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MENTAL HEALTH

PEER-REVIEWED EXCELLENCE IN NURSE LIFE CARE PLANNING SINCE 2006

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From the Editor

Stephen Axtell
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Summer is a time of light and life for many of us. Beaches and sun, frolicking and fun are wonderfully restorative. But while this might be the cultural expectation, it isn't a reality for many of our patients, their caretakers, and even ourselves much of the time.

Revisiting Mental Health was designed to help life care planners find, or establish, better mental health practices for every stakeholder involved from patients to caregivers, and even the life care planner themselves. I am proud of this issue and what it provides, but since this topic is complex, wide-ranging, and touches on every part of the practice of life care planning; this is a topic that will be featured again at a later date. This realm deserves more material and support.

If you or your patients came out of this summer more stressed than going in, celebrate your progress and validate the core struggles at issue. Don't forget what Arthur Ashe said: "Start where you are; use what you have; do what you can." Engage with your resources, activate support systems, then take a breath and read our issue here.

If you are interested in contributing to this ongoing topic, my door is always open. Please reach out to me at Journal@aanlcp.org.

Don't miss our upcoming fall conference where you will find even more support for your practice! Check out page 35.

Information for Authors

Information for Authors

AANLCP® invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning. Submitted material must be original. Manuscripts and queries may be addressed to the Editor. 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)
- Place author name, contact information, and article title on a separate title page
- Use APA style (Publication Manual of the American Psychological Assoc. current edition)

Art, Figures, Links

- All photos, figures, and artwork must be in JPG or PDF format (JPG preferred for photos).
- Line art must 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 must be submitted as a separate file, 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, 2019). Graphic elements embedded in a word processing document cannot be used.
- Live links are encouraged. Please include the full URL for each.

Editing and Permissions

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- 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. Submission indicates that the author accepts these terms. Queries may be addressed to the care of the Editor at: journal@aanlcp.org

Manuscript Review Process

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and nursing. 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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A Message from the President

Dear Members, Colleagues and Fellow Nurse Life Care Planners,

It is hard to believe that fall is quickly approaching. Any seasoned nurse life care planner knows we are approaching one of the busiest times of the year for our industry. Henry David Thoreau said "never look back unless you are planning to go that way." Well, I do not think any of us want to go back to lockdown, social distancing from our loved ones, and seeing our colleagues on the front-lines of a pandemic. I do think, however, that each of us must take the time to review the business outlook for life care planners in the post pandemic environment. Some of our clients may have retired. Some of them may have moved. Some of them may have changed the type of cases they now pursue. How has the work-flow changed? Are the changes permanent? What is the best way to market to clients? How can one continue or begin to grow a business when attorneys and paralegals are working from home and seem even more inaccessible? You might find yourself asking "now what?"

I recently read an article by Susanna Newsonen, Masters of Applied Psychology, and would like to share 7 of her tips for letting go of the past and moving into the future.

- Acknowledge the past that has happened. This gives it less power.
- Thank the past for what it has taught you. This opens the door to new learning in the future. Don't ruminate about your past mistakes, what didn't go as planned, or how you could have done things differently.
- Check if you're creating an overly nostalgic view of the past.
- It's ok to be scared and let go of the past. Now is the time to brave the next new future.
- Practice being in the present. This helps you ruminate on the past less. Pick up mindfulness practices that suit you, like meditation, yoga, or mindful walking.
- Identify the first, easiest thing you can do to move forward – and then do it! Think of your goals and ambition, what excites you, or what inspires you.
- Notice how you are feeling on your journey forward.
- Remember growth, change and unfamiliarity can feel challenging – but there should be a glimmer of excitement, inspiration, or something good showing that you are on the right journey. This is what will keep you motivated on your journey forward!

As you get back in the swing of things in this post pandemic work environment, one way to spark your excitement and inspiration would be to attend the AANLCP's virtual fall conference that will be held October 12, 2023. Registration will begin soon! The fall conference will be an opportunity to obtain valuable educational opportunities right from the comfort of your own home or office!

Another way to achieve professional growth is to become involved in the AANLCP. The AANLCP's officers and committee members are volunteers. We appreciate all our volunteers and the time and effort they spend on behalf of the Association. If you would like to be involved in a committee or serve as a life care plan mentor, please send an inquiry to info@aanlcp.org We are always looking for excellent speakers, too!

As many are aware, there seems to be many changes in our industry. The AANLCP advocates for nurse life care planning. It is the premier professional member organization of nurses working in the field of life care planning. The AANLCP is not a certifying board. The Executive Board of the AANLCP has no voting rights, input, or advanced notice of what various certifying entities choose to do. The various certifying boards are separate business entities.

The AANLCP aims to provide the support each life care plan expert needs as we continue the journey forward in this post pandemic environment by delivering the tools and resources needed to assist in developing and maintaining a strong life care planning practice. Do you have a need for help with technology, marketing, research or growing your practice? Let us know!

It is my sincere hope that you will enjoy this issue of The Journal of Nurse Life Care Planning and find it useful to you as you begin, grow, or develop your life care planning business. We are proud to support our members and encourage our members to reach out via info@aanlcp.org with questions, comments, or assistance. We appreciate all our colleagues in the AANLCP and hope to see you at the 2023 virtual fall conference!

Sincerely,

Misty L. Coffman

Misty Coffman, RN, MSCC, CNLCP
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Contributors to this Issue

Lee Barks, PhD, APRN, CRRN, CNLCP, LCP-C

Lee Barks, PhD, MN, APRN, is a nurse scientist, clinical specialist, and nurse practitioner. She consulted as an expert on federal lawsuits for 2 decades. She has conducted clinical assessment of risk and developed programs for patient positioning and mobility in the long term care setting, working continuously to decrease health effects of immobility. She received her BSN from the University of Virginia, her MN from the University of Florida, and her PhD from the University of South Florida and trained in the Patient Safety Fellowship and the VA Postdoctoral Nursing Research Fellowship at Tampa VA. Dr. Barks' research focuses on rehab outcomes of posture resulting from patient positioning. These are health and safety outcomes such as seating interface pressure, resident-days of pneumonia, and physical function. She became a CNLCP in 2021 and has written numerous articles and book chapters.

Dr. Nicholas Thaler

Dr. Thaler is a board-certified clinical neuropsychologist with extensive experience working with patients across the lifespan. He specializes in assessing patients with learning disabilities, ADHD, and traumatic brain injury and has published over 50 peer-reviewed papers on neuropsychological conditions. He maintains a faculty position at the UCLA Neuropsychology training program and is a past president of the Asian Neuropsychological Association.

Dawn Cook RN, CLCP, CNLCP

Dawn Cook is a licensed registered nurse with over 40 years of experience in clinical settings. She has been working as a Life Care Planner and Medical Bill Reviewer since 2011 and has prepared over 1300 expert reports in 35 states in Life Care Planning and Past Medical Bill Reviews. Dawn has testified at Federal Court in Illinois, New Mexico, and Oregon, and at State Courts in California, Georgia, Iowa, Nevada, and New Mexico as an expert in Life Care Planning and State Court in California, New Mexico, and Nevada as an expert in Past Medical Bill Reviews.

In 2022, Dawn was awarded the "Distinguished Service Award" by the American Association of Nurse Life Care Planners.

Dawn's previous publications include "Crafting Surgical Letters", "What to Bring to a Deposition", "Cracking the Code for Therapy", "It's all about the Numbers", "Required Elements for Nurse Life Care Planning Testimony", and "Platelet-Rich Plasma, Considerations for Life Care Planners."

Dawn Cook has been a speaker at numerous national conferences, including the American Rehabilitation Economists Association, American Academy of Professional Coders, National Nurses in Business Association, International Transplant Nurses Association and the American Society of Pain Management Nursing American Association of Nurse Life Care Planners, International Association of Rehabilitation Professionals, American Association of Legal Nurse Consultants.

Contributors to this Issue

Barb Loftus, RN, BSN, LPC, NCC, LCP-C

Barb Loftus has been a Registered Nurse since 1986 and a Licensed Professional Counselor since 2009. She has extensive experience working with physical and emotional trauma in both of these roles. Barb has worked as an emergency department Nurse and as a Counselor for sexual trauma survivors. She currently works as a Certified Pediatric Nurse in ambulatory specialty care for The Children's Hospital of Philadelphia, as well as a Licensed Professional Counselor with children, adolescents, and adults for Springfield Psychological Services. In 2022, she received her LCP-C certification after studying with FIG Education, and works as a Life Care Planner for The Verity Group. Barb is a member of the American Association of Nurse Life Care Planners, the National Board for Certified Counselors, and the American Nurses Association.

Melinda Pearson, LMSW, CLCP

Ms. Pearson has been providing rehabilitation services since 1997, when she earned her Master's in Social Work. For more than 25 years, she has been providing services for people with traumatic brain injuries under the New York State Department of Health TBI Medicaid Waiver Services. This has given Melinda the unique experience of supporting people with disabilities for years beyond leaving the rehabilitation setting. Melinda continues to support injured people in the community and her experience has culminated in the provision of Life Care Plans for plaintiff and defense attorneys.

Melinda has been providing life care plans and medical cost projections for Promedica Verity Group, now The Verity Group, since December 2021. She is a licensed Social Worker and she is board certified through the International Commission of Health Care Certification as a Life Care Planner since 2019. She studied Life Care Planning with FIG in North Carolina. In 1992, she earned her bachelor's in psychology from Loyola Marymount University, Los Angeles. In 1996, she earned her Master of Social Work from Yeshiva University's Wurzweiler School of Social Work in New York City. She is a member of the Association of Nurse Life Care Planners, and National Association of Social Workers.

Devorah Kurtz-Wechsler, Ph.D.

Dr. Devorah Kurtz-Wechsler is a clinical psychologist who specializes in providing comprehensive neuropsychological and psychological assessments, treatment plans, psychotherapy, and cognitive rehabilitation. She has devoted over a decade of her career to the educational world, providing evaluations, individualized cognitive and psychotherapeutic treatment, and consultations to schools, teachers, and parents. In 2019, she shifted her focus, dedicating herself to treating patients who have suffered a traumatic brain injury. She conducts in-depth assessments and provides psychotherapy and cognitive rehabilitation. She continues to consult for clinics, schools, and mental health providers in the United States and Canada.

Dr. Kurtz-Wechsler's interdisciplinary and holistic approach, combining seminal tenets from multiple theories and ensuring her care meets the multifaceted needs of each patient, makes her a sought-after psychologist. She can be reached via email at devokurtz@gmail.com.

Supporting Life Care Plan Recommendations for Evidence-Based Citations

By: Lee Barks, PhD, APRN, CRRN, CNLCP, LCP-C

Keywords: Recommendations, Evidence Based, Citations, References

"Nursing has shifted from tradition to evidence-based approaches" (Shelene Giles, FIG Education, 2020). In fact, all of healthcare and the discipline of Education have shifted to evidence-based approaches. In 1972, a British epidemiologist, Dr. Archie Cochrane revolutionized health care by criticizing the medical profession for "not providing the public with rigorous systematic reviews of evidence from existing studies." (Fineout-Overholt, Melnyk, & Schultz, 2005, p.335.)

Dr. Cochrane emphasized that thousands of deaths of preterm babies could have been prevented if research about preterm labor had been compiled and analyzed to affect obstetric practice. The Cochrane Center in 1992 and the Cochrane Collaboration in 1993 were founded to develop, maintain, and update systematic reviews of healthcare interventions and to ensure public access to these reviews. Academic nurse researchers then took up the pursuit of Evidence-Based Practice (EBP) when they realized that it could lead to better clinical practice and patient outcomes (Fineout-Overholt, Melnyk, & Schultz, 2005, p.335).

Also in the 1970s, nursing research was beginning to mature and clinical practice guidelines for specific conditions and situations began to evolve from the evidence. Later, nurse educators began to teach EBP to nursing students. Today, when clinical practice is supported by high quality, rigorous research, the interventions used and recommendations for this care gain credibility. In the same way, recommendations for health care made by experts in the courts gain credibility when they are supported by high quality research. The priorities in citing Life Care Plan (LCP) recommendations are first to cite clinical practice guidelines where they can be found, and if they do not exist, then to cite the highest level and quality of evidence in the health care literature to support LCP recommendations. This article will discuss the evidence base and clinical practice guidelines, the most practical places for the Nurse Life Care Planner (NLCP) to find these, and what to do if your search is not fruitful.

The Evidence Base

Evidence Based Practice is unlike *research utilization*, which in the past typically has considered a single study for use in practice. Research utilization has obvious limits, when a single study's findings are contradicted or simply not found in another study. Melnyk, Gallagher-Ford, and Fineout-Overholt (2017) have defined Evidence-Based Practice as "a lifelong

problem-solving approach to how healthcare is delivered that integrates the best evidence from high-quality studies with a clinician's expertise and also a patient's preferences and values" (2017, p. 8). This is a process that begins with systematically searching multiple databases of scientific literature (articles) to find the most current, relevant research on clinical situations and interventions. Then the evidence is appraised for quality and quantity (number of studies on the intervention), and the best evidence is selected and combined with the expertise of the practitioner, along with patient preferences and values (Melnyk & Fineout-Overholt, 2019). For the practitioner in a specialty area, appraising evidence is narrower in focus and easier to cover the amount of available evidence. For generalists like NLCPs, it is more difficult and time-consuming to cover the evidence for each intervention in a number of different injuries. Identifying the best evidence for recommendations is the first step in citing Life Care Plan (LCP) recommendations.

The evidence base is the foundation of clinical practice guidelines. Clinical practice guidelines, where they can be found, have already been formulated from the best, most current evidence. This is the first choice in citing LCP recommendations; then the Nurse Life Care Planner (NLCP) turns to the scientific literature to evaluate available evidence.

Kinds of Studies and Levels of Evidence

Quantitative studies (Melnyk and Fineout-Overholt Levels I-IV and Polit & Beck Levels I-V) are studies that identify variables of interest, measure them in a reliable, valid way, and tightly control the context. This enables the researcher to rule out extraneous effects and eliminate or reduce bias in the findings (Houser, 2021). Qualitative studies (Melnyk and Fineout-Overholt Levels V-VII and Polit & Beck Levels VI-VIII) use interviews, focus groups, case studies, and verbal descriptions in research that generally seeks to study the lived experience of a phenomenon, such as the lived experience of women after pregnancy loss (Houser, 2021). Mixed methods research combines description of the measurable state of a phenomenon (quantitative) and individuals' subjective response to it (qualitative). NLCPs most often are concerned with quantitative studies, because these are most often involved in testing interventions that would be in LCP recommendations; however, qualitative studies can also be cited. An example could be a qualitative study about caregivers of individuals with traumatic brain injury and their experience of needing respite.

Authors of research reports should state the type of study they are reporting, in the abstract or in the body of the paper, such as in the Methods section: "This paper reports a randomized control trial (RCT) of an intervention to…" If the study type is not stated, the Life Care Planner will have to deduce it and follow the evidence pyramid. Any article cited should be no older than 10 years old; 5 years old or less is preferred, unless the publication is a classic or seminal work. (A classic or seminal work is so important that it birthed other studies on the topic and is cited almost always in articles on the subject.) Current nursing research literature about nursing interventions is somewhat scarce. There are many more research publications on medical interventions, such as studies of drug efficacy.

External evidence is generated through rigorous research such as RCTs or cohort studies. (Cohort studies are observations of a group—a cohort—over time to determine the development of an outcome, such as a disease.) External evidence is intended to be generalized to a larger group of patients than just the sample in the study (Melnyk & Fineout-Overholt, 2019). *Internal evidence* is usually "generated through practice initiatives such as quality improvement projects" that are focused on "improving clinical care in the setting in which it is produced." (Melnyk & Fineout-Overholt, 2019). Both kinds of evidence are extremely important in nursing, but research study reports are generalizable outside the sample and so are stronger evidence. NLCPs cite high quality evidence for the interventions they recommend, knowing that the highest level of published evidence (Level I) is a systematic review or meta-analysis of all relevant RCTs. This level is followed by evidence obtained from well-designed RCTs (Level II). Different scholars have listed levels slightly differently, as in Table 1 below. The best way to handle this may be to recognize the differences in the hierarchies and cite the article(s) at the correct level of evidence, most often

Table 1. The evidence hierarchy. Levels of evidence most ready for use in practice* (Melnyk & Fineout-Overholt, 2019; Polit & Beck, 2021).

Melnyk & Fineout-Overholt (2019) Evidence Obtained From:	Polit & Beck (2021) Evidence Obtained From:
Level I: Systematic review or meta-analysis of all relevant randomized control trials (RCTs)	Level I: Systematic review or meta-analysis of all relevant randomized control trials (RCTs)
Level II: Well-designed RCTs	Level II: A single RCT
Level III: Well-designed controlled trials without randomization	Level III: A nonrandomized trial (quasi-experimental)
Level IV: Well-designed case-control** and cohort studies***	Level IV: A systematic review of non-experimental (observational) studies
Level V: Systematic reviews of descriptive and qualitative studies	Level V: A nonexperimental (observational) studies
Level VI: Single descriptive or qualitative studies	Level VI: Systematic review/meta synthesis of qualitative studies
Level VII: Opinion of authorities and/or reports of expert committees	Level VII: Qualitative study/descriptive study
	Level VIII: Non-research source (expert opinion, internal evidence, etc.)

* From highest level (Level I) to lowest (Level VII or VIII); least biased to most biased

** Case-control studies are comparisons of individuals with a condition—the cases—with those who don't have the condition—the controls—to determine the characteristics that might predict the condition. "Start with an outcome and go back in time to study the risk factor." (Medicowesome, 2023).

*** Cohort studies are observation of a group—a cohort—over time to determine the development of an outcome, such as a disease. "Start with a risk factor and see who developed the [condition]and who did not." (Medicowesome, 2023).

using Melnyk & Fineout-Overholt's hierarchy, which is primarily focused on clinical practice.

Medical evidence is evidence for the recommendations made by the treating physician, and whether the NLCP is responsible for providing it may be controversial. Depending on the state's medical practice act, prescription of these interventions is reserved for licensed physicians and may be delegated to nurse practitioners under protocol. The treating provider is responsible for providing the evidence for medical interventions, only if the court requires it. Providing evidence for nursing interventions recommended by the NLCP following nursing diagnosis is the responsibility of the NLCP. Evidence-based nursing does not equal evidence-based medicine: the more an experiment is controlled, as in a medical RCT, the less applicable the results are in the real world (Houser, 2021). That is, RCTs may not apply to individual patients with a broad range of physical, psychological and behavioral conditions. Nursing requires a holistic approach to care of individuals with physical, psychosocial, and/or spiritual needs. It is founded on the nurse-patient relationship, the nursing diagnosis, and the nurse's appreciation of the patient's unique needs (Houser, 2021).

In appraising available evidence (looking for the quality and quantity of available evidence), Melnyk, Gallagher-Ford, & Fineout-Overholt (2017, p. 83) offer Rapid Critical Appraisal Checklists that encourage the NLCP to ask 3 questions:

1. Did the researcher do a good job of conducting the research?
2. Do the findings show that clinicians can also get close to what researchers found in the study?
3. Is this approach appropriate to use with the NLCP's population (individual)?

The NLCP can paraphrase question 3 to ask if the results are applicable in the recommended care of the individual and decide if the evidence applies to the individual in the LCP. Then in terms of quality of the evidence, the NLCP can determine the level of the evidence--the higher the level, the better--understanding that Levels I and II in nursing interventions may be rare, with more abundant nursing studies that are Level III and below. Pierce and Gies (2022) offer an organized six-step way to read and appraise scientific publications when more depth is needed.

Resources—Where to Find It

Melnyk and Fineout-Overholt (2019) have said, "when clinicians explore only one source of information, they may conclude that there is no evidence to answer their question. For example, if clinicians are searching for RCTs… and only search a web-based search engine [such as Google], they may not find any recent trials."

The first place to search is the Cochrane Library, to find evidence for any kind of intervention (medical or nursing). The Cochrane Library has "Cochrane Reviews", a database of systematic reviews of studies on interventions. In case no systematic review of multiple studies is found, the "Trials" tab leads to a database of single RCT and other types of studies of interventions. A single RCT may be all the evidence that is found; for example, when searching for use of cranberries for prevention of urinary tract infections (UTIs) (Cochrane, May 2, 2023), 26 of 45 studies showed that cranberry products appeared to reduce the incidence of recurrent UTIs in women, children, and people following interventions such as bladder radiotherapy. They did not reduce UTI incidence in elderly institutionalized people or in adults with neuromuscular bladder dysfunction.

The next place to search is the Model Systems Knowledge Translation Centers (MSKTC) for Traumatic Brain Injury, Spinal Cord Injury, and Burns, if the condition fits one of these categories (Model Systems Knowledge Translation Center, 2023). This website is dedicated to the translation of current knowledge and is current as of this writing. It is maintained by the National Institute on Disability, Independent Living and Rehabilitation Research, and it offers interventions.

After MSKTC, the next place to search for nursing interventions is JBI, formerly known as the Joanna Briggs Institute. JBI is "a global organization promoting and supporting evidence-based decisions that improve health and health service delivery." It was founded by a nurse and named for the first Matron of the Royal Adelaide Hospital in Australia. The purpose of JBI is "to provide the best available evidence to inform clinical decision-making at the point of care." The JBI "Evidence-Based Practice Database is an online resource for… [rapid access of] the best available evidence on a wide range of clinical topics." To access JBI, a subscription is needed through the Wolters Kluwer publishing corporation and may be held by university or college health sciences libraries or hospital medical libraries. Only institutional subscriptions are sold through this publisher. To access a subscription, a relationship is needed with the medical librarian at a health sciences library. This may be possible through a nursing school alumni group, or other organization.

Another place to search is Evidence-Based Nursing Care Guidelines; Medical Surgical Interventions by Ackley, Ladwig, Swan & Tucker. There is only one edition of this book, published in 2008, with nursing interventions such as heat and cold application and animal assisted therapy. The downside is that the references are not current, from the early 2000s; however, the NLCP can search PubMed for updated references for the nursing interventions and early authors.

Finally, the best place to search for evidence is PubMed, which will index articles of many levels of evidence, organized in order from most recent to the oldest articles, and PubMed has the largest number of articles, because it includes all

health publications from the National Library of Medicine. The downside is that this is a "grab bag" of different levels of evidence, so the NLCP will need to cull the pertinent articles and appraise them for level of evidence and number of studies that show similar results or show contradictory or no results (strength). This search is for the highest level, strongest evidence. Many of these articles will have a link to "full text", or "free article".

In the past, the National Guideline Clearinghouse was a good source of evidence; however, funding of the Clearinghouse ended in 2018, and it closed.

Google Scholar may also be a good place to look, but it is insufficient as the only source of evidence. The NLCP enters keywords to search this database. The results will hopefully be an array of articles. The bottom of each entry will show "Cited by XX". The larger the number of citations, the likelier that the article is an important article on the subject. Many articles will have a link to a full-text article to read, and these articles are likely to be important articles. The article may not be about the exact intervention the NLCP is seeking. If it comprises a lower level of evidence such as a cohort study, however, it may represent the only existing level of the evidence, and this is notable.

Reputable, credible evidence has been published by a "refereed" (peer-reviewed) journal or edited textbook. Any research article should always state that the study was reviewed by an institutional review board and the organizational affiliation of the IRB, such as a university. Even when the study has not directly collected data from human participants, an IRB or ethics review board must review it. If this is not stated, the article may be poor quality. Funded research states that the study was funded and by whom; research funding indicates that the study was valued highly enough for its rigorous conduct and its merit to have been awarded funding in a competitive process. Current citations in sufficient numbers also may indicate that the author(s) are knowledgeable and have reviewed current thinking on the subject.

Evidence for Chronic Long-Term Care

When searching PubMed for long-term care AND cost AND chronic condition for the last 10 years, no intervention studies were found. The first study, a worldwide, World Health Organization scoping review of 305 studies about older adults "aimed at scanning the scientific literature to gain an overview of the long-term interventions provided around the world and approach its appraisal in a descriptive manner was found (Arias-Casals et al., 2022)…The most frequently reported interventions were multimodal exercise…person-centered assessment and care plan development…case management for continuum care…multicomponent interventions… psychoeducational interventions for caregivers…and interventions mitigating cognitive decline…This study did not focus on the effectiveness of the individual interventions."

When searching PubMed for long term care AND cost, the second, older study was found, a review of literature from 1995 to 2012. This study compared "the outcome trajectories of older adults served through [Home and Community Based Services] (including assisted living [AL]) and in nursing homes (NHs) for physical function, cognition, mental health, mortality, use of acute care, and associated harms (e.g., accidents, abuse, and neglect) and costs. NH and AL residents did not differ in physical function, cognition, mental health, and mortality outcomes. The differences in harms between HCBS recipients and NH residents were mixed. Evidence was insufficient for cost comparisons. More and better research is needed to draw robust conclusions about how the service setting influences the outcomes and costs of [Long-Term Supports and Services] for older adults. Future research should address the numerous methodological challenges present in this field of research and should emphasize studies evaluating the effectiveness of HCBS." (Wysocki, et al, 2015).

The NLCP may want to report these studies, noting their limitations, and continue with cost comparisons for the individual.

What to Do If You Can't Find Any Evidence

Although there may actually be no evidence yet on the subject you search for, the NLCP should be able to find some articles, however remotely related they seem to be to the subject. Remember that researchers are building a pyramid of knowledge and the highest level of available evidence is the place for the next study to start. It is always permissible, if the NLCP is sure that no more studies exist at a higher level of evidence, to present the existing evidence and explain how it relates to the recommendations in the LCP. The lowest level of evidence is expert opinion or internal evidence, and the injured individual's values and preferences must also be considered, not just existing evidence.

Citing the Evidence

Evidence should be cited according to the American Psychological Association Publication Manual, 7th edition. It is generally placed below the costing tables, as close as possible to the recommendation it supports, in footnote form, as well as in the Resources section of the LCP.

Implications for NLCPs and Conclusion

Citations of the evidence support the NLCP's recommendations more strongly than, and in addition to one's own word. The NLCP should be prepared, as always, to explain why the evidence supports the recommendations made, and evidence should be presented extremely clearly. More time and effort are required to find the highest level and quantity of evidence to cite; however, citing the strongest evidence continually adds credibility and professionalism to the field of Life Care Planning.

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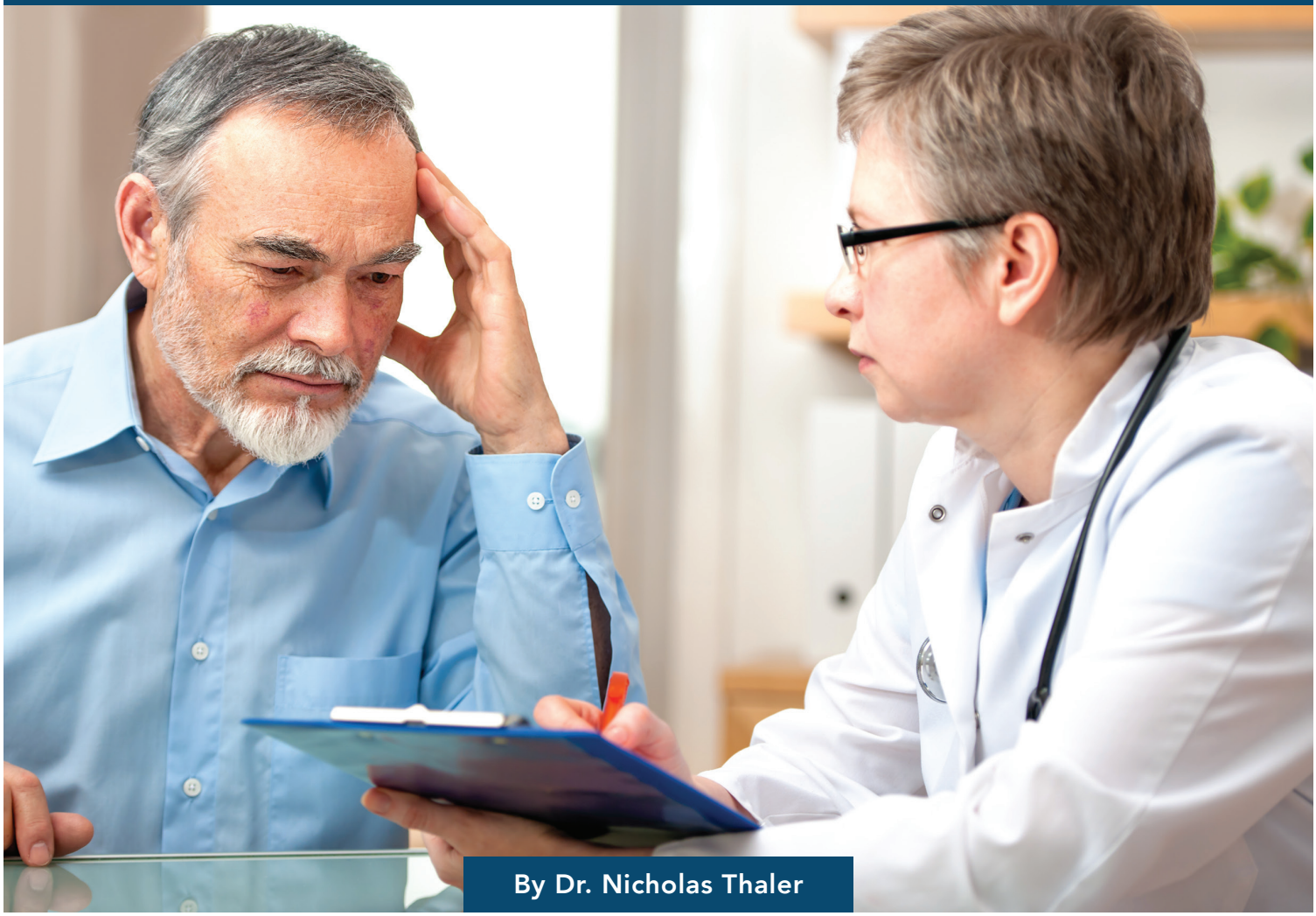
Pediatric Neuropsychological Assessments: How They Inform Life Care Planning



By Dr. Nicholas Thaler

Keywords: Cognition, Pediatrics, Psychological Care, Neurological, Assessment

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2021-2023

1. **Domain 4, Activity/rest; Class 5, Readiness for enhanced self-care**
2. **Domain 13, Growth/development; Class 2, Development**
3. **Domain 7 Role Relationship; Class 1: Caregiver role strain**

Clinical neuropsychology is a subspecialty of clinical psychology that examines brain-behavior relationships with patients who have known or are suspected to have neurological/neurodevelopmental conditions. Cognition is objectively assessed vis-à-vis cognitive tests in a one-on-one setting. Neuropsychological data differentiates among different clinical groups, aligns with neuroimaging, and has predictive validity on long-term functioning that is useful for life care planning (Bryant & McLean, 2004). Pediatric neuropsychologists provide vital information to life care planners when a child has faced a tragic accident that impacts their ability to function in school, home, and the community. It is important to keep in mind that neuropsychological profiles have better predictive validity a year or more out from the injury. (Chu et al., 2007) In addition, children under the age

of six often yield test data that is not reliable or strongly predictive of long-term outcome.

This article will review some of the methods and tools used in assessment and some practical considerations of how deficits might map onto functional capacity and outcome. Neuropsychologists examine how a patient's performance on a test compared to others of a similar age and background, and also how the patient performs relative to their expected abilities in certain domains. The literature demonstrates that socioeconomic status and parental education are robust predictors of a child's potential educational achievement (Yeates et al., 2004). A child's general cognitive functioning, as measured by IQ inventories, covaries with these variables and so marked deviations from expected performance and so may be seen as a clinical marker of residual deficits.

While Full-Scale IQ scores have substantial limitations, in situations where the obtained score is deemed to be a reasonable approximation of actual cognitive skills, they can serve as a marker of one's predicted trajectory. For example, younger children with impairments on broad-band IQ tests after sustaining a traumatic brain injury (TBI) have poorer outcomes ten years later (Anderson et al., 2012). In addition, there are some measures, such as vocabulary and pattern recognition tests, which generally do not deteriorate following brain injury except in the most severe of cases. When interpreted in the right context, these scores can provide information about the potential that a child might have had if they did not suffer an injury. For example, there is literature to support that measures of fluid reasoning correlate strongly with adaptive living skills (Treble-Barna et al, 2017).

Specific neuropsychological domains can also inform on prognoses. Children who have memory loss from an injury will likely have persisting memory loss as adults that will limit their ability to learn and adapt to novel information. Executive functioning, which includes response inhibition, multi-tasking, working memory, and planning, is a domain of skills all children must develop. If there is evidence that an injured child's executive functioning trajectory is cut short, this has implications for when they reach full maturation. Attention, which is tied with executive functioning, can also be impacted by a brain injury and some children develop symptoms similar to Attention Deficit/Hyperactivity Disorder (ADHD) in the years following a traumatic insult (Hendriksen et al., 2015).

Measures of academic achievement can provide snapshots of a child's proficiency in reading, writing, and mathematics. While achievement scores can vary year-to-year and are highly contingent on academic opportunities presented to the child, they can provide real-world and tangible data that can inform life care planners. It is generally accepted that sixth-grade proficiency is necessary for independent living, while eighth-grade proficiency at minimum is expected for most competitive jobs. Thus, a senior in high school who reads at a fourth-grade level would be a striking finding. Neuropsychologists can integrate both cognitive and achievement test results to offer predictions about the viability of a child graduating high school, attending college, and seeking advanced an graduate education in the future.

An in-depth guide on how neuropsychological data informs functional outcomes requires a textbook in-and-of itself, but this article will summarize some general guidelines. Most children will typically score between the 16th and 84th percentile on tests. There is always variability in how a child performs on a test but if scores cluster below the 16th percentile, there may be some degree of difficulty in the area being assessed. It bears mentioning that many children will score below the 16th percentile due to attentional or motivational issues and/or normal development. Scores below the 9th percentile often indicate some degree of functional limitation. Scores below the 3rd percentile speak towards functional impairment, with scores below the 1st percentile suggestive of an obvious disability that might be qualitatively observed by anyone (e.g., a clear speech latency due to frontal brain injury). Not all tests are equal though, and it is more striking if a child's fluid reasoning is below the 1st percentile than an attention test, particularly if the child is young and clearly off-task throughout the assessment. Other environmental variables must also be accounted for.

Children cannot be assessed in a vacuum, and it is becoming increasingly clear, if not inherently obvious, that the child's environment has a tremendous impact on their neurodevelopment. Family dynamics and access to educational resources and healthcare strongly correlate with adaptive living skills in injured youth (Yeates et al., 2010). Thus, it is important to obtain a holistic picture of how a child functions in their environment to offer long-term prognosis with better precision. Family medical and psychological history are vital to obtain whenever possible as these factors can influence a neuropsychologist's opinion about an individual case (e.g., a child developing ADHD is less significant if both parents have ADHD). Culture and language must be considered in a proper assessment as assessing children in their non-native language can distort the data and obfuscate clinical impressions that might be typically gleaned from results. Thus, professionals should have expertise working with patients of the child's cultural and ethnic background.

Neuropsychologists are psychologists first, and so a child's emotional functioning, personality, and behavior are assessed in the evaluation. Certain behavioral traits can offer a more positive prognosis including grit, self-efficacy, and lower impulse control. Other traits will paint a bleaker picture, such as children with emotional regulation issues, conduct disorder and antisocial traits, and those who engage in physical aggression. Thus, a child with very limited impulse control, anger, and instances of violence will likely require

substantially more comprehensive care than a child who is persevering at school, has close attachments to caregivers, and is not aggressive, even if the two children had the exact same injury.

Indeed, the variability in outcome observed in children who superficially appear to have the same injuries cannot be ignored. Initial markers of injury severity, such as the Glasgow Coma Scale score and neuroimaging findings, do not have as much prognostic value regarding a patient's long-term prognosis after injury (Allen et al., 2013). This may be even murkier with pediatric populations as children present differently than adults in the acute period of an injury (e.g., less likely to lose consciousness with more severe injuries) and go on to grow and develop their cognitive skills through their mid-twenties. The neuropsychological evaluation then, can be seen as a "sieve" that separates some of the noise and confusion surrounding a child's injury into objective data that can guide and serve patients, their families, and professionals around them.

Neuropsychologists provide treatment recommendations that are salient for life care planning. Children with brain disorders often lag in academic development and so educational therapy is often warranted; in some situations, placement in alternative or more restrictive environments is indicated. Recommendations for occupational, speech, and physical therapy are offered, as well as comprehensive cognitive rehabilitation. Recommendations for follow-up care with providers are provided. In circumstances where there is evidence for long-term impairment, recommendations after the child can no longer be served by their current professionals can be added. In severe cases, long-term care may be required.

A comprehensive neuropsychological evaluation is an essential part of planning for a child's acute and long-term care. Life care planners who work closely with neuropsychologists will benefit from the information presented in the reports to better inform and provide medically probable treatments that will benefit a child with a brain injury.

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Managing Mental Health Medical Codes

By Dawn Cook RN, CLCP, CNLCP

Keywords: Coding, Mental Health, CBT

Abstract

When developing or rebutting a life care plan or writing a bill review, life care planners must be aware of medical billing codes and corresponding definitions that can be utilized specific to the diagnosis and treatment of mental health. This article will review the Current Procedural Terminology (CPT) codes as well as provide resources for several national associations applicable to the delivery of mental health care.

Historically, the American Medical Association (AMA) created the Current Procedural Terminology (CPT) coding system in 1966 as a method of standardizing reporting needed for reimbursement of services performed by healthcare providers (AAPC; CPT). Evaluation and management (E/M) codes are used by physicians, nurse practitioners and physician assistants and are formatted based on 1) the numeric code, 2) the place where and or the type of service provided (inpatient or outpatient), 3) the actual service provided based on the code definition, and 4) the time spent as specified in the code definition. E/M codes are found CPT 99202 – 99499; code 99211 and 99281 are exceptions as those codes may be used with other clinicians (CPT® Evaluation and Management (E/M) Code and Guidelines Changes).

Time components stated in E/M codes include both face-to-face time spent with the patient and the family or caregiver as well as non- face-to-face activities including locating medical records and test results, communicating with additional members of the care team and coordinating care (Sophocles, A. 2003). Time based codes used for various therapies indicate that the time spent directly with the patient, typically occurring in 15 minute increments, (Tornese, N. 2023), four units totals one hour of therapy, for example. Reviewing the definition of individual CPT codes will assist in determining if the code is

time or unit based. Untimed or unit-based codes indicate the provision of a service regardless of the time spent, often once per day (Centers for Medicare & Medicaid Services). Mental health related timed codes are included in both E/M and therapeutic modalities.

Mental Health Defined

The World Health Organization defines mental health as a "state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community." The WHO further described mental health not as the absence of diagnoses rather a "complex continuum" of symptoms that vary experientially and in the level of impact from person to person (WHO, 2022).

Mental health and physical injury/chronic illness have a co-associated relationship. Among the causes of depression, anxiety and Post-Traumatic Stress Disorder are physical injury and chronic illness. Similarly, the ability to recover from injury or illness in the presence of an existing mental health issue is negatively impacted (Altius Group, 2023).

Statistically, among adults living in the United States, 1 in 5 live with a mental illness. For teens ages 13 – 18 years old, more than 1 in 5 currently have or will develop "a seriously debilitating mental illness (US Department of Health, 2023)."

Mental Health Care

Given the correlation between mental health, physical injury, and chronic illness, it is important to consider treatment when developing a life care plan.

Mental health recommendations may include care by:

1. Neurologists
2. Psychiatrists
3. Neuropsychologists
4. Psychologists
5. Behavior Health professionals
6. Cognitive therapists

The types of care may include:

1. Assessments
2. Therapy
3. Treatment

Mental Health Care Team; Therapy Codes & Associations

Neurology

Neurologists are medical doctors who specialize in treating diseases of the nervous system including the brain and spinal cord as well as the peripheral nerves and muscles.

a. Associations:

i. American Academy of Neurology: https://www.aan.com

ii. American Neurological Association: https://myana.org/

iii. American Association of Neurological Surgeons: https://www.aans.org

iv. Clinical Neurological Society of America: https://www.neuroamerica.org

v. American Association of Neuroscience Nurses: https://aann.org

vi. Child Neurology Society: https://www.childneurologysociety.org

b. Coding:

i. Neurologists may use Evaluation and Management (E/M) codes for billing (CPT 99202 – 99499). Since the start of the global pandemic, many people have opted for services that do not require an in-office visit. In these instances, neurologists use codes 99441 - 99443). The codes are time-based. These codes are not specific to mental health.

ii. Code 99484 allows the neurologist the opportunity to capture charges when providing case management specific for behavioral health conditions; limited to 20 minutes per month.

Psychiatry

1. Psychiatrists are medical doctors specializing in the mental health field.

a. Associations:

i. American Psychiatric Association: https://www.psychiatry.org

ii. American Psychiatric Association Foundation: https://www.apafdn.org

iii. American Psychiatric Nurses Association: https://www.apna.org

b. Coding:

i. Intake: there are two primary CPT codes for a psychiatric evaluation:

ii. 90791: Psychiatric Diagnostic Evaluation. This code can be used when billing an evaluation performed by psychiatry, psychology, licensed professional counselors, licensed marriage and family therapists, and licensed clinical social workers and others.

ii. 90792: Psychiatric Diagnostic Evaluation with medical services. With the addition of medical services included in the evaluation, this code is valid only for those with medical licensure (MD/DO) and prescriptive authorization (i.e.: Nurse practitioner or Physician's Assistant).

iii. As physicians, psychiatrists use E/M codes for billing (CPT 99202 – 99499); time-based codes. Psychiatrists may also bill when providing psychotherapy/counseling services.

iv. CPT codes are available differentiating between the type of therapy provided (i.e., individual, family, group), the expediency of therapy (i.e., routine care or crisis), the therapeutic modality used (i.e., biofeedback, hypnotherapy, psychotherapy) and the length of time spent: noted in the table below.

c. Coding tips:

i. CPT 90785 is an add-on code to be used for interactive complexity. This code may be used with the psychiatric evaluation (90791; 90792; 99441-99443) and psychotherapy (90832-90834, 90836-90838, 90853) (American Psychological Association; 2016).

Neuropsychology

1. Neuropsychologists evaluate the relationship between the brain (cognition/mental health) and the behavior stemming from illness involving or injury to the central nervous system.

a. Associations:

i. National Academy of Neuropsychology: https://www.nanonline.org

ii. American Board of Clinical Neuropsychology: https://theabcn.org

iii. American Academy of Clinical Neuropsychology: https://theaacn.org

iv. The Society for Clinical Neuropsychology: https://scn40.org

b. Coding:

i. Neuropsychologists are not physicians and do not bill using E/M codes.

ii. Neuropsychologists provide testing and analytical services and bill according to the services rendered.

iii. Developmental/emotional/behavioral screening and testing (96110, 96112, 96113, and 96127).

iv. Neurobehavioral status examinations (96116 and 96121)

v. Neuropsychological testing (96132 and 96133)

vi. Psychological/neuropsychological testing (96136, 96137, 96138 and 96139)

c. Coding tips:

i. The codes used are dependent both on the type of testing as well as the credentials of the person performing the testing (i.e., physician, psychologist, therapist or technician).

ii. For automated testing and results for psychological / neuropsychological testing use code 96146.

iii. The codes are time based. When developing a life care plan, indicate the number for units planned for each code included.

iv. Code 99484 can be used with the codes noted above when providing case management specific for behavioral health conditions; limited to 20 minutes per month.

Psychology

1. Psychologists are therapists who are educated in the mind and behavior. They provide services to people with mental health conditions and those going through distressing or difficult times. Various titles are used including therapist; psychotherapists; counselor; analyst; cognitive behavior therapists; and psychoanalysts.

a. Association:

i. American Psychological Association: https://www.apa.org

ii. Association for Psychological Science: https://www.psychologicalscience.org

iii. American Counseling Association: https://counseling.org

iv. American Association for Marriage and Family Therapy: https://www.aamft.org

v. There is an extensive list available on the website (https://mindremakeproject.org) for Mind Remake Project, a therapy and mental health resource site: 78 Professional Membership Organizations for Mental Health Workers. The article was updated 01/22/22 and includes sub-sections of different professional organizations. Examples include:

1. American Psychiatric Association: Goal: "To promote the rights and best interests of patients and those actually or potentially making use of psychiatric services for mental illness, including substance use disorders (American Psychiatric Association Goals)."

2. American Psychological Association "is the leading scientific and professional organization representing psychology in the United States, with more than 146,000 researchers, educators, clinicians, consultants, and students as its members (American Psychological Association: About)."

3. Anxiety Disorders Association of America "works to prevent, treat, and cure anxiety disorders and depression (Anxiety & Depression Association of America: About)."
4. Mental Health America's "work is driven by its commitment to promote mental health as a critical part of overall wellness, including prevention services for all; early identification and intervention for those at risk; integrated care, services, and supports for those who need them; with recovery as the goal (https://www.mhanational.org/policy-issues)."
5. National Alliance on Mental Illness "is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness (https://nami.org/About-NAMI)."
6. National Alliance of Professional Psychology Providers "mission is to promote and advocate for the clinical practice of doctoral level psychology (https://www.nappp.org/)."
7. National Association of County Behavioral Health & Developmental Disabilities: "Through education, policy analysis, and advocacy, NACBHDD brings the unique perspective of our members to Congress and the Executive Branch and promotes national policies that recognize and support the critical role counties play in caring for people affected by mental illness, addiction, and developmental disabilities (https://nacbhdd.org/)."
8. North American Mental Health Professional Advice Council "is a nonprofit group dedicated to mental health resources. Run by advocates and volunteers, the NAMHPAC strives to provide professional guidance to improve your well-being (https://www.namhpac.org/)."
9. National Association of State Mental Health Program Directors represents "state executives responsible for the public mental health service delivery system serving millions of people annually in all 50 states, 6 territories and pacific jurisdictions, and the District of Columbia (https://www.nasmhpd.org/)."
10. National Council for Mental Wellbeing is "a 501(c)(3) association and the unifying voice of organizations that deliver mental health and substance use services in America (https://www.thenationalcouncil.org/?s=501)."
11. National Institute of Mental Health "is the lead federal agency for research on mental disorders. NIMH is one of the 27 Institutes and Centers that make up the National Institutes of Health (NIH), the largest biomedical research agency in the world. NIH is part of the U.S. Department of Health and Human Services (HHS) (https://www.nimh.nih.gov/about)."
12. Substance Abuse and Mental Health Services Administration "is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation (US Department of Health.Substance.Mental Health)."

b. Coding:

i. Psychological services use CPT codes: evaluation (90791) and psychotherapy (90832–90853). Code 99441 – 99443 may be used for telephone evaluation/management visits, however, are not specific to mental health. Code 99484 for case management related to mental health can be added; limited to 20 minutes per month.

ii. As with psychiatry, CPT codes are available differentiating between the type of therapy provided (i.e., individual, family, group), the expediency of therapy (i.e., routine care or crisis), the therapeutic modality used (i.e., biofeedback, hypnotherapy, psychotherapy) and the length of time spent: noted in the table below.

c. Coding tips:

i. The American Psychological Association published a billing and coding guide in 2019, which can be found online at https://www.apaservices.org/practice/reimbursement/health-codes/testing/billing-coding.pdf

ii. The APA also published a case study addendum https://www.apaservices.org/practice/reimbursement/health-codes/testing/billing-coding-addendum.pdf

iii. CPT 90785 is an add-on code to be used for interactive complexity. This code may be used with the psychiatric evaluation (90791); care provided via the telephone (99441-99443) and psychotherapy (90832-90834, 90836-90838, 90853).

Behavioral Health Specialist

1. Behavioral Health Specialists are trained to provide counseling to people dealing with mental illness.
    a. Association:
        i. American Mental Health Counselors Association: https://www.amhca.org/home
        ii. National Association for Behavioral Healthcare: https://www.nabh.org
        iii. National Council for Mental Wellbeing: https://www.thenationalcouncil.org
    b. Coding:
        i. In addition to using the codes listed for psychologists, code 96127 is used for an emotional/behavior assessment.
        ii. Code 99484 may be used for case management services related to a behavioral health condition; limited to 20 minutes per month.

Cognitive Behavioral Therapists

1. Cognitive Behavioral Therapists are licensed psychologists, social workers and counselors utilizing Cognitive Behavioral Therapy in the treatment of mental health conditions.
    a. Association:
        i. Association for Behavioral and Cognitive Therapies: https://www.abct.org
    b. Coding:
        i. The code used for an initial CBT evaluation is 90791. Subsequent sessions are coded as 90834 which is for 50 minutes of individual psychotherapy; the standard length of a CBT session.
        ii. Codes for group and or caregiver behavior management training without the patient present are 96202 (initial 60 minutes) and 96203 (each additional 15 minutes).
        iii. Codes for Remote Therapeutic Monitoring (RTM) when measuring Cognitive Behavior Therapy include: 98978 (measuring adherence and response; each 30 days); 98980 (First 20 minutes in a calendar month); and 98981 (each additional 20 minutes).
        iv. Cognitive Processing Therapy (CPT) is a type of CBT used for patients who have experienced trauma (i.e., child abuse, combat, rape and natural disasters) (APA (2017) Cognitive Processing Therapy). This therapy is often 12 sessions and is coded the same as CBT.

Emergency Services and Inpatient Specific Codes

1. For people with mental health concerns, the Emergency Department can be an important resource for care, particularly on a continuum when urgent care is needed. Emergency Departments are able to access psychiatric evaluations and connect patients with resources in their community that may otherwise be difficult to gain access to (Navas, C., et al. (2022 July 13).
    a. Coding:
        i. Consultation codes while in the Emergency Department include: CPT 99242 – 99255.
        ii. Emergency Department Services CPT codes are 99281 – 99288.
2. Observation services are commonly seen for patients presenting to an emergency department and either require additional time to receive treatment or are being monitored to make a decision regarding inpatient admission or discharge.
    a. Typically, less than 48 hours are spent in observation.
    b. CPT codes 99221 – 99239 are used for observation from admission to discharge.
    c. Consultation codes when the patient is in observation 99252 – 99255.

1. Inpatient services from admission to discharge:
    a. CPT codes 99221 – 99239 are used for inpatient stays from the initial day to discharge.
    b. Consultation codes for an inpatient stay include 99252 – 99255.
    c. Inpatient Critical Care: 99291 – 99292
    d. Diagnosis Related Groups (DRGs) for inpatient stays related to mental health include:
        i. DRG 880: Acute Adjustment Reaction and Psychosocial Dysfunction
        ii. DRG 881: Depressive neuroses
        iii. DRG 882: Neuroses Except Depressive
        iv. DRG 883: Disorders of Personality and Impulse Control
        v. DRG 884: Organic Disturbances and Mental Retardation
        vi. DRG 885: Psychoses
        vii. DRG 886: Behavioral and Developmental Disorders
        viii. DRG 887: Other Mental Disorder Diagnoses (Centers for Medicare-Medicaid Services ICD-10)

Conclusion: Whether developing or rebutting a life care plan or bill review, it is important for the life care planner to know the proper medical billing codes pertaining to the diagnosis and treatment of mental health. The AMA provides annual reviews of the CPT codes; revising, deleting in addition to releasing new code (AAPC; CPT). The codes go into effect on January 1st each year. In 2023 for instance, there were 393 editorial changes including 225 new codes, 75 deletions and 93 revisions; a total of 10,969 codes available (American Medical Association, 2022). Professional association websites at the national, regional and state levels are useful ways to stay up to date on the CPT codes and their current application.

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A Family Affair:

Caregiver Recommendations in the Life Care Plan

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Keywords: Caregiver, Burnout, Family, Best Practices

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2021-2023

1. **Domain 7, Role Relationship; Class 2: Family Relationships**
2. **Domain 9, Coping—Stress Tolerance; Class 2: Coping Responses**
3. **Domain 7 Role Relationship; Class 1: Caregiver role strain**

"If you are traveling with a child or someone who requires assistance, secure your mask first and then assist the other person."

When traveling, many of us have heard similar words from a flight attendant prior to the plane taking off. The concept of meeting one's own needs before being able to fully support another's needs is well-known in the psychology of self-care. We practice self-care because it is beneficial to our well-being. But there is an additional benefit: that our well-being can aid those for whom we care and with whom we are in a relationship.

This is true for the family, and for the caregivers of a person affected by a catastrophic injury. Lee Woodruff, wife of injured ABC news correspondent Bob Woodruff, spoke poignantly about her and her family's experience following Bob's Traumatic Brain Injury (TBI):

"My brother-in-law said something which has always resonated with me. 'It wasn't just Bob who was hit by the IED, it was the whole family.' Just substitute anything for IED… For the caregiver, it is after the acute phase, especially with a brain injury, long-term diagnosis or lifelong disability that the road becomes long, flat and forever." (Close, 2008).

Given the number of persons injured each year, we can extrapolate an even larger number of family members and caregivers that directly provide support for them post-injury:

- There are approximately 223,135 TBI-related hospitalizations in 2019 and 69,473 TBI-related deaths in 2021. (https://www.cdc.gov/traumaticbraininjury/data/index.html, accessed 5/4/23).
- The estimated average number of people with SCI living in the United States is approximately 299,000 persons, and there are about 18,000 new SCI cases each year. (https://msktc.org/sites/default/files/SCI-Facts-Figs-2022-Eng-508.pdf, accessed 5/4/23).

- The incidence of serious birth trauma is reported at 4.67 per 1000 hospital births. (Gupta, 2021)
- Over 450,000 serious burn injuries occur every year in the United States that require medical treatment. (https://ameriburn.org/wp-content/uploads/2019/08/2018-abls-providermanual.pdf, accessed 5/4/23)

Medical professionals and researchers also recognize that family members play a critical role in the recovery process of individuals after life-altering injuries. Additionally, clinicians have offered insights into the benefit of therapeutic modalities to support families and caregivers.

As Life Care Planners, we can incorporate evidence-based practices that benefit our client's quality of life by including recommendations that support their caregivers and family as they travel the road of recovery together. This article explores the evidenced-based practice that informs an understanding of and support for these recommendations.

The Families Speak

Karpa, et al. researched the perspectives of family members of TBI survivors, finding themes of family strengths, but also of family losses and adjustments. Participants in this narrative study shared things such as:

"When Marie had that accident, it was like we lost a family member. After the accident she was a different person. We have never really known what she would have been like before her accident…"

"We do have a document through the lawyer…Melanie will always need some assistance with living. The children are already getting a sense that they will hold the unit together and be with their parents and things like that. So, in the future, it'll still go on. Family looks after family and this is family."

Howland spoke with burn survivors about their experiences, and they shared things like:

"Emotionally, I think therapy should be a part of recovery, family therapy; there are still issues about this in my family and we can't ever talk about it together. My mother can't look at my le.g, so I keep it covered when I visit her; she cries when it's mentioned. She won't talk about it with a therapist. My brother still blames himself because he was in charge of me when it happened, but it wasn't his fault."

"The thing that turned out to be surprisingly helpful was the company I kept. It's so important to have positive and real people around you. You have great mountains and low valleys and someone who can be really with you on that journey is very helpful…."

According to data from AARP, nearly 4 in10 caregivers consider their caregiving situation to be highly stressful; an additional 28 percent report moderate emotional stress. On average, caregivers of adults report emotional stress of 3 out of 5 on a rating scale.

Additionally, they found that caregivers of younger adults ages 18–49 spent 32.5 hours a week, on average, providing care, more than caregivers of older adults, which was about 22.3 hours a week. The average time spent helping with Activities of Daily Living (ADLs) averaged 1.5 hours and Instrumental Activities of Daily Living (IADLs), such as grocery shopping, medication management, and housekeeping, was 4.5. Fifty percent of caregivers helped with medical/nursing tasks, and more than one in three caregivers provided more than 40 hours of care per week. Emotional stress was more common than physical strain among caregivers of younger adults ages 18–49.

Some common indicators of caregiver stress include:

- Anxiety
- Depression
- Irritability
- Feeling tired or run-down
- Poor sleep
- Emotional reactivity
- Health effects
- Trouble focusing
- Increasing resentment
- Maladaptive coping mechanisms (such as excessive drinking, smoking, or overeating)
- Neglecting responsibilities
- Cutting back on leisure activities

Common indicators of caregiver burnout include:

- Decreased energy
- Exhaustion in spite of adequate rest and sleep
- Feeling helpless or hopeless
- Increasing impatience or irritability with the care recipient
- Trouble relaxing during downtime
- Neglect of caregiver needs
- Weakened immune system, evidenced by getting sick more often

The Research Speaks

Empirical evidence

Research seems to show mixed results from family-based interventions, but it does suggest that the family plays an extremely important role in survivors' rehabilitation, significantly affecting survivors' psychological adjustment to injury-related challenges.

Sheperd-Banigan et al. (2018) reviewed thirteen studies that evaluated psychological or rehabilitation interventions involving caregivers of individuals with TBI or PTSD and found mixed patterns of intervention effects. Couples-based therapies showed the most promise for improving patient PTSD symptoms, other psychological symptoms, and patient-reported interpersonal relationships. The researchers concluded that caregiver interventions may be a promising approach and deserve further study.

Rasmussen et al. (2021) studied the effectiveness of an eight-session family system intervention to assess the impact on improving individual and family functioning after mild to severe traumatic brain injury. The study group received eight sessions, which included topics such as "Making Meaning", "Shifting Focus", "Managing Emotions", "Communicating Effectively", "Finding Solutions", and "Boundary Making". The control group families received a 2.5-hour psychoeducational group session focused on brain anatomy, traumatic brain injury, and post-injury challenges in functioning and resuming daily life activities and work, but not specifically on family functioning. Both groups received specialized rehabilitation and were assessed at two months and eight months post interventions.

During the intervention period, there were statistically significant improvements in mental health related quality of life, caregiver burden, family functioning, communication and satisfaction in the intervention group, indicating that the family intervention possibly contributed a boost in the recovery process. At the eight-month follow-up, however, there were no statistical differences between the groups. The researchers thought that the findings suggested that the family intervention might have contributed to a boost in individual and family functioning during the intervention period, and that it suggests a benefit for ongoing support for individuals and families to produce longer-term results.

Jones, et al. (2021) reported on interviews conducted at two trauma centers in England, with 13 children and parents/guardians after traumatic injuries. Although a small sample, the parents and caregivers identified stress around the increase in their responsibilities and the effect on the family's relationships and roles. Additionally, their ability to work and manage everyday tasks was an area of vulnerability. Ongoing support by healthcare professionals was identified as helpful in managing their life stressors.

A longitudinal study out of Norway reported on 80 family members of patients with severe traumatic brain injury, to assess burden and life satisfaction (Manskow, 2017). They assessed family members at one and two years post-injury and found that 30% reported an increase in burden between years one and two post-injury and that life satisfaction for the study sample was lower at the two-year follow-up than at the one-year. Their analysis showed that experiencing loneliness was an independent predictor of the increased burden from one to two years post-injury.

Testa and colleagues found that distressed family functioning correlated strongly with increased rates of survivors' neurobehavioral symptoms

Testa, J. A., Malec, J. F., Moessner, A. M., & Brown, A. W. (2006). Predicting family functioning after TBI. Impact of neurobehavioral factors. Journal of Head Trauma and Rehabilitation, 3, 236-247.

The Clinicians Speak

Researchers at The Children's Hospital of Philadelphia (Kassam-Adams), worked with 334 parents of children who had suffered road traffic injuries requiring hospital care. One month after their child was injured, 37% of the parents experienced acute stress disorder (ASD) or significant traumatic stress symptoms, including:

- Re-experiencing the incident
- Avoiding reminders of the incident
- Increased general anxiety
- Jumpiness

Of those parents, 15 % displayed longer-term symptoms of post-traumatic stress disorder (PTSD) more than six months after the initial injury. Factors that predicted the severity of acute trauma symptoms in the first month and PTSD (longer-lasting trauma symptoms rated about six months later) in parents of the injured children included prior trauma exposure, peri-trauma exposure, and perceptions of the child's pain and life threat, child ASD severity, and parent-rated child physical health at follow-up.

Thirty-five years ago, clinicians recognized the effect of traumatic brain injury on the well-being of the family as well as the individual. Neuropsychologist Miriam Lezak (1988) opined that brain injury is a family affair, and that family burdens and disruptions may be relieved through education, counseling, and emotional support. There are several therapies that are recommended as helpful for patients and families that are adjusting to life post-catastrophic injury.

Stejskal, et al. reviewed several theory-based interventions to assist clinicians in effectively intervening with families, including Family Therapy, Cognitive Behavioral Therapy (CBT), Narrative Therapy (NT), and Solution-Focused therapy (SFT).

Family Therapy

Goals for family therapy can include helping the survivor and family members better understand the injury, assisting family members to set realistic expectations and to adjust to the injury, and supporting the family system over the course of rehabilitation (Stejskal, et al). Ideally, family therapy facilitates growth and lasting change for the whole family, as they grow and change together.

Stejksal identified an evidence-based family intervention for post-brain injury, the Brain Injury Family Intervention (BIFI). BIFI is a comprehensive, whole-family intervention intended to meet the complex needs of families after brain injury. It is based on CBT and Family Systems Counseling theories and was designed by Dr. Jeffrey Kreutzer to promote effective coping strategies for families experiencing emotional and behavioral changes post-injury.

CBT

This model presupposes that cognition, behavior, and emotion are interlinked, so that change in one area is thought to produce symptom change in the other areas of functioning. The American Psychological Association endorses CBT as a recommended treatment for those with PTSD, recommending 12-16 weeks of sessions.

Narrative Therapy

Narrative therapy helps individuals and families reauthor their personal stories. The therapist assists to identify beliefs, externalize the issues, help deconstruct negative assumptions, and create more beneficial viewpoints. A key feature of this therapy is that a person is not the "problem", the problem is the problem.

Solution-Focused Therapy

SFT emphasizes solutions and competencies, viewing the patient and family as the drivers of the therapy, with the goal of autonomy, and self-reliance. SFT advocates a shift from focusing on the problem to concentrating on solutions, and helps them do or think in different ways, rather than repeat past unsuccessful patterns.

CPT codes

Coding for family psychotherapy for the benefit of the injured person, which is billed to the injured person and not the family member(s), includes:

CPT code 96161 should be reported for use of a standardized instrument to screen for health risks, such as depression, in the caregiver, to the benefit of the patient. Although the screening is completed by the caregiver, CPT 96161 is to be reported as part of the survivor's care plan, as it is a service for the benefit of the patient. A full list of psychotherapy CPT codes is available at https://www.apaservices.org/practice/reimbursement/health-codes/psychotherapy.

Recommendations

The length, frequency, and duration of counseling and psychotherapy are highly individualized and therefore can be challenging to quantify for the purposes of Life Care Planning. Centers for Medicaid & Medicare Services (CMS) states "The duration of a course of psychotherapy must be individualized for each patient," and family psychologist Daniel V. Papero opined, "while research findings have begun to coalesce around objectives for individual treatment, much remains to be done to address the chronic anxiety and chronic stress of the family unit." (Papero 2017).

CPT® Code	Descriptor
90832	Psychotherapy, 30 minutes with patient (16-37 minutes)
90834	Psychotherapy, 45 minutes with patient (38-52 minutes)
90837	Psychotherapy, 60 minutes with patient (53 minutes or more)
90845	Psychoanalysis
90846	Family psychotherapy (without the patient present), 50 minutes (26 minutes or more)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes (26 minutes or more)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
96153: Health and Behavior intervention, group (2 or more patients)	96153 Health and Behavior intervention, group (2 or more patients)
• 96154: Health and Behavior family intervention with the patient present	• 96154 Health and Behavior family intervention with the patient present
96161: Caregiver-focused health risk assessment	96161 Caregiver-focused health risk assessment (e.g. depression) in the caregiver, for the benefit of the patient

https://www.apaservices.org/practice/reimbursement/health-codes/psychotherapy

The APA suggests that 12-16 weekly sessions of CBT are beneficial for PTSD treatment, while Harvard posits that 12-20 is helpful. The Mayo Clinic suggests 12 sessions for Family Therapy, and the American Association of Marriage and Family (AAMFT) reports an average of 12 sessions for marriage and family therapy. Narrative Therapy can range from 12-16 sessions, and Solution-Focused Therapy tends to be even shorter in duration, often as few as six sessions.

Robinson (2020) conducted a literature review and found optimal sessions of psychotherapy to range between 4 and 26 sessions, depending on clinical setting, client characteristics, and outcome measures.

In my own personal communications and collaborations with other mental health professionals, there is an agreement that family therapy is an important ongoing part of supportive care for a catastrophically injured person. Intermittent, long-term family counseling over the course of a survivor's lifetime provides support for the adjustments, losses, challenges, and crises that a family will inevitably experience in some measure.

Based upon the three facets of evidence-based practice considered in this article, a conservative allotment for family counseling would include an average of 6-12 weekly sessions of family therapy yearly for the first three years post-injury, when adjustments tend to be most significant, and then 6 weekly sessions every other year thereafter for the lifetime of the injured person. As we as Life Care Planners continue to learn from the families and survivors, research, and clinicians about the benefits of family therapy, our recommendations will undoubtedly become strengthened!

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A Guide for Life Care Planners to Psychotherapeutic Approaches and Treatment Costs for Individuals with Traumatic Brain Injury

By Melinda Pearson, LMSW, CLCP and Devorah Kurtz-Wechsler, Ph.D.

Keywords: Traumatic Brain Injury, Psychotherapeutic Treatment, Costing, Treatment, Approaches

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2021-2023

1. **Labile Emotional Control; Domain 5, Perception/ cognition; Class 4, Cognition.**
2. **Ineffective emotional control; Domain 5, Perception/cognition; Class 4, Cognition.**
3. **Risk for ineffective activity planning; Domain 9 Coping/Stress tolerance; Class 2 Coping responses**

Abstract
This article provides life care planners with comprehensive information regarding psychotherapeutic treatment options for patients who sustained a traumatic brain injury (TBI). The first section of the article details the differences in mental health providers, psychotherapeutic approaches, and modalities.

The second half of the article gives an example of the issues related to coding and costing psychotherapy for a TBI subject when the frequency and duration are moving targets. The context provides exposure to coding and costing and helps to create understanding, but nothing is hard and fast. Predicting optimal duration and frequency of treatment is challenging because everyone is different, and no two people or brain injuries are alike.

A traumatic brain injury (TBI) is defined as a disruption of brain structure and/or function resulting from the application of biomechanical forces, as manifested immediately by one or more of the following clinical signs: loss of consciousness, loss of memory for events immediately before or after the injury, alteration in mental state, or focal neurological signs (American Psychiatric Association, 2013). Outcomes of a TBI are extremely diverse, ranging from a full recovery to persistent life-changing clinical sequelae of somatic, cognitive, physical, behavioral, and emotional symptoms. Symptoms can include sleep disturbances, memory lapses, trouble concentrating, irritability, anger outbursts, and personality changes.(American Psychiatric Association, 2013).

Mental Health Professionals

Mental health professionals provide psychotherapeutic resources and support to patients and their families. Experts include clinical psychologists, psychiatrists, licensed master social workers, licensed clinical social workers, and mental health counselors. While these professionals share similarities in their work, there are seminal distinctions regarding their qualifications, licensing, educational background, training, and scope of practice that life care planners and individuals should be cognizant of in helping to make informed decisions.

Clinical psychologists (Ph.D. or Psy.D.) hold doctoral degrees in psychology and are trained to assess, diagnose, and treat a wide range of mental health disorders. They undergo extensive training in psychological assessments, diagnoses, interventions, and research methods in addition to completing approximately 2-3 years of practice as part of their educational training or licensure requirements. Clinical psychologists can work in various settings and are permitted to open a private practice. Clinical psychologists differ from psychiatrists in that psychiatrists are medical doctors and can prescribe medication. Psychiatry is a medical specialty focused on diagnosing and treating mental health disorders through pharmaceutical approaches.

Social workers receive training in social work theories, policy, advocacy, and clinical practice. They can provide counseling and resources, such as access to housing, healthcare, or public assistance, and work in settings, such as mental health clinics, social service agencies, and hospitals. Social workers include Licensed Master Social Workers (LMSW) or Licensed Clinical Social Workers (LCSW). The primary difference is in their levels of licensure and the scope of practice they are authorized to engage in. An LMSW typically holds a master's degree in social work and works under the supervision of a fully licensed clinical social worker or licensed psychologist. An LCSW similarly holds a master's degree in social work, but as part of their training, they are required to complete a designated number of clinical hours, which enlarges their scope of practice. An LCSW, in contrast to an LMSW, may be able to establish a private practice.

Mental health counselors generally hold a master's degree in counseling or psychology and are trained to utilize a multitude of therapeutic approaches. They are competent to provide services to individuals, couples, families, or groups experiencing mental health challenges and emotional difficulties.

As denoted, there is ample overlap between providers. Yet, life care planners need to be cognizant of their differences to facilitate collaboration with specialists. The CPT codes, which are detailed below, remain the same code for all providers, regardless of the treatment modality the provider utilizes. It is also important to note that licensure and specific state regulations can vary across different countries, which can affect the professional's scope of practice.

It is additionally critical for life care planners to consider the professional's specific areas of expertise, such as anxiety, trauma, or grief, their therapeutic approaches, and the modalities they employ. Additional factors such as the therapist's rapport style, cultural competency, and clinical setting should also be acknowledged.

Common Psychotherapeutic Approaches

There are a myriad of psychotherapeutic approaches and evidence-based interventions that can support individuals and their families. Modalities differ in theoretical underpinnings, objectives, and clinical outcomes. A life care planner often follows psychotherapeutic recommendations prescribed by physicians. Thus, life care planners should be conversant with the different therapeutic approaches. The following modalities discussed, although the list is not exhaustive, are optimal for helping patients navigate brain injuries and are beneficial in treating anxiety, depression, trauma, grief, and additional mental health disorders.

Cognitive Behavior Therapy (CBT) is predicated on the notion that thoughts and feelings impact behavior. CBT helps patients recognize and challenge cognitive distortions and replace maladaptive thought patterns and behaviors. Techniques include cognitive restructuring, reframing, journaling, developing coping strategies, and relaxation techniques. The American Psychological Association endorses CBT as a recommended treatment for individuals with PTSD and TBI, recommending 12-16 weeks of sessions. (https://www.apa.org/ptsd-guideline/treatments)

Dialectical Behavior Therapy (DBT) is a change-based and acceptance-based behavioral intervention. DBT fuses cognitive-behavioral techniques with mindfulness strategies for accepting and tolerating pain and distress. DBT focuses on affect regulation, interpersonal effectiveness, dialectics, and distress tolerance skills. Whereas CBT and DBT are more focused on the present, psychodynamic therapy centers on helping the individual understand the influence of their past. Emphasis is placed on early and underlying feelings, emotions, and experiences, with the acknowledgment that the past heavily impacts present behaviors, emotions, and relationships.

Trauma therapy is specific to helping individuals that have endured traumatic experiences that impact their overall well-being. There are numerous approaches to trauma therapy, which include Eye Movement Desensitization and Reprocessing Therapy (EMDR), exposure therapy, and somatic therapy.

EMDR is designed to desensitize an individual to their trauma memory by having them relive their experience in a safe therapeutic environment. The therapist will utilize bilateral stimulation to facilitate reprocessing of the memory to reduce the emotions associated with the trauma memories. In exposure therapy, the therapist helps the

individual face their fears by having the patient confront their traumatic experiences. With the guidance of the therapists, individuals learn to acknowledge their trauma, gain a sense of control over their fear responses, and decrease avoidance. Exposure therapy can include in-vivo, imaginal, or virtual reality exposure. Somatic therapy focuses on the connection of the mind and body. Treatment is concentrated on helping to release stress, tension, and trauma from the body, and patients learn to pay attention to their physical responses and reactions to traumatic memories. Treatment techniques include body movements, exercise, vocal work, and yoga.

Family therapy involves working collaboratively with family members to understand and explore their relationships, interactional dynamics, communication styles, and strengths and weaknesses. Family therapists generally focus on the relational aspects between family members and aim to reduce stress and conflict, enhance the family's resources, and strengthen the family's problem-solving patterns. Grief counselors utilize any of the modalities mentioned above but focus on helping and supporting the individual in dealing with the emotional and behavioral pain of mourning, bereavement, adjusting, and acceptance.

It is also important to note that clinicians must acknowledge and address the cognitive impairments the patient may be experiencing. Neurobehavioral deficits can manifest as challenges with executive functioning, memory, organizational skills, attention, and inhibition. Clinicians need to be adept at identifying such weaknesses and adapting their sessions accordingly. This may involve modifying the cognitive demands that some treatments require, adjusting learning expectations of new information, utilizing multiple modalities to present information, and creating a calm environment free of distraction.

Coding and Costing

The New York State TBI Medicaid Waiver provides a counseling service that addresses the emotional difficulties a program participant experiences in adjusting to and living in the community. A program participant could be seen one hour per week over a period of 40-52 weeks for 20 years; although this is an outlier, it demonstrates the persistent challenge of poor speech, slow cognitive processing, memory challenges, and executive function on the whole person and their ability to function. These challenges slow sessions and the healing process, resulting in a longer duration of the intervention. In addition, individual communication issues with family, work, and community continually increase stress levels and subsequently impede emotional health progress. Family dynamics and caregiver burnout, leave people irritable and unable to rationalize and adjust to various life events resulting in ongoing therapy.

For example: Figure 1

Psychotherapy 90837	80 units @ $173.00 (CMS, NYC)	$13,840 one time allotment
Family Psychotherapy 90846	24 units @ $160.00 (cash fee for example)	$3840 one time allotment

(Rates for demonstration only)

People with TBI often are challenged as they re-enter the community and face integration into society, work, family, and social situations. The frequency and duration of counseling services are challenging to assess and are ongoing. No two brain injuries are alike, and the person may struggle with memory and carryover from each session; different modalities help, such as journaling which might be imperative for this carryover or used as a compensatory strategy. Additionally, processing skills, thinking, and communication may be slower than the average person, and therefore processing feelings and other areas for improvement may increase the time needed to complete the therapeutic process.

This presents a challenge when life care planners collaborate with mental health providers to assess the frequency and duration of counseling services because each TBI is different, and the provider cannot predict the duration of the service. https://www.biausa.org/wp-content/uploads/Guidebook-for-Psychologists-Working-with-TBI-hk.pdf

In this example, the counselor justified eighty units per year which are calculated by taking 75 percent of 104 units allowable over a two-year period by The New York State TBI Medicaid Waiver Program. Of note, on the TBI waiver, at the end of two years, with a physician's prescription, the service can be justified to continue annually as needed. (Andrea Leo, Service and Waiver Compliance Coordinator, CBIS) Unfortunately, as this example shows, establishing a limit in duration and frequency is difficult because of the deficits that slow processing and the goal is to help the individual be whole again, resulting in annual assessments that can be approved annually over a number of years.

The providers report that it is difficult to predict the frequency and duration of this service because the patient has undergone significant changes. So, until they can accept that their lives are different socially, economically, and vocationally, they will continue to suffer, and the supportive service is going to be necessary. It is difficult to predict the frequency and duration and is on a case-by-case basis. (Dr. Mckee, Ph.D., Chrystal Rubang, LMHC)

The life care planner can consult the therapist and obtain the code for the initial evaluation time and an estimate of the projected time for ongoing services. Otherwise, the life care planner can also use costs and codes found in the invoices or bills. Typically, a therapist bills the time for evaluation and then the length of the session followed by the frequency. CPT codes vary and are descriptive of each service based on the length of the session, group session, or individual evaluation services.

In conclusion, persons who sustained TBI commonly endure mental health disorders, significant trauma, cognitive impairments, executive dysfunction, and psychosocial challenges. It is imperative that life care plans meet the multifaceted needs of such individuals. Life care planners play a vital role in collaborating with mental health therapists to ensure that future costs of service are addressed in the medical cost projections.

Life care planners can utilize the information gleaned from this article as a guide to understanding the differences in mental health providers, psychotherapeutic approaches, and the challenges regarding the duration and frequency of treatment, including costing and coding. The life care planner must follow standards of practice and methodology for identifying costing techniques using verifiable data from appropriately referenced sources. The costs need to be identified and geographically specific, usual and customary prices, and there should be more than one estimate. Sticking to standardized protocols is essential.

CPT® Code	Descriptor
90832	Psychotherapy, 30 minutes with patient (16-37 minutes)
90834	Psychotherapy, 45 minutes with patient (38-52 minutes)
90837	Psychotherapy, 60 minutes with patient (53 minutes or more)
90845	Psychoanalysis
90846	Family psychotherapy (without the patient present), 50 minutes (26 minutes or more)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes (26 minutes or more)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
96153: Health and Behavior intervention, group (2 or more patients)	96153 Health and Behavior intervention, group (2 or more patients)
• 96154: Health and Behavior family intervention with the patient present	• 96154 Health and Behavior family intervention with the patient present

https://www.apaservices.org/practice/reimbursement/health-codes/psychotherapy

Code	Service	2021 Nonfacility Rate	2021 Facility Rate	Difference
90791	Diagnostic Interview	$180.75	$156.32	(24.43)
90832	Psychotherapy 30-minutes	$77.81	$68.74	(11.07)
90837	Psychotherapy 60-minutes	$152.48	$132.69	(17.80)
96132	Neuropsych Test Eval	$133.29	$106.08	(27.22)
96158	Hlth Bhvr Intrv Indvl	$66.65	$58.97	(7.68)

https://www.apaservices.org/practice/medicare/medicare-news/2022-fee-schedule

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The AANLCP invites interested professionals to speak at our 2024 AANLCP Conference to educate about current clinical practice methods and professional development related to Life Care Planning.

We are seeking high-quality speakers who can share their expertise with their fellow Life Care Planners. We are hoping to have speakers for some of the following topics: Economic Projection Reporting, Vocational Rehabilitation, Home Modifications, Assistive Technology, Speech Therapy, Report Rebuttals and Geriatric Patients

APPLY NOW! Prospective speakers are required to submit a proposal by Oct 31, 2023.

Questions? Please contact:

2023 AANLCP Conference Committee
Jessica Urie, Co-Chair & Speaker Committee Lead
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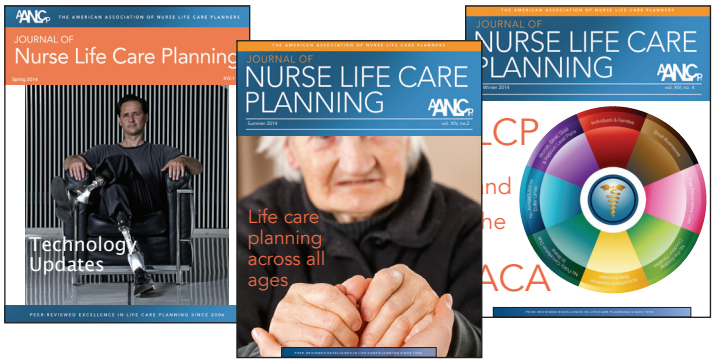

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