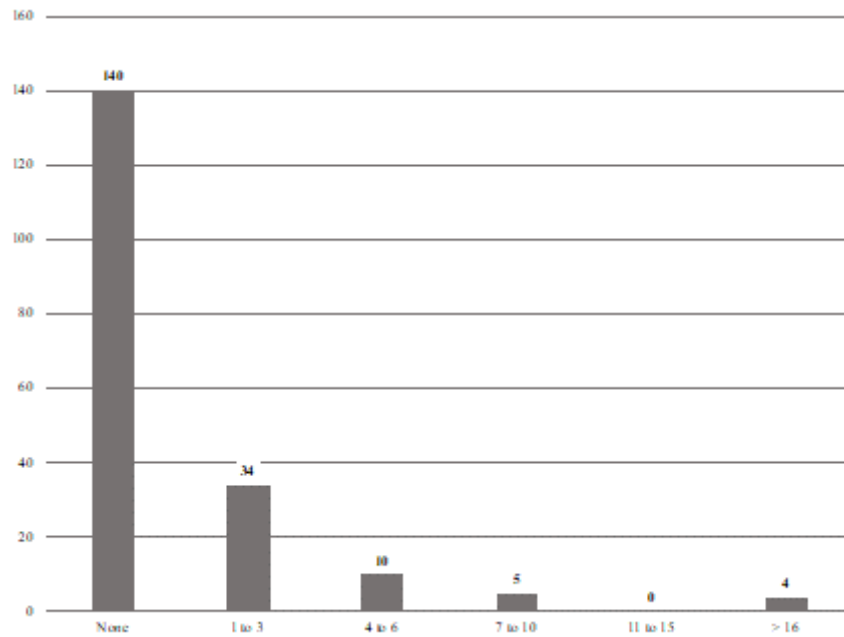
*In what % of the trials in which you have testified have you been asked to discuss costs appearing in a LCP that you have written? (n = 209)*



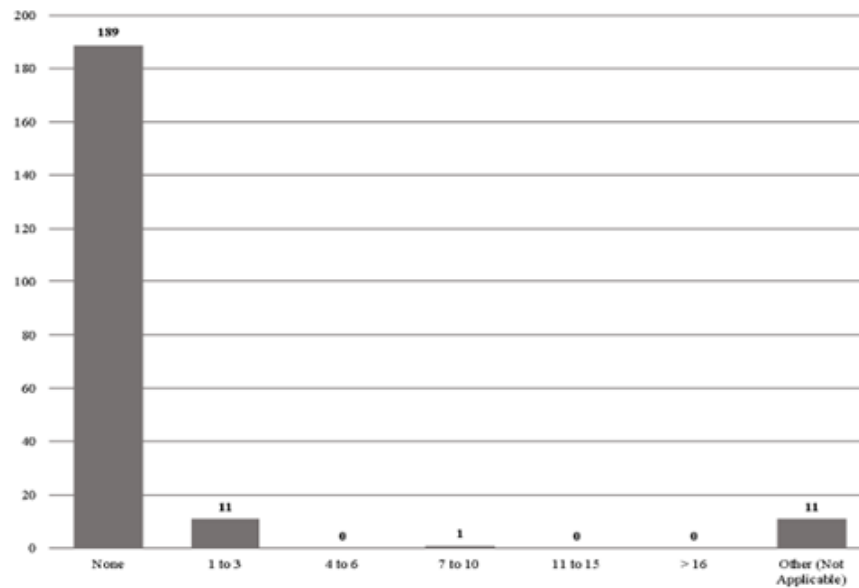
*In what % of the trials in which you have testified have you been asked to discuss the sources of costs appearing in a LCP that you have written? (n = 209)*



*How many times has your testimony regarding the costs contained in a LCP been challenged in a motion in limine? (n = 209)*



*How many times were you excluded from testimony as a result of such a motion? (n = 209)*



### Focus Group Sessions

Following the presentation of the survey results, attendees participated in a focus group. The purpose of the focus group was to allow participants to openly discuss various techniques used to identify costs and services within a life care plan. Dr. Pomeranz and Dr. Yu led the focus group using the Top Hat Platform. Top Hat is an interactive online platform that allows users to interact in a conference environment using their personal electronic device (laptop, tablet, phone) (Top Hat, 2023). Top Hat was selected so that the Summit leaders could capture the data electronically, and allow participants to have time to provide their responses. All attendees received access to Top Hat prior to the date of the summit. Additionally, the attendees received a one hour training session on using the Top Hat platform as well as the focus group methodology.

The focus groups were divided into two sessions. The first session involved questions regarding specific costing techniques with questions divided based on strengths and challenges associated with each technique. The second session related directly to addressing the techniques during preparing and receiving questions during testimony.

### Focus Group Questions

For the first session, questions were divided into strengths of using a technique, challenges of using the technique, and reasons why a costing technique is not used by the Summit participant. The questions were divided across four costing techniques: telephone calls, paid databases, and free/open access databases, and medical bills. See Table C below for the full list of questions from the first focus group session:

**Table 2**

#### *Focus Group Questions Session 1*

Technique	Focus Group Question
<b>Telephone Calls</b>	<p>Please discuss the strengths of using telephone calls when costing out goods and services within a life care plan.</p> <p>Please discuss the challenges of using telephone calls when costing out goods and services within a life care plan.</p> <p>If you do not utilize telephone calls as a technique, please explain why.</p>
Continued on next page	



**Table 2 – continued from previous page**

Technique	Focus Group Question
<b>Paid Databases</b>	<p>Please discuss the strengths of using paid databases when costing out goods and services within a life care plan (refer to the list of databases provided on screen and mention any specific database you are referring to in your response).</p> <p>Please discuss the challenges of using paid databases when costing out goods and services within a life care plan (refer to the list of databases provided on screen and mention any specific database you are referring to in your response).</p> <p>If you do not utilize paid databases as a technique, please explain why.</p>
<b>Free Databases/Open Access</b>	<p>Please discuss the strengths of using free or open access databases when costing out goods and services within a life care plan (refer to the list of databases provided on screen and mention any specific database you are referring to in your response).</p> <p>Please discuss the challenges of free or open access when costing out goods and services within a life care plan (refer to the list of databases provided on screen and mention any specific database you are referring to in your response).</p> <p>If you do not utilize free or open access databases as a technique, please explain why.</p>
<b>Medical Bills</b>	<p>Please discuss the strengths of using medical bills when costing out goods and services within a life care plan.</p> <p>Please discuss the challenges of using medical bills when costing out goods and services within a life care plan.</p> <p>If you do not utilize medical bills as a technique, please explain why.</p>

The second focus group session was based on using the costing techniques described above during testimony. The questions were divided between preparing for and receiving questions during testimony. See Table D below for the full list of questions from the first focus group session.

**Table 3**

*Focus Group Questions Session 1*

Technique	Focus Group Question
<b>Preparation: Telephone</b>	What information do you have prepared regarding telephone costing techniques before testifying?
<b>Preparation: Database</b>	What information do you have prepared regarding database costing techniques before testifying?.
<b>Preparation: Percentile</b>	Please discuss the use of the 80th percentile as opposed to 75th, 50th or 25th percentile as your industry standard when costing?
<b>Preparation: Medical Costing</b>	What information do you have prepared regarding medical billing costing techniques before testifying?
<b>Preparation: Other</b>	Please describe any information you prepare before testifying for other formats used to collect costing information directly (emails, letters, fax).
<b>Questions Received: Telephone</b>	Please describe questions you have received during testimony and how you responded regarding telephone-costing techniques?
<b>Questions Received: Database</b>	Please describe questions you have received during testimony and how you responded regarding database techniques?
<b>Questions Received: Medical Billing</b>	Please describe questions you have received during testimony and how you responded regarding medical billing costing techniques?

**Ranking**

The last step of the focus group sessions involved asking participants to 'like' responses by the summit participant's responses. The facilitator was then able to rank the

responses that summit attendees 'liked' the most. The summit attendees then had an opportunity to ask questions and discuss the top ranked responses. For example, the first focus group question of session 1 was: *Please discuss the strengths of using telephone calls when costing out goods and services within a life care plan.* After every response, participants then used the Top Hat platform to 'like' responses they considered the most important (participants can see everyone's responses on their own device). The facilitator then showed everyone the top 'liked responses'. In this instance, the most 'liked' response was "Attendant care is subject to rather rapid changes geographically and must be tailored to the person's specific needs. It is an area that lends itself to phone surveys." The facilitator then led a brief discussion on the top 'liked responses. During the discussion all participants had an opportunity to provide verbal input using a microphone so all attendees could hear. A transcriber was present in the room to document the discussion of 'liked responses.' The timing for each focus group question was as follows:

1. Read and respond to the focus group question using the Top Hat platform: 3 minutes
2. Rank ("Like") the most important responses: 2 minutes
3. Discussion of the top ranked responses: 10 minutes

All qualitative data has been recorded and is currently being analyzed. The results from the focus group qualitative data will be presented in a future manuscript.

At the 2022 Summit, participants called for the development of a costing framework to help guide life care plan costing. Dana Penilton and Laura Woodard were assigned by the Summit planning committee to co-chair this project. A call for volunteers was sent to life care planning associations (IARP, AANLCP, and AAPLCP) on July 18, 2022, and closed on October 7, 2022. Thirty-five people were selected to be on a working group and 21 people were chosen to be on an advisory committee. Members of the summit planning committee serve on either the working group or the advisory committee. The volunteers represent diversity of profession, geographic location, experience, and credentials.

The Summit Committee's goals for the development of the costing framework are to build a tool to identify the variables to be considered in making cost decisions, identify the circumstances when the variables are relevant, and identify the pros and cons of using or not using the variables. The resulting work product will provide guidance for life care plan costing. The committee will consider whether the creation of an algorithm for costing decision-making (i.e. a decision tree) will be beneficial to the field, and if so, will create one.

Meetings of the working group are initially scheduled monthly, with individual assignments and subcommittee tasks completed between meetings. Our first meetings were held on November 15, 2022 and December 9, 2022. The initial focus of the working group is on a review of the literature and other authoritative sources, and an analysis of 2022 Summit data. The advisory committee will be tasked with special assignments and will review and edit the costing framework documents created by the working group. The costing framework project is expected to take a year or two, or as long as it takes to develop a meaningful tool.

### Conclusion

Life care planners for over two decades have continued to take responsibility for the specialty practice of life care planning. They have continued to collaborate routinely to iden-

tify and address emerging issues. Costing in life care plans has been and continues to be a source of debate and discussion. The development of a committee to develop a costing framework in support of the life care planning specialty will once again demonstrate how Life Care Planning Summits provide for life care planners in their ongoing practices.

### 2022 Summit Attendees

2022 Summit attendees are listed below. They were an integral part in the determination of costing techniques in the field of life care planning.

**Table 4**

*Focus Group Questions Session 1*

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Tracy Albee	Heidi Fawber	Lauren Petkoff
Holly Allman	Ellen Fernandez	April Pettengill
Lisa Anderson	Julia Finn	Jamie Pomeranz
Kristi Bagnell	Leesa Fisher	Victoria Powell
Dan Bagwell	Cindy Fleury	Karen Preston
Payam Bahador	Jordan Frankel	Edmond Provder
Daniel Baierl	Brienne Frey	James Quinn
Rebecca Bailey	Carol Fricks	Paul Ramos
Gretchen Bakkenson	Michael Fryar	Dena Ramsey
Barbara Bate	Cecilia Garcia	Scott Ranney
Richard Bays	Thomas Garzillo	Rhonda Renteria
Kimberly Beladi	Lisa Gay	Susan Riddick-Grisham
Lindsey Bennett	Shelene Giles	Evelyn Robert
Jennifer Bennett	Susan Guth	Jan Roughan
Harold Bialsky	Cheryl Halkowicz	Anne Savage Veh
Stephanie Birely	Todd Harden	Julie Sawyer-Little
Rose Bock	Stephanie Haupt	Jeffrey Schiro

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**Table 4 – continued from previous page**


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Marianne Boeing	Teresa Hearn	Linda Schwieger
Cynthia Bourbeau	Ian Hegwood	Dionne Sellick
Brandy Bradley	Claire Heusinger	Member Services
Melissa Brassfield	Deborah Hilby	Allison Shipp
Susan Burke	Jocelyn Holt	Dianne Simmons-Grab
Rebecca Busch	Cloie Johnson	Kate Smith
Andrew Busch	Elizabeth Kattman	Ronald Smolarski
Sandra Callaghan	Melissa Keddington	Stella Spencer
Charlene Canada	Betsy Keesler	Gil Spruance
Todd Capielano	Julie Kevan	Ryan Stephenson
Penelope Caragonne	Valerie Knafelc	David Stewart
Donna Carlton	Trudy Koslow	Amy Stone
Garson Caruso	Kimberly Kushner	Amy Sutton
Tony Choppa	Sarah Larsen	Kirsten Thomas
Nick Choppa	Ashley Lastrapes	Lisa Thomas
Michelle Clarence	Sherry Latham	Kenneth Totz
Michele Cook	Sarah Malloy	Robert Tresp
Dawn Cook	Debbe Marcinko	Jessica Urie
Alisa Cornetto	Elizabeth Martina	Miranda Van Horn
Aubrey Corwin	Michael Martinez	Joanna Vasquez
Mariann Cosby	Chris McDermott	Liz Vinton
Lisa Cox	Holly McLendon	Kim Wages
Jenn Craigmyle	Stephanie McLeroy	Deborah Watkins

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**Table 4 – continued from previous page**


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Colleen Crunstedt	Judy Metekingi	Leslie Watson
Becky Czarnik	Teresa Millsap	Heidee White
Heather Dahl	Courtney Mitchell	Caroline Williams
Maria Dalisay	Bryan Muench	Tracy Witty
Brian Daly	Andrea Nebel	Aaron Wolfson
Shirley Daugherty	Erin O'Connell	Laura Woodard
Elizabeth Davis	Linda Olzack	Helen Woodard
Kelly Dawson	Britane Outlaw	Nami Yu
Tyla Dimaria	Betty Overbey	Steven Yuhas
Cheryl DiPane	John Panek	Khyber Zaffarkhan
Katherine Dunlap	Sharla Paso	David Zak
Stephanie Engler	Dana Penilton	Elizabeth Zaras
Dawn Espinoza	Gerri Pennachio	
Susan Farris	Elizabeth Peralta	

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# A Walk-Through from Referral to Testimony: Methodology & Admissibility

John R. Cary, Nick Choppa, Cloie B. Johnson, John Fountaine, and  
Tony Choppa

OSC Vocational Rehabilitation Systems Inc.

## Abstract

The focus of this paper is to address the issue of rehabilitation professionals having their credibility and the admissibility of their opinions challenged when called to testify in litigation matters, and how rehabilitation professionals should adhere to proper methodology that reflects their day-to-day clinical work. The objectives of this paper are to identify what qualifies rehabilitation professionals to provide opinions to the court, to discuss subjects of credibility often raised in a deposition and at trial, and how to address these subjects from various perspectives. Beginning at the point of referral and moving through the full spectrum of an assessment (i.e. clinical interview, testing, research, consultations, and report writing), the authors discuss effectively defending the relevance and admissibility of their opinions in a deposition and at trial. This paper covers the following topics: clinical practice, methodology, court rules, and the line between professional style, professional preference, and admissible practices.

*Keywords:* admissibility, methodology, clinical judgment, testing, specialized knowledge, training, education, court rules

The main factors that qualify rehabilitation professionals to serve as subject matter experts in legal proceedings are knowledge, skills, experience, training, and education. When a rehabilitation professional's opinions are challenged due to admissibility, these core factors are what can be called upon to establish expertise and admissibility. This paper delves into the specifics of the rules of evidence, potential lines of challenging the admissibility or qualifications of an expert and their opinions, key concepts and phrases to rely upon when testifying

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at trial and in depositions, and how to respond to a motion in limine.

## Literature Review

### Admissibility

According to Field and Choppa (2005), what qualifies a rehabilitation professional in their day-to-day clinical work is what qualifies them as experts and ultimately establishes their admissibility as an expert in the court. The main factors relied upon to establish subject matter expertise are knowledge, skills, experience, training, and education. These are the primary factors rehabilitation professionals call upon to qualify the admissibility of their opinions. Additionally, demonstrated compliance with proper peer-reviewed methodology, use of valid and reliable information and data, and remaining within one's scope of practice are essential to maintaining admissibility. Field and Choppa (2005) recommended:

The reliance on reliable and relevant principles and methods are critical to the work of the qualified expert who will be distinguished by such credentialing factors as knowledge, skill, experience, training, or education. Equally important is to develop an opinion predicated on valid, reliable, and relevant information which will be consistent with the facts of the case.

The stare decisis set by two precedent setting cases have established rules of admissibility. The first case is *Frye v. United States* (1923) which found that "[t]he thing from which a deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs." Frye reemphasized the importance of adhering to established, peer-reviewed methodology, and acting within one's scope of practice.

The second case is *Daubert v. Merrell Dow Pharmaceuticals* (1993). The decision in this case hinged on chemistry, a hard science, and so resulted in criteria that addressed hard science processes. According to Field and Choppa (2005), Daubert made clear that "the inquiry [on methodology] is a flexible one, and its focus must be solely on principles and methodology, not on the conclusions they generate." The inquiry is "intended to evaluate testimony related to scientific method, not to serve as criteria for all testimony, including soft sciences."

The results of *Daubert* place emphasis on the four basic criteria for testimony that align with the scientific process: Can the theory be tested? Has the theory or technique been subjected to peer review and publications? What is the known error rate of the particular scientific method? Is there an explicit identification and acceptance of the theory and technique by a relevant scientific community?

While application of these criteria may be straightforward for hard sciences, the same is not true for soft sciences, making it an important point of consideration for rehabilitation professionals when defending the admissibility of their opinions. Rehabilitation professionals work with the nature of the human condition; every individual is unique, and the results of findings are not necessarily reproducible in a lab. *Daubert* applies differently to the work of rehabilitation professionals as there is no standard error of measurement. Rehabilitation professionals are assessing evaluatees, as such an N of 1, therefore there is no standard error of measurement. However, there are peer-reviewed and generally accepted methodologies that must be adhered to in both clinical and expert settings.



The *Daubert* case had rippling impacts, such as depositions colloquially referred to as “Daubert deps” which are depositions that set out to ask questions for the purpose of later attempting to disqualify an expert. These deposition questions are not always obvious, and so attention to language is essential. Queries that are seemingly innocuous may be crafted to discredit the admissibility of an opinion, or the expert altogether.

The *Daubert* case connects to the admissibility of the rehabilitation professional’s expert opinions through Federal Rule of Evidence (FRE) 702, which states:

If scientific, technical, or other specialized knowledge will assist the Trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

FRE 702 identifies areas of scientific, technical, and specialized knowledge as legitimate domains for testimony that do not necessarily conflict with the *Daubert* factors. Experts can be qualified based on knowledge, skill, experience, training, and education, and these are the core tenets of expertise for rehabilitation professionals to remember when qualifying themselves as an expert in a deposition or at trial. Specialized knowledge is more specifically a combination of the aforementioned tenets, with emphasis placed on recent and past clinical work and education experience, and how these are essential elements that inform the rehabilitation professional’s opinions as an expert and distinguish them from laypersons.

Number of years of experience can be a factor in establishing one’s expertise, but it is unclear as to the minimum necessary quantity. Years of experience bears less weight, and so there is no concrete answer because it depends on the individual expert and their ability to articulate why they are qualified. Qualification as an expert includes the core tenets of expertise, as well as an ability to articulate these tenets with proper terminology, membership and participation in professional associations, adherence to a code of ethics, continuation of education and training, and a history of specific professional experience. The actual quantity of years has variable relevance in the face of these other factors.

The concept of specialized knowledge includes qualitative and quantitative information for triangulating data and formulating valid opinions. This is analogous to diagnostic imaging: the imaging provides quantitative data, while the qualitative data is the radiologist’s impression of the imaging. Both types of data are relevant and necessary for arriving at a conclusion.

Pertaining to the question of how rehabilitation professionals do what they do, given the background that they have, the following quotes by Grimes (2002) apply:

“The accuracy of the analysis is primarily based upon the three factors of methodology, clinical expertise and accurate application of the available researched data.”

“The [vocational expert] (VE) is vulnerable to error in the decision-making process when they lack the experience in evaluating a case and are overly reliant upon the data.”

“The experienced VE is prone to analysis error if they are overly reliant upon their experience and ignore the data or fail to evaluate how the data applies to a specific individual.”

Grimes (2002) implies that there is a balance between exercising expertise and clinical judgment, just as there is a balance between the qualitative and quantitative data utilized for arriving at an objective opinion, such as the radiologist relies on diagnostic imaging to inform their opinions.

There are several relevant cases that explain how The Court’s rules apply to expert opinions, and have further fine tuned the rules to explain why experts are needed by courts.

*General Electric Co. v. Joiner* (1997) defined the judge as the “gatekeeper” with regard to determining the admissibility of evidence, thus positioning the trier of fact as possessing discretion to admit or exclude testimony by an expert. Ultimately, it is the judge who decides whether an expert’s testimony is admissible or not.

*McKendall v. Crown Control Corp.* (1997) directed the Court to first “determine whether the expert has specialized knowledge that will assist the trier of fact to understand the evidence” (Field & Choppa, 2005). The *McKendall* decision connects back to *Daubert*: “*Daubert* factors are confined to the evaluation of scientific knowledge, and ruled that an expert may be qualified to testify by knowledge, skill, experience, training, and education” (Field 2000).

“*Kumho Tire Co. v. Carmichael*” (1999) further clarified the role of the gatekeeper by allowing judges considerable leeway in scrutinizing the testimony of an expert in the context of technical and specialized knowledge. The court would now have leeway to admit testimony that might not meet one or more of the *Daubert* factors.

Although memorization of the aforementioned cases is unnecessary, the importance of understanding the implications of these and other decisions, as they pertain to rehabilitation professionals relying on their clinical qualifications and experience as the basis of their expertise cannot be overstated. Understanding the context of these rulings allows rehabilitation professionals to adequately assess the underlying purpose of questions related to their credibility and expertise. Questions regarding the standard of measurement for rehabilitation assessments relate to this issue and are appropriately addressed with responses that explain that rehabilitation professionals deal with individual evaluatees (n of 1) and rely on a mixture of quantitative and qualitative data and specialized knowledge, not standard measurement per se.

In a deposition or trial setting, it is necessary to be able to use precise language that accurately articulates the scope of professional practice. Again, rehabilitation professionals must operate within the scope of their practice, adhere to a code of ethics, utilize generally accepted published and peer-reviewed methodologies, and rely on data that is both valid and reliable. The primary tenets of being an expert rehabilitation professional are: be properly credentialed, offer services and testimony within one’s area of expertise, rely on valid and customary foundations for information and data, and be clear on selected methodologies that have been generally accepted and peer reviewed.

## Skills

### Case Conceptualization, Clinical Judgment, and Methodology

Regarding case conceptualization and clinical judgment, articulating the utilized methodology is not only a function of knowing what has been done, but why it has been done. Chapter 3 of Dr. Rick Robinson's (2014) book *Foundations for Forensic Vocational Rehabilitation* emphasized the importance of understanding the methodology utilized for arriving at an opinion and being able to articulate the underpinnings of the methodology (Choppa et al., 2014). Dr. Robinson's book reviews over 25 methodologies and is a valuable resource for understanding and articulating methodology utilized by rehabilitation professionals.

Case conceptualization is the process of developing an understanding of the facts of a case and formulating opinions while adhering to proper methodology to remain within the parameters of admissibility (Choppa et al., 2014). The process serves not only to understand the larger picture of an evaluatee's circumstances, but to also assist in identifying any gaps in information that may be needed for an evaluation. This information is typically obtained, or identified as needed, during the evaluation of records, intake interview process, and consultations. Specialized knowledge is applied to the case conceptualization process and outlines the characteristics for what distinguishes an expert from a layperson. The expert's specialized knowledge informs the identification of relevant questions toward obtaining relevant and reliable information for arriving at valid opinions.

Clinical judgment acts in conjunction with case conceptualization. Dr. Robinson's (2014) text is referenced for its focus on case conceptualization and how Opinion Validity® is achieved through the lens of clinical judgment: as the application of relevant information requires clinical judgment. Clinical judgment ties back to admissibility factors in that clinical judgment uses experience and understanding of methodology to properly opine on and apply relevant and reliable information. Choppa et al. (2014) recommended,

Clinical judgment requires that the final opinion be predicated on valid, reliable and relevant foundation information and data that are scientifically established through theory and technique building which has been tested, peer reviewed, and published, with known error rates, and is generally accepted within the professional community. (p. 135).

Clinical judgment is defined as experience understood (Choppa et al., 2005); the application of clinical judgment is used in conjunction with generally accepted, published, peer-reviewed methodology. Clinical judgment ideally strikes a balance between the expert's experience and education as suggested by Grimes (2002).

Case conceptualization occurs throughout the assessment process, (i.e. during the review of records, interviews, consultations, and while researching) and in tandem with the rehabilitation professional's application of specialized knowledge and clinical judgment to formulate opinions. Case conceptualization plays an essential role in the preparation of a report, and when given an opportunity, during review of an opposing expert's report.

"Can you spell the methodology you use?" is an idiom that stresses the importance of understanding case conceptualization and methodology. Specifically, it references a recent federal court case where a gentleman was injured; records were reviewed, interviews and testing were done, and residual functional capacity determined that he would not be able to

do the work he did pre-injury. The plaintiff expert utilized the RAPEL method, looking at the evaluatee's vocational rehabilitation and life care plan, access to the labor market, placeability, earnings capacity, and labor force participation. An opposing expert wrote in their report that the plaintiff's expert "used RAPHEL testing to determine...vocational aptitudes." It was clear the opposing expert was not familiar with this generally accepted and peer reviewed methodology and mistakes it for a test instrument. The expert could have indicated they were unfamiliar with RAPEL, but instead left themselves vulnerable to issues of admissibility.

The main takeaway being, reliance-upon methodologies that are generally accepted and peer-reviewed is the standard; and experts should be able to adeptly articulate the relied upon methodology in a written report or when testifying in a deposition or at trial. In addition to peer reviewed and accepted methodology, articulating the case conceptualization process and clinical judgments relied upon for arriving at an opinion, in a way that others will understand, is necessary to ensuring the admissibility of rehabilitation professional's opinions.

## **Referral**

There are multiple phases in a case, beginning with receiving a new referral, and within each phase are elements that often intersect with factors of admissibility. Conflict checks are essential to avoid unnecessary problems, which can be accomplished by obtaining the name of the parties involved (e.g. plaintiff, defendant, referring, and opposing attorneys) along with the date and nature of the injury. The scope and description of assignment is also important to obtain at the onset of referral, which includes determination of case needs, communication of background and limitations, and establishment of jurisdiction. It is recommended to obtain case schedules and deadlines for expert reports, discovery cutoff dates, mediation dates, and trial dates, keeping in mind any potential scheduling conflicts. Deadlines are vital to meet; if a deadline for a report or the actual testimony is missed, it is almost guaranteed that an expert's opinion will be excluded. While this is not related to methodology, it is a matter of professional practice.

It is also important to discuss and be transparent about fees and retainers from the start of a referral. Having a clear rate sheet sent to the referral source that defines billing rates and invoicing practices is recommended and required in some venues. If there are variations in what is charged, the reasons for those variations should be understandable. Most important is being clear about billing and invoicing practices and policy upfront for the sake of setting reasonable expectations. Billing, and when to do so, is often a subject targeted in depositions. Actual billing is often less relevant than being clear and consistent about billing practices. It is important to note that experts are paid for their professional time, not their testimony or opinions per se. Additionally, rates do not change based on the outcome of a case as there are ethical considerations that disallow rehabilitation professionals from billing based on contingency. Keeping a record of time worked is incredibly helpful for addressing questions related to billing as well as demonstrating the amount of time spent on the case, which in turn can help validate the rigors of arriving at an opinion.

At its core, the above elements are tools to ensure a mutual understanding that the nature of the assignment is within the expert's scope of practice and to ensure that there are no conflicts. Clarification of the scope of work early helps to negate any potential confusion of expectations between the rehabilitation professional and referral source. Case conflicts

bear their own implications, and addressing these key subjects from the start is critical to avoiding any potential misunderstandings.

The process of documentation from the very beginning and adhering to generally accepted and peer reviewed methodology are standard actions that help to support the admissibility and validity of an opinion. Part of this is distinguishing between one's own expert opinions versus that of the referral source's opinion. For example, a referral source may describe a client as "totally disabled" upon referral but that may not be the opinion of the rehabilitation professional assessing the case. The proper response to this situation is to use caution, making sure to attribute any opinions belonging to the referral source as theirs alone, and that the rehabilitation professional's opinion is independent and the result of the utilization of peer reviewed and accepted methodology.

Obtaining relevant records is necessary to having the information needed in order to build foundational knowledge on data customarily relied upon. When acquiring records, it helps to consider the record review process to decipher what records are actually needed. There are a variety of records generally relied upon for arriving at an opinion. There are instances when it may seem unclear which records to request, or when a referral source is reluctant to provide the requested records. While each case is distinct, generally speaking, it is advisable to make note and keep a record of what was reviewed, and whether information was requested and if it was denied or not. Ultimately, a rehabilitation professional can only formulate an opinion using the materials that are made accessible to them; when a referral source is reluctant to share or withholds information that is a reflection on them, not on the rehabilitation professional and their ability to reach an opinion. In addition to record reviews, there are also uncertainties about whether a rehabilitation professional can rely on a medical chronology or summary authored by another professional.

On one hand, medical summaries created by other professionals may be helpful for conceptualizing the whole picture and reinforcing an understanding of a client while delving more deeply into the details of their history and situation. On the other hand, rehabilitation professionals are encouraged to confirm and verify the information they rely upon. Alternatives for summarizing the information and pulling excerpts verbatim as a synthesis are acceptable so long as they are accurate; direct quotes are helpful in ensuring specificity and accuracy of language. Both methods are acceptable so long as they are accurate. Additionally, having documentation relied upon in summary during a deposition may be helpful as attorneys are apt to pose questions regarding those documents or records. It is key to be able to demonstrate that while records are not memorized, there is in fact a way of showing the records were reviewed by having key documents or quotations readily available when being questioned. The types of records reviewed and the time spent reviewing them are a means for establishing that the work was thorough and reliable.

### **Intake Interview**

Specialized knowledge serves as a means for curating reliable information, being able to digest it, and being able to determine how to apply it. The information used must be relevant and reliable. Relevant and reliable information is often obtained in several ways, but most immediately through records, intake interviews and testing.

There are instances in which conducting an intake interview is not possible, not permitted, or simply does not happen. For example, when the evaluatee is deceased or is a child,

or in cases involving cognitive impairments, when access to an evaluatee is denied, it is recommended to make note of that so that; should the issue arise in a deposition or trial, there is then a record that an attempt was made to coordinate an interview or testing. When an interview simply is not possible, it is important to consider methodology and use clinical experience/knowledge, training, and case conceptualization to assess the information and determine whether a sound opinion can be provided or additional information is needed. Then, how to obtain the information somewhere else, such as parents, friends, or family members should be considered. Alternatives such as sitting in on live depositions or a doctor's evaluation of an evaluatee, which may be helpful for obtaining the information.

When it comes to conducting and memorializing a clinical interview, there are multiple approaches and practices, but all must be considered through the lens of proper methodology, which leads to admissibility. Documentation is a matter of professional style, but must have sound reasoning; for example, notes can be hand-written or typed, notes may be destroyed as some professionals choose to do, or there may be no notes at all.

Questions may arise as to the validity and reliability of an assessment when access to an evaluatee is denied. However, according to published peer-reviewed journals, a valid and reliable assessment can be conducted without access, so long as the resulting conclusions are based on sound clinical judgment, though it must be stated when there was no access, followed by what information was relied upon. Again, it is specialized knowledge, experience, and clinical judgment that make rehabilitation professionals qualified experts, able to assess the information provided and draw a reliable conclusion.

Questions from previous depositions provide examples of what a rehabilitation professional may face regarding the intake interview process, admissibility, and methodology. The following deposition questions were detail-oriented, highlighting the importance of focusing on such details throughout the progression of a case: When was the evaluatee interviewed? Was the meeting in person? How long was the interview? How rehabilitation professionals address these questions relates back to case conceptualization, adherence to methodology, and using clinical judgment. Each interview question hits on one piece of the puzzle and rehabilitation professionals use their specialized knowledge to assess the need for additional information, or whether to perform testing for aptitude, interest, or achievement. The process for determining what is needed for any given assessment, when conducting an intake interview, provides the correct response for the questions a rehabilitation professional can expect to hear when in a deposition or trial regarding this topic.

## **Training**

### **Conflicting Medical Opinions**

It is not uncommon to encounter conflicting medical opinions. Approaching these conflicts is often a matter of proper application of peer-reviewed methodology. The rehabilitation professional is not typically a trained or licensed medical provider and cannot judge, for example, two orthopedists with differing opinions, to determine which is most accurate. However, the rehabilitation professional has the ability to address such conflicts within the context of their analysis. Other times, the expert is simply asked to rely upon one medical opinion or another for their analysis. Ultimately, this is left to the judge or jury.

## Research & Data

Admissibility factors regarding use of research and data include not sourcing irrelevant or unreliable data. Generally speaking, state and federal data have historically been considered reliable. Use of research and data must include genuine analysis of materials and involves a proper assessment of the reliability and validity of those materials. Some sources have an undisclosed agenda or purpose, or only include only limited aspects of a larger topic that may be the subject of the research; knowing these things is important to ensure that an opinion is truly and properly informed. Similar to testing, rehabilitation professionals must be able to articulate what is being relied upon and the underpinnings of the source and data. Ultimately, emphasis is placed on being knowledgeable and informed about what is being used to arrive at an opinion. Rehabilitation professionals should be able to speak to what has been included in a report, and at times, include a disclaimer that it is not the intent of a report to summarize all the records and data relied upon but to reflect the relevancy of specific data and sources relied upon. Additionally, when it comes to writing the report, it may be helpful to make a statement that, should additional information become available, the report will be updated as necessary.

## Experience

### Testing

Questions of admissibility may be raised at all phases, including testing. Testing involves instruments that have standard errors of measurement, and there are some considerations to being able to articulate the use of testing and how the testing is then applied back to the individual evaluatee. Conducting testing as rehabilitation professional is a practice in the qualitative-quantitative synthesis of the individual. When it comes to testing, there are important elements to consider: the tests being administered, where the tests are being administered, and how important it is to be familiar with the test's validity and reliability. Questions related to these elements point back to *Daubert*; specifically, regarding whether a theory or technique has been subjected to peer review and publication, whether there is a known error rate of the particular scientific method, and whether there is an explicit identification and acceptance of the theory and technique by a relevant scientific community.

Rehabilitation professionals use instruments and techniques that are generally accepted. An expert who administers a spelling test in which the expert determined the words for the test, for example, is unacceptable. The standard methodology includes using a wide range of peer reviewed and accepted achievement tests for scholastic assessment, not self-designed tests. Similarly, if an expert administers a test unfamiliar to another rehabilitation professional, albeit obscure, that does not necessarily make the test inappropriate. However, it is generally advisable to stay abreast of testing and stay within proper methodology.

When assessing whether an instrument is acceptable to use, it is advisable to consider the following questions: Is the instrument or test generally accepted and used in the field? Is it the same type of instrument or test relied on in other settings? Are the strengths and limitations of the instrument understandable and relatable to others? While this information does not necessarily need to be memorized, rehabilitation professionals should be able to articulate and define what is being used as part of their specialized knowledge and methodology. It is not uncommon to be unable to remember everything read and assessed,

and when being deposed or questioned, that may open the door to questions of admissibility. To avoid being vulnerable to a motion in limine when questioned about such details, it is important to provide a full and complete answer that explains that although the information may not be accessible at the moment, the information can be obtained and provided. The main point for rehabilitation professionals to remember is that the outcomes of testing administered have been applied to the assessment as part of synthesizing qualitative and quantitative data for arriving at an opinion. These are standard methodological approaches that are utilized in clinical practice. The standard error of measurements for testing does not need to be memorized. Rather, rehabilitation professionals need to know the tests that are being used and be able to articulate that testing relies on peer-reviewed and accepted test instruments that are generally used in the field of rehabilitation. There should be no change in the method or instruments used clinically when evaluating individuals forensically. The rehabilitation professional is looking at the data derived from the testing and applying the data to their assessment, while synthesizing qualitative and quantitative measures. These daily clinical practices, what we do, deem rehabilitation professionals' assessments relevant and their opinions admissible.

The following examples are actual past deposition questions intended to address admissibility: "You administered several assessments to [the evaluatee] during your interview...what is the sum and substance of that test?" and "Do you think [the evaluatee] is smart?" Regarding the first question, as a matter of admissibility, the data derived from testing (quantitative) are evaluated with the other data points discussed, e.g., interviews (qualitative) and are applied to the assessment (synthesis). Regarding the second, the question itself should prompt a response that clarifies that rehabilitation professionals engage with academic skills, aptitude levels, experience, and academic achievement levels, not personal opinions about if someone is "smart."

## **Consultations**

Utilization of consultations during the assessment process is common. Consultations are collaborative discussions between professionals and are used when additional information is needed but exists outside the scope of one's own practice. Given a rehabilitation professional's specialized knowledge and training in the medical, psychiatric, and social aspects of disabilities, rehabilitation professionals are uniquely qualified to consult with the appropriate health care professionals to help define the nature and extent of impairment and its application to all areas of an evaluatee's life. Rehabilitation professionals then interpret what the nature and extent of those impairments are and how they apply in the world of work or independent living. It is of the utmost importance to stay within one's own scope of practice and know when to seek external consultation to gather the necessary information and foundation for reliable opinions. This remains the same when others seek consultation with rehabilitation professionals.

With regard to memorializing consultations, documentation is valuable, and it is recommended to do so in writing when appropriate. After a consultation, it is useful to send confirmation restating the recommendations, which does two things: it creates a record of the consultation and what was covered, and it establishes that the information and opinions discussed were correctly understood. In clinical work, a follow-up letter is not always necessary due to the ongoing nature of the work, but it is often utilized by the presenters in their



clinical practices for documentation and relationship-building. With forensic consultations, however, there is often a trial deadline and ongoing work does not continue into the future, like it typically does in a clinical setting. Memorializing the consultation clearly documents who was met, what was discussed, and allows the details of the consultation to be revisited throughout the case conceptualization process, in addition to providing a record for often busy physicians who may not recall what was discussed during the consultation.

## **Depositions**

Depositions require active and careful listening, because language is precise and meanings are easily distorted when improper language is being used by the questioner, or by the rehabilitation professional, though the distinctions are often subtle. The types of inquiry that rehabilitation professionals may routinely face in deposition or at trial can be remembered by the idiom “Yours, Mine, and Ours.” A rehabilitation professional may receive an inquiry about “your” attorney in the case. It is important to remember that rehabilitation professionals are retained experts and do not have an attorney present representing their interests in a deposition or at trial. Rehabilitation professionals may encounter a question similar to, “What percentage of time, if any, do you represent the defendant or plaintiff in civil litigation?” The key word in this question is “represent” as rehabilitation professionals do not represent anyone in these matters. Another example is, “Talk to me about “your” methodology?” Rehabilitation professionals rely on peer-reviewed and generally accepted methodologies published in professional journals. These methodologies do not belong to any individual rehabilitation professional.

These kinds of questions in a deposition or in trial are rarely innocent, and it is important to correct an attorney when questions misstate key nuances in order to avoid potential downstream admissibility issues. Glas (2020) published a list of deposition and trial questions regarding a rehabilitation professional’s qualifications as examples of what might be encountered by rehabilitation professionals to encourage that they be comfortable with questions and know themselves and their expertise, as the answers to these questions are often what qualify or disqualify a rehabilitation professional as an expert:

- “What is your primary field of practice?”
- “Are you licensed or certified?”
- “Are your certifications private or non-profit, do you know?”
- “Do you actually provide vocational rehabilitation?”
- “Do you hold an active membership in a professional association?”
- “Do you adhere to a code of ethics, and have you ever been excluded or rejected as an expert?”

Similarly, rehabilitation professionals can expect to be asked about the methodology that was utilized to arrive at an opinion:

- utilized to arrive at an opinion:
- “Did you conduct an in-person interview?”
- “Do you charge by the hour or flat fee?”
- “What do you charge for your opinion?”
- “Do you have a duty to maintain records of research and supporting documentation?”

These questions more often than not harbor ulterior motives and can be meant to lead to a line of questioning regarding the methodology followed when arriving at an opinion.

Deposition questions may be asked that seek to simplify an opinion, and while they may seem straightforward on face value, they often pose issues of admissibility after the deposition is complete. For example, a question that begins with, “Do you just mean...” is one that immediately needs to be addressed. The response may be, “No,” along with what was meant so as to take control of the narrative and make sure opinions and testimony are not being misinterpreted or manipulated, whether accidentally or intentionally. Rarely is there an innocent question in a deposition or at trial.

The *Hanford* (*In re Hanford Nuclear Reservation Litigation*, 1991) case is an example of a case that resulted in a significant motion in limine intended to exclude the admissibility of a qualified rehabilitation professional. Questions that were posed during a Hanford deposition were crafted to challenge the admissibility of a rehabilitation professional’s opinion, predicated on the assumption that the rehabilitation professional, for example, was unable to describe their profession, the methodology that was utilized, or the different factors and value that a rehabilitation professional adds to the fact finding process and the credence of their opinions. Using the key terms listed throughout this paper, rehabilitation professionals are able to answer these challenging questions because they know their expertise, which consists of specialized knowledge, experience, education, and clinical background.

### **Motions in Limine**

The motion in limine (MIL) is a written document from an opposing counsel that may cite excerpts from an expert report, a deposition, case law, and at times, may mischaracterize opinions and responses to deposition questions and reports. The MIL is specifically written to challenge the admissibility of an expert based on two key facets: Is the expert qualified to render the opinion, and did the expert rely on proper methodology? The expert’s knowledge, skills, training, experience, and ability to articulate these factors are all important to withstanding an MIL, as well as understanding the rules and language of the venue.

The sequencing of addressing a MIL includes reviewing the motion when filed, responding to the MIL point by point through a deceleration, and listing qualifications and methodology relied upon as the foundation for the rehabilitation professionals’ opinions (A. Choppa et al., 2005). Responding to a MIL begins by preparing a declaration relying on specialized knowledge, articulating expertise and qualifications, and cogently addressing any argument in the MIL that asserts a lack of qualifications.

After the declaration and response to a MIL is filed, the party that filed the MIL has an opportunity to reply before there is a hearing and ruling from the trier of fact. Rulings are typically made at a hearing in advance of, or at the time of trial. More often than not, the subject expert of the MIL is not present at the hearing, but there are times they may be asked to participate.

Responding to an MIL should include special attention being given to the nuance of the MIL and comparing the original deposition testimony against how testimony was quoted or misquoted or taken out of context.

For example, the MIL filed in the Hanford case after the expert’s deposition referenced above, many of the responses addressed inaccuracies and misstatements contained within the MIL. Every assertion in the MIL was meticulously addressed point by point, with

emphasis again given to the importance of being able to articulate the rehabilitation process, methodology relied upon, and qualifications to do so. However, there are scenarios where a MIL is filed against a retained expert and the retaining referral source does not inform the expert. This is a dangerous situation for the rehabilitation professional, because the retaining attorney may believe they know how to respond, but can only respond as attorneys, not as a rehabilitation professional. One possible solution is to consider stipulating in a retainer agreement would include a statement such as, “should there be a MIL filed, the retained expert will be made aware and given an opportunity to participate in the response.”

An example of an MIL to exclude an expert based on lack of qualifications and improper methodology, where the expert was excluded, is *Goldstine v. Federal Express* (2021). In this case a Certified Public Accountant, did not practice within the scope of their practice, adopted the opinions of a vocational expert (VE) not disclosed in the matter, rendered their own vocational opinions outside their area of expertise, and was excluded for improper methodology. The court ruled that even if the undisclosed VE that the CPA relied upon had been called to testify, his methodology was flawed. The Court stated, stating, “It is unclear whether Defendant intends to call [VE] to testify as a vocational expert. In any event, the Court does not find that [VE’s] vocational opinions survive a Daubert analysis” (*Goldstine v. Federal Express*, 2021). The judge stated of the VE,

His conflation of "local" jobs available in [Plaintiff’s] geographic area with the "local" truck driving that is [Plaintiff’s] job requirement, combined with his use of local driving jobs and long-haul driving jobs in his data demonstrate a singular lack of understanding about the nature of the work performed by [Plaintiff]. His opinion fails for lack of reliable data based on a mischaracterization of what would constitute "equivalent" work for [Mr. Plaintiff]. Plaintiff’s motion to exclude [VE’s] opinions, either as a basis for [CPA’s] testimony or for the testimony of [VE] himself, is granted.

The excluded expert did not possess the proper credentials and was not qualified to render vocational opinions, and therefore was practicing outside of their scope of practice. The undisclosed VE did not follow proper methodology and would not have survive a Daubert analysis.

In another MIL filed against a rehabilitation professional and their economic damage expert colleague, it was clear that the motion was filed because the opposing counsel simply did not like the expert’s opinions. The matter involved the wrongful death of a young woman where the rehabilitation professional provided vocational analysis and their colleague provided economic damage calculations. Neither of the experts was deposed, and a MIL was filed against both experts to exclude their opinions, solely relying on the opposing counsel’s rebuttal expert’s assertion that the opinions were flawed and therefore inadmissible. Both experts read the rebuttal expert’s reports, read the MILs, worked on the declarations in response to the MILs, articulated their qualifications, and responded point by point to assertions attempting to undermine their qualifications and methodology. The following is from the declaration in response to the MIL:

[VE] is a Vocational Rehabilitation Counselor and Case Manager, who has worked in the field for over 33 years. She opined that J.K. would have a “pre-death earning capacity” equivalent to “that of an Associate’s degree. She noted that certain

statistics reported an upward trend of educational attainment since 1940. She concluded that based on J.K.'s family background and research, she believed J.K. would have had the capacity to get an associate degree and would possess the ability to earn an income compatible with the average for this level of education for full time year around employment. She relied on the U.S. Census Bureau, Current Population Survey, 2019 Annual Social and Economic Supplement that indicates the year-round earnings for persons completing some college to an associate degree is between \$60,806 to \$65,490 annually.

[Economic Damages Calculations expert]has over six years of experience in Economic Damages Calculations and over 39 years in the fields of Rehabilitation counseling, vocational rehabilitation, and case management. He relied on National Vital Statistics to conclude the mean age of mothers at first birth was 26.9, and the projection of a second birth involves lots of factors. He used 30 for the age that J.K. would have her second child. In computing her marital partners' income, he concluded her spouse would possess an associate degree and make about the same amount of money. He also computed her consumption. His final calculation was that a reduction to present value for J.K.'s wage earning capacity will range from \$2,266,443.42 to \$3,235,807.85.

Ultimately the court ruled the experts did in fact possess the knowledge, training, and experience to render opinions using established methodology and specialized knowledge, and allowed both experts to proceed in the matter. The following is from Court's ruling:

The Court finds that Plaintiff has met his burden of showing that the [experts'] testimonies are relevant, reliable, and could be helpful to the jury, and thus they meet Fed. R. Evid. 702 requirements for admissibility. Both experts provided economic damages calculations in a manner consistent with established methodology, using specialized knowledge, relying on sufficient fact and data and reliably applying principles and methods of economic damage calculations.

Central to success is relying on peer-reviewed, generally accepted methodology, and specialized knowledge.

## **Trial**

While professional style may vary, there are some best practices offered by the authors that they have implemented when proceeding to trial. It is encouraged to discuss the proceedings to date with the retaining attorney the day before scheduled testimony to understand any MIL decisions to be considered. For example, an injured person with a significant substance abuse problem 15 years ago. The plaintiffs moved to exclude discussion of this history, which was granted. It is important to know this to avoid accidentally broaching a subject that has been excluded from testimony.

Also, getting a sense from the retaining attorney of who has already testified is important. Knowing if doctors have testified is helpful to understand what foundation has been presented to the jury. Knowing who the jury has heard from regarding the nature and extent of the impairment is important because there is a good chance the expert's opinion will not

make sense to the jury if the medical foundation has not been laid out by the various medical professionals who are addressing the nature and extent of impairment.

There are also instances where physicians have testified at trial and said something different than what was discussed with the expert. Knowing what if any changes have occurred in medical treatment, medical opinions, or work status is essential, since this may require adapting opinions to reflect the changes. The expert must know that the facts and data that they have relied upon for their opinions are still the facts and data being presented at trial. If the facts change, that likely has nothing to do with the expert, but may require a modification of opinion.

### Conclusions and Recommendations

While much of what has been discussed can be broadly applied, there are specific instances and nuances when clinical rehabilitation professionals are asked to provide their opinions in matters involving litigation. Rehabilitation professionals must adhere to standards of practice, codes of ethics, and relied upon methodologies that are peer reviewed and accepted. When the credibility and the admissibility of their opinions are challenged when called to testify in litigation matters, rehabilitation professionals must be able to articulate that their opinions reflects adherence to the same standards followed in their day-to-day clinical work. The qualifications that a rehabilitation professional has to provide clinical services are often discussed as a matter of credibility in a deposition and at trial. The rehabilitation professional is advised to know how the methodologies they rely upon in their day-to-day clinical work inform their opinions and is the basis of their expertise. Rehabilitation professionals are encouraged to remain aware of the admissibility factors that occur from the inception of a new referral through the full spectrum of an assessment (i.e. clinical interview, testing, research, consultations, and report writing). Effectively defending the relevance and admissibility of opinions in a deposition and at trial is directly correlated to the rehabilitation professionals' clinical practice, methodology, understanding the Court's rules, and the difference between professional style, professional preference, and admissible practices.

In conclusion, all aspects from referral to testimony should follow valid and reliable, generally accepted, peer-reviewed methodology to ensure admissibility. Additionally, rehabilitation professionals should be aware of and knowledgeable about their specialized knowledge, skills, experience, training, and education since these key facets are the basis for establishing expertise and therefore admissibility.

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# Multiple Amputations: Considerations for Life Care Planning

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Case In Point Life Care Planning

## Abstract

This article will explore the unique challenges that a person with multiple limb amputation faces and provide recommendations for potential items to include in a related life care plan. There have been significant advances in prosthetic technology in the past several years and the tendency is to provide someone with multiple limb amputations with the most advanced dynamic systems such as myoelectric arms for a person with bilateral upper extremity amputation; however, the authors caution that although these technologically advanced systems have their place in life care plans, sometimes body powered systems provide a greater level of functionality and comfort. This article will explore the causes of multiple amputations, types of upper and lower extremity amputations, and the impact the level of disarticulation has on prosthesis use and functional abilities. Furthermore, upper and lower extremity prosthesis options will be reviewed, inclusive of criteria that are considered by the prosthetist when determining the optimum choice, which may include both body-powered and myoelectric/microprocessor prosthetic devices. Innovations in customization will be reviewed. The authors also provide items for consideration for inclusion in a life care plan unique to an evaluatee with multiple amputations that will increase independent function as much as possible while acknowledging the potentially significant limitations created by multiple limb loss. Geographical location is also considered as having the potential to impact the needs of the evaluatee. Finally, prosthetic costing, frequency, and use of the L-Code HCPCS System will be reviewed.

## Introduction

Many amputations are caused by vascular disease and trauma, although cancer and congenital deformities are also less frequent etiologies (Varma et al., 2014). Approximately 7% of individuals with a trauma-associated amputation have multiple limb loss. Bilateral lower extremity amputation is the most common type of amputation related to trauma (64%),

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The costs associated with prosthetic systems are always changing. Costs provided in this article are for reference only and should not be used within a life care plan. The authors have no affiliation with any company cited within this article.

with unilateral upper and lower extremity amputations second highest at 21%, bilateral upper limb amputation at 11%, and amputation of three limbs at 4%. Causes of traumatic multiple limb loss include motor vehicle/motorcycle accidents, railway accidents, electrocution, workplace accidents, agricultural accidents with farm equipment, and fireworks/explosives. Interestingly, amputations related to military injuries are not a large category for overall amputations but are a disproportionately large contributor to multiple amputations. According to data from 2014, Operation Iraqi Freedom and Operation New Dawn: 1,648 individuals suffered military-related major limb amputations and nearly 31% of those individuals lost more than one limb (Pasquina et al., 2014).

Although the authors have prepared numerous life care plans for evaluatees with multiple limb loss due to traumatic etiology, the primary causes for amputation in life care plans for triple and quad amputations are from a vascular or infectious etiology, particularly sepsis secondary to necrotizing fasciitis, compartment syndrome, or pyelonephritis. Pasquina et al. (2014) noted that

along with amputations resulting from trauma, many individuals with multiple amputations have endured them as a result of dysvascular disease. Over recent years, amputations as a result of dysvascular disease have risen to comprise more than 80% of new amputations occurring in the United States every year. Those with diabetes comorbid with dysvascular disease make up 74% of those with dysvascular amputations, and these individuals with diabetes comorbid with dysvascular disease have a 55% chance of enduring an amputation of their contralateral limb within 2-3 years of their initial amputation.

Etiology comes into play when determining the probability of interventions being required by the evaluatee. For instance, an evaluatee with traumatic amputations of multiple limbs will likely require multiple revision surgeries to optimize their residual limbs. There may also be additional issues related to trauma such as fractures, soft tissue damage, peripheral nerve damage, traumatic brain injury and/or post-traumatic stress disorder that need to be considered as well. For an infectious or vascular etiology of multiple limb loss, co-morbidities need to be considered such as diabetes, hypertension, kidney disease and peripheral vascular disease, and an apportionment of future costs may be indicated. Of note, evaluatees with vascular compromise are likely to have underlying cardiac disease and may have a decreased tolerance for prosthetic usage as it is estimated that the energy cost of ambulation for individuals with bilateral trans-femoral amputations increases nearly threefold (Pasquina et al., 2014).

### **Upper Extremity Amputations**

Upper extremity amputations account for the majority (68%) of trauma-related amputations (Varma et al., 2014) and include: forequarter, shoulder disarticulation, transhumeral (above elbow), elbow disarticulation, transradial (below elbow), hand/wrist disarticulation, transcarpal and finger amputations. Per Arm Dynamics (2022), body-powered elbow prostheses with myoelectric hands are typically used for individuals with transhumeral, shoulder disarticulation, or forequarter amputations. Myoelectric limbs are typically not well tolerated by evaluatees with this level of amputation, largely due to the weight of the prosthetic limb. Body powered prostheses rely on a system of cables or harnesses along with



manual controls in many cases, to control the limb itself. The user operates and controls the prosthetic arm using other parts of the body, such as their shoulder, elbow, or chest. The myoelectric-controlled prosthetic arms are externally powered but are not driven by the muscle strength of the evaluatee. For individuals with bilateral transhumeral amputations, a prosthetist may prescribe both body-powered and myoelectric prosthetic arms. Some individuals use body-powered prostheses for some activities such as gardening, sports or shoveling snow, and use myoelectric prostheses for work or avocational activities.

In some cases, a prosthetist will not prescribe a myoelectric arm until their patient can demonstrate proficiency with functional use of the body-powered limb. Many individuals still prefer the classic hook hand as they find this device to be more functional. Also, for the more complex myoelectric limbs and hands, there is an increased risk of malfunction and the need for more frequent repairs. Body-powered limbs have the advantages of durability, shorter training time, lighter weight, biofeedback through the cable system, and less frequent need for maintenance; however, they could benefit from improvements in control. Conversely, myoelectric prostheses have been shown to improve cosmesis, offer reduction in harnessing, provide access to effortless strength, and have multiple grip patterns and more natural hand movements, but they tend to be less durable and many of them cannot get wet. There is a prosthesis rejection rate of 30% to 80% with the lowest rejections occurring for transradial prostheses and the highest rejection rate for partial hands, shoulder and transhumeral prostheses. Additionally, 30% to 50% of individuals with amputations do not use a prosthesis regularly and compliant users average a wearing time of 9.5 hours per day (Berry, 2020b).

Options for myoelectric arms and hands include the Hero Arm by Open Bionics, iLimb by Touch Bionics, and a hybrid system that uses a shoulder girdle with a myoelectric ErgoArm Plus elbow and a myoelectric wrist/hand. Disadvantages of these systems include the high device costs, frequency of maintenance including replacing the motor at regular intervals, materials used to construct the limb which can cause skin irritation, inflammation or infection, the level of training required takes longer, and they can be difficult to control. For reference purposes, a myoelectric prosthetic arm with a myoelectric hand can cost approximately \$100,000 - \$120,000, and the cost for the same myoelectric prosthetic system with added Co-Apt system can be 20% to 45% higher. Conversely, a hybrid system built with carbon fiber that utilizes a body powered lockable elbow, a myoelectric wrist, and basic myoelectric hand with an additional split hook costs approximately \$80,000. An example of an alternate, more cost-effective, myoelectric option is the Hero Arm, which costs between \$10,000 and \$20,000 depending on custom features, but with this decreased cost there can also be decreased features and functionality, such as lifting strength, which would need to be taken into consideration.

There have also been significant advances in myoelectric hands which include the Otobock's MyoHand VariPlus Speed, Greifer hand, Electrohand 2000 for children, Michelangelo hand, and bebionic hand, and Touch Bionics i-Limb Ultra Revolution - an iPhone compatible hand. The Michelangelo hand is one of the most technologically advanced bionic hands available and offers nine different movement patterns. If the evaluatee has been determined to be an appropriate candidate for myoelectric arms/hands, consideration should be given to include a back-up body-powered system, as bionic limbs often break down and require frequent maintenance. Additionally, there are other prosthetic arm/hand options which are

considered cosmetic-only prostheses and lack functionality, which include full or partial silicone prostheses and the Ottobock MyoSkin Natural cosmetic gloves, which come in a variety of colors and custom skin tones. These cosmetic options can be very beneficial for everyday or situational use by the evaluatee, and inclusion of these options should be considered based on the evaluatee's individual concerns and goals. Unless the life care planner is also a prosthetist, cost estimates should only be included in the life care plan for the prostheses prescribed by the treating Prosthetist. Life care planners should not go beyond their scope of practice and include costs for prosthetic limbs not currently being used by the evaluatee, nor likely to be prescribed in the future. If possible, establishing communication with the treating prosthetist is optimal to obtain information about whether other prosthetic systems are being considered.

Cost estimates for supplies for upper extremity prostheses should be individualized, but costs typically include socks/liners, gloves, and potentially lotions or skin care products. For a body-powered prosthetic limb, supplies may also include a hook to hand cable adapter and hook tension bands. Typical supplies for myoelectric prostheses include replacement batteries and battery charger as well as custom gloves and/or living skin.

### **Lower Extremity Amputations**

Lower extremity amputations include hemipelvectomy, hip disarticulation, transfemoral (above knee), knee disarticulation, transtibial (below knee), ankle disarticulation, Syme, and foot which could include partial foot, transmetatarsal, or numerous toes. Options for prostheses include passive systems, microprocessor knees, patellar-tendon weight bearing (PTB) prostheses, and the Blatchford Aqualimb for showering. The PTB is suitable for 90% of individuals with transtibial amputations. Potential passive knee joints include the mono or polycentric manual-lock weight activated or hydraulic system, or a jointless transtibial prosthesis such as the Ottobock manual lock knee. There are also enhanced composite design passive prosthetic feet including Ottobock's Taleo foot and Terion K2 foot, and Infinite Technologies' BiOM ankle foot. As for the more advanced programmable options, there are microprocessor knees like the Kenevo, Genium X3 and C-Leg 4 knees produced by Ottobock, and microprocessor feet like the Empower and Meridium, also produced by Ottobock.

An important factor in determining which type of prosthetic device is considered reasonable for inclusion in the life care plan is the functional ambulation level (K-level) of the individual with a lower extremity amputation. There are five K-levels as depicted in Table 1.

The ambulation level of the individual will largely influence the type and complexity of the prescribed prosthesis. For example, the Genium x3 was specifically designed for a K4 level ambulator and supports activities such as running, swimming, and ascending stairs step-over-step and would not be an appropriate prosthesis for a K2 or K3 level ambulator. Body weight and habitus are also considered as there are weight limitations to the microprocessor knees. Again, the life care planner is cautioned to not go beyond their scope of practice and include cost estimates for prostheses that have not been prescribed by the treating prosthetist.

Additionally, the K-level of the individual will be important to consider when determining which specialty attachments and which level/type of assistive aids and back-up ambulation options should be included. For an individual with multiple amputations, the requirements dictated by their multiple amputations may outweigh what would be reasonable based on ambulation level alone. For example, it may be more reasonable to include a

Levels	Rehabilitation Potential
K0	Does not have the ability or potential to ambulate safely. (non-prosthetic wearer)
K1	Has the ability or potential to use a prosthesis for ambulation on level surfaces. (transfer prosthesis, limited/unlimited household ambulator)
K2	Has the ability or potential to ambulate and successfully navigate low level environmental barriers such as curbs or stairs. (unlimited household ambulator/limited community ambulator)
K3	Has the ability or potential for ambulation and to successfully navigate most environmental barriers with some utilization beyond simple locomotion. (unlimited community ambulator)
K4	has the ability or potential to ambulate exceeding basic ambulation skills with high impact, stress, or energy. (typical child or adult athlete).

**Table 1**

*Functional ambulation level (K-level) of the individual with a lower extremity amputation*

manual wheelchair rather than a power wheelchair for a K3/K4 ambulator; however, if that K3/K4 ambulator also has an upper extremity amputation, a power wheelchair may be the more reasonable primary option, with inclusion of a manual wheelchair as a back-up.

Cost estimates for supplies for lower extremity prosthesis should be individualized and typically include liners and socks, which are available in 1, 3 and 5 ply thickness. An evaluatee may require varying ply thickness throughout their lifetime and the individual is typically provided with 6 socks which are replaced every 6 months. Additional supplies may include prosthetic salves, chafe barrier cream, Ottobock Derma repair, Adaptskin ointment and/or powders.

### **Life Care Planning Considerations**

Preparing a life care plan for an evaluatee with multiple amputations requires additional considerations to maximize the individual's ability to function as independently as possible and to enhance their quality of life. Per Pasquina et al. (2014), the challenges faced by those with single-limb loss are amplified for those with multiple amputations. Pain, lifestyle adjustment, and quality of life return are just a few key areas of concern in this population. Individuals with multiple limb loss are optimally followed and managed by a multi-disciplinary team inclusive of the primary care physician, orthopedic surgeon/plastic surgeon, pain management physician, physiatrist, psychologist/psychiatrist, rehabilitation nurse, prosthetist, physical therapist, occupational therapist, case manager and assistive technology specialist. Additional specialists that may be involved include speech language pathology, recreational therapy, vocational rehabilitation, neuropsychology, certified driver rehabilitation, cardiology, nephrology, and oncology, depending on the individual needs of

each evaluatee. In general, it is recommended that the multi-disciplinary team be led by a single provider who is designated as the coordinator of information and communication with the evaluatee, family members and the multi-disciplinary team. The team coordinator could be the physiatrist or potentially the rehabilitation nurse or case manager/clinical social worker. The advantage of utilizing a case manager as the team coordinator is that in addition to their role as a facilitator of communication to all involved parties, they also have the ability to provide the evaluatee and family with information regarding community resources and vendors for equipment and supplies. Also, it is not uncommon for individuals with traumatic etiology for limb loss to have additional injuries which were not initially detected and show up later in the rehabilitative process, such as sprains/strains, traumatic brain injury, or mood disturbance that may be detected by the physical or occupational therapist. Access to support groups and individual counseling will likely be of benefit to address grief, altered body image, and adjustment/coping.

There are numerous things that are taken into consideration when determining which prosthetic system is most appropriate for each individual. These include the level of the amputation/disarticulation, the activity and ambulation level of the individual, their body type and stature, the weight of the prosthetic, and how likely the individual is to use the prosthetic limb. The most critical aspect of prosthetic limb selection is obtaining the optimal fit of the socket. The BOA system is a patented system by Arm Dynamics that is used in body-powered prosthetic limbs and in sports shoes that allows the wearer to tighten or loosen the socket or shoe while wearing it. The BOA system allows for optimization of fit and allows for volume fluctuation. In general, it is recommended that, when possible, the individual with an amputation should work with a limb specific Certified Prosthetist/Orthotist (CPO). For individuals with upper and lower extremity amputations, optimally they should be evaluated by both an upper extremity CPO specialist and a lower extremity CPO specialist with coordination of care.

The key to successful prosthesis use is the ease of independent donning and doffing of the prosthesis which is particularly challenging for individuals with bilateral upper extremity amputations. This usually requires the use of a bilateral harness system using a control suspension or attachment strap that allows the prostheses to be removed in a place/position to be ready for re-donning, such as a wall mounted hook or rack. An individual with mixed upper and lower limb loss will have challenges associated with an absent hand or hands when donning and doffing their lower extremity prosthesis. The attachment of pull-tabs to the lower extremity prosthesis or liner to allow for manipulation with an upper extremity end prosthetic device or an individual's teeth is a simple solution that should be considered (Pasquina et al., 2014).

In general, individuals with bilateral lower extremity amputations should have a properly fitting manual wheelchair as a back-up for times when not wearing their prosthetic legs. For individuals with upper and lower extremity amputations, a combination of manual and power wheelchairs should be included in the life care plan. Home modifications for individuals who are likely to utilize a wheelchair, such as entry and threshold ramps and widened doors and hallways, need to be taken into account, even if the wheelchair is not in daily use. Special seating systems will be required for individuals with hip disarticulation or hemipelvectomy amputations for both optimized positioning and pressure sore prevention. Additionally, when considering alternate ambulation options for those with myoelectric or

microprocessor prostheses, it is reasonable to include a well-fitting body-powered or passive prosthetic device as a back-up to be worn for tasks incompatible with the more technology-driven device and during myoelectric/microprocessor maintenance periods.

Additional considerations for life care planning for an evaluatee with multiple amputations include pain management/pain control interventions, adaptive clothing and a clothing allowance as use of prosthetic limbs can cause increased wear and tear on clothing, vehicle modifications and training, attendant care, and home maintenance/yard maintenance. Pain management measures that can be considered are TENS units, acupuncture, massage and mirror therapy. Attendant care requirements will likely be increased for individuals with multiple limb loss, with the amount of care determined by the evaluatee and treating providers.

Assistive devices/adaptive aids should also be considered, both for use with and without a prosthetic device. Items to consider include a universal cuff which can be used with a residual limb for holding utensils, modified eating utensils (swivel, build up grip, and/or angled), bidets, clamps and suction cups to hold personal grooming items like brushes and toothbrushes, voice activated cell phones and electronic devices, and environmental controls for an individual's home (Johnson, 2011). Additionally, home items and modifications such as an electric hi-low bed like the Flex-A-Bed, a three-in-one lift recliner chair, padded shower chair/bench, door levers instead of knobs, motion- or foot-activated soap dispensers, a full-body air-blower for hands-free drying, and motion-activated lighting can improve safety and quality of life for an individual. An environmental control system such as the Amazon Alexa Smart Home ecosystem, which is a convenience for many of us, is a necessity for someone with multiple limb loss, particularly those with bilateral upper extremity amputations. Smart home technology allows for voice activation of thermostats, virtual assistants, home entertainment, lighting, security systems, cameras, sensors, kitchen appliances, automated vacuums, etc., and is highly recommended for inclusion in the life care plan for an individual with multiple limb loss.

Optimally, life care plans for individuals with multiple limb loss should include prosthetic attachments that allow the individual to resume as many previously enjoyed recreational and sports activities as possible. Companies such as Fillauer TRS Inc. offer numerous options for prosthetic attachments that allow an individual to resume activities such as basketball, volleyball, swimming, paddleboarding/canoeing, field hockey, cycling, baseball, golfing, fishing, shooting, archery, billiards, and downhill skiing. Most of Fillauer's attachments are off the shelf, however, they will work with individuals to design custom attachments for other activities such as high-level competitive lifting. Of note, all their sports attachments are designed for use with only body-powered prosthetic limbs. The company also has a line of pediatric attachments which allow a child to grasp toys and various objects, as well as enable the child to crawl. Optimal function can be acquired with these prosthetic attachments; however, it should be noted that the key to optimization of function is the socket fit which can be fine-tuned with the BOA system for personalized on-the-go adjustment of the socket. For the active individual with bilateral lower extremity amputations, several options exist for carbon fiber running blades such as those from Ossur, Fillauer, and Freedom. Ottobock offers a Pro Carve Sports prosthesis that allows the user to ski or snowboard. Additionally, adjustable heel prosthetics are now available allowing the individual with lower limb amputation(s) to wear heels.

### **Geographical Considerations**

Individuals who reside in remote areas such as the US Territories (Puerto Rico, US Virgin Islands, Guam, etc.) may not have access to a local prosthetist and therefore would likely need to travel for their initial prosthesis selection and fitting, and then need to send their prosthesis to the States for maintenance and repairs. In these situations, it would be reasonable to include a back-up prosthetic limb, particularly for someone who wears their prosthetic limb(s) on a daily basis at work. The heat and humidity experienced in island communities causes items such as prosthetic limbs to be more susceptible to mold and degradation. Evaluatees in these climates may require more frequent replacement of parts or prostheses and use of their old prosthesis for back-up is not ideal. Also, for evaluatees who have to travel to their prosthetist, cost estimates should be included for this expense and, if appropriate, additional costs for hotel expenses and a rental car. Evaluatees living in remote or rural communities in the mainland United States may also incur travel expenses to see their specialist and/or prosthetist that should be included in the life care plan. Additionally, individuals living in areas such as the Midwest and northern states, cost estimates should be included for snow removal services. Replacement costs of housecleaning, home maintenance and yard/lawn maintenance are also typically required for an individual with multiple limb loss.

### **Prosthetic Costing**

Costing for prosthetic devices is based on the Medicare L-Code Healthcare Common Procedure Coding System (HCPCS), such that each component can be identified by a four-digit L-Code which can be used to determine the associated Medicare reimbursement rate. Medicare reimbursement rates can be found in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) list available through the Centers for Medicare and Medicaid Services website (CMS.gov). When costing for the purposes of the life care plan, two important things need to be considered. First, the Medicare contracted reimbursement rate does not equate to the fair market value or usual, customary and reasonable (UCR) rate that is billed by medical providers. According to an article by Berry (2020a), the UCR rate for prosthetic devices and parts is usually set between 20% to 30% above the Medicare pricing point with an average rate nationally of about 26.5% above the Medicare rate. Second, the geographic region can impact the Medicare reimbursement rate, and costs should be calculated for the evaluatee's specific geographic region using the state/territory specific reimbursement rate or nationally using the average reimbursement rate. It may be useful to know that the geographically specific UCR rates for many L-Codes can also be found through many costing databases like Find-A-Code and Context4 Healthcare.

In addition to the prosthetic device cost, costs will also be necessary for prosthetic supplies. Each evaluatee will likely require standard supplies such as socks and liners and possibly skin care items, as well as additional supplies that are chosen to meet their individualized needs, concerns and goals, like the previously mentioned cosmetic covers. It is important to note, that regardless of the supplies being included, the cost of supplies is not relational to the cost of the prosthesis being utilized. The supplies have designated costs, and therefore, the costs for supplies should be calculated based on the cost of each item. As a result, the costs for standard supplies should be fairly consistent across life care plans.

Another factor affecting costs within the life care plan is replacement frequency. When determining replacement frequency, it is important to consider where the evaluatee falls in their prosthetic progression. For the first 24 to 36 months following amputation the residual limb is still healing and changing, resulting in substantial changes to the prosthesis and more frequent socket replacement. During this period, socket replacement frequency may be as frequent as every four to six months, while long-term socket replacement frequency is closer to once every two to three years. Additionally, the primary goal post-amputation is to get the individual up and ambulating, therefore, it is common for the individual to be fitted with a preliminary simple prosthesis. This would be replaced with subsequent progressive prostheses as their abilities improve until they reach the training and ambulation capabilities compatible with their optimal prosthetic device end point. During the initial 24 to 36 months, the individual may go through several device replacements/upgrades at an increased frequency; however, after this period, the long-term reasonable useful life of an adult prosthesis corresponds to a replacement frequency of once every five years. The typical replacement frequency for pediatric prostheses is every 12 to 18 months to accommodate for the child's rapid growth.

For multiple amputations, it is important to consider the necessary training and progression for each device and how multiple amputations may influence this timeline for each individual device. For bilateral upper extremity amputation, training should begin with the prosthesis used on the longer residual limb, which is likely to be the dominant arm or hand. The prosthetic training process will be repeated on the non-dominant side once competency is achieved. Lastly, training is continued with the individual performing their daily tasks wearing both upper extremity prostheses (Johnson, 2011). Individuals with mixed upper and lower limb loss may utilize an upper extremity crutch prosthesis when beginning their standing and ambulation training with their lower extremity prosthesis (Pasquina et al., 2014).

Medical bills are sometimes considered regarding costs and replacement frequencies; however, because of the progressive nature of the initial post-amputation stages, past medical bills may not accurately reflect the long-term needs of the individual with regards to the specific prosthetic device and replacement frequency. Another reason past medical bills may not be a reliable source for costs is the limitations set by the individual's insurance benefits coverage. It is possible for an evaluatee to have a current prosthetic device that is suboptimal for their functional goals due to device cost restrictions based on their benefits coverage, or even the etiology of their amputation. For example, Aetna's policy specifies that a microprocessor leg prosthesis will be provided for K3 or above functional level individuals with knee disarticulation or transfemoral amputation "from a non-vascular cause (usually trauma or tumor)" (Aetna Clinical Policy Bulletin, 2022). When constructing the life care plan, it is important to include the most optimal prosthetic device, as recommended by a prosthetist, to meet the evaluatee's goals, rather than allowing past medical bills to dictate which device is included.

## **Conclusions**

Creating a life care plan for an evaluatee with multiple limb loss requires much more than the sum cost of each limb's prosthetic device or system. Individualization is required for the type and level of each amputation, the preexisting capabilities of the evaluatee, and the

activities they wish to perform. Comorbidities – both those which were preexisting and those which developed in relation to the amputation or traumatic etiology, geographic location, and the wishes and goals of the evaluatee should be considered. A multi-disciplinary team, which incorporates numerous physicians, therapists, nurses, and specialized prosthetists, is required and the visits and therapy schedules will likely be prolonged in order to focus on proper care and training related to each amputation site. A life care planner should consider the need for back-up prosthetic devices and wheelchairs, devices and attachments for specialized activities, supply needs, maintenance requirements, and the cost of each prosthetic system. Customization of the environment and adaptive aids for an individual with multiple limb loss will be crucial to helping them achieve the highest possible level of function and quality of life. The authors did not include a discussion on the life care planning considerations for a child, young adult, or geriatric evaluatee with multiple limb loss as this would likely require separate articles.

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## **Book Review:**

### *The Valuation of Monetary Damages in Injury Cases: A Damages Expert's Perspective by Michael Shahnasarian*

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**Publisher:** American Bar Association Book Publishing,  
**ISBN:** 9781639051519

#### **The Author's Biopic is Compelling**

As one of the six founding members of NARPPS/IARP, I enjoy writing book reviews from time to time and I attempt to perform this task in a balanced manner. Surprise! Not this time. I am so very impressed with what I have learned in *The Valuation of Monetary Damages in Injury Cases*. The author is Michael Shahnasarian, PhD, CRC, CVE, CLCP, IPEC, NCC (Emeritus) and Licensed Psychologist. Having provided his expertise in over 5,000 litigated cases, Dr. Shahnasarian is robed in Fellow status by APA, IARP, IALCP, and NCDA. He regularly appears in dozens of major media outlets and is a columnist for USA Today. He has personally mentored over 50 graduate students through internships and residencies.

Yes, I confess to some measure of bias here. The author regards me as one of his own mentors. After all, as a young professor I introduced him to new contacts and opportunities in private sector rehabilitation. However, truth be known, I have been thrice his mentee through a number of collaborations and digesting his 13 books and 70 scholarly publications over a friendship of 40 years. The author's character, philanthropy, integrity and ready access to all earnest professionals makes him "one of us." He is genuine, transparent, and magnanimous. Naturally his character traits contribute to his credibility as a witness. His biopic appears on pages xix and xx. It sets a tone so you should have high expectations for investing in this book. You will not be disappointed. Many experts covet and hoard what they regard as their own intellectual property, but not this author. Dr. Shahnasarian "puts in out there" only after verifying his own knowledge and dissemination. This is very much in the interest of advancing our professions.

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Author Note: Early in 2022, Professor Emeritus David Hershenson published this important article: Hershenson, D.B. (2022). Fifty-Five Books That Shaped Rehabilitation Counseling. *Rehabilitation Counseling Bulletin*, 65(3), 223 –226. I can safely predict that in its second printing you will find "Damages" in the years to come. Until then, Expert Witness work in private sector rehabilitation will continue to flourish.

### **The Book's Content: A Carefully Planned Journey**

The reputable American Bar Association is the publisher of *Monetary Damages* (2022). The book is organized into Four Parts. Each is constructively added to the foundation of its predecessor. Part One includes but one foundational Chapter One, which explains the types of damages associated with injury claims. These include Loss of Earnings Capacity, Restorative Rehabilitation Costs (Rehabilitation), and Causally Related Pain and Suffering. The all important qualifications required to perform these assessments are discussed. The author makes no secret that these qualifications require patience and diligent, step-by-step adherence to the training materials. If the book will be used for education, numerous “pearls of wisdom” will pop up. These are rooted in the author’s extensive research, case studies, and experience. In brief, you are fully informed early and often that Expert Witness careers are not for the faint-hearted. Surprisingly, the book does not feel like a boring, legal, reference-only product. The “pearls”, anecdotes and case studies keep it jumping.

Part Two includes 4 chapters focused solely upon the construction of opinions that result in Loss of Earning Capacity Assessments. Mainstream and nonmainstream methodologies are disclosed by applying tools that are both theoretical and applied. Priceless are the forms to help you understand psychometric issues, peer reviews, admissibility, and case studies. These processes and mechanics as prescribed will help you build high quality records reviews, vocational rehabilitation examinations, standardized testing findings, sample reports, summaries, and impressions. The latter Chapters 2 and 3 of Part Two are devoted to exemplary case studies which distinguish between Pediatric/Youth versus Adult situations. The pages turn quickly now, and you get the feeling of reading a first-rate legal thriller as the stakeholders jostle and banter back and forth.

Part Three includes 5 chapters devoted to the construction of opinions for Life Care Plans (LCP)s. As above, LCP roles and both contextual and methodological considerations are rendered. Care is taken to distinguish Non Catastrophic from Catastrophic LCPs. A value added chapter provides guidance when building an LCP in which the cause of the injury is disputed. In Part Four the author devotes 2 chapters to special considerations involving:

- Daubert Motions and challenges which aim to strike or limit the presentation of Opinions.
- Presenting Damages Assessments

Presenting of Damages Assessments is, in my opinion, the most exciting chapter of the book (Chapter 12). It is one thing to create a satisfying and compelling report. It is quite another to present it persuasively. To help you along, the author guides you through the types of expert evidence you will encounter as you prepare. Deposition testimony is contrasted with trial testimony. Direct examination, cross examination, and redirect examination are compared and contrasted. But the priceless closing pages (Evidence Extraneous to a Case at Hand, Internal Consistency of Evidence Presented, and A Final Word on Presenting Evidence) is personal, gripping, and somewhat sad. The aspiring Expert Witness is reminded again that this career is not for the faint hearted. If the training does not generate a sufficient measure of professional confidence and competence, best to revert to more preparation.

The audience for this book is massive. Lawyers, judges, financial experts, insurance adjusters, and economists will gobble it up. Not because they like the content, but because

they need it. These professionals are extremely competitive and often conflict oriented. The need the type of materials shared by the author. This is their sport, their coliseum, with the goal being to WIN the competition. Justice is often reduced to a pipe dream, and injured plaintiffs are lost in the shuffle. The group of professionals will measure an outcome by the size of damages which may or may not comport with the plaintiff needs, preferences, goals, or mental health.

Conversely, there exists a second group of witnesses who are trained as Rehabilitation Professionals (vocational rehabilitation, rehabilitation medicine, rehabilitation psychology, occupational therapy, rehabilitation nursing, case management, life care planning). The book is as or more valuable for this group, but requires a different work personality in general. Rehabbers are more clinically oriented (client first, be helpful, identify individual needs, etc). This group of witnesses is less conflict oriented and is often surprised by outcomes which do not align with justice. The author explains that the former group (legal/economic) is favored by the process. As for the Rehabilitation group, Chapter 12 explains the significant levels of pressure and preparation which opposing counsel will go through to make you feel, well, “not ready for prime time.” Your sensitivities and compassion alone will not likely win the day.

However, the less experienced reader will be relieved to know that *Damages* also has value as a stand-alone reference work. Interns, trainees, journeymen/women with less experience will discover that the attorney who retains you as a witness will likely require some, but never all, of these reports. Some reports are mutually exclusive; e.g., an assessment of the youngster makes an assessment of the adult unnecessary. The level of injury is not both catastrophic and non-catastrophic. In brief, good witness training involves supervision that is careful, deliberate, and expects small steps as progress. The expertise grows gradually and grows naturally for both groups. But the requirement of tenacity, competence and confidence is essential for both groups.

Exceedingly helpful for every stakeholder is the treasure trove provided as appendices at the close of Part Four. Many of these takeaways are a must-read for If you want to prevail on the career path of Expert Witness. Part Four closes the book with everything you need:

- an 80 item Bibliography of recommended readings, 25 of which were generated by the author.
- b) 16 appendices replete with helpful forms and protocols that you can use or customize to your own needs.

Four endorsements appear on the rear cover of “*Damages*” including two attorneys and two names that you will recognize as distinguished Rehabilitation Professionals: Dr. Timothy F Field and Dr. Roger O Weed. By means of this review I add my very highest endorsement for Dr. Shahnasarian’s attention to best practices.

To show his range as an author, Dr. Shahnasarian wrote a refreshing fictional novel: *Justice Indicted*, 2013, Overmountain Press, 220pp. The publisher’s description reads: “a gripping story of a real-life, behind-the-scenes look into the dark side of our justice system, where even a war hero is treated like the enemy.” For 7 years prior to my retirement, I required this book for graduate students as a final examination. They absolutely loved it.



INTERNATIONAL ASSOCIATION OF  
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