Rehabilitation Medicine
Version 6
Clinical Indicator User Manual
The data collected with this User Manual are to be reported and submitted to ACHS using the ACHS Performance Indicator Reporting Tool (PIRT ONLINE) at https://pirt.achs.org.au/login.aspx

The Rehabilitation Medicine Working Party is led by Ms Frances Simmonds
Version 6 of this set of clinical indicators will be released for data collection in January 2017

Participating Colleges, Societies and Associations

Australasian Faculty of Rehabilitation Medicine

Australasian Rehabilitation Outcomes Centre

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FOREWORD

History
The Clinical Indicators in Rehabilitation Medicine were first developed by a Working Party of the Australasian Faculty of Rehabilitation Medicine (AFRM) of the Royal Australasian College of Physicians (RACP). The process of the AFRM Clinical Indicator development started in 1992 when a field review was conducted. This was followed by the drafting of Clinical Indicators in July 1994. The indicators were then field tested in 1995 and on the basis of the data comments received, the indicators were modified by the Working Party.

Version 1 of the Clinical Indicators were formally approved by the AFRM Council in May 1996 and introduced into the ACHS Evaluation and Quality Improvement Program (EQuIP) from January 1997.

Version 2 was introduced for collection in 1999 following minor changes to Version 1. During 2001 the Working Party again reviewed the indicators, amending the definition of terms and introduced the categories of facilities under which the results are collected.

Version 3 was collected from 2002 and three years later required further review. During 2005 the AFRM in consultation with the ACHS planned to conduct a major review of the Rehabilitation Medicine Indicators. However the AFRM’s Clinical Indicator Working Party was disbanded during 2005, and, early in 2006, the Australasian Rehabilitation Outcomes Centre (AROC) was asked to take over the role of advising the AFRM Council about Clinical Indicators.

AROC convened a small committee which reviewed the ACHS Rehabilitation Clinical Indicators. The proposed revisions were then circulated via the AFRM’s E-Bulletin facility to all Rehabilitation Physicians for their feedback and input. The committee considered all feedback received, and developed a revised set of recommendations which was articulated in a further discussion paper. This paper was again circulated to all Rehabilitation Physicians through the AFRM’s E-bulletin, and was also circulated to other interested stakeholders for any final comments. This process has resulted in Version 4 of the Rehabilitation Clinical Indicators.

A number of changes to the Version 3 indicators were recommended, including a change to the perspective of many of the indicators. Instead of counting when something has not happened, the Version 4 indicators require a count of when an event has happened. Two indicators have been deleted – Program Interruption and Inpatient Mortality. Two new outcome based indicators have been included - FIM Change Achieved and Discharge Destination. Version 4 of the Clinical Indicators were formally approved by the AFRM Council in February 2007 and were implemented from 1 January 2008.

AROC were pleased to be able to continue their advisory role for development of Version 5 of the Clinical Indicators. Expression of interest was sought from Faculty members in May 2011 followed by the formation of a Working Party where Version 4 was reviewed. The draft user manual of Version 5 was sent to all Rehabilitation Physicians and the AROC Scientific and Clinical Advisory Committee (SCAC), and all feedback from this circulation was incorporated.
Latest Review

The development of Version 6 of the Clinical Indicators followed a slightly different trajectory. Members of the AFRM Council and AFRM Policy & Advocacy committee formed the committee that reviewed, with input from AROC, the Version 5 indicators. These revised indicators were then sent to the AFRM college wide committee for final approval. Changes to this version have been minor, the main change being to Indicator 6, which has reverted to describing discharge destination rather than a combination of discharge destination and carer status.

Frances Simmonds
Chair, Rehabilitation Medicine Working Party
Australasian Rehabilitation Outcomes Centre
STRATIFICATION VARIABLES

The ACHS, in collaboration with relevant professional colleges, associations and specialty societies, has developed the following stratification variables to enable ‘like’ organisations to be grouped for the purpose of comparison.

Four levels of comparison are available:

- An individual organisation’s data compared to **ALL** organisations that submit data for a particular indicator
- Each individual organisation’s data compared to all other organisations submitting data within the same sector, that is, public or private
- Within the Australasian Clinical Indicator Report (published annually), data are compared by state, public/private and on a metropolitan/non-metropolitan basis. These historical data are accessible from the ‘Retrospective ACIR data in full’ tab via the following link on the ACHS website: [http://www.achs.org.au/publications-resources/australasian-clinical-indicator-report/](http://www.achs.org.au/publications-resources/australasian-clinical-indicator-report/)
- An individual organisation’s data compared to other organisations classified according to defined stratification variables for the indicator set. The criteria used to stratify an indicator set are based on the factors that the Working Party believes may impact how different healthcare organisations perform.

Organisations interested to see their data stratified against additional variables, should contact POS ([pos@achs.org.au](mailto:pos@achs.org.au)) to request the additional reports.

**Rehabilitation Medicine stratification variables**

All organisations are stratified into public / private categories and type of rehabilitation care:

- **Category 1**: Rehabilitation service provided by allied health professionals under the clinical supervision of the referring medical officer.
- **Category 2**: Rehabilitation service providing rehabilitation within a particular medical speciality such as orthopaedics, geriatrics or cardiology and is under the direction of an appropriate qualified specialist.
- **Category 3**: Rehabilitation service under the direction of a Rehabilitation Medicine Specialist and providing a full range of rehabilitation services.
REHM AREA 1: Timely assessment of function on admission

Rationale
The implementation of an effective rehabilitation program is dependent upon the early assessment of patient function. Use of a standardised assessment instrument provides a baseline from which functional improvement can be measured.

(See Background for more information)

Reporting periods
1 January – 30 June
1 July – 31 December

Inclusions
• As per numerator and denominator.

Exclusions
• Patients admitted to a rehabilitation unit / facility whose length of stay is less than 72 hours are to be EXCLUDED.

Data cleaning rules
• Nil

Suggested Data Collection
Interrogation of the AROC data set.

Definitions of terms
For the purpose of CI 1.1:

Functional assessment should include both cognitive and physical function through the use of a standardised functional assessment instrument such as FIM, WeeFIM, Barthels Index or MMSE.¹ ²

Assessment is complete when the last item of a standardised functional assessment instrument is completed and the time stamp should be the date on which this occurs. Even if the recording of this date happens on a day subsequent to the day the last item of a standardised functional assessment instrument was completed, the date recorded must be the date the last item of any assessment was completed.

AROC data indicates that more than 98% of episodes currently achieve this timeframe. Whilst the achievement of 100% is ideal, it is acknowledged that a facility / unit may not be able to achieve this. A performance benchmark of at least 90% should be the target.
**Indicator(s) within this Area**

### CI 1.1: Functional assessment within 72 hours of admission

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients admitted to a rehabilitation unit / facility for whom there is documented evidence of a functional assessment within 72 hours of patient admission, during the 6 month reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of patients admitted to the rehabilitation unit / facility with a minimum length of stay of 72 hours, during the 6 month reporting period.</td>
</tr>
</tbody>
</table>

**Desirable rate:**
- High
- Low
- Not specified

**Indicator type:**
- Structure
- Process
- Outcome

### Background

Rehabilitation medicine focuses on the prevention and reduction of functional loss due to impairment, with care being centred on the return to optimal functioning.³, ⁴ The use of appropriate assessment tools have the ability to provide a functional prognosis.⁵ The ability of healthcare professionals to make a quick prognostic decision is especially important in the current healthcare environment due to the focus on reducing patients' length of stay in hospital.⁵⁻⁷ An early assessment and prognosis of function provides the following important benefits:⁵

- setting of realistic functional goals
- facilitating appropriate discharge planning
- anticipating the need for provisions, modifications, and/or support needs

The Functional Independence Measure (FIM™) instrument and its paediatric counter-part (WeeFIM®) provides a severity of disability score through the assessment of 18 items associated with motor and cognitive function.¹, ⁸ The FIM™ is routinely collected by rehabilitation facilities / units and is used as a basis for benchmarking a patient's outcomes, and remains one of the key assessment tools recommended by the Australasian Rehabilitation Outcomes Centre (AROC).¹, ⁸ The FIM™ tool is most effective if conducted by a multidisciplinary team in an inpatient setting within 72 hours of admission.¹ The literature recommends that the FIM™ instrument be used concurrently with other tools for patients at the extreme ends of the functional spectrum (either very high functioning or very low functioning).⁹ This will facilitate the capacity to measure the significant and minimal functional progressions that can occur in these extreme populations.⁹

The Australasian Faculty of Rehabilitation Medicine (AFRM) and AROC recommends functional assessment be conducted at admission, enabling baseline data to be captured prior to an intervention, such as a rehabilitation program.⁴, ¹⁰ The AROC stipulates that the FIM™ assessment needs to be completed within 72 hours of admission, with the assessment completion being the time the last item within the FIM™ is completed.¹¹ The literature has shown a correlation between the time from injury to commencement of rehabilitation and the rehabilitation outcomes,¹², ¹³ highlighting the importance of timely functional assessment and initiation of a rehabilitation program.
References
**REHM AREA 2: Assessment of function prior to episode end**

**Rationale**
Functional assessment prior to episode end is required so that the patient’s functional improvement during the rehabilitation program can be measured. Ideally this assessment should be carried out no more than 72 hours prior to the episode end. FIM / WeeFIM is the standardised functional assessment instrument that is routinely collected by rehabilitation facilities / units and is used as a basis for benchmarking their outcomes.

*(See Background for more information)*

**Reporting periods**

1 January – 30 June

1 July – 31 December

**Inclusions**

- Patients who are transferred to a maintenance program are to be **INCLUDED**.

**Exclusions**

- Patients who die are to be **EXCLUDED**.
- Patients whose suspension of rehabilitation treatment leads to a care type change to acute care are to be **EXCLUDED**.

**Data cleaning rules**

- Nil

**Suggested Data Collection**

Interrogation of the AROC data set.

**Definitions of terms**

For the purpose of CI 2.1:

**Functional assessment** should include both cognitive and physical function through the use of a standardised functional assessment instrument such as FIM, WeeFIM, Barthels Index or MMSE.¹,²

**Assessment is complete when** the last item of any standardised assessment instrument is completed and the time stamp should be the date on which this occurs. Even if the recording of this date happens on a day subsequent to the day the last item of any standardised assessment instrument was completed, the date recorded must be the date the last item of any assessment was completed.

**Prior to episode cessation** means before the patient is discharged from the rehabilitation program, but ideally no more than 72 hours **BEFORE** the episode ends.
Area 2: Assessment of function prior to episode end

Indicator(s) within this Area

CI 2.1: Functional assessment within 72 hours before end of rehabilitation

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of inpatients for whom there is documented evidence of a completed standardised functional assessment within 72 hours prior to episode cessation of an inpatient rehabilitation program, during the 6 month reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of inpatients who cease an inpatient rehabilitation program, during the 6 month reporting period.</td>
</tr>
</tbody>
</table>

Desirable rate: High ✅ Low ☐ Not specified ☐
Indicator type: Structure ☐ Process ✅ Outcome ☐

Background

An episode is deemed to have ended in the inpatient rehabilitation setting when the patient is discharged from the rehabilitation unit, either to their final or an interim discharge destination, or there is a change in the patient’s care type, for example they are moved to palliative care. In some situations there may be a delay between when the patient is able to be discharged and when they are actually discharged due to factors such as the unavailability of a bed in a community-based facility, a change in medical stability, or unavailability of assessment or support services. The Australasian Rehabilitation Outcomes Centre (AROC) recommends functional assessment be conducted at discharge. The end of episode assessment should not be conducted more than 72 hours before discharge and will be able to provide healthcare professionals, patients and family members / carers with a comparison to the score achieved within the admission assessment. Assessment tools used prior to discharge should be selected and assessed in an individualised manner, thus monitoring the outcomes of assessment against the patient’s progress and future functional goals.

References

REHM AREA 3: Timely establishment of an initial multidisciplinary rehabilitation plan

**Rationale**

The establishment of an initial rehabilitation plan with regular review is necessary for effective patient rehabilitation. The multidisciplinary clinical team meeting is a vital component of the rehabilitation planning process. 

(See Background for more information)

**Reporting periods**

1 January – 30 June 1 July – 31 December

**Inclusions**

- As per numerator and denominator.

**Exclusions**

- Patients admitted to a rehabilitation unit / facility whose length of stay is less than 7 days are to be EXCLUDED.

**Data cleaning rules**

- Nil

**Suggested Data Collection**

Interrogation of the AROC data set.

**Definitions of terms**

For the purpose of CI 3.1:

**Rehabilitation plan** refers to a series of documented and agreed initiatives/treatments (including specified program goals and timeframes as appropriate), which has been initiated through a multidisciplinary clinical treatment team meeting led by a Rehabilitation Physician or a Physician with an interest and expertise in rehabilitation. Where appropriate, the patient (or carer) should be consulted during the planning process.
Area 3: Timely establishment of an initial multidisciplinary rehabilitation plan

Indicator(s) within this Area

CI 3.1: Multidisciplinary team plan within 7 days

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients admitted to a rehabilitation unit / facility for whom there is a documented establishment of an initial multidisciplinary rehabilitation plan within 7 days of patient admission, during the 6 month reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of patients admitted to a rehabilitation unit / facility with a minimum length of stay of 7 days, during the 6 month reporting period.</td>
</tr>
</tbody>
</table>

Desirable rate: High ☑ Low □ Not specified □
Indicator type: Structure □ Process ☑ Outcome □

Background

The quality of care provided to rehabilitation patients is optimised when multidisciplinary teams have effective communication and decision making processes. Common members of the rehabilitation multidisciplinary team include doctors, nurses and allied health staff, however the team can vary depending on the environment. The sharing of knowledge, in a structured and unstructured manner, fosters collaborative working within a multidisciplinary team and between professional specialties, and assists in the establishment of common terminology and values. The formation of the Australasian Rehabilitation Nurses’ Association (ARNA) in the early 1990s greatly influenced the development of rehabilitation as a specialty of nursing, and lead to the creation of rehabilitation nursing competency standards. Nurses can be a key player in the coordination of the team. The introduction of a structured multidisciplinary team development programme will facilitate thought being given to crucial operational components such as the meeting time, facilitator, agenda, documentation etc. which are variables that will impact upon the function of a multidisciplinary rehabilitation team.

The Australasian Faculty of Rehabilitation Medicine (AFRM) standards state that a multidisciplinary team must create a written rehabilitation plan for each patient based on the patient’s assessment at admission to the facility. The AFRM also recommends that staffing in rehabilitation units be sufficient enough in time allocation to allow for the provision of individualised programs to meet the needs of the rehabilitation patient. Patient outcomes are optimised when there is the establishment of patient-centred goals that cross many different health disciplines, rather than a discipline-centred goal. Patients who are actively involved in the rehabilitation planning process are more likely to experience positive outcomes. The rehabilitation plan can be a powerful goal setting tool that is reviewed regularly and the patient evaluated against the established plan.
Area 3: Timely establishment of an initial multidisciplinary rehabilitation plan

References

6. Davies K, Harrison K, Clouder DL et al. Making the transition from physiotherapy student to interprofessional team member. Physiotherapy 2011; 97(2): 139-144.
REHM AREA 4: Multidisciplinary discharge documentation

Rationale
An effective rehabilitation program should provide multidisciplinary discharge documentation to optimise the patient's transition to the next phase of care. The document provides effective communication to the patient as well as being an effective handover to a general practitioner and community support services (if relevant). It is vital that the discharge document is in place prior to discharge.

(See Background for more information)

Reporting periods
1 January – 30 June
1 July – 31 December

Inclusions
- As per numerator and denominator.

Exclusions
- Patients who die are to be EXCLUDED.
- Patients whose suspension of rehabilitation treatment leads to a care type change to acute care are to be EXCLUDED.

Data cleaning rules
- Nil

Suggested Data Collection
Interrogation of the AROC data set.

Definition of terms
For the purpose of CI 4.1:

Appropriate multidisciplinary discharge documentation is a document that optimises the transition of the patient from an inpatient rehabilitation unit / facility to the next phase of care and ensures effective communication with the patient and future service providers. It includes multidisciplinary documentation of the progress made by the patient during the rehabilitation program, and an indication of notification to the patient's general practitioner and community support services. The plan should be established prior to separation in consultation with the patient and/or care providers and be available at the time of patient separation.
Indicator(s) within this Area

CI 4.1: Discharge plan on separation

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of separations for which there is <strong>appropriate multidisciplinary discharge documentation</strong> for a patient, during the 6 month reporting period.</td>
<td>Number of separations, during the 6 month reporting period.</td>
</tr>
</tbody>
</table>

Desirable rate:  
- High ☑  
- Low ☐  
- Not specified ☐  

Indicator type:  
- Structure ☐  
- Process ☑  
- Outcome ☐  

**Background**

A patient is deemed ready for discharge when their rehabilitation needs have been met or can be suitably met by services other than those within the inpatient setting. A patient's ability to perform activities of daily living is often a key determinant of their suitability for discharge. The Australasian Faculty of Rehabilitation Medicine (AFRM) standards state that there must be a formal discharge procedure for rehabilitation patients. The difficulty of the patient transitioning from the hospital-based setting to the community-based setting is the continuity of documentation and assessment of outcomes. A discharge plan provides a summary of the rehabilitation provided, any medications that the patient is taking and suggested follow-up care. Patient satisfaction and ongoing quality of life can be improved through the provision of a discharge care plan. Due to the multidisciplinary nature of care for patients requiring rehabilitation, there is a large amount of planning and coordination required for care provision and the completion of logistical tasks such as the discharge process. Discharge planning will be enhanced if there is good communication and collaboration between the multidisciplinary team.

There is a growing trend in Australia of rehabilitation provision outside the hospital which can be a cost effective approach and reduce the risk of deconditioning due to long periods of hospitalisation for older adults with an acute illness. The move within health care to reduce the length of stay of patients within hospitals has also had a direct impact upon the growing need to provide patients with rehabilitation programs that can be performed in home-based settings. A patient discharge plan can assist the general practitioner to provide suitable ongoing support to the patient and has a potential to improve the overall accessibility to rehabilitation services. Supported discharge, whereby the patient is provided with outpatient services, generally increases the achievement of functionality goals and improves the patient's quality of life. The healthcare professional plays a large role in the selection of patients that are suitable for supported discharge, therefore it is important that they are adequately equipped with knowledge of the available services and their benefits, and refer patients to these services accordingly.
References

REHM AREA 5: Functional gain achieved by rehabilitation program

Rationale
Rehabilitation programs aim to provide the highest level of independence (physically, psychologically and socially) to people with loss of function or ability due to injury or disease. This indicator serves as a broad measure that the unit is achieving functional gains on behalf of their patients. FIM / WeeFIM is the standardised functional assessment instrument that is routinely collected by rehabilitation facilities / units and is used as a basis for benchmarking their outcomes.

(See Background for more information)

Reporting periods
1 January – 30 June 1 July – 31 December

Inclusions
- As per numerator and denominator.

Exclusions
- Patients who die are to be EXCLUDED.
- Patients whose suspension of rehabilitation treatment leads to a care type change to acute care are to be EXCLUDED.

Data cleaning rules
- Nil

Suggested Data Collection
Interrogation of the AROC data set.

Definition of terms
For the purpose of CI 5.1:

A completed rehabilitation program occurs when a patient finishes their program and undergoes a functional assessment prior to episode end.

Rehabilitation program refers to a multidisciplinary rehabilitation plan as documented within the patient record.

Functional gain means that the standardised functional assessment instrument used indicates a positive difference between the admission score and the score at episode end.1
Area 5: Functional gain achieved by rehabilitation program

Assessment of function should include both cognitive and physical function through the use of a standardised functional assessment instrument (such as FIM, WeeFIM, Barthels Index or MMSE). \(^1,2\)

**Indicator(s) within this Area**

**CI 5.1: Functional gain following completed rehabilitation program**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients who have completed a rehabilitation program and for whom there is documented evidence of functional gain, during the 6 month reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of patients who have completed a rehabilitation program, during the 6 month reporting period.</td>
</tr>
</tbody>
</table>

**Desirable rate:**

<table>
<thead>
<tr>
<th></th>
<th>High ☑</th>
<th>Low ☐</th>
<th>Not specified ☐</th>
</tr>
</thead>
</table>

**Indicator type:**

<table>
<thead>
<tr>
<th></th>
<th>Structure ☐</th>
<th>Process ☐</th>
<th>Outcome ☑</th>
</tr>
</thead>
</table>

**Background**

The evaluation of a rehabilitation program is important to determine if the program is meeting its objectives. The Functional Independence Measure (FIM\(^{TM}\)) gain achieved through a rehabilitation program is a strong predictor of long-term mortality risk. \(^3\) The improved ability to conduct activities of daily living and the ability to walk safely are common objectives of rehabilitation programs. \(^4\) Follow-up assessments are important to gain feedback on whether the prescribed program was firstly, completed by the patient, and secondly, effective in producing functional gains for the patient. \(^5\) There are several tools that can be utilised to evaluate a rehabilitation program. Analysis of a tool's responsiveness to genuine functional change should be a key determinant in the selection of the appropriate assessment tool for that particular patient or rehabilitation program. \(^6\) The functional gains achieved by a rehabilitation program can also be assessed through the monitoring of carer involvement required. \(^7\)

The success of a rehabilitation program can be impacted upon by developed or existing comorbidities, such as cardiac disease, drug and alcohol abuse, and respiratory disease, and complications, such as a fracture, infection, or fall. \(^7\) It is important for a healthcare professional to identify and document comorbidity and complication confounders, and monitor occasions where they may have interrupted the compliance with a rehabilitation program as it will likely impact upon the functional gain reached. \(^7\) Compliance with a rehabilitation program can also be enhanced through the forming of a meaningful relationship between the patient and the multidisciplinary team members. \(^8\)
References

REHM AREA 6: Discharge destination

Rationale
One measure of an effective rehabilitation program is that it allows the patient to return to a previous, similar or improved type of accommodation. Measuring the destination of a patient subsequent to discharge from a rehabilitation program is both an outcome measure and a quality measure.

(See Background for more information)

Reporting periods
1 January – 30 June 1 July – 31 December

Inclusions
- As per numerator and denominator.

Exclusions
- Patients who die are to be EXCLUDED.
- Patients whose suspension of rehabilitation treatment leads to a care type change to acute care are to be EXCLUDED.

Data cleaning rules
- Nil

Suggested Data Collection
Interrogation of the AROC data set.

Definition of terms
For the purpose of CI 6.1:

Destination refers to the final place that the patient will go to after the end of their rehabilitation program, for example private residence, nursing home, etc. Some patients transition through another form of accommodation prior to attaining their final private residence destination. Where there is a definite plan that the ultimate discharge destination will be a private residence within a defined timeframe, then for the purpose of this indicator, the private residence should be considered the discharge destination.

A completed rehabilitation program occurs when a patient finishes their program and undergoes a functional assessment prior to episode end.

Rehabilitation program refers to a multidisciplinary rehabilitation plan as documented within the patient record.
Area 6: Discharge destination

Indicator(s) within this Area

CI 6.1: Destination after discharge from a rehabilitation program

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients who have completed a rehabilitation program and been discharged to a previous, similar or improved type of accommodation, during the 6 month reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of patients who have completed a rehabilitation program and been discharged, during the 6 month reporting period.</td>
</tr>
</tbody>
</table>

Desirable rate: High ☑ Low □ Not specified □

Indicator type: Structure □ Process □ Outcome ☑

Background

The discharge destination is a factor that can influence a patient’s functional ability and progress following hospital discharge.¹ Some patients are deemed suitable for discharge but they require a period of time in an interim destination, possibly for further rehabilitation or whilst the final destination is appropriately prepared.² The early prediction of discharge destination generally allows for appropriate planning and preparation by the patient and carer, families members and/or support agencies.³ ⁴ Furthermore, the early determination of likely discharge destination and timing, facilitates appropriate resource allocation within the health system, which is an important benefit if resources are constrained.⁵

There is a high correlation between high Functional Independence Measure (FIM™) scores at admission and discharge to home rather than another facility.¹ Research has found that a patient’s excretion control, ability to care for themselves and transfer ability are key determinants in a patient’s suitability to be discharged to their home rather than alternate location.⁶ The presence of home support is also a strong predictor of a patient being able to be discharged home.⁷ For stroke patients it has been shown that as well as their Motor Assessment Scale (MAS) results, their residential status and age were key determinants in predicting their discharge destination.³ Home-based rehabilitation initiatives have been shown to target a broad range of conditions with good outcomes, including improvements to function and quality of life whilst remaining within the community.¹ ⁶-¹⁰ Whilst it has been reported that some healthcare professionals remain cautious regarding the outcomes that can be achieved by a home-based rehabilitation program,¹¹ recent literature reviews have found that home-based rehabilitation can have outcomes comparable, and potentially even better than, inpatient rehabilitation programs for a number of patient groups.⁹ ¹¹ It has been comprehensively demonstrated in the literature that the patients in need of rehabilitation in the home-based setting have the best outcomes when they are supported by physiotherapists and occupational therapists.⁹ A recent investigation into the use of rehabilitation in the home (RITH) in metropolitan Perth found that the main reason for readmission of patients was due to the presence of comorbidities. The study therefore recommended the careful selection of appropriate patients to RITH to improve the chances of optimal outcomes.⁸
References


APPENDICES

APPENDIX 1: ICD-10-AM Codes applicable to the Rehabilitation Medicine indicator set

REHM AREA 1: Timely assessment of function on admission
No ICD-10-AM codes identified.

REHM AREA 2: Assessment of function prior to episode end
No ICD-10-AM codes identified.

REHM AREA 3: Timely establishment of an initial multidisciplinary rehabilitation plan
No ICD-10-AM codes identified.

REHM AREA 4: Multidisciplinary discharge documentation
No ICD-10-AM codes identified.

REHM AREA 5: Functional gain achieved by rehabilitation program
No ICD-10-AM codes identified.

REHM AREA 6: Discharge destination
No ICD-10-AM codes identified.
APPENDIX 2: NSQHS Standards / EQuIPNational and these clinical indicators

The use of clinical indicators by healthcare organisations supports quality oversight and provides a foundation for quality improvement within the organisation and its departments. The monitoring of clinical indicators and an organisation’s response to the data remain an important option for presenting evidence to demonstrate performance against criteria in the NSQHS Standards and EQuIPNational.

Actions from EQuIPNational (including NSQHS Standards, where applicable) that may be evidenced with these Rehabilitation Medicine CIs are outlined in the appendix.

<table>
<thead>
<tr>
<th>STANDARD 1: GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criterion: Governance and quality improvement systems</td>
</tr>
<tr>
<td>Action 1.2.1</td>
</tr>
<tr>
<td>Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance.</td>
</tr>
<tr>
<td>Relevant CIs from this set: ALL REHM CIs</td>
</tr>
<tr>
<td>Action 1.2.2</td>
</tr>
<tr>
<td>Action is taken to improve the safety and quality of patient care.</td>
</tr>
<tr>
<td>Relevant CIs from this set: ALL REHM CIs</td>
</tr>
<tr>
<td>Action 1.5.2</td>
</tr>
<tr>
<td>Actions are taken to minimise risks to patient safety and quality of care.</td>
</tr>
<tr>
<td>Relevant CIs from this set: ALL REHM CIs</td>
</tr>
<tr>
<td>Action 1.6.1</td>
</tr>
<tr>
<td>An organisation-wide quality management system is used and regularly monitored.</td>
</tr>
<tr>
<td>Relevant CIs from this set: ALL REHM CIs</td>
</tr>
<tr>
<td>Action 1.6.2</td>
</tr>
<tr>
<td>Actions are taken to maximise patient quality of care.</td>
</tr>
<tr>
<td>Relevant CIs from this set: ALL REHM CIs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STANDARD 11: SERVICE DELIVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criterion: Appropriate and effective care</td>
</tr>
<tr>
<td>Action 11.5.1</td>
</tr>
<tr>
<td>The organisation ensures appropriate and effective care through:</td>
</tr>
<tr>
<td>• processes used to assess the appropriateness of care</td>
</tr>
<tr>
<td>• an evaluation of the appropriateness of services provided</td>
</tr>
<tr>
<td>• the involvement of clinicians, managers and consumers / patients in the evaluation of care and services.</td>
</tr>
<tr>
<td>Relevant indicators from this CI set: ALL REHM CIs</td>
</tr>
</tbody>
</table>
## STANDARD 12: PROVISION OF CARE

### Criterion: Assessment and care planning

<table>
<thead>
<tr>
<th>Action 12.2.1</th>
<th>The assessment process is evaluated to ensure that it includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• timely assessment with consumer / patient and, where appropriate, carer participation</td>
</tr>
<tr>
<td></td>
<td>• regular assessment of the consumer / patient need for pain / symptom management</td>
</tr>
<tr>
<td></td>
<td>• provision of information to the consumer / patient on their health status</td>
</tr>
<tr>
<td></td>
<td>Relevant indicators from this CI set:</td>
</tr>
<tr>
<td></td>
<td><strong>REHM CI 1.1</strong>: Functional assessment within 72 hours of admission</td>
</tr>
<tr>
<td></td>
<td><strong>REHM CI 2.1</strong>: Functional assessment within 72 hours before end of rehabilitation</td>
</tr>
</tbody>
</table>

### Criterion: Ongoing care and discharge / transfer

| Action 12.8.1 | Discharge / transfer information is discussed with the consumer / patient and a written discharge summary and / or discharge instructions are provided. |
| Action 12.8.2 | Arrangements with other service providers and, where appropriate, the carer are made with consumer / patient consent and input, and confirmed prior to discharge / transfer of care. |
| Action 12.10.1 | Formal processes for timely, multidisciplinary care coordination and / or case management for consumers / patients with ongoing care needs are evaluated, and improved as required. |

### Relevant indicators from this CI set:

| **REHM CI 4.1**: Discharge plan on separation |

## STANDARD 14: INFORMATION MANAGEMENT

### Criterion: Collection, use and storage of information

<table>
<thead>
<tr>
<th>Action 14.6.1</th>
<th>Monitoring and analysis of clinical and non-clinical data and information occurs to ensure:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• accuracy, integrity and completeness</td>
</tr>
<tr>
<td></td>
<td>• the timeliness of information and reports</td>
</tr>
<tr>
<td></td>
<td>• that the needs of the organisation are met and improvements are made as required.</td>
</tr>
<tr>
<td></td>
<td>Relevant CIs from this set:</td>
</tr>
<tr>
<td></td>
<td><strong>ALL REHM CIs</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action 14.7.1</th>
<th>The organisation uses data from external databases and registers for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• research</td>
</tr>
<tr>
<td></td>
<td>• development</td>
</tr>
<tr>
<td></td>
<td>• improvement activities</td>
</tr>
<tr>
<td></td>
<td>Relevant CIs from this set:</td>
</tr>
<tr>
<td></td>
<td><strong>ALL REHM CIs</strong></td>
</tr>
</tbody>
</table>
### Appendices

- education
- corporate and clinical decision making
- improvement of care and services.
APPENDIX 3: Changes to the user manual from the previous version

The Rehabilitation Medicine Working Party convened in May 2016 and conducted a series of consultations, resulting in the revised set of Rehabilitation Medicine Clinical Indicators (CIs) version 6.

The six CIs in the previous Rehabilitation Medicine set v5 were organised into six areas:
1. Timely assessment of function on admission
2. Assessment function prior to episode end
3. Timely establishment of a multidisciplinary team rehabilitation plan
4. Multidisciplinary discharge documentation
5. Functional gain achieved by rehabilitation program
6. Discharge destination

Rehabilitation Medicine version 6

In version 6, the Rehabilitation Medicine Working Party has decided to retain the six areas. The Working Party reviewed the CIs to ensure they continued to be current, relevant and collectable. A background section has now been provided for each area to build on the rationale for why these CIs were selected.

The following actions were taken in the revision of the Rehabilitation Medicine CIs:

REHM AREA 1: Timely assessment of function on admission

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1: Functional assessment within 72 hours of admission</td>
<td>Retained</td>
</tr>
</tbody>
</table>

REHM AREA 2: Assessment of function prior to episode end

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1: Functional assessment within 72 hours before end of rehabilitation</td>
<td>Retained</td>
</tr>
</tbody>
</table>

REHM AREA 3: Timely establishment of an initial multidisciplinary rehabilitation plan

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1: Multidisciplinary team plan within 7 days</td>
<td>Retained</td>
</tr>
</tbody>
</table>

REHM AREA 4: Multidisciplinary discharge documentation

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1: Discharge plan on separation</td>
<td>Retained</td>
</tr>
</tbody>
</table>
## REHM AREA 5: Functional gain achieved by rehabilitation program

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1: Functional gain following completed rehabilitation program</td>
<td>Retained</td>
</tr>
</tbody>
</table>

## REHM AREA 6: Discharge destination

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1: Destination after discharge from a rehabilitation program</td>
<td>Revised</td>
</tr>
</tbody>
</table>