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Record Group/Collection: Donated Historical Materials
Collection/Office of Origin: Frieden, Lex, Collection
Series: Disability Rights Organizations
Subseries:

OA/ID Number: 52064
Folder ID Number: 52064-003

Folder Title:
[TIRR] New Options Modules [1974-1977]

Stack: **Row:** **Section:** **Shelf:** **Position:**

Do one module at a time.

R.S.#_____

NEW OPTIONS MODULE RATINGS

initials backwards

DATE:_____ MODULE SUBJECT:_____

I. Circle the response which best shows how you feel about each of the following;

1. The number of sessions — too many — about right — too few

2. The length of sessions — too long — about right — too short

3. The subject of sessions — How many sessions did we have? - How many do you feel you had?

   a. interesting — not sure — not interesting

   b. useful — not sure — not useful

   c. enjoyable — not sure — not enjoyable

   d. understandable — not sure — not understandable

4. The group leader — identify — helpful — not sure — not helpful

5. The associates — help them identify associates — helpful — not sure — not helpful

6. The field trips associated with this module — whatever you consider appropriate — trip could be both - eg airport to mobility for problem solving — helpful — not sure — not helpful

7. The group discussion — helpful — not sure — not helpful

8. What new information did you get in this area?

9. What information do you need that you did not get?

10. How would you improve this module?

Draw from responses

* whatever they said to staff privately, please say it again on these papers. Imp. to document this in writing. — Also, continue Daily Logs to us privately. confidentiality

(use back of page if necessary)

- ✓ living arrangements
- ✓ group
- ✓ functional skills
- ✓ medical needs
- ✓ sexuality
- ✓ home mgmt
- ✓ problem-solving
- ✓ mobility + transportation
- ✓ consumer affairs
- ✓ soc educ
- ✓ financial mgmt

weekend swimming Busch park picnic

personal problems solved
group sessions — special group sessions re project problems

participants' meetings about the program

REQUEST

NEW OPTIONS TRANSITIONAL PROJECT
TEXAS INSTITUTE FOR REHABILITATION AND RESEARCH

INSTRUCTIONS FOR COUNSELOR'S REFERRAL FORM

In the New Options transitional project the participant's TRC counselor or social worker will play an important role, both before the client enters the program and after he or she leaves. This form will hopefully initiate an on-going relationship between New Options staff members and the TRC counselors or social workers of project participants.

The referral form is intended to

convey important background information to the project staff about the applicant.

help you in assessing the appropriateness of the referral of your client to this project.

prompt your thinking about follow-up possibilities for the participant after he or she leaves the program.

Project staff members will be glad to provide additional information and to answer any questions you have about the project. For further information on New Options, please contact the Project Director. Questions concerning TRC involvement in the project can be answered by the New Options Courtesy Counselor or by the Program Specialist for the Severely Disabled.

Jean Cole, Ph.D.
New Options Project Director
TIRR Annex
105 Drew Street
Houston, Texas 77006
713-797-1440

Ms. Rebecca Langley
New Options Courtesy Counselor
Texas Rehabilitation Commission
1964 West Grey
Houston, Texas 77019
713-526-8511

Mr. Ted Thayer
Program Specialist for the Severely Disabled
Texas Rehabilitation Commission
7745 Chevy Chase Drive
Austin, Texas 78752
512-452-8192

If the client's status in any of the following areas has changed since

NEW OPTIONS TRANSITIONAL PROJECT
TEXAS INSTITUTE FOR REHABILITATION & RESEARCH

COUNSELOR'S REFERRAL FORM

Program applicant: _____

Person making referral: _____

Mailing address of
person making referral: _____ Telephone: _____

_____

Position: _____

Briefly describe the applicant's living situation.

Briefly describe the applicant's family relationships.

Briefly describe the applicant's community and the resources there for housing, employment, etc.

Do you now have any ideas about possible educational or vocational options for the applicant? Please list any options that seem reasonable.

What housing options might be reasonable for the applicant after he or she leaves the transitional project?

What possible sources of support and reinforcement might be available to the individual when he or she leaves the transitional project? (on-going relationship with you, family members, other agency personnel, etc.)

What do you see as the applicant's major strengths or assets?

What do you see as the applicant's major weaknesses? Exclude reference to physical disability.

What goals do you feel are important to the individual?

Do you think these goals are reasonable?

Would you be willing to participate in a follow-up program for this applicant (to include some on-going counseling support for the invididual plus some feedback information to the project)?

Please give reasons for your recommendation of this person for participation in the transitional project.

Date: _____ Signature of person making referral: _____

PLEASE MAIL THIS FORM DIRECTLY TO:

NEW OPTIONS TRANSITIONAL PROJECT
TIRR ANNEX
105 DREW STREET
HOUSTON, TEXAS 77006

NEW OPTIONS TRANSITIONAL PROJECT
TEXAS INSTITUTE FOR REHABILITATION AND RESEARCH

PHYSICIAN'S REFERRAL FORM

Patient's name: _____

Address: _____

_____

Diagnosis of major physical disability:

Does patient frequently have bladder or kidney infections?

Does patient frequently have pressure sores?

Does patient frequently have respiratory problems? Is s/he dependent on respiratory aids?

Does patient have difficulties in communication? (hard of hearing, speech difficulties, etc.)

Do you feel that this patient is physically capable of participating in a program that includes at least 8 hours a day of organized activity including field trips?

Date: _____ Name of Physician: _____

Address: _____

_____

Signature: _____

PLEASE MAIL THIS FORM DIRECTLY TO:

NEW OPTIONS TRANSITIONAL PROJECT
TIRR ANNEX
105 DREW STREET
HOUSTON, TEXAS 77006

KEY WORDS: Goal setting; rehabilitation

Goal Setting: A Joint Patient-Staff Method

Marjorie C. Becker, Ph.D., Kathleen S. Abrams, M.A., Janice Onder, M.S.W.

• Too often the silent member of the rehabilitation team is the patient himself. Rehabilitation treatment plans are formed by professional team members without information from the patient or his family regarding his or their specific rehabilitation goals. Treatment time is wasted if the patient either does not participate fully in residential treatment or does not utilize his new skills after discharge. To establish the patient and his family as working members of the rehabilitation team, a goal sheet and an interview procedure were instituted in one University of Michigan rehabilitation unit.

The goal sheet lists 30 specific items of possible improvement covering all rehabilitation areas. At intake, the interviewer discusses these items with the patient and his family separately. Discrepancies between family and patient goals are noted by staff and compared with their own goals for the patient and family. Treatment contracts are based on agreed-upon goals. Team conferences, often including patient and family, serve as a monitoring function for goal-directed therapy.

Conflicts between any combination of staff-patient-family goals are readily identifiable; the need for negotiation is evident; compromise goals can be agreed upon. Sabotage of treatment goals by the patient or family does not occur as frequently when they are involved in goal-setting. Each patient's individual circumstances are thus the focal point of rehabilitation programing.

There are many more opportunities for communication among rehabilitation personnel than for communication between the staff and the patient-family group. To increase the interaction of the staff with the patient-family group and to include the patient and his family in the designing of the treatment program, a goal sheet and plans for its systematic use were developed.

The use of the goal sheet is based upon the philosophy that patients and families who have a central role in determining treatment goals are less likely to undermine therapy and more likely to see skills learned as relevant enough to carry over into the home environment. The table enumerates the spectrum of physical, educational, vocational and psychosocial skills which can be developed during an inpatient stay at the University of Michigan Medical Center.

The individual goals are phrased in functional, nontechnical language with an open category included to make sure that all of the patient or family goals have been specified. Whenever possible, goal information is obtained by face-to-face interview so that terms which the respondent does not understand may be explained. The in- or out-patient interview is one of the first contacts the patient and family may have with the rehabilitation unit. They are interviewed separately, then the goal sheets compared. This interview gives staff members a chance to orient the patient and family toward a rehabilitation plan which is constructed around a core of desired skills identified by the family, staff and patient. The interview may be conducted by any team member. Items are read to the respondent, with clarification when necessary. Responses are noted on different colored sheets for family and patient and go unmodified to the medical record.

From the University of Michigan Medical School and Parkview Medical Center, Ann Arbor, MI.

Presented at the 49th Annual Session of the American Congress of Rehabilitation Medicine, Denver, CO, August 23, 1972.

Submitted for publication in revised form July 25, 1973.

Utilization

Complete goal sheets are used by physicians and therapists in planning treatment. Goal discrepancies can interfere with treatment, resulting in the patient either refusing to work on prescribed tasks or working on the tasks while under direct care and treatment but not transferring learned skills to his home environment.

The following case summary is an example of a goal discrepancy between the patient and his family versus staff:

Twelve months after a cerebrovascular accident, a right hemiplegic woman and her husband indicated upon admission that they wanted her to regain the use of her right hand. The staff saw as a more realistic goal learning effective use of the left hand. To avoid potential sabotage to the prescribed treatment program of minimal emphasis on the motor return, a compromise goal was negotiated. The patient would work on a program of exercises for the right hand so as to maintain muscle tone should she get more return, and also learn better left-handed dexterity which would be of use to her for as long as she was unable to use her right hand. The family accepted this goal. If the husband participates by encouraging the patient to use her left hand as well as to exercise her right hand, she is likely to continue attempting both sorts of activities and positively affect the rehabilitation outcome.

Other goal discrepancies that may occur are those between staff and patient versus relatives, patient versus staff and relatives, staff versus staff, or staff versus patient with no relatives. If one or more discrepancies can be identified early in the patient's stay, meetings are scheduled between involved parties to try to negotiate compromise goals.

Discussion

In addition to helping to design treatment programs, the goal sheets have proved useful in monitoring the progress of treatment during weekly team meetings, as well as in the evaluation of results or goal achievement at the end of treatment. Goal sheets can also be used as a basis for follow-up evaluation of whether or not the patient continues to use the skills learned once he returns home.

As noted, most patients and their families do not expect to be involved in treatment planning. The goal sheets serve to orient the patient and families at admission to the fact that they are expected to participate actively in this treatment.

Encouraging patients and families to participate in the treatment plan at all, with or without the use of goal sheets, creates difficulties for staff members. Instead of operating autonomously and relying on their own professional skills and judgments, the staff members are asked not only to consider the patient and family's point of view, but also to allow these goals to supersede their own. When the goals of the patient and family are at drastic variance with those of the staff—for personal or professional reasons—it is very difficult if not impossible for staff members to facilitate attainment of these goals through therapy.

Not every goal discrepancy is dealt with by direct intervention. Some are expected to be treated environmentally with the hope that patients with unrealistic or absent goals will modify their own goals by exposure to other patients with similar disabilities. For example, a quadriplegic person who does not select cooking as a goal at admission may later request instruction after being exposed to other quadriplegic patients who are using the kitchen facilities. Some goal discrepancies are dealt with by subtle treatment. A patient who refuses to work on increasing his ambulation endurance within the rehabilitation center might, out of boredom, agree to be included in a trip to a coffee shop or local store which necessitates that he walk a greater distance than treatment would require.

Desired Goals

Moving around better in a wheelchair	Learning to follow special diet
Getting into and out of a car	Learning to follow medication plan
Driving a car	Learning skin inspection and care
Loading and unloading wheelchair in car	Bowel and bladder care
Getting into and out of bed	Strengthening legs
Getting into and out of tub or shower	Strengthening arms
Getting into and out of chair	Exercises to keep arms or legs loose
Getting up and down from floor	
Getting through doors	New sexual information
Walking	Getting out of the house more
Standing	Dating
	Learning how to meet people
Dressing and/or undressing	Having a hobby
Washing self—sink and bath	Leisure time activity
Brushing teeth	
Shaving	Reading
Feeding self	Going to school
Combing, brushing or washing hair	
	Job training
Talking	New living plans needed after discharge
Writing or typing	Finding out what kind of jobs can be done
Cooking more easily	
Cleaning more easily	Family education
Shopping at the store	Purchase of equipment
Using the telephone	
Making decisions for self	
Using toilet without help	
Riding a cab or bus	
Practice living alone or with roommate	

Results

Establishment of written goal sheets and goal-setting as a basis for treatment of severely physically disabled patients has supported the following observations: (1) very early identification of conflicts between any combination of patient-staff-family goals, (2) truly individualizing treatment programs, (3) enhancing family-patient-staff interaction through negotiation and the setting of treatment priorities, (4) including the patient and his family as active and responsible team members, (5) teaching staff how to achieve longer lasting rehabilitation goals through intermediate or compromise goals and (6) reducing

sabotage to rehabilitation programs by patient, staff or families.

ADDRESS REPRINT REQUESTS TO:
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University Hospital
University of Michigan Medical Center
Ann Arbor, MI 48104

References

1. Wolf BA, Abrams HA: Organizational structure for social-vocational rehabilitation of severely physically disabled. Presented at the 48th Annual Session of the American Congress of Rehabilitation Medicine, San Juan, Puerto Rico, November 10, 1971.
2. Slater SB, Sussman MB, Stroud BW III: Participation in household activities as prognostic factor for rehabilitation. Arch Phys Med Rehabil 51:605-610, 613, Oct 1970
3. Weed L: Medical Records, Medical Education, and Patient Care; Problem-Oriented Record as Basic Tool. Cleveland, Ohio, The Press of Case Western Reserve University, 1970

INDIVIDUAL ASSESSMENT OF PARTICIPANT FORM

NAME OF PARTICIPANT _____ DATE _____

MODULE _____ STAFF PERSON _____

1) Did participant seem interested in content presented?

   a) If yes, what behaviors expressed this?

   b) If no, what behaviors expressed this?

2) How would you rate individual's degree of involvement in group discussion?

1		5
(low)		(high)

3) Were the individual's contribution to the group discussion appropriate or did they tend to get the group off the subject?

4) Please circle any further comments on the space below:

From: Basic Data Requirements: Individual Care And Internal Management Of Long-Term Institutions And Services - "Physical" Rehabilitation Institutions and Services by W.A. Spencer, R. L. Baker, and D. D. Stock

Changes in EPI scores over time are useful for evaluation of differences in functional performance capacity of spinal cord injured persons during and after rehabilitation. Figure 7 is a computer produced graphic analysis of EPI total scores for quadriplegics in days after the first test following admission to TIRR who were undergoing comprehensive rehabilitation and follow-up from 1970 to 1973. This sub-group had complete lesions as judged by clinical diagnosis of motor and sensory impairment levels at intake.

These examples were selected to substantiate the potential value of such data collection in uniform long-term care data bases and some of the approaches being made to their validation. For general usage the Bush social preference scale would have patient care evaluative utility and general reporting value. (see Appendix VI)

PROPOSED DATA BASES FOR REHABILITATION ARRANGED ACCORDING TO PATIENT CARE ENCOUNTER, INSTITUTIONAL MANAGEMENT, & REPORTING PURPOSES

The following multilevel minimal data set plan is offered as an example of a possible rehabilitation data base. Reported data should be abstractable from institutional and patient care data. Data at the service level should be selectively evaluated for the degree of detailing required in order to capture missing data for reporting purposes when ambiguities or unusual deviations occur in interpretation of general reports and trends. Anonymity of personal source data should be preserved for extrainstitutional reporting and some features of institutional analysis.

The following Table 4 lists classes of data elements for reporting purposes, institutional management, and patient care. Progressively expanded levels of detail should be evident from reporting (the minimal data base) to patient care where classification and qualifiers are necessary. Coding linkage and security access protection could be arranged in various files to protect access to levels of detail entirely personal and relevant only to individual care. Qualified professional persons could provide institutional management and general reporting files with abstraction and

From rough draft of Long Term Care Data Conference paper.

Figure 7

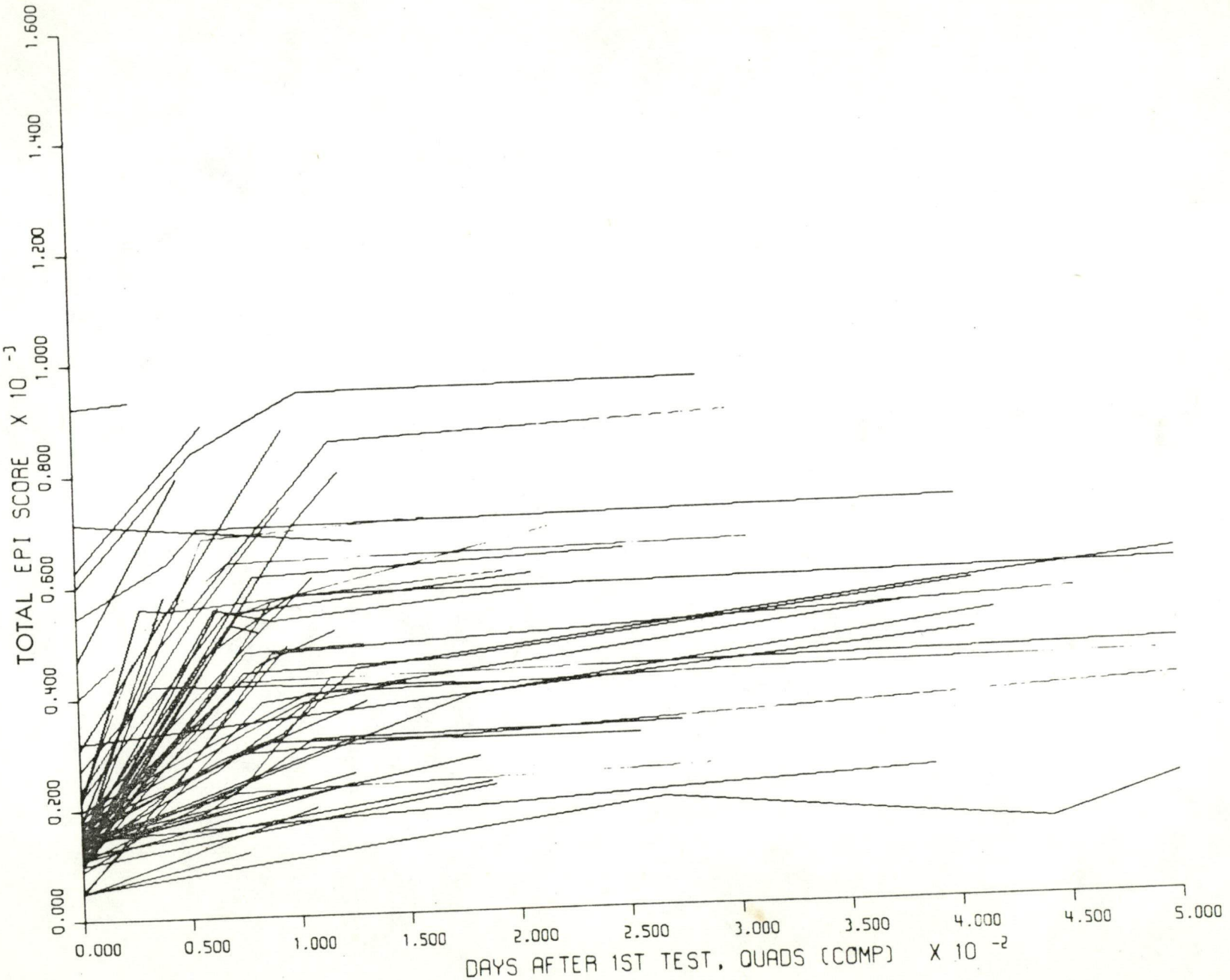

TOTAL EPI SCORE X 10 -3
0.000
0.200
0.400
0.600
0.800
1.000
1.200
1.400
1.600
0.000
0.500
1.000
1.500
2.000
2.500
3.000
3.500
4.000
4.500
5.000
DAYS AFTER 1ST TEST, QUADS (COMP) X 10 -2
N = 54

TABLE 4

LONG TERM CARE REHABILITATION DATA BASE
LEVELS OF DETAIL AND PURPOSES

CLASS OF DATA ELEMENTS	REPORTING	INSTITUTIONAL MANAGEMENT	PATIENT CARE RECORD
1.0 Demographic	1.01 R Composite LTC Accession # Unique Accession # (who) | Census Tract Origin (where) | Code Reference to Institution Source & Type (what place) | S R A Sex Race Age Code | *Cit non-Cit 1.02 R Date of Report /Y/M/D/ 1.03 R Reporting Epoch in Units (e.g. RY 75.5) 1.04 R Place of Service for this Report (update) 1.05 R Sponsorship Code (self, public, private third party, mixed, other) 1.051 R Reference Code to Public Sponsor File (e.g. VA #, SS #, Medicare, Medicaid, etc.) 1.06 R Income Amount at Intake & Adequacy of Income Code Adequate/Inadequate (Relative to condition & health status support) *Citizen, Non-citizen Code	1.01 M Unique LTC Accession # Assigned Institutional Patient Record # 1.02 M Address 1.03 M Census Tract & Region 1.04 M County, State, Zip 1.05 M Name & Social Security # 1.06 M Age Grouping - Classification 1.07 M Admitting Program Code and/or Bed Location Code 1.08 M Days Stay in Facility This Episode 1.09 M Fiscal Accounting Billing Reference Code · Anticipated Sources of Payment → Satisfactory / Unsatisfactory 1.10 M Sponsor Billing Reference · Single or Multiple · Specific Sponsors 1.11 M Barriers to Satisfactory Coverage · 30-day sponsorship only · exhausted sponsorship source · age · waiting period delays · evaluation coverage only	1.01 C LTC Accession # & Institution # 1.02 C Social Security # 1.03 C Name & Surname & Date of Name Change 1.04 C Sex 1.05 C Race Code 1.06 C Last (most recent) Address 1.061 C Previous Address 1.07 C Referral Source Code 1.08 C Date of Birth (year) Religious Pref. 1.09 C Date of Onset /Y/M/D/ 1.10 C Date of Admission /Y/M/D/ 1.11 C Date of Disposition /Y/M/D/ 1.12 C Family Status & Relatives (next of kin) 1.13 C Usual Living Situation (housing/physical) 1.14 C Total # in Household 1.15 C Current Ages of Household Members 1.16 C Education 1.17 C Usual Occupation 1.18 C Employment Status 1.19 C Financial Status 1.20 C Sources of Income Classification 1.21 C Sources of Sponsorship

TABLE 4 (cont'd)

PATIENT CARE RECORD	QUALIFIERS
1.01 C LTC Accession # & Institution #	Code Information Reliability (all items-1.R, 1.M, 1.C)
1.02 C Social Security #	
1.03 C Name & Surname & Date of Name Change	
1.04 C Sex	
1.05 C Race Code	
1.06 C Last (most recent) Address 1.061 C Previous Address 1.07 C Referral Source Code	Primary or Secondary Referral (1.07 C)
1.08 C Date of Birth (year) Religious Pref.	
1.09 C Date of Onset /Y/M/D/	Onset (1.09 C) Acquired Congenital
1.10 C Date of Admission/Y/M/D/	
1.11 C Date of Disposition /Y/M/D/	Age at Onset (1.09 C)
1.12 C Family Status & Relatives (next of kin) • Single • Married Living with Spouse • Unmarried & Significant Other • Separated Legal Forced • Divorced • Widowed	Quality of Relationship Variables (1.12 C) Duration of Status (1.12 C) Support Availability (1.12 C) Adequacy (1.12 C) Desirability (1.12 C)
1.13 C Usual Living Situation (Housing/Physical) • Apartment • House • Rental Room • Personal Care Facility (ECF & Type) • Hospital & Type • Rehabilitation Center • Special Residence	Safety (1.13 C) Security (1.13 C) Logistics - Wheelchair Accessibility (1.13 C) Satisfaction Level (1.13 C)

TABLE 4 (cont'd)

PATIENT CARE RECORD	QUALIFIERS
1.14 C Total # in Household # Adult # Children	
1.15 C Current Ages of Household Members Adults Children	
1.16 C Education • Earned Degree • Highest Level Reached High School 1→12 College 1→4 Grad. School 1→4 • Vocational Training	Special Education & Performance Goals (1.16 C) Time Spent Acquiring (1.16 C)
1.17 C Usual Occupation • DOT Code if Applicable • Other • Never Employed	Job Change Frequency (1.18 C) Reasons for Change (1.18 C) Evidence of Economic Mobility (1.19 C)
1.18 C Employment Status • Full-Time — Regular / Sheltered / Homebound • Part-Time	Consistency of Earnings (1.19 C) $↑ or ↓ within the past 12 months (1.19 C) Pre- & post-disability Budget Analysis (1.19 C) Stability (1.19 C)
1.19 C Financial Status • Monthly Income Classification • Family Income Classificato	Availability (1.19 C, 1.20 C) Accessibility (1.20 C)
1.20 C Sources of Income Classification • None • Personal Employment • Social Security • Pension & Annuities • Veterans Benefits • Welfare • Family • Self & Savings	Adequacy (1.20 C) Eligibility (1.20 C, 1.21 C) Barriers (1.20 C, 1.21 C)

TABLE 4 (cont'd)

PATIENT CARE RECORD	QUALIFIERS
1.21 C Sources of Sponsorship • Self • Insurance • Medicare • Workmen's Compensation Ins. • State Rehabilitation Agency • Medicaid • Local Financial Assistance • Programs (Public & Voluntary) • CHAMPUS • VA • Crippled Children's Agency	Completeness/Incompleteness (1.21 C) Coordinated (1.21 C) yes ____ no ____ Limitations (1.21 C) $ Amount (1.21 C) Days Stay (1.21 C) Conditions at Intake (1.21 C)

TABLE 4 (cont'd)

CLASS OF DATA ELEMENTS	REPORTING	INSTITUTIONAL MANAGEMENT	PATIENT CARE RECORD
2.0 Intake Status	2.01 R Handicap Manifestation Code 2.02 R Impairment or Diagnostic Code 2.03 R Mean Functional Status # at Intake 2.04 R Katz Functional Code 2.05 R Primary Purpose of Encounter Code # · Acute Care-Intercurrent Medical Care-Episodic · Rehabilitation-Restoration-Comprehensive · Problem Preventive-Elective · Medical Condition Upgrade-Readmission · Functional Status Upgrade · Follow-up Care-Adjustment · Maintenance & Supportive Living · Follow-up Evaluation · Special Training Vocational Work Evaluation & Placement Adjustment Sheltered Employment Education and Schooling · Terminal Care	2.01 M Primary Diagnosis Impairment Codes, SNODO, ICDA 2.02 M Handicap Manifestations Code, Index 0-15 Movement and Social Service Ranking 2.03 M Mean Functional Status at Intake 2.04 M Program Admission Codes · Evaluation & Planning · Comprehensive Rehabilitation (Tier) · Physical Restoration · Emergency Admission (compl.) · Reconstructive or Remedial Surgical · Upgrade-Follow-up · Follow-up Evaluation · Terminal Care · Personal & Family Adjustment · Interim Planning & Re-evaluation 2.05 M Services Received listing by Cost Center of Origin for Itemized Billing and Service Utilization Profiles	2.01 C Results of Referral Code 2.02 C Pre-admission Costs (Estimated) 2.03 C Primary Diagnosis 2.04 C Primary Disability Code 2.05 C Complications Code 2.06 C Functional Status Code (Bush) 2.07 C Primary Purpose of Encounter Code # 2.08 C Actions to Manage Disability Matrix 2.09 C Rehabilitation Care Objectives (Functional) 2.091 C Rehabilitation Care Objectives (Vocational-Social) 2.10 C Potential to Benefit Barriers

TABLE 4 (cont'd)

PATIENT CARE RECORD	QUALIFIERS
2.01 C Results of Referral Code	Quality of Acute Care Follow-up (2.04 C)
2.02 C Pre-admission Costs (estimated)	
2.03 C Primary Diagnosis	
2.04 C Primary Disability Code	Extent Handicap/Disability (2.02 C)
2.05 C Complications Code 0 ⟶ 15 Variables	Mobility Scale (2.06 C see Bush scale in Appendix V) 0⟶5
2.06 C Functional Status Code (Bush) 0 — 31 Level	Physical Activity Scale (2.06 C) 0⟶4
2.07 C Primary Purpose of Encounter Code # • Acute Care-Intercurrent Medical Care-Episodic • Rehab.-Restoration-Comprehensive • Problem Preventive-Elective • Medical Condition Upgrade-Readmission • Functional Status Upgrade • Follow-up Care-Adjustment • Maintenance & Supportive Living • Follow-up Evaluation • Special Training Vocational Work Evaluation & Placement Adjustment Sheltered Employment Education and Schooling • Terminal Care	Social Activity Scale (2.06 C) 0⟶5 Alternative ADL Scores, etc. (2.06 C) Realistic/Unrealistic (2.07 C) Detail of Rehabilitation Potential (2.06 C) (Regrouped National Needs Study) Diagnosis and Potential (2.07 C) Barriers and Gaps (2.09 C, 2.10 C) Availability (2.10 C) Access (2.10 C) Eligibility Adequacy (2.02 C) Adequacy to Needs (2.10 C)
2.08 C Actions to Manage Disability (see matrix)	
2.09 C Rehabilitation Care Objectives (Functional) • No treatment objective-Evaluation Only • Recovery Attainment Objectives: Complete, Total Self-Reliance Require Assist. with Personal Care only Require Assistance with More than Personal Care Minimal Recovery/Attainment-Nursing Care with Dependent Status Return to, or entry into, Social Living but will require: Special Residential	Primary Disability Code (2.04 C) Rehabilitation Services Administration, DHEW AP - Amputation AR - Arthritis CR - Cardiac CP - Cerebral Palsy CD - Congenital Deformity EP - Epilepsy HR - Hearing IS - Idiopathic Scoliosis LR - Learning Problem MR - Mental Retardation MS - Multiple Sclerosis MD - Muscular Dystrophy ND - Neurological Disorder OP - Orthopedic PP - Polio Paraplegia PQ - Polio Quadriplegia PY - Psychiatric RE - Respiratory CV - Stroke TH - Traumatic Head Injury TP - Traumatic Paraplegia TQ - Traumatic Quadriplegia OR - Other NA - Data Not Available

TABLE 4 (cont'd)

PATIENT CARE RECORD	QUALIFIERS
Community Physical Care Supports Family Supports Financial Assistance Compensation for Loss of: Vision Hearing Upper Extremities or Parts Lower Extremities or Parts Other Preservation of Assets Preparation for Referral	
2.091 C Rehabilitation Care Objectives (Vocational-Social) • No Treatment Objective-Evaluation Only • Restoration to or Entry into: Competitive Labor Market Non-competitive Labor Market Unrestricted Homemaking Activities Partial Homemaking Activities Social Attendance • Preparation for Training • Counseling-Psycho-therapy • Preparation for Referral	
2.10 C Potential to Benefit Barriers • Service Resources Adequacy • Problem/Solution Feasibility-Capability • Functional Status Change Potential Social Weaknesses-Strengths • Probability of Resolving Medical-Psycho-Social Complications • Feasibility of Surmounting Intake-Care Barriers and Gaps • Feasibility of Surmounting Disposition Care Barriers and Gaps	

TABLE 4 (cont'd)

2.0 ACTIONS EXPECTED TO MANAGE DISABILITY

Factors Contributing to Disability Status	Evaluation Only	Evaluative & Definitive Services		
		Eliminate or Remedy	Control or Stabilize	Assistive Devices & Systems
Biologic Problems of Handicap				
Sensory Deficits (1.1-1.2)*				
CNS Processing Deficits (2.1-2.2)*				
CNS Output Deficits (3.1 & 3.3)*				
CNS & Effector System Problems (3.2, 3.4, 3.5)*				
Anatomical Conditions (4.1-4.6)*				
Life Supportive System Problems				
- Metabolic				
- Respiratory				
- Circulatory				
- Cutaneous				
- Emunctory				
- Renal				
Complications				
- Pain				
- ↓ Endurance				
- Immobilization Effects				
- Infection				
- Nutritional, etc.				
Accompanying Diseases, Injuries or Defects				
Risk Factors				

*Numbers refer to Table 2.

TABLE 4 (cont'd)

2.0 ACTIONS EXPECTED TO MANAGE DISABILITY

ctors Contributing to sability Status	Evaluation Only	Evaluative & Definitive Services: Eliminate or Remedy	Evaluative & Definitive Services: Control or Stabilize	Evaluative & Definitive Services: Assistive Devices & Systems	Psycho-Social and/or Vocational Services: Remove or Remedy	Psycho-Social and/or Vocational Services: Control or Stabilize
havioral Problems**						
ersonality Disturbances						
ognitive Inadequacies						
ounterproductive Attitudes						
or Habits						
nvironmental-Social Impairments						
roubled Life Situation						
Educational Inadequacies						
Vocational Disruption						
Cultural Deprivation						
Financial Inadequacies						
Environmental-Architectural Impairments**						
At Home						
In Transit						
At School or Work						
Functional Performance Limitations						
Self-Activation-Motivation						
Self-Care						
Self-Development						
Physical Mobility						
Social Mobility						

for Management of Selected Data in Medical Rehabilitation. Monograph published by Tufts

TABLE 4 (cont'd)

CLASS OF DATA ELEMENTS	REPORTING	INSTITUTIONAL MANAGEMENT	PATIENT CARE RECORD
3.0 Disposition Status	3.01 R Days Stay Accumulated in Facility 3.02 R Mean Functional Status at Disposition *3.03 R Magnitude of Change Vector for Reporting Epoch Direction Health Status Change + ____ - ____ 3.04 R Cost of Care for Each Encounter Inst.____ Prof. Services____ *3.05 R Cumulative Cost of Care for Epoch Total____ 3.06 R Place of Residence at Disp. Date Code# ____ *3.07 R Income Level Change Vector for Epoch +____amt./year -____amt./year (adjusted to $ worth Ref. Std.) 3.08 R Scale # of Barriers Modifying Outcome *Derived Values from data base processing.	3.01 M Results of Encounter Code · Rehabilitation Goals Surpassed · Rehabilitation Goals Fully Achieved · Rehabilitation Goals Not Fully Achieved · Medical Condition Improved · Medical Condition Uncertain · Medical Condition Worsened · Deceased · No Data 3.02 M Mean Functional Status # at Disposition (Magnitude of Change Vector During Stay) 3.03 M Date of Disposition 3.04 M Type of Disposition · Permanent · Temporary · Against Medical Advice — Yes / No 3.05 M Reason for Change in Disposition 3.06 M Follow-up Plan Arranged yes____ no____ 3.07 M Level of Inst. Responsibility following Disposition · Routine Clinic Visits Only · Annual Hospitalization · Visits in Home · Resource Referral Only · Consultation with Community Services · No Response	3.01 C Kind & Extent of Care Goal Attainment 3.02 C Problem Status Change 3.03 C Functional Status Profile Changes 3.04 C Service Need Status 3.05 C Interim Goals Achieved Fully____ Partially____ 3.06 C Disposition Change yes____ no____ 3.07 C Reason for Change in Disposition 3.08 C Dispositioned to: 3.09 C Adequacy of Disposition Plan 3.10 C Cost of Care Estimates

TABLE 4 (cont'd)

PATIENT CARE RECORD	QUALIFIERS

3.01 C Kind & Extent of Care Goal Attainment

3.02 C Problem Status Change

3.03 C Functional Status Profile Changes

3.04 C Service Need Status

Services	Required	Obtainable	Un-Obtainable
Medical Services			
Psycho-social assistance			
Nursing Services			
Vocational Training			
Employment			
Educational Planning			
Recreational			
Transportation			
Homemaking/Attendants			
PT/OT			
Family Ed. Training			
Financial Assistance			

Quality & Value (3.04 R)

3.05 C Interim Goals Achieved
Fully____
Partially____

3.06 C Disposition Change
yes____ no____

3.07 C Reason for Change in Disposition

- Progressed Beyond Goal
- Previous Goals-Objectives Achieved
- Further Progress Toward Goal
- Former Disposition Status Maintained
- Former Disposition Status Not Maintained
- Temporarily Institutionalized
  Same Impairment
- Permanently Institutionalized
  New Impairment
- Self-Discharged
- Deceased
- No Data

TABLE 4 (cont'd)

PATIENT CARE RECORD	QUALIFIERS
3.08 C Dispositioned to: • Usual Living Situation • New Living Situation-Not Listed Below • Nursing Home • Foster Home • General Hospital • Other Rehabilitation Facility • Halfway House • Special Residence for Handicapped • Live Alone • Live with New Physical Care Supports	Available Agency Resources (3.09 C) • Financial • Medical • Employment • Education • Vocational Training • Psycho-therapy
3.09 C Adequacy of Disposition Plan	Level of Existing Obstacles (3.09 C)
3.10 C Cost of Care Estimates • Family • Sponsors • Service Provider	Follow-up & Service Barriers (3.09 C) Availability (3.09 C) Accessibility (3.09 C) Yearly Cost (3.09 C) Supplies Drugs

TABLE 4 (cont'd)

CLASS OF DATA ELEMENTS	REPORTING	INSTITUTIONAL MANAGEMENT	PATIENT CARE RECORD
4.0 Follow-up Status	4.01 R Follow-up Status • Unable to follow due to $ limitations • Lost to follow-up • Continuing • Not needed • Deceased Date: Cause: • Refused 4.02 R Next Report Source Code	4.01 M Facility Responsibility for Follow-up — Yes / No 4.02 M Follow-up Plan Arranged — Yes / No 4.03 M Date of Return 4.04 M Plan of Care by Service Emphasis 4.05 M Method of Follow-up Care • Planned Home Visits • Annual Hospitalization • Visiting Nurses • Clinic Visits • Telephone Contact 4.06 M Follow-up Referral Source Code 4.07 M Anticipated Costs to Institution for Follow-up Care 4.08 M Follow-up Service Resource Code Primary_____ Secondary_____	4.01 C Re-evaluation & Follow-up Plan 4.02 C Visits per Year & Schedule 4.03 C Psycho-social Needs 4.04 C Follow-up Responsibility Reasons Resources to be Used 4.05 C Barriers to Follow-up Care (see attached list) 4.06 C Risk Factor for Health Status 4.07 C Estimated Annual Cost of Equipment 4.08 C Estimated Annual Cost of Meds-Supplies

TABLE 4 (cont'd)

PATIENT CARE RECORD	QUALIFIERS
4.01 C Re-evaluation & follow-up plan	Individualized summary-detail principal problems (4.01 C, 4.03 C)
4.02 C Visits per year & schedule	Adequacy of responsible facility, agency, etc. (4.01 M, 4.04 M, 4.05 M)
4.03 C Psycho-social needs	
4.04 C Follow-up responsibility Reasons Resources to be used	
4.05 C Barriers to follow-up care (see attached)	
4.06 C Risk factor for health status	
4.07 C Estimated annual cost of equipment	Cost to whom, patient, sponsor, institution, other (4.07 C, 4.08 C)
4.08 C Estimated annual cost of meds-supplies	Adequacy of coverage (4.07 C, 4.08 C)
	Appropriateness of equipment (4.07 C)
	Sufficiency of purchasing capacity (4.08 C)

4.05 C Barriers to Follow-up Care

1. Patient opposed to leaving hospital (for one or more of the following reasons):

   A. feels further treatment would render him more functional
   B. feels that family members are unable to render specialized care which he believes is indicated
   C. has become accustomed to a more comfortable physical environment than will be available at home
   D. feels his presence in the home will pose extreme hardship on family
   E. feels that family really does not want him in the home.

2. Patient looks forward to discharge so that he can manage own routine and care procedures in a manner that is medically contraindicated.

3. Patient's lack of consideration for and his unusual demands on family will create problems. (This may or may not be recognized by family at this time.)

4. There is no family member available or capable of providing the necessary care (physical and/or financial) that patient requires.

5. Responsible family members opposed to patient's discharge to home (for one or more of the following reasons):

   A. feel that additional treatment will render patient more functional
   B. dubious of their ability to render type and amount of care his condition requires
   C. unwilling to make personal sacrifices required in accepting responsibility for providing the degree of care patient requires

6. Family looks forward to patient's discharge so that they can establish a routine of care that is medically contraindicated.

7. Unavailability of a local physician who has interest in and concern for patient and his follow-up care.

8. Physical aspects of the home environment are not conducive to maintaining patient's health and welfare unless many revisions and modifications can be made.

9. Patient's community is lacking in the structured, organized health and welfare services that he will need at home; presently unaware of interested individuals or groups that may fill the gap by providing supportive measures.

10. Lack of financial resources (both within the family and community) may endanger the success of a home care routine.

subjective judgmental scales derived from detailed patient care records.

Details of care process plans and schedules have been omitted from this proposed data base because of the previously mentioned variance in intensive comprehensive rehabilitation care processes. The intake and disposition matrices relating the patient need, problem and condition classifications to intended activities in the rehabilitation care process are a substitute for reporting and analysis of results of care purposes. Detailed results of care matrix could be constructed from estimates of the extent of accomplishment and results of the planned actions. For less intensive care facilities for health maintenance and life supportive services, the Densen[17] type of summary treatment documents may be adequate for arrangement, provision and assessment of treatment or general management. Our experience in comprehensive rehabilitation facilities has been that there are indeed prototype care plans and schedules which can be tailored to individual problem and need sets at intake and in course of rehabilitation.[18] These problems, however, are particularly modified by changes in the concepts and technology of rehabilitation and in medicine. The careful selection of variables for general institutional reporting of patient encounters has been arranged to allow useful correlations for derivation of magnitude of need and service benefit assessment in a local inter-institutional care system or at regional and federal levels. Such analyses could provide for performance analysis and for policy guidance. The listings suggest some details of coding, classification, and a partial listing of qualifiers to be recorded for the individual patient data base. These details would be used to trace reasons for unique differences among individuals in a group included in summary reports and for more accurate assessments for differences in performance effectiveness of the service encounter among patients and among several service institutions. Coding details are incomplete except for the minimal reporting data base. Some require validation and reliability checks; some have not yet been adequately conceptualized. The minimum set, however, includes presently available data except for costs.

Organization of the Medical Record for Rehabilitation

Carl V. Granger, M.D.

There is general concern for the quality of medical care and the adequacy of systems for delivering care in the United States. The physician is the major figure on the health care team. Therefore, it is viewed that "if the quality of the individual physician's performance is raised, the general level of medical care should improve".[1] Consequently, there are a number of evaluation studies being conducted to extensively and explicitly investigate physician performance. So far, most studies have concentrated on acute aspects of care but, no doubt, aspects of rehabilitation and long-term care will also come under close scrutiny.

It remains difficult to determine how the dimensions of physician performance should be measured. As cited by Barro, Donabedian (1969) states, "Assessment of process is the evaluation of the activities of physician and other health professionals in the management of patients;.....assessment of outcome is the evaluation of end-results in terms of health and satisfaction." Further, the tendency to concentrate on the technical aspects of physician performance and to neglect the interpersonal dimensions continue to present formidable problems in assessment of quality care.

Third-party payers, such as Medicare, Medicaid, Blue Cross and Blue Shield are concerned about cost-accountability. They and other health care insurers are applying standards to determine whether professional services rendered constitute necessary and covered care for purposes of insurance payment. For the most part these standards are empirically derived, are subject to frequent re-interpretation through publication of revised regulations and are frequently criticised as not

being valid criteria. Regardless of objections, concepts of quality care are being significantly modified by the need to justify clinical activities in terms of necessary levels of care, cost-effectiveness, and other economic frames-of-references.

Audit of the medical record is one method for assessing quality of physician performance. In fact, the patient's record and hospital chart have become documents used by the third party payers to justify and to cost-account clinical care. There are a number of common deficiencies of data that render patient records imperfect as accounting documents. However, "greater use of problem-oriented records may help considerably to improve the quality of data,"[1] particularly to correct incompleteness, inaccuracies and non-standard expressions.

We have gone through a series of steps to improve our medical record as a guidance system, as a management tool and as an accounting document. Our goal is to have the medical record clearly reflect the patient's status before, during and after therapeutic or rehabilitative intervention.

Four new tools were adopted for this purpose:[2]

1. the problem-oriented medical record[3]
2. programmed examination formats[4]
3. a computer terminal (MUMPS System on PDP 11/20 time-sharing computer) where we were formerly using a programmable (magnetic tape cassette) editing typewriter
4. standardized assessments of functional abilities.[2]

Advantageous features of the programmed examination formats include the following:

* A uniform and comprehensive examination is defined and encouraged but not limited by form design;

* More than one agent or examiner may interact in compiling information;

* The preliminary form is a worksheet and may be audited, verified or corrected to assure accuracy and for teaching;

* Incorrect or insignificant responses may be suppressed and relevant data and detail may be added;

* The print-out is legible, organized in a predictable format and represents condensation of positive information;

* Design of the print-out is intended to permit quick scanning and highlighting of significant information;

* Communication between members of the health-care team is facilitated; and

* Purposes of Peer Review are served on an ongoing basis to permit rapid audit of the medical record for assuring high standards of care and efficient use of services.

We regard outcomes as the differences between functional status on admission, on discharge and on follow-up. The Barthel Index scores (Fig. 1) and the PULSES scores (Fig. 2) are incorporated into the assessments to give a numerical equivalent of functional status for comparison of change over time. We find the following descriptive items necessary in order to compare outcomes of disabled persons: age group, sex, duration since onset, Barthel score, PULSES score, behavioral (intellectual/emotional) adjustment, adequacy of family unit, financial status, vocational status, major handicapping condition, and associated medical disorders.

To develop a uniform and complete data base we designed a history questionnaire in which the information generated by the patient is subject to verification and augmentation by the physician. From his interview with the patient the physician adds explanatory detail including the present illness. Display of the history information is in a predictable sequence under standard headings. Asterisks serve to highlight certain responses of questions that have been

answered affirmatively. Information from the physical examination is arranged under headings to highlight abnormal findings. Systems not examined are clearly listed. The problems and plans are combined as a working document in the front of the chart to display past and present diagnoses, symptoms and signs of concern, possible problems for the future and the disabling consequences of somatic, psychological, social, economic, vocational or environmental impairment. By using a pre-numbered and a pre-titled problem list (Fig. 3) for selection we find that the initial problem list is more likely to be complete and that writing progress notes for common problems, such as mobility and self-care, for example, is facilitated because the numbers and titles of these problems are always the same from patient to patient. A summary of functional abilities enlarges the data base beyond history, physical examination and laboratory data by recording whether the activities and behaviors of daily living are performed independently or with assistance. Information is also recorded as to the status of critical supporting systems including competency of the family unit, financial resources and patient's ability to engage in educational or vocational pursuits. All descriptive items are specifically defined and are coded.

Using a standardized assessment system it is possible to display each item of admission, discharge and follow-up on a single sheet (Fig. 4) in order to show functional status and changes at three points in time. Additionally, storage of these data items in the computer is simply one additional step for comparison of rehabilitation outcomes of larger groups of patients. [7, 8]

The APPENDIX contains examples of data collection and input sheets and the corresponding printouts from the computer on a simulated case of "John Watt" at admission, discharge and followup.

5

BARTHEL INDEX

	CATEGORIES	INDEPENDENT	WITH HELP
i.	Feeding (if food needs to be cut up = help)	10	5
ii.	Moving from wheelchair to bed and return	15	10-5
iii.	Personal toilet (wash face, comb hair, shave, clean teeth)	5	0
iv.	Getting on and off toilet (handling clothes, wipe, flush)	10	5
v.	Bathing self	5	0
vi.	Walking on level surface (or if unable to walk, propel wheelchair)	15	10
	*score only if unable to walk	*5	*0
vii.	Ascend and descend stairs	10	5
viii.	Dressing (includes tying shoes, fastening fasteners)	10	5
ix.	Controlling bowels	10	5
x.	Controlling bladder	10	5

A patient scoring 100 Barthel Index is continent, feeds himself, dresses himself, gets up out of bed and chairs, bathes himself, walks at least a block, and can ascend and descend stairs. This does not mean that he is able to live alone; he may not be able to cook, keep house, and meet the public, but he is able to get along without attendant care.

P Physical condition including diseases of the viscera (cardiovascular, gastro-intestinal, urologic, and endocrine) and neurologic disorders:

1. Medical problems sufficiently stable that medical or nursing monitoring is not required more often than 3 month intervals.
2. Medical or nurse monitoring is needed more often than 3 month intervals but not each week.
3. Medical problems are sufficiently unstable as to require regular medical and/or nursing attention at least weekly.
4. Medical problems require intensive medical and/or nursing attention at least daily (excluding personal care assistance only).

U Self care activities (drink/feed, dress upper/lower, brace/prosthesis, groom, wash/bathe, perineal care) dependent mainly upon upper limb function:

1. Independent in self care without impairment of upper limbs.
2. Independent in self care with some impairment of upper limbs.
3. Dependent upon assistance or supervision in self care with or without impairment of upper limbs.
4. Dependent totally in self care with marked impairment of upper limbs.

L Mobility activities (transfer chair/toilet/tub or shower, walk, stairs, wheelchair) dependent mainly upon lower limb function:

1. Independent in mobility without impairment of lower limbs.
2. Independent in mobility with some impairment in lower limbs; such as needing ambulatory aids, a brace or prosthesis, or else fully independent in a wheelchair without significant architectural or environmental barriers.
3. Dependent upon assistance or supervision in mobility with or without impairment of lower limbs, or else partly independent in a wheelchair or else there are significant architectural or environmental barriers.
4. Dependent totally in mobility with marked impairment of lower limbs.

S Sensory components relating to communication (speech and hearing) and vision:

1. Independent in communication and vision without impairment.
2. Independent in communication and vision with some impairment such as mild dysarthria, mild aphasia, or need for eyeglasses or hearing aid, or needing regular medication.
3. Dependent upon assistance, an interpreter or supervision in communication or vision.
4. Dependent totally in communication or vision.

E Excretory functions (bladder and bowel):

1. Complete voluntary control of bladder and bowel sphincters.
2. Control of sphincters allows normal social activities despite urgency or need for catheter, appliance, suppositories, etc. Able to care for needs without assistance.
3. Dependent upon assistance in sphincter management or else has accidents occasionally.
4. Frequent wetting or soiling from incontinence of bladder or bowel sphincters.

S Consider intellectual and emotional adaptability, support from family unit, and financial ability:

1. Able to fulfill usual role(s) and perform customary tasks.
2. Must make some modification in usual role(s) or performance of customary tasks.
3. Dependent upon assistance, supervision, encouragement or assistance from a public or private agency due to any of the above considerations.
4. Dependent upon long-term institutional care (chronic hospital, nursing home, etc.) excluding time-limited hospitalization for specific evaluation, treatment or active rehabilitation,

PULSES TOTAL -- BEST SCORE IS 6/6. WORST SCORE IS 6/24.

PROGRAMMED PROBLEM-PLAN LIST - PPPL

Name and #:_____ Date formulated:_____

Select MEDICAL PROBLEM Number by Somatic System:

# 3 ( )Auditory	# 9 ( )General/Systemic	# 15( )Ophthalmic	# 21( )Urological
# 4 ( )Cardiac	# 10( )Genito/Reproduc	# 16( )Otolaryngol	# 22( )Foot
# 5 ( )Circulatory	# 11( )Hematologic	# 17( )Respiratory	# 23( )Hand
# 6 ( )Dental	# 12( )Immunologic	# 18( )Rheumatologic	# 24( )_____
# 7 ( )Endocr/Metabolic	# 13( )Muscular	# 19( )Skeletal	# 25( )_____
# 8 ( )Gastrointestinal	# 14( )Neurological	# 20( )Skin	

Select DISABILITY PROBLEM Number by Functional System:

# 26( )Mobility	# 32( )Intellect/Emotional	# 38( )Appearance	# 44( )Operate auto
# 27( )Self-care	# 33( )Perceptual-motor	# 39( )Procre/sex	# 45( )Recreational
# 28( )Hand skills	# 34( )Self-esteem	# 40( )Family/home	# 46( )Mechan/devices
# 29( )Sphincter control	# 35( )Social adjustments	# 41( )Household	# 47( )Unreal Expect.
# 30( )Communication	# 36( )Pain relief	# 42( )Educational	# 48( )_____
# 31( )Visual adequacy	# 37( )Endurance	# 43( )Vocational	

NO.	DATE ONSET	DETAIL OF PROBLEM	PLAN	STABLE

LONG RANGE EVALUATION SUMMARY

1	HOSPITAL NO. & NAME: Shirley Donacheck 00 00 01			
2	SEX: Female			
3	MARITAL STATUS: Single			
4	BIRTH DATE: 03/16/48			
5	ZIP CODE: 02368			
6	T-NEMC REHABILITATION INSTITUTE at T-NEMC			
7	LONG-RANGE EVALUATION SUMMARY INTAKE DATE: 09/18/67			
8		ADMISSION	DISCHARGE	FOLLOWUP
9	DATE OF EVALUATION:	09/18/67	05/12/68	08/17/72
10	CONDITION-RT7: 012 Spinal Cord Disorder			
11	PHYSICIAN/EVALUATOR	REHAB INST	REHAB INST	REHAB INST
12	MODE OF EVALUATION			Inpt/Discharge
13	RIGHT UPPER LIMB	III POOR	=	=
14	LEFT UPPER LIMB	III POOR	=	=
15	RIGHT LOWER LIMB	IV NULL	=	=
16	LEFT LOWER LIMB	IV NULL	=	=
17	DEPENDENT	DRINK, FEED	None	=
18	DEPENDENT	DRESS UPPER, LOWER	=	None
19	DEPENDENT	GROOM,WASH, PERIN	=	None
20	DEPENDENT	BLADDER	=	=
21	DEPENDENT	BOWEL	=	=
22	DEPENDENT	T/CHAIR,TOILET	None	=
23	DEPENDENT	T/TUB,SHOWER	=	=
24	DEPENDENT	WALK,STAIRS	=	=
25	DEPENDENT	WHEELCHAIR	None	=
26	SELF CARE SCORE	17/53	25/53	43/53
27	MOBILITY SCORE	0/47	26/47	26/47
28	BARTHEL TOTAL	17/100	51/100	69/100
29	VERBAL COMMUNICATION		I INTACT	=
30	HEARING		I INTACT	=
31	VISION		I INTACT	=
32	INTELL/EMOTIONAL		I INTACT	=
33	FAMILY SUPPORT		I INTACT	IV NULL
34	ABILITY IN HOME		III ASSISTANCE	II LIMITED
35	ARCHITECTURAL BAR		MINOR	=
36	VOCATIONAL ABILITY		IV NULL	III HELPER
37	FINANCIAL ABILITY		II LIMITED	IV NULL
38	HOUSEHOLD MEMBERS		PARENT(S)	ALONE
39	SOURCE OF REFERRAL	OTHER HOSPITAL		REHAB IN-PT
40	COMMUNITY AGENCY			VOC AGENCY
41	SOURCE OF PAYMENT	INSURANCE/PLAN		WELFARE
42	VOCATIONAL STATUS	COMPET/DISABLED	DISABLED	HOMEMAKER
43	HEALTH CARE SOURCES			PMD/REHAB
44	NEW PROBLEMS			(URINARY)
45	NEW SERVICE NEEDS			EDUCATION
46	REFERRED TO		VOC AGENCY	COLLEGE
47	P		2	1
	U		3	3
	L		3	3
	S		1	1
	E		3	3
	S = Total		2 = 6/14	2 = 6/13
48	MEDICAL DIAGNOSES		QUAD/OBESE	= + ILEAL LOOP
49	DISHCARGED TO		HOME	HOME
50	ONSET OF DISABILITY	07/67		

The sheet entitled Long Range Evaluation Summary with three columns of information listed is a simulated output from computer-stored data. Information from three "patient-encounters" over a five-year period (for simplicity intervening encounters are omitted) is presented. Equal sign (=) indicates "no change".

Interpretation of this sheet is as follows:

Lines 1-7 identify the patient at the facility

Lines 8-9 indicate the dates and circumstances of the patient encounter

Line 10 indicates the condition code which equals spinal cord disorder

Line 11 identifies the reporting institution

Lines 13-16 describe the function of the limbs being essentially unchanged neurologically from initial contact to the last visit i.e. the upper limbs lack full power, full range of motion or normal sensibility but have some usefulness and the lower limbs lack usefulness

Lines 17-25 indicate the specific areas of dependency in physical performances of self-care and mobility

Lines 26-28 summarize the self-care and mobility factors via the Barthel Score, that is, self-care improved between the three encounters while mobility did not improve beyond the second encounter

Lines 29-32 describe intactness of communication skills and emotional and intellectual abilities

Line 33 describes loss of family support between the second encounter and the third encounter

Line 34 indicates ability at home improved to a level of limited independence

Line 35 indicates that minor architectural barriers exist at home

Line 36 indicates that vocational (educational) ability improved

Line 37 indicates total dependence on public assistance financially has occurred

Line 38 indicates a move from the parents' home to living alone (adapted housing)

Lines 39-43 are self-explanatory

Line 44 indicates a new problem occurred (in the past)

Lines 45&46 indicate that application and acceptance to college occurred

Line 47 indicates the PULSES global assessments

Lines 48-50 are self-explanatory

References

1. Barro, Arlene R.: Survey and Evaluation of Approaches to Physician Performance Measurement. J. Med. Educ. (A Supplement) 48:1047-1093, 1973.

2. Granger, C.V.: A Monograph: A System for Management of Selected Data in Medical Rehabilitation. Medical Rehabilitation Research and Training Center, Tufts New England Medical Center, Boston. April, 1973.

3. Weed, L.: Medical Records, Medical Education and Patient Care. The Press of Case Western Reserve University, Cleveland, Ohio, 1969.

4. Granger, C. F. and Delabarre, E. M.: Programmed Examination Formats: Use in Rehabilitation Medicine. Arch. Phys. Med. Rehabil. 55:235-239, May, 1974.

5. Mahoney, F. I., and Barthel, D. W.: Functional Evaluation: The Barthel Index. Maryland Medical Journal 14:61-65, 1965.

6. Moscowitz, E., and McCann, C.: Classification of Disability in the Chronically Ill and Aging. J. Chr. Dis., 5:342-346, 1967.

7. Granger, C. V., Greer, D. S., Liset, E., Coulombe, J., O'Brien, E.: Measurement of Outcomes of Care for Stroke Patients. Stroke 6:34-41, 1975.

8. Granger, C. V., Greer, D. S.: Functional Status Measurement and Medical Rehabilitation Outcomes. Arch. Phys. Med. and Rehabil. 57:103-109, 1976.

APPENDIX

CONTENTS

- Worksheet - Admission
- Worksheet - Discharge
- Worksheet - Out-patient/Followup
- Printout - Admission
- Printout - Discharge
- Printout - Out-patient/Followup

T-NEMC REHABILITATION INSTITUTE
LONG-RANGE EVALUATION SUMMARY
Facility:_____
IN-PATIENT ADMISSION

Intake Date :__ __ / __ __ / __ __ (X)G49

Admission Date: __ __ / __ __ / __ __

Name: _____

Hosp. No.:_____ ____

D O B: __ __ / __ __ / __ __

SS#: __ __ __--__ __--__ __ __ __ ( )G60

Male( ) Female( )

Single( )G66 Married( )G67 Widowed( )G68

Divorced( )G69 Separated( )G70

Major Handicapping Condition (X)G71

R T 7 Code: __ __ __

Physician:_____ Code:__ __(X)G72

TYPIST--GO TO REVERSE SIDE AND RETURN

Source of Referral:
Living in LTCF (nursing home/chron. hosp)( )K24
Rehab In-pt.( )K26
In-House Acute Care( )K27
In-House OPD( )K28
Other hospital _____ ( )K29
Other physician _____ ( )K30
Vocational Rehabilitation Agency( )K31
Welfare( )K32
Other _____( )K33

Community Agency Involved:
Visiting Nurse Association( )K34
Vocational Rehabilitation Agency( )K35
Welfare( )K36
Other _____ ( )K37

Source of Payment (choose one):
Self/Family( )K38
Insurance plan (BC/BS, etc)( )K39
Workers' Compensation( )K40
Vocational Rehabilitation Agency( )K41
Welfare/Medicaid( )K42
Medicare( )K43
Assoc/Fund( )K44
Other _____ ( )K45

Vocational Status (choose one):
Homemaker( )K46
Student( )K47
Competitive employment( )K48
Non-competitive employment (sheltered)( )K49
Unemployed/employable cannot find work( )K50
Retired due to age( )K51
Too disabled to work/homemaker/student( )K52

IF A REVISIT:
Less than 2 years( )K93
More than 2 years( )K94

Evaluator:_____ Code:__ __ (X)L42

G52(X)Today's Date: __ __/__ __/__ __ Name:_____

Good	Fair	Poor	Null	ACTIVE MOTION OF LIMBS
G80( )	G81( )	G82( )	G83( )	Right upper limb
G84( )	G85( )	G86( )	G87( )	Left upper limb
G88( )	G89( )	G90( )	G91( )	Right lower limb
G92( )	G93( )	G94( )	G95( )	Left lower limb

G96( ) Remarks on active motion:

INDEPENDENT		DEPENDENT		
Intact	Limited	Helper	Null	SELF CARE
H18( )	H19( )	H20( )	H21( )	Drink from cup
H22( )	H23( )	H24( )	H25( )	Feed from dish
H26( )	H27( )	H28( )	H29( )	Dress upper body
H30( )	H31( )	H32( )	H33( )	Dress lower body
H34( )	H35( )	H36( )	None( )	Don brace or prosthesis
H37( )	H38( )	H39( )	H40( )	Grooming
H41( )	H42( )	H43( )	H44( )	Wash or bathe
H45( )	H46( )	H47( )Acc.	H48( )Inc.	Bladder continence
H49( )	H50( )	H51( )Acc.	H52( )Inc.	Bowel continence
H53( )	H54( )	H55( )	H56( )	Care of perineum/clothing at toilet
H57( )	H58( )	H59( )	H60( )	Other hand skills

H61( ) Remarks on self care:

Intact	Limited	Helper	Null	MOBILITY
H62( )	H63( )	H64( )	H65( )	Transfer, chair
H66( )	H67( )	H68( )	H69( )	Transfer, toilet
H70( )	H71( )	H72( )	H73( )	Transfer, tub or shower
H74( )	H75( )	H76( )	H77( )	Transfer, automobile
H78( )	H79( )	H80( )	H81( )	Walk on level 50 yards or more
H82( )	H83( )	H84( )	H85( )	Up and down stairs for 1 flight or more
H86( )	H87( )	H88( )	H89( )	Walk outdoors 50 yards or more
H90( )	H91( )	H92( )	None( )	Wheelchair/50 yds-Only if <u>not</u> <u>walking</u>

H93( ) Remarks on mobility:

INDEPENDENT		DEPENDENT		
Intact	Limited	Helper	Null	
I68( )	I69( )	I70( )	I71( )	VERBAL COMMUNICATION
I72( )	I73( )	I74( )	I75( )	HEARING COMMUNICATION
I76( )	I77( )	I78( )	I79( )	VISION

I80( ) Remarks on communication and vision:

REPORTED BY:(Sign on reverse side at L42)

T-NEMC REHABILITATION INSTITUTE
LONG-RANGE EVALUATION SUMMARY
Facility: _____
IN-PATIENT DISCHARGE

Discharge Date: __ __/__ __/__ __

Name: _____

No. & Street: _____ (X)G54

Town & State: _____ (X)G55

ZIP Code: __ __ __ __ __ (X)G56

Telephone No. __ __ __--__ __ __ __ (X)G57

Hosp. No. _____ ____

Active Motion of Limbs

Good	Fair	Poor	Null	
( )G80	( )G81	( )G82	( )G83	R Upper
( )G84	( )G85	( )G86	( )G87	L Upper
( )G88	( )G89	( )G90	( )G91	R Lower
( )G92	( )G93	( )G94	( )G95	L Lower

INDEPENDENT DEPENDENT SELF-CARE & MOBILITY

Intact	Limited	Helper	Null	
( )H18	( )H19	( )H20	( )H21	Drink from cup
( )H22	( )H23	( )H24	( )H25	Feed from dish
( )H26	( )H27	( )H28	( )H29	Dress upper body
( )H30	( )H31	( )H32	( )H33	Dress lower body
( )H34	( )H35	( )H36	( )None	Brace/Prosthesis
( )H37	( )H38	( )H39	( )H40	Groom
( )H41	( )H42	( )H43	( )H44	Wash/bathe
( )H45	( )H46	( )H47	( )H48	Bladder continence
( )H49	( )H50	( )H51	( )H52	Bowel continence
( )H53	( )H54	( )H55	( )H56	Perineal care
( )H57	( )H58	( )H59	( )H60	Hand skills

( )H61 Remarks:

( )H62	( )H63	( )H64	( )H65	T/Chair
( )H66	( )H67	( )H68	( )H69	T/Toilet
( )H70	( )H71	( )H72	( )H73	T/Tub or shower
( )H74	( )H75	( )H76	( )H77	T/Automobile
( )H78	( )H79	( )H80	( )H81	Walk 50 yards
( )H82	( )H83	( )H84	( )H85	Stairs 1 flight
( )H86	( )H87	( )H88	( )H89	Outdoors
( )H90	( )H91	( )H92	( )None	Wheelchair

( )H93 Remarks:

Communication

Intact	Limited	Helper	Null	
( )I68	( )I69	( )I70	( )I71	Verbal
( )I72	( )I73	( )I74	( )I75	Hearing
( )I76	( )I77	( )I78	( )I79	Vision

Intellectual and Emotional Adaptability

Intact	Limited	Helper	Null
( )J39	( )J40	( )J41	( )J42

Support from Family Unit

Intact	Limited	Helper	Null
( )J43	( )J44	( )J45	( )J46

Ability in Home

Intact	Limited	Helper	Null
( )J47	( )J48	( )J49	( )J50

Architectural Barriers

Absent( )J51 Minor( )J52 Major( )J53

Describe if present: ( )J54

_____

Household Constellation:

Alone( )K17
Spouse( )K18
Children( )K19
Spouse and children( )K20
Parent(s)( )K21
Other relatives( )K22
Friends( )K23
Institution( )K24
Other _____( )K25

Vocational Status (choose one):

Homemaker( )K46
Student( )K47
Competitive employment( )K48
Non-competitive employment (sheltered)( )K49
Unemployed/employable cannot find work( )K50
Retired due to age( )K51
Too disabled to work/homemaker/student( )K52

Vocational Ability

Intact	Limited	Helper	Null
( )K59	( )K60	( )K61	( )K62

Remarks: _____ ( )K65

_____

_____

_____

_____

_____

_____

_____

New Action Taken (Referrals made):

VNA( )K77
MRC or Other State Voc. Agency( )K78
Welfare/Medicaid( )K79
Private physician( )K80
Other hospital _____( )K81
Other _____( )K82

Financial Ability

Intact	Limited	Helper	Null
( )K83	( )K84	( )K85	( )K86

List proven or suspected complications (other than the major handicapping condition) that significantly interfered with the rehabilitation effort or delayed discharge. Prefix number (1) if it was present before admission or number (2) if it occurred after admission:

#1 __ __ __ ( )K87

#2 __ __ __ ( )K88

#3 __ __ __ ( )K89

#4 __ __ __ ( )K90

Physician: _____ Code: __ __(X)K92

If the patient was transferred to in-house acute care and returned prior to discharge: Record number of days: __ __ __ ( )L01

Functional Profile:

	One	Two	Three	Four
P	( )L03	( )L04	( )L05	( )L06
U	( )L07	( )L08	( )L09	( )L10
L	( )L11	( )L12	( )L13	( )L14
S	( )L15	( )L16	( )L17	( )L18
E	( )L19	( )L20	( )L21	( )L22
S	( )L23	( )L24	( )L25	( )L26

Reason for this admission for this major handicapping condition:

First comprehensive effort( )L28
A subsequent or continuing effort( )L29
For limited evaluation/problem/other( )L30

Major Handicapping Condition (X)L33

R T 7 Code: __ __ __

Diagnostic Code / PULSES P (X)L34

#1 __ __ __ __ / __ ( )L35

#2 __ __ __ __ / __ ( )L36

#3 __ __ __ __ / __ ( )L37

#4 __ __ __ __ / __ ( )L38

#5 __ __ __ __ / __ ( )L39

#6 __ __ __ __ / __ ( )L40

#7 __ __ __ __ / __ ( )L41

Discharged to:

Home( )L43
Acute hospital _____( )L44
Chronic hospital _____( )L45
Nursing home( )L46
Other _____( )L47

Onset of disability: __ __ / __ __ / __ __(X)L48

Name:_____ Number:_____ Date:_____

Mode of Evaluation (Choose only one)

G73( )OPD Visit G74( )Rehab home visit G75( )Tele. w/pt G76( )VNA home visit
G77( )Tele. with: _____

G54( )Address--No. and Street: _____

G55( )Address--Town and State: _____ G56( )ZIP Code: _ _ _ _ _

G57( )Telephone Number: _ _ _--_ _ _ _ G59( )Date of Birth: _ _ / _ _ / _ _

G64( )Male G65( )Female

G66( )Single G67( )Married G68( )Widowed G69( )Divorced G70( )Separated

L33( )Major Handicapping RT-7 Code: _ _ _ L48( )Onset of disability: _ _ / _ _ / _ _

LIMBS	Good	Fair	Poor	Null	COMMUNICATION	Intact	Limited	Helper	Null
R Upper	( )G80	( )G81	( )G82	( )G83	Verbal	( )I68	( )I69	( )I70	( )I71
L Upper	( )G84	( )G85	( )G86	( )G87	Hearing	( )I72	( )I73	( )I74	( )I75
R Lower	( )G88	( )G89	( )G90	( )G91	Vision	( )I76	( )I77	( )I78	( )I79
L Lower	( )G92	( )G93	( )G94	( )G95					

Note degree of independence or need for assistance for each of the activities listed:

Intact	Limited	Helper	Null	SELF CARE
H18( )	H19( )	H20( )	H21( )	Drink from cup
H22( )	H23( )	H24( )	H25( )	Feed from dish
H26( )	H27( )	H28( )	H29( )	Dress upper body
H30( )	H31( )	H32( )	H33( )	Dress lower body
H34( )	H35( )	H36( )	None( )	Don brace or prosthesis
H37( )	H38( )	H39( )	H40( )	Grooming
H41( )	H42( )	H43( )	H44( )	Wash or bathe
H53( )	H54( )	H55( )	H56( )	Care of perineum/clothing at toilet
H57( )	H58( )	H59( )	H60( )	Other hand skills

Rate according to one of the following descriptions: (U of PULSES)

L07( )Independent in self care without impairment of upper limbs.
L08( )Independent in self care with some impairment of upper limbs.
L09( )Dependent upon assistance or supervision in self care with or without impairment of upper limbs.
L10( )Dependent totally in self care with marked impairment of upper limbs.

Note degree of independence or need for assistance for each of the activities listed:

Intact	Limited	Helper	Null	MOBILITY
H62( )	H63( )	H64( )	H65( )	Transfer, chair
H66( )	H67( )	H68( )	H69( )	Transfer, toilet
H70( )	H71( )	H72( )	H73( )	Transfer, tub or shower
H74( )	H75( )	H76( )	H77( )	Transfer, automobile
H78( )	H79( )	H80( )	H81( )	Walk on level 50 yards or more
H82( )	H83( )	H84( )	H85( )	Up and down stairs for 1 flight or more
H86( )	H87( )	H88( )	H89( )	Walk outdoors 50 yards or more
H90( )	H91( )	H92( )	None( )	Wheelchair/50 yds-Only if not walking

Rate according to one of the following descriptions: (L of PULSES)

L11( )Independent in mobility without impairment of lower limbs.
L12( )Independent in mobility with some impairment of lower limbs; such as needing ambulatory aids, a brace (orthosis) or prosthesis, or else fully independent in a wheelchair.
L13( )Dependent upon assistance or supervision in mobility with or without impairment of lower limbs, or else partly independent in a wheelchair or else there are significant architectural or environmental barriers.
L14( )Dependent totally in mobility with marked impairment of lower limbs.

Rate according to one of the following descriptions: (S of PULSES)

L15( )Independent in communication (speech and hearing) and vision without impairment.
L16( )Independent in communication (speech and hearing) and vision with some impairment such as mild dysarthria, mild aphasia, or need for eyeglasses or hearing aid, or needing regular medication for eyes.
L17( )Dependent upon assistance, an interpreter or supervision in communication (speech or hearing) or vision.
L18( )Dependent totally in communication (speech or hearing) or vision.

Note degree of independence or need for assistance for each of the activities listed:

Intact	Limited	Helper	Null	SPHINCTER CONTINENCE
H45( )	H46( )	H47( )Acc.	H48( )Inc.	Bladder continence
H49( )	H50( )	H51( )Acc.	H52( )Inc.	Bowel continence

Rate according to one of the following descriptions: (E of PULSES)

L19( )Complete voluntary control of bladder and bowel sphincters.
L20( )Control of sphincters allows normal social activities despite urgency or need for catheter, appliance, suppositories, etc. Able to care for needs without assistance.
L21( )Dependent upon assistance in sphincter management or else has accidents occasionally.
L22( )Frequent wetting or soiling from incontinence or bladder or bowel sphincters.

Rate according to one of the following descriptions: Consider intellectual and emotional adaptability, support from family unit, and financial ability: (S of PULSES)

L23( )Able to fulfill usual role(s) and perform customary tasks.
L24( )Must make some modification in usual role(s) or performance of customary tasks.
L25( )Dependent upon assistance, supervision, encouragement or assistance from a public private agency due to any of the above considerations.
L26( )Dependent upon long-term institutional care (chronic hospital, nursing home, etc.) excluding time-limited hospitalization for specific evaluation, treatment or active rehabilitation.

List diagnostic terms for medical conditions. Follow with four-digit ICDA-8 code number. Add a fifth digit (1-4) after the / following each ICDA-8 number to indicate the degree of physician or nurse (RN or LPN) care required for that condition (P of PULSES).

L03( ) 1. Medical problem is sufficiently stable that physician or nurse monitoring is not required more often than 3-month intervals.
L04( ) 2. Medical problem requires physician or nurse monitoring more often than 3-month intervals but not each week.
L05( ) 3. Medical problem is sufficiently unstable as to require regular physician and/or nurse attention at least weekly.
L06( ) 4. Medical problem requires intensive physician and/or nurse attention at least daily (excluding personal care assistance only).

****

ONLY ADD DIAGNOSES NOT PREVIOUSLY RECORDED

	Diagnosis	ICDA-8 Code	P Score
L34(X)			
L35( )	_____	_ _ _ _ /	_
L36( )	_____	_ _ _ _ /	_
L37( )	_____	_ _ _ _ /	_
L38( )	_____	_ _ _ _ /	_
L39( )	_____	_ _ _ _ /	_
L40( )	_____	_ _ _ _ /	_
L41( )	_____	_ _ _ _ /	_

List proven or suspected complications (other than the major handicapping condition) that significantly interfered with the rehabilitation effort or delayed discharge. Prefix number (1) if it was present before admission or number (2) if it occurred after admission.

( )K87 #1 _ _ _ ( )K88 #2 _ _ _ ( )K89 #3 _ _ _ ( )K90 #4 _ _ _

****

Architectural Barriers

J51( ) Irrelevant--Has access into and out of home, to all levels if multi-story, and to all rooms without safety hazard or requiring assistance or else not relevant to the problem.

J52( ) Minor--Has access into and out of home and to all essential levels if multi-story and to all rooms essential to well-being and participation in family activities. Some non-essential rooms may not be accessible or else inconvenience may be imposed by thresholds, narrow passages or awkward arrangement of furniture. However, able to manage without assistance.

J53( ) Major--Not able to manage without assistance in getting into or out of home or in gaining access to rooms essential to well-being and/or participation in family activities.

Rate according to one of the following descriptions: ENVIRONMENT (E of ESCROW)

L76( )Lives in privately supported living quarters that are adequate for size of family unit, without major architectural barriers, accessible to convenient forms of transportation and other necessary facilities, in a safe neighborhood and free of significant or major problems.

L77( )Lives in privately supported living quarters that are either inadequate for size of family unit, with minor architectural barriers, inaccessible to convenient forms of transportation or necessary facilities, in a marginal neighborhood or else has other minor problems.

L78( )Lives in privately supported housing with major problems.

L79( )Lives in publicly supported housing.

Rate according to one of the following descriptions: SOCIAL SUPPORTS (S of ESCROW)

L80( )Maintains a balance of social contacts by way of visiting, telephone calls, hobbies and interests, etc. Able to solve problems without undue reliance on others outside the family unit. Has one or more close or dependable friendships.

L81( )Social contacts are restrictive. May frequently rely on others outside the family unit to solve problems. Does not readily identify a close or dependable friendship.

L82( )Someone in the family unit occasionally requires assistance from a person or agency from the outside such as the visiting nurse association, home care, counseling services, etc.

L83( )Someone in the family unit is consistently dependent upon assistance from a community agency at least weekly.

Household Constellation

K17( ) Alone
K18( ) Spouse
K19( ) Children
K20( ) Spouse and children
K21( ) Parent(s)
K22( ) Other relatives
K23( ) Friend(s)
K24( ) Institution
K25( ) Other: _____

Community Agency Involved

K34( ) VNA
K35( ) State Vocational Agency
K36( ) Welfare
K37( ) Other: _____

Rate according to one of the following descriptions: CLUSTER OF FAMILY MEMBERS (C of ESCROW)

L84( )The family unit consists of a least one member beside the patient related by marriage, kinship, or else a close personal companion; as a unit the family is sufficiently competent physically and mentally to provide adequate support to the patient at home at this time and under foreseeable circumstances.

L85( )The family unit is as above but under particular conditions of stress they may not be able to support the patient either physically or mentally or else particular circumstances such as a job require a crucial family member to be away from the home part of the day.

L86( )The impact of the disability has been such to change either the work effort, pattern of socialization, interests and hobbies or other important activities of some family member.

L87( )The impact of the disability has been such as to produce severe strain or produce disruptions of relationships between family members or else the patient lives alone.

Source of Referral: (choose one)

K26( ) Rehab In-patient
K27( ) In-House Acute Care
K28( ) In-House OPD
K29( ) Other hospital _____
K30( ) Other physician _____
K31( ) Vocational Rehabilitation Agency
K32( ) Welfare/Medicaid
K33( ) Other: _____

Source of Payment

K38( ) Self/Family
K39( ) Insurance Plan
K40( ) Workers' Compensation
K41( ) Vocational Rehabilitation Agency
K42( ) Welfare/Medicaid
K43( ) Medicare
K44( ) Association/Fund
K45( ) Other: _____

Sources of Health Care:

K54( ) Private physician
K55( ) Rehab OPD
K56( ) In-House OPD
K57( ) Other _____
K58( ) Other hospital _____

New Action Taken (Referrals made

K77( ) Visiting Nurse Association
K78( ) Vocational Rehabilitation Agency
K79( ) Welfare/Medicaid
K80( ) Private Physician
K81( ) Other hospital _____
K82( ) Other _____

Rate according to one of the following descriptions: RESOURCES (R of ESCROW)

L88( )The family is able to absorb the costs of the disability without increased indebtedness.

L89( )The family is required to incur debts to handle costs of the disability.

L90( )The family requires some form of public assistance to cover medically related costs (Medicaid).

L91( )The family requires public assistance to cover medical and subsistence costs (Welfare or SSI--Supplemental Security Income).

****

THIS SECTION IS OPTIONAL

Problem-Solving

L50( ) Intact--Able to comprehend meaning, retain instructions and follow through a sequence of steps particularly in a novel situation. Makes use of previously learned information. Able to self correct if errors are made. Sustains attention until task is completed.

L51( ) Limited--Minimal limitations in problem-solving; modification of environment may be required.

L52( ) Helper--Limitations in problem-solving require a structured environment and/or another person is involved for supervision, cueing, coaxing, or assistance.

L53( ) Null--Unable to function appropriately due to limitation despite assistance.

Emotional Stability / Regard for Others

L54( ) Intact--Able to remain coooperative without being demanding or overly dependent upon others. Evidence of satisfying interactions with staff, other patients and family members.

L55( ) Limited--Minimal limitations in emotional stability; modification of environment may be required.

L56( ) Helper--Anti-social behavior requires a structured envioronment; and/or another person is involved for assistance, supervision, cueing, or coaxing.

L57( ) Null--Anti-social behavior severely limits function despite assistance.

Perceptual-Motor Ability / Gnosis-Praxis

L58( ) Intact--Able to discriminate between differences in the environment by hearing, sight, touch and visuo-spatial orientation. Able to reproduce a requested motion or activity.

L59( ) Limited--Limitation in perceptual-motor minimal; modification of environment may be required.

L60( ) Helper--Another person is involved for assistance, supervision, cueing, coaxing; and/or a structured environment is required for adequate function.

L61( ) Null--Unable to function due to limitations despite assistance.

Judgment-Reliability / Insight (Realism)

L62( ) Intact--Aware of and understands limitations or disability problems. Able to plan, work out, or incorporate compensations or substitutions, or else asks for appropriate assistance while working towards solutions and while using sound judgment.

L63( ) Limited--Minimal limitations in insight; may require environmental modification.

L64( ) Helper--Poor insight, judgment or reliability require a structured setting and/or another person involved for assistance, supervision, cueing, or coaxing.

L65( ) Null--Insight, judgment, or reliability are not appreciably helped by assistance.

Self-Esteem / Regard for Self (Hopefulness)

L66( ) Intact--Able to feel hopeful about situation with sense of purpose and worthwhileness preserved. No evidence of inappropriate discouragement or anxiety, hypochondriasis, misuse of drugs or alcohol. Able to go through grief reation to real loss without undue denial, indifference or hysteria.

L67( ) Limited--Minimal limitations in self-esteem; a modified environment may be required.

L68( ) Helper--Manifest depression requires another person to be involved for assistance, supervision or cueing. A structured environment is required.

L69( ) Null--Manifest depression severely limits function despite assistance.

****

Rate according to one of the following descriptions: OUTLOOK (O of ESCROW)

L92( )The individual functions independently without impairment in the following areas: problem-solving, regard for other, perceptual-motor ability, judgment-reliability, and self-esteem. The individual feels able to make decisions easily.
L93( )The individual functions independently with mild impairment in some area(s) mentioned above or else has moderate difficulty making decisions.
L94( )The individual is observed to function appreciably better with assistance, supervision, cueing coaxing or a structured environment due to one or more of the problems mentioned above or else has great difficulty making decisions.
L95( )The individual is not particularly benefitted by assistance with problems mentioned above or else actually makes very few, if any, decisions.

Vocational Status

K46( ) Homemaker
K47( ) Student
K48( ) Competitive employment
K49( ) Non-competitive employment (sheltered workshop, etc.)
K50( ) Unemployed, but employable and unable to find work
K51( ) Retired due to age
K52( ) Too disabled to work, or be a homemaker, or be a student, or else retired for disability

Educational or Vocational Ability

K59( ) Intact--Able to be vocationally independent or attend school without limitation at work or school or in transportation to and from.
K60( ) Limited--Able to be vocationally independent or attend school but with some limitation either at work or school or in transportation to and from.
K61( ) Helper--Is receiving assistance by way of counseling, training, or fiscal sponsorship for work or education or else assistance is received in transportation to and from.
K62( ) Null--No ability at present for work or education outside of the home; or else is retired.

Rate according to one of the following descriptions: WORK/SCHOOL STATUS (W of ESCROW)

L96( )Educational and vocational levels are compatible. There are no work or educational restrictions. The individual is working full-time in the free job market or as a full-time student. Time lost from work does not exceed one day per month on the average. If retired, the indivual fulfills usual and customary tasks and roles in the household and/or the community.
L97( )The individual desires more education or training or work but it may not be readily available. If working or attending school there may be some modification such as part-time, light work, etc. Time lost from work/school averages no more than 2 to 5 days per month. If retired, the individual fulfills the usual and customary tasks and roles in the household and/or the community in a limited way.
L98( )The individual works or attends school in a special facility adapted for the handicapped or else loses more than an average of one week per month at a full-time or part-time job.
L99( )The individual is too disabled for employment or schooling or, if retired, is not able to fulfill usual and customary roles and tasks in the household or the community.

L75( ) REMARKS:

G10( ) KEY FOR PURPOSE OF ASSESSMENT: _ _

Discharge only if KEY equals 13, 14 or 15

DISCHARGED TO:

L43( )Home
L44( )Acute Hospital:_____
L45( )Chronic Hospital:_____
L46( )Nursing Home
L47( )Other:_____

L42(X) EVALUATOR: _____ Code:_ _

(Simulated Patient) Watt, John 9999999

T-NEMC REHABILITATION INSTITUTE LONG-RANGE EVALUATION SUMMARY

Facility: NEMCH

IN-PATIENT ADMISSION

Intake date: April 6, 1970

Admission date: April 6, 1970

Name: Watt, John

No. & Street: 45 Brewster St.
Town & State: Podunck, Mass.
Zip Code: 02055

Telephone No.: 888-4321
Hosp. No.: 9999999
Date of Birth: June 19, 1950
SS #: 050-66-9349
Male
Married

Major handicapping condition RT7 Code: 011 Focal Cerebral Disorder
Physician: Dr. Carrington Code: 01

ACTIVE MOTION OF LIMBS

I		Right upper limb motion is intact
	III	Left upper limb motion is poor or uses a prosthesis
I		Right lower limb motion is intact
	III	Left lower limb motion is poor or uses a prosthesis

INDEPENDENT	DEPENDENT		SELF CARE & MOBILITY (Barthel index score)
II		1	Drinking is limited
II		4	Feeding is limited
	III	3	Dressing upper body needs assistance
	III	2	Dressing lower body needs assistance
	III		Grooming needs assistance
	III		Wash/bathing needs assistance
	III	5	Bladder continence needs assistance
II		10	Bowel continence is limited
	III	2	Perineal care needs assistance
	III		Hand skills need assistance

Remarks on self care: 27/53 Barthel sub-score

	III	7	Transfer to chair needs assistance
	III	3	Transfer to toilet needs assistance
	IV		Transfer to tub/shower is not done
	IV		Transfer to automobile is not done
	IV		Walks less than 50 yards or not at all
	IV		Up/down stairs 1 flight is not done
	IV		Walking outdoors is not done

Remarks on mobility:10/47 Barthel sub-score
Total Barthel score: 37/100

III	VERBAL COMMUNICATION needs assistance
II	HEARING COMMUNICATION is limited
II	VISION slightly to moderately impaired

Source of referral: Community agency not MRC/Welfare

Community agency involved: VNA

Source of payment: Self/family

Vocational status: too disabled for work/homemaker/student

Evaluator: R EATON Code: 01

WATT, JOHN
9999999

T-NEMC REHABILITATION INSTITUTE
LONG-RANGE EVALUATION SUMMARY

Facility: NEMCH

IN-PATIENT DISCHARGE

Discharge date: July 15, 1970

Name: WATT, JOHN

No. & Street: 45 Brewster St.
Town & State: Podunck, Mass.
Zip Code: 02055

Telephone No.: 888-4321
Hosp. No.: 9999999

ACTIVE MOTION OF LIMBS

I	Right upper limb motion is intact
II	Left upper limb motion is fair
I	Right lower limb motion is intact
II	Left lower limb motion is fair

INDEPENDENT	DEPENDENT		SELF CARE & MOBILITY (Barthel index score)
I		4	Drinking is intact
I		6	Feeding is intact
	III	3	Dressing upper body needs assistance
	III	2	Dressing lower body needs assistance
	III	-2	Don brace or prosthesis needs assistance
II		5	Grooming is limited
II		4	Wash/bathing is limited
I		10	Bladder incontinence is intact
II		10	Bowel continence is limited
I		4	Perineal care is intact
II			Hand skills are limited

Remarks on self care:46/53 Barthel sub-score

II	15	Transfer to chair is limited
II	6	Transfer to toilet is limited
II	1	Transfer to tub/shower is limited
II		Transfer to automobile is limited
II	15	Walking 50 yards or more is limited
II	10	Up/down stairs 1 flight is limited
II		Walking outdoors is limited

Remarks on mobility:47/47 Barthel sub-score
Total barthel score:93/100

II	VERBAL COMMUNICATION is limited
I	HEARING COMMUNICATION is intact
II	VISION slightly to moderately impaired

III INTELLECTUAL/EMOTIONAL ADAPTABILITY needs assistance

II SUPPORT FROM FAMILY UNIT is limited

III ABILITY IN HOME needs assistance

Architectural barriers: are absent

Household constellation: Spouse

Household constellation: Other relative

Vocational status: too disabled for work/homemaker/student

IV VOCATIONAL ABILITY is null

Remarks on new medical/disability problems: Well motivated but becomes angry and frustrated when confronted with his problem-solving limitations. Can be left alone for about one or two hours watching TV. To live in apartment with wife in home of relative. Will continue with outpatient visits to OT and speech three times per week. Wife is taking driving lessons.

III FINANCIAL ABILITY needs public assistance

Transferred to in-house acute care and returned in 021 days

FUNCTIONAL PROFILE:
P 2
U 3
L 2
S 2
E 2
S 3

PULSES TOTAL = 6/14
Reason for admission: First comprehensive effort

Major handicapping condition RT7 Code: 011

Medical Diagnosis (International Code)
8509 - Post-traumatic Encephalopathy
8520 - Subdural Hematoma
3441 - Hemiparesis; Hemiplegia
3580 - Reflex Sympathetic Dystrophy

Complication: 225 - Post Admission - Surgical procedure

Complication: 226 - Post Admission - Contractures

Discharged to HOME IN APAT. OF RELATIVES

Onset of disability -- 01/01/70

Physician: DR. CARRINGTON Code: 01

WATT, JOHN
9999999

T-NEMC REHABILITATION INSTITUTE
LONG-RANGE EVALUATION SUMMARY

Facility: NEMCH

OUT-PATIENT/FOLLOWUP

Intake date: April 6, 1970

Today's date May 3, 1971

Name: WATT, JOHN
No. & Street: 45 BREWSTER ST.
Town & State: PODUNCK, MASS.
Zip Code: 02055

Telephone No.: 888-4321
Hosp. No.: 9999999
Date of birth: JUNE 19, 1950
SS #: 050-66-9349
Male
Married
Mode of evaluation: OPD visit

ACTIVE MOTION OF LIMBS

I	Right upper limb motion is intact
II	Left upper limb motion is fair
I	Right lower limb motion is intact
II	Left lower limb motion is fair

INDEPENDENT	DEPENDENT		SELF CARE & MOBILITY (Barthel index score)
I		4	Drinking is intact
I		6	Feeding is intact
	III	3	Dressing upper body needs assistance
II		5	Dressing lower body is limited
I		5	Grooming is intact
II		4	Wash/bathing is limited
I		10	Bladder continence is intact
I		10	Bowel continence is intact
I		4	Perineal care is intact
II			Hand skills are limited

Remarks on self care: 51/53 Barthel sub-score

I	15	Transfer to chair is intact
I	6	Transfer to toilet is intact
II	1	Transfer to tub/shower is limited
I		Transfer to automobile is intact
II	15	Walking 50 yards or more is limited
II	10	Up/down stairs 1 flight is limited
II		Walking outdoors is limited

Remarks on mobility:47/47 Barthel sub-score

Total Barthel score: 98/100

II	VERBAL COMMUNICATION is limited
I	HEARING COMMUNICATION is intact
II	VISION slightly to moderately impaired
II	INTELLECTUAL/EMOTIONAL ADAPTABILITY is limited
I	SUPPORT FROM FAMILY UNIT is intact
II	ABILITY IN HOME is limited

Architectural barriers: are absent

III	VOCATIONAL ABILITY needs assistance
III	FINANCIAL ABILITY needs public assistance

Household constellation: Spouse

Household constellation: Other relative

Source of referral: Rehab In-patient

Community agency involved: MRC or Other State Voc. Agency

Community agency involved: Welfare

Source of payment: Welfare/Medicaid

Vocational status: too disabled for work/homemaker/student

Source of health care: private MD
Source of health care: Rehab OPD
Remarks on new medical/disability problems: Able to be left home alone while wife is working and in-laws are out. Has contact with MRC and will begin prevocational testing. Frustration level has improved remarkably.

New service needs: educational

Functional PROFILE:

P	1
U	3
L	2
S	2
E	1
S	3

PULSES TOTAL = 6/12

Major Handicapping Condition RT7 Code: 011 Focal Cerebral Condition

WATT, JOHN
9999999

Medical Diagnosis (International Code)

8509 - Post-traumatic Encephalopathy
3441 - Hemiparesis; Hemiplegia

Evaluator: S. GOBEL Code: 01

Onset of disability -- 01/01/70

FUNCTIONAL PROFILE:
E 2
S 3
C 2
R 3
O 3
W 4

ESCROW TOTAL = 6/17

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Financial Management

I. Person responsible: Lex Frieden

II. Staff associates:

Jim Veerkamp - quadriplegic, Certified Public Accountant, Attorney at Law
Cherry Albertson - Department of Public Welfare, Caseworker

III. Average number of meetings per cycle and average time of modules:

5 meetings - 2 hours each

IV. Goal of the module:

This module is designed to emphasize the importance of gaining financial independence by using resources wisely and taking advantage of birthright opportunities, earnings, and financial aid programs without abusing the privilege or losing eligibility.

V. A brief description of methods utilized to reach this goal:

Lectures, field trips, individual assignments, group discussions, expert consultation, and written handouts are used as methods in this module.

VI. A typical cycle schedule:

Meeting 1 Content: The wide range of possible financial and programs available are listed and discussed with special consideration given to eligibility criteria and application procedures. The concepts of income maintenance, financial planning, need analysis, welfare, budgeting, and saving are discussed generally.

Meeting 2 Content: Various Social Security program (SSDI, SSI, Medicare, and self support plans) and procedures are discussed in detail with a representative of that agency.

Meeting 3 Content: Various DPW programs (Medicaid, homemaker-chore service, AFDC, food stamps, visiting nurses, social service, transportation, etc.)and procedures are discussed in detail with a representative of that agency.

Meeting 4 Content: Various TRC programs (vocational training, attendant care, transportation, medical care, extended rehabilitation services, self support plans, etc.) and procedures are discussed in detail with a representative of that agency.

Meeting 5 Content: Field trip to a local bank to meet with a loan officer and account executive. Also, Housing Authority Rent Subsidies, and Small Business Administration loans are discussed.

VII. Special areas that have been addressed because of particular needs of some groups:

JS/asm
3/7/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Mobility

I. Person responsible: Lex Frieden and Jane Sperry

II. Staff Associates:

David Kope - engineer and inventor of value control steering for quadriplegics
Bob Henry - driver of specially adapted vehicle , consultant to Texas A&M mobility aids research project, and former supervisor of TIRR Driver Training Program

III. Average number of meetings per cycle and average time of modules:

5 meetings - averaging 3 hours each

IV. Goal of the module:

to provide information needed by the individual to plan for present and future transportation needs in a realistic way.

V. A brief description of methods utilized to reach this goal:

field trips/tours
interviews/group discussions

VI. A typical cycle schedule:

Meeting 1 Content: Meet at annex for group discussion about: (a) personal experiences (b) range of options for transportation (c) mobility with respect to changing needs (living arrangement, job, school) (d) mobility related to socialization and risk taking. Then roll to Westheimer in chairs and visit a restaurant or club.

Meeting 2 Content: take field trip to wheelchair repair shop to inquire about proper self care and maintenance of personal wheelchairs. Find out about ordering parts, service charges, and new products.)

Note: At least one field trip is made using transportation service provided by a handicapped driver.

Meeting 3 Content:	take field trip to Greyhound Bus Depot and meet with manager to ask about special services, accommodations and necessary arrangements for making a bus trip, or take field trip to Amtrak Train Depot and meet with Station Master to ask about special services, accommodations and necessary arrangements for making a train trip.
Meeting 4 Content:	meet at the annex - hear presentation and watch films of David Kope about specially adapted driving controls (valve steering foot steering) - discuss han d controls, lifts, raised roofs, power seats, etc. - discuss motor vehicle and driver licensing requirements and procedures.
Meeting 5 Content:	take field trip to Intercontinental Airport to meet with airline representatives and tour the passenger terminal; tour includes boarding a jetliner, visiting the baggage claim and ticketing area, visiting with customs agents, and riding the underground shuttle train; questions about special services, accommodations and necessary arrangements are answered by airline personnel.
Meeting 6 Content:	(optional) take field trip to travel agency and interview agent about planning a trip with considerations for special needs. (ie. accessible transportation, lodging, recreational areas, etc.)

VII. Special areas that have been addressed because of particular needs of some groups:

N/A

JS/asm
3/7/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Functional Skills

I. Person responsible: Jane Sperry

II. Staff associates:

Laurie Gerken - paraplegic
Marilyn Kraft - OTR
Carwyn Abraham - quadriplegic

III. Goal of the module:

The functional skills module seeks to assist participants in solving problems in their physical environment by exposing them to new ideas, techniques, and equipment.

IV. Average number of meetings per cycle and average time of module:

4-5 meetings - averaging 1½ hour each

V. Brief description of methods utilized to reach this goal:

Using group discussions, guest speakers, field trips, and individual sessions, the participants are encouraged to assess the ways they function and are shown possible alternatives which they may evaluate.

VI. A typical cycle schedule:

Meeting 1 Content: group discussion on the philosophy of functional skills, discussion of wheelchairs, accessories, and modifications using participant's wheelchairs and wheelchair catalogues.

Meeting 2 Content: overview of equipment catalogues, Marilyn Kraft, OTR, demonstrating adaptive devices and ADL equipment, discussion of House & Apartment Guidelines

Meeting 3 Content: field trip to an apartment occupied by a disabled person to see changes that person has made to allow her to function better

Meeting 4 Content: a person with quadriplegia will discuss and demonstrate how he functions in his environment

Meeting 5 Content: visit to a vacant apartment to evaluate layout, design, and possible changes to improve accessibility; also a meeting with the apartment manager to discuss whether suggested changes are possible in that apartment complex.

VII. Special areas that have been addressed because of particular needs of some groups:

swimming discussion, preparation and experience; car transfers, wheelchair into car, curb jumping, floor to wheelchair transfers, bed transfers

JS/asm
3/7/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Attendant Management

I. Person responsible: Jean Cole

II. Staff associates:

Ed Rhame - resident management, Council at Cooperative Living ; has lived in 3 different systems (nursing home, Cooperative Living, Independence Hall)

Barbara Brownlow - former attendant at Cooperative Living

III. Average number of meetings per cycle and average time of modules:

4 meetings - averaging 1½ hours each

IV. Goal of the module:

to examine the pros and cons of alternative ways to arrange attendant assistance
to increase awareness of social interaction patterns between disabled persons & attendants

V. A brief description of methods utilized to reach this goal:

group discussions with a staff associate & a former attendant
role playing an employment interview

VI. A typical cycle schedule:

Meeting 1 Content:	introduction & exploration of alternative models (1:1, shared, live-in)
Meeting 2 Content:	social interaction 1: the disabled person's viewpoint (Ed Rhame)
Meeting 3 Content:	social interaction 2: the attendant's viewpoint (Barbara)
Meeting 4 Content:	practical considerations: hiring, payment, training (role play employment interview with prospective attendant.

VII, Special areas that have been addressed because of particular needs of some groups:

JS/asm
3/7/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Medical Needs

I. Person responsible: Jean Cole, Joyce Nelson

II. Staff associates:

Dr. Spencer -Rehab. doctor
Dr. Carter -Rehab. doctor
Dr. Halstead - Rehab. doctor
Dr. Fry - Rehab. Urologist
Dr. Vineberg - Psychologist

III. Average number of meetings per cycle and average time of modules:

6 meetings - averaging 1½ hours each

IV. Goal of the module:

to educate disabled persons on their own physical care, to stimulate feelings of responsibility toward their body, to help individuals plan how they will get needed medical care in the community.

V. A brief description of methods utilized to reach this goal:

lectures and discussions with doctors, slides when appropriate, and handouts.

VI. A typical cycle schedule:

Meeting 1 Content:	introduction & decision by group of program content
Meeting 2 Content:	circulation and respiratory
Meeting 3 Content:	nerves, diet and bowel
Meeting 4 Content:	skin - pressure sores, temp. regulation, burns
Meeting 5 Content:	urinary tract - infections, stones, medications
Meeting 6 Content:	emergency care - care in the community, patients rights, physicians rights.

VII. Special areas that have been addressed because of particular needs of some groups:

excessive sweating
alcohols effect on prescriptions
swelling of feet
depression

JC/asm
3/7/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Vocational

I. Person responsible: Wayne Alfred, M.A.
Coordinator of Rehabilitation Services
Department of Vocational Services
TIRR

II. Staff associates:

Herman Litt, M.A. - Vocational Counselor, TIRR
Larry Patrick, B.A. - Workshop Supervisor, TIRR
Ray Lenart, M.A. - Counselor, University of Houston
Gary Bethke, M.A. - Chief Evaluator, TIRR
Margaret Watson - Coordinator, Micrographics Training TIRR
Bob Kafka, B.A. - Coordinator for Handicapped Students University of Houston

III. Average number of meetings per cycle and average time of module:

7-8 meetings - 4-6 hours per sessions during 1st week
2 hours per sessions during remaining weeks

IV. Goals of the module:

assist participants to become aware of the vocational/educational options open to them

assist participants to achieve a higher level of vocational maturity

V. Brief description of methods utilized to reach this goal:

Variety of methods are utilized including individual counseling, group training, group discussions, videotape presentations, work/training experiences, and site visits.

VI. Typical cycle schedule:

Meeting 1 Content: individual vocational diagnostic interview
Meeting 2-4 Content: vocational mini evaluation
Meeting 5 Content: individual conference focused on interpretation and discussion of

evaluation results with implications for future vocational planning

Meeting 6-8 Content: dependent upon group needs; selection is made from the following:

- vocational exploration training
- job seeking skills training
- work/training exposure
- site visits to places of employment or to educational facilities

Meeting 9 Content: individual conferences focused on future vocational directions

VII. Special areas that have been addressed because of particular needs of some groups:

JS/asm
3/7/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Living Arrangements

I. Person responsible: Lex Frieden

II. Staff associates:

residents at Independence Hall:
Guy Bell
Ken Terry
Ed Rhame
Joe Hallmark

residents at Windhill:
Evelyn Thibideaux
Paul Pommier

residents at French Village:
Mac Harper
Richard Wilson
Ken Arnold
George Clark

residents at Banyon:
Rodney Shaw
George Broyles
Bob Henry
Mary Richardson
Mike Moline
Roberta Forbes

residents of single family dwellings:
Bob Geyer
Randy Goldsoble

III. Average number of meetings per cycle and average time of modules:

5 meetings - averaging 3 hours each

IV. Goal of the module:

This module is designed to introduce participants to the wide variety of living arrangements available to them. It seeks to provide them with the information necessary to find and manage a suitable arrangement, and maintain a lifestyle consistent with their needs, their resources, and their reasonable desires.

V. A brief description of methods utilized to reach this goal:

Field trips, lectures, informal interviews, tours, group discussions, handouts, individual assignments, reports, and surveys are used as methods in this module.

VI. A typical cycle schedule:

Meeting 1 Content: meet at annex to discuss various alternatives for independent living arrangements; analyze the components of a satisfactory living arrangement (ie. physical and social environment, personal care arrangements); describe what is or might be available; discuss philosophy of independence and various sorts of independence; discuss physical environment; develop framework for analysis; talk about various attendant arrangements; talk about institutions, formal and informal; discuss personal experience, goals and expectations about living arrangements; discuss changing needs relating to vocation, marriage, and physical health.

Meeting 2 Content: field trip to Independence Hall where participants tour the facility, and meet with residents in attendant care unit and attendant manager.

Meeting 3 Content: field trip to French Villages, Spring Tree, or Windhill Apartments where participants tour the complex and meet with disabled residents and attendants

Meeting 4 Content: field trip to visit quadriplegic who lives at home with parents and employs a personal care assistant, or field trip to home of quadriplegic who lives alone with his wife.

Meeting 5 Content: field trip to Banyon Condominiums where participants visit one or two residents and meet with the founders of Independent Lifestyles, Inc.

VII. Special areas that have been addressed because of particular needs of some groups:

JS/asm
3/7/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Leisure Module

I. Person responsible: Linda Lavinson

II. Staff associates:

Bob Kafka - Vice-President, Coalition for Barrier Free Living, SWAA member
Will Clark - President, Coalition for Barrier Free Living, SWAA member

III. Average number of meetings per cycle and average time of modules:

5 meetings - averaging 2 hours each

IV. Goal of the module:

to learn cooperation with peers
to learn responsibility and experience being held accountable
to learn to compromise
to experience a variety of leisure activities as a person in a wheelchair
to learn how to find out about accessibility to various places.

V. A brief description of methods utilized to reach this goal:

small group discussions; field trips to various leisure type activities; staff associates who are actively involved in specific leisure activities will discuss their experiences.

VI. A typical cycle schedule:

Meeting 1 Content: Discuss purpose of module; successive meetings will relate to the planning and actual participation in those activities the group wants to become involved with.

VII. Special areas that have been addressed because of particular needs of some groups:

JS/asm
3/9/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Consumer Affairs

I. Person responsible: Bill Wild

II. Staff associates:

III. Average number of meetings per cycle and average time of modules:

4-5 meetings - averaging 2 hours each

IV. Goal of the module:

to develop self-awareness; exposure to potentials and possibilities; job possibilities; role as consumer

V. A brief description of methods utilized to reach this goal:

discussion; field trips

VI. A typical cycle schedule:

Meeting 1 Content:	self-image, dealing with disability
Meeting 2 Content:	consequences of minority group status
Meeting 3 Content:	career opportunities, library trip
Meeting 4 Content:	how to deal with TRC, affirmative action
Meeting 5 Content:	transportation, follow-up previous modules
Meeting 6 Content:	field trip to area of barriers and sometimes confrontation with management.

VII. Special areas that have been addressed because of particular needs of some groups:

assessing some career goals, economic realities of disability

JS/asm
3/9/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Social Skills

I. Person responsible: Linda Lavinson

II. Staff associates: none

III. Average number of meetings per cycle and average time of modules:

5 meetings - averaging 1½ to 2 hours each

IV. Goal of the module:

to improve satisfaction and effectiveness in relating to people
to assume responsibility for ourselves
to learn to ask for what we want and need
to learn how well our behavior matches our intentions

V. A brief description of methods utilized to reach this goal:

small group discussions
instruction by group leader
experiential exercises
role play
peer feedback
questionnaires
field trips

VI. A typical cycle schedule:

Meeting 1 Content: discussion of purpose and how we will achieve it; developments of group ground rules. Hand out "Assertive Inventory" check list to be filled out in group.

Meeting 2 Content: group exercise in listening; discussion on communication skills; - (a) reasons it is important to communicate well; (b) non-verbal behaviors and body positioning; (c) factors which aid communication; (d) factors which impede communication.

Meeting 3 Content: "Sending a message" exercise (discussion on how information gets distorted); assumptions (how they get us in trouble); dis-

cussion on results of assertive inventory list done 1st module.

Meeting 4 Content: discussion on assertive rights; discussion on the difference between passivity, assertion and aggression; practice on assertive techniques.

Meeting 5 Content: field trip with behavior assignments based on individual responses from assertive inventory.

VII. Special areas that have been addressed because of particular needs of some groups:

JC/asm
3/8/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Problem Solving

I. Person responsible: Mary Ann Board

II. Staff associates:

not determined at this time

III. Average number of meetings per cycle and average time of modules:

4 meetings - averaging 1½-2 hours each

IV. Goal of the module:

to teach participants to identify and solve problems in a logical sequence

V. A brief description of methods utilized to reach this goal:

lecture
group discussions
actual practice in the community

VI. A typical cycle schedule:

Meeting 1 Content:	the basic steps of problem-solving and a sample problem; assignment to choose and solve a problem following P.S. outline
Meeting 2 Content:	discussion of assignment, plans for community trip
Meeting 3 Content:	community trip - participants are given a list of task & problems which they attempt to solve
Meeting 4 Content:	discussion of trip & problems encountered.

VII. Special areas that have been addressed because of particular needs of some groups:

JS/asm
3/7/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Sexuality

I. Person responsible: Joyce Nelson

II. Staff associates:

Dr. Meier - Rehab. doctor
Linda Neely - sexually active spinal cord injured paraplegic.
Bob Henry - sexually active polio quadriplegic.
David Ellinwood - married spinal cord injured quadriplegic.
Alice Ellinwood - wife of spinal cord injured quadriplegic.
Robert Hipp - sexually active spinal cord injured quadriplegic.

III. Average number of meetings per cycle and average time of modules:

5 meetings - averaging 2 hours each

IV. Goal of the module:

to help physically disabled person understand their own sexuality.

V. A brief description of methods utilized to reach this goal:

films of sexually active physically disabled persons, a panel of sexually active physically disabled persons to answer questions on their sexuality, lecture and discussion by a doctor on the effects of physical disability on a persons sexual ability, along with many group discussions.

VI. A typical cycle schedule:

Meeting 1 Content:	planning & discussion over vocabulary.
Meeting 2 Content:	films - discussion on films & doctors lecture and discussion.
Meeting 3 Content:	films - discussion on relationships versus sex.
Meeting 4 Content:	panel - discussion on meeting people, dating, body image.
Meeting 5 Content:	films - discussion over changes in attitude, mobility, close.

VII. Special areas that have been addressed because of particular needs of some groups:

oral-genital sex
homosexuality
relationships
body image

JS/asm
3/4/77

NEW OPTIONS MODULE CONTENT OUTLINE

TITLE: Home Management

I. Person responsible: Jean Cole

II. Staff associates: Laura Gerken - T-11, Para

III. Average number of meetings per cycle and average time of modules:

3 meetings - averaging 1 hour each

IV. Goal of the module:

To demonstrate adapted techniques and problem solving methods associated with home management.

V. A brief description of methods utilized to reach this goal:

site visit to an occupied apartment
shopping from wheelchair techniques
visiting empty apartment
meeting with an apartment manager

VI. A typical cycle schedule:

Meeting 1 Content: site visit to an apartment occupied by a disabled person
Meeting 2 Content: shopping trip
Meeting 3 Content: visit to empty apartment and meeting with apartment manager.

VII. Special areas that have been addressed because of particular needs of some groups:

financial arrangements (TRC)
transportation
apartment hunting - questions that should be asked of an apartment manager.

JS/asm
3/14/77

FREE LIVES, INC.

Name:_____ Date:_____

Age:_____ Sex:_____ Height:_____ Weight:_____

Marital Status:_____

Education completed:_____

Current Address:_____

Telephone:_____

Disability:_____ If spinal cord injury, please indicate level:_____

Date of onset:_____

Upper extremity status:

1. one extremity impaired
2. both extremities impaired
3. no impairment

Lower extremity status:

1. one extremity impaired
2. both extremities impaired
3. no impairment

Present living arrangements:

1. home of parents or relatives
2. own home or apartment
3. nursing home
4. specialized housing for the disabled
5. other (specify)

Activities at present time:

1. at home
2. college or junior college
3. vocational training program
4. working part-time
5. working full-time
6. other (specify)

Transportation:

1. self-owned vehicle

Do you drive yourself?_____
Do you transfer yourself?_____

2. family or friends
3. specialized transportation service (specify)
4. public transportation
5. other (specify)

Who provides the physical assistance you require:

1. no assistance required
2. family member or friend
3. private attendant
4. nursing home staff
5. other (specify)

Salary per Month:_____

How much time do you require from an assistant in getting up in the morning?

How much time do you require from an assistant in going to bed in the evening?

How do you transfer?

1. Alone
2. with help

What method is used for transferring?

1. sliding board
2. one-man lift
3. two-man lift
4. Hoyer lift
5. monkey bars
6. other (describe)

Urinary device used:

1. none
2. external catheter
3. internal Foley catheter
5. ileal loop
6. vesicotomy
7. other (specify)

Bowel program:

1. in bed
2. on commode with commode chair
3. on commode without commode chair

Bowel Program is:

1. voluntary
2. regulated by suppositories (explain)

Type of wheelchair:

Other special equipment used and procedure used in assisting with this equipment:

Activities in which assistance is required:

eating
dressing
bathing
bladder needs
bowel needs
turning at night
others (specify)

Medication taken:

How are medications purchased?

Attendant care: Will you use male or female attendants?

OBJECTIVES:

jsk
10-22-75

NEW YORK UNIVERSITY MEDICAL CENTER
Institute of Rehabilitation Medicine
400 EAST 34TH STREET, NEW YORK, N.Y. 10016
AREA 212 679-3200
CABLE ADDRESS: NYU MEDIC

MEMORANDUM

TO: Proposal Recepients

FROM: Project Staff

DATE: December 10, 1976

RE: REHABILITATION INDICATORS: A METHOD FOR ENHANCING ACCOUNTABILITY AND THE PROVISION OF REHABILITATION SERVICES

Addenda and corrections to the proposal

1. The name of one member of this project's Advisory Committee was inadvertantly omitted from the list on p. 98:

Douglas Inkster, Ph.D.
Director
New York Infirmary
Center for Independent Living
New York

2. The following corrections, which may influence the proposal's readability, should be noted:

p. 1, line 14: change from "Objective #3, pp. 6-10" to "Objective 1c, pp. 9-10 "

p. 8, lines 1&2: change underlined words "(2) All RI's will describe observable and potentially modifiable environmental..."

p. 69, line 26: Insert "which is" following "that"

p. 75, lines 18-20: Delete "However, Objective 1d...plan."

p. A35, line 17: Insert "methods using RIs" following "For example"

p. A36 line 10: Delete "(?)"

NEW OPTIONS TRANSITIONAL PROJECT

TEXAS INSTITUTE FOR REHABILITATION AND RESEARCH

PHYSICIAN'S REFERRAL FORM

Patient's name: _____

Address: _____

_____

_____

1. Diagnosis of major physical disability and onset date:

2. Does patient:

	No	Yes	If yes, please elaborate
Frequently have bladder or kidney infections?			
Frequently have pressure sores?			
Frequently have respiratory problems?			
Have difficulties in communication?			

3. Is patient presently under your care for problems relating to his disability?
   Yes _____ No _____ If yes, what are the problems?

4. Do you feel that this patient is physically capable of participating in a program that includes at least 8 hours a day of organized activity including field trips?

5. How much contact have you had with this person?

Date: _____ Name of Physician: _____

Address: _____

_____

Signature: _____

PLEASE MAIL THIS FORM DIRECTLY TO:

NEW OPTIONS TRANSITIONAL PROJECT
TIRR ANNEX
105 DREW STREET
HOUSTON, TEXAS 77006

11/76

NEW OPTIONS TRANSITIONAL PROJECT
TEXAS INSTITUTE FOR REHABILITATION AND RESEARCH

INSTRUCTIONS FOR COUNSELOR'S REFERRAL FORM

In the New Options transitional project the participant's TRC counselor or social worker will play an important role, both before the client enters the program and after he or she leaves. This form will hopefully initiate an on-going relationship between New Options staff members and the TRC counselors or social workers of project participants.

The referral form is intended to

convey important background information to the project staff about the applicant.

let us know about areas you are currently working on with the applicant

help you in assessing the appropriateness of the referral of your client to this project.

prompt your thinking about follow-up possibilities for the participant after he or she leaves the program.

If you currently have any psychological or vocational evaluation reports on the applicant, please send these with your referral.

Project staff members will be glad to provide additional information and to answer any questions you have about the project. For further information on New Options, please contact the Project Director. Questions concerning TRC involvement in the project can be answered by the New Options Courtesy Counselor.

Jean Cole, Ph.D.
New Options Project Director
TIRR Annex
105 Drew St.
Houston, Texas 77006

(713) 797-1440, ext. 505

Ms. Rebecca Langley
New Options Courtesy Counselor
Texas Rehabilitation Commission
1964 West Gray
Houston, Texas 77019

(713) 526-8511

NEW OPTIONS TRANSITIONAL PROJECT
TEXAS INSTITUTE FOR REHABILITATION AND RESEARCH

COUNSELOR'S REFERRAL FORM

Program applicant:_____

Applicant's disability:_____

Person making referral: _____

Mailing address of
person making referral:_____

_____ Phone:_____

Position: _____

Briefly describe the applicant's living situation.

Briefly describe the applicant's family relationships.

Briefly describe the applicant's community and the resources there for housing, employment, etc.

Do you now have any ideas about possible educational or vocational options for the applicant? Please list any options that seem reasonable.

What housing options might be reasonable for the applicant after he or she leaves the transitional project?

What possible sources of support and reinforcement might be available to the individual when he or she leaves the transitional project? (on-going relationship with you, family members, other agency personnel, etc.)

What do you see as the applicant's major strengths or assets?

What do you see as the applicant's major weaknesses? Exclude reference to physical disability.

What goals do you feel are important to the individual?

Do you think these goals are reasonable? How might they be achieved?

Please describe your relationship with the applicant and identify any areas you are currently working on with this individual.

Would you be willing to participate in a follow-up program for this applicant (to include some on-going counseling support for the individual plus some feedback information to the project)?

Please give reasons for your recommendation of this person for participation in the transitional project.

Date:_____ Signature of person making referral: _____

If you currently have psychological or vocational evaluation reports on the applicant, please send these with your referral.

PLEASE MAIL THIS FORM DIRECTLY TO:

NEW OPTIONS TRANSITIONAL PROJECT
TIRR ANNEX
105 DREW STREET
HOUSTON, TEXAS 77006

revised 12/76

NEW OPTIONS TRANSITIONAL PROJECT
TEXAS INSTITUTE FOR REHABILITATION AND RESEARCH

APPLICATION FOR ADMISSION

INSTRUCTIONS: This form is to be completed by persons who want to enter the project. Please answer as many of the questions as you can. If you are uncertain about some of the questions, just put "don't know".

Name: _____ Current Date: _____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Marital Status: _____ Race: _____

Highest level of education completed: _____

Years of employment: _____ Type of work: _____

Current address: _____ Telephone: _____

_____

_____

Disability: _____

If spinal cord injury, please indicate level: _____

If your disability was caused by injury, please explain how this injury occurred: _____

_____

Physician: _____

_____

address of physician _____

TRC Counselor: _____

address of counselor _____

1. Briefly describe the activities you were involved in before the onset of your disability.

2. Have you ever participated in a rehabilitation program? If so, please describe. (medical rehabilitation, vocational training, etc.)

3. Briefly describe what you have done since the onset of your disability.

4. Where are you living now?

5. How are your transportation needs met?

6. Who provides the physical assistance you require (if any)? If you have a private attendant, how was this person found?

7. How much time do you require from an assistant in getting up in the morning?

8. How much time do you require from an assistant in going to bed in the evening?

9. How do you transfer? (sliding board, one man lift, etc.)

10. What kind of urinary device do you use, if any? (external catheter, internal Foley catheter, ileal loop, etc.)

11. What sort of bowel program do you use? (in bed every other day using suppositories, on commode with commode chair, etc.)

12. Please place a check mark by any of the following activities in which you require assistance:

☐	eating	☐	mobility with wheelchair
☐	dressing	☐	turning at night
☐	bathing	☐	writing
☐	bladder needs	☐	other (please specify)
☐	bowel needs		

13. What type of wheelchair do you use?

_____ electric _____ other

_____ manual, If manual, can you push yourself?

14. Can you drive a car? Do you use special equipment for this? Do you own a car?

15. Do you have a driver's license or driving permit?

16. How well can you write? (not at all, can type only, can write legibly but slowly, write with no difficulty, etc.)

17. Do you have any difficulties in communication? (hard of hearing, speech difficulties, etc.)

18. If you use any special breathing equipment, please describe what you use and the kind of help you need with this equipment.

19. What medications do you take?

FINANCIAL STATUS EVALUATION

Please indicate the amounts of your monthly income in each category:

	earnings
	social security (SSDI) based on own work history
	social security (SSDI) based on parents' work history
	supplemental security income (SSI)
	department of vocational rehabilitation (TRC)
	veterans' administration
	insurance compensation
	scholarship or stipend
	parents
	spouse
	State Crippled Children's program
	other
	TOTAL MONTHLY INCOME

How are the checks made out (to you, to a parent, to a guardian, etc.)?
To whom are they sent?

Who pays for your medications? Supplies?

How do you pay for medical care? (Do you have Medicare? Medicaid? Private Insurance? TRC Sponsorship? State Crippled Childrens coverage? Other resources?)

What arrangements have you made for financial sponsorship in the transitional project?

20. What do people think of you?

21. Do you have any ideas about what you would like to be doing five years from now?

22. Why do you want to be a participant in the transitional project?

23. If you are chosen as a participant, when would you be available to move into the project? Who would be available to help you move in?

PLEASE MAIL THIS FORM TO:
New Options Transitional Project
TIRR Annex, 105 Drew Street
Houston, Texas 77006

NEW YORK UNIVERSITY MEDICAL CENTER
Institute of Rehabilitation Medicine
400 EAST 34TH STREET, NEW YORK, N.Y. 10016
AREA 212 679-3200
CABLE ADDRESS: NYU MEDIC

REHABILITATION INDICATORS: A METHOD FOR ENHANCING ACCOUNTABILITY AND THE PROVISION OF REHABILITATION SERVICES

Summary & Description of Project Proposal

This project proposal was submitted to RSA in December 1976, requesting funding for a three-year period. The proposal contains most of the ideas we have developed in the past two years, but in a format that is useful for the funding reviewers but may confuse other readers. We hope you will read relevant portions of this document prior to the meeting, in that the major purpose of the meeting will be to obtain your comments and suggestions with respect to the ideas developed to this point and the proposed future directions. To assist you in reading the proposal, we have provided this combination summary and reading guide.

If you wish to read all or most of the proposal, a suggested order of reading is provided on page i of the proposal. The suggested order of reading will first provide you a brief introduction (pp. i-vi) then the project's conceptualization (pp. 36-77) and the major purposes to be served (pp. 78-84), and then the Rehabilitation Indicators and glossary of terms that are frequently used in the proposal (pp. A2-A34, A63-A66). The other sections of the proposal (in suggested reading order) include a discussion of three of RSA's Issues that the project addresses (pp. 1-5) ("RSA Issues" are defined by the Rehabilitation Services Administration, DHEW, and include possible areas of research and development that they have identified as of interest to them); then the objectives (pp. 6-10), work plan and methodology (pp. 11-24, 25-34) of the next three years of project activities are described; finally, the project's background and a brief review of the literature are presented (pp. 85-105, 106-108).

In order to further assist your understanding of the proposal (particularly the complexities of pp. 36-74) we have diagrammed the relationships between this project's conceptual level , product level (RI's) and the proposed operational level (see diagram next page).

At the conceptual level this project proposes several definitions which bear both on the product (RI's) and operational levels:

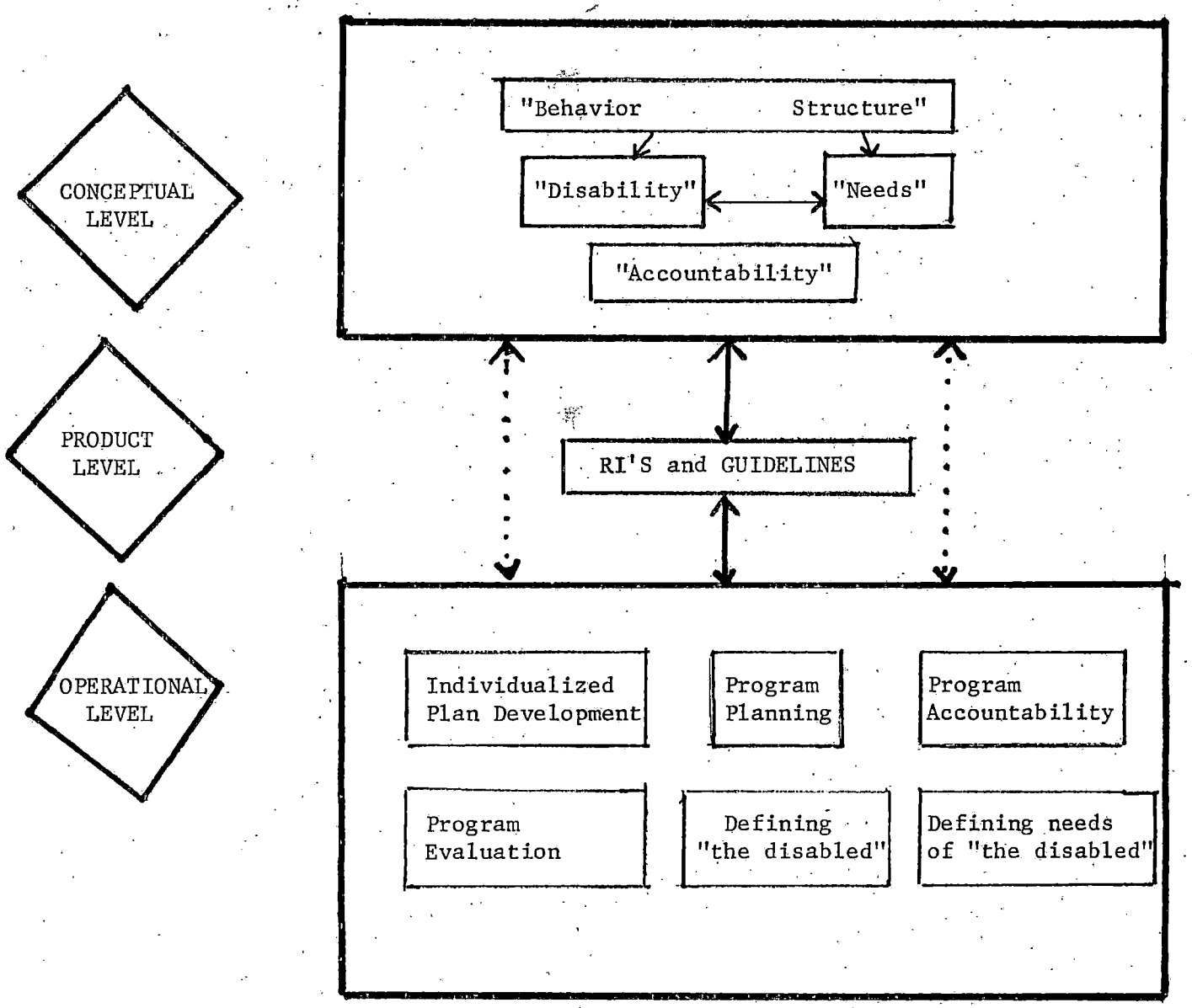
(1) A description of elements of "behavior structure" (pp. 42-45) is offered which is the basis for conceptually defining "disability" (pp. 46-50) and "needs" (pp. 50-56).

(2) "Accountability" is also defined conceptually (pp. 39-42).

These conceptual definitions are important in two ways: (1) They have helped define the specific nature of RI's and guidelines for using RI's (PRODUCT LEVEL) and (2) they have provided a basis for defining the operational purposes that RI's will serve (OPERATIONAL LEVEL).

At the operational level the major purposes that RI's can be used to serve are:

(1) Program Accountability: (See pp. 1-2, 39-42, 67-70) RI's would be the base for enhanced program decision-making in line with the resource


CONCEPTUAL LEVEL
PRODUCT LEVEL
OPERATIONAL LEVEL
"Behavior
Structure"
"Disability"
"Needs"
"Accountability"
RI'S and GUIDELINES
Individualized Plan Development
Program Planning
Program Accountability
Program Evaluation
Defining "the disabled"
Defining needs of "the disabled"

provider's expectations and would assist in providing information about services to resource providers.

(2) Program Evaluation: (See pp. 1-2, 67-70) RI's would provide the basis for that component of program evaluation that looks at the program's impact on client functioning (change in functioning, client 'outcome', problem alleviation, goals attained, etc.).

(3) Program Planning: (See pp. 80-84) RI's, combined with information about inputs (e.g. services provided to clients, types of staff, funds used), could be used in the long run to increase the program administrator's awareness of the relationships between inputs, resources and outputs. This information would help in planningprograms to fit special needs, to maximize benefits/costs or to fulfill any other purposes selected by program planners, administrators, and/or resource providers.

(4) Individualized Plan Development: (See pp. 56-67, 72-74) RI's are to be fully integrated into development of a plan of services for each client. RI's can be used in any model of rehabilitation planning and service provision (goal setting, problem oriented, management by objectives, free wheeling, cyclic goals, etc.); use of RI's in a goal setting model is presented on p. 73.

(5) Defining "Disability" and "Needs". (See pp. 2-4, 46-56, 70-71) RI's have great potential for defining "disability" in functional/environmental terms and defining "needs" in similar terms. This potential for defining severity and type of disability and needs may prove to be useful in surveying "the disabled" in the population and in defining "needs" and "disability" of individual clients. This project does not intend to survey the population, but to develop a methodology which may be compatible with that RSA-defined need.

We hope these few comments will be kept in mind as you read the proposal, to help you in understanding how each section fits into a conceptual-operational whole.

TEXAS INSTITUTE FOR REHABILITATION AND RESEARCH
IN THE
TEXAS MEDICAL CENTER
1333 MOURSUND AVENUE
HOUSTON, TEXAS 77030

P. O. Box 20095
Houston, Texas 77025

Telephone
Area Code 713, 797-1440

MEMORANDUM 3/2/77

TO: New Options Program Staff
Lex Frieden ✓ Linda Lavinson
Jane Sperry Wayne Alfred
Dr. Spencer Rusty Hamilton

FROM: Jean Cole, Project Director

SUBJ: Proposed Goal Worksheet

I have been thinking about the meeting we have after the first week of each cycle to share our assessments of each participant and to plan individual goals for the remaining five weeks. In order to do this planning more systematically, I would like to experiment with the attached goal worksheet at our meeting next Tuesday. The background portion could be filled out before our meeting and distributed to each of you. The assessment and goals would be logged at the meeting as each area is discussed by the group.

The purposes of using this worksheet would be

a) to share our individual assessments of each participant more concisely in the group.

b) to provide a means of documenting these assessments.

c) to document goals that we intend to work on with each participant during the project so that progress can be monitored during the six weeks.

d) to assist in determining what we have accomplished with each participant at the end of the cycle.

I would welcome your comments. If you have opinions about the idea itself or suggestions on elements of the worksheet as I have sketched it out, please give these to me by Monday.

Thanks.

JAC/asm

BACKGROUND INFORMATION SUMMARY

demographic

- name
- age
- marital status
- hometown

medical

- disability
- time since onset
- previous rehabilitation

financial status

- income

vocational status

- educational history
- work history
- intellectual functioning

living arrangements

- residence
- physical assistance
- transportation

ASSESSMENTS AND GOALS

CONTENT AREA	CURRENT STATUS	PROJECT GOALS	OUTCOMES
medical			
urological management			
bowel program			
skin & sitting			
other			
functional status			
mobility with wheelchair			
driving			
self-care			
home management			
using physical help			
self-abilities			
knowledge base			
social interaction			

CONTENT AREA	CURRENT STATUS	PROJECT GOALS	OUTCOMES
financial status			
living arrangements			
vocational options			
physical skills			
other capabilities			
vocational awareness			
interests (existing and to be explored)			

CONTENT AREA	CURRENT STATUS	PROJECT GOALS	OUTCOMES
social functioning			
family relationships			
social interaction and relationships			
personal functioning			
self-esteem			
self-direction (planning, decision-making, problem-solving)			

JC/asm
3/2/77

6 mo. to 1 yr. follow up

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Name: _____ Current date: _____

Date of birth: _____ Sex: _____ Height: _____ Weight: _____

Marital status: _____ Race: _____

Highest level of education completed: _____

Years of employment: _____ Type of work: _____

Current address: _____ Telephone: _____

_____

Disability: _____ If spinal cord injury, please indicate level. _____

Date of onset: _____ Age at onset: _____

Physician: _____

address of physician _____

_____

TRC Counselor: _____

address of counselor _____

_____

Have you ever participated in a rehabilitation program? If so, please describe. (medical rehabilitation, vocational training, etc.)

Briefly describe the activities you were involved in before the onset of your disability.

Briefly describe what you have done since the onset of your disability.

Where are you living now?

How are your transportation needs met?

Who provides the physical assistance you require (if any)? If you have a private attendant, how was this person found?

How much time do you require from an assistant in getting up in the morning?

How much time do you require from an assistant in going to bed in the evening?

How do you transfer? (sliding board, one man lift, etc.)

What kind of urinary device do you use, if any? (external catheter, internal Foley catheter, ileal loop, etc.)

What sort of bowel program do you use? (in bed every other day using suppositories, on commode with commode chair, etc.)

Please place a check mark by any of the following activities in which you require assistance:

eating	mobility with wheelchair
dressing	turning at night
bathing	writing
bladder needs	other (please specify)
bowel needs	

What type of wheelchair do you use? If manual, can you push yourself?

Can you drive a car? Do you use special equipment for this? Do you own a car?

How well can you write? (not at all, can type only, can write legibly but slowly, write with no difficulty, etc.)

Do you have any difficulties in communication? (hard of hearing, speech difficulties, etc.)

If you use any special breathing equipment, please describe what you use and the kind of help you need with this equipment.

What medications do you take?

Please indicate the amounts of your monthly income in each category:

earnings

social security

supplemental security income

department of vcational rehabilitation (TRC)

veterans' administration

insurance compensation

scholarship or stipend

parents

spouse

other (please specify)

TOTAL MONTHLY INCOME

What arrangements have you made for financial sponsorship in the transitional project?

Why do you want to be a participant in the transitional project?

What did you gain as a result of your transitional project experience?

Do you have any ideas about what you would like to be doing five years from now?

If you are chosen as a participant, when would you be available to move into the project? Who would be available to help you move in?

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HOUSTON, TEXAS 77006