AROC Ambulatory Data Dictionary for Clinicians (NZ) V4.1

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Path

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

Justification:

Guide for use:

Codeset values:

01 Consult liaison

02 In-reach rehabilitation care

03 Inpatient direct care

04 Ambulatory direct care

05 Ambulatory shared care

06 Ambulatory shared care (one off assessment)

Establishment ID

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: A code which represents the facility.

Justification:

Guide for use: This would usually be the code issued by the Department of Health.

Establishment Name

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: The name of the facility collecting and submitting the data.

Justification:

Guide for use:

Ward ID / Team ID

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	A 4 character alphanumeric code representing a ward or team.
Justification:	'Ward Identifier' and 'Ward Name' included for those facilities who have more than one ward and wish to: 1. Identify their data at ward/team level 2. Enable assignment of episodes of care to the appropriate ward/team.
Guide for use:	It is not manadatory to collect this data item if the facility has only one rehabilitation ward/team.

Ward Name / Team Name

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The name of a ward or team within a facility.
Justification:	'Ward Identifier' and 'Ward Name' included for those facilities who have more than one ward and wish to: 1. Identify their data at ward/team level 2. Enable assignment of episodes of care to the appropriate ward/team.
Guide for use:	It is not manadatory to collect this data item if the facility only has one rehabilitation ward/team.

Unique Record Number

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Unique record identifier established by the facility.

Justification:

Guide for use:

Letters of Name

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	Letters of name is a 5 letter word made up of the 2nd, 3rd and 5th letters of the patient's surname, followed by the 2nd and 3rd letters of the patient's first name.
Justification:	This information forms part of the statistical key (SLK) used by AROC to link patient's episodes through their rehabilitation journey.
Guide for use:	In the first three spaces record the 2nd, 3rd and 5th letters of the patient's surname. In the following two spaces, record the 2nd and 3rd letters of the patient's first name. For more information on SLK, please refer to the AROC website, V4 resources, SLK.

Date of Birth

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The date of birth of the person being treated by the facility.
Justification:	Date of birth allows generation of age which is important for analysis. It also forms part of the Statistical Linkage Key (SLK) formula used by AROC to link patient's episodes through their rehabilitation journey.
Guide for use:	Enter in format DD/MM/YYYY. For more information on SLK, please refer to the AROC website, V4 resources, SLK.

Date of Birth Estimate

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Flag to indicate if Date of Birth item is a known or estimated value.

Justification: Required as part of the Statistical Linkage Key (SLK) formula used by AROC to link patient's episodes through their rehabilitation journey.

Guide for use: For more information on SLK, please refer to the AROC website, V4 resources, SLK.

Codeset values:

01 Estimated

02 Not estimated

Sex

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The biological differences between males and females, as represented by a code.

Justification: Collected to allow analysis of outcomes by sex.

Guide for use:

Codeset values:

01 Male

02 Female

03 Indeterminate

09 Not stated/inadequately defined

Indigenous Status (NZ)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

In Australia, indigenous status is a measure of whether a patient identifies as being of Aboriginal or Torres Strait Islander origin.
In NZ, indigenous status is a measure of whether a patient identifies as being of Maori or Non-Maori origin.

Justification:

Australia's Aboriginal and Torres Strait Islander peoples and New Zealand's Maori peoples occupy a unique place in respective societies and cultures. Accurate and consistent statistics about indigenous status are needed in order to plan, promote and deliver services. The purpose of this item is to provide information about people who identify as being of Aboriginal or Torres Strait Islander origin in Australia and Maori or non-Maori in New Zealand.

Guide for use:

Codeset values:

01 Maori

04 Non-Maori

09 Not stated or inadequately defined

Ethnicity

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Ethnicity is defined as a social group whose members have one or more of the following four characteristics: they share a sense of common origins, claim a common and distinctive history and destiny, possess one or more dimensions of collective cultural individuality and/or feel a sense of unique collective solidarity.

Justification: In NZ, there is a focus on understanding health outcomes for different ethnic groups.

Guide for use: A person may identify with some or all four of the above characteristics in one context and identify with a different mix of characteristics in another, resulting in a different choice of ethnic affiliation. Given this possibility, it would be extremely difficult for anybody other than the person concerned to choose which ethnic group they identify with in a particular circumstance. Therefore the person concerned should identify their ethnic affiliation wherever feasible. If not feasible, ask family or friend.

Codeset values:

10	European not further defined
11	New Zealand European/Pakeha
12	Other European
21	Maori
30	Pacific Peoples not further defined
31	Samoan
32	Cook Island Maori
33	Tongan
34	Niuean
35	Tokelauan
36	Fijian
37	Other Pacific Peoples
40	Asian not further defined
41	Southeast Asian
42	Chinese
43	Indian
44	Other Asian
51	Middle Eastern
52	Latin American/ Hispanic
53	African (or cultural group of African origin)
61	Other Ethnicity
94	Patient doesn't know
95	Refused to Answer
97	Response Unidentifiable
99	Not stated

Geographical Residence (NZ)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Geographical residence is the state (Australia) or region (NZ) that the patient usually resides in.

Justification: This information may be used for identification of referral patterns and for analysis of outcomes by geographical area.

Guide for use: Record the state (Australia) or region (NZ) that the patient usually resides in.

Codeset values:

11 Northland
12 Auckland
13 Waikato
14 Bay of Plenty
15 Gisborne
16 Hawkes Bay
17 Taranaki
18 Manawatu-Wanganui
19 Wellington
20 Tasman
21 Nelson
22 Marlborough
23 West Coast
24 Canterbury
25 Otago
26 Southland
27 Chatnam Islands, Kermadecs and Subantarctic Islands
28 Not NZ

Postcode

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	Postcode is the numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of patient. Record the postcode of the patient's usual place of residence.
Justification:	This information may be used for identification of referral patterns and for analysis of outcomes by area.
Guide for use:	Record the postcode of the patient's usual place of residence.Record 8888 for not applicable. Record 9999 for unknown.

Episode begin date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	Record the date that the patient commenced rehabilitation care. This date defines the beginning of the rehabilitation episode and is the date from which length of stay (LOS) calculation begins. This is not dependant on geography or location of the patient. The begin date for an ambulatory, direct, episode of care, is the date that the patient's care is transferred to a rehabilitation physician or physician with an interest in rehabilitation and it's recorded in the medical record that the ambulatory rehabilitation team has commenced the rehabilitation program/ provision of care. The begin date for an episode of shared care, is the date an ambulatory patient, who is receiving care from a clinical service provider (e.g. GP), was first seen by a member of another service provider (e.g. Rehabilitation team) and there is documented evidence in the medical record that the two services have agreed on a shared care arrangement that includes joint care planning and exchange of clinical information.
Justification:	This item is required to establish time periods between critical points through the rehabilitation episode.
Guide for use:	Record the date that the patient commenced rehabilitation care.

Episode end date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

Record the date that the patient completes their rehabilitation episode. This date defines the end of the rehabilitation episode and is the date at which the length of stay (LOS) concludes.
Inpatient rehabilitation episode ends when the patient is discharged from the rehabilitation unit and/or the care type is changed from rehabilitation to acute or some other form of sub-acute (maintenance/ palliative care) no matter where the patient is physically located (rehabilitation ward/ acute ward).
Ambulatory rehabilitation ends when the patient is discharged from the ambulatory rehabilitation program and/or the care type is changed from rehabilitation to either acute or some other form of sub-acute (maintenance/ palliative care), either inpatient or ambulatory.
The end date for a consultation liaison episode of rehabilitation is when the patient is discharged by the rehabilitation physician or team completing the one-off consultation, no matter where the patient is physically located (rehabilitation ward/ acute ward). A consultation begin and end date may be the same at times.
The end date for an episode of shared care is the date the rehabilitation provider discharges the ambulatory patient from their service. At this point the ambulatory patient may or may not continue to receive care from their other clinical service provider that was involved in the shared care arrangement (e.g. GP).

Justification:

This item is required to establish time periods between critical points through the rehabilitation episode.

Guide for use:

Record the date that the patient completes their rehabilitation episode or when the patient does not come back for treatment (ambulatory), or when the patient is discharged at their own risk.

Funding Source (NZ)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The principal source of funding for the patient in rehabilitation.

Justification: Collection of this data item enables AROC to further separate episodes based on who funded the care where the funding source is a health fund or other payer.

Guide for use: If there is more than one contributor to the funding of the episode, please indicate the major funding source. If funding source = 2,4 or 5 then complete related data item D12, Health Fund/other payer.

Codeset values:

01 NZ Ministry of Health (public patient)
02 Private health insurance
03 Self-funded
04 Workers compensation
05 Motor vehicle third party personal claim
06 Other compensation (eg public liability, common law, medical negligence)
10 Other hospital or public authority (contracted care)
11 Reciprocal health care agreement (other countries)
12 NZ Disability
13 Accident Compensation Corporation
98 Other
99 Not known

Referral Date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The date that the rehabilitation team RECEIVED a referral for the patient.

Justification: This item is being collected to measure the impact of delay between date referral RECEIVED and date rehabilitation started. Please note: Date referral RECEIVED is being collected and not date the referral was made, because at times these dates may differ and it was deemed unfair to include these extra days in the analysis. Under other circumstances, date referral RECEIVED and date referral made will be the same.

Guide for use: Record the date the referral was RECEIVED.
Referrals can be made by phone, fax or face to face across all settings.
For example: An in-patient on the Intensive care ward was thought clinically ready for rehabilitation on 01/02/2012. A clinician on the intensive care ward calls the rehabilitation ward and makes a verbal referral the same day. Record 01/02/2012, the date the referral was received by the rehabilitation ward.
An in-patient will require out-patient therapy once discharged. A referral was made after hours by fax on 01/02/2012, but only received by the outpatient service on 02/02/2012. Record 02/02/2012, the date the referral was received by the out-pt service.
A patient was assessed in their home in rural Australia. He was deemed clinically ready for a boost of home based rehabilitation. A referral was faxed through to the local therapy team on 01/02/2012. The referral was received on 04/02/2012 when the part time staff returned to work. Record 04/02/2012, the date the referral was received.

AROC Impairment Code

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The AROC Impairment codes are used to classify rehabilitation epsiodes into like clinical groups. The Australian codes are based on the Uniform Data System for Medical Rehabilitation (UDSMR) codes. The selected code should reflect the primary reason for the current episode of rehabilitation care.

Justification: Classification into like clinical groups provides a basis for analysing outcomes for clinically homogenous types of patient rehabilitation episodes.

Guide for use: Refer to the AROC Impairment Codes Coding Guidelines attached, which were developed to assist in correctly classifying rehabilitation episodes according to impairment groups.
Please note:
1. The episode should be classified according to the primary reason for the current episode of rehabilitation care.
2. Rehabilitation program names related to funding are not necessarily the same as the impairment group names.

Codeset values:

1.11 Stroke, Haemorrhagic, Left Body Involvement (Right Brain)
1.12 Stroke, Haemorrhagic, Right Body Involvement (Left Brain)
1.13 Stroke, Haemorrhagic, Bilateral Involvement
1.14 Stroke, Haemorrhagic, No Paresis
1.19 Other haemorrhagic stroke
1.21 Stroke, Ischaemic, Left Body Involvement (Right Brain)
1.22 Stroke, Ischaemic, Right Body Involvement (Left Brain)
1.23 Stroke, Ischaemic, Bilateral Involvement
1.24 Stroke, Ischaemic, No Paresis
1.29 Other ischaemic stroke
2.11 Brain Dysfunction, Non traumatic, subarachnoid haemorrhage
2.12 Brain Dysfunction, Non traumatic, Anoxic brain damage
2.13 Other non-traumatic brain dysfunction
2.21 Brain Dysfunction, Traumatic, open injury
2.22 Brain Dysfunction, Traumatic, closed injury
3.1 Neurological conditions, Multiple sclerosis
3.2 Neurological conditions, Parkinsonism
3.3 Neurological conditions, Polyneuropathy
3.4 Neurological conditions, Guillian-Barre
3.5 Neurological conditions, Cerebral palsy
3.8 Neurological conditions, Neuromuscular disorders
3.9 Other neurological conditions
4.111 Spinal Cord Dysfunction, Non-traumatic, Paraplegia, incomplete
4.112 Spinal Cord Dysfunction, Non-traumatic, Paraplegia, complete
4.1211 Spinal Cord Dysfunction, Non-traumatic, Quadriplegia incomplete C1-4
4.1212 Spinal Cord Dysfunction, Non-traumatic, Quadriplegia incomplete C5-8
4.1221 Spinal Cord Dysfunction, Non-traumatic, Quadriplegia complete C1-4
4.1222 Spinal Cord Dysfunction, Non-traumatic, Quadriplegia complete C5-8
4.13 Other non-traumatic spinal cord dysfunction
4.211 Spinal Cord Dysfunction, Traumatic, Paraplegia, incomplete

4.212 Spinal Cord Dysfunction, Traumatic, Paraplegia, complete
4.2211 Spinal Cord Dysfunction, Traumatic, Quadriplegia incomplete C1-4
4.2212 Spinal Cord Dysfunction, Traumatic, Quadriplegia incomplete C5-8
4.2221 Spinal Cord Dysfunction, Traumatic, Quadriplegia complete C1-4
4.2222 Spinal Cord Dysfunction, Traumatic, Quadriplegia complete C5-8
4.23 Other traumatic spinal cord dysfunction
5.11 Amputation of Limb, Non traumatic, Single upper amputation above the elbow
5.12 Amputation of Limb, Non traumatic, Single upper amputation below the elbow
5.13 Amputation of Limb, Non traumatic, Single lower amputation above the knee
5.14 Amputation of Limb, Non traumatic, Single lower amputation below the knee
5.15 Amputation of Limb, Non traumatic, Double lower amputation above the knee
5.16 Amputation of Limb, Non traumatic, Double lower amputation above/below the knee
5.17 Amputation of Limb, Non traumatic, Double lower amputation below the knee
5.18 Amputation of Limb, Non traumatic, Partial foot amputation (includes single/double)
5.19 Other non-traumatic amputation
5.21 Amputation of Limb, Traumatic, Single upper I amputation above the elbow
5.22 Amputation of Limb, Traumatic, Single upper amputation below the elbow
5.23 Amputation of Limb, Traumatic, Single lower amputation above the knee
5.24 Amputation of Limb, Traumatic, Single lower amputation below the knee
5.25 Amputation of Limb, Traumatic, Double lower amputation above the knee
5.26 Amputation of Limb, Traumatic, Double lower amputation above/below the knee
5.27 Amputation of Limb, Traumatic, Double lower amputation below the knee
5.28 Amputation of Limb, Traumatic, Partial foot amputation (includes single/double)
5.29 Other traumatic amputation
6.1 Arthritis, Rheumatoid arthritis
6.2 Arthritis, Osteoarthritis
6.9 Other arthritis
7.1 Pain, Neck pain
7.2 Pain, Back pain
7.3 Pain, Extremity pain
7.4 Pain, Headache (includes migraine)
7.5 Pain, Multi-site pain
7.9 Other pain
8.111 Orthopaedic Conditions, Fracture of hip, unilateral (includes #NOF)
8.112 Orthopaedic Conditions, Fracture of hip, bilateral (includes #NOF)
8.12 Orthopaedic Conditions, Fracture of shaft of femur (excludes femur involving knee joint)
8.13 Orthopaedic Conditions, Fracture of pelvis
8.141 Orthopaedic Conditions, Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)
8.142 Orthopaedic Conditions, Fracture of leg, ankle, foot
8.15 Orthopaedic Conditions, Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)
8.16 Orthopaedic Conditions, Fracture of spine (excludes where the major disorder is pain)
8.17 Orthopaedic Conditions, Fracture of multiple sites
8.19 Other orthopaedic fracture
8.211 Post orthopaedic surgery, Unilateral hip replacement
8.212 Post orthopaedic surgery, Bilateral hip replacement

8.221 Post orthopaedic surgery, Unilateral knee replacement
8.222 Post orthopaedic surgery, Bilateral knee replacement
8.231 Post orthopaedic surgery, Knee and hip replacement same side
8.232 Post orthopaedic surgery, Knee and hip replacement different sides
8.24 Post orthopaedic surgery, Shoulder replacement or repair
8.25 Post orthopaedic surgery, Post spinal surgery
8.26 Other orthopaedic surgery
8.3 Soft tissue injury
9.1 Cardiac, Following recent onset of new cardiac impairment
9.2 Cardiac, Chronic cardiac insufficiency
9.3 Cardiac, Heart or heart/lung transplant
10.1 Pulmonary, Chronic obstructive pulmonary disease
10.2 Pulmonary, Lung transplant
10.9 Other pulmonary
11 Burns
12.1 Congenital Deformities, Spina bifida
12.9 Other congenital
13.1 Other Disabling Impairments, Lymphoedema
13.3 Other Disabling Impairments, Conversion disorder
13.9 Other disabling impairments. This classification should rarely be used.
14.1 Major Multiple Trauma, Brain + spinal cord injury
14.2 Major Multiple Trauma, Brain + multiple fracture/amputation
14.3 Major Multiple Trauma, Spinal cord + multiple fracture/ amputation
14.9 Other multiple trauma
15.1 Developmental disabilities
16.1 Re-conditioning following surgery
16.2 Re-conditioning following medical illness
16.3 Cancer rehabilitation

Date of injury/impairment onset

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	Record the date of the injury or impairment that has directly driven the need for the current episode of rehabilitation. For example, date the patient fractured their hip, or the date the patient had a stroke, or the date the patient had a limb amputated.
Justification:	This item is being collected to be able to measure the time between injury/event and admission to rehabilitation, and analyse this against outcomes achieved.
Guide for use:	This data element is one of a data pair. It is only collected if the exact date of injury/impairment is known. If the exact date is unknown, leave blank and record data item “time since onset or acute exacerbation of a chronic condition” instead. Do not record both items within this data pair.

Time since onset or acute exacerbation of chronic condition

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:
The time that has elapsed since the onset of the patient's condition that is the reason for this episode of rehabilitation care.

Justification:
It is thought that the time between the onset of the impairment (or exacerbation) and admission to a rehabilitation program affects FIM improvement, and the patient's length of stay in the hospital. This AROC item provides data which may help support this theory.

Guide for use:
This data element is one of a data pair and is only collected if the exact date of injury/impairment is not known or the reason for rehabilitation is not related to an acute injury/ impairment. Record this data item OR date of injury/impairment, NOT both.
In some cases, the impairment that has driven the need for rehabilitation may be a chronic disease with an insidious onset, and in these cases, record when the impairment started affecting the patient's function. For example, a patient admitted for rehabilitation for arthritis – no relevant acute admission – where the arthritis flared up 6 months ago and started affecting the patient's functioning, record codeset "6 months to less than 1 year".

Codeset values:

01 Less than one month ago
02 1 month to less than 3 months
03 3 months to less than 6 months
04 6 months to less than a year
05 1 year to less than 2 years
06 2 years to less than 5 years
07 5 or more years
09 Unknown

Date of relevant inpatient episode

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	Record the date of discharge from an acute admission or inpatient rehabilitation episode relevant to the current episode of ambulatory rehabilitation.
Justification:	This item is being collected to enable calculation of the time between inpatient episode discharge and ambulatory rehabilitation start dates and analysed against outcomes achieved.
Guide for use:	Only collect this data item if the current episode of ambulatory rehabilitation care was preceded by an episode of inpatient care, in the previous three months, relevant to the current rehabilitation episode. Example 1: a patient sustains a stroke, with mild deficits and does not require inpatient rehabilitation. Following a 5 day acute stay the patient is discharge back to the community with a referral to ambulatory rehabilitation. Record the date that the patient was discharged from the acute care episode. Example 2: a patient sustains a severe TBI and spends 6 weeks in acute care then 2 months in inpatient rehabilitation. Upon discharge to the community they attend ambulatory rehabilitation as a day therapy patient. Record the date that the patient was discharged from the inpatient rehabilitation care episode. Example 3: a patient required multiple hospital admissions for one acute condition, such as infection post knee or hip replacement. In such cases, record the discharge date from the acute admission immediately prior to the current ambulatory rehabilitation episode.

Mode of Episode Start

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item records data about where the patient came from when the ambulatory rehabilitation episode started.

Justification: This data items defines how the patient commenced their ambulatory rehabilitation journey. Different entry points may affect a patient's progress.

Guide for use: Patient may be transferred.

Codeset values:

01 Referred by GP
02 Referred by therapist
03 Referred directly from specialist rooms
04 Referred from ED
05 Referred from acute specialist unit
06 Referred from acute inpatient care same hospital
07 Referred from acute inpatient care different hospital
08 Referred from SAC same service
09 Referred from SAC different service

Is this the first direct care rehabilitation episode for this impairment/exacerbation of a chronic condition?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

"Direct care" is when the patient is directly under the care of the rehabilitation physician or team, in other words, the rehabilitation physician or team hold the "bed card"/medical governance for the patient. An episode of direct care can be provided in the inpatient setting, outpatient setting and/ or community setting.

For example, a patient who had a Stroke, has an episode of acute care and is then transferred to an in-patient rehabilitation program. This is the first direct rehabilitation episode of care they have received for their stroke.

A patient who has had a stroke, has been admitted for inpatient rehabilitation, and is now undertaking an ambulatory rehabilitation episode – the ambulatory rehabilitation episode is NOT their first direct rehabilitation episode for their stroke, the inpatient rehabilitation episode was.

A patient who is admitted directly to an ambulatory rehabilitation program after having a hip replacement – this would be their first direct care rehabilitation episode for their hip replacement.

For brain injury and spinal cord injury specialist units; if a patient is temporarily held in any other rehabilitation ward and then transferred to the specialist unit rehabilitation ward, code this as 1, "Yes".

For specialist brain and spinal injury units the first direct care rehabilitation episode is coded 1, 'Yes', if it is the first contact with a specialist unit for this impairment. The patient may also have received rehabilitation elsewhere, for example in-reach rehabilitation on an acute ward, or been temporarily admitted to a general rehabilitation ward while waiting specialist unit placement.

Justification:

This item attempts to differentiate the patient's first direct care rehabilitation episode from subsequent episodes through the patient's rehabilitation journey. It is important to accurately collect data about first direct care rehabilitation episode as data relating to first episode of care and subsequent episodes has an impact on outcome benchmarks.

Guide for use:

The item relates to the patient's impairment, not the particular hospital. For example, if a previous episode of direct rehabilitation care for the current impairment has taken place in a different hospital, enter 2 , "No".

Subsequent direct rehabilitation episodes of care are more common in certain impairments such as brain injury, spinal cord injury and/or amputee, where the patient often has multiple rehabilitation episodes across a variety of settings. E.g: a patient with an acquired brain injury received their first direct episode of rehabilitation care on the in-patient brain injury ward. He was then discharged into the community where he received ongoing ambulatory rehabilitation care. After 6 months, he was discharged from ambulatory rehabilitation and 12 months later re-admitted for another boost of in-patient rehabilitation care relating to the original brain injury.

Codeset values:

01 Yes

02 No

Need for interpreter service?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Record whether an interpreter service (paid or unpaid e.g: family member) is required for the patient.

Justification: Collection of this item will allow analysis of impact of a requirement for an interpreter on length of stay (LOS) and other outcomes.

Guide for use:

Codeset values:

01 Yes - Interpreter needed

02 No - Interpreter not needed

Date multi-disciplinary team rehabilitation plan established

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	A multidisciplinary team rehabilitation plan comprises a series of documented and agreed initiatives/treatment (specifying program goals and time frames), which has been established through multi-disciplinary consultation and consultation with the patient. Record the date the multidisciplinary team rehabilitation plan was first recorded.
Justification:	The establishment of a multidisciplinary team rehabilitation plan with regular review is necessary for effective patient rehabilitation. In the inpatient setting this item is required for collection and calculation of the version 4 ACHS Rehabilitation Medicine clinical indicators; reflects timely establishment of a multi-disciplinary team rehabilitation plan.
Guide for use:	Record the date the multidisciplinary team rehabilitation plan is formally documented in the patients' medical record. It must be a record of the plan formulated by the team on initial assessment of the patient. Often, the initial case conference document is a formal multidisciplinary plan for the patients care while participating in rehabilitation. In other cases, the patient may be assessed by a multidisciplinary team prior to commencing a rehabilitation program, and the plan formulated from this assessment may form the multidisciplinary rehabilitation plan.

Type of accommodation prior to this impairment (NZ)

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: The type of accommodation the patient lived in prior to the rehabilitation episode of care.

Justification: Type of accommodation before and after rehabilitation are collected to reflect and compare where the patient has come from (what was their usual accommodation) and where they are going to (what will become their usual accommodation after discharge from rehabilitation). Comparison of accommodation pre and post rehabilitation is an indicator of rehabilitation outcome.

Guide for use: Record the patient's accommodation type prior to their current episode of rehabilitation care. The patient's usual accommodation prior to rehabilitation will not necessarily be their usual accommodation after rehabilitation.

‘Supported Living’ is a service that helps people to live independently by providing support in those areas of their life where help is needed.

If 'Other', please record the type of accommodation in 'General Comments' section to enable analysis.

Codeset values:

01 Private residence (including unit in retirement village)

02 Rest home level care / Hospital level care (requires 24hr nursing care)

03 Supported living

08 Other

Carer status prior to this impairment

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:
Record the level of carer support the patient received prior to their current ambulatory admission. Include both paid and/or unpaid carer support received. Paid carer support includes both government funded and private health funded carers. Unpaid carer support includes care provided by a relative, friend, partner of the patient.

Justification:
Carer status is a key outcome measure for rehabilitation. Carer status before and after rehabilitation can be compared as a indication of patient's rehabilitation outcomes.

Guide for use:
Only complete if the patient's type of accommodation prior was private residence (including unit in retirement village), otherwise leave blank.
Include both paid and unpaid carer support.
Example of paid carer support: Mrs Jackson has a paid carer who comes to her home and assist her with personal care in the morning and the evening.
Example of unpaid carer support: Mr Price's daughter completes his weekly grocery shop for him as he is no longer able to drive.
Within the code set,
"Co-dependent" is when the carer and a patient depend on each other for assistance with functional tasks. For example Mr Jones receives assistance from his wife to cut up his food and Mrs Jones receives assistance from her husband to remember to take her medication.

Codeset values:

01 NO CARER and DOES NOT need one

02 NO CARER and NEEDS one

03 CARER NOT living in

04 CARER living in, NOT codependent

05 CARER living in, codependent

Employment status prior to this impairment

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:
This item records the patient's employment status before they had their impairment (or exacerbation of impairment.)

Justification:
Employment is an important outcome that can be measured through the patient's rehabilitation journey. Employment status prior to this impairment is collected as a baseline measure and can be used to group patients into "similar" cohorts for analysis. Employed patients are flagged on admission and their employment status, or potential, is re-assessed at discharge, enabling a measure of change.

Guide for use:
Record the patient's employment status before they had their impairment (or exacerbation of impairment.)
Within the codeset,
Employment includes patients who performed work for wages or salary, in cash or in kind (including self employed and volunteers). It also includes patients temporarily absent from a paid employment, but who retained a formal attachment to that job, e.g. unpaid maternity leave.
Unemployed includes patients who are without a job or out of work, usually involuntarily.
Student/child includes patients who are enrolled, either full-time or part-time, in an accredited teaching institution providing instruction.
Not in the labour force includes patients who have left the labour force e.g. retired by choice, mothers choosing to stay at home and care for children.
Retired for age includes patients who have left the workforce due to their age and do not intend on recturning to paid work in any capacity.
Retired for disability includes patients who have left the workforce due to a disability which is preventing them from working.

Codeset values:

01 Employed
02 Unemployed
03 Student
04 Not in labour force
05 Retired for age
06 Retired for disability

Type of accommodation during ambulatory episode (NZ)

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

Record the type of accommodation in which the patient resides during this episode of ambulatory rehabilitation.

Justification:

The type of accommodation before, during and after rehabilitation treatment are collected to reflect and compare where the patient has come from (what was their usual accommodation) and where they are going to end up (what will become their usual accommodation). Comparison of accommodation pre, during and post rehabilitation treatment is an indicator of rehabilitation outcomes.

Guide for use:

If the patient is residing in a "private residence" during this ambulatory episode of care, only answer 1, “pre-impairment accommodation (same address),” if the addresses before and during the rehabilitation episode are the same. E.g: Mrs Bee lived at 13 Mornington Cresent before and during this ambulatory episode of care.

If the patient is residing in a “private residence” during this ambulatory episode of care, but the address is different to their usual accommodation, specify the reason for the change of address ie: 2, interim accommodation due to geographical (access) issues, 3, Interim accommodation due to increased support required or 4, other.

Within the code set,
Interim accommodation, due to geographical (access) issues (may be private residence, rest home level care/hospital level care or supported living) relates to patients who may be required to stay with friends and/or family in order to get to the ambulatory rehabilitation service. This would include patients who come from remote or isolated communities, or patients where specialist rehabilitation services are not provided locally.

Interim accommodation, due to increased support required (may be private residence, rest home level care/hospital level care or supported living) relates to patients who require increased assistance with ADL's (including transport,) as well as those who cannot stay at their usual address because their homes need modifications or because of their decreased functional ability post impairment E.g: External or internal stairs, inaccessible amenities.

Codeset values:

01 Pre impairment accommodation

02 Interim accommodation due to geographical (access) issue (may be private residence, rest home level care/hospital level care or supported living)

03 Interim accommodation due to increased support required (may be private residence, rest home level care/hospital level care or supported living)

08 Other

Carer status during ambulatory episode

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record carer status (paid and unpaid) during the ambulatory episode of care. Paid carer support includes both government funded and private health funded carers. Unpaid carer support include care provided by a relative, friend, partner of the patient.

Justification: Carer status is a key outcome measure for rehabilitation. Carer status before, during and after rehabilitation can be compared as a indication of patient's rehabilitation progress

Guide for use: Include both paid and unpaid carer support received during their rehabilitation episode of care.
Example of paid carer support: Mrs Jackson has a paid carer who comes to her home and assist her with personal care in the morning and the evening.
Example of unpaid carer support: Mr Price's daughter completes his weekly grocery shop for him as he is no longer able to drive.
Within the code set,
"Co-dependent" is when the carer and a patient depend on each other for assistance with functional tasks. For example Mr Jones receives assistance from his wife to cut up his food and Mrs Jones receives assistance from her husband to remember to take her medication.

Codeset values:

01 NO CARER and DOES NOT need one

02 NO CARER and needs one

03 CARER not living in

04 CARER living in, NOT co-dependent

05 CARER living in, co-dependent

Is there an existing comorbidity interfering with this episode

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item identifies whether the patient had any other significant existing illness/impairment, not part of the principal presenting condition, which interfered with the process of rehabilitation.

Justification: It is important to identify whether the patient had co morbidities, as investigation of such data may reflect a relationship between the presence of comorbidities, the rehabilitation outcome and length of stay.

Guide for use: Only record 1, “YES” if the patient’s rehabilitation program was affected by the comorbidity, otherwise answer 2, “No”. The effect of the comorbidity should be apparent in the patient’s medical record. For example, the patient required extensive medication management for diabetes and had variability in blood sugar levels during the admission that affected their ability to participate, the patient required a longer length of stay to accommodate fatigue after dialysis, or the patient had one or more epileptic fits that caused the patient to need extra time to recover and be able to participate at the same level prior to the fit. Do not leave blank. If a comorbidity is present and it has interfered with the patient’s rehabilitation, it is highly likely a suspension of treatment may also have occurred and would need to be recorded.

Codeset values:

01 Yes

02 No

Comorbidities Interfering with Rehabilitation Episode

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: This item identifies which comorbidities interfered with the rehabilitation episode.

Justification: It is important to identify which comorbidities interfered with the rehabilitation episode, as investigation of such data may reflect a relationship between the comorbidity, the rehabilitation outcome and length of stay.

Guide for use:
Only record comorbidities that have interfered with the rehabilitation episode.
Up to four comorbidities can be entered from the code list.
Please carefully consider the use of the code '99 Other' as this contributes to non-specific data. If you find a trend in your patient group that is not covered by the codeset options please contact AROC.
If a comorbidity is present and it has interfered with the patient's rehabilitation, it is highly likely a suspension of treatment may also have occurred and would need to be recorded.

Data Items:

Comorbidities Interfering with Rehabilitation Episode
Comorbidities Interfering with Rehabilitation Episode
Comorbidities Interfering with Rehabilitation Episode
Comorbidities Interfering with Rehabilitation Episode

Codeset values:

01 Cardiac disease
02 Respiratory disease
03 Drug and alcohol abuse
04 Dementia
05 Delirium, pre-existing
06 Mental health problem
07 Renal failure with dialysis
08 Renal failure NO dialysis
09 Epilepsy
10 Parkinsons disease
11 Stroke
12 Spinal cord injury/disease
13 Brain injury
14 Multiple sclerosis
15 Hearing impairment
16 Diabetes mellitus
17 Morbid obesity
18 Inflammatory arthritis
19 Osteoarthritis
20 Osteoporosis
21 Chronic pain
22 Cancer
23 Pressure ulcer, pre-existing
24 Visual impairment
99 Other

Cognitive impairment impacting on rehabilitation participation

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

This item identifies whether the patient had a cognitive impairment, not part of the principal presenting condition, which impacted on the process of rehabilitation.

Justification:

It is important to identify whether the patient had a cognitive impairment which impacted on the process of rehabilitation, to enable analysis of such data to investigate whether there is a relationship with rehabilitation outcomes.

Guide for use:

Only record 1, 'Yes' if the patient's rehabilitation program was affected by having a comorbid cognitive impairment, which was not part of the principal presenting condition, otherwise answer 2, 'No'.
The effect of the cognitive impairment should be apparent in the patient's treatment record. For example, the patient may require additional time for rehabilitation because of some degree of difficulty in understanding and following directions.

Example:
Record 'No' if the patient had sustained a TBI resulting in cognitive difficulties which impacted on their ability to engage in rehabilitation, because this is part of the presenting condition.

Record 'Yes' if the patient had pre-existing cognitive decline independent of their presenting condition (eg total knee replacement or deconditioning due to a medical illness impairment). This includes cognitive decline which is above the threshold for dementia, ie 'mild cognitive decline'. The primary identifying characteristics are gradually increasing memory problems and deteriorating mental skills in at least one other area.

If the patient had been diagnosed with 'dementia' prior to this admission, record this as an existing comorbidity AND answer 'Yes' to this item. To be considered dementia, mental impairment must affect at least two brain functions. Dementia may affect:
•memory
•thinking
•language
•judgment
•behaviour

Codeset values:

01 Yes

02 No

Mode of episode end

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:
This item records data about where the patient went to at the end of their ambulatory rehabilitation episode.There are two broad categories reflecting where the patient can go:
1. Remain in the community
2. Return to the hospital system

Justification:
This data items defines how the patient ended their rehabilitation journey. Different exit points are indicative of a patient's progress in rehabilitation.

Guide for use:
Patient can be discharged and remain in the community, either directly to their final destination and what will be their home from now on (could be private residence or a nursing home), or to an interim destination.
Other major option is that person is discharged back to a hospital setting.
If patient is discharged to their final destination, provide final destination details under data item, "final destination." If patient is discharged to "an interim destination", provide details of interim destination under data item, "interim destination" and then if known, details of their final destination under data item, "final destination."
Please carefully consider the use of the code 9, "Other and unspecified" as this contributes to non-specific data. If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

01 Discharged to final destination
02 Discharged to interim destination
03 Death
04 Admitted to hospital as sub acute/non acute inpatient
05 Admitted to hospital as an acute inpatient
08 Discharged at own risk
09 Other and unspecified

Final destination (NZ)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

Final destination may be defined as the accommodation that a patient is discharged to that is the most appropriate long term accommodation for the patient.

Justification:

Type of accommodation before, during and after rehabilitation treatment are collected to reflect and compare where the patient has come from (what was their usual accommodation) and where they are going to (what will become their usual accommodation). Comparison of accommodation pre and post rehabilitation is an indicator of rehabilitation outcome.

Guide for use:

Only complete if recorded “discharged to final destination” or “discharged to interim destination” at mode of episode end. Please carefully consider the use of the code set value '9, Unknown' as this contributes to non-specific data.

‘Supported Living’ is a service that helps people to live independently by providing support in those areas of their life where help is needed.

Codeset values:

01 Private residence (including unit in retirement village)

02 Rest home level care / Hospital level care (requires 24hrs nursing)

03 Supported living

08 Other

09 Unknown

Carer status post discharge

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Record the level of carer support the patient receives post discharge from their inpatient or ambulatory rehabilitation episode of care. Include both paid and/or unpaid carers. Paid carer support includes both government funded and private health funded carers. Unpaid carer support include care provided by a relative, friend, partner of the patient.

Justification: Carer status is a key outcome measure for rehabilitation. Carer status before and after rehabilitation can be compared as a indication of patient's rehabilitation outcomes.

Guide for use: Only record if "final destination" or "interim destination" was private residence (including unit in retirement village), otherwise leave blank.
Include both paid and unpaid carer support.
Example of paid carer support: Mrs Jackson will have a paid carer come to her home and assist her with personal care in the morning and the evenings post discharge.
Example of unpaid carer support: Mr Price's daughter will complete his weekly grocery shop for him as he is no longer able to drive.
Within the code set, "co-dependent" is when the carer and a patient depend on each other for assistance with functional tasks. For example Mr Jones will receive assistance from his wife to cut up his food and Mrs Jones will receive assistance from her husband to remember to take her medication.

Codeset values:

01 NO CARER and DOES NOT need one

02 NO CARER and NEEDS one

03 CARER NOT living in

04 CARER living in, NOT codependent

05 CARER living in, codependent

Employment status after, or anticipated employment status after discharge

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

Record the patient's employment status, or anticipated employment status, after discharge.

Justification:

Employment is an important outcome that can be measured through the patient's rehabilitation journey. If the patient was employed prior to this impairment, AROC is interested in knowing if their rehabilitation has enabled them to achieve a level of function that allows them to return to work or not. If they have, AROC is also interested in knowing to what level they are able to return to work.

Collection of this data will enable analysis of employment outcome achievement. E.g. A patient was employed prior to admission and returned to their same or similar job, with reduced hours upon discharge may have different functional outcomes to a patient was employed prior to their admission, but is unable to work upon discharge.

Guide for use:

Only complete this item if the patient was employed prior to this impairment (or exacerbation of this impairment). Record the patient's employment status, or anticipated employment status, after discharge. This is a new item in the v4 dataset.

Codeset values:

01 Same or similar job, same or similar hours

02 Same or similar job, reduced hours

03 Different job by choice

04 Different job due to reduced function

05 Not able to work

06 Chosen to retire

07 Too early to determine

Return to pre-impairment leisure and recreational activities

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the patient's level of return to participation in pre-impairment leisure and recreational activities.

Justification: Participation in leisure and recreational activities is an important aspect of life.

Guide for use:
Record 1 if the patient was able to return to all pre-impairment leisure and recreational activities
Record 2 if the patient was able to return to some degree of participation in pre-impairment leisure and recreational activities
Record 3 if the patient was moderately limited in participation in pre-impairment leisure and recreational activities
Record 4 if the patient was severely limited in participation in pre-impairment leisure and recreational activities
Record 5 if the patient has not been able to return to ANY pre-impairment leisure and recreational activities

Codeset values:

01 Normal participation (ie pre-impairment level)
02 Mild difficulty in these activities but maintains normal participation
03 Mildly limited participation
04 Moderately limited participation
05 No or rare participation

Total number of days seen

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the total number of days that service(s) were provided to the patient during their episode of care.

Justification: This item enables an accurate count of the total number of ACTUAL days the patient received therapy during their rehabilitation episode of care, which may impact on patient outcomes. In the ambulatory setting, rehabilitation days are not necessarily continuous. A patient may attend therapy sessions 2 or 3 times a week for a number of weeks, thus the count of days between episode start and episode end may (and is usually) many more days than the count of ACTUAL number of days that services were provided to the patient.

Guide for use: In the ambulatory setting, this should total all days that service(s) were provided to the patient. For example, if the patient participated in the rehabilitation program 2 x per week for 4 weeks, the total number of days seen would be 8.
In the inpatient setting, this item is only collected for in-patients who are seen once for a one off assessment (consult liaison) e.g. when a 'second opinion', advice on a particular problem, a case review, a one-off assessment or therapy session is required. In such cases, the patient has been seen once, so you would record “total number of days seen” as 1.

Total number of occasions of service

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:
Record the total number of occasions of service to the patient. An occasion of service may be defined as “each time therapy is provided to the patient; one therapy provider may provide an occasion of service to one or many patients at the same time (individual vs. group therapy). A patient may receive a number of occasions of service on the same day (e.g: physiotherapy in the morning and speech pathology in the afternoon).

Justification:
This item is recorded to enable an accurate count of the number of occasions of service during the episode of care as number of occasions of services may impact on patient outcomes.

Guide for use:
In the ambulatory setting, this should be the total of all occasions of service(s) that were provided to the patient. For example, if the patient attended the rehabilitation centre 2 x a week for 4 weeks, and had physiotherapy and occupational therapy at each visit the total number of occasions of service would be 16.
In the inpatient setting, this item is only collected for in-patients who are seen once for a one off assessment (consult liaison) e.g. when a 'second opinion', advice on a particular problem, a case review, a one-off assessment or therapy session is required. In such cases, the patient has been seen once, so you would record “occasions of service” as 1

Disciplines involved in therapy

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:	Record the type(s) of health professional or other care provider who provided treatment to the patient during their rehabilitation episode of care.
Justification:	This item is required to enable analysis of inputs (therapy type) and their impact on functional outcomes.
Guide for use:	Please indicate all types of therapy providers who provided treatment to the child during this episode of care. Choose up to 10.

Data Items:

Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care

Codeset values:

01 Aboriginal Liaison Worker
02 Audiologist
03 Case Manager
04 Clinical Nurse Consultant
05 Clinical Nurse Specialist
06 Community support worker
07 Dietitian
08 Enrolled nurse
09 Exercise physiologist / Remedial Gymnast
10 Educational tutor
11 Hydrotherapist
12 Interpreter
13 Medical Officer
14 Nurse Practitioner
15 Neuro-psychologist
16 Occupational Therapist
17 Physiotherapist
18 Podiatrist
19 Psychologist
20 Registered Nurse
21 Recreational Therapist
22 Speech Pathologist
23 Social Worker
24 Therapy Aide
25 Vocational Co-ordinator
98 Other

Date episode start Lawton's Assessed

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:	Record the date on which the Lawton's assessment was scored at episode start (admission).
Justification:	This item reflects timely assessment of function on admission to ambulatory rehabilitation. It also enables groupings of ambulatory patients for benchmarking and outcome measurement.
Guide for use:	Record the date on which the Lawton's assessment was scored at episode start (admission).

Lawton's admission scores (items 1-6)

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the Australian Modified Lawton's score on admission to ambulatory rehabilitation.

Justification: The functional ability of a patient changes during rehabilitation and the Australian Modified Lawton's instrument is used to track those changes which are a key outcome measure of the ambulatory rehabilitation episode. Thus AROC collects Lawton's scores at episode start and episode end.

Guide for use: Record for all impairments.

Rate what the person is currently capable of doing rather than what they actually do. In assessing capability, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). Consumers able to complete a task with verbal prompting should not be rated as independent (and therefore should be rated as a 2 or a 3).

In rating an item that is irrelevant (for example, the person does not havea phone or has no shops in the vicinity or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation.

When assessing issues such as whether diet is adequate or there are acceptable standards of cleanliness, take into account the person's social and cultural context. Rate based on what is adequate or acceptable in that context and not in your own.

Refer to the Lawton's Activities of Daily Living Assessment for specific wording of the rating for each item.

Data Items:

Score episode start Lawton's for telephone
Score episode start Lawton's for shopping
Score episode start Lawton's for food preparation
Score episode start Lawton's for housekeeping
Score episode start Lawton's for laundry excluding ironing
Score episode start Lawton's for mode of transportation

Codeset values:

01 Not able to perform activity of daily living (ADL)
02 Requires moderate assistance to perform ADL
03 Requires some assistance to perform ADL
04 Capable of independently performing ADL

Lawton's admission scores (items 7-8)

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

Record the Australian Modified Lawton's score on admission to ambulatory rehabilitation.

Justification:

The functional ability of a patient changes during rehabilitation and the Australian Modified Lawton's instrument is used to track those changes which are a key outcome measure of the ambulatory rehabilitation episode. Thus AROC collects Lawton's scores at episode start and episode end.

Guide for use:

Record for all impairments.

Rate what the person is currently capable of doing rather than what they actually do. In assessing capability, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). Consumers able to complete a task with verbal prompting should not be rated as independent (and therefore should be rated as a 2 or a 3).

In rating an item that is irrelevant (for example, the person does not havea phone or has no shops in the vicinity or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation.

When assessing issues such as whether diet is adequate or there are acceptable standards of cleanliness, take into account the person's social and cultural context. Rate based on what is adequate or acceptable in that context and not in your own.

Refer to the Lawton's Activities of Daily Living Assessment for specific wording of the rating for each item.

Data Items:

Score episode start Lawton's for responsibility for own medications

Score episode start Lawton's for ability to handle finances

Codeset values:

01 Not able to perform activity of daily living (ADL)

02 Requires some assistance to perform ADL

03 Capable of independently performing ADL

Date episode end Lawton's Assessed

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:	Record the date on which the Australian Modified Lawton's assessment was scored at episode end (discharge).
Justification:	This item reflects timely assessment of function upon discharge from ambulatory rehabilitation. It also enables groupings of ambulatory patients for benchmarking and outcome measurement.
Guide for use:	Record the date on which the Australian Modified Lawton's assessment was scored at episode end (discharge).

Lawton's discharge scores (items 1-6)

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the Australian Modified Lawton's score at end of ambulatory rehabilitation.

Justification: The functional ability of a patient changes during rehabilitation and the Australian Modified Lawton's instrument is used to track those changes which are a key outcome measure of the ambulatory rehabilitation episode. Thus AROC collects Lawton's scores at episode start and episode end.

Guide for use: Record for all impairments.

Rate what the person is currently capable of doing rather than what they actually do. In assessing capability, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). Consumers able to complete a task with verbal prompting should not be rated as independent (and therefore should be rated as a 2 or a 3).

In rating an item that is irrelevant (for example, the person does not havea phone or has no shops in the vicinity or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation.

When assessing issues such as whether diet is adequate or there are acceptable standards of cleanliness, take into account the person's social and cultural context. Rate based on what is adequate or acceptable in that context and not in your own.

Refer to the Lawton's Activities of Daily Living Assessment for specific wording of the rating for each item.

Data Items:

Score episode end Lawton's for telephone

Score episode end Lawton's for shopping

Score episode end Lawton's for food preparation

Score episode end Lawton's for housekeeping

Score episode end Lawton's for laundry excluding ironing

Score episode end Lawton's for mode of transportation

Codeset values:

01 Not able to perform activity of daily living (ADL)

02 Requires moderate assistance to perform ADL

03 Requires some assistance to perform ADL

04 Capable of independently performing ADL

Lawton's discharge scores (items 7-8)

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

Record the Australian Modified Lawton's score at end of ambulatory rehabilitation.

Justification:

The functional ability of a patient changes during rehabilitation and the Australian Modified Lawton's instrument is used to track those changes which are a key outcome measure of the ambulatory rehabilitation episode. Thus AROC collects Lawton's scores at episode start and episode end.

Guide for use:

Record for all impairments.

Rate what the person is currently capable of doing rather than what they actually do. In assessing capability, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). Consumers able to complete a task with verbal prompting should not be rated as independent (and therefore should be rated as a 2 or a 3).

In rating an item that is irrelevant (for example, the person does not havea phone or has no shops in the vicinity or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation.

When assessing issues such as whether diet is adequate or there are acceptable standards of cleanliness, take into account the person's social and cultural context. Rate based on what is adequate or acceptable in that context and not in your own.

Refer to the Lawton's Activities of Daily Living Assessment for specific wording of the rating for each item.

Data Items:

Score episode end Lawton's for responsibility for own medications

Score episode end Lawton's for ability to handle finances

Codeset values:

01 Not able to perform activity of daily living (ADL)

02 Requires some assistance to perform ADL

03 Capable of independently performing ADL

Was Rehabilitation aimed at Upper Limb Function

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Specify if rehabilitation was aimed at upper limb function; if yes, complete the Upper Limb Motor Assessment Scale (UL-MAS).

Justification: Stroke may impact on a range of different functions, which are better evaluated by a combination of relevant outcome measures.

Guide for use: ONLY complete for AROC impairment codes:
1.11, 1.12, 1.13, 1.14,1.19 (Haemorrhagic stroke)
1.21, 1.22, 1.23,1.24,1.29 (Ischaemic stroke)

Indicate whether rehabilitation was aimed at upper limb function:

Codeset values:

01 Yes
02 No

Was Rehabilitation aimed at Gait Retraining

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Specify if rehabilitation was aimed at gait training; if yes, complete the 10 metre walk +/- aid test.

Justification: Stroke may impact on a range of different functions, which are better evaluated by a combination of relevant outcome measures.

Guide for use: ONLY complete for AROC impairment codes:
1.11, 1.12, 1.13, 1.14,1.19 (Haemorrhagic stroke)
1.21, 1.22, 1.23,1.24,1.29 (Ischaemic stroke)

Indicate whether rehabilitation was aimed at gait training:

Codeset values:

01 Yes
02 No

Was Rehabilitation aimed at Aphasia

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Specify if rehabilitation was aimed at aphasia; if yes, record outcome measured used and pre/post treatment scores in the 'General Comments' section.

Justification: Stroke may impact on a range of different functions, which are better evaluated by a combination of relevant outcome measures. At this stage a single outcome tool for evaluating aphasia has not yet been determined for use in the AROC data collection.

Guide for use: ONLY complete for AROC impairment codes:
1.11, 1.12, 1.13, 1.14,1.19 (Haemorrhagic stroke)
1.21, 1.22, 1.23,1.24,1.29 (Ischaemic stroke)

Indicate whether rehabilitation was aimed at aphasia:

Codeset values:

01 Yes
02 No

Upper Limb Motor Assessment Scale (ULMAS) Start Date

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the date that the ULMAS was scored at episode start (admission).

Justification:

Guide for use:

Upper Limb Motor Assessment Scale (ULMAS) Start Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the Upper Limb Motor Assessment Scale scores for each of the assessment items, at the beginning of the ambulatory rehabilitation episode.

Justification: The Upper Limb Motor Assessment Scale assesses everyday upper limb motor function in adults following stroke. The UL-MAS is a responsive, valid and reliable measure of upper limb function in adults following stroke.

Guide for use: ONLY complete for AROC impairment codes:

1.11, 1.12, 1.13, 1.14,1.19 (Haemorrhagic stroke)
1.21, 1.22, 1.23,1.24,1.29 (Ischaemic stroke)

Record the patient's Motor Assessment Scale – Upper Limb scores for each of the assessment items, at the beginning of the ambulatory rehabilitation episode.

Note: Clinicians score Upper Arm Function, Hand Movements and Hand Activities against UL-MAS scoring criteria.

Data Items:

ULMAS Start Upper Arm Function

ULMAS Start Hand Movements

ULMAS Start Hand Activities

Codeset values:

00 0 No function
01 1 Minimal function
02 2
03 3
04 4
05 5
06 6 Maximal function

Upper Limb Motor Assessment Scale (ULMAS) End Date

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the date that the ULMAS was scored at episode end (discharge).

Justification:

Guide for use:

Upper Limb Motor Assessment Scale (ULMAS) End Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:
Record the Upper Limb Motor Assessment Scale scores for each of the assessment items, at the end of the ambulatory rehabilitation episode.

Justification:
The Upper Limb Motor Assessment Scale assesses everyday upper limb motor function in adults following stroke. The UL-MAS is a responsive, valid and reliable measure of upper limb function in adults following stroke.

Guide for use:
ONLY complete for AROC impairment codes:

1.11, 1.12, 1.13, 1.14,1.19 (Haemorrhagic stroke)
1.21, 1.22, 1.23,1.24,1.29 (Ischaemic stroke)

Record the patient's Motor Assessment Scale – Upper Limb scores for each of the assessment items, at the end of the ambulatory rehabilitation episode.

Note: Clinicians score Upper Arm Function, Hand Movements and Hand Activities against UL-MAS scoring criteria.

Data Items:

ULMAS End Upper Arm Function

ULMAS End Hand Movements

ULMAS End Hand Activities

Codeset values:

00	0 No function
01	1 Minimal function
02	2
03	3
04	4
05	5
06	6 Maximal function

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) Start Date

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the date that the MPAI-4 was assessed at episode start (admission).

Justification:

Guide for use:

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Abilities Start Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

Record the patient's MPAI-4 Abilities scores at the beginning of the ambulatory rehabilitation episode.

Justification:

The MPAI-4 was specifically designed for the evaluation of individuals during the post-acute period following ABI. The MPAI-4 consists of 29 items in three subscales (the Ability Index, the Adjustment Index and the Participation Index) plus an additional six items that are not included in the MPAI-4 score. Items are rated on a 5-point scale from 0 to 4 where 0 represents the most favourable outcome, no problem or independence and 4 represents the presence of severe problems.

Guide for use:

ONLY complete for AROC impairment codes:

2.11, 2.12, 2.13 (non-traumatic brain injury)
2.21, 2.22 (traumatic brain injury)
14.1 (Major Multiple Trauma: brain + spinal cord injury)
14.2 (Major Multiple Trauma: brain + multiple fracture/amputation)

For the purposes of the AROC data collection, the MPAI-4 should be completed by professional staff engaged with the patient's rehabilitation. The ratings should be completed by team consensus.

Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

Note: Clinicians score MPAI-4 items against the relevant scoring criteria described in the tool.

Data Items:

MPAI4AStartMobility
MPAI4 A-Start Use Of Hands
MPAI4 A-Start Vision
MPAI4 A-Start Audition
MPAI4 A-Start Dizziness
MPAI4 A-Start Motor Speech
MPAI4 A-Start Verbal Commmunication
MPAI4 A-Start Nonverbal Communication
MPAI4 A-Start Attention/Concentration
MPAI4 A-Start Fund Of Information
MPAI4 A-Start Novel Problem Solving
MPAI4 A-Start Visuospatial abilities

Codeset values:

00 None
01 Mild problem but does not interfere with activities or function
02 Mild problem; interferes with activities to some degree
03 Moderate problem
04 Severe problem

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Adjustment Start Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

Record the patient's MPAI-4 Adjustment scores at the beginning of the ambulatory rehabilitation episode.

Justification:

The MPAI-4 was specifically designed for the evaluation of individuals during the post-acute period following ABI. The MPAI-4 consists of 29 items in three subscales (the Ability Index, the Adjustment Index and the Participation Index) plus an additional six items that are not included in the MPAI-4 score. Items are rated on a 5-point scale from 0 to 4 where 0 represents the most favourable outcome, no problem or independence and 4 represents the presence of severe problems.

Guide for use:

ONLY complete for AROC impairment codes:

2.11, 2.12, 2.13 (non-traumatic brain injury)
2.21, 2.22 (traumatic brain injury)
14.1 (Major Multiple Trauma: brain + spinal cord injury)
14.2 (Major Multiple Trauma: brain + multiple fracture/amputation)

For the purposes of the AROC data collection, the MPAI-4 should be completed by professional staff engaged with the patient's rehabilitation. The ratings should be completed by team consensus.

Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

Note: Clinicians score MPAI-4 items against the relevant scoring criteria described in the tool.

Data Items:

MPAI4 B-Start Anxiety
MPAI4 B-Start Depression
MPAI4 B-Start Irritability
MPAI4 B-Start Pain Headache
MPAI4 B-Start Fatigue
MPAI4 B-Start Sensitivity to Mild Symptoms
MPAI4 B-Start Inappropriate Social interaction
MPAI4 B-Start Impaired Self-Awareness
MPAI4 B-Start Family

Codeset values:

00 None
01 Mild problem but does not interfere with activities or function
02 Mild problem; interferes with activities to some degree
03 Moderate problem
04 Severe problem

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Participation Start Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

Record the patient's MPAI-4 Participation scores at the beginning of the ambulatory rehabilitation episode.

Justification:

The MPAI-4 was specifically designed for the evaluation of individuals during the post-acute period following ABI. The MPAI-4 consists of 29 items in three subscales (the Ability Index, the Adjustment Index and the Participation Index) plus an additional six items that are not included in the MPAI-4 score. Items are rated on a 5-point scale from 0 to 4 where 0 represents the most favourable outcome, no problem or independence and 4 represents the presence of severe problems.

Guide for use:

ONLY complete for AROC impairment codes:

2.11, 2.12, 2.13 (non-traumatic brain injury)
2.21, 2.22 (traumatic brain injury)
14.1 (Major Multiple Trauma: brain + spinal cord injury)
14.2 (Major Multiple Trauma: brain + multiple fracture/amputation)

For the purposes of the AROC data collection, the MPAI-4 should be completed by professional staff engaged with the patient's rehabilitation. The ratings should be completed by team consensus.

Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

Note: Clinicians score MPAI-4 items against the relevant scoring criteria described in the tool.

Data Items:

MPAI4 C-Start Initiation
MPAI4 C-Start Social Contact
MPAI4 C-Start Leisure
MPAI4 C-Start Self Care
MPAI4 C-Start Residence
MPAI4 C-Start Transportation
MPAI4 C-Start Paid Employment
MPAI4 C-Start Other Employment
MPAI4 C-Start Finances

Codeset values:

00 None
01 Mild problem but does not interfere with activities or function
02 Mild problem; interferes with activities to some degree
03 Moderate problem
04 Severe problem

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) End Date

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the date that the MPAI-4 was assessed at episode end (discharge).

Justification:

Guide for use:

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Abilities End Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

Record the patient's MPAI-4 Abilities scores at the end of the ambulatory rehabilitation episode.

Justification:

The MPAI-4 was specifically designed for the evaluation of individuals during the post-acute period following ABI. The MPAI-4 consists of 29 items in three subscales (the Ability Index, the Adjustment Index and the Participation Index) plus an additional six items that are not included in the MPAI-4 score. Items are rated on a 5-point scale from 0 to 4 where 0 represents the most favourable outcome, no problem or independence and 4 represents the presence of severe problems.

Guide for use:

ONLY complete for AROC impairment codes:

2.11, 2.12, 2.13 (non-traumatic brain injury)
2.21, 2.22 (traumatic brain injury)
14.1 (Major Multiple Trauma: brain + spinal cord injury)
14.2 (Major Multiple Trauma: brain + multiple fracture/amputation)

For the purposes of the AROC data collection, the MPAI-4 should be completed by professional staff engaged with the patient's rehabilitation. The ratings should be completed by team consensus.

Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

Note: Clinicians score MPAI-4 items against the relevant scoring criteria described in the tool.

Data Items:

MPAI4 A-End Mobility
MPAI4 A-End Use Of Hands
MPAI4 A-End Vision
MPAI4 A-End Audition
MPAI4 A-End Dizziness
MPAI4 A-End Motor Speech
MPAI4 A-End Verbal Communication
MPAI4 A-End Nonverbal Communication
MPAI4 A-End Attention/Concentration
MPAI4 A-End Memory
MPAI4 A-End Fund Of Information
MPAI4 A-End Novel Problem Solving
MPAI4 A-End Visuospatial abilities

Codeset values:

00 None
01 Mild problem but does not interfere with activities or function
02 Mild problem; interferes with activities to some degree
03 Moderate problem
04 Severe problem

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Adjustment End Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

Record the patient's MPAI-4 Adjustment scores at the end of the ambulatory rehabilitation episode.

Justification:

The MPAI-4 was specifically designed for the evaluation of individuals during the post-acute period following ABI. The MPAI-4 consists of 29 items in three subscales (the Ability Index, the Adjustment Index and the Participation Index) plus an additional six items that are not included in the MPAI-4 score. Items are rated on a 5-point scale from 0 to 4 where 0 represents the most favourable outcome, no problem or independence and 4 represents the presence of severe problems.

Guide for use:

ONLY complete for AROC impairment codes:

2.11, 2.12, 2.13 (non-traumatic brain injury)
2.21, 2.22 (traumatic brain injury)
14.1 (Major Multiple Trauma: brain + spinal cord injury)
14.2 (Major Multiple Trauma: brain + multiple fracture/amputation)

For the purposes of the AROC data collection, the MPAI-4 should be completed by professional staff engaged with the patient's rehabilitation. The ratings should be completed by team consensus.

Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

Note: Clinicians score MPAI-4 items against the relevant scoring criteria described in the tool.

Data Items:

MPAI4 B-End Anxiety
MPAI4 B-End Depression
MPAI4 B-End Irritability
MPAI4 B-End Pain Headache
MPAI4 B-End Fatigue
MPAI4 B-End Sensitivity to Mild Symptoms
MPAI4 B-End Inappropriate Social Interaction
MPAI4 B-End Impaired Self
MPAI4 B-End Family

Codeset values:

00 None
01 Mild problem but does not interfere with activities or function
02 Mild problem; interferes with activities to some degree
03 Moderate problem
04 Severe problem

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Participation End Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

Record the patient's MPAI-4 Participation scores at the end of the ambulatory rehabilitation episode.

Justification:

The MPAI-4 was specifically designed for the evaluation of individuals during the post-acute period following ABI. The MPAI-4 consists of 29 items in three subscales (the Ability Index, the Adjustment Index and the Participation Index) plus an additional six items that are not included in the MPAI-4 score. Items are rated on a 5-point scale from 0 to 4 where 0 represents the most favourable outcome, no problem or independence and 4 represents the presence of severe problems.

Guide for use:

ONLY complete for AROC impairment codes:

2.11, 2.12, 2.13 (non-traumatic brain injury)
2.21, 2.22 (traumatic brain injury)
14.1 (Major Multiple Trauma: brain + spinal cord injury)
14.2 (Major Multiple Trauma: brain + multiple fracture/amputation)

For the purposes of the AROC data collection, the MPAI-4 should be completed by professional staff engaged with the patient's rehabilitation. The ratings should be completed by team consensus.

Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

Note: Clinicians score MPAI-4 items against the relevant scoring criteria described in the tool.

Data Items:

MPAI4 C-End Initiation
MPAI4 C-End Social Contact
MPAI4 C-End Leisure
MPAI4 C-End Self Care
MPAI4 C-End Residence
MPAI4 C-End Transportation
MPAI4 C-End Paid Employment
MPAI4 C-End Other Employment
MPAI4 C-End Finances

Codeset values:

00 None
01 Mild problem but does not interfere with activities or function
02 Mild problem; interferes with activities to some degree
03 Moderate problem
04 Severe problem

Level of SCI Start

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the level of spinal cord injury (SCI) at the start of the patient's ambulatory episode of care.

Justification: This item is required to be able to group patients into cohorts for data analysis.

Guide for use: Collect for AROC impairment code 4 (spinal cord dysfunction) only.
Leave blank for all other AROC impairment codes.
If patient is cauda equina, record "cauda equina" in general comment field. If unable to establish level of injury, record "paraplegia" or "quadriplegia" in the general comments field.

Codeset values:

01 C1
02 C2
03 C3
04 C4
05 C5
06 C6
07 C7
08 C8
09 T1
10 T2
11 T3
12 T4
13 T5
14 T6
15 T7
16 T8
17 T9
18 T10
19 T11
20 T12
21 L1
22 L2
23 L3
24 L4
25 L5
26 S1
27 S2
28 S3
29 S4
30 S5

de Morton Mobility Index (DEMMI) Start Date

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the date that the DEMMI was assessed at episode start (admission).

Justification:

Guide for use:

de Morton Mobility Index (DEMMI) Start Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:
Record the patient's DEMMI scores for each of the assessment items at the beginning of the ambulatory rehabilitation episode.

Justification:
The DEMMI is an advanced instrument for accurately measuring and monitoring changes in mobility for all older adults.
Mobility is an important indicator of the health status of older adults. Poor mobility is associated with loss of independence in activities of daily living and increased risk of falls, carer burden, mortality and healthcare costs. The DEMMI, has been developed to accurately measure the important construct of mobility for all older people.

Guide for use:
The DEMMI is administered by clinician observation of performance on 15 hierarchical mobility challenges.

Only complete for AROC impairment codes:

16.1 - Reconditioning following surgery
16.2 - Reconditioning following medical illnes
16.3 - Cancer rehabilitation

Data Items:

DEMMI Start Bridge
DEMMI Start Roll Onto Side
DEMMI Start Lying To Sitting
DEMMI Start Sit Unsupported in Chair
DEMMI Start Sit To Stand From Chair
DEMMI Start Sit To Stand No Arms
DEMMI Start Stand Unsupported
DEMMI Start Stand Feet Together
DEMMI Start Stand On Toes
DEMMI Start Tandem Stand
DEMMI Start Walking Distance
DEMMI Start Gait Aid
DEMMI Start Walking Independence
DEMMI Start Pick Up Pen
DEMMI Start Walks 4 Steps Back
DEMMI Start Jump

Codeset values:

00	Score 0
01	Score 1
02	Score 2

de Morton Mobility Index (DEMMI) End Date

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the date that the DEMMI was assessed at episode end (discharge).

Justification:

Guide for use:

de Morton Mobility Index (DEMMI) End Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:
Record the patient's DEMMI scores for each of the assessment items at the end of the ambulatory rehabilitation episode.

Justification:
The DEMMI is an advanced instrument for accurately measuring and monitoring changes in mobility for all older adults.
Mobility is an important indicator of the health status of older adults. Poor mobility is associated with loss of independence in activities of daily living and increased risk of falls, carer burden, mortality and healthcare costs. The DEMMI, has been developed to accurately measure the important construct of mobility for all older people.

Guide for use:
The DEMMI is administered by clinician observation of performance on 15 hierarchical mobility challenges.

Only complete for AROC impairment codes:

16.1 - Reconditioning following surgery
16.2 - Reconditioning following medical illnes
16.3 - Cancer rehabilitation

Data Items:

DEMMI End Bridge
DEMMI End Roll Onto Side
DEMMI End Lying To Sitting
DEMMI End Sit Unsupported in Chair
DEMMI End Sit To Stand From Chair
DEMMI End Sit To Stand No Arms
DEMMI End Stand Unsupported
DEMMI End Stand Feet Together
DEMMI End Stand On Toes
DEMMI End Tandem Stand
DEMMI End Walking Distance
DEMMI End Gait Aid
DEMMI End Walking Independence
DEMMI End Pick Up Pen
DEMMI End Walks 4 Steps Back
DEMMI End Jump

Codeset values:

00	Score 0
01	Score 1
02	Score 2

Ready For Casting Date

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:	Record the date the treating rehabilitation physician or team deems the stump is ready for casting.
Justification:	This item is required to establish time periods between critical points through the rehabilitation episode.
Guide for use:	Collect for AROC impairment code 5 (amputation of limb) only. Leave blank for all other AROC impairment codes. If the date is known enter exact date. Use date format DD/MM/YYYY. If casting is planned but the date is not yet known enter 07/07/7777. If casting is not clinically appropriate enter 08/08/8888.

Amputee Care Start

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:

Record the phase of amputee care the patient is in at episode start (admission)

Justification:

This item is required to be able to define the different paths through rehabilitation for amputees and to ensure benchmarking between like cohorts.

Guide for use:

Collect for AROC impairment code 5 (amputation of limb) only. Leave blank for all other AROC impairment codes.
Use the code set definitions to assist with defining of amputee phase of care at admission. Record 1 phase only.

Within the codeset,

Preoperative phase is the phase during which the clinical decision to perform amputation occurs, including assessment of urgency (following trauma or infection.) A comprehensive interdisciplinary baseline assessment of the patient's status including medical assessment, functional status (including function of contra lateral limb), pain control and psychological and cognitive assessment is completed. Patient's goals, social environment and support systems are all defined. A post-operative care plan should be determined by the surgeon and rehabilitation team to address medical, wound or surgical and rehabilitation requirements. Delayed wound phase is the phase where problems occur with wound healing and additional interventions are considered as needed, including revision surgery, vascular and infection evaluation, aggressive local wound care and hyperbaric oxygen.

Pre prosthetic phase is the phase where a patient is discharged from acute care and enters in-patient rehabilitation program or is treated in ambulatory setting. Postoperative assessment to review patient's status, including physical and functional assessment; completion of FIM baseline and other relevant assessments are completed. Rehabilitation goals are determined, rehabilitation treatment plan is established and updated and patient education is provided. Provide physical and functional interventions based on current and potential function. Determine whether a prosthesis is appropriate to improve functional status and meet realistic patient goals.

Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. Prosthesis is prescirbed based on current or potential level of ambulation. Patient receives interim or permanent prosthetic fitting and training, and early rehabilitation management. Prosthetic gait training and patient education on functional use of prosthesis for transfers, balance and safety is provided.

Follow-up phase is the phase where follow-up appointment after discharge from rehabilitation is scheduled. Assessment of patient's goals, functional assessment, secondary complications, prosthetic assessment (repair, replacement, mechanical adjustment and new technology) and vocational and recreational needs are completed. Secondary amputation prevention is provided (where relevant). This also includes the provision of rehabilitation for patients who are not suitable for a prosthesis. Rehabilitation focus may include transfers, functional mobility, wheelchair mobility, ADL training.

Codeset values:

01 Pre-operative
02 Delayed wound
03 Pre Prosthetic
04 Prosthetic
05 Follow-up

Phase of amputee care during episode - Delayed wound?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Record whether the amputee patient passed through the phase “delayed wound” during their rehabilitation episode. The phase “delayed wound” is the phase where problems with wound healing occur and additional interventions should be considered including: revision surgery, vascular and infection evaluation, aggressive local wound care and hyperbaric oxygen.

Justification: This item is required to be able to define the different paths through rehabilitation for amputees and to ensure benchmarking between like cohorts.

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.
Leave blank for all other AROC impairment codes.
Record 1, “Yes” or 2,” No” if the patient passes through the phase “delayed wound” during their rehabilitation episode.

Codeset values:

01 Yes
02 No

Phase of amputee care during episode - Pre prosthetic?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

Record whether the amputee patient passed through the phase “pre prosthetic” during their rehabilitation episode.

Pre prosthetic phase is the phase where a patient is discharged from acute care and enters in-patient rehabilitation program or is treated in ambulatory setting. Postoperative assessment to review patient’s status, including physical and functional assessment; completion of FIM baseline and other relevant assessments are completed. Rehabilitation goals are determined, rehabilitation treatment plan is established and updated and patient education is provided. Provide physical and functional interventions based on current and potential function. Determine whether a prosthesis is appropriate to improve functional status and meet realistic patient goals.

Justification:

This item is required to be able to define the different paths through rehabilitation for amputees and to ensure benchmarking between like cohorts.

Guide for use:

Collect for AROC impairment code 5 (amputation of limb) only.
Leave blank for all other AROC impairment codes.
Record 1, “Yes” or 2,” No” if the patient passes through the phase “pre prosthetic” during their rehabilitation episode.

Codeset values:

01 Yes
02 No

Phase of amputee care during episode - Prosthetic?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Record whether the amputee patient passed through the phase “prosthetic” during their rehabilitation episode. Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. Prosthesis is prescirbed based on current or potential level of ambulation. Patient receives interim or permanent prosthetic fitting and training, and early rehabilitation management. Prosthetic gait training and patient education on functional use of prosthesis for transfers, balance and safety is provided.

Justification: This item is required to be able to define the different paths through rehabilitation for amputees and to ensure benchmarking between like cohorts.

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.
Leave blank for all other AROC impairment codes.
Record 1, “Yes” or 2,” No” if the patient passes through the phase “prosthetic” during their rehabilitation episode.

Codeset values:

01 Yes

02 No

Phase of amputee care at episode end

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

Record phase of amputee care just before discharge from rehabilitation.

Justification:

This item is required to be able to define the different paths through rehabilitation for amputees and to ensure benchmarking between like cohorts.

Guide for use:

Collect for AROC impairment code 5 (amputation of limb) only.
Leave blank for all other AROC impairment codes.
Use the code set definitions to assist with defining of amputee phase of care at episode end (discharge).
Record 1 phase only.

Within the codeset,

Preoperative phase is the phase during which the clinical decision to perform amputation occurs, including assessment of urgency (following trauma or infection.) A comprehensive interdisciplinary baseline assessment of the patient's status including medical assessment, functional status (including function of contra lateral limb), pain control and psychological and cognitive assessment is completed. Patient's goals, social environment and support systems are all defined. A post-operative care plan should be determined by the surgeon and rehabilitation team to address medical, wound or surgical and rehabilitation requirements.

Delayed wound phase is the phase where problems occur with wound healing and additional interventions are considered as needed, including revision surgery, vascular and infection evaluation, aggressive local wound care and hyperbaric oxygen.

Pre prosthetic phase is the phase where a patient is discharged from acute care and enters in-patient rehabilitation program or is treated in ambulatory setting. Postoperative assessment to review patient's status, including physical and functional assessment; completion of FIM baseline and other relevant assessments are completed. Rehabilitation goals are determined, rehabilitation treatment plan is established and updated and patient education is provided. Provide physical and functional interventions based on current and potential function. Determine whether a prosthesis is appropriate to improve functional status and meet realistic patient goals.

Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. Prosthesis is prescirbed based on current or potential level of ambulation. Patient receives interim or permanent prosthetic fitting and training, and early rehabilitation management. Prosthetic gait training and patient education on functional use of prosthesis for transfers, balance and safety is provided.

Follow-up phase is the phase where follow-up appointment after discharge from rehabilitation is scheduled. Assessment of patient's goals, functional assessment, secondary complications, prosthetic assessment (repair, replacement, mechanical adjustment and new technology) and vocational and recreational needs are completed. Secondary amputation prevention is provided (where relevant). This also includes the provision of rehabilitation for patients who are not suitable for a prosthesis. Rehabilitation focus may include transfers, functional mobility, wheelchair mobility, ADL training.

Codeset values:

01 Pre-operative
02 Delayed wound
03 Pre prosthetic
04 Prosthetic
05 Follow-up

Prosthetic device fitted?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: A patient is deemed “prosthetic” if they already have a prosthetic device fitted, or will have one fitted in the future. A patient is deemed “non-prosthetic” if there is no intention to fit a limb.

Justification: This item is required to be able to define cohorts to ensure appropriate benchmarking.

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.
Leave blank for all other AROC impairment codes.
Record 1, “Yes”, if they already have a prosthetic device fitted, or will have one fitted in the future. Record 2, “No”, if there is no intention to fit a limb. Only record this data item for lower limb amputees.

Codeset values:

01 Yes

02 No

Date of first prosthetic fitting

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Record the date of the first interim prosthetic fitting.

Justification: This item is required to establish time periods between critical points through the rehabilitation episode.

Guide for use:
Collect for AROC impairment code 5 (amputation of limb) only.
Leave blank for all other AROC impairment codes.
Only complete this item if patient is prosthetic, that is: you answered 1,"Yes" to the data item, "does the patient have a prosthetic device fillted, OR will have one fitted in the future?"
If date is known enter exact date. Use the date format DD/MM/YYYY.
If a prosthetic fitting is planned but the date not yet known enter 07/07/7777.
If the patient has a prosthetic device fitted but the date of fitting is not known enter 09/09/9999.

Reason for delay in first prosthetic fitting

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Record the reason for the delay in first interim prosthetic fitting.

Justification: This item is required to be able to identify the reasons causing delays, so that they can be addressed.

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.
Leave blank for all other AROC impairment codes.
Only complete this item if patient is “prosthetic”, that is: you answered ”Yes” to the data item, "prosthetic?" If there was no delay, record 0, “No delay”. If the reason for delay is not listed, record 6, “All other issues” and provide details in the general comment section.

Codeset values:

00 No Delay
01 Issues around wound healing
02 Other issues around the stump
03 Other health issues of the patient
04 Issues around availability of componentry
05 Issues around availability of the service
06 All other issues (to be specified in the AROC comment section)

Discharge timed up and go test

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	Record the time in completed seconds and complete assessment just before patient is discharged.
Justification:	This is a functional outcome measure. It is required to enable groupings of patients with similar levels of amputation and analysis of their outcomes. There are also population averages, which can serve as benchmarks.
Guide for use:	Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes. Record time in COMPLETED seconds e.g: If patient takes 9.3 seconds to complete TUG, record 9 seconds. If patient takes 9.7 seconds to complete TUG, record 9 seconds. If patient takes 1 minute 18 seconds, record 78 seconds. If the patient is unable to complete the test or the test is non applicable for this episode of care, code 9999.

Discharge 6 minute walk test

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	Record distance in meters. Complete the 6 minute walk test just before patient is discharged.
Justification:	This is a functional outcome measure. It is required to enable groupings of patients with similar levels of amputation and analysis of their outcomes. There are also population averages, which can serve as benchmarks.
Guide for use:	Collection is Optional. Collect for AROC impairment code 5 (amputation of limb) only. Leave blank for all other AROC impairment codes. If the patient is unable to complete the test or the test is non applicable for this episode of care, code 999.9.

10 metre walk +/- aid test start date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Record the date that the 10 metre walk +/- aid test was assessed at episode start (admission).

Justification:

Guide for use:

Admission 10 metre walk +/- aid test

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

Record the time taken in completed seconds. Complete assessment at commencement of the ambulatory rehabilitation program.

Justification:

This is a functional outcome measure. It is required to enable groupings of patients with similar levels of amputation and analysis of their outcomes. There are also population averages, which can serve as benchmarks.

Guide for use:

Collect for AROC impairment codes 1 (stroke) and 8 (orthopaedic conditions). Optional collection for code 5 (amputation of limb).
Leave blank for all other AROC impairment codes.

Record time in COMPLETED seconds e.g:
If patient takes 20.2 seconds to complete the 10 metre walk +/- aid test , record 20 seconds.
If patient takes 20.8 seconds to complete 10 metre walk +/- aid test, record 20 seconds.
If patient takes 1 minute 18 seconds, record 78 seconds.
If the patient is unable to complete the test or the test is non applicable for this episode of care, code 9999.

Test version used: available at http://www.rehabmeasures.org/10 metre walk test instructions.pdf
The test is also available from the AROC website at
http://ahsri.uow.edu.au/aroc/ambulatorydataset/index.html

General Information:
•individual walks 10 meters without assistance
•time is measured for the intermediate 6 meters to allow for acceleration and deceleration.
•start timing when the toes of the leading foot crosses the 2-meter mark
•stop timing when the toes of the leading foot crosses the 8-meter mark
•assistive devices can be used but should be kept consistent and documented from test to test
•if physical assistance is required to walk, this should not be performed
•performed at fastest walking speed
•collect three trials and calculate the average of the three trials

Set up:
•Measure and mark a 10-metre walkway
•Add a mark at 2 metres
•Add a mark at eight meters

10 metre walk +/- aid test end date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Record the date that the 10 metre walk +/- aid test was assessed at episode end (discharge).

Justification:

Guide for use:

Discharge 10 metre walk +/- aid test

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Record the time in completed seconds and complete assessment just before patient is discharged.

Justification: This is a functional outcome measure. It is required to enable groupings of patients with similar levels of amputation and analysis of their outcomes. There are also population averages, which can serve as benchmarks.

Guide for use:

Collect for AROC impairment codes 1 (stroke) and 8 (orthopaedic conditions). Optional collection for AROC impairment code 5 (amputation of limb).
Leave blank for all other AROC impairment codes.

Record time in COMPLETED seconds e.g:
If patient takes 20.2 seconds to complete the 10 metre walk +/- aid test , record 20 seconds.
If patient takes 20.8 seconds to complete 10 metre walk +/- aid test, record 20 seconds.
If patient takes 1 minute 18 seconds, record 78 seconds.
If the patient is unable to complete the test or the test is non applicable for this episode of care, code 9999.

Test version used: available at http://www.rehabmeasures.org/10 metre walk test instructions.pdf
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General Information:
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•assistive devices can be used but should be kept consistent and documented from test to test
•if physical assistance is required to walk, this should not be performed
•performed at fastest walking speed
•collect three trials and calculate the average of the three trials

Set up:
•Measure and mark a 10-metre walkway
•Add a mark at 2 metres
•Add a mark at eight meter

Goal Attainment Scale (GAS) Descriptions

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Identify and describe up to five rehabilitation goals.

Justification: Individual goal setting has become a routine part of rehabilitation. Goal attainment scaling is a technique which captures the extent to which individual goals for rehabilitation have been achieved. The formalised process of goal setting and defining, and agreeing expected levels of achievement with the patient and their family supports the sharing of information at an early stage of rehabilitation and the negotiation of realistic goals.

Guide for use:

1) Identify presenting problems in conjunction with the patient, and family where relevant.
2) Determine if the presenting problems are amenable to treatment, and if so what that might be.
3) Identify broad goal areas, and determine if they are worthwhile.
4) Define each goal and record SMARTer goals related to a specific function and
– expected level of achievement
– intended time frame for achievement

A realistic expected outcome should be negotiated and agreed for each goal, with possible outcomes ranging from:

-2 Much worse than expected level
-1 Somewhat worse than expected level
0 Achieved expected level
+1 Somewhat better than expected level
+2 Much better than expected level

Data Items:

GAS Goal 1 Description
GAS Goal 2 Description
GAS Goal 3 Description
GAS Goal 4 Description
GAS Goal 5 Description

Goal Attainment Scale (GAS) Start Date

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the date that the Goal Attainment Scale was scored at episode start (admission).

Justification:

Guide for use:

Goal Attainment Scale (GAS) Start Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the patient's Goal Attainment Scale scores for each of the nominated goals at the beginning of the ambulatory rehabilitation episode.

Justification:

Guide for use: At baseline, individual rehabilitation goals are negotiated. Each goal will have a predetermined, realistic expected outcome. At baseline record whether the patient has:
– some function in relation to the expected outcome (score -1)
– no function in relation to the expected outcome (score -2)

Data Items:

GAS Goal 1 Start Score

GAS Goal 2 Start Score

GAS Goal 3 Start Score

GAS Goal 4 Start Score

GAS Goal 5 Start Score

Codeset values:

-02 -2 No Function

-01 -1 Some Function

Goal Attainment Scale (GAS) End Date

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the date that the Goal Attainment Scale was scored at episode end (discharge).

Justification:

Guide for use:

Goal Attainment Scale (GAS) End Scores

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: Record the patient's Goal Attainment Scale scores for each of the nominated goals at the end of the ambulatory rehabilitation episode.

Justification:

Guide for use:

Data Items:

GAS Goal 1 End Score

GAS Goal 2 End Score

GAS Goal 3 End Score

GAS Goal 4 End Score

GAS Goal 5 End Score

Codeset values:

-02	-2 Much worse than expected level
-01	-1 Somewhat worse than expected level
00	0 Achieved expected level
01	1 Somewhat better than expected level
02	2 Much better than expected level

General Comments

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Comment relevant to this episode of care.

Justification:

Guide for use: