The Business of Life Care Planning
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Welcome to the summer issue! Where I live there is a heat wave with temperatures expected to be above 100 degrees for the next week. It was a scalding 109 degrees today with higher temperatures expected tomorrow. Although the temperatures will likely taper by the time this reaches your inbox, I hope this issue will sizzle and provide you with ideas and energy for growing your life care planning practice and business!

This issue was created for our members in response to requests for information on the business of life care planning. It is packed with tips and techniques to help you grow and continue to be successful. Pat Iyer’s article conveys the importance of the five pillars that comprise the foundation of a successful business in *Top Tips for a Successful Life Care Planning Business*. Natasha Davis describes the importance of *Leveraging the Use of Branding for Nurses in Business* to acquire and retain customers. Michelle Podlensi drives home the importance of gaining and retaining customers through marketing.

Techniques for you to consider include the importance of integrating health literacy strategies (Cartwright-Vanzant), how to classify evidence and clarify the expert witness role (Barros-Bailey & Dominick), and the use of narrative interviewing techniques (Akande). And finally, Carla Seyler provides a synopsis of the round table discussions that were part of the International Association of Rehabilitation Professionals conference in October. Key AANLCP® members were part of the multidisciplinary group of professionals who contributed to the round table topics that included life care planning business practice trends.

As the Editor, I am pleased to announce some changes in the journal format. To that end, two departments have been added: The Dear Carole column and the Aging and (the issue focus) Resources. The table of contents has a fresh new look that lists the leaders of the Association and the Journal Committee. Coming full circle from years past, all the Journal Committee members who contributed to the issue are acknowledged. I am most appreciative of the volunteer team efforts to locate and recruit authors or personally participate in the peer review, editing, or the proofing processes; all of which are necessary elements for a successful journal. So, thank you to everyone who contributed to this issue! If you are looking for A Message From the President feature, be patient. She opted to address the members via letter rather than in this issue.

As always, the Journal Committee welcomes your feedback and input. Please send your comments to the Editor.

Enjoy your summer!

Mariann F. Cosby, DNP, MPA, RN, PHN, CEN, NE-BC, LNCC, CLCP, CCM, MSCC
Editor, JNLCP
smfc@surewest.net
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 New Roman 12 point font
- 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 6th Ed)

**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**

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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: smfc@surewest.net

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

Come join us as we find the evidence to support our practice!

Are you...

... curious about how and why the nursing process supports our specialty practice of Nurse Life Care Planning? Are you in a formal education/practice program and need ideas for a research project and paper? Let’s talk!

Your Research Committee is currently studying how and why Nurse Life Care Planners put case management services into life care plans. We need help doing literature reviews and identifying tools to determine variables in using case management services.

... already working on research in a formal advanced education/practice program? Did you know that AANLCP would love to know about your research project?! Tell us about it!

~ Colleen Manzetti, DNP, RN, CNLCP, CNE
Chair, AANLCP Research Committee

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

Participate:
email cmanzetti@aol.com
Phone 732-261-1761
Contributors

ABIGAIL O. AKANDE
PhD, CRC

Dr. Abigail Akande is an Assistant Professor of Rehabilitation Counseling at the University of Arkansas at Little Rock. She obtained a Ph.D. in Rehabilitation from the University of Arizona and has been a Certified Rehabilitation Counselor since 2006. Her clinical experience spans five states within the fields of vocational rehabilitation counseling, behavioral health, university career services, and academia. Dr. Akande's research interests include multicultural, immigrant and women's issues in rehabilitation counseling, legislation regarding disability and chronic health conditions, and narrative interviewing.

MARY BARROS-BAILEY
PhD, CRC, NCC

Dr. Mary Barros-Bailey is a life care planner, rehabilitation counselor, and vocational expert as well as clinical and teaching adjunct faculty with the University of Idaho.

RACHEL CARTWRIGHT-VANZANT
PhD, MS, RN, LHRM

Rachel provides consultative services including education seminars, identification of patient safety interventions, and legal case reviews. Her research on health literacy identified opportunities that healthcare providers can act on to improve the health literacy of patients. Documentation of patient care is critical to preserve evidence that minimum expectations are met during a patient encounter and she speaks nationally to health care providers on the legal aspects of documentation incorporating the challenges of the electronic health record. She consults with legal counsel on medically related injury cases and provides expert testimony on nursing standards of practice. She is an active member of the National Speakers Association and Healthcare Speakers Network. She can be contacted at rachel@contactmlc.com.

NATASHA E. DAVIS
MBA-M, RN-BSN, CEME, CSMA

Natasha E. Davis is a registered nurse and branding strategist for healthcare professionals and organizations. Prior to doing consulting, she worked for over 12 years as an emergency and trauma nurse. Today, she speaks and trains on the international circuit on branding, marketing, process improvement and audit readiness. For the past 10 years she’s been the Chief Executive Officer of Impact Branding Consulting, Inc where the mission is to help the healthcare industry and government agencies boost the impact of their brand. She has authored and published two books. She currently resides in Atlanta, Georgia and can be reached via www.ImpactBrandingConsulting.com

BOBBI K. DOMINICK
JD, SPHR, SHRM-SCP

Bobbi K. Dominick is an employment and appellate law attorney as well as an employment practice expert witness with a focus on effective human resources practices.
to this issue

PAT IYER
MSN, RN, LNCC
Pat Iyer is the president of the LNCAcademy.com, a division of The Pat Iyer Group. She works with legal nurse consultants who want to make more money, get more clients and avoid expensive mistakes. Her other sites include legalnursebusiness.com, which provides education for LNCs and LNCEEU.com, a membership continuing education site for LNCs. Pat is the host of Legal Nurse Podcast, found on Itunes and legalnursepodcasts.com. She draws on her deep expertise as an independent legal nurse consultant. Pat founded Med League Support Services, Inc. in Flemington, NJ in 1989, and ran this business for 26 years before she sold it in 2015. Pat is a national past president of the American Association of Legal Nurse Consulting. Pat has written, coauthored or edited over 800 books, chapters, case studies, online courses or articles about nursing or legal nurse consulting. Contact Pat at patriciaiyer@gmail.com or through her websites at www.legalnursebusiness.com or IncAcademyinc.com.

MICHELLE PODLESNI, RN
Michelle Podlesni, RN ("Unconventional Nurse: Going from Burnout to Bliss!") is President of the National Nurses in Business Association and CEO/President of Bloom Service Group, Inc. She is a proud US Navy veteran and nurse with over 30 years’ experience ranging from clinical care, case management, and healthcare information systems to nationally known speaker, best-selling author, and successful nurse entrepreneur. She has a proven track record of leadership success in managing strategic direction, marketing, operations and technical areas of start-ups and multi-million dollar companies. Michelle is a widely recognized and respected authority in business and is passionate about empowering nurses on the path to business success.

CARLA D. SEYLER
MS, CRC, CCM, CLCP, LRC
Carla Seyler was the moderator of the Round Table Fast Track at the 2016 Conference for the International Association of Rehabilitation Professionals/International Symposium for Life Care Planning (IARP/ISLCP). In suggesting the “speed dating” concept for the Round Table, she hoped that it would lead to enhanced learning through more dynamic discussions, or a long term relationship with a new idea or two. This is Ms. Seyler’s 40th year in the field of rehabilitation counseling. She retired at the end of 2016 from Seyler Favaloro Ltd., a Vocational Rehabilitation and Life Care Planning practice based in New Orleans that she co-founded in 1992. She is currently President-Elect of the Louisiana chapter of IARP. Ms. Seyler has taught courses at LSU School of Allied Health in the Department of Clinical Rehabilitation Counseling. She has a master degree in Counseling from Loyola University of New Orleans. She is a certified Life Care Planner, a Licensed Rehabilitation Counselor and a Certified Rehabilitation Counselor. She served for nine years on the Louisiana Licensed Professional Vocational Rehabilitation Counselors Board of Examiners, and as its Chair for two years. She can be reached by email at cdseyler17@gmail.com.
Aging and the Business of Life Care Planning

Resource List

Compiled by:
Kelly K. Campbell, RN, BSN, CP, CLNC, CLCP
Jenn Craigmyle, RN, BSN, CLNC, LNCP-C, CLCP

1. A Pleasurable Plan for Retirement by Carol Ebert

2. Fuel Career Satisfaction EBP can rejuvenate your career or indicate it's time for a change
http://resources.nurse.com/fuel-career-satisfaction

3. Mistakes to Avoid When Selling Your Small Business by Debbie Allen
https://www.thebalance.com/selling-your-small-business-mistakes-2890127

http://dailynurse.com/retirement-planning-nurses-beginners-guide/

5. Retirement Plans for Small Businesses

6. Women's Institute for A Secure Retirement: Improving the long-term financial security of all women through education and advocacy.

7. Retirement Readiness: A Joint Project of the Center for American Nurses and WISER, the Women’s Institute for a Secure Retirement

8. Is Retirement an Ending or New Beginning? By Donna Cardillo, RN, MA
http://donnacardillo.com/articles/retirement/

9. Retired Nurse/ facebook
Facebook.com

10. YOUR RETIREMENT DREAM HERE!!!

KELLY K. CAMPBELL, RN, BSN, CP, CLNC, CLCP
Kelly K. Campbell earned her Bachelor of Science degree in Nursing from Penn State University in 1996 and a certificate of Perfusion from Texas Heart Institute in 1998. In 2013 she earned her Legal Nurse Consultant certification and 2014 she completed her Life Care Plan education from Capital University Law School. In addition to Co-Chair Journal of Nurse Life Care Planning, she serves on the AALNC committee as an Associate Editor and author for revision of Principles and Practice 4th Edition. Her specialty interests include Medical Device, Brain Injury, Amputation, Chronic Pain and Cardiac.

JENN CRAIGMYLE, RN, BSN, CLNC, LNCP-C, CLCP
Jenn Craigmyle is a bachelor’s prepared Registered Nurse with experience as a clinical nurse in neurology and critical care, nursing educator for an ADN school of nursing, legal nurse consultant, life care planner, and care manager. She earned her certification in life care planning in 2012 and is the one owner of Craigmyle Legal Nurse Services, LLC based out of Southern California. She is Co-Chair of the Journal of Nurse Life Care Planning committee.
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The Business of Life Care Planning

The Journal of Nurse Life Care Planning is pleased to follow up on the announcement last quarter and present the questions and answers column for the business of Life Care Planning via the Dear Carole column. With the input of invited guest authors, the goal is to provide the details of starting a business from the concept of a business to the everyday management of the business. Keep sending your questions to DearCaroleColumn@gmail.com so that we provide information that benefits all members.

The following question was asked at the AANLCP conference in Scottsdale, Arizona this year.

Dear Carole,

**What is the best way to handle billing in a new business?**

As we well know, without a stable financial base there will be no business in the long term. Billing, income and expenses, receivables, profit margin on product; all of these numbers have meaning in your new business.

Starting a business will require an investment of cash to provide the capital to purchase equipment and supplies and pay your salary. How much cash is dependent on the business plan that was created before starting the business. In the business plan you will want to have outlined the revenue projections for the next five year and infuse cash into the organization to allow for operating expenses for the first six months to assure the company has a cash flow for financial solvency. The business plan will also outline the services offered services aside from Nurse Life Care Planning.

Now, on to how to handle the accounting. One option is to hire a virtual assistant. A virtual assistant is not on-site in your office but can be anywhere in the country. This person may handle the business aspects of others as well as your company. Another option is to hire an on-site, part time
assistant. The assistant can come to your location or work in a remote location on an as needed basis depending on work volume and time demands from other sources of work assignments. The other alternative is to outsource that task to an accounting agency. If you have the expertise to select and use an accounting system and the time to do the work, then you might decide to decrease overhead and keep the task on your list as principle of the organization.

As your business for the company grows it may make better sense to not keep those tasks on your desk but delegate them to someone else and oversee the data. You may decide early on to delegate the task so that you can concentrate on marketing your business and providing the services you are well prepared to do. When selecting a provider some sources for assistance may be the Chamber of Commerce, The Small Business Administration, other local business owners, a church or community association, or local small business groups. Exercise the utmost care in delegating this task and have a list of alternatives if the first plan does not work out as you hoped. Without question it is important to review the financial data frequently and know where the assets are being spent on a monthly, quarterly, and annual basis.

DISCLAIMER: The content of this column is intended as a brief introduction to general business concepts and has no legal or accounting expertise implied or suggested. The members of the journal committee and the invited contributors recommend the readers seek their own legal counsel and financial advice for guidance on their business requirements.

Please keep the questions coming to: DearCaroleColumn@gmail.com

CAROLE UPMAN, RN, MA, CCM, CRC, CDMS/R, CNLCP®

Carole is a registered nurse and master prepared rehabilitation counselor. She founded and managed Chesapeake Disability Management, an outcome driven medical and vocational rehabilitation company in 1991 at her dining room table. That organization eventually grew to a staff of 20 in multiple states on the East coast. In the past she served as a board member and chaired the Commission for Certification of Case Managers (CCMC). She currently serves on the Book of Knowledge editorial board for CCMC and held a board member position on a charter school in Baltimore City, Maryland in the past. She loves the ocean, her husband and life.
Coming!
Summer 2018

Core Curriculum for Nurse Life Care Planning
2nd edition

To contribute, contact
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What does it take to run a successful practice as a Life Care Planner? You have mastered the fundamentals of Life Care Planning, and you have gotten some cases, but you know you could be doing more to build your business or improve cash flow. Successful Life Care Planners pay attention to five pillars: expertise, marketing, client management, finance, and business development. I call these pillars because they form the foundation of your business. They support you and allow you to grow.

**Expertise**
Attorneys understand that Life Care Planners are usually needed for large damages cases involving a patient whose survival will depend on complex care. There is a lot at stake in such cases including factors that we may not see. For example, plaintiff attorneys may have taken loans to finance a large case. Defense attorneys are concerned about large settlements or awards and how they might affect their relationship with the carrier. Everyone wants to know, “What are the numbers?” Your expertise affects the answers to that question.

Your Life Care Plan must be well written, well researched and easy to follow. The people who will read your plan are not healthcare providers and thus need adequate explanations and a medical summary written for lay people. Spell out abbreviations and define terms. Use a format with sufficient white space. Be sure your tables are clear and easy to comprehend. Although an attorney may attempt to apply pressure to influence your calculations, remember your role in being impartial. A Life Care Planner hired by the defense attorney may see items a plaintiff’s Life Care Planner missed, items that would improve the quality of the plaintiff’s life. Whenever you prepare a Life Care Plan, envision yourself being cross-examined about why you included specific elements in a plan. Your expertise is founded on your detail-oriented analysis of the patient’s needs and is rooted in your up-to-date knowledge of medical and nursing care. Remember that your work product is of no value if you do not meet the attorney’s deadlines. You can destroy your Life Care Planning business by gaining a reputation of being undependable.

**Marketing**
Just about every Life Care Planner needs to market to start or maintain a business. This is the second pillar of a sound business. “Push” marketing involves reaching out to attorneys through networking, cold calls and cold visits. “Pull” marketing reverses the dynamics by using methods to attract clients. Both types of marketing have a role in building a business (Lockard, 2016).

The goal of any marketing is to establish rapport with the prospect, to help that person know, like and trust you, as well as remember you when a case comes in that needs a Life Care Plan. Who do you want to work with? It is far easier to get cases when you have a clear picture of who needs your services. Who is your ideal client?
What market do you best serve? What types of cases are the ones where you have the deepest knowledge? How can you get known as the go-to Life Care Planner for that type of case?

Both attorneys and legal nurse consultants hire Life Care Planners. They may find out about your services through list servs, networking, word of mouth referrals, your web site, publications, or a booth at a trade show. Legal nurse consultants may hire you as a subcontractor or refer you to an attorney. This is often an ideal arrangement if subcontracting provides you with support such as organized medical records and report proofreading services.

Marketing requires persistent, consistent effort. Consider your referral sources. Who else markets to the attorneys who have cases that require Life Care Plans? Get to know the engineering firms that handle accident investigations. Network with the vocational experts, demonstrative evidence firms, and economists who get involved in cases with medical damages. Request introductions to attorneys who may be able to use your services.

Analyze how you stay in touch with clients to remind them of your existence. Do you have a website with a blog? Blogging is a way for an expert witness to demonstrate expertise and get the attention of those who are in hiring positions. After doing the work to formulate a thoughtful, informative blog, don’t stop there. Repurpose your blog posts in a newsletter that you send out a minimum of once a month. Provide helpful tips in a form that is quickly digestible.

Ask your own clients for referrals. Give them specific language to use in a phone call or email to a colleague to pave the way for your conversation with the prospect (Newman, 2013). For example, ask your client to say, “Bob, I want to introduce Grace Galley, a Life Care Planner who has been helpful to me in my personal injury cases. I know you handle similar cases and think it would be of value to have a conversation with her. She will be calling you. Please take a moment to talk to her.”

Client Management
Maintaining sound relationships with clients is the third pillar of a sound business. It costs five times more to market to a new prospect than it does to retain satisfied clients (Saleh, n.d.). Your reputation and ability to establish strong relationships with attorneys will make or break your business. In general, attorneys are quick, intelligent, and great negotiators. They are trained to win. They need your help to do so. They like stability. When they find a great Life Care Planner, they prefer to stay with that person.

Encourage client loyalty by taking a hard look at how you care for customers. Everyone is increasingly aware of the power of social media to spread both complaints and compliments about your services. Attorneys are networked in ways that may be invisible to you. They participate on list servs and share recommendations with each other.

Look at each step of your process of handling your clients. What can you do to make them feel even more cared for, respected, and valued (Sandler, 2015)? Do you acknowledge receipt of records? Do you ask for feedback on your Life Care Plan? Do you ask your clients what you should stop doing, start doing, or continue doing? We are often surprised by the answers we get when we ask our clients these questions.

You’ve heard that 80% of your work comes from 20% of your clients. Who are your best clients? What do you do to make them feel even more special? People love to be appreciated and acknowledged. How often do you connect with them or send them a small gift to show appreciation?

Finance
Life Care Plans can consume dozens of hours of your time; some attorneys are surprised by the size of the invoice. Head off collection problems by following some best practices. First, set the expectations at the beginning of the case regarding the sizes of invoices. Although it is never possible to make precise predictions of how many hours it will take to prepare your plan, you should, with experience, be able to give a range of hours.

Secondly, obtain a retainer. Require at least 10 hours. You can double that amount for most involved Life Care Plans. I also recommend you ask the attorney to replenish the retainer before you exhaust it. Asking for another retainer when you have used 75% of the existing one is a great plan that keeps cash flowing.

A practice of asking for replenishing retainers demands that you keep on top of the total number of hours you have spent on the case and anticipate when you will be depleting the retainer. You have the option of stopping work while waiting for the new retainer. Being proactive in requesting additional money is essential when the client is new or has an uneven payment history.

There are several opportunities in the life of a case when you can use leverage. You have leverage when the attorney needs the report submitted by a certain date or when you are noticed about a deposition or asked to analyze opposing counsel’s Life Care Plan or to appear at trial. Use leverage to obtain payment.

If you are not working from retainer to retainer, don’t allow large numbers of hours to accumulate without payment. And don’t avoid or delay collection efforts. Sometimes it is easy to put off collection efforts in the hopes the check will appear in the mail or because you are distracted by cases. Your bills won’t wait, though. The most important financial best practice is to know your profit and loss, your expenses, and your accounts receivable. Know your numbers.

Business Development
Business development is the last pillar. It encompasses examining
your operations and looking for opportunities to add new services or improve your efficiency. Are there aspects of your business that pose roadblocks? Are there services your clients are asking for that you should add? Listen to what your clients are saying and be open to ways to expand.

Some Life Care Planners grow by adding research assistants, who may be effective in collecting the data you need for the plan, and thus improve your efficiency. Subcontractors expand your capability to respond to new cases. Although there is a degree of training and supervision needed to work with another person, the rewards are great. Subcontractors enable you to accept the case you might have had to turn away because you were already committed to another case. Without subcontractors, your ability to generate income is limited to the number of hours you can work.

Conclusion
The five pillars work together to grow your business. You show your expertise in your work product and use it to attract clients and cases. You manage your clients to satisfy their requirements and generate repeat business. You handle your invoicing and retainer requirements so that you maintain a healthy cash flow. And you use business practices that enable you to leverage your time and expand your capabilities.

REFERENCES


PAT IYER, MSN, RN, LNCC
Pat Iyer is the president of the LNCAcademy.com, a division of The Pat Iyer Group. She works with legal nurse consultants who want to make more money, get more clients and avoid expensive mistakes. Her other sites include legalnursebusiness.com, which provides education for LNCs and LNCCEU.com, a membership continuing education site for LNCs. Pat is the host of Legal Nurse Podcast, found on iTunes and legalnursepodcasts.com. She draws on her deep expertise as an independent legal nurse consultant. Pat founded Med League Support Services, Inc. in Flemington, NJ in 1989, and ran this business for 26 years before she sold it in 2015. Pat is a national past president of the American Association of Legal Nurse Consulting. Pat has written, coauthored or edited over 800 books, chapters, case studies, online courses or articles about nursing or legal nurse consulting. Contact Pat at patriciaiyer@gmail.com or through her websites at www.legalnursebusiness.com or LncAcademyinc.com.
Introduction

Becoming a registered nurse automatically appoints a brand society has assigned to the professional. The interesting thing about this is, depending on which societal group is evaluating the registered nurse, the brand will mean different things at different times. The brand image that is a constant for every registered nurse regardless of the societal group is “caregiver” (American Nurses Association [ANA], n.d.-a, n.d.-b). Nurses are known as the nucleus and the foundation for quality of care (Dolansky & Moore, 2013). Today, nurses remain rooted in the foundation of quality. The delivery of quality has crossed over from not just clinical care but also to the delivery of service and management of business (Dykes & Collins, 2013). A Nurse Life Care Planner (NLCP), is a distinct group in the nursing profession. However, an entrepreneurial Nurse Life Care Planner is also a subgroup of the business community, particularly the healthcare business community.

As an entrepreneurial nurse, understanding business is critical to your company’s success. One area of struggle for entrepreneurial nurses is developing a solid brand for themselves and their company. When strong branding strategies are used for company development and marketing, it allows the NLCP to become a permanent fixture in the minds of their consumers (Davis, 2016b). At this point the question of “what is branding?”, may come to mind. Branding is the foundation to the position and relevance a company has in the marketplace. Branding is the house of a company and what you fill that house with are things like logo’s, pricing strategy, websites, social media, customer profiles, content strategy, and even communication styles (Davis, 2016b). Without solid branding, the foundation, a company, the house will be weak and at risk for destruction. Consumers evaluate the structure of a
brand before they commit to engage a company. Today, the consumer wants to know who they are giving their business to before they have a consultation with that service provider (Davis, 2016b). The marketplace seeks to find the best company for the job; the one who will get results and creates solutions.

Consumers today have the ability to be more informed about the company by way of the internet, especially through the use of social media. Social media gives insight into how a company treats and communicates with their clients. According to the Pew Research Center, social media continues to be the go-to source when searching for information (Greenwood, Perrin, & Duggan, 2016). The study found that 79% of adults use Facebook which is more than double that of Twitter and Pinterest. However, Pinterest’s 47 million users tend to visit company websites directly from the social platform at a 5% conversion rate (Delzio, 2015; Greenwood et al., 2016).

As one can see, it’s not enough to have a business plan and a social media page anymore. The entrepreneurial NLCP must have a strategy for the company’s brand and then be able to leverage that strategy to connect with consumers and achieve success on various platforms (Davis, 2016b). The key to all of this is to ensure the company’s brand is unforgettable and viewed as a resource. It must be unforgettable and resourceful on social media, in printed material, on your website and in the media (Davis, 2016b). Ask yourself these questions. Does my brand represent me well? Does my brand consistently attract the attention of my ideal client? Does my brand make an impact? Does my brand communicate the uniqueness and value of my company? Understanding the importance of branding and how to apply that branding will make the difference between the successful nurse in business and the struggling nurse in business (Davis, 2016b).

What is Branding?
The concept and principles of branding have been around for centuries. However, over time due to lack of knowledge, the importance and value of branding took a backseat especially in healthcare; which created significant challenges for healthcare organizations. In reverse, the use of effective branding has generated significant revenue for those who make branding a priority (Donohue, 2014). The National Research Corporation released a case study emphasizing why and how healthcare organizations must develop brand equity if they want to survive and flourish in this ever changing landscape (Donohue, 2014). Impact Branding Consulting (Davis, 2016a) published a blog outlining the difference between branding and marketing to help business owners and marketers better understand how to implement the two.

At times people confuse marketing for branding. Marketing sits under the umbrella of branding, yet it is a vital component. Marketing is the action taken to broadcast the message about the company. Branding is the strategy used to develop the correct message, identify the ideal recipient of the message, and enhance the company’s sustainability. Marketing is the advertisement of the service or product. Branding is pricing the service and identification of the market to target the advertisement (Davis, 2016b). Marketing is social media activity and website creation. Branding is developing the content to be placed on social media and on the website that will resonate with the ideal consumer. As you can see, one without the other is a recipe for waste and frustration. Once the entrepreneurial NLCP knows where they want their company to go and who they want their company to serve, the NLCP will know how to get positioned on the right road and avoid dead ends.

For example, in 2013, the automaker Hyundai Motor wanted to promote their new IX35 crossover vehicle, and highlight its 100% water emissions feature. As a way to emphasize this feature they released a commercial depicting a man trying to commit suicide in his garage with a running car. Their brand took a significant hit from several communities as being a company that is insensitive to mental illness and to people that have lost family members to suicide. The automaker released an official apology for their insensitivity and pulled the campaign (Bunkley, 2013).

In 2015, J. D. Power released the member health plan study. The study found that the insurance provider Humana, saved $2.1 million dollars in claims by implementing a new consumer engagement model to their branding strategy. One of the key elements to the new model was developing a system to ensure consumer centric habits became a priority across the spectrum of the organization and in all daily activities (J.D. Power, 2016).

Harness Your Success with Branding
Harnessing success through branding can be accomplished by using a few techniques. These techniques will boost the impact of your brand and position your company to be unforgettable in the hearts of your consumers. Building a successful and profitable business takes focus and discipline in many areas. With that being said, the cost of ineffective branding or disjoined branding, will cost thousands in lost productivity, lost revenue, and loss of market share. Customer acquisition and customer retention is easier when the brand is cohesive. Here are a few simple, yet effective techniques to implement in order to harness your success with branding.

1) Competitive Edge: evaluate the uniqueness of the company’s brand
and identify what makes you different from your competition. The goal is to highlight your “Me Only” quality in the industry. Do you perform a process in a certain way to get results or offer a special service that is specific to your company? Do a thorough assessment of the unique points and once that uniqueness is clearly identified use it to capture the attention of your potential clients while keeping the interest of your existing clients (Davis, 2016b).

2) **Content Strategy** is supposed to engage the marketplace. In this extremely busy world, a company has to justify their place in the minds and days of the marketplace. The content development game plan has to appeal to your potential and actual customers. Remember, the content must speak the language of the customer and appeal to their needs; not yours. Therefore, content distribution regardless of the channel used, must be intentional and not full of sales pitch copyrights. It must be consistent in timing and be relevant to what's happening in your industry and the economy. The Chief Executive Officer (CEO) of Impact Branding, developed a content strategy ratio model called the 60/20/20 (Davis, 2016b). The model guides companies on when, what and how much time to spend on educating their consumers, engaging their consumers, and asking their consumers for the sale.

3) **Customer Engagement Activities** requires consistent attention for it to be effective. Attracting the customer is hard work as well as retaining the customer. In your next strategic meeting, outline the top four ways the company will consistently engage with your customers and how your customers can engage with the company. Of the top four, none of them can be social media posts or newsletters. Engagement is the most effective way to communicate “partnership” to your customers. Communicating the sense of partnership with your clients will drive loyalty to your products and service. They will internalize the value and your genuine concern for them. Your company will achieve what very few small businesses achieve and that is brand loyalty. Brand loyalty happens when the brand has become a comfortable habit and is perceived as dependable (Aaker & Marcum, 2017).

4) **Brand Architecture** is the driving force behind a sustainable company. Every company regardless of its size and industry must evaluate and improve the structure of their brand. The simple and most efficient way to do this is to develop three specific brand positions for the company: the visual brand, the auditory brand, and the emotional brand (Davis, 2016b). Davis’ (2016b) #BeUnleashed book teaches companies how to create and improve their brand architecture by developing solid brand positioning. Once brand positioning is created, the company will earn brand equity. Brand equity is when your company becomes the preferred choice for the marketplace and begins to experience consistent profits.

## The Shift for Entrepreneurial Nurses

Nurses have evolved from bedside clinicians into speakers, authors, and CEOs. The shift from bedside nurse to entrepreneur nurse requires a shift in mindset from being a caregiver to being a leader. Often, novice entrepreneur nurses struggle with delegation, strategy, effective networking, fear of failing, and financial management. In Davis’ (2016b) #BeUnleashed: Unleash Your Millionaire Mindset and Build Your Brand, applicable steps are outlined for how to address these challenges using simple and effective principles. Two specific principles offered are how to reach the zone of operational excellence and how to close developmental gaps.

In operational excellence, one shift that needs to happen is profitable time management. As a nurse, the natural response is to help and nurture. However as a CEO and a leader the first response has to align with making decisions and choices that move the company forward. The next shift is closing developmental gaps. Developmental gaps have four quadrants through which each person transitions. Two of those quadrants are very important to address: unconscious competence and unconscious incompetence. As a clinical nurse, developmental gaps are closed through the pairing with preceptors and mandatory continuing education. However, as a CEO and a leader the entrepreneur nurse has to make a choice to manage gaps with a mentor or coach and choose to continue to be educated to remain cutting edge. Making the shift into entrepreneurship must be intentional (Davis, 2016b).

## Conclusion

Branding and marketing go hand in hand. One without the other creates a disconnect and confusion in the company’s position within the marketplace. Marketing is under the umbrella of branding; and branding is the strategy needed to execute effective and profitable marketing. As an entrepreneurial nurse, making the successful shift from clinician to business owner will reduce growth challenges and thwart growth delays. During the shift you will also reduce waste of resources and money while increasing business success. The key to leveraging the use of branding is to understand it, then applying it on a daily basis. Forbes, identified several trends in branding for this year (Arruda, 2016). One of the big trends is the efficient use of technology. Forbes reports over 70% of companies currently use video technology to reduce cost, increase engagement, drive results, and in their recruiting process (Arruda, 2016). In addition to using technology to position your brand as the preferred Nurse Life Care Planner in your market, consider evaluating, improving, and implementing the four simple techniques to harness your success. Be intentional with your strategy as you continue to shift from a clinician to a business owner.
REFERENCES


Dolansky, M. A., & Moore, S. M. (2013, September, 30). Quality and safety education for nurses (QSEN): The key is systems thinking” The Online Journal of Issues in Nursing 18(3), Manuscript 1. doi: 10.3912/OJIN.Vol18No03Man01


NATASHA E. DAVIS, MBA-M, RN-BSN, CEME, CSMA

Natasha E. Davis is a registered nurse and branding strategist for healthcare professionals and organizations. Prior to doing consulting, she worked for over 12 years as an emergency and trauma nurse. Today, she speaks and trains on the international circuit on branding, marketing, process improvement and audit readiness. For the past 10 years she’s been the Chief Executive Officer of Impact Branding Consulting, Inc where the mission is to help the healthcare industry and government agencies boost the impact of their brand. She has authored and published two books. She currently resides in Atlanta, Georgia and can be reached via www.ImpactBrandingConsulting.com
Introduction

Promotion of health and disease prevention is a foundation for all health care providers. But if patients do not understand what is being told to them by their healthcare provider, then how can it be expected that they change behaviors to promote health and prevent diseases? For example, an elderly person recently learns of having diabetes hears the word “insulin”; the parents of a newborn baby learn their baby has a genetic disorder and hears the word “neurofibromatosis”; or a limited English speaking immigrant is injured or becomes ill while at work and hears the words “hypertension” or “carbohydrates”. These words will more likely not be understood by nearly nine out of ten adults who have difficulty understanding health information (Kutner, Greenberg, Jin, & Paulsen, 2006).

Over 50% of adults living in the United States are classified as low health literate at an annual cost to the economy estimated to be between 106 and 236 billion dollars (Oluwatoyosi, Kimbrough, Obafemi, & Strack, 2014). There are increased costs associated with health literacy among the population with type 2 diabetes mellitus. Haun et al. (2015) estimated an increase of $143 million over three years associated with veterans’ inadequate health literacy.

Identifying Low Health Literacy

Health literacy affects all individuals, but is more frequently identified in the elderly, persons with limited command of the English language, individuals of lower socioeconomic status, and individuals of lower educational level (Ortega, Rodriguez, & Bustamante, 2014; Parker & Ratzan, 2010). Health literacy is determined in part, by an individual’s basic literacy skills. Literacy is not the same as health literacy even though they both require reading, comprehension, and numerical skills. Health literacy is dependent on an individual’s ability to process health information that is presented to them.

RACHEL CARTWRIGHT-VANZANT PhD, MS, RN, LHRM

IDENTIFY AND ADDRESS HEALTH LITERACY NEEDS TO ESTABLISH RELEVANT GOALS AND STRATEGIES FOR THE LIFE CARE PLAN
or discussed with them when they need to make healthcare decisions. Patients who do not understand health information presented to them or become confused about how to apply the information to their lifestyle are less likely to comply with instructions or follow-up on health care recommendations by a healthcare provider (Scheckel, Emery, & Nosek, 2010). Berkman, Davis, and McCormack (2010) reported that 90 million English speaking adults living in the United States have difficulty integrating information from complex documents like insurance benefits and performing calculations that required two or more sequential operations which is considered to be below a high school level.

The effects of low health literacy are evidenced by: more hospitalizations related to chronic illnesses, more frequent use of the emergency room, less frequent mammogram screenings, poorer ability to take medications as directed, poorer overall health status, and increased mortality rates among the older population (Berkman et al., 2011a; Squellati, 2010). Surveys show 36 % of the US population to be at the basic or below basic health literacy level (An Issue Brief from the U.S. Department of Health and Human Services, 2008). This equates to 87 million US adults having low health literacy (Vernon, Trujillo, Rosenbaum, & DeBuono, 2007).

Health Literacy Defined
Three literacy scales are described in Table 1. The National Assessment of Adult Literacy organized health literacy tasks representing three domains described in Table 2. The assumption is that in order for individuals to perform health literacy tasks they must: be familiar with health-related content like a drug label; and have some experience with written material that contains health-related content like a drug label; and have some understanding of how a health care system works so they can navigate to access the care they need (National Institute of Health, 2006).

Table 1: Literacy Scales

<table>
<thead>
<tr>
<th>Literacy Scale</th>
<th>Description</th>
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<tbody>
<tr>
<td>Prose literacy</td>
<td>The knowledge and skill required to perform prose tasks such as: searching for information, comprehending what is read, and locating information from news stories, brochures, and instructional materials.</td>
</tr>
<tr>
<td>Document literacy</td>
<td>The knowledge and skill required to perform tasks such as: searching for information, comprehending what is read in various formats. Examples include job applications, bus transportation schedules, reading a map, understanding information presented in a table format, or on food products and drug labels.</td>
</tr>
<tr>
<td>Quantitative literacy</td>
<td>The knowledge and skill required to perform tasks that involve computations using numbers presented in printed material. Examples of these tasks are balancing a check book, calculating a tip, filling out an order form, and determining how much interest will be paid from an advertising promotion.</td>
</tr>
</tbody>
</table>

Brown (1996); Kutner et al. (2006); Mohadjer et al. (2009)

Table 2: Domains of Health Literacy Tasks

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical domain</td>
<td>The encounters between the patient and the healthcare provider and the activities that surround the relationship.</td>
<td>Tasks associated with these activities may include completing a patient information form, understanding how to take their medications including calculating the dosage, and following the instruction for a diagnostic test.</td>
</tr>
<tr>
<td>Prevention domain</td>
<td>The activities associated with maintaining and improving health, preventing disease, taking early action when a health problem presents, and managing self-care with chronic illnesses.</td>
<td>Examples of tasks associated with these activities may include following guidelines for preventative health services that are age appropriate, identifying significant health problems that need to be reported to a healthcare provider, and establishing a diet and exercise routine can decrease risks for developing serious health issues.</td>
</tr>
<tr>
<td>Navigation of the health system</td>
<td>The activities patients encounter when seeking access to care. It also highlights the patient’s individual rights and responsibilities in health care.</td>
<td>Examples of activities associated with this domain may include understanding what insurance plans will pay for and what they will not, determining the eligibility requirements for public assistance programs, providing informed consent for procedures or other health services.</td>
</tr>
</tbody>
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National Institute of Health (2006)
errors, hospital readmissions, compromised health status, or other costly outcomes caused, at least in part, by miscommunication and misunderstanding of health information or health instructions. Communication is effected by language barriers and persons with disabilities are known to experience a decrease in the quality of care they receive.

Low health literacy significantly correlates with poorer health outcomes and poorer use of health resources (Berkman et al., 2010; Easton, Entwistle, & Williams, 2013). The National Patient Safety Foundation (NPSF) (n.d.) announced in 2013 that low health literacy is an enormous burden on the American healthcare system and that the annual health care costs for individuals with low literacy skills are four times higher than those with higher literacy skills. The additional costs of limited health literacy range from 7 to 17% of the total healthcare cost per year. The cost associated with low health literacy affects all individuals and is estimated at $106 billion (Vernon et al., 2007).

### Health Diseases

Baker, Parker, Williams, and Clark (1998) studied the association between patient literacy and health literacy and found that patients with inadequate functional health literacy had an increased risk of hospital admission. The functionally illiterate were more likely to be poor, unemployed, and working in seasonal type jobs that fluctuated with the economy. The functionally illiterate had difficulty reading prescription bottles, appointment slips, self-care instructions, and patient education brochures. Patients with low literacy skills have a 50% increased risk of hospitalization compared with patients who had adequate literacy skills (DeWalt et al., 2006, p. 2; Mitty & Flores, 2008). Low health literacy contributes to poorer self-management skills. Easton et al. (2013) goes on to say patients with low health literacy have poorer knowledge of health diseases and are not as able to adequately manage health conditions such as asthma, diabetes, and heart disease.

The work of Gazmararian, Williams, Peel, and Baker (2003) reported that individuals with a chronic disease such as diabetes, asthma, or hypertension and were determined to have low health literacy had less knowledge of how to manage their disease and were less able to correctly demonstrate self-care skills than those individuals with adequate health literacy. Health literacy was determined to be an “independent predictor of patient’s knowledge of their chronic illness” (p. 273). Patients with low health literacy who appear to understand information about their disease have the worse health outcomes. Patients will conceal their lack of understanding to avoid the shame and the negative stigma associated with low literacy and low health literacy (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011b).

To remedy this situation, health education must be adjusted according to the patient’s level of health literacy and available written material must be appropriate to individuals with low health literacy. The relationship between low health literacy and health outcomes has been appreciated in a broad respect when studying diseases such as congestive heart failure, diabetes, hypertension, and preventative measures to improve health.

### Medication Errors

Lie, Carter-Pokras, Braun, and Coleman (2012) and Kanj and Mitic (2009) agree that a reason why patients who are not able to comply with a treatment plan or experience a medication error may be related to poor understanding of health information. About 50% of all patients take medications as directed. The numerical and computation skills required to take medications can be overwhelming if the patient is not able to work with numbers in even simple mathematical calculations. This is why the literacy category addressing numeracy, or numbers, is necessary to evaluate when assessing health literacy needs.

People with low literacy make more medication or treatment errors, are less able to comply with treatments, lack the skills needed to successfully negotiate the health care system, and are at a higher risk for hospitalization than people with adequate literacy skills (Easton et al., 2013, pp.5-6, 9). Individuals who have difficulty with numbers will, more likely than not, have difficulty understanding health information. It becomes clearer why approximately 50% of patients do not take medications as directed. As a result, a medication error occurs in the home that may lead to a primary care provider visit or even hospitalization (Kanj & Mitic, 2009; Wolf et al., 2007).

Wolf et al. (2007) reported patients with low literacy stated they had problems with taking medications, needed help with health related reading tasks, and had difficulty understanding and following instructions written on their appointment slip. For example, patients with the lowest literacy level; less than third grade level; may become confused about their medications because of the difficulties with reading or comprehending the information written on the medicine bottle. More than half of patients at or below the third grade level request help to read medicine bottles; 15% of them reported missing doctor’s appointments because they could not read the appointment slip very well (Kanj & Mitic, 2009; Wolf et al., 2007). All healthcare providers should have the knowledge to be able to validate a patient’s understanding of health instruction and make observations of tasks associated with low health literacy based on these known factors and intervene when warranted.

### Legal Implications

Clark (2011) discussed the legal position of how individual rights are affected by health literacy. Individual rights include the universal principles of biomedical ethics: patient autonomy, justice, and beneficence. Patient autonomy corresponds to the legal principles of informed consent. Courts have ruled on cases where issues of verbal and written literacy were the main premise for the legal action during the consent process for
treatment. Limited command of the English language, for both English and non-English speaking individuals, influences the ability of the individual to adequately understand health care issues and engage in the decision making processes regarding their personal health.

In Quintanilla v. Dunkleman (2005), the court ruled that because a patient was not able to read the consent form that was signed, the consent was not valid. Therefore, the burden of proof was shifted to the physician to prove informed consent was obtained through other means. This example demonstrates the complexities of our health care systems and how literacy, limited English proficiency (LEP), and health literacy are entwined when healthcare providers pressure individuals to make personal health care decisions.

High Expectations Negatively Influence Patient Communication

Healthcare providers expect a patient with limited English proficiency to ask for medical forms in their primary language or request an interpreter. Patients are expected to ask questions if they do not understand. These are high expectations the health care systems and healthcare providers place on patients with low literacy skills and limited English proficiency whom are also very likely experiencing not only shame and embarrassment because they do not understand but, stress and fear because of the health issue at hand (Yip, 2012). In some respects, the health care provider may actually contribute to the health disparities because of the demands of the health care systems and communication techniques used with patients of low health literacy. Healthcare providers have a duty to disclose information to the patient in a meaningful manner when the patient asks for it, or when it becomes known the patient requires additional information to make informed health care or treatment choices (Clark, 2011).

Stigma, Shame and Embarrassment

Healthcare providers expect patients to have skills to read medication labels, appointment slips, consent documents, and health education materials. When patients are not able to read, or are not able to read well, they are more likely to withhold their literacy limitations from the healthcare provider because of shame and embarrassment. Patients with low functional health literacy feel shame, have feelings of inadequacy, fear, and low self-esteem. Wolf et al. (2007) reports nearly one half of patients who read at less than or equal to a third grade level experience shame and embarrassment about their reading abilities and more than one third expressed they would be ashamed if the healthcare provider knew of their reading difficulties. Patients with marginal or low literacy skills agreed to have a note put in their medical chart to indicate they had difficulty with medical words, but they also confirmed that having this entry in their medical chart would be shameful or embarrassing to them (Wolf et al., 2007).

A strategy to address the issue of shame is the implementation of the “universal precautions” approach. When healthcare providers use this approach, all patients are addressed as if a limited health literacy issue exists.

Health Literacy Tools

The Newest Vital Sign

The Newest Vital Sign (NVS) is the first literacy screening tool available in both Spanish and English. Linnebur and Linnebur (2016) share how beneficial the NVS is during a patient encounter. It takes approximately 3 minutes to complete which makes it easy to administer in most health care settings. The sensitivity of this tool may identify more patients as low health literacy than actually are; however, this is felt to be acceptable as opposed to not being sensitive enough, or not identifying enough of those who are low health literate. The healthcare provider can elect to adjust the health education material or content accordingly and as necessary. The screening tool is based on reading and interpreting a nutrition label. This everyday activity contributes to functional literacy particularly with chronic illness (Devraj, Butler, Gupchup, & Poirier, 2010).

Rapid Estimate Assessment of Adult Literacy in Medicine

Rapid Estimate Assessment of Adult Literacy in Medicine (REALM) is designed to be administered in public health or primary care settings (Dewalt, Berkman, Sheridan, Lohr, & Pignone, 2004). The REALM-R (revised) is an effective tool to assess quick health literacy in a busy clinical setting. The test requires approximately 3 minutes to complete and relies on word recognition and pronunciation. It does not measure comprehension and only measures reading ability below the ninth grade level (Dewalt et al., 2004).

Test of Functional Health Literacy of Adults

The Test of Functional Health Literacy of Adults (TOFHLA) is available in both Spanish and English (Baker, Williams, Parker, Gazmararian, & Nurss, 1999). It measures functional literacy, numeracy literacy, and comprehension of health related materials. The S-TOFHLA was developed in response to the time sensitive issues present in the clinical settings (Ciampa et al., 2013).

Single Item Literacy Screener (SILS)

This tool was designed to assist the healthcare provider in identifying those patients with reading difficulty. The SILS asks, “How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?” (Morris, MacLean, Chew, & Littenberg, 2006, p. 2). The SILS is administered as part of the initial patient questionnaire. When comparing the S-TOFHLA with the SILS, the SILS was determined to perform well in identifying patients with reading difficulty in addition to being simple and practical in varied health care settings.

Three Health Literacy Screening Questions

Chew, Bradley, and Boyko (2004) used three questions as opposed to the one
used by SILS to determine not only those patients with reading difficulty but to also identify those patients with marginal health literacy. The three questions used were (a) “How often do you have someone (like a family member, friend, hospital/clinic worker or caregiver) help you read hospital material?”; (b) “How often do you have problems learning about your medical condition because of difficulty understanding written information?”; and (c) “How confident are you filling out forms by yourself?” (p. 562). The results showed the question about filling out forms performed significantly better that the other two questions even though all three did identify patients with inadequate health literacy. When patients are identified as having inadequate health literacy, the healthcare provider then must choose the most appropriate interventions to meet the health literacy needs.

**Interventions for Low Literacy Patients**

Effective interventions can be initiated by the health care provider once low health literacy is identified. Research has identified methods proven to enhance communication with persons with low health literacy: speak slowly (Schwartzberg, Cowett, VanGeest, & Wolf, 2007), use plain language (Cornett, 2009; Roett & Wessel, 2012; Stableford & Mettger, 2007), limit the amount of information given at one time or during one education session (Roett & Wessel, 2012), and verify the patient understood the education material presented by using the teach-back technique (The Joint Commission, 2007, 2010; Volandes & Paasche-Orlow, 2007).

When providing or using written material, use only short sentences and only one or two syllable words; each page should have no more than two or three concepts and ample white space should be included around the boarder (Cornett, 2009; Roett & Wessel, 2012). To enhance comprehension, incorporate pictures and drawings with the verbal or written material as much as possible. Relating personal stories relevant to the topic being discussed are also known to be useful (Roett & Wessel, 2012).

**Summary**

Life care planning requires collecting comprehensive data pertinent to the needs of an injured or ill individual. An assessment of their health status, ongoing medical, psychosocial, educational, vocational needs and the cost of those products and services, over the life of the client. When conducting the face-to-face interview with the client the Life Care Planner can personally assess for inadequate health literacy and incorporate the education support necessary to improve the person’s ability to understand their health status, access ongoing medical treatment that is warranted, and manage day-to-day activities safely. Assessing all clients through a lens that includes a focal point on health literacy needs may improve quality of life and improve health outcomes. It is impossible to tell by looking at an individual who may be infected with disease that is transmitted through blood or bodily fluids; similarly, it is impossible to tell by looking at an individual who may be affected by inadequate health literacy. Follow the universal precautions approach because health literacy is an issue that affects everyone.

**REFERENCES**


**OTHER RESOURCES**


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**RACHEL CARTWRIGHT-VANZANT, PhD, MS, RN, LHRM**

Rachel provides consultative services including education seminars, identification of patient safety interventions, and legal case reviews. Her research on health literacy identified opportunities that healthcare providers can act on to improve the health literacy of patients. Documentation of patient care is critical to preserve evidence that minimum expectations are met during a patient encounter and she speaks nationally to health care providers on the legal aspects of documentation incorporating the challenges of the electronic health record. She consults with legal counsel on medically related injury cases and provides expert testimony on nursing standards of practice. She is an active member of the National Speakers Association and Healthcare Speakers Network. She can be contacted at rachel@contactmlc.com.
Abstract
This article provides an overview of the members who may be retained as part of an expert witness team in an employment law case. In addition, types of evidence, scopes of retention, and ethical standards for all members of the team are discussed.

Keywords
Employment law, employment practices, expert witness team.

Employment law cases are not typically considered an expert witness referral source for nurses. Examples of employment law cases are claims such as: 1) discrimination based on disability; 2) wrongful termination; and 3) failure to accommodate a disability. This article provides an overview of the expert witness team in the liability/causation and damages sides of an employment law case, and introduces the potential role of nurses in such cases.

Data and Evidence
Data are bits of information and evidence is information in support of a proposition (Barros-Bailey, 2015a, 2015b). Barros-Bailey (2015a, 2015b) identified data and evidence as falling into two categories with three components each. The first category is what the expert collects (called primary data) and the second category is what others collect (called secondary data). Primary data comes in three forms: 1) interviews of the plaintiff or collateral sources (e.g., family, treatment team, employers); 2) observation (e.g., exam or testing the evaluatee, such as taking vital signs or administering a norm-referenced test); and, 3) participant-observation (e.g., observing the evaluatee while being part of the intervention). Likewise, secondary data comes in three forms: 1) documents (e.g., medical/psychological or legal records, peer-reviewed articles, electronic records); 2) archival (e.g., raw databases of data, such as from government or research organizations, vital records); and, 3) physical artifacts (e.g., durable medical equipment or assistive technology used, specimens collected).

Fact or Expert Witness: What’s the Difference?
When a nurse is referred an employment law case, the first thing that should be determined before data is reviewed or collected is if the nurse is being asked to be a fact or an expert witness – or an expert witness retained or not retained for litigation. Per Rule 26 of the Federal Rules of Civil Procedure, a fact witness testifies about direct observations and knowledge personally possessed about the case or to corroborate circumstantial evidence, but does not offer opinions or draw conclusions (U.S. Courts, 2016). On the other hand, an expert witness has scientific, technical, or specialized knowledge personally possessed about the case or to corroborate circumstantial evidence, but does not offer opinions or draw conclusions (U.S. Courts, 2016).
Most professionals who may be reading this article are likely considered expert witnesses. A distinction not well known or recognized is that expert witnesses should identify whether they are or are not being retained for litigation. For example, a treating nurse practitioner may have the scientific, technical, or specialized knowledge to be an expert witness. By the nurse’s knowledge of treatment standards, the nurse may be asked to serve as a fact witness by offering expert testimony specific to the facts and conclusions of the individual’s treatment in the pending legal action. However, the retaining parties may retain another nurse practitioner to serve as the expert witness for litigation whose duties are to provide expert testimony about the evidence and draw conclusions and opinions in either the liability/causation or damages sides of a case. Therefore, it is important to understand the role that is being requested in any case retention: fact or expert witness, and if an expert witness, retained for testimony or for consultation. Clarification should be sought if there is any confusion or potential overlap or need to navigate professionally or ethically.

**Liability/Causation or Damages, or Both?**

There are typically two main components of a case. The liability or causation side considers what happened, or could have happened to cause the alleged incident or condition. The damages component considers the impact of the incident or condition. Expert witnesses can be hired in either or both parts of the employment law case. An expert witness hired on both parts of a case needs to be very clear as to the opinions and testimony of each part.

An example in an employment case is when a vocational expert is hired to consider what the employer did or did not do to accommodate an individual with disabilities (causation), but also testifies about the plaintiff’s earning capacity (damages). Another example is when a nurse testifies about a breach or lack thereof of the standard of care in a medical malpractice case (causation), but also offers a Life Care Plan as an intervention (damages).

As these two example depict, it is important to seek clarification about the responsibilities in either role and if the expectations are to serve as an expert on both parts of a case. If the scope of the retention is limited to a single role (e.g., life care planning), the expert should not offer opinions that bridge into another role (who was at fault for the incident). If asked about opinions on causation when the retention was to solely assess damages on a case or vice versa, the expert should indicate that those opinions are outside the scope of the retention. Instead, experts should focus exclusively on the factors that align with the retention request.

**The Expert Witness Team in Employment Law Cases**

Employment cases can be based on violation claims based on a variety of laws. Those identified by Barros-Bailey and Dominick (2016) include the Americans with Disabilities Act (ADA), discrimination or harassment (age, gender, national origin, race/color, religion), wrongful termination, and the Family Medical Leave Act (FMLA) and may or may not include disability or medical issues. Therefore, the expert witness team hired by plaintiff or defense counsel may be as varied as the needs of a case.

In ADA cases, for example, a typical causation expert witness team retained for litigation may include a vocational expert who testifies about the interventions attempted or omitted that could have made the difference in employment or retention of the plaintiff. There may be a psychiatric nurse practitioner who testifies about the individual’s mental health diagnosis and medication regime that may or may not have interfered with the plaintiff’s ability to perform the essential functions of the job. The team may contain an employment practices expert who testifies about the employer’s duty to provide reasonable accommodation and engage in an interactive process to seek the proper accommodation.

On the damages side of the case, retaining counsel may hire a vocational expert to determine any earning capacity effects of the alleged action and incident and/or the potential intervention that would assist the individual to mitigate those losses. Depending on the impact of the incident, a Life Care Planner may be hired to consider the probable accessories, adaptive, aids, care, diagnostic, drugs, equipment, evaluations, supplies, therapy, or other needs. An economist may be retained to bring the cost of the opinions of the damages experts into present value to summarize the economic damages of a case.

**Ethics of Practice for All Members of the Expert Witness Team**

Whether hired for the causation or damages side of a case, or both, expert witnesses often come from varied disciplines that may or may not have informal or formal ethical standards of practice. Some disciplines may have oversight by credentialing bodies with established and strict due process guidelines. Others may have no level of credentialing whatsoever either by a body in the profession (certification) or a government entity (licensing) or other professional parameters.

Regardless of the level of guidance or enforcement of standards within a profession or discipline, or the type or side of a case where someone is retained as an expert, in 2011, the American Bar Association Section of Litigation (ABA/SL) (2011) proposed the Standards of Conduct for Experts Retained by Lawyers. The drafters noted the lack of consistent standards had led to: (a) inconsistent expectations of experts’ required conduct, (b) unnecessary surprises that have negatively impacted the lawyer-expert relationship, and (c) disqualification motions challenging the conduct of certain experts (p. 1). Therefore, the ABA/SL (2011) proposed standards pertaining to all experts fall into five categories as follows:

1. **INTEGRITY/PROFESSIONALISM:** An expert shall act with integrity and in a professional manner throughout an engagement (p. 2).
II. COMPETENCE: An expert shall not undertake an engagement unless the expert is competent to do so (p. 2).

III. CONFIDENTIALITY: The expert shall treat any information received or work product produced by the expert during an engagement as confidential, and shall not disclose any such information except as required by law, as retaining counsel shall determine and advise, or with the consent of the client (p. 4).

IV. CONFLICTS OF INTEREST AND DISCLOSURE: Unless the client provides informed consent, an expert shall not accept an engagement if the acceptance would create a conflict of interest (p. 5). These conflicts include financial interest, “communication or contacts with any adverse party or lawyer” (p. 6), prior public testimony, adverse opinions by a judge on an expert’s qualifications in the last 10 years, etc.

V. CONTINGENT COMPENSATION OF EXPERTS IN LITIGATED MATTERS: The expert shall not accept compensation that is contingent on the outcome of litigation (p. 8).

While the proposed code was adopted by the Section of Litigation, it was never adopted by the full delegation of the American Bar Associates (Hansen, 2012). Nevertheless, this code serves as a model unifying standard of conduct for an expert witness team between and among different sides of a case, and within and between jurisdictions.

Competence is an area of the code that deserves additional explanation and consideration. Although the disciplines of experts on the team are typically diverse, there are times when they may be complementary or have some overlap. For instance, the employment practices expert may rely upon the literature and tenets of behavioral experts, social science experts, cultural experts, and gender bias experts. Therefore, if a member of the expert witness team comes from a scope of practice that has some aspect that bridges or dovetails with that of the employment practices expert, care should be taken to understand the nature of any overlap between the experts and avoid conflicts. Another example may be between the vocational expert and forensic economist on the damages team where there may be areas of overlap, such as opinions about worklife expectancies or the selection of worklife expectancy tables.

Summary and Implications

Whether or not an expert’s practice focuses specifically on employment cases, understanding how to classify evidence in an analysis and in the expressed opinions and recommendations is fundamental. Identifying and clarifying one’s role will potentially avoid any conflicts with the retaining source, or other experts on the causation or damages teams. When retained as an expert, the role and expectations need to be clear. Whether the requested services fall within the scope of practice and competence of the expert needs to be ascertained. Find out who the other members of the expert team may be, whether the expert may need to understand and communicate with those experts, and the limits of disclosure and privilege if communication is needed. Lastly, understand the essential ethical standards under which all experts on any team operate. Educate those who may not know the presented information about the existence of common standards that serve as a guide to experts’ professional behavior.

REFERENCES


MARY BARROS-BAILEY, PhD, CRC, NCC
Dr. Mary Barros-Bailey is a life care planner, rehabilitation counselor, and vocational expert as well as clinical and teaching adjunct faculty with the University of Idaho.

BOBBI K. DOMINICK, JD, SPHR, SHRM-SCP
Bobbi K. Dominick is an employment and appellate law attorney as well as an employment practice expert witness with a focus on effective human resources practices.
Introduction

The International Association of Rehabilitation Professionals (IARP) (www.rehabpro.org) held its annual conference from October 20, 2016 through October 22, 2016 in Pittsburgh, Pennsylvania. Significant to the 2016 conference was the decision by IARP to combine two major conferences usually presented annually by the organization. In the past, IARP has offered an annual International Symposium for Life Care Planning (ISLCP) (https://connect.rehabpro.org/lcp) and an IARP Annual Conference. At the separate conferences, the organization provided a vast array of medical topics and research, and speakers regarding standard of care, emerging technology, approaches to medical/vocational case management and transition, practical applications for the rehabilitation/Life Care Planner’s practice, ethical issues, forensic practice, and courtroom testimony. Traditionally there was more focus on medical and Life Care Planning practice issues during the Symposium while the IARP Annual Conference placed more emphasis on return to work and forensic issues. To be more responsive to the needs of its membership, IARP combined the two conferences.

Maintaining Objectivity

In another break with tradition, IARP invited the American Association of Nurse Life Care Planners (http://www.aanlcp.org/) to co-moderate one of the discussions of the round table fast track session. The round table fast track discussions involved organized, 15 minute conversations led by leaders in Life Care Planning. Each participant had the option to visit four of nine tables during the one hour session. In planning the session, several issues emerged as pertinent to Life Care Planners. These topics included: maintaining objectivity, the influence of the Affordable Care Act in Life Care Planning (www.healthcare.gov), vocational aspects of Life Care Planning, medical foundation, marketing Life Care Planning services, costing and coding, FAIR Health, Inc. (www.fairhealth.org), the Journal of Life Care Planning, and professional designations in Life Care Planning. What follows is a brief synopsis of the round table discussions.

Maintaining Objectivity

For the discussion in regard to maintaining objectivity, participants reported feeling no undue pressure from referral sources. They did experience challenges when multiple experts were involved in the Life Planning process and there was no consensus of opinions. The group discussed ways to deal with this, such as attempting to achieve consensus through conferencing with the experts; identifying the range of opinions associated with each expert in the Life Care Plan; and/or the Life Care Planner selecting one of the opinions depending on the expertise of the expert. This table also debated the potential hazards in developing a Life Care Plan where a dual relationship exists. For example, for an attorney involved in personal injury suit who also is a referral source.

Affordable Care Act

For the discussion in regard to maintaining objectivity, participants reported feeling no undue pressure from referral sources. They did experience challenges when multiple experts were involved in the Life Planning process and there was no consensus of opinions. The group discussed ways to deal with this, such as attempting to achieve consensus through conferencing with the experts; identifying the range of opinions associated with each expert in the Life Care Plan; and/or the Life Care Planner selecting one of the opinions depending on the expertise of the expert. This table also debated the potential hazards in developing a Life Care Plan where a dual relationship exists. For example, for an attorney involved in personal injury suit who also is a referral source.
was consensus that the Life Care Planning professional must discuss with the referral source the specific collateral source rules applicable to the case, as differences exist in different jurisdictions across the country. Participants in different geographic areas described varying levels of interest in including the ACA in Life Care Plans. Emphasis was placed on using geographically relevant and transparent sources in the identification of services and costs in order to adhere to IARP standards of practice and consensus statements.

Vocational Aspects of Life Care Planning

Vocational aspects of Life Care Planning is a topic the organizers of the round table session believed was of considerable importance. This discussion involved the process to develop objective vocational projections, using the foundation of transferable skills analysis and occupational/labor market research. There was consensus among the participants that vocational issues are important and at times overlooked in Life Care Plans. The table attendees suggested that it would be appropriate to consult with a vocational rehabilitation counselor if the Life Care Planner is not able to independently determine the evaluatee’s wage earning capacity or is not able to place a value on wage loss and loss to wage earning capacity.

Medical Foundation

One issue discussed at the medical foundation round table was the difficulty in obtaining recommendations for pediatric cases due to the need for long term projections. Options suggested included working with a qualified physician who could address both pediatric and adult needs, or consulting with two physicians, so that one healthcare provider could address pediatric needs while the second could recommend the likely services needed when the child is grown.

Marketing Life Care Planning Services

Most of the participants at the marketing Life Care Planning services discussion were interested in developing a Life Care Planning practice. The moderators suggested a number of approaches, including developing a business website, approaching attorneys for potential speaking opportunities at professional meetings, seeking a mentor, and participating in professional organizations such as IARP and IALCP both locally and nationally. These groups offer learning opportunities through webinars, conferences, and more informally through discussion groups available on List-serve. The young Planners were encouraged to explore Life Care Plan software programs. The moderators recommended that they volunteer in social service venues for both intrinsic rewards and networking.

Costing and Coding

At the costing and coding table, the moderator had prepared a series of questions to obtain participants’ opinions regarding resources for information. Most participants use Medical Fees by Practice Management Information Corporation (http://pmiconline.stores.yahoo.net/mefa201.html) and Physician Fee Reference (https://wasserman-medical.com/shop/product/physician-fee-reference) for current procedural terminology (CPT) services. For surgical fees, the majority use American Hospital Directory (AHD) (www.ahd.com), along with state specific data bases. For prescription costs, attendees frequently use the cash prices listed on GoodRx.com. Many professionals identify the costs through the individual’s actual pharmacy printout. This discussion group was one of the best attended round tables.

FAIR Health, Inc.

The FAIR Health round table offered an opportunity to discuss how to better utilize the FAIR Health program and introduce the resource to potential new users. FAIR Health maintains a large database of privately billed healthcare claims, which it uses to develop benchmark costs for inpatient, outpatient, dental, medical, and anesthesia services. The benchmarks are based on 12 months of claims data, organized by procedure code and geographic area. IARP members can access FAIR Health data through a special contractual agreement. There was also some discussion of FAIR Health at the cost and coding round table, and use of this resource appears to be rising.

Journal of Life Care Planning

The Journal of Life Care Planning (https://www.rehabpro.org/publications/jlcp-index) provides a forum to facilitate discussion and debate regarding Life Care Planning for IARP members. The Journal publishes independent research, educational articles on a variety of topics, and builds consensus on practice guidelines. At this round table, the moderator led a discussion regarding this important publication and its role in the continuing education and professionalism of its members. The moderator answered questions of getting an article published.

Professional Designations

The topic of the last round table discussion was professional designations in Life Care Planning. Moderators, from the American Association of Nurse Life Care Planners, the International Commission on Health Care Certification and the IARP Fellow Program were available to lead the discussion. The intent of the organizers was to offer an opportunity to discuss and contrast the different professional designations, including the qualifications required and standards associated with each. It was hoped that common ground would be identified, with perhaps additional opportunities for future discussion. Feedback from the moderators suggests that this was difficult to accomplish in practice. While there were some visitors to this round table, there was little interaction among those from the different disciplines. There were in fact two representatives each for both the AANLCP® and the ICHCC (www.ichcc.org), resulting in five moderators at the table. This may have presented
the impression that the table was busy, perhaps creating an obstacle to attendees who may have wanted to engage in more cross-specialty discussion.

Although there was limited discussion regarding the Fellow designation, this may offer some potential as a bridge between the different backgrounds and specialties of Life Care Planners. The International Association of Life Care Planners, a section of IARP, requires the potential Fellow to meet ten criteria in order to be considered for this professional designation. In addition to being licensed and certified in his/her healthcare discipline, the Life Care Planner must contribute to the field through providing education, conducting research, publishing in professional journals or texts and/or providing mentoring to other Life Care Planners. The applicant must have letters of recommendation, and have completed a minimum of 50 Life Care Plans as well as a minimum of five years as a Life Care Planner. In addition, the Life Care Planner must submit at least two Life Care Plans completed within the last twelve months, which are reviewed for criteria such as objectivity, data analysis, accuracy, completeness and internal consistency. Additional information can be obtained about the Fellow program at https://connect.rehabpro.org/lcp/about/fellows.

Conclusion

Overall, the format for the round table discussions was considered successful (Seyler, 2017). The organizers found that having the session at the end of the conference day created a more relaxed atmosphere. In developing topics for the round table discussions, the organizers sought input from a larger number of conference planners. Round tables that generated the most participants and discussion appeared to be those representing the challenges associated with Life Care Planning practice. Topics such as costing and coding, FAIR Health, the Affordable Care Act, and maintaining objectivity are nuts and bolts issues that challenge practitioners routinely, and they wanted to talk about them (Seyler, 2017)! By encouraging attendees to rotate among the tables fairly quickly (in 15 minute segments), there appeared to be greater participation in a number of different discussion topics. For those table discussions with fewer attendees, the organizers suggest that a round table format may not be a suitable venue for some topics. For example, for the Life Care Planner who is not comfortable with vocational issues, a more appropriate forum may be a small workshop as opposed to an open discussion. Overall, the participants appeared to enjoy this learning format and appreciated the participation of AANLCP® in the IARP Annual conference.

REFERENCES


CARLA D. SEYLER, MS, CRC, CCM, CLCP, LRC

Carla Seyler was the moderator of the Round Table Fast Track at the 2016 Conference for the International Association of Rehabilitation Professionals/International Symposium for Life Care Planning (IARP/ISLCP). In suggesting the “speed dating” concept for the Round Table, she hoped that it would lead to enhanced learning through more dynamic discussions, or a long term relationship with a new idea or two. This is Ms. Seyler’s 40th year in the field of rehabilitation counseling. She retired at the end of 2016 from Seyler Favaloro Ltd., a Vocational Rehabilitation and Life Care Planning practice based in New Orleans that she co-founded in 1992. She is currently President-Elect of the Louisiana chapter of IARP. Ms. Seyler has taught courses at LSU School of Allied Health in the Department of Clinical Rehabilitation Counseling. She has a master degree in Counseling from Loyola University of New Orleans. She is a certified Life Care Planner, a Licensed Rehabilitation Counselor and a Certified Rehabilitation Counselor. She served for nine years on the Louisiana Licensed Professional Vocational Rehabilitation Counselors Board of Examiners, and as its Chair for two years. She can be reached by email at cdseyler17@gmail.com.
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The Nurse Life Care Planner (NLCP) is an expert in case/care management. From identifying needs and resources to strategizing and implementing effective plans of care, the NLCP aims at ensuring the best possible outcome for each unique patient situation. And while the desire to help others may be the driving force behind the work, Life Care Planning is not an effortless endeavor. To be effective, NLCPs need a solid understanding of injuries and illness, the implications of treatment and interventions, the cost of care, availability of resources, and how to leverage these and other factors for the best results (American Association of Nurse Life Care Planners [AANLCP®] & Certified Nurse Life Care Planner Certification Board [CNLCP®]), 2014).

Running a successful business, however, requires more than drive. Understanding marketing principles, knowing how to align them with the business plan, and determining which strategies bring the best return are also needed to build a sustainable client base. Simply put, marketing strategy is to business what care management is to Nurse Life Care Planning—absolutely essential.

Marketing Principles: An Overview
Marketing serves as the wellspring from which business flows. Considered part science, part art, effective marketing principles are research-based, backed by evidence, and ideally, delivered with thoughtfulness and sincerity. Only with continual marketing can the NLCP draw attention to the business, the services offered, and the benefits they provide. In other words, marketing is a must. Success in business, therefore, requires a dynamic marketing plan, a document added to over time, and through experience that provides structure for current and future strategizing (Arons, van den Driest, & Weed, 2014). The first step involves breaking down every process of the marketing program, from definition of service to customer follow-up. Evaluate each step and select areas for improvement. By improving only one or two of them, business owners will begin to experience more success gaining and retaining customers (Holmes, 2007).

Define Products or Services
We all know the customer comes first, but before focusing on the customer, the savvy nurse entrepreneur must define the products or services available. For example, how would NLCPs describe their specialty to someone unfamiliar with this line of work? Do they provide or arrange care? Do they offer legal advice? How do they handle ethical concerns?
What services fall outside their scope of practice? These are just a few of many questions to ask when laying the groundwork for marketing strategy. The services offered might vary according to customer need. Strategic marketing should be focused accordingly.

**Identify Customers**

Without customers, NLCPs have no business. Identifying who those customers are will depend on the services offered. Keep in mind that potential customers may not only be those who directly benefit from the proposed work, but also colleagues, families, and other circles of influence. Be as inclusive and descriptive as possible when building customer lists by asking those who, where, what, why, how, and when questions.

Whether marketing to healthcare professionals, lawyers, insurance companies, or individuals, the strategies used should be adapted to fit their need. As an advocate, spend time getting acquainted with each patient giving each patient time to become acquainted with you. Relationship building is not accidental; neither is building a business.

**Understand the Process**

After defining services and identifying customers, it is time to employ the skills used in Nurse Life Care Planning. Remember, marketing strategy is the heart of the business. To run a successful business it is important to understand the buying process from the customer's perspective (Bygrave & Zackarakis, 2010). Typically, this includes addressing the following areas:

- Awareness of need
- Information search
- Evaluation of alternatives
- Purchase
- Post-purchase evaluation

Each of these areas is explained in greater detail below, along with a marketing strategy to help build the business by meeting customers where they are.

**Awareness of Need**

Before customers are ready to buy, they must first have an awareness of need or an interest in the services available. For example, a middle-aged daughter becomes aware of her mother's failing health and realizes that she is unable to care for herself as independently as before. Who will the daughter likely turn to for help? She may contact her mother's physician, a clinical social worker, or the local senior service center. Whomever she reaches out to will also be motivated by an awareness of need.

Another example might be an attorney representing a client who sustained serious on the job injuries resulting in life-altering disability. This attorney would likely be interested in the services of a NLCP. Identifying professionals who work with these types of clients will provide a greater chance of engaging them as customers. Marketing strategy should address how prospective clients become aware of services and/or products.

**Information Search**

Today's technology means that consumers have instant access to information on their computers, notebooks, and smart phones. Social media sites, including Facebook, Twitter, and Instagram are excellent vehicles for increasing visibility and directing clients to the business.

While having a dynamic blog and well-designed website also provides exposure, they can be costly and time-consuming to set up and maintain. A good alternative is LinkedIn (https://www.linkedin.com) where nurse entrepreneurs can network and share information by publishing articles and posts about their services and other topics of interest to consumers.

The key ingredients when providing accessible information include building trust, maintaining professionalism, and ensuring clear messaging. Be careful not to neglect more traditional (and often more trusted) sources of information such as family members, friends, local businesses and experts. Marketing strategy should include accessible and comprehensive information positioned to reach the customer and positively influence their decision-making.

**Evaluation of Alternatives**

Buyers often struggle with challenging decisions regarding which solutions best fit their situation. For the most part, they do not make these decisions alone, but with the input of a decision influencer. For example, consider the family of a chronically ill child who requires complex case management and Life Care Planning. The buyer may be the child's mother, but her husband (the influencer) knows his wife overtakes herself to the extent that she has little energy left to care for their other children. To make the best decision for their circumstances, they must be informed of their options. Marketing strategy should address the diverse concerns of both the decision maker and their influencer(s).

**Commitment to Proceed**

This is the point of sale—the commitment to proceed with the service offering. It may also be a time of anxiety and uncertainty for the customer. This is a prime opportunity for the NLCP to build trust by addressing any concerns, questions, and sense of risk the buyer may have. Clearly communicating what happens next, what the customer can expect, and anticipated timeframes for delivery, etc., reaffirms to the customer that they are making an informed and good decision. Marketing strategy should demonstrate the level of performance and professionalism the client can expect from you.

**Post-purchase Evaluation**

During the post-purchase phase of the buying process customers need reassurance that they have made the right choice. For some, the after-effects
of their decision may be psychological, such as wondering if they should have waited longer or asked more questions. Others may feel anxiety and even fear (Grewel, Kline, & Davies, 2013). During this time, the trust and rapport built along the way either solidifies or fades. Marketing strategy should include thoughtful, professional, and reassuring follow-up.

**Customer Retention**

The success of business depends on the ability to gain and retain customers. The effort put into customer retention comes with a payoff as the cost of securing a new client is six times that of selling additional products or services to a current client (Bygrave & Zacharakis, 2010). Nurse business owners would be wise to invest in their follow-up process. Once having secured an assignment, the NCLP is now top of mind with the customer, especially if trust and rapport have developed. Continue developing procedures, activities and additional services to remain top of mind. This consists of developing relationships and setting up the business to become more profitable.

**Follow-up**

No one wants to feel forgotten. Ensure customers feel valued and provide ongoing reassurance for further needs they may have by paying attention to the following areas:

- Excellent service
- Leave-behinds
- Newsletters
- Emails
- Traditional mail

Each of these areas should be tailored according to the type of client served. For example, a Business-to-Business (B2B) customer follow-up would differ from that for a Business to Consumer (B2C) client. Providing personal attention reminds customers that they matter. Sending helpful information helps keep you and your business on their mind as well. Now more than ever, thoughtful and sincere customer service is often what sets one business apart from the others.

The AANLCP® serves as a perfect example of excellent customer service by providing support to its membership through tools and resources designed to strengthen practice, such as webinars with industry leaders, research & coding resources, newsletters, etc. As a nurse business owner, providing support to customers and maintaining a meaningful relationship with them is more than simply a marketing strategy, it is a heartfelt testimony of you as a nurse, a person, and valuable Life Care Planner.

**Conclusion**

Nurse Life Care Planners are dedicated to improving the quality and meaningfulness of life to those affected by disability and/or chronic illness. Marketing is the care and dedication given to a business by creating, communicating, delivering, and exchanging offerings that have value for customers, clients, partners, and society. Effective marketing allows the Nurse Life Care Planner to bring unique value forward, resulting in the development of meaningful relations and ultimately, bettering more lives.

**REFERENCES**


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**MICHELLE PODLESNI, RN**

Michelle Podlesni, RN (“Unconventional Nurse: Going from Burnout to Bliss!”) is President of the National Nurses in Business Association and CEO/President of Bloom Service Group, Inc. She is a proud US Navy veteran and nurse with over 30 years’ experience ranging from clinical care, case management, and healthcare information systems to nationally known speaker, best-selling author, and successful nurse entrepreneur. She has a proven track record of leadership success in managing strategic direction, marketing, operations and technical areas of start-ups and multi-million dollar companies. Michelle is a widely recognized and respected authority in business and is passionate about empowering nurses on the path to business success.
Value of CNLCP® Certification

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 affirms achievement of proficiency beyond basic licensure.

The Certified Nurse Life Care Planner (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), 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.

The policies and procedures used by the CNLCP® Certification Board to construct and review items and examination forms for the CNLCP® examination are consistent with guidelines recommended by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education (AERA, APA, NCME; 2014) as well as other industry standards such as: Standards for the Accreditation of Certification Programs (National Commission for Certifying Agencies, 2014) and Conformity assessment — General requirements for bodies operating certification of persons (ISO/IEC 17024).

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Abstract
The clinical, research, and educational advantages of narrative interviewing in case management and rehabilitation counseling settings are discussed. The translation of narrative interviewing as a research approach to narrative interviewing as a practical clinical approach supports in-depth client interviewing, self-reflection, information-gathering, and rapport-building in clinical settings where counselors do not traditionally perceive that they have opportunities to do so. Storytelling is cross-culturally intrinsic, familiar, and relevant, and allows the client an uncommon platform in the rehabilitation field. Narrative interviewing techniques and basic counseling responses were taught to master’s level rehabilitation counseling fieldwork students who integrated the techniques into their work with clients. Longitudinal follow-up assessed student impressions of and fidelity to the narrative approach, which supported the technique and highlighted areas for future inquiry.

Keywords
Counseling, case management, rehabilitation, narrative.

Introduction
“Can we call what we do counseling?” This was the question posed by audience members at the author’s session at the International Association of Rehabilitation Professionals/Symposium on Life Care Planning’s in Pittsburgh last November. For many, the answer to this question is dependent upon the demands of the work setting, the needs of the clients, and/or the interests and scope of practice of the counselor. Many rehabilitation counselors perceive counseling as an important aspect of their jobs that is often not highly prioritized because of other more pressing job duties.

Leahy, Chan, and Saunders (2003) surveyed rehabilitation counselors and determined case management to be the most important aspect of their jobs. Counseling, along with professional advocacy, was determined to be the third most important and most frequently performed aspect of their jobs. This study highlighted a desire and perceived need for counseling services for which there does not seem to be time. Interestingly, the researchers also reported that topics such as Life Care Planning and human sexuality were regarded as marginally important (Leahy, Chan, & Saunders, 2003).

ABIGAIL O. AKANDE, PhD, CRC
A Narrative Interviewing Technique for Master’s Level Counselors in Case Management Roles
A similar study explored the role and function of case managers (Tahan, Watson, & Sminkey, 2015). The participants consisted of nurses, certified case managers, rehabilitation counselors, certified disability management specialists, and others from related fields. Those surveyed indicated that psychosocial and economic issues were regarded as an essential activity domain (i.e. assessing social/emotional support systems, identifying community resources, using motivational interviewing, counseling, and coaching techniques). In addition, those interviewed expressed the importance of psychosocial and support systems of clients as an important knowledge domain. While these topics were regarded as essential, there was no discussion of the actual performance of these tasks in the case manager's day to day activities.

In the master's level fieldwork courses of practicum and internship taught by the author, the concept that rehabilitation counselors are in fact counselors is emphasized. The students are equipped with counseling skills and work with a diverse group of consumers who have acute and chronic emotional, psychological, and developmental concerns that can benefit from such interventions. This is true for many practitioners in case management roles. In fact, nurses from a wide variety of educational backgrounds specialize in Life Care Planning. Some enter with counseling skill sets from their academic training programs (Van Wieren & Reid, 2007). The challenge in the field is determining how to do it and when to do it.

The Basic Counseling Responses

The field of vocational rehabilitation counseling is unique as it is a branch of counseling that was officially established by the federal government (Elliott & Leung, 2005). The case management tendencies of the field can be attributed to its roots, and why the name rehabilitation counseling is perceived by some as a misnomer. Yet it is important to remember that the international classification of functioning, disability, and health (ICF) outlines the interconnectedness of environmental and personal factors, health, and body functioning and their impact on an individual's activities of daily living (Rouquette et al., 2015). While gainful employment for instance may be the primary goal of a vocational rehabilitation client, it should not be the only concern of the client or the counselor. Obtaining and maintaining employment is absolutely contingent upon the maintenance of an individual's mental and physical health, addressing unhealthy relationships, challenging addictions, and the recognition of other risk factors in the individual's life.

The basic counseling responses, as presented by Haney and Leibsohn (2001), are an example of the fundamental counseling skills that are taught to master's level students in counseling and can be quite beneficial to any clinician working in the social services field. These responses and techniques include the essential responses of opening/closing and attending; the passive responses of empathizing, paraphrasing, giving feedback; and the active responses of clarifying, directing, and questioning. Interpretive or challenging responses include playing a hunch, noting a theme, noting a discrepancy, noting a connection, and reframing. Lastly, there are the discretionary responses of allowing for silence and self-disclosing. Furthermore, all of these responses are housed in one or more “intents” or purposes for the responses, which are to explore, to challenge, or to acknowledge. A counselor approaches a client most effectively when that client has first identified the intent before uttering the response. A counselor armed with these skills is more than capable of exploring feelings with clients and identifying root causes of presenting issues – issues that may negatively impact clinical goals if not adequately addressed.

Vocational rehabilitation counselors and other clinicians in case management roles need to also determine when and with whom this approach is appropriate. With a caseload of two or three hundred and sometimes more, it is not reasonable to expect to provide this service to every client. Rehabilitation counselors are typically liaisons who coordinate various services for their consumers within the agency and the community, and often therapy is one of those services. But for clients without clinical mental health diagnoses, chronic psychiatric conditions, or perhaps the adequate medical insurance to cover the mental health care that they need, it is then within the scope of practice of a master's prepared counselor to provide basic counseling services (American Counseling Association, 2014; Commission on Rehabilitation Counseling Certification, 2009).

Also, Life Care Planners often conduct personal interviews as part of the initial assessment process with their clients (Barker, 2007). This is one example of a great opportunity to begin therapeutic engagement with a client. Similar to the initial interview of the rehabilitation counselor, much information can be obtained at this stage about client experiences, emotions, and clinical needs. Lastly, practitioners who work in independent practices or proprietors have more freedom with their style of service provision, caseload sizes, and theoretical approaches. Forty-one percent of Life Care Planners are solo proprietors (Barker, 2007).

Narrative Interviewing

Narrative interviewing is a qualitative research approach that garners rich, in-depth client narratives (Jovchelovich & Bauer, 2000). After implementing narrative interviewing as a research approach in a study with rehabilitation counselors, the author realized the potential benefits that a modified approach might have within counseling relationships (Akande, 2017). The paper presents a follow-up study to show the usefulness of this adapted approach in the clinical setting.

Jovchelovitch & Bauer (2000) described five steps in their narrative interviewing research protocol. The first, preparation, is when the researcher develops a preliminary understanding of the topic of investigation or research.
questions (literature review), the initial topic of discussion with the research participants, and the prompts or interview questions. The initiation phase involves obtaining participant consent by explaining the context of the research, and the main idea of narrative inquiry, the concept of “uninterrupted storytelling”. During the narration phase (participant responses to the interview questions through storytelling), the researcher takes extensive notes while audio recording, actively listening, and practicing self-control by not interrupting. Although, the completely uninterrupted narrative storytelling that does not require additional prompts or questions is considered an “ideal-typical procedure”, that approach will not be adhered to at all times (Jovchelovitch & Bauer, 2000, p. 8). Each interruption has the potential to deter the direction in which the storyteller is taking the story. The questioning phase allows the researcher to ask questions to address any gaps or unanswered research questions, and to confirm preliminary themes in the data. It's important to use the language of the client when phrasing questions, so as not to inadvertently contribute to or detract from the client's sentiments. Lastly, the concluding talk phase marks the formal end of the interview. Although the recorder is turned off, the researcher may continue to take notes on small talk or afterthoughts shared on the part of the research participant. The idea is that if the recorder causes any anxiety that can inhibit expression, then there may be useful information shared by the interviewee after the recorder is turned off. The interviewees’ stories are later transcribed and qualitatively coded for themes related to the original research question(s).

As previously stated, the author had the opportunity to employ this approach with a group of rehabilitation counselors and explored their experiences providing services to immigrant women with disabilities (Akande, 2017). This research prompted the recognition of benefits of storytelling in rehabilitation research and the translation of narrative interviewing from research to practice. Some of these benefits included interviewee ownership of and engagement in the conversation, and a reaping of in-depth information and details about feelings, experiences, emotions, protective factors, and previously unexplored or subconscious sentiments. It provided interviewees with opportunities to reflect on their stories, the meanings of their stories, and solutions to problems within their stories. It's also important to remember that people's stories are centered on events, and aren’t always linear – which can tend to be the way that clinicians’ questions are structured (Bell, 2002). With the narrative approach, clients are indirectly establishing importance by being given a liberty in their dialogue. Narrative as a research or clinical approach is rare in the field of rehabilitation, yet it has many benefits and is cross-culturally appropriate and intrinsic (Bell, 2002; Mattingly & Lawlor, 2000).

**Narrative Interviewing in Practice**

Six master’s level rehabilitation counseling practicum students received instruction on the adapted narrative interviewing protocol (see Table 1), along with the basic counseling responses, during a 10-week summer session course. The students were employed at a variety of clinical sites, such as state vocational rehabilitation agencies, mental health agencies, and homeless shelters. Practicum experiences require at least 40 hours of direct service and 60 hours of indirect service with clients (CRCC, 2009). Students were asked to identify opportunities with clients, as appropriate, where the narrative interviewing technique could be practiced and might contribute to the progression of the counseling relationship and the therapeutic process. The purpose of this study was to longitudinally explore student experiences with the use of narrative interviewing, by inquiring about their continued engagement with the technique, their adherence to the protocol, and their perceptions of its utility in the counseling process. The students’ experiences with the narrative protocol in clinical settings were explored through individual follow-up interviews. Table 1 contains the narrative interviewing protocol for practice, adapted by the author from the Jovchelovitch and Bauer (2000) research protocol.

A follow-up interview with students one to two semesters after the summer practicum course assessed which counseling techniques the students decided to use at their internship sites, and specifically if and how they used the narrative interviewing approach. The following interview questions were used during the longitudinal follow-up:

1) Tell me about your internship placement. Discuss the population you served, the location, the demographics of your caseload, and other pertinent information.

2) Did you incorporate narrative interviewing into your service provision at your internship site? Why or why not?

3) What other counseling or therapeutic approaches did you use during internship?

**Results**

Students interned at state vocational rehabilitation agencies, mental health agencies, and homeless shelters. Internship requires students to log 600 clinical hours, with at least 240 of those being direct service to clients. When the students were asked whether they incorporated narrative interviewing techniques in their practice at their internship sites, four out of six students responded that they did use the technique in some form. One student who did not use narrative interviewing explained that as an intern at a vocational rehabilitation office, her experience resulted in mostly first appointments with clients that did not allow many opportunities for follow-up or rapport building. She also explained that she was at a site that did not provide much mental health counseling. The second student also interned at a vocational rehabilitation site and did not attempt narrative interviewing because she never had the opportunity to meet with clients alone.
The following are some interview excerpts in response to this question:

- "I really didn’t because it’s a vocational rehab site… not much mental health counseling." - (Student A)
- "Definitely, especially with new clients… [I] let them roll with it." - (Student B)
- "I sort of did… they needed the time. They haven’t had anybody to listen… They haven’t had anybody to listen.”
- "I attempted to… I used pieces of it." - (Student D)
- "It lets you get to know the client… no matter how much I already knew.” – (Student C)

When asked about additional counseling responses used during service provision, the students mentioned reflecting (feelings), clarifying, open-ended questions, paraphrasing, summarizing, and reframing. Students also cited the use of theoretical approaches, such as cognitive behavioral therapy, person centered therapy, problem solving therapy, gestalt therapy, and meditation.

**Discussion**

The overall impression of narrative interviewing in clinical practice on this group of students was a positive one. From their practicum experiences, it is evident that they had identified a potential usefulness for the approach, even though the implementation was not always perceived as possible or they did not adhere exactly to the protocol. One student praised the approach for the way that it shed light on the client’s “personal experience.” One student who did not have an opportunity to fully implement narrative interviewing according to protocol lamented that her large caseloads and limited time with clients allowed her to “sort of” integrate narrative interviewing into practice, as she acknowledged that her clients “…needed the time… They haven’t had anybody to listen.”

There were a few issues raised from the students’ experiences and responses that can positively inform future study on this topic. As noted by Akande (2017), there is a “new to narrative” phenomenon that can occur with interviewees who are either uncomfortable or do not fully understand the concept of uninterrupted storytelling. It can prompt insecurity in some individuals, as they may be used to relying on traditional interviewing that involves more frequent prompts and questioning. There is also a concern with feeling like they are talking too much, even though that is the objective. The results of this study seem to indicate that new to narrative can also apply to the interviewer. Either case would warrant more extensive instruction and coaching. In this particular case, students were instructed over the course of a 10-week summer session. Students would likely benefit from instruction over the course of a traditional semester, or a summer semester that was more intensive (i.e. providing in-class practice sessions). Also, a stronger grasp of the technique and the basic counseling responses would make for more effective execution of some of the theoretical approaches that were mentioned by the students – as they can arguably be considered the building blocks of client/counselor conversation.

More extensive practice might have also led to a more stringent adherence to the protocol, which makes or breaks the success of the approach. If a clinician does not adhere to the protocol, then the approach is not narrative interviewing, but traditional interviewing. During the review of
recorded sessions of students while in practicum, most students initially had difficulty with not interrupting the storytelling – which is rooted in the quality of the prompts, the effectiveness of orienting the interviewee to the process, and counselor self-control.

Lastly, some students used the rationale that vocational rehabilitation or case management settings were not conducive to the narrative interviewing approach. While their specific situations might have rendered this to be true (i.e. lack of privacy, limited follow-up sessions), the case management setting in and of itself should not serve as a deterrent to apply this approach to certain clients who might benefit from it. In fact, one could even employ narrative interviewing during a first session or initial interview with a client. A time that for many is used to obtain basic demographic information about a client and explore clinical goals could easily be structured to encourage the client to formulate stories – rather than simple responses to close-ended questions.

Conclusion
So, can we call what we do counseling? If you answered no at the beginning of this article, then hopefully you have considered the contrary. No clinical approach is suitable for every counselor, with every client, and in every setting. But for the vast number of rehabilitation counselors and case managers who have identified a need for counseling in their practice without a modus operandi, perhaps narrative interviewing and the basic counseling responses can serve them and their clients in a way that is therapeutically and ethically appropriate. The results of this study show promise for future research and application of narrative interviewing in case management and clinical settings.

REFERENCES

ABIGAIL O. AKANDE, PhD, CRC
Dr. Abigail Akande is an Assistant Professor of Rehabilitation Counseling at the University of Arkansas at Little Rock. She obtained a Ph.D. in Rehabilitation from the University of Arizona and has been a Certified Rehabilitation Counselor since 2006. Her clinical experience spans five states within the fields of vocational rehabilitation counseling, behavioral health, university career services, and academia. Dr. Akande’s research interests include multicultural, immigrant and women’s issues in rehabilitation counseling, legislation regarding disability and chronic health conditions, and narrative interviewing.
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