

Chapter 9: Discussion and Recommendations

9.1 Introduction

This chapter summarises the study findings and discusses them in relation to the ICF model described in Chapter 1 and the literature reviewed in Chapter 2. The study limitations and recommendations are also outlined in this chapter.

9.2 Description of RITH services

One of the gaps identified in the literature was the lack of description of rehabilitation services. This study has fully described one inpatient service and two models of home-based rehabilitation services (see Chapter 5). There were some similarities and differences between the three service types. The three service types all had similar target groups, service aims and eligibility criteria. All three service types had a multi-disciplinary team approach with aspects of inter-disciplinary teamwork. All services had physiotherapy and occupational therapy but there was a much greater degree of nursing and medical input and less case management and program co-ordination in the inpatient program compared with both RITH service types. Nursing services differed between RITH programs with two out of three bed substitution services providing nursing directly, compared with one of five ambulatory programs. All teams said that they thought involvement of the client and carer in the rehabilitation process was important, but they had various ways of going about this and processes for inclusion of client and carer input were more refined in some teams than others.

There were some similarities and differences between the services included in this study and the limited descriptions of home-based rehabilitation found in the literature. The services described in the literature were more likely to target a specific diagnostic group (for example, stroke or hip fracture). The service aims and eligibility criteria were not described. All the programs described in the literature took a multi and/or inter-disciplinary team approach to rehabilitation, all had physiotherapy and occupational therapy services and all aimed to include the client and carer in the rehabilitation process, although they approached this in different ways. For example one service held their weekly team meetings in the client's home and clients and carers were invited to contribute to the medical record which was also located in the client's home (Rodgers et al., 1997).

However, the service descriptions seemed closer to the bed substitution services described in this study than the ambulatory services. All except one (Gladman et al., 1994) included early discharge from hospital as a goal. Seven services liaised with staff and clients in the inpatient acute and/or rehabilitation wards prior to discharge to RITH. Five completed a home visit prior to discharge from the inpatient setting. Furthermore case management was a feature of six of the programs. These three features: goal of early discharge; close liaison

with the hospital; and case management were aspects of the bed substitution models rather than the ambulatory services included in this study.

Only two of the studies reviewed in the literature reported on the level of intervention provided by their services and only one described the level of service in hours per week. This service provided an average of 1 hour and 54 minutes of therapy per week (Widén Holmqvist et al., 1996). To compare the programs in this study with the Widén Holmqvist study, a calculation of direct therapy hours per week for neurological clients only was made. This revealed that the bed substitution RITH participants in this study were receiving a much higher level of service than the Widén Holmqvist study (6.49 hours per week) but the ambulatory clients were receiving a comparable level of direct therapy hours per week (2.18 hours). The other study (Mayo et al., 2000) stated that their clients received on average 3.6 visits per week from rehabilitation staff. It is not known how long these visits lasted but it appears that the service provided in the Mayo et al. study (which was also restricted to stroke clients) was within the range provided by the two RITH service types in this study. Although these data do not include brokered services, it appears that none of the RITH services described here or elsewhere are providing a level of service that is comparable to inpatient rehabilitation. Despite this, the services reviewed in the literature were achieving the same if not better outcomes for their clients. This was not the finding of this study.

9.3 Client and carer outcomes

9.3.1 Client Impairment Outcomes

The only impairment measure included in this study was the Timed Up and Go. Significant improvements occurred for participants who completed the Timed Up and Go (n=26) with scores improving from 31.3 seconds at admission to 24.1 at discharge and 23.4 3-months post discharge. The sample was too small to compare rehabilitation types.

9.3.2 Client Activity Limitation (Disability) Outcomes

In the current study, participants in all three settings improved significantly on outcomes related to activity limitation or disability, from admission to discharge and post discharge. At 3-months post discharge, the majority of participants (70%) maintained progress or continued to improve on outcomes since discharge. Thirty-five participants had adverse outcomes (14% of inpatient, 18% bed substitution and 26% of ambulatory participants). Most adverse outcomes were illness, readmission to hospital and deterioration probably due to the influence of co-morbidities. Across the study period one bed substitution and two ambulatory participants died.

Overall outcomes relating to activity restriction (BI, DFADL, HART OK by self) indicated that:

- Inpatient participants had poorer function on admission but showed the greatest level of improvement across discharge and post discharge.
- Bed substitution participants improved more than ambulatory participants. The greatest difference occurred between discharge and 3-months post discharge where bed

substitution participants continued to improve but ambulatory participants' progress tended to slow. This pattern was more pronounced for neurological participants than orthopaedic participants. However, ambulatory participants were more likely to live alone and be older, than bed substitution participants.

The above findings differ from those obtained in previous published research. As outlined in the literature review, nine RCTs that compared outcomes for clients receiving home and hospital rehabilitation found no differences; four found improved outcomes for home-based clients and only one recorded better outcomes for a hospital/outpatient group. The BI or FIM was used in 13 of these studies. The different findings in the current study may be because this study was not a randomised controlled trial and did not include comparable groups. However, findings in Chapter 4 indicate that differences between participants from different rehabilitation types on the BI, DFADL, and HART (OK by self) on admission were not significantly different. This provides some support that the groups were similar and could be compared. Another difference in this study to that of the literature was the inclusion of ambulatory services. Only one of the interventions trialed in the literature reviewed for this study was comparable to an ambulatory service (Gladman et al., 1994).

9.3.3 *Client Participation Restriction (Handicap) Outcomes*

The results from the HART showed that, as expected, home-based participants had few personal care participation restrictions. The majority of RITH participants had <2 "Not OK" items on the HART on admission and this reduced to <1 on discharge. Inpatient participants had more "Not OK" items on admission (mean = 3.95). This finding was supported by staff at focus groups who indicated that if there were any key personal care participation restrictions that were "Not OK" for clients referred from hospital, it would be considered inappropriate to discharge the client home for rehabilitation. However, assessment of "Not OK" in hospital did not take into account the support that was available to the client. If the client had been at home or about to go home, carer and service availability would be considered before a "Not OK" rating was made.

Due to the small proportion of participants with items "Not OK", there is little room to identify change in participation restriction across the study period. The table shown in Appendix R also includes the percentage of participants needing help with HART items at the three study time points

There is little comparable research in the literature as the HART was not used in any of the published research. Only three RCTs used a measure of participation restriction (Crotty et al., 2002; Rodgers et al., 1997; & Rudd et al., 1997). There were no differences in participation restriction outcomes between hospital and home-based rehabilitation clients found in these studies.

9.3.4 *Quality of Life*

According to the results achieved on the AQoL (n=79), there was a significant improvement in quality of life for the whole sample. However, the rate of change differed between rehabilitation types. Bed substitution participants for both diagnoses reported the poorest

quality of life at admission but improved the most across discharge and 3-months post discharge. Ambulatory neurological participants reported poorer quality of life at discharge than admission although at 3-months post discharge scores were slightly better than at admission. Of all groups, inpatient orthopaedic participants reported the highest quality of life at all time points.

Only four studies in the published literature reported on quality of life (QOL). Three found that there were no differences in QOL between client groups (Crotty et al., 2002; Mayo et al., 2000; & Ronning & Guldvog, 1998) and one (Shepperd et al., 1998b) found that for hip replacement patients, the home rehabilitation group recorded higher quality of life, according to the mental health component of the SF-36 (The Short Form 36 Health Survey). Crotty et al. (2002) found that carers in the intervention (home rehabilitation) group showed significantly greater improvement on the mental health component of the SF-36 at 4-months post randomisation than the control group. The findings of this study cannot be directly compared with previous research but there is some evidence in this study and the Crotty et al. (2002) study that QOL for clients and/or carers improves more with (intensive) home rehabilitation than hospital rehabilitation. This is an important area for further research as quality of life is an important aspect of rehabilitation and can be used as a measure of cost effectiveness.

9.3.5 Satisfaction

Satisfaction with rehabilitation from participating clients and carers was generally high. However, there were four areas in which satisfaction was lower for both clients and carers. These were: information about the causes and nature of their illness (or the illness of the person that they provided care for); sufficiency of therapy; and adequacy of information about and support from community services. These findings were supported by the limited examination of satisfaction in the published literature. Only four of the randomised controlled trials reported in Chapter 2 measured satisfaction. These studies consistently found that clients and carers in both groups were satisfied with the care that they received. One study found that clients at home were more satisfied with their rehabilitation than clients in hospital (Rudd et al., 1997). Another study found that lower satisfaction was associated with poorer understanding and lack of information about stroke (Anderson et al., 2000a).

In the current study, clients were asked to rate their agreement with the statement, '*If needed again in the future, I would prefer rehabilitation to be provided at hospital and not at home.*' A significant difference was found between groups on responses to this question. Participants being discharged from an inpatient rehabilitation service were more likely to agree to this question (62%) indicating that they would want rehabilitation to be provided in the hospital if required in the future. In contrast, 59% of home-based participants disagree with this statement, not preferring rehabilitation in hospital. Carers were given a slightly different question. They were asked to nominate where they would prefer rehabilitation for the person they care for to be provided in the future if required. The majority of inpatient and ambulatory participant carers would prefer a combination of rehabilitation types while bed substitution participants would prefer home-based rehabilitation (not significant). These findings, taken together with the qualitative findings

from the interviews with clients and carers indicate that people prefer a combination of service types, probably depending on their needs at any one time but that if they have experienced both RITH and inpatient rehabilitation, that they prefer RITH.

9.3.6 *Carer Demand*

The findings of previous research in relation to home rehabilitation carers have been mixed, with most studies reporting no difference in carer stress between the two groups (Gladman et al., 1994; Rodgers et al., 1997; Rudd et al., 1997; Young & Forster, 1992; and Shepperd et al., 1998b); two studies reporting poorer mental health outcomes for carers (Anderson et al., 2000a; Widén Holmqvist et al., 2000); and three studies reporting better outcomes for carers (Crotty et al., 2002; Crotty et al., 2003; Teng et al., 2003). In this study carer demand, rather than carer stress was measured in order to capture a more objective measure of the impact that home rehabilitation might be having on carers. Caregiving Demand Scale (CDS) scores (n=25) for RITH carers remained the same from admission to discharge but improved significantly from discharge to 3-months post discharge. It is likely that as the client's functional ability improved, the carer demand lessened. Highest areas of demand were additional household tasks, provision of transport and emotional support.

9.3.7 *Goal setting*

There is no previous research reported in the literature that outlines the process of goal setting and the outcomes in terms of goals achieved for clients in home-based rehabilitation. The current study examined goals from the point of view of staff and clients. Staff were asked to note the overall goal of the client's admission to their program on the admission sheet and to assess whether this had been achieved upon discharge. Most participants were discharged because, from the rehabilitation team's perspective, they had completed their rehabilitation (83%) and had fully (80%) or partially (17%) achieved the rehabilitation program's goals. There was a slightly higher proportion of participants with goals fully achieved in the inpatient program (56%) compared to the home-based programs (46% of bed substitution and 43% of ambulatory).

Although study participants were given no specific help or guidance about how to set their rehabilitation goals, a large proportion (98%) of the sample who completed the AQoL recorded at least one goal at the end of the AQoL form. Half of the goals set by participants were considered fully achieved by the participant and another quarter of goals were partially achieved by the 3-month follow-up assessment.

9.3.8 *Relationship between outcomes and service provision*

To examine the relationship between service provision and outcomes, correlations were made for each diagnostic group between improvements in the BI, DFADL, HART (OK by self) and AQoL with various service measures. The study found that outcomes for neurological participants achieved from admission to discharge correlated with service measures including total hours of therapy (particularly direct hours of therapy), hours of therapy per day and number of therapies. The relationship between outcomes and service levels for orthopaedic participants, however, became more evident post discharge where a

positive relationship was found between total number of therapies and services received during rehabilitation and improved outcomes. As community services are likely to continue after rehabilitation ceases, it could be argued that they are having a positive effect on further progress of function post discharge for orthopaedic participants. There was also some indication of a relationship between shorter lengths of stay in the study rehabilitation and improvements achieved post discharge. These findings suggest that a greater range of therapies and more intensive therapy are more closely associated with positive rehabilitation outcomes than a longer length of stay. Orthopaedic participants referred to CRC post discharge showed smaller improvements than those not referred while for neurological participants this trend was reversed with improvements in the HART significantly greater for those referred to CRC than those not. Finally, improvements in quality of life did not correlate with service provision variables. This is an area requiring further investigation as it is unclear whether there is a relationship between rehabilitation and health-related quality of life.

9.3.9 Summary

Overall, findings indicated that participants achieved significant improvements in activity and health related quality of life through the course of the study and most were able to fully or partially achieve the goals they had set at the commencement of rehabilitation. However, greater improvements for both diagnostic groups appeared to be achieved in the inpatient setting than at home. Also, greater improvements were identified for bed substitution than ambulatory participants, particularly for those with a neurological primary diagnosis. These data support the need for more intensive therapy for those with a neurological diagnosis than those with an orthopaedic diagnosis. There were, however, some limitations to comparing the three rehabilitation types as outlined in 9.6 below.

9.4 Client and carer experiences of home-based rehabilitation

The client participants interviewed who had experienced home rehabilitation preferred it to hospital-based rehabilitation although hospital-based rehabilitation was acknowledged as important for people who are really unwell or in need of specialist equipment. Home-based rehabilitation was generally experienced as an effective, individually tailored, high quality service that enabled participants to achieve their rehabilitation goals whilst enjoying the benefits of being at home with their friends and family. Hospital-based rehabilitation was also regarded positively by most participants who had experienced it. However, therapy in hospital was more often (than home-based therapy) perceived as not intensive enough, even though it was (objectively) more intensive than home-based therapy. Younger participants and participants with young families seemed to find hospital-based rehabilitation particularly frustrating, although one client with MS felt that at times she needed a respite from the pressures at home which hospital provided.

Most participants indicated that they wanted to be given more clear and accurate information about the services they were entitled to receive, about the therapy program (especially decisions about discharge), and about their medical condition. Information about their medical condition was the most consistently problematic area for participants, a finding that was supported by the results of the satisfaction surveys.

Although many participants said they did not see it as their place to set goals or influence the therapy, others found the goal setting process to be very beneficial and some participants found therapy frustrating and counter-productive when their goals were not taken into account.

Transition for hospital to home with RITH seemed to be handled well and participants appreciated the preparation they received prior to discharge from hospital. Transition from RITH to the next phase of rehabilitation could at times have been handled better, with better preparation for discharge and follow-up being suggested by participants.

In conclusion, RITH seemed to be viewed by most client participants as an excellent program that was individually tailored to meet their rehabilitation needs. Carers also seemed to be generally happy with the service. The main areas that clients and carers felt could be improved on were: the provision of information regarding their medical conditions; preparation for discharge from RITH; carer support; and for some participants, involvement in their care plan and follow-up post discharge from RITH.

9.5 Staff perceptions of home-based rehabilitation

According to the staff working in this area, rehabilitation in the home had numerous benefits for clients and carers. Not only did therapy in the home provide situation specific therapy in a realistic environment but it assisted clients in the adjustment from hospital to home often reducing hospital LOS. Clinicians were better able to identify motivators and barriers for therapy and how well the client and carer would cope at home, which was sometimes difficult to determine in hospital. RITH was advantageous for clients who couldn't access centre-based therapy and it put clients more in control of their therapy. Through RITH, carers too could be more involved in therapy and didn't have to visit the client in hospital. It also reduced boredom for clients as medically stable patients in hospital were often bored.

There were many ways in which home rehabilitation services appeared to be working well at present. Staff valued the team-work, support and communication within their current work environments. Having experienced staff and working within an organisational context that provided opportunities for staff development (eg teaching hospital) were also regarded positively by staff. The service flexibility that RITH was able to provide to clients was also valued. However OHS issues; access to cars; continuity of care for clients; and the provision of adequate services to clients were identified by RITH staff as areas that needed to be addressed.

9.6 Study critique

This study used a mix of qualitative and quantitative data to investigate different models of home-based rehabilitation, different outcomes for clients, and features of best practice in providing a home-based rehabilitation program. The qualitative focus group methodology for describing the models of rehabilitation in Victoria was comprehensive and in-depth and lead to saturation of information indicating that the methodology was sound. The features

of best practice were developed through a combination of qualitative information from clients, carers and service providers along with satisfaction surveys and surveys from referring agencies. The range of information has allowed the perspectives of best practice to be considered from service user, service providers and referrers to the service. Again saturation of information suggests that an adequate number of participants from each perspective were collected. The examination of outcomes for clients, however, has some methodological limitations as outlined below.

- *No control group:* As with most studies examining current practice, a randomised control study was not possible as it was considered unethical to provide a Government funded program that randomly allocated clients to either go home for rehabilitation, stay in hospital for rehabilitation or be sent home without services. Therefore, there was no comparison group that did not receive rehabilitation and, therefore, it can not be concluded whether changes identified would have been better, the same or worse for clients sent home without any rehabilitation.
- *Comparability of different rehabilitation types:* Underpinning the comparison between inpatient, bed substitution and ambulatory participants is the assumption that participants in each rehabilitation group will have similar functional status and other characteristics related to rehabilitation outcomes. If this assumption holds, any variation in improvement across rehabilitation types can be attributed to the service provided rather than different client characteristics. One of the limitations of this study is that clients accessing different rehabilitation types may have been at a different stage in the rehabilitation episode. For example, clients admitted to RITH may have already had a period of inpatient rehabilitation. Therefore, clients at discharge to inpatient rehabilitation would have similar function to clients on admission to RITH. To help overcome this problem the inpatient program selected did not have access to a RITH program and therefore, on discharge these participants should have been at a level ready for CRC as would clients discharged from a RITH program. This still has limitations however, as it includes a group of patients who would not ordinarily be admitted to RITH. Despite these possible drawbacks, the outcome measures used in this study indicated that on admission, there were no significant differences in relation to activity measures.
- *Grouping different rehabilitation programs as one type:* Another possible limitation to the project was grouping different rehabilitation programs as one service type. For example, one ambulatory program may provide a different range of services to another ambulatory program. However, the receipt of funding was determined to be the key measure of what differentiated inpatient, bed substitution and ambulatory programs. To help overcome this issue, correlations were drawn between various service/therapy measures and participant outcomes. This data supported that larger amounts of therapy were associated with improved outcomes, regardless of rehabilitation type.
- *Timing of completion of outcome measures:* There were also some potential limitations in the timing and administration of the outcome measures used. It is not known whether the admission information completed by clients and carers was really at admission. It may have been closer to discharge, particularly if the client had only a short length of stay.

- *Variability in assessors:* There was a range of people completing the assessments across the 7 participating programs. Furthermore, although in most cases, the admission and discharge measures were completed by the same clinician, a different person completed the measures for the 3-month follow-up. However, as most of the tools selected have been tested for inter-rater reliability this should not be a major limitation.
- *Exclusion criteria:* To reduce variability in participant outcomes, only clients with orthopaedic and neurological diagnoses were included in the study. Outcomes can not be generalised, therefore to clients with other rehabilitation diagnoses. Also, although clients with cognitive impairment and from CALD backgrounds were not purposely excluded from the project, there appeared to be an under-representation of these clients, perhaps reflecting additional tasks involved in recruiting these clients (i.e. getting third party consent or involving an interpreter). To try to prevent this limitation, rehabilitation teams were offered subsidies for any participants requiring an interpreter.
- *Missing data:* Although 164 clients and 75 carers were recruited to the study, only 137 full data sets from clients and 28 from carers were able to be used in the data analysis.

9.6.1 Critique of outcome measures:

There were no tools identified that met all the criteria identified by the researchers in conjunction with the clinicians working in rehabilitation. There is, to date, no comprehensive outcome measure that has been validated for use in the home. Concerns were raised by clinicians early in the study that tools available and commonly used were more likely to identify change within a hospital setting and that goals of home-based rehabilitation would differ considerably across the client group and therefore not easily measured. It was also considered important to implement measures that could be used by most members of the rehabilitation team and would minimise the burden of data collection on clinicians. For this reason self-report measures for both carer demand and patient assessment of quality of life were considered favourably. Despite possible limitations of outcome measures, the measures consistently identified improvement for participants from all rehabilitation types and also consistently found a greater rate of improvement for inpatient participants compared to RITH participants and bed substitution participants compared to ambulatory participants. Also, despite clinicians' concerns that measurement tools would not identify change, particularly for neurological participants, significant improvements were identified for both diagnoses on all activity measures:

- *DFADL:* Was found to identify a substantial shift in function. It was also short, easy to administer, did not have ceiling effects and was able to indicate changes in activity status across periods of only a few weeks of rehabilitation. Although to date it has had limited use it is also being introduced to home-based services through the Primary Care Partnership initiative
- *BI:* was also able to identify change, however, use of the FIM would have enabled measurement of change in cognitive as well as physical activity.
- *HART:* Adding another dimension to the HART by including a measure of assistance required (OK split into OK by self or OK with help) enabled greater change to be identified than the two level scale allowed. The greatest change occurred in the

proportion of participants undertaking tasks independently rather than the number of activities that were "Not OK".

- *CDS*: for a small sample of carers was able to identify a significant change and was also found to be quick and easy for carers to complete.
- *AQoL*: clients often requested assistance in interpreting questions. If rehabilitation teams were considering implementing this for their clients, they may need to be available for responding to difficulties clients may have.
- *TUG*: generally quick and easy to administer although only appropriate for a sub-group of clients. Sometimes there were difficulties finding suitable space in the client's home to undertake the test.

In conclusion, despite the concerns outlined above, the methodology incorporated into this study built substantially on the existing body of research in this area. Using the best available outcome measures (within the criteria outlined earlier) and supplementary qualitative methods, the study methodology addressed gaps identified in the literature review and achieved the study aims.

9.7 Conclusions

This study aimed to describe the current practice models of home-based rehabilitation in Victoria. This was achieved through interviews with clients, carers and staff and collection of data about client groups, service provision and referral patterns. The study concludes that there are some clear differences between the services that receive funding for bed substitution and ambulatory models.

The second aim of the study was to compare outcomes for clients and carers between inpatient rehabilitation and the two RITH models. The study achieved this by administering a range of outcome measures to clients and carers at three time points. It found that participant outcomes improved with all three service types but that outcomes were better for inpatient than home-based rehabilitation and for bed substitution than ambulatory RITH. This study finding was different to that found in previous research and may be partially explained by the different methodology adopted. However, it was supported by the finding that service range and intensity (both of which were greater in inpatient rehabilitation) were associated with better outcomes. Therefore in this study, more intensive therapy seemed to be associated with better outcomes for rehabilitation clients with an orthopaedic or neurological primary diagnosis - particularly clients with a neurological condition.

Finally the study aimed to recommend a framework for best practice in home-based rehabilitation. The current practice in home-based rehabilitation was seen as being of a very high quality by staff, clients and carers alike. However, there were some areas in which service improvements were seen to be required. These were: the provision of information to clients and carers; the amount of therapy provided; OHS issues for RITH staff; resource allocation to RITH services; follow-up with clients and carers post discharge; and continuity of care – specifically communication with referrers; communication with GPs; on referral after the RITH program ceased; continuity of service between hospital and home; and better integration of RITH and CRC.

In conclusion, the study found that clients and carers require a mix of hospital, home and centre-based rehabilitation that is able to respond to their needs and preferences at each phase of the rehabilitation continuum. Ideally, there would be a seamless service that enabled clients to make the transition from hospital to home, as soon as they felt confident about going home. This service would provide an individualised inter-disciplinary service that was based on the client's goals. Community support services would be provided (brokered) by the service according to the principles of client and carer need and continuity of care. Clients and carers would be involved in all phases of care planning (unless they requested otherwise) and kept fully informed about their service entitlements, the causes and nature of their condition and provided with active follow-up after discharge. The service would have the flexibility to provide home or centre-based services depending on the client's needs regardless of the location of the client.

The service would be staffed by appropriately qualified staff in a mix that was determined by the needs of the client population. Staff would be able to work in an environment where OHS principles were maintained. Junior staff would be involved in all aspects of the service where appropriate mentoring and supervision was available. Referrals would be responded to in a timely manner and interim arrangements made where clients could not be admitted immediately. The service would have mechanisms for quality assurance and be adequately resourced to undertake all other aspects of the work.

Finally, an additional outcome of this study has been the collection of considerable feedback on the use of outcome measures in home-based rehabilitation. Apart from the BI and the FIM, neither of which were designed for home use, the DFADL emerged as the preferred tool for ongoing use in home-based rehabilitation.

9.8 Recommendations

The study recommends that:

1. The Best Practice Principles outlined in Chapter 8 be discussed with the DHS personnel responsible for funding rehabilitation services, health service managers and the managers of home-based rehabilitation services and reviewed in terms of their practicability and feasibility for adoption.
2. Both home and hospital-based models of rehabilitation be maintained and developed and where possible clients be offered a choice to continue rehabilitation at home as soon as they are ready to do so.
3. That further research be undertaken to investigate:
 - The actual cost of provision of the different types of rehabilitation services in Victoria to enable a cost effectiveness analysis;
 - Outcome measures that are appropriate for home-based rehabilitation and practical to use;
 - The relationship between quality of life and rehabilitation; and
 - A process of client-centred goal setting that could be adopted in rehabilitation and potentially used to measure outcomes.