In order to be an effective life care planner one must follow the basic tenets guiding the practice of life care planning. This reading assignment will introduce the reader to the basic tenets of life care planning.

**The Principle of Consistency**

The Merriam-Webster Dictionary defines consistency as “(a) an agreement or harmony of parts or features to one another or a whole; (b) ability to be asserted together without contradiction; (c) harmony or conduct of practice with profession.”

Each of these subtle variations of the meaning of “consistency” are appropriate definitions relative to the methodology of life care planning. Without a consistent approach to gathering patient-specific data, analyzing it, and organizing it into a sensible format, it is unlikely that the plan will be effectively implemented.

The most respected life care planners follow a consistent approach to plan development with each and every case- their plans are based upon the demonstrated needs of each individual for whom a plan is created. Life care plans are based upon the needs of an individual, not the forecasted financial resources available for implementation.

To these planners, it does not matter whether they are hired by the plaintiff or defense in a litigated case, by an insurance company to assist with case management in reserve setting, or by any other party to develop a life care plan. The developed plan will be tailored to the actual needs of the individual as dictated by the onset of disability. Variations between individuals with similar disabilities will occur because of different variables being considered, but the methodology for analysis should remain consistent.

*Consistency in Litigation*

When involved in forensic cases, life care planners should not develop “luxury” plans that include the most expensive options possible when hired by a plaintiff, yet search for ways to provide the barest minimum of services regardless of individual needs when hired by an insurance company. If this sort of a pattern is detected, the planner’s professional credibility and ethical conduct will eventually be called into question.
In some catastrophic injury cases, the needs of the individual may very well exceed the financial resources available to meet those needs. When this occurs, the discrepancy between the needs and the available funds must be quantified and the life care planner must educate those involved as to the consequences of not meeting the projected needs of the patient. Beyond that, the planner may convene members of the planning and implementation teams (including the patient and family) and consider alternative resources, community programs, and creative resolutions to the issues of concern.

The Basic Tenets of Life Care Planning

The following principles constitute the guiding philosophies of life care planning:

First and foremost, life care planners are rehabilitation professionals and educators. The role of the life care planner is that of an educator, not advocate. When developing a plan, one must maintain objectivity and base recommendations upon research literature, the opinions of consulting team members (physicians, therapists, etc.), and patient-specific data. The responsibility of the life care planner is to set forth attainable rehabilitation goals and to assure that all parties involved in the process understand why specific items are included, how/when services should be provided, and how the plan is best implemented.

All plan recommendations should clearly relate to patient-specific evaluation data. It is essential that each recommendation is carefully tied back to the data collected in the clinical interview and history taken with the patient and family, as well as the review of all medical/health related professional records. The basis for each item citation should be clear to others who review the life care plan. No one should be left to wonder why specific recommendations were made.

Assume the probability of success of recommendations. It is inappropriate to make recommendations in a plan, then to proceed as though those recommendations were not going to be successful. If the recommendations are worthy of inclusion, it is appropriate to assume the probability of their success. The plan should be built upon successful outcomes.

Life care plans are designed to answer questions, not raise them. The life care plan should be self-explanatory. If it is not, revisions should be made so that it is easily understood by all. The planner should develop a format that is natural to their writing style, but also reader-friendly. Explanations should be used in the comment box and footnote sections.
wherever necessary and a team member should review the plan and objectively comment of the document’s readability as this will improve communication and reduce the time spent in deposition, if the plan will be scrutinized within the forensic setting. This is even more critical when the plan is referred to within a general case management setting. Clarity of communication with the patient, family, and interested third parties is critical so that recommendations are not misinterpreted or misapplied.

**Life care plans specific provisions throughout life expectancy and cannot depend on any one individual, service, or supplier for fulfilling plan recommendations.** The life care planner should always use at least three sources for the major cost items in the plan and not use negotiated rates as there is no guarantee that the cost will remain constant if the business/supplier should change hands; life care planners should not get into the habit of seeking discounted rates for repeat referrals. During the phase of plan development, cost should reflect real values of goods and services found within the patient’s local market. Also, eliminate the outliers from the market analysis so that unrealistically low/high rates do not misinterpret the actual cost of an item.

**Recommendations must consider disability, individual, family and regional factors.** The planner should make sure that the recommended services are available in the patient’s geographic location; if not, transportation expenses need to be provided or a program developed using area resources. For example, if the patient lives in a rural setting with few paved sidewalks, the recommended wheelchair should be compatible with that environment. The planner should always consider the individual variable that make the plan a custom fit to this patient and family. There are no generic life care plans!

**Attend to details.** A clearly written, well-documented life care plan and a professional imagine are significant steps toward credibility. The planner should strive to maintain professionalism and to produce a professional product and carefully proof all work for careless mathematical, grammatical, or terminology errors. The narrative report, life care plan, and all correspondence need to be evaluated for internal consistency and make certain that the recommendations progress in a logical sequence. When reviewing work for submission to the referral source, patient, and family, the planner should remember that they are not likely to be familiar with the terminology, acronyms, medical codes, abbreviations, and nomenclature taken for granted by the planner. The plan is a tool of communication, not confusion!
**Recommendations are proactive, not reactive.** Life care plans should be developed and implemented in a preventative manner that minimizes the frequency of occurrence, severity, and duration of complications. The recommendations must be clearly related to evaluation data identifying specific individual needs, and must be expected to benefit the individual.

*If an individual is not expected to benefit from a given service or piece of equipment, that recommendation should not be made. On the other hand, if a recommendation is expected to benefit the individual, the expected benefit should be considered in developing the rest of the plan.*

*For example, if an individual with paraplegia but no history of decubiti is provided appropriate wheelchair cushioning, and training regarding pressure release, skin inspection, and other methods to prevent the development of decubiti, that individual’s life care plan should not include four surgeries per year to treat decubiti. The assumption being made is that the best care and recommendations will not work and such complications will occur unabated regardless of preventative intervention. It suggests that complications can be accurately predicted despite the lack of statistical basis for that assumption. It also fails to consider the impact such an assumption concerning ongoing complications may have on life expectancy.*

**Recognize the benefits of maximizing patient potential.** In addition to individual quality of life benefits, financial benefits may also result from maximizing rehabilitation outcomes through the provision of timely and appropriate services.

*Consider the following example: Imagine the costs over a lifetime for two different 24-year old individuals with C5-6 spinal cord injuries. One can turn himself at night or can tolerate six hours without being turned. The other cannot. The difference in expected lifetime costs reduced to the present value for these two individuals is over two million dollars. This difference is based upon the patients’ functional limitations and the degree to which their levels of independence impact staffing requirements for support care.*

**Life care planning is multidimensional.** Life care planning is multidimensional, with each recommendation potentially effecting each other recommendation and elements of the plan. Driven by a specific functional limitation or impairment, all items cited within a plan will impact other recommendations both directly and indirectly.

*For example, multiple disabilities and multiple service providers might dictate similar recommendations, resulting in service overlaps or duplications. Consider the effects of a change from intermittent catheterization every four to
six hours to a suprapubic catheterization program for a C5 tetraplegic who is not independent in self-catheterization.

With intermittent catheterization, the patient requires:
   (a) An LPN to perform the procedure
   (b) Visiting nurses are impractical, because the program would require four to six visits every twenty-four hours;
   (c) The cost of visiting nurses would preclude this form of care from being a realistic, fiscally responsible option;
   (d) Two twelve-hour shifts, or three eight-hour shifts, of skilled nursing care are necessary;

If a change to a suprapubic catheter occurs, the skilled nursing care can be accomplished with nursing visits for the bowel program every other day, at which time they can deal with the flushing of the suprapubic tube and once per month tube change.

In addition to the modifications within the home care element of the plan, changes would also be required in supplies, routine and invasive medical care, and possibly within the medication element of the plan.

Consider the entire cost of each recommendation. Not only life care plan developers, but also case managers implementing these plans need to consider all of the cost factors associated with a given service option or piece of equipment.

For equipment, the overall cost must take into account the cost of maintenance and the necessary frequency of replacement. This is particularly true when calculating the cumulative cost of assistive technology and equipment that makes use of consumable substances.

Thomas and Kitchen (1996) compared the costs of hiring a personal care attendant through an agency versus through private hire. When the total cost (including employer social security and Medicare matches, state unemployment taxes, fringe benefits, payroll expenses, background checks, appropriate supervision, etc.) of a private hire is considered, the appeal of hiring through an agency increases.

The costs provided in a life care plan do not include two important categories: (1) potential complications; and (2) future technology. The costs associated with these areas cannot be accurately predicted. The degree to which complications will be experienced or future technology developed to meet a given individual’s needs cannot be known. Therefore, these costs are not included in the final cost analysis of life care plans. However, it is
important for life care planners and case managers to inform decision-makers that there is a potential for development of complications, as well as invention of future technology, which could have an impact even though they have not been included in life care plan projections.

Within the narrative report or the life care plan, the planner should clearly state that the issues of complications and technological advancement were not ignored, but that no valid method of calculating the costs/needs associated with either area exists. Life care planners must be certain to educate others and indicate that recommendations are based upon what has been determined to occur within “reasonable rehabilitation probability.” Events that lie beyond the realm of reasonable rehabilitation probability simply cannot be accurately evaluated.

Consider the psychological effects of the injury or disability. Psychological factors have a significant impact on the quality of life for individuals with catastrophic injuries. Making the individual a part of the decision-making team early in the process, and at what level they can participate, is critical to the success of plan implementation. Having choices and exercising control over one’s environment are especially important for individuals with catastrophic injuries that interfere with mobility and physical function.

For example, installation of an environmental control unit is a psychological intervention, an aid for independent function, and a safety precaution. If a tetraplegic individual has a personal care attendant available to turn the channels on a television set or to dial a telephone, for example, a naïve individual might question the need for a voice-activated system to operate those items. However, the psychological importance of restoring as much choice and independent control over one’s environment as possible should not be underestimated.

Psychological interventions should take into consideration the current demonstrated needs of the individual and his or her family, as well as future adjustments anticipated over the life span. For an adult who is injured, adjustments are expected during critical life phases, such as marriage, beginning a family, and retirement. For children with disabilities, appropriate short-term psychological goals should be established for different developmental stages.

Disability interacts with age to produce additional concerns. Not only psychological aspects, but also physical aspects of function, will normally vary with age. When disability interacts with the aging process, specific body
parts are known to wear out faster than they would for an individual without a disability.

For example, an individual who uses a manual wheelchair during young adulthood may be expected to require a power chair later in life. The patient’s shoulders, which were not designed to be weight-bearing joints, will lose function over time faster than would be experienced by an individual who does not use a wheelchair. Aging with disability is a critical part of the life care planning process. The plan does not remain static throughout the life span of the patient, but must anticipate items and services made necessary by the effects of age and disability. An excellent example of the research done in this area is discussed in *Aging With Spinal Cord Injury* by Whiteneck, Charlifue, and Gerhart (1993).

**References:**


Merriam-Webster Dictionary. Available online at: [http://www.m-w.com/home.htm](http://www.m-w.com/home.htm).
