Journal of Life Care Planning, Vol. 18, No. 2, (3-67)
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2020 Int'l Assoc. of Rehab Professionals

The International Commission on Health Care Certification Life Care Planner Role and Function Investigation

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Abstract

Life care planning role and function studies serve to identify job task inventories and competencies specific to life care planning service delivery. These job tasks/competencies are essential for the development of credentialing examinations specific to life care planning service delivery and serve to provide life care planning training programs a basis on which to manage, adjust, or modify their training units. This article describes a 3-year study of the roles and functions of life care planners who were surveyed which included health care professionals certified as life care planners under the ICHCC and health care professionals not certified as life care planners under the ICHCC practicing in this specialized service delivery health care system. Subject matter experts (SMEs) met on three occasions to identify job tasks/competencies and to develop the survey instrument that identified 197 job tasks and competencies that typify life care planning service delivery. There were five hypotheses generated to ascertain any significant differences among the responding diverse groups of health care professionals regarding 1) the identification of job tasks/competencies that comprise life care planning service delivery 2) any differences in life care planning practice perceptions between Certified Life Care Planners (CLCP) and Certified Nurse Life Care Planners (CNLCP) 3) the perceptions of life care planning service delivery among physician/doctoral level (i.e., M.D., Ph.D., Ed.D., PsyD., Rh.D., DPT)., and non-physician/doctoral level practitioners (i.e., A.D., A.B., B.A., B.S., M.S., M.A.) 4) the differences in the amount of time spent on life care planning services among the varying groups of responding practitioners and 5) the differences in life care planning practice perceptions based on the formal academic degree statuses among the groups of responding practitioners. The results of this study have strong implications for life care planning training program development/revision, certification examination content management and validation, and adjustment/expansion of practitioners' life

Keywords: certification, credentialing, transdisciplinary, knowledge domains, competencies, job tasks, Job Task Inventory (JTI)

Investigation

The International Commission on Health Care Certification is the oldest and largest certifying agency offering a credential in life care planning service delivery to qualified health care professionals in the United States and Canada. The ICHCC developed the Certified Life Care Planner (CLCP) credential from1995 to 1996 in response to the rapid growth of need for managed care rehabilitation services by the private insurance industry. The expanded need for such services was due in part by the dramatic increase in the numbers of individuals with disabilities surviving catastrophic injuries because of advances in medical research, procedures, and technological development (May, 1998). The National Health Survey conducted by the United States Public Health Service in the winter of 1935-1936 revealed that for the year 1939 an estimated 7 million persons with disabilities would be living in the United States. The Social Security Administration updated this survey in 1978 and found that the number of persons with disabilities in the United States had increased to approximately 21 million, or 16.5% of the population (May, 1998). The most recent survey of persons with disabilities was conducted by Kraus, Lauer, Coleman, and Houtenville (2018). They found that the population of the United States in 2016 totaled 325.1 million persons, and of this population 41,600,000 persons had disabilities. A breakdown of the population with disabilities revealed that 51% were between the ages of 18-65, 41.4% were 65 and older, 7.3% were 5-17 years of age, and less than 5 years of age there were 0.3%.

Private sector rehabilitation service providers found that they were well-suited for the expanding health care service delivery market, more so than their colleagues employed within public rehabilitation agencies. The expanded health care markets allowed private sector rehabilitation providers to offer services beyond the traditional rehabilitation counseling and job placement services in the public sector. These private sector services included vocational evaluation, case medical management, rehabilitation plan development, and entry into the litigation market through expert testimony (Hotz, et al., 1984). By the end of the 1970s, private sector rehabilitation service providers had expanded their service delivery systems to include personal injury, product liability, work-related injury, and divorce litigation (May, 1998). It was during this time period of the early 1980s that the legal community became more accepting of private practitioners as experts who could detail an individual's recovery needs from injury (catastrophic and non-catastrophic) that included future medical and rehabilitative service costs, and the frequency and duration of services.

The term "Life Care Plan" first appeared in 1982 in

Damages in Tort Actions (Neulicht, et al., 2010). It was not until two years later that Drs. Paul Deutsch and Horace Sawyer wrote the first textbook specifically for the purpose of serving as an instructional guide for health care practitioners interested in learning and pursuing a practice in life care planning (Deutsch & Sawyer, 1985; H. Sawyer, personal communication, April 19, 2020; May, 1998). This textbook set the stage for a plethora of developmental activities that included life care planning organizations, textbooks, organization-sponsored life care planning summits, the development of life care planning training programs, two certification agencies, the establishment of the Foundation for Life Care Planning Research (FLCPR), and a peer reviewed quarterly journal specific to life care planning.

The International Commission on Health Care Certification (ICHCC) established a dissertation funding grant at Southern Illinois University for the support of dissertation research in life care planning and other health care related settings in 1994. It was during this time through the Rehabilitation Institute at Southern Illinois University that the ICHCC was able to fund as well as sit on the dissertation committee of its first validity and reliability research of its examination and standards of practice. What resulted was the first empirical research into the role and functions of life care planners (May & Lubinskas, 2004; Turner, et al., 2000).

The FLCPR was created in 2002 to provide funding through grants and scholarships in an effort to support research on the Life Care Planning Model service delivery system with its primary focus on reliability and validation research of the Life Care Planning Model process (Deutsch, 2006). Through the rapid growth of the Life Care Planning Model and the resulting growing population of health care providers being trained in this system process, the FLCPR upgraded its mission to consider any well-developed research design in life care planning that advances the field and/or makes a significant contribution to the population of individuals with disabilities whom life care planners serve (Foundation for Life Care Planning Research, 2015).

One of the leading organizations that evolved over the years was the International Academy of Life Care Planners, that eventually became a membership section of the International Association of Rehabilitation Professionals (IALCP) (International Association of Rehabilitation Professionals: Life Care Planning, 2019). The IALCP was established as a result of the growing numbers of health care providers and members of its umbrella association, the International Association of Rehabilitation Professionals (IARP), interested in learning and establishing a practice in life care planning service delivery. This agency is the only professional membership association catering to all disciplines involved in life care planning and produces and co-sponsors the biennial Life Care Planning Summit and the annual International Symposium of Life Care Planning.

The Life Care Planning Model is well supported in today's health care marketplace with more training programs evolving and more health care practitioners becoming trained in this health care specialty service system. With the support of organizations like the International Academy of Life Care Planners, the Foundation for Life Care Planning Research and the International Commission on Certifying Agencies, the field will continue to sustain a healthy and strong presence in rehabilitation and case management settings.

Life Care Planning as Transdisciplinary

Given the strength and sustainability of the Life Care Planning Model in the current health care marketplace, the rapid influx of health care professionals from various disciplines into life care planning training and practice is clearly understood. As such, life care planning does not belong to a single health care specialty field of training or education. Rather, life care planning practitioners are from diverse backgrounds, educational programs (formal degrees), and disciplines, all of which have contributed significantly to the robust nature of this specialized service delivery system. A good example of the diversity among the health care service providers who are certified under the ICHCC as Certified Life Care Planners (CLCP) is best illustrated in the descriptive statistics of this role and function study. Of the respondents to this current survey, 21 different licenses and certifications and 15 different academic degrees ranging from diploma nurses, associate and bachelor nurse degrees, to Bachelor, Master, and Ph.D. rehabilitation providers and M.D. medical providers were reported within 11 health care specialty fields (See Appendix D for a full compilation of participant demographics).

Mauk (2019) defined transdisciplinary "as a process in which individuals work jointly using a shared conceptual framework that draws together discipline-specific theories, concepts, and approaches to address a common problem" (p.5). One problem that Mauk (2019) addressed was that given the diversity in areas of expertise, one barrier to overcome was that of one's ability to gain a deep understanding of two or more disciplines and to merge ideas from those disciplines into one life care plan. However, the life care plan in and of itself is transdisciplinary and can be developed by one qualified health care practitioner with input from practitioners specializing in rehabilitative and medical settings identified within the categories of need in the final plan (Mauk, 2019).

The initial period of life care planning development as a health care service delivery system has its roots in the work of Dr. Paul Deutsch, who launched the first public life care planning training program as the Rehabilitation Training Institute (RTI) in the late 1980s (H. Sawyer, personal communication, December 3, 2019). Dr. Deutsch sold his training program to Intelicus, a company that has strong ties with the University of Florida, and it was at this time that the ICHCC was approached by the University to develop a credential for life care planners; the Certified Life Care

Planner (CLCP). It is obvious that the University planned for the continued growth of a training program that had proven to be attractive to health care providers internationally, and the University program administrators felt a need to ensure accountability among its associated certificate graduates. Accountability of practitioners is best achieved through the credentialing process that was a natural fit for the ICHCC.

Given the transdisciplinary nature of health care practitioners entering and practicing in the life care planning field of service delivery, there remains a significant hindrance in the identification of life care planning competencies due to the competency restrictions among practitioner groups. For example, the American Academy of Nurse Life Care Planners and more recently, the American Academy of Physician Life Care Planners, have established their own definitions, life care planning methodologies, standards of practice, and their own certifications in life care planning (Gonzales & Zotovas, 2014). Add to this the standards of practice and ethical principles of conduct in life care planning as established by the ICHCC for their certificants (ICHCC Standards and Guidelines Manual, 2020), and the standards of practice and ethical guidelines established by the International Academy of Life Care Planners for its membership (Standards of Practice for Life Care Planners, 2015), one can understand the difficulty in writing criterion-referenced test items common to all disciplines. This is best addressed, however, through research-driven role and function studies that identify knowledge domains and delineate competencies for each domain through surveying all disciplines associated with life care planning (National Academies of Sciences, Engineering, and Medicine, 2017).

Credentialing

Credentialing is the process that involves the defining of attitudes, competencies, knowledge (domains) or skills to be certified. Additionally, credentialing addresses the assessment of candidates to determine if they meet the certification requisites, and it results in the issuance of a document (certificate) to attest to each individual's possession of the requisites (St. Clair, 2002). Accountability, then, requires the identification and validation of programs of service to be delivered (i.e., the certification exam), and the established qualifications of practitioners providing those services (Matkin, 1985). Credentialing is focused on the qualifications and the preparation of the practitioner to perform life care planning service delivery.

Seilding (2015) suggested that credentialing is broader than the certification process in that credentialing attests to the fact that the certification candidate has completed a specified set of required courses (training) and/or field experiences (internships or a compatible work history). Once completed, the candidate is provided a certificate of completion by the training agency, which is one of several qualifying components necessary for the candidate to sit for the CLCP examination. The presumption follows that completion of the required evaluation courses with qualified work/job experience prepares those individuals to perform competently as life care planners and therefore allows the candidate to sit for the certification examination.

Credentialing achieves accountability through various components that comprise a well-structured certification agency designed to provide safeguards for the consumer of services, as well as certified practitioners. Such safeguards should be mandatory, although not all agencies subscribe to the following recommended safeguards for agency structure, as recommended by Moore & Shook (2001):

1. A registry of certified practitioners (ICHCC Website listings of credentialed practitioners as well as in-office server databases).
2. Adherence to established professional standards (ICHCC Standards developed through subject matter experts (SME) and Board of Commissioners meetings and published in Standards and Practice Guidelines manuals).
3. Endorsements that rate the performance of the certification candidate (ICHCC requests of CLCP Candidates' professional references).
4. Specific course work requirements (requires 120 minimum hours of life care planning training by agency pre-approved ICHCC 120 hour training program).
5. Degree requirements (Designated degrees for acceptance into CLCP candidacy by CLCP Commissioner Board).
6. Experience requirements, frequently with some sort of supervision (3 out of the last 5 years supervised work experience as determined by documented work

history).

7. Satisfactory performance on a professionally developed written examination (CLCP validated item examination).
8. Evaluation of a work sample (ICHCC Mandatory life care plan submitted for peer review prior to acceptance as a certification candidate).
9. Provision for maintaining expertise in the profession through continuing education (ICHCC's Mandatory 80 hours every 5 years, with 8 hours dedicated to ethics).
10. Provision for discipline of individuals who violate established professional standards (ICHCC's Principles of ethics review board with documented and approved consequences of actions/behaviors).

Certification as applied to life care planning differs from credentialing in that certification is regarded as the process required to determine competency levels (knowledge and skill levels) when performing the essential functions of life care planning. In essence, this process results in the issuing of certificates attesting that the certification candidate is competent to perform life care planning services (Seilding, 2015).

Role and function studies in health care settings are essential in the growth and continuing development of a health care service delivery system. These studies identify the competencies associated with a specific health care service such as life care planning, enabling training programs as well as certifying agencies to adjust curriculum content and focus, modify, rewrite, or remove outdated items from the item-pool (Pomeranz, Yu, and Reid, 2010). We associate knowledge domains and related subfactor tasks as competencies since competencies are regarded as set of related knowledge, skills, and attitudes that evolve over one's formal educational training, post graduate training, and work history. Kling and Stevahn (2015) surmised that such formal training and post graduate training in the respective field of credentialing enables an individual to effectively perform the activities of a given occupation or job function to the standards assigned to the respective credentialing process.

Associating competencies across all disciplines continues to challenge item-pool development, and only through repeated role-delineated studies that identify competencies that span the varying disciplines will good criterion-related test items and overall test validity be ensured for the field.

Research Format and Structure

Subscribers to the *Journal of Life Care Planning*, like other social sciences journal readers, may hesitate to scroll through a research article that is oriented with statistical tables, statistical results, and the statistical applications of the findings. The authors believe it would be more beneficial for the reader if we provided an explanation of terminology that typifies such articles, the format of such articles, and perhaps allow the reader to find an easier way through the statistical jargon and applications of this article through our discussion that follows.

Many of us have been exposed to the term, "Empirical Research." The term empirical is a term that originated in ancient Greece among practitioners of medicine who rejected the notion of accepting the perception of medical fact without true observation of phenomena. In essence, it is from the word *empeirikos* meaning "experience" and the medical community at that time adopted the premise that medical findings were validated through observation or experience rather than dogmatic doctrines accepted earlier in Greek medicine ("Empirical research," n.d.). As such, *Empirical Research* is based on "observation and measured phenomena and derives knowledge from actual experience rather than from theory or belief (Penn State University Libraries, n.d., p. 2). Regarding survey research, the measured phenomena is referred to the survey instrument that contains the Likert scale numbers chosen by the survey participant and analyzed statistically in determining statistical significance among the collective choices of the survey participants.

There are two methodologies used in empirical research; 1) Quantitative research and 2) Qualitative research. Bhat (2019) and Golafshani (2003) differentiate between the two methodologies in their combined definitions that are as follows:

1. *Quantitative Research:* Quantitative research methods are used to gather information through numerical data. It is used to quantify opinions, behaviors, or other defined variables. These are predetermined and are in a more structured format. Some of the commonly used methods are survey, longitudinal studies, polls, etc. Quantitative research employs experimental methods and measures to test hypothetical generalizations, and quantitative studies emphasize measurement and analysis of causal relations between variables.

2. *Qualitative Research:* Qualitative research methods are used to gather non numerical data. It is used to find meanings, opinions, or the underlying reasons from its subjects. These methods are unstructured or semi structured. The sample size for such research is usually small and it is a conversational type of method to provide more insight or in-depth information about the problem. Some of the most popular forms of methods are focus groups, open-surveys, interviews, etc. (Types and methodologies of empirical research, 2nd and 3rd paragraphs). Qualitative research produces findings not arrived at by means of statistical procedures or other means of quantification, whereby the researcher does not attempt to manipulate the phenomenon of interest but rather observes the phenomenon to unfold naturally.

As applied to survey research, the actual collection of data from surveys and its subsequent statistical analyses fall under the quantitative research methodology. Quantitatively, the knowledge domains and subfactors, or competencies

were identified for this study as a result of the quantitative research method that analyzed the data contained within the completed survey instruments. Additionally, the statistical analysis of the research questions as applied to the transdisciplines based on specific life care planning variables were quantitatively analyzed as well. Qualitative research involves the development and content validation of survey items by volunteer life care planners for the purpose of developing the survey instrument for distribution to the sample population of practicing life care planners. In essence, this life care planning role and function study included both research methodologies given the qualitative development of the survey instrument used to collect data regarding life care planning job tasks/competencies as identified and documented by the participating practitioner group volunteers. Quantitative research applications were met through the testing of the hypotheses to delineate any differences in life care planning perceptions among the groups based on certain practice variables.

The standard report format for social sciences journals for research-based articles is based upon the IMRaD format. The IMRaD acronym stands for *Introduction-Methods-Results-and- Discussion*, which format was established among scientists in the early 20th century (Dominiczak, 2013), and eventually adopted twice by the American National Standards Institute (ANSI); once in 1972 and again finalized in 1979 (Nair & Nair, 2014). The actual IMRaD format is illustrated in Table 1.

Table 1

The IMRaD Format – Sections of a Research Paper

Section	Purpose
Title	What the paper is about
Authors	Names and affiliations of authors
Keywords	Words by which to paper should be indexed by abstracting services
Abstract	A short narrative of the paper
Introduction	Literature review
Methods	Identifies steps taken to collect and analyze data
Results	The core of the paper, new knowledge is expressed in terms of statistical results
Discussion	Interpretation and applications of results for future consideration
Conclusion	Implications of results
Acknowledgements	Acknowledgment of persons who contributed to the collection and analysis of the data
References	Listing of literature cited
Appendices	Supplementary materials

Purpose

Role and function studies are essential in the continued maintenance of established life care planning training curricula and certification programs. Identifying the competencies associated with the knowledge domains of life care planning provide an essential foundation for curriculum design and maintenance, and for determining and maintaining the appropriate content for certification examinations for life care planners (Pomeranz, et al., 2010; Turner, et al., 2000). This study follows this premise with some additional investigation into the perceptions of the transdisciplinary groups of practitioners. The purposes are clarified as follows:

1. To clarify the current roles and functions (knowledge domains and competencies) of practicing life care planners and thereby provide a foundation for the content validation of the Certified Life Care Planner examination and training program curriculum maintenance/modifications.
2. To investigate the perceptions of life care planners across multiple disciplines regarding their preference for service delivery methodologies, the influence of time spent on life care planning service delivery across disciplines, and the influence of formal education/training among the many disciplines on life care planning service delivery.

Method

Participants

Participants (n=212) were those chosen from the ICHCC internet credential discussion board, an email "blast" to all current registered Certified Life Care Planners registered with the ICHCC, and the Care Planner Network internet life care planning discussion board. The total population accumulated from the above resources spanned all 50 states, Australia, and Canada, and were identified as health care practitioners practicing as life care planners. It was originally suggested that we only survey Certified Life Care Planners and keep the study within the ICHCC standards and practice guidelines model. After much discussion, the Board recommended that all practitioners who offered life care planning services either as Certified Life Care Planners, Certified Canadian Life Care Planners, Certified Physician Life Care Planners, and Certified Nurse Life Care Planners be surveyed. Finally, the Board ruled that persons who offered and performed life care planning services without being credentialed in life care planning service deliver be allowed to participate as well.

Instrument

The instrument used in the study was the ICHCC Role and Function Survey that is comprised of two sections; 1) The Demographic Section and 2) the Survey of Job Task Inventory for the Delivery of Life Care Planning Services. The Demographic Section is composed of 11 items with multiple choices that were identified as relating to the participant by use of check-boxes. The Survey of Job Task Inventory for the Delivery of Life Care Planning Services composed of a 5-point Likjert-type rating scale and 197 competency (Job Task) statements. This instrument was designed and dissemminated using the SurveyGold® application that focuses on surveys as applied to the social sciences (Boudreaux, 2020). A complete questionnaire is included in Appendix A.

Demographics. The Demographic Section was constructed to reflect demographic items from prior life care planning role and funciton studies that included Turner et al. (2000), Pomeranz et al. (2010), and Neulicht, et al. (2009). The Neulicht et al. study was particulary relevant to the demographics of this study since it relied heavily on the demographics of its study's sample population for analysis of differences among nurses, rehabilitation professionals, and others, similar to this study's analysis of its sample population's research questions.

Content Validity. Content validity is the "...systematic examination of the [survey] content to determine whether it covers a representative sample of the competncy domain to be measured" (Anastatsi, 1978, pp. 134-135). As such, subject matter experts (SMEs) were assembled for three separate meetings to identifiy competencies/job tasks that apply to life care planning service delivery as well as categorize the knowledge domains post-analysis. These SMEs were healthcare professionals who were certified as Certified Life Care Planners and were either members of the Certified Life Care Planner Board of Commissioners practicing life care planning service delivery or who had individual practicies in life care planning service delivery without Board appointments. The process in which the SMEs performed the content validation of the instrument, developing it into its final form for submission to the public, as well as identifing the knowledge domain subject matter and associated subfactors post analyses included the following activities in their chronicle order:

1. SMEs were requested to write on a legal pad all tasks that they performed that comprised their personal life care planning service delivery methodology. This included from the time the referral was received in their offices through the time of case settlement or trial and any post-settlement/trial followup. They were required to recall only those tasks that they performed without having access to any prior life care planning role and function literature for recall purposes.
2. Life care planning role and function studies published by Turner et al., and Pomeranz et al. were reviewed following their job task listings. The factors under each knowledge domain from each study were cut from the printed article and placed in a pile in the center of the conference room table. Added to this pile of competencies were each of the SME's

documented tasks associated with their individual life care planning methodologies. The resulting number of pre-sorted competencies totalled 236 job tasks.

3. The SMEs were instructed to review all competencies and to work individually in a rational–sorting process. This process required each subject matter expert to review a job-task and place it with related job-task items. However, placement of the respective job-task in a specific item-related pile was performed following a majority agreement among the SMEs that the item belonged in the respective pile. Each pile of items was designated as a Knowledge Domain pile, and the total number of knowledge domain piles totaled nine.
4. Following the placement of all job-tasks in their respective piles, the SMEs were instructed to review all job-tasks and to discard any duplicate competencies that may have been placed. Addidtionally, the SMEs were instructed to review each job task and to make modificaiton in its description as necessary, to rewrite the item to better identify its purpose, or to remove it from the survey altogether if the job-task no longer applied to the life care planning process. The final number of job tasks included in the survey totaled 197.
5. A pilot study was conducted among nine SMEs who volunteered to take the survey to ensure construct validity. Following their survey completion, they met to discuss any adjustments that may have been necessary in the demographic and job-task sections of the survey document, and a final draft of the survey resulted for disseminaiton to the life care planning field.
6. The SMEs met for the third meeting to review the factor loadings of the factor analysis. The SMEs labled the knowledge domains as well as assigned job tasks to the respective subfactor groups of the knowledge domains. They labeled the subfactors based on the homogeneity of content among each respective subfactor grouping of job tasks. The result was 16 knowledge domains and 23 subfactor groupings. A complete listing of knowledge domains and associated subfactors can be found in Appendix B, and the raw data factor loadings are presented in Appendix C.

Reliability. Since the validity of every questionnaire is an important component in research, we used Cronbach's alpha to test the reliability of the questionnaire. Reliability is concerned with the ability of an instrument to measure consistently, and it should be noted that the reliability of an instrument is closely associated with its validity (Anastasi, 1976; Golafshani, 2003). Cronbach's alpha provides a measure of internal consistency of a test or scale (survey instrument) (Tavakol & Dennick, 2011). Internal consistency describes the "...extent to which all of the job tasks in a survey instrument measure the same concept or construct and hence it is connected to the inter-relatedness of the job task items within the survey instrument" (Tavakol & Dennick, 2011, p. 53). This statistic is used to identify how closely related a set of items are as a group. A high value for alpha means that the researcher(s) can consider the questionnaire to be reliable. However, it should be noted that Cronbach's alpha is not a statistical test. Generally, a Cronbach's alpha of .70 or higher is considered as an acceptable reliability coefficient in most social science research situations (Tavakol & Dennick, 2011). The Cronbach's alpha for 197 items is 0.987. This result suggests that internally, the items have high internal consistency. The results of the reliability analysis for the survey of job task inventory for the delivery of life care planning services are illustrated in Table 2.

Case Processing Summary

		N	%
Cases	**Valid**	212	100.0
	Excluded	0	.0
	Total	212	100.0

Cronbach's Alpha	N of Items
.987	197

Procedure. All active (1512) ICHCC Certified Life Care Planners received a survey through an email-blast using the ICHCC CLCP database. An additional survey was placed on the Care Planner Network and on the International Academy of Life Care Planning (IALCP) list serve so that data from any life care planner credentialed from a separate agency or who was practicing life care planning service delivery without any certification related to life care planning could be included in the final analysis.

Data Analysis. We designed one research question and four hypotheses to analyze based upon the survey participants' ratings of the total job task inventory (JTI). The one research question called for the validation of the job tasks as presented in the survey instrument. Since the number of job task items in the questionnaire was quite large (there were 197 task items for the survey of the job task inventory for the delivery of life care planning services), it is difficult to make inferences based on every single question. Instead, we used the Statistical Package for Social Sciences (SPSS-22) and employed factor analysis to describe the variability among observed variables and lower numbers of unobserved (latent) variables. These latent variables are called "factor" and we

want them to be independent (Kline, 2014). Principal component analysis (PCA) is a widely applied statistical method for extracting factors to explain the variation in the data. We used varimax rotation as our statistical rotation method, which is a common practice in factor analysis that allows factors to fall into a better fit of the data once they are extracted (Polit & Beck, 2008). The rotation also helps to ease the interpretation of the resulting loads. It is worth mentioning that SPSS analysis system has the option to perform a *direct oblimin* rotation to obtain a non-orthogonal representation as well. However, we chose to stay with the orthogonal method.

We used the exploratory factor analysis (EFA) to identify the interrelationships among questions and we used the PCA and varimax rotation to obtain these factors, which results can be found in the results section. Thus, we make no a priori assumptions about relationships among factors and we only keep the latent variables with the eigenvalue being 2 or larger. With the eigenvalue set to be greater than or equal to 2, we were able to explain about 65% of the variation of the data with 16 factors. If we had set the eigenvalue to be greater than or equal to 1, which is the software's default and common cut point in practice, then we would explain about 68% of the variation in the data with 31 factors. This means adding more than twice the number of factors while it only explains 3% more than the one with a much smaller factor. Thus, we decided to use the value 2 as our cut-off point.

Since using parallel analysis (PA) led to the same results as it is reported, we decided to not report them to prevent redundancy. Furthermore, despite its promising performance in simulation studies, some researchers consider PA to be sensitive to sample size (Warne and Larsen, 2014). It is worth mentioning that this procedure also depends on the cut-off value and choosing different cut-off values can lead to a different number of factors (Fabrigar et al., 1999).

Regarding the research hypotheses, we formatted four research hypotheses in addition to the roles and functions identification research question that are presented in the section below. The statistical analyses applied to each hypothesis varied that required us to use two different statistical applications: 1) t-tests and 2) analysis of variance. The t-test analysis allowed us to compare scores between two groups (e.g., doctoral level group's life care planning perceptions compared to those of the non-doctoral level group's perceptions, and the CLCP group practitioner's life care planning perceptions to those of the CNLCP group practitioners' perceptions). This test is most commonly applied to research to determine if the means of two groups are significantly different from each other ("Student's t-test", 2020; Connelly, 2011; Etchegaray, et al., 2012; Poloniecki & Mavik, 1993; Huck et al., 1974). In essence, the t-test statistical analysis allowed us to compare the means of the two groups in two of the stated hypotheses to determine if there was any significant difference between the respective groups' means of the related hypotheses.

To test the assumption of equal variances between two groups we used the Levene's Test of Equality of Variances (Gastwirth et al., 2009). The Levene's Test is an inferential statistic used to test the assumption that the population from which different samples are drawn are equal. The null hypothesis is stated in proposition that the population variances are equal (i.e., homogeneity of variance exists between the two groups). If the resulting p-value of Levene's test statistic is less than the a priory set Type I error, the obtained differences in sample variances are unlikely to have occurred based on random sampling from a population with equal variances ("Levene's Test, 2020). Thus, the null hypothesis of equal variances is rejected and it is concluded that there is a difference between the variances in the population.

To reduce the possibility of a Type I error using multiple t-tests analyses we used the Bonferroni's correction statistic (Armstrong, 2014.) This statistic application adjusts probability p- values due to the increased risk of rejecting the null hypothesis when it should be retained.

We used the Analysis of Variance statistical protocol to test two of the four hypotheses, which included testing the difference among life care planners in their perceptions of roles and function of life care planners based on their daily time spent involved in the performing life care planning service delivery, and the influence of formal educational degree levels among life care planners in their perceptions of roles and function in life care planning service delivery. The Analysis of Variance allows us to investigate more than two groups that we need to compare based on the demographic hypotheses (Ott & Longnecker, 2016).

Total Variance Explained

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	71.072	36.077	36.077	71.072	36.077	36.077	41.169	20.898	20.898
2	9.810	4.980	41.057	9.810	4.980	41.057	21.158	10.740	31.638
3	7.454	3.784	44.840	7.454	3.784	44.840	8.339	4.233	35.871
4	5.405	2.744	47.584	5.405	2.744	47.584	7.587	3.852	39.722
5	4.493	2.281	49.865	4.493	2.281	49.865	6.700	3.401	43.123
6	3.957	2.008	51.873	3.957	2.008	51.873	5.031	2.554	45.677
7	3.353	1.702	53.575	3.353	1.702	53.575	4.573	2.321	47.998
8	3.174	1.611	55.186	3.174	1.611	55.186	4.233	2.149	50.147
9	2.918	1.481	56.667	2.918	1.481	56.667	4.090	2.076	52.223
10	2.620	1.330	57.997	2.620	1.330	57.997	4.070	2.066	54.289
11	2.457	1.247	59.244	2.457	1.247	59.244	3.775	1.916	56.205
12	2.392	1.214	60.458	2.392	1.214	60.458	3.660	1.858	58.063
13	2.285	1.160	61.618	2.285	1.160	61.618	3.507	1.780	59.843
14	2.164	1.098	62.716	2.164	1.098	62.716	3.387	1.719	61.562
15	2.074	1.053	63.769	2.074	1.053	63.769	3.243	1.646	63.208
16	2.030	1.030	64.800	2.030	1.030	64.800	3.135	1.591	64.800

Research Questions

One advantage of survey research for the ICHCC is that its research team has an opportunity to investigate if there are differences in how job tasks are perceived and at what level they are performed among the diverse population of health care providers the ICHCC certifies for the Certified Life Care Planner (CLCP) credential. Collecting and analyzing demographic data is essential to ensure that the CLCP test items address all facets of life care planning including all field areas of practice as well as education levels of current life care planning practitioners. The research questions that the study investigated and for which analyses are reported in the results section included:

1. What are the roles and functions of healthcare practitioners offering life care planning services?
2. Do the roles and functions differ between Certified Life Care Planners and Certified Nurse Life Care planners?
3. Do the roles and functions differ between doctoral/physician level practitioners and non-doctoral level practitioners?
4. Are there differences among life care planners in their perceptions of roles and functions of life care planners based on their daily time spent involved in performing life care planning service delivery?
5. Are there differences among life care planners in their perceptions of roles and functions of life care planners based on their degree level?

Results

Research Question

1. What are the roles and functions of healthcare practitioners offering life care planning services?

Factor analysis is used in the analysis of 197 job tasks contained within this study's job task inventory (JTI). This analysis is run using SPSS-22. While the exploratory factor analysis identified the interrelationships among questions, it is noteworthy that the principal component analysis and varimax rotation produced a more parsimonious result resulting in 16 factors when compared to the 22 factors identified in the 2010 Pomeranz et al. (2010) study. Thus, these results suggest that more job tasks are applied to fewer factors creating subfactors that share some congruency with their respective primary factor. The factors and their associated loadings, mean, and standard deviation (std) are presented in Appendix C.

2. Are there differences in the perceptions of roles and functions of life care planners between

Table 4

Independent Samples Test Measuring Perceptions of Roles and Functions Between CLCPs and CNLCPs

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95th Confidence Interval of the Difference	
									Lower	Upper
REGR factor score 3 for analysis 1	Equal Variances Assumed	.914	.341	-2.152	159	.033	-.78013522	.36258971	-1.49624852	-.06402192
	Equal Variances Not Assumed			-3.129	7.306	.016	-.78013522	.24931628	-1.36470944	-.19556099
REGR factor score 4 or analysis 1	Equal Variances Assumed	.403	.527	-2.308	159	.022	-.83831348	.36325278	-1.55573634	-.12089062
	Equal Variances Not Assumed			-2.863	6.904	.025	-.83831348	.29283103	-1.53270408	-.14392288

Certified Life Care Planners and Certified Nurse Life Care Planners?

3. **Do the roles and functions differ between doctoral/physician level practitioners and non-doctoral level practitioners?**

In order to test the perceived role and function differences between the Certified Life Care Planners (CLCP) and Certified Nurse Life Care Planners (CNLCP), and doctoral level practitioners and non-doctoral level practitioners, we used t-tests on the factor scores for each factor. Regarding questions 2 and 3, the null hypothesis is that there is no difference between the Certified Life Care Planners and Certified Nurse Life Care Planners, and no difference between doctoral level practitioners and non-doctoral level practitioners.

CLCP and CNLCP Analysis. Since a majority of the participants who have CLCP also have CNLCP, we included the participants who have only one of these two certificates. The results of the t-test for each of the significant factor scores are illustrated in Table 4.

When we use an independent t-test we have to check to see if the variance between two groups is equal or not (Ott & Longnecker, 2016). As noted in the Data Analysis section the Levene's for the Equality of Variances was applied to determine if the variances of the two groups are equal. Based on the results of the Levene's test, we can see that we fail to reject the null hypothesis. Therefore, we can conclude that the variance in both groups is equal. Now we can use the rows in the Table 4 to reflect that the equal variances are assumed. As it can be seen from the table, the *p-value* for the independent t-test for Factor 3- Vocational Consideration and Factor 4 - Litigation Support are less than *0.05*. Therefore, we can reject the null hypothesis in favor to the alternative. This means that there exists enough evidence to show that there is a statistically significant difference between CLCP and CNLCP for the perceptions of roles and functions of life care planners for these two factors. The results indicate that the *p-value* for the difference between CLCP and CNLCP for the perceptions of roles and functions of life care planners for the other factors is greater than 0.05. Therefore, we fail to reject the null hypothesis. This means that there is not a significant difference between CLCP and CNLCP for the perceptions of roles and functions of life care planners for other factors.

Using multiple t-tests can potentially increase the type I error. Therefore, we applied the Bonferroni's correction that adjusts the *p-value* (coefficient of significance) when multiple t-tests are being performed simultaneously on a single data set (Abdi, 2007). However, it is noteworthy that the routine use of this test has been criticized as deleterious to sound statistical judgment, testing the wrong hypothesis, and reducing the chance of a type I error but at the expense of a type II error; yet it remains popular in social science research (Armstrong, 2014). In order to perform the Bonferroni correction, one divides the critical *p-value* by the number of tests. This means for our study, the *p-value* should be less than 0.0031 (0.05/16) to reject the null hypothesis.

Table 5

Multivariate Tests[a] (MANOVA) of CLCP and CNLCP Group Variances

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.035	.441[b]	16.000	195.000	.970
	Wilks' Lambda	.965	.441[b]	16.000	195.000	.970
	Hotelling's Trace	.036	.441[b]	16.000	195.000	.970
	Roy's Largest Root	.036	.441[b]	16.000	195.000	.970
CNCLP vs. CLCP	Pillai's Trace	.173	2.558[b]	16.000	195.000	.001
	Wilks' Lambda	.827	2.558[b]	16.000	195.000	.001
	Hotelling's Trace	.210	2.558[b]	16.000	195.000	.001
	Roy's Largest Root	.210	2.558[b]	16.000	195.000	.001

Using this correction, it can be seen from the above table that we fail to reject the null hypothesis. This means that there is not a significant difference between CLCP and CNLCP for the perceptions of roles and functions of life care planners for any of the factors. One important criticism for using such an approach is that correction protocols are very conservative and there is a potential for dramatic increase in type II errors, or failing to reject a null hypothesis when it should be rejected (Perneger, 1998). One strategy for minimizing the probability of a type II error would be to use the one-way multivariate analysis of variance (one-way MANOVA). This method was used to make a comparison between independent groups for cases with more than one continuous dependent variable (O'Brien & Kaiser, 1985). It is worth mentioning that by using this procedure we cannot run the post hoc test because we only have two groups. The results of this analysis are presented in Table 5.

As it can be seen from the above table, the *p-value* for all the tests including the Hotelling's trace test are less than 0.05. Therefore, we have enough evidence to reject the null hypothesis. This means that there is evidence to support that the mean of the loading of at least one factor is different between CLCP and CNLCP. This finding is closer to what we found in multiple t-tests rather than the finding of the Bonferroni's correction method, which suggests that the null hypothesis cannot be rejected. Thus, the null hypothesis is rejected given the results of the multiple t-test and the multivariate analysis results vs. the Bonferroni correction results.

Doctoral Level Practitioners and Non/Doctoral Level Practitioners Analyses. We used multiple t-tests were used on the factor scores of each of the 16 factors to test the difference between doctoral level life care planners and non-doctoral level life care planners just as we did on Question 2 to test for differences in perceptions between CLCPs and CNLCPs. The null hypothesis was that there was no difference between the doctoral level group and the non-doctoral level group. Those who have doctoral-level degrees (i.e., M.D., D.O. D.C. Ph.D., Rh.D, Ed. D., and DPT) comprised the doctoral group and the rest of the participants were classified in the non-doctoral group (i.e., M.S., M.A., B.A., A.B., A.D., and Diploma RN. The results of the t-tests for each factor scores are presented in Table 6 on next couple of pages.

Again, and similar to Question 2 regarding CLCP and CNLCP perceptions of life care planning service delivery, we used Levene's Test for Equality of Variances and based on the results we find that we fail to reject the null hypothesis. Therefore, we can conclude that the variance in both groups is equal. Now, we can use the rows in the table that the equal variances are assumed. As it can be seen from Table 6, the *p-value* for the independent t-test for all the factors is above 0.05. Therefore, we fail to reject the null hypothesis. This means that there is not enough evidence to show that there is a statistically significant difference between doctoral-level and non-doctoral level practitioners for the perceptions of roles and functions of life care planners. We applied the Bonferroni's correction protocol to address the assumption of a presumptive Type I error. The *p-value* for the second research question analysis failed to meet the criteria for rejection of the null hypothesis. Using the Bonferroni's correction statistic as documented in Table 6, it can be seen that we fail to reject the null hypothesis. This means that there is not a significant difference between the doctoral-level and non-doctoral level groups for the perceptions of roles and functions of life care planners for any of the factors. Given the possibility of a possible Type II error, we used a one-way multivariate analysis of variance (one-way MANOVA) to control for the possibility of a Type II error as we did in Question 2. The results are presented in Tables 7 and 8.

Table 6

Independent Samples Test Measuring Doctoral and Non-Doctoral Perception of Roles and Functions of Life Care Planners

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95th Confidence Interval of the Difference	
									Lower	Upper
REGR factor score 1 for analysis 1	Equal Variances Assumed	1.511	.220	-.328	210	.743	-.14862992	.45354284	-1.04271016	.74545033
	Equal Variances Not Assumed			-.918	6.063	.394	-.14862992	.16195352	-.54392079	.24666096
REGR factor score 2 or analysis 1	Equal Variances Assumed	.10	.744	-.505	210	.614	-.22918436	.45338304	-1.12294959	.66458087
	Equal Variances Not Assumed			-.460	4.160	.669	-.22918436	.49841800	-1.59226276	1.13389403

Table 6

Independent Samples Test Measuring Doctoral and Non-Doctoral Perception of Roles and Functions of Life Care Planners

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95th Confidence Interval of the Difference	
									Lower	Upper
REGR factor score 3 for analysis 1	Equal Variances Assumed	.19	.658	-.196	210	.845	-.08881006	.45361740	-.98303729	.80541716
	Equal Variances Not Assumed			-261	4.361	.806	-.08881006	.34009566	-1.00301039	.82539026
REGR factor score 4 for analysis 1	Equal Variances Assumed	.66	.423	.827	210	.409	.37444264	.45292234	-.51841441	1.26729968
	Equal Variances Not Assumed			.677	4.128	.534	.37444264	.55272946	-1.14153172	1.89041700
REGR factor score 5 for analysis 1	Equal Variances Assumed	1.564	.212	.444	210	.657	.20134758	.45344597	-/69254171	1.09523687
	Equal Variances Not Assumed			.322	4.099	.763	.20134758	.62534534	-1.51844021	1.92113537
REGR factor score 6 or analysis 1	Equal Variances Assumed	3.206	.705	-1.79	210	.075	-.80591806	.45023708	-1.69348157	.08164546
	Equal Variances Not Assumed			-4.94	5.992	.003	-.80591806	.16286844	-1.20457295	-.40726317

Table 6

Independent Samples Test Measuring Doctoral and Non-Doctoral Perception of Roles and Functions of Life Care Planners

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95th Confidence Interval of the Difference	
									Lower	Upper
REGR factor score 7 for analysis 1	Equal Variances Assumed	.04	.838	.349	210	.728	.15806448	.45352765	-.73598583	1.05211478
	Equal Variances Not Assumed			.374	4.226	.727	.15806448	.42315603	-.99239442	1.30852338
REGR factor score 8 for analysis 1	Equal Variances Assumed	.041	.840	.191	210	.849	08651304	.45361951	-.80771835	.98074444
	Equal Variances Not Assumed			.183	4.179	.863	.08651304	.47288699	-1.20453844	1.37756453
REGR factor score 9 for analysis 1	Equal Variances Assumed	1.549	.215	1.000	210	.318	-.45263933	.45258223	-1.34482590	.43954723
	Equal Variances Not Assumed			-.743	4.104	.498	-.45263933	.60938845	-2.12773871	1.22246004

Table 6

Independent Samples Test Measuring Doctoral and Non-Doctoral Perception of Roles and Functions of Life Care Planners

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95th Confidence Interval of the Difference	
									Lower	Upper
REGR factor score 11 or analysis 1	Equal Variances Assumed	.685	.409	-1.055	210	.292	-.47752981	.45246041	-1.36947624	.41441662
	Equal Variances Not Assumed			-.744	4.093	.407	-.47752981	.64182970	-2.24360078	1.28854116
REGR factor score 12 for analysis 1	Equal Variances Assumed	1.146	.286	-1.544	210	.124	-.69644512	.45110598	-1.58572153	.19283130
	Equal Variances Not Assumed			-2.537	4.570	.057	-.69644512	.27456031	-1.42268378	.02979355
REGR factor score 13 or analysis 1	Equal Variances Assumed	11.539	.001	.714	210	.476	.32343389	.45310944	-.56979198	1.21665976
	Equal Variances Not Assumed			.360	4.046	.737	.32343389	.89791875	-2.15853743	2.80640522
REGR factor score 14 for analysis 1	Equal Variances Assumed	.753	.387	-.104	210	.917	-.04710019	.45364715	-.94138607	.84718569
	Equal Variances Not Assumed			-.138	4.357	.897	-.04710019	.34189468	-.96643830	.87223793

Table 6

Independent Samples Test Measuring Doctoral and Non-Doctoral Perception of Roles and Functions of Life Care Planners

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95th Confidence Interval of the Difference	
									Lower	Upper
REGR factor score 15 for analysis 1	Equal Variances Assumed	.028	.868	.414	210	.679	.18794817	.45347336	-.70599512	1.08189145
	Equal Variances Not Assumed			.416	4.197	.698	.18794817	.45225299	-1.04484075	1.42073708
REGR factor score 16 for analysis 1	Equal Variances Assumed	.380	.528	-.143	210	.886	-.06495308	.45363665	-.95921827	.82931210
	Equal Variances Not Assumed			-.216	4.471	.839	-.06495308	.30109881	-.86734722	.73744105

Table 7

Multivariate Tests[a] (MANOVA) of Doctoral and Non-Doctoral Group Variances

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.053	.682[b]	16.000	195.000	.809
	Wilks Lambda	.947	.682[b]	16.000	195.000	.809
	Hotelling's Trace	.056	.682[b]	16.000	195.000	.809
	Roy's Largest Root	.056	.682[b]	16.000	195.000	.809
Doctoral. vs. non-Doctoral	Pillai's Trace	.058	.752[b]	16.000	195.000	.738
	Wilks' Lambda	.942	.752[b]	16.000	195.000	.738
	Hotelling's Trace	.062	.752[b]	16.000	195.000	.738
	Roy's Largest Root	.062	.752[b]	16.000	195.000	.738

Table 8

Multivariate Tests[a] (MANOVA) of Doctoral and Non Doctoral Group Variances

Effect		Partial Eta Squared	Noncent. Parameter	Observed Power[c]
Intercept	Pillai's Trace	.053	10.919	.457
	Wilks' Lambda	.053	10.919	.457
	Hotelling's Trace	.053	10.919	.457
	Roy's Largest Root	.053	10.919	.457
Doctoral vs. Non-Doctoral	Pillai's Trace	.058	12.026	.505
	Wilks' Lambda	.058	12.026	.505
	Hotelling's Trace	.058	12.026	.505
	Roy's Largest Root	.058	12.026	.505

As it can be seen from these tables the p-value for all the tests including Hotelling's trace test are above 0.05. Therefore, we fail to reject the null hypothesis. This means that there is not enough evidence to show that there is a statistically significant difference between doctoral-level and non-doctoral level groups for the perceptions of roles and functions of life care planners.

4. Are there differences among life care planners in their perceptions of roles and functions of life care planners based on their daily time spent involved in performing life care planning service delivery?

When we use an ANOVA, first we check to see if there exists any group that its mean is statistically different from other groups. As it can be seen from Table 9, the p-values for the ANOVA for Factors 1 – Care Plan Development, 2 – Needs Assessment, 4 – Litigation Support, 7 – Information Sharing, and 13 – Financial Resources are less than p-value of 0.05.

Therefore, we can reject the null hypothesis in favor of the alternative. This means that there is enough evidence to show that there is at least one group that its mean is statistically significantly different from other groups. In order

Table 9

ANOVA Results among Groups for Time Spent on Life Care Planning Service Delivery

		Sum of Squares	df	Mean Square	F	Sig.
REGR factor score 1 for analysis 1	Between Groups	28.280	4	7.070	8.009	.000
	Within Groups	182.720	207	.883		
	Total	211.000	211			
REGR factor score 2 for analysis 1	Between Groups	10.840	4	2.710	2.802	.027
	Within Groups	200.160	207	.967		
	Total	211.000	211			
REGR factor score 4 for analysis 1	Between Groups	11.884	4	2.971	3.089	.017
	Within Groups	199.116	207	.962		
	Total	211.000	211			
REGR factor score 7 for analysis 1	Between Groups	11.915	4	2.979	3.097	.017
	Within Groups	199.085	207	.962		
	Total	211.000	211			
REGR factor score 13 for analysis 1	Between Groups	18.144	4	4.536	4.869	.001
	Within Groups	192.856	207	.932		
	Total	211.000	211			

to find which group/groups are different, one needs to use a post-hoc test. Here we need a post hoc statistic that can perform pairwise comparisons of means to determine mean-differences among the groups (Roscoe, 1975). We used Tukey's post-hoc test for those factors that are statistically significant to find the group/groups that have different means. The results of the post-hoc test are presented in Table 10.

As it can be seen from Table 10, for Factor 1 – Care Plan Development, the mean of the group that answered none is statistically different from all the other groups. The means of the other groups are not statistically different from each other. For Factor 2 – Needs Assessment, the mean of the group that answered none is statistically different from the mean of those who chose 51-75% of time spent on life care planning service delivery. The means of the other groups are not statistically different from each other. For factor 4 –

Table 10

Multiple Comparisons of Groups Regarding their Time Spent on Life Care Planning

Tukey HSD							
Dependent Variable	Life Care Planning Activities Constitute Approximately ___ of My Work Activities	Life Care Planning Activities Constitute Approximately ___ of My Work Activities	Mean Difference	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
REGR factor score 1 for analysis 1	None	1 – 25%	1.46990417*	.3030853	.000	.6358215	2.3039868
		26 – 50%	1.74118272*	.3360640	.000	.8163436	2.6660218
		51 – 75%	1.70836674*	.32167576	.000	.8231237	2.5936097
		76 – 100%	1.56347040*	.30815246	.000	.7154432	2.4114976
	1 – 25%	None	-1.46990417*	.3030853	.000	-2.3039868	-.6358215
	51-75%	None	-1.70836674*	.32167576	.000	-2.5936097	-.8231237
	76 - 100%	None	-1.56347040*	.30815246	.000	-2.4114976	-.7154432
REGR factor score 2 for analysis 1	51 – 75%	None	-1.94179791*	.33667734	.044	-1.8683248	-.0152710
REGR factor score 4 for analysis 1	1 – 25%	76 – 100%	.53499374*	.16937723	.016	.0688722	1.0011153
	76 - 100%	1 – 25%	-.53499374*	.16937723	.016	-1.0011153	-.0688722
REGR factor score 7 for analysis 1	1 – 25%	76 – 100%	-.51954056*	.16936420	.020	-.9856262	-.0534549
	76 – 100%	1 – 25%	-.51954056*	.16936420	.020	.0534549	.9856262
	1 – 25%	76 – 100%	-68884950*	.16669334	.000	-1.1475851	-.2301139
	76 – 100%	1 – 25%	-68884950*	.16669334	.000	2301139	1.1475851

Litigation Support, the mean of the group that answered 1-25% is statistically different from the mean of those who chose 76-100% of time spent in life care planning service delivery. The means of the other groups are not statistically different from each other. Similar results can be seen for Factors 7 – Information Sharing and 13 – Financial Resources.

5. Are there differences among life care planners in their perceptions of roles and functions of life care planners based on their degree?

There were 17 different degrees which the respondents could choose on the demographic questionnaire. We removed those degrees that had only one participant, thereby removing that individual's responses to this question from the analysis. Additionally, we considered the highest degree of those participants who had multiple degrees. We ran the ANOVA on the factor scores for each of the 16 factors. The null hypothesis is that there is no difference among the life care planners with varying academic degrees in their perceptions of the roles and functions of life care planners. The results of the ANOVA for each of the factor scores are presented in Table 11.

As noted above, when we use an ANOVA we check first to determine if there exists any group which mean is statistically different from other groups. As it can be seen in Table 11, the p-values for the ANOVA for Factors 2 – Needs Assessment, 4 – Litigation Support, 5 – Knowledge Applications, and 10 – Records Request are less 0.05. Therefore, we can reject the null hypothesis in favor to the alternative. This means that there is enough evidence to show that there is at least one group which mean is statistically significantly different from other groups at the 95% level. In order to find which group/groups are different, we used Tukey's post-hoc test for those factors that are statistically significant to find the group/groups that have different means. The results of the post-hoc tests are presented in Table 12 in which the significant group means are listed.

From post-hoc Table 12 it can be seen that for Factor 2 – Needs Assessment, group 4 (Bachelor's Degree Rehabilitation Counseling/Vocational Evaluator) are significantly different from the rest of the other groups and they have higher factor loading. For Factor 4 – Litigation Support, group 4 (Bachelor's Degree Rehabilitation Counseling/Vocational Evaluator) is significantly different from the other groups and the mean of the factor loading for group 4 is higher than the mean of the factor loading for other groups. In addition, group 5 (Bachelor's Degree – Other) is also significantly different from group 7 (Master's Degree-Rehab/Psych) and group 13 (Medical Doctor [M.D]) and the mean of the factor loading for group 5 (Bachelor's Degree – Other) is higher than the mean of the factor loading for groups 7 (Master's Degree- Rehab/Psych) and 13(Medical Doctor [M.D]). For Factor 5 – Knowledge Applications, group 7 (Master's Degree- Rehab/Psych) is significantly

Table 11

Multiple Comparisons of Life Care Planners Perceptions of Life Care Planners Roles and Functions Who Hold Various Academic Degrees

		Tukey HSD				
		Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**
REGR factor score 2 for analysis 1	Between Groups	47.022	13	3.617	4.339	.000
	Within Groups	163.388	196	.834		
	Total	210.409	209			
REGR factor score 4 for analysis 1	Between Groups	40.118	13	3.086	3.556	.000
	Within Groups	170.071	196	.868		
	Total	210.189	209			
REGR factor score 5 for analysis 1	Between Groups	25.325	13	1.948	2.070	.017
	Within Groups	184.461	196	.941		
	Total	209.785	209			
REGR factor score 10 for analysis 1	Between Groups	31.396	13	2.415	2.689	.002
	Within Groups	176.013	196	.898		
	Total	207.409	209			

Table 12

Tukey's Post-Hoc Test to Determine Differences among Means of Groups

Multiple Comparisons

Tukey HSD

Dependent Variable			Mean Difference (I-J)	Std. Error	Sig.
REGR factor score 2 for analysis 1	.00				
		4.00	-4.30470851*	.69733291	.000
Needs Assessment	1.00				
		4.00	-4.02196534*	.71374299	.000
	2.00	.00			
		4.00	-4.36308474*	.67308956	.000
	3.00	.00			
		4.00	-4.27041011*	.66432189	.000
	4.00	.00	4.30470851*	.69733291	.000
		1.00	4.02196534*	.71374299	.000
		2.00	4.36308474*	.67308956	.000
		3.00	4.27041011*	.66432189	.000
		5.00	4.19526836*	.66379444	.000
		6.00	4.44293804*	.68052724	.000
		7.00	4.07093541*	.65919800	.000
		8.00	3.75559122*	.83347225	.001
		9.00	4.08824654*	.70722465	.000
		12.00	4.71409822*	.91302310	.000
		13.00	3.76482609*	.73204706	.000
		16.00	4.12968287*	.76388993	.000
	5.00				
		4.00	-4.19526836*	.66379444	.000
		4.00	-4.44293804*	.68052724	.000
		4.00	-4.07093541*	.65919800	.000
		2.00	.60749352	.56045906	.998

Table 12

Tukey's Post-Hoc Test to Determine Differences among Means of Groups

Multiple Comparisons

Tukey HSD

Dependent Variable			Mean Difference (I-J)	Std. Error	Sig.
		4.00	-3.75559122*	.83347225	.001
	9.00	4.00	-4.08824654*	.70722465	.000
	12.00	4.00	-4.71409822*	.91302310	.000
	13.00	4.00	-3.76482609*	.73204706	.000
	16.00	4.00	-4.12968287*	.76388993	.000
REGR factor score 4 for analysis 1 **Litigation Support**	.00	4.00	-2.87486501*	.71145104	.006
	1.00	4.00	-2.84431704*	.72819336	.009
		4.00	-2.72841336*	.67777168	.006
	4.00	.00	2.87486501*	.71145104	.006
		1.00	2.84431704*	.72819336	.009
		3.00	2.72841336*	.67777168	.006
		6.00	2.88134294*	.69430512	.004
		7.00	2.89851965*	.67254405	.002
		8.00	3.35817396*	.85034664	.008
		9.00	3.08103629*	.72154305	.002
		13.00	3.46115796*	.74686801	.001
		16.00	2.83074015*	.77935557	.024
	5.00	7.00	.73086771*	.20797474	.035
	6.00	4.00	-2.88134294*	.69430512	.004
	7.00	4.00	-2.89851965*	.67254405	.002
		5.00	-.73086771*	.20797474	.035

Table 12

Tukey's Post-Hoc Test to Determine Differences among Means of Groups

Multiple Comparisons

Tukey HSD

Dependent Variable			Mean Difference (I-J)	Std. Error	Sig.
	8.00				
		4.00	-3.35817396*	.85034664	.008
	9.00				
		4.00	-3.08103629*	.72154305	.002
		17.00	-.33146282	.61319368	1.000
	13.00				
		4.00	-3.46115796*	.74686801	.001
	16.00				
		4.00	-2.83074015*	.77935557	.024
REGR factor score 5 for analysis 1 **Knowledge Applications**	.00				
	3.00				
		7.00	-.74629052*	.21841267	.047
REGR factor score 10 for analysis 1 **Records Request**	.00				
	5.00				
		7.00	.84525571*	.21157668	.007
	7.00	.00			
		5.00	-.84525571*	.21157668	.007
	12.00	.00			
REGR factor score 15 for analysis 1 **Collaboration**	16.00	.00	-.77216419	.52372237	.971
		1.00	-.50499453	.54879488	1.000
		2.00	-.69609181	.48549235	.977
		3.00	-.07833924	.47125952	1.000
		4.00	-.74785320	.82319232	1.000
		5.00	-.37381454	.47039561	1.000
		6.00	-.02982117	.49738760	1.000
		7.00	-.51779525	.46282843	.998
		8.00	-.71734348	.71854117	.999
		9.00	-.05377436	.53890588	1.000

Table 12

Tukey's Post-Hoc Test to Determine Differences among Means of Groups

Multiple Comparisons

Tukey HSD

Dependent Variable			Mean Difference (I-J)	Std. Error	Sig.
		12.00	-1.08877071	.82319232	.988
		13.00	-1.04312132	.57611461	.869
		17.00	-1.47925635	.71854117	.728
REGR factor score 16 for analysis 1 **Records Review**	.00	6.00	1.27799097*	.36551187	.037
	2.00	6.00	1.07489883*	.30864518	.038
	3.00	6.00	1.03078727*	.28588653	.026
	6.00	.00	-1.27799097*	.36551187	.037
		2.00	-1.07489883*	.30864518	.038
		3.00	-1.03078727*	.28588653	.026
		5.00	-.97104934*	.28446929	.047

*. The mean difference is significant at the 0.05 level.

It is worth mentioning that these numbers are assigned to different degrees as follows:

0	No answer
1	Diploma Nurse RN
2	Associate's Degree RN
3	Bachelor's Degree RN (BSN)
4	Bachelor's Degree Rehabilitation Counseling/Vocational Evaluator
5	Bachelor's Degree - Other
6	Master's Degree RN
7	Master's Degree- Rehab/Psych
8	Master's of Social Work (MSW)
9	Doctor of Philosophy (Ph.D.)
10	Doctor of Education (Ed.D.)
11	Doctor of Rehabilitation (Rh.D.)
12	Doctor of Physical Therapy (DPT)
13	Medical Doctor (M.D.)
14	Doctor of Osteopathy (D.O.)
15	Doctor of Chiropractic (D.C.)
16	Juris Doctor (J.D.)
17	Other

different from groups 3 (Bachelor's Degree RN (BSN]) and group 6 (Master's Degree RN) and the mean of the factor loading for group 7 (Master's Degree- Rehab/Psych) is higher. For Factor 10 – Records Request, group 5 (Bachelor's Degree – Other) is significantly different from group 7 (Master's Degree- Rehab/Psych) and the mean of the factor loading for group 5 (Bachelor's Degree – Other) is higher. For Factor 16 – Records Review, group 6 (Master's Degree RN) is significantly different from groups 1 (Diploma Nurse RN), 2 (Associate's Degree RN), 3 (Bachelor's Degree RN [BSN]), 5 (Bachelor's Degree - Other), and 7(Master's Degree-Rehab/Psych). This group (group 6 [Master's Degree RN]) has a lower factor loading compared to the rest of the other groups.

Discussion

The results of this investigation have some significant implications for life care planning curriculum content and the CLCP international examination overall. However, there is the issue of limitations in this study that need to be acknowledged. While the field participation rate (212 responses) was high in terms of studies that focused on determining life care planners' roles and functions to date, caution should be taken when casual generalizations are made from this study's results. There is no doubt that there are a significantly greater number of healthcare professionals offering life care planning services than the number of Certified Life Care Planners who responded to this survey. Given the low response rate of 13% there remains a threat to the external validity of the study's results. Therefore, replication of this investigation is warranted and encouraged as a method for determining the validation parallel of results between this and other studies.

Job Task Inventory/Competencies

There are 16 factor loadings with 24 subfactor groupings of competencies identified in this study. A comparison was made to Turner's et al. (2000) study, the earliest life care planning role and function study, which utilized factor analysis for grouping its factors. This comparison reveals that job tasks in the 2000 study correlate well with the first 4 factors of this study, as well as factors 6 and 15. For example, Turner's et al. job task inventory contained 56 competencies, of which 45 achieved the loading criterion of .40 for retention in their study. Turner's et al. competencies spread across three factors categorized by the SME participants as Factor 1 - Assessing Client's Medical and Independent Living Needs, Factor 2 – Vocational Assessment, and Factor 3 – Consultant to the Legal System. The first 4 factors of this current study as presented in Appendix B include Factor 1-Care Plan Development, Factor 2-Needs Assessment, Factor 3-Vocational Consideration, and Factor 4-Litigation Support, Factor 6-Marketing Subfactor 1 and Factor 15-Collaboration. Turner's et al. study listed 29 competencies in their Factor 1-Assessing Client's Medical and Independent Living Needs of which 16 were factored into this study's Factor 1-Care Plan Development, 9 in Factor 2- Needs Assessment, and 2 in Factor 6- Marketing Subfactor 1. Turner's et al. Factor 2-Vocational Assessment had a total of 6 competencies, all of which were factored into this study's Factor 3-Vocational Consideration. Finally, Turner's et al. study had 10 competencies grouped into their study's Factor 3-Consultant Services to the legal system, and 6 of those competencies were grouped into this study's Factor 4-Litigation Support, 2 in Factor 1 Care Plan Development, 1 in Factor 3-Vocational Consideration, and 1 in Factor 15-Collaboration. The total competency listing from the Turner et al. study that were loaded into this study's job task inventory (JTI) was 82%, suggesting that on the surface competencies from the Turner et al. study remain valid essential functions in today's Life Care Planning Model.

Similar observations are made with reference to the Pomeranz et al. (2010) study when compared to the findings of this current role and function study's factor loadings. Due to the number of factors in the Pomeranz et al. study and this study, and for the purposes of brevity only the number of factors and percentages of factors loading common to both studies are identified.

The Pomeranz et al. (2010) study listed 122 competencies within its job task inventory (JTI), with the results revealing 22 factors of which is a significant increase in factor loadings over the 10-years spanning the Turner et al. and Pomeranz et al. role and function studies. Specifically, the competencies listed in the job task inventory of Pomeranz's et al. had increased in number by 54% when compared to Turner et al., and when compared to this study's JTI the number of competencies in today's life care planning service delivery methodology had increased by 42%. When comparing Turner's et al. first JTI numbers to this study's most recent JTI numbers, one finds an increase in identified competencies of 89%. This is a significant increase and suggests that life care planning has experienced a remarkable growth in structure and methodologies over the 20 years spanning the three role and function studies.

Research Questions

Question 1. Do life care planning roles and functions differ between Certified Life Care Planners and Certified Nurse Life Care planners?

There was a significant difference in the perceptions of life care planning service delivery between Certified Life Care Planners (CLCP) and Certified Nurse Life Care Planners (CNLCP) on Factor 3-Vocational Consideration and Factor 4-Litigation Support. This may be explained best when reviewing some of the literature addressing the responsibilities of Certified Nurse life care planners vs. the responsibilities of Certified Life Care Planners.

The American Association of Nurse Life Care Planners (AANLCP) and the Certified Nurse Life Care Planner (CNLCP) credential were established in 1997, and in 2008

the CNLCP established a separate non-profit entity referred to as the Certified Nurse Life Care Planner Certification Board (Manzetti, et al., 2014). Howland (2015) noted that the AANLCP based its scope of practice on the American Nursing Association's (ANA) Social Policy Statement that reads as follows: "Nursing is the protection, promotion, and optimization of health and abilities; prevention of illness and injury; alleviation of suffering through the diagnosis and treatment of human response; and advocacy in the care of individuals, families, communities, and populations" (p. 4).

Specifically, the AANCLCP based its foundation and framework for the practicing nurse life care planner on three documents that included the 1) Nursing Scope and Standards of Practice, Second Edition (ANA, as cited in Howland, 2015), 2) Nursing's Social Policy Statement: The Essence of the Profession (ANA, as cited in Howland, 2015), and 3) The Code of Ethics for Nurses with Interpretive Statements (ANA, as cited in Howland, 2015). Thus, in concert with the tenets of the ANA scope of practice, Howland (2015) defined nurse life care planning as the "protection, promotion, and optimization of health and chronic and complex health conditions" (p. 6).

Further review of the scope and practice standards developed and accepted by the AANLCP finds that this association advocated the adoption of the nursing process as defined by the National League for Nursing. Thus, Howland (2015) concluded the following:

> Nurse life care planners apply advocacy, judgement, and critical thinking skills using the nursing process to develop long-term or lifetime plans of care, including the cost associated with all of a plan's components, which included identified evaluations and interventions, health maintenance, health promotion, and optimization of physical and psychological abilities (p. 4)

To this point, most of the documentation that the AANLCP uses for their practice guidance implies that the CNLCP practitioner advocates for the person with the disability/ subject of the life care plan, which is admirable and in fact covers one of the basic ethical tenets adopted by the ICHCC; to do no harm (International Commission on Health Care Certification Standards and Guidelines, 2020). However, advocacy connotes bias, which suggests possible problems in the processing of the total life care plan that is easily recognized by the referral sources.

Manzetti et al. (2014) noted that their development of a nurse life care planner role delineation survey resulted in 136 task statements, 16 knowledge areas, and 15 demographic questions. The study's focus was on the frequency of performance of tasks and how important the respective task was for competent performance. The study's frequency cut score for inclusion was a 3.5 mean frequency rating score among the task ratings. The study included many of the competencies identified by this role and function study, other than any task related to legal consultation or litigation involvement. The nurse study concluded that there were 8 tasks that failed to meet the 3.5 mean frequency rating score and were excluded, all of which were related to legal consultation. These tasks included arbitration, mediation, settlement conference, deposition, development of a rebuttal or comparison of opposing counsel's life care plan expert's report, assistance in developing questions for deposition, and assistance in developing questions for cross examination.

Sutton (2019) confirmed that all nurses shared the basic tenets of the nursing process as defined by the National League for Nursing, which she noted included assessment, nursing diagnosis, outcome/planning, implementation, and evaluation. She also documented the role of rehabilitation nurses as retained by insurance companies and as practicing case managers to include roles as educators, caregivers, collaborators, client advocates, and consultants. Riddick-Grisham (as cited in Sutton, 2019) documented 24 desirable traits for rehabilitation nurse life care planners, none of which identified with legal consultations or litigation case involvement. However, Sutton (2019) acknowledged in her "Other Roles" section that rehabilitation nurse life care planners may be involved with attorneys through their advisement regarding the selection of life care planners and how to evaluate the opposing counsel's life care planner's background and credentials; assist attorneys in selecting other specialties that should be retained or consulted; assist attorneys in preparing deposition questions for patients, family members, experts, and treating physicians.

In essence, Certified Nurse Life Care Planners differed from Certified Life Care Planners in their involvement with legal consultation due to the premise that their obligations and training differ from that of the Certified Life Care Planner. Their obligations are to the nursing process as applied to the Life Care Planning Model, whereby litigation involvement may not be their focus, but rather educating and interpreting for all persons involved in the respective case the required categories of need facing the individual with a disability for the individual's remaining life span.

The Certified Life Care Planner, however, is exposed to legal consultation as one of the main factors in the Life Care Planning Model, as it was in Turner's et al. first investigation into life care planners' roles and function, and as the 4th factor in this study's investigation. Certified Life Care Planner candidates spend much of their 120-hour training reviewing the litigation applications to the life care planning process and what the role of the Certified Life Care Planner is to the legal community.

Certified Nurse Life Care Planners differed from Certified Life Care Planners in their perceptions of vocational tasks as enumerated in Factor 3 - Vocational Consideration. Given the CNLCP's reliance on the ANA's Nursing Scope and Standards of Practice, the ANA's Nursing Social Policy Statement, and the Code of Ethics for Nurses, there is no wonder as to why CNLCPs should even approach or investigate the complexities of worker trait profile adjustments to the respective individual with the disability or

the transferable skills process as effected by the residuals of the disability in question, and of course, the individual's degree of loss of access to the labor market. Sambucini (2013) recognized that the nursing process methodology is accepted and followed by all registered nurses and is therefore accepted and followed by all CNLCP practitioners. One of the tenets of this process as applied to the CNLCP practice methodology is the supposition that the CNLCP practitioner identifies and delegates different sections of the life care plan to an appropriate provider, and vocational information is addressed predominantly in the CNLCP life care plan by vocational rehabilitation consultants.

Question 2. Do the roles and functions differ between doctoral level practitioners and non-doctoral level practitioners?

There were no differences in the perceptions of the life care planning process and methodology between doctoral/physician level practitioners and non-doctoral/physical level practitioners. This is attributed to the consistency of the 120-hour pre-certification training program in their comprehensive curricula which focus on the teaching of life care planning methodology based on the rehabilitation/case management model. There are three 120 hour pre-certification programs the ICHCC has approved for its CLCP and CCLCP candidates to sit for those respective life care planning examinations, and these programs include the 1) Capital University Life Care Planner Program, 2) Institute of Rehabilitation and Education Training (IRET), and 3) FIG "Tree of Life." The one common denominator all CLCP's have, past and present, is that all Certified Life Care Planners and Canadian Certified Life Care Planners have completed their mandatory 120-hour training in one of the above listed training programs. These programs have maintained excellent consistency in delivering training in the life care planning rehabilitation/case management model such that all CLCP's who participated in this role and function study regardless of degree level agreed as to the relevance levels of the 196 competencies as applied to the Life Care Planning Model.

Question 3. Are there differences among life care planners in their perceptions of roles and functions of life care planners based on their daily time spent involved in performing life care planning service delivery?

The lack of time spent on life care planning service delivery post-certification had the greatest effect on those persons who completed their training and learned the process, but for various reasons never sustained a practice in life care planning and/or attempted and found themselves preferring to focus more on their pre-training and certification practices, rather than on life care planning service delivery. Dorfman (n.d.) hypothesized that a business firm decides how much of each commodity it sells or output it will produce and how much labor, fixed capital goods, etc., that it employs and it will use. Such a combination of time, "sweat-equity", and business costs have a definitive effect on sustained production output and predicting one's success in business management and product sales and delivery. The same can be applied to that of a life care planner who has just completed the 120-hour training and has successfully passed the Certified Life Care Planner examination. The next step is to launch a marketing plan to procure cases from known referral sources. Some may find little success in establishing a referral base for various reasons. The practitioner who lacks the training and skill-set necessary to develop a marking plan and strategy list usually results in the practitioner decreasing their effort to establish marketing relationships with potential case referral sources. This failed effort can result in business costs that exceed the return on investment, enticing practitioners to resume the practice that has always worked for them outside of life care planning service delivery.

We found that those persons who failed to establish a business model for life care planning were significantly different from all of the other time-on-task percentage groups. They never experienced Factor 1 – Care Plan Development that called for conducting an initial interview, communicating with referral sources following a case referral, conducting costs analyses, writing the report, or serving as an expert witness as a life care planner. Additionally, they had different perceptions of Factor 2 - Needs Assessment than did those more experienced life care planners who spent 51% to 75% of their time involved in providing life care planning services. The "None" group never performed needs assessments or published the needs of an individual with a disability in a life care plan.

The group that spent 1% to 25% of their time developing life care plans was significantly different in their perceptions of life care planning service delivery, when compared to the more experienced life care planners who spent 76% to 100% of their time providing life care planning services. These perceptions were different in Factor 4 – Litigation Support, Factor 7 – Information Sharing, and Factor 13 - Financial Resources.

The results suggest that the less time one spends providing life care planning services, the greater the differences in their perceptions of service delivery when compared to the more experienced life care planners. Those life care planners who do not put forth much time in making the effort to procure cases through establishing referral relationships do so because they are frustrated and discouraged with their failed efforts to connect with potential referral sources. They leave the training programs without much exposure to marketing planning and skill development or learning how to develop appropriate strategies necessary for securing referrals. The training programs have a great opportunity to expand their training units to include marketing. Alternatively, webinars addressing case procurement strategies from the CLCP/CCLCP pre-certification training programs as well as from CEU programs could resolve some of the anxiety experienced by

Table 13

Pre-approved 120-hour Training Programs

Training Program	Program Units	Marketing Unit – Market Access, Skill, and Strategy Development
FIG	24 Learning Units	None
Institute of Rehabilitation and Education Training	7 Specialty Topics 6 Units	None
Capital University Life Care Planner Program	8 Modules	None

some of the newly Certified Life Care Planners. A review of the ICHCC preapproved 120-hour training programs suggest an absence of program learning units that address the machinations of marketing skill development and strategies. These findings are best illustrated in Table 13.

Question 4. Are there differences among life care planners in their perceptions of roles and functions of life care planners based on their degree level?

This question identified 4 factors in which specific degree-groups differed significantly in their mean-ratings regarding job tasks required of life care planning methodology. The factors that had significant rating differences among specific degree groups included Factor 2 – Needs Assessment, Factor 4 – Litigation Support, Factor 5 – Knowledge Applications, Factor 10 – Records Request, and Factor 16 – Records Review. The Bachelor's Degree in Rehabilitation Counseling/Vocational evaluation had the highest rating means of all of the other groups in Factors 2 and 4. This is reasonable given the results of the most recent studies of the essential competencies required of rehabilitation counselors. Leahy, Chan, Sung, and Kim (2012) identified 4 knowledge domains, several of which apply to this role and function study directly. For example, regarding Factor 2 – Needs Assessment, Leahy et al. (2012) documented rehabilitation counselors requiring expertise in the tests and evaluation techniques available to assess clients' needs, interpretation of assessment results for rehabilitation planning purposes, computer-based and on-line assessment tools, professional roles, functions, and relationships with other human service providers, techniques for working effectively in teams and across disciplines, and programs and services for specialty populations (e.g., spinal cord injury, traumatic brain injury, mental health, etc.). Regarding Factor 4 – Litigation Support, Leahy et al. documented rehabilitation counselors' need for expertise in forensic rehabilitation that included expert testimony, life care planning, and earning capacity evaluation.

Group 7 – Masters' Degree Rehabilitation Psychologists had the highest mean ratings of all of the other groups in Factor 5 – Knowledge Applications. Leahy et al. (2012) revealed that rehabilitation counselors at the Master's level are adept in their knowledge of psychosocial and cultural impact of disability on the individual in question, what specific resources and services are available for rehabilitation planning, the medical aspects and implications of various disabilities, implications of medications as they apply to individuals with disabilities, rehabilitation terminology and concepts, and in knowledge of the case management process including case finding, planning, service coordination, and referral to and utilization of other disciplines. Their study revealed that the Master's level group of rehabilitation counselors were knowledgeable in laws and public polices affecting individuals with disabilities in addition to health care benefits and delivery systems.

The Leahy et al. (2012) initial rehabilitation counselor

competency study was updated by Leahy, Chan, Lwanaga, Umucu, Sung, Bishop, and Strauser (2019) which provided additional evidence of rehabilitation counselors prevalence in Factors 2, 4, and 5 of this study over the other degree-groups. Leahy et al. (2019) documented that the competencies of rehabilitation counselors had become more specific in needs assessment, litigation support, and knowledge applications since their initial study of 2012. They documented rehabilitation counselors' competency areas to include knowledge and understanding of insurance programs (e.g., Medicare, Medicaid, group and individual short-and-long-term disability, personal injury no-fault), managed care concepts (e.g., PPO, HMO, POS, evidenced-based practice, etc.), professional roles, functions, and relationships with other human service providers, case recording and documentation, negotiation, mediation, and conflict resolution strategies, financial resources for rehabilitation services, appropriate medical intervention resources, expert testimony, and earnings capacity evaluation and determination.

The highest mean rating in Factor 10 – Records Request was Group 5 - Bachelor's Degree – Other followed by Group 7 - Master's Degree in Rehabilitation Psychology, which mean rating was also significantly different from the other groups. The last of the Factors with significant mean-ratings was Factor 16 – Records Review. The nursing population of this study dominated this factor which is understandable given their commitment to the National League for Nursing policies and the ANA Scope and Standards of Practice, Social Policy Statement, and the Code of Ethics. Nurses are well-trained in patient care and carry this tenet of practice into their life care planning practices. Record reviews are a crucial element of any health care delivery system and nurses are relied upon by many law firms and insurance companies to review, summarize, and prepare chronological medical histories as a function of their consulting roles. Interestingly, Group 6 – Master's Degree RN had a lower mean rating than Group 1 – Diploma Nurse, Group 2 – Associate Degree Nurse, Group 3 – BSN, Group 5 – Bachelor's Degree – Other, and Group 7 – Master's Degree Rehabilitation Psychology.

Conclusion

The Life Care Planning Model has evolved over the years as a formidable health care delivery system that encompasses a wide breadth of interdisciplinary service providers. The strength of life care planning rests with the inclusion of interdisciplinary formally trained service providers who work together in developing life care plans. These medical and rehabilitative service providers contribute to the life care plan as consultants per the request of life care planners who must address medical, rehabilitative, and habilitative services in areas *outside* of their expertise. Additionally and in concert with the importance of contributions made by the interdisciplinary providers, life care planning has solidified its position in medical and rehabilitative healthcare settings through its development of national and international organizations, training programs with university and non-university affiliations, peer-reviewed journals, multiple certifications of select provider populations, and established peer-reviewed methodologies. While it is evident in the results of this study that the varying healthcare disciplines providing life care planning services may perceive service delivery somewhat differently that other peer-planners, the goal remains the same; to provide and document medical, rehabilitation, and environmental information that will assist the individual with the disability in returning as close as possible to pre-injury functional capacities and comfort, as well as determining the lifetime costs of such recommendations.

This study identified 16 knowledge domains and 23 subfactors of these domains with established instrument reliability and that were validated by field practitioners. The ICHCC is committed to maintaining current examination items directly related to life care planning service delivery and will continue to investigate the perceived roles and functions of life care planning service providers for years to come. The ICHCC recognizes the need to interact with its pre-approved 120-hour training programs to ensure that the curricula of these programs, as well as the ICHCC agency's CLCP examination content, remain consistent.

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The research was funded in total by the International Commission on Health Care Certification. Special appreciation is acknowledged for the people who assisted with instrument development, serving as subject matter experts, organizing meetings for developing the job task inventory, and for allowing dissemination of the survey instrument on several electronic discussion/informational internet services.

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Appendix A
Life Care Planning Survey Instrument

CLCP Role & Function Survey

Please answer all job task statements included in this Role & Function survey.

Please note that we are asking for your name and other personal information so that we can acknowledge and award you for your participation. You will receive 4 CEUs in ethics for completing this survey.

Thank you for helping ICHCC improve the CLCP certification. Should you have any questions, please contact us at 804-378-7273.

Demographic Section - Part I

First Name

Last Name

Current Title

Email

Certificate No.

Demographics - Part II

1. Gender

(Select all that apply)

- ☐ Male
- ☐ Female

2. Age in Years

(Select all that apply)

- ☐ 20 - 25
- ☐ 26 - 35
- ☐ 36 - 45
- ☐ 46 - 55
- ☐ 56 - 65
- ☐ Over 65

3. Formal Education/Degree - Check all that Apply

(Select all that apply)

- ☐ Diploma Nurse RN
- ☐ Associate's Degree RN
- ☐ Bachelor's Degree RN (BSN)
- ☐ Bachelor's Degree Rehabilitation Counseling/Vocational Evaluation/Job Placement
- ☐ Bachelor's Degree - Other
- ☐ Master's Degree RN
- ☐ Master's Degree- Rehab/Psych
- ☐ Master's of Social Work (MSW)
- ☐ Doctor of Philosophy (Ph.D.)
- ☐ Doctor of Education (Ed.D.)
- ☐ Doctor of Rehabilitation (Rh.D.)
- ☐ Doctor of Physical Therapy (DPT)
- ☐ Medical Doctor (M.D.)
- ☐ Doctor of Osteopathy (D.O.)
- ☐ Doctor of Chiropractic (D.C.)
- ☐ Juris Doctor (J.D.)
- ☐ Other:

4. Primary Clinical Fields of Practice

(Select all that apply)

- ☐ Case Management
- ☐ Counseling
- ☐ Medicine
- ☐ Nursing
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech-Language Pathology
- ☐ Psychology/Neuropsychological
- ☐ Rehabilitation Counseling
- ☐ Social Work
- ☐ Marriage and Family Counseling
- ☐ Other:

5. Licensed, Registered, and/or Certified as a:

(Select all that apply)

- ☐ ABDA
- ☐ ABPP
- ☐ ABVE
- ☐ ACSW
- ☐ CCM
- ☐ CDMS
- ☐ CLCP
- ☐ CCLCP
- ☐ CGCM
- ☐ CLNC
- ☐ CNLCP
- ☐ CRC
- ☐ CRRN
- ☐ CVE
- ☐ FIALCP
- ☐ LMHC
- ☐ LNCC
- ☐ LPC
- ☐ MSCC
- ☐ NCC
- ☐ OT
- ☐ PT
- ☐ RN
- ☐ Other:

6. Current Practice Setting:

(Select all that apply)

- ☐ Attorney's Office
- ☐ Corporation
- ☐ Hospital
- ☐ Rehabilitation Facility/Setting
- ☐ Insurance Company
- ☐ Owner/Independent Practice without Employees
- ☐ Owner/Independent Practice with Employees
- ☐ Private Rehabilitation Company as an Employee
- ☐ Educational Setting

☐ Owner S, C or LLC Corporation
☐ Other:

7. Life Care Planning Activities Constitute Approximately ____ of My Work Activities
(Select only one)
☐ None
☐ 1 - 25%
☐ 26 - 50%
☐ 51 - 75%
☐ 76 - 100%

8. Provide Life Care Planning Services on a ____ Level
(Select only one)
☐ Local (e.g., city and surrounding counties)
☐ Regional (e.g., statewide/Province)
☐☐ National
☐ International

9. Population You Provide LCP services
(Select all that apply)
☐ Acquired Brain Injury
☐ Amputations
☐ Birth Injuries/Anoxia
☐ Burns
☐ Chronic Diseases (e.g., MS, Diabetes, Chronic Pain, Cancer)
☐ Developmental Disabilities
☐ Non-Catastrophic Injuries
☐ Organ Transplants
☐ Orthopaedic Conditions
☐ Psychological/Psychiatric Conditions
☐ Spinal Cord Injuries
☐ Other:

10. Office Staff/Subcontractees who assist you with development of the Life Care Plan
(Select only one)
☐ Yes
☐ No

11. If Yes, Which activities do the Office Staff/Subcontractees Perform?
(Select all that apply)
☐ Verbal Correspondence
☐ Written Correspondence
☐ Medical Review
☐ Research for Supporting Recommendations
☐ Costing Research
☐ Report Development
☐ Other:

Survey of Job Task Inventory for the Delivery of Life Care Planning Services

Instructions - Please review each suggested essential function associated with the delivery of life care planning services. Check the associated box that matches your opinion.

12. Market LCP services through mailings, e-mail, presentations, etc.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

13. Obtain and sign retainer fee agreement from referral source
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

14. Obtain HIPAA Release from referral source/injured person
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

15. Upon receipt of referral, communicate with referral source regarding specific case needs, projected time for LCP completion, and projected fee for completed life care plan
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

16. Request specific medical records
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

17. Request educational transcripts
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

18. Request vocational/employment records
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

19. Request financial records
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

20. Request deposition transcripts
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

21. Request social records if available (i.e., foster care, juvenile detention, adult detention)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

22. Review medical records, associated summaries, and all other requested records
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

23. Review medical records from physicians, nurses, PTs, OTs, and speech therapists to assess the evaluee's medical status
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

24. Sorts medical records by chronological order
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

25. Sorts medical records by medical provider(S)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

26. Schedule Initial Interview/Home Visit
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

27. Monitor evaluee progress and outcomes during the life care planning process
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

28. Perform face-to-face interview with injured person
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

29. During Initial Interview/Home Visit, document current medical condition
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

30. Document Current Medications During Initial Interview/Home Visit
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

31. Evaluate through observation or through test cognitive status During Initial Interview/Home Visit
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

32. Sorts medical records by facility
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

33. Observes or requests demonstration of activities of daily living During Initial Interview/Home Visit
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

34. Evaluate through observation physical limitations During Initial Interview/Home Visit
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

35. Assess the need for training in activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as cooking, shopping, housekeeping, and budgeting
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

36. If applicable, specifies cost for independent living and adaptive equipment needs for independent function/living
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

37. Address needs/preferences of the evaluee and/or family
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

38. During Initial Interview/Home Visit evaluates socio-economic status
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

39. During Initial Interview/Home Visit makes notes of potential home barriers and identifies some potential home modification needs
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

40. During Initial Interview/Home Visit assesses presence of familial support system for the evaluee
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

41. Interviews immediate family members
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

42. Identify attitudinal, social, economic, and environmental forces that may present barriers and/or advantages to evaluee's rehabilitation.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

43. Educate evaluee regarding his/her rights under federal and state law
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

44. Explain the services and limitations of various community resources to evaluees.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

45. Apply advocacy, negotiation, and conflict resolution knowledge.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree

☐ Disagree
☐ Strongly Disagree

46. Educate evaluees how to facilitate choice and negotiate for needed services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

47. Upon return to office, summarizes assessment/home visit
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

48. Maintains log of time and mileage
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

49. Contact attending physician and medical/ rehabilitation providers
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

50. Examines the relationship between the evaluee's needs and existing functional capabilities
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

51. Determines costs of needed equipment for the injured person
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

52. Assess injured person's potential for long-term independent functioning
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

53. Assess independent living and adaptive equipment needs.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

54. Assess the need for transportation (e.g., adapted/modified vehicle with hand controls)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

55. During Initial Interview/Home Visit gathers a work history from the evaluee
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

56. Determines needed medical supplies
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

57. Determines a feasible support system for the evaluee if none exists
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

58. Assess the need for home/attendant/facility care (e.g., personal assistance, nursing care)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

59. Determines Assistive Devices needed by the evaluee
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

60. Determines evaluee's adaptive equipment needs
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

61. Provides an assessment of the evaluee's potential for self-care
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

62. During Initial Interview/Home Visit documents current family members living in and away from residence
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

63. Identifies the need for physical therapy services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

64. Identifies the need for speech therapy
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

65. Identifies need for occupational therapy
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

66. Determines evaluee's need for counseling services (i.e., psychological intervention, licensed professional counselor services, licensed social worker counseling services)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

67. Specifies cost for physical therapy services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

68. Specifies the cost of speech therapy services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

69. Specifies the cost of occupational services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

70. Reviews current catalogs to determine the costs of assistive devices needed by the evaluee
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

71. Specifies costs for maintaining the evaluee's exercise equipment
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

72. Assess the need for wheelchair/mobility needs
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

73. Assess the need for wheelchair/mobility accessories and maintenance
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

74. Specifies cost for wheelchair/mobility needs
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

75. Assess the need for medications and supplies (bowel/bladder supplies, skin care supplies)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

76. Assess the need for future routine medical care (e.g., annual evaluations, psychiatry, urology, etc.)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

77. Assess the need for and replacement of orthotics and prosthetics (e.g., braces, ankle/foot orthotics)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

78. Specifies cost for and replacement of orthotics and prosthetics (e.g., braces, ankle/foot orthotics)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

79. Identifies the need for music therapy
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

80. Specifies cost for projected evaluations (e.g., PT/OT, SLP, individual counseling, family counseling, group counseling, marital counseling, etc.)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

81. Specifies cost for projected therapeutic modalities (e.g., PT 0T, SLP,individual counseling, family counseling, group counseling, marital counseling, etc.)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

82. Specifies cost for case management services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

83. Projects associated costs for non medical diagnostic evaluations(e.g., recreational, nutritional) for the injured person
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

84. Identifies the need for pharmaceutical counseling
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

85. Determines evaluee's home furnishings and accessories needs (e.g., specialty bed, portable ramps, patient lifts)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

86. Specifies cost for architectural renovations for accessibility (e.g., widen doorways, ramp installations)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

87. Specifies costs for evaluee's home furnishing needs and accessories (e.g., specialty bed, portable ramps, patient lifts)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

88. Assesses the evaluee's recreational equipment needs
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

89. Assess the need for health/strength maintenance (e.g., adaptive sports equipment and exercise/strength training)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

90. Specifies cost for health/strength maintenance (e.g., adaptive sports equipment and exercise/strength training)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

91. Identifies the need for nutritional counseling
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

92. Identifies the need for audiological services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

93. Determines costs of needed social services for the evaluee
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

94. Recommend services that maximize functional capacity and independence for persons with catastrophic disabilities through the aging process
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

95. Assess the need for case management services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

96. Educate life care planning subject in modifying their lifestyles to accommodate functional limitations
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

97. Research and investigate the community to identify client-appropriate services for creating and coordinating agency service delivery
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

98. Makes referrals for assessments of the evaluee
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

99. Evaluate and select facilities that provide specialized care services for evaluees
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

100. Request meeting with treatment/rehabilitation team members
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

101. Request meeting with medical providers
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

102. Request meetings with extraneous entities that may include daycare facilities, education facilities, recreational facilities, etc.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

103. Either personally or through vocational rehabilitation consult referral, identifies the evaluee's need for long-term vocational/educational services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

104. Either personally or through vocational consult referral, assesses the evaluee's need for vocational services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

105. Either personally or through vocational rehabilitation consult referral, determine's the evaluee's ability to pursue gainful employment
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

106. Either personally or through vocational rehabilitation consult referral, obtains information on past occupational/educational performance for purposes of vocational planning
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

107. Either personally or through vocational rehabilitation consult referral, specifies cost for long-term vocational/educational services for the evaluee.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

108. Determines costs of needed medical services for the evaluee
(Select only one)
☐Strongly Agree
☐Agree
☐Neither Agree nor Disagree
☐Disagree
☐Strongly Disagree

109. Documents and summarizes all meetings with medical and rehabilitative providers, and extraneous facilities.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

110. Write the report to include a log of all resources contacted
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

111. Write the report to include a complete chronology of the medical and rehabilitation histories
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

112. Write the report to include demographic information
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

113. Write the report to include formatting the report template rather than an office clerical person
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

114. Write the report to include recommendations based on assessment of evaluee, home visit, review of all medical and rehabilitative records, and communications with medical and rehabilitative team members and providers.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

115. Present various health care options (facility vs. home care).
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

116. Write the report to include all graphs and tables.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

117. Write the report to include comorbid conditions
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

118. Write the report to include category of need tables
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

119. Write the report to include bibliography
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

120. Write the report to include life expectancy
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

121. Research pricing of medical recommendations
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

122. Write the report to include coding for costs
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

123. Apply knowledge of family dynamics, gender, multicultural, and geographical issues
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

124. Research services costs and frequencies
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

125. Research literature for standard of care for client for national, regional, and local areas and include in report
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

126. Write the report to include bills the evaluee is expected to incur onetime only, monthly, annually, and remaining lifetime
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

127. Clearly state the nature of the evaluee's problems for referral to service providers
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

128. Apply knowledge regarding the types of personal care (e.g., hospital, extended care facility, subacute facility; home, hospice) when developing the life care plan
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

129. Recognize psychological problems (e.g., depression, suicidal ideation) requiring consultation or referral
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

130. Include recommendations that are within your area of expertise
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

131. Accept referrals only in the areas of yours or your agency's competency
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

132. Refrain from inappropriate, distorted or untrue comments about colleagues and/or life care planning training programs
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

133. Identify one's own biases, strengths, and weaknesses that may affect the development of healthy client relationships
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

134. Avoid dual/biased relationships, including but not limited to, pre-existing personal relationships with clients, sexual contact with evaluees, accepting referrals from sources where objectivity can be challenged (such as dating or being married to the referral source), etc
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

135. Be credentialed in your area of expertise that also provides a mechanism for ethics complaint resolution
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

136. Abide by life care planning-related ethical and legal considerations of case communication and recording (e.g., confidentiality)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

137. Consider the worth and dignity of individuals with catastrophic disabilities
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

138. Prepare case notes and reports using applicable forms and systems in order to document case activities in compliance with standard practices and regulations
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

139. Monitor to ensure that the life care planning work is performed and that it meets standards and accepted practices
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

140. Disclose to the evaluee and referral sources what role you are assuming and when or if roles shift
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

141. Remain objective in your assessments
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

142. Total all spreadsheets and check figures for accuracy
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

143. Finalize the plan and proof it
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

144. Itemize your bill for services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

145. Send your bill with the report
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

146. Add the case to your list of cases for Federal Rules of Evidence purposes, marketing, etc.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

147. Assists with the development of information for settlement negotiations for legal representatives
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

148. Serves as an expert witness in court case for an individual who sustains a catastrophic injury or a non-catastrophic injury
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

149.Consults with a plaintiff attorney to reasonably map out what long-term care services will be needed for the evaluee
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

150. Consults with a defense attorney to reasonably map out what long-term care services will be needed for the evaluee
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

151. Provides information located in the LCP to an official of the court
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

152. Consults an economist for an estimate of the lifetime costs of the LCP
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

153. Advises the evaluee's attorney on the cross-examination of opposing counsel's expert witness
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

154. Recommends other expert witnesses to an evaluee's attorney when appropriate
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

155. Advises defense attorney on the cross-examination of plaintiff counsel's expert witness
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

156. Review the plaintiff's plan and develop a rebuttal or comparison plan when consulting with defense attorneys
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

157. Apply knowledge regarding other funding sources as it relates to legal cases
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

158. Provide progress of life care plan development to retaining party
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

159. Apply interpersonal communication skills (verbal and written) when working with all parties involved in a case
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

160. Maintain contact with life care planning recipients in an empathetic, respectful, and genuine manner, and encourage participation
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

161. Reviews current catalogs and web sites to determine the costs of needs and services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

162. Provide fair and representative costs relevant to the geographic area or region
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

163. Synthesize assessment information to prioritize care needs and develop the life care plan
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

164. Compile and interpret evaluee information to maintain a current case record
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

165. Provide list and date of responses received from life care planning referral sources
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

166. Select evaluation/assessment instruments and strategies according to their appropriateness and usefulness for a particular evaluee
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

167. As appropriate, review/utilize current literature, published research and data to provide a foundation for opinions, conclusions and life care planning recommendations
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

168. Use reliable, dependable, and consistent methodologies for drawing life care planning conclusions
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

169. Have an adequate amount of medical and other data to form recommendation
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

170. Apply knowledge of clinical pathways, standards of care, practice guidelines
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

171. Apply managed care (insurance industry) knowledge when developing life care plans
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

172. Apply knowledge regarding workers' compensation benefits within the state of injury as it relates to life care planning
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

173. Keep abreast of the laws, policies, and rule making affecting health care and disability-related rehabilitation service delivery
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

174. Apply knowledge regarding legal rules (justification for valid entries in a life care plan may vary from state to state and jurisdiction to jurisdiction)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

175. Apply knowledge of health care/medical/ rehabilitation terminology
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

176. When working with pediatric cases, keep abreast of guardian issues for protecting minors or those deemed mentally incompetent
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

177. Attend conferences/workshops for continuing education to be applied to recertification and/or licensure renewal
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

178. Address gaps in records and/or life care plan recommendations
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

179. Assess the need for projected evaluations (e.g., PT/OT, SLP, individual counseling, family counseling, group counseling, marital counseling, etc.)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

180. Assess the need for projected therapeutic modalities (e.g., PT/OT, SLP, individual counseling, family counseling, group counseling, marital counseling, etc)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

181. Assess the need for diagnostic testing/educational assessment (e.g., neuropsychological, educational, medical labs)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

182. Apply medical knowledge of potential complications, injury/disease process, including the expected length of recovery and the treatment options available
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

183. Apply knowledge regarding the interrelationship between medical, psychological, sociological, and behavioral components of injury/illness
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

184. Apply knowledge of human growth and development as it relates to life care planning
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

185. Apply knowledge of the existence, strengths and weaknesses of psychological and neuropsychological assessments
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

186. Consider the impact of aging on disability and function when developing life care planning recommendations
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

187. Establish fee schedules (how much you or your practice charge) for life care planning services to be rendered
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

188. Promote and market the field of life care planning
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

189. Provide information regarding your organization's programs to current and potential referral sources
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

190. Educate parties (e.g., attorneys, evaluees, insurance companies, students, family members) regarding the life care planning process
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

191. Use effective time management strategies when developing the life care plan
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

192. Perform life care planning in multiple venues (e.g., personal injury, special needs trust,case management)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

193. Stay current with the relevant life care planning literature
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

194. Evaluate one's own practices and compare to ongoing evidence-based practice
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

195. Attend professional conferences
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

196. Belong to an organization that reviews life care planning topics and issues, as well as offers continuing education specifically related to the industry
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

197. Maintain continuing education in areas associated with your life care planning practice
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

198. Obtain regular client feedback regarding the satisfaction with services recommended and suggestions for improvement in a life care plan
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

199. Perform program evaluations and research functions to document improvements in evaluee outcomes following life care plan development
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

200. As appropriate, rely upon qualified medical and allied health professional opinions when developing the life care plan
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

201. Have a physician review the life care plan prior to submission to referral source
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

202. Assess the need for short/long-term vocational/ educational services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

203. Specifies cost for short/long-term vocational/ educational services
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

204. Apply financial management knowledge when working with evaluees (e.g., balance checkbook, banking, etc.)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

205. Conduct a comprehensive interview with the evaluee, his/her family and/or significant other(s), if possible
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

206. Apply risk management knowledge as it relates to life care planning
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

207. Obtain and review day-in-the-life videos of clients when developing a life care plan.
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

208. Utilize medical coding when developing a life care plan (e.g., CPT, ICD-9/10, HCPIC coder)
(Select only one)
☐ Strongly Agree
☐ Agree
☐ Neither Agree nor Disagree
☐ Disagree
☐ Strongly Disagree

Appendix B
SMEs' Knowledge Domains and Subfactors Labeling

Factor 1 - Care Plan Development

Subfactor 1 - Initial Interview

14 Obtain HIPAA Release from referral source/injured person
26 Schedule Initial Interview/Home Visit
28 Perform face-to-face interview with injured person
29 During Initial Interview/Home Visit, document current medical condition
30 Document Current Medications During Initial Interview/Home Visit
31 Evaluate through observation or through test cognitive status During Initial Interview/Home Visit
34 Evaluate through observation physical limitations During Initial Interview/Home Visit
35 Assess the need for training in activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as cooking, shopping, housekeeping, and budgeting
37 Address needs/preferences of the evaluee and/or family
39 During Initial Interview/Home Visit makes notes of potential home barriers and identifies some potential home modification needs
40 During Initial Interview/Home Visit assesses presence of familial support system for the evaluee
41 Interviews immediate family members
42 dentify attitudinal, social, economic, and environmental forces that may present barriers and/or advantages to evaluee's rehabilitation
50 Examines the relationship between the evaluee's needs and existing functional capabilities
52 Assess injured person's potential for long-term independent functioning
53 Assess independent living and adaptive equipment needs.
54 Assess the need for transportation (e.g., adapted/modified vehicle with hand controls)
62 During Initial Interview/Home Visit documents current family members living in and away from residence
205 Conduct a comprehensive interview with the evaluee, his/her family and/or significant other(s), if possible

Subfactor 2- Referral Source Contact

15 Upon receipt of referral, communicate with referral source regarding specific case needs, projected time for LCP completion, and projected fee for completed life care plan
16 Request specific medical records

Subfactor 3 - Cost Analysis

36 If applicable, specifies cost for independent living and adaptive equipment needs for independent function/living
51 Determines costs of needed equipment for the injured person
67 Specifies cost for physical therapy services
68 Specifies the cost of speech therapy services
69 Specifies the cost of occupational services
70 Reviews current catalogs to determine the costs of assistive devices needed by the evaluee
78 Specifies cost for and replacement of orthotics and prosthetics (e.g., braces, ankle/foot orthotics)
80 Specifies cost for projected evaluations (e.g., PT/OT, SLP, individual counseling, family counseling, group counseling, family counseling, group counseling, marital counseling, etc.)
81 Specifies cost for projected therapeutic modalities (e.g., PT, 0T, SLP, individual counseling, family counseling, group counseling, marital counseling, etc.
82 Specifies cost for case management services
83 Projects associated costs for non medical diagnostic evaluations (e.g., recreational, nutritional) for the injured person
86 Specifies cost for architectural renovations for accessibility (e.g., widen doorways, ramp installations)
87 Specifies costs for evaluee's home furnishing needs and accessories (e.g., specialty bed, portable ramps, patient lifts)
90 Specifies cost for health/strength maintenance (e.g., adaptive sports equipment and exercise/strength training)
93 Determines costs of needed social services for the evaluee
108 Determines costs of needed medical services for the evaluee
121 Research pricing of medical recommendations
124 Research services costs and frequencies
161 Reviews current catalogs and web sites to determine the costs of needs and services
162 Provide fair and representative costs relevant to the geographic area or region

Subfactor 4 - Report Writing

47 Upon return to office, summarizes assessment/home visit
48 Maintains log of time and mileage
49 Contact attending physician and medical/rehabilitation providers
109 Documents and summarizes all meetings with medical and rehabilitative providers, and extraneous facilities.
110 Write the report to include a log of all resources
111 Write the report to include a complete chronology of

the medical and rehabilitation histories

112 Write the report to include demographic information

114 Write the report to include recommendations based on assessment of evaluee, home visit, review of all medical and rehabilitative records, and communications with medical and rehabilitative team members and providers

115 Present various health care options (facility vs. home care).

117 Write the report to include comorbid conditions

123 Apply knowledge of family dynamics, gender, multicultural, and geographical issues

127 Clearly state the nature of the evaluee's problems for referral to service providers

128 Apply knowledge regarding the types of personal care (e.g., hospital, extended care facility, subacute facility; home, hospice) when developing the life care plan

129 Recognize psychological problems (e.g., depression, suicidal ideation) requiring consultation or referral

138 Prepare case notes and reports using applicable forms and systems in order to document case activities in compliance with standard practices and regulations

142 Total all spreadsheets and check figures for accuracy

143 Finalize the plan and proof it

144 Itemize your bill for services

163 Synthesize assessment information to prioritize care needs and develop the life care plan

164 Compile and interpret evaluee information to maintain a current case record

165 Provide list and date of responses received from life care planning referral sources

166 Select evaluation/assessment instruments and strategies according to their appropriateness and usefulness for a particular client

167 As appropriate, review/utilize current literature, published research, and data to provide a foundation for opinions, conclusions and life care planning recommendations

168 Use reliable, dependable, and consistent methodologies for drawing life care planning conclusions

169 Have an adequate amount of medical and other data to form recommendation

178 Address gaps in records and/or life care plan recommendations

186 Consider the impact of aging on disability and function when developing life care planning recommendations

200 As appropriate, rely upon qualified medical and allied health professional opinions when developing the life care plan

Subfactor 5 - Standards of Practice

131 Accept referrals only in the areas of yours or your agency's competency

132 Refrain from inappropriate, distorted, or untrue comments about colleagues and/or life care planning training programs

133 Identify one's own biases, strengths, and weaknesses that may affect the development of healthy client relationships

134 Avoid dual/biased relationships, including but not limited to, pre-existing personal relationships with clients, sexual contact with clients, accepting referrals from sources where objectivity can be challenged (such as dating or being married to the referral source, etc.)

135 Be credentialed in your area of expertise that also provides a mechanism for ethics complaint resolution

136 Abide by life care planning-related ethical and legal considerations of case communication and recording (e.g., confidentiality)

137 Consider the worth and dignity of individuals with catastrophic disabilities

139 Monitor to ensure that the life care planning work is performed and that it meets standards and accepted practices

140 Disclose to the evaluee and referral sources what role you are assuming and when or if roles shift

158 Provide progress of life care plan development to retaining party

170 Apply knowledge of clinical pathways, standards of care, practice guidelines

176 When working with pediatric cases, keep abreast of guardian issues for protecting minors or those deemed mentally incompetent

190 Educate parties (e.g., attorneys, evaluees, insurance companies, students, family members) regarding the life care planning process

193 Stay current with the relevant life care planning literature

196 Belong to an organization that reviews life care planning topics and issues, as well as offers continuing education specifically related to the industry

197 Maintain continuing education in areas associated with your life care planning practice

Subfactor 6 - Forensics

148 Serves as an expert witness in court case for an individual who sustains a catastrophic injury or a non-catastrophic injury

Subfactor 7 - Communication Skills

159 Apply interpersonal communication skills (verbal and written) when working with all parties involved in a case

Subfactor 8 - Fee Schedule

187 Establish fee schedules (how much you or your practice charge) for life care planning services to be rendered

Subfactor 9 - Practice Analysis

194 Evaluate one's own practices and compare to ongoing evidence-based practice

Factor 2 - Needs Assessment

56 Determines needed medical supplies
57 Determines a feasible support system for the evaluee if none exists
58 Assess the need for home/attendant/facility care (e.g., personal assistance, nursing care)
59 Determines Assistive Devices needed by the evaluee
60 Determines evaluee's adaptive equipment needs
61 Provides an assessment of the evaluee's potential for self-care
63 Identifies the need for physical therapy services
64 Identifies the need for speech therapy
65 Identifies need for occupational therapy
66 Determines evaluee's need for counseling services (i.e., psychological intervention, licensed professional counselor services, licensed social worker, counseling services
72 Assess the need for wheelchair/mobility needs
73 Assess the need for wheelchair/mobility accessories and maintenance
74 Specifies cost for wheelchair/mobility needs
75 Assess the need for medications and supplies (bowel/bladder supplies, skin care supplies)
76 Assess the need for future routine medical care (e.g., annual evaluations, psychiatry, urology, etc.)
77 Assess the need for and replacement of orthotics and prosthetics (e.g., braces, ankle/foot orthotics)
79 Identifies the need for music therapy
85 Determines evaluee's home furnishings and accessories needs (e.g., specialty bed, portable ramps, patient lifts)
88 Assesses the evaluee's recreational equipment needs
89 Assess the need for health/strength maintenance (e.g., adaptive sports equipment and exercise/strength training)
91 Identifies the need for nutritional counseling
92 Identifies the need for audiological services
95 Assess the need for case management services
179 Assess the need for projected evaluations (e.g., PT/OT, SLP, individual counseling, family counseling, group counseling, marital counseling, etc.)
180 Assess the need for projected therapeutic modalities (e.g., PT/OT, SLP, individual counseling, family counseling, group counseling, marital counseling, etc.)
181 Assess the need for diagnostic testing/educational assessment (e.g., neuropsychological, educational, medical labs)

Subfactor 1 - Service Recommendation

94 Recommend services that maximize functional capacity and independence for persons with catastrophic disabilities through the aging process
99 Evaluate and select facilities that provide specialized care services for evaluees
130 Include recommendations that are within your area of expertise

Factor 3 - Vocational Consideration

55 During Initial Interview/Home Visit gathers a work history from the evaluee
103 Either personally or through vocational rehabilitation consult referral, identifies the evaluee's need for long-term vocational/educational services
104 Either personally or through vocational consult referral, assesses the evaluee's need for vocational services
105 Either personally or through vocational rehabilitation consult referral, determines the evaluee's ability to pursue gainful employment
106 Either personally or through vocational rehabilitation consult referral, obtains information on past occupational/educational performance for purposes of vocational planning
107 Either personally or through vocational rehabilitation consult referral, specifies cost for long-term vocational/educational services for the injured person
202 Assess the need for short/long-term vocational/educational services
203 Specifies cost for short/long-term vocational/educational services

Subfactor 1 - Economist Consult

152 Consults an economist for an estimate of the lifetime costs of the LCP

Factor 4 - Litigation Support

146 Add the case to your list of cases for Federal Rules of Evidence purposes, marketing, etc.
147 Assists with the development of information for settlement negotiations for legal representatives
149 Consults with a plaintiff attorney to reasonably map out what long-term care services will be

needed for the evaluee

150 Consults with a defense attorney to reasonably map out what long-term care services will be needed for the evaluee

151 Provides information located in the LCP to an official of the court

153 Advises the evaluee's attorney on the cross-examination of opposing counsel's expert witness

154 Recommends other expert witnesses to an evaluee's attorney when appropriate

155 Advises defense attorney on the cross-examination of plaintiff counsel's expert witness

156 Review the plaintiff's plan and develop a rebuttal or comparison plan when consulting with defense attorneys

Factor 5 - Knowledge Applications

174 Apply knowledge regarding legal rules (justification for valid entries in a life care plan may vary from state to state

175 Apply knowledge of health care/medical/ rehabilitation terminology

182 Apply medical knowledge of potential complications, injury/disease process, including the expected length of recovery and the treatment options available

183 Apply knowledge regarding the interrelationship between medical, psychological, sociological, and behavioral components

184 Apply knowledge of human growth and development as it relates to life care planning

185 Apply knowledge of the existence, strengths, and weaknesses of psychological and neuropsychological assessments

Subfactor 1 - Evaluee Interactions

160 Maintain contact with life care planning recipients in an empathetic, respectful, and genuine manner, and encourage participation

ubfactor 2 - Time Management

191 Use effective time management strategies when developing the life care plan

Factor 6 - Marketing

188 Promote and market the field of life care planning

192 Perform life care planning in multiple venues (e.g., personal injury, special needs trust, case management)

198 Obtain regular client feedback regarding the satisfaction with services recommended and suggestions for improvement in a life care plan

Subfactor 1 - Report Writing

71 Specifies costs for maintaining the evaluee's exercise equipment

84 Identifies the need for pharmaceutical counseling

97 Research and investigate the community to identify client-appropriate services for creating and coordinating agency service delivery

113 Write the report to include formatting the report template rather than an office clerical person

119 Write the report to include bibliography

Subfactor 2 - Process Evaluation

199 Perform program evaluations and research functions to document improvements in evaluee outcomes following life care plan development

Factor 7 - Information Sharing

43 Educate evaluee regarding his/her rights under federal and state law

44 Explain the services and limitations of various community resources to evaluees.

45 Apply advocacy, negotiation, and conflict resolution knowledge.

46 Educate evaluees how to facilitate choice and negotiate for needed services

96 Educate life care planning subject in modifying their lifestyles to accommodate functional limitations

Subfactor 1 - Invoicing

145 Send your bill with the report

Factor 8 - Data Collection

33 Observes or requests demonstration of activities of daily living During Initial Interview/Home Visit

38 During Initial Interview/Home Visit evaluates socio-economic status

125 Research literature for standard of care for client for national, regional, and local areas and include in report

Subfactor 1 - Expense Projection

126 Write the report to include bills the evaluee is expected to incur onetime only, monthly, annually, and remaining lifetime

Subfactor 2 - Resource Application

204 Apply financial management knowledge when working with evaluees (e.g., balance checkbook, banking, etc.)

206 Apply risk management knowledge as it relates to life care planning

Factor 9 - Report Preparation

25 Sorts medical records by medical provider(S)
32 Sorts medical records by facility
116 Write the report to include all graphs and tables.
118 Write the report to include category of need tables

Subfactor 1 - Marketing

12 Market LCP services through mailings, e-mail, presentations, etc.
189 Provide information regarding your organization's programs to current and potential referral sources

Factor 10 - Records Request

17 Request educational transcripts
18 Request vocational/employment records
19 Request financial records
21 Request social records if available (i.e., foster care, juvenile detention, adult detention)

Factor 11 - Professional Development

177 Attend conferences/workshops for continuing education to be applied to recertification and/or licensure renewal
195 Attend professional conferences

Factor 12 - Report Writing

120 Write the report to include life expectancy
122 Write the report to include coding for costs
208 Utilize medical coding when developing a life care plan (e.g., CPT, ICD-9/10, HCPIC coder)

Factor 13 - Financial Resources

157 Apply knowledge regarding other funding sources as it relates to legal cases
171 Apply managed care (insurance industry) knowledge when developing life care plans
172 Apply knowledge regarding workers' compensation benefits within the state of injury as it relates to life care planning
173 Keep abreast of the laws, policies, and rule making affecting health care and disability-related rehabilitation service

Factor 14 - File Development

Subfactor 1 - Primary Data Collection

13 Obtain and sign retainer fee agreement from referral source

Subfactor 2 - Secondary Data Collection

20 Request deposition transcripts
27 Monitor evaluee progress and outcomes during the life care planning process
207 Obtain and review day-in-the-life videos of clients when developing a life care plan.

Subfactor 3 – Tertiary Data Collection

201 Have a physician review the life care plan prior to submission to referral source

Factor 15 - Collaboration

98 Makes referrals for assessments of the evaluee
100 Request meeting with treatment/rehabilitation team members
101 Request meeting with medical providers
102 Request meetings with extraneous entities that may include daycare facilities, education facilities, recreational facilities, etc.

Factor 16 - Records Review

22 Review medical records, associated summaries, and all other requested records
23 Review medical records from physicians, nurses, PTs, OTs, and speech therapists to assess the evaluee's medical status
24 Sorts medical records by chronological order

Subfactor 1 - Objectivity

141 Remain objective in your assessments

Appendix C

Raw Data Factor Loadings

Factor 1	Factor Loading	mean	std
Obtain HIPAA Release from referral source/injured person	**0.392**	1.4811	0.76945
Upon receipt of referral, communicate with referral source regarding specific case needs, projected time for LCP completion	**0.465**	1.3491	0.58484
Request specific medical records	**0.618**	1.2170	0.58423
Schedule Initial Interview/Home Visit	**0.662**	1.2925	0.61524
Perform face-to-face interview with injured person	**0.561**	1.3585	0.64122
During Initial Interview/Home Visit, document current medical condition	**0.772**	1.2500	0.54967
Document Current Medications During Initial Interview/Home Visit	**0.821**	1.1981	0.50438
Evaluate through observation or through test cognitive status During Initial Interview/Home Visit	**0.443**	1.5708	0.82594
Evaluate through observation physical limitations During Initial Interview/Home Visit	**0.579**	1.4764	0.67761
Assess the need for training in activities of daily living (ADLs) and instrumental activities of daily living (IADLs), s	**0.505**	1.5000	0.71212
If applicable, specifies cost for independent living and adaptive equipment needs for independent function/living	**0.783**	1.2547	0.52540
Address needs/preferences of the evaluee and/or family	**0.553**	1.4292	0.64558
During Initial Interview/Home Visit makes notes of potential home barriers and identifies some potential home modifications	**0.707**	1.2972	0.56046
During Initial Interview/Home Visit assesses presence of familial support system for the evaluee	**0.544**	1.4481	0.68990
Interviews immediate family members	**0.444**	1.7406	0.74379
Identify attitudinal, social, economic, and environmental forces that may present barriers and/or advantages to evaluee'	**0.524**	1.5708	0.70185
Upon return to office, summarizes assessment/home visit	**0.582**	1.4858	0.61942
Maintains log of time and mileage	**0.636**	1.3491	0.63905
Contact attending physician and medical/rehabilitation providers	**0.471**	1.4434	0.66147
Examines the relationship between the evaluee's needs and existing functional capabilities	**0.570**	1.3396	0.59039
Determines costs of needed equipment for the injured person	**0.764**	1.2217	0.45965
Assess injured person's potential for long-term independent functioning	**0.694**	1.3491	0.57668
Assess independent living and adaptive equipment needs.	**0.679**	1.2689	0.49488
Assess the need for transportation (e.g., adapted/modified vehicle with hand controls)	**0.741**	1.3019	0.55366
During Initial Interview/Home Visit documents current family members living in and away from residence	**0.595**	1.5330	0.69107
Specifies cost for physical therapy services	**0.653**	1.3302	0.52828
Specifies the cost of speech therapy services	**0.670**	1.3255	0.53566
Specifies the cost of occupational services	**0.672**	1.3349	0.52978
Reviews current catalogs to determine the costs of assistive devices needed by the evaluee	**0.430**	1.7028	0.80366

Factor 1	Factor Loading	mean	std
Specifies cost for and replacement of orthotics and prosthetics (e.g., braces, ankle/foot orthotics)	**0.778**	1.2736	0.53384
Specifies cost for projected evaluations (e.g., PT/OT, SLP, individual counseling, family counseling, group counseling,	**0.664**	1.3019	0.51829
Specifies cost for projected therapeutic modalities (e.g., PT 0T, SLP, individual counseling, family counseling, group co	**0.765**	1.2736	0.52489
Specifies cost for case management services	**0.700**	1.3726	0.57417
Projects associated costs for non medical diagnostic evaluations(e.g., recreational, nutritional) for the injured person	**0.587**	1.5047	0.69866
Specifies cost for architectural renovations for accessibility (e.g., widen doorways, ramp installations)	**0.501**	1.5283	0.79343
Specifies costs for evaluee's home furnishing needs and accessories (e.g., specialty bed, portable ramps, patient lifts)	**0.718**	1.3585	0.60313
Specifies cost for health/strength maintenance (e.g., adaptive sports equipment and exercise/strength training)	**0.659**	1.4528	0.64774
Determines costs of needed social services for the evaluee	**0.457**	1.6557	0.81416
Determines costs of needed medical services for the evaluee	**0.602**	1.4104	0.67205
Documents and summarizes all meetings with medical and rehabilitative providers, and extraneous facilities.	**0.702**	1.3821	0.60821
Write the report to include a log of all resources contacted	**0.435**	1.5708	0.82018
Write the report to include a complete chronology of the medical and rehabilitation histories	**0.304**	1.7075	0.93856
Write the report to include demographic information	**0.638**	1.4009	0.60378
Write the report to include recommendations based on assessment of evaluee, home visit, review of all medical and rehabilitation	**0.534**	1.3066	0.61216
Present various health care options (facility vs. home care).	**0.514**	1.5519	0.74283
Write the report to include comorbid conditions	**0.331**	1.5472	0.73674
Research pricing of medical recommendations	**0.535**	1.3066	0.53799
Apply knowledge of family dynamics, gender, multicultural, and geographical issues	**0.432**	1.6792	0.78550
Research services costs and frequencies	**0.693**	1.3349	0.57277
Clearly state the nature of the evaluee's problems for referral to service providers	**0.369**	1.6462	0.79234
Apply knowledge regarding the types of personal care (e.g., hospital, extended care facility, subacute facility; home, h	**0.749**	1.3679	0.55632
Recognize psychological problems (e.g., depression, suicidal ideation) requiring consultation or referral	**0.508**	1.4481	0.66186
Accept referrals only in the areas of yours or your agency's competency	**0.498**	1.5094	0.79388
Refrain from inappropriate, distorted or untrue comments about colleagues and/or life care planning training programs	**0.708**	1.1792	0.47291
Identify one's own biases, strengths, and weaknesses that may affect the development of healthy client relationships	**0.353**	1.6038	0.84516

Factor 1	**Factor Loading**	mean	std
Avoid dual/biased relationships, including but not limited to, pre-existing personal relationships with clients, sexual	**0.692**	1.2075	0.49100
Be credentialed in your area of expertise that also provides a mechanism for ethics complaint resolution	**0.600**	1.3208	0.60090
Abide by life care planning-related ethical and legal considerations of case communication and recording (e.g., confidentiality	**0.768**	1.1651	0.45259
Consider the worth and dignity of individuals with catastrophic disabilities	**0.601**	1.2075	0.61138
Prepare case notes and reports using applicable forms and systems in order to document case activities in compliance wit	**0.693**	1.3632	0.59633
Monitor to ensure that the life care planning work is performed and that it meets standards and accepted practices	**0.649**	1.3160	0.62273
Disclose to the evaluee and referral sources what role you are assuming and when or if roles shift	**0.668**	1.3349	0.63553
Total all spreadsheets and check figures for accuracy	**0.386**	1.3443	0.62288
Finalize the plan and proof it	**0.628**	1.1698	0.38874
Itemize your bill for services	**0.487**	1.3962	0.70448
Serves as an expert witness in court case for an individual who sustains a catastrophic injury or a non-catastrophic injury	**0.577**	1.4858	0.73167
Provide progress of life care plan development to retaining party	**0.395**	1.6981	0.69759
Apply interpersonal communication skills (verbal and written) when working with all parties involved in a case	**0.648**	1.4292	0.62317
Reviews current catalogs and web sites to determine the costs of needs and services	**0.643**	1.4811	0.64184
Provide fair and representative costs relevant to the geographic area or region	**0.772**	1.2830	0.53776
Synthesize assessment information to prioritize care needs and develop the life care plan	**0.624**	1.3726	0.63679
Compile and interpret evaluee information to maintain a current case record	**0.587**	1.4575	0.62574
Provide list and date of responses received from life care planning referral sources	**0.418**	1.7500	0.84805
Select evaluation/assessment instruments and strategies according to their appropriateness and usefulness for a particular job	**0.469**	1.5849	0.74615
As appropriate, review/utilize current literature, published research and data to provide a foundation for opinions, con	**0.484**	1.4245	0.55840
Use reliable, dependable, and consistent methodologies for drawing life care planning conclusions	**0.763**	1.2594	0.50930
Have an adequate amount of medical and other data to form recommendation	**0.732**	1.3113	0.54838
Apply knowledge of clinical pathways, standards of care, practice guidelines	**0.494**	1.4717	0.67040
When working with pediatric cases, keep abreast of guardian issues for protecting minors or those deemed mentally incompetent	**0.361**	1.7642	0.79753
Address gaps in records and/or life care plan recommendations	**0.647**	1.4387	0.62417
Consider the impact of aging on disability and function when developing life care planning recommendations	**0.675**	1.3302	0.56303
Establish fee schedules (how much you or your practice charge) for life care planning services to be rendered	**0.614**	1.4104	0.63581
Stay current with the relevant life care planning literature	**0.666**	1.3396	0.54009
Evaluate one's own practices and compare to ongoing evidence-based practice	**0.601**	1.5142	0.64931
Belong to an organization that reviews life care planning topics and issues, as well as offers continuing education spec	**0.518**	1.4340	0.61604

Factor 1	**Factor Loading**	mean	std
Maintain continuing education in areas associated with your life care planning practice	**0.511**	1.2925	0.46624
As appropriate, rely upon qualified medical and allied health professional opinions when developing the life care plan	**0.548**	1.2830	0.49173
Conduct a comprehensive interview with the evaluee, his/her family and/or significant other(s), if possible	**0.573**	1.3396	0.61400
Educate parties (e.g., attorneys, evaluees, insurance companies, students, family members) regarding the life care plan	**0.627**	1.4481	0.62503
Factor 2	Factor Loading	Mean	std
Determines needed medical supplies	**0.720**	1.2925	0.56714
Determines a feasible support system for the evaluee if none exists	**0.555**	1.6462	0.83316
Assess the need for home/attendant/facility care (e.g., personal assistance, nursing care)	**0.742**	1.3066	0.61986
Determines Assistive Devices needed by the evaluee	**0.756**	1.3632	0.66401
Determines evaluee's adaptive equipment needs	**0.652**	1.3538	0.63271
Provides an assessment of the evaluee's potential for self-care	**0.662**	1.4057	0.70581
Identifies the need for physical therapy services	**0.788**	1.5425	0.76232
Identifies the need for speech therapy	**0.785**	1.5613	0.76723
Identifies need for occupational therapy	**0.785**	1.5236	0.73788
Determines evaluee's need for counseling services (i.e., psychological intervention, licensed professional counselor ser	**0.744**	1.5377	0.72432
Assess the need for wheelchair/mobility needs	**0.750**	1.3726	0.64419
Assess the need for wheelchair/mobility accessories and maintenance	**0.728**	1.3774	0.64511
Specifies cost for wheelchair/mobility needs	**0.644**	1.3208	0.58492
Assess the need for medications and supplies (bowel/bladder supplies, skin care supplies)	**0.776**	1.3868	0.70302
Assess the need for future routine medical care (e.g., annual evaluations, psychiatry, urology, etc.)	**0.682**	1.4387	0.75477
Assess the need for and replacement of orthotics and prosthetics (e.g., braces, ankle/foot orthotics)	**0.673**	1.3774	0.67386
Identifies the need for music therapy	**0.312**	2.5472	0.94525
Determines evaluee's home furnishings and accessories needs (e.g., specialty bed, portable ramps, patient lifts)	**0.766**	1.4198	0.70083
Assesses the evaluee's recreational equipment needs	**0.665**	1.6651	0.82388
Assess the need for health/strength maintenance (e.g., adaptive sports equipment and exercise/strength training)	**0.727**	1.5943	0.81198
Identifies the need for nutritional counseling	**0.655**	1.6368	0.78200
Identifies the need for audiological services	**0.630**	1.7075	0.83145
Recommend services that maximize functional capacity and independence for persons with catastrophic disabilities through	**0.650**	1.4575	0.71748
Assess the need for case management services	**0.746**	1.4057	0.61233
Evaluate and select facilities that provide specialized care services for evaluees	**0.386**	1.9481	0.99865
Include recommendations that are within your area of expertise	**0.531**	1.4057	0.71249
Assess the need for projected evaluations (e.g., PT/OT, SLP, individual counseling, family counseling, group counseling,	**0.634**	1.3726	0.59045

Factor 2	**Factor Loading**	Mean	std
Assess the need for projected therapeutic modalities (e.g., PT/OT, SLP, individual counseling, family counseling, group	**0.651**	1.3679	0.58131
Assess the need for diagnostic testing/educational assessment (e.g., neuropsychological, educational, medical labs)	**0.626**	1.4057	0.60454
Factor 3			
During Initial Interview/Home Visit gathers a work history from the evaluee	**0.498**	1.6085	0.74942
Either personally or through vocational rehabilitation consult referral, identifies the evaluee's need for long-term voc	**0.805**	1.7406	0.78713
Either personally or through vocational consult referral, assesses the evaluee's need for vocational services	**0.817**	1.7311	0.77788
Either personally or through vocational rehabilitation consult referral, determines the evaluee's ability to pursue gain	**0.818**	1.8632	0.89504
Either personally or through vocational rehabilitation consult referral, obtains information on past occupational/educator	**0.799**	1.8302	0.87049
Either personally or through vocational rehabilitation consult referral, specifies cost for long-term vocational/education	**0.827**	1.7358	0.78857
Consults an economist for an estimate of the lifetime costs of the LCP	**0.281**	2.2972	1.08037
Assess the need for short/long-term vocational/educational services	**0.594**	1.7877	0.81295
Specifies cost for short/long-term vocational/educational services	**0.637**	1.7830	0.82617
Factor 4			
Add the case to your list of cases for Federal Rules of Evidence purposes, marketing, etc.	**0.370**	1.9009	0.96606
Assists with the development of information for settlement negotiations for legal representatives	**0.539**	1.9292	0.97829
Consults with a plaintiff attorney to reasonably map out what long-term care services will be needed for the evaluee	**0.715**	1.9151	1.04512
Consults with a defense attorney to reasonably map out what long-term care services will be needed for the evaluee	**0.760**	1.9387	1.05355
Provides information located in the LCP to an official of the court	**0.601**	2.0330	1.01358
Advises the evaluee's attorney on the cross-examination of opposing counsel's expert witness	**0.776**	2.2075	1.00442
Recommends other expert witnesses to an evaluee's attorney when appropriate	**0.592**	1.9858	0.88953
Advises defense attorney on the cross-examination of plaintiff counsel's expert witness	**0.809**	2.2689	1.00632
Review the plaintiff's plan and develop a rebuttal or comparison plan when consulting with defense attorneys	**0.679**	1.9151	0.89885
Factor 5			
Maintain contact with life care planning recipients in an empathetic, respectful, and genuine manner, and encourage part	**0.313**	1.5991	0.81723
Apply knowledge regarding legal rules (justification for valid entries in a life care plan may vary from state to state	**0.391**	1.6792	0.69592
Apply knowledge of health care/medical/rehabilitation terminology	**0.480**	1.3443	0.50525
Apply medical knowledge of potential complications, injury/disease process, including the expected length of recovery an	**0.496**	1.5425	0.76851
Apply knowledge regarding the interrelationship between medical, psychological, sociological, and behavioral components	**0.704**	1.5425	0.69738

Factor 5	**Factor Loading**	Mean	std
Apply knowledge of human growth and development as it relates to life care planning	**0.569**	1.5660	0.70232
Apply knowledge of the existence, strengths and weaknesses of psychological and neuropsychological assessments	**0.551**	1.6887	0.84161
Use effective time management strategies when developing the life care plan	**0.492**	1.4858	0.61172
Factor 6			
Specifies costs for maintaining the evaluee's exercise equipment	**0.439**	1.5613	0.66104
Identifies the need for pharmaceutical counseling	**0.368**	2.1604	0.98939
Research and investigate the community to identify client-appropriate services for creating and coordinating agency services	**0.466**	1.7689	0.85341
Write the report to include formatting the report template rather than an office clerical person	**0.357**	1.8774	0.95593
Write the report to include bibliography	**0.400**	2.0660	0.92638
Promote and market the field of life care planning	**0.441**	1.9481	0.82734
Perform life care planning in multiple venues (e.g., personal injury, special needs trust, case management)	**0.404**	1.9009	0.86786
Obtain regular client feedback regarding the satisfaction with services recommended and suggestions for improvement in a	**0.501**	1.9528	0.83617
Perform program evaluations and research functions to document improvements in evaluee outcomes following life care plan	**0.559**	2.4387	0.93940
Factor 7			
Educate evaluee regarding his/her rights under federal and state law	**0.523**	2.6509	1.12315
Explain the services and limitations of various community resources to evaluees.	**0.594**	2.2453	0.91653
Apply advocacy, negotiation, and conflict resolution knowledge.	**0.527**	2.5330	1.06822
Educate life care planning subject in modifying their lifestyles to accommodate functional limitations	**0.381**	2.1368	1.02812
Send your bill with the report	**0.439**	1.9528	0.94775
Educate evaluees how to facilitate choice and negotiate for needed services	**0.636**	2.5613	0.96920
Factor 8			
Observes or requests demonstration of activities of daily living During Initial Interview/Home Visit	**0.510**	1.6840	0.84826
During Initial Interview/Home Visit evaluates socio-economic status	**0.473**	1.9623	0.83097
Research literature for standard of care for client for national, regional, and local areas and include in report	**0.328**	1.9057	0.91360
Write the report to include bills the evaluee is expected to incur onetime only, monthly, annually, and remaining lifetime	**0.324**	1.7783	0.99900
Apply financial management knowledge when working with evaluees (e.g., balance checkbook, banking, etc.)	**0.328**	2.5236	1.03695
Apply risk management knowledge as it relates to life care planning	**0.420**	2.2264	0.98600
Factor 9			
Market LCP services through mailings, e-mail, presentations, etc.	**0.622**	2.5802	1.07896

Factor 9	**Factor Loading**	Mean	std
Sorts medical records by medical provider(S)	**0.543**	2.0472	0.99174
Sorts medical records by facility	**0.568**	2.1887	1.00815
Write the report to include all graphs and tables.	**0.386**	1.9198	0.91754
Write the report to include category of need tables	**0.417**	1.7028	0.88772
Provide information regarding your organization's programs to current and potential referral sources	**0.388**	1.8113	0.82741
Factor 10			
Request educational transcripts	**0.632**	2.1085	0.97481
Request vocational/employment records	**0.637**	2.0896	1.00070
Request financial records	**0.670**	2.5708	1.01164
Request social records if available (i.e., foster care, juvenile detention, adult detention)	**0.630**	2.2170	1.03955
Factor 11			
Attend conferences/workshops for continuing education to be applied to recertification and/or licensure renewal	**0.526**	1.2877	0.52179
Attend professional conferences	**0.623**	1.4104	0.60526
Factor 12			
Write the report to include life expectancy	**0.744**	2.1321	1.16891
Write the report to include coding for costs	**0.746**	2.5047	1.10791
Utilize medical coding when developing a life care plan (e.g., CPT, ICD-9/10, HCPIC coder)	**0.737**	2.1604	1.11548
Factor 13			
Apply knowledge regarding other funding sources as it relates to legal cases	**0.348**	2.3160	1.11395
Apply managed care (insurance industry) knowledge when developing life care plans	**0.789**	2.7358	1.12534
Apply knowledge regarding workers' compensation benefits within the state of injury as it relates to life care planning	**0.786**	2.6557	1.14342
Keep abreast of the laws, policies, and rule making affecting health care and disability-related rehabilitation service	**0.391**	1.6792	0.71606
Factor 14			
Obtain and sign retainer fee agreement from referral source	**0.337**	1.6934	1.01895
Request deposition transcripts	**0.382**	1.5566	0.81549
Monitor evaluee progress and outcomes during the life care planning process	**0.395**	1.8491	0.89010
Have a physician review the life care plan prior to submission to referral source	**0.437**	2.4057	1.10388
Obtain and review day-in-the-life videos of clients when developing a life care plan.	**0.573**	2.3066	0.88983

Factor 15	Factor Loading	Mean	std
Makes referrals for assessments of the evaluee	**0.477**	2.3726	1.15106
Request meeting with treatment/rehabilitation team members	**0.636**	2.0047	0.86259
Request meeting with medical providers	**0.517**	1.9292	0.85968
Request meetings with extraneous entities that may include daycare facilities, education facilities, recreational facility	**0.405**	2.3491	0.88743
Factor 16			
Review medical records, associated summaries, and all other requested records	**0.510**	1.0943	0.30874
Review medical records from physicians, nurses, PTs, OTs, and speech therapists to assess the evaluee's medical status	**0.471**	1.0943	0.35179
Sorts medical records by chronological order	**0.448**	1.6415	0.87826
Remain objective in your assessments	**0.541**	1.1651	0.37214