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In order to make safe and effective judgments using NANDA-I nursing diagnoses it is essential that nurses refer to the definitions and defining characteristics of the diagnoses listed in this work.
Editor’s Note

Welcome to the Winter 2014 issue of the Journal of Nurse Life Care Planning focusing on life care planning in the age of the Affordable Care Act. This might not be an issue you’ll breeze through! It’s a weighty topic that’s provoked considerable speculation and angst within and outside of our profession. We hope this issue will give you some useful information the next time somebody asks you for your opinion, while recognizing that opinions vary and the jury is still out on the final answers.

We also have another installment in our series of guides to doing better research. Note especially that the author, David Dillard, is willing to help anyone who contacts him, so do think about it when you have a knotty research problem.

It’s hard to believe that it’s been six full years since the JNLCPP reformatted and became a reliably quarterly publication. As we head into deep midwinter, please let me extend my very warmest thanks and praise to the many nurses and others who have donated their expertise to strengthen our profession by working on your Journal. If you check the last page, you’ll find an index of all past articles since 2009 (all available for free download at www.aanlcp.org) and a new feature: the list of all the issues in the planning stages. Do you know people who’d be perfect resources for one of those? Tell them we’d like to be able to recognize them, too.

Cordially,

Wendie Howland

Editor, Journal of Nurse Life Care Planning
whowland@howlandhealthconsulting.com
www.howlandhealthconsulting.com
Information for Authors

AANLCP® invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning within the medical-legal community. Submitted material must be original. Manuscripts and queries may be addressed to the Editorial Committee. Authors should use the following guidelines for articles to be considered for publication. Please note capitalization of Nurse Life Care Plan, Planning, etc.

Text
Manuscript length: 1500 – 3000 words

- Use Word® format (.doc, .docx) or Pages (.pages)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Use Times, Times New Roman, or Arial font, 12 point
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for editorial review
- Use APA style (Publication Manual of the American Psychological Association)

Art, Figures, Links

All photos, figures, and artwork should be in JPG or PDF format (JPG preferred for photos). Line art should have a minimum resolution of 1000 dpi, half-tone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.

Each table, figure, photo, or art should be on a separate page, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003)

Live links are encouraged. Please include the full URL for each.

Editing and Permissions

The author must accompany the submission with written release from:

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All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned in their work.

All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission.

The author, not the Journal, is responsible for the views and conclusions of a published manuscript.

Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

All manuscripts published become the property of the Journal. Manuscripts not published will be returned to the author.

Queries may be addressed to the care of the Editor at: whowland@howlandhealthconsulting.com

Manuscript Review Process

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and the nursing profession. Acceptance is based on manuscript content, originality, suitability for the intended audience, relevance to Nurse Life Care Planning, and quality of the submitted material. If you would like to review articles for this journal, please contact the Editor.

AANLCP® Journal Reviewers for this issue

Wendie Howland MN RN-BC CRRN CCM CNLCP LNCC

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Contributing To This Issue

Ken Coleman ("Catastrophic injury and ACA Health Plan Selection") is Head of Research and Data at HealthPocket.com where he is the author of the HealthPocket InfoStat Reports. Mr. Coleman performs research across the healthcare market, leveraging emerging sources of data from government, nonprofit, and private sectors. Key areas of study for Mr. Coleman include healthcare consumerism and issues associated with the implementation of the Affordable Care Act.

David Dillard ("Databases Replacing Print Tools") has degrees in history and library science. He has worked at Temple University Libraries since 1970, first in the Business Library; he moved to Reference and concurrently began to learn bibliographic database searching. He now does collection development for Tourism, Hospitality, Sports Management, Recreation, Therapeutic Recreation, Public Health, Kinesiology, Disabilities, Social Work and Communication Disorders. Dave started sharing information sources and answers to questions on internet discussion groups around 1998 and that has grown to a cottage business. He started a network of public search engine indexed discussion groups and archives for sharing of posts of good websites, bibliographies of sources on a wide variety of topics, and news story summaries with source citations and links to those sources. He is a regular on several nursing specialty lists and is very open to contact from anyone to help with searches on any topic.

Patrick Hindert ("How the Affordable Care Act Affects Nurse Life Care Planners") is Managing Director of S2KM Limited. He is member of the Ohio State Bar Association and graduated from Harvard College and the University of Michigan Law School. Hindert has been a leader within the structured settlement industry since 1977. He previously served as President of Benefit Designs, Inc. (1977-98) and The National Structured Settlement Trade Association (NSSTA) (1990-91) as well as Executive Director of the Society of Settlement Planners (SSP) (2003). Hindert authors S2KM’s blog "Beyond Structured Settlements" as well as S2KM’s wikis. With Daniel Hindert and Joseph Dehner, he authors “Structured Settlements and Periodic Payment Judgments” published by Law Journal Press and updated semiannually.

Winter in Utah
Liz Holaciewicz
Letters to the Editor

Dear Readers,

Just after we published the September JNLCP (XIV.3, Psych Topics in LCP), I received a letter no editor ever wants to get: Nancy Mitchell, MA, OTR/L, ATP, CLCP, FIALCP wrote to tell me that the Ethics in Action vignette we published in that issue was a word-for-word duplicate of one she had in an earlier issue of the Journal of Life Care Planning. She graciously offered that it was likely an inadvertent error, but wanted clarification. I replied to her to say what we would do:

Dear Nancy:

I had absolutely no idea that this had been previously published. (I don’t get the JLCP regularly). When we started this column a year or two ago, I asked members of my committee and the general membership for examples of ethical problems they’d encountered in their practices. This is one of the ones that came in, and has been sitting in my file of them awaiting its time to be published. Just so I’m sure I’m referring to the right wrong, as it were, can you please confirm that you mean this one? “I agreed to subcontract life care planning work with a local case management and life care planning company. I was told that my work would be edited. I assumed that the editing would be for typographical errors. I submitted my work on my first case and later received a copy. I found not only the replacement frequencies in the plan increased but costs were amplified as well. This was a plaintiff case. My name is on this plan but the report does not accurately represent my research or my opinion. What should I do?”

I am truly shocked to hear this was previously published in the JLCP and know that my apology is inadequate for the situation. I will replace it in this issue, direct the Association’s admin to post the revised issue on the website asap, and put a note in the next issue in case anyone has already downloaded it directing them to the new iteration. I will also discuss this in our next committee meeting this week. Please feel free to excerpt this email and use it as you see fit. I appreciate your kindness in writing.

Cordially,

Wendie

From the Certification Board

Please join us in offering congratulations to the new CNLCP Class of 2014 and to recertifying CNLCPs. For information on obtaining certification by examination or reciprocity, please go to the Certified Nurse Life Care Planner Certification Board website at http://www.cnlcp.org/page5.asp Ed.

New Certification

Rebecca J. Bur
Darius Garcia
Shay Harlan
Nellie Kreimer
Jan Norman
Joanna Rodgers
Margaret Stelzel-Eberle
Jane Wrigley

Renewing Certification

Jill Aggersbury
Amy Beth Baron
Diane Casavant
Michele Cataline-Becker
Janice Haris
Nina Hoagland
Robin Karns
Ramone Kimmins
Shelly Kinney
Karen Klemme
Jan Klosterman
Barbara Krasa
Nancy Kunte
Kelly Lance
Rhonda LeBeau
Sandra Lowery
Susan Maraglino
Irene Mefford
Connie Mills
April Pettengill
Anne Sambucini
Kim Wages
Lora White

continued next page
Obituary

Wayne Arthur Eklund, registered nurse, nurse consultant, and certified nurse life care planner passed away November 18, 2014. Wayne was an expert, resource, and volunteer advocate in the specialty of rehabilitation and neurological injuries. Wayne became associated with the Brain Injury Association of Oregon in 1990, and he served in executive leadership and on the board of the organization for many years. Later he was also associated with the Brain Injury Association of Hawaii. He is survived by his widow, sons, and his family in Salem OR.

Erratum

The article “A Survey of Nurse Life Care Planners: A Role Delineation Study in the United States” by Manzetti, Bate, and Pettengill in the September 2014 issue of the JNLCM misstated the credentials of Dr. Paul Deutsch. He is a rehabilitation psychologist with a Ph.D. in counseling psychology with a primary emphasis in rehabilitation. Dr. Deutsch has spent the past forty years researching the applications for life care planning as it relates to each catastrophic disability and illness. The JNLCP regrets the error.
Ethics in Action

Rush job, iffy documents?

This scenario came from a life care planner. The comments are from a group of nurse life care planners who were asked to share their opinions. Nothing in this column is to be taken as legal advice or as the official position of the AANLCP, its board, or the JNLCNP.

I took a case on short notice for a new client, an expert referral business working for an attorney. He wanted a quick letter regarding a standard of care breach involving a patient fall case, and he wanted it in three days. The referral agency sent me a summary they had prepared on the case to work from. It didn’t look too bad until I got the medical records on Day 3 and realized that 1) they were very skimpy, 2) they contradicted some important details in the summary, and 3) the referral principal wanted me to give the attorney the expert opinion he wanted based on his summary, without data to back it up, saying, "We'll take the responsibility for this." Your thoughts?

Q. Whose signature will be on the report? The person who says he will take responsibility? Not likely! This whole case is a recipe for career disaster. Experts are meant to provide their expert opinion based on the objective information and their experience. It is not always what the referral source wants to hear. There are two options: do the work, bill for it, and document the discrepancies OR simply say you do not have enough information or time to offer an opinion and refuse the work.

A. I have always enjoyed the phrase: "Your lack of planning is not my emergency." The referral source always has options if they need more time. Don’t jump in on short notice if you can’t do a good job. You will earn respect in the end.

I would let the referral source know that there is a considerable discrepancy in facts between the summary and the actual records and that the expert opinion provided based on the available documents may be counterproductive to the case. I would try to speak with the referral principal and stress that it would be unprofessional on my part to provide expert opinion under these circumstances. If the referral principal does not seem to understand the complexity of this situation, then I would think twice before working with him or her.

I would point out the discrepancies and tell them that I would be happy to write a summary but it would be based on my medical record review. On the other hand, could it be possible that they are asking you to assume certain facts are true (which they will later prove in court) when developing your opinions? If this is the case, I would be very clear in my report as to what I was relying on for information and where it came from.

The expert opinion we give is ours and no one can take "responsibility for this" except us. Several times I have found documentation which has presented a contradiction to the case according to the principal and I tactfully brought it to their attention providing them the opportunity to "rethink." As I explained to an attorney recently, I only have one reputation and it is not for sale at any price.

Oh, it’s NOT your fault that they waited until the last minute to pull their case together!

Why would you jeopardize your reputation and credibility?

Any documentation used to form an opinion is discoverable. The expert will be asked by defense counsel, what documents and/or treatises were reviewed to help form their opinion. The fact that a referring agency prepared a summary for the expert to work from is a red flag. The conflicting reports may have been overlooked by the referring source and/or the attorney or their paralegal but picked up by the nurse reviewing the case. After reviewing the medicals, if the nurse felt, based on his/her education, training and ex-
experience, her opinion was different than what the referring source wanted to hear, he/she had a duty to verbally advise the referring source and speak with the attorney. If his/her request was denied, the nurse had a duty to pull out, indicating he/she is not a scribe. The report will represent his/her opinion and nothing else.

Disagreements on the merits of a case occur often. That is why there are plaintiff and defense experts. Advising experts on what their opinion should be is another huge red flag. Telling the nurse they would take the responsibility for this implies there will be controversy. It’s the nurse’s name on the report and no one else.

Just a side note, it is for this reason, one should always request a retainer up front! If the referral source wanted the report in three days, they certainly can overnight a retainer check to the expert. Sounds like this new client is looking for a hired gun. You have no obligation to provide them with an opinion based on what they prefer you say. I would contact the client and have a discussion about this. No matter what, you need to provide a thorough and objective evaluation. You can’t go wrong when you’re able to back up what you say with the facts of the case. Besides, the opposing council will surely prepare questions to challenge your opinion during deposition.

This kind of request happens all too often. Be sure to allow enough time to examine the actual records. Their summary might be handy, but as noted, they didn’t tell “the rest of the story.” Don’t risk your license or your reputation, it’s all you have.

I would write a letter stating the purpose of being hired (“to render an expert opinion on the standard of care for x) and the contradictory details in the summary. I would follow this by, “Based on the incomplete records I am unable to provide an opinion regarding whether standards of care have been breached. If you would like me to render an opinion regarding this case I will need the complete medical records. If those records are not available, then I will not be able to render an expert opinion. Please find my invoice for my time attached.”

No matter what the referral principal has said, you are responsible for your expert opinion and you are responsible for being able to support your opinion with valid data. Explaining this concept to the referral principal might cost you a loss of further cases from this source, but providing an opinion that you cannot support could result in the loss of your professional reputation and all of your future business.

Based on the information given, I would not be qualified to render an expert opinion unless I was currently providing direct nursing care to this population of patients. The scenario given does not provide the information on the nurse’s qualifications.

If I did have the required qualifications, then I would contact the attorney to see if the summary was “work product.” If it was work product, then I would not be able to rely on the summary information. If it was not work product, then I would summarize the summary along with the medical records provided when rendering my opinion.

I would not let anyone jeopardize my reputation by claiming to assume responsibility. That is a ridiculous comment.

For the next issue:

“I was asked to do a life care plan for a middle-aged man who suffered a TBI when he fell through a floor of a home under construction. The attorney had experience in TBI cases and told me the name of the TBI rehab center he wanted included in the plan.

“Although I found this particular facility would do very well to meet the client’s rehabilitation needs, it was the most expensive and there were comparable options available in the same geographic area at much lower cost.

“When I informed the attorney, he said, ‘There are no options.’ What should I have done next?”

Share your expertise and advice. Send your confidential opinions and recommendations to the Editor at whowland@howlandhealthconsulting.com.
“Awesome Field Trip!”

In September 2014 a group of life care planners and one prosthetist made the trip to BiOM in Bedford MA for a day of learning and fellowship. We heard from staff, current users, and a plaintiff attorney on all aspects of patient valuation, manufacture, quality control, replacement, and costs. One of the things we heard over and over was how much everyone, from the boss all the way to the techs in the lab, loved to come to work every day and see the results of their work.

As luck would have it, as we were leaving a young man came in with his wife and 4-year-old to get his BiOM foot and ankle and try it for the first time. He strode more and more firmly up and down the ramp and stairs while the little boy ran after him and his wife stood by watching. It was a wonderful moment.

The consensus was that we should make this an annual event to keep up with developments. Stay tuned for a September 2015 date!

Attendees: Dennis Amtower, Wendie Howland, Linda Husted, Cheryl Kaufman, Joanne Rodgers, April Pettengill, Diane Reboy, Eileen Sheehan
Searching: Databases Replacing Print Tools
David Dillard BA MLS

Dave continues his series on learning about searches, and how you can do them better!

Doing literature searches in the first seven decades of the twentieth century meant using hardcopy printed materials. In libraries, you would go to the card catalog to find publications owned by the library, listed by author, title, or subject. You would have to know the exact spelling of the author’s last name, the first word of a publication title, or the subject heading used by the Library of Congress to find anything in a card catalog. Printed indexes for professional journals also required you to know the proper descriptors.

Researchers often had to go back and forth between volumes of indexes and volumes of abstracts to find what they needed, using print tools like Psychological Abstracts and Index Medicus. You’d have to work very hard to find a very few relevant works, and then follow leads in their bibliographies in these sources to find more (and older) sources. To make it more interesting, each publication used different headings, descriptors, or keywords.

Online databases began to appear around 1970, replacing printed materials over the next few decades.

Computer databases radically changed how to find information, allowing you to leave hard-copy print indexes and card catalogs far behind. One useful side effect: now you can use a much richer group of terms without being restricted to using index terminology. This makes it possible to

- search any term or group of synonyms
- combine that term or group of terms with another term or group of terms,
- find sources that had information from both

Unfortunately, instructional guides have not kept up with users’ changing needs. The

David Dillard has degrees in history and library science. He has worked at Temple University Libraries since 1970. He started sharing information sources and answers to questions on internet discussion groups around 1998 and started a network of public search engine indexed discussion groups and archives for sharing of posts of good websites, bibliographies of sources on a wide variety of topics. He is a regular on several nursing specialty lists and is very open to contact from anyone to help with searches on any topic. He can be reached at jwne@temple.edu
guides that do exist are generally well hidden from the people who need them most. *(Ed. note: For an easy, step-by-step review of using search terms, see Dillard’s article in the Fall 2013 JNLCP, p. 93-99, [http://www.aanlcp.org/resources/images/2013-Fall-Journal.pdf](http://www.aanlcp.org/resources/images/2013-Fall-Journal.pdf))*

You can be very adventurous in your search terms depending on what a document contains. You can search indexing and subject headings only, or abstracts, or indexing and subject headings and article summary, or the full text of the article.

For example: Did you ever need to know if Ronald Reagan had an affect on the jelly bean industry? Check this article: Dillard, David (2006). Librarians, Jelly Beans, and Google Book Search Online March / April 2006 30:2: 20-21

You could never find any of this abundant content about our former President’s sweet tooth using the “proper subject headings” in hardcopy print indexes. Doing it that way would take you years.

There’s a tradeoff in going from old methods to new. The critical problem is that skills aren’t commonly taught at most high schools or colleges. Furthermore, most people think you can find anything on any topic in Google. Unfortunately, this misconception results in many lawyers, physicians, and nurses reading poor quality content.

As an example, look at the results of these searches, looking for information on teaching database skills in high school and college. Very low numbers of sources discuss this issue. *Hint: Putting words in quotation marks makes search engines treat the words enclosed as one word.*

1) "database searching skills" AND ("high school" OR "secondary schools" OR "high schools" OR "secondary education") AND (curriculum OR teaching OR learning OR instruction OR "instructional materials")

- Google Scholar: About 30 results [http://tinyurl.com/c9r32u4](http://tinyurl.com/c9r32u4)
- Google Books: About 49 results [http://tinyurl.com/c5kp2cb](http://tinyurl.com/c5kp2cb)
- Temple Summon Search: 62 Sources Including the ALL Collections Summon includes internationally [http://tinyurl.com/d8vls2g](http://tinyurl.com/d8vls2g)

*continued next page*
2) "database searching skills" AND (college OR colleges OR university OR universities OR "higher education") AND (curriculum OR teaching OR learning OR instruction OR "instructional materials")

Google Scholar: 214 Results
http://tinyurl.com/bpr6dkh

Google Books: 1,290 Results
http://tinyurl.com/cgje2pv

Temple Summon Search: 143 Results
http://tinyurl.com/bmjb9sj

Not too impressive, is it? This small sample will give you an idea of the variety of returns you’ll find:

Teaching and Assessing the Database Searching Skills of Student Nurses
Author: Carlock, Danielle
Journal: Nurse educator
ISSN: 0363-3624 Date: 11/2007
Volume: 32 Issue: 6 Page: 251
DOI: 10.1097/01.NNE.0000299477.57185.ba

A strategy for curriculum integration of information skills instruction.
Author: Burrows, S
Journal: Bulletin of the Medical Library Association
ISSN: 0025-7338 Date: 1989
Volume: 77 Issue: 3 Page: 245

Evaluating evidence-based medicine skills during a performance-based examination
Author: Davidson, RA
Journal: Academic medicine
ISSN: 1040-2446 Date: 2004
Volume: 79 Issue: 3 Page: 272

Using online video to promote database searching skills: the creation of a virtual tutorial for Health and Social Care students
Author: Gravett, K
Journal: Journal of information literacy
Date: 2010
Volume: 4 Issue: 1 Page: 66

Evaluating information skills training in health libraries: a systematic review
Author: Brettle, Alison
Journal: Health information and libraries journal
ISSN: 1471-1834 Date: 12/2007
Volume: 24 Issue: s1 Page: 18
DOI: 10.1111/j.1471-1842.2007.00740.x

Predictors of knowledge, attitudes, use and future use of evidence-based practice among baccalaureate nursing students at two universities
Author: Brown, Caroline E.
Journal: Nurse education today
ISSN: 0260-6917 Date: 08/2010
Volume: 30 Issue: 6 Page: 521
DOI: 10.1016/j.nedt.2009.10.021

Teaching Evidence-Based Medicine: A Regional Dissemination Model
Author: Leipzig, Rosanne M.
Journal: Teaching and learning in medicine
ISSN: 1040-1334 Date: 07/2003
Volume: 15 Issue: 3 Page: 204
DOI: 10.1207/S15328015TLM1503_09

These results make it seem that database searching skills are much less important than, say, math. Look what happens when you substitute math or mathematics for database searching skills in just the previous Google Scholar search.

Google Scholar, high school: 18,300 Results
http://tinyurl.com/cva9rff

Google Scholar, college: About 2,200,000 results
http://tinyurl.com/ce85wfy
continued next page
How do people find health information online? Or do they? The ideas of information literacy, health literacy, media literacy and evidence-based are more commonly found in sources that do not discuss searching skills.

Google Scholar: "information literacy" OR "health literacy" OR "media literacy" OR "evidence based research" yields about 17,100 results

If you needed to search for information on how people identify good resources in an Internet search, take a look at what you’d get when you add terms about searching databases or the Internet:

("information literacy" OR "health literacy" OR "media literacy" OR "evidence based research") AND "database searching" OR "internet searching" OR "searching databases" OR "searching the internet")

- Without databases searching: About 327,000 results
  http://tinyurl.com/cm56fz9
- With database searching: 949 Results
  http://tinyurl.com/ctn4vc8

Some Perspective
If you had complex software like Excel, Photoshop, or even Microsoft Word, you’d never open it for the first time and simply start using it without study, manual reading, or training in how it works. Academic institutions teach very little about using search tools. End users, from students to professionals, use internet search engines and specialized databases without much -- or even any -- attempt to learn how to do it well. You don’t need to be that person.

In future articles, I’ll discuss the skills and resources you need to find information by life care planners and other professionals. First among these is defining the search question. For example, “How do you determine architectural and construction needs for a home for a wheelchair-bound elderly person?” You’d need terms like seniors, older persons, elders, old age, gerontology, and geriatrics, not just elderly. Looking for information on some aspect of care for a 15-year-old, you’d need adolescent, adolescents, adolescence, teens, teenager, teenagers, youths, and juveniles.

You’d need one or more databases for this search, too. Then you’d design a search that follows the rules of the search system you’re using. You’d have to check the results to see if they meet your needs; if not, you’d have to redesign the search strategy to give you better ones.

These skills can and must be learned over time. Plan to put some practice time and effort into thinking carefully about your subject, all meanings of the words about it, and which (if any) are can lead to useless content due to other meanings.
Show Them The Evidence

Evidenced-based practice begins with research.
If you write life care plans you already do research.
No fear! Lighten the load!
Strengthen the practice!

Together we can learn the scoop
share knowledge
build a body of evidence
by life care planners
for nurse life care planners

RESEARCH

Participate:
email cmanzetti@aol.com
The Affordable Care Act (ACA) refers to two controversial laws enacted in March 2010, the Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act. They restructure the fundamental relationship among government, health care providers and health care recipients, and profoundly affect persons with disabilities.

The ACA has been the subject of numerous legal challenges. The United States Supreme Court, however, upheld nearly all ACA’s provisions in June 2012, including the individual mandate and elimination of preexisting condition restrictions, which became effective nationally on January 1, 2014.

Although some exemptions apply, the individual mandate requires all eligible Americans to maintain at least "minimum essential" health insurance or pay a fee based upon "modified adjusted gross income" (MAGI). The ACA also requires all health insurance companies to cover all applicants and offer the same rates within new minimum standards regardless of preexisting medical conditions or sex.

How does the ACA affect nurse life care planners and, more specifically, their scope of practice and work product in personal injury cases?

As a point of reference for discussing this question, it is helpful to consider the following excerpts from The American Association of Nurse Life Care Planners (AANLCP) Scope and Standards of Practice:

- "The primary role of the nurse life care planner is to provide a life care plan by applying the nursing process methodology: assessment, diagnosis, outcomes identification, planning, implementation, and evaluation of the injured or chronically ill person."

- "The life care plan is developed for individuals with injuries or chronic conditions whose complex healthcare needs may benefit from long-term planning. This dynamic document provides an organized,
concise plan of estimated reasonable and necessary (and reasonably certain to be necessary) healthcare needs, for current and future periods, with associated costs and frequencies of goods and services. A plan outlines an individual's needs throughout the healthcare continuum, in multiple settings, and throughout the life expectancy. Therefore, a plan is flexible, i.e., evaluated and updated periodically with change in the needs."

- "The Affordable Care Act is still being challenged and its full affect remains to be seen."
- "Life care planning as a nursing specialty is at a relatively new stage in its evolution."

Quoting the American Nursing Association (ANA) Scope and Standards of Practice:

- "[r]egistered nurses must proactively deal with constant change and must be prepared for an evolving healthcare environment."
- “The market for nurse life care plans has expanded, encompassing legal, medical, liability insurance, financial sector for special needs trusts, and Medicare set-aside projections."

- Therefore, while it is true that the full affect of the ACA on nurse life care planners remains uncertain, it is also true, necessary, and appropriate for nurse life care planners to discuss, debate, and continue to analyze the ACA's affect. The purposes of this article are to:

  - Review the collateral source rule, one of the most important ACA issues related to personal injury cases
  - Highlight published opinions of how the ACA generally, and the collateral source rule more specifically, now affect nurse life care planners
  - Summarize ACA-related cost-containment programs likely to benefit Medicare recipients
  - Encourage the AANLCP and its members to self-evaluate their work product and scope and standards of practice cases in the context of ACA-related issues and developments.

ACA will almost certainly create new business opportunities for nurse life care planners

ACA and Collateral Source Rule

Writers and expert commentators generally agree the ACA will affect life care planners and life care plans in personal injury cases. Their analysis and conclusions, however, differ greatly, depending upon their understanding and analysis of the collateral source rule.

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The common law collateral source rule was first recognized in U.S. case law in 1854 and has since been incorporated into Section 920A of the Restatement (Second) of Torts, entitled "Effect of Payments Made to Injured Party," which provides:

"(1) A payment made by a tortfeasor or by a person acting for him to a person whom he has injured is credited against his tort liability, as are payments made by another who is, or believes he is, subject to the same tort liability.

"(2) Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor’s liability although they cover all or a part of the harm for which the tortfeasor is liable."

The Restatement's comment explains Part 2 of Section 920A, in part, as follows: "Payments made or benefits conferred by other sources are known as collateral-source benefits. They do not have the effect of reducing the recovery against the defendant. The injured party’s net loss may have been reduced correspondingly, and to the extent that the defendant is required to pay the total amount there may be a double compensation for a part of the plaintiff’s injury. But it is the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor...."

The Restatement's comment further states that collateral benefits include insurance policies as well as social legislative benefits such as social security, Medicare and Medicaid.

The collateral source rule affects how much money a plaintiff will receive in a personal injury case because it allows a judge to exclude collateral compensation as evidence during trial and when calculating damages. As a result, some plaintiffs with health insurance historically have been able to recover twice for medical expenses related to their injuries - once from their insurer and again from the tortfeasor.

As another result, except in special circumstances, nurse life care planners' work product and testimony historically have not included or addressed health insurance. Another reason why nurse life care planners historically have excluded health insurance: before the ACA, most seriously injured plaintiffs could not obtain ongoing health insurance as a result of preexisting conditions -- their injuries.

Collateral source rule proponents have justified this controversial result by emphasizing the deterrence theory of tort law, which seeks to punish tortfeasors and deter them from injuring future payments, and with the following additional arguments (Levenson 2013):

- Defendants should not be unjustly enriched if a plaintiff purchases medical insurance.
- The CSR incentivizes plaintiffs to purchase medical insurance.

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• Collateral sources never fully reimburse plaintiffs.
• Subrogation rights reduce and/or prevent double recoveries.
• The CSR promotes independence of jury determinations.

Collateral source rule opponents argue the purpose of tort law is compensation for harm, not deterrence (Levin 2013). They criticize the collateral source rule for:

• Allowing some plaintiffs to recover twice.
• Generating different damage awards for the same injuries in different cases.
• Adding an unjustified element of punitive damages.
• Inflating awards.
• Encouraging claimants to go to trial.

Because the traditional collateral source rule appears to overcompensate plaintiffs, tort reform advocates (generally personal injury defendants and their insurers) have targeted and opposed it. As a result, 39 states have modified the collateral source rule from its common law (Restatement) form (Table 1).

The increasing use of subrogation by insurers has affected the collateral source rule in personal injury cases by allowing the insurer to assert the rights of an insured plaintiff against the defendant and/or its liability insurer and thereby seek repayment after the plaintiff has received an award or settlement. Subrogation negates the collateral source rule’s double-recovery effect, because the plaintiff receives damages which exclude the collateral insurance payments and the defendant pays the full measure of damages to the plaintiff and the insurer (Todd 2012).

How the ACA will affect the collateral source rule is the subject of debate and litigation between defendants and plaintiffs.

The Individual Mandate Because of the ACA’s individual mandate and elimination of pre-existing condition restrictions, some de-
fendants and commentators argue that plaintiffs' recoveries for future medical expenses in personal injury cases should now be restricted to the ACA's annual maximum out-of-pocket limit plus the current cost of purchasing medical insurance. The result in some cases, which plaintiff attorneys view as prejudicial and unfair: Juries may reduce the amount of recoverable future damages while still permitting the collateral source provider to seek reimbursement from the plaintiff. (Cardeli 2014)

Other commentators maintain the ACA has minimal effect on the collateral source rule relating to healthcare damages in tort actions despite undermining some of its justifications. (Todd 2012) This view is supported by Aidan Ming-Ho Leung v. Verdugo Hills Hospital, a California medical malpractice state court case that resulted in a damage award for future medical expenses. On appeal, the defendant hospital argued evidence of the plaintiff's health insurance should have been allowed to rebut the plaintiff's claim of future medical expenses as a result of the ACA. The appellate court disagreed holding: "(S)uch evidence, standing alone, is irrelevant to prove reasonably certain insurance coverage...because it has no tendency in reason to prove that specific items of future care and treatment will be covered, the amount of that coverage, or the duration of that coverage."

**Affect on NLCP** How will these divergent views of the ACA and the collateral source rule affect nurse life care planners? Again, interpretations vary.

The key issue to be litigated, according to some commentators, is: "...whether it remains fair to continue to force the fiction upon the jury that future medical expenses projected by a plaintiff's life care plan will be paid 100% out-of-pocket, when in the post-ACA world, that will be the case for almost no one." (Yagerman and Bookman 2014) They argue: 
"[i]f defendants in an ACA world are permitted to dispense with the collateral source hearing and present evidence of health insurance coverage directly to the jury, such evidence should significantly curtail the persuasiveness that life care plans' projections represent actual future medical expenses that are supposedly to be paid completely out-of-pocket by the plaintiff."

Other experts, even those who "...believe the ACA changes the underlying reason of excluding collateral source compensation from inclusion in tort cases," still anticipate life care planners will play an increasingly important role in personal injury damage analysis. (Congdon-Hohman and Matheson 2012)

Before the ACA, life care planners were tasked with identifying medical and living expenses not otherwise required but for the ac-

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incident. Under the ACA, these experts maintain that life care planners must also identify which health care and living expenses will, and will not, be covered by the ACA’s minimum insurance requirements. And despite certain minimum federal standards, these requirements may differ by state.

**ACA’s Effect on Medicare and Medicaid**
Regardless of how the ACA affects the state-specific collateral source rule, nurse life care planners will need to know how the ACA affects Medicare and Medicaid. This is true especially with Medicare because of the increasingly important role of nurse life care planners in Medicare set-aside (MSA) calculations.

**Medicare** The official U.S. government site for Medicare ([www.medicare.gov](http://www.medicare.gov)) lists several ACA-related benefits for Medicare recipients:

- Medicare recipients are not required to replace Medicare coverage with ACA health insurance marketplace coverage and they retain the same Medicare benefits and protections.
- The ACA includes discounts and additional coverage to make Part D Medicare prescription drug coverage more affordable and closes the coverage gap (donut hole) in 2020.
- In addition to a free yearly wellness exam, the ACA expands Medicare coverage to cover preventive services, such as mammograms and colonoscopies, with no deductible or Part B coinsurance.
- The ACA provides new incentives for doctors to coordinate care and provide more consistent treatments.
  - The ACA extends the Medicare trust fund to at least 2029 by reducing Medicare waste, fraud, abuse, and costs, thereby reducing future premiums and co-insurance.

Commentators (Chiplin and Lilly 2013) have identified additional ACA cost-containment programs they believe will reduce future Medicare health care costs:

- **Patient-Centered Medical Home (PCMH).** The purpose of this program, currently being tested in CMS-designed demonstration models, is to “redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations.” To qualify, a participant must be enrolled in Medicare Parts A and Part B and have at

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least one eligible chronic disease as defined by CMS.

- **Medicare Shared Savings Program (MSSP).** The purpose of this program is "to promote accountability for a defined patient population, coordinate items and services under traditional Medicare Parts A and B, and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery." Under the MSSP, groups of providers and suppliers that meet criteria defined by the Department of Health and Human Services (HHS) can work together to manage and coordinate care for Medicare fee-for-service beneficiaries through Accountable Care Organizations (ACOs). ACOs will be eligible to share cost savings if they meet HHS-defined quality performance standards.

- **The Independent Payment Advisory Board (IPAB).** The IPAB is a 15-member board of health care experts appointed by the President whose mission is to develop recommendations to "reduce the per capita rate of growth in Medicare spending." The IPAB cannot make recommendations "to ration health care, raise revenues, raise Medicare beneficiary premiums, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria." The IPAB reports will be submitted to MedPAC, HHS, the President and Congress. The report will explain each recommendation and include both a legislative proposal and a CMS actuarial opinion. HHS will adopt IPAB recommendations unless Congress votes to prevent implementation.

- **Quality Review Mechanisms** The ACA features several quality measurement initiatives that restrict payments for services and procedures that do not meet care standards:
  - Incentive payments for hospitals
  - Limiting payment for hospital-acquired conditions
  - National strategy to improve healthcare quality
  - Interagency working group on health-care quality
  - Quality measurement development
  - Health information technology
  - Data collection to reduce health care disparities
  - The Center for Medicare and Medicaid Innovation
  - Preventive services

**Medicaid** In addition to expanding private health insurance, the ACA also expanded Medicaid eligibility by offering financial support to states that expand Medicaid eligibility to non-elderly individuals in families with incomes below 133 percent of the Federal Poverty Level. Through 2016, the Federal government has committed to paying participat-

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ing states 100% of the related costs, reducing to 90% in 2020 and thereafter. The U.S. Supreme Court ruled in 2012 that the Federal government could give states a choice to accept Medicaid expansion but could not require them to do so. To date, 28 states and D.C. have expanded Medicaid, and 22 states have not.

To promote further Medicaid expansion, the Council of Economic Advisers published a report in July 2014 titled "Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid" (CEA report). The CEA report concludes: "by expanding their Medicaid programs, States can improve access to essential medical care, reduce financial hardship, improve their citizens' mental health and longevity, and claim billions of dollars in Federal funding that could boost their economies today." The CEA report quantifies the following purported benefits for newly insured individuals on a state-by-state basis with supporting maps and tables:

- Improved access to care.
- Greater financial security.
- Better mental and overall health.

**Conclusion**

Nurse life care planners play an increasingly important role in personal injury damage analysis and the scope of their practice continues to expand.

The ACA is expected to reduce health care costs and will likely require changes to traditional personal injury life care plans to account for the expanded availability of health insurance resulting from the individual mandate and elimination of pre-existing condition restrictions. Many such changes will likely result from state-specific litigation (or new state legislation) to determine whether and how the ACA affects existing collateral source rules and, therefore, the calculation of future medical damages. This process will take time and the state-specific changes are unlikely to be uniform without additional federal legislation.

In addition, the ACA includes important cost-containment programs intended to reduce future Medicare cost as well as oppor-
opportunities for state to expand Medicaid coverage.

Regardless of the timing and result, the ACA will almost certainly create new business opportunities for nurse life care planners. These new business opportunities could include reviews of previous life care plans as well as life care plans for new cases. Nurse life care planners are encouraged to continue monitoring and studying the ACA and its state-specific affect on personal injury damage analysis.

References
Section 920A of the Restatement (Second) of Torts, entitled "Effect of Payments Made to Injured Party"
The American Association of Nurse Life Care Planners (AANLCP) Scope and Standards of Practice.
Seth Cardeli, "Thwart the Assault on Future Medical Expenses," Trial Magazine, May 2014.
Aidan Ming-Ho Leung v. Verdugo Hills Hospital, Court of Appeals of California, Second District, Division Four, Filed 2013.
Joshua Congdon-Hohman and Victor A. Matheson, "Potential Effects of the Affordable Care Act on the Award of Life Care Expenses," College of the Holy Cross, Department of Economics, Faculty Research Series (Paper No. 12-01), 2012.
S2KM Limited’s blog “Beyond Structured Settlements” (s2kmblog.typepad.com) and the Structured Settlement Wiki (http://structuredsettlement.wikispaces.com).
Generally overlooked in the national debate surrounding the Patient Protection and Affordable Care Act (ACA) is the effect the new law will have on personal injury litigation. If standard loss-allocation and mitigation rules are followed, the new law should have a significant impact on a personal injury plaintiff’s ability to recover the cost of future medical care, thus limiting a defendant’s exposure for such damages. Though no definitive judicial rulings have been issued on this topic, the new law has the potential to substantially lower the risk of exposure to defendants and their insurers.

The cost of future medical care can be a significant component of a plaintiff’s economic damages, often running into the millions of dollars. In states that do not enforce the common law collateral source rule, which precludes the reduction of a personal injury award by the amount of compensation a plaintiff receives from a source other than the tortfeasor, such awards should be reduced to the cost of obtaining necessary insurance to pay for the care, so long as the insurer does not maintain a legal right of subrogation. Some jurisdictions, such as New York, have limited an insurer’s right of subrogation while other subrogation rights are guaranteed by statute.

Judicial Consideration of the Affordable Care Act
Once the ACA was upheld by the United States Supreme Court and the key provisions of the law took effect, courts began to consider limiting a plaintiff’s economic damages by admitting evidence at the time of trial pertaining to insurance available under the new law.

For example, in Caronia v. Philip Morris USA, Inc., 2013 N.Y. Slip Op. 8372 (December 17, 2013), the New York State Court of Appeals considered whether the plaintiffs (who were smokers for 20 years or more, but who had not yet been diagnosed with a smoking-related disease) could pursue an independent cause of action and recover the cost of monitoring for future diseases. The court ruled that they could not because

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the plaintiffs had not yet sustained an injury. In a dissenting opinion, Chief Judge Lippman found unpersuasive the defendants’ argument that under the terms of the ACA, the plaintiffs would soon be able to obtain free access to such monitoring. However, he acknowledged that there was a potential for an offset under the law for a reduction of the plaintiffs’ damages. See also, Cowden v. BNSF Railway Company, 2013 U.S. Dist. LEXIS 155486 (E.D.Mo., October 2013).

Duty to Mitigate Damages and Collateral Offset Rules in New York
New York is one of several states to abandon the common law collateral source rule. To prevent double recoveries and to help allocate the costs of compensating plaintiffs for injuries, the New York State Legislature enacted section 4545(a) of the Civil Practice Law and Rules. Pursuant to this rule, a judgment in a personal injury or wrongful death action must be reduced by the amount of collateral source payments. Such payments include amounts that a plaintiff has received or will, “with reasonable certainty,” receive from collateral sources such as insurance.

Section 4545(a) provides that a collateral source should be “pursuant to a contract or otherwise enforceable agreement.” Although the ACA is not, in and of itself, a contract or an agreement, the mandatory insurance policies one must purchase pursuant to it are contracts. Even if a plaintiff has not yet purchased health insurance coverage under the Act, it should be assumed that he or she will do so since it makes little economic sense to pay the higher costs of the medical care than the lower costs of the insurance. This issue has not yet been resolved by the courts. Nevertheless, because a plaintiff has a duty to mitigate his or her damages, the courts should be encouraged to apply the law so as to avoid the inequitable result of a plaintiff receiving a double recovery.

Duty to Mitigate Damages
There is a long-standing common law rule that limits an injured party’s recovery if he or she has failed to reasonably mitigate his or her damages (sometimes referred to a “duty to mitigate”). The Restatement Second of Torts describes the rule as follows: “one injured by the tort of another is not entitled to recover damages for any harm that he could have avoided by the use of reasonable effort or expenditure after the commission of the tort.”

Williams v. Bright, 230 A.D.2d 548, 550 (1st Dept. 1997), citing Blate v. Third Ave. RR Co., held that “a party who claims to have suffered damage by the tort of another is bound ‘to use reasonable and proper efforts to make the damage as small as practicable,’” and citing Hamilton v. McPherson, “If an injured party allows the damages to be unnecessarily enhanced, the incurred loss justly falls upon him.” Applying this rule of law to the ACA, it becomes clear that because insurance is now available to everyone, regardless of any preexisting medical conditions, sound public policy would require an injured plaintiff to purchase insurance to pay for his future medical care.

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The proper time to apply the new law would be immediately after a verdict is reached. Before a court may enter judgment on a verdict in an action to recover damages for personal injury, injury to property or wrongful death, it must first apply to the findings of past and future damages any applicable rule of law, including setoffs, credits and any reductions for comparative negligence. See, CPLR § 5041(a) (Consol. 2013). Following a verdict, a defendant cast in damages should immediately move for a collateral source offset hearing. Failure to grant such a hearing in cases involving a structured verdict is in error and requires a judgment be set aside (Garrison v. Lapine, 22 Misc. 3d 1128(A) (Sup. Ct., Ulster Cty. 2009) aff’d 72 A.D.3d 1441 (3d Dept. 2010).

Section 4545(a) specifically does not apply to insurance or other collateral sources to which there is a statutory right of subrogation. Such statutory rights to subrogation exist for Workers’ Compensation insurance as well as benefits paid under Title XVII of the Social Security Act (codified as 42 USC Section 1395, et seq.), which govern health insurance for the aged and disabled. A review of the provisions of the ACA does not indicate that there is any similar right to repayment, reimbursement or subrogation under the Act. As noted previously, New York has recently limited an insurer’s right of subrogation to recover amounts paid for medical care from any settlement for personal injury, medical, dental or podiatric malpractice or wrongful death. Thus, in New York, a defendant should be entitled to a reduction for amounts awarded for future medical care, unless that medical care will be paid for by Medicare, Medicaid, Workers’ Compensation insurance or, in certain circumstances, Personal Injury Protection benefits awarded under a no-fault automobile policy.

Recommended Best Practices

The issue of collateral source offsets and the implications of the ACA should be raised at the earliest possible time in defending a tort action. Mitigation of damages and the reduction of any award based on collateral source offsets should be pled as affirmative defenses in a defendant’s answer. If an action is already pending and if these defenses have not been raised, counsel should move to amend the answer to assert them.

The application of the Affordable Care Act, Article 50b of the CPLR and section 5-335 of the General Obligations Law, should be pled in a defendant’s bill of particulars where appropriate. Discovery demands should include authorizations for all health insurance records, Workers’ Compensation records, and the Centers for Medicare and Medicaid Services.

Defense counsel may wish to consider retaining an expert insurance actuary to testify to the cost of insurance, and the expert should be disclosed as early as possible. Preparing these arguments at an early stage can have benefits if and when a case is presented for alternative dispute resolution. It should also be anticipated that a plaintiff will move to preclude any evidence of insurance from the trial. The prudent practitioner should be prepared with memo-

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randa of law to support the relevance of the insurance provisions of the ACA. Finally, defense counsel should move for a collateral source hearing as soon as possible following any verdict. Failure to make a timely application for such relief could result in a waiver of a substantial right.

To date, no court of record has applied the provisions of the ACA to reduce or limit an award for future economic damages. By applying existing principles to the new law, however, a practitioner should be able to use the Act to prevent an excess recovery by a plaintiff and to limit the exposure of a defendant or the defendant’s insurer. Because the purpose of an award for economic damages is to compensate a plaintiff for his actual damages and not to bestow a windfall, this should be seen as a matter of simple justice and equity.
In cases where a person must purchase a health plan after a catastrophic injury, the individual health insurance market now provides options where previous there were few. However, not every private health plan is appropriate for every catastrophically injured person. For those whose medical bills are paid by a tortfeasor (i.e., a person who committed a wrongful act injuring another), health plan selection is easier because out-of-pocket costs along with premiums are the tortfeasor’s responsibility. However, for those whose injuries have not resulted in a third party payor, three main features must be evaluated before enrollment into a privately purchased health plan: healthcare provider network, drug formulary, and annual expenses including out-of-pocket costs.

Provider network
The first shopping consideration for the catastrophically injured is the healthcare provider networks of the available health plans. Health insurance is only as good as the doctors and hospitals that accept it. Depending on the injury, prospects for improved health or quality of life may be closely associated with the services of specific medical experts in the region. Consequently, it is imperative to confirm these experts’ participation in a plan’s provider network before enrollment. Out-of-network healthcare providers are typically uncovered by health plans in nonemergency situations. The catastrophically injured should remember when confirming network participation that key healthcare providers may be personnel other than just physicians. These providers can include specialized nurses, hospitals, physical therapists, or other healthcare workers.

Investigating a health plan’s inclusion of key healthcare providers does not end with validating the providers’ network participation. If the health plan’s network is tiered, it is important to clarify in which tier each key healthcare provider belongs and the out-of-pocket costs for services within each tier.

Kevin Coleman is Head of Research and Data at HealthPocket.com. He can be contacted at kevin.coleman@healthpocket.com
Drug/formulary cost

The concept of tiering also applies to medications. Medications that are included in a health plan’s formulary (i.e., the list of covered medications) are assigned to a tier. The tier indicates the cost-sharing obligations associated with each covered medication. The tier’s cost-sharing design is normally a flat fee co-payment or a coinsurance fee representing a percentage of the drug’s total cost. The cost of off-formulary drugs is normally not paid by the health plan and these costs are not capped by the plan’s annual cap on out-of-pocket healthcare expenses. Since a catastrophic injury may result in the use of one or more maintenance drugs (e.g., blood thinners, anti-seizure or anti-convulsive medications, etc.), prospective health plans’ formularies must be reviewed to confirm coverage for each maintenance drug as well as the cost-sharing dictated by the drug’s tier assignment.

Alongside drug coverage and tier assignment, each formulary should be reviewed to identify any cost utilization measures for a drug. A cost utilization measure is a restriction associated with an on-formulary drug by the health plan. The three main cost utilization measures are quantity limits, prior authorization, and step therapy. Quantity limits are the maximum units of a drug that can be obtained per prescription period. Prior authorization is the requirement to obtain a health plan’s approval before a drug may be obtained. Step therapy is the requirement to try one or more less expensive drugs in the same class and establish unacceptable efficacy before the drug with the step therapy restriction is approved for use.

Out-of-pocket costs

The final of the three main factors in health plan selection for the catastrophically injured is total annual costs. Not all catastrophically injured have the benefit of a tortfeasor to pay bills and, instead, limited family resources are expected to cover premiums and out-of-pocket costs. (http://www.healthpocket.com/individual-health-insurance/out-of-pocket-costs/#.VGPF1fTSlOE) Accordingly, the costs of anticipated healthcare use must be evaluated alongside premium costs. Given the higher rate of healthcare usage among the catastrophically

Actuarial value is not an indicator of out-of-pocket costs. A plan with a 70% actuarial value does not mean that 70 cents of every dollar of healthcare is paid by the plan.
injured, out-of-pocket costs may exceed premiums with respect to annual spending.

Is there a catch?
Affordable Care Act health plans are categorized by actuarial value and actuarial value has some bearing on out-of-pocket costs. Actuarial value represents the percentage of healthcare costs paid by the plan. A bronze plan has a 60% actuarial value, a silver plan 70%, a gold plan 80%, and a platinum plan 90%. (https://www.healthcare.gov/choose-a-plan/plans-categories/) However, actuarial value is not a transparent indicator of an enrollee’s out-of-pocket costs. For example, a plan with a 70% actuarial value does not mean that 70 cents of every dollar of healthcare is paid by the plan. Rather, for all the enrollees of a health plan, the insurer anticipates to pay 70% of the enrollees’ covered healthcare costs. Consequently, for some enrollees the plan may pay a higher percentage of healthcare costs and for others the plan will pay less.

Another complication is that plans with the same actuarial value can have very different combinations of medical deductibles, drug deductibles, copayments, co-insurance fees, and caps on annual out-of-pocket spending. In order to find the lowest total health insurance expenses for a year, a person must document his or her anticipated medical and drug usage for the year and calculate what the out-of-pocket costs would be for this usage under the plan along with the plan’s annual premium costs.

Prior to the Affordable Care Act, buying private insurance was not an option for the catastrophically injured in most states. Applicants usually faced medical underwriting, an evaluation by which those applicants with costly health conditions were typically rejected. With the introduction of guaranteed issue requirements, the catastrophically injured can no longer be denied an individual health plan due to medical considerations.

Moreover, the common law collateral source rule prohibits health insurance payments from being used to mitigate damages in situations where a catastrophic injury was sustained due to a third party.

However, access to the individual health plan market does not prevent the catastrophically injured from selecting the wrong plan for their circumstances. Shopping health plans in light of provider network, drug coverage, and total annualized expenses position anyone, catastrophically injured or not, for the optimal health insurance selection.

For life care planners assisting the catastrophically injured with health insurance decisions, HealthCare.gov provides comparisons continued next page
Questions for Kev Coleman:

After reading an article you wrote recently indicating premiums will change in 2015, I don’t know how a life care planner could assume knowing the cost of premiums over, say, the next 40 years.

That is absolutely correct. You cannot know future premiums. In some markets, there have been significant rate increases in recent years due to changes in regulation, the competitive landscape, and risk pool composition.

Is it possible to know the premiums year after year and will the copays remain the same?

No. Health plans are reviewed and approved annually. Cost-sharing is tricky because it encompasses a plurality of services alongside deductibles. Consequently, you can remain in the same actuarial value but change a variety of copays and co-insurance fees that will affect some enrollees more than others due to the nature of their personal healthcare usage.

Would essential benefits cover unlimited therapies, medical visits, diagnostic testing or would the insurance company determine what would the maximum limit in essential health benefits would be?

Essential Health Benefits, as defined by the benchmark plan selection at the state level, typically provides specifics of what services within a broader category (e.g., drug coverage) are included. My experience is that the number of visits are defined as much as what procedures are covered (e.g. bariatric surgery and IVF infertility treatments are covered in EHB in some states but not others) and how many medications within a drug class must be included (the ACA minimum is 1 but the benchmark plan redefines the minimum generics and brand names in each drug class).
of on-exchange health plans and HealthPocket.com provides comparisons of both on-exchange and off-exchange health plans. It is important for life care planners to remember that:

- Premiums vary among plans in the same metal tier (e.g., platinum plans)
- Caps on annual out-of-pocket costs vary among plans in the same metal tier
- Health insurance premium subsidies are only available for on-exchange health plans
- On-exchange plans exhibit an increased use of “narrow networks” where a reduced set of doctors and hospitals serve a larger pool of enrollees
- Out-of-network healthcare providers are typically not covered by a health plan in situations where no medical emergency is present

The health plan selection process should ideally be revisited every annual enrollment period because a health plan’s drug formulary may change for the new calendar year as well as premium, deductible, and provider network. What was the best plan this year will not necessarily be the best plan next year.

**Further Reading:**

“Actuarial Value of Obamacare Health Plans.” HealthPocket.com
https://www.healthpocket.com/obamacare/actuarial-value-of-obamacare-health-plans#VD0x_ue-18E


Your colleagues on the Editorial Committee are pleased to report out on the 2014 Annual Readership Survey. As we have in the last few years, we posted the link to this survey in the last 3 issues and invited any reader of any background, member or not, nurse or not, to comment. Want to add your two cents’ worth? Contact the Editor at whowland@howlandhealthconsulting.com, or any of the other committee members listed on page 721.

1) How often do you read the JNLCP?
   Every issue: 89%            Once or twice annually / rarely: 11%

Comments:
   • Every issue has useful information!
   • Every issue has a wealth of knowledge and variety in articles from the advanced life care planner to the new or just starting out.
   • Time constraints
   • Enjoy the content and always learn something new
   • Very informative materials!

2) How do you access and read it? (Total >100% due to multiple responses)
   • I read it online at my computer: 88%
   • I read it on an e-reader (Kindle, iPad, etc.): 19%
   • I print it out to read in hard copy: 39%
   • I save issues on my computer: 63%
   • I save issues in hard copy: 19%
   • I go to the AANLCP website if I want back issues: 63%

Comments:
   • I will print out pertinent articles for later use (2).
   • All, I access the journal through all methods listed.

3) How often do you read ...

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<td>63%</td>
<td>3.56</td>
</tr>
<tr>
<td>Suggested NsgDx</td>
<td>0%</td>
<td>13%</td>
<td>13%</td>
<td>75%</td>
<td>3.63</td>
</tr>
<tr>
<td>Tools of the Trade</td>
<td>0%</td>
<td>0%</td>
<td>25%</td>
<td>75%</td>
<td>3.75</td>
</tr>
<tr>
<td>Book review</td>
<td>14%</td>
<td>7%</td>
<td>50%</td>
<td>28%</td>
<td>2.93</td>
</tr>
<tr>
<td>Ads</td>
<td>7%</td>
<td>7%</td>
<td>53%</td>
<td>33%</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Comments: (none)

4. In the last year, the issue(s) or article(s) I remember best is ... because ...
   • Every issue is fantastic. Scrambler Therapy is of great interest. (March, Technology)
   • Scrambler therapy
   • None (2)
• Too many to list, doing a really good job with the Journal!
• The research article by David Dillard (March, Selecting databases)
• The ones I reviewed. Sorry, I would have a biased answer as a committee member.
• All! I print out each and keep them by year, on a book shelf. I often refer back to a journal to find an article specific to my needs or to review references.
• Using algebra for research which then further enhanced by the author at the recent AANLCP conference (Fall 2013, Dillard, The Science of Searches)
• Shelly Kinney’s on military services (December 2012, VA Issue)
• One on technology and I wrote to the author to say thank you.
• Technology (March, Technology Update)
• Like them all
• The current issue (March, Technology Update)
• The one I wrote! ;)
• Amputations because I was working on a LCP for an amputation. (Winter 2009, Amputation)

5) JNLCP features I like:

<table>
<thead>
<tr>
<th>Feature</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bibliographies</td>
<td>44%</td>
</tr>
<tr>
<td>Live links to websites</td>
<td>81%</td>
</tr>
<tr>
<td>Product features</td>
<td>56%</td>
</tr>
<tr>
<td>Author contact info</td>
<td>44%</td>
</tr>
<tr>
<td>Art/photos/layout</td>
<td>19%</td>
</tr>
<tr>
<td>Index</td>
<td>50%</td>
</tr>
</tbody>
</table>

Comments:
• I would love a searchable index attached to all issues so I can go to my latest issue and search for things I need.
• I appreciate the pictures of equipment, devices, graphs, charts and side bars and so forth. It is a nice break when reading an article. Great benefit to each article.
• Don't like the layout as it strikes me as "too cute." Love the ethics questions and answers.
• Articles are applicable to my LCPs. I cite the JNLCP journal articles in my LCPs.

6) Within the past year, have you shared an article or issue with a client, colleague, or friend?

Yes: 53%  No: 47%

Comments:
• Scrambler Therapy
• Whole journals
• Can't remember right now.
• References.
• Qualifying as an Expert Witness was recommended to a nurse who felt she didn't have enough education to testify as an expert.

7) How do you feel about:

<table>
<thead>
<tr>
<th>Type of Article</th>
<th>Don’t like at all</th>
<th>Too much</th>
<th>Just about right</th>
<th>Want more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Articles from CNLCPs</td>
<td>0</td>
<td>0</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>Articles from non-nurses</td>
<td>0</td>
<td>7%</td>
<td>87%</td>
<td>7%</td>
</tr>
<tr>
<td>1st person reports</td>
<td>0</td>
<td>7%</td>
<td>73%</td>
<td>20%</td>
</tr>
<tr>
<td>Scholarly articles</td>
<td>0</td>
<td>0</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Original research</td>
<td>0</td>
<td>0</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>Colloquial articles</td>
<td>7%</td>
<td>7%</td>
<td>79%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Comments:
• Not sure how we can get more scholarly research, but we are lacking in this area. Perhaps we could meet the need with more reprints from other nursing journals.
• We learn from the experience of others. An article written by a non-nurse is just as valuable as an article written by a nurse. All authors who have the education, training and experience and are willing to share, regardless of the letters after one’s name, can provide information critical for the NLCP to use as a resource or reference.

8) Features I'd like to see added to the Journal:
• Searchable for the entire body of works of the Journal, also like to see articles about what research that people add to their life care plans, what books and online sources people have, how they get physician cooperation, and getting anesthesia prices. "What’s in YOUR library?"
• More of the legal side of our business (e.g., how to prep for deposition, legal strategy, etc.)
• Nothing comes to mind.
• I like the journal as is / I cannot think of a change to the journal
• Continuing education credits for studying articles or reading issues.
• The journal currently has a wide variety of topics to meet the interests of so many, not just nurses. Really enjoy the topics. Thank you.
• Regular article with research tips; recently "found" LCP resource materials, i.e. good stuff perhaps found deep within the bowels of a website

9) We'd like NLCPs from novice to expert to give our authors feedback. Would you be willing to review submitted articles for content and readability?
   Yes: 39%  No: 46%  Maybe: 15%

Well! That was great feedback. In no particular order:

• We are working on identifying a way to publish the Journal with a new format that will support both searching and indexing better, and make it possible to click on the table of contents and go directly to the article.
• The Education Committee is looking into how to present CEs for issues/articles.
• The Research Committee is looking into providing you with more research advice content, too.

In collaboration with the Committees, we hope to have these three up and running by March.

“What’s in YOUR library?” sounds like a great short department! What books or online resources do you have that you couldn’t do without? Why? Send me your contributions, no more than a paragraph, and we’ll see what develops.

~ wah
NURSE LIFE CARE PLANNING CERTIFICATION

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CNLCP® HANDBOOK & APPLICATIONS FOR CANDIDATES

Application by Exam: http://www.ptcny.com/PDF/CNLCP.pdf

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As healthcare has become more complex, it is increasingly vital to assure the public that healthcare professionals are competent. Individual State Registered Nurse (RN) licensure measures entry-level competence only; and, in so doing, provides the legal authority for an individual to practice nursing. It is the minimum professional practice standard.

Certification, on the other hand, is a formal recognition that validates knowledge, experience, skills and clinical judgment within a specific nursing specialty; and, as such, is reflective of a more stringent professional practice standard. It reflects achievement of proficiency beyond basic licensure.

The CNLCP® Certification Board is a separately incorporated entity that facilitates consumer health and safety through credentialing/certification of nurse life care planners. It ensures that their practice is consistent with established standards of excellence in the development and defense of the life care planning document.

Similar to consumers knowing to seek out certification status within other professions (e.g., dentists, pharmacists, etc.), certification within the field of nurse life care planning has become an important indicator that a certified nurse not only holds state licensure to practice nursing, but is qualified, competent and has met rigorous requirements in the achievement of the CNLCP® credential.

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Glenda Evans-Shaw, Chairperson
glenda@suttercreek.com /phone: (209) 267-0890

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2009
IX.1 MSA
IX.2 SCI
IX.3 Preconference
IX.4 Amputation

2010
X.1 Pediatric LCP
X.2 Elder LCP
X.3 Preconference / Multitrauma
X.4 Tools for NLCP

2011
XI.1 Adaptive Technology
XI.2 Recreation and Voc in NLCP
XI.3 Preconference / Burns
XI.4 Chronic Pain

2012
XII.1 Coding and Costing
XII.2 Electrical Stimulation Technology
XII.3 Preconference / Brain Injury
XII.4 Veterans Administration

2013
XIII.1 LCP for Motor and Developmental Disorders
XIII.2 Ethical Topics in LCP
XIII.3 Preconference / Exemplars in NLCP
XIII.4 Home Modifications

2014
XIV.1 Technology Updates
XIV.2 LCP Across All Ages
XIV.3 Psych topics in LCP
XIV.4 LCP and the ACA

2015
XV.1 Transplants
XV.2 Spinal Cord Injury Updates
XV.3 Burns Updates
XV.4 Perinatal Injury

2016
XVI.1 Pediatric LCP
XVI.2 Gastrointestinal
XVI.3 Hematology/Oncology
XVI.4

2017
XVI1
XVI.2
XVI.3
XVI.4
The JNLCP Editorial Committee wishes you all a safe and prosperous New Year!

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- Dataflow between LCP, MSA, MCP
- Customize templates by injury for future files
- Set page breaks or change page orientation
- Customize Narrative headings or use default
- Create “options” in LCP, MSA or MCP
- Upload files into template
- Submitter cover letter for MSA
- Calculates “Seed” money
- MSA template for WC and Liability files
- Limited use “User” available for certain sections
- LCP Narrative Section
- LCP Tables Section
- Customize Cover Pages

- Customize Company Logo or Customer Logo
- Footer information
- Admin. section to assign users
- Group files by customer on “Dashboard”
- Custom Data Lists reduces data entry
- Screen lock on “non-usage” for security
- Calculates age
- Calculates life expectancy
- Inflation factor built into template tables
- Calculates tables
- Customize table headings
- Create custom text tables
- Tables Summary with inflation numbers
- End notes section
- Notes section
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