AUSTRALASIAN REHABILITATION OUTCOMES CENTRE

RITH DATA DICTIONARY V1

FOR CLINICIANS - AUSTRALIAN VERSION

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Path

Definition:

Inpatient substitution includes RITH models that accept referrals primarily from inpatient services and attempt to substitute for some or all of an inpatient rehabilitation stay. These models accept patients onto a program prior to an inpatient discharge and this program commences as soon as practical (i.e. within 48 hours of discharge into the community).

RITH teams sit under the medical governance of a rehabilitation physician or a physician with training and expertise in rehabilitation. RITH teams should have clearly defined policies regarding the roles and responsibility of the general practitioner and the rehabilitation physician particularly with regards to general medical care and after hours care.

RITH teams are multidisciplinary with, at least two allied health disciplines and a registered nurse or access to one. For inpatient substitution models the patient must be assessed as requiring nursing care. The exact make up of allied health disciplines should be relevant to the patient casemix that the team will be servicing.

RITH programs commence with a multidisciplinary assessment, are time limited and goal directed. All patients undergoing a RITH program should have their goals documented on a rehabilitation plan which is reviewed at least weekly in a multidisciplinary meeting.

RITH programs can be delivered via face to face and/or telehealth where appropriate.

***The term inpatient substitution is being used here in common parlance not in reference to the Private Health Insurance Act 2007

Justification: Enables assignment of episodes of care to the correct pathway for analysis.

Guide for use: Select pathway 7 for RITH

Codeset values:

7	Rehab in the Home (RITH)

Establishment ID

Definition: A code which represents the facility.

Justification: Enables episodes of care to be assigned to the correct facility for analysis.

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

Ward ID/Team ID

Definition: A 4 character alphanumeric code representing a ward or team.

Justification: 'Ward identifier' and 'Ward name' are 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 mandatory to collect this data item if the facility has only one rehabilitation ward/team.

While Ward ID is optional and can be left blank, it is required if analysis and/or receiving benchmark reports by ward is required or may be required at any point in the future.
If you are entering a Ward ID, then it is essential that it is entered consistently and correctly for every episode – it is the Ward ID that determines which benchmark report the episode is reported in.
The actual value recorded against Ward ID is at the facility's discretion. To reduce errors in data entry AROC suggest keeping the Ward ID used as simple as possible, i.e. use "1A", rather than "Ward 1A".

Ward name/Team name

Definition: The name of a ward or team within a facility.

Justification: 'Ward identifier' and 'Ward name' are 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 mandatory to collect this data item if the facility only has one rehabilitation ward/team.

While Ward name is optional and can be left blank, it is required if analysis and/or receiving benchmark reports by ward is required or may be required at any point in the future.
The actual value recorded against Ward name is at the facility's discretion but should be consistent with every episode that is treated on that ward

Patient Identifier

Definition:	Unique record number established by the facility to enable communication regarding data quality issues pertaining to that episode.
Justification:	This variable is required in order to facilitate communication between AROC and facilities about data quality issues.
Guide for use:	Facilities are not required or asked to use MRN/NHI as their unique record number, only to use some code which would enable them to 'locate' the person referred to by that code in their own IT system for the purpose of correcting data quality issues.

Letters of name

Definition: This is a 5 letter character string 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 Linkage 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

Definition: The date of birth of the patient 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

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:

1	Estimated
2	Not estimated

Sex

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: Record the appropriate sex of the patient.

Codeset values:

1	Male
2	Female
3	Indeterminate
9	Not stated/inadequately defined

Indigenous status (AU)

Definition: Indigenous status is a measure of whether a patient identifies as being of Aboriginal or Torres Strait Islander origin.

Justification: Australia's Aboriginal and Torres Strait Islander 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.

Guide for use: Record the appropriate indigenous status.

Codeset values:

1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
9	Not stated / inadequately defined

Geographical residence (AU)

Definition: Geographical residence is the state 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 that the patient usually resides in.

Codeset values:

1	NSW
2	Vic
3	Qld
4	SA
5	WA
6	Tas
7	NT
8	ACT
9	Other Australian Territory
10	Not Australia

Postcode

Definition: Postcode is the numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of patient.

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

Guide for use: Record the postcode of the patient's usual place of residence.
Record 8888 for not applicable.
Record 9999 for unknown.

Funding source (AU)

Definition: The principal source of funding for the patient's rehabilitation episode.

Justification: Collection of this data item enables AROC to distinguish rehabilitation episodes of care based on the funding sources of 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.
If using 'Other', please use the General comments section to provide additional information.
If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

1	Australian Health Care Agreement (public patient)
2	Private Health Insurance
3	Self-funded
4	Workers compensation
5	Motor vehicle third party personal claim
6	Other compensation (e.g. public liability, common law, medical negligence)
7	Department of Veterans' Affairs
8	Department of Defence
9	Correctional facility
10	Other hospital or public authority (contracted care)
11	Reciprocal health care agreement (other countries)
98	Other
99	Not known

Health fund/other payer

Definition: Code corresponding to the person's private health fund, workers' compensation insurer or Compulsory Third Party (CTP) insurer as listed in codeset below.

Justification: Collection of this data item enables AROC to distinguish rehabilitation episodes of care based on the funding sources of health fund or other payer.

Guide for use: Only complete if “funding source” = 2 private health insurance, 4 workers' compensation or 5 motor vehicle third party personal claim.

Codeset values:

1	ACA Health Benefits Fund
2	The Doctor’s Health Fund Ltd
11	Australian Health Management Group
13	Australian Unity Health Limited
14	BUPA Australia Health Pty Ltd (trading as HBA in Vic & Mutual Community in SA)
18	CBHS Health Fund Limited
19	Cessnock District Health Benefits Fund (CDH benefit fund)
20	CUA Health Ltd
22	Defence Health Limited
25	Druids Friendly Society - Victoria
26	Druids Friendly Society - NSW
29	Geelong Medical and Hospital Benefits Assoc Ltd (GMHBA)
32	Grand United Corporate Health Limited (GU Health)
37	Health Care Insurance Limited
38	Health Insurance Fund of Australia
40	Healthguard Health Benefits Fund Ltd (trading as Central West Health, CY Health & GMF Health)
41	Health Partners
46	Latrobe Health Services Inc.
47	Lysaght Peoplecare Ltd (Peoplecare Ltd)
48	Manchester Unity Australia Ltd
49	MBF Australia Ltd
50	Medibank Private Ltd
53	Mildura District Hospital Fund Limited
56	Navy Health Ltd
57	NIB Health Funds Ltd
61	Phoenix Health Fund Ltd
65	Queensland Country Health Ltd
66	Railway & transport Health Fund Ltd (rt Healthfund)
68	Reserve Bank Health Society Ltd
71	St Luke's Medical & Hospital Benefits Association Ltd
74	Teachers Federation Health Ltd
77	HBF Health Funds Inc
78	HCF - Hospitals Contribution Fund of Australia Ltd, The
81	Transport Health Pty Ltd
83	Westfund Ltd
85	NRMA Health (MBF Alliances)
86	Queensland Teachers’ Union Health Fund Ltd
87	Police Health
91	Onemedifund
92	health.com.au (HEA)
93	CBHS Corporate Health Pty Ltd
94	Emergency Services Health Pty Ltd
95	Nurses & Midwives Health Pty Ltd
96	MyOwn
401	WorkCover Qld
402	Allianz Australia Workers Compensation
403	Cambridge Integrated Services Vic Pty Ltd
404	CGU Workers Compensation

405	JLT Workers Compensation Services Pty Ltd
406	QBE Worker's Compensation
407	Wyatt Gallagher Bassett Workers Compensation Victoria Pty Ltd
408	Employers' Mutual Indemnity
409	GIO Workers Compensation (NSW)
410	Royal & Sun Alliance Workers Compensation
411	CATHOLIC CHURCH INSURANCES LTD
412	GUILD INSURANCE LTD
413	INSURANCE COMMISSION OF WA
414	Zurich Australia Insurance Ltd
415	WESFARMERS FEDERATION INSURANCE LTD
416	Territory Insurance Office
417	ComCare
418	Victoria Workcover Authority
601	Allianz Australia Insurance Ltd
602	Australian Associated Motor Insurers Ltd
603	QBE Insurance (Australia)
604	Suncorp/Metway
605	RACQ Insurance Ltd
606	NRMA Insurance Ltd
607	Transport Accident Commission Vic
608	AAMI
609	CIC
610	GIO
611	QBE
612	Zurich
613	Insurance Commission of Western Australia
614	Motor Accident Insurance Board Tasmania
615	Territory Insurance Office NT
616	SGIC General Insurance
999	Unknown (enter in comments)

Need for interpreter service?

Definition: An interpreter service may be paid or unpaid and includes the use of family members for interpretation.

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: Record whether an interpreter service was required for the patient.

Codeset values:

1 Yes – Interpreter needed
2 No – Interpreter not needed

Referral date

Definition: The date that the rehabilitation in the home (RITH) team received a referral for the patient.

Justification: This item is being collected to measure the impact of delay between the date a referral is received and the date RITH 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 inaccurate 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.
Across services referrals can be made in multiple ways including face-to-face, in writing, by telephone, fax, email or electronically.

For example:
An inpatient in the subacute rehab ward was deemed clinically ready for RITH on 01/02/2024 A clinician in rehab ward calls the RITH team and makes a verbal referral the same day. Record 01/02/2024, the date the referral was received by the RITH team.

A referral was sent from another hospital after hours on 01/02/2024, but only received by the RITH service the next morning. Record 02/02/2024, the date the referral was received by the RITH service.

Assessment date

Definition: The date the patient was first seen by a clinician from the RITH team to assess their appropriateness for RITH care.

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

Guide for use: Current best practice for a clinician is to assess the patient via a face-to-face meeting with the patient and/or their significant other/primary carer, and staff currently looking after the patient, and to also undertake a review of their clinical records. In some cases, geography or other issues may make a face- to-face assessment impractical, and in these cases a telephone or teleconference assessment may be undertaken.

Where the patient is being referred by a rehabilitation service within the same facility, or where there is a local agreement on referral acceptance in place, an additional assessment may not be required. In this case record the referral date as the assessment date.

Date clinically ready for RITH care

Definition: A patient is “clinically ready for RITH care” when the rehabilitation physician, or physician with an interest in rehabilitation, deems the patient ready to start their RITH program and have documented this in the patient’s medical record.

Justification: This item is collected to flag episodes that experienced a delay between being clinically ready for RITH and RITH actually starting.

Guide for use: Record the date the patient is clinically ready for RITH which may or may not be the date RITH actually started.

Was there a delay in episode start?

Definition: This item identifies whether there was a delay between the patient being assessed as clinically ready for RITH and the RITH program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the RITH program commencing.

Justification: This item is collected to flag episodes that experienced a delay in their RITH start.

Guide for use: Record 1, “Yes” if there was a delay and 2, “No” if there was not. If “Yes”, complete the next 5 questions about reason(s) for delay in episode start. See examples in the Guide for use section for the reasons for delay.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Patient related issues (medical)

Definition: This item collects information about patient related medical issues that have caused a delay between the patient being assessed as clinically ready for RITH and the RITH program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the RITH program commencing.

Justification: This item enables identification of RITH episodes whose RITH start was delayed by patient related medical issues.

Guide for use: For example:
The patient was assessed as clinically ready for RITH, but the patient requires further medical examination, investigation or tests, which cannot be provided in the RITH program.
If you would like to provide additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Service issues

Definition:

This item collects information about service issues that have caused a delay between the patient being assessed as clinically ready for RITH and the RITH program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the RITH program commencing.

Service issues are those that are governed by the RITH service or the hospital service that impact the RITH episode.

Justification:

This item enables identification of RITH episodes whose RITH start was delayed by service issues.

Guide for use:

For example:
There are no available RITH beds, so the patient remains on an inpatient ward until a bed becomes available.
Education about the clinical needs of the patient need to be completed prior to transfer to RITH, for example: a patient requires specialist wound management and the RITH staff need to receive this education before the patient can be transferred.
Patient requires a home visit to be completed prior to commencing RITH and this has not been completed.
If you would like to provide additional information, please use the General comments section. Leave blank if you indicated that there was no delay in the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - External support issues

Definition: This item collects information about external support issues that have caused a delay between the patient being assessed as clinically ready for RITH and the rehabilitation program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the RITH program commencing. External support issues are those that are not governed by the hospital system.

Justification: This item enables identification of rehabilitation episodes whose rehabilitation start was delayed by external support issues.

Guide for use: For example:
Patient requires carers to be at home prior to commencing on RITH and they are not available.
Patient requires services to commence that the RITH team do not provide to be at home but there is a delay in these commencing.
If you would like to provide additional information, please use the General comments section. Leave blank if you indicated that there was no delay in the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Equipment issues

Definition: This item collects information about equipment issues that have caused a delay between the patient being assessed as clinically ready for RITH and the RITH program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the RITH program commencing.

Justification: This item enables identification of RITH episodes whose RITH start was delayed by equipment issues.

Guide for use: For example:
Specialist equipment, such as bariatric equipment, is not available and needs to be hired prior to being transferred to RITH.
If you would like to provide additional information, please use the General comments section. Leave blank if you indicated that there was no delay in the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Patient behavioural issues

Definition: This item collects information about patient behavioural issues that have caused a delay between the patient being assessed as clinically ready for RITH and the RITH program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the RITH program commencing.

Justification: This item enables identification of the rehabilitation episodes whose rehabilitation start was delayed by patient behavioural issues.

Guide for use: For example:
The patient is refusing to transfer to RITH or the patient has challenging behaviours that cannot be managed by the RITH team at this time.
If you would like to provide additional information, please use the General comments section. Leave blank if you indicated that there was no delay in the episode start

Codeset values:

1	Yes
2	No

Episode begin date

Definition: The date the patient commenced RITH care. This date defines the beginning of the RITH episode and is the date from which length of stay (LOS) calculation begins.

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

Guide for use: Record the date that the patient commenced on the RITH team

Type of accommodation prior to this impairment (AU)

Definition: The type of accommodation the patient lived in prior to this impairment.

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 impairment.
If the patient was transferred from hospital, code their usual accommodation prior to admission to hospital.
The patient's usual accommodation prior to rehabilitation will not necessarily be their usual accommodation after rehabilitation, e.g.: the patient may have come from a private residence and be discharged to residential care.
If using 'Other', please use the General comments section to provide additional information.
If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

1	Private residence (including unit in retirement village)
2	Residential, low level care (hostel)
3	Residential, high level care (nursing home)
4	Community group home
5	Boarding house
6	Transitional living unit
8	Other

Carer status prior to this impairment

Definition: The level of carer support the patient received prior to their current RITH admission. If the patients was transferred from hospital into the RITH program consider the carer support prior to the inpatient 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, and/or partner of the patient.

Justification: Carer status is a key outcome measure for rehabilitation. Carer status before and after rehabilitation can be compared as an 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.
A patient may receive care from both a carer who lives in and a carer not living in. In this case, code the carer who provides the higher proportion 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:

1	NO CARER and DOES NOT need one
2	NO CARER and NEEDS one
3	CARER NOT living in
4	CARER living in, NOT co-dependent
5	CARER living in, co-dependent

Were any packages of services being received within the month prior to this impairment?

Definition: This item identifies whether a package(s) of services were received by the person prior to this impairment. A package of services refers to an externally funded (normally government) services package.

Justification: Service(s) received relates to degree of functional independence of the person, and as increased functional independence is a key outcome measure for rehabilitation, it is important to ascertain the person's level of functional independence prior to rehabilitation. Services are often delivered as a part of a government funded package. Services received before and after rehabilitation can be compared as an indication of change in the person's functional independence after rehabilitation.

Guide for use: If the patient only receives services outside of an externally funded package than record No for this item.
Record 1,"Yes," if a package of services were received and 2,"No,' if no a package of services were not received in the month prior to this impairment (or exacerbation of impairment).

Codeset values:

1	Yes
2	No

Packages of services received prior to impairment

Definition: These items collect information about which package(s) of services were being received prior to this impairment

Justification: The type of service(s) received before and after rehabilitation can be compared as an indication of patient's rehabilitation progress.

Guide for use: Only collect these data items if the patient received a package of services prior to this impairment.
Options for other may include DVA funded services, if delivered as a coordinated package

Data Items:

Packaged services received prior - Level 1/2 Package

Packaged services received prior - Level 3/4 Package

Packaged services received prior - Transitional Care Package

Packaged services received prior - NDIS

Packaged services received prior - Other

Packaged services received prior - Other specified

Codeset values:

1	Yes
2	No

Packaged services received prior - Other - specified

Definition: This item collects information about which other package(s) of services were being received prior to this impairment

Justification: The type of service(s) received before and after rehabilitation can be compared as an indication of patient's rehabilitation progress.

Guide for use: Only collect this data item if you have selected other services prior received

Were any services being received within the month prior to this impairment that were NOT part of a package above?

Definition: This item identifies whether services were received by the person prior to this impairment that were not part of a package of services. “Services” refers to paid or unpaid services received in the month prior to this impairment (or exacerbation of impairment). Paid service(s) include both government funded and private health funded services, as long as they were not included.as part of a package identified in the previous data item. Unpaid service(s) include care provided by a relative, friend, and/or partner of the patient.

Justification: Service(s) received relates to degree of functional independence of the person, and as increased functional independence is a key outcome measure for rehabilitation, it is important to ascertain the person's level of functional independence prior to rehabilitation. Service(s) received before and after rehabilitation can be compared as an indication of change in the person's functional independence after rehabilitation.

Guide for use: Only collect this data item if accommodation prior to this impairment was private residence (including unit in retirement village,) otherwise leave blank.
Do not include services that are received as part of package.
Discretionary services received by the patient, but that are not functionally necessary, should not be included e.g. a house cleaner because the patient doesn’t like cleaning, rather than functionally can’t clean.
Record 1,”Yes,” if service(s) were received that were not part of a package and 2,”No,’ if no service(s) were not received or all services received in the month prior to this impairment (or exacerbation of impairment) were including in a package.

Codeset values:

1	Yes
2	No

Packages of services received prior to impairment

Definition: This item collects information about whether the patient received paid or unpaid services in the month prior to their impairment that were NOT part of a package. Paid service(s) include both government funded and private health funded services that are delivered outside of packages. Unpaid service(s) include care provided by a relative, friend, and/or partner of the patient.

Justification: The type of service(s) received before and after rehabilitation can be compared as an indication of patient's rehabilitation progress.

Guide for use: Only collect this data item if the patient received any paid or unpaid assistance. Record 1, "Yes" if they received assistance and 2, "No" if they did not receive assistance (paid or unpaid).

Discretionary services received by the patient, but that are not functionally necessary, should not be included e.g. a house cleaner because the patient doesn't like cleaning rather than functionally can't clean.

Do not include services that are received as part of package.

Domestic tasks include: household cleaning, vacuuming, ironing, shopping, managing finances, and meal preparation. Paid domestic assistance service(s) include both government funded and private health funded services.

Social support includes: daily wellbeing through telephone calls, medication reminders, counselling etc. Paid social support service(s) include both government funded and private health funded services.

Nursing care includes: nurse visiting a patient to administer wound care, medication, manage incontinence etc. Paid nursing care includes both government funded and private health funded services.

Allied health care includes: provision of physiotherapy, occupational therapy, speech and language therapy, recreational therapy, social work, psychology etc. Paid allied health care include both government funded and private health funded services.

Personal care includes: washing, dressing, grooming, eating, toileting etc. Paid personal care service(s) include both government funded and private health funded services.

Meals include: ready meals such as meals on wheels or lite and easy meals etc. Paid meal service(s) include both government funded and private health funded meal services.

Goods and equipment include: specialised equipment such as a shower chair, commode, hoist, wheelchair or smaller aids such as a plate guard for eating, adapted cutlery, long handled sponge for washing etc. Paid goods and equipment include both government funded and private health funded goods and equipment.

Transport services include: community transport for shopping or attending medical appointments, taxi vouchers, community bus and/or use of patient transport assistance vehicle etc. Paid transport service(s) include both government funded and private health funded services.

Case management may be defined as a service that provides assessment, planning, facilitation and advocacy for options and services to meet a patient’s needs. Paid case management includes both government funded and private health funded case management services

Data Items:

Service received prior to impairment - Domestic assistance

Service received prior to impairment - Social support

Service received prior to impairment - Nursing care

Service received prior to impairment - Allied health care

Service received prior to impairment - Personal care

Service received prior to impairment - Meals

Service received prior to impairment - Provision of goods & equipment

Service received prior to impairment - Transport services

Service received prior to impairment - Case management

Codeset values:

1	Yes
2	No

Employment status prior to this impairment

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

Justification: Employment is an important outcome that can be measured throughout 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 their impairment or exacerbation of impairment. Within the codeset:
Employed 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, parents 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 returning 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:

1	Employed
2	Unemployed
3	Student
4	Not in labour force
5	Retired for age
6	Retired for disability

Is this the first direct care rehabilitation episode for this impairment?

Definition:

This item relates to the patient's impairment and setting, not the particular facility/service. "Direct care" is when the patient is under the direct care of the rehabilitation physician or team, i.e. they hold medical governance over the patient.

The first direct care RITH episode for this impairment considers only those episodes occurring in the RITH setting regardless of facility/service. This aims to identify those patients that have repeated RITH admissions/discharges within the RITH setting. (NOTE: subsequent episodes caused by adhering to any required jurisdictional business rules will be concatenated into one primary episode as long as they occur within the same facility/service).

Justification:

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

Guide for use:

RITH following RITH: a patient is discharged from the RITH team, and then later readmitted from the community for the same impairment to prevent a hospital admission. This not the first RITH admission, record 2 – No

RITH following inreach rehabilitation: a patient is admitted to the RITH program after being discharged from the inreach rehabilitation team. This is the first RITH episode, record 1 - Yes

RITH following inpatient subacute rehabilitation: a patient is admitted to the RITH program after being discharged from the subacute rehabilitation ward. This is the first RITH episode, record 1 - Yes

Codeset values:

1	Yes
2	No

Is the patient an NDIS participant on admission?

Definition: This item is collects whether the patient was an NDIS participant on admission to the RITH service.

Justification: Accessing the NDIS program is a process. Understanding whether a patient is on the NDIS program prior to a RITH admission or requires to access it during the admission can assist in understanding the affects this may have on rehabilitation outcomes.

Guide for use: Record 1 Yes, if the patient is an NDIS participant at admission, record 2 No, if they are not.
For this item it doesn't matter whether the NDIS plan is relevant to the current admission.
If the patient has applied to the NDIS but is still awaiting a decision record 2 No.

Codeset values:

1	Yes
2	No

If Yes, is the primary impairment for this rehab admission related to their primary disability recognised in their NDIS plan?

Definition: This item collects information on whether the primary reason for this rehab admission (i.e. AROC Impairment Code) is related to their primary disability recognised in their NDIS plan.

Justification: This item determines whether the patient's NDIS plan is directly related to the primary reason for rehab admission and therefore potentially more likely to impact the current rehabilitation episode

Guide for use: Only complete this item if the patient is a NDIS participant on admission.
Record 1 Yes, if the patient's primary impairment for rehabilitation is the same as their primary disability recognised in their NDIS plan, record 2 No, if it is not.
For Example;
Mr. Lewis has an NDIS plan where his primary disability is recognsied as Parkinson's disease. He was admitted to RITH for further rehabilitation post a decline in function related to his Parkinson's disease. Record Yes.
Mrs. Smith is admitted to RITH for further stroke rehabilitation. She is also currently an NDIS participant due to a mental health condition. Record No.

Codeset values:

1	Yes
2	No

Date of injury/impairment onset

Definition: The date of the injury or impairment that has directly driven the need for the current episode of rehabilitation. For example, the date the patient fractured their hip, the date the patient had a stroke, or the date the patient had a limb amputated.

Justification: This item is collected to be able to measure the time between injury/impairment and admission to rehabilitation, and enable analysis against outcomes achieved.

Guide for use: This data element is one of a data pair and 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

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: This item is collected to measure the time between injury/impairment and admission to rehabilitation, and enable analysis against outcomes achieved.

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. 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:

1	Less than one month ago
2	1 month to less than 3 months
3	3 months to less than 6 months
4	6 months to less than a year
5	1 year to less than 2 years
6	2 years to less than 5 years
7	5 or more years
9	Unknown

Admission date of relevant acute episode

Definition: The date of the acute admission relevant to the current RITH episode. This could be an acute episode that was directly prior to the RITH episode or directly prior to a subacute episode that is directly prior to the RITH episode.

Justification: This item is collected to enable calculation of the time between acute admission and RITH start dates, and analysis against outcomes achieved.

Guide for use: Only collect this data item if the current RITH episode was preceded by an episode of acute care relevant to the current rehabilitation episode.

For example:
Mr. Nguyen fell and suffered a fractured hip. He was admitted to hospital on 2/5/2023. He was transferred from acute care to subacute rehab on 12/5/2023 and then transferred to RITH on 19/5/2023. Record the acute admission date as 12/5/2023.

A patient may have required multiple hospital admissions for the one acute condition, such as a recurrent subdural haematoma, or an infection post knee or hip replacement. In such cases, record the date of acute admission immediately post impairment. At times, this date may be the same as Date of injury/impairment onset.

Discharge date of relevant acute episode

Definition: The discharge date of the acute episode relevant to the current RITH episode. . This could be an acute episode that was directly prior to the RITH episode or directly prior to a subacute episode that is directly prior to the RITH episode.

Justification: This item is collected to enable calculation of important time points and periods of the patient's medical/rehabilitation journey prior to commencing RITH.

Guide for use: Only collect this data item if the current RITH episode was preceded by an episode of acute care relevant to the current RITH episode.
If the patient is admitted to RITH directly from an acute episode of care this date will likely be the same as the RITH start date.
For Example;
Mr. Nguyen fell and suffered a fractured hip. He was admitted to hospital on 2/5/2023. He was transferred from acute care to subacute rehab on 12/5/2023 and then transferred to RITH on 19/5/2023. Record the discharge from acute date as 12/5/2023.

Admission date of relevant subacute episode

Definition: The admission date of the subacute episode relevant to the current RITH episode. That is a subacute episode that immediately proceeded the RITH episode.

Justification: This item is collected to enable calculation of important time points and periods of the patient's medical/rehabilitation journey prior to commencing RITH.

Guide for use: Only collect this data item if the current RITH episode was preceded by an episode of subacute care relevant to the current RITH episode.
For Example:
Mr. Nguyen fell and suffered a fractured hip. He was admitted to hospital on 2/5/2023. He was transferred from acute care to subacute rehab on 12/5/2023 and then transferred to RITH on 19/5/2023. Record the admission of relevant subacute episode as 12/5/2023.

Discharge date of relevant subacute episode

Definition: This is the date of discharge of a subacute episode that was relevant to the current RITH episode. That is a subacute episode that immediately proceeded the RITH episode.

Justification: This item is collected to enable calculation of important time points and periods of the patient's medical/rehabilitation journey prior to commencing RITH.

Guide for use: Only collect this data item if the current RITH episode was preceded by an episode of subacute care, relevant to the current RITH episode
If the patient is admitted to RITH directly from a subacute episode of care this date will likely be the same as the RITH start date.
For Example;
Mr. Nguyen fell and suffered a fractured hip. He was admitted to hospital on 2/5/2023. He was transferred from acute care to subacute rehab on 12/5/2023 and then transferred to RITH on 19/5/2023. Record the discharge date of the relevant subacute episode as 19/5/2023.

Mode of episode start - RITH

Definition: This item records the referral source of the patient for the RITH episode.

Justification: This data item defines how the patient commenced their RITH episode. Different entry points may affect a patient's progress.

Guide for use: Patients can be admitted from a hospital setting or the community, either directly from their home (usual accommodation which could be a private residence or residential care), or from somewhere other than their usual accommodation (staying with friends).

Within the code set:
"Usual accommodation" may be defined as the patient's regular fixed abode e.g. their own home/rented residence or residential care.

"Other than usual accommodation" may be defined as temporary accommodation e.g. patient was away on holiday or business or visiting family and friends.

'Same organisation/district/health service' refers to the private hospital organisation/group that RITH services belongs to in the private setting. Or the public setting the district, health service or network the RITH services belongs too.

For Example: A RITH service in the Sydney Local Health District receives a referral from a hospital with the Sydney Local Health district.

If using 'Other', please use the General comments section to provide additional information.
If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

1	Admitted from usual accommodation
2	Admitted from other than usual accommodation
3	Transferred from hospital – same organisation/district/health service
4	Transferred from hospital – another organisation/district/health service
9	Other

If transferred from hospital. What type of care were they receiving prior to transfer?

Definition: This item records the care type the patient was receiving prior to RITH is they were transferred from hospital.

Justification: This data item defines how the patient commenced their RITH episode and their overall rehabilitation journey.

Guide for use: Only complete if the patient was transferred from hospital as the mode of episode start, otherwise leave blank.

Codeset values:

1	Acute care
2	Inpatient Rehabilitation
3	Geriatric Evaluation and Management (GEM)
4	Other sub/non-acute care

AROC impairment code

Definition: The AROC impairment codes are used to classify rehabilitation episodes 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: The AROC Impairment Coding Guidelines provide assistance 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.

The AROC Impairment Coding Guidelines are available on the AROC website (www.aroc.org.au) under "Tools and Resources/AROC V4 dataset resources".

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

18.1 COVID-19 with pulmonary issues
18.2 COVID-19 with deconditioning
18.9 COVID-19 all other

Admission FIM Scores

Definition: The patient's Functional Independence Measure (FIM) score for each of the 18 FIM items, assessed at the time of admission. This item is mandatory for the RITH data collection.

Justification: The FIM scores and the AROC Impairment codes are based on the Uniform Data System for Medical Rehabilitation (UDSMR); a minimum data set that includes a system for grouping rehabilitation episodes by impairment type and a rating scale to measure function, the FIM. The FIM is a basic indicator of severity of disability. The functional ability of a patient changes during rehabilitation and the FIM is used to track those changes which are a key outcome measure of rehabilitation episodes.

Guide for use: Admission FIM scoring needs to be completed as soon as possible after admission to establish an appropriate baseline functional score. FIM assessment should always be undertaken by credentialed FIM assessors.

Data Items:

Admission FIM score for eating

Admission FIM score for grooming

Admission FIM score for bathing

Admission FIM score for dressing upper body

Admission FIM score for dressing lower body

Admission FIM score for toileting

Admission FIM score for bladder management

Admission FIM score for bowel management

Admission FIM score for transfer to bed/chair/wheelchair

Admission FIM score for transfer to toilet

Admission FIM score for transfer to shower/tub

Admission FIM score for locomotion

Admission FIM score for stairs

Admission FIM score for comprehension

Admission FIM score for expression

Admission FIM score for social interaction

Admission FIM score for problem solving

Admission FIM score for memory

Codeset values:

1	Total contact assistance
2	Maximal contact assistance
3	Moderate contact assistance
4	Minimal contact assistance
5	Supervision or setup
6	Modified independence
7	Complete independence

Admission FAM Scores

Definition: The patient's Functional Assessment Measure (FAM) score (including the EADLs module), assessed at the time of admission. This item is mandatory for the RITH data collection.

Justification: The FAM is a set of additional items on top of the FIM. The FAM items helps to measure changes in function that are relevant to a RITH setting that are not covered by the FIM.

Guide for use: Admission FAM scoring needs to be completed as soon as possible after admission to establish an appropriate baseline functional score.

Data Items:

Admission FAM score for swallowing

Admission FAM score for car transfer

Admission FAM score for community mobility

Admission FAM score for reading

Admission FAM score for writing

Admission FAM score for speech intelligibility

Admission FAM score for emotional status

Admission FAM score for adjustment to limitations

Admission FAM score for leisure activities

Admission FAM score for orientation

Admission FAM score for concentration

Admission FAM score for safety awareness

Admission FAM score for meal preparation

Admission FAM score for laundry

Admission FAM score for housework

Admission FAM score for shopping

Admission FAM score for home finances

Admission FAM score for work/education

Codeset values:

1	Total contact assistance
2	Maximal contact assistance
3	Moderate contact assistance
4	Minimal contact assistance
5	Supervision or setup
6	Modified independence
7	Complete independence

DASS21 Episode Start

Definition: The Depression, Anxiety and Stress Scale – 21 items (DASS21), score on admission to the RITH program

Justification: The DASS21 is a self-reported measure of depression, anxiety and stress. Depression, anxiety and stress are common among rehabilitation populations. Measuring them helps to establish clear pathways of when to refer on for specialist support, as well as identifying when to implement strategies within the RITH's team scope to assist the patient in their rehabilitation program.

Guide for use: This a self-reported measure, so the scores are completed by the patient and not the clinician. Record the patients score for each of the DASS 21 items.
If a patient is unable to complete the DASS 21, leave these items blank and note in the comments field why, for example: DASS 21 unable to complete due to aphasia.

Data Items:

Admission DASS21 I found it hard to wind down

Admission DASS21 I was aware of dryness of my mouth

Admission DASS21 I couldn't seem to experience any positive feeling at all

Admission DASS21 I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)

Admission DASS21 I found it difficult to work up the initiative to do things

Admission DASS21 I tended to over-react to situations

Admission DASS21 I experienced trembling (e.g. in the hands)

Admission DASS21 I felt that I was using a lot of nervous energy

Admission DASS21 I was worried about situations in which I might panic and make a fool of myself

Admission DASS21 I felt that I had nothing to look forward to

Admission DASS21 I found myself getting agitated

Admission DASS21 I found it difficult to relax

Admission DASS21 I felt down-hearted and blue

Admission DASS21 I was intolerant of anything that kept me from getting on with what I was doing

Admission DASS21 I felt I was close to panic

Admission DASS21 I was unable to become enthusiastic about anything

Admission DASS21 I felt I wasn't worth much as a person

Admission DASS21 I felt that I was rather touchy

Admission DASS21 I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)

Admission DASS21 I felt scared without any good reason

Admission DASS21 I felt that life was meaningless

Codeset values:

0	Did not apply to me at all
1	Applied to me to some degree, or some of the time
2	Applied to me to a considerable degree or a good part of time
3	Applied to me very much or most of the time

Rockwood Frailty Score (pre-morbid)

Definition: Frailty may be defined as a condition, seen particularly in older patients, characterised by low functional reserve, easy tiring, decreased libido, mood disturbance, accelerated osteoporosis, decreased muscle strength, and high susceptibility to disease.

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

Guide for use: Use the Rockwood Clinical Frailty Scale to record the patient's level of frailty prior to their injury or exacerbation of impairment.

Codeset values:

1	Very fit
2	Well
3	Well, with treated comorbid disease
4	Apparently vulnerable
5	Mildly Frail
6	Moderately Frail
7	Severely Frail
8	Terminally ill
9	Unknown or N/A

EQ5D5L Episode Start

Definition: The patient's EQ-5D-5L scores on admission to the RITH service.

Justification: The EQ-5D-5L is a self-reported measure of health. Measuring self-reported health at the beginning and end of the RITH episode enables the review of health outcomes achieved on the program from the patient's perspective.

Guide for use: This a self-reported measure, so the scores are completed by the patient and not the clinician. Record the EQ-5D-5L as soon as possible after admission.
The EQ-5D-5L can be completed by a proxy if the patient is unable to complete. If completing with a proxy use the proxy version and note in comments field that a proxy was used.

Data Items:

Admission EQ5D5L Mobility

Admission EQ5D5L Self Care

Admission EQ5D5L Usual Activities

Admission EQ5D5L Pain/Discomfort

Admission EQ5D5L Anxiety/Depression

Admission EQ5D5L Your Health Today

Codeset values:

1	No problems
2	Slight problems
3	Moderate problems
4	Severe problems
5	Extreme problems or unable to complete task

Timed Up and Go Episode Start

Definition: The time in completed seconds to complete the Timed Up and Go (TUG) test as assessed on admission.

Justification: This is a measure of functional mobility. Measuring it at the start and end of admission allows for the calculation of change of functional mobility.

Guide for use: 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.

Employment status after, or anticipated employment status after discharge

Definition: The time in completed seconds for walking 6 metres OR 10 metres; as assessed on admission.

Justification: The measurement of walking speed at the beginning and end of admission allows for the calculation of change over the RITH episode. Walking speed is indicative of a person's level of ambulation and can used to track progress across their rehabilitation journey.

Guide for use: You only need to collect either the 6 meter or 10 metre walk test. Complete the same test on admission and discharge.

If the patient requires a walking aid, where possible use the walking aid that is likely to be used on discharge from the RITH program.

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 not applicable for this episode of care, code 9999.

6 OR 10 metre walk test at Episode Start

Definition: The time in completed seconds for walking 6 metres OR 10 metres; as assessed on admission.

Justification: The measurement of walking speed at the beginning and end of admission allows for the calculation of change over the RITH episode. Walking speed is indicative of a person's level of ambulation and can used to track progress across their rehabilitation journey.

Guide for use: You only need to collect either the 6 meter or 10 metre walk test. Complete the same test on admission and discharge.

If the patient requires a walking aid, where possible use the walking aid that is likely to be used on discharge from the RITH program.

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 not applicable for this episode of care, code 9999.

Employment status after, or anticipated employment status after discharge

Definition: 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, this item identifies if their rehabilitation has enabled them to achieve a level of function that allows them to return to work and at what level or if they have been unable to return to work.

Collection of this data will enable analysis of employment outcome achievement. For example, a patient 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.

Codeset values:

1	Same or similar job, same or similar hours
2	Same or similar job, reduced hours
3	Different job by choice
4	Different job due to reduced function
5	Not able to work
6	Chosen to retire
7	Too early to determine

Discharge FIM scores

Definition: The patient's Functional Independence Measure (FIM) score for each of the 18 FIM items, assessed at the time of discharge. This item is mandatory for the RITH data collection.

Justification: The FIM scores and the AROC Impairment codes are based on the Uniform Data System for Medical Rehabilitation (UDSMR); a minimum data set that includes a system for grouping rehabilitation episodes by impairment type and a rating scale to measure function, the FIM. The FIM is a basic indicator of severity of disability. The functional ability of a patient changes during rehabilitation and the FIM is used to track those changes which are a key outcome measure of rehabilitation episodes.

Guide for use: Discharge FIM scoring needs to be completed before the patient is discharged from the RITH program. The score should reflect the functional status of the patient at discharge.
FIM assessment should always be undertaken by credentialed FIM assessors.

Data Items:

Discharge FIM score for eating

Discharge FIM score for grooming

Discharge FIM score for bathing

Discharge FIM score for dressing upper body

Discharge FIM score for dressing lower body

Discharge FIM score for toileting

Discharge FIM score for bladder management

Discharge FIM score for bowel management

Discharge FIM score for transfer to bed/chair/wheelchair

Discharge FIM score for transfer to toilet

Discharge FIM score for transfer to shower/tub

Discharge FIM score for locomotion

Discharge FIM score for stairs

Discharge FIM score for comprehension

Discharge FIM score for expression

Discharge FIM score for social interaction

Discharge FIM score for problem solving

Discharge FIM score for memory

Codeset values:

1	Total contact assistance
2	Maximal contact assistance
3	Moderate contact assistance
4	Minimal contact assistance
5	Supervision or setup
6	Modified independence
7	Complete independence

FAM Episode End

Definition: The patient's Functional Assessment Measure (FAM) score (including the EADLs module), assessed at the time of discharge. This item is mandatory for the RITH data collection.

Justification: The FAM is a set of additional items on top of the FIM. The FAM items helps to measure changes in function that are relevant to a RITH setting that are not covered by the FIM.

Guide for use: Discharge FAM scoring needs to be completed as close to discharge as possible.

Data Items:

Discharge FAM score for swallowing

Discharge FAM score for car transfer

Discharge FAM score for community mobility

Discharge FAM score for reading

Discharge FAM score for writing

Discharge FAM score for speech intelligibility

Discharge FAM score for emotional status

Discharge FAM score for adjustment to limitations

Discharge FAM score for leisure activities

Discharge FAM score for orientation

Discharge FAM score for concentration

Discharge FAM score for safety awareness

Discharge FAM score for meal preparation

Discharge FAM score for laundry

Discharge FAM score for housework

Discharge FAM score for shopping

Discharge FAM score for home finances

Discharge FAM score for work/education

Codeset values:

1	Total contact assistance
2	Maximal contact assistance
3	Moderate contact assistance
4	Minimal contact assistance
5	Supervision or setup
6	Modified independence
7	Complete independence

DASS21 Episode End

Definition: The Depression, Anxiety and Stress Scale – 21 items (DASS21), score on discharge from the RITH program.

Justification: The DASS21 is a self-reported measure of depression, anxiety and stress. Depression, anxiety and stress are common among rehabilitation. Measuring them on admission and discharge helps to calculate effectiveness of the rehab team in managing these concerns for their patients.

Guide for use: This a self-reported measure, so the scores are completed by the patient and not the clinician. Record the patients score for each of the DASS 21 items.

Data Items:

Discharge DASS21 I found it hard to wind down

Discharge DASS21 I was aware of dryness of my mouth

Discharge DASS21 I couldn't seem to experience any positive feeling at all

Discharge DASS21 I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)

Discharge DASS21 I found it difficult to work up the initiative to do things

Discharge DASS21 I tended to over-react to situations

Discharge DASS21 I experienced trembling (e.g. in the hands)

Discharge DASS21 I felt that I was using a lot of nervous energy

Discharge DASS21 I was worried about situations in which I might panic and make a fool of myself

Discharge DASS21 I felt that I had nothing to look forward to

Discharge DASS21 I found myself getting agitated

Discharge DASS21 I found it difficult to relax

Discharge DASS21 I felt down-hearted and blue

Discharge DASS21 I was intolerant of anything that kept me from getting on with what I was doing

Discharge DASS21 I felt I was close to panic

Discharge DASS21 I was unable to become enthusiastic about anything

Discharge DASS21 I felt I wasn't worth much as a person

Discharge DASS21 I felt that I was rather touchy

Discharge DASS21 I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)

Discharge DASS21 I felt scared without any good reason

Discharge DASS21 I felt that life was meaningless

Codeset values:

0	Did not apply to me at all
1	Applied to me to some degree, or some of the time
2	Applied to me to a considerable degree or a good part of time
3	Applied to me very much or most of the time

EQ5D5L Episode End

Definition: The patient's EQ-5D-5L scores on discharge from the RITH service.

Justification: The EQ-5D-5L is a self-reported measure of health. Measuring self-reported health at the beginning and end of the RITH episode enables the review of health outcomes achieved on the program from the patient's perspective.

Guide for use: This a self-reported measure, so the scores are completed by the patient and not the clinician. Record the EQ-5D-5L as close to discharge as possible.

The EQ-5D-5L can be completed by a proxy if the patient is unable to complete. If completing with a proxy use the proxy version and note in comments field that a proxy was used.

Data Items:

Discharge EQ5D5L Mobility

Discharge EQ5D5L Self Care

Discharge EQ5D5L Usual Activities

Discharge EQ5D5L Pain/Discomfort

Discharge EQ5D5L Anxiety/Depression

Discharge EQ5D5L Your Health Today

Codeset values:

1	No problems
2	Slight problems
3	Moderate problems
4	Severe problems
5	Extreme problems or unable to complete task

Timed Up and Go Episode End

Definition: The time in completed seconds to complete the Timed Up and Go (TUG) test as assessed just before the patient is discharged.

Justification: This is a measure of functional mobility. Measuring it at the start and end of admission allows for the calculation of change of functional mobility.

Guide for use: 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.

6 OR 10 metre walk test at Episode End

Definition: The time in completed seconds for walking 6 metres OR 10 metres; as assessed on discharge.

Justification: The measurement of walking speed at the beginning and end of admission allows for the calculation of change over the RITH episode. Walking speed is indicative of a person's level of ambulation and can used to track progress across their rehabilitation journey.

Guide for use: You only need to collect either the 6 meter or 10 metre walk test.
Complete the same test that was completed on admission.

The patient may use the walking aid they are currently using.

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 not applicable for this episode of care, code 9999.

Was there a delay in discharge?

Definition: This item identifies whether there was a delay between the patient being assessed as clinically ready for discharge from RITH and the date of discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

Justification: This item is collected to flag episodes that experienced a delay in their discharge.

Guide for use: Record 1, “Yes” if there was a delay and 2, “No” if there was not. If “Yes”, complete the next 5 questions about reason(s) for delay in discharge. See examples in the Guide for use section for the reasons for delay.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Patient related issues (medical)

Definition: This item collects information about patient related medical issues that have caused a delay in discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the RITH program.

Justification: This item enables identification of the rehabilitation episodes whose rehabilitation end was delayed by patient related medical issues.

Guide for use: For example:
A patient becomes medically unwell prior to discharge and remains on the RITH program for monitoring prior to being discharged.

If you would like to provide additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Service issues

Definition:

This item collects information about service issues that have caused a delay between the patient being assessed as clinically ready for discharge from RITH and the date of discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

Service issues are those that are governed by the rehabilitation service or the hospital service that impact the RITH episode.

Justification:

This item enables identification of the rehabilitation episodes whose RITH end was delayed by service issues.

Guide for use:

Examples include:
Patient requires ambulatory rehabilitation services, however there is a waiting list. The RITH team feel that the patient cannot be discharged until ambulatory rehabilitation is confirmed.

If you would like to provide additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge – External support issues

Definition:

This item collects information about external support issues that have caused a delay between the patient being assessed as clinically ready for discharge from RITH and the date of discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

External support issues are those that are not governed by the RITH/rehabilitation service.

Justification:

This item enables identification of the rehabilitation episodes whose rehabilitation end was delayed by external support issues.

Guide for use:

Do not use this for delays due to NDIS processes, instead use the delay 'NDIS process'

For example:
Education to carer or family about clinical needs of patient need to be completed to ensure safe discharge and carer or family member not available until after set discharge date.

Family delays discharge, e.g. family thinks patient would benefit from further RITH rehabilitation or medical team continue to negotiate with family regarding care they can provide.

If you would like to provide additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge – Equipment issues

Definition: This item collects information about equipment issues that have caused a delay in discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the RITH program.

Justification: This item enables identification of RITH episodes whose discharge was delayed by equipment issues.

Guide for use: For example:
Major or minor home modifications required for safe discharge are not complete.

Patient is borrowing equipment from the RITH team and have not sourced their own equipment by the scheduled discharge date.

If you would like to provide additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge – Patient behavioural issues

Definition: This item collects information about patient behavioural issues that have caused a delay in discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

Justification: This item is required to be able to identify the RITH episodes whose discharge was delayed by patient behavioural issues.

Guide for use: For example:
The patient is refusing to be discharged.

If you would like to provide additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge – Finding appropriate housing

Definition: This item collects information about delays in discharge caused by finding appropriate housing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

Justification: This item is required to be able to identify the RITH episodes whose discharge was delayed by finding appropriate housing.

Guide for use: For example:
Patient requires specialist disability accommodation (SDA) which takes two weeks to be arranged after the patient was ready for discharge.

If you would like to provide additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge – NDIS processes

Definition: This item collects information about NDIS processes that have caused a delay in discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

Justification: This item is required to be able to identify the RITH episodes whose discharge was delayed by NDIS processes.

Guide for use: For example:
The patient is unable to be discharged until existing NDIS services have been increased. Waiting for the approval of a new plan causes a delay in the patient's discharge.

If you would like to provide additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

If NDIS processes was a reason for delay, indicate the processes that delayed the discharge

Definition: This item collects information about which NDIS processes have caused a delay in discharge.

Justification: This item is required to be able to identify which NDIS processes cause delays in RITH episodes.

Guide for use: Only complete if there was a delay in discharge record as NDIS processes.

Tick all NDIS process that contributed to the delay in discharge. A process have been relevant to the patient's episode but not contributed to a delay in discharge, do not code these e.g. patient required new equipment and a review of their plan prior to discharge. The equipment has approved and arrived in time for discharge but the plan review caused a delay. Code the plan review but do not code the equipment.

Data Items:

NDIS Process delay - Eligibility determination

NDIS Process delay - Review of plan for exisiting NDIS participant

NDIS Process delay - Development of a plan for new NDIS participant

NDIS Process delay - Appeal of decision

NDIS Process delay - Commencement of services

NDIS Process delay - Equipment

NDIS Process delay - Other

Codeset values:

1	Yes
2	No

Is there an existing comorbidity interfering with this episode?

Definition: A comorbidity is defined as any other significant existing illness/impairment, not part of the principal impairment, which interfered with the process of rehabilitation.

Justification: It is important to identify whether the patient had comorbidities, 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 has stable controlled atrial fibrillation. DO NOT code as a comorbidity.

The patient has congestive heart failure which limits therapy sessions to only 10-15mins.

Patient has residual hemiplegia and cognitive impairment from a previous stroke that affected their participation in their current rehabilitation program.

Patient has a previous stroke but their residual impairments do not affect their rehabilitation program. DO NOT code as a comorbidity.

Do not leave blank.

Codeset values:

1	Yes
2	No

Comorbidity Items

Definition: Comorbidities interfering with the rehabilitation program (up to four can be selected).

Justification: It is important to identify whether the patient had comorbidities and which ones, as investigation of such data may reflect a relationship between the presence of a particular comorbidity, the rehabilitation outcomes and length of stay.

Guide for use: If there is an existing comorbidity interfering with this episode, then record up to a maximum of four comorbidities from the codeset.

If using 'Other', please use the General comments section to detail the comorbidity.

If you find a trend in your patient group that is not covered by the codeset options, please contact AROC.

Data Items:

Comorbidities Interfering with Rehabilitation Episode (1)

Comorbidities Interfering with Rehabilitation Episode (2)

Comorbidities Interfering with Rehabilitation Episode (3)

Comorbidities Interfering with Rehabilitation Episode (4)

Codeset values:

1	Cardiac disease
2	Respiratory disease
3	Drug and alcohol abuse
4	Dementia
5	Delirium, pre-existing
6	Mental health problem
7	Renal failure with dialysis
8	Renal failure NO dialysis
9	Epilepsy
10	Parkinson's 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
25	Acute COVID (1-4 weeks)
26	Post COVID (5-12 weeks)
27	Long COVID (13+ weeks)
99	Other

Were there any complications interfering with this episode?

Definition: A complication may be defined as a disease or disorder concurrent with the principal impairment (or exacerbation of impairment), which prevents the patient from engaging at the anticipated intensity in their planned rehabilitation program. Report only those complications arising during the rehabilitation episode.

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

Guide for use: Only record 1, “Yes” if the patient’s complication prevented them from engaging at the anticipated intensity in their planned rehabilitation program, otherwise answer 2, “No”.

Report only those complications arising during the rehabilitation episode, for example: A spinal patient developed a pressure ulcer which prevented them from engaging at the anticipated intensity in their planned rehabilitation program.

A patient developed a UTI, became confused and was unable to engage at the anticipated intensity in their planned rehabilitation program.

A patient has a fall during their rehabilitation episode and suffers bruising and a lack of confidence that resulted in the patient missing some days of therapy.

A patient has an electrolyte imbalance which is managed by IV fluids. The fluids are delivered around the patient’s rehabilitation program allowing them to continue their normal program. DO NOT code as a complication.

A patient develops urinary incontinence during their rehabilitation episode. This is well managed with incontinence pads which allows the patient to continue their rehabilitation program with minimal interruptions. DO NOT code as a complication.

If a complication 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:

1	Yes
2	No

Complication Items

Definition: Complications arising during the rehabilitation episode and interfering with the planned rehabilitation program (up to four can be selected).

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

Guide for use: If there is an existing complication interfering with this episode indicated then record up to a maximum of four complications from the codeset.

If using 'Other', please use the General comments section to detail the complication.

If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Data Items:

Complication Interfering with Rehabilitation Episode (1)

Complication Interfering with Rehabilitation Episode (2)

Complication Interfering with Rehabilitation Episode (3)

Complication Interfering with Rehabilitation Episode (4)

Codeset values:

1	UTI
2	Incontinence faecal
3	Incontinence urinary
4	Delirium
5	Fracture
6	Pressure ulcer
7	Wound infection
8	DVT/PE
9	Chest infection
10	Significant electrolyte imbalance
11	Fall
12	Faecal impaction
13	Acute COVID 1-28 days since COVID diagnosis (Weeks 1-4)
99	Other

Episode end date

Definition: The date that the patient completed their rehabilitation episode. This date defines the end of the rehabilitation episode and is the date at which the length of stay (LOS) concludes.

The RITH rehabilitation episode ends when the patient is discharged from the RITH program.

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

Guide for use: Record the date that the patient was discharged from the RITH program.

Mode of episode end (Inpatient)

Definition: This item records data about where the patient went to at the end of their RITH rehabilitation episode.

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

Guide for use: If a 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 nonspecific data. If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

1	Discharged to final destination
2	Discharged to interim destination
3	Death
4	Admitted to hospital acute care
5	Admitted to inpatient subacute rehabilitation
6	Admitted to other sub-acute/non acute care
7	Discharged at own risk
8	Other and unspecified

Interim destination (AU)

Definition: This and the next item collect the type of accommodation a patient is going to post discharge from RITH. In many cases this will be the same destination that the RITH program was delivered in, but not always. An interim destination may be defined as accommodation that is only intended to be temporary, which the rehabilitation team considers as a 'middle step' to a final destination.

Justification: This data item allows the facility to capture the fact the patient is unable to be discharged to what is intended to be their final destination immediately after rehabilitation. Feedback from AROC members indicates that this scenario is quite common and may indicate complexity of the patients discharge, or the lack of equipment and/or services available to the patient.

Guide for use: Interim accommodation acknowledges that the patient has not been able to return to the most ideal accommodation immediately post discharge, and that even though their rehabilitation is deemed complete, they still have one more step to complete before reaching their final destination. Interim destination is about intentions, not time frames.

A transitional living unit provides short term accommodation (live-in facility) and therapeutic intervention – physio, OT, social work, nursing /personal care. It is a time-limited and goal-oriented service. There is a focus on improving functional capacity and independent living skills and ensuring long term care/support arrangements are organised. These are generally used in specialised brain and spinal cord rehabilitation units.

If a patient is discharged with a transitional care program/package (TCP), code the destination where that program/package will be received (i.e. private residence or residential care).

For example:
Mr Major was discharged to his daughter's home (interim accommodation) whilst awaiting completion of home modifications to his own home (final accommodation).

Only complete if recorded "discharged to interim destination" at mode of episode end.
If using 'Other', please use the General comments section to provide additional information.
If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

1	Private residence (including unit in retirement village)
2	Residential, low level care(hostel)
3	Residential, high level care(nursing home)
4	Community group home
5	Boarding house
6	Transitional living unit
7	Hospital
8	Other
9	Unknown

Final destination (AU)

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 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 outcomes.

Guide for use: Only complete if recorded “discharged to final destination” or “discharged to interim destination” at mode of episode end. If the patient has been discharged to an interim destination, record the final destination as the anticipated/intended final destination at the time of discharge.

If a patient is discharged with a transitional care program/package (TCP), code the destination where that program/package will be received (i.e. private residence or residential care).

If using ‘Other’, please use the General comments section to provide additional information.
If you find a trend in your patient group that is not covered by the codeset options please contact AROC. Please carefully consider the use of the code set value '9, Unknown' as this contributes to non-specific data.

Codeset values:

1	Private residence (including unit in retirement village)
2	Residential, low level care(hostel)
3	Residential, high level care(nursing home)
4	Community group home
5	Boarding house
8	Other
9	Unknown

Carer status post discharge

Definition: The level of carer support the patient receives post discharge from RITH episode of care. Including both paid and/or unpaid carers. Paid carer support includes both government funded and private health funded carers. Unpaid carer support includes care provided by a relative, friend and/or partner of the patient.

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

A patient may receive care from both a carer who lives in and a carer who does not live in. In this case, code the carer who provides the higher proportion of care.

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:

1	NO CARER and DOES NOT need one
2	NO CARER and NEEDS one
3	CARER NOT living in
4	CARER living in, NOT co-dependent
5	CARER living in, co-dependent

Total number of suspension days

Definition: The sum of the number of days RITH treatment was suspended for a medical reason during an episode of RITH. Where a patient's rehabilitation treatment is suspended for a period, and the patient then comes back onto the same program of rehabilitation (that is, a new program is not required to be developed). The suspension period must be a minimum of 1 day (24 hours).

Justification: Achievement of a patient's rehabilitation goals may be dependent upon the consistency of treatment. Any requirement to suspend rehabilitation treatment may significantly impact upon treatment outcomes and the efficiency with which these can be achieved. Collection of this data item will provide facilities with information that they can use to help explain their outcomes to interested parties.

Guide for use: There may be a number of reasons for the suspension of a rehabilitation program, for example:

A medical condition that prevents the patient participating in their rehabilitation program. For example: Mr. Jones has flare up of gout and is unable to complete his RITH program for two days. Once the gout settles he recommences his same rehab program. Record a suspension for two days.

The requirement for a medical procedure (e.g. Gastroscopy, renal dialysis, chemotherapy) that prevents the patient participating in their RITH program for a period of time.

Enter the number of days that the patient's treatment was suspended. If there were none enter '0'.

Where a patient's rehabilitation treatment is suspended for a period, but on their return to rehabilitation it is necessary to develop a new rehabilitation program for them (due to a change in the patient's functional status, or to the objectives of the rehabilitation program) then the period of absence is not counted as a suspension. Rather, the patient should be discharged (from the date their rehabilitation treatment was suspended) and a new episode commenced (from the date they return to rehabilitation).

Please note that where a patient participates in their rehabilitation program in the morning and then has, for example, their renal dialysis in the afternoon, this is not a suspension of treatment, because the patient has participated in their program on that day.

Please note that where a patient refuses to participate in their rehabilitation program for a period of time – this is not considered a suspension of treatment.

Total number of suspension occurrences

Definition: The total number of rehabilitation treatment suspension occurrences during this admission.

Justification: Achievement of a patient's rehabilitation goals may be dependent upon the consistency of treatment. The number of treatment suspensions occurrences as well as the total number of suspension days may significantly impact upon treatment outcomes and the efficiency with which these can be achieved.
Collection of this data item will provide facilities with information that they can use to help explain their outcomes to interested parties.

Guide for use: Enter the number of periods of rehabilitation treatment suspensions that occurred during the episode. If there were none, enter 0.

For example: Mrs. Jones commences her RITH program on Monday. On Thursday her asthma flares up and she is unable to undertake her rehab program on Thursday and Friday. She starts again on Saturday. The following Wednesday her asthma flares up again and she does not have rehabilitation treatment on Wednesday, but starts again on Thursday. Mrs. Jones has had 2 occurrences of treatment suspensions.

Will any packages of services be received post discharge?

Definition: This item identifies whether a package(s) of services will be received by the person post their discharge from the RITH program. A package of services refers to an externally funded (normally government) services package.

Justification: Service(s) received relates to degree of functional independence of the person, and as increased functional independence is a key outcome measure for rehabilitation, it is important to ascertain the person's level of functional independence prior to rehabilitation. Services are often delivered as a part of a government funded package. Services received before and after rehabilitation can be compared as an indication of change in the person's functional independence after rehabilitation.

Guide for use: Only collect this data item if the patient's final discharge destination is private residence (including unit in retirement village), otherwise leave blank. Record 1,"Yes", if a package of service(s) will be received required and 2,"No", if no package of service(s) will be received.

If the patient only receives services outside of an externally funded package than record No for this item.

If they patient has been referred for a new package of services (e.g. Level 3/4) it is unlikely they will commence at the time of discharge. In these cases code Yes for this item, and choose the appropriate option in the next data item (e.g. Referred for new level 3/4 package). Record 1,"Yes," if a package of services will be received and 2,"No,' if no a package of services will not be received.

Codeset values:

1	Yes
2	No

Packages of services received post discharge

Definition: This item collects information about which package(s) of services will be received post discharge from the RITH program.

Justification: The type of service(s) received before and after rehabilitation can be compared as an indication of patient's rehabilitation progress.

Guide for use: Only collect this data item if Will any packages of services be received post discharge was Yes, otherwise leave blank.

Select all option that apply.

For example;
Mr. Chan was discharged from RITH on a community TCP program and his existing Level 1/2 package. Record both Community Transitional Care Package and Existing Level 1/2 Package.

Ms. Stafford was discharged from RITH with her existing Level 1/2 package, she is also on the waiting list for a Level 3/4 package after a referral was completed. Record existing Level 1/2 package and Referred for new Level 3/4 package.

Options for other may include DVA funded services.

Data Items:

Packaged services received after DC - Existing Level 1/2 Package

Packaged services received after DC - Existing Level 3/4 Package

Packaged services received after DC - Community Transitional Care Package

Packaged services received after DC - Existing NDIS plan

Packaged services received after DC - Referred for new Level 1/2 Package

Packaged services received after DC - Referred for new Level 3/4 Package

Packaged services received after DC - Residential Transitional Care Package

Packaged services received after DC - New NDIS Plan

Packaged services received after DC - Other

Codeset values:

1	Yes
2	No

Will any services be received post discharge that are NOT part of a package above?

Definition: This item identifies whether services were received by the person post discharge that were not part of a package of services. “Services” refers to paid or unpaid services required post discharge, that is: all services that have been discussed, agreed, planned and booked for the patient prior to discharge. Paid service(s) include both government funded and private health funded services, as long as they were not included.as part of a package identified in the previous data item. Unpaid service(s) include care provided by a relative, friend, and/or partner of the patient.

Justification: Service(s) received relates to the degree of functional independence of the person, and as increased functional independence is a key outcome measure for rehabilitation, it is important to ascertain the person's level of functional independence before and after rehabilitation. Service(s) received before and after rehabilitation can be compared as an indication of any change in the person's functional independence after rehabilitation.

Guide for use: Only collect this data item if the patient’s final discharge destination is private residence (including unit in retirement village), otherwise leave blank.

Do not include services that are received as part of a package

Record 1,”Yes", if service(s) will be received outside of a care package and 2,”No", if no service(s) will be received outside of a care package.

Discretionary services received by the patient, but that are not functionally necessary, should not be included e.g. a house cleaner because the patient doesn’t like cleaning, rather than functionally unable to clean.

Codeset values:

1	Yes
2	No

Services received post discharge that were NOT part of a package

Definition: This item collects information about whether the patient received paid or unpaid services post discharge that were NOT part of a package. Paid service(s) include both government funded and private health funded services that are delivered outside of packages. Unpaid service(s) include care provided by a relative, friend, and/or partner of the patient.

Justification: The type of service(s) received before and after rehabilitation can be compared as an indication of patient's rehabilitation progress.

Guide for use: Only collect this data item if the patient will receive services outside of package post discharge, otherwise leave blank.

Record 1, "Yes" if they will receive services outside of a package and 2, "No" if they did not receive services outside of a package

Discretionary services received by the patient, but that are not functionally necessary, should not be included e.g. a house cleaner because the patient doesn't like cleaning rather than functionally can't clean.

Do not include services received as part of a package

Domestic tasks include: household cleaning, vacuuming, ironing, shopping, managing finances, and meal preparation. Paid domestic assistance service(s) include both government funded and private health funded services.

Social support includes: daily wellbeing through telephone calls, medication reminders, counselling etc. Paid social support service(s) include both government funded and private health funded services.

Nursing care includes: nurse visiting a patient to administer wound care, medication, manage incontinence etc. Paid nursing care includes both government funded and private health funded services.

Allied health care includes: provision of physiotherapy, occupational therapy, speech and language therapy, recreational therapy, social work, psychology etc. Paid allied health care include both government funded and private health funded services.

Personal care includes: washing, dressing, grooming, eating, toileting etc. Paid personal care service(s) include both government funded and private health funded services.

Meals include: ready meals such as meals on wheels or lite and easy meals etc. Paid meal service(s) include both government funded and private health funded meal services.

Goods and equipment include: specialised equipment such as a shower chair, commode, hoist, wheelchair or smaller aids such as a plate guard for eating, adapted cutlery, long handled sponge for washing etc. Paid goods and equipment include both government funded and private health funded goods and equipment.

Transport services include: community transport for shopping or attending medical appointments, taxi vouchers, community bus and/or use of patient transport assistance vehicle etc. Paid transport service(s) include both government funded and private health funded services.

Data Items:

Service received prior to impairment – Domestic assistance

Service received prior to impairment – Social support

Service received prior to impairment – Nursing care

Service received prior to impairment – Allied health care

Service received prior to impairment – Personal care

Service received prior to impairment – Meals

Service received prior to impairment – Provision of goods & equipment

Service received prior to impairment – Transport services

Service received prior to impairment – Case management

Codeset values:

1	Yes
2	No

Will a discharge plan be available to patient prior to discharge?

Definition: A discharge plan is a formal document that summarises the episode of rehabilitation, and provides information about medications the patient was receiving on discharge, and follow-up care (such as doctor's appointments). This document may also be sent to the GP on discharge.

Justification: A discharge plan is best practice to ensure a patient's ongoing rehabilitation and medical needs are communicated.

Guide for use: Answer 1, "Yes" if the patient is provided with a formal document that summarises the episode of rehabilitation, and provides information about medications the patient was receiving on discharge and follow-up care (such as doctor's appointments). This document may also be sent to the GP on discharge, otherwise answer 2, "No".

Codeset values:

1	Yes
2	No

Did you pursue an NDIS application or changes to their current plan during this rehabilitation episode?

Definition: This item records whether a new NDIS application was competed or changes sought to a current NDIS plan for an existing participant during the RITH episode. This item is not concerned whether the application was successful, just simply whether it was pursued.

Justification: Accessing the NDIS program is a process. Understanding whether a patient was pursing an NDIS application during their RITH admission can assist in understanding the affects this may have on rehabilitation outcomes and RITH rehabilitation teams.

Guide for use: Record 1 Yes, if either a new application was sought or a changes to current plan were submitted during the RITH episode. Record 2 No, if it was not.

If you completed some of an application that was either handed over to you from a previous rehabilitation service or that you started and then handed over, record 1 Yes.

Codeset values:

1	Yes
2	No

Which phases of the NDIS process did the team support during this rehabilitation episode?

Definition: This item records the phases of the NDIS process that the RITH team support the patient through during this RITH rehabilitation episode

Justification: Accessing the NDIS program is a process. Understanding what phases a patient was completing during their RITH admission can assist in understanding the affects this may have on rehabilitation outcomes and RITH rehabilitation teams

Guide for use: Only complete if you recorded Yes for 'Did you pursue an NDIS application or changes to their current plan during this rehabilitation episode'

Record the phases that were supported during the RITH rehabilitation episode only.

Record as many phases that were supported during the RITH episode even if it commenced or concluded outside the RITH episode (e.g. the inpatient rehab team commenced revision/change of current plan but this was then completed with the support of the RITH team)

Record regardless of whether the application was successful or not.

Data Items:

NDIS Phase - Supporting access

NDIS Phase - Support revision/change of current plan

NDIS Phase - Home and living application process

NDIS Phase - Preparation for planning meeting

NDIS Phase - Plan implementation

Codeset values:

1	Yes
2	No

Is the patient an NDIS participant at discharge?

Definition: This item is collects whether the patient was an NDIS participant at their discharge from the RITH service.

Justification: Accessing the NDIS program is a process. Understanding whether a patient is an NDIS participant at the discharge point of the program can assist in understanding the affects this may have on rehabilitation outcomes.

Guide for use: Record 1 Yes, if the patient is an NDIS participant at discharge, record 2 No, if they are not.
For this item it doesn't matter whether the NDIS plan is relevant to the current admission.
If the patient was applied to the NDIS but is still awaiting a decision record 2 No.

Codeset values:

1	Yes
2	No

OOS by discipline

Definition: The number of occasions of service (OOS) completed over the entire RITH program by each discipline. OSS are recorded as either face to face or telehealth.

Justification: RITH is seeking to substitute for inpatient rehabilitation and as such it is important to know the amount of rehabilitation received as this may impact on outcomes.

Guide for use: Record the number of face to face and telehealth OOS for each discipline. An OOS must contain therapeutic/clinical content and result in an entry into the patients' medical record. A phone call to arrange an appointment should not be counted as an OOS.

Only record OOS that were delivered. If an OOS was unable to be delivered e.g. patient declined, do not record it.

Data Items:

Face to face OOS - Clinical Nurse Consultant
Face to face OOS - Clinical Nurse Specialist
Face to face OOS - Dietitian
Face to face OOS - Enrolled Nurse
Face to face OOS - Exercise physiologist
Face to face OOS - Hydrotherapist
Face to face OOS - Medical Officer
Face to face OOS - Nurse practitioner
Face to face OOS - Neuro-psychologist
Face to face OOS - Occupational Therapist
Face to face OOS - Physiotherapist
Face to face OOS - Podiatrist
Face to face OOS - Prosthetist/Orthotist
Face to face OOS - Psychologist
Face to face OOS - Registered Nurse
Face to face OOS - Recreational Therapist
Face to face OOS - Speech Pathologist
Face to face OOS - Social Worker
Face to face OOS - Therapy Aide
Face to face OOS - Vocational Co-ordinator
Face to face OOS - Other
Telehealth OOS - Clinical Nurse Consultant
Telehealth OOS - Clinical Nurse Specialist
Telehealth OOS - Dietitian
Telehealth OOS - Enrolled Nurse
Telehealth OOS - Exercise physiologist
Telehealth OOS - Hydrotherapist

Telehealth OOS - Medical Officer
Telehealth OOS - Nurse practitioner
Telehealth OOS - Neuro-psychologist
Telehealth OOS - Occupational Therapist
Telehealth OOS - Physiotherapist
Telehealth OOS - Podiatrist
Telehealth OOS - Prosthetist/Orthotist
Telehealth OOS - Psychologist
Telehealth OOS - Registered Nurse
Telehealth OOS - Recreational Therapist
Telehealth OOS - Speech Pathologist
Telehealth OOS - Social Worker
Telehealth OOS - Therapy Aide
Telehealth OOS - Vocational Co-ordinator
Telehealth OOS - Other

Modes of telehealth delivery

Definition: The mode(s) of telehealth used across the RITH program.

Justification: Telehealth is expanding in RITH services, however different technologies are available in different areas. Collection of this data will enable analysis around the usage of different technologies.

Guide for use: Record all the modes that were used during the patient's RITH program.

Only record when the telehealth modality was used to deliver an OOS. E.g. do not include phone, if a phone a call was only used to organise a face to face appointment.

Data Items:

Modes of telehealth delivery - Phone call

Modes of telehealth delivery - Tele conference

Modes of telehealth delivery - Tele monitoring

Modes of telehealth delivery - Other

Codeset values:

1	Yes
2	No

General comments

Definition: Comments relevant to this episode of care.

Justification: This item allows additional information to be recorded.

Guide for use: Record any relevant comments about this episode of care, such as:

*any further details for any 'other' code used
*any further details useful to the facility

DO NOT RECORD PATIENT NAMES HERE