Journal of Life Care Planning

INTERNATIONAL ASSOCIATION OF REHABILITATION PROFESSIONALS

Volume 17, Number 1, 2019

Elliott & Fitzpatrick, Inc.

Journal of Life Care Planning, Vol. 17, No. 1, (1-1)

Editor's Message

Tanya Rutherford Owen, Ph.D.

This week while reviewing the deposition of a newer physician life care planner, the testimony was that there were two professional life care planning groups: one for the nurses and one for physicians. Later in the deposition, he properly credited the history of life care planning back to its origins with Dr. Paul Deutsch. I wondered to myself how someone in the field could know enough to properly credit Dr. Deutsch, yet so little to completely deny the existence of the longest standing group of life care planners, currently under the umbrella of IARP. Over the weekend, when putting the finishing touches on the book review of Dr. Weed and Dr. Berens' text book, I read again the passage where Dr. Weed recounted reviewing testimony by a life care planner who could name no life care planning texts. Again, this reminded me of our ongoing need for such valuable resources as the textbooks brought to us by Dr. Weed and Dr. Berens (and others), the articles offered through the *Journal of Life Care Planning* and the important learning that we do together as a community of separately trained individuals, who are not members of a homogenous group.

As such, you will find in this edition, a culmination of the vision of Karen Preston with the efforts of article contributors from IARP including a physician, nurses, occupational therapists, speech therapists, physical therapists, psychologists and rehabilitation counselors. Such diversity in training allows us to benefit from each of our contributor's subject matter expertise. There is simply no way that one single individual can possess the subject matter expertise of all of these fields, yet our readers get the benefit from their diverse training. The goal of this issue is to succinctly outline the backgrounds of each of the subspecialties commonly involved in life care planning, noting what each of these subspecialties contributes to the life care planning process and field as a whole. Karen Preston has created easy-to read (and easy to reference) tables that consolidate the information from each discipline as it relates to life care planning. There is no doubt that these tables will become a critical resource for practicing life care planners. I cannot express enough my appreciation for everyone who worked on this project, most of all Karen, but also the authors of the articles, practically every member of our editorial board and those who served as outside reviewers when they were needed. The result of all of your efforts is now an invaluable resource for current and future life care planners.

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Guest Editorial

Karen Preston

In April 2010, at the Life Care Planning Summit held in Atlanta, Georgia, life care planners debated the issue of who can make recommendations for future care, while establishing the necessary foundation for admissibility. By the close of the Summit, the following two statements (Berens, Johnson, Pomeranz, and Preston, 2010) were created:

> **"Life care planners may independently make recommendations for care items/services that are within their scope of practice."**
> **"Life care planners seek recommendations from other qualified professionals and/or relevant sources for inclusion of care items/services outside the individual life care planner's professional scope(s) of practice."**

These statements have allowed life care planners, who come from many health care professions, to exercise their professional judgement and improve the visibility and credibility of their own valuable knowledge and experience. These also reflect the reality of the complexity of today's health care: no single profession or specialty can address every need of the patient or client. While a physician prescription may still be required for certain care, it is many times a formality to ensure insurance coverage rather than to direct or supervise another professional. Indeed, there are many times that the physician will refer to another professional and rely on that professional to determine the best plan and details of service. The Standards of Practice for Life Care Planners 3rd edition (International Academy of Life Care Planners, 2015) further solidify the expertise of life care planners by stating that the professional discipline provides sufficient education and training:

> **The education and training allows practitioners in the discipline to independently perform assessments, analyze and interpret data, make judgments and decisions on goals and interventions, and evaluate responses and outcomes.**

I hope this has contributed to fewer claims that life care planners are "just scribes" for a physician, and recognition that all health care professionals have standing for making independent judgments. However, the next challenge is to know enough about each other's profession to recognize when recommendations fall within scope of practice and when another profession must be included in making recommendations.

Our Standards of Practice, in discussing scope of practice, identifies life care planning as a transdisciplinary practice. The term transdisciplinary implies transcending, or moving beyond, a boundary. Understanding this term is important for examining the scope of a life care planner's abilities, yet recognizing that there can be overlap and collaborative effort with other professions or specialties to create a whole life care plan. Kristen Mauk's article gives us a launching point for considering this important concept as we move into greater depth in examining the scope of practice for each profession. Following this article are a series of tables and articles that provide detailed information for seven of the most common professions engaged in life care planning. In alphabetical order, there is an in-depth look at occupational therapy, physical therapy, physician PM&R specialist, psychologist/neuropsychologist, registered nurse, rehabilitation counselor, and speech/language pathologist. Life care planners from each of these professions share detailed information about their field and how this translates into what can and cannot be put into the life care plan under their own scope of practice. Thank you to this team of writers for sharing their expertise.

The goal of this special issue is to provide information that will help life care planners explain their own scope of practice and, when critiquing someone else's life care plan, to evaluate whether scope of practice was followed. Knowing the scope of practice for each profession is just the beginning, though. There are specialties within professions, specialty certifications, and post-graduate training that allows individuals to expand their personal scope of knowledge, skills, and array of interventions that can be ordered in clinical practice and recommended in life care plans. Including this information on a curriculum vita or resume is important to let others know the full scope of what can be recommended by the individual life care planner. So, think of this issue as laying the foundation for scope of practice for each profession, but recognize that each life care planner needs to look at their own "extras" and consider the "extras" that another life care planner has when reviewing another person's life care plan.

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Journal of Life Care Planning, Vol. 17, No. 1, (5-6)

Revisiting the Concept of Transdisciplinary Life Care Planning

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Abstract

The field of life care planning is relatively young in comparison with others. The life care plan (LCP) can be completed by professionals from various disciplines, posing a challenge for interpretation and understanding when clinicians come from diverse backgrounds and educational levels. All life care planners must adhere to both the standards of practice for their discipline, but also for life care planning. Both the life care planning process and the life care plan (LCP) itself provide an exemplar of transdisciplinary team work. The purpose of this article is to revisit the term *transdisciplinary* and the implications of this concept for the field of life care planning.

Keywords: Life care plan, life care planners, transdisciplinary

Revisiting the Concept of Transdisciplinary Life Care Planning

Life care planning is an evolving transdisciplinary specialty practice (Gamez, Johnson, & Stajduhar, 2017). Because a life care plan (LCP) can be devised by any of a variety of professionals, a review of the scope of practice of each of the seven most common major disciplines is the focus of this special issue. Members of these disciplines share their expertise and scope of practice to give a greater understanding of what each specialist has to contribute to the transdisciplinary team and the field of life care planning. The concept of transdisciplinary work has several facets that bear mentioning. The purpose of this article is to revisit the term *transdisciplinary* and its implications for the field of life care planning.

Definitions

There are many definitions of the term *transdisciplinary*. Some relate to collaborative research done across disciplines. Others focus on cross-training in the clinical setting, with the accompanying challenge of blurring of roles in patient care. The term transdisciplinary as used in rehabilitation has at times fallen into disfavor because of the lack of success in using such models in patient care settings. This is due largely to the barriers of overlapping responsibilities and team members being asked to work outside their comfort zones in areas for which they were not educationally prepared in basic training.

The concept of transdisciplinary within the life care planning field is an interesting one because it encompasses two unique aspect of the process: the life care plan itself and the educational background of life care planners who develop the plans. It may be helpful, then, to look at a few definitions of the term transdisciplinary, in order to enlighten the conversation.

Fuqua stated that "transdisciplinarity is considered a goal to strive for, but it is difficult to achieve due to the extensive time needed to overcome barriers, to gain a deep understanding of two or more disciplines, and to merge ideas in those disciplines" (Fuqua, 2012, p. ix). Certainly by looking at the comparison chart included in this special issue, all professionals can see the variety of educational backgrounds, scope of practice, licensure and certification requirements, and expertise unique to each field. Transdisciplinary teamwork suggests that clinicians from various disciplines "regularly teach, learn and provide care across disciplinary boundaries" (Cartmill, Soklaridis, & Cassidy, 2011, p. 8). This integrated type of practice has been associated with higher satisfaction and better patient-focused care coordination. Certainly this could also be said of life care planning. No matter the specialty area of the life care planner, the life care plan itself is transdisciplinary and can be developed by an expert from any one of seven major disciplines, provided appropriate scope and standards of practice are adhered to.

The concept of life care planning being transdisciplinary must also be distinguished between closely related terms such as *multidisciplinary* and *interdisciplinary* (or interprofessional). Multidisciplinary suggests that professionals work independently within their areas of expertise, but not with common goals - rather in silos. That represents an old way of thinking. Being interdisciplinary, or interprofessional, denotes a cooperation and collaboration between disciplines, also working toward common patient-centered goals. In rehabilitation, the term *interprofessional* has been adapted as the preferred term to denote clinicians working collaboratively toward a common patient-centered goal. This is true of life care planning, but the unique nature of life care plan development itself requires an even higher level of interaction. This is how life care planners engage in the work that is transdisciplinary, where it is identified "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" (Fuqua, 2012, p. viii).

So, it can be concluded that the concept of life care planning being transdisciplinary is indeed fulfilled in two distinct ways – the planner and the plan. Founders of life care planning saw a vision of a transdisciplinary team not found in other fields.

Implications of Transdisciplinary Teamwork

There is indeed benefit to collaborating and consulting with expert life care planners from other disciplines. For

example, as illustrated in the tables that appears in this issue, physical or occupational therapists have specific items that fall within their scope of practice such as ordering equipment, knowledge of adaptive equipment and their lifespan, and the potential functional outcomes after therapy. Nurses, rehabilitation counselors, and physicians can gain valuable information from these peers. Conversely, physicians and psychologists can provide expert knowledge on diagnostic testing, disease processes and necessary labs. Nurses, particularly those with a rehabilitation background, know about community resources, communication with family members, medications, and teaching/learning principles in addition to potential health complications associated with various disease processes. The rehabilitation counselor has inside information on all things about returning to work. And the speech-language pathologist brings dedicated expertise on cognition, speech and swallowing. As Wirt and Porter (2012) summarized, "development of the LCP benefits when each member of the multidisciplinary team is given the opportunity to provide his or her input and expertise" (p. 473). All of the team members together comprise a compelling force that makes the LCP credible.

Interestingly, as life care planning is a younger specialty area than many, it provides an exemplar of transdisciplinary teamwork. While life care planners may represent different disciplines, all must abide by the scope and standards of their own profession including ethical practice, accountability, and quality assurance (Weed & Beren, 2019). In addition, life care planners also abide by the standards of life care planning according to industry standards and organizational governance (Johnson, 2015; Johnson, Lacerte, & Fountaine, 2015; Preston & Reid, 2015). The planner brings unique expertise to the plan, and the LCP itself should demonstrate transdisciplinary interventions. Even considering the numerous standards this type of work entails, the usefulness of the LCP for both litigation and advance care planning for catastrophic injury or chronic illness has gained it favor with the health and judicial communities. Certainly the transciplinary nature of the LCP not only makes the process more complex, but it also stands as one of its most powerful strengths.

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Journal of Life Care Planning, Vol. 17, No. 1, (7-11)

What Life Care Planners Need to Know About the Professional Discipline of Occupational Therapist

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Abstract

Occupational therapy evaluations provide important information to address many key areas required in the formulation of a life care plan. The purpose of this article is to educate life care planners about the professional competencies of occupational therapists by reviewing the educational and licensing requirements of occupational therapists, their scope of practice, and clinical areas of expertise.

Keywords: occupational therapy, occupational therapist, life care planning, scope of practice

History and development of this profession

The occupational therapy profession originated during the first World War (1914-1918) when soldiers with disabilities were provided with vocational training in military hospitals to help return them to a useful, independent life (American Association of Occupational Therapists [AOTA] 2018). The profession of occupational therapy was officially named in 1921 in both the United States and Canada (AOTA, 2019; Ontario Society of Occupational Therapists [OSOT], 2018). Challenging the views of the mainstream medical model, occupational therapy was founded on the belief that that dysfunction was caused by complex interactions of biological, psychological and social factors and that participation in "occupations" had remedial properties (OSOT, 2018). The National Society for the Promotion of Occupational Therapy, now the American Occupational Therapy Association (AOTA) was established in 1917 in the United States. The national association, the Canadian Association of Occupational Therapy (later Therapists - CAOT), was founded in 1926 to support the profession and ensure occupational therapy is valued and accessible to Canadians. Similar to CAOT, AOTA works to advance the profession through standard setting and advocacy (AOTA, 2018).

After two decades of combined training, the 1970s ushered in the separation of occupational and physical therapy programs and led to the replacement of the diploma with the baccalaureate degree in Canada (OSOT, 2018). A bachelor's degree in occupational therapy was the expected credential for entry-level occupational therapy education in Canada until 2008. Since 2008, CAOT accredits only occupational therapy educational programs that lead to a professional master's degree in occupational therapy as the entry-level credential (CAOT, 2018). Successful applicants entering into the master's degree programs come from diverse educational backgrounds not limited to bachelor's degrees in the basic sciences, psychology, kinesiology, or social work.

In the U.S., occupational therapy is also a regulated healthcare profession and since 2007, the minimum educational level is also a master's degree. Currently, the Accreditation Council for Occupational Therapy Education (ACOTE) is exploring a change for the entry-level degree requirement for occupational therapy to the doctoral level by July 1, 2027 (AOTA, 2018).

Other names by which this profession may be known

In Canada and the U.S., there are no other names by which occupational therapy is known.

Education to enter the profession

Curricula may vary slightly across accredited programs in the U.S. and Canada, however foundational training includes courses in a) assessment and evaluation, b) professional practice, c) occupational therapy theory, d) mental health conditions, e) assistive technology, f) evidence-based practice, g) knowledge translation, h) return to work, i) occupational therapy across the lifespan, j) neurology, k) program evaluation, l) human anatomy and physiology, m) interprofessional teams and n) psycho-social influences on occupation and research (Association of Canadian Occupational Therapy University Programs, 2018; University of Florida, Department of Occupational Therapy, 2018).

In addition to the in-class educational curriculum, supervised fieldwork experiences are required. In the U.S., students are required to complete 24 weeks of full-time supervised on-the- job training (AOTA, 2018). Canadian-trained occupational therapists complete a minimum of 1000 hours of supervised fieldwork experience (CAOT, 2012). These are often done in a variety of settings (i.e., inpatient, outpatient or community) to give a better understanding of the role of occupational therapy in various practice areas such as pediatrics, orthopaedics, neurology, and/or psychiatry.

Licensing or mandated certification requirements and authorizing entity that permits someone to practice in this profession

The title 'occupational therapist' is protected under provincial Health Professions Acts in Canada and by state

licensure in the U.S (AOTA, 2018). These regulations provide a regulatory framework for governance of the occupational therapy professions and provide accountability to the public. For example, the British Columbia Health Regulators (2018) cite that requirements of a regulated health professional include but are not limited to:

- Only people who can use the professional title
- Meet educational requirement
- Maintain a code of ethics
- Subject to criminal record checks
- Complete and pass national and/or provincial exam(s) to test their skills and abilities; and review legal, professional, and ethical practice
- Publicly register within their regulatory college and renew their registration annually
- Keep their skills up to date
- Undertake scope of practice within their professional limits
- Meet professional and practice standards
- Subjected to a complaints process if standards are not met
- Recognized under the appropriate Health Professions Act.

In Canada, occupational therapy is a regulated health profession in ten provinces. The accreditation standards are set by CAOT. Graduates from Canadian occupational therapy programs must become registered in the province in which they intend to practice. In addition to meeting education and practice standards, applicants must also successfully complete the National Occupational Therapy Certification Exam (NOTCE). Each province has a regulatory organization with its own unique registration requirements that is responsible for ensuring that occupational therapists maintain their competency to ensure public safety. In the three Canadian territories, (i.e., Yukon, Northwest Territories and Nunavut), occupational therapy is not currently regulated.

The path to registration is different for internationally educated occupational therapists (IEOTs) who wish to practice in Canada. More information about IEOTs can be found at www.acotro-acore.org. In Canada, information about the knowledge, skills and attitudes required for occupational therapists to demonstrate that they are competent for occupational therapy practice for both clinical and nonclinical work is outlined by The Association of Canadian Occupational Therapy Regulatory Organizations [ACOTRO] in the *Essential Competencies for Practice for Occupational Therapists in Canada* (ACOTRO, 2011).

Credentialing of occupational therapists in the United States is provided through the National Board for Certification in Occupational Therapy (NBCOT). Each state also regulates the practice of occupational therapy by licensure (AOTA, 2018). The standards of practice for occupational therapy are developed and maintained by the American Occupational Therapy Association as well as the National Board for Certification in Occupational Therapy (AOTA, 2019; Delany et al., 2010; National Board of Certification in Occupational Therapy, 2018).

After completion of fieldwork, U.S. practitioners must pass a national board certification exam. They can then obtain state licensure. This process varies by state but often requires one to pass a background check and prove completion of the national board exam as well as completion of the required master's degree or clinical doctoral degree.

License renewal frequency depends upon the state. Each state requires proof of continuing education and requires disclosure if a practitioner is convicted of a crime or is disciplined by another public agency. Each state also has its own ethical standards of practice and disciplinary guidelines. An occupational therapist must be licensed in the state in which they practice.

Occupational therapists can delegate or assign components of an occupational therapy service to an occupational therapy assistant. An occupational therapy evaluation must be completed by a registered occupational therapist but follow-up treatment can be completed by an assistant under supervision of the registered therapist (McCracken & Winistorfer, 2016). Whether practicing in Canada or in the U.S., occupational therapists need to be mindful of the licensing restrictions in each province or state, as it may limit their ability to perform an evaluation or life care plan in a state where they do not hold a license.

Common specialty areas, roles, and credentials that can expand expertise and scope of contribution to life care plans

Occupational therapists can obtain additional certifications in a variety of areas, some of which also require a specific number of practice hours in the field or a certification exam. For example, occupational therapists can take advanced training to become a Certified Hand therapist (CHT), Assistive Technology Professional (ATP), Seating and Mobility Specialist (ATP/SMS), Certified Brain Injury Specialist (CBIS) or Certified Industrial Ergonomic Evaluator (CIEE) . In addition, occupational therapists who conduct medical-legal assessments may take additional training or certifications to conduct functional capacity evaluations, functional cognitive assessments, ergonomic assessments/interventions, and/or work conditioning/ hardening to build expertise. The American Occupational Therapy Association also offers board certifications in Gerontology (BCG), Mental Health (BCG), Pediatrics (BCP), and Physical Rehabilitation (BCPR) (AOTA, 2018).

Occupational therapists have been establishing their role in the field of personal injury litigation for decades (Brangam, 1987; DeMaio-Feldman, 1987; Harris, Henry, Green and Dodson, 1994). In Canada, occupational therapists have been accepted as experts in cost of future health care since the early 1990s (Harris et al., 1994).

An occupational therapist can also develop skills, knowledge and competencies in different areas of practice through work experience. For example, occupational therapists may build expertise by working in either mental health or physical medicine. Within these two areas of practice, individuals may specialize in pediatric or adult populations and/or by where they work, i.e., community-based or in institutions. Within physical medicine, there may be further areas of rehabilitation practices including focusing on diagnoses or conditions such as traumatic brain injury rehabilitation, cardiac rehabilitation, chronic pain management, spinal cord injury, driving rehabilitation, or low-vision rehabilitation. Occupational therapists can also develop expertise in assisting individuals to return to work or stay in work by implementing accommodations and therapy for mental health conditions (e.g., anxiety, depression, PTSD) or physical problems (e.g., chronic pain, wheelchair dependence).

The kinds of patients and problems usually seen and addressed

Grounded in both physical and social sciences, occupational therapists provide a holistic approach to assessment and treatment of individuals who face challenges in meeting their customary roles. Occupational therapists take into account both the individual's mental (cognitive and emotional) and physical functioning when determining the impact of illness or injuries on carrying out activities, including basic activities of daily living (ADLs) such as eating, dressing, grooming, as well as instrumental activities of daily living (IADLs), such as shopping, medication management, household chores, paid or unpaid work, taking care of children or driving. The individual's level of function is also assessed/examined within the context of their social, physical, spiritual and cultural environment.

Utilizing a client-centered approach, occupational therapists enable clients to engage in occupations that people "need to, want to and are expected to do" (World Federation of Occupational Therapists, 2012). Occupational therapists implement evidence-based interventions that may restore, develop, or maintain function or compensate for permanent disabilities by providing adaptive equipment and/or by educating/training individuals to utilize alternate approaches to tasks to facilitate their independence. Additionally, preventative measures are recommended to minimize the risk of complications or development of other conditions in the future.

Regardless of the diagnoses or age of the person, the focus of occupational therapy interventions revolves around helping individuals carry out their daily activities over their lifespan. Recognizing that disabilities can result from cognitive, emotional and/or physical impairment(s) as well as environments, occupational therapists have expertise in the assessment and treatment of these areas. Both ADLs and IADLs, along with any other daily activities that an individual needs to, wants to, or is expected to do constitute "occupations". Occupational therapists provide an in-depth understanding of the impact that specific capacities/deficits can have in the daily occupations of life. Occupational therapists administer a variety of assessments that include assessment of the person (e.g., cognitive function, sensory, perceptual, emotional regulation, physical capacities, spiritual beliefs), their task performance (i.e., ADLs, IADLs) or the environment (ergonomics, home and worksite) (Asher, 1996; Mitchell, Mitchell, & Stetten, 2017). When available, standardized assessments with good reliability and validity are utilized. These assessments are supplemented by functional evaluations of the individual's ability to perform activities required to fulfill their roles (e.g., housekeeping assessment, work simulation, personal care assessment, etc.) to add ecological validity and inform associated practical recommendations for the future. Occupational therapists also have expertise in recommending adaptive equipment, environmental modifications, assistive technology and other strategies that help optimize a person's level of independence.

Misconceptions about Occupational Therapy

One of the most common misconceptions regarding the profession is that occupational therapists are only involved in helping people return to their job or occupation (i.e., competitive employment). Although they may be involved in facilitating an individual's return to work in some situations, occupational therapists define "occupation" more broadly to include "everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life" (WFOT, 2012). This would include engagement in any activity of daily life (occupations). such as bathing, dressing and toileting, community access, leisure and recreational activities, driving, as well as home-making, shopping, childcare and paid or unpaid work.

Another misconception is that occupational therapists are only involved in treating individuals with severe injuries or disabilities. Occupational therapists treat anyone with an injury, illness or disability, regardless of the type or severity. Occupational therapists have the skills and training to address physical injury and disability as well as cognitive and emotional conditions that prevent individuals from engaging in their valued occupations.

Another common misconception about occupational therapists is that their interventions are not as critical or essential in the recovery of a patient compared to that of doctors, nurses or other health professionals. On the surface, occupational therapy interventions may appear simple because everyday activities are simple and easy to perform. However, for the individual who is struggling with either their mental or physical health, they may experience significant challenges when they try to bathe, cook or access public transportation independently. Occupational therapists are skilled at activity analysis and may break down these

activities into more manageable steps and/or recommend adaptive equipment for the individual to engage in necessary and meaningful activities in their lives. Successful occupational therapy interventions can make the difference in an individual resuming life independently in the community or requiring long-term care. These interventions, therefore, may have significant implications for the current and future needs outlined in a life care plan.

Information a life care planner who comes from the profession should include in a resume or CV to support the ability to make future care recommendations and information to understand the scope of practice, independence, or limitations of the profession

A curriculum vitae or resume should include not only the credentials of the occupational therapist, but also a history of areas worked, and tasks/duties performed at each job. Additional certifications and areas of expertise including professional development courses should be included to demonstrate advanced training, knowledge and currency in specific areas of practice.

Occupational therapists' scope of practice domains are similar to the information required in the formulation of a life care plan; thus, an occupational therapist's assessment of, and recommendations for an individual's functional capacities at home, work and leisure contribute to key areas required in a life care plan (Klinger, Baptiste, Adams, 2004; Mitchell & Mitchell, 2018). Since the 1980s, there has been a growing demand for occupational therapists to provide opinions regarding the functional implications that injuries have on independent living and work capacity for litigation, insurance, compensation and life care plans (Allen, Carlson, Ownsworth, Strong, 2010). Occupational therapists' opinions provide valuable information upon which decisions are made pertaining to the functional losses a person has experienced and for which the person receives compensation.

Life care planning methodology (Weed & Berens, 2018) emphasizes collaboration with the treating healthcare professionals (International Association of Rehabilitation Professionals, 2015). Within the scope of practice of occupational therapy, occupational therapists rely on their knowledge and skills to provide recommendations for activities of daily living including, but not limited to assistance with housekeeping, personal care, adaptive equipment and supplies, indoor and outdoor home maintenance, child care, and community access. Recommendations may be included for assistive devices/equipment to enhance independence and for ergonomic modifications/adaptive equipment for the home and workplace. As well, occupational therapists can identify the need for involvement of other professionals such as those in mental health treatment and/or exercise physiology to maximize health and wellness. Recommendations for exercise, relaxation/stress management training, pain management, graduated return to work, or further vocational planning are also within the scope of occupational therapy practice. Occupational therapists also often assume a case management role, and their ability to "see the whole picture" and assist clients when managing the various professionals involved in rehabilitation over the lifespan also provides a solid foundation developing a life care plan.

In contrast, occupational therapists are not independently able to prescribe medications, nor should they provide commentary on any medication management over the lifespan without reference or consultation with a qualified healthcare professional. Similarly, occupational therapists cannot independently provide recommendations on future events such as degeneration of a condition or surgery, in the absence of any reference in the medical documentation. However, if future surgery is postulated by a qualified healthcare professional, an occupational therapist can comment on the temporary or permanent needs post-surgery in relation to the individual's activities of daily living. Finally, occupational therapists do not independently diagnose but rather rely on diagnoses provided in the medical documentation when developing a life care plan.

Conclusion

The scope of practice of occupational therapy, and the findings of occupational therapy evaluations and associated recommendations with respect to daily functioning address many key areas required in the formulation of the life care plan. The profession has continued to mature since it was established in the early 1920s with the refinement of assessment tools and treatment recommendations that integrate the biological, psychological and social factors affecting functional performance. The holistic approach that is foundational to the field of occupational therapy provides an in-depth understanding of the impact that different factors can have on an individual's ability to carry out their daily activities and fulfill their customary roles and provides valuable information for the formulation of life care plan.

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Journal of Life Care Planning, Vol. 17, No. 1, (13-17)

What Life Care Planners Need to Know About the Professional Discipline of Physical Therapy

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Abstract

The profession of physical therapy began during WWI with "reconstruction aides". Since then, the profession has grown to a doctoral entry level degree with many diverse specialties. The licensure requirements vary some from state to state and between the USA and Canada. The universal goal of physical therapy is, in collaboration with other health care team members, to restore functional mobility and quality of life. Many of the core components of a life care plan fall under the professional education, scope of practice, professional experience and domain of the physical therapist. Physical therapists are well prepared to make valuable contributions to the life care planning profession.

History and development of this profession

The profession of physical therapy began with the reconstruction aides who were civilian employees of the Medical Department of the United States Army during World War I (American Physical Therapy Association [APTA], 2018). Marguerite Sanderson oversaw the first reconstruction aides and established the Division of Physical Reconstruction. Mary McMillan was the first female appointed as the first reconstruction aide in February 1918. She organized the Physiotherapy Department at Walter Reed General Hospital. Of the original 18 Aides, 16 of them created the American Women's Physical Therapeutic Association, which is now known as the American Physical Therapy Association (APTA) (APTA, 2018). The original reconstruction aides were college-educated, but their clinical education consisted of on-the-job training. In 1928, reconstruction aides participated in a 9-month, 1,200-hour program.

Education to enter the profession

Over the decades, physical therapy evolved from a Bachelor's of Science to a Master's of Science degree, and in 2015, all accredited and developing physical therapist programs evolved into a post-baccalaureate 3-year Doctor of Physical Therapy (DPT) degree (APTA, 2015). In 2000, the American Physical Therapy Association (APTA) passed its *Vision 2020* statement, which advocates for direct access to physical therapy evaluation and treatment without a physician's referral (APTA, 2000). As of January 1, 2015, all 50 states and the District of Columbia allow some form of direct access to physical therapists. Physical therapy/therapist is also referred to as physiotherapy/therapist, but the two nomenclatures are interchangeable. Although physiotherapy/therapist is British in origin, it is not common in the U.S but is used in Canada and Australia.

Basic physical therapy curriculum includes, but is not limited to, the following courses: Functional, Neuromuscular and Musculoskeletal Anatomy with Dissection Lab, Neuroanatomy and Neurophysiology, Exercise Physiology, Musculoskeletal Disorders, Neurorehabilitation, Pharmacology for Physical Therapy Practice, Principles of Disease, Radiology and Diagnostic Imaging in Physical Therapy Practice, Motor Control/Therapeutic Modalities (therapeutic intervention skills – including manual skills, exercise, and neuro rehab intervention), Differential Diagnosis, Prosthetics and Orthotics, Evidence Based Practice, Health Promotion and Wellness, and Clinical Skills, Psychosocial/Behavioral Content, Ethics, Human Development/Life Span, and Business Principles.

Licensing or mandated certification requirements and authorizing entity that permits someone to practice in this profession

Physical therapists are currently licensed and regulated in all 50 states and the District of Columbia, Puerto Rico and the U.S. Virgin Islands (APTA, 2015). Each state requires state licensure which must be renewed on a regular basis. Each of the states in the United States of America has its own licensing board for physical therapists. Following a passing score on the National Physical Therapy Exam, licensure candidates may apply for a license in the state in which they reside and/or work.

Students in Canada must take and pass the Physiotherapy Competency Examination, which is administered by the Canadian Alliance of Physiotherapy Regulators. The requirements and fees are similar state to state and province to province, but are separate and individual to that state/province. These requirements can be found easily with an online search. Once physical therapists are licensed in a particular state, they must abide by those laws and practice regulations. Most states offer a renewal every two years and require a minimum number of continued education hours along with a fee, for those renewals. Physical therapists may legally only provide physical therapy services in states where they hold active licensure. Recently, the PT Compact, an interstate agreement between member states began its work and is adding states systematically as each state's legislation allows. Ultimately, this Compact will allow physical therapists to practice across state lines. This will allow for easier access to physical therapy through telehealth or mobile platforms.

In Canada, the profession of physiotherapist is regulated in all Canadian provinces and territories (except the Northwest

Territories and Nunavut). The provincial / territorial regulators set the standards for licensure. A candidate must meet all the licensing or registration requirements of the province or territory where they wish to work.

Common specialty areas, roles, and credentials that can expand expertise and scope of contribution to life care plans

Programs such as clinical residencies, clinical fellowships, and certified clinical specialization allow physical therapists to expand their expertise within defined areas of practice, or "specialties" (APTA, Specialty areas offered by the American Board of Physical Therapy Specialties include cardiovascular and pulmonary physical therapy, geriatrics, neurology, orthopedics, pediatrics, sports, women's health, and clinical electrophysiology.

The focus of physical therapy specific to cardiovascular and pulmonary physical therapy focuses on treating clients who have experienced heart attacks, constructive pulmonary obstructive disease (COPD), pulmonary fibrosis and related diseases. Geriatric physical therapy, however, includes treatment related to injuries and illnesses of older adults, including arthritis, cancer, osteoporosis, joint replacements and balance problems. Spinal cord injury and disease, cerebral vascular accident (CVA), brain injury, multiple sclerosis, and Parkinson's disease are just a few examples of neurological conditions and impairments on which the clinical specialty of neurology focuses. Orthopedic physical therapy centers primarily on injury and dysfunction of musculoskeletal system. Pediatric physical therapy treatment is aimed at children with birth defects, genetic disorders, childhood muscle diseases, acute injuries, head trauma and a vast array of disabilities. Women's health focuses on issues including as pelvic pain, and urinary incontinence. Lastly, electrophysiology focuses on electromyography (EMG) and nerve conduction studies (NCS) which can be utilized to create a physical therapy treatment plan.

Many residency programs prepare therapists to apply for clinical specialization exams. Other certifications in areas such as but certainly not limited to strength and conditioning, various manual therapy methods, vestibular rehabilitation, dry needling, and nutrition can be attained by physical therapists practicing in a particular niche. Practicing physical therapists have a diversity of certifications and specialty areas. A physical therapist's curriculum vitae should include the physical therapist's licensure, education, certification credentials, continuing education, certification credentials, work history, publications and presentations, as well as specialization, if any.

Scope of Practice

Physical therapists are trained and experienced in collaboratively working with a multi-disciplinary team, consisting of, but not limited to, physicians, psychotherapists, occupational and speech therapists, orthotists, prosthetists, nurses, vocational evaluators, massage therapists, acupuncturists, social workers, personal trainers, attendant and companion caregivers in settings such as home care, skilled nursing, and intermediate and assistive care facilities, as well as hospitals, school systems, and outpatient practices. Physical therapists treat clients with various treatment modalities and teach them how to safely and effectively use medical and durable medical equipment, such as walkers, canes, wheelchairs and accessories, power scooters, shower benches, grab bars, TENS units, braces and splints, as well as a wide variety of exercise equipment. It is within a physical therapist's scope of practice and clinical experience as a rehabilitation professional and educator to provide recommendations related to these types of rehabilitation equipment with reasonable replacement schedules.

A physical therapy treatment begins with an evaluation with an interview of the client or caregiver. Through careful questioning and listening, the primary problems, and impairments, co-existing conditions, past medical and surgical history, medications, support systems, functional goals, pain levels, psychosocial and cognitive issues, and previous or current medical and social services are identified. Limitations in functional mobility can be due to both objective and subjective impairments. During this initial interview, any pain, dizziness, or other reported discomfort is identified and documented, often with ratings by the client using to a numerical scale.

The objective portion of the evaluation includes general system screens, more in-depth exams, and special tests. General screens include basic soft tissue evaluation, range of motion, strength, sensory systems, gait analysis, flexibility, balance, and functional mobility such as transfers. With the information obtained from the subjective reporting, as well as findings on general screens, a physical therapist knows what areas to further examine/ treat. More specific exams include, but are not limited to a neurological exam, joint mobility, an in-depth soft tissue exam, detailed gait analysis, cardiovascular fitness testing, vestibular testing, specific manual muscle testing, and functional capacity testing. Some of these are very extensive, such as vestibular and post-concussion testing or functional and work capacity testing, and may require a second visit in order to fully complete the evaluation. Within these more detailed examinations, physical therapists have a wide range and depth of specialized standardized tests and measures in order to identify the originating and contributing causes of impairment, measure the disabilities, and provide baseline levels from which to establish goals and treatment plans.

In addition to these goals and treatment plans, physical therapists make recommendations for equipment, make referrals to other professionals (i.e., physician specialist or orthotist) and provide information related to general health, safety and condition related precautions or restrictions. In many situations, a physical therapist is one of the most qualified professionals to make recommendations related to return to work, school or athletic activities.

The role of a physical therapist overlaps that of other medical professionals. In the area of Activities of Daily Living (ADL), occupational and physical therapists work closely together. Occupational therapists usually have more training in specific adaptive equipment. In some settings, occupational

therapists prescribe wheelchairs, and in others physical therapists make those recommendations. In most settings with both professions, a physical therapist will make the recommendations for equipment related to walking, transfers, and gross motor mobility. An occupational therapist will make recommendations for equipment related to self-care. Orthotists and physical therapists can overlap as well. Some physical therapists are specially trained in evaluating for and providing orthotics. It is more typical that a physical therapist would evaluate the functional impairments and communicate the improvements desired from an orthotic. The orthotist would then fit and provide the product, with the physical therapist making the final assessment of the benefits gained.

Physical therapists working in home care settings provide functional mobility strengthening and balance training, teach energy conservation techniques and offer recommendations for architectural modifications. As rehabilitation professionals and educators, it is within the physical therapy scope of practice to provide recommendations for adaptive aids used for cooking, bathing, and grooming, as well as widening of doors and installation of ramps for wheelchair accessibility, railings for stair navigation, and walk-in showers for safe bathing. Physical therapists evaluate critical work-related physical demands by providing job-site analyses and functional capacity evaluations. A Functional Capacity Evaluation (FCE) is a comprehensive battery of performance-based tests that is used measures a worker's safe physical capacities, as well as limitations in respect to work, activities of daily living, or leisure activities.

Physical therapists who are trained in FCE's provide objective and clinical data that can be integrated into services related to gardening, handyman services and heavy housecleaning. For example, if a client exhibits trunk flexion range of motion and strength limitations, poor grip and manual and finger dexterity, and the FCE demonstrates that the client is unable to lift/carry more than three pounds, the physical therapist can provide recommendations for assistance with activities of daily living and household services.

The kinds of patients and problems usually seen and addressed

Physical therapy services are provided by physical therapists with the goal of maintaining or regaining maximum movement, strength and function to clients of all ages with regard to injury, pain, and disease. Physical therapists (PT) evaluate and treat adult and pediatric clients who have sustained brain injuries, spinal cord injuries, traumatic amputations, orthopedic injuries, and neurological conditions and chronic pain and other physical impairments related to musculoskeletal function. Physical therapists are equipped to advise patients/clients on issues related to general health and wellness in the realm of functional mobility in addition to pathological conditions. Physical therapists also have the breadth of knowledge to serve as an advocate or case manager for individuals who have multiple and diverse needs best provided by a team of specialized health care providers. According to the American Physical Therapy Association (2012), the physical therapist's responsibility in the diagnostic process is to organize and interpret information collected through taking a relevant history, conducing a systems review and selecting and administering specific tests and measure (APTA, 2012). In doing so, a physical therapist may order appropriate tests to be performed by themselves or other health care professionals (APTA, 2012).

Physical therapists are health care professionals who maintain, restore, and improve movement, activity, and health enabling individuals of all ages to have optimal functioning and quality of life (APTA, 2011). Physical therapist interventions include therapeutic exercises, manual therapy (including mobilization/ manipulation); electrotherapeutic and ultrasound modalities; functional activity training; transfer and gait training; training in the use of assistive technology; home care, including activities of daily living (ADL) training; community integration; fabrication of devices and equipment; teaching safe patient handling techniques to families and health providers; and providing airway clearance. The goals of physical therapy include mobility restoration, pain reduction, home exercise program and self-care implementation, increasing physical fitness, increasing endurance, regaining or maintaining maximal or functional independence, and reducing or preventing potential illness or injury. In summary, physical therapy intervention focuses on improving, maximizing or maintaining an individual's independence, activity level and health well-being, as well as preventing injuries.

Differences between Canadian and U.S. practitioners in this profession

Though the clinical practice of physical therapy is very similar in the United States and Canada, the access to physical therapy and licensing practices differ, due to the differences in the health systems. Differences in settings and salaries exist within each country based on area of the country and demand for physical therapists.

Other information important for life care planners to know

Art Peddle, in his chapter on the role of the physical therapist in life care planning, indicates that, "Physical therapists serve as facilitators of health" (Weed, 2010, p. 124). A physical therapist evaluates body systems, areas of dysfunction and injury, and potential for return to activities of daily living, work related skills, and recreational activities. During the evaluation, which includes interview, examination and assessment, the physical therapist determines impairments to function, provides functional diagnoses, and develops a treatment plan and recommendations in order to return an individual to a maximal level of functional independence, physical comfort, and safety. These functional goals are dependent upon the extent and type of impairments, which inform the physical therapist's assessment of potential. Physical therapists are either generalists or specialists with regard to age groups and disability types. This is much like a physician model of specialization. A generalized physical therapist can assess most any physical mobility problem and knows when the problem requires a more specialized clinician.

An important role of the physical therapist in life care planning is the assessment of future needs. When there is a disability or impairment in some aspect or multiple aspects of mobility, the wear and tear on the body is altered from that of a typically aging individual. The systems which were possibly once injured in isolation from other body systems, with time can affect the health of other parts. Art Peedle (Weed, 2010, p. 131) describes an example of an individual who is unable to use her lower body and requires a wheelchair for mobility. Over time, she has wear and tear on her upper body and therefore may in the future require medical attention which might not have otherwise been required. This same individual may have had no integumentary problems initially, but because of the inability to move out of a chair, is at much greater risk of pressure related issues in the future. Because of the in-depth training and education in musculoskeletal, neurological, and biomechanical systems, a physical therapist is able to predict and advise potential secondary system impairments which might require care in the future.

The individual who has a life care plan will likely be one who will have physical therapy treatment as part of that plan. Generally, physical therapy treatment is episodic. These episodes begin with an evaluation for one or more specific problems. Treatment goals, a plan and an estimated time frame are established. The patient is discharged from physical therapy at the conclusion of this sequence of treatment visits. Length of visits, frequency and total duration of the episode of care varies greatly based on the impairments, treatment goals, and prognosis. An individual with a chronic condition will likely require at least one episode of care per year, and many times several. There are instances when it is determined that ongoing maintenance care provided by a skilled physical therapist is the only option available to provide the treatment needed to prevent a decline in function. These ongoing treatment plans are not typical, but at times necessary to prevent more costly future treatment.

Other life care planning considerations for which a physical therapist is capable of advising might include predicted replacement of mobility equipment, a change of equipment due to predicted mobility changes of the client over time, home adaptations for increased safety and independence, amount and frequency of caregiver assistance required, and transportation needs and adaptations.

According to Paul M. Deutsch (1994), the tenants of life care planning include the consideration of many elements. Listed below are considered areas with additional comments by these authors related to the role of physical therapy in life care planning.

- **Projected evaluations-** Physical therapists are able to project the frequency of physical therapy evaluations for the evaluee, as well as lend assistance to the life care planner in suggestions of the likelihood of various other medical evaluations which might be required. The life care planner would need input from disciplines outside of physical therapy.
- **Projected therapeutic modalities**- Physical therapists are able to project the frequency of physical therapy treatments for the evaluee, as well as lend assistance to the life care planner in suggestions of the likelihood of various other medical evaluations which might be required. The life care planner would need input from disciplines outside of physical therapy.
- **Diagnostic testing and educational assessments**- Physical therapists are able to advise on, but not order, diagnostic testing. Those physical therapists working in the U.S. military system are legally able to order limited diagnostic tests.
- **Wheelchair-** Physical therapists have the skill, education and legal ability to advise, fit, and prescribe wheelchairs. Due to physical therapist specialization, some physical therapists might defer to other professionals for this area.
- **Wheelchair accessories and maintenance-** Physical therapists have the skill, education and legal ability to advise on this topic. Due to physical therapist specialization, some physical therapists might defer to other professionals or wheelchair manufacturers and vendors.
- **Orthopedic equipment**- In most cases, physical therapists have the skill, education, and training to advise and collaborate with others in this area.
- **Orthotic or prosthetic requirements-** Due to the immense advances in prosthetic technology, a physical therapist typically will work with a prosthetist to make decisions about prosthetic limbs. The physical therapist is the functional mobility expert as well as the one projecting the future needs and capabilities for the client. The prosthetist is able to provide expertise on how best to meet those needs with the prosthetic device. Training of the client is also usually a collaborative effort. Orthotics are similar, however, at times can be handled solely by the physical therapist.
- **Home furnishings and accessories-** Physical therapists are able to provide a wide variety of recommendations in this category.
- **Aids for independent function-** Physical therapists are able to provide a wide variety of recommendations in this category.
- **Medication**-Physical therapists have the education to make recommendations for consults with physicians, physicians' assistants, or nurse practitioners on impairments which might be improved by certain classes of medication. For example, a physical therapist might recommend that the evaluee discuss with the physician the possibility of muscle relaxer in order to improve mobility.
- **Supply needs-**Physical therapists are able to recommend supplies related to physical therapy treatments and those conditions requiring care from a physical therapist.
- **Home care or facility-based care needs-** Because they are highly skilled in determining the independence and safety of the evaluee in terms of physical mobility, physical therapists have valuable recommendations and

considerations for this area. Collaboration with occupational therapy and possibly neuropsychology is beneficial.

- **Projected routine future medical care-**Physical therapists would, in some cases have input in this area; however, would likely defer to physicians.
- **Projected surgical treatment or other aggressive medical care**- Physical therapists would, in most cases defer to physicians and surgeons.
- **Transportation needs-** Some physical therapists have advanced knowledge in this area. Occupational therapists typically are in these care roles.
- **Architectural renovations-** Physical therapists are able to provide a wide variety of recommendations in this category. Collaborating with a carpenter skilled in making home modifications, allows for the evaluee's needs to be matched with the ability of the home to be modified in such ways as to provide the necessary safety and independence.
- **Leisure or recreational equipment-** Many physical therapists are highly skilled in this area. Occupational and recreational therapists are as well.

While also following the methodology of consultation with the client's team and lead physician, physical therapists who are practicing as life care planners may consider projected therapeutic evaluations and modalities, wheelchair needs, orthopedic equipment needs, home furnishings and accessories, aids for independent functions, recreational equipment, durable medical supplies, transportation needs, architectural renovations and home care versus facility based care among the items and services that they can recommend when preparing a life care plan.

Conclusion

Many of the core components of a life care plan fall under the professional education, scope of practice, professional experience and domain of the physical therapist. As rehabilitation specialists, physical therapists focus on maximizing functional abilities of individuals with disabilities of all ages with the goal of restoring patients or clients to their maximum level of function, the basis for life care planning. Those life care planners in professions other than physical therapy, should consider consultation with a physical therapist in the areas involving functional mobility and physical independence. The process of evaluation and treating a patient has strong parallels to the methodology used in life care planning. Physical therapists are well prepared to make valuable contributions to the life care planning profession.

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Journal of Life Care Planning, Vol. 17, No. 1, (19-21)

What Life Care Planners Need to Know About the Professional Discipline of Physician Physiatrist

Stephen Mann

Abstract

Physical medicine and rehabilitation (PM&R), or physiatry, is a medical specialty focused on prevention, diagnosis, rehabilitation, and therapy for patients who experience functional limitations. These limitations can result from injury, disease, or malformation. This specialty is a relatively young one (with beginnings in the early twentieth century in the USA), but fundamentals of the field originated during ancient times. The greatest advances in the field of physical medicine and rehabilitation are directly related to improved care of injuries. There are numerous sub specialties in the field. These include spinal cord injury, traumatic brain injury, pain medicine, sports medicine, electrodiagnostic medicine, and pediatric rehabilitation to name a few.

History and development of this profession

Physical medicine and rehabilitation as a medical specialty began in the 1930s, but the concept of rehabilitation has been advanced for much longer. Exercises to prevent and treat problems were first described by Herodicus in the 5th century BCE. In the USA the first comprehensive rehabilitation facility is attributed to Franklin D. Roosevelt. Roosevelt contracted polio in 1921. He started rehabilitation at Warm Springs, GA. It was thought that therapeutic swimming and sun exposure were beneficial. He purchased land there and tuned it into a comprehensive rehabilitation center to help other patients afflicted with polio.

The person who is considered the founding father of the medical specialty was Dr. Knudson. He became interested in the mid-1930s in using physical modalities to treat disease after he himself contracted tuberculosis. Dr. Knudson was at Temple University at the time when he developed the concept of physical medicine and rehabilitation (PM&R) as a specialty. Dr. Knudson then went to the Mayo Clinic in Rochester, where he established the first department of physical medicine and rehabilitation 1936.

With the beginning of World War II, physical medicine and rehabilitation was necessary to treat the service members who sustained injuries in war. As the service members returned via ships from both the Europe and the South Pacific, the initial rehabilitation units were set up along the east and west coasts. Prior to WWII, the treatment of polio patients was consistent with the concepts of PM&R until the polio vaccine was developed in 1955 (Becker, 2018).

The major advances in the field of rehabilitation have been as a result of treating war injuries. For the first time during the Vietnam war, spinal cord injury patients survived their initial injuries. Hence was born the field of spinal cord medicine. The areas that have seen much development as a result of the wars in Afghanistan and the Middle East include traumatic brain injuries, amputations and prosthetics, and burn treatments (Watson Institute, 2018).

Other names by which this profession may be known

These physician specialists may be called physiatrists, physical medicine and rehabilitation physicians, or PM&R physicians.

Education to enter the profession

Training for physical medicine and rehabilitation typically begins with undergraduate studies that often include courses in organic and inorganic chemistry, physics, calculus, and biology. Most students applying to medical schools will take the required courses in a four-year program. The acceptance rate into medical schools are relatively low, ranging from 1.4% at the Mayo Clinic to 16.1% at the University of Puerto Rico. The average GPA in undergraduate studies ranged from 3.9 at the Mayo Clinic to 3.794 at lower ranking schools (BeMo Academic Consulting, 2018).

Most medical training consists of four years of medical school followed by a three year residency. The coursework of medical school includes anatomy, physiology, pathology and microbiology in the first two years. The last two years are spent in clinical rotations. Students are exposed to pediatrics, internal medicine, surgery, and OB-GYN. In the final year of medical school, students pick electives based upon their interests, which provides students a chance to spend more time in that area of medicine they wish to pursue.

It is noted that due to the shortage in primary care physicians, some medical school programs have designed three-year medical school programs. The other potential reason for this is widespread medical school debt. Currently, one-third of medical students owe $200,000 and a fifth owe between $100,00 and $150,000 (Association of American Medical Colleges, 2017).

Most residency programs in PM&R currently require a year of general internship during which the physician will be exposed to pediatrics, neurology, general surgery and OB-GYN. The usual physical medicine rehabilitation program lasts for three years, during which physicians spend time caring for patients with traumatic brain injury, spinal cord injuries, cerebrovascular accidents and other diagnoses that require time on the rehabilitation unit. In an outpatient practice, the physician will treat patients with amputations, chronic pain, traumatic brain injuries, and spinal cord

injuries. Residents will also receive training in electrodiagnostic studies.

Licensing or mandated certification requirements and authorizing entity that permits someone to practice in this profession

Medical licenses are issued and regulated by each state. There are currently 24 states and one territory and 31 medical and osteopathic boards in those states and territories that have reciprocity (Interstate Medical Licensure Compact, 2018). In order to obtain a license, one must submit documentation of completion of at least an internship and preferably a residency program. An applicant must also submit letters of recommendation and documentation verifying completion of an accredited medical school and passing the appropriate national boards.

State medical boards are in charge of policing physicians. Once a complaint is received, it is referred out to a physician case reviewer. The medical records are provided to that physician and the physician is given guidance as to what the questions are. If the reviewing physician believes that there was an issue of standard of care, the board will investigate further. If there has been a serious breach of practice, then the state board will take action against that practitioner. This may involve further continuing education, probationary period and in the most egregious cases, forfeiture of the physician's medical license.

Common specialty areas, roles, and credentials that can expand expertise and scope of contribution to life care plans

Specialty board certification is obtained through the American Academy of Physical Medicine and Rehabilitation. The first written examination occurs at the end of the residency program. Upon completion of the first year of practice, an oral examination is required. There is requirement of retaking tests every 10 years to maintain certification.

There are currently two organizations that certify physician life care planners. The International Commission on Healthcare Certification (ICHCC) is the main certifying body. Physician life care planners complete the same coursework and examination that all candidates do to obtain the Certified Life Care Planner (CLCP) designation. The obvious advantage for the physician in life care plan training is that training units dealing with medical issues require little extra learning. The physician life care planner is subject to the same rules regarding recertification as all other diplomats.

The American Academy of physician lifecare planners also certifies physicians for life care planning. They do not take the same coursework nor the same exams as diplomats of ICHCC. To date, this organization is not recognized as a specialization by the of American Board of Medical Specialties.

The kinds of patients and problems usually seen and addressed, and misconceptions about what this profession is, or can do, or cannot do

The major misconception about the professional specialty is exactly what we do. Disciplines that work with physical medicine and rehabilitation have no problems identifying what physiatry does but those who have no contact with PM&R have no idea exactly what this specialty does. Typically, an inpatient physiatry practice deals with traumatic brain injuries, spinal cord injuries, amputations, and polytrauma. The physiatrist is in charge of the team of ancillary disciplines (e.g., physical or occupational therapy) and handles the medical issues. Once the patient is discharged, the physiatrist will provide patient follow-up in the outpatient setting. Physical medicine and rehabilitation specialists follow the patients for years, until they relocate, pass away or the physician retires.

Other information important for life care planners to know

All PM&R training programs give the physician the ability to broadly opine in the life care plan. Physiatrists are educated to have a holistic and comprehensive approach caring for a patient and are trained to understand and anticipate many medical conditions, including those conditions where the actual treatment may be performed by a different physician specialist. While the physiatrist can comment on the patient's needs from other medical specialists, it is important that an effort be made to talk to other specialists personally to document what the needs are. Life care plans often come under intense scrutiny from opposing lawyers and there have been several cases where the life care planner has not survived a Daubert challenge because options are being offered that are beyond the scope of practice.

The advantage to using a physiatrist life care planning is discussed in Weed and Berens (2010), who indicate:

> Physicians specializing in physical medicine and rehabilitation (also known as physiatrists) are uniquely trained and qualified in the development and foundation of forward-looking life care plans. Physical medicine and rehabilitation is the medical specialty that focuses on patient long-term functional outcome following catastrophic injuries or illness (p. 18).

Conclusion

Physiatrists are experts in dealing with disabling, chronic illness and injury. This gives Physiatrists a unique role in lifecare planning. Since Physiatry deals with patients on a long-term basis, we know what to expect down the road with time. We are able to consider the normal aging process superimposed upon the residual of the injury. This experience allows physiatry to play a vital role in the development of life care plans.

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Journal of Life Care Planning, Vol. 17, No. 1, (23-29)

What Life Care Planners Need to Know About the Professional Discipline of Psychologist

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Abstract

Psychology covers a wide range of human activities across diverse settings and situations and it is important to understand both the capacities and limitations of the field. Psychological assessment can be a key component in the development of a life care plan, and subsequent psychological services, if integrated into the plan can help an individual adapt to and optimize their post-index event lives. Psychology constitutes much more than "talk therapy" and there are a variety of clinical, procedural and licensure issues that life care planners need to consider within the course of their work.

Keywords: Psychology, assessment, treatment, training, qualifications

History and development of this profession

Attributions regarding human behavior are likely as old as our species. Psychology, like many disciplines of scientific inquiry evolved from philosophy, religion and inquiry of body, mind and soul (Leahey, 2018). Many early recorded civilizations including Egyptians, Mesopotamians, Greeks, Romans, Chinese and Indians widely postulated about the nature of mind and behavior. Though many early explanations were based in supernatural and spiritual attributions, physiological bases of the mind were also a point of inquiry. Hence, there were formulations regarding mind-body interactions (i.e., dualism), considerations regarding nature vs. nurture, attempts to explain a variety of basic neurological impairments (seizures, stroke, neuropsychiatric dysfunction, etc.), and postulations regarding other then-considered aberrant behaviors. History is replete with multiple approaches to the treatment of physiological and behavioral manifestations. Thus, while trepanation, sequestration, bloodletting, asylums, exorcism, torture, death and abandonment occurred, meaningful productive activity engagement, early forms of psychotherapy, supportive communities, and association of behavioral manifestations to specific physiological / medical conditions were also present; oftentimes during similar epochs (Slater and Cantab, 2005).

Treatment and attributions regarding mental / behavioral dysfunction varied throughout the Middle Ages and into the early Renaissance, ranging from punitive to humanistic approaches. Tolerance, as well as the parameters regarding definitions of behavioral maladies often fluctuated with dynamic changes in social, religious, financial, cultural and monarchial orders.[1] For example, prior to the establishment of asylums, treatment, when available, was usually the providence of clergy, early permutations of "physicians," medical astrologers, traditional healers or, in some cases concerned community groups, though resources were generally sparse (Foerschner, 2010; MacDonald, 1981; Slater & Cantab, 2005).

Scientific inquiry gained increasing acceptance and technically evolved as the Renaissance progressed. Francis Bacon, physician and philosopher, who published *Novum Organum* in 1878, is considered an early proponent of the scientific method. John Locke and his contemporaries further promoted concepts of empiricism as valued means of investigation that allowed for more objective analyses (Schultz & Schultz, 2011). Still, diverse perspectives regarding the assessment and treatment of behavioral manifestations remained.

Many early scientific investigations focused on psychophysics, in part from expanding physiological investigations of the nervous system (Baker & Sperry, 2018). Sensation, perception, neural conduction, early brain localization and language were among topics studied by the likes of Bell, Magendie, Muller, Broca, Wernicke, Hitzig, Ferrier and Helmholtz (Wikipedia, 2018). In 1874, the German physician, Wilhelm Wundt published *Principles of Physiological Psychology*. He is frequently credited for inspiring modern psychology because of his strong advocacy for scientific investigation (Blumenthal, 1985). Scientific psychology laboratories began developing in the late 19th century in Europe, the United States and other countries, as did psychological associations. The American Psychological Association (APA) was established in 1892, along with other organizations at that time who represented more specific aspects of the field. By the beginning of the 21st century, there were well over 1,000 psychological associations, societies and organizations internationally (Pickren &

1 Notably, this still continues, though in a more structured manner, as per the periodical reformulation of the DSM – Diagnostic and Statistical Manual of the American Psychiatric Association (American Psychiatric Association, 2013). Concepts about acceptable and unacceptable behavior and social mores are dynamic and in continuing flux.

Fowler, 2003).

Some of the early psychology pioneers in the United States included Wundt's student Edward Titchner, who sought to describe the structure of the mind (structuralism) while at Cornell, William James, an early proponent of functional psychology at Harvard; G. Stanley Hall who focused on educational psychology at Johns Hopkins; James McKeen Cattel, mental measurements at the University of Pennsylvania; Edward Lee Thorndike, learning theory and education at Columbia University; John B. Watson, behaviorism, also at Columbia, among others (Baker & Sperry, 2018). Their efforts merged with psychologists internationally, helping to expand and diversify the field into conceptual areas such as structuralism, functionalism, behaviorism, gestalt, cognitive, comparative, developmental, neurobiological, psychodynamic, social, industrial, educational, statistical, neuropsychology, etc. (Buxton, 1985; Schultz & Schultz, 2011). Currently, the APA recognizes 54 different divisions of psychology, each addressing specific psychological approaches, treatment / evaluation focuses, or distinct populations (APA, 2018). Appendix A provides a list of these divisions.

Names by which this profession may be known

Definitions of psychology are as diverse as the field. According to the APA, "Psychology is the study of the mind and behavior. The discipline embraces all aspects of the human experience — from the functions of the brain to the actions of nations, from child development to care for the aged. In every conceivable setting from scientific research centers to mental healthcare services, 'the understanding of behavior' is the enterprise of psychologists." (American Psychological Association, 2011). Different schools of psychology also offer their own definitions. Perhaps more succinctly stated is a common internet definition that: "The purpose of psychology is to accurately describe, explain, predict and change human behavior and mental processes" (Reference.com, 2018).

According to the APA: "Psychologists have a doctoral degree in psychology from an organized, sequential program in a regionally accredited university or professional school." The APA generally refers to people with "masters-level positions as counselors, specialists, clinicians and so forth [rather than 'psychologists']" (American Psychological Association, 2011). However, state psychology licensure boards sometimes establish different parameters.

Education to enter the profession

In the United States, most states require a doctoral degree (PhD or PsyD) for psychology licensure. The exceptions, when they occur, are typically for school psychology, some forms of applied psychology and in sub-specialty roles such as an assistant, examiner or technician who is usually under the supervision of a fully licensed psychologist. Training and licensure procedures are similar in Canada, though licensure in one country does not confer licensure in the other (American Psychological Association, 2011). Additionally, the Canadian Psychological Association and the American Psychological Association (2017) signed an accord mutually recognizing the quality assurance of each other's psychology doctoral and internship programs.

Aspiring psychologists can enter graduate programs with a wide range of baccalaureate degrees. Unless the student is only seeking a terminal master's degree, most students will seek programs that allow their matriculation to a doctoral degree. Some programs require completion of a master's degree as part of this process, while others do not. Historically, psychologists earned PhD (Doctor of Philosophy) degrees that focus on both research and treatment. The PsyD (Doctor of Psychology) degree was introduced in the 1970's as an alternative for those more interested in providing psychological services (i.e., applying scientific knowledge of psychology) than in directly conducting research (Fowler and Michalski, 2016). However, there can be overlap between the two degrees, which are each accepted as "doctoral level."

Licensing or mandated certification requirements and authorizing entity that permits someone to practice in this profession

Psychology graduate school curricula vary and not all graduate degrees create psychologists who are eligible for licensure; an unfortunate awakening that some newly matriculated psychologists discover each year. Additionally, most states have different requirements and associated privileges of practice for licensure as a clinical vs. a school vs. an applied psychologist. Some states also have special designations for specialties such as neuropsychology and prescribing psychology. The type of licensure acquired substantially affects a psychologist's practice and scope of work. Though there may be minor variances across states for licensure qualification, the Commonwealth of Virginia offers a good example of general state psychology board expectations across different types of licenses (Virginia Board of Psychology, 2018) and is used in the following discussion.[2]

A person applying for licensure as a clinical psychologist must hold a doctorate from a regionally accredited university.[3] At least three academic years of full-time graduate study (or equivalent) are required in substantive

2. In part due to the principle author's domicile. Specific licensure requirements for other states can be obtained by querying "[name of state] psychology board" on an internet search engine.

3. This can involve accreditation by the APA in clinical or counseling psychology, or documentation that their program was within an institution of higher education accredited by an accrediting agency recognized by the United States Department of Education (USDOE) or the Association of Universities and Colleges of Canada (AUCC) as a member in good standing.

core content areas of: biological bases of behavior, cognitive-affective bases of behavior, social bases of behavior, psychological measurement, research methodology, techniques of data analysis and professional standards and ethics, individual differences in behavior, human development, dysfunctional behavior, theories and methods of intellectual assessment and diagnosis, theories and methods of personality assessment and diagnosis, and effective interventions and evaluating the efficacy of interventions. Comprehensive practicum experiences in assessment and diagnosis, psychotherapy, consultation and supervision are also required, along with 1,500 hours of supervised professional experience.

Individuals seeking applied psychology licensure have similar requirements for doctoral program completion. There are fewer core content areas (biological bases of behavior, cognitive-affective bases of behavior, social bases of behavior, psychological measurement, research methodology, techniques of data analysis, and professional standards and ethics) in addition to concentrated study in an affiliated area of psychology in place of practicum and supervision experiences.

School psychologist licensure requires a master's degree of at least 60 semester credit hours with slightly different program accreditations[4] and at least two full-time years of graduate study in core content areas of: psychological foundations, educational foundations, interventions / problem-solving, statistics and research methodologies, and professional school psychology. Required practicum experiences include: orientation to the educational process, assessment for intervention, direct intervention – including counseling and behavior management, and indirect intervention – including consultation.

States with additional licensure categories in neuropsychology, prescribing psychology, or other areas may have additional educational, training and experience requirements.

Approved applicants for licensure must then pass background checks, a state jurisprudence examination, the Examination for Professional Practice in Psychology (EPPP) and meet other requirements. All licensed psychologists are subsequently required to complete continuing education requirements on an annual or biannual basis and adhere to legal and ethical guidelines to sustain licensure. Most states only allow individuals who have completed these steps and remain in good standing to represent themselves as "psychologists" and provide their compensated services to the public. There are some exceptions for properly trained professionals working in selected situations, oftentimes at schools, in university teaching positions, in specific public hospitals, or programs, but these exceptions are becoming more limited over time. Furthermore, state psychology laws recognize that other licensed professionals may also be allowed to use selected psychological procedures, per the qualifications of their own professional state licensing boards.

Perhaps the biggest challenge for life care planners is understanding that psychology licensure occurs on a state by state basis. A psychologist typically has to be qualified, via licensure or other state approval, to provide services in the state where anticipated psychological services are requested. It is not unusual for the evaluee / client to travel to the psychologist's home state for an evaluation when the psychologist is not licensed in the evaluee's / client's home state. However, there may be situations where on-site psychological evaluation is required or where the psychologist is required to testify in court within the client's state.

Some, but not all states offer reciprocity and each inter-state compact may be different. A psychologist who is not licensed in a specific state might be permitted to provide services through a reciprocity agreement, or a state may allow licensed psychologists who are in good standing in their home state to practice on a time limited basis for a specific purpose, such as for evaluation or court testimony. Some states require specific application for such privileges, while other states do not if the services occur for a limited period. In other states, services by an out-of-state psychologist may require supervision by a psychologist so licensed there, or an in-state psychologist may be required to provide all case psychological opinions. The type of court and sometimes even individual judges might also determine testimony privileges for out-of-state psychologists. Though it is each psychologist's (and perhaps the retaining attorney's) responsibility to understand these requirements prior to case involvement, on more than one occasion, an unwary psychologist has been disqualified and may also face professional, criminal and civil penalties (Simon and Shuman, 1999).

Common specialty areas, roles, and credentials that can expand expertise and scope of contribution to life care plans

Psychology is not just "talk therapy," but covers broad areas of assessment, intervention, research, data analysis, program development and evaluation, education, artificial intelligence, assistive technology, statistics, environmental design, projective modeling, etc. Although there are always exceptions, life care planners are more likely to come into contact with some of the types of psychologists outlined

4 Accreditation by the APA, the National Council for Accreditation of Teacher Education, or the National Association of School Psychologists; or an institution of higher education accredited by an accrediting agency recognized by the USDOE, or the AUCC as a member in good standing.

below (Jacobs, 2018). These categories are not mutually exclusive. There can be overlap across categories and individual psychologists may also practice across several different areas.

1. Clinical psychologists address a broad spectrum of complicated human problems involving mental, emotional and behavioral disorders. They are often a first point of contact for the general public when seeking help to determine what types of problems exist and possible venues for treatment. Because of the diversity of human challenges, most clinical psychologists specialize in distinct areas. Some may provide primary screening and assessment of referring issues and then help direct the individual to more specific psychological services. Clinical psychologists may also specialize within areas of treatment according to symptomatic presentation, age groupings, methods of assessment, therapeutic approaches and techniques utilized, modes of delivery, venues for service provision, etc.

2. Clinical neuropsychologists have special training and expertise in understanding the relationships between brain and behavior, particularly as these relationships can be applied to the diagnosis of brain disorders, or in the assessment of cognitive and behavioral functioning. Neuropsychological evaluations are often used in cases of neurological trauma, such as brain injury; learning and developmental challenges; and to provide differential diagnoses, such as helping to determine if noted cognitive or behavioral changes might be attributable to psychiatric, neurological, or other impairments.

3. Behavioral psychologists analyze environmental factors and their functional relationships to behavior. Through empirical analysis, results can be used to help an individual optimize their capabilities and moderate dysfunctional, or problematic behaviors. Over the past decade many states have begun licensing behavior analysts, separately from psychology. Behavior analysts may have different training and focus than licensed psychologists with similar training and may focus more specifically on functional analyses of behavior, training, contingency management and environmental design.

4. Rehabilitation psychologists provide services on behalf of individuals with disabilities and to society through activities such as research, assessment, treatment, program development, teaching, public education, development of social policy, and advocacy. Some rehabilitation psychologists also provide clinical, behavioral or neuropsychological evaluations according to their training and credentialing while other rehabilitation psychologists may be more focused on treatment development, direct intervention and coordination of services.

5. Prescribing psychologists have specialized training in medicine and pharmacology and can prescribe selected medications for specific psychological / clinical issues. This relatively new specialty is currently only licensed in New Mexico, Louisiana, Illinois and Ohio. Additionally, trained psychologists may now be credentialed to prescribe in the U.S. Defense Department, the U.S. Public Health Service and the Indian Health Service. Each state or entity has different training and qualification requirements for prescribing psychologists and the scope of professional activities allowed also varies significantly across jurisdictions.

6. Developmental psychologists examine cognitive, social, and psychomotor development of individuals relative to their age-related peers. Developmental psychologists often evaluate children, and their findings may be useful following catastrophic events before adulthood to determine if the child is keeping up with peers or premorbid trajectories. However, developmental psychologists are also sometimes sought in adult cases to understand the client's psychological presentation relative to earlier developmental issues or to characterize a client's current psychological presentation relative to developmental templates.

7. Gerontological psychologists work primarily with older clients and are able to integrate behavioral, emotional, cognitive, social, familial, financial / resource, medical concerns, spiritual and cultural factors into assessment and treatment, as well as understand the pragmatics of available service delivery in the individual's community.

8. Psychodynamic / psychoanalytic psychologists incorporate the theories of Sigmund Freud, Alfred Adler, Harry Stack Sullivan, Karen Horney, Erik Erikson, and others. They typically focus on dynamic aspects of relationships presumed to originate in infancy and childhood. They may be retained in a case to provide an integrative description of a person's personality or to explain factors that may direct their conscious behavior.

9. Treatment by Other Disciplines: Some psychological techniques are also used by other professions, and, in fair play, psychologists use some procedures originated by other disciplines. This sometimes causes confusion, but it may sometimes open up additional treatment options. One of the broadest areas of professional overlap involves "counseling." There are many different approaches to counseling, including cognitive-behavior therapy, psychoanalysis, desensitization, immersion, motivational interviewing, goal-setting, dialectical behavior therapy, grief / trauma, psychodrama, etc. There are also other disciplines that offer effective counseling in specific areas according to the training, credentialing and experience of each individual therapist. This may include professional counselors, social workers, marriage and family therapists, motivational coaches, licensed mental health counselors, school counselors, substance abuse treatment practitioners, rehabilitation counselors, psychologists, etc. Similar overlap can occur in other areas, such as assessment. For example, a speech language pathologist may use some of the same assessment instruments as a neuropsychologist, though they may evaluate the findings in a different context.

Other information important for life care planners to know

In most situations, psychologists are oriented toward patient care and are generally familiar with the type of information that life care planners solicit, though they may need guidance in articulating these issues for a life care plan. Most psychologists also understand multidisciplinary treatment approaches, which can help them integrate their recommendations with other recommended supports and services (Jacobs, 2018). Additionally, those with a data-based or scientific focus may also be able to offer both qualitative and quantitative recommendations which can help to operationalize the dynamic basis of most life care plans.

Some variation in reporting may occur according to the psychologist's primary role; i.e., whether they have been providing direct treatment / evaluation of the evaluee for some period of time, or they have been retained as an expert in the case. The expert may be more likely to provide concise, empirical and needs based information – this is likely what they were retained to do, whereas some treating professionals with little knowledge about life care plans may benefit from some guidance regarding the goals of life care planning and clarification of their recommendations to expert standards. This is why it is important for the life care planner to have a good grasp of the evaluee prior to discussing the case with the psychologist, as well as explicit questions and areas of inquiry.

Understanding the psychologist's training, orientation, practice areas, specific areas of expertise and access to other professional and institutional resources are also important points of reference relative to their recommendations. Sometimes the match between psychologist and evaluee may be incongruent or incomplete and it may be necessary to suggest input from another psychologist.

It is also important that each psychologist establish their recommendations relative to their professional judgment of an evaluee's clinical lifetime needs rather than current medical insurance policy limits or other administrative guidelines; i.e., number of contractually or regulatory allowed visits, type of treatments allowed, duration of sessions, etc. On more than one occasion a treater has expressed that what the evaluee needs is different than what the evaluee's insurance is paying for. Because life care plans are needs based, it may be necessary to explain this to the treater.

The basis for the life care plan may also affect a professional's willingness to participate, especially if it involves forensic issues. Shahnasarian (2017) discusses issues of inhibition about participating in litigation-related consultations. Some treating professionals may be hesitant to get involved in a forensic case due to fear, discomfort or naiveté with legal processes; concern that the time involved will take away from other higher priority responsibilities, such as clinical treatment of other individuals; or due to prohibition of such participation by their employers. A candid discussion about the case and the importance of the professional's opinions may help in such situations.

While most psychological recommendations will come from psychologists or the associated professionals previously noted, other disciplines might also make psychology-based recommendations. Sometimes, physicians, nurse practitioners or other qualified experts / treaters may identify the need for psychological services in medical cases. Some may have specific recommendations. For example, there may be well researched psychological protocols for certain pain management treatment, pre-surgical assessments, addictions counseling, behavior management, etc. that are inherent in associated systematic service delivery. In other situations, such professionals may recognize the need for psychological intervention but not understand the nuances of what is specifically needed; e.g., "he needs counseling on an ongoing basis." Similarly, teachers or other educational specialists might make recommendations in pediatric or adolescent cases.

Ideally, these recommendations are correlated with more specific recommendations by a psychologist. However, sometimes these recommendations are independent of a psychologist's input, or no psychologist may be involved in the case. In such situations it is then especially for the life care planner to determine with these professionals if their psychological recommendations are within their professional scope of practice. If not, additional psychological input may be advised.

Life care planners should be aware of the characteristics of contacted psychologists or clinical groups when researching charges for psychological services. For example, when searching online or in referral databases, the life care planner might select an assortment of therapists without reference to professional certifications, areas of expertise, past treatment of similar issues and populations, etc. This information by itself may not only result in providers who cannot effectively address an evaluee's specific needs, but the research might also reflect inaccurate charges that are either too high or too low. All of these factors can hamper the evaluee's ability to actually access or benefit from treatment. As a result, it is important to query this information when surveying charges.

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Appendix I:
Divisions of the American Psychological Association

(Numeration for Divisions 4 and 11 are not currently assigned, but reserved for future use.)

1. Society for General Psychology
2. Society for the Teaching of Psychology
3. Society for Experimental Psychology and Cognitive Science
5. Quantitative and Qualitative Methods
6. Society for Behavioral Neuroscience and Comparative Psychology
7. Developmental Psychology
8. Society for Personality and Social Psychology
9. Society for the Psychological Study of Social Issues (SPSSI)
10. Society for the Psychology of Aesthetics, Creativity and the Arts
12. Society of Clinical Psychology
13. Society of Consulting Psychology
14. Society for Industrial and Organizational Psychology
15. Educational Psychology
16. School Psychology
17. Society of Counseling Psychology
18. Psychologists in Public Service
19. Society for Military Psychology
20. Adult Development and Aging
21. Applied Experimental and Engineering Psychology
22. Rehabilitation Psychology
23. Society for Consumer Psychology
24. Society for Theoretical and Philosophical Psychology
25. Behavior Analysis
26. Society for the History of Psychology
27. Society for Community Research and Action: Division of Community Psychology
28. Psychopharmacology and Substance Abuse
29. Society for the Advancement of Psychotherapy
30. Society of Psychological Hypnosis
31. State, Provincial and Territorial Psychological Association Affairs
32. Society for Humanistic Psychology
33. Intellectual and Developmental Disabilities / Autism Spectrum Disorder
34. Society for Environmental, Population and Conservation Psychology
35. Society for the Psychology of Women
36. Society for the Psychology of Religion and Spirituality
37. Society for Child and Family Policy and Practice
38. Society for Health Psychology
39. Psychoanalysis
40. Society for Clinical Neuropsychology
41. American Psychology-Law Society
42. Psychologists in Independent Practice
43. Society for Couple and Family Psychology
44. Society for the Psychology of Sexual Orientation and Gender Diversity
45. Society for the Psychological Study of Culture, Ethnicity and Race
46. Society for Media Psychology and Technology
47. Society for Sport, Exercise and Performance Psychology
48. Society for the Study of Peace, Conflict and Violence: Peace Psychology Division
49. Society of Group Psychology and Group Psychotherapy
50. Society of Addiction Psychology
51. Society for the Psychological Study of Men and Masculinities
52. International Psychology
53. Society of Clinical Child and Adolescent Psychology
54. Society of Pediatric Psychology
55. American Society for the Advancement of Pharmacotherapy
56. Trauma Psychology

Journal of Life Care Planning, Vol. 17, No. 1, (31-38)

What Life Care Planners Need to Know About the Professional Discipline of Registered Nurse

Ellen M. Carey
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Abstract

This article provides a framework for determining the qualifications of the registered nurse (RN) to make opinions regarding treatment recommendations in the development of a life care plan. A brief history of nursing and the current definition of nursing is provided. Education for the undergraduate prepared RN, graduate prepared masters or doctorate nurse, and advance practice nurse is discussed. Practice parameters including licensure, the Nurse Practice Act, scope of practice, standards of practice, standards of performance, code of ethics, and nursing diagnoses are reviewed. A decision-making framework is outlined to assist in evaluating whether nursing actions are within of the scope of nursing practice. Experience obtained through specialty roles, credentialing, and work experience are recognized as additional foundations of expertise. All these factors must be taken into consideration when evaluating whether the RN is qualified to opine in any area or category of a life care plan.

Keywords: Registered nurse, RN, Nursing education, Nurse Practice Act, Scope of nursing practice, Standards of performance, Nursing diagnoses, Specialty roles, Credentialing, Qualifications to opine, Life Care Plan

History and development of this profession

The roots of modern nursing began in the 19th century. Florence Nightingale provided a foundation for nursing and the basis for autonomous nursing practice as distinct from medicine (American Nurses Association, 2015). Nightingale demonstrated that education and use of scientific principles improved outcomes. She is credited with identifying the importance of collecting empirical evidence, the groundwork of nursing's current emphasis on evidence-based practice. Nightingale established the first nursing school in London which would become the model for nursing education in the United States (Black, 2014).

In North America, the need for nursing care during the Civil War opened the door for formal education and nurse training programs in the United States. By the late 19th century, hospital-based nursing schools were prevalent. In 1900, the first issue of the *American Journal of Nursing* was distributed. In 1901, the first state nurses' associations were organized to develop state laws to govern nursing practice (Historical Review, n.d.). Nursing research flourished with the advances in educational preparation in the early 1900s. The *American Journal of Nursing* published case studies on nursing interventions in the 1920s and 1930s (American Nurses Association, 2015). The World Wars resulted in another significant demand for nurses and many colleges and universities received funding at that time to develop nursing programs to help meet the nursing need (Black, 2014).

The American Nurses Association (ANA) developed a position paper in 1965 recommending baccalaureate education as the foundation for professional practice. Three levels of nursing were described: Baccalaureate education for beginning nursing practice, associate degree education for beginning technical nursing practice, and vocational education for assistants in the health service occupations (Black, 2014).

Hospital-based diploma nursing schools began to rapidly decline as more nursing programs were offered within community colleges and universities. With nursing education firmly anchored within the academic setting, the number of Master in Nursing and Doctorate Nursing programs grew. The first issue of *Nursing Research* was published in 1952 and in 1985 the National Center for Nursing Research was established within the National Institutes of Health (ANA, 2015). Nursing research continues to develop and expand the scientific basis for practice. The increasing complexity of healthcare has given rise to the development of many nursing specialties.

The American Nurses Association (2015) states that:

> Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations (p. 1).

Other names by which this profession may be known

The term professional nurse is often used interchangeably with registered nurse (RN). Other names are identified and discussed in the following sections discussing nursing education.

Education to enter the profession

Undergraduate nursing education provides a broad foundation in the behavioral, life, and nursing sciences for the general practice of nursing. Nursing education preparation for general practice includes the promotion of health, prevention of illness, and care of physically ill, mentally ill, and people with disabilities of all ages and in all

healthcare and other community settings. Nursing education prepares the nurse to carry out healthcare teaching, to be an active, participating member of the healthcare team, to supervise and train nursing and healthcare auxiliaries, and to be involved in research (International Council of Nurses. 2018).

Registered nurses play an integral role in the:

> [C]are coordination process to improve healthcare consumers' care quality and outcomes across patient populations and healthcare settings, while stewarding the efficient and effective use of healthcare resources… ….Patient-centered care coordination is a core professional standard and competency for all registered nursing practice…in partnership with other healthcare professionals, registered nurses have demonstrated leadership and innovation in the design, implementation, and evaluation of successful team-based care coordination processes and models (American Nurses Association Congress on Nursing Practice and Economics, 2012, p.1).

In the United States, there are three basic pathways for entry-level license to practice as a RN. Each involves training in clinical skills, nursing theories and practices including nursing assessment, nursing care planning and clinical reasoning. The pathways to become a RN are by diploma, associate degree, or baccalaureate degree in nursing. Each of these educational pathways is discussed below.

> The registered nurse is educationally prepared for competent practice at the entry level upon graduation from an accredited diploma, associate degree, baccalaureate, or master's degree nursing program and is qualified by national examination (National Council Licensure Examination for Registered Nurses, known as NCLEX-RN) for RN licensure (ANA. 2015, p.41).

Diploma in Nursing

While hospital-based diploma nursing programs are decreasing in number, they continue to exist. A diploma in nursing meets the current educational criteria for becoming an RN. The diploma program is usually a one to three-year course of study, depending upon the institution. The curriculum includes prerequisite courses, completion of which must occur prior to the start of nursing-specific coursework. Emphasis of the diploma curriculum is on patient care / clinical practice. Nursing-specific courses include: clinical practice, basic pharmacology, nursing informatics, elements of patient care, introduction to patient care specialties, psychiatric nursing, lifespan nursing concepts (e.g., infant, child, adult, family, geriatric), and psychology/sociology (Nursing School.Org. n.d.).

Associate's Degree in Nursing (ADN)

An associate degree in nursing is a two to three year undergraduate degree, typically provided by a community or technical college, as well as some baccalaureate degree granting colleges. Degree names may include Associate Degree in Nursing (ADN), Associate in Nursing (AN), or Associate of Science in Nursing (ASN) (Associate Degrees Online, 2018).

Educational curricula for an associate degree in nursing include: Anatomy / physiology, biology, pharmacology, microbiology, chemistry, nutrition, adult / family / pediatric mental health, community / global health, human growth and development, psychosocial aspects / psychology, ethics, evidence based practice / leadership, supervised training and clinical skills, and nursing theory and practice (Nursing School.Org. n.d.).

Bachelor of Science in Nursing (BSN)

A Bachelor of Science in Nursing (BSN) is a four-year baccalaureate degree obtained from a college or university program. The BSN provides the foundation for an advanced degree in nursing. Common names include Bachelor of Science in Nursing (BSN or BScN), Bachelor in Nursing (BN), Bachelor in Nursing Science (BNS) or Bachelor of Science (BS) in Nursing (All Acronyms 2005-2018). The BSN curriculum includes core /required components within any bachelor degrees including courses such as humanities, English, literature, history, math, and social sciences. In addition to the nursing courses listed above for the ADN program, the education curriculum for a BSN also includes: pathophysiology, statistics, genetics, ethics, healthcare delivery systems / interdisciplinary role, critical thinking, evidence based practice / research / statistics, nursing theory, nursing process, communication, and management / leadership (Auburn University, 2018, Nursing School.Org. n.d.; University of Pittsburgh, 2018). Several educational avenues exist to promote bridging academic progression to achieve the baccalaureate (BSN) degree or higher. Further information on accreditation of nursing education programs can be obtained by contacting the Commission on Collegiate Nursing Education (CCNE) at http://ccneaccreditation.org/ and the Accreditation Commission for Education in Nursing (ACEN) at http://www.acenursing.org/.

Graduate and Doctorate Nursing

Registered nurses with a master and doctoral-level of education may serve as primary care providers (see Advanced Practice Nursing below), researchers, and nursing faculty. They include Master of Science in Nursing (MSN), Doctor of Nursing Practice (DPN), Doctor of Philosophy (PhD), or Doctor of Nursing Science (DNS). Graduate level registered nurses "have advanced knowledge, skills, abilities, and judgement; as designated by elements of the nurse's position; and are not required to have additional regulatory oversight" (ANA, 2015, p.2).

Advanced Practice Registered Nurse (APRN)

Advanced practice registered nurses are RNs who have completed an accredited graduate level educational program and provide direct patient care. They are "prepared by education and certification to assess, diagnose, and manage patient problems, order tests, and prescribe medications" (National Council of State Boards of Nursing, 2018). Advanced practice nursing is regulated on a state-by-state basis. Licensing boards, governed by state regulations and statutes, define APRN practice within each state.

According to the ANA, the four recognized APRN roles include: certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM), clinical nurse specialists (CNS), and certified nurse practitioners (CNP). Within the CNP designation, there are several subspecialties including, but not limited to, family care, adult care, gerontology, pediatrics, psychiatric / mental health, and women's health within the primary and acute care settings (American Association of Nurse Practitioners, n.d.)

The subspecialty of CNS includes areas of specialties based upon a specific patient population served such as pediatrics, women's health, or geriatrics, a clinical setting such as critical care or emergency department, a disease/medical subspecialty such as diabetes or oncology, a type of care such as rehabilitation or psychiatric, or a specific type of problem such as pain management or wound care (National Council of Clinical Nurse Specialists, 2018).

Continuing Education

Each state board of nursing mandates its own continuing education (CE) requirements to maintain licensure. Continuing education requirements vary from state to state. More than two-thirds of states currently require some form of continuing education for re-licensure. Individual state requirements can be found at https://www.nurse.com/state-nurse-ce-requirements.

Licensing or mandated certification requirements and authorizing entity that permits someone to practice in this profession

Entry into nursing practice is by licensure. Registered nurses are licensed by a state, commonwealth, territory, government, or regulatory body to practice as a registered nurse (ANA, 2015). The Nursing Licensure Compact (NLC), originally adopted in 1997, is a reciprocity agreement among states that recognizes nursing licensure between member states. On January 19, 2018, the Enhanced Nursing Licensure Compact (eNLC) was implemented, allowing nurses licensed in one state to have the ability to practice in person or via telehealth in other states that are part of the agreement. The original NLC states were "grandfathered" into the eNLC if a multistate license was held on July 20, 2017. The National Council of State Boards of Nursing has established uniform licensure requirements for multistate licenses so that so that all nurses applying for licensure in a state that is part of the eNLC meet the same standards: graduation from a board-approved education program or an accredited international education verified by an independent credentials review agency; proof of English proficiency by exam if the international education program was not taught in English; having passed an NCLEX-RN exam, eligible for or holds an active, unencumbered license; has submitted to state and federal fingerprint-based criminal background checks, has not been found guilty, or has entered into an agreed disposition, of a felony offense, has no misdemeanor convictions related to the practice of nursing; is not currently a participant in an alternative program or must self-disclose participation in an alternative program; and has a valid US Social Security number (National Council of State Board of Nursing, 2018). A list of compact member states can be obtained at https://www.ncsbn.org/nurse-licensure-compact.htm.

Nurse Practice Act

"All states and territories legislated a nurse practice act (NPA) which establishes a board of nursing (BON) with the authority to develop administrative rules or regulations.... once enacted, rules and regulations have the full force and effect of law" (National Council of State Boards of Nursing, 2018.). While NPAs vary, they generally address: authority, power and composition of a board of nursing; education program standards; standards and scope of nursing practice; types of titles and licenses; requirements for licensure; and grounds for disciplinary action, other violations, and possible remedies (Russell, 2017).

Scope of Practice

The ANA's Nursing Scope and Standards of Practice describe the 'who, what, where, when, why, and how' of nursing practice (ANA, 2015). "Who" consists of RNs and APRNs who maintain active licensure. "What" is the definition of nursing, previously described. "Where" encompasses wherever there is a patient in need of care, information, or advocacy. "When" occurs whenever there is a need for nursing knowledge, caring, and leadership. The why of nursing is answered by the fact that the profession exists to achieve the most positive patient outcomes while keeping with nursing's social contract and obligation to society.

Standards of Practice

The Standards of Practice are published by the ANA. They define parameters of competence for all registered nurses, in any role, specialty, or area of focus. Competent nursing care utilizes a critical thinking model known as the nursing process which includes assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. The nursing process forms the foundation for making nursing decisions and taking action. It is recognized that the application of the standards must take into account

the context within which the RN duties are performed (ANA, 2015). It is also important to understand that many nurses engage in multidisciplinary roles that may have additional standards of practice. For example, the nurse life care planner would be held to the standards of nursing practice as well as those of the life care planner.

Standards of Performance

Standards of performance describe competent behavior for the professional nurse. The standards set expectations for nursing care to be delivered in an ethical manner with sensitivity and respect for the culture / religion of the individual or group. Other performance standards include effective communication, collaboration with team members, and leadership. The bar is set for the professional nurse to serve as an educator, utilize evidence-based practice and research, evaluate the effectiveness and quality of nursing practice, efficiently use resources, and to align nursing actions to support the health of our environment (ANA, 2015).

Code of Ethics

The *Code of Ethics for Nurses with Interpretive Statements* lists "provisions and accompanying interpretive statements that establish the ethical framework for registered nurses' practice across all roles, levels, and settings" (ANA, 2015, p. xi).

Nursing Diagnosis

Prior to 2002, NANDA was an acronym for the North American Nursing Diagnosis Association. Recognizing the growth of membership outside of North America, the name officially became NANDA International or NANDA-I. According to NANDA-I, a nursing diagnosis may address a specific health problem, target health promotion, or identify real or potential health risks. Clinical judgement is utilized to assess the human response to an illness, disease, or normal life process such as childbirth, childhood development, or aging. The nursing diagnosis identifies vulnerabilities of the individual, family, group, or community with the intention of proactively addressing these vulnerabilities to promote health and wellbeing. (Herdman and Kamitsuru, 2018).

Decision-Making Framework

In 2015, major nursing organizations collaborated to develop a "standardized, decision-making framework for all licensed nurses in all settings with respect to their education, role, function, and accountability within the scope of nursing practice" (Ballard, et al., 2016, p.19). The contributing nursing organizations included the American Association of Colleges of Nursing (AACN), the American Nurses Association (ANA), the American Organization of Nurse Executives (AONE), and the National League for Nursing (NLN), in collaboration with the National Council of State Boards of Nursing (NCSBN). The *Scope of Nursing Practice Decision-Making Framework* considers whether the nursing action taken is within the governing nurse practice act, applicable rules, regulations, or laws, and whether the action is consistent with evidence-based nursing and healthcare literature (Ballard et al., 2016). Additional considerations include: Does the practice setting have policies and procedures to support the activity? Has the nurse completed the necessary education to safely perform the activity and is there documented evidence of current competence to perform the activity? Does the nurse have appropriate resources available to perform the activity? Would a reasonable and prudent nurse perform this activity? And lastly, is the nurse prepared to accept accountability for the action and related outcomes (Ballard, et al, 2016)?

Common specialty areas, roles, and credentials that can expand expertise and scope of contribution to life care plans

In addition to academic degree and licensure, a RN can hold additional certifications and credentials. As RNs and APRNs practice in a particular field of nursing, they may pursue additional credentialing to achieve formal recognition of their specialized knowledge and experience. Specialty certifications are available through various organizations. Several of these are discussed below.

Life Care Planning

There are two avenues of certification for life care planning. The Certified Life Care Planner (CLCP), available through the International Commission on Health Care Certification (ICHCC), and the Certified Nurse Life Care Planner (CNLCP) available through the Nurse Life Care Planner Certification Board. The ICHCC also offers certification for Canadian Certified Life Care Planner (CCLCP). These certifications require a nurse to hold a valid, unrestricted nursing license, specialized education and training in life care planning, and field experience within the timelines set by each organization. The CLCP / CCLCP designation is not limited to RNs and is open to other qualified professionals. The CNLCP requires that the applicant be a RN.

Nursing Specialty Certification through the American Nurses Credentialing Center

The American Nurses Credentialing Center (ANCC) Certification Program is one of the largest organizations for nursing specialty certification in the United States. Credentials obtained through the ANCC are recognized by the International Organization for Standardization (ISO), an independent, non-governmental, worldwide federation that develops and publishes standards. As of October 2018, nursingworld.org, an official website of ANA and ANCC, lists 24 certifications available through the ANCC. Qualifying requirements, which include education, licensure, and clinical experience vary depending on the specialty

certification. The reader is referred to the website https://www.nursingworld.org/our-certifications/ for the complete list of specialty certifications available through ANCC and for information regarding the qualifying criteria for each specialty.

According to the ANCC 2017 Certification Renewal Requirements, renewal for all ANCC certifications is due every five years. Renewal requirements include mandatory 75 continuing education hours, plus one or more of the eight ANCC renewal categories, all in the certification specialty. The eight ANCC renewal categories include: continuing education hours in the certification specialty, academic credits, presentations, evidence-based practice/quality improvement project /publication or research, preceptor hours, professional service, practice hours, and assessment/exam. Additionally, the APRN, CNS, and NP must complete 25 continuing education hours of pharmacotherapeutics as a portion of the mandatory 75 continuing education hours. (ANCC, June, 2016).

Additional specialty certifications (other than those offered through ANCC)

Information regarding specialty certifications accredited by organizations other than the ANCC can be found at https://www.nursingcenter.com/career/guideto-certification. Additional certifications are available through a variety of professional organizations. It is important to verify the credibility of the certifying body. The ANA publishes a list of recognized national, state, and international nursing organizations which may be a helpful starting point in assessing the credibility of a certifying body. This list is available online at https://nurse.org/orgs.html. Some of the non ANCC specialty certifications commonly held in conjunction with the life care planning certification are listed below.

The Certified Rehabilitation Registered Nurse (CRRN) credential is administered by the Rehabilitation Nursing Certification Board (RNCB), an autonomous component of Association of Rehabilitation Nurses. Nurses with the CRRN credential often work within inpatient or outpatient rehabilitation centers. The CRRN demonstrates a commitment to excellence in caring for people with physical disabilities and chronic illnesses, rehabilitation, and restorative nursing. More information can be found at https://rehabnurse.org/crrn-certification/crrn-certification.

The legal nurse consultant is a licensed RN who performs a critical analysis of healthcare related issues in a variety of settings in the legal arena. Examples may include assisting attorneys and/or insurers with cases involving potential medical negligence, personal injury or workers compensation injuries, medical cost projections, trial witness preparation, and to facilitate communication with medical providers. The American Association of Legal Nurse Consultants (AALNC) offers the designation of Legal Nurse Consultant Certified (LNCC). More information can be found at http://lncc.aalnc.org/

Another option for certification in legal nursing includes The American Institute of Health Care Professionals (AIHCP) which offers the designation of Certified Specialists in Legal Nurse Consulting (LNC-CSp) through the American College of Legal Nurse Consulting (ACLNC). More information can be found at https://www.aihcp.org/

The Certified Case Manager (CCM) certification is offered through the Commission for Case Manager Certification (CCMC). The CCM designation is not limited to nurses. Individuals with a baccalaureate or masters' degree from an accredited institution in health or human services or who hold a qualifying certification, such as Certified Rehabilitation Counselor, are eligible. For more information refer to https://ccmcertification.org/.

Another option for case management certification is Nursing Case Management Certification RN-BC. This is one of the 24 ANCC specialty certifications previously discussed. We specifically mention this particular ANCC certification within the context of options for case management credentialing. Case managers focus on managing components of healthcare with the goal of quality care outcomes and financial appropriateness. Case managers are often utilized by workers' compensation insurers, health insurance companies, and utilization review in healthcare facilities.

The Medicare Set-Aside Certified Consultant credential is available to, but not limited to, registered nurses. Certification is obtained through the International Commission for Health Care Certification (ICHCC). Qualifications are based on career experience, including but not limited to case management for workers' compensation, work injuries, legal or insurance claim management, or rehabilitation case management. To obtain the MSCC credential, professionals must complete approved training and demonstrate knowledge regarding the Medicare set-aside process. Further information can be obtained at https://www.ichcc.org/medicare-set-aside-certified-consultant-mscc.html. The MSCC plays an important role in assisting compliance with the federal mandate to protect Medicare's interest with regard to settlement of future medical expenses in workers' compensation and third party liability.

Information a life care planner who comes from this profession should include in a resume or CV to support the ability to make future care recommendations and information to understand the scope of practice, independence, or limitations of the profession

The resume or curriculum vitae (CV) should provide a summary of education and degree(s), unique skills, generalized and specialized knowledge, and experience. In addition to the above, the nurse life care planner's resume or CV should demonstrate her RN licensure and jurisdiction, certifications, work experience including specialty practice

experience (including the role and practice setting), forensic experience, continuing education, articles written, research conducted, and relevant volunteer/service experience. Specialty training and certification expands a nurse's scope and ability. The resume or CV should also identify membership in professional organizations which reflect commitment to the profession(s). This information establishes one's qualifications and areas of expertise.

Differences between Canadian and U.S. practitioners in this profession

The Canadian Nurses Association's (CNA) is the national professional organization for RNs in Canada. The *Framework for the Practice of Registered Nurses in Canada*, (CNA, 2015) states the nursing profession consists of four regulated nursing groups: Registered nurses; nurse practitioners (NPs); licensed practical nurses (LPNs); and registered psychiatric nurses. In Canada, regulation of RNs is specifically defined in jurisdictional legislation developed by provincial and territorial regulatory bodies (CNA, 2015).

Similar to the United States, basic nursing education in Canada has shifted away from diploma programs. Because this shift started in the late 1990s, currently both diploma-prepared and baccalaureate prepared RNs continue to practice in Canada. According to the CNA (2015), all Canadian provinces and territories, except Quebec, require a bachelor's degree for new RN entry to practice. Additionally, nurses must successfully pass the registration exam to practice in all Canadian Provinces and territories, except Quebec which has its own licensure exam (CNA, 2015).

The CNA offers RN certification in 21 nursing practice specialties. Each specialty has a national association which collectively forms CNA's Canadian Network of Nursing Specialties (CNA, 2018). For nurses interested in obtaining certification as a life care planner in Canada, the Certified Canadian Life Care Planner (CCLCP) credential is available through the International Commission on Health Care Certification (ICHCC) as discussed previously.

Other information important for life care planners to know

The building blocks for the nurse's scope of knowledge have been outlined in this article. Education, licensure, scope of practice, standards of performance, the nursing process, nursing diagnoses, additional specialty credentialing, continuing education, work experience, articles written, and research conducted provide foundational expertise for professional nursing practice and can be readily applied to the development a life care plan. The RN's qualifications to make opinions within areas or categories commonly included within a life care plan are considered to be either independent opinions, collaborative contribution to opinions, or unable/unqualified to opine.

We define independent opinions based on the undergraduate preparation for RN licensure. Independent opinions within the life care plan are opinions made either within the nursing scope of knowledge, personal experience gained through practice, consistent with evidence-based guidelines, or based on information established within in the medical record. Three examples of independent opinions for inclusion in the life care plan are: 1) laboratory studies such as complete blood count (CBC) or comprehensive metabolic panel (CMP), or a liver function test (LFT) to evaluate potential side effects of known medication use, consistent with evidence based practice; 2) inclusion of necessary supplies for urinary catheterization, when the procedure is medically indicated; or 3) follow-up visits with a physician / provider when the medical record reflects a historical pattern or a specific recommendation stated in the record. It is noted that Advance Practice Nurses have expanded scope and abilities which may result in additional qualifications to make independent opinions.

Collaboration with appropriate team members is one of the ANA's Standards of Performance for the professional nurse. The RN is expected to utilize clinical judgment to independently identify care needs (nursing diagnoses) and effectively communicate this assessment with other disciplines / providers to collaboratively plan and implement appropriate interventions. Therefore, we believe that the RN is qualified to make collaborative contribution to opinions for the majority of the areas or categories within the life care plan. An example of a qualified collaborative opinion includes impaired mobility. While a RN is independently qualified to recommend a basic, standard wheelchair, the RN may also assess that the individual's needs would be better met by a specialized, custom wheelchair. The RN would then collaborate with a medical provider with prescriptive authority to prescribe a custom wheelchair and collaborate with a qualified physical therapist or occupational therapist to obtain a therapeutic evaluation to determine the specific components of a specialized, custom wheelchair.

Unable to opine indicates that the treatment or service recommended within the life care plan is outside the independent or collaborative scope of the RN. Examples, within a life care plan, where a RN is unable to opine include recommendations for surgery and aggressive or invasive procedures. The undergraduate-prepared RN is unqualified to opine regarding drugs that require a prescription, though an APRN may be qualified to do so.

A life care plan is intended to provide a comprehensive analysis of projected future healthcare needs. When a RN is unable to opine on a particular treatment or service, this service or treatment is included in the life care plan when medical foundation has been established by other qualified medical providers.

Conclusion

The education, scope of knowledge, and skills of the undergraduate prepared RN transfer readily and are easily applied to the field of life care planning. Registered nurses

are knowledgeable of the healthcare delivery system, the availability of healthcare professionals including specialists, as well as community and national resources. Registered nurses have direct, clinically based knowledge of high-risk populations of all ages, from neonatal to elderly individuals, who have complex health needs, multiple comorbidities, and chronic illness.

Given the complexities and specialization within healthcare, advanced nursing degrees that formally recognize expertise in a subspecialty area, licensure, nurse practice acts by jurisdiction, the variety of specialty credentials available, and differences in work experience, it is important to recognize that the RN's qualifications to opine within a life care plan will vary depending upon the individual. All of these factors must be taken into consideration when evaluating whether the RN is qualified to opine in any area or category of a life care plan.

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Journal of Life Care Planning, Vol. 17, No. 1, (39-44)

What Life Care Planners Need to Know About the Professional Discipline of Rehabilitation Counselors

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Abstract

The specialty practice of life care planning was originally begun by a rehabilitation counselor and includes vocation as an essential life domain. Rehabilitation counseling has historically, and still is today, a profession that focuses on providing the highest degree of community, vocational, recreational, and independent functioning possible. The primary credential that identifies a rehabilitation counselor is the Certified Rehabilitation Counselor (CRC) certification which can be commonly misunderstood as strictly a vocational support profession. Rehabilitation Counselors who also coordinate life care plans have the expertise to not only provide input for the vocational aspects of the plan, but the ability to coordinate care and assist in building independence.

History and development of this profession

The genesis of life care planning occurred within the rehabilitation counseling discipline. The first mention of a "life care plan" was in Deutsch & Raffa's *Damages in Tort Actions* in 1981 (Pomeranz, Yu, & Robinson, 2014), although there is clear evidence that rehabilitation counselors were using some of the main principles now common to the standard methodology of life care planning decades earlier (McGowan & Porter, 1967). The lead author of the aforementioned book, Paul M. Deutsch. Ph.D. was a certified rehabilitation counselor who is credited as the founder of the field of life care planning and did so out of applying the principles of rehabilitation counseling already in use in the field for many years. Although the practice of life care planning began in the early 1980's, by the time standards of the profession were being established in 1992 (Weed & Berens, 2010), the American health care system was "undergoing one of its periodic structural transitions" (Friedman, 1996) where competition and profit-driven managed care was seeking new ways to cut costs for medical care, often at the expense of quality. As the health care system became more complicated and patient advocacy continued to require more guidance in times of illness or disability, the need to understand the patient experience from a holistic perspective grew.

The vocational life of citizens as an important part of individual and social health has been clear since the early days of rehabilitation. While the history of disability rights in America can be traced back to the mid-18th century, the vocational contributions relevant to life care planning can be greatly attributed to the post-WWII recognition of the importance of rehabilitation medicine (Rubin & Roessler, 2008). The growth of vocational rehabilitation between the years of 1954 and 1972 are considered to be the "Golden Era" of rehabilitation in the United States (Rubin & Roessler, 2008). During this era, federal funding for vocational rehabilitation and advocacy by consumer rights groups established the need for vocation in rehabilitation planning after illness or injury. In particular, the Rehabilitation Services Administration was established via The Rehabilitation Act of 1973. It was also at this time (1972) that the Council On Rehabilitation Education (CORE) was established to accredit training programs in rehabilitation counseling (Linkowski & Szymanski, 1993). In the years following, an increase in rehabilitation counseling training programs and greater establishment of a profession that provides vocational assistance to people with disabilities became a mainstay in communities across the United States.

Much of the Golden Era of rehabilitation drove public provisions of rehabilitation services, but it was during the early 1980's, right at the time that life care planning was born, that proprietary vocational rehabilitation emerged in the private sector. Many states began requiring vocational rehabilitation counseling for injured workers through a compensation system.

> While cost efficiency is not a primary concern for the public sector, where rehabilitation is viewed as an entitlement for those who receive it, it is critical to the insurance executive, the actuary, the underwriter, and the employer who must arrange the premiums and assign or pay the cost of coverage. (Dunn, 2017, p. 94)

By the early 1990's when the standards of a life care planning methodology and practice were being established, proprietary vocational rehabilitation was at its peak (Dunn, 2017). By this time, the role of achieving maximum vocational potential was considered an essential to life, liberty, and the pursuit of happiness among all people, including those with severe disabilities. The need to provide rehabilitation services, coupled with the changes in health care spending to control costs, further clarified the need to understand the services and costs of people who live with illness or injury. Thus, the role of the rehabilitation counselor in life care planning provides a valuable contribution to the life care planning process, not just to establish a single line-item need for vocational services, but assessing the range of

services a person may need.

Other names by which this profession may be known

Rehabilitation counseling is commonly misunderstood by the general public as being related to either substance abuse or occupational therapy, however specific vocational expertise positions rehabilitation counselors to provide vocational assistance to people with disabilities. Just like a "doctor" is a general term for a specific type of doctor, such as a psychiatrist or physiatrist, a rehabilitation counselor may work under different titles. Some of these titles include: vocational expert, vocational consultant, rehabilitation case manager, forensic vocational counselor, rehabilitation specialist, and/or vocational placement specialist. These titles generally refer to the counselor's specialty area. A vocational expert or forensic vocational counselor typically will specialize in legal reporting of one's earning potential (or capacity), availability of a person with a disability to be employable given medical restrictions, or matching individuals with disabilities in a given economic area. A rehabilitation case manager or vocational placement specialist may specialize in specifically matching individuals with disabilities to employers or other community services related to vocation, avocation, or personal independence.

Education to enter the profession

Rehabilitation counselors receive education and training concerning the medical and psychosocial aspects of disability, assistive technology, and a myriad of other topics designed to maximize the abilities of people with disabilities. The Commission on Rehabilitation Counselor Certification (CRCC) administers the certification examination for the Certified Rehabilitation Counselor (CRC) credential and is the oldest (1975) independently accredited, non-profit credential among others in the field (Albee, Gamez & Johnson, 2017). While it is the most common in the field of rehabilitation counseling and most counselors acquire it, this is changing. In some states, master's degrees are not required to work at state vocational rehabilitation programs and there may be more people who use the title of Rehabilitation Counselor who are not certified or academically trained in vocational potential or disability-related issues. While it is not required to hold a CRC certification in order to practice as a life care planner, some of the credibility of the vocational counselor is established by maintaining the CRC designation. Unlike state licensing bodies which regulate the practice of certain professions within states, the CRC holds its value by the standards through which vocational and disability-related content are held in training and practice (Leahy, Chan & Saunders, 2003; Leahy, Muenzen, Saunders & Strauser, 2009). Specifically, an examination is required to demonstrate knowledge and competency in the educational content areas described below, and counselors are required to continue their education in order to maintain a valid credential. Some states recognize the CRC exam as comparable to the National Counselor Exam (NCE), which is the exam required for general counseling licensure, while others do not. What is important to know about the CRC certification is that while it is not required to practice as a rehabilitation counselor or life care planner, it does establish basic competency and a commitment to continued education in vocational and disability-related issues.

Related to the issue of basic competency and credibility, there are rehabilitation undergraduate majors focused on similar issues of disability and work, but the programs are not accredited and the students are not eligible for a CRC or state licensure. Given the level of expertise and specific roles of a life care planner, these authors would hope that misrepresentation would not occur, however the title of rehabilitation counselor can be interpreted widely and may include counselors with varying degrees of credibility.

Currently 76% of CRC certified counselors have graduated from a rehabilitation counseling program focusing on the specialized knowledge of disability and work according to a 2008 study conducted by the Commission on Rehabilitation Counselor Certification (CRCC, 2008c). In that same study, it is reported that 92% of the field holds master's degrees and 8% hold doctoral level degrees. The master's degree is known as the terminal degree, which is the highest level of education required to practice as a counselor. The majority of doctoral level degrees focus on education of counselors and research. All of these counselors are trained in the same base training requirements regarding disability and vocation.

Contained within the CRC Examination Knowledge Domains are subjects of particular importance to the practice of life care planning. Those domains include: medical and psychosocial aspects of chronic illness and disability; assessment, occupational analysis, and service implementation; career development and job placement; community resources and partnerships; case management and health care and disability management (CRCC, 2018a).

Similarly, the CRC Scope of Practice statement identifies "specific techniques and modalities utilized within" the rehabilitation counseling profession, including: assessment and appraisal; case management, referral, and service coordination; interventions to remove environmental, employment, and attitudinal barriers, consultation services among multiple parties and regulatory systems, job analysis, job development, and placement services, including assistance with employment and job accommodations; and provision of consultation about and access to rehabilitation technology (CRC Scope of Practice, 2018b).

The field of rehabilitation counseling is currently going through a transition of accrediting bodies, which changes the educational content required for graduation. The Council on Rehabilitation Education (CORE) has been the foremost accrediting body for the field of rehabilitation counseling. Recently some programs have chosen the option to be dually accredited by the Council for Accreditation of Counseling

and Related Education Programs (CACREP). The primary differences for the purposes of identifying the training requirements for counselors are course content requirements and licensure/certification options post-graduation.

For those programs not choosing to seek CACREP accreditation, they will primarily be offering what is considered a "traditional" vocational counselor training. These students will be CRC eligible following a 48 credit-hour program with a 700-hour clinical experience element. These requirements will be the same as they always have been for CORE accredited programs. Any counselor graduating with a master's degree in Rehabilitation Counseling prior to 2013 will have met these requirements. Students will have covered the following curriculum knowledge domains: professional identity and ethical behavior; psychosocial aspects of disability and cultural diversity; human growth and development; employment and career development; counseling approaches and principles; group work and family dynamics; assessment; research and program evaluation; medical, functional, and environmental aspects of disability; rehabilitation services, case management, and related services; and, clinical experience (CORE Standards, 2018).

Although these students will have a clinical experience following course work, they are not awarded the degree of clinical rehabilitation counselor unless they complete a CACREP accredited program requiring 60 credit-hours and 700 hours of clinical experience. This clinical designation loosely refers to training in more mental-health specific content, not just relating to disability or vocation. Students graduating from a CACREP program have the option of maintaining an identity of rehabilitation counselor and are eligible for the CRC; however, they are also eligible for state mental health licensure. (See common specialties areas below for more on state licensure.) Many of the knowledge domains are, for practical purposes, are the same except for an additional focus on mental health diagnosis and substance abuse. A similar focus on identity, ethics, theory, medical aspects, assessment, roles and scope of practice, service delivery, independent living, psychopharmacology, family services, assistive technology, work and employment, cultural factors, and advocacy exist in the CACREP standards (CACREP, 2015). In addition to this, CACREP requires that all training programs require students to take courses with the following foundational content areas that are directly related to life care planning: a) social science theory that addresses the psychosocial aspects of disability, b) principles, models, and documentation formats of biopsychosocial case conceptualization and treatment planning, c) neurobiological and medical foundation and etiology of addiction and co-occuring disorders, d) etiology and effects of disabilities and terminology relevant to clinical rehabilitation counseling, e) and, screening and assessment instruments that are reliable and valid for individuals with disabilities (CACREP, 2016). For a full review of contextual dimensions and practice requirements of education and training programs, the most recent copy of CACREP standards can be found at https://www.cacrep.org/for-programs/2016-cacrep-standards/. Given the differences in course titles it is not possible to list the specific courses that rehabilitation counselors take in order to be qualified to write life care plans, however any program that trained a counselor and is CORE or CACREP accredited will have covered the appropriate foundational medical and psychosocial elements necessary for life care planning. The specific pre and post-graduate experiences of the counselor will provide more insight into their specific preparedness and qualification for life care planning.

A general take-away is that rehabilitation counselors are specially trained to understand how disabilities affect an individual's vocational and psychosocial life. They are trained in social and legal issues affecting those with disabilities and are most uniquely trained to assess vocational aspects of disability. However, given the differences among a state's vocational rehabilitation educational requirements and individual state's mental health licensing requirements, counselors may be less or more qualified in any of these areas. Counselors have an ethical responsibility to properly represent their credentials and experience (CRCC Code of Ethics, 2017, D.4).

Common specialty areas, roles, and credentials that can expand expertise and scope of contribution to life care plans

The most common credential in the field is the Certified Rehabilitation Counselor (CRC), which has already been discussed. Some counselors choose to acquire other certifications such as Vocational Rehabilitation Expert (VRE), Certified Disability Management Specialist (CDMS), American Board of Vocational Experts (ABVE), International Psychometric Evaluation Certification (IPEC), Certified Vocational Evaluator (CVE), Certified Case Manager (CCM), and others. This is by no means a complete list.

In addition to vocational and disability specific credentials, many counselors seek licensure as a mental health counselor. Mental health licenses are regulated and issued at the state level and the most common across the country are the Licensed Professional Counselor (LPC), Licensed Professional Clinical Counselor (LPCC), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Mental Health Counselor (LMHC), and Licensed Clinical Professional Counselor (LCPC). In addition to these common licenses, some counselors choose to represent themselves with the designation of NBCC as a National Board Certified Counselor or NCE as someone who has passed the National Counselor Examination. These are not licenses to practice but they are credentials that represent competency in the counseling profession. A complete list of counseling requirements by state can be found at

www.counseling.org/knowledge-center/licensure-requirements.

Misconceptions about what this profession is, or can do, or cannot do

Some of the most common misconceptions about the profession are related to its name. The general public is typically not well-versed in the specific role of a rehabilitation counselor and assumes it is either something regarding substance abuse or just like occupational therapy. Even among other helping professionals or social service providers, there is often a lack of clarity of the specific niche that rehabilitation counselors fill. There are some cross-over skills that rehabilitation counselors share with other professions, but the unique niche involves an understanding of the vocational needs of individuals with disabilities and how that matches with the employment needs of specific labor markets. More specifically, rehabilitation counselors specialize in identifying how an individual's abilities match up with a specific job's requirements. Professionals may choose to specialize further in a specific disability or a work for a specific funding source, but the general rule of job-matching applies.

Another misconception is that rehabilitation counselors are not able to adequately author life care plans due to the emphasis on medical knowledge. While the educational standards of training programs are addressed above, it is worth noting here that the Standards of Practice for Life Care Planners 3rd edition (International Academy of Life Care Planners, 2015) requires that the Life Care Plan author only make recommendations within their professional scope of practice. All other recommendations must be drawn from other qualified professionals or authoritative sources. Thus, the Life Care Planner may use skills from developing medical treatment plans, nursing care plans, therapy plans or rehabilitation plans to develop a comprehensive program addressing the constellation of needs the recipient requires over the remaining lifespan. Case management, health care management and counseling skills are useful in coordinating the recommendations of the various disciplines and integrating them into a single document. While rehabilitation counselors must demonstrate adequate training and experience to be able to offer credible opinions, this is not unlike any other professional offering their perspective in a life care plan.

Differences between Canadian and U.S. practitioners in this profession

The Canadian certification equivalent to the CRC in the United States is the Canadian Certified Rehabilitation Counselor (CCRC). For practical purposes, they share much of the same requirements for certification. "The profession of rehabilitation counseling within Canada shares a common scope of practice, theoretical foundation, and roles and functions validated through empirical evidence" (Riggar & Maki, 2004, p. 87). While the role of the counselors may be similar, training requirements are a bit different. Canadian Counselors do not emphasize the same mental health requirements as their U.S. counterparts, specifically "group counseling, family counseling, and school-to-work transition" (Riggar & Maki, 2008, p. 86). Also, the differing governmental organization and health care policy means that Canadians view the provision of health care differently than the U.S.

The CCRC is the most common certification for vocational counselors in Canada, however further specialization can be obtained through several other designations. A certified Vocational Evaluator (CVE) is a bachelor's level certification that is obtained through a written examination and adherence to a code of ethics and requires continuing education. The Canadian Certified Counselor (CCC) is a master's level also requires adherence to a code of ethics and requires continuing education. Another more general designation, the Registered Rehabilitation Professional (RRP), can be obtained through evidenced course work, a bachelor's degree, and letters of reference. It is likely that the most common credentials encountered by life care planners are the CCRC and CCC, in addition, of course, to the Canadian Certified Life Care Planner which is accredited by the International Commission on Health Care Certification (ICHCC) located in the U.S. and follows the same experiential and training requirements.

Other information important for life care planners to know

The primary contribution of rehabilitation counseling to the life care plan may appear to be the specific expertise related a patient's vocational life post-injury or illness. However, rehabilitation counselors have served a crucial role in identifying an individual's ability to work and find meaning while living with illness or injury as well as the identification and coordination of services and needs for individuals with injury and disability. While the vocational expertise of rehabilitation counselors certainly aids in development of future vocational potential in a life care plan, they also assess for a range of services a person may need. Given the specific training of rehabilitation counselors in disability related issues, they are uniquely positioned to intimately know outcomes of disability in terms of psychological adjustment and vocational potential.

A 2009 research study queried 648 CRC certificants to identify essential knowledge domains for rehabilitation counselors finding that many of the subdomains identified were directly applicable to life care planning, including: Individual and family adjustment to disability; Psychosocial and cultural impact of disability on the individual; Psychosocial and cultural impact of disability on the family; Attitudinal barriers for individuals with disabilities; Interpretation of assessment results for rehabilitation planning purposes; Assistive technology; Vocational

implications of functional limitations; Case management process, including rehabilitation planning, service coordination, and referral to and collaboration with other disciplines; Techniques for working effectively in teams and across disciplines; Medical aspects and implication of various disabilities; Function capacities of individuals with physical, psychiatric, and/or cognitive disabilities; and Environmental barriers for individuals with disabilities (Leahy, Muenzen, Saunders & Strauser, 2009). Whatever the professional discipline of the author of the life care plan, many sections of the life care plan may be out of the scope of practice of the practitioner, therefore, collaboration with other allied health professions is required to develop a comprehensive life care plan (International Academy of Life Care Planners, 2015; Robinson, 2014).

Rehabilitation counseling education, training and certification requirements, discussed above, demonstrate the value and wide range of input the rehabilitation counselor can make to the life care plan. The rehabilitation counselor determines whether the subject of the life care plan would have the ability to perform any type of work activity or if they lack such ability. If work is possible, the rehabilitation counselor must determine what types of work would be functionally appropriate. Vocational services such as counseling, training, training supplies and expenses, assistive technology, transportation, and vocational support services must be described along with cost, frequency, and duration of such items (Berens & Weed, 2009).

If a successful employment outcome is anticipated or realized, services to support continued employment must be assessed and provided for in the life care plan. Impairment-related work expenses will vary greatly depending upon the needs of the individual but can include: Employment-related attendant care services, readers for those with visual impairments or interpreters for those with hearing loss, work-related medical devices, technology or prosthetics; modification of the work space, a service animal and/or transportation costs (Blackwell, Powers, & Weed, 1994.) A study of vocational outcomes for individuals after brain injury for whom a life care plan was developed, found 52% were employed in supported, transitional, school, training, or direct employment, with 20.5% stably employed. The authors cautioned, "there are clear implications for life care planners not to forget their commitment to vocational rehabilitation in plan development" (Deutsch, Kendall, Daninhirsch, Cimino-Ferguson & McCollom, 2006, p. 312.

Conclusion

This article has provided an explanation of the history of rehabilitation counseling and how it is recognized today internationally in the U.S. and Canada through training and certification. The goal of this article is to help explain what rehabilitation counseling is, what certifications counselors hold and their purpose, the educational requirements and training foundations of the profession, and, most importantly, how vocational counseling is essential to a complete life care plan. Many people view work as part of their identity and when that identity is altered due to disability, perceptions of self-worth may be diminished, quality of life may decline, and negative effects on life expectancy may result (Robinson, 2014). For people with disabilities, loss of employment and lack of employment opportunities prevents them from obtaining "full community inclusion and participation, stalls upward mobility, greatly affects their health-related quality of life, and subjective well-being" (Leahy, et al., 2014). Fortunately, life care planning methodology recognizes the need to include vocational planning as an essential life domain. Most specifically, rehabilitation counselors provide special expertise regarding the vocational potential, as well as a range of other services that are essential to a complete life care plan.

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Journal of Life Care Planning, Vol. 17, No. 1, (45-72)

What Life Care Planners Need to Know About the Professional Discipline of Speech-Language Pathology

Carolyn Wiles Higdon

Abstract

Speech-Language Pathologists'(SLPS) professional responsibilities include prevention, assessment, diagnosis, and treatment of communication disorders with individuals ranging in age from infancy through geriatrics. Professional practice environments include different research, education and health care settings with varying roles and client populations. Speech language pathologists evaluate and/or treat individuals with cognitive-communication disorders, social communication disorders, speech sound disorders, receptive/expressive/pragmatic language disorders, swallowing impairments, as well as hearing and voice disorders. Speech language pathologists provide communication intervention, working as part of a collaborative, transdisciplinary team in medical and educational settings, including counseling and education to family and caregivers. Many SLPs engage in evidence-based research to provide new assessment and treatment methods as well as training and educating future SLPs.

History and Development of Speech-Language Pathology

Lubinski and Hudson (2017) outlined the history and development of speech-language pathology beginning in the early 1900s, when there were enough self-proclaimed speech correctionists in the United States to form special interest groups. One group comprised of speech correctionists were originally schoolteachers. Like their fellow teachers, they attended meetings of the National Education Association (NEA) and formed a subgroup that was affiliated with the NEA. The group was led by Walter Babcock Swift, an academic at Western Reserve University in Cleveland. This public school group, which called itself the National Society for the Study and Correction of Speech Disorders, began around 1918 and continued under the leadership of Swift until 1939.

A second special interest group, the one that eventually became the American Speech-Language-Hearing Association (after several name changes), was organized by physicians, scholars, and public school administrators who belonged to the National Association of Teachers of Speech. This group formed in 1925, seven years after Swift's group of public school clinicians. It was comprised of approximately 25 members who had been attending and presenting papers at specialized panels of their parent organization.

This group called itself the American Academy of Speech Correction (AASC). The membership was affiliated with university training programs, including departments of speech communication, speech correction programs, psychology and English departments. There were 25 charter members with thirteen from academic training programs, one graduate student, three physicians, two otolaryngologists, and one psychiatrist. Nine founders were affiliated with public or private school speech programs.

The 25 charter members of AASC were committed to keeping their organization small and selective. They aimed to maintain high educational standards in their newly formed discipline, setting the minimal criteria for membership to those with master's degrees or publications records. This disallowed those whom they considered quacks and most of the public school clinicians from Swift's organization, though they did not know of its existence at the time.

The master's degree required by AASC did not have to be in the field of speech correction. Indeed, they could not require a specialty degree in speech-language pathology since there were few graduate programs specializing in speech correction at that time. The leading graduate program, established in 1914, at the University of Wisconsin was well-represented with 20% of the attendees at the early AASC meetings.

Lubinski and Hudson (2017) list the following milestones in the history of speech-language pathology and audiology in the United States in their text book publication titled Professional Issues in Speech-Language Pathology.

- 1870-1914 Period of progressive movement in the United States, one that promoted values that provided a context for development of the helping professions.
- 1914 Establishment of the first graduate-level program in speech pathology organized by Smiley Blanton at the University of Wisconsin.
- 1918 Walter Babcock Swift organized public school clinicians in the Northeast. Their group affiliated with the National Education Association (NEA), was called the National Society for the Study and Correction of Speech Disorders.
- 1922 First commercial audiometer made available.
- 1925 Formation of the American Academy of Speech Correction
- 1926-1927 Formation and approval of the constitution of the American Academy of Speech Correction, including bylaws.
- 1930 American Academy of Speech Correction created an associate level of membership, allowing

practitioners to become members.
- 1934 American Society for the Study of Disorders of Speech renamed the American Speech Correction Association
- 1945 Establishment of audiology as a profession, following World War II.
- 1947 American Speech Correction Association renamed the American Speech and Hearing Association.
- 1952 Two sets of membership requirements were created by American Speech and Hearing Association, one for speech pathology and one for audiology.
- 1952 ASHA separated its membership and credentialing requirements—one could become a member but not be certified as a clinician.
- 1965 Certificate of Clinical Competence was established for both speech pathologists and audiologists.
- 1968 Master's level degree was required to practice in hospitals and agencies.
- 1969 State of Florida began a movement for state certification of professionals in speech pathology to work in non-educational settings.
- 1970 American Speech and Hearing Association published Elaine Pagel Paden's book tracing its 1925 origins.
- 1978 American Speech and Hearing Association renamed the American Speech-Language-Hearing Association (ASHA).
- 1978 Certification and membership requirements were separated. One could become certified without being a member of the association (this has since been reversed).
- 1988 Formation of the American Academy of Audiology (AAA).
- 1993 Language requirements were instituted for certification.
- 1997 The professional doctorate in audiology was established. It went into effect in 2012.
- 1999 First national convention of AAA was held.
- 1999 First issue of the Journal of the American Academy of Audiology was published.
- 1999 Continuing education requirement was established for continued membership in ASHA.
- 2009 James Jerger's book on the history of audiology was published.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 204,000 audiologists, speech-language pathologists and speech, language and hearing scientists, speech-language hearing support personnel, and students. (ASHA, 2019). The vision of the Association for all speech-language pathologists is making effective communication a human right, accessible and achievable for all (ASHA, 2019). The mission is to encourage and support audiologists, speech-language pathologists, and speech, language and hearing scientists by advancing science, setting standards, building excellence in professional practice, and advocating for members and consumers (ASHA, 2019).

Other names by which this profession may be known

Over the years, individuals in the field have been called speech therapists, speech-language pathologists, and speech teachers. The name formally applied to masters or doctoral level practicing clinicians and academicians is speech-language pathologist (SLP) (ASHA, 2019). The term speech therapist is typically used for bachelors level SLPs, some of whom practice in the schools and medical facilities as support personnel. Support personnel use a variety of names including speech-language pathology assistant (SLPA), paraprofessionals, communication aide, or SLP aide.

Content included in basic education

Academic and clinical training begins in the first four years of the undergraduate program with two years of general education courses followed by two years devoted to core courses in communication sciences and disorders, including but not limited to anatomy and physiology, neuroscience, speech science, speech and language development, stuttering, voice, cognitive communication, audiology and speech sound disorders. Undergraduate students may also be introduced to clinical assessment methodology as well as the possibility of some supervised treatment. This varies from program to program and is dependent on the philosophy of the training program. Some programs prefer to wait until the entry level degree which is the master's degree to teach assessment and treatment methodology. The Master's program typically consists of four to seven semesters of advanced study in communication sciences and disorders. Graduate plans of study may include language disorders in children and adults, phonological disabilities, speech and hearing science, augmentative and alternative communication (AAC), stuttering, medical and functional voice disorders including transgender voice therapy, oral and pharyngeal dysphagia (swallowing), craniofacial anomalies, neuromotor disorders of speech, social communication, and research methods and practice. Graduate students receive assessment and treatment training across medical and educational settings. Clinical practicum settings may include medical placements such as inpatient and acute care, rehabilitation, outpatient, long term care, and home health services and educational settings such as early intervention, private and public school settings, and vocational training. Students are trained in the business aspects of private practice settings, in telehealth, and in supervision. Graduate students must obtain 400 clock hours, of which 325 clinical hours must be completed while the student is in the graduate program, and 75 may be obtained at the undergraduate level.

Licensing or mandated certification requirements and authorizing entity that permits practice in this profession

Speech-language pathologists will have a master, doctorate, or other recognized post-baccalaureate degree from a graduate program accredited by the Council on Academic Accreditation in Speech-Language Pathology (CAA). Once the academic coursework and clinical experiences are completed, meeting the knowledge and skills delineated in the CAA standards, the clinical fellowship experience occurs under the mentorship of an individual who holds the ASHA Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP). Prior to applying for certification (the Certificate of Clinical Competence), the applicant must also take the Praxis Examination in Speech-Language Pathology from the Educational Testing Services (ETS) and submit a passing score directly from ETS to ASHA (ASHA, 2019). This Praxis Examination is based on information gathered across all practice settings compiled through skills validation studies and practice analyses.

The Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP), is a nationally recognized professional credential that represents a level of excellence through meeting rigorous academic and professional standards in the field of Speech-Language Pathology. The American Speech-Language-Hearing Association is the nation's leading professional, credentialing, and scientific organization for speech-language pathologists, audiologists, and speech/language/hearing scientists. The American Speech-Language-Hearing Association (ASHA) has been certifying professionals since 1952. The Clinical Certification Program is overseen by the ASHA Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC)) which establishes minimum standards for the specialty areas of practice.

Speech language pathologists who hold the CCC in Speech-Language Pathology must obtain 30 certification maintenance hours of professional development during every three year period. Collecting the 30 hours and submitting the compliance documentation, following the ASHA Code of Ethics, and paying annual dues or certification fees is required to maintain certification.

The doctoral degrees are the Doctorate of Philosophy (Ph.D.) and Doctor of Education (Ed.D.) degrees, recognized to prepare individuals for careers in research and/or teaching. In 2015, the Ad Hoc Committee on Guidelines for Clinical Doctorate in Speech-Language Pathology developed clinical doctorate guidelines for academic programs offering the clinical doctorate in speech-language pathology (SLP-D)(ASHA, 2015). These guidelines were created in lieu of developing a recognition program or an accreditation program for the SLP clinical doctorate.

Individuals who receive their education outside of the United States or its territories must confirm that the institution bestowing the degree is regionally accredited or recognized by that country. These individuals must also meet the CAA standards including the program of study, knowledge outcomes, skills outcomes, assessment requirements, and then must complete the clinical fellowship experience (ASHA, 2014).

Individuals completing a bachelor's degree may practice as support personnel under the supervision of a certified master's level or certified doctoral level speech-language pathologist.

The following list of requirements addresses more specific state teacher requirements and licensing trends for speech-language pathologists in school/education-based settings. This list can be accessed on the ASHA website (www.asha.org) and is useful in determining the requirements for an SLP to practice in particular states. The chart lists states that allow or require state licensure for school-based SLPs, states that allow or require state licensure with additional requirements for teaching certificate/licensure/endorsements for school-based SLPs, states that require Master's degree for teaching certificate/license for school-based SLPs, states that allow a minimum of a bachelor's degree for emergency and temporary situations (often with proof of enrollment in a master's program), states that allow a minimum of a bachelor's degree for teaching certificate/licensure for school based SLPs and states that allow/require ASHA certification for school-based SLPs. A growing number of states are considering universal licensure, one license for SLPs regardless of where they practice. At this time, approximately twenty states have some form of universal licensure (ASHA, 2019).

The future of speech-language pathology over the next ten years (2019-2029) is positive with an expected growth of 18%, faster than the average for all occupations. This growth is projected because of an expanding aging population (Administration on Aging, 2010; United States Census Bureau, 2018) with medical conditions in speech, language and swallowing, medical advances improving the survival rate of premature infants and trauma and stroke victims, improved awareness and early identification of speech, language and swallowing disorders in young children, increased growth in school enrollments, including special education students, and an increase in the use of SLPs in hospitals and nursing care facilities (ASHA, 2019).

Common specialty areas, roles, and credentials that can expand expertise and scope of contribution to life care plans

Current specialty areas of speech-language pathology beyond the bachelor, master and doctoral degrees include specialty recognitions that are developed within the association structure. The American-Speech-Language-Hearing Association also has a Specialty Certification Board (SCB) which approves applications for new clinical specialty areas listed above. As noted on the ASHA website (ASHA, 2019) currently-approved specialty areas are child language and language disorders supported by the American Board of

Child Language and Language Disorders, fluency and fluency disorders supported by the American Board of Fluency and Fluency Disorders, swallowing and swallowing disorders supported by the American Board of Swallowing and Swallowing Disorders, and intraoperative monitoring supported by the American Audiology Board of Intraoperative Monitoring. In addition, several special interest groups (SIGS) are seeking to establish new specialty certification programs, including augmentative and alternative communication and voice and upper airways disorders. Clinical specialty certification enables a speech-language pathologist with advanced knowledge, skills, and experience beyond the Certificate of Clinical Competence (CCC) to be identified to the public as a Board Certified Specialist (BCS) in a specific area of clinical practice. Holding specialty certification is completely voluntary in an area of clinical practice and is not currently required to practice in that area. However, the added credibility of the BCS in the specific practice area enhances the credibility of the individual's practice skills and knowledge. Each Specialty Certification Board (SCB) is responsible for specifying the educational, experiential, and clinical experience beyond the CCC-SLP with the minimum standards set by the CFCC that must be met to qualify for specialty certification in that BCS's area of practice. Additionally, each BCS is responsible for implementing its specific specialty certification program, including reviewing of individual applications and conferring Board Certified Specialist (BCS) status on qualified applicants (ASHA, 2019).

The kinds of patients and problems usually seen and addressed

Listed below are many of the types of patients and problems typically treated by speech language pathologists.

Misconceptions about what this profession is, or can do,

Accent modification
Augmentative/alternative communication
Assistive technology for communication
Assistive technology for cognition
Aural rehabilitation for adults
Auditory processing disorders
Autism spectrum disorder
Balance system disorders
Bilingual service delivery
Childhood apraxia
Central auditory processing disorders
Classroom acoustics
Craniofacial anomalies; cleft palate/cleft lip
Clinical education and supervision
Cochlear implants for children and adults
Collaborating with interpreters, transliterators, translators
Computer access for speech-language impairments
Cultural competence

Acquired apraxia
Dementia
Dysarthria
Oral and pharyngeal dysphagia
Early intervention
Fluency disorders
Head and neck cancer
Hearing aids
Hearing loss
Hearing screenings
Intellectual disabilities
Late language emergence
Orofacial myofunctional disorders
Permanent childhood hearing loss
Resonance disorders
Right hemisphere damage
Selective mutism
Social communication disorders
Speech sound disorders
Transgender voice
Traumatic brain injuries
Medical and functional voice disorders/ pathologies
Tracheotomy and ventilator dependent patients
Written language disorders

or cannot do

Speech language pathologists make clinical decisions, not medical decisions. Speech-language pathologists consider all medical, neurological and rehabilitation information and then make the best decisions based on all available information. The American Speech Language Hearing Association's Code of Ethics (American Speech-Language-Hearing Association [ASHA], 2016) is the basis for ethical conduct described by Principles of Ethics and by Rules of Ethics. The American Speech Language Hearing Association's (2019) four Principles of Ethics form the underlying philosophical basis for the Code of Ethics and are reflected in the following areas:

> (I) responsibility to persons served professionally and to research participants, both human and animal; (II) responsibility for one's professional competence; (III) responsibility to the public; and (IV) responsibility for professional relationships. Individuals shall honor and abide by these Principles as affirmative obligations under all conditions of applicable professional activity.

The ASHA Code of Ethics is the guidance to members for professional decision-making giving consumers the most successful outcomes.

Information a life care planner who comes from the profession should include in a resume or CV to support the ability to make future care recommendations and information to understand the scope of practice, independence, or limitations of the profession

The speech-language pathologist who is contributing to a life care plan should include his or her degree designation (e.g., Masters, Ph.D., Ed.D.), as well as years of experience in different settings and with different communication disorders in the supporting documentation. This is an important consideration, since a master's level CCC-SLP practicing in one setting (i.e., schools or early intervention) will be less likely to be able to provide the details and prognoses that a life care planner would need for treatment and economic predictions for a child or an adult. Advanced degrees, clinical certification, specialty certification, and a strong foundation of experiences, as well as an interdisciplinary approach, will yield stronger and more accurate information for the life care planner. In addition, the ability to project prognosis and future needs, the economic implications of equipment, technology, and services assists the life care planner in facilitating the most accurate and appropriate life care plan.

Differences between Canadian and U.S. practitioners in this profession

There are differences as well as similarities between US and Canada in the discipline of speech-language pathology (Speech-Language and Audiology, Canada, 2019). First, all of the programs are master's entry level, meaning there are no undergraduate degrees in SLP. The University of Montreal was the last program to have an undergraduate program followed by a master's program. Applicants to SLP programs generally hold degrees in a related field (e.g., linguistics, psychology, neuroscience, etc.), but they can come from any undergraduate field as long as they have the prerequisite coursework. The prerequisites are not in Communication Sciences and Disorders/SLP, but in linguistics, psychology, statistics, neuroanatomy, etc. The specific prerequisites differ across the 12 programs. Dalhousie, Halifax is the exception as it has a three year program and no prerequisites.

Some of the programs have an in-house clinic for introductory placements, but many prefer their students to get all of their clinical practical in real-life settings. Graduates apply for "registration" in the province in which they choose to work (similar to United States state licensure). Speech language pathology is a regulated profession in most provinces, and those provinces have a regulatory "college" that handles registration. In some provinces, the college is separate from the association, but in others, they are part of the same organization. Registration is required to work in any setting including hospitals, rehab centers, clinics, schools, early intervention, private practice, etc. Settings are similar to the settings in the United States. Some school-based SLPs are hired through the healthcare system, but assigned to work in schools, while others are employed by the school boards.

There are currently eight regulated provinces of: British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Newfoundland and Labrador (Speech-Language and Audiology, Canada, 2019). They are part of an alliance and are making great progress towards harmonization. Speech language pathologists and audiologists can also earn certification through Speech-Language and Audiology Canada (SAC, formerly Canadian Association of Speech-Language Pathologists and Audiologists, CASLPA). To be "certified" applicants must meet all of the academic and clinical requirements and pass a national certification exam. However, certification is not required to practice in regulated provinces, where it remains optional. Many programs promote certification as the gold standard. In addition, the Mutual Recognition Agreement with ASHA and the Royal College of Speech and Language Therapists (RCSLT) (ASHA Mutual Recognition, 2019) are with SAC and not with the provincial regulators. However, The Canadian Alliance of Audiology and Speech Language Pathology Regulators (CAASPR) will be introducing an "entry to practice" exam in 2020, and at that time the SAC certification exam will be discontinued. It is uncertain what SAC plans to do in terms of certification, and if they will continue to have some additional requirements that set certified professionals apart from registered ones. The questions will be how SAC certification develops and what these new developments will mean for the international mutual recognition agreements. The regulators, at this time, do not acknowledge the mutual recognition agreements, and evaluate internationally educated applicants on an individual

basis following a review of their coursework, clinical hours, etc.

Other information important for life care planners to know

In reviewing someone else's work, speech-language pathologists need information to understand that individual's scope of practice and independence/limitations which includes the individual's credentials (i.e., certification, licensure), training and education, and currency of treatment or assessment of the patient/client. Typically, a speech-language pathologist's most accurate information is gathered from treating or assessing physicians, licensed psychologists, and licensed rehabilitation providers. Additional useful information comes from educators, vocational experts, and mental health providers. Recent assessment and treating information should be given more weight in the review process than more dated information.

The "best" selection of a speech-language pathologist for a life care planning team, is one with advanced degrees, specialty trainings, a wide range of professional experiences, as well as a transdisciplinary understanding of related disciplines and team members' professional perspectives. Background and knowledge in business and economics, an understanding of federal and state educational policies, an introductory knowledge of the legal system, and an understanding of evidence-based outcomes of rehabilitation medicine are added benefits. Although it seems to be a given, the "best" speech-language pathologist should be able to demonstrate excellent written and verbal communication abilities and leadership skills.

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Table 1 Occupational therapist at-a-glance

Definition	"Occupational therapy is a client-centered health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement". (WFOT 2012)
Standards of Practice Source	Canada: Essential Competencies of Practice for Occupational Therapists in Canada, 3rd edition. (ACOTRO, 2012) U.S.: Standards and Interpretive Guide (AOTA, 2018) and National Board for Certification in Occupational Therapy, Inc. Professional Practice Standards (NBCOT, 2018).
Scope of Practice	Canada: Determined by each province. Examples: British Columbia states "A registrant may assess occupational performance and modify human and environmental conditions to maintain, restore or enhance occupational performance and health". (Health professions act, 2008). Ontario states "The practice of occupational therapy is the assessment of function and adaptive behaviour and the treatment and prevention of disorders which affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function or adaptive behaviour in the areas of self-care, productivity and leisure." (Occupational Therapy Act, 1991) U.S.: While AOTA has published a document that describes occupational therapy scope of practice they defer to the individual states for specifics. In Minnesota for example, scope of practice includes: skilled observation, or the administration and interpretation of tests and measures. Sensory integrative, neuromuscular, and motor components of performance; development of emotional motivational cognitive or psychosocial components of performance; daily living skills; feeding and swallowing skills; play and leisure skills; education performance; work performance and readiness; ergonomics; orthotics and prosthetics; assistive technology; environmental control; wheelchair and positioning; applying physical agent modalities and the promotion of health and wellness. (State of Minnesota, 2017)
General Goals	To enhance performance of tasks (occupations) through restorative and compensatory treatment approaches.
Use of Diagnoses	Canada: Do not identify diagnoses; use medical diagnoses to guide assessment & intervention U.S.: Provide treatment diagnoses which guides assessment and treatment of the medical diagnoses
Interventions	Wide range of services provided from hands on treatment, to provision of education, program development, and consultation. Populations served range from pediatrics to geriatrics. Treatment interventions address both mental health issues (e.g. cognitive rehabilitation, psychiatric interventions/groups, stress management; pain management skill training) and rehabilitation for physical disabilities (splinting, orthotics, hand therapy, work conditioning, low vision rehabilitation, cardiac rehabilitation, ergonomics, prescribe adaptive equipment/strategies); address basic activities of daily living (eating/swallowing; dressing, bathing) and instrumental activities (e.g. driving rehabilitation, community living skills; housekeeping, employment).
Collaboration in Planning	In clinical practice, the OT coordinates treatment with other disciplines involved. Co-treatment sessions with another discipline occur as needed. Numerous areas of the life care plan such as those dealing with environmental modification, task analysis, task modification, and assistive technology prescription fall within the scope of an occupational therapist. OT life care planners can critique the entirety of an opposing life care plan, however, the occupational therapist must be mindful of the limits of their scope of practice in the development of a life care plan.

American Occupational Therapy Association. 2018. https://www.aota.org/~/media/Corporate/Files/EducationCareers/Accredit/Standards/2011-Standards-and-Interpretive-Guide.pdf

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World Federation Of Occupational Therapists, 2012. http://www.wfot.org/faqs/aboutoccupationaltherapy.aspx

Table 2 Physical therapist at-a-glance

Definition	"Physical therapists are health care professionals who maintain, restore, and improve movement, activity, and health enabling an individual to have optimal functioning and quality of life, while ensuring patient safety and applying evidence to provide efficient and effective care. Physical therapists evaluate, diagnose, and manage individuals of all ages who have impairments, activity limitations, and participation restrictions. In addition, physical therapists are involved in promoting health, wellness, and fitness through risk factor identification and the implementation of services to reduce risk, slow the progression of or prevent functional decline and disability, and enhance participation in chosen life situations. Physical therapy scope of practice is dynamic, evolving with evidence and societal needs." [APTA, 2011]
Standards of Practice Source	The American Physical Therapy Association (APTA) publishes standards of practice. Membership in this professional organization is not required. Each state has laws and rules regulating the practice of physical therapy in that particular state. Every PT is legally obligated to follow the regulations of the state in which they practice, and ethically obligated to follow the professional standards and code of ethics created by the APTA.
Scope of Practice	As provided by the APTA: 1. examining (history, system review and tests and measures) individuals with impairment, functional limitation, and disability or other health-related conditions in order to determine a diagnosis, prognosis, and intervention, 2. alleviating impairment and functional limitation by designing, implementing, and modifying therapeutic interventions, 3. preventing injury, impairment, functional limitation, and disability, including the promotion and maintenance of health, wellness, fitness, and quality of life in all age populations, and 4. engaging in consultation, education, and research.
General Goals	Physical Therapists provide care to patients/ clients of all ages who have impairments, activity limitations, and participation restrictions due to musculoskeletal, neuromuscular, cardiovascular/pulmonary, and/or integumentary disorders.
Use of Diagnoses	The diagnostic process describes the individual condition in terms that will guide the physical therapist in determining the prognosis, plan of care, and intervention strategies. The diagnostic description or classification relates to the primary impairments, activity limitations, and participation restrictions toward which the physical therapist establishes goals and selects interventions.
Interventions	Examination and assessment, therapeutic exercise, gait training, neuromuscular re-education, functional therapeutic activities training, manual therapy, vestibular treatment/ canalith repositioning, various modalities such as electrical stimulation, ultrasound, heat and cold therapy, dry needling, education, collaboration and conferencing with other care providers.
Collaboration in Planning	A physical therapist, many times, is the care provider who, by the nature of the treatment plan, is afforded the most one on one time with the patient/client. Physical therapists therefore have a unique opportunity to monitor and discuss responses to interventions not only provided by the PT, but by other medical professionals. A PT must discuss those interventions out of the scope of PT practice with the appropriate provider.

American Physical Therapy Association (2011). Today's Physical Therapist: A Comprehensive Review of a 21st Century Health Profession.

Table 3 Physician Physiatrist at-a-glance

Definition	A physician deals with promoting, maintaining, and restoring health. This is accomplished through diagnosis and treatment of the disease. This may include physical or mental diagnoses.
Standards of Practice Source	American Medical Association (AMA, 2016); American Academy of Physical Medicine and Rehabilitation
Scope of Practice	PM&R specialists take care of patients in both the inpatient and outpatient setting. In the inpatient setting, the PM&R may take over care of the patient when in the acute rehabilitation setting. The physiatrist will coordinate all aspects of the patient care while inpatient. The physiatrist is sufficiently knowledgeable about other medical specialties to determine whether proper treatment is being ordered.
General Goals	To appropriately diagnose conditions and offer appropriate treatment options. To improve functional ability and prevent additional complications. Focus is on relieving impairments in functional status arising from physical and/or mental diagnoses, including personal care activities of daily living, instrumental activities of daily living, social function, work function, community function.
Use of Diagnoses	ICD-10-CM is a diagnosis identification tool, which is developed and maintained by National Center for Health Statistics (NCHS) under the Centers for Disease Control and Prevention (CDC). The Health Insurance Portability and Accountability Act (HIPPA) named it as the standard code for reporting diagnoses. The ICD-10 is copyrighted by the World Health Organization (WHO), which owns and publishes the classification. (CDC NCHS 2018).
Interventions	Must demonstrate competency to perform procedures either in residencies, fellowship or undergo proctoring in the clinical setting. Interventions are described by Current Procedural Terminology (CPT) codes, which is developed and maintained by the AMA. Interventions are also described by ICD-10-PCS. Permitted to perform all coded interventions in which competency is demonstrated. (AMA 2018)
Collaboration in Planning	The physician functions as the quarterback taking in information from all the subspecialists, therapists, and nurses involved with a patient and recommending a treatment plan. In the quarterback role, a PM&R specialist will discuss/suggest what other specialists are going to do and has the authority to agree whether or not other peoples' interventions are appropriate. Highly specialized or uncommon interventions may require consultation with other specialists to include in a life care plan.

American Medical Association. 2018. https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology

Centers for Disease Control and Prevention National Center for Health Statistics. 2018. https://www.cdc.gov/nchs/icd/icd10cm.htm

Table 4 Psychologist at-a-glance

Definition	Psychology is the study of the mind and behavior. The discipline embraces all aspects of the human experience — from the functions of the brain to the actions of nations, from child development to care for the aged. In every conceivable setting from scientific research centers to mental healthcare services, "the understanding of behavior" is the enterprise of psychologists. (American Psychological Association, 2018.)
Standards of Practice Source	The American Psychological Association (APA) is considered a primary reference regarding standards of practice. The APA has a wide range of guidelines for the general practice of psychology, as well as a wide range of specialty issues including evaluations, clinical issues, diverse populations, treatment, etc. Different psychology specialty boards outside of the APA, such as forensic psychology, neuropsychology, medical prescribing psychology, etc., may also offer their own standards.
Scope of Practice	Scope of practice is determined by licensure, training and experience. Psychologists practice in solo, group, educational, community, medical, institutional and other settings. Areas of practice can expand with additional training and/or supervised experience. Psychologists often work in in multi-disciplinary, inter-disciplinary or trans-disciplinary settings.
General Goals	To accurately describe, explain, predict, and change human behavior and mental processes. Behavior and mental processes include trauma, grief, learning, intelligence, cognition, emotional and behavioral reactions, thinking, reasoning, intra and interpersonal interactions, socialization, developmental processes, behavioral / emotional / psychiatric decompensation, crisis intervention, addictions, assessment, rehabilitation, medical issues, criminality, etc.
Use of Diagnoses	The type of diagnosis used depends on the nature of the referring question, requested services, the psychologist's involvement and other professionals involved in the case. DSM5 taxonomies and ICD-10-CM coding are the most prevalent, but functional behavior analysis, developmental profiles, psychoeducational assessments and other evaluative profiles are also pertinent according to the case.
Interventions	Ranging from assessment to individual 1:1 therapeutic process to group and cultural interventions. Interventions may occur in clinics, schools, medical and rehabilitative facilities, natural environments and most any other environment or situation where humans exist. With the exception of prescribing psychologists, most states preclude psychologists from making medical decisions or representing that they can do so.
Collaboration in Planning	Psychologists frequently share their professional opinions with other involved disciplines and participate in treatment team and other multiple disciplinary meetings. They also provide guidance regarding issues of psychological well-being and vulnerability in terms of how services by others or conditions or situations outside of their purview can affect a person's actions, outcomes and safety. Psychologists may also solicit the recommendations and findings of other involved parties in developing their own assessments and service delivery. Psychologists are required by law to report concerns regarding possible abuse, neglect, potential imminent harm to self or others to appropriate state agencies.

Table 5 Registered Nurse at-a-glance

Definition	Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations. (American Nurses Association 2018)
Standards of Practice Source	RN: American Nurses Association, applicable to all registered nurses. Clinical or role specialty may have additional Standards. Nurses may engage in multidisciplinary roles that have additional Standards. Thus, a nurse may simultaneously be subjected to multiples Standards.
Scope of Practice	Generalist and specialist roles in a variety of provider-based and community-based settings. Competency should be demonstrated in all activities encompassed by a role and setting. All RNs have authority to assess, interpret, define nursing diagnoses, set goals, plan interventions, implement, and evaluate. Specialty training and/or certification expands the scope and abilities. The nurse may have prescriptive authority if a nurse practitioner.
General Goals	To achieve or improve self-management of conditions and bodily functions; to prevent complications and co-morbidities; to promote full participation in all community roles and settings. Goals encompass physical, emotional, psychological, social aspects using a holistic approach that considers the individual, significant other, community, resources, and environmental factors.
Use of Diagnoses	Nursing diagnoses identify human responses to health, illness, and injury; nursing diagnoses are created and approved by NANDA-I. Nurses do not determine medical diagnoses, but use them to inform their assessment and planning.
Interventions	Ranges from hands-on treatments to education and consultation. Permitted to perform certain invasive procedures. Collaborates with others to identify all interventions and may perform interventions identified by other disciplines (trans-disciplinary). Becomes liable when performing or facilitating interventions ordered by another disciple, thus the collaboration includes ascertaining appropriateness of the intervention.
Collaboration in Planning	RNs routinely assess the impact of interventions done by other disciplines and must be prepared to implement actions in the case of adverse consequences. RNs contribute to team conferencing that includes discussion of proposed actions. RNs may perform actions ordered by other disciplines and share legal liability, thus RNs must believe that those actions are appropriate and safe. RNs facilitate communication and planning between disciplines so need to be aware of compatibility and risks of planned actions.

Table 6 Rehabilitation Counselor at-a-glance

Definition	A rehabilitation counselor reflects the discipline's focus of providing required services to return a person, with a disability, to the highest degree of community, vocational, recreational and independent functioning possible.
Standards of Practice Source	CRCC Code of Professional Ethics
Scope of Practice	https://www.crccertification.com/crc-crcc-scope-of-practice
General Goals	Return a person, with a disability, to the highest degree of community, vocational, recreational and independent functioning possible. Addresses ability and adjustment to disability, particularly vocational potential.
Use of Diagnoses	Depending on training acquired, some counselors diagnose mental health conditions based on the DSM-V, others diagnose potential for employment. Rules about the ability to diagnose mental disorders vary from state to state. State licensing boards can be referenced for specific state allowances regarding diagnoses.
Interventions	Vocational Assessments, including vocational evaluation interviews, testing and rehabilitation plan development.
Collaboration in Planning	Rehabilitation Counselors work frequently with inter-disciplinary treatment teams, rehabilitation facilities, education and training programs, and families to develop, monitor, adjust, and ensure the success of rehabilitation plans.

Table 7 Speech-Language Pathologist at-a-glance

Definition	"The speech-language pathologist is the professional who engages in clinical services, prevention, advocacy, education, administration, and research in the areas of communication and swallowing across the life span from infancy through geriatrics. Speech-language pathologists address typical and atypical impairs and disorders related to communication and swallowing in the areas of speech sound production, resonance, voice, fluency, language (comprehension and expression), cognition, and feeding and swallowing." (ASHA, 2014)
Standards of Practice Source	Speech-Language & Audiology Canada: The Canadian Alliance of Audiology and Speech Language Pathology Regulators (Speech-Language and Audiology Canada, 2019) American Speech-Language-Hearing Association: Council of Academic Accreditation (ASHA, 2014)
Scope of Practice	The overall objective of speech-language pathology services is to optimize individuals' abilities to communicate and to swallow, thereby improving quality of life. Services are provided across the lifespan. Service delivery areas include all aspects of communication and swallowing and related areas that impact communication and swallowing: speech production, fluency, language, cognition, voice, resonance, feeding, swallowing, and hearing. With the practice of speech-language pathology continually evolving, SLPs play critical roles in health literacy; screening, diagnosis, and treatment of autism spectrum disorder; and use of the *International Classification of Functioning, Disability and Health* (ICF; World Health Organization [WHO], 2014) to develop functional goals and collaborative practice. As technology and science advance, the areas of assessment and intervention related to communication and swallowing disorders grow accordingly. (ASHA, 2016)
General Goals	The eight domains of speech-language pathology service delivery are collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities, technology, and instrumentation; and population and systems. SLPs address communication, speech, language, hearing, and swallowing within these eight domains. For more detail please refer to the ASHA Scope of Practice (ASHA, 2016)
Use of Diagnoses	Current Procedural Terminology (CPT), Healthcare Common Procedure Codes (HCPCS), International Classification of Diseases, 10th revision, Clinical Modifications (ICD-10) are used for diagnostic and billing determinations.
Interventions	Clinical areas of service may include, but are not limited to: speech sound production; resonance; voice; fluency; pre-linguistic communication; language comprehension and expression; pre-literacy and literacy skills; cognitive communication; social (pragmatic) communication; executive functions; feeding and swallowing; alternative and augmentative communication; aural (re)habilitation; accent modification; and the impacts of communication and swallowing disorders on everyday life across the lifespan. Must demonstrate competency to perform procedures such as oral peripheral examinations, administer tests and interpret the obtained data during internships, clinical fellowship year, understand diagnosis provided, and contribute to the overall well-being of the client. (ASHA,2019)
Collaboration in Planning	Speech-language pathologists may practice independently or within an inter-professional framework, collaborating with other professionals such as audiologists, physicians, nurses, educators, dietitians, occupational therapists, physiotherapists, psychologists, child care staff and social workers, as well as communication health assistants. Speech-language pathologists provide a broad range of clinical and other professional services. Work collaboratively with other disciplines, educate, mentor and train caregivers, school and allied health professionals, participate in multi-disciplinary treatment teams and provide plans and recommendations focused on speech, language and communication skills.

American Speech-Language-Hearing Association (2016) Scope of Practice in Speech-Language Pathology. Retrieved February 20, 2019. https://www.asha.org/policy/SP2016-00343/

American Speech-Language-Hearing Association. (2014). "New National Definition Broadens SLPs' Scope of Practice". https://leader.pubs.asha.org/doi/10.1044/leader.NIB2.19112014.11 Retrieved January 23, 2019.

Council for Clinical Certification in Audiology and Speech-Language Pathology of the American Speech-Language-Hearing Association (2014). 2014 Standards for the Certificate of Clinical Competence in Speech-Language Pathology. Retrieved [February 19, 2019] from http://www.asha.org/Certification/2014-Speech-Language-Pathology-Certification-Standards/

Speech-Language and Audiology Canada. (2019). Scope of Practice for Speech-Language Pathology. Retrieved from https://www.sac-oac.ca/

World Health Organization (2014). International Classification of Functioning, Disability and Health (ICF). Retrieved (February 19, 2019) from https://www.who.int/classifications/icf/en/.

Table 1 Occupational Therapist Contributions to Life Care Plan Recommendations

Care Category	Can Occupational Therapist Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Can refer to some specialists within scope of practice, otherwise collaborative
Physician (MD, DO) On-Going Visits	Outside of scope of practice
Chiropractic Visits	Outside of scope of practice
Dentist On-Going Visits and Sedation	Outside of scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice to recommend referrals
Ancillary On-Going Visits	Within scope of practice for OT, otherwise not within scope of practice
Diagnostic Testing	Outside of scope of practice
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Outside of scope of practice, except that acupuncture may be performed by Canadian OT with training
Wheelchairs, Including Features and Accessories	Within scope of practice
Other Mobility Equipment	Within scope of practice
Orthotics	Within scope of practice
Prosthetics	Collaborative
Other Medical Equipment	Collaborative for some equipment or outside of scope of practice
Adaptive Aids for Independent Function	Within scope of practice
Drugs Requiring Prescription	Outside of scope of practice
Over-the-Counter Drugs	Outside of scope of practice
Disposable Supplies	Outside of scope of practice
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Within scope of practice to identify need for assistance and level of assistance
Home Care Hours	Within scope of practice
Household (housekeeping, yard care, house repairs) Services and Hours	Within scope of practice

Adapted Transportation (Evaluation, Training, Equipment)	Within scope of practice
Alternative Transportation	Within scope of practice
Architectural Modification	Within scope of practice but most often collaborative
Home Furnishings	Within scope of practice
Health Maintenance	Within scope of practice for exercise programs
Adaptive or Therapeutic Recreation	Within scope of practice or collaborative with therapeutic recreation specialist
Potential Complications	Within scope of practice or collaborative

Table 2 Physical Therapist Contributions to Life Care Plan Recommendations

Care Category	Can Physical Therapist Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Within scope of practice for specialists within similar practice area, otherwise outside of scope of practice
Physician (MD, DO) On-Going Visits	Outside of scope of practice
Chiropractic Visits	Within scope of practice
Dentist On-Going Visits and Sedation	Outside of scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice for OT, SLP, acupressure, massage; collaborative for psychology
Ancillary On-Going Visits	Within scope of practice for PT, OT, acupressure, massage, otherwise outside of scope of practice
Diagnostic Testing	Collaborative for some tests, otherwise outside of scope of practice
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Within scope of practice for specialty programs within practice area, such as chronic pain functional restoration program or TBI program, otherwise outside of scope of practice
Wheelchairs, Including Features and Accessories	Within scope of practice
Other Mobility Equipment	Within scope of practice
Orthotics	Within scope of practice
Prosthetics	Collaborative
Other Medical Equipment	Within scope of practice or collaborative
Adaptive Aids for Independent Function	Within scope of practice
Drugs Requiring Prescription	Outside of scope of practice
Over-the-Counter Drugs	Outside of scope of practice
Disposable Supplies	Within scope of practice or collaborative
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Within scope of practice
Home Care Hours	Within scope of practice

Household (housekeeping, yard care, house repairs) Services and Hours	Within scope of practice
Adapted Transportation (Evaluation, Training, Equipment)	Within scope of practice
Alternative Transportation	Within scope of practice
Architectural Modification	Within scope of practice
Home Furnishings	Within scope of practice
Health Maintenance	Within scope of practice
Adaptive or Therapeutic Recreation	Within scope of practice
Potential Complications	Collaborative

Table 3 Physician Physiatrist Contributions to Life Care Plan Recommendations

Care Category	Can Physician Physiatrist Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Within scope of practice
Physician (MD, DO) On-Going Visits	Within scope of practice
Chiropractic Visits	Collaborative
Dentist On-Going Visits and Sedation	Within scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice
Ancillary On-Going Visits	Collaborative
Diagnostic Testing	Within scope of practice
Surgery	Within scope of practice to identify need; may be collaborative to determine some details
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Within scope of practice or collaborative depending on intervention
Wheelchairs, Including Features and Accessories	Within scope of practice to identify need; may be collaborative to determine some details
Other Mobility Equipment	Within scope of practice to identify need; may be collaborative to determine some details
Orthotics	Within scope of practice or collaborative
Prosthetics	Collaborative
Other Medical Equipment	Within scope of practice or collaborative depending on equipment
Adaptive Aids for Independent Function	Within scope of practice to identify need; may be collaborative to determine some details
Drugs Requiring Prescription	Within scope of practice
Over-the-Counter Drugs	Within scope of practice
Disposable Supplies	Within scope of practice to identify need; collaborative to determine details
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Collaborative
Home Care Hours	Collaborative
Household (housekeeping, yard care, house repairs) Services and Hours	Collaborative

Adapted Transportation (Evaluation, Training, Equipment)	Within scope of practice to identify need; collaborative or outside of scope of practice to determine equipment details
Alternative Transportation	Collaborative
Architectural Modification	Within scope of practice to identify need; collaborative or outside of scope of practice to determine details
Home Furnishings	Outside of scope of practice
Health Maintenance	Within scope of practice
Adaptive or Therapeutic Recreation	Collaborative
Potential Complications	Within scope of practice

Table 4 Psychologist Contributions to Life Care Plan Recommendations

Care Category	Can Psychologist Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Within scope of practice
Physician (MD, DO) On-Going Visits	Outside of scope of practice
Chiropractic Visits	Outside of scope of practice
Dentist On-Going Visits and Sedation	Outside of scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice
Ancillary On-Going Visits	Collaborative
Diagnostic Testing	Within scope of practice for psychological testing, otherwise outside of scope of practice
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Within scope of practice for psychological interventions, otherwise outside of scope of practice
Wheelchairs, Including Features and Accessories	Outside of scope of practice to prescribe but collaborative on factors that affect use
Other Mobility Equipment	Outside of scope of practice to prescribe but collaborative on factors that affect use
Orthotics	Outside of scope of practice to prescribe but collaborative on factors that affect use
Prosthetics	Within scope of practice for cognitive/behavioral prosthetics, otherwise outside of scope of practice
Other Medical Equipment	Outside of scope of practice to prescribe but collaborative on factors that affect use
Adaptive Aids for Independent Function	Within scope of practice for cognitive/behavioral aids, otherwise outside of scope of practice
Drugs Requiring Prescription	Outside of scope of practice except for allowed drugs for prescribing psychologists (4 states, U.S. Defense Department, U.S. Public Health Service, and Indian Health Service)
Over-the-Counter Drugs	Outside of scope of practice except for prescribing psychologists
Disposable Supplies	Within scope of practice if related to psychological treatment, otherwise outside of scope of practice
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Collaborative related to cognitive and behavioral capacity or needs
Home Care Hours	Collaborative related to cognitive and behavioral capacity or needs

Household (housekeeping, yard care, house repairs) Services and Hours	Collaborative related to cognitive and behavioral capacity or needs
Adapted Transportation (Evaluation, Training, Equipment)	Collaborative related to cognitive and behavioral capacity or needs
Alternative Transportation	Collaborative related to cognitive and behavioral capacity or needs
Architectural Modification	Collaborative related to cognitive and behavioral capacity or needs
Home Furnishings	Collaborative related to cognitive and behavioral capacity or needs
Health Maintenance	Collaborative related to cognitive and behavioral capacity or needs
Adaptive or Therapeutic Recreation	Collaborative related to cognitive and behavioral capacity or needs
Potential Complications	Within scope of practice if related to psychological, cognitive, behavioral, or emotional, otherwise outside of scope of practice

Table 5 Registered Nurse Contributions to Life Care Plan Recommendations

Care Category	Can Registered Nurse Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Within scope of practice
Physician (MD, DO) On-Going Visits	Within scope of using evidence-based practice guidelines or collaborative
Chiropractic Visits	Collaborative
Dentist On-Going Visits and Sedation	Collaborative
Ancillary (Non-physician Professionals) Referrals	Within scope of using evidence-based practice guidelines or collaborative
Ancillary On-Going Visits	Collaborative
Diagnostic Testing	Within scope of using evidence-based practice guidelines or collaborative
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Within scope of using evidence-based practice guidelines, such as TBI rehabilitation programs, outside of scope of practice
Wheelchairs, Including Features and Accessories	Within scope of practice for standard chairs, collaborative for custom chairs, outside of scope of practice for fitting
Other Mobility Equipment	Within scope of practice or collaborative
Orthotics	Collaborative
Prosthetics	Collaborative
Other Medical Equipment	Within scope of practice or collaborative
Adaptive Aids for Independent Function	Within scope of practice or collaborative
Drugs Requiring Prescription	Within scope of practice for nurses with prescriptive authority, otherwise outside of scope of practice
Over-the-Counter Drugs	Within scope of practice or collaborative
Disposable Supplies	Within scope of practice or collaborative
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Within scope of practice or collaborative
Home Care Hours	Within scope of practice or collaborative

Household (housekeeping, yard care, house repairs) Services and Hours	Within scope of practice or collaborative
Adapted Transportation (Evaluation, Training, Equipment)	Within scope of practice or collaborative
Alternative Transportation	Within scope of practice or collaborative
Architectural Modification	Within scope of practice or collaborative
Home Furnishings	Within scope of practice or collaborative
Health Maintenance	Within scope of practice or collaborative
Adaptive or Therapeutic Recreation	Within scope of practice or collaborative
Potential Complications	Within scope of practice or collaborative

Table 6 Rehabilitation Counselor Contributions to Life Care Plan Recommendations

Care Category	Can Rehabilitation Counselor Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Outside of scope of practice
Physician (MD, DO) On-Going Visits	Outside of scope of practice
Chiropractic Visits	Outside of scope of practice
Dentist On-Going Visits and Sedation	Outside of scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice
Ancillary On-Going Visits	Within scope of practice for rehabilitation counseling and case management, otherwise outside of scope of practice
Diagnostic Testing	Outside of scope of practice
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Outside of scope of practice
Wheelchairs, Including Features and Accessories	Collaborative
Other Mobility Equipment	Collaborative
Orthotics	Outside of scope of practice
Prosthetics	Outside of scope of practice
Other Medical Equipment	Within scope of practice for some equipment, otherwise collaborative or outside scope of practice
Adaptive Aids for Independent Function	Within scope of practice for some aids, otherwise collaborative or outside scope of practice
Drugs Requiring Prescription	Outside of scope of practice
Over-the-Counter Drugs	Outside of scope of practice
Disposable Supplies	Within scope of practice for some supplies, otherwise collaborative or outside scope of practice
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Within scope of practice
Home Care Hours	Within scope of practice
Household (housekeeping, yard care, house repairs) Services and Hours	Within scope of practice

Adapted Transportation (Evaluation, Training, Equipment)	Within scope of practice
Alternative Transportation	Within scope of practice
Architectural Modification	Within scope of practice
Home Furnishings	Within scope of practice
Health Maintenance	Within scope of practice for mental or psychosocial health, otherwise collaborative
Adaptive or Therapeutic Recreation	Within scope of practice
Potential Complications	Within scope of practice for vocational or psychosocial, otherwise collaborative or outside of scope of practice

Table 7 Speech-Language Pathologist (SLP) Contributions to Life Care Plan Recommendations

Care Category	Can SLP Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Within scope of practice
Physician (MD, DO) On-Going Visits	Must collaborate with others
Chiropractic Visits	Outside of scope of practice
Dentist On-Going Visits and Sedation	Outside of scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice
Ancillary On-Going Visits	Within scope of practice for SLP services Otherwise must collaborate with others
Diagnostic Testing	Within scope of practice for tests within ASHA Scope of Practice and Code of Ethics Other tests outside of scope of practice
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Within scope of practice for fiberoptic endoscopic assessments (invasive) and treatment; video fluoroscopic assessments of swallowing, neuromuscular electrical stimulation for swallowing impairments Other interventions outside of scope of practice
Wheelchairs, Including Features and Accessories	Within scope of practice for features to accommodate augmentative communication technology for communication, writing, reading Otherwise outside of scope of practice
Other Mobility Equipment	Within scope of practice for features to accommodate augmentative communication technology for communication, writing, reading Otherwise outside of scope of practice
Orthotics	Outside of scope of practice
Prosthetics	Within scope of practice for voice prosthetics Otherwise outside of scope of practice
Other Medical Equipment	Within scope of practice for: • communication tools • voice prosthetics • tools to assist memory • apps to assist communication, reading writing and memory skills • computer technology

	• devices for voice and others such as humidifiers for vocal issues • dental tools to address oral hygiene • vibrators for facial exercises • aids to assist with vision in consultation with other health professionals • FM listening units to address problems with central auditory processes • environmental controls Otherwise outside of scope of practice
Adaptive Aids for Independent Function	Within scope of practice for communication and safety aids Otherwise outside of scope of practice
Drugs Requiring Prescription	Outside of scope of practice
Over-the-Counter Drugs	Outside of scope of practice
Disposable Supplies	Within scope of practice for supplies associated with equipment and aids recommended by SLP Otherwise outside of scope of practice
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	In collaboration with others
Home Care Hours	Outside of scope of practice
Household (housekeeping, yard care, house repairs) Services and Hours	In collaboration with others
Adapted Transportation (Evaluation, Training, Equipment)	Outside of scope of practice
Alternative Transportation	Outside of scope of practice
Architectural Modification	In collaboration with others for design of modifications
Home Furnishings	Within scope of practice for desks, lamps, and other furnishings which can facilitate reading and writing skills, promote independent recreational skills, maximize working and learning skills, accommodate communication technology
Health Maintenance	In collaboration with others
Adaptive or Therapeutic Recreation	Within scope of practice for recreation for social skills, executive function, expressive skills
Potential Complications	Within scope of practice for complications related to swallowing, voice, receptive and expressive skills, executive functions, memory skills, reading and writing skills, and academic success

Book Review

Weed, R. O., & Berens, D. E. (2018). ***Life Care Planning and Case Management Handbook*** **(4th ed.). New York, NY: Routledge.**

Tanya Rutherford Owen, Ph.D.

In 2018, the life care planning community was offered what is, by all accounts, the most thorough and up-to-date account of life care planning techniques and resources that exists in this rehabilitation subspecialty. In this edition, Dr. Roger Weed and Dr. Debra Berens provide the most comprehensive manifesto in life care planning literature, with individual chapters written by individuals who have specific subject matter expertise and book editors who together possess over 60 years of life care planning experience.

This edition begins with the chapter entitled *Life Care Planning: Past, Present and Future*, in which Dr. Weed outlines the roots of life care planning as well as the current state of life care planning. Dr. Weed traces our roots as a field back to the early 1980s, properly crediting seminal individuals in the field including Dr. Paul Deutsch, Susan Riddick-Grisham, Patti McCollum and others who have fundamentally shaped what today is the international community of life care planners. Almost 900 pages later, this edition ends with a comprehensive 16-page index of articles contained in the *Journal of Life Care Planning* from 2002 until 2017. Such historical context highlights the countless hours and the numerous individuals who have propelled our field from relative obscurity a mere 30 years ago to the prolific field that it is today.

The fourth edition of this text includes updated chapters from many of the individuals who have contributed to the prior editions including Richard Bonfiglio, MD, Nancy Mitchell, OTR/L and Carolyn Wiles Higdon, Ph.D., CCC-SLP, demonstrating the richness of the diversity of training of members of the life care planning field. Within this portion of the text are chapters including contributions to life care planning by professionals in physiatry, physical therapy, occupational therapy, rehabilitation nursing, rehabilitation counseling, neuropsychology, audiology and speech language pathology, to name a few. Similar to this current issue of the *Journal of Life Care Planning*, subject matter specialists in 10 specialty areas outline the role that these specialists play in life care plan development as well as the treatment modalities to be considered by all life care planners when developing a plan that encompasses physical, occupational or speech therapy, psychological care, rehabilitation services, etc.

Additionally, to keep with the expansion that is occurring in the field of life care planning, the editors have incorporated new chapters including chapters on admissibility considerations, cultural considerations and life care planning in Canada. As life care planning has expanded from the United States, we have seen a growing number of practitioners and educators come from outside of the U.S. As such, this edition of the text includes a chapter dedicated to life care planning in Canada, where approximately 159 currently hold life care planning certification of Canadian Certified Life Care Planner (CCLCP). This chapter, written by Canadian life care planner, Dana Weldon, provides practice suggestions for Canadian life care planners as well as a detailed 10-page outline of Canadian Supreme Court Judgments related to life care planning issues.

Also as a reflection of the expansion of the field of life care planning, Dr. Mary Barros-Bailey provides, in this edition, a chapter entitled *Cultural Considerations for Life Care Planning*. This concept, which was not well-examined in the life care planning literature until 2016, is introduced through its chronological evolution of the inclusion of multicultural issues within the Pomeranz et al., 2010 study through Caragonne's (2016) detailed 9-stage process for developing a cross-cultural life care plan.

In chapters 12-20, the reader is provided detailed examples of life care plan tables for individuals with amputations, burn injuries, brain injuries, chronic pain, spinal cord injuries, visual impairments, organ transplants and psychological disorders. It also includes many of the tools commonly invoked in situations where life care plans are used including day-in-the-life videos and resources including UCR and pricing information, life care planning software, medical coding and billing software, and other specific resources (e.g., *Cost of Care Surveys, U.S. Life Tables and HCUP* data) that will be vital to anyone seeking to learn or better understand the various components utilized in the life care planning process.

While admittedly this text is being reviewed by someone who has over 20 years of experience in the field and owns every edition of this text published to date, I cannot help but think that it would be both necessary and sufficient for someone aspiring to build a career in life care planning. Were I to hire a novice life care planner and provide that individual with only one item on which to launch them into the field, this would be it. This text draws upon the knowledge of over 30 professionals, each of whom offers specialized knowledge and training within their assigned chapter, which would simply be beyond the scope of study for any one life care planner to gather such depth and breadth of information. Dr. Weed and Dr. Berens, with their extensive knowledge and historical roots in the field, have documented where we as a rehabilitation subspecialty have been, where we currently are, and where we will be going. For those who are new to the practice, who want to remain well-versed in life care planning processes, who want to update their knowledge of available life care planning resources or better understand life care planning controversies, this text should certainly be the next thing you "Buy Now".

Journal of Life Care Planning, Vol. 17, No. 1, (75-79)

Ethics Interface

Nancy Mitchell

This column is the collaborative effort of Nancy Mitchell, Mary Barros-Bailey, Sherry Latham, Ann Neulicht, and Bobbi Dominick. The author is grateful for their editorial support, wisdom, and collective experience.

The column is meant to be an educational forum for life care planners. It is not designed to offer an authoritative opinion from the editor or editorial board of the Journal of Life Care Planning, the board of the International Academy of Life Care Planners, or the board of its parent organization, the International Association of Rehabilitation Professionals, nor is it designed to represent or replace official opinions from the certifying body or other organizations associated with the practice of life care planning.

Dilemma

I received my certification as both a CLCP and a CNLCP years ago, but I never renewed them. Is it okay that I continue to use those acronyms after my name? I did everything to apply for and earn those credentials.

Response

An awarded credential may only be used during the valid time period of the certification/license. If you fail to recertify or renew your certification you must immediately stop using the credential designation. The misuse of credentials is a clear violation of our standards of performance and ethical standards. Individuals who continue to use a credential beyond its expiration should be reported to the certifying board. The fraudulent use of credentials will likely have a negative impact on one's professional reputation.

Relevant Organizational Standards

From the International Academy of Life Care Planning Standards of Practice (2015)

I. INTRODUCTION

C. Transdisciplinary Perspective

Life care planning is a transdisciplinary specialty practice. Each profession brings to the process of life care planning practice standards which must be adhered to by the individual professional, and these standards remain applicable while the practitioner engages in life care planning activities. Each professional works within specific standards of practice and regulatory requirements for his or her discipline to ensure accountability, provide direction, and mandate responsibility for the standards for which he or she is accountable. These standards include, but are not limited to, activities related to quality of care, qualifications, collaboration, law, ethics, advocacy, resource utilization, and research. In addition, each individual practitioner is responsible for following the Standards of Practice for Life Care Planners.

III. STANDARDS OF PERFORMANCE

1. STANDARD: The life care planner has an educational background and professional preparation suitable for life care planning.

MEASUREMENT CRITERIA:

a. Possesses the appropriate educational requirements in a rehabilitation or health care field as defined by his or her professional discipline.
b. Maintains current professional licensure, provincial registration, or national board certification that is required to practice a professional rehabilitation or health care discipline.
d. Participates in specific continuing education as required to maintain the individual practitioner's licensure, registration, or certification within his or her profession.
e. Obtains continuing education and/or training to remain current in the knowledge and skills relevant to life care planning.

2. STANDARD: The life care planner shall practice in an ethical manner and follow the Code of Ethics of his or her respective professions, roles, certifications and credentials.

MEASUREMENT CRITERIA:

a. Follows the Code of Ethics for his or her profession.
b. Follows the Code of Ethics for his or her professional roles, certifications, and credentials.

From the International Commission on Health Care Certification (2015)

X. PRINCIPLES AND ASSOCIATED RULES

Principle 1 - Professional and Legal Standards

ICHCC certificants shall behave in legal, ethical, and professional manner in the conduct of their profession, maintaining the integrity of the Code of the Professional Ethics and avoiding any behavior which would cause harm to other entities and/or individuals.

Rules of Professional Conduct:

R1.1--ICHCC Certificants shall obey the laws and statutes in the legal jurisdiction in which they practice and are subject to disciplinary action for any violation, the extent that such violation suggests the likelihood of professional misconduct.

R1.3--ICHCC Certificants shall be familiar with, observe and discuss with their evaluees as well as referral sources the legal limitations of their services.

R1.4--ICHCC Certificants shall not engage in any acts or omission of a dishonest, deceitful, or fraudulent nature in

the conduct of their professional activities.

R1.5--ICHCC Certificants shall understand and abide by the Principles and Rules of Professional Conducts which are prescribed in the Code of Professional Ethics.

R1.6—ICHCC Certificants shall not advocate, sanction, participate in or cause to be accomplished, otherwise carry out through another, or condone any act, which the ICHCC Certificants are prohibited from performing by the Code of Professional Ethics.

R1.8--ICHCC Certificants shall not misrepresent the credential.

Principle 2 - Evaluee and ICHCC Certificants Relationship

ICHCC Certificants shall respect the integrity and protect the welfare of people and groups with whom they work. The primary obligation of the certificant is to the evaluee outside of independent medical examinations and independent review of plans in which no physician/patient relationship exists.

Rules of Professional Conduct:

R2.1 ICHCC Certificants shall not misrepresent their role or competence to evaluee. Certificants will not misrepresent their role or competence to patients. Certificants will provide information about their credentials, if requested.

Principle 4 - Professional Relationships

ICHCC Certificants shall act with integrity in their relationships with colleagues, other organizations, agencies, institutions, referral sources and other professions as to facilitate the contributions of all specialists.

Rules of Professional Conduct:

R4.8 ICHCC Certificants possessing knowledge of any rule violation of this Code of Professional Ethics is obligated to reveal information to the International Commission on Health Care Certification unless the information is protected by law.

Principle 5 Public Statements/Fees

ICHCC Certificants shall adhere to professional standards in establishing fees and promoting their services.

Rules of Professional Conduct:

R5.2 ICHCC Certificants who advertise their services to the general public shall fairly and accurately present the material.

Principle 9-Competence

Rules of Professional Conduct:

R9.1 ICHCC Certificants shall function within the limits of which they are professionally qualified and competent.

R9.2 ICHCC Certificants shall continuously strive through reading, attending professional meetings and taking course instruction to keep abreast of new developments, concepts, and practices that are essential to providing the highest quality of services to their evaluees.

VI. CERTIFICATION MAINTENANCE AND RENEWAL: The International Commission on Health Care Certification asserts that certified professionals should maintain a high level of skills and knowledge through development of professional skills and continuing education. Requirements for certification renewal are designed to encourage the continuation of professional development which will aid in the effective delivery of health care services.

Failure to renew your certification will result in the revocation of your certified status. The applicant acknowledges that the information submitted on a signed application is accurate. ICHCC retains the right to revoke or suspend certification if a certification is granted on the basis of false, misleading or inaccurate information if such information becomes evident upon inquiry.

The maintenance period for the CLCP/CCLCP credential is 5 years, and 80 clock-hours of continuing educational units (CEU's) are required over this period due to the broad spectrum of concepts within this area. The CLCP/CCLCP professional is required to have 8 of the 80 required recertification hours to be of ethical practice subject matter. The ICHCC reviews training programs to determine if the training content has any application to life care planning service delivery. It does not accredit nor approve any training or educational programs that may be applied specific to the CLCP examination. Rather, the ICHCC charges a review fee to all entities requesting coverage of their CEU's for application to the Certified Life Care Planner and the Canadian Certified Life Care Planner credentials, whether the entity meets the approval criteria or is rejected. Criteria for approval or rejection of the reviewed program for CEUs are based on the following:

1. Option One: 80 clock hours of pre-approved and post-approved education/training for each five-year period. Documentation is required to validate that the education or training has been successfully completed in one or more of the focus areas related to life care planning:

a. Pre-approved: If a course was pre-approved, the CLCP/CCLCP professional only needs to send the attendance verification and the attached form. The fee is $250.

b. Non-Preapproved: If the CLCP/CCLP professional attended a program which was not approved for CLCP/CCLCP hours, the required documentation must be submitted and is subject to review. This includes a completed ICHCC Non-Preapproved CEU form (found on the ICHCC website), the program agenda and the attendance verification/certificate of completion. The fee is $250 + a $10 review fee per non-preapproved program. You may submit as many non-preapproved programs as you wish, but you can only be charged for a maximum of 5 non-preapproved programs for a maximum non-preapproved fee of $50 in addition to the $250 recertification fee.

2. Option Two: Re-examination. The fee is $350 and covers both the examination fee and certification renewal.

From the CDMS Code of Professional Conduct (2015)

DEFINITIONS

Throughout this document, and for the purposes of this document, the following words are defined as:

Certificant: One who holds an active Certified Disability Management Specialist (CDMS) credential.

PRINCIPLES

Principle 6: Certificants shall honor the integrity and respect the limitations placed on the use of the CDMS credential.

Principle 7: Certificants shall obey all laws and regulations, avoiding any conduct or activity that could harm others.

RPC 1.12 - Misconduct

Certificants shall not engage in professional misconduct. It is professional misconduct if the certificant:

RULES OF PROFESSIONAL CONDUCT

SECTION 1 - Relationship with All Parties

a. engages in conduct involving dishonesty, fraud, deceit, or misrepresentation.

RPC 1.09 - Reports

Certificants shall be accurate, honest, unbiased, and timely in reporting the results of their professional activities to appropriate third parties.

RPC 1.12 - Misconduct

Certificants shall not engage in professional misconduct. It is professional misconduct if the certificant:

a. engages in conduct involving dishonesty, fraud, deceit, or misrepresentation;

RPC 1.15 - Advertising

Certificants who describe/advertise services shall do so in a manner that accurately informs the public of the services, expertise, and techniques being offered. Descriptions/ advertisements by a certificant shall not contain false, inaccurate, misleading, out-of-context, or otherwise deceptive material or statements.

RPC 1.20 - Use of CDMS Credential

The Certified Disability Management Specialist (CDMS) is a professional credential, and the

initials "CDMS" are personal in nature and may be used only by a current certified individual. The certificant shall not utilize the credential or initials as part of a company, partnership, corporate name, trademark, or logo.

From the Commission for Case Manager Certification Code, Professional Conduct for Case Managers for Standards, Rules, Procedures, and Penalties (2015)

PRINCIPLES

Principle 7: Certificants will obey all laws and regulations.

CCMC RULES OF CONDUCT

Violation of any of these rules may result in disciplinary action by the Commission up to and including revocation of the individual's certification.

Rule 1: A Certificant will not intentionally falsify an application or other documents.

STANDARDS FOR PROFESSIONAL CONDUCT

Section 2 – Professional Responsibility

S 2 - Representation of Practice

Certificants will practice only within the boundaries of their competence, based on their education, training, professional experience, and other professional credentials. They will not misrepresent their role or competence to clients.

S 6 - Use of CCM Designation

The designation of Certified Case Manager and the initials "CCM" may only be used by individuals currently certified by the Commission for Case Manager Certification.

From the Commission on Rehabilitation Counselor Certification, Code of Professional Ethics for Rehabilitation Counselors (2017)

D.1. PROFESSIONAL COMPETENCE

a. BOUNDARIES OF COMPETENCE. Rehabilitation counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, professional credentials, and appropriate professional experience. Rehabilitation counselors do not misrepresent their competence to clients or others.

b. NEW SPECIALTY AREAS OF PRACTICE. Rehabilitation counselors transitioning into specialty areas requiring new core competencies begin practicing only after having obtained appropriate consultation, education, training, and/or supervised experience. While developing skills in new specialty areas, rehabilitation counselors make reasonable efforts to ensure the competence of their work and to protect clients from possible harm.

f. CONTINUING EDUCATION. Rehabilitation counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. They maintain their competence in the skills they use, are open to new procedures, and keep current with professional and community resources for diverse and specific populations with which they work.

D.4. PROFESSIONAL CREDENTIALS

a. ACCURATE REPRESENTATION. Rehabilitation counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations

of their qualifications by others. They truthfully represent their qualifications and those of their professional colleagues. Rehabilitation counselors accurately represent the accreditations of their academic programs and accurately describe their continuing education and specialized training.

b. CREDENTIALS. Rehabilitation counselors claim only licenses or certifications that are current and in good standing.
c. EDUCATIONAL DEGREES. Rehabilitation counselors clearly differentiate between earned and honorary degrees.
d. IMPLYING DOCTORAL-LEVEL COMPETENCE. Rehabilitation counselors refer to themselves as "doctor" in a counseling context only when their doctorate is in rehabilitation counseling or a closely related field from an accredited university. If rehabilitation counselors have a doctoral-level degree in an unrelated field, they clearly state the field in which the doctoral degree was earned. Rehabilitation counselors do not use any abbreviation or statement to imply the attainment of a credential.

E.3. PROVISION OF CONSULTATION SERVICES

b. CONSULTANT COMPETENCY. Rehabilitation counselors provide consultation only in areas in which they are competent. They make reasonable efforts to ensure they have the appropriate resources and competencies. Rehabilitation counselors provide appropriate referral resources when requested or needed.

F.2. FORENSIC COMPETENCY AND CONDUCT

b. QUALIFICATION TO PROVIDE EXPERT TESTIMONY. Forensic rehabilitation counselors have an obligation to present to finders of fact the boundaries of their competence, the factual bases (knowledge, skill, experience, training, and education) for their qualifications as experts, and the relevance of those factual bases to their qualifications as experts on the specific matters at issue.FOUNDATION OF KNOWLEDGE. Forensic rehabilitation counselors have an obligation to maintain current knowledge of scientific, professional, and legal developments within their area of competence. They use knowledge, consistent with accepted clinical and scientific standards, and accepted data collection methods and procedures for evaluation, treatment, consultation, or scholarly/empirical investigations.

K.1. ADVERTISING AND SOLICITING CLIENTS

a. ACCURATE ADVERTISING. When advertising or otherwise representing their services to the public in any form of media, rehabilitation counselors identify their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent.

From the American Association of Nurse Life Care Planners- Code of Ethics 2015

AANLCP Code of Ethics

The Code of Professional Ethics and Conduct for the American Association of Nurse Life Care Planners® is based upon the belief that all members have an ethical obligation to practice nurse life care planning with the utmost integrity, competency, and accountability. The code of ethical conduct provides a guideline for the professional performance and behavior of nurse life care planners. As nurse life care planners, we also recognize and support the code of ethics and conduct of the American Nurses Association.

Ethics and Nurse Life Care Planners

The AANLCP® Code of Ethics and Conduct was developed as a guide to the core values and obligations of the profession. ANA's Code to Ethics with Interpretive Statement was looked to as a resource with the belief that all nursing professionals have an ethical obligation to practice with the utmost integrity, competency and accountability. A Code of Ethics and Conduct committee was created in 2011 to explore the current and evolving issues that might be encountered by the nurse life care planner.

2. The nurse life care planner maintains professional nursing competency as well as competency in practice of nurse life care planning.

A. The nurse life care planner maintains an active license in good standing as a registered nurse.
B. The nurse life care planner recognizes and adheres to nursing standards of practice and standards of practice for nurse life care planners.
C. The nurse life care planner practices according to the Nurse Practice Act

3. The nurse life care planner incorporates high standards of professional conduct through continuum of the nurse life care planning services.

A. The nurse life care planner demonstrates, honesty, integrity, responsibility, accountability, timeliness and respect for human dignity.
B. The nurse life care planner will not knowingly engage in unethical or unlawful activities nor will they knowingly misrepresent their background or credentials or promote personal interests for personal gain.

7. The NLCP participates in the advancement of the profession through participating in and promoting mentorship, collegiality, education and ongoing knowledge development.

From the American Association of Nurse Life Care Planners Scope and Standards of Practice.

Values and principles guiding nurse life care planning practice. Nurse life care planners embrace the following values and principles that are reflected in the AANLCP Ethics Statement:

Competence: NLCP recognize the continual professional growth, particularly in the knowledge and skill, requires a commitment to lifelong learning. Such learning includes, but is not limited to continue education, networking with professional colleagues, self-study professional reading, certification and seeking advance degrees.

Integrity: For nurse life care planners, integrity is the foundation of practice and demonstrates wholeness of character that is realized through congruence of thoughts, words and actions. As one of the core values, integrity means being truthful, honest, reliable and authentic in all personal and professional matters.

Certification for nurse life care planners is recognized for a period of five years at which time the candidate must retake and pass the current Certification Examination for Nurse Life Care Planners or meet such alternative requirements in effect at that time in order to retain certification.

The CNLCP® recertification criteria includes verification of 60 continuing education units (i.e. CEU's or credit hours) in nurse life care planning, or completion of at least 12 academic semester credits of nursing coursework related to nurse life care planning at the licensee's current level of licensure or higher.

References

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Certification of Disability Management Specialists Commission. (2015). Code of professional conduct with disciplinary rules procedures and penalties. Schaumburg, IL: Author. Retrieved from: www. http://cdms.org/uploads/files/CDMS_Code of Professional_Conduct.pdf

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International Association of Rehabilitation Professionals. (2009). Code of ethics, standards of practice, and competencies. Retrieved from http://www.rehabpro.org/publications/standards-ethics/12.2007.pdf/view

International Academy of Life Care Planners. (2015). Standards of practice for life care planners. Third Edition. International Academy of Life Care Planners, The Life Care Planning Section of The Association of Rehabilitation Professionals. Retrieved from https://higherlogicdownload.s3.amazonaws.com/REHABPRO/Standards%20of%20Practice%20for%20Life%20Care%20Planners%2

Health Care Certification

International Commission on Health Care Certification. (2015). Standards and examination guidelines. Retrieved from: www.http://ICHCC.org/PDF.s/ICHCC_Standards andGuidelines.pdf

1. Using a credential designation after it has expired is:

a. fine.
b. prudent.
c. ethical.
d. unethical.

2. If you find someone using a credential designation after it has expired, you should:

a. report the individual to the appropriate credentialing board.
b. file an ethical complaint with a professional organization.
c. do the same.
d. do nothing.

3. To maintain a credential in life care planning, what must the certificant do on an ongoing basis?

a. vote in organizational elections.
b. attend continuing education opportunities.
c. participate on professional listservs.
d. join a professional committee.

4. A CLCP or CNLCP documents 15 hours of continuing education within a five-year period. This will result in:

a. recertification.
b. extension of the credential
c. revocation of the credential.
d. a request for proposals.

5. To intentionally sign a report (document) that falsely suggests you have a credential that is not current would be grounds for an ethical complaint under the rules of which organization?

a. CRCC
b. CDMSC
c. CCMC
d. ICHCC

6. The CRCC Code of Professional Ethics for Rehabilitation Counselors requires certificants to truthfully represent the qualifications of:

a. colleagues.
b. certifying bodies.
c. professional organizations.
d. employers.

7. If you receive an honorary graduate degree, how do you represent it on your business card?

a. after the name.
b. as a subline.
c. you don't.
d. with initials.

8. I have a doctorate in chemistry and master's in nursing. After my name I list:

a. MSN only.
b. PhD only.
c. MSN, PhD.
d. PhD, MSN.

9. If you unknowingly misrepresent your background or credentials, you will likely be found in violation of which code of ethics?

a. AANLCP.
b. CRCC.
c. ICHCC.
d. All.

10. A credential indicates the life care planner holds:

a. the highest level of competence in the specialty.
b. the minimal level of competence in the specialty.
c. competence to evaluate but not assess.
d. competence in all areas of life care planning.

CEU INFORMATION

This article has been approved for continuing education credits from CRC, CCM, CDMS, CLCP through the IARP Certification Maintenance Program. To qualify for CEUs, you must complete the exam following the article and the evaluation form.

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Evaluation Form	Excellent	Very Good	Good	Average	Poor
1. The article was clearly written.	5	4	3	2	1
2. The article furthered my knowledge of the dissemination and utilization of disability information.	5	4	3	2	1
3. The article provided information which will be useful to me regarding the dissemination and utilization of disability information.	5	4	3	2	1
4. The issues addressed in this article were valuable.	5	4	3	2	1
5. The article furthered my career.	5	4	3	2	1

Your comments are appreciated. Please use a separate sheet of paper

Call for Manuscripts

The *Journal of Life Care Planning* (JLCP), the premiere peer-reviewed, professional journal dedicated to the specialty practice of life care planning, is seeking manuscripts for publication. One of the *Journal's* objectives is to publish material that will add to the research and knowledge base of life care planning practitioners. The *Journal* strives to publish information that is relevant and valuable to life care planners and is appropriate and accurate within standards in the field. Research and evidence-based articles are welcome as well as case studies or real practice examples.

The editorial team welcomes contributions for peer review. Manuscripts are acknowledged upon receipt and following preliminary review by the editor, are sent to members of the editorial board for anonymous review.

Manuscripts should be double spaced, in Times New Roman font and adhere to the APA (*Publication Manual of the American Psychological Association*, 6th edition. Guidelines can be found at: www.apastyle.org/. All submissions should include a cover sheet with the manuscript title, the authors' names, degrees/affiliations and author notes with contact information provided for the primary author. An abstract of approximately 100 words should appear on page two providing a brief summary of content.

Upon review, manuscripts are either accepted, rejected or returned for revision. Accepted articles are typically published in order of receipt. Manuscripts should be submitted in a Microsoft Word document via email to Tanya Rutherford-Owen, editor, *Journal of Life Care Planning*, owenvoc@gmail.com. Dr. Owen can be contacted with additional questions at 479-695-1772.

Guidelines for Authors

Purpose and Objectives

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

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

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Submission of articles and manuscripts consistent with the objectives of the *Journal* are welcome. In the preparation of any submission to the *Journal*, please carefully consider the following:

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2. Manuscripts should be submitted to the *Journal* Editor via email (Preferred format: MSWord 2010 or earlier). It is expected that most manuscripts will need some revision or enhancement following the *Journal's* review process. The final draft of a revised manuscript should be resubmitted to the Editor via email.
3. Use proper language with regard to a person's sex and/or disabling condition.
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6. Submit articles and manuscripts to Tanya Rutherford Owen, email at owenvoc@gmail.com.

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Publisher: International Association of Rehabilitation Professionals, 1000 Westgate Drive, #252, St. Paul, MN 55114, 888-IARPQaA (888-427-7722), webpage: http://www.rehabpro.org

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