Topics in Ethics in Life Care Planning
JOURNAL OF NURSE LIFE CARE PLANNING
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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. Other diagnoses may be relevant depending on patient needs.
The JNLCP is pleased to present this issue on Ethical Topics in Life Care Planning. While I don’t usually cite Wikipedia as an authoritative source, in this case the following paraphrase from their article on ethics is succinct: The Cambridge Dictionary of Philosophy notes that the word ethics is "commonly used interchangeably with 'morality' ... and sometimes it is used more narrowly to mean the moral principles of a particular tradition, group, or individual." Ethics does not provide rules like morals but it can be used as a means to determine moral values (attitudes or behaviors giving priority to social values, e.g. ethics or morals).

As registered nurses we are bound by the ANA Code of Ethics (which see). The AANLCP Code of Ethics has been updated and should be appearing on our website.

This issue also begins a new department, Ethics in Action (page 61). We welcome your comments, ethical vignettes for consideration, and responses to those shared in by your colleagues. We see this as an opportunity for our readers to share from their unique perspectives. After all, where one stands depends on where one sits.

Cordially,

Wendie Howland

Editor, Journal of Nurse Life Care Planning

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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)
• Set 1-inch margins
• 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, halftone 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:

• Any recognizable identified facility or patient/client, for the use of their name or image
• Any recognizable person in a photograph, for unrestricted use of the image
• Any copyright holder, for copyrighted materials including illustrations, photographs, tables, etc.

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 article_name.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 Committee for this issue

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Contributing To this Issue

Penelope Caragonne PhD ("ECUs: Part 3") has served persons with multiple disabilities for over 36 years. She has lectured extensively on long-term planning and case management as a model for comprehensive service delivery both within and outside a litigation context. She also provides long-term case management services to individuals with catastrophic injuries, assistive technology assessment, prescription, installation, training and repair services. Her company offers job site modification, educational access services, and forensic assessment, consultation, and testimony. She has served as Vice President of External Affairs, American Rehabilitation Economics Association, book review editor of The Earnings Analyst, Director of Research, International Association of Rehabilitation Professionals in the private sector and has authored multiple articles for the rehabilitation and forensic economics literature.

Wendie Howland ("Patient, Client, Or...?") is the Editor of the Journal of Nurse Life Care Planning. Before entering the legal nursing field she had a long career in critical care, nursing education, and case management. She is the owner and principal of Howland Health Consulting, Inc., on Cape Cod MA, providing life care planning, case management, Medicare set-asides, and editing for health professionals. She may be reached at whowland@howlandhealthconsulting.com

Colleen Manzetti, DNP RN CNE CNLCP ("Patient, Client, Or...?") is the principal of Prodigy Life Care Planning & Consulting Services, LLC in New Jersey, providing life care planning, legal nurse consulting, medical cost projections, case management, and expert witness services. Dr. Manzetti has extensive experience as a managed care expert working for Fortune 500 insurance companies. Dr. Manzetti serves as a board member on the CNLCP® Certification Board and is an assistant professor at Marjorie K. Unterberg School of Nursing and Health Studies at Monmouth University.

April Pettengill ("Ethical Issues and the CNLCP Certification Board") has over 25 years of experience as a Registered Nurse. For the last 19 years she has been a case manager for work-related injuries and illnesses. Ms. Pettengill has extensive experience with catastrophic injuries and in 2004 she became certified as a Nurse Life Care Planner. Ms. Pettengill became a Medicare Set Aside Consultant Certified in 2005 and began writing MSAs. She currently works per diem for a local Home Health Agency with patients over the continuum of care including High Tech Pediatric patients. In 2005, Ms. Pettengill founded ALP Medical Consultants providing medical case management services, medical cost projections, file reviews, life care plans and Medicare Set Aside Allocations.

Keith Sofka ("ECUs, Part 3") is a principal of Caragonne and Associates, Ajijic, Jalisco, MX. He has practiced the provision of assistive technology services for the past 30 years. Mr. Sofka provides consultation to hundreds of companies, schools, Government Agencies and individuals. A major focus of Mr. Sofka’s work has been to provide recommendations for and implementation of school and workplace reasonable accommodation recommendations for individuals and organizations. This work typically includes housing and commercial building access as well as transportation, mobility and completion of daily living needs as well as modifications to the individual worksite. He has also taken training and practiced in other areas of assistive technology including custom seating and positioning for individuals with severe orthopedic involvement. His work has always been focused on ways to use technology to increase the independence of the individual.
IEP and the Educational Case Manager

I know a lot of families here in MA who hire educational advocates, what is often called an Educational Case Manager. It is a fairly unregulated industry. While I'm not sure that it belongs as a service in a Life Care Plan, I do know many families here in MA who feel strongly that they need an advocate just to access the special education system for their children. The grass roots special education watchdog group Spedwatch has a large following here in Massachusetts, and I'm not sure if there are similar groups out there in other states.

While the special education programs in public schools have legal responsibilities and guidelines to educate children with disabilities, I know of many cases where they do not provide the services, provide less-than-adequate services, or disagree with and decline to implement the evidence-based services that parents or clinicians recommend.

The Department of Education's six-year review cycle demonstrates repeated noncompliance by individual schools with both special education programming and the corrective action required once deficiencies are identified. So, while it is the responsibility of the public schools to provide specially designed instruction and related services as part of an IEP, it often doesn't happen in reality.

Kids get passed from year to year, never receiving appropriate skill-building or supports to overcome or learn to compensate for their areas of weakness. The evidence is clear when one looks carefully at the achievement of students who have been identified as having disabilities. The vast majority of children receiving special education have no intellectual disability and have average to above-average intelligence. Yet they do not receive an appropriate education and fall far behind their peers. That is the grim reality, and I have first-hand experience in this area.

I'm not sure if life care plans can honestly address the needs of disabled children from an educational perspective if we are relying on the public school's special education system as a collateral source when there are so many deficiencies in the system overall.

Does anyone have any thoughts on this?

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Thank you for this addition to the discussion of IEPs for our most vulnerable population. Ed.

Errata

The JNLCPS XIII.1 omitted the middle initial of Mariann F. Cosby from the header of her article “Pediatric Life Care Plan Development: An Overview of IDEA and Section 504.” The contact information for her business, MFC Consulting, is smfc@deepwell.com. We regret the omission.

Letters on any topic are welcome and may be sent to the Editor at whowland@howlandhealthconsulting.com. Letters may be edited for brevity.
Professional nurses are educated to provide care and advocacy. Nurse life care planners (NLCP) serve in the expert role by outlining health care needs within the dynamic document called a life care plan and, perhaps, by providing expert testimony. Whether writing or testifying, which term does the NLCP use to identify the individual for whose care the plan is developed?

Both “patient” and “client” are commonly found interchangeably in the literature, depending on the practice setting, and defined to include an individual, family, group, community, or population who require nursing expertise (College of Registered Nurses of British Columbia, 2006). Mylott (2005) notes that nurses must adhere to the American Nurses Association (ANA) Code of Ethics.

The American Association of Nurse Life Care Planners (AANLCP) Code of Professional Ethics and Conduct (2012) states, “… all members have an ethical obligation to practice nurse life care planning with the utmost integrity, competency and accountability.” The ANA Code of Ethics (2010) notes, “… the nurse’s primary commitment is to the patient, whether an individual, family, group, or community.” The ANA Code’s interpretative statements use “patient” to refer to the recipient of nursing care and “practice” for the “action of the nurse in whatever role the nurse fulfills, including direct patient care provider, educator, administrator, researcher, policy developer, or other. The values and obligations expressed in the code of ethics apply to all nurses in all roles and settings.” (ANA Code of Ethics, 2010)

The Case Management Society of America (CMSA) defined key terms used in case management practice (CMSA Standards of Practice, 2010). CMSA defines “client” as (an)

(1) Individual who is the recipient of case management services. This individual can be a patient, beneficiary, injured work claimant, enrollee, member, college student, resident, or health care consumer of any age group. In addition, when the “client” is used, it may infer the inclusion of the client’s support.
(2) “Client” can also imply the business relationship with a company who contracts for or pays for case management services. The first definition is the one used throughout the Standards of Practice 2010. (CMSA Standard of Practice, 2010)

Lachman (2009), in her interpretation of the ANA Nursing Code of Ethics, makes it clear that the nurse’s primary responsibility is to the patient regardless of the nurse’s role or business priority.

Nurse life care planners use the nursing process and nursing diagnoses, unique to nursing, to develop a plan of care. Nursing diagnoses drive the intervention, outcomes, and the patient’s plan of care related to the health problems and life processes (NANDA International, 2013). Nursing diagnosis provides the rationale for nursing interventions to achieve outcomes for which the nurse has accountability, as possible and appropriate.

The NLCP is required to collaborate with members of the treating team, as possible and appropriate, and objectively advocate for the individual and family by outlining future care and costs (AANLCP Scope of Practice, 2012). Iyer noted (2001) that, “Nurses are uniquely qualified to prepare life care plans. They have medical training and experience to understand the needs of the injured person and to anticipated those needs and services which have not yet been addressed by health care providers … Nurses are well experienced in organizing plans of care and coordinating the recommendations of team members.”

Nurses continue to be ranked very high (85%) for honesty and ethical standards compared to other professionals according to the 2012 Gallup poll (Blazek, 2012). The term “nurse” combined with the title of life care planner increases the value of the specialty because “nurse” communicates to the public that as a profession nurses can be trusted to do the right thing on the patient/client’s behalf. Nurses are responsible to adhere to the standards and guidelines put forth by the American Nurses Association (ANA) (2010) and the American Association of Nurse Life Care Planners (AANLCP) Code of Professional Ethics and Conduct (2012).

Therefore, should the NLCP use the term “patient” and/or “client” to identify the individual for whom a life care plan is developed?

Previous discussion on this topic in the nurse life care planning literature has been cursory. The burden of choice regarding the use of “patient” or “client” is

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often deferred to a payor source, such as an insurance carrier or attorney, with the consensus being that neither is acceptable. Should nurse life care planning professionals take our cues from the CMSA consensus model? Should we urge our own governing and accreditation agencies to come together and formally decide? Should nurse life care planning professionals continue to allow other professions to dictate what term is appropriate? Fortunately, an answer is already at hand.

Both the American Nurses Association (2010) and the American Association of Nurse Life Care Planners (2012) use the term “healthcare consumer” in their respective Scope and Standards of Practice statements. Nurse life care planners can and should use the language currently set forth by our own professional associations. Therefore, we will use the term “healthcare consumer” to describe the individuals or families for whom the life care plan is developed.

References


American Nurses Association (2010), Scope and Standards of Practice, 2nd ed. Silver Springs MD


A life care planner has put recommendations for equipment and an associated service contract into a life care plan, referencing a particular vendor. Quite by accident you learn that the life care planner's spouse is the owner of the business entity named to provide these. You are not involved in the legal case. What would you do? What should happen?

1) With my LCPs, I take a comparable piece of equipment and service, provide 3 vendors' charges, and average the costs out for the LCP. I don't do this if I am projecting costs on the equipment/service they already have, then I would use the existing vendor for the LCP. In this situation, I would look to see if the LCP’s spouse’s charges are in line with other vendors. If they are, I don’t have a problem with it. (anonymous)

2) If I am a LCP Planner, but I am not involved in this case, then I would do nothing at this time. In the future, if I were to oppose this LCP Planner, I would certainly take a close look at those recommendations; comparing the costs with this spousal vendor with other vendors in the area. If the costs at the spousal-owned facility were more, I would certainly bring this up in an effort to discredit the recommendations. (anonymous)

3) In my opinion the life care planner has violated a standard of practice, whether knowingly or not. A complaint should be filed with the relevant certification board for further investigation. The intent needs to be clarified for the recommendation made because as nurses we are not always aware of such business-related issues and how they may be perceived. The board should provide the appropriate consequences, if any, for the violation. In fact, the membership board should have bylaws in place with how to deal with ethical violations (I did not look them up to review if any such bylaw, rule, or regulation exists). Because I am not a party to the litigation, I would not get involved in it. The attorney should recognize that if only one recommended vendor is offered that others should be sought out. Most life care planners belong to an association of members and agree to abide by its standards (Of course, there is no law that states any life care planner need to belong to any group so that raises another question: What to do if s/he belongs to NO association?)

Direct intervention from one life care planner to the one in question is not appropriate, whether they are both members of the same association or not.

In my opinion, a life care planner should never recommend a particular vendor because of the liability they may take on if that vendor ends up causing a tort. Instead, a life care planner should give a minimum of three choices. I do not feel there is nothing wrong with her making a recommendation of the husband's company, if she adds a disclaimer that she has a financial interest with that vendor, but I would include the additional vendors as well (for the liability reasons I mentioned earlier).

Whether this is an ethical issue is questionable. It may or may not be. It depends on the intent, but just as easily the suspicion can be removed with the disclaimer. (anonymous)

4) Part of LCP training should include business/legal ethics content. Nurses should already have a preexisting awareness of healthcare ethical issues and how to deal with them, but new nurse life care planners

This scenario came from a nurse 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. Opinions given are those of their authors and are not to be taken as the official position of the AANLCP, its board, or the JNLP.
are likely new to business/legal ethical aspects of their new careers. (*anonymous*)

5) All practicing life care planners should know that referencing a business owned by one’s spouse in one’s life care plan is a clear conflict of interest. If you were involved in the case, it would be important to advise the attorney who hired you. Additionally, consider one or more of the options below.

Since this dilemma involves discovery of this conflict of interest when you are not involved in the case, there seem to be several possible options:

- Ignore this discovery since you are not involved in the case.
- Advise this life care planner that this is a clear conflict of interest.

Personally, if I were not involved in the case, I would either ignore my discovery, or consider asking forum members if they think this an example of a conflict of interest, without naming names. Perhaps we can use a reminder now and again of examples of conflicts of interest. (*Linda Husted*)

**For the next issue:** A broker has managed the finances of a very wealthy widow for many years. After they had gotten to know each other, she asked him to also be her power of attorney, fiscal POA and medical POA. His firm has now advised that it is a conflict of interest for him to do so.

The broker asked if I could serve as her medical POA. The widow has no relatives and her friends have since died or unable to serve as medical POA. I suggested perhaps an attorney but the widow is cold to that idea and would like someone who is willing to listen to and understand her desires, someone with perceived compassion. Should I do this? Under what circumstances, if any?

Send your thoughts on either of these scenarios to the Editor.

Note whether you would prefer to be anonymous if your comments are chosen for publication.

Future topics also welcome.
Ethical Issues and the Certified Nurse Life Care Planning® Certification Board

April Pettengill BSN RN CRRN CDMS CNLCP MSCC

The CNLCP® Certification Board directs the certification program for nurse life care planners and promotes the specialty of the nurse life care planners’ professional practice and role. This oversight includes but is not limited to certification and recertification of nurse life care planners and quality assurance of the examination.

Misconduct allegations
The CNLCP® Certification Board will investigate allegations concerning alleged misconduct by Certificants. Reports of alleged misconduct must be in writing, signed, and sent by certified mail to the Certification Board within 120 days of the alleged violation(s). Supporting documentation must accompany the complaint.

Complaints can include but are not limited to:

- Ineligibility for certification
- Irregularity in connection with the certification examination

- Material misrepresentation or fraud in any statement to CNLCP® Certification Board or to the public including but not limited to statements made to assist the Certificant or another applying for obtaining or retaining certification, gross or repeated negligence in professional work, the convocation of plea of guilty or plea of no contest to a felony or misdemeanor which is directly related to the practice of nurse life care planning.

- Failure to adhere to the eligibility requirements for certification candidacy or continuing certification requirements.

If there is any misrepresentation or noncompliance, the CNLCP® Certification Board will review the allegation and take any one of the following actions:

In 2005, Ms. Pettengill founded ALP Medical Consultants providing medical case management services, medical cost projections, file reviews, life care plans and Medicare Set Aside Allocations. She has been a member of AANLCP since 2004, most recently as a director on the CNLCP Certification Board. She is also a member of NAMSAP and chairperson of the communication committee for NAMSAP. Contact her at 195 Goodrich Hill Rd.Fairfax, VT 05454 802-849-2956

We urge you to review the AANLCP Code of Professional Ethics and Conduct on the AANLCP Webpage.
• Conduct a full investigation of the allegation and initiate sanction.
• Dismiss the allegation for insufficient evidence.
• Finalize the decision unless appealed within 30 days.
• If appealed, the Certification Board will review additional evidence and appoint a hearing panel within 60 days. The panel will convene within 60 days of appointment. Upon conclusion of the hearing the panel will render its written decision. All decisions will be delivered via certified mail to all parties involved.

Sanctions Per the policies and procedures of the CNLCP® Certification Board, sanctions may include, but not be limited to, one or more of the following:

• Reprimand with or without remedial requirements
• CNLCP probation for a specified period of time with remedial requirements and a deadline date to meet same.
• Suspension of the Certificant’s CNLCP for a specified period of time, with remedial requirements identified and a deadline date (60-90 days) for their completion for consideration of reinstatement.
• Revocation of the Certificant’s CNLCP certification prohibiting use of the designation.

If remedial requirements are not completed in the specified period of time, and fulfilled in a satisfactory manner within the timeframe specified, the Certificant’s CNLCP certification will be revoked.

If a violation has been identified and verified and the Certificant’s certification has been suspended or revoked, a notice of action will be published on the website and the respective nursing board will be notified in writing by the Board Chair on CNLCP® Certification Board letterhead. This letter will outline the complaint, the findings and the action taken by the board.

Appeals The Certificant has the right to appeal the findings of the board and the remediation set forth by the board. The appeal must be sent to the Certification Board by postal service within 45 days of receipt of notification of the board’s decision and action.

If a violation decision is appealed, the Certification Board will review additional evidence and appoint a Hearing Panel, comprised of two Certification Board Members, the Public Member of the Certification Board, two Members of the Executive Board of AANLCP(R) and two randomly selected CNLCPs within forty-five days of the appeal.

The Panel will convene within sixty days of appointment; and will render and communicate a written decision within thirty days. The Panel may recommend any sanction, up to, and including, revocation or reinstatement of the Certificant’s certification.

All decisions will be delivered via certified mail with return receipt to all involved parties. All deci-

continued next page
sions of the hearing panel are final and cannot be appealed.

**History of complaints** The CNLCP® Certification Board has had very few complaints. In the past 6 years there have been two complaints. One involved an allegation of a non-renewed nursing license. This was fully investigated and the nurse was contacted. She renewed her license and provided a copy of the renewal.

The other complaint came from a physician who alleged a CNLCP had gone beyond her practice area in developing her life care plan. He had also reported this to the nursing board of the nurse’s state. We reviewed the information provided by the physician and the nurse was interviewed. It was determined that the allegation had no merit and was dismissed with no sanctions. The board of nursing from the nurse’s state also dismissed the allegation.

**Summary**

It is important that any allegation against a Certificant be reported in writing to the chair of the certification board. The certification board will coordinate with the American Association of Nurse Life Care Planners Executive Board to investigate any allegations. We urge you to review the AANLCP Code of Professional Ethics and Conduct on the AANLCP Webpage. This outlines the code of ethics for the nurse life care planner and provides examples. The code of ethics is congruent with that of the American Nurses Association. The CNLCP® Certification Board is committed to upholding the ethical practice of nurse life care planning.

Chives and milkweed
Cape Cod MA
Here is the third and final installment about Environmental Control Units (ECU). Part I described the general category of environmental control in Assistive Technology (AT). Part II expanded on this and described what should be considered before prescribing an environmental control device. This column will describe what environmental control devices are available now and expected in the near future.

ECU manufacturers have always targeted the parallel market for able-bodied people (i.e., home automation) with what could be described as “yuppie toys.” There is some irony in that: When working with individuals with disabilities, we make every effort to avoid over-prescribing equipment, never providing a device to perform a task that the person can perform without assistance. Yet many ECU electronics exist largely because some able-bodied people want home automation: electronic control of devices that able-bodied individuals can control independently. It is safe to say that ECU costs would be higher and many devices currently available would cease to be available without the able-bodied market. This market also drives the future of environmental control for individuals with disabilities. Like everything else that historically moved from a necessity for a few to mainstream use (e.g., eyeglasses) ECUs have evolved from ugly medical-looking grey boxes to stylish smart phones, status symbols as much as necessary productivity tools for work and home. Take three minutes to watch this video demonstrating voice control for an able-bodied user using a smart phone as an interface:

http://www.youtube.com/watch?v=RjTj0ymhbBw&feature=youtu.be

From Technology Corner

Environmental Control Units (Part 3): The future

Keith Sofka ATP (retired) and Penelope Caragonne, MSW, Ph.D, CLCP

Keith Sofka has practiced the provision of assistive technology services for the past 30 years. Mr. Sofka provides consultation to hundreds of companies, schools, Government Agencies and individuals. Penelope Caragonne has lectured extensively on long-term planning and case management as a model for comprehensive service delivery both within and outside a litigation context. Together as Caragonne and Associates, they offer job site modification, educational access services, and forensic assessment, consultation, and testimony. They may be contacted at Mail@Caragonne.com or 866-285-0665 toll-free.
This is possible right now, with easily available technology, although still a fairly complicated project to assemble, requiring a specialist to assemble and program the system. This can and will change with increased consumer demand and a major player’s decision to develop the next big consumer product.

These new methods for developing an ECU are practical, depending upon the number of devices to be controlled. Not including the cost of the phone, the basic hardware would cost between $1,200 and $3,000 for a system that can outperform an “old-school” ECU in every way. The current leader in development of the home automation controls market is a company called MiCasaVerde (http://www.micasaverde.com/). This type of ECU requires five components used together, detailed below.

**First, a smart phone: Apple iOS or Android OS.** Although I would choose Android if I were building this system today, Apple is noted for standing markets on their ear with one product release and anything can happen.

**Second, the software running on the phone.** For someone with limited or no hand use, this would include command software to control devices and voice control software to operate the phone’s functions and apps. *Vera Mobile* makes the most popular device control software for both iOS and Android, and other apps will likely join this market as demand grows. A current competitor in the Android operating system is called AuthHomationHD.

The voice control software that is most popular for Android is called *Tasker*, using a plug-in called *AutoVoice*. The Apple iOS has a built-in speech recognition app, *Siri*, although other applications will be available in the future. For more information about these apps, search the online app store for your operating system.

**Third, devices that receive the signals from the phone and control the devices in the environment.** With old-school ECUs these were typically X-10 devices. These switches and controllers have been around for many years and have the advantage of being low in cost. The newest controllers and switches, called Z-Wave (http://www.z-wave.com/) use WiFi and offer greater reliability and consistent operation but at a cost, as much as 10 times more per controller.

The X-10 devices sent a signal along the existing electrical wiring. There are many problems with this method and the X-10 switches are less than 100%...
reliable as a result. With a WiFi based system, if you have an acceptable WiFi signal, you have control over your devices. There are several manufacturers each with a slightly different method of control, so it is difficult to say which technology will become dominant.

**Fourth, someone has to put this system together.** In the past that was often the sales representative. Now, begin your search with the terms “home automation” or “home theater.” Resources like this exist where there is a surplus of money so they may be hard to find in smaller cities or rural areas.

Be sure to evaluate the vendor’s capabilities. Ask if they have assembled systems like these before. With luck, they will have assembled something like this many times. Ask for references and to audition a system like the one you seek.

Be sure that the system doesn’t exceed the abilities of your intended user. These systems are complex and may well exceed the skills and capabilities of the average user. This system would best suit someone who is already familiar with or can acquire the skills needed to manage sophisticated technology, as this will require extensive initial training and periodic retraining.

**Fifth, always include training** for the end-user and all caregivers. This is crucial to keep the system from being relegated to a closet. Also be sure to provide for maintenance and repairs from the beginning.

Finally, there is one more “yuppie toy” to consider. It falls somewhere between old-school ECU’s and the phone-based systems described above. It is called VoicePod ([http://www.voicepod.com/](http://www.voicepod.com/)). The VoicePod is a dedicated device that uses speech to control devices. One is required per room where the person desires voice control. Each unit retails for $695, not including switches and other control devices. The controllers and switches used are similar to Z-Wave. VoicePod works with controllers made by Control4 ([http://www.control4.com/](http://www.control4.com/)) so you must use the control devices that are compatible with your system.

Check the VoicePod website for a dealer and more information and look around on YouTube for more video demonstrations of ECU systems.
Tools of the Trade

Save the Dates: Events for Healthcare Professionals

28th Annual Nurses in Business Conference

The 2013 NNBA Annual Education Conference will be held in Orlando, Florida, on the weekend of October 5 and 6, 2013. The NNBA conference is perfect for:

- nurses new to the idea of being an independent nurse or nurse entrepreneur;
- self-employed nurses and nurse business owners in the startup and growth mode;
- nurse entrepreneurs and nurse consultants successful in business.

Health Care Entrepreneurship Summit

July 19th and 20th, 2013 - Embassy Suites Orlando - International Drive/Jamaican Court
The University of Florida Professional Development unit is proud to host the 2013 Health Care Entrepreneurship Summit. The purpose of this summit is to explore entrepreneurship and business opportunities in the following areas.

- Geriatric care management
- Life care planning
- Forensic vocational rehabilitation

Why should I become an NNBA Member?

To receive a discounts of $100 to either conference. And, you can start your business faster for less money, avoid costly mistakes, lower your expenses and make more profit, and satisfaction is guaranteed or your money back. [Join now](#)

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CALL FOR SPEAKERS

SUBMISSION DEADLINE: APRIL 25, 2013

The Education Committee welcomes 45 to 75 minute general session presentation proposals on any topic matter pertinent to the field of nurse life care planning.

Potential topic ideas

- Using Nursing Diagnoses as a framework for the Life Care Plan
- Life Care Planning Issues for Persons with Specific Nursing Diagnoses
- Examples of topics: Mobility Deficits; Upper Extremity Deficits; Cognitive Deficits; Respiratory Dysfunction; Self Care Deficits; etc.
- Assessment Tools useful to the Nurse preparing a Life Care Plan
- Assuring Appropriate Foundation for the Life Care Plan (Medical recommendations; equipment, supplies, medications; Level of Nursing Care / Attendant Care; Need for Replacement Services
- Preparing for testimony
- Ethical Issues
- Review of a specific disease or injury from acute to chronic states

CALL FOR POSTERS

SUBMISSION DEADLINE: SEPTEMBER 1, 2013

Poster presentation submissions are encouraged as a way to share knowledge, skills and expertise with your colleagues. Posters will be on display throughout the conference. Poster presenters will be asked to prepare a five minute overview of their presentation to be delivered to the general session audience. Awards will be given to poster preparers. Poster presentations will be reviewed by the Journal of Nurse Life Care Planning for possible invitation to expand the subject matter into a full text article for publication. Posters of all subject matters pertinent to the field of nurse life care planning are welcomed.

Potential poster topic ideas

- A comparison of methodologies for incorporating nursing diagnoses within a LCP
- LCP examples of that clearly demonstrate use of the nursing process within the body of the report
- A review of the literature related to a specific nursing diagnosis

(Please print or type)

☐ Speaker ☐ Poster

Name & Credentials

________________________________________________________

Street Address

________________________________________________________

City, State, ZIP

Phone

________________________________________________________

E-mail address

Poster or presentation topic or title:

________________________________________________________

________________________________________________________

Description of presentation (please attach additional pages if additional space is needed):

Please fax this form to 1-610-664-2227 or email it to monayudkoff@verizon.net
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