AUSTRALASIAN REHABILITATION OUTCOMES CENTRE

AMBULATORY DATA DICTIONARY V4.2

FOR CLINICIANS – NEW ZEALAND VERSION

For technical queries regarding this document or for more information, please contact the AROC team.

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Ambulatory Data Dictionary for Clinicians

BACKGROUND

This data dictionary includes all of the data items that are in the AROC Ambulatory V4.1 dataset. Each data item is listed, along with the definition, justification and guide for use. The language and information is aimed to assist clinically trained staff in using and understanding the AROC data. AROC recommends that this dictionary is used as a support document for staff members collecting data on our data collection forms. If you find that this dictionary does not adequately clarify your query of a data item, please contact aroc@uow.edu.au.

AMBULATORY DATA DICTIONARY VERSION

Version	Date	Nature of change
4.2	July 2022	Overall review incorporating updates to Definition, Justification and Guide for use sections to provide clarity and add more examples. Addition of COVID impairment codes
4.14	June 2019	Update to formatting.
4.13	April 2019	Minor dataset changes to the following items: *10 metre walk +/- aid test start date* and *10 metre walk +/- aid test end date*.
4.12	December 2018	Minor dataset changes to the following item: *AROC Impairment Code*.
4.11	November 2018	Minor codeset changes to the following item group: *de Morton Mobility Index (DEMMI)*.

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AROC Ambulatory Data Dictionary for Clinicians (NZ) V4.2

Path

Definition: Pathway of care being provided for this episode.

Justification: N/A

Guide for use:

Ambulatory rehabilitation:
• Is delivered in an ambulatory setting. Examples of ambulatory settings include day rehabilitation, outpatient departments and community-based rehabilitation programs.
• Is multi-disciplinary, although all therapies may not necessarily be delivered concurrently.
• Starts with a multi-disciplinary assessment.
• Is goal oriented – includes goal setting and review.
• Program of care is time limited.

Ambulatory rehabilitation may occur as:
• The continuation of an inpatient episode of rehabilitation.
• A rehabilitation program provided solely in an ambulatory setting.

Codeset values:

4	Ambulatory care

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.

Establishment name

Definition:	The name of the facility collecting and submitting the data.
Justification:	Enables episodes of care to be assigned to the correct facility for analysis.
Guide for use:	Enter the name of the facility.

Team ID

Definition:	A code representing an ambulatory rehabilitation ward/team.
Justification:	'Team identifier' and 'Team name' are included for those facilities who have more than one ambulatory rehabilitation ward/team 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.

Team name

Definition:	The name of an ambulatory rehabilitation ward/team within a service.
Justification:	'Team identifier' and 'Team name' are included for those facilities who have more than one ambulatory rehabilitation ward/team and wish to: 1.Identify their data at 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 ambulatory rehabilitation ward/team.

Unique record number

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. For more information on SLK, please refer to the AROC website, V4 resources, SLK.
Guide for use:	Enter in format DD/MM/YYYY. If unknown day of birth use 01 (record as DOB estimated). If unknown month of birth use 01 (record as DOB estimated). If unknown year of birth enter best estimate and record DOB as estimated.

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 (NZ)

Definition: Indigenous status is a measure of whether a patient identifies as being of Maori or Non-Maori origin.

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

Guide for use: Record the appropriate indigenous status.

Codeset values:

1	Maori
4	Non-Maori
9	Not stated or inadequately defined

Ethnicity

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

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

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

Codeset values:

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

Geographical residence (NZ)

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

Codeset values:

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

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.

Episode begin date

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

Episode end date

Definition:	The date the patient completed their ambulatory rehabilitation episode. The ambulatory rehabilitation episode ends when the patient is discharged from the ambulatory rehabilitation 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 completed their ambulatory rehabilitation episode.

Funding source (NZ)

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

Referral date

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

Justification: This item is collected to measure the impact of delay between date referral received and date rehabilitation started. Please note: Date referral received is being collected and not date the referral was made, because at times these dates may differ and it was deemed 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.
Referrals can be made by phone, fax or face to face across all settings.

Example 1: An in-patient will require out-patient therapy once discharged. A referral was made after hours by fax on 01/02/2012, but only received by the outpatient service on 02/02/2012. Record 02/02/2012, the date the referral was received by the out-patient service.

Example 2: A patient was assessed in their rural home and deemed clinically ready for a boost of home-based rehabilitation. A referral was faxed through to the local therapy team on 01/02/2012. The referral was received on 04/02/2012 when the part time staff returned to work. Record 04/02/2012, the date the referral was received.

AROC impairment code

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, Guillain-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	Reconditioning following surgery
16.2	Reconditioning 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

Date of injury/impairment onset

Definition:	This is 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, or 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 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 not known or the reason for rehabilitation is not related to an acute injury/impairment. Record this data item OR date of injury/impairment, NOT both.

In some cases, the impairment that has driven the need for rehabilitation may be a chronic disease with an insidious onset, and in these cases, record when the impairment started affecting the patient's function. For example, a patient admitted for rehabilitation for arthritis – no relevant acute admission – where the arthritis flared up 6 months ago and started affecting the patient's functioning, record codeset "6 months to less than 1 year".

Codeset values:

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

Date of relevant inpatient episode

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

Mode of episode start

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

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

Guide for use: Patients may be referred from a range of sources to an ambulatory rehabilitation program including the acute setting of a hospital, from a General Practitioner or a community based therapist.

Codeset values:

1	Referred by GP
2	Referred by therapist
3	Referred directly from specialist rooms
4	Referred from ED
5	Referred from acute specialist unit
6	Referred from acute inpatient care same hospital
7	Referred from acute inpatient care different hospital
8	Referred from sub-acute care (SAC) same service
9	Referred from sub-acute care (SAC) different service

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

Definition:

This item relates to the patient's impairment and setting, not the particular facility.

"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. An episode of direct care can be provided in the inpatient rehabilitation setting or ambulatory rehabilitation setting (e.g. outpatient and/ or community).

The first direct care rehabilitation episode for this impairment considers only those episodes occurring in this setting regardless of facility i.e. it aims to identify those patients that have repeated rehabilitation admissions/discharges within the one setting as subsequent episodes are typically quite different to primary episodes

Subsequent direct rehabilitation episodes of care are more common in certain impairments such as brain injury, spinal cord injury and/or amputee, where the patient often has multiple rehabilitation episodes across a variety of settings.

Justification:

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

Guide for use:

AMBULATORY ONLY: A patient who is admitted directly to an ambulatory rehabilitation program after having a hip replacement. This is the first direct care rehabilitation episode for their hip replacement in the ambulatory setting — record 1=Yes.

AMBULATORY FOLLOWING INPATIENT: A patient admitted for inpatient rehabilitation following a stroke and is now undertaking an ambulatory rehabilitation episode. While the ambulatory rehabilitation episode is NOT their first direct rehabilitation episode for this stroke, it is the first direct rehabilitation episode of care in the ambulatory setting – record 1=Yes.

Codeset values:

1	Yes
2	No

Need for interpreter service?

Definition: The identification by the patient (or family/carer) of the need for an interpreter service. An interpreter service can be paid or unpaid and includes the use of family members to assist the patient.

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

Guide for use: Record whether an interpreter service is required for the patient.

Codeset values:

1	Yes - Interpreter needed
2	No - Interpreter not needed

Date multi-disciplinary team rehabilitation plan established

Definition:	A multidisciplinary team rehabilitation plan comprises a series of documented and agreed initiatives/treatments (specifying program goals and time frames), which has been established through multidisciplinary consultation and consultation with the patient.
Justification:	The establishment of a multidisciplinary team rehabilitation plan with regular review is necessary for effective patient rehabilitation.
Guide for use:	Record the date the multidisciplinary team rehabilitation plan is formally documented in the patient's medical record. It must be a record of the plan formulated by the team on initial assessment of the patient. Often, the initial case conference document is a formal multidisciplinary plan for the patient's care while participating in rehabilitation. In other cases, the patient may be assessed by a multidisciplinary team prior to commencing a rehabilitation program, and the plan formulated from this assessment may form the multidisciplinary rehabilitation plan.

Type of accommodation prior to this impairment (NZ)

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 outcomes.

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

‘Supported Living’ is any service that helps people to live independently by providing support in those areas of their life where help is needed. Examples include: boarding house, supported disability accommodation, community group home.

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

Codeset values:

1	Private residence (including unit in retirement village)
2	Rest home level care / Hospital level care (requires 24hr nursing care)
3	Supported living
8	Other

Carer status prior to this impairment

Definition:

The level of carer support the patient received prior to their impairment or exacerbation of impairment. This includes both paid and/or unpaid carer support received. Paid carer support including both government funded and private health funded carers. Unpaid carer support including 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 complete if the patient's type of accommodation prior to this impairment was private residence (including unit in retirement village), otherwise leave blank. Include both paid and unpaid carer support.

If the ambulatory episode is continuing on from an inpatient rehabilitation episode, code the carer status prior to the impairment or exacerbation of impairment that was the reason for the inpatient rehabilitation episode.

Example: Mrs Nguyen was independent prior to her stroke. Mrs Nguyen had an inpatient rehabilitation episode following her stroke and was discharged home with personal care assistance from her husband. Mrs Nguyen is now continuing her rehabilitation in the ambulatory setting. Code the carer status prior to Mrs Nguyen's stroke 'NO CARER and DOES NOT need one'.

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 assists 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.
Example of co-dependent: 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

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 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

Type of accommodation during ambulatory episode (NZ)

Definition:

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

Justification:

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

Guide for use:

If the patient is residing in a "private residence" during this ambulatory episode of care and the addresses before and during the rehabilitation episode are the same, select "Pre-impairment accommodation.,"

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

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

Interim accommodation due to increased support required relates to patients who require increased assistance with ADL's (including transport,) as well as those who cannot stay at their usual address because their homes need modifications or because of their decreased functional ability post impairment E.g. External or internal stairs, inaccessible amenities.

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	Pre impairment accommodation
2	Interim accommodation due to geographical (access) issue (may be private residence, rest home level care/hospita level care or supported living)
3	Interim accommodation due to increased support required (may be private residence, rest home level care/hospital level care or supported living)
8	Other

Carer status during ambulatory episode

Definition:

The level of carer support the patient receives during their ambulatory episode of care, including both paid and/or unpaid carers. Paid carer support including both government funded and private health funded carers. Unpaid carer support including 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, during and after rehabilitation can be compared as an indication of patient's rehabilitation progress.

Guide for use:

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 assists 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.
Example of co-dependent: 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

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 presenting condition, 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 outcomes 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’s fatigue after dialysis impacted their ability to participate in their ambulatory program.
Do not leave blank.

Codeset values:

1	Yes
2	No

Comorbidities interfering with rehabilitation episode

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

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

Please carefully consider the use of the code '99 Other' as this contributes to non-specific data. If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

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

Cognitive impairment impacting on rehabilitation participation

Definition:

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

Justification:

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

Guide for use:

Only record 1, 'Yes' if the patient's rehabilitation program was affected by having a comorbid cognitive impairment, which was not part of the principal presenting condition, otherwise answer 2, 'No'.

The effect of the cognitive impairment should be apparent in the patient's treatment record. For example, the patient may require additional time for rehabilitation because of some degree of difficulty in understanding and following directions.

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

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

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

If recording YES, using the outcome measure of choice, record the tool name, start and end scores in the General comments section.

Codeset values:

1	Yes
2	No

Mode of episode end

Definition:

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

Justification:

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

Guide for use:

Patients can be discharged and remain in the community, either directly to their final destination and what will be their home from now on (could be private residence or residential care), or to an interim destination. If the patient is discharged to their final or interim destination, provide final destination details under data item, "final destination."

The other major option is that the patient is discharged back to a hospital setting.
Please carefully consider the use of the code 9, "Other and unspecified" as this contributes to non-specific data. If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

1	Discharged to final destination
2	Discharged to interim destination
3	Death
4	Admitted to hospital as sub acute/non acute inpatient
5	Admitted to hospital as an acute inpatient
8	Discharged at own risk
9	Other and unspecified

Final destination (NZ)

Definition:

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

Justification:

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

Guide for use:

Only complete if recorded “discharged to final destination” or “discharged to interim destination” at mode of episode end.

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.

‘Supported Living’ is a service that helps people to live independently by providing support in those areas of their life where help is needed. Examples include: boarding house, supported disability accommodation, community group home.

If Final Destination is 1='Private residence' complete the item Carer Status Post Discharge.

Codeset values:

1	Private residence (including unit in retirement village)
2	Rest home level care / Hospital level care (requires 24hrs nursing)
3	Supported living
8	Other
9	Unknown

Carer status post discharge

Definition: The level of carer support the patient receives post discharge from their ambulatory rehabilitation 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" 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 has a paid carer who comes to her home and assist her with personal care in the morning and the evening.

Unpaid carer support includes care provided by a relative, friend, partner of the patient.
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.
Example of co-dependent: 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

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. E.g. A patient was employed prior to admission and returned to their same or similar job, with reduced hours upon discharge may have different functional outcomes to a patient was employed prior to their admission, but is unable to work upon discharge.

Guide for use:

Only complete this item if the patient was employed prior to this impairment (or exacerbation of this impairment).
Record the patient's employment status, or anticipated employment status, after discharge.

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

Return to pre-impairment leisure and recreational activities

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

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

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

Codeset values:

1	Normal participation (ie pre-impairment level)
2	Mild difficulty in these activities but maintains normal participation
3	Mildly limited participation
4	Moderately limited participation
5	No or rare participation

Total number of days seen

Definition:	The total number of days that service(s) were provided to the patient during their episode of care.
Justification:	This item enables an accurate count of the total number of ACTUAL days the patient received therapy during their rehabilitation episode of care, which may impact patient outcomes. In the ambulatory setting, rehabilitation days are not necessarily continuous. A patient may attend therapy sessions 2 or 3 times a week for a number of weeks, thus the count of days between episode start and episode end may be (and is usually) many more days than the count of ACTUAL number of days that services were provided to the patient.
Guide for use:	In the ambulatory setting, this should total all days that service(s) were provided to the patient. For example, if the patient participated in the rehabilitation program 2 x per week for 4 weeks, the total number of days seen would be 8.

Total number of occasions of service

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

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

Guide for use: In the ambulatory setting, this should be the total of all occasions of service(s) that were provided to the patient. For example, if the patient attended the rehabilitation centre 2 x a week for 4 weeks, and had physiotherapy and occupational therapy at each visit the total number of occasions of service would be 16.

Include both in person and telerehabilitation occasions of service.

Disciplines involved in therapy

Definition: The type(s) of health professional or other care provider who provided treatment to the patient during their ambulatory rehabilitation episode of care.

Justification: This item is required to enable analysis of inputs (therapy type) and their impact on functional outcomes.

Guide for use: Please indicate all types of therapy providers who provided treatment to the patient during this episode of care. Choose up to 10, a minimum of 2 must be selected. Please indicate hydrotherapist as the staff type even if the hydrotherapy was provided by a physiotherapist.

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.

Data Items:

Staff type providing therapy during episode of care 1
Staff type providing therapy during episode of care 2
Staff type providing therapy during episode of care 3
Staff type providing therapy during episode of care 4
Staff type providing therapy during episode of care 5
Staff type providing therapy during episode of care 6
Staff type providing therapy during episode of care 7
Staff type providing therapy during episode of care 8
Staff type providing therapy during episode of care 9
Staff type providing therapy during episode of care 10

Codeset values:

1	Aboriginal/Maori Liaison Worker
2	Audiologist
3	Case Manager
4	Clinical Nurse Consultant
5	Clinical Nurse Specialist
6	Community support worker
7	Dietitian
8	Enrolled nurse
9	Exercise physiologist / Remedial Gymnast
10	Educational tutor
11	Hydrotherapist
12	Interpreter
13	Medical Officer
14	Nurse Practitioner
15	Neuro-psychologist
16	Occupational Therapist
17	Physiotherapist
18	Podiatrist
19	Psychologist
20	Registered Nurse
21	Recreational Therapist
22	Speech Pathologist/Therapist
23	Social Worker
24	Therapy Aide
25	Vocational Co-ordinator
98	Other

Date episode start Lawton's Assessed

Definition: The date on which the Australian modified Lawton's assessment was scored at episode start (admission).

Justification: This item reflects timely assessment of function on admission to ambulatory rehabilitation. It also enables groupings of ambulatory patients for benchmarking and outcome measurement.

Guide for use: Record the date on which the Lawton's assessment was scored at episode start (admission).

For more information about this and other outcome measures used in the AROC 4.1 ambulatory dataset please refer to: https://www.uow.edu.au/ahsri/aroc/dataset/ambulatory-dataset/

Lawton's admission scores (items 1-6)

Definition: The Australian Modified Lawton's score on admission to ambulatory rehabilitation (items 1-6 of 8).

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

Guide for use: Record for all impairments.

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

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

When assessing issues such as whether diet is adequate or there are acceptable standards of cleanliness, take into account the person's social and cultural context. Rate based on what is adequate or acceptable in that context.

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

Data Items:

Score episode start Lawton's for telephone

Score episode start Lawton's for shopping

Score episode start Lawton's for food preparation

Score episode start Lawton's for housekeeping

Score episode start Lawton's for laundry excluding ironing

Score episode start Lawton's for mode of transportation

Codeset values:

1	Not able to perform activity of daily living (ADL)
2	Requires moderate assistance to perform ADL
3	Requires some assistance to perform ADL
4	Capable of independently performing ADL

Lawton's admission scores (items 7-8)

Definition: The Australian Modified Lawton's score on admission to ambulatory rehabilitation (items 7-8 of 8).

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

Guide for use: Record for all impairments.

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

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

When assessing issues such as whether diet is adequate or there are acceptable standards of cleanliness, take into account the person's social and cultural context. Rate based on what is adequate or acceptable in that context.

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

Data Items:

Score episode start Lawton's for responsibility for own medications

Score episode start Lawton's for ability to handle finances

Codeset values:

1	Not able to perform activity of daily living (ADL)
2	Requires some assistance to perform ADL
3	Capable of independently performing ADL

Date episode end Lawton's Assessed

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

Lawton's discharge scores (items 1-6)

Definition: The Australian Modified Lawton's score at end of ambulatory rehabilitation (items 1-6 of 8).

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

Guide for use: Record for all impairments.

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

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

When assessing issues such as whether diet is adequate or there are acceptable standards of cleanliness, take into account the person's social and cultural context. Rate based on what is adequate or acceptable in that context.

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

Data Items:

Score episode end Lawton's for telephone

Score episode end Lawton's for shopping

Score episode end Lawton's for food preparation

Score episode end Lawton's for housekeeping

Score episode end Lawton's for laundry excluding ironing

Score episode end Lawton's for mode of transportation

Codeset values:

1	Not able to perform activity of daily living (ADL)
2	Requires moderate assistance to perform ADL
3	Requires some assistance to perform ADL
4	Capable of independently performing ADL

Lawton's discharge scores (items 7-8)

Definition: The Australian Modified Lawton's score at end of ambulatory rehabilitation (items 7-8 of 8).

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

Guide for use: Record for all impairments.

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

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

When assessing issues such as whether diet is adequate or there are acceptable standards of cleanliness, take into account the person's social and cultural context. Rate based on what is adequate or acceptable in that context.

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

Data Items:

Score episode end Lawton's for responsibility for own medications

Score episode end Lawton's for ability to handle finances

Codeset values:

1	Not able to perform activity of daily living (ADL)
2	Requires some assistance to perform ADL
3	Capable of independently performing ADL

Was rehabilitation aimed at upper limb function

Definition: Indicates if the ambulatory stroke rehabilitation was aimed at upper limb function

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

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

Specify whether rehabilitation was aimed at upper limb function. If yes, complete the Upper Limb Motor Assessment Scale (ULMAS).

Codeset values:

1	Yes
2	No

Was rehabilitation aimed at gait retraining

Definition: Indicates if ambulatory stroke rehabilitation was aimed at gait training.

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

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

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

Codeset values:

1	Yes
2	No

Was rehabilitation aimed at aphasia

Definition: Indicates whether ambulatory stroke rehabilitation was aimed at aphasia.

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

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

Specify if rehabilitation was aimed at aphasia, if yes, record outcome measure used and pre/post treatment scores in the 'General comments' section.

Codeset values:

1	Yes
2	No

Upper Limb Motor Assessment Scale (ULMAS) start date

Definition:

The date the Upper Limb Motor Assessment Scale (ULMAS) was scored at episode start (admission).

Justification:

The ULMAS assesses everyday upper limb motor function in adults following stroke. The ULMAS is a responsive, valid and reliable measure of upper limb function in adults following stroke.

Guide for use:

ONLY complete for AROC impairment codes:

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

and where "Was rehabilitation aimed at upper limb function" = Yes.
Record the date that the ULMAS was scored at episode start (admission).

For more information about this and other outcome measures used in the AROC 4.1 ambulatory dataset please refer to: https://www.uow.edu.au/ahsri/aroc/dataset/ambulatory-dataset/

Upper Limb Motor Assessment Scale (ULMAS) start scores

Definition: The Upper Limb Motor Assessment Scale (ULMAS) scores for each of the three assessment items, at the beginning of the ambulatory rehabilitation episode.

Justification: The ULMAS assesses everyday upper limb motor function in adults following stroke. The ULMAS is a responsive, valid and reliable measure of upper limb function in adults following stroke.

Guide for use: ONLY complete for AROC impairment codes:

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

and where "Was rehabilitation aimed at upper limb function" = Yes.

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

Note: Clinicians score upper arm function, hand movements and hand activities against ULMAS scoring criteria

Data Items:

ULMAS Start Upper Arm Function

ULMAS Start Hand Movements

ULMAS Start Hand Activities

Codeset values:

0	0 No function
1	1 Minimal function
2	2
3	3
4	4
5	5
6	6 Maximal function

Upper Limb Motor Assessment Scale (ULMAS) end date

Definition: The date that the Upper Limb Motor Assessment Scale (ULMAS) was scored at episode end (discharge).

Justification: The ULMAS assesses everyday upper limb motor function in adults following stroke. The ULMAS is a responsive, valid and reliable measure of upper limb function in adults following stroke.

Guide for use: ONLY complete for AROC impairment codes:

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

and where "Mode of episode end" = Discharged to final or interim destination and "Was rehabilitation aimed at upper limb function" = Yes.

Upper Limb Motor Assessment Scale (ULMAS) end scores

Definition:

The Upper Limb Motor Assessment Scale (ULMAS) scores for each of the three assessment items, at the end of the ambulatory rehabilitation episode.

Justification:

The ULMAS assesses everyday upper limb motor function in adults following stroke. The ULMAS is a responsive, valid and reliable measure of upper limb function in adults following stroke.

Guide for use:

ONLY complete for AROC impairment codes:

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

and where "Mode of episode end" = Discharged to final or interim destination and "Was rehabilitation aimed at upper limb function" = Yes.

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

Note: Clinicians score upper arm function, hand movements and hand activities against ULMAS scoring criteria.

Data Items:

ULMAS End Upper Arm Function

ULMAS End Hand Movements

ULMAS End Hand Activities

Codeset values:

0	0 No function
1	1 Minimal function
2	2
3	3
4	4
5	5
6	6 Maximal function

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) start date

Definition:

The date that the Mayo-Portland Adaptability Inventory - 4 (MPAI-4) was assessed at ambulatory episode start (admission).

Justification:

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

Guide for use:

ONLY complete for AROC impairment codes:

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

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

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

For more information about this and other outcome measures used in the AROC 4.1 ambulatory dataset please refer to: https://www.uow.edu.au/ahsri/aroc/dataset/ambulatory-dataset/

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) Abilities start scores

Definition:

The patient's Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Abilities scores at the beginning of the ambulatory rehabilitation episode.

Justification:

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

Guide for use:

ONLY complete for AROC impairment codes:

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

Record the patient's MPAI-4 Abilities scores at the beginning of the ambulatory rehabilitation episode. Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

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

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

Data Items:

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

Codeset values:

0	None
1	Mild problem but does not interfere with activities or function
2	Mild problem; interferes with activities to some degree
3	Moderate problem
4	Severe problem

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) Adjustment start scores

Definition:

The patient's Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Adjustment scores at the beginning of the ambulatory rehabilitation episode.

Justification:

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

Guide for use:

ONLY complete for AROC impairment codes:

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

Record the patient's MPAI-4 Adjustment scores at the beginning of the ambulatory rehabilitation episode. Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

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

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

Data Items:

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

Codeset values:

0	None
1	Mild problem but does not interfere with activities or function
2	Mild problem; interferes with activities to some degree
3	Moderate problem
4	Severe problem

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) Participation start scores

Definition:

The patient's Mayo-Portland Adaptability Inventory - 4 (MPAI-4) – Participation scores at the beginning of the ambulatory rehabilitation episode.

Justification:

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

Guide for use:

ONLY complete for AROC impairment codes:

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

Record the patient's MPAI-4 Participation scores at the beginning of the ambulatory rehabilitation episode. Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

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

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

Data Items:

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

Codeset values:

0	None
1	Mild problem but does not interfere with activities or function
2	Mild problem; interferes with activities to some degree
3	Moderate problem
4	Severe problem

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) end date

Definition:

The date that the Mayo-Portland Adaptability Inventory - 4 (MPAI-4) was assessed at ambulatory episode end (discharge).

Justification:

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

Guide for use:

ONLY complete for AROC impairment codes:

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

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

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

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) Abilities end scores

Definition:

The patient's Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Abilities scores at the end of the ambulatory rehabilitation episode (discharge).

Justification:

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

Guide for use:

ONLY complete for AROC impairment codes:

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

Record the patient's MPAI-4 Abilities scores at the end of the ambulatory rehabilitation episode. Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

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

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

Data Items:

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

Codeset values:

0	None
1	Mild problem but does not interfere with activities or function
2	Mild problem; interferes with activities to some degree
3	Moderate problem
4	Severe problem

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) Adjustment end scores

Definition:

The patient's Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Adjustment scores at the end of the ambulatory rehabilitation episode (discharge).

Justification:

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

Guide for use:

ONLY complete for AROC impairment codes:

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

Record the patient's MPAI-4 Adjustment scores at the end of the ambulatory rehabilitation episode. Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

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

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

Data Items:

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

Codeset values:

0	None
1	Mild problem but does not interfere with activities or function
2	Mild problem; interferes with activities to some degree
3	Moderate problem
4	Severe problem

Mayo-Portland Adaptability Inventory - 4 (MPAI-4) Participation end scores

Definition:

The patient's Mayo-Portland Adaptability Inventory - 4 (MPAI-4) - Participation scores at the end of the ambulatory rehabilitation episode (discharge).

Justification:

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

Guide for use:

ONLY complete for AROC impairment codes:

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

Record the patient's MPAI-4 Participation scores at the end of the ambulatory rehabilitation episode. Rate each item 0-4, where 0 represents no problem or difficulty with the item, and 4 represents a severe problem. Refer to the MPAI-4 rating form for specific wording of the rating scale for each item.

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

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

Data Items:

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

Codeset values:

0	None
1	Mild problem but does not interfere with activities or function
2	Mild problem; interferes with activities to some degree
3	Moderate problem
4	Severe problem

Level of SCI Start

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

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

Guide for use: ONLY complete for AROC impairment codes:

4.111 - 4.23 (all spinal cord dysfunction codes)
14.1 OR 14.3 (Major Multiple Trauma codes involving spinal cord dysfunction).

If patient has cauda equina, record "cauda equina" in General comments field. If unable to establish level of injury, record "paraplegia" or "quadriplegia" in the General comments field.

For more information about this and other outcome measures used in the AROC 4.1 ambulatory dataset please refer to: https://www.uow.edu.au/ahsri/aroc/dataset/ambulatory-dataset/

Codeset values:

1	C1
2	C2
3	C3
4	C4
5	C5
6	C6
7	C7
8	C8
9	T1
10	T2
11	T3
12	T4
13	T5
14	T6
15	T7
16	T8
17	T9
18	T10
19	T11
20	T12
21	L1
22	L2
23	L3
24	L4
25	L5
26	S1
27	S2
28	S3
29	S4
30	S5

de Morton Mobility Index (DEMMI) start date

Definition:

The date that the de Morton Mobility Index (DEMMI) was assessed at the beginning of the ambulatory rehabilitation episode.

Justification:

The DEMMI is an advanced instrument for accurately measuring and monitoring changes in mobility for all older adults.

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

Guide for use:

Only complete for AROC impairment codes:

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

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

For more information about this and other outcome measures used in the AROC 4.1 ambulatory dataset please refer to: https://www.uow.edu.au/ahsri/aroc/dataset/ambulatory-dataset/

de Morton Mobility Index (DEMMI) start scores

Definition:

The patient's de Morton Mobility Index (DEMMI) scores for each of the 15 assessment items at the beginning of the ambulatory rehabilitation episode.

Justification:

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

Guide for use:

Only complete for AROC impairment codes:

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

The DEMMI is administered by clinician observation of performance on 15 hierarchical mobility challenges. Record the patient's DEMMI scores for each of the assessment items at the beginning of the ambulatory rehabilitation episode.

** IMPORTANT NOTE **
The following items have a different codeset to the other items, as follows:

DEMMI Start Gait Aid
1 = nil
2 = frame
3 = stick
4 = other

DEMMI Start Lying to Sitting
DEMMI Start Sit To Stand From Chair
DEMMI Start Walking Distance
DEMMI Start Walking Independence
0 = score 0
1 = score 1
2 = score 2

Data Items:

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

Codeset values:

0	Score 0
1	Score 1

de Morton Mobility Index (DEMMI) end date

Definition:

The date that the de Morton Mobility Index (DEMMI) was assessed at the end of the ambulatory rehabilitation episode (discharge).

Justification:

The DEMMI is an advanced instrument for accurately measuring and monitoring changes in mobility for all older adults.

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

Guide for use:

Only complete for AROC impairment codes:

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

and where "Mode of episode end" = Discharged to final or interim destination.

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

de Morton Mobility Index (DEMMI) end scores

Definition:

The patient's de Morton Mobility Index (DEMMI) scores for each of the 15 assessment items at the end of the ambulatory rehabilitation episode (discharge).

Justification:

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

Guide for use:

Only complete for AROC impairment codes:

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

and where "Mode of episode end" = Discharged to final or interim destination.

The DEMMI is administered by clinician observation of performance on 15 hierarchical mobility challenges. Record the patient's DEMMI scores for each of the assessment items at the end of the ambulatory rehabilitation episode.

** IMPORTANT NOTE **
The following items have a different codeset to the other items, as follows:

DEMMI End Gait Aid
1 = nil
2 = frame
3 = stick
4 = other

DEMMI End Lying to Sitting
DEMMI End Sit To Stand From Chair
DEMMI End Walking Distance
DEMMI End Walking Independence
0 = score 0
1 = score 1
2 = score 2

Data Items:

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

Codeset values:

0	Score 0
1	Score 1

Ready for casting date

Definition: The date the treating rehabilitation physician or team deems the stump is ready for casting.

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

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.

Only complete this item if patient is prosthetic, that is: you answered 1,"Yes" to the data item, "does the patient have a prosthetic device fitted, OR will have one fitted in the future?"

If the date is known enter exact date. Use date format DD/MM/YYYY.
If casting is planned but the date is not yet known enter 07/07/7777.
If casting is not clinically appropriate enter 08/08/8888.

Amputee care start phase

Definition: The phase of amputee care the patient is in at ambulatory rehabilitation episode start (admission).

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

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.

Use the code set definitions to assist with defining of amputee phase of care at admission. Record 1 phase only.

Within the codeset:

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

Pre-prosthetic phase is the phase where a patient is discharged from acute care and enters inpatient rehabilitation program or is treated in an ambulatory setting. Postoperative assessment to review patient's status, including physical and functional assessment; completion of FIM baseline and other relevant assessments are completed. Rehabilitation goals are determined, rehabilitation treatment plan is established and updated and patient education is provided. Physical and functional interventions are provided and decisions are made on the appropriateness of a prosthesis to improve a patient's functioning and meet their rehabilitation goals.

Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. A prosthesis is prescribed based on current or potential level of ambulation. Patient receives interim or permanent prosthetic fitting and training, and early rehabilitation management. Prosthetic gait training and patient education on functional use of prosthesis for transfers, balance and safety is provided. Physical and functional interventions are provided and decisions are made on the appropriateness of a prosthesis to improve a patient's functioning and meet their rehabilitation goals.

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

Codeset values:

1	Pre-operative
2	Delayed wound
3	Pre-prosthetic
4	Prosthetic
5	Follow-up

Phase of amputee care during episode - Delayed wound?

Definition:

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

Justification:

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

Guide for use:

Collect for AROC impairment code 5 (amputation of limb) only.

Record 1, “Yes” or 2,” No” if the patient passes through the phase “delayed wound” during their rehabilitation episode.

Codeset values:

1	Yes
2	No

Phase of amputee care during episode - Pre prosthetic?

Definition:

Identifies whether the amputee patient passed through the phase “pre-prosthetic” during their rehabilitation episode. Pre-prosthetic phase is the phase where a patient is discharged from acute care and enters inpatient rehabilitation program or is treated in an ambulatory setting. Postoperative assessment to review patient’s status, including physical and functional assessment; completion of FIM baseline and other relevant assessments are completed. Rehabilitation goals are determined, rehabilitation treatment plan is established and updated and patient education is provided. Physical and functional interventions are provided and decisions are made on the appropriateness of a prosthesis to improve a patient’s functioning and meet their rehabilitation goals.

Justification:

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

Guide for use:

Collect for AROC impairment code 5 (amputation of limb) only.

Record 1, “Yes” or 2,” No” if the patient passes through the phase “pre-prosthetic” during their rehabilitation episode.

Codeset values:

1	Yes
2	No

Phase of amputee care during episode - Prosthetic?

Definition:

Identifies whether the amputee patient passed through the phase “prosthetic” during their rehabilitation episode. Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. A prosthesis is prescribed based on current or potential level of ambulation. Patient receives interim or permanent prosthetic fitting and training, and early rehabilitation management. Prosthetic gait training and patient education on functional use of prosthesis for transfers, balance and safety is provided. Physical and functional interventions are provided and decisions are made on the appropriateness of a prosthesis to improve a patient’s functioning and meet their rehabilitation goals.

Justification:

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

Guide for use:

Collect for AROC impairment code 5 (amputation of limb) only.

Record 1, “Yes” or 2,” No” if the patient passes through the phase “prosthetic” during their rehabilitation episode.

Codeset values:

1	Yes
2	No

Phase of amputee care at episode end

Definition: The phase of amputee care just before discharge from the ambulatory rehabilitation episode.

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

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.

Use the code set definitions to assist with defining of amputee phase of care at episode end (discharge). Record 1 phase only.

Within the codeset,

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

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

Pre-prosthetic phase is the phase where a patient is discharged from acute care and enters inpatient rehabilitation program or is treated in an ambulatory setting. Postoperative assessment to review patient's status, including physical and functional assessment; completion of FIM baseline and other relevant assessments are completed. Rehabilitation goals are determined, rehabilitation treatment plan is established and updated and patient education is provided. Physical and functional interventions are provided and decisions are made on the appropriateness of a prosthesis to improve a patient's functioning and meet their rehabilitation goals.

Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. A prosthesis is prescribed based on current or potential level of ambulation. Patient receives interim or permanent prosthetic fitting and training, and early rehabilitation management. Prosthetic gait training and patient education on functional use of prosthesis for transfers, balance and safety is provided. Physical and functional interventions are provided and decisions are made on the appropriateness of a prosthesis to improve a patient's functioning and meet their rehabilitation goals.

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

Codeset values:

1	Pre-operative
2	Delayed wound
3	Pre-prosthetic
4	Prosthetic
5	Follow-up

Prosthetic device fitted?

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

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

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.

Record 1, “Yes”, if they already have a prosthetic device fitted, or will have one fitted in the future.
Record 2, “No”, if there is no intention to fit a limb.

Codeset values:

1	Yes
2	No

Date of first prosthetic fitting

Definition: The date of the first interim prosthetic fitting.

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

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.

Only complete this item if patient is prosthetic, that is: you answered 1,"Yes" to the data item, "does the patient have a prosthetic device fitted, OR will have one fitted in the future?"

If date is known enter exact date. Use the date format DD/MM/YYYY.
If a prosthetic fitting is planned but the date not yet known enter 07/07/7777.
If the patient has a prosthetic device fitted but the date of fitting is not known enter 09/09/9999.

Reason for delay in first prosthetic fitting

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

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

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.

Only complete this item if patient is prosthetic, that is: you answered 1,"Yes" to the data item, "Does the patient have a prosthetic device fitted, OR will have one fitted in the future?"

If there was no delay, record 0, “No delay”.
If the reason for delay is not listed, record 6, “All other issues” and provide details in the General comments section.

Codeset values:

0	No Delay
1	Issues around wound healing
2	Other issues around the stump
3	Other health issues of the patient
4	Issues around availability of componentry
5	Issues around availability of the service
6	All other issues (to be specified in the AROC comment section)

Discharge timed up and go test

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

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

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only.

Record time in completed seconds e.g.:
If patient takes 9.3 seconds to complete TUG, record 9 seconds.
If patient takes 9.7 seconds to complete TUG, record 9 seconds.
If patient takes 1 minute 18 seconds, record 78 seconds.

If the patient is unable to complete the test or the test is non applicable for this episode of care, code 9999.

For more information about this and other outcome measures used in the AROC 4.1 ambulatory dataset please refer to: https://www.uow.edu.au/ahsri/aroc/dataset/ambulatory-dataset/

Discharge 6 minute walk test

Definition: The distance in metres achieved in the 6 minute walk test completed just before patient is discharged.

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

Guide for use: Collection is optional. Collect for AROC impairment code 5 (amputation of limb) only.

If the patient is unable to complete the test or the test is non-applicable for this episode of care, code 999.9.

For more information about this and other outcome measures used in the AROC 4.1 ambulatory dataset please refer to: https://www.uow.edu.au/ahsri/aroc/dataset/ambulatory-dataset/

10 metre walk +/- aid test start date

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

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

Guide for use: ONLY complete for AROC impairment codes:

1 (stroke)
8 (orthopaedic conditions)

and where "Was rehabilitation aimed at gait retraining" = Yes.

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

If the patient is unable to complete the 10 metre walk test, or it is not applicable for that episode of care code: 09/09/9999.

For more information about this and other outcome measures used in the AROC 4.1 ambulatory dataset please refer to: https://www.uow.edu.au/ahsri/aroc/dataset/ambulatory-dataset/

Admission 10 metre walk +/- aid test

Definition:

The time taken in completed seconds at commencement of the ambulatory rehabilitation program.

Justification:

This is a functional outcome measure. There are also population averages, which can serve as benchmarks.

Guide for use:

ONLY complete for AROC impairment codes:

1 (stroke)
8 (orthopaedic conditions)

and where "Was rehabilitation aimed at gait retraining" = Yes.

Record time in completed seconds taken for the 10 metre walk +/- aid test at episode start (admission)
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.

10 metre walk +/- aid test end date

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

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

Guide for use: ONLY complete for AROC impairment codes:

1 (stroke)
8 (orthopaedic conditions)

and where "Mode of episode end" = Discharged to final or interim destination and "Was rehabilitation aimed at gait retraining" = Yes.

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

If the patient is unable to complete the 10 metre walk test, or it is not applicable for that episode of care code: 09/09/9999.

Discharge 10 metre walk +/- aid test

Definition:

The time taken in completed seconds just before patient is discharged from the ambulatory rehabilitation program.

Justification:

This is a functional outcome measure. There are also population averages, which can serve as benchmarks.

Guide for use:

ONLY complete for AROC impairment codes:

Mandatory collection for 1 (stroke)
Mandatory collection for 8 (orthopaedic conditions).
Optional collection for 5 (amputation of limb).

and where "Mode of episode end" = Discharged to final or interim destination and "Was rehabilitation aimed at gait retraining" = Yes.

Record time in COMPLETED seconds taken for the 10 metre walk +/- aid test at episode end (discharge)
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.

Goal Attainment Scale (GAS) descriptions

Definition:

Goal Attainment Scale (GAS) descriptions - up to five rehabilitation goals can be entered.

Justification:

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

Guide for use:

Identify and describe up to five rehabilitation goals.

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

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

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

For more information about this and other outcome measures used in the AROC 4.1 ambulatory dataset please refer to: https://www.uow.edu.au/ahsri/aroc/dataset/ambulatory-dataset/

Data Items:

GAS Goal 1 Description

GAS Goal 2 Description

GAS Goal 3 Description

GAS Goal 4 Description

GAS Goal 5 Description

Goal Attainment Scale (GAS) start date

Definition:	The date that the Goal Attainment Scale (GAS) was scored at the beginning of the ambulatory rehabilitation episode (admission).
Justification:	Individual goal setting has become a routine part of rehabilitation. Goal attainment scaling is a technique which captures the extent to which individual goals for rehabilitation have been achieved. The formalised process of goal setting and defining, and agreeing expected levels of achievement with the patient and their family supports the sharing of information at an early stage of rehabilitation and the negotiation of realistic goals.
Guide for use:	Record the date that the GAS was scored at the beginning of the ambulatory rehabilitation episode (admission).

Goal Attainment Scale (GAS) start scores

Definition:

The patient's Goal Attainment Scale (GAS) scores for each of the nominated goals at the beginning of the ambulatory rehabilitation episode.

Justification:

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

Guide for use:

Record the patient's GAS scores for each of the nominated goals at the beginning of the ambulatory rehabilitation episode.

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

Data Items:

GAS Goal 1 Start Score

GAS Goal 2 Start Score

GAS Goal 3 Start Score

GAS Goal 4 Start Score

GAS Goal 5 Start Score

Codeset values:

-2	No Function
-1	Some Function

Goal Attainment Scale (GAS) end date

Definition:	The date that the Goal Attainment Scale (GAS) was scored at the end of the ambulatory rehabilitation episode (discharge).
Justification:	Individual goal setting has become a routine part of rehabilitation. Goal attainment scaling is a technique which captures the extent to which individual goals for rehabilitation have been achieved. The formalised process of goal setting and defining, and agreeing expected levels of achievement with the patient and their family supports the sharing of information at an early stage of rehabilitation and the negotiation of realistic goals.
Guide for use:	Record the date that the GAS was scored at the end of the ambulatory rehabilitation episode (discharge).

Goal Attainment Scale (GAS) end scores

Definition:

The patient's Goal Attainment Scale (GAS) scores for each of the nominated goals at the end of the ambulatory rehabilitation episode.

Justification:

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

Guide for use:

Record the patient's GAS scores for each of the nominated goals at the end of the ambulatory rehabilitation episode, with possible outcomes ranging from:

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

Data Items:

GAS Goal 1 End Score

GAS Goal 2 End Score

GAS Goal 3 End Score

GAS Goal 4 End Score

GAS Goal 5 End Score

Codeset values:

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

General comments

Definition: Comment relevant to this episode of care.

Justification: This item allows any additional information to be recorded.

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

- the tool used if the patient had a cognitive impairment which impacted on their ability to participate in rehabilitation
- the tool used if the patient had a stroke and was receiving ambulatory rehabilitation aimed at aphasia
- any further details for any 'other' code used
- any further details useful to the facility

DO NOT RECORD PATIENT NAMES HERE