2005 Missouri TBI Early Referral Program Evaluation

Bridging the Gap
From Hospitalization to Community

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June 2006

Table of Contents

Acknowledgements……………………………………………………….………………2

Executive Summary………………………………………………………………………... 3

Background / History of Early Referral Program………………………………………... 7

DHSS Services Provided and Functional Outcomes……………………………………..12
Evaluation Participants
Methods
Findings

Consumer Satisfaction and Qualitative Data……………………………………..............18
Evaluation Participants
Methods
Findings

Consurmer Medicaid Comparisons………………………………………………………….23
Evaluation Participants
Questions
Methods
Findings
Summary

Summary and Recommendations………………………………………………………… 25

Appendix A: Survey Instruments…………………………………………………............ 26

Acknowledgements

We wish to acknowledge the essential contributions made by the individuals with traumatic brain injury (TBI) and their family members who participated in this evaluation. By allowing us to document their functioning, providers and the community may gain a better understanding the experiences of individuals and their families in coping with TBI.

We would like to thank Diane Poole, Missouri Department of Health and Senior Services, and Laura Schopp, Ph.D., Department of Health Psychology, University of Missouri-Columbia, whose combined vision resulted in the initial development of this the project.

We would also like to thank the following individuals, whose contributions were invaluable:

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Executive Summary

TBI Early Referral Program History

The TBI Early Referral Program was designed by the Bureau of Special Health Care Needs (SHCN) of the Department of Health and Senior Services (DHSS) as a person-centered, community-based procedure for providing services to individuals who have sustained a traumatic brain injury (TBI). Through this program, individuals with a TBI are offered the services of a TBI service coordinator early in the course of their rehabilitation (e.g., while an inpatient or outpatient in an acute rehabilitation facility). The service coordinator collaborates with the client, the family, and the hospital's discharge planner to identify and coordinate needed community-based services prior to discharge, so they are available when the client returns to the community.

The TBI Early Referral Program was designed to hasten the availability of needed services, to minimize the repetition of information by the consumer and to improve inter-agency coordination to minimize fragmentation and/or duplication of services. In 2003, piloting of the TBI Early Referral Program began at 5 hospital sites where the discharge planners were informed of the process for working with the TBI service coordinators and agreed to participate in the program.

TBI Early Referral Program Evaluation

In 2004, the University of Missouri, Department of Health Psychology contracted to conduct an evaluation of the Early Referral Program to assess the effectiveness of this early referral system for individuals with TBI. Ninety-eight (98) clients working with the Bureau of Special Health Care Needs Head Injury Program in 2004-2005 were identified as the sample to be evaluated. Early Referral clients include those who were referred for services within 90 days of their injury and/or those who were referred by one of the five identified partners in the Head Injury Program's Early Referral Program. Clients who were referred >90 days post-injury and not by one of the five program partners were identified as the comparison group of clients.

Evaluation Questions

- Do clients who are referred earlier to the TBI service coordinator use fewer total resources than those entering the system at a later point following their injury?
- Is earlier referral related to less frustration on the part of clients/families?
- Is the Early Referral Program seen as a useful service among clients/families?
- Does the Early Referral Program result in health care cost reduction?
- What are the barriers to implementing the Early Referral Program?

Evaluation Data Sources

- Data from DHSS regarding clients' functioning upon enrollment in the Head Injury Program (e.g., need for assistance with daily living skills, social functioning, cognitive functioning), as well as the nature of services provided by the Head Injury Program (e.g., case management) to a sample of Early Referral clients and a comparison group.
- Telephone survey data from clients/families who have worked with Head Injury Program, including some who were early referrals to the program and some who were referred at a later point post-TBI (comparison group). These data include information about the clients' current social, vocational, and emotional functioning, as well as indications of their satisfaction with TBI Head Injury Program services.
- Medicaid utilization and costs in 2004 and 2005 for clients who were early referrals and the comparison group; obtained through Missouri Department of Social Services Division of Medical Services (DMS). Specific variables included frequency/cost of doctor office visits, units/cost of personal care, and frequency/cost of emergency room visits.

***"I didn't know what services were out there [after my injury].
The TBI service coordinator helped me find out what's available to me.
She encouraged me to use the resources that are available for TBI."***[1]

Review of Findings

This evaluation sought to address whether clients in the TBI Early Referral Program experienced different functional outcomes compared to their later referred counterparts. Evidence of the program's effectiveness included findings that individuals in the Early Referral Program had relatively better functional outcomes and higher ratings of consumer satisfaction compared to the comparison group of clients.

Functional Outcomes Findings

- Clients in the Early Referral (ER) group had significantly greater functional limitations (i.e., problems with activities of daily living) when contrasted with a comparison group of later referred individuals (CG).
    - Possible reasons for this include:
        - Clients in the ER group may be earlier in the process of their recovery from the TBI.
        - Differences in referral patterns to the Head Injury Program (i.e., individuals may be more likely to receive an early referral if they are experiencing relatively more TBI-related difficulties).

[1] A 40 year-old, female client who sustained a TBI in a motor vehicle accident, describing why she would refer someone to the SHCN Head Injury Service.

- Despite greater functional limitations at the time of initial involvement with the TBI Head Injury Program, at the time of this evaluation clients in the ER group were experiencing significantly better functioning than their CG counterparts in multiple important domains:
  - Social integration (i.e., social and community involvement)
  - Emotional well-being (i.e., symptoms of depression, anxiety)
  - Vocational functioning (i.e., number of weeks competitively employed, monthly income)
- Importantly, individuals in the ER group did *not* require/receive more frequent contact by SHCN Service Coordinators to achieve these better functional outcomes.

Key Consumer Perspective Findings

- Clients and families in the Early Referral Program reported being more satisfied with services they received than individuals referred later.
- Clients in the Early Referral Program were less likely to report experiencing difficulties with agency coordination than those referred later.
- Across both evaluation groups, a vast majority of individuals (91%) who have received services through DHSS Head Injury Program reported that they feel this program is essential for individuals with TBI and their families.
- A majority of consumers in both groups (98%) reported that they felt TBI services should be initiated when the injured individual is in the hospital or shortly thereafter, which is in line with the Early Referral Program model for services.
- Service coordination, support, and education/advocacy were among the most valued services provided by SHCN Head Injury Program.

Service Utilization / Cost Outcomes

- Medicaid utilization data generally revealed a need for services that was consistent with the functional limitations experienced by program participants.
  - Clients in the Early Referral Program had higher rates of and costs for doctor office visits and personal care services in 2004.
  - In 2005, clients in the Early Referral Program continued to have more doctor office visits and use more personal care services.
- However, in 2005 clients in the Early Referral Program were significantly less likely to receive emergency room care.
  - This may reflect success in addressing medical needs on an ongoing basis rather than in an acute crisis management model, which results in seeking emergency services.

Summary and Recommendations

This evaluation confirmed that consumers view the DHSS Bureau of Special Health Care Needs Head Injury Program as an essential support to individuals with TBI and their families. Consumers are in agreement with the goal of establishing an early contact with clients and their families during or shortly after acute rehabilitation, so that appropriate services can be identified and initiated and time is not lost in the process of community re-integration. Perhaps most importantly, the TBI Early Referral Program is associated with better functional outcomes in terms of social/emotional functioning and the ability to return to work.

While these data are promising, this evaluation is seen as a formative evaluation. The TBI Early Referral Program is in the early stages of implementation, having been initiated less than 2 years prior to the start of this evaluation. As such, the results from this evaluation may be used to inform the ongoing development and refinement of this program.

Based on this evaluation, several future goals for the DHSS Bureau of Special Health Care Needs TBI Early Referral Program may be considered, including:

- Continue to inform consumers and the public of the valuable services available and provided by the TBI Early Referral Program.
- Support the current system of direct referrals from pilot hospital sites and expand this referral process to other hospitals throughout the state.
- Continue to use available funding to maximize the impact of the program for individuals with TBI.
- Develop a system for ongoing evaluation of the TBI Early Referral Program, to monitor its impact and provide information to inform the public of its services.

Improved functional outcomes are achieved
through the TBI Early Referral Program
without additional expenditure of effort/expense.

History of Early Referral Program

"The Right Service at the Right Time Without Repetition"

The TBI Early Referral Program is a component of the Missouri Department of Health and Senior Services (DHSS) Division of Community & Public Health Special Health Care Needs, which leads the state in providing needed services to individuals with TBI. The foundation for this program was established by the following events:

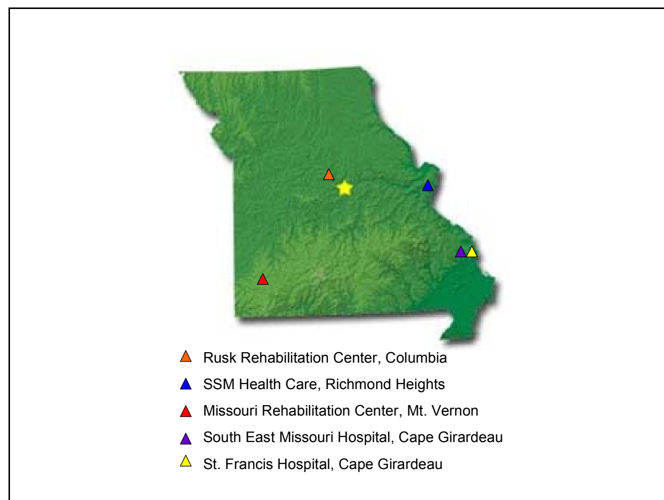
- In March 1985, the State of Missouri legislature passed a bill appropriating funding to the Missouri Department of Health to provide brain injury services beginning in FY '86.
- Legislation passed in 1987 that established the DHSS as the regulator of a statewide trauma system.
- Four years later, in 1991, the DHSS was identified by the legislature as the lead state agency for TBI.

Throughout this development, the DHSS has worked to maximize service value by ensuring that appropriate services are offered with minimal duplication of efforts within and across agencies.

- The *TBI Early Referral Program*, which was established in 5 pilot sites across the state in 2003.
- The *TBI Early Referral Program* uses a collaborative approach to deliver services to individuals with TBI.
- This program involves establishing a connection between individuals with TBI and TBI service coordinators while the individual is in the hospital.
    - This allows for the identification of available services to ensure a more seamless transition into the community and promote better outcomes.

As Figure 1 demonstrates, hospitals involved as pilot sites for the TBI Early Referral Program cover a range of counties across the State of Missouri.

Figure 1: TBI Early Referral Pilot Sites

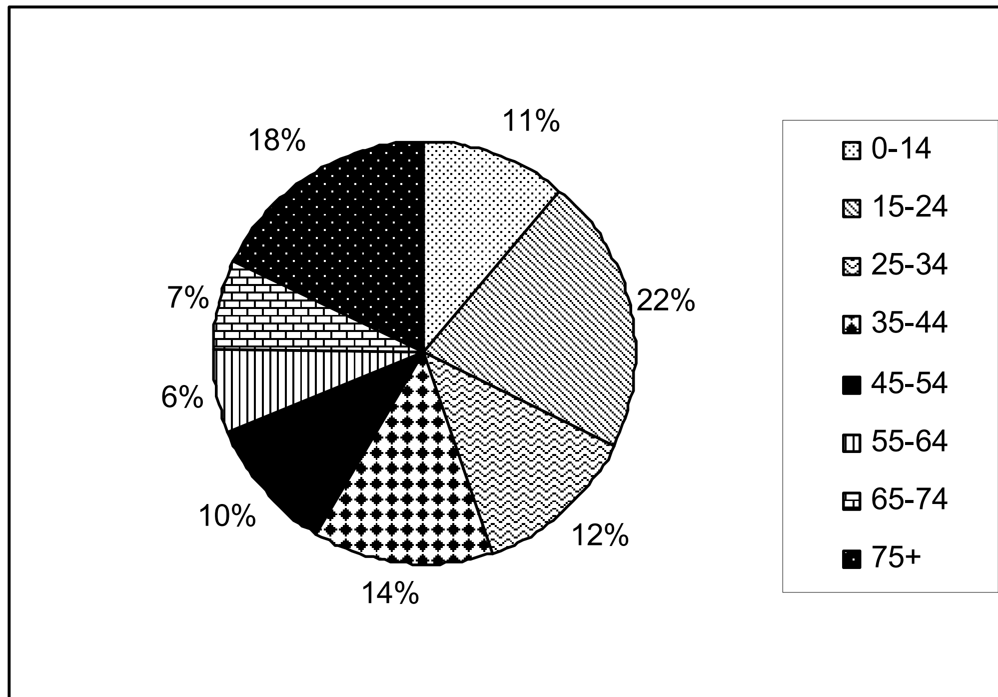


Evidence of the Need for Services

Prevalence of TBI

Approximately 1.4 million individuals sustain a TBI each year[2]. In 2002, an estimated 5,501 citizens of the State of Missouri were hospitalized for TBI, while another 1,084 died as a result of TBI[3]. Males are twice as likely as females to sustain a TBI. Motor vehicle accidents are the most frequent cause of TBIs requiring hospitalization, accounting for approximately 20% of all TBIs[1].

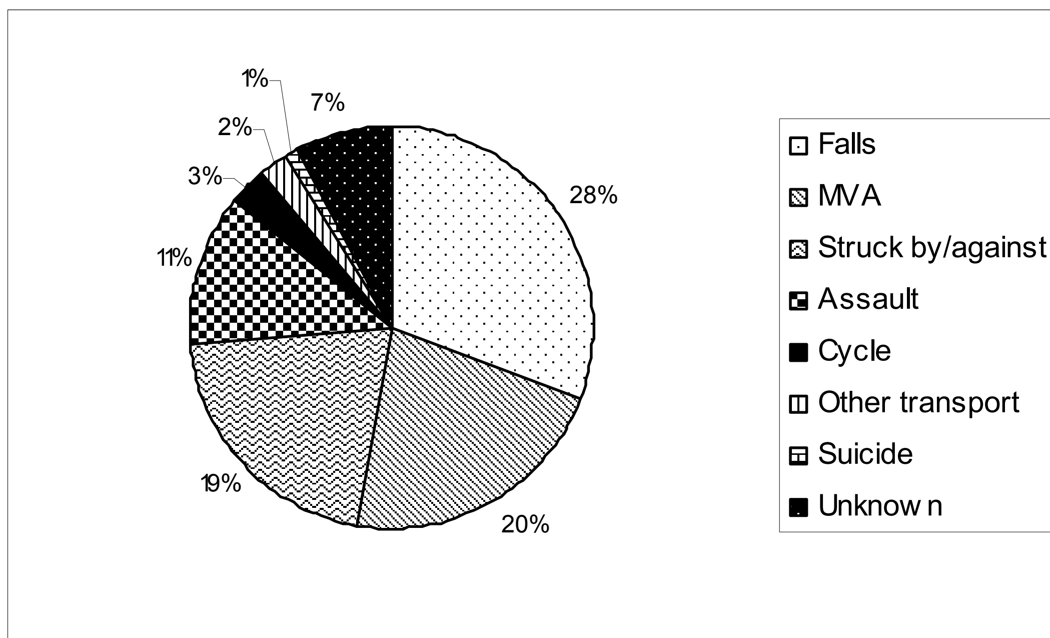
Figure 2: Missouri TBI Hospitalizations by Age



[2] Langlois JA, Rutland-Brown W, Thomas KE. Traumatic brain injury in the United States: emergency department visits, hospitalizations, and deaths. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2004.

[3] Data obtained on 06/06/06 from the Missouri Department of Health and Senior Services website: http://www.dhss.mo.gov/TBI/Stats.html

Figure 3: Causes of TBI Nationwide



Head Injury Program: Caring for Missourians

Research has indicated that in addition to acute and long-term rehabilitation interventions, service coordination activities can have a significant positive impact on long term outcomes following TBI[4].

Meeting this need for service coordination activities is the Missouri DHSS Bureau of Special Health Care Needs Head Injury Program.

- The number of individuals served by this program increased from 243 in 1997 to 491 in 2002. Following this peak in numbers served, there has been a small decline in consumers reflecting a smaller budget.
- In FY 2005, 370 individuals participated in the Head Injury Program.
- DHSS Special Health Care Needs Head Injury Program provided solely case coordination services to an additional 257 individuals with TBI who were deemed either ineligible or not requiring Head Injury Services.
- Thus, the total number of individuals with TBI served by the DHSS Special Health Care Needs program in 2005 was 607, which included 118 new enrollees.

[4] Cope DN, Mayer NH, Cervelli L (2005). Development of Systems of Care for Persons with Traumatic Brain Injury, Journal of Head Trauma Rehabilitation, 20(2), 128-142.

Head Injury Program: Review of Services

Demographics of clients involved in the Missouri DHSS Special Health Care Needs Head Injury Program in 2005 are provided below.

Figure 4: Racial and Ethnic Background
2005 Missouri Head Injury Program Clients

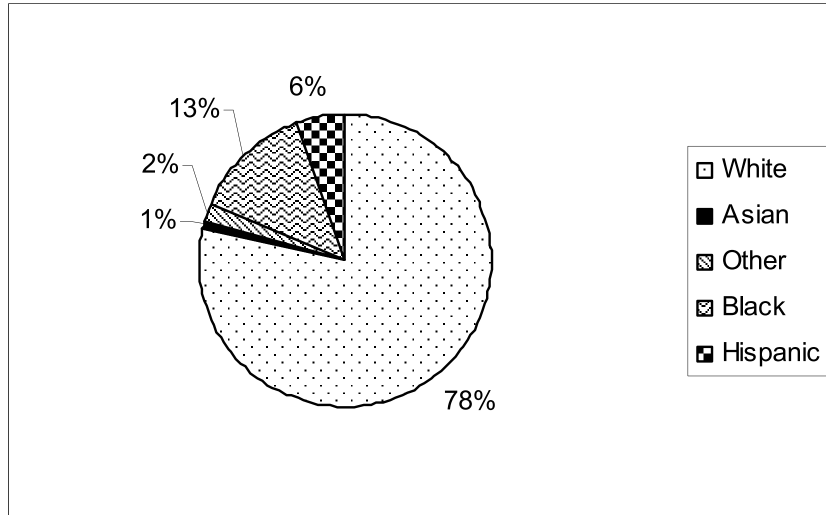
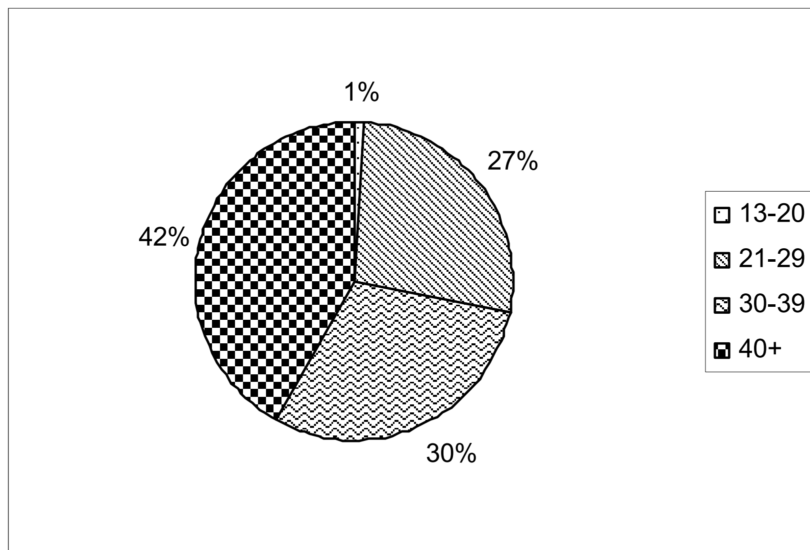
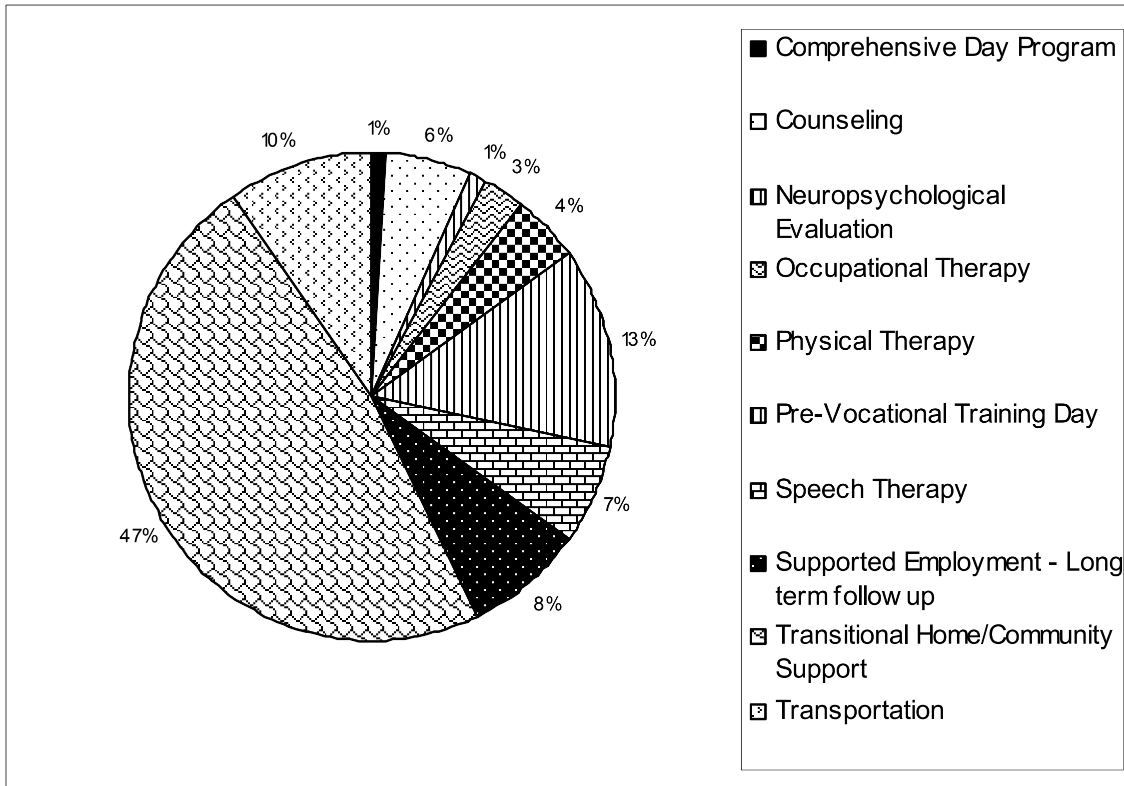


Figure 5: Age Distribution
2005 Missouri Head Injury Program Clients



In addition to case management services, the DHSS Bureau of Special Health Care Needs Head Injury Program provides a range of rehabilitation services to the consumers. Key services include Transitional Home and Community Support, Pre-Vocational Training, and Transportation. The following graph demonstrates the distribution of services provided to consumers in 2005.

Figure 6: Distribution of 2005 Missouri Head Injury Program Services



DHSS Services Provided and Functional Outcomes

Evaluation Participants

Ninety-eight (98) individuals with a history of traumatic brain injury (TBI) who requested services from the DHSS Head Injury Program were identified. They were separated into two groups (Early Referral [ER] and Comparison group [CG]). Clients who were referred for services within 90 days of their injury and/or those who were referred by one of the five identified partners in the Head Injury Program's Early Referral Project (see Figure 1) were identified as ER clients. Clients who were referred after 90 days post-injury and not by one of the five program partners were identified as CG clients.

The ER group was comprised of 67 clients, while the CG group included 31 clients. The groups did not differ significantly in terms of age (ER *M*=36.39, *SD*=10.23; CG *M*=36.87, *SD*=12.70). There were more men than women in both groups (see Figures 7 and 8). Both groups had approximately equivalent number of individuals residing in urban and rural counties (see Figures 9 and 10). Additionally, a majority of individuals across both groups had the equivalent of a high school education or less (see Figures 11 and 12).

Figure 7: Early Referral Gender Distribution

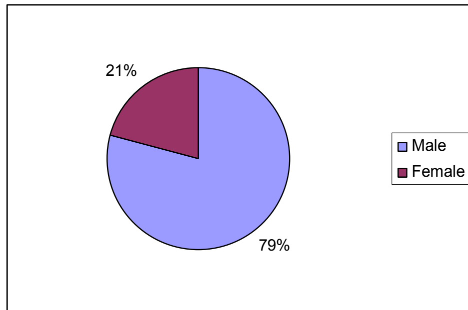


Figure 8: Comparison Group Gender Distribution

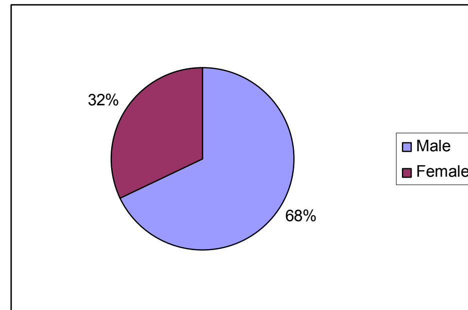


Figure 9: Early Referral Rural/Urban Residence

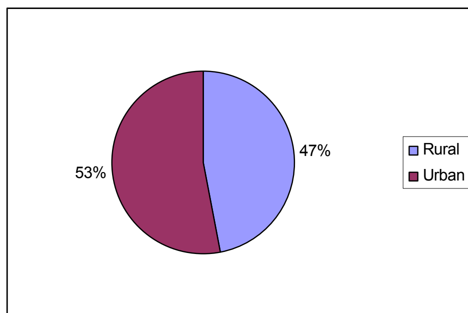


Figure 10: Comparison Group Rural/Urban Residence

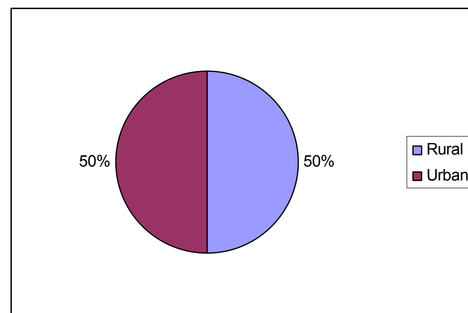


Figure 11: Early Referral Education

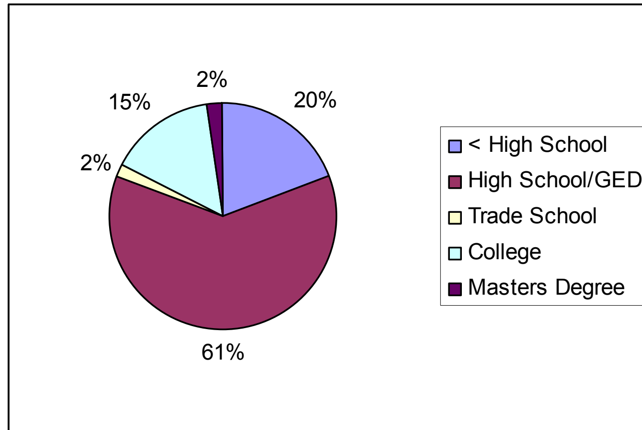
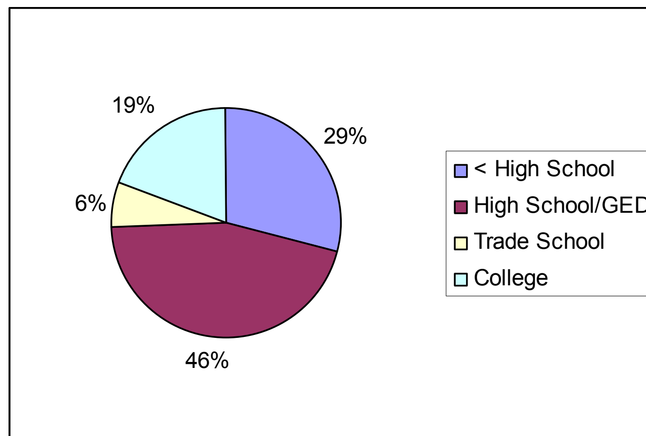


Figure 12: Comparison Group Education



Methods

DHSS Service Data. Information regarding clients' level of functioning when they began working with the Head Injury Services program was obtained from assessments completed by service coordinators at the time of enrollment: the Head Injury Program Assessment Tool [HIPAT] or the Special Health Care Needs Comprehensive Assessment Tool [CAT] (see Appendix A). Data regarding specific services provided by the TBI service coordinators were obtained from DHSS.

To provide an indication of TBI severity in each group, between group comparisons were conducted using HIPAT/CAT data, which documented the need for assistance in daily living skills, social functioning, and cognitive functioning at the time of enrollment in the Head Injury Program.

DHSS data were analyzed to compare the two groups in terms of contact with the TBI service coordinator. Given the clients' varying lengths of time enrolled in the program, a variable was created to document the number of contact hours as a function of the time enrolled. Between-group comparisons were conducted using a Wilcoxon Rank Sum test to assess for group differences in number of contacts (both the total and by contact type).

Functional Outcomes. Telephone surveys were used to evaluate outcomes in terms of Daily Living Skills, Community Involvement, Emotional Well-Being, and Vocational Status for individuals in both groups (see Appendix A). To enhance recruitment of participants for this evaluation, SHCN service coordinators were asked to contact their clients to confirm their contact information, inform them of this project, and invite their involvement.

Of the 98 potential participants, 34 individuals either declined to participate or could not be contacted. Each of the remaining 64 potential participants was called by phone a minimum of 5 times at varying points throughout the day and week (including evening and weekends). Thirteen (13) individuals could not be contacted. This resulted in the successful completion of phone interviews for 29 individuals in the Early Referral group and 22 individuals in the Later Referral group.

Findings

DHSS Service Data. A Wilcoxon Rank Sum test revealed a statistically significant difference in the overall functional status of clients in the Early Referral program compared to those who were referred at a later date ($p < 0.0001$) at the time of their initial enrollment. Specifically, and not surprisingly, those who were referred to the Head Injury Program more quickly after they sustained their TBI evidenced greater overall needs for assistance in daily living skills (e.g., meal preparation, financial management), social/emotional functioning, and cognitive abilities (e.g., communication, memory).

Largely consistent with the known effects of traumatic brain injury, it was noted that across groups, a greater percentage of individuals were identified as having functional limitations in the areas of social/emotional and cognitive functioning compared to mobility and basic daily living skills.

Figure 13: Early Referral Clients
Needing Assistance with Mobility

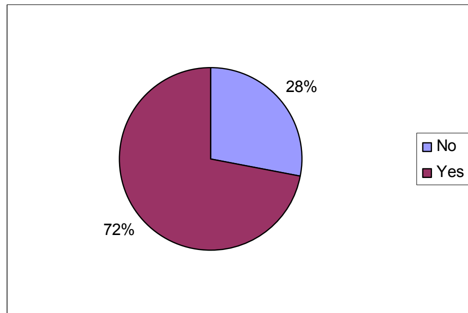


Figure 14: Comparison Group Clients
Needing Assistance with Mobility

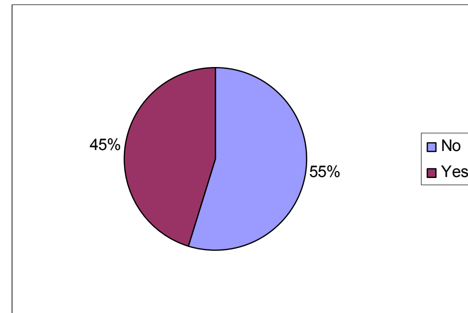


Figure 15: Early Referral Clients
Needing Assistance with ADLs

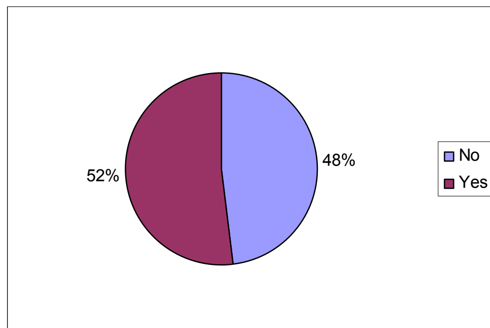


Figure 16: Comparison Group Clients
Needing Assistance with ADLs

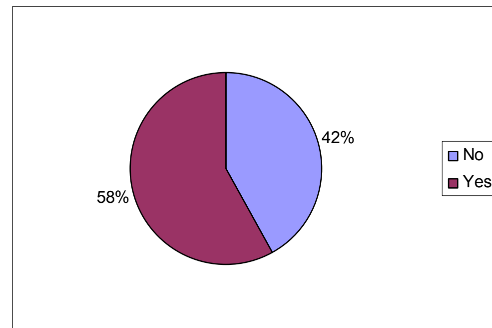


Figure 17: Early Referral Clients
Needing Assistance with Social Skills

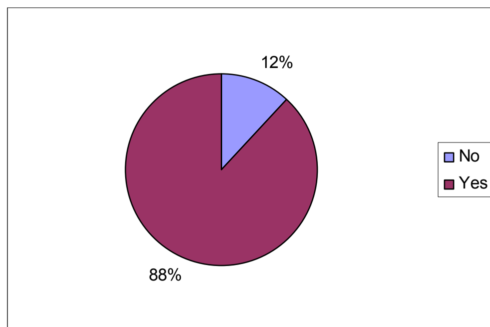


Figure 18: Comparison Group Clients
Needing Assistance with Social Skills

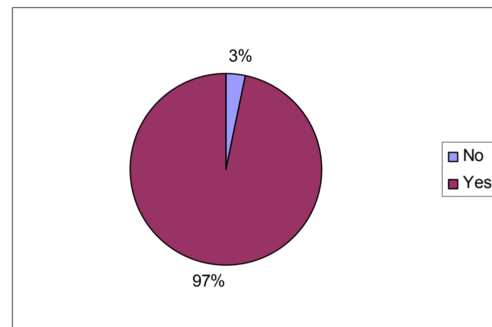


Figure 19: Early Referral Clients
Needing Assistance with Cognitive Skills

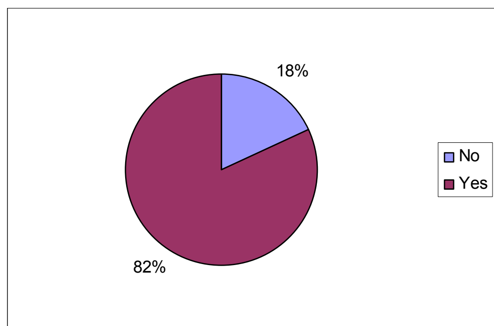
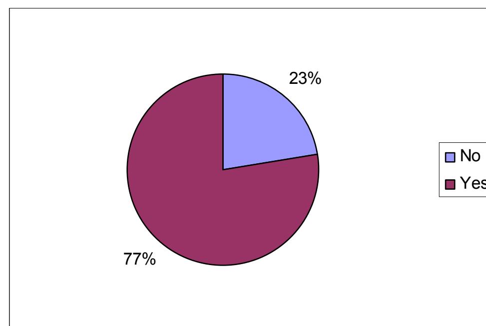


Figure 20: Comparison Group Clients
Needing Assistance with Cognitive Skills



Despite the greater functional limitations evidenced by clients in the ER group at the time of their initial enrollment in the Head Injury Program, there were no group differences in number or types of SHCN services received over time. Specifically, a Wilcoxon Rank Sum test revealed no significant difference between the two groups in terms of total number of contacts by the service coordinators ($p = 0.51$). In other words, the average number of contacts per year was no different among those referred following acute rehabilitation and those who came to the Head Injury program at a later date.

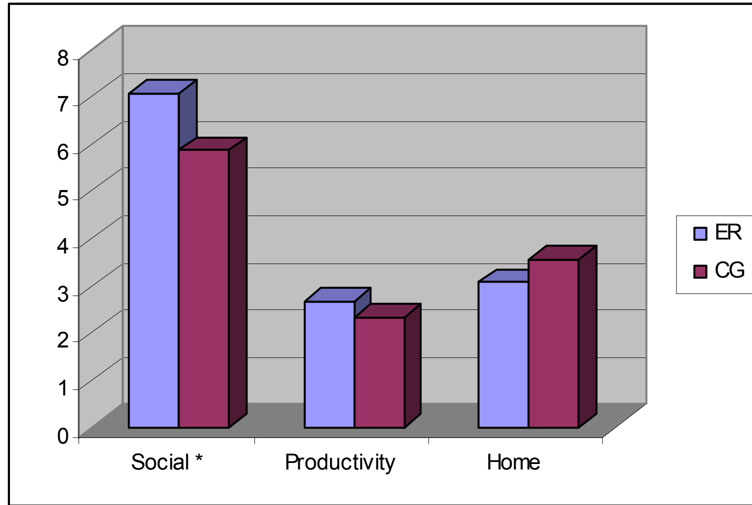
Subsequent analyses also revealed no group differences in the total number of services offered to the clients ($p = 0.17$) or in each type of service that was offered. Specifically, the groups did not differ in the amount of assistance received to address housing needs ($p = 0.28$) or work skills ($p = .76$). They also did not differ in their demands for general case management services ($p = 1$) or in case management/coordination with other agencies ($p = 0.70$).

These data are particularly interesting given that clients in the Early Referral Program had better functional outcomes than those referred later (see analyses below), as they suggest that the early application of a comparable level of services may result in better functional outcomes.

Functional Outcomes. Community involvement was measured with questions derived from the Community Integration Questionnaire[5], which has subscales including Home Integration, Social Integration, and Productivity. A Wilcoxon Rank Sum Test indicated that there was a statistically significant difference in levels of Social Integration between the two groups ($p < 0.0001$). Specifically, clients in the ER group reported significantly more involvement in practical and leisure activities outside of the home (e.g., shopping, visiting friends/family) compared to clients referred later. No differences were found in Home Integration ($p = 0.49$), which includes managing household chores, or general Productivity ($p = 0.17$), which includes involvement in activities outside the home such as school or work. (See Figure 21.)

[5] Willer BS, Rosenthal M, Kreutzer J, Gordon W, and Rempel R (1993). Assessment of the community integration following rehabilitation for traumatic brain injury. Journal of Head Trauma & Rehabilitation, 8(2), 75-87.

Figure 21: Differences in Community Involvement



Emotional status was measured by computing a composite score from a series of evaluation-specific questions that sought ratings of symptoms of distress during the past 30 days (e.g., sadness, anxiety, sleep difficulties). A Wilcoxon Rank Sum Test indicated that there were statistically significantly differences between the groups in emotional functioning ($p < 0.0001$), with notably lower levels of distress being reported by clients in the ER group.

Vocational functioning was evaluated in terms of number of weeks of competitive pay in the past year and number of hours of competitive pay per week. Analyses utilizing Wilcoxon Rank Sum Tests indicated that clients in the ER group are reporting significantly more hours of competitive pay/week ($p < 0.0001$) and significantly more weeks of competitive pay/year ($p < 0.0001$). When taking all sources of income into account (e.g., SSI, SSDI), individuals in the later referred group are reporting significantly higher total annual income ($p = 0.01$). This latter finding suggests that individuals in the comparison group were receiving greater financial support from non-work related sources compared to individuals in the ER group.

Consumer Satisfaction and Qualitative Data

Evaluation Participants

Ninety-eight (98) individuals with a history of traumatic brain injury (TBI) who requested services from the DHSS Head Injury Program were identified. The Early Referral (ER) group was comprised of 67 clients, while the comparison group (CG) included 31 clients. As noted above, of these 98 potential participants, 34 individuals either declined to participate or could not be contacted. Each of the remaining 64 potential participants was called by phone a minimum of 5 times at varying points throughout the day and week (including evening and weekends). This resulted in the successful completion of phone interviews for 29 individuals in the ER group and 22 individuals in the CG group.

Methods

Telephone surveys were conducted to evaluate consumer satisfaction with DHSS SHCN services using a questionnaire with five statements, and participants were asked to indicate the extent to which they agreed or disagreed with each. Additionally, to provide consumers with an opportunity to provide additional information regarding their experiences and perceptions of the DHSS SHCN program, nine open-ended questions were asked of each participant (See Appendix A). Quantitative comparisons of responses between the two groups were undertaken to determine whether the ER program resulted in greater satisfaction among consumers. Additionally, an analysis of the qualitative data was also completing, allowing the identification of themes for each group and across the entire sample.

"The most helpful assistance has been the emotional support. [The service coordinator] is consistent. She always checks up on me and keeps me informed about what is available for me."[6]

Findings

Satisfaction with Services. A composite variable of all satisfaction questionnaire items was created to compare the groups' ratings of their satisfaction with DHSS SHCN services. A Wilcoxon Rank Sum Test indicated there was a statistically significant difference between the total satisfaction reported by these two groups ($p<.0001$). Specifically, individuals in the ER group reported significantly higher levels of satisfaction compared to the CG group.

While the Early Referral Program is associated with greater overall satisfaction with services, it is worth noting that a high level of satisfaction is reported across both groups receiving Head Injury Services. For example, <u>98%</u> of all participants agreed with the statement *"I feel that the TBI Service Coordinators are an important part of the TBI*

[6] A 27 year-old woman with a history of TBI sustained in a motor vehicle accident, describing what she feels was the most helpful assistance she received from the TBI service coordinator.

Early Referral Program." Additionally, 91% of all participants interviewed agreed with the statement *"The TBI Early Referral Program is an Important Program for TBI survivors and family members."* Moreover, 90% of all participants indicated they would recommend the program to others dealing with traumatic brain injury.

Figures 13 and 14 demonstrate the high general level of satisfaction reported by consumers participating in the SHCN Head Injury Program. Additionally, it appears that the value of the program has perhaps been better demonstrated among those receiving services via Early Referral, as a greater number of these consumers identified the program as important (Figure 14).

Figure 13: Percentage Indicating TBI Service Coordinators are Important

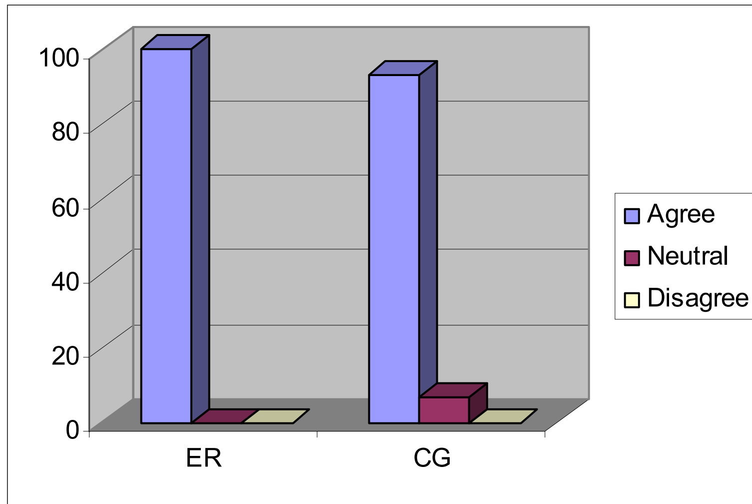
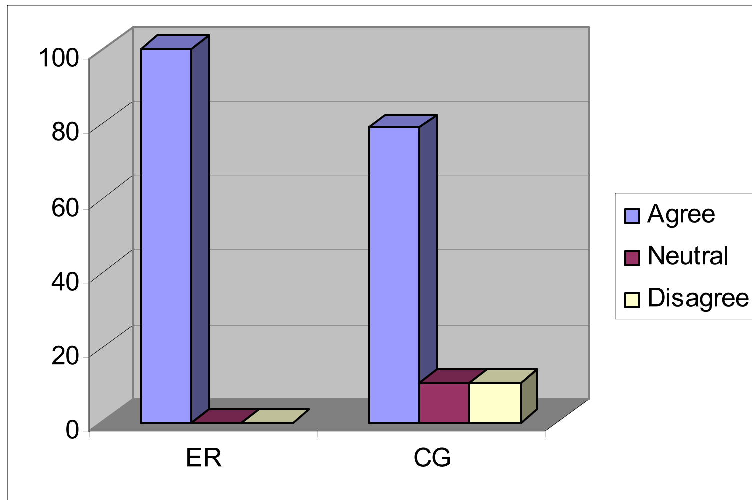


Figure 14: Percentage Indicating TBI Head Injury Program is Important



Although they reported being pleased with the DHSS SHCN program, consumers did indicate they have experienced some difficulties receiving TBI-related services in their community. Specifically, 52% of all participants report being dissatisfied with the TBI services in their communities, and 55% indicated they feel there is a general lack of services and resources for TBI survivors and family members. However, as Figures 15 and 16 demonstrate, individuals in the ER group were less dissatisfied than the CG group with their ability to access services, perhaps reflecting the positive benefits they have experienced with service coordination through the Early Referral Program.

Figure 15: Percentage Reporting Satisfaction with Access to Services in their Community

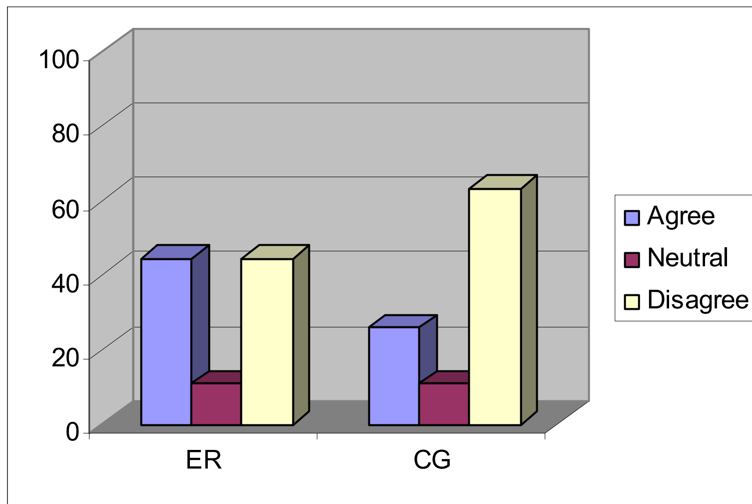
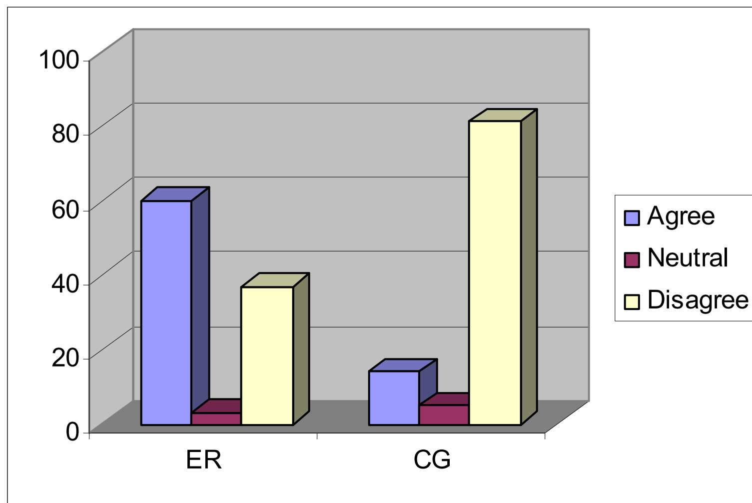


Figure 16: Percentage Reporting General Satisfaction with Services for TBI



Qualitative Themes. The telephone surveys included open-ended questions and qualitative analyses were conducted to identify impressions and concerns expressed by consumers. General themes revealed in responses to the questions are provided below:

(1) Few individuals reported problems with agency coordination, etc. while working with the service coordinator.

- 87% of individuals in the Early Referral Program reported no problems.
- 58% of individuals in the later referred group reported no problems.
- Of those who reported concerns, primary issues included difficulties with service providers at other agencies, problems applying for services from other programs (e.g., Social Security Disability), and the perception that not enough services were available.

(2) Consumers, particularly from the comparison group, reported wishing that information was provided sooner in the course of their recovery from TBI.

- Consumers stated it would have been helpful to have more information about state resources for TBI.
- Others indicated they would have benefit from more information about the consequences of TBI.
- Family members also reported they would have appreciated learning more about how to care for someone with TBI.

(3) A majority of consumers did not identify barriers to receiving assistance from the Bureau of Special Health Care Needs TBI service coordinators.

- 73% of individuals in the Early Referral Program reported no perceived barriers.
- 60% of individuals in the later referred group reported no perceived barriers.
- Of those who noted barriers, common concerns included perceptions that the program requires more funding and problems due to limited resources in the community (e.g., for physical therapies, etc.).

(4) Consumers identified services that they would appreciate receiving through the Bureau of Special Health Care Needs, including:

- More of the same services (e.g., in home assistance) and reinstatement of previously funded services (e.g., physical therapy, speech therapy).
- Increased availability of support groups and social activities for individuals with TBI and their families.
- Greater assistance with obtaining/maintaining employment, particularly for those individuals with more severe injuries.
- Increased access to transportation, particularly in rural areas.

(5) Consumers reported benefiting from the full complement of services offered by SHCN. Particularly valued services included:

- Social support and caring offered by the service coordinator.
- Coordination of services.
- Funding for other services (e.g., therapies, in home help).
- Advocacy and education regarding TBI.
- Transportation assistance.

(6) A majority of consumers reported realizing they would require community supports shortly after their return home following hospitalization. They indicated information regarding TBI services in Missouri should be provided early in the recovery process.

- 79% of respondents indicated information about services should be provided during acute rehabilitation and/or within one month following the individual's return home.
- 21% of respondents suggested that information be provided at multiple points during each individual's recovery following TBI (e.g., during acute rehabilitation, following their return home, 6-12 months after their return home) so that changing needs could be identified and addressed.

"It doesn't have to be a real bad injury to affect your whole life, and people need to be educated about this. The family especially needs information about what to expect in terms of long-term functioning. A TBI affects the whole family."[7]

[7] A 63 year-old man who sustained a TBI in a motor vehicle accident, describing why individuals who sustained a TBI need education about community services immediately after their injury.

Consumer Medicaid Comparisons

Evaluation Participants

As with the DHSS data comparisons, for these analyses ninety-eight (98) individuals with a history of traumatic brain injury (TBI) who requested services from the DHSS Head Injury Program were identified and separated into two groups (Early Referral [ER] and a comparison group of clients referred later [CG]). The ER group was comprised of 67 clients, while the CG group included 31 clients.

Questions

The goal of these analyses was to evaluate whether involvement in the Early Referral Program was associated with a reduction in use of medical services. Therefore, data from 2004 and 2005 were sought regarding the following variables: (1) annual number of doctor office visits, (2) annual costs of doctor office visits, (3) annual number of emergency room visits, (4) annual costs of emergency room visits, (5) annual number of personal care units, and (6) annual costs of personal care.

Methods

Data regarding the use and costs of medical services provided to the participants during 2004 and 2005 were obtained from the Division of Medical Services (DMS) of DHSS. In obtaining the data, several steps were taken to protect the privacy of the individual consumers who were involved in this project. The evaluation team provided DMS with a list of individuals for whom data was sought, with an indication of their group membership (i.e., whether they were part of the ER or CG group). DMS then provided the data to the evaluation team in format that had no identifying information other than an indication of whether the person was part of the ER or the CG group.

Between-group comparisons were conducted to evaluate whether involvement in the Early Referral program would be associated with fewer medical services and costs. Data from each year were analyzed separately.

Findings

Services in 2004. Data regarding services and Medicaid costs for 2004 were analyzed using a Wilcoxon Rank Sum Test, revealing a statistically significant difference between groups the number of doctor office visits ($p = 0.0003$) and personal care units used ($p < 0.0001$). Specifically, in 2004, individuals in the ER group went to the doctor's office more frequently and used more personal care services than those in the CG group. Related to these findings, in 2004 significantly more Medicaid funds were used for doctor office visits ($p < 0.0001$) and personal care services ($p < 0.0001$) for the ER group compared to the CG group. No significant between-group differences in frequency or costs of emergency room visits were observed in 2004.

In sum, the data from 2004 suggest that individuals in the Early Referral program required more medical and personal care services than those who were referred to the Head Injury Service at a later point in their recovery. While these findings were not originally predicted, in fact they are not surprising given the more recent nature of their

head injuries and the greater levels of functional impairment demonstrated by individuals in the ER group at the time of their enrollment in the Head Injury Program.

Services in 2005. Data regarding services and Medicaid costs for 2005 were also analyzed using a Wilcoxon Rank Sum Test. For 2005, there were no statistically significant differences between groups in terms of the number of doctor office visits; however, there was a difference in costs of doctor office visits ($p = 0.0007$), revealing greater costs associated with the ER group. Significantly more personal care units ($p < 0.0001$) and costs ($p < 0.0001$) were also found in 2005 for the ER group compared to the CG group.

Contrary to findings from 2004 data, there were significant group differences in frequency of visits and costs for emergency room services. Specifically, individuals in the CG group visited the emergency room more frequently than the ER individuals ($p < 0.0001$), and they incurred higher Medicaid costs for emergency room care ($p < 0.0001$).

Summary

It had been hypothesized that involvement in the TBI Early Referral Program would be associated with reduced medical services utilization and costs; however, data from 2004-2005 do not immediately support this. Rather, they reveal that in the early years of their involvement in the TBI Early Referral Program, these clients utilized more medical services than a comparison group of later referred individuals.

In considering these findings, it is worth noting that these analyses are limited because data from only the first 2 years of the program are available. It might be expected that, while clients in the Early Referral Program initially have greater medical needs due to their more recent TBIs, over time they may require relatively fewer services because medical and personal care requirements have been more proactively identified and addressed. Thus, while there may not be immediate cost benefits to the Early Referral Program, a net gain may be seen over time. Future analyses can further address this possibility.

Summary and Recommendations

Data from this evaluation reveal that the Department of Health and Senior Services Bureau of Special Health Care Needs TBI Early Referral Program provides a model of services that has great promise for meeting the needs of Missourians with a history of TBI.

As a group, current clients in this program are demonstrating better functioning in community, social and work settings than clients referred later to the Head Injury Program. Clients and families involved with the TBI Early Referral Program are also reporting higher levels of general satisfaction with the Bureau's Head Injury Program.

Importantly, these positive benefits are seen without additional expenditure of resources by the Head Injury Program, suggesting that early intervention may indeed be a key to maximizing clients' outcomes following a TBI.

Based on this formative evaluation, several future goals for the TBI Early Referral Program may be considered, including:

- Expand program to other hospitals / rehabilitation sites across the state. Service coordinators already covering the entirety of the state, so a goal would include strengthening relationships with all hospitals / rehabilitation facilities in Missouri.
- Shorten the wait list. Consumers indicated the services they received were valuable and they would have benefit from having them available more directly post-discharge.
- Continue to have contact with clients at regular intervals (e.g., 6 months, 1 year, 2 years), particularly if the clients have not been receiving services, as needs may have evolved.
- Enhance system for tracking individuals served in the TBI Early Referral Program so that functional outcomes can continue to be monitored.
- Establish a regular monitoring system of client satisfaction (e.g., mailed questionnaire 1x/year).
- Conduct a follow-up program evaluation with a prospective design, allowing for the pre-evaluation identification of individuals in the TBI Early Referral Program and a comparison group so that longitudinal analyses could be conducted.
- Continue to publicize the TBI Early Referral Program to ensure that consumers and the public are aware of the program's accomplishments, and so that all eligible consumers are identified and can be served.

Appendix A

Head Injury Program Assessment Tool [HIPAT]

Special Health Care Needs Comprehensive Assessment Tool [CAT]

TBI Early Referral Interview Form

TBI Early Referral Interview Open Ended Questions

TBI Early Referral Program Satisfaction Questionnaire

Head Injury Program Assessment Tool (HIPAT).

SECTION ONE - General Information

1) Reminder: Be sure to obtain an Authorization to Obtain and Release Information Form CC-21and discuss it with the consumer. Please have him/her read and sign it prior to the completion of the interview if not already on file.

2) Assessment Date:____________________________________

Assessment Type:
☐ Initial
☐ Update (*significant change*)
☐ Annual

3) Medical Records:
☐ Received documenting TBI information with referral.
☐ Request for medical records documentation of TBI Sent: ______
Received: ______

4) Referred by:
Individual: ____
Agency: ____
Telephone: ____
Date: ____

5) Please indicate primary source of information:
☐ Client
☐ Other, Name:____________________________________
Agency:____
Relationship:____________________________________
Telephone:______________________________________

6) Please indicate secondary source(s) of information:
☐ Medical Record
☐ Physician
Name:____
Telephone:______________________________________
☐ Other, Name:____________________________________
Agency:____
Telephone:______________________________________
☐ Other, Name:____________________________________
Agency:____
Telephone:______________________________________

Comments:

7) (*Check the appropriate box for both PLACE OF ASSESSMENT and for USUAL LIVING ARRANGEMENT prior to assessment. One box should be checked under each category.)*

If applicable, please note date of admission: ___________

Place of Assessment:	Usual Pre-TBI Living Arrangement	Usual Post-TBI Living Arrangement:	Choices:
☐	☐	☐	0 - No Residence
☐	☐	☐	1 - State Institution (Psych)
☐	☐	☐	2 - Nursing Facility
☐	☐	☐	3 - Residential Care Facility
☐	☐	☐	4 - ICF/MR
☐	☐	☐	5 - Other's Residence
☐	☐	☐	6 - Family's Residence/Apartment
☐	☐	☐	7 - Client's Own Residence/ Apt.
☐	☐	☐	8 - OTHER_________________

Comments:

8) Substitute Decision-Maker: (*check any number*)
☐ None
☐ Informal Decision Maker
☐ Guardian /Conservator (Non-DD)
☐ Living Will
☐ Guardian /Conservator(DD)
☐ Representative or Protective Payee
☐ Power of Attorney
☐ Power of Attorney for Health Care
☐ Limited Power of Attorney
☐ Other_________________
Name:____
Relationship: __________________ Telephone:______________
Comments:

9) Primary Language:____________________________________

Requires interpreter: ☐ YES ☐ NO

10) Legal Status: ☐ N/A ☐ On probation or parole
☐ Currently involved in criminal proceedings
☐ Commitment to:___________________
☐ Other:__________________________
Comments: *(If applicable, please note any legal restrictions)*

11) Preparing for discharge from hospital, nursing facility, or Institution:
☐ YES ☐ NO
Planned discharge date:
____
Comments:

12) Community Activity Level: Identify the client's level of social/ leisure community activity participation.

	PRE-TBI	POST-TBI
0 - No Community Activities.	☐	☐
1 - Some Community Activities, Supervised Group of Persons with Special Needs 100% of Time	☐	☐
2 - Some Community Activities, Supervised Group of Persons with Special Needs 75% of Time	☐	☐
3 - Some Community Activities, Supervised Group of Persons with Special Needs 50-75% of Time - Occasionally Activities are Integrated.	☐	☐
4 - Some Community Activities, Supervised Group of Persons with Special Needs 25-50% of Time - Frequently Activities are Integrated.	☐	☐
5 - Some Community Activities, Supervised Group of Persons with Special Needs 25% of Time - Most Activities are Integrated.	☐	☐
6 - Participates in Integrated Activities 100% of Time.	☐	☐

Client or family goal? ☐ YES. ☐ NO

Head Injury Program Assessment Tool (HIPAT).

SECTION ONE - General Information (continued)

13) Primary Caregiver information: Is client in a custodial facility? ☐ YES ☐ NO **IF YES, skip to question 19.**
Is there a primary caregiver? ☐YES ☐ NO **IF NO, skip to question 19.**

Is primary caregiver paid? ☐ NO ☐YES If **YES**, what is (are) the source(s) of payment?________________________________

If there is a primary caregiver, answer the following questions (check the appropriate box) : ☐ Caregiver not present
☐ Caregiver present at assessment.

Name of Primary Caregiver (current or potential):______________________________ **Telephone:**___________________

Address: ____ **City:** _____________________ **State:** _____________

14) Relationship:	**15) Age:**	**16) Hours available to provide care:** *(Fill in the hours on the specific days, such as Mon: 8 am - 1 pm. Add any comments below.)*	**17) Length of time as client's caregiver:**	**18) Special Training:** *(Check all that apply.)*
☐ Spouse ☐ Relative ☐ Other (please specify) _________________ _________________	☐ Under 18 ☐ 18-20 ☐ 21-39 ☐ 40-59 ☐ 60-74 ☐ 75-85 ☐ 86+	Mon________________ Tues________________ Wed________________ Thur________________ Fri________________ Sat________________ Sun________________	___________ Years ___________ Months	☐ N/A ☐ First Aid ☐ CPR (Cardiopulmonary Resuscitation) ☐ CNA (Certified Nursing Assistant) ☐ Other _________________ _________________

19) Caregiver Supports Needed: (*Obtain the caregiver's opinion about what he/she thinks is required for additional help or support for living in the community. Attach additional sheet if needed.)*

☐ TBI Education:

☐ Respite:

☐ Additional Caregiver(s):

☐ Other:

20) Additional caregivers / supports available: *(please list the name and check the box to indicate paid or unpaid status)*

Name	Paid	Unpaid	Name	Paid	Unpaid
____________________	☐	☐	____________________	☐	☐
____________________	☐	☐	____________________	☐	☐
____________________	☐	☐	____________________	☐	☐

21) Comments about current or future availability, or problems related to these caregiver/supports:
(Attach additional sheet if needed.)

22) Abuse, Neglect, or Exploitation: Is client currently experiencing or at risk for abuse, neglect, or exploitation? Check one box only. *(See instruction page for definitions. Any indication of abuse, neglect, or exploitation REQUIRES referral for assessment/investigation.)*

☐ **No indication** of any abuse, neglect, or exploitation occurring.
☐ **Indication of material abuse, neglect, or exploitation** that involves misuse of funds, property, or resources. The client is not in danger of any physical injury or pain.
☐ **Indication of psychological abuse, neglect, or exploitation** such as verbal assaults, threats, isolation, coercion, etc.
☐ **Indication of physical abuse, neglect, or exploitation and extreme violation of rights** where the client's health and safety are in danger.

Head Injury Program Assessment Tool (HIPAT)

SECTION TWO – General Health Information, Functional Abilities, Supports, and Related Information

1) Current Diagnosis (Physical and Mental Health): *(Check all that apply.)*

☐ **ALCOHOLISM/SUBSTANCE ABUSE**
☐ **BLOOD-RELATED PROBLEMS**
☐ **CANCER** Type: ________________
CARDIOVASCULAR PROBLEMS
☐ Circulation
☐ Heart Trouble
☐ High Blood Pressure
☐ Other Cardiovascular Problems
____
DEMENTIA
☐ Alzheimer's
☐ Non-Alzheimer's
DEVELOPMENTAL DISABILITIES
☐ Mental Retardation
☐ Cerebral Palsy
☐ Epilepsy/Seizure Disorder
☐ Related Conditions
____

☐ **DIGESTIVE/LIVER/GALL BLADDER**
ENDOCRINE (GLAND) PROBLEMS
☐ Diabetes
☐ Thyroid
☐ Other EndocrineProblems
____
☐ **EYE DISORDERS**
☐ **IMMUNE SYSTEM DISORDERS**
MUSCULAR / SKELETAL
☐ Arthritis / Rheumatoid Arthritis
☐ Osteoporosis
☐ Other Muscular / Skeletal Problems
____
NEUROLOGICAL PROBLEMS
☐ Traumatic Brain Injury
☐ Epilepsy/Seizure Disorders (non-DD)
☐ Spinal Cord Injury
☐ Stroke
☐ Other Neurological Problems
____

PSYCHIATRIC PROBLEMS
☐ Anxiety Disorders
☐ Bipolar
☐ Major Depression
☐ Personality Disorder
☐ Schizophrenia
☐ Other Psychiatric Problems
Pre-existing ☐ YES ☐ NO
RESPIRATORY PROBLEMS
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Pneumonia
☐ Other Respiratory Problems
____
URINARY / REPRODUCTIVE PROBLEMS
☐ Other Urinary / Reproductive Problems
____
☐ **ALL OTHER PROBLEMS**
____

2) Pertinent History (Physical and Mental Health):

3) Date of TBI:________________________ **Cause of TBI:** ________________________

4) Pertinent Treatment History for TBI:

5) CurrentTreatments / Therapies: ☐ **CHECK HERE IF NONE CURRENTLY**
(Use these codes to indicate frequency.)
01 QD *(once a day)* 03 2-3X a week 05 4-5X a week 07 Weekly 30 Monthly 66 PRN *(as needed)* 99 Other

Treatments/Therapies: Identify physician ordered / referred, or authorized services client currently receives. Check all that apply.	**FREQ.**	**PAYMENT SOURCE**	**Treatments/Therapies:** Identify physician ordered / referred, or authorized services client currently receives. Check all that apply.	**FREQ.**	**PAYMENT SOURCE**
☐ Behavioral Management Program………..	_____	________	☐ Ostomy Care.	_____	________
☐ Bladder Control Program…………………	_____	________	☐ Physical Therapy.	_____	________
☐ Bowel Control Program……………………	_____	________	☐ Psychotherapy.	_____	________
☐ Service Coordination / Case Management Assistance	_____	________	☐ Psych / Social Rehabilitation Svs.	_____	________
☐ Catheter Care.	_____	________	☐ Range of Motion / Strengthening.	_____	________
☐ Decubitus Care.	_____	________	☐ Recreation Therapy.	_____	________
☐ Diabetic Management.	_____	________	☐ Respiratory Therapy.	_____	________
☐ Licensed Nursing Care / Assessment. . . .	_____	________	☐ Restorative Therapy Program.	_____	________
☐ Medication Management.	_____	________	☐ Speech Therapy.	_____	________
☐ Occupational Therapy	_____	________	☐ Tracheostomy Suctioning.	_____	________
			☐ Tube Feeding.	_____	________
			☐ Wound or Skin Care.	_____	________
			☐ Other:__________________________	_____	________
			☐ Other:__________________________	_____	_______

6) Identify assistance required to follow through with treatments/therapies:

Head Injury Program Assessment Tool (HIPAT)

SECTION TWO – General Health Information, Functional Abilities, Supports, and Related Information (continued)

7) MEDICATIONS: ☐ Check here if NO PRESCRIBED MEDICATIONS

Total number of prescribed medications: ___________. Prescribing Physician: ____

Use These Route Codes:		Use These Frequency Codes:	
01 Oral	06 Inhalant	01 QD *(once a day)*	08 2-3X a week
02 IM / subcuta	07 IV / intravenous	02 BID *(2X a day)*	09 4-5X a week
03 NG / gastric	08 Other	03 TID *(3X a day)*	10 PRN *(as needed)*
04 Topical	09 Unknown	04 QID *(4X a day)*	11 Weekly
05 Rectal / vaginal		05 5 or more / 24 hours	12 Monthly
		06 QOD *(every other day)*	13 Other
		07 HS *(at bedtime)*	

Name / Dosage (list)	RTE	FRQ
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________
______________________________	________	________

8) Comments regarding medication use: *(Be sure to note whether client requires liquids versus pill form, crushed pills, etc.) Indicate whether the client and/or family need further education about the reason medication is prescribed and/or potential side effects.*

9) Does the client use any Over-the-Counter (OTC) medications or home remedies? ☐ **No** ☐ **Yes** IF YES, please list.

Head Injury Program Assessment Tool (HIPAT)

<table>
<tr><td colspan="3">SECTION TWO – General Health Information, Functional Abilities, Supports, and Related Information
Directions: Check one of the following in each item: N = None, MI = Minimal, MO = Moderate, E = Extensive, T = Total to show degree of assistance required. In the <u>Available Supports</u> column, Indicate the degree of existing supports received that are not paid by the Department of Health and/or other state agency. Include supports received from family, friends, neighbors, volunteers, church & paid caregivers, etc.</td></tr>
<tr><td>FUNCTION/ASSISTANCE REQUIRED:</td><td>Available Supports:
(Note assistive devices used)</td><td><u>Comments:</u></td></tr>
<tr><td>8) HEALTH/MEDICAL:</td><td></td><td></td></tr>
<tr><td>GENERAL HEALTH: ☐N ☐MI ☐MO ☐E ☐T
Identify the client's ability to manage general health care.

Medical home identified: ☐Yes ☐No

Primary Care Physician: ______________________

Address:__________________________________

__________________________________</td><td></td><td></td></tr>
<tr><td>MEDICATION ADMINISTRATION: ☐N ☐MI ☐MO ☐E ☐T
Identify the client's physical/cognitive ability to self-administer his/her own medication.</td><td></td><td></td></tr>
<tr><td>9) MOVEMENT/MOBILITY:</td><td></td><td></td></tr>
<tr><td>MOBILITY: ☐N ☐MI ☐MO ☐E ☐T
Identify the client's physical ability to get around, both inside and outside, using mechanical aids if needed.</td><td></td><td></td></tr>
<tr><td>TRANSFERRING: ☐N ☐MI ☐MO ☐E ☐T
Identify the client's ability to transfer when in bed or wheelchair.

.</td><td></td><td></td></tr>
<tr><td>ACCESS TO TRANSPORTATION: ☐N ☐MI ☐MO ☐E ☐T
Identify the client's ability to get to and from stores, medical facilities, and other community activities, considering the ability both to access and use transportation.</td><td></td><td></td></tr>
<tr><td>10) DAILY LIVING SKILLS:</td><td></td><td></td></tr>
<tr><td>PREPARING MEALS: ☐N ☐MI ☐MO ☐E ☐T
Identify the client's ability to prepare own food. Consider safety issues such as whether burners are left on or improper refrigeration of food.</td><td></td><td></td></tr>
<tr><td>TOILETING: ☐N ☐MI ☐MO ☐E ☐T
Identify the client's ability to get to and from the toilet (including commode, bedpan, and urinal), manage colostomy or other devices, to cleanse after eliminating, and to adjust clothing.
<u>Bowel Control Concerns:</u> ☐ YES ☐ NO
<u>Bladder Control Concerns</u>: ☐ YES ☐ NO
If YES, describe problems, including any special risks or care needed</td><td></td><td></td></tr>
<tr><td>PERSONAL HYGIENE: ☐N ☐MI ☐MO ☐E ☐T
Identify the client's ability to shave, care for mouth, and comb hair.</td><td></td><td></td></tr>
<tr><td>DRESSING: ☐N ☐MI ☐MO ☐E ☐T
Identify the client's ability to dress and undress, including selection of clean clothing or appropriate seasonal clothing.</td><td></td><td></td></tr>
</table>

Head Injury Program Assessment Tool (HIPAT)

SECTION TWO – General Health Information, Functional Abilities, Supports, and Related Information (continued) **Directions:** Check one of the following in each item: N = None, MI = Minimal, MO = Moderate, E = Extensive, T = Total to show degree of assistance required. In the *Available Supports* column, Indicate the degree of existing supports received that are not paid by the Department of Health and/or other state agency. Include supports received from family, friends, neighbors, volunteers, church & paid caregivers, etc.		
FUNCTION/ASSISTANCE REQUIRED:	Available Supports: (Note assistive devices used)	Comments:
10) DAILY LIVING SKILLS (continued):		
BATHING: ☐**N** ☐**MI** ☐**MO** ☐**E** ☐**T** Identify the client's ability to bathe and wash hair. Skin Problems: ☐ YES ☐ NO If YES, describe problems, including any special wound care, nail care, etc.		
FINANCES: ☐**N** ☐**MI** ☐**MO** ☐**E** ☐**T** Identify the client's ability to handle paying bills, managing checking/ savings accounts, and overseeing other items which are part of a household budget.		
SHOPPING: ☐**N** ☐**MI** ☐**MO** ☐**E** ☐**T** Identify the client's ability to shop for food and personal items.		
LAUNDRY: ☐**N** ☐**MI** ☐**MO** ☐**E** ☐**T** Identify the client's ability to do own laundry either at home or at Laundromat.		
HOUSEWORK: ☐**N** ☐**MI** ☐**MO** ☐**E** ☐**T** Identify the client's ability to clean surfaces and furnishings in his/her living quarters, including dishes, floors, and bathroom fixtures, and disposing of household garbage.		
11) NUTRITION:		
EATING MEALS: ☐**N** ☐**MI** ☐**MO** ☐**E** ☐**T** Identify the level of assistance needed to perform the activity of feeding and eating with special equipment if regularly used or special tray setup. Identify any special dietary needs/restrictions. Identify any medications that may affect nutritional status. Identify any behavioral issues that place client at nutritional risk: ☐ Consumes alcoholic beverages ☐ Poor denture status ☐ Forgets to eat ☐ Forgets having eaten		
12) COMMUNICATION:		
RECEPTIVE SPEECH: ☐**N** ☐**MI** ☐**MO** ☐**E** ☐**T** Identify the client's ability to understand information and/or environmental cues conveyed by others or encountered in usual community surroundings.		
EXPRESSIVE SPEECH: ☐**N** ☐**MI** ☐**MO** ☐**E** ☐**T** Identify the level of assistance needed to communicate client's wishes or ideas. Assistive device used: ☐Yes ☐No Has internet capacity: ☐Yes ☐No		

Head Injury Program Assessment Tool (HIPAT)

SECTION TWO – General Health Information, Functional Abilities, Supports, and Related Information (continued) **Directions:** Check one of the following in each item: N = None, MI = Minimal, MO = Moderate, E = Extensive, T = Total to show degree of assistance required. In the *Available Supports* column, Indicate the degree of existing supports received that are not paid by the Department of Health and/or other state agency. Include supports received from family, friends, neighbors, volunteers, church & paid caregivers, etc.		
FUNCTION/ASSISTANCE REQUIRED:	Available Supports: (Note assistive devices used)	Comments:
12) COMMUNICATION (continued):		
NONVERBAL: ☐N ☐MI ☐MO ☐E ☐T Identify the client's ability to present self in a social situation using acceptable body language.		
VISION: ☐N ☐MI ☐MO ☐E ☐T Identify client's ability to see for functional community activities. Assistive device used: ☐Yes ☐No If YES, describe:_______________________________________		
HEARING: ☐N ☐MI ☐MO ☐E ☐T Identify client's functional ability to hear for participation in community activities. Assistive device used: ☐Yes ☐No If YES, describe:_______________________________________		
13) SOCIAL/EMOTIONAL:		
DEPRESSION: ☐N ☐MI ☐MO ☐E ☐T Identify the degree to which symptoms of depression affect the client's day-to-day functioning. Medication prescribed: ☐Yes ☐No		
ANXIETY: ☐N ☐MI ☐MO ☐E ☐T Identify the degree to which symptoms of anxiety affect the client's day-to-day functioning. Medication prescribed: ☐Yes ☐No		
DISRUPTIVE/SOCIALLY INAPPROPRIATE BEHAVIOR: **☐N ☐MI ☐MO ☐E ☐T** Identify the degree to which disruptive/socially inappropriate behavior interferes with family or community relationships. Medication prescribed for behavioral management: ☐Yes ☐No Behaviors occur most often with: ☐Family ☐Other Behaviors most often are: ☐ Verbal abuse/threats ☐ Emotional Lability ☐ Physical aggression/threats/assaults		
ALCOHOL/DRUG ABUSE: ☐N ☐MI ☐MO ☐E ☐T Identify the level to which alcohol/drug abuse affects the client's health, overall independent functioning, and relationships with others. Pre TBI problem/treatment: ☐Yes ☐No Post TBI problem/treatment: ☐Yes ☐No		
SELF-PRESERVATION/ VICTIMIZATION: : **☐N ☐MI ☐MO ☐E ☐T** Identify the client's ability to discern and avoid situations in which he/she may be abused, neglected, or exploited.		

Head Injury Program Assessment Tool (HIPAT)

SECTION TWO – General Health Information, Functional Abilities, Supports, and Related Information (continued) **Directions:** Check one of the following in each item: N = None, MI = Minimal, MO = Moderate, E = Extensive, T = Total to show degree of assistance required. In the *Available Supports* column, Indicate the degree of existing supports received that are not paid by the Department of Health and/or other state agency. Include supports received from family, friends, neighbors, volunteers, church & paid caregivers, etc.		
FUNCTION/ASSISTANCE REQUIRED:	Available Supports: (Note assistive devices used)	Comments:
13) SOCIAL/EMOTIONAL (continued):		
DANGER TO SELF: ☐N ☐MI ☐MO ☐E ☐T Identify the degree to which the client displays self-injurious behavior such as self-mutilation, suicidal ideation/plans/gestures. Medication prescribed for problem: ☐Yes ☐No		
HALLUCINATIONS: ☐N ☐MI ☐MO ☐E ☐T Identify the degree to which the client displays symptoms of mental illness which complicates recovery and community re-entry. Pre TBI mental illness diagnosis/treatment: ☐Yes ☐No Post TBI treatment indicated: ☐Yes ☐No Symptoms: Medication prescribed: ☐Yes ☐No		
14) COGNITIVE:		
EMERGENCY RESPONSE: ☐N ☐MI ☐MO ☐E ☐T Identify the client's ability to recognize the need for and to seek emergency help.		
SUPERVISION: ☐N ☐MI ☐MO ☐E ☐T Identify the client's ability to remain in assigned area or on assigned tasks.		
ORIENTATION: ☐N ☐MI ☐MO ☐E ☐T Identify the client's ability to relate to person, place, time, and/or situation.		
MEMORY: ☐N ☐MI ☐MO ☐E ☐T Identify the client's ability to remember and use information. If a problem, strategies identified: ☐Yes ☐No If yes, most effective: ☐ Self-written notes. ☐ Verbal reminders. ☐ Written instructions from others.		
JUDGMENT: ☐N ☐MI ☐MO ☐E ☐T Identify the client's ability to use good judgement in simple, familiar situations. If a problem, strategies/supports identified: ☐Yes ☐No Life areas affected most often: ☐ Safety to self/others. ☐ Personal/family finances. ☐ Other: ____.		
PLANNING/ORGANIZING: ☐N ☐MI ☐MO ☐E ☐T Identify the client's ability to develop, initiate and follow through with planning/organizing day to day life activities.		
ATTENTION: ☐N ☐MI ☐MO ☐E ☐T Identify the client's ability to attend to person/task at hand or return to activity after short break.		

Head Injury Program Assessment Tool (HIPAT)

SECTION TWO – General Health Information, Functional Abilities, Supports, and Related Information (continued)

Directions: In the *Available Supports* column, Indicate the degree of existing supports received that are not paid by the Department of Health and/or other state agency. Include supports received from family, friends, neighbors, volunteers, church & paid caregivers, etc.

STATUS/ASSISTANCE REQUIRED:	Available Supports: (Note assistive devices used)	Comments:
15) EDUCATIONAL/VOCATIONAL:		
EDUCATION: Identify the client's educational achievement. PRE-TBI / POST-TBI 0 - No High School Diploma ☐ ☐ 1 - High School Diploma/GED ☐ ☐ 2 - Trade School ☐ ☐ 3 - Some College ☐ ☐ 4 - Bachelor Degree ☐ ☐ 5 - Master's Degree ☐ ☐ 6 - Ph.D. ☐ ☐ Special Education? ☐ YES. ☐ NO Client or family goal? ☐ YES. ☐ NO Currently in School? ☐ YES. ☐ NO If YES: ☐ Full Time ☐ Part Time Coursework: ______________________________ Type of assistance required:______________________________ ______________________________		
VOCATIONAL: Identify client's work status. *(Enter Full or Part Time where applicable)* PRE-TBI / POST-TBI 0 - No Employment ☐ ☐ 1 - In School/Training ☐ ☐ 2 - Volunteer ☐ ☐ 3 - Sheltered Workshop ☐ ☐ 4 - Sporadic/Casual Employment ☐ ☐ 5 - Supported Employment ☐ ☐ 6 - Independent Competitive Employment ☐ ☐ Type of work done:______________________________ Longest job held: ______________________________ Client or family's goal? ☐ YES. ☐ NO		
16) FAMILY		
IDENTIFY FAMILY SUPPORTS AVAILABLE: ☐ Poor/no family support. ☐ Family requires education on TBI/strategies. ☐ Family appears functional and realistically supportive. ☐ Family has accommodated for important roles and responsibilities.		
17) CULTURAL/BELIEF SYSTEM		
ARE THERE ANY CULTURAL/BELIEF SYSTEM CONCERNS? ☐ YES. ☐ NO. Explain:		

Head Injury Program Assessment Tool (HIPAT)

SECTION TWO – General Health Information, Functional Abilities, Supports, and Related Information *(continued)*

IMPORTANT: THIS PAGE MUST BE COMPLETED IF CLIENT IS SEEKING SERVICES IN THE HOME.

18) Please note source of information: ☐ Observed through site inspection ☐ Reported by client and/or client's representative

19) ENVIRONMENT - *Exterior* **CHECK ALL THAT APPLY**

Areas to Review	Observations	N/A	Areas to Review	Observations	N/A
LIVING ARRANGEMENT	☐ Own ☐ Trailer ☐ Rent ☐ One-Story ☐ Apartment ☐ Two-Story ☐ House ☐Three Story ☐ Duplex		SIDEWALKS	☐ Adequate ☐ Uneven ☐ Missing ☐ Cracked	
			HANDRAILS	☐ Adequate ☐ Missing ☐ Too low ☐ Loose	
WINDOWS	☐ Adequate ☐ Poor fit ☐ Won't lock ☐ No shade ☐ Glass broken		PORCH	☐ Adequate ☐ Uneven ☐ No stairs ☐ Needs ramp ☐ Unstable	
MAINTENANCE	☐ Adequate ☐ Unkempt ☐ Scattered rubbish ☐ Snow removal ☐ Pet droppings		DOORS	☐ Adequate ☐ Poor locks ☐ Poor fit ☐ Broken glass	
NEIGHBORHOOD SAFETY	☐ Adequate ☐ Client concern ☐ Unable to assess		HOUSE NUMBER	☐ Adequate ☐ Hidden ☐ None	

20) ENVIRONMENT - *Interior* **CHECK ALL THAT APPLY**

Areas to Review	Observations	N/A	Areas to Review	Observations	N/A
WHEELCHAIR ACCESS	☐ Adequate ☐ Needs Modifications (Please identify type and location)		LIGHTING	☐ Adequate ☐ Night lights ☐ Burned out bulbs ☐ Inadequate lighting ☐ Unable to assess	
FLOORS	☐ Adequate ☐ Uneven ☐ Broken ☐ Loose carpeting ☐ Excessive clutter		STAIRS	☐ Adequate ☐ Cluttered ☐ Need repair ☐ Narrow ☐ Need handrail ☐ Steep	
TUB/SHOWER	☐ Adequate ☐ Unsanitary ☐ Clogged drain ☐ No handrail ☐ No transfer space ☐ Needs safety equipment		ELECTRICAL SAFETY	☐ Adequate ☐ Bare wires ☐ Unsafe extension cords ☐ Overloaded ☐ Power off ☐ Unable to assess	
TOILET	☐ Adequate ☐ Leaks ☐ Won't flush ☐ Outdoors ☐ Needs safety bar ☐ No transfer space		APPLIANCES	☐ Adequate ☐ Needs repair *(Please identify appliances and reason for repair)*	
CLEANLINESS	☐ Adequate ☐ Odor ☐ Rubbish/Trash ☐ Unclean food prep area ☐ Excrement /urine in inappropriate receptacle		HEATING/ COOLING	☐ Adequate ☐ Poor ventilation ☐ Space heaters ☐ Gas fumes ☐ Furnace not working ☐ Unable to assess	
OTHER ISSUES	☐ None ☐ Insects ☐ Pet droppings ☐ Rats / Mice ☐ Termites ☐ Cockroaches ☐ No hot water ☐ Fleas		SAFETY FACTORS	☐ Adequate ☐ No smoke alarm ☐ Inaccessible exits ☐ Limited phone access ☐ No telephone ☐ Improper chem. storage ☐ No emergency food ☐ No knowledge of emergency access or 911 ☐ Other_______________________	

21) Are there other things around the home that need modification and/or care/repair?

Head Injury Program Assessment Tool (HIPAT)

Summary Sheet & Program Service Plan Considerations

Client Name: DCN Number:

SECTION ONE - Usual Living Arrangement Summary
Enter number corresponding to Usual Post TBI Living Arrangement.
Usual Living Arrangement Score = ______ (Initial) _______ Score at Update/Date.

SECTION TWO - Functional Abilities, Supports, and Related Information Summary
(Use instructions to determine scores.) Enter **H** (3-4) for high unmet need, **M** (2) for moderate unmet need, **L** (0-1) for low unmet need.

Functional Area	Score	Unmet Need (H,M,L)	Functional Area	Score	Unmet Need (H,M,L)
HEALTH/MEDICAL			Hearing		
General Health			**TOTAL COMMUNICATION**		
Medication Administration			SOCIAL/EMOTIONAL		
TOTAL FOR HEALTH/MEDICAL			Depression		
MOVEMENT/MOBILITY			Anxiety		
Mobility			Disruptive/Socially inappropriate behavior		
Transferring			Alcohol / Drug Abuse		
Access to Transportation			Self Preservation / Victimization		
TOTAL MOVEMENT/MOBILITY			Danger to Self		
DAILY LIVING SKILLS			**TOTAL SOCIAL/ EMOTIONAL**		
Preparing Meals			COGNITIVE		
Toileting			Emergency Response		
Personal Hygiene			Supervision		
Dressing			Orientation		
Bathing			Memory		
Finances			Judgement		
Shopping			Planning / Organizing		
Laundry			Attention		
Housework			**TOTAL COGNITIVE**		
TOTAL DAILY LIVING SKILLS			RELATED INFORMATION	**STATUS/GOAL INDICATOR (H,M,L)**	
NUTRITION			Usual Living Arrangement		
Eating Meals			Community Activity Level		
TOTAL NUTRITION			Educational		
COMMUNICATION			Vocational		
Receptive Speech			Family Supports		
Expressive Speech			Cultural/Belief System		
Non-Verbal			Environmental Exterior		
Vision			Environmental Interior		
			TOTAL RELATED INFORMATION		

41) Does a recommendation need to be made that the client see a physician for a medical problem not being addressed?

☐ **YES** ☐ **NO**

Specifics:____

____

____

42) What is the client's stated long-term goal? (Record verbatim)

____

____

____

Summary Sheet & Care Plan Considerations (continued)						
42) Identify assistance required and potential funding source/or natural supports:	**DOH**	**DMH**	**DMS**	**DVR**	**INS**	**COMMENTS:**
☐ Comprehensive Day Program						
☐ Counseling						
☐ Neuropsychological Evaluation & Consultation						
☐ Occupational Therapy						
☐ Physical Therapy						
☐ Pre-Vocational / Pre-Employment Training						
☐ Recreation (Service & Transportation)						
☐ Speech / Language Therapy						
☐ Supported Employment – Long Term Follow-up						
☐ Transitional Home & Community Support						
☐ Transportation						
☐ Other: ______________________________						
☐ Other: ______________________________						

SUMMARY OF REFERRALS:

Referral Made to:	Reason for Referral:	Referral Date:
________________________________	____	______
________________________________	____	______
________________________________	____	______

ASSESSOR(S) SIGNATURE(S):

HIPAT Section 1: Name:__________________________ **Agency:**________________**Telephone:**________________ **Date:**________

HIPAT Section 2: Name:__________________________ **Agency:**________________**Telephone:**________________ **Date:**________

HIPAT Section 3: Name:__________________________ **Agency:**________________**Telephone:**________________ **Date:**________

HIPAT Section 4: Name:__________________________ **Agency:**________________**Telephone:**________________ **Date:**________

PROGRAM SERVICE PLAN CONSIDERATIONS:

Client Name: ____ DCN No:___________________________________

Summary of Care Needed: (*Include summary of any needs related to primary caregiver support, exterior/interior environmental issues, assistive devices and medical equipment, functional supports and abilities, psychological/social/cognitive concerns, and any other information necessary to generate a care plan.)*

COMMENT SPACE

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Special Health Care Needs Comprehensive Assessment Tool (CAT)
Adult Life-Stage (21-65)

SECTION ONE-PARTICIPANT INFORMATION

Home Address: ____________________________________

____

Mailing Address: ____________________________________

____

Phone: ____________________________________

Primary Language: ____________________________________

Participant/Family requires an interpreter: ☐ Yes ☐ No

Responsible Party/Substitute Decision Maker/Contact Information (check all that apply):

☐ Parent:
☐ Guardian/Conservator
☐ Power of Attorney
☐ Limited Power of Attorney
☐ Informal Decision Maker
☐ Representative or Protective Payee
☐ None ____________________________________
☐ Other, specify: ____________________________________

Service Coordinator: ______________________________

Assessment Type:

☐ Initial Date: ____________________

☐ Annual Date: ____________________

Medical Records:

☐ Requested Date: ____________________

☐ Received Date: ____________________

Name and Address of the person indicated:

Name: ____________________________________

Address: ____________________________________

Phone: ____________________________________

Health Care Team and Information Sources:

☐ Participant
☐ Parent
☐ Foster Parent
☐ Caregiver

Phone:

Name and Address of the person indicated:

Name: ____________________________________

Address: ____________________________________

____

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION ONE-PARTICIPANT INFORMATION (CONTINUED)

☐ Physician/PCP

Name: ____________________

Address: ____________________

Phone: ____________________

☐ Physician/Specialist:

Name: ____________________

Address: ____________________

Phone: ____________________

☐ Physician/Specialist

Name: ____________________

Address: ____________________

Phone: ____________________

☐ Physician/Specialist:

Name: ____________________

Address: ____________________

Phone: ____________________

☐ Other

Name: ____________________

Address: ____________________

Phone: ____________________

☐ Other:

Name: ____________________

Address: ____________________

Phone: ____________________

☐ Medical Records

Insurance/Third Party Payer: ____________________

Comments: ____________________

Name: ______________________________ DOB: _____________ DCN: _____________ Date: _____________

Adult Life-Stage (21-65)

SECTION TWO-GENERAL HEALTH AND CURRENT TREATMENT

Medical Home Tool

Individuals with SHCN will receive coordinated ongoing comprehensive care within a medical home.

1. Participant has a usual source of medical care:
   - Participant has a usual source of care when sick ☐ Yes ☐ No
   - Participant has a usual source for preventive care ☐ Yes ☐ No
2. Participant has seen a PCP or specialist within the past year ☐ Yes ☐ No
3. Effective service coordination is provided:
   - Participant's health care providers share information with each other ☐ Yes ☐ No
   - Participant's health care providers and other ☐ Yes ☐ No
   - non-medical professionals (school, child care, other agencies, etc.) share information with each other ☐ Yes ☐ No
4. Participant receives family-centered care:
   Does the physician who sees the participant the most:
   - Usually or always spend enough time at visits? ☐ Yes ☐ No
   - Usually or always listen carefully? ☐ Yes ☐ No
   - Usually or always consider our values & customs? ☐ Yes ☐ No
   - Usually or always provide needed information? ☐ Yes ☐ No
   - Usually or always make my family feel like a partner? ☐ Yes ☐ No
5. Community-based services are organized so that they are easy for myself or my family to use:
   - My family and I know who to call when we need services ☐ Yes ☐ No
   - The participant can get referrals when they are needed ☐ Yes ☐ No
   - The participant receives the majority of services in our local community. ☐ Yes ☐ No
   - The participant has adequate health insurance to pay for needed services ☐ Yes ☐ No
   - There are no language or mobility barriers that interfere with getting care for the participant (e.g., language interpreter is available, office is wheelchair accessible) ☐ Yes ☐ No

Criteria are met for Medical Home ☐ Yes ☐ No

Instructions

For the purpose of this assessment, "Criteria are met for Medical Home", will be indicated as "yes" if:

1. Questions 1 and 2 are answered "yes", and
2. A total of five items from questions 3, 4 & 5 are answered "yes". There should be at least one "yes" response for each of these three questions.

Developed through collaboration of the Missouri Department of Health and Senior Services, Unit of Special Health Care Needs, and the Missouri Partnership for Enhanced Delivery of Services (MO-PEDS), a program of the University of Missouri-Columbia

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION TWO-GENERAL HEALTH AND CURRENT TREATMENT (CONTINUED)

Health History (Physical and Mental): ____

____

____

Current Status: ____

____

____

Diagnosis (include ICD-9 codes -all that apply): ____

____

Last Hospitalization (Date and Reason): ____

____

____

Last Physical Exam (Date/recommendations/next appointment): ____

____

Last Specialist Exam (Date/recommendations/next appointment): ____

____

Last Hearing Exam (Date/recommendations/next appointment): ____

____

Last Vision Exam (Date/recommendations/next appointment): ____

____

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION TWO-GENERAL HEALTH AND CURRENT TREATMENT (CONTINUED)

Last Dental Exam (Date/recommendations/next appointment): ______________________________

____

Immunization Status: ☐ Current ☐ Immunizations needed

Comments: ______________________________

____

Does the participant need to be referred to a physician for a medical problem not being addressed? ☐ Yes

Specifics: ______________________________

____

Current Treatments/Therapies/Services:

☐ No current treatments/therapies/services

Treatment/Therapies: (i.e., PT, OT, ST, SN, PCA, APC, PDN, ARN, Counseling, and DME, etc.)

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION TWO-GENERAL HEALTH AND CURRENT TREATMENT (CONTINUED)

Medications:

☐ Participant takes no prescription medications ☐ No known allergies

☐ Medications are listed on an attachment ☐ Allergies ________

List Medication / Dosage / Route of Administration / Frequency (include over the counter medication and home remedies)	Prescribing Physician

Comments regarding medication use: ____

____

____

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION THREE-ADULT LIFE-STAGE ASSESSMENT

HEALTH/MEDICAL:

How do you keep track of knowing when your medical appointments are coming up?

If you're not sure, who helps you remember?

Describe how you keep track of when it's time to go to your doctor for a regular checkup?

Is there anything about your health that concerns you or your family right now?

Do you take your medications by yourself, or need help?

What kind of help do you need, and who helps you?

HEALTH/MEDICAL NEED(S):

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION THREE-ADULT LIFE-STAGE ASSESSMENT (CONT.)

MOVEMENT/MOBILITY:

Is there any equipment you use to get around in your home?

Can you transfer to the bed/commode by yourself, or need someone to help you?

If so, what kind of help do you need, and who helps you?

What about in the community? How easy is it for you to get to and from stores or to appointments?

Can you drive yourself/take a bus or taxi?

If not, what kind of help do you need, and who usually helps you?

Describe some examples of activities you've done this week outside of your home.

Current Community Participation Level

- ❑ 0 – No Community Activities
- ❑ 1 – Some Community Activities – 50-100% supervised/special needs groups
- ❑ 2 - Some Community Activities - 25-50% supervised/SN groups
- ❑ 3 – Frequent Integrated Community Activities (Independent or with family

MOVEMENT/MOBILITY NEED(S):

Name: ____________________________ DOB: _____________ DCN: _____________ Date: _____________

Adult Life-Stage (21-65)

SECTION THREE-ADULT LIFE-STAGE ASSESSMENT (CONT.)

DAILY LIVING SKILLS:

Note: It is necessary to ask for concrete examples to show actual performance of activities, the type of assistance provided by another, and scope of the need.

Do you fix your own meals?

If not, what kind of help do you need, and who helps with this?

If you cook, do you use the stove or microwave?

Are you able to get to and from the toilet on your own and clean yourself up?

If not, what kind of help do you need?

Who helps you?

Do you have any concerns about controlling your bladder or bowels?

If so, what are they?

Do you take care of bathing, brushing your own teeth, shaving, combing your hair?

If not, what kind of help do you need, and who helps you?

Do you pick out your own clothes each day and dress yourself?

If not, what kind of help do you need, and who helps you?

Do you have a checking or savings account in your name?

If yes, have you had any problems being overdrawn in the past six months or so?

Do you have a budget so you know how much money you have to spend for certain things?

Adult Life-Stage (21-65)

SECTION THREE-ADULT LIFE-STAGE ASSESSMENT (CONT.)

If yes, do you usually stay within your budget?

Do you take care of your own shopping for groceries or other things?

If not, what kind of help do you need, and who helps you?

Do you take care of washing and drying your own clothes?

If not, what kind of help do you need, and who helps you?

Do you have a washer/dryer at home or do you go to the Laundromat?

Do you take care of cleaning your own house (dishes, floors, garbage, bathroom, etc.)?

If not, what kind of help do you need, and who helps you?

Current Independent Living Level

- ❑ 0 - Group home/supervised living
- ❑ 1 - Independent with external supports
- ❑ 2 - Independent with natural supports
- ❑ 3 - Fully Independent

DAILY LIVING SKILLS NEED(S):

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION THREE-ADULT LIFE-STAGE ASSESSMENT (CONT.)

NUTRITION:

Do you have any concerns about your weight or eating? If so, what?

Describe your usual eating habits:

Do you require a special diet or nutrition supplement?

Do you require any feeding devices? If so, what?

NUTRITION NEED(S):

COMMUNICATION:

Is there any equipment you use to help you communicate?

If so, what?

Do others in your family or your friends know how to help you communicate?

Describe any problems/misunderstandings you have when communicating with others:

Family members:

Acquaintances or people you see outside the home:

COMMUNICATION NEED(S):

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION THREE-ADULT LIFE-STAGE ASSESSMENT (CONT.):

SOCIAL/EMOTIONAL

How often do you get out of the house for enjoyment?

What kinds of activities do you do?

What activities do you enjoy?

Who do you do these activities with, friends or family?

Describe some entertaining activities you did this past month.

Is there anything about your social life that has changed in the last year?

Have any of the following been a problem for you in the past year?

- Feeling depressed?
- Feeling overly anxious/nervous?
- Acting out: such as yelling at people, hitting, avoiding others because you get angry or upset when around them?
- Drinking or taking drugs?
- Hurting yourself/thoughts of or attempts at suicide?
- Feeling neglected or abused?
  - If yes, how, and by whom?
  - If no, have any of these ever been a problem that you had to get professional help for in the past?

SOCIAL/EMOTIONAL NEED(S):

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION THREE-ADULT LIFE-STAGE ASSESSMENT (CONT.)

COGNITIVE/INTELLECTUAL:

Describe a problem or situation you've had to think through recently, and how you handled it.

Was there anyone who helped you?

If yes, what kind of help was given and who helped you?

How long do you usually sit and read or watch TV?

Can you usually make sense out of what you've read or watched, or has this been a problem?

Describe what you would do to help yourself remember something important?

Describe how you usually go about planning for a regular shopping trip or other activity:

What steps do you take to get ready?

Are any of those steps that are hard for you?

If yes, which areas do you need help with and what kind of help would you need, and who would help you?

Give an example of a situation that required you to use your judgment:

How do you feel you handled that situation?

As well as you could, or do you wish you had handled it differently?

If someone else (like your family) were asked, would they give the same answer?

COGNITIVE/INTELLECTUAL NEEDS:

Name: _____________________________ DOB: _____________ DCN: _____________ Date: _____________

Adult Life-Stage (21-65)

SECTION THREE-ADULT LIFE-STAGE ASSESSMENT (CONT.)

VOCATIONAL/EDUCATIONAL:

What was the highest grade in school you completed?

What were your average grades?

Do you have a diploma?

Did you have any Special Education Services?

If yes, what were they?

What classes did you like the best or do the best in?

Did you participate in extracurricular activities?

What kinds of jobs have you done in the past?

What was the longest job you held?

What was the reason you usually left jobs?

What is your present job status?

Current Vocational Level

0 - No Employment

1 – In School/Training

2 – Volunteer

3 – Sheltered Workshop

4 - Sporadic/casual employment

5 – Supported Employment

6 – Independent Competitive Employment

Are you currently restricted in any way by the courts (probation/parole, current court case pending, any legal restrictions on traveling, etc.)?

Are you interested in going to work or school in the next year or so?

VOCATIONAL/EDUCATIONAL NEED(S):

____

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION THREE-ADULT LIFE-STAGE ASSESSMENT (CONT.)

FAMILY/FUNCTIONING:

Note: The following questions are designed to be asked of family members, if available. The interviewer should reword these questions if no family member is present to ask the participant's perspective of the family involvement.

Describe what you (family members) understand about the participant's condition and special needs:

How willing and able are you and the rest of the family to assist the participant in becoming more independent?

What would interfere with the family helping?

Do any key family members have problems now or in the past that might affect the participant's success in becoming independent (abuse, neglect, alcohol/drug use, emotional issues)?

Describe a time when your family has been faced with a big problem, and how they handled it:

What financial resources are there to assist the participant (insurance, other assets available, etc):

FAMILY NEED(S):

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION THREE-ADULT LIFE-STAGE ASSESSMENT (CONT.)

CULTURAL/BELIEF SYSTEM:

Are there any cultural beliefs that others who work with you or your family need to be aware of?

Does your family have a cultural/belief system that makes it difficult or prevents you or your family from:

accessing medical services: ☐ Yes ☐ No explain:

accessing community/state services: ☐ Yes ☐ No explain:

becoming independent: ☐ Yes ☐ No explain:

Do you or your family have access to other people in the community that have the same cultural/belief system to provide support? _____☐ Yes ☐ No

Explain:

CULTURAL/BELIEF NEED(S):

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION FOUR-ENVIRONMENTAL FACTORS

Environment (The primary purpose of this section is to assist the family/participant in recognizing barriers to daily activities, safety concerns, emergency evacuation and community access.)

____

____

____

____

Modifications or repairs needed:

____

____

____

____

Emergency Plan**:**

- ☐ Emergency Response Form completed
- ☐ Participant/family can communicate the plan
- ☐ Red Cross Book Disaster Preparedness for People with Disabilities given to participant/family
- ☐ Authorization for Disclosure

____

____

____

____

Name: ______________________________ DOB: ______________ DCN: ______________ Date: ______________

Adult Life-Stage (21-65)

SECTION FIVE-PARTICIPANT/FAMILY STATEMENT

Concerns:

____

____

____

____

____

Goals/Priorities:

____

____

____

____

____

Resources/Supports:

____

____

____

____

ICD-9 REFERENCE GUIDE

For Use With SECTION TWO – General Health and Current Treatment
PARTICIPANT'S DIAGNOSIS - Specify exact diagnosis and ICD Code-enter all that apply.

Infections and Parasitic Diseases (001-139) – Meningitis, Measles, Chicken Pox, Tuberculosis, Mumps, Cytomegalovirus, etc.	**Diseases of the Genitourinary System** (580-629) – Urethral Stricture, Tortion of Testis, etc.
Neoplasm (140-239) – Malignant Neoplasm, Benign Neoplasm, Neurofibromatosis, Hypothyroidism, etc.	**Complications of Pregnancy/Childbirth/Puerperium** (630-677) Suspected Damage to Fetus From Drugs
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279) – Hypothyroidism, Diabetes, Hypoglycemia, PKU, Cystic Fibrosis, etc.	**Diseases of Skin and Subcutaneous Tissue** (680-709) – Erythematous Conditions, Pilonidal Cyst, Psoriasis, Keratoderma, Scar Conditions and Fibrosis of Skin, etc.
Diseases of the Blood/Blood-Forming Organs (280-289) – Sickle Cell Anemia, Hemophilia, etc.	**Diseases of the Musculoskeletal System & Connective Tissue** (710-739) – Systemic Lupus Erythematosus, Juvenile Chronic Polyarthritis, Osteomyelitis, Fractures, Scoliosis, etc.
Mental Disorders (290-319) – Psychoses, Neurotic Disorders, Mental Retardation, etc.	**Congenital Anormalies** (740-759) – Spina Bifida, Microcephalus, Tetralogy of Fallot, Ventricular Septal Defect, Choanal Atresia, Cleft Lip and Palate, Hirschsprung's Disease, Undescended Testis, etc.
Diseases of the Nervous System and Sense Organs (320 – 389) – Cerebral Palsy, Multiple Sclerosis, Diplegia, Hemiplegia, Quadriplegia, Epilepsy, Bell's Palsy, Muscular Dystrophy, Diseases of the Eye, Otitis Media, Hearing Impairments, etc.	**Certain Conditions Originating in the Perinatal Period** (760-779) – Fetus or Newborn Affected by Maternal Complications of Pregnancy, Slow Fetal Growth or Malnutrition, Birth Trauma, Intrauterine Hypoxia and Birth Asphyxia, Respiratory Distress Syndrome, etc.
Diseases of the Circulatory System (390-459) – Rheumatic Fever, Diseases of Mitral Valve, Diseases of Aortic Valve, Intracerebral Hemorrhage, Endocarditis, etc.	**Symptoms, Signs, and Ill-Defined Conditions** (780-799) – Persistent Vegetative State, Sleep Disturbances, Chronic Fatigue Syndrome, Failure to Thrive, etc.
Diseases of the Respiratory System (460-519) – Chronic Tonsillitis and Adenoiditis, Chronic Sinusitus, Pneumonia, Asthma, Chronic Respiratory Failure, etc.	**Injury and Poisoning** (800-999) – Intracranial Injury of other and Unspecified Nature. Head Injury requires E code.

Summary Sheet (Adult Head Injury Only)

Living Arrangement Summary	Priority (H, M, L)
Current Living Arrangement	______________
Caregiver Support	______________
Plan when Caregiver is unavailable	______________

FUNCTIONAL AREA	Priority (H,M,L)	FUNCTIONAL AREA	Priority (H,M,L)
HEALTH/MEDICAL		SOCIAL/EMOTIONAL	
General Health		Depression	
Medication Administration		Anxiety	
MOVEMENT/MOBILITY		Disruptive/Socially inappropriate behavior	
Equipment		Alcohol / Drug Abuse	
Toileting		Victimization	
Access to Transportation		Danger to Self	
DAILY LIVING SKILLS		COGNITIVE	
Preparing Meals		Attention	
Personal Hygiene		Memory	
Dressing		Judgment	
Finances		Planning/Organizing	
Shopping		RELATED INFORMATION	
Laundry		Community Activity Level	
Housework		Independent Living Level	
NUTRITION		Educational/Vocational Level	
Diet		Family Supports	
Eating Meals		Cultural/Belief System	
COMMUNICATION		Environmental	
Equipment		Emergency Evacuation	
Social Communication			

SHCN Service Outcomes (Adult Head Injury Only)

Community Participation Outcomes

- ☐ Fully Integrated
- ☐ Integrated with natural supports *
- ☐ Integrated with special ext. supports **
- ☐ Primary dependent on specialized supports

Vocational Outcomes

- ☐ Competitive Employment
- ☐ Supported Employment
- ☐ Sheltered Employment
- ☐ Volunteer

Independent Living Outcomes

- ☐ Fully Independent
- ☐ Independent with natural supports *
- ☐ Independent with external supports **
- ☐ Group home/supervised living

*** Family, friends, neighbors, coworkers**
**** Provided by private or state agencies**

INSTRUCTIONS

COMPREHENSIVE ASSESSMENT TOOL (CAT)

Header:

- Enter the participant name, date of birth, DCN, and the date of the assessment.

Section One – Participant Information:

- Enter the participant's home and mailing address.
- Enter the participant's phone number.
- Enter the name of the participant's service coordinator.
- Indicate the type of assessment (initial or annual) and the assessment date.
- Enter the primary language used in the home.
- Indicate if the participant/family requires an interpreter.
- Indicate all members of the health care team and all sources of information used in the assessment.
- Enter the name(s) of insurance carriers and/or third party payers.

Section Two – General Health and Current Treatment

Medical Home:

For the purposes of this assessment, "Criteria are met for Medical home", will be indicated as "yes" if:

- Questions 1 and 2 are answered "yes" and
- A total of five items from questions 3, 4, 5 are answered "yes". There should be at least one "yes" response for each of these three questions.

Primary Care Physician does not only mean Family Physician, as a specialist could be serving in this role.

- Enter pertinent health history (include physical and Mental health conditions).
- Enter current health status.
- List diagnoses reported by the family and confirmed by medical reports. List ICD-9 code for each diagnosis. List all known diagnoses.
- Enter appropriate information regarding examinations/screening the participant has received.
- Identify treatments/therapies/services that the participant currently receives.
  Examples of treatments/therapies/services: Percussion Vest, Hyperbaric Chamber, Ventilator, Bowel Program, PT OT, Speech Therapy, Aqua Therapy, Therapeutic Horseback Riding, SN, PCA APC, PDN, ARN, Counseling, DME, etc.
- List medications the participant currently takes.

Section Three – Life Stage Assessment

Select the assessment appropriate for the participant's chronological age.

Infant and Toddler Life-Stage:	Birth to Three
Children Life-Stage:	Three to Thirteen
Adolescent and Youth Life-Stage:	Thirteen to Twenty-One
Adult Life-Stage:	Twenty-One to Sixty-Five

For participants in the PDW program – Only Sections 1, 2, 4, and 5 of the Adult Life-Stage Assessment must be completed (Section 3 is optional). The PDW Client Assessment form must be completed.

Section Four – Environmental Factors

- List barriers to daily activities, safety concerns, emergency evacuation plans, and community access.
- Note any modifications or repairs needed to the home to assist with emergency evacuation.
- Assist the family in developing an emergency plan and indicate that the appropriate forms and instructions have been shared with the family.

Section Five – Participant/Family Statement

- Enter the participant/family's concerns, goals/priorities, resources/supports. The responses must be written in the family/participant's own words.

Annual Service Plan

Header:

- Enter the participant name, address, phone number, DCN, Date of Birth.
- Enter the date of the Service Plan (cannot exceed one year).
- Enter the name of the Legal Representative (responsible party/guardian/parent).
- Enter the name of the Service Coordinator.

Current Services:

Enter services that are currently in place with needs being addressed.

- Strategy/Service - Enter strategy/services needed to meet the goal.
- Goal – Enter the expected outcome of the strategy/service.
- Assessment Area – Indicate the assessment area(s) that this strategy/service will address. Check all that apply.
- Frequency/Duration - Enter the number of sessions per week or month and the length of time for the service, i.e. three times a week for six months.
- Funding Source – Enter the funding source paying for the strategy/service.
- Provider - Enter the person/agency responsible for the strategy/service.
- Re-evaluation Date - Enter the date the service coordinator will check on the status of this goal.

Identified Service Needs:

Enter services that are identified as being needed, but are not currently in place.

- Strategy/Service - Enter strategy/services needed to meet the goal.
- Goal – Enter the expected outcome of the strategy/service.
- Assessment Area – Indicate the assessment area(s) that this strategy/service will address. Check all that apply.
- Frequency/Duration - Enter the number of sessions per week or month and the length of time for the service, i.e. three times a week for six months.
- Funding Source – Enter the funding source paying for the strategy/service.
- Provider - Enter the person/agency responsible for the strategy/service.
- Re-evaluation Date - Enter the date the service coordinator will check on the status of this goal.

Service Plan Addendum

If a change occurs during a participant's Service Plan year that necessitated a revision to the service plan, the service coordinator must complete a service plan addendum.

- Enter the appropriate participant information in the heading.
- Indicate if this addendum is in regard to a current service or a newly identified service.
- Complete the Strategy/Service section as indicated above.

An addendum does not need to be completed each time PDN and PCA services change. However, the most current PA must be referenced for documentation of these changes.

Name:	**Date of Plan:**	
Address:	**DCN:**	**Date of Birth:**
	Legal Representative:	
Phone:	**Service Coordinator:**	

CURRENT SERVICES

(Services in place with needs being addressed)

Strategy/Service:		**Goal:**
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Strategy/Service:		**Goal:**
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

CURRENT SERVICES (services in place with needs being addressed)

Strategy/Service:		**Goal:**
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Strategy/Service:		**Goal:**
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Strategy/Service:		**Goal:**
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Identified Service Needs
(Services needed but not in place)

Strategy/Service:		Goal:
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Strategy/Service:		Goal:
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Strategy/Service:		Goal:
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Identified Service Needs
(Services needed but not in place)

Strategy/Service:		Goal:
☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System	
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Strategy/Service:		Goal:
☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System	
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

I have participated in the development of this plan. The goals have been discussed with me and I agree to follow through with my responsibilities as outlined in the plan. I understand that the goals will help me work toward the best possible health and the highest level of functioning.

____________________________________ ____________________
Participant /Legal Representative Date

____________________________________ ____________________
SHCN Service Coordinator Date

SPECIAL HEALTH CARE NEEDS

SERVICE PLAN ADDENDUM

Name:	**Date of Plan:**	**Revision Date:**
Address:	**DCN:**	**Date of Birth:**
	Legal Representative:	
Phone:	**Service Coordinator:**	

Strategy/Service: ☐ Current Service ☐ Identified Service		**Goal:**
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Strategy/Service: ☐ Current Service ☐ Identified Service		**Goal:**
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Strategy/Service:		**Goal:**
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Strategy/Service:		**Goal:**
Assessment Areas: (check all that apply) ☐ Health/Medical ☐ Movement/Mobility ☐ Daily Living Skills	☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Identified Service Needs
(Services needed but not in place)

Strategy/Service:		**Goal:**
☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System	
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

Strategy/Service:		**Goal:**
☐ Nutrition ☐ Communication ☐ Social/Emotional ☐ Cognitive	☐ Educational/Vocational ☐ Family Functioning ☐ Cultural/Belief System	
Frequency/Duration:		**Funding Source:**
Provider:		**Re-evaluation Date:**

I have participated in the development of this plan. The goals have been discussed with me and I agree to follow through with my responsibilities as outlined in the plan. I understand that the goals will help me work toward the best possible health and the highest level of functioning.

_______________________________________ _____________________

Participant /Legal Representative Date

_______________________________________ _____________________

SHCN Service Coordinator Date

TBI EARLY REFERRAL INTERVIEW FORM

Date	Time	Contact	Comments

START HERE:

Hello, my name is ____________________. I am calling for the Department of Health Psychology at the University of Missouri-Columbia. May I speak with ____________________? As part of an evaluation of the state of Missouri's Early Referral Program, I would like to interview you regarding your experiences as a survivor of traumatic brain injury. The interview should only last ~ 30 minutes.

Before we begin, let me assure you that all of your responses will be kept strictly confidential. If I ask you any questions that you do not want to answer, just let me know and I will go on to the next section.

1. Are you the person in your home who has the brain injury?

   Yes: Do you have any questions before we get started?

   No: Could you please tell me the first name of the person in your home that uses these services? ____________________

   What is your relationship with this person? ____________________

2. How old (are you/is "Survivor's Name")? _______________

3. What ethnic group are (you/"Survivor's Name") a member of? _______________

4. What town (do you/does "Survivor's Name") live in (or closest to)? ____________________

5. How did (you/"Survivor's Name's") brain injury occur?

   ____

   ____

6. When did it occur? _______________

7. (Were you/Was "Survivor's Name") hospitalized at the time?

    1. Yes
    2. No
    3. DK

8. Did (you/"Survivor's Name") receive rehabilitation?

    1. Yes
    2. No
    3. DK

Now I have some questions about how the brain injury may have affected (Your/Name's) life.

9. Would (you/"Survivor's Name") say that in general (you/"Survivor's Name") health is:

    1. Excellent
    2. Very Good
    3. Fair
    4. Poor
    5. DK

10. Are (you/"Survivor's Name") limited in any way in any activities because of physical, mental, or emotional problems?

    1. Yes
    2. No
    3. DK

11. Does (you/"Survivor's Name") TBI require (you/"Survivor's Name") to use special equipment, such as a cane, a wheel chair, a special bed, or a special telephone?

    1. Yes
    2. No
    3. DK

12. For how long have (your/"Survivor's Name") activities been limited because of your TBI?

    1. Days
    2. Weeks
    3. Months
    4. Years
    5. DK

13. Because of (your/"Survivor's Name") TBI, do (you/"Survivor's Name") need the help of other persons with (your/"Survivor's Name") personal care needs, such as eating, bathing, dressing, or getting around the house?

    1. Yes
    2. No
    3. DK

14. Because of (your/"Survivor's Name") TBI, do (your/"Survivor's Name") need the help of other persons in handling (your/"Survivor's Name") routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

    1. Yes
    2. No
    3. DK

15. During the past 30 days, for about how many days did pain make it hard for (you/"Survivor's Name") to do (your/"Survivor's Name") usual activities, such as self-care, work, or recreation?

    1. Number of days: __________
    2. None
    3. DK

16. During the past 30 days, for about how many days have (you/"Survivor's Name") felt sad, blue, or depressed?

    1. Number of days: __________
    2. None
    3. DK

17. During the past 30 days, for about how many days have (you/"Survivor's Name") felt worried, tense, or anxious?

    1. Number of days: __________
    2. None
    3. DK

18. During the past 30 days, for about how many days have (you/"Survivor's Name") felt that (you/"Survivor's Name") did not get enough rest or sleep?

    1. Number of days: __________
    2. None
    3. DK

19. During the past 30 days, for about how many days have (you/“Survivor’s Name”) felt very healthy and full of energy?

    1. Number of days: __________
    2. None
    3. DK

20. (Do you/Does “Survivor’s Name”) have any physical difficulties as a result of the brain injury?

    1. Yes
    2. No
    3. DK

21. (Do you/Does “Survivor’s Name”) have any difficulties remembering things as a result of the brain injury?

    1. Yes
    2. No
    3. DK

22. (Do you/Does “Survivor’s Name”) have any difficulties organizing (your/“Survivor’s Name”) daily activities as a result of the brain injury?

    1. Yes
    2. No
    3. DK

23. (Do you/Does “Survivor’s Name”) have any difficulties making decisions as a result of the brain injury?

    1. Yes
    2. No
    3. DK

24. (Do you/Does “Survivor’s Name”) have any learning difficulties as a result of the brain injury?

    1. Yes
    2. No
    3. DK

Please answer the following questions related to daily living after your TBI. This information will remain confidential, as will all other information from this study.

Home Integration Section

25. Who usually does shopping for groceries or other necessities in your household?

Answer	Score
yourself alone	2
yourself and someone else	1
someone else	0

26. Who usually prepares meals in your household?

Answer	Score
yourself alone	2
yourself and someone else	1
someone else	0

27. In your home who usually does normal everyday housework?

Answer	Score
yourself alone	2
yourself and someone else	1
someone else	0

28. Who usually cares for the children in your home?

Answer	Score
yourself alone	2
yourself and someone else	1
someone else	0
not applicable/ no children under 17 in the home	*

29. Who usually plans social arrangements such as get-togethers with family and friends?

Answer	Score
yourself alone	2
yourself and someone else	1
someone else	0

Social Integration Section

30. Who usually looks after your personal finances, such as banking or paying bills?

Answer	Score
yourself alone	2
yourself and someone else	1
someone else	0

Questions 7-9: ***Can you tell me approximately how many times a month you now usually participate in the following activities outside your home?***

31. Shopping

Answer	Score
5 or more	2
1-4 times	1
Never	0

32. Leisure activities such as movies, sports, restaurants, etc.

Answer	Score
5 or more	2
1-4 times	1
Never	0

33. Visiting friends or relatives

Answer	Score
5 or more	2
1-4 times	1
Never	0

34. When you participate in leisure activities do you usually do this alone or with others?

Answer	Score
mostly alone	0
mostly with friends who have head injuries	1
mostly with family members	1
mostly with friends who do not have head injuries	2
with a combination of family and friends	2

35. Do you have a best friend with whom you confide?

Answer	Score
yes	2
no	0

Productivity Section

36. How often do you travel outside the home?

Answer	Score
almost every day	2
almost every week	1
seldom/never (less than once per week)	0

37. Please check the answer below that best corresponds to your current (during the past month) work situation:

Answer
full-time (more than 20 hours per week)
part-time (less than or equal to 20 hours per wk)
not working, but actively looking for work
not working, not looking for work
not applicable, retired due to age

38. Please check the answer below that best corresponds to your current (during the past month) school or training program situation:

Answer
full-time
part-time
not attending school or training program
not applicable, retired due to age

39. In the past month, how often did you engage in volunteer activities?

Answer
5 or more
1-4 times
never

Please answer the following questions related to employment status as well as any personal income and public financial assistance you receive. This information will remain confidential, as with all other information from this study.

Employment Status

40. Please indicate your employment status by checking one or more of the following:

- Competitively Employed (Minimum Wage or Greater) _____
- Competitively Employed (Supported Employment: job coach/sheltered workshop) _____
- Unemployed (Looking for Job) _____
- Unemployed (Not Looking for Job) _____
- Retired (Age Related) _____
- Retired (Disability Related) _____

41. **IF EMPLOYED, GOTO "Occupational Data Collection Form", OTHERWISE CONTINUE.**

42. In the PAST FIVE YEARS, because of ongoing health problem(s), have (you/"Survivor's Name") been fired from a job, laid off, or told to resign?

1. Yes 2. No 3. DK

43. In the PAST FIVE YEARS, because of ongoing health problem(s), have (you/"Survivor's Name") refused employment?

1. Yes 2. No 3. DK

44. In the PAST FIVE YEARS, because of ongoing health problem(s), have (you/"Survivor's Name") refused a promotion?

1. Yes 2. No 3. DK

45. In the PAST FIVE YEARS, because of ongoing health problem(s), have (you/"Survivor's Name") refused a transfer?

1. Yes 2. No 3. DK

46. In the PAST FIVE YEARS, because of ongoing health problem(s), have (you/"Survivor's Name") refused access to training programs?

1. Yes 2. No 3. DK

47. IF UNEMPLOYED, does an ongoing health problem, impairment, or disability now make it difficult for (you/"Survivor's Name") to look for work?

1. Yes 2. No 3. DK

Personal Income

48. What is your current monthly income from (your/"Survivor's Name") current employment? ______

49. What is (you/"Survivor's Name") hourly wage? __________
 OR
 What is (you/"Survivor's Name") annual salary? __________

50. How many hours (per week) are (you/"Survivor's Name") paid in competitive employment? ______

51. How many weeks of paid competitive employment have (you/"Survivor's Name") had **in the past year**? ___________

52. What is (your/"Survivor's Name") County of Residence within the state of Missouri? _________________

Public/Other Assistance

53. Please indicate the amount of monthly income you receive from each of the following sources:

Supplemental Security Income (SSI)	($):____________
Social Security Disability Income (SSDI)	($):____________
Temporary Assistance for Needy Families (TANF)	($):____________
Welfare (General Relief)	($):____________
Unemployment Insurance (UI)	($):____________
Worker's Compensation	($):____________
Other	($):____________

Annual Earnings of Person: (total earnings from all sources, i.e., employment and public assistance)

54. Please circle the amount listed below which corresponds to the total income you have each year:

1=$9,999 or less
2=10,000-19,999
3=20,000-29,999
4=30,000-39,999
5=40,000-49,999
6=50,000-59,999
7=60,000-69,999
8=70,000-79,999
9=80,000-89,999
10=90,000-99,999
11=100,000 or more
77=Refused
88=N/A, not employed
99=Unknown

We appreciate the time you have given us to help with this important effort. Thank you!

TBI Early Referral Interview Open-Ended Questions

1) Did you have to deal with any major issues (i.e., agency coordination, etc.) while working with your service coordinator?

2) Looking back, is there anything that you now know that you wish you knew about a few months back? Is there any way that this information could have been available then?

3) Can you think of anything that got in the way of receiving satisfying assistance from your service coordinator? What could have been done to address/deal with this problem?

4) What other services do you think the program should offer?

5) What would you say was the most helpful assistance that you received through the Adult Head Injury Program and your service coordinator?

6) Would you recommend the program to other people dealing with head injury? Why/why not?

TBI Early Referral Program Satisfaction Questionnaire

Please indicate your degree of satisfaction with the following services and resources provided by the State of Missouri's Head Injury Service Program for TBI survivors and family members. Circle the one number for each question that comes closest to reflecting your opinion about it.

1. I feel that the TBI Service Coordinators are an important part of the TBI Head Injury Service Program.

Disagree Very Much	Disagree Moderately	Disagree Slightly	Neither Disagree Nor Agree	Agree Slightly	Agree Moderately	Agree Very Much
1	2	3	4	5	6	7

2. I am satisfied with the amount of say I have in the decisions made about my treatment plans.

Disagree Very Much	Disagree Moderately	Disagree Slightly	Neither Disagree Nor Agree	Agree Slightly	Agree Moderately	Agree Very Much
1	2	3	4	5	6	7

3. I do not feel that I have access to TBI services and resources in the community.

Disagree Very Much	Disagree Moderately	Disagree Slightly	Neither Disagree Nor Agree	Agree Slightly	Agree Moderately	Agree Very Much
1	2	3	4	5	6	7

4. The Head Injury Service Program is an important program for TBI survivors and family members.

Disagree Very Much	Disagree Moderately	Disagree Slightly	Neither Disagree Nor Agree	Agree Slightly	Agree Moderately	Agree Very Much
1	2	3	4	5	6	7

5. I am frustrated with the lack of services and resources for TBI survivors and family members.

Disagree Very Much	Disagree Moderately	Disagree Slightly	Neither Disagree Nor Agree	Agree Slightly	Agree Moderately	Agree Very Much
1	2	3	4	5	6	7