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Topic

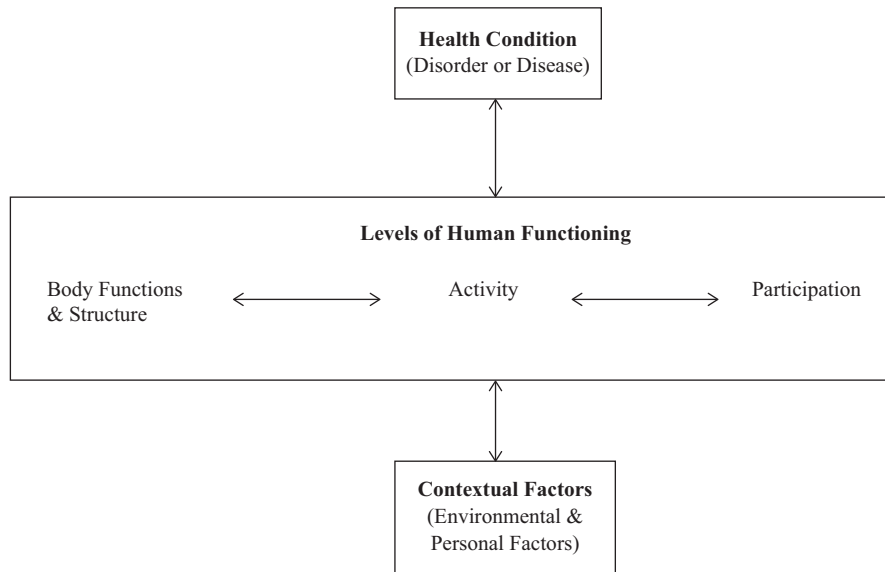
This chapter summarizes important terms commonly used in rehabilitation settings.

A. *Common Language*

The World Health Organization's (WHO) International Classification of Functioning, Disability, and Health (ICF) provides a common, standard language for classifying and describing health and health-related states in health and health-related sectors. The ICF is the WHO's framework for defining, measuring, and formulating policy in the realm of health and disability. The ICF

describes a biopsychosocial model of disability that is illustrated in the figure below. This model incorporates the medical, physical, personal, social, and environmental aspects of disability. In this model, human functioning is defined by the physical, task, and societal levels, while disability involves a breakdown at one or more of these levels. Thus, "disability and functioning are viewed as outcomes of interactions between health conditions (diseases, disorders, and injuries) and contextual factors. Among contextual factors are external environmental factors and internal personal factors that influence how disability is experienced by the individual" [1].

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1. **Functioning and Disability**

Functioning refers to all *body functions and structures, activities, and participation*. Disability refers to a breakdown in each level of functioning, respectively, including *impairments, activity limitations, and participation restrictions*.

- *Body functions and structures* refer to the physical level of body structures and their associated functions. *Impairments* are problems in body functions or anatomical structures, such as diabetes, amputation, or paralysis.
- *Activity* occurs at the task level and refers to the performance of a task or action by an individual. *Activity limitations* involve disturbed abilities in the performance of usual age-appropriate activities, such as feeding, dressing, shopping, and operating a motor vehicle.
- *Participation* occurs at the societal level and refers to involvement in a life situation. *Participation restrictions* involve disturbance in social role performance, such as vocational or recreational participation.

2. **Person- and Identity-First Language**

The American Psychological Association (APA) has advocated using person-first language when referring to people with disabili-

ties (e.g., “person with an amputation” rather than “amputee”) to help reduce negative attitudes and stigma surrounding disabilities. However, disability culture advocates suggest the use of not only person-first, but also identity-first language (e.g., “amputee”). They assert that not all individuals with disabilities use person-first language, and that its exclusive use may unintentionally communicate that disabilities are undesirable and negative, as it separates the person from the disability. Alternatively, disability culture advocates suggest using both disability- and person-first language interchangeably, while taking into account individuals’ and groups’ preferences, which “ensures inclusion, addresses issues raised by disability studies and disability culture, respectively, and allows APA-style writing to evolve along with contemporary trends” [2].

3. **Medical Abbreviations**

Significant system-wide efforts by the Joint Commission on Accreditation of Healthcare Organizations and Institute for Safe Medication Practices have been made to improve language precision in order to reduce errors and patient morbidity and mortality through the identification of error-prone and problematic abbreviations, symbols, and medication dose

designations. For example, the abbreviation “tiw” may be misinterpreted as “3 times a day” or “3 times in a week.” Instead, it is advisable to write out “3 times weekly” to reduce misinterpretations and errors [3, 4]. The following are commonly used and permissible abbreviations in medical and rehabilitation settings [5]:

- ADL = activities of daily living
- AMA = against medical advice
- BKA = below knee amputation
- bx = biopsy
- cath = catheter
- CVA = cerebrovascular accident
- L.E. = lower extremities
- LOC = loss of consciousness
- L(R)UE = left(right) upper extremity
- L(R)LE = left(right) lower extremity
- MVC = motor vehicle crash
- NKA = no known allergies
- NPO = nothing by mouth
- OOB = out of bed
- prn = as needed
- PMH = past medical history

- ROS = review of symptoms
- SCI = spinal cord injury
- W/C = wheelchair
- WNL = within normal limits

B. Rehabilitation Programs

The Commission on Accreditation of Rehabilitation Facilities (CARF International), founded in 1966, is an independent, nonprofit accreditor of health and human services in the field of medical rehabilitation, among others (e.g., aging, behavioral health). CARF International’s mission is to “promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of persons served” [6]. CARF accreditation is an ongoing process that applies set international organizational and program standards to service areas and business practices which highlights providers’ commitment to improving services, encouraging and utilizing feedback, and serving the community.

CARF-defined types of medical rehabilitation programs [7]

Program	Focus	Setting
Comprehensive Integrated Inpatient Rehabilitation	24-hour comprehensive rehabilitation driven by the individual’s needs and predicted outcomes	Hospitals, skilled nursing facilities, long-term care hospitals, acute hospitals, hospitals with transitional rehabilitation beds
Outpatient Medical Rehabilitation	Individualized, coordinated, outcomes-driven program geared toward early intervention that optimizes an individual’s activities and participation	Hospitals, freestanding outpatient rehabilitation centers, day hospitals, private practices
Home and Community Services	Promote and optimize the individual’s activities, function, performance, productivity, participation, and quality of life	Private homes, residential and community settings, schools, and workplaces
Residential Rehabilitation	Outcomes-driven services primarily focused on home and community integration and engagement in productive activities	Transitional or long-term settings
Vocational Services	Individualized services to help people meet their identified vocational outcomes	Hospitals, freestanding outpatient rehabilitation centers, residential and community settings, schools
Pediatric Specialty	Family-centered care primarily serving children/adolescents who have substantial functional limitations secondary to acquired or congenital conditions	Hospitals, freestanding outpatient rehabilitation centers, residential and community settings, schools
Amputation Specialty	Focuses on collaboration to inform perioperative care, prevention, minimizing impairment, maximizing independence, and maximizing quality of life	Hospitals, healthcare systems, outpatient clinics, community-based programs, transitional or long-term residential settings

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Program	Focus	Setting
Brain Injury Specialty	Focuses on the unique medical, physical, cognitive, psychosocial, behavioral, vocational, educational, and recreational needs of individuals with acquired brain injury	Hospitals, healthcare systems, outpatient clinics, community-based programs, transitional or long-term residential settings
Cancer Rehabilitation Specialty	Addresses preventative, restorative, supportive, and palliative needs unique to individuals diagnosed with cancer	Hospitals, healthcare systems, outpatient clinics, community-based programs
Spinal Cord System of Care	Focuses on identifying care options and facilitating utilization of such options, achieving predicted outcomes, providing and facilitating medical interventions, lifelong follow-up, providing education and training	Hospitals, healthcare systems, outpatient clinics, community-based programs, transitional or long-term residential settings
Stroke Specialty	Focuses on minimizing impairments and secondary complications, reducing activity limitations, maximizing participation and quality of life, and decreasing environmental barriers, and preventing the recurrence of strokes	Hospitals, healthcare systems, outpatient clinics, community-based programs, transitional or long-term residential settings
Interdisciplinary Pain Rehabilitation	Focuses on minimizing impairments and secondary complications, reducing activity limitations, maximizing participation and quality of life, and decreasing environmental barriers	Hospitals, healthcare systems, outpatient clinics, community-based programs
Occupational Rehabilitation	Focuses on return to work while minimizing risk and optimizing work capability	Hospital-based, outpatient programs, private or group practice, at the job site

C. *Basic and Instrumental Activities of Daily Living*

1. **Basic ADLs or ADLs:** these include routine tasks of everyday life, including eating, toileting, bathing, dressing, and transferring.
2. **Instrumental ADLs (IADLs):** complex everyday tasks, including driving/independent transportation, managing the household finances, managing medications, phone use, shopping, cooking, and managing the home.
3. **Measuring independence with activities of daily living:**
 - Assessment of an individual's functional status is essential in determining his or her ability to perform tasks necessary for independent and safe living within the community. Additionally, independence with such tasks affects individuals' feelings of self-efficacy and perceived quality of life.
 - Can be used in combination with or are included in outcome measures (discussed below).

- Can be assessed via interview with the patient and/or family/caregivers or through formal measures.
 - a. The most commonly used measure of basic ADLs is the *Katz Index of Independence in Activities of Daily Living* [8].
 - b. The most commonly used measure of IADLs is The *Lawton Instrumental Activities of Daily Living Scale* [9].

Importance

Given the multidisciplinary nature of rehabilitation settings, it is vital that a common language is utilized among providers across the various disciplines (e.g., medicine, nursing, physical therapy, occupational therapy, psychology) and with the patients and caregivers to optimize and ensure effective communication and treatment planning/goals.

Practical Applications

A. Outcomes Measurement

1. Purpose

- Outcomes are the desired benefits of rehabilitation program efforts, and reflect the quality of care and effectiveness of a particular program.
- Results from outcomes measurement can be utilized to direct quality improvement within programs and organizations.
- Of particular interest are measures that focus on an individual's level of participation, or involvement in and fulfillment of activities and roles within society (e.g., as an employee).

2. Commonly Used Measures of Rehabilitation Outcomes

- *FIM™*: previously an acronym for Functional Independence Measure, is the most widely used measure of outcome. It is an 18-item ordinal rating scale of disability across seven areas (self-care, sphincter control, mobility, locomotion, communication, psychosocial adjustment, and cognitive function). It allows for tracking changes/progress in an individual's functional status in these areas over time [10].
- *Disability Rating Scale (DRS)*: a short, 8-item scale used frequently in traumatic brain injury (TBI) research to measure changes in adult TBI recovery. Total scores reflect level of disability, with the 8 items measuring eye opening, communication ability, motor response, cognitive ability to feed, cognitive ability to toilet, cognitive ability to groom, overall level of functioning, and employability [11].
- *Craig Handicap Assessment and Reporting Technique (CHART)*: consists of 38 items that measure the level of social integration of individuals with disabilities across six scales (physical independence, mobility, occupation, social integration, economic independence,

and orientation). Also available in a 19-item short form (CHART-SF) [12].

- *Extended Glasgow Outcome Scale (GOS-E)*: The GOS-E extends from the original five categories to eight categories (Dead, Vegetative State, Lower Severe Disability, Upper Moderate Disability, Lower Good Recovery, and Upper Good Recovery) in a structured interview format [13].
- *Satisfaction with Life Scale (SWLS)*: a 5-item measure of life satisfaction and subjective well-being [14].

Tips

A. Language matters

When possible, avoid the use of medical jargon and unfamiliar acronyms when providing information to the patient and family/caregivers, which can be confusing and overwhelming.

B. Be consistent

Providers from various disciplines should use the same language/terminology among each other and with patients/family for consistency and to minimize confusion and misunderstanding.

C. Simplify

Explain and simplify the terminology used, and provide information in both verbal and written format to improve communication and ensure understanding.

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