

Appendices

Appendix A – List of randomised controlled trials

Study	NHMRC Level	Article	Focus of study(s)	Major variables	Outcome measures used
1 (review of seven RCTs)	1	(Anderson et al., 2002)	Review of studies of cost effectiveness	Cost effectiveness	Hospital LOS Mortality Institutionalisation Various activity measures Readmission rates Resource use – hospital stay and rehabilitation and community services
2	2	(Anderson et al., 2000a)	Home-based rehabilitation for stroke in 2 hospitals in Adelaide, South Australia	Quality of life Activity Mental status Activities General health Carer strain Patient and carer satisfaction Cost	36 item short form questionnaire (SF-36) Nottingham Health Profile Modified Barthel Index (MBI) Mini Mental Status Examination (MMSE) General Health Questionnaire (GHQ) – 28 Adelaide Activities Profile (AAP) McMaster Family Assessment Device (MFAD) Caregiver Strain Index (CSI) Satisfaction surveys Cost – see Appendix B
		(Anderson et al., 2000b)			
3	2	(Rudd et al., 1997)	Home-based rehabilitation for stroke in London, UK	Impairment Activity Anxiety and depression Participation restriction Carer strain Patient and carer satisfaction	BI Motoricity index MMSE Frenchay aphasia screening test Rivermead ADL HADS 5m walk Nottingham Health Profile CSI Patient and carer satisfaction questionnaires Cost – see Appendix B
		(Beech et al., 1999)			

Study	NHMRC Level	Article	Focus of study(s)	Major variables	Outcome measures used
4	2	(Crotty et al., 2002)	Home-based rehabilitation for hip fracture in Adelaide, South Australia	Balance and falls Participation restriction Carer strain Carer satisfaction Service use Readmissions	SF-36 MMSE MBI Timed up and go Berg Balance Scale Activities-specific Balance Confidence Scale Falls Efficacy Scale London Handicap Scale CSI Patient and carer interviews Use of community services Incidence of readmissions and falls
5	2	Fjeartoft et al 2003	Extended stroke unit service incorporating early supported discharge compared with ordinary stroke unit service	ADL Residence	Barthel Index Rankin Scale – modified Change in residence
6	2	(J. R. F. Gladman & Lincoln, 1994) (J. R. F. Gladman et al., 1994)	DOMINO stroke program, UK	Activity Cognitive status Carer life satisfaction and social engagement Mortality Residence Cost	BI AMTS Nottingham Health Profile Carer – Brief Assessment of Social Engagement and the Nottingham Version of the Life Satisfaction Index Mortality Place of residence Cost – see table 7
6+7	2	(J. Gladman, Forster, & Young, 1995)	DOMINO stroke program and Bradford Community Stroke Trial (BCST)	As above for DOMINO and as below for BCST.	
8	2	(Young & Forster, 1992)	Bradford Community Stroke Trial, UK	Activity Carer stress Level of treatment and community care provision	BI Motor Club Assessment Frenchay Activities Index Nottingham Health Profile Carer stress – GHQ Level of treatment and community care provision
9	2	(Indredavik et al., 2000)	Extended Stroke Unit Service, Norway	Global independence ADL independence Residence Mortality Cost	BI Rankin Scale LOS in institutions Cost – see Appendix B

Study	NHMRC Level	Article	Focus of study(s)	Major variables	Outcome measures used
10	1	Legg et al 2004	Review to assess the effects of therapy based rehabilitation services targeted toward stroke patients resident in the community 1 year post stroke	ADL	
11	2	(Mayo et al., 2000)	Home-based rehabilitation for stroke, Canada	Physical health Mobility Activity Instrumental ADL Mental health Community reintegration Health related QOL	Physical and mental health components of the SF-36 Timed up and go BI Older Americans' Resource Scale for IADL RNL
12	1	Outpatient Service Trialists. 2004	Systematic review completed to assess the effects of therapy based rehabilitation services targeted towards stroke patients resident in the community	PADL	
13	2	Patel et al 2004	Primarily cost effective and cost utility analyses comparing stroke unit/ stroke team and domicillary services	Costs Quality of life Functional measures	BADL EQ-5D
14	2	Ricauda et al 2004	Home based V general medical ward treatment for elderly patients with acute uncomplicated stroke	Survival rate Function Neurological impairment Depression Morbidity Admission to rehabilitation and long term care facilities	Co-morbidities e.g. HT, COAD Hematocrit, blood glucose, serum creatinine concentration and BP. FIM Canadian Neurological scale Modified National institutes of Health Stroke Scale Geriatric Depression scale Chart review for e.g. morbidities such as UTI, catheterization, pneumonia, pressure sores

Study	NHMRC Level	Article	Focus of study(s)	Major variables	Outcome measures used
15	2	(Rodgers et al., 1997)	Home-based rehabilitation for stroke, UK	Hospital LOS ADL Participation restriction Depression General health Carer stress Mortality Residence Readmissions	Nottingham Extended ADL scale Oxford Handicap Scale Wakefield Depression Inventory Dartmouth COOP Function Charts Carers – GHQ
16	2	(Ronning & Guldvog, 1998)	Hospital rehabilitation compared with municipal health services, Norway	Activity Impairment Mortality Dependence in ADL Quality of life Hospital LOS	BI Scandinavian Stroke Scale
17	2	(Shepperd, Harwood, Jenkinson et al., 1998) (Shepperd, Harwood, Gray et al., 1998)	Hospital treatment compared with hospital at home, UK	General health Activity Impairment Hospital readmissions Carer strain Patients and carers preferences Mortality Cost	Dartmouth COOP chart SF-36 BI Oxford Hip Score Bristol Knee Score CSI Cost – see Appendix B
18	2	Teng et al 2003	Hospital treatment compared with early supported discharge for stroke clients	Cost Care giver burden	Caregiver Burden index Cost
19	1	Teasel et al 2003	Review to assess the effectiveness of early supported discharge	Function Cost Hospital LOS	
20	1	Ward et al 2004	Review to compare the effects of care home environments versus hospital environments and own home environments	Function (personal and instrumental ADL) Subjective health status QoL Residence Mortality Adverse effects Re-admission rates Patient and Carer satisfaction Number of days in target service	

Study	NHMRC Level	Article	Focus of study(s)	Major variables	Outcome measures used
21	2	(von Koch, Widén Holmqvist, Kostulas, Almazan, & de Pedro Cuesta, 2000) (Widen Holmqvist et al., 1998) (von Koch, de Pedro-Cuesta, Kostulas, Almazan, & Widen Holmqvist, 2001)	Home-based rehabilitation for stroke, Sweden	Motor capacity ADLs Social activities Perceived dysfunction Mortality Falls Cost	Lindmark Motor Capacity Index Time to walk 10m Nine-hole peg test Scandinavian Stroke Scale MMSE BI Katz ADL Frenchay Activities Index Sickness Impact Profile Sense of Cohesion Questionnaire Cost – see Appendix B

Appendix B – Studies of cost effectiveness

Study	Hospital costs	Home costs	Study findings
(Anderson et al., 2000b)	Direct & indirect staff costs Community services % of overheads	Direct & indirect staff costs Aids and adaptations Community services Residential care costs Carer time	Reduced LOS. Increased informal care costs. Home-based rehabilitation no less costly.
Andersson et al., 2002	Hospital costs of acute and rehabilitation stays. Nursing home and home help services.	Hospital costs of acute and rehabilitation stays. Nursing home and home help services	Reduced LOS in acute care for home rehab. group. Rehab costs significantly lower in home-based group but cost of home-help was higher in the home-based group. Total costs for the care episode did not differ significantly for the 2 groups.
(Beech, Rudd, Tilling, & Wolfe, 1999)	Units of therapy Direct and indirect client attributable time Contacts with GPs and other medical practitioners Service use	Units of therapy Direct and indirect client attributable time Contacts with GPs and other medical practitioners Service use	Reduced inpatient costs but higher non-inpatient costs. Early discharge is unlikely to lead to financial savings but can increase throughput.
(Farnworth et al., 1994)	Average bed day costs on orthopaedic ward adjusted for client dependency.	Hospital costs. Staff time, use of medical goods, office space and travel time, excluding those services that would have been supplied in the absence of the program.	Reduced LOS.
(J. R. F. Gladman, Whynes, & Lincoln, 1994)	Direct costs for day hospital and outpatient rehabilitation –plus a share of the hospital overhead costs and ambulance travel costs.	Gross employment costs of therapists plus vehicle running costs.	Overall hospital-based services cheaper but day hospital care cost 25% more than domiciliary care and domiciliary care cost 2.6 times more than outpatient care.
(Indredavik et al., 2000)	LOS	LOS in hospital	Reduced LOS No overall cost analysis
(Mayo et al., 2000)	Bed days Number of therapy sessions Service use Outpatient usage	Bed days Number of therapy sessions Service use Outpatient usage Cost of home rehabilitation service	Reduced LOS No overall cost analysis

Study	Hospital costs	Home costs	Study findings
Patel et al 2004	Hospital resource use Therapy inputs	Costs of medical investigations or readmissions to hospital or other medical resources required Costs of therapy staff and voluntary sector services Costs of social services Informal care costs (2 ways – minimum wage and social services home help worker)	Most expensive – stroke unit; Least expensive domiciliary service. Although better functional outcomes with stroke unit care. A third to half costs can be attributed to informal care
(Rodgers et al., 1997) (McNamee et al., 1998)	Per day inpatient costs adjusted for dependency Staff costs per hour (including % of overheads) Community services	Per day inpatient costs adjusted for dependency Staff costs per hour (including % of overheads) Community services	Reduced LOS. Additional costs of home supports countered by reduced LOS
(Ronning & Guldvog, 1998)	LOS	Hospital LOS and community services	Reduced LOS No overall cost analysis
(Shepperd, Harwood, Gray et al., 1998a)	Direct and indirect staffing costs, non-staffing costs, including equipment and pharmaceuticals, and capital costs, adjusted for client dependency. GP costs Carer costs	Staffing and non-staffing running costs – including direct client contact, non-contact time. Administration, travel, medication, and equipment. GP costs Carer expenditure, loss of earnings and time caring for client.	No difference for hip or knee replacement or elderly medical clients. H@H increased cost for hysterectomy and COAD clients. Increased GP costs for hysterectomy and COAD clients.
Teng et al 2003		Hospital, physician and home care services. ED admissions To note, care giver cost not considered Home therapy staff (on rate as if employed by acute care hospital)	Providing care at home was no more (or less) expensive for those with greater functional limitation than for those with less. ESD is a cost effective alternative to conventional hospital procedures for stroke patients. This arises primarily from a reduction in hospital LOS. Fewer resources are expended to obtain a better clinical result freeing up resources for other patients
(Widén Holmqvist et al., 1996)	Bed days	Staffing costs, medication, technical aids, home adaptations, transport, home help, and cost of carer time.	Reduced LOS. Home-based rehabilitation less expensive.

LOS = Length of stay in hospital for intervention group.

Appendix C – Objectives, data collection strategies, and data analysis techniques

Objectives	Data collection strategies	Data analysis techniques
<p>1a) To gain a profile of the main client groups involved in home-based rehabilitation.</p> <p>1b) To investigate the following practices in home-based rehabilitation</p> <ul style="list-style-type: none"> - Referral and assessment - Goal setting and review - Continuity of care pathways from inpatient rehabilitation setting to leaving rehabilitation. - Interdisciplinary teamwork - Frequency of rehabilitation interventions and the disciplines involved - Type and frequency of other services supplied by the rehabilitation service. - Current outcome measures <p>1c) To ascertain when and why people are referred to centre-based rehabilitation from either home-based or inpatient rehabilitation</p>	<p>1a) Complete client profile. Demographic data collection on project participants (clients).</p> <p>1b) Focus group interviews with staff from participating programs.</p> <p>Survey of inpatient teams who refer to participating programs</p> <p>Service provision data collected about all participating clients.</p> <p>Outcome measure survey</p> <p>1c) Focus groups with home-based and inpatient rehabilitation staff.</p> <p>Data from discharge sheets.</p>	<p>1a) Frequency of clients with each diagnostic condition and study response rate.</p>
<p>2a) Review the existing literature comparing the effectiveness of home-based rehabilitation with inpatient rehabilitation.</p> <p>2b) To compare LOS in inpatient rehabilitation with LOS in inpatient and/or home-based rehabilitation.</p> <p>2c) To compare length of “episode of care” with the different service configurations for similar client groups.</p> <p>2d) To investigate the outcomes achieved by the different models of rehabilitation at the completion of the inpatient and/or home rehabilitation episode using comparable groups and at three months following completion of rehabilitation in terms of:</p> <ul style="list-style-type: none"> - Client goals 	<p>2a) Literature review</p> <p>2b) Data collection on project participants (clients).</p> <p>2c) As for 2b) above</p> <p>2d) see below</p> <p>Completed client goal sheets and client</p>	

Objectives	Data collection strategies	Data analysis techniques
<ul style="list-style-type: none"> - Functional outcomes - Carer demand - Client and carer satisfaction 	<p>interviews</p> <p>BI or FIM on admission, discharge and 3m follow-up</p> <p>HART on admission, discharge and 3m follow-up</p> <p>Timed up and go on admission, discharge and 3m follow-up</p> <p>Domestic functioning assessment in activities of daily living on admission, discharge and at 3m follow-up.</p> <p>Caregiving Demand Scale (CDS) on admission, discharge and 3m follow-up</p> <p>Client/carers satisfaction survey on discharge.</p>	
<p>3a) To identify the factors that are associated with best outcomes for clients according to the measures outlined in 2d) above.</p> <p>3b) To explore the perceptions of home-based rehabilitation clients, carers and staff about best practice in home-based rehabilitation.</p>	<p>3a) Statistical analysis of the data collected about client and carer outcomes, their demographic data, and the data collected about service type, length and frequency.</p> <p>3b) Focus group interviews with home-based and inpatient rehabilitation staff.</p> <p>In-depth interviews with clients and carers.</p>	

Appendix D – Participant Information and Consent Form

NATIONAL AGEING RESEARCH INSTITUTE

Incorporated A0029603G

Poplar Road Parkville Victoria 3052 Australia
PO Box 31 Parkville Victoria 3052 Australia
ABN 17 203 790 712



Director Professor Allan McLean

Phone 61 3 8387 2148 Facsimile 61 3 9387 4030
Email info@nari.unimelb.edu.au
<http://www.nari.unimelb.edu.au/>

PARTICIPANT INFORMATION FORM (CLIENT)

You are invited to be part of a research project about hospital and home-based rehabilitation. The aim of the project is to evaluate a number of different types of rehabilitation services in Victoria to see which ones work best for people like yourself.

To do this the staff working in the rehabilitation service that you are involved in will be asked to collect some information about you. The information will include things like your date of birth, living arrangements and gender. This information will be sent to a research team at the National Ageing Research Institute (NARI) which is based in Parkville in Melbourne. Your name and phone number will also be passed on so that the researchers can contact you later and organise to come and see you. The rehabilitation service staff will also collect information about how you are managing with your day to day activities, such as walking, cooking a meal, getting dressed and shopping for groceries.

You and your carer (if you have one) will also be asked to fill in some forms and send them in to the NARI research team. These will include questions about your quality of life, your rehabilitation goals and the sorts of things that your carer is doing for you at the moment.

All this information will be collected when you are first admitted to the rehabilitation service and again when you are discharged. At discharge you will also be asked to fill in a form about how satisfied you are with the service.

The next step will involve a visit from one of the NARI researchers three months after you have been discharged from the home-based rehabilitation program. Either Briony, Kirsten or Fiona will contact you and arrange to come and visit you at your home to complete some more forms. These forms will be the same as those completed by the staff when you were first admitted to the program. The information gathered from these forms will show how much you have improved since you were first admitted to rehabilitation and whether your progress has been sustained over time. This visit will take about an hour.

Finally, you may be asked to participate in an interview with the NARI researchers to discuss your experiences of rehabilitation. This would take about 30 minutes and would be done at the same time as the visit described above.

Although your name and address will be collected and passed on to the researchers at NARI, this is only so that they can piece together your initial information with the information collected later and so they can contact you to arrange a visit. This information will not be passed on to anyone else (except as required by law) and it will be kept in a locked filing cabinet or in a password protected computer program. If you give us your permission by signing the consent form we plan to share, discuss and publish the results with the public. However, the information will only be provided in a way that you cannot be identified.

We do not expect that there will be any risks to you as a result of being part of this project but you could find talking about your rehabilitation experiences causes you some discomfort. The NARI researchers are all qualified and experienced interviewers and will be able to provide you with support and information if you need it. You can also choose to stop the interview at any time.

We would really like you to be part of this project as your participation will help us to find out more about what is the most effective way to provide rehabilitation services. The information collected from this project will be passed on to the Department of Human Services so that they can use it to develop rehabilitation services in the future.

If you would like any further information about this project or if you have any problems with your participation in the project you can contact any one of the NARI research team listed below.

Briony Dow (principal researcher)	8387 2377
Fiona Bremner	8387 2169
Kirsten Black	8387 2666

If you have any complaints about the project you can speak to the Secretary of the Ballarat Health Services Human Research Ethics Committee Dr Ian Graham on 5320 4278.

Participation in research is voluntary. If you do not wish to take part you do not have to and you can withdraw your consent at any time. Whether or not you choose to be part of this project will not affect your involvement in the rehabilitation service.

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PARTICIPANT INFORMATION form (Carer)

As a carer for someone who is currently a client of a rehabilitation service, you are invited to be part of a research project about hospital and home-based rehabilitation. The aim of the project is to evaluate a number of different types of rehabilitation services in Victoria to see which ones work best.

If you decide to participate in this project, you will be asked to complete a form that asks about the sorts of things that you are doing for your friend or relative. This form will be sent to you three times - at the beginning and the end of the rehabilitation program and three months after discharge. You will be asked to send these forms to a research team at the National Ageing Research Institute (NARI) which is based in Parkville in Melbourne. Your name and address will be included in the information collected from you so that the researchers can contact you later and organise to come and see you. When your friend or relative is discharged from the rehabilitation service, you will also be asked to fill in a form about how satisfied you are with the service.

Finally, three months after your friend or relative has been discharged from the home-based rehabilitation program, you may be asked to participate in an interview with the NARI researchers to discuss your experiences of rehabilitation. This would take about 30 minutes and will be arranged at a time that is convenient to you.

Although your name and address will be collected and passed on to the researchers at NARI, this is only so that they can piece together your initial information with the information collected later and so they can contact you to arrange a visit. This information will not be passed on to anyone else (except as required by law) and it will be kept in a locked filing cabinet or in a password protected computer program. If you give us your permission by signing the consent form we plan to share, discuss and publish the results with the public. However, the information will only be provided in a way that you cannot be identified.

We do not expect that there will be any risks to you as a result of being part of this project but you could find talking about your rehabilitation experiences causes you some discomfort. The NARI researchers are all qualified and experienced interviewers and will be able to provide you with support and information if you need it. You can also choose to stop the interview at any time.

We would like you to be part of this project as your participation will help us to find out more about what is the most effective way to provide rehabilitation services and how much carers are doing for home and hospital rehabilitation clients. The information collected from this project will be passed on to the Department of Human Services so that they can use it to develop rehabilitation services in the future.

If you would like any further information about this project or if you have any problems with your participation in the project you can contact any one of the NARI research team listed below.

Briony Dow (principal researcher)	8387 2377
Fiona Bremner	8387 2169
Kirsten Black	8387 2666

If you have any complaints about the project you can speak to Secretary of the Ballarat Health Services Human Research Ethics Committee Dr Ian Graham on 5320 4278.

Participation in research is voluntary. If you do not wish to take part you do not have to and you can withdraw your consent at any time. Whether or not you choose to be part of this project will not affect your or your friend or relative's involvement in the rehabilitation service.

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Consent Form

Version 2 Dated 8/8/03

Site: Ballarat Health Services – Rehabilitation in the Home Program

**Full Project Title: Evaluation of home based rehabilitation services
Victoria – with 3 month follow up**

I have read, or have had read to me in my first language, and I understand the Participant Information Form (Client) or Participant Information (Carer) (delete whichever is not applicable) dated 8/8/2003.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant's Name (printed)

Signature _____ Date _____

Name of Witness to Participant's Signature (printed)

Signature _____ Date _____

Researcher's Name (printed)

Signature _____ Date _____

Note: All parties signing the Consent Form must date their own signature.

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Third Party Acknowledgement Form

Version 2 Dated 8/8/03

Site: Ballarat Health Services – Rehabilitation in the Home Program

**Full Project Title: Evaluation of Home based rehabilitation services
Victoria – with 3 month follow up**

I have read, or have had read to me in my first language, and I understand the Participant Information Form (Client) dated 8/8/2003.

I acknowledge that the researchers would like to enrol _____
in the research project named above, according to the conditions in the
Participant Information.

I will be given a copy of Participant Information and Third Party
Acknowledgment Form to keep.

The researcher has agreed not to reveal _____
identity and personal details if information about this project is published or
presented in any public form.

Participant's Name (printed) _____

Name of Person providing Third Party Acknowledgment (printed) _____

Relationship to participant: _____

Signature

Date

Witness to Signature (printed) _____

Signature

Date

Researcher's Name (printed) _____

Signature

Date

Note: All parties signing the Consent Form must date their own signature.

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Revocation of Consent Form

Full Project Title: Evaluation of Home based rehabilitation Services Victoria – with 3 month follow up

I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise any treatment or my relationship with Ballarat Health Services.

Participant's Name (printed) _____

Signature

Date

Appendix E - Outcome measures used by each home-based rehabilitation service

	Health and Function measures							Balance					Gait		Muscle Strength			Nutrition	Home ax
	Barthel	FIM	SMAF	COPM	RNL	HART	GDS	CTSIB	Step test	Functional reach	Timed Up & Go	BBS	Velocity	Stride length	Oxford Scale	Timed stand/sit	Dyno	BMI	Home FAST
Angliss Health Service	✓	✓	-	◆	✓	-	-	◆	✓	✓	✓	-	◆	◆	✓	✓	◆	✓	-
Ballarat Health Services	✓	✓	-	✓	◆	-	◆	-	-	-	-	-	-	-	-	-	-	◆	-
Barwon Health	-	✓	✓	◆	-	-	-	◆	◆	-	◆	-	◆	-	◆	-	◆	✓	-
Broadmeadows Health Service	✓	✓	-	◆	-	-	-	-	✓	◆	✓	-	✓	✓	✓	✓	-	-	-
Bundoora Extended Care Centre*	✓	✓	-	-	-	-	-	◆	✓	✓	◆	-	✓	✓	✓	✓	-	-	-
Caulfield General Medical Centre	-	✓	#	-	-	-	◆15	-	-	-	✓	-	-	-	◆	-	◆	✓	-
Lyndoch Warrnambool Inc.	-+	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	◆	-	-
Melbourne Health	✓	✓	-	✓	-	-	-	-	◆	◆	◆	-	◆	◆	◆	-	-	◆	-
Peter James Centre	◆	-	-	-	-	-	-	-	✓	◆	◆	-	✓	-	✓	◆	◆	✓	-
Peninsula Health	✓	✓**	✓**	◆	-	-	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	-	◆
Royal Talbot Rehabilitation Centre	✓	✓	-	-	-	-	-	✓	◆	-	◆	-	◆	◆	✓	◆	◆	✓	-
Kingston Centre	✓	-	-	✓	-	-	-	✓	✓	◆	✓	-	✓	✓	✓	-	✓	✓	-
St Vincent's Hospital	-	✓	-	-	-	-	-	◆	◆	-	✓	-	✓	✓	✓	-	-	-	-
Sunshine Hospital	✓	✓	-	✓	-	◆	◆	✓	✓	◆	✓	-	✓	✓	✓	-	-	-	-
Wangaratta District Health Service	✓	◆	-	◆	-	-	◆15	✓	✓	◆	✓	◆	✓	✓	✓	-	-	-	-
Wodonga Regional Health Service	✓	◆	-	◆	-	-	◆	◆	◆	◆	◆	-	◆	◆	✓	◆	◆	✓	-

	Health and Function measures							Balance					Gait		Muscle Strength			Nutrition	Home ax
	Barthel	FIM	SMAF	COPM	RNL	HART	GDS	CTSIB	Step test	Functional reach	Timed Up & Go	BBS	Velocity	Stride length	Oxford Scale	Timed stand/sit	Dyno	BMI	Home FAST
Wonthaggi District Hospital	◆	✓	-	-	-	-	◆15	-	-	-	-	-	-	-	◆	-	◆	-	-

Notes: ✓ Outcome measure used on a routine basis at admission and discharge. ◆ Outcome measure used only when required.

*Continuity of Care Program; #CGMC has been using the SMAF for the past six months but stopped data collection on 27/12/02; **currently trialing; +used to use.

FIM: Functional Independence Measure; SMAF: Functional Autonomy Measurement System; COPM: Canadian Occupational Performance Measure; RNL: Reintegration to Normal Living Index; HART: Handicap Assessment Resource Tool; GDS: Geriatric Depression Scale; CTSIB: Clinical Test of Sensory Integration of Balance; BBS: Berg Balance Scale; BMI: Body Mass Index; Home FAST: Home Falls and Accident Screening Tool

Appendix F - Description of measures used in this study

Scale	Barthel Index	Handicap Assessment and Resource Tool	Domestic Functioning Assessment in Activities of Daily Living	Care-giving demand scale	Assessment of health related quality of life	Client and carer satisfaction survey	Timed Up and Go
Reference	Mahoney & Barthel 1965; Wade & Collin 1988	Vertaisi and Darzins et al 2000	Eagar, Owen et al., 2001. Modified from Lawton and Brody, 1969	Oberst et al, 1989	Hawthorne et al, 1999	Dow, 1999	Podsiadlo and Richardson 1991
ICF level	Activity Limitation	Participation restriction	Activity limitation	Environmental factor	Personal factor	N/A	Impairment
Purpose	To assess ability to perform personal care and mobility tasks.	To measure personal care participation restriction.	Developed for HACC users to assess community clients	Designed to measure care-giving demand "by obtaining ratings of the time and energy devoted to 10 common caregiving activities" (Kinsella et al, 1998, p.40)	To measure health related quality of life and gains associated with health care interventions.	To measure satisfaction with rehabilitation services	Measures speed during several manoeuvres which potentially threaten balance (Podsiadlo & Richardson 1991)
Application	Trained health professional. Direct observation, interview, telephone or via medical records. Takes 2-5 minutes to administer, or can be self administered in about 10 minutes	Trained health professional. Completed by asking the client and their carer about the client's level of functioning. Takes approx 40 minutes if using full assessment. Takes between 2-5 minutes to complete summary sheet using information obtained via standard clinical assessment.	Interview (trained interviewer) Takes 5 minutes (Burns et al. 1999)	Self report Simple to administer and score (Kinsella et al, 1998)	Designed for self administration however able to be administered via telephone, direct interview or completion by proxy (e.g. caregiver). Takes approximately 10 – 15 minutes to complete via self report.	Takes approximately 5 minutes to complete. Self administered questionnaire.	Administered by physiotherapist or other trained health professional. Takes approximately 3 minutes

Scale	Barthel Index	Handicap Assessment and Resource Tool	Domestic Functioning Assessment in Activities of Daily Living	Care-giving demand scale	Assessment of health related quality of life	Client and carer satisfaction survey	Timed Up and Go
Items	Several versions exist: original 10 items; modified 10 items proposed by Collin et al. (1988); expanded 15 items proposed by Granger and Greer (1979).	43 items across 7 domains (clothing, hygiene, nutrition, mobility, safety, residence and supports)	8 items including telephone, shopping, food preparation, housekeeping, laundry, transportation, medication, and finances.	10 items including personal care, emotional support, medical/ nursing treatments and transportation. Activities are rated on a 5 point scale ranging from "little or not time and energy" to "a great deal of time and energy" (Kinsella et al, 1998, p. 40)	15 questions, 5 domains including: illness, independent living, social relationships, physical senses and psychological well being. Each domain has 3 questions. Each question has 4 options – client is instructed to choose the alternative that best describes themselves over the last week.	12 items including adequacy of preparation for home; treatment by staff; care and therapy; information provision and community supports; and help with reintegration back into the community.	NA
Scoring/ Interpret'n	Overall score determined by adding individual scores. Score ranges from 0 – 100 with higher scores indicating independence in performing personal care tasks.	Possible responses are 'OK by self', 'OK with help', 'Not OK' and 'NA'. Where there is a discrepancy between the level of functioning reported by the client and the carer, the clinician asks the client to undertake the task. Responses are recorded as a global score - 'OK by self', 'OK with help' or 'Not OK' on the task being assessed.	Total score / 30. Scoring on a 4-point scale except for 2 items, which are scored, on a 3-point scale. The lower the score the higher the level of dependency. Rates what a person is currently capable of doing rather than what they actually do. If an item is not relevant it is rated according to what they are capable of doing if the item was relevant.	Ratings are added to provide a total score. Higher scores indicate more demand.	Responses are scored as 1 – 4 and added to provide a total score. Lower scores indicate higher quality of life.	Each response is marked on a five point Likert scale that ranges from 0 – strongly disagree to 5 - strongly agree.	Normative scores: healthy older people, mean age 75 years, mean of 8.5 seconds (Podsiadlo and Richardson, 1991) Healthy older women (mean age 74 years), mean TUG 9.1 seconds (95% CI 6.6-11.6); Significant increase with increasing age (Hill et al, 1999)

Scale	Barthel Index	Handicap Assessment and Resource Tool	Domestic Functioning Assessment in Activities of Daily Living	Care-giving demand scale	Assessment of health related quality of life	Client and carer satisfaction survey	Timed Up and Go
Reliability	10 item version Internal consistency coefficients > 0.87 (Shinar et al. 1987) Inter-observer correlation 0.99 (Roy et al. 1988). Different rating methods – self report, nurse, clinical impressions, physio gave Kendall's coeff. of concordance 0.93 (Collin et al. 1988)	The tool has been trailed in acute hospitals, long term care facilities and within the community more broadly. The HART is currently being tested for reliability, validity and sensitivity.	Not tested	On a sample of 47 family caregivers of adults undergoing radiotherapy reported a Cronbach's alpha of 0.87. Evidence of the measure's test-retest reliability is lacking (Kinsella et al 1998)	Internal consistency of scale, alpha = 0.81, test retest r = 0.80	Not tested	Inter-rater reliability ICC = 0.99 (Podsiadlo and Richardson, 1991) in a sample of Day Hospital subjects. Retest reliability ICC = 0.99 (Podsiadlo and Richardson, 1991) in sample of Day Hospital subjects. High retest and inter-rater reliability in Parkinson disease patients both in the "on" and "off" phases of medication (Smith et al, 2001)
Validity	Predictive validity – discharge home; length of stay, prognosis & discharge outcome (McDowell and Newell 1996); number of services being received in the community (Poulos 1999) 15 item version - Correlation's between PULSES profile, KATZ, FIM (McDowell and Newell 1996).	The developers of the tool contend that the tool has content validity (Vertesi, Darzins et al. 2000)	Not tested	CDS scores demonstrated adequate variation across the sample (ranging from 12 to 47 with a mean of 26.8), and were significantly associated with patient dependency (r=0.53), duration of patient treatment (r=0.35), and residency status (mean CDS of 28.4 if living with patient, 19.9 if not), providing evidence of construct validity.	Good content validity when compared to similar instruments such as the SF-36 and the EuroQuol (Hawthorne et al 1997) Sensitive to different affect levels, different functional levels and also discriminates between those with different levels of general health	Face validity. Specific items can be addressed by the service if consistently rated poorly.	Significant correlation with Berg Balance Scale, Tinetti Mobility Index and Barthel Index in older people (Berg et al, 1992)

Scale	Barthel Index	Handicap Assessment and Resource Tool	Domestic Functioning Assessment in Activities of Daily Living	Care-giving demand scale	Assessment of health related quality of life	Client and carer satisfaction survey	Timed Up and Go
Comments	Floor and Ceiling effects and reduced sensitivity to change for many rehabilitation patients. (Darzins, Bremner et al 2002)	Does not measure broader areas of participation restriction such as return to productivity and leisure roles. Has the ability to rate risk and record methods for addressing participation restrictions assessed. Modified version used in this study has not been tested for validity or reliability.	Noted to have floor effects in some items for the HACC population. Some items may not be culturally appropriate.	Provides an overall summary of caregiving behaviour without factor analytic support for the presence of a single dimension. Does not measure subjective burden	Psychometric testing has not been completed for use in other languages.	There is a tendency for respondents to mark all responses with a 4 or 5. Negatively worded questions are often answered with a 5 – strongly agree.	4 out of 6 participating home based rehabilitation services use the Timed up and go as a standard outcome measurement tool for all clients.

Appendix G - The Barthel Index/ Functional Independence Measure conversion scale

This conversion method was developed by (Nyein et al., 1999). It was trailed with clients with brain injury. A strong correlation (Spearman's rho=.99) was reported between total scores of the direct and derived BI with good agreement on the majority of items. Grooming and feeding were shown to have weaker correlations.

FIM Score	7	6	5	4	3	2	1
Eating	10	5	0	0	0	0	0
Grooming	5	5	0	0	0	0	0
Bathing	4	4	0	0	0	0	0
Dressing Upper	5	5	3	3	3	0	0
Dressing Lower	5	5	2	2	2	0	0
Toiletting	4	4	2	2	2	0	0
Bladder Mngmt	10	10	5	5	5	0	0
Bowel Mngmt	10	10	5	5	5	0	0
Transfers Bed etc.	15	15	7	7	7	0	0
Transfers Toilet	6	5	3	3	3	0	0
Transfers Tub/shwr	1	1	0	0	0	0	0
Locomotion	15	15	10	10	10	0	0
Stairs	10	10	5	5	5	0	0

Note: Subtract 10 points from locomotion score if scored 3 – 6 FIM in wheelchair
 Subtract 2 points if assistance is required putting on brace or artificial limb

Appendix H – Client and Carer Satisfaction surveys

CLIENT SATISFACTION SURVEY

Please read each statement and mark on the line the answer that is nearest your view. There are no right or wrong answers. It is your opinion we are interested in. Please answer every question. Can you please write your name below so that we can link this survey with other information that we have collected from you.

Name: _____

Service:

- 1. Things were well prepared for my home (ie aids such as rails and wheelchairs had been organised if necessary).**

|-----|-----|-----|-----|
Strongly Disagree Neither agree Agree Strongly agree
disagree nor disagree

- 2. I have been treated with kindness and respect by the rehabilitation staff**

|-----|-----|-----|-----|
Strongly Disagree Neither agree Agree Strongly agree
disagree nor disagree

- 3. I felt able to talk to the staff about any problems I might have had**

|-----|-----|-----|-----|
Strongly Disagree Neither agree Agree Strongly agree
disagree nor disagree

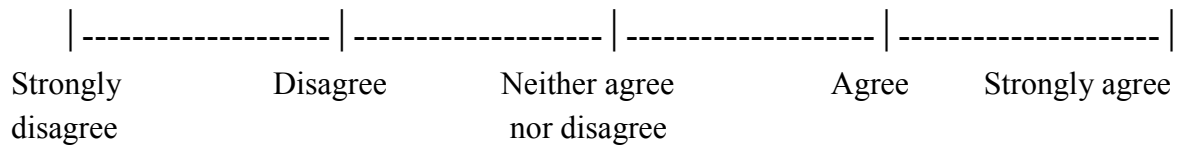
- 4. I have not received sufficient information about the causes and nature of my illness**

|-----|-----|-----|-----|
Strongly Disagree Neither agree Agree Strongly agree
disagree nor disagree

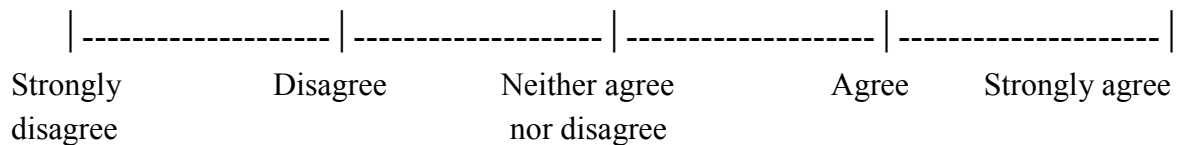
- 5. I have had all the medical attention I need whilst in rehabilitation**

|-----|-----|-----|-----|
Strongly Disagree Neither agree Agree Strongly agree
disagree nor disagree

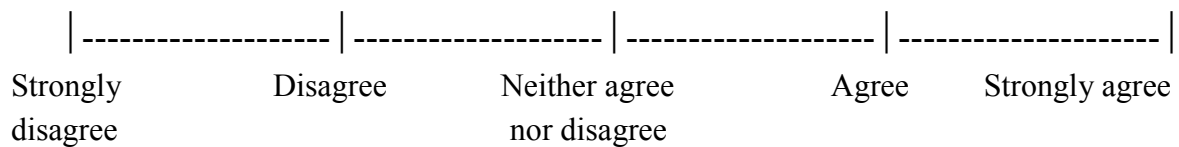
6. I was satisfied with the type of care the nurses have given me



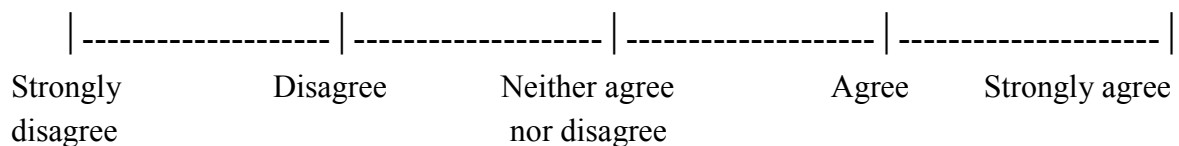
7. I was satisfied with the type of treatment the therapists have given me (e.g. physiotherapy, occupational therapy, speech therapy)



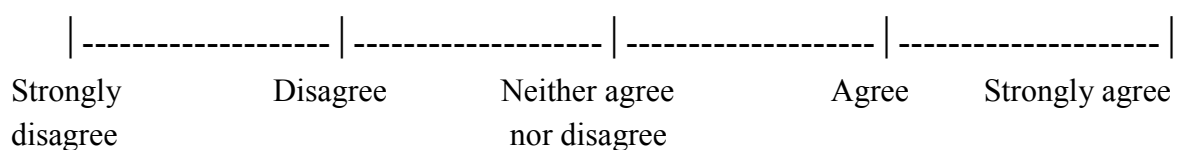
8. I have not had enough therapy



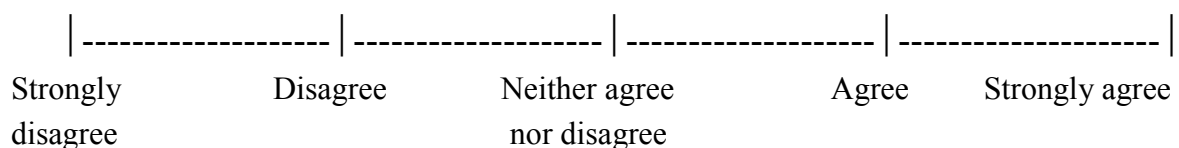
9. I was not given sufficient information about the allowances and services I needed after rehabilitation finished



10. I found rehabilitation helped me to settle back into my family and community life



11. I now get all the support I need from services such as Meals on Wheels, Home Care, District Nursing Service etc.



CARER SATISFACTION SURVEY

This survey asks about your experience of the rehabilitation program provided to the person you provide care for. Please read each statement and mark on the line the answer that is nearest your view. There are no right or wrong answers. It is your opinion we are interested in. Please answer every question. Can you please write your name below so that we can link this survey with other information that we have collected from you.

Name: _____

Service: _____

1. Things were well prepared for the person I provide care for (ie aids such as rails and wheelchairs had been organised if necessary).

|-----|-----|-----|-----|
Strongly Disagree Neither agree Agree Strongly agree
disagree nor disagree

2. I have been treated with kindness and respect by the rehabilitation staff

|-----|-----|-----|-----|
Strongly Disagree Neither agree Agree Strongly agree
disagree nor disagree

3. I felt able to talk to the staff about any problems I might have had

|-----|-----|-----|-----|
Strongly Disagree Neither agree Agree Strongly agree
disagree nor disagree

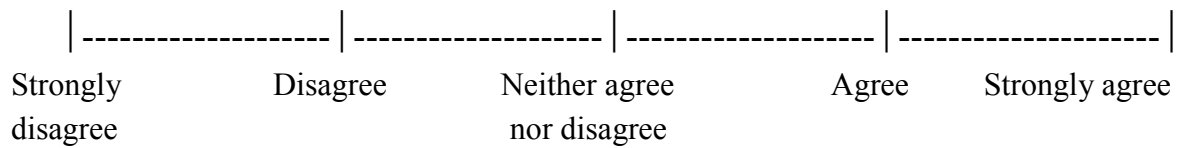
4. I have not received sufficient information about the causes and nature of the illness that the person I provide care for has

|-----|-----|-----|-----|
Strongly Disagree Neither agree Agree Strongly agree
disagree nor disagree

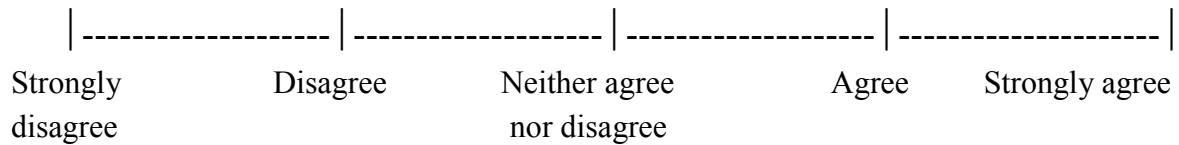
5. The person I provide care for had all the medical attention needed whilst receiving rehabilitation

|-----|-----|-----|-----|
Strongly Disagree Neither agree Agree Strongly agree
disagree nor disagree

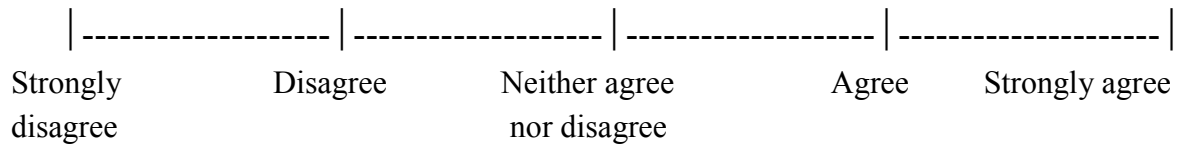
6. I was satisfied with the type of care the nurses provided



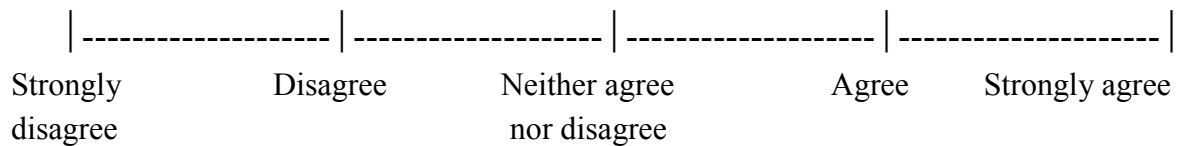
7. I was satisfied with the type of treatment the therapists provided (e.g. physiotherapy, occupational therapy, speech therapy)



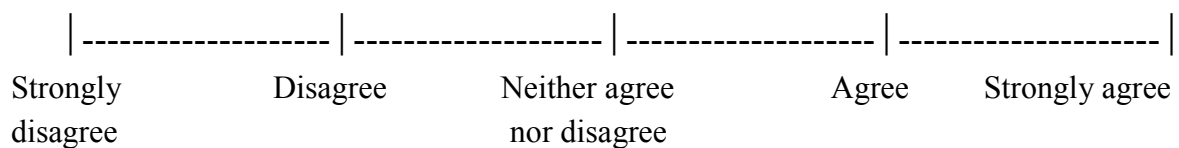
8. The person I care for did not have enough therapy



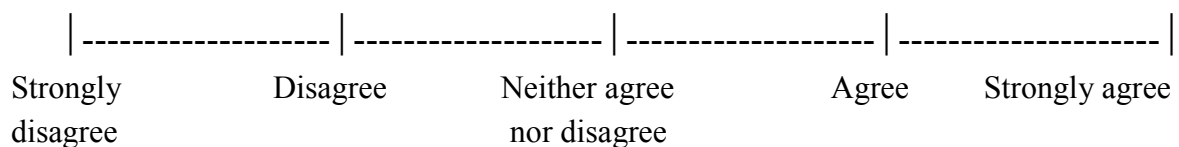
9. I was not given sufficient information about the allowances and services needed after the rehabilitation finished



10. I found rehabilitation helped the person I provide care for to settle back into family and community life



11. We now get all the support we need from services such as Meals on Wheels, Home Care, District Nursing Service etc.



12. If needed again in the future, I would prefer rehabilitation for the person I provide care for to be provided:

- at hospital
- at home
- at a community centre / outpatient setting
- a combination of the above

Please take the opportunity to add your own comments about the rehabilitation program:

If you would like any assistance in completing this form, please contact any of the following NARI project staff members:
Briony Dow or Fiona Bremner Ph: 8387 2377
Kirsten Black Ph: 8387 2666

Assessment of Quality of Life Scale (AQoL)

(Admission)

This questionnaire has 15 questions and will take about ten minutes to complete. The questions are about your health during the last week. Please circle the alternative that best describes you during the last week. Can you please put your name on the survey so that we can link it to the other information that we have collected from you.

Thank you.

Name: _____

Service: (service name inserted)

1. Concerning use of prescribed medicines:

- I do not or rarely use any medicines at all
- I use one or two medicinal drugs regularly
- I need to use three or four medicinal drugs regularly
- I use five or more medicinal drugs regularly

2. To what extent do I rely on medicines or a medical aid? (NOT glasses or a hearing aid.)

- I do not use any medicines and/or medical aids
- I occasionally use medicines and/or medical aids
- I regularly use medicines and/or medical aids
- I have to constantly take medicines or use a medical aid

3. Do I need regular medical treatment from a doctor or other health professional?

- I do not need regular medical treatment
- Although I have some regular medical treatment, I am not dependent on this
- I am dependent on having regular medical treatment
- My life is dependent upon regular medical treatment

4. Do I need any help looking after myself?

- I need no help at all
- Occasionally I need some help with personal care tasks
- I need help with the more difficult personal care tasks
- I need daily help with most or all personal care tasks

5. When doing household tasks:

- I need no help at all
- Occasionally I need some help with household tasks
- I need help with the more difficult household tasks
- I need daily help with most or all household tasks

6. Thinking about how easily I can get around my home and community:

- I get around my home and community by myself without any difficulty
- I find it difficult to get around my home and community by myself
- I cannot get around the community by myself, but I can get around my home with some difficulty
- I cannot get around either the community or my home by myself

7. Because of my health , my relationships generally:

- Are very close and warm
- Are sometimes close and warm
- Are seldom close and warm
- I have no close and warm relationships

8. Thinking about my relationship with other people:

- I have plenty of friends, and am never lonely
- Although I have friends, I am occasionally lonely
- I have some friends, but am often lonely for company
- I am socially isolated and feel lonely

9. Thinking about my health and my relationship with my family:

- My role in the family is unaffected by my health
- There are some parts of my family role I cannot carry out
- There are many parts of my family role I cannot carry out
- I cannot carry out any part of my family role

10. Thinking about my vision, including when using my glasses or contact lenses if needed:

- I see normally
- I have some difficulty focusing on things, or I do not see them sharply
- I have a lot of difficulty seeing things. My vision is blurred
- I only see general shapes, or am blind.

11. Thinking about my hearing, including using my hearing aid if needed:

- I hear normally
- I have some difficulty hearing or I do not hear clearly
- I have difficulty hearing things clearly
- I hear very little indeed

12. When I communicate with others:

- I have no trouble speaking to them or understanding what they are saying
- I have some difficulty being understood by people who do not know me. I have no trouble understanding what others are saying to me
- I am only understood by people who know me well. I have great trouble understanding what others are saying to me
- I cannot adequately communicate with others

13. If I think about how I sleep:

- I am able to sleep without difficulty most of the time
- My sleep is interrupted some of the time, but I am usually able to go back to sleep without difficulty
- My sleep is interrupted most nights, but I am usually able to go back to sleep without difficulty
- I sleep in short bursts only. I am awake most of the night

14. Thinking about how I generally feel:

- I do not feel anxious, worried or depressed
- I am slightly anxious, worried or depressed
- I feel moderately anxious, worried or depressed
- I am extremely anxious, worried or depressed

15. How much pain or discomfort do I experience?

- None at all
- I have moderate pain
- I suffer from severe pain
- I suffer unbearable pain

Client goals

We are interested in finding out what your therapy goals are.

Please list 5 things that you want to have achieved by the time you have finished your rehabilitation with this service.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

If you have any queries about the survey please contact Kirsten Black on: 8387 2666.

Please return the survey in the reply paid envelope provided.

Thank you

Appendix J – Program Admission Profile

Please complete for all patients admitted to your rehab service during the recruitment period of the Home Rehab evaluation project

	Date	Gender M/F	Age	Referral Source (1=inpatient rehab, 2=acute inpatient, 3=community)	Primary Diagnosis (1= neuro, 2=ortho, 3=amputee, 4=other rehab)	If neuro or ortho whether agreed to participate (yes, no, not asked) Give reason for refusing or not asking
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Appendix K - Participant Admission Information

Participant Admission Information

1. Site: _____

2. Patient's Name: _____

3. Patient Phone Number: _____

4. Language Spoken: _____ **Interpreter Required:** Y/ N

5. Gender Male Female

6. Date of Birth: ____/____/____ **Age:** _____

7. Referral Source

Acute Hospital LOS _____ Discharge Date _____

Inpatient Rehabilitation LOS _____ Discharge Date _____

GEM LOS _____ Discharge Date _____

Community

Other, please specify: _____

8. Admission Date to current service: ____/____/____

9. What is the main aim of this admission to your service (eg transition to home, functional improvement)?

10. Primary Diagnosis: (Diagnostic Related Groups 1, 3, 6 & 8 only)

Orthopaedic

Neurology

11. Co-morbidities Please Specify relevant comorbidities impacting on patient outcomes

12. Living Arrangements and Carer Availability

Recent Living Arrangement	Tick one
Lives alone	
Lives with others	
Residential - Low level care	
Residential - High level care	
Other supported accommodation	
Not known	

Carer Availability	Tick one
No carer available	
Resident carer available	
Non-resident carer available	

13. Cognitive Screen (if used): MMSE score /30 or AMTS score /10

14. Timed Up and Go (if used):

(3m distance): _____seconds

15. Barthel Index Score: (if used): /100

Please attach a copy of the completed FIM (if used instead of the Barthel), and also complete the attached HART and Domestic Functioning Assessment in Activities of Daily Living.

Please ensure you have provided clients and carers with a copy of the AQoL and the Caregiving Demand Scale. Please encourage them to return the completed forms to the NARI research team in the envelope provided. Thank you

Appendix L – Discharge Record

Participant Discharge Information

1. Site: _____

2. Patient's Name: _____

3. Discharge date: ____/____/____

Reason for discharge:

- readmission into an acute setting, please specify reason: _____
- completed rehabilitation period
- other, please specify: _____

4. Do you think that the main aim of this admission to your service has been achieved?

- yes no partially

5. Rehabilitation sessions: please indicate the time (in hours) spent with or doing tasks for the client by staff directly employed in your program during the client's admission. Please include travel in the indirect time recorded. (D = direct time; I = indirect time)

	Wk 1		Wk 2		Wk 3		Wk 4		Wk 5		Wk 6		Wk 7		Wk 8	
	D	I	D	I	D	I	D	I	D	I	D	I	D	I	D	I
Medical																
Nursing																
O.T																
Social work																
Physio																
A.H.A																
Dietician																
Speech Path																
Psychology																
Podiatry																
Case Mg't																
Other																

Please indicate what "other" includes _____

6. Service provision during rehabilitation period: (please tick all boxes that apply and indicate frequency of service provided)

	Received prior to home rehab admission (indicate frequency)	Received during home rehab admission		Assessed as needed but not received during home rehab admission		Amount of service (Time and frequency) E.g. 2 hrs / week home care
		Supplied by another service	Brokered by your health service	Could have been brokered	Referred to another service	
Food Services						
Home Care						
Home nursing						
PCA						
CACP						
Linkages						
Day Centre						
Respite						
Personal alarm						
Community rehabilitation						
PAC						
TCP						
CHC						
Pharmacy						
GP						
Hire of equipment						
Other						

(see definition sheet in folder)

7. Living Arrangements and Carer Availability at discharge:

Recent Living Arrangement	Tick one
Lives alone	
Lives with others	
Residential - Low level care	
Residential - High level care	
Other supported accommodation	
Not known	

Carer Availability	Tick one
No carer available	
Resident carer available	
Non-resident carer available	

8. If appropriate, describe the ongoing aims requiring referral to a Community Rehabilitation Centre

9. Timed up and go (if used):

(3m distance): _____ seconds

10. Barthel Index Score (if used):

/100

Please attach a copy of the completed FIM (if used instead of the Barthel), and complete the attached HART and Domestic Functioning Assessment in Activities of Daily Living.

Please ensure you have provided clients and carers with a copy of the AQoL, Caregiving demand scale and satisfaction surveys. Please encourage them to return the completed forms to the NARI research team in the self addressed envelope provided.

Thank you

Appendix M – 3-Month Follow - up Record

Participant Information – 3-month follow-up

1. Site: _____

2. Patient's Name: _____

3. Today's date ____/____/____

4. Client Goals

Goal 1: (enter goal prior to follow-up) _____

How would you rate your current performance of this goal?

- Achieved
- Partially achieved
- Not achieved but may be achieved in the next 3 months
- Not likely to be achieved in the next 6 months

How important does this goal remain?

- High importance
- Moderate importance
- Less important but still a goal
- No longer a goal

Goal 2: (enter goal prior to follow-up) _____

How would you rate your current performance of this goal?

- Achieved
- Partially achieved
- Not achieved but may be achieved in the next 3 months
- Not likely to be achieved in the next 6 months

How important does this goal remain?

- High importance
- Moderate importance
- Less important but still a goal
- No longer a goal

Goal 3: (enter goal prior to follow-up)_____

How would you rate your current performance of this goal?

- Achieved
- Partially achieved
- Not achieved but may be achieved in the next 3 months
- Not likely to be achieved in the next 6 months

How important does this goal remain?

- High importance
- Moderate importance
- Less important but still a goal
- No longer a goal

Goal 4: (enter goal prior to follow-up)_____

How would you rate your current performance of this goal?

- Achieved
- Partially achieved
- Not achieved but may be achieved in the next 3 months
- Not likely to be achieved in the next 6 months

How important does this goal remain?

- High importance
- Moderate importance
- Less important but still a goal
- No longer a goal

Goal 5: (enter goal prior to follow-up)_____

How would you rate your current performance of this goal?

- Achieved
- Partially achieved
- Not achieved but may be achieved in the next 3 months
- Not likely to be achieved in the next 6 months

How important does this goal remain?

- High importance
- Moderate importance
- Less important but still a goal
- No longer a goal

5. Living Arrangements and Carer Availability

Please indicate the client’s living arrangement and carer availability at 3 months post discharge from home or inpatient rehabilitation. Please make a note if this has changed since discharge.

Recent Living Arrangement	Tick one
Lives alone	
Lives with others	
Residential - Low level care	
Residential - High level care	
Other supported accommodation	
Not known	

Carer Availability	Tick one
No carer available	
Resident carer available	
Non-resident carer available	

Comments: _____

6. Any other comments/observations about the rehabilitation service:

7. Services (please tick all boxes that apply and indicate frequency)

	Received	Referred to but not received	Frequency (hours, meals, etc, per week)
Food Services			
Home Care			
Home nursing			
PCA			
CACP			
Linkages			
Day Centre			
Respite			
Personal alarm			NA
Community rehabilitation			
PAC			
TCP			
CHC			
Pharmacy			
GP			
Hire of equipment			
Other			

8. Timed up and go

(3m distance): _____ seconds

9. Barthel Score: _____ /100

Please attach copies of the completed Barthel, HART and Domestic Functioning assessment in activities of daily living. Please ask patient to complete AQoL. Please ask carer to complete CDS.

Appendix N – Client and carer interview schedules

Client Interview Protocol

Prior to the interview you will need to consider various information already collected for this client to be able to build on this information. Things to consider are

- The rehab service model they experienced (inpatient, bed substitution, ambulatory)
- Referral source
- Goals and achievement/satisfaction with goals
- Availability of a carer
- Changes in outcome measures and living arrangements
- Results on AQoL and satisfaction surveys

Given that the client may have had interaction with various service providers, you will also need to ensure that the client understands which group of services you are talking about.

1. Location of rehab (What were advantages/disadvantages of location of rehab?)

Prompts: did you feel more comfortable at home than at hospital (or vice versa), did you feel safe at home? Was access to medical treatment an issue? Did you prefer being at home than at hospital?, What do you think was easier –for you and for your carer? Where would you prefer to have rehabilitation if you required it again in the future?

2. The therapy (did the therapy meet your needs)

Prompts: was there enough therapy? Was it the right mix of therapists? Were you encouraged to practice between therapy sessions?

3. Your involvement in service delivery and planning (how much were you involved in the organising and planning of rehabilitation?)

Prompts: which interventions were made, frequency and timing of therapy, referral to other services etc.

4. Your goals (client or practitioner developed)

Prompts: Were you encouraged to develop your own goals as part of therapy? Did the therapists help you develop goals? Were you able to achieve your goals? If not, why not?

5. Information. (did the rehab service keep you adequately informed)

Prompts- information about other services, about the client's illness, careplan, expectations of service and client's progress.

6. Transition between services (start and end of rehabilitation- especially where there was a discharge from hospital)

Prompts: how quickly were things set up (rehab services, aids and modifications, community services etc)

7. Issues since service ceased

Prompts: have your achievement's been maintained? Have you made further progress on original (or new) goals? Have your goals changed? If so why? Has this changed since the rehab service was provided?

8. Do you have any suggestions in how the rehab service could better meet yours and (carer name)'s needs?

Carer Interview Protocol

Prior to interview you will need to know whether resident or non-resident carer as well as the responses the carer has given on carer surveys.

1. Location of rehab (What were advantages/disadvantages of location of rehab?)

Prompts: travelling time, safety or health concerns at home, loneliness if client in hospital, preferences about care provided in home, access to medical treatment, additional stress or additional caring required?

2. The therapy (did the therapy meet (client's name) needs?)

Prompts: was there enough therapy? Was it the right mix of therapists? Was (client's name) encouraged to practice between therapy sessions?

3. Carer involvement (how much were you involved in the organising and planning of rehabilitation?)

Prompts: which interventions were made, frequency and timing of therapy, referral to other services etc.

4. Information. (did the rehab service keep you adequately informed)

Prompts- information about other services, about the client's illness, careplan, expectations of service and client's progress.

5. Transition between services (start and end of rehabilitation- especially where there was a discharge from hospital)

Prompts: how quickly were things set up (rehab services, aids and modifications, community services etc)

6. Issues since service ceased

Prompts: has (client's name) achievement's been maintained? Has (client's name) made further progress on original (or new) goals? Do you feel you have enough support to maintain your caring role? Has this changed since the rehab service was provided?

7. Do you have any suggestions in how the rehab service could better meet your and (client's name)'s needs?

Appendix O – Survey for referring agencies

Survey of agencies who refer to home based rehabilitation

Background:

The National Ageing Research Institute has been commissioned by the Victorian Department of Human Services to complete an evaluation of home based rehabilitation services.

As part of our methodology, we are interested in consulting with services that refer to home based rehabilitation. Inpatient rehabilitation services have been identified as a significant referring agency for many of the home based rehabilitation services involved in our study.

Survey Purpose:

To understand how home based rehabilitation is used by your service

To identify opportunities and barriers that ensure best use of the service to meet the needs of clients

To identify factors which may improve use of home based rehabilitation in meeting client need

How long will the survey take:

The survey is two pages in length. The survey should take no longer than 10 minutes to complete. Input from all members of the inpatient rehabilitation team would be appreciated. Preferably we would ask you to complete the survey within a team meeting. If this is inconvenient we have attached a few copies of the survey that could be disseminated to different team members.

How will the information be used:

The information you provide will be used in a report provided to the Department of Human Services Victoria. The information you provide will be subject to content analysis. Key themes will be identified using data gathered from 7 inpatient rehabilitation teams. Information will be reported in a way to ensure that it cannot be directly attributable to an individual or an agency. Direct quotes may be used to illustrate a theme.

A reply paid envelope has been provided for your convenience. Please return this survey by Friday 11th July, 2003

If you have any queries, please contact Briony Dow principal investigator for the project on:

Phone: 8 387 2377.

b.dow@nari.unimelb.edu.au

Thank you for your participation.

With kind regards,

Briony Dow, Fiona Bremner and Kirsten Black

1. What is your understanding of the service provided by home-based rehabilitation?

2. Do you refer patients to the home-based rehabilitation service located in your hospital?

Yes

No

If not, why not?

3. If yes, how do you make referrals to home-based rehabilitation?

How often?

Frequently- at least once a week

Fortnightly

Monthly

Less than monthly

4. Are you satisfied with the means of referring to home based rehabilitation?

Yes

No

Somewhat

Please comment:

5. What clients benefit most from referral to a home based rehabilitation program (i.e. diagnostic categories, demographic characteristics)?

6. What do you see as the role of home based rehabilitation?

7. Are you satisfied with the service that home based rehabilitation provides?

Yes

No

Somewhat

Please comment:

8. In your view, what are the strengths of the home based rehabilitation service you refer to?

9. In your view, what are the weaknesses of the home based rehabilitation service you refer to?

10. How do you think home based rehabilitation could be improved to better meet the needs of your clients?

11. Are there any additional comments you would like to make regarding home based rehabilitation?

Thank you for your time

Appendix P – Outcome Measures Survey

Outcome Measures Survey

Dear Colleagues,

As part of the focus group methodology the research team aimed to seek your perspective about the potential clinical and administrative utility of the outcome measures used in the research. As most of the focus groups were conducted near to the commencement of data collection many teams reported that they had not had enough time to use the outcome measures for them to make any comment.

We have attached a questionnaire to address this issue. The questionnaire is 3 pages in length and should take approximately 5 – 10 minutes of your time. We have sent the questionnaire to all of the co-ordinators of the services involved in the study. We would welcome however the input of all team participants who have used the tools.

If you any queries regarding this survey please contact Briony Dow or Fiona Bremner on 8 387 2377 or Kirsten Black on 8 387 2699.

Thank you for returning this survey by **Friday 19th September**. We have included a self addressed envelope for your convenience.

Thank you for your time.

Name of Service: _____

Disciplines involved in the completion of the questionnaire: _____

1. What were the advantages and disadvantages of using the following outcome measures in your service?

(Please note an additional section has been provided at the end of the questionnaire for you to make further comments regarding any of the measures as/if required).

Measure	Advantages	Disadvantages
Barthel Index		
Domestic Functioning Assessment in ADL		
Handicap Assessment Resource Tool (HART)		
Caregiving Demand Scale		
Assessment in Quality of Life Scale (AQoL)		
Timed Up and Go (TUG)		
Client satisfaction		
Carer satisfaction		
Client goals		

2. Please indicate by placing a tick in the box below if you would consider continuing to use any of the outcome measures listed - either on a routine or 'as needed' basis. If team participants have differing opinions, please include both responses.

Measure	Already using routinely or 'as needed' (please circle)	Would consider using <i>routinely</i> in practice	Would consider using ' <i>as needed</i> ' in practice	Would not use again	Number of participant completing this question
Barthel Index	Routine Use As Needed				
Domestic Functioning Assessment in ADL	Routine Use As Needed				
HART	Routine Use As Needed				
CDS	Routine Use As needed				
AQoL	Routine Use As Needed				
TUG	Routine Use As Needed				
Client satisfaction	Routine Use As Needed				
Carer satisfaction	Routine Use As Needed				
Client goals	Routine Use As Needed				

3. If appropriate, please describe any additional information you would need to better determine whether you would continue to use the above measures:

4. Please provide any other comments you may have:

Thank you for your time



Appendix Q - Analysis of participant goals

ICF type	Goal	Inpatient (n = 19) (%)	Ambulatory (n=57) (%)	Bed subs (n=50) (%)	Total (n=126) (%)
Impairment	Use of limbs	6 (31.6)	13 (22.8)	7 (14.0)	26 (20.6)
	Pain free/reduced	6 (31.6)	8 (14.0)	10 (20.0)	24 (19.0)
	Sleep	2 (10.5)	1 (1.8)	4 (8.0)	7 (5.6)
	Endurance/strength/stamina	1 (5.3)	4 (7.0)	2 (4.0)	7 (5.6)
	No pain killers or other medications	1 (5.3)	3 (5.3)	2 (4.0)	6 (4.8)
	Continued good health/full recovery	3 (15.7)		2 (4.0)	5 (4.0)
	Speak clearly		2 (3.5)	3 (6.0)	5 (4.0)
	Normal diet/eat properly		3 (5.3)	2 (4.0)	5 (4.0)
	Discard TEDS/trolley/stick	1 (5.3)	1 (1.8)	2 (4.0)	4 (3.2)
	Improved strength in limbs		1 (1.8)	2 (4.0)	3 (2.4)
	Improved balance	1 (5.3)	2 (3.5)		3 (2.4)
	Improve memory			2 (4.0)	2 (1.6)
	Understand others	1 (5.3)		1 (2.0)	2 (1.6)
	Think clearly	1 (5.3)		1 (2.0)	2 (1.6)
	Improved vision	1 (5.3)	1 (1.8)		2 (1.6)
	Use rails		1 (1.8)		1 (0.8)
	Sit comfortably for long periods		1 (1.8)		1 (0.8)
	Exercise without assistance		1 (1.8)		1 (0.8)
	Reduce dizziness	1 (5.3)			1 (0.8)
	Regain feeling		1 (1.8)		1 (0.8)
	Improve hearing		1 (1.8)		1 (0.8)
	Better posture		1 (1.8)		1 (0.8)
	Stop dribbling				1 (2.0)
Activity	To walk better (somewhere, unaided, properly, with aides etc)	13 (68.4)	46 (78.9)	28 (56.0)	87 (69.0)
	Driving car	5 (26.3)	20 (35.1)	14 (28.0)	39 (31.0)
	Housework/home maintenance	1 (5.3)	9 (15.8)	13 (26.0)	23 (18.3)
	Resume independent self care – Dressing, grooming, bathing, toileting, transfers etc	3 (15.7)	8 (14.0)	10 (20.0)	21 (16.7)
	To go shopping		10 (17.5)	10 (20.0)	20 (15.9)
	To cook/prepare meals	2 (10.5)	6 (10.5)	7 (14.0)	15 (11.9)
	To garden	1 (5.3)	7 (12.3)	6 (12.0)	14 (11.1)
	To write		6 (10.5)	5 (10.0)	11 (8.7)
	To read		2 (3.5)	6 (12.0)	8 (6.3)
	Travel in a car/taxi	1 (5.3)	3 (5.3)	2 (4.0)	6 (4.8)
	Use public transport		1 (1.8)	4 (8.0)	5 (4.0)

ICF type	Goal	Inpatient (n = 19) (%)	Ambulatory (n=57) (%)	Bed subs (n=50) (%)	Total (n=126) (%)
Activity cont	Managing finances		3 (5.3)	2 (4.0)	5 (4.0)
	Get outside	1 (5.3)	4 (7.0)		5 (4.0)
	Climb stairs		2 (3.5)	1 (2.0)	3 (2.4)
	Mow the lawn			1 (2.0)	1 (0.8)
	Take own medications		1 (1.8)		1 (0.8)
	Ride scooter			1 (2.0)	1 (0.8)
Participation	To be independent/ self sufficient	5 (26.3)	8 (14.0)	8 (16.0)	21 (16.7)
	To get back to normal life	6 (31.6)	3 (5.3)	7 (14.0)	16 (12.7)
	Resume sporting activities – golf, bowls, swimming, bike riding, fishing	1 (5.3)	7 (12.3)	6 (2.0)	14 (11.1)
	Family responsibilities /celebrations/role within family	4 (21.1)	3 (5.3)	5 (10.0)	12 (9.5)
	Go out more (socially), bingo, football		9 (15.8)	2 (4.0)	11 (8.7)
	Fundraising, church and committee roles/volunteer work	1 (5.3)	3 (5.3)	6 (2.0)	10 (8.0)
	Resume hobbies – sewing, knitting, painting, scrapbooking, crosswords, organ playing	1 (5.3)	2 (3.5)	6 (2.0)	9 (7.1)
	Back to work, study	2 (10.5)	2 (3.5)	3 (6.0)	7 (5.6)
	Take a trip out of town/holiday		2 (3.5)	1 (2.0)	3 (2.4)
	Go out to appointments		2 (3.5)		2 (1.6)
	Walk the dog		1 (1.8)	1 (2.0)	2 (1.6)
	Go home	2 (10.5)			2 (1.6)
	Go to hairdresser		1 (1.8)		1 (0.8)
Enviro. factor	Access to services		2 (3.5)		2 (1.6)
	Consider future housing options		1 (1.8)		1 (0.8)
Personal factor	Not feel scared/feel more secure/less tense/manage anxiety/stop worrying	2 (10.5)	2 (3.5)	1 (2.0)	5 (4.0)
	Confidence and self esteem		3 (5.3)	1 (2.0)	4 (3.2)
	Improve QOL/be happier	1 (5.3)	1 (1.8)	2 (4.0)	4 (3.2)
	Total	77	225	200	502

Note – some participants recorded the same goal twice – goals have only been counted once per participant. Also some goals have been recorded as two – eg to have the stamina to travel in a car – “improve endurance” and “travel in a car” or to speak and write clearly

Appendix R - % HART items "Not OK" (% OK with help)

	Admission, n=159	Discharge, n=156	3-months post discharge, n=137
Dress: top	1.3 (18.2)	0 (7.7)	0 (8.8)
Dress: pants	5.7 (31.4)	0 (12.2)	0 (9.5)
Dress: footwear	4.4 (42.8)	0.6 (18.6)	0.7 (15.3)
Selection of clothing	0.6 (15.7)	0 (8.3)	0 (8.0)
Changes clothes	3.1 (38.4)	0 (23.7)	0 (11.7)
Toilet: transfer	4.4 (11.3)	1.3 (6.4)	0.7 (3.6)
Bladder control	3.1 (8.2)	1.9 (4.5)	5.1 (5.1)
Bowel control	1.3 (6.3)	0 (2.6)	1.5 (2.9)
Groom: hair	0 (18.2)	0 (10.3)	0 (5.8)
Groom: teeth	0.6 (8.8)	0 (4.5)	0 (3.6)
Groom: shave menst'n	0 (8.2)	0 (3.8)	0 (5.1)
Bathing	2.5 (38.4)	0.6 (16.7)	0.7 (12.4)
Bath transfer	8.8 (31.4)	0.6 (17.9)	0.7 (16.1)
Eat: weight	5.7 (6.9)	0 (2.6)	11.7 (8.8)
Eat: choke	3.1 (6.3)	1.3 (2.6)	2.2 (1.5)
Meal: plan	1.3 (40.9)	0.6 (24.4)	0 (38.7)
Meal: make	5.0 (66.0)	0.6 (41.0)	0 (45.3)
Groceries	5.7 (80.5)	1.3 (69.9)	0 (50.4)
Food: restriction	0 (11.3)	0 (11.5)	0 (13.1)
Stove	3.8 (29.6)	0.6 (22.4)	0.7 (21.2)
Spoiled food	0 (14.5)	0 (9.0)	0 (10.2)
Mobility	8.2 (17.0)	0.6 (6.4)	1.5 (5.8)
Bed	2.5 (16.4)	0.6 (6.4)	1.5 (4.4)
Falls	11.9 (16.4)	3.2 (9.0)	15.3 (2.9)
Steps	27.0 (35.8)	7.1 (21.2)	9.5 (11.7)
Outside	26.4 (49.7)	1.3 (37.8)	5.8 (15.3)
Transportation	8.8 (71.1)	3.2 (55.1)	2.9 (46.7)
Wandering	0 (8.8)	0.6 (9.6)	0 (0.7)
Orientation	1.3 (14.5)	0 (10.3)	1.5 (5.1)
Medications	0 (27.0)	0 (19.2)	0 (24.8)
Substance abuse	0.6 (1.9)	0.6 (0)	0.7 (0.7)
Illness	1.9 (28.9)	1.3 (16.7)	0.7 (16.1)
Emergency help	3.8 (21.4)	2.6 (12.8)	0 (8.0)

	Admission, n=159	Discharge, n=156	3-months post discharge, n=137
Smoking	0 (0.6)	0 (0)	0 (0.7)
Hazards	13.2 (15.1)	3.2 (9.6)	8.8 (9.5)
Money management	0.6 (49.7)	0.6 (37.8)	1.5 (29.2)
Security	0.6 (16.4)	0 (10.9)	1.5 (13.9)
Personal information	0.6 (12.6)	0 (11.5)	0 (8.8)
Shopping	8.2 (77.4)	0 (69.9)	0 (60.6)
Temperature	0.6 (11.3)	0 (8.3)	0 (13.9)
Supports: adequate	8.2 (NA)	0.6 (NA)	2.2 (NA)
Supports: stability/can cope	6.9 (NA)	1.9 (NA)	2.9 (NA)