Rehabilitative Care Alliance

Overview of Key Findings from OP/AMB MDS Provincial Validation Survey:

March 2015

Ontario
Local Health Integration Network

Overview

1. Background on Outpatient/Ambulatory Minimum Data Set Initiative
2. Development and Purpose of the OP/AMB Minimum Data Set Validation Survey
3. Results of the OP/AMB Minimum Data Set Validation Survey
4. Summary of Implementation Considerations and Key Findings of the OP/AMB Minimum Data Set Validation Survey
5. Appendices

1. Background on Outpatient/Ambulatory Minimum Data Set Initiative and Provincial Validation Survey FAQ

Mandate of the Outpatient/Ambulatory Task Group

Develop a comprehensive and standardized minimum dataset for Ministry/LHIN-funded outpatient and ambulatory rehabilitative care programs.

Note: This includes hospital-based and ambulatory clinics

Impact & Implications of the Outpatient/Ambulatory Initiative

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The MDS will address the identified need for data on outpatient rehabilitation:

- Clinical decision makers have long expressed interest in evaluating outpatient rehabilitation[2], particularly given the reported erosion of outpatient rehab services over the last 10 years and observed access issues in the literature.
- The need for data is also linked to a renewed focus on understanding the role of outpatient rehabilitation within an integrated and efficient healthcare system[3].

[2]GTA Rehab Network. Outpatient Rehabilitation in the GTA: Understanding the Current State. Final Report (June 2011).
[3]GTA Rehab Network. Developing a Performance Framework for Out-Patient Rehabilitation: Discussion Document (February 2013)

Impact & Implications of the Outpatient/Ambulatory Initiative (cont'd)

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The MDS will address the identified need for data on outpatient rehabilitation:

- Health Quality Ontario's QBP Handbooks suggest that the "absence of standardized provincial reporting of outpatient rehabilitation clinic activity creates a void in understanding the pathway of hip fracture patients[4]" and that since hospitals are not required to report on outpatient rehabilitation clinic activity, there is "a significant gap in provincial information systems[5]".

[4]Quality-Based Procedures: Clinical Handbook for Hip Fracture Health Quality Ontario & Ministry of Health and Long-Term Care (May 2013)

[5]Quality-Based Procedures: Clinical Handbook for Primary Hip and Knee Replacement Health Quality Ontario & Ministry of Health and Long-Term Care (November 2013)

Impact & Implications of the Outpatient/Ambulatory Initiative (cont'd)

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Health Quality Ontario's QBP Handbook for Chronic Obstructive Pulmonary Disease also identifies the need for data on outpatient rehabilitation:

- *"Virtually no patient-level data on COPD-related outpatient clinic services are currently collected or reported in Ontario. The ministry should adopt this as a priority area for new data collection, starting with the collection of activity data from outpatient pulmonary rehabilitation clinics[6]"*

[6]Quality-Based Procedures: Clinical Handbook for Chronic Obstructive Pulmonary Disease (Acute and Postacute), (February 2015)

Impact & Implications of the Outpatient/Ambulatory Initiative (cont'd)

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Auditor General of Ontario's (AGO) 2013 report indicates that in order to ensure that patients have timely access to required outpatient services, hospitals should collect information regarding the efficiency and effectiveness of outpatient resources, such as "***information on the number of appointment cancellations and patient no-shows, and on the change in patient functionality between when outpatients start and when they complete outpatient rehabilitation***".

The AGO goes on to recommend that, "***in order to have good information for current and future decision-making, the Ministry should establish, in conjunction with its shareholders, what information should be collected on restorative inpatient and outpatient services and how best to collect the data***[7]".

[7]2013 Annual Report – Office of the Auditor General of Ontario

Guiding Principles

- Consideration will be given to the relative ease of collection and reporting of data elements.
- Recommended data elements will align with data elements currently collected within other sectors (e.g. Community Clinics, CCAC) to support cross continuum data collection and reporting(where possible).
- Elements included in the dataset will help to inform evidence of the benefits of outpatient/ambulatory rehabilitative care in achieving health system goals (e.g. patient outcomes, implementation of best practices, costs)

Process to Develop a Minimum Data Set for OP/AMB Rehabilitative Care

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#1 Identify Desired Outcomes (Jan-Feb 2014)

↓

#2 Identify Key Metrics / Indicators (Feb-May 2014)

↓

#3 Identify Data Elements Required to Inform the Metrics/Indicators (Spring-Fall 2014)

↓

#4 Finalize Minimum Data Set and Validate with Provincial Stakeholders (Fall 2014)

↓

5 Develop toolkit/report including technical details of MDS and considerations for implementation of recommendations (Dec-Mar 2015)

Deliverables

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Evaluative Framework to Support Development of an OP/AMB MDS

A. Overarching Questions

1. What is the primary reason for which the patient is seeking treatment in the outpatient/ambulatory program?
2. What is the primary diagnosis for which the patient is seeking treatment in the outpatient/ambulatory program?

B. Patient/Caregiver Experience	C. Clinical Outcomes	D. Access and Transition	E. Financial Performance
B1. What is the patient's / caregiver's reported experience of their outpatient rehabilitative care?	C1. How much functional change occurred in activity and/or participation while attending an outpatient/ambulatory program whose primary function is to restore/optimize function? C2. Where the objective of outpatient/ambulatory program was maintenance, education, self-management or consultative/ assessment, was that objective achieved? C3. Did the outpatient/ambulatory program influence the caregivers' level of stress/burden associated with caring for the patient?	D1. Which type of organization referred the patient to Outpatient rehab? (acute care, home care, inpatient rehab etc.) D2. How many days did the patient wait (once ready for rehab) for the first treatment appointment date? D3. Of the patients requesting treatment, how many actually received treatment? D4. How many referrals were declined? Reason for declined referral? D5. How many patients were accepted to be treated by the Outpatient program but the patient did not accept?	E1. Was the treatment plan completed? If not, why? E2. What is the average direct cost for an episode of care to treat each discharged patient by patient population? a) How many discharged patients were treated by the program per reporting period? b) What types of health discipline services did the patients receive? c) What was the average length of each episode of care? d) How many visits/attendances (average/ median) per health discipline functional centre and for all health discipline functional centres did each patient receive in the episode of care? e) How much time is the program providing to the patient per episode of care?

2. Development and Purpose of the OP/AMB Minimum Data Set Validation Survey

Minimum Data Set Validation Survey

- The Secretariat and OP/AMB Task Group consulted with multiple branches of the Ministry of Health, HQO, OHA to develop a survey.
- Each LHIN was sent a survey on November 3rd, 2014 for distribution to OP/AMB Rehabilitative Care providers in their regions.
- The Secretariat distributed the survey to Community Physiotherapy Clinics (CPCs) on November 10th, 2014 after receiving confirmation from the Ministry to include this sector.
- All completed surveys were to be submitted to the RCA Secretariat by November 21, 2014.

Minimum Data Set Validation Survey

The purpose of the OP/AMB MDS Validation survey was:

- To generate a list of outpatient rehab (OPR) programs funded by the Ministry/LHINs and an estimate of service volumes across programs.
- To understand the type of data currently collected by the OPR programs.
- To understand the potential implications of implementing the proposed minimum dataset.

Defining the Scope of the Outpatient/ Ambulatory Rehabilitation Validation Survey

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- Programs/Services funded by the Ministry of Health and Long-term Care of Local Health Integration Networks (LHINs).
- Programs/Services delivered by a single or interdisciplinary provider(s)
- Rehabilitation-focused programs/services with the presence of at least one regulated health professional (e.g., nurse, OT, PT, or SLP, etc.). May include services that include assessment & treatment or assessment-based only, provided there is nursing or health discipline involvement.
- Program of care is time-limited, and goal oriented – includes goal setting and review.
- Programs/Services delivered either in hospital or community so long as the services are hospital funded/governed.
- Including Community Based Physiotherapy Clinics

Exclusion Criteria for the Outpatient/Ambulatory Rehabilitation Validation Survey

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- Programs/Services that are not funded by the Ministry of Health and Long-term Care, Local Health Integration Networks (LHINs)
- Programs/Services that are provided through third party funding (e.g., WSIB, MVC, etc.).
- Programs/Services that are primarily medical in nature: physician-driven, goals are medically oriented where physicians bill OHIP directly and do not consume hospital resources (e.g., Physician-led clinic with no nursing or allied health discipline involvement).
- Programs/Services that are primarily recreational/respite in nature (e.g., Adult Day Programs).
- Programs/Services funded or governed by CCACs
- Programs/Services provided through Community Health Centres
- Community based falls prevention & general exercise classes

3. Results of the OP/AMB Minimum Data Set Validation Survey

Survey Considerations/Parameters

- In order to reduce the burden of data collection/reporting for survey respondents, the RCA requested 1 survey per organization, not per program.
- Additionally, it was a survey and not an inventory.
- Therefore the provincial numbers cannot be interpreted to represent the full number of programs/services offered across the province, nor does it represent a comprehensive count of the volume of patients served.

Survey Considerations/Parameters

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Community Physiotherapy Clinics

- Patients are treated by physiotherapist and/or support staff only (i.e., multidisciplinary services provided through CPCs are not LHIN/MOHLTC-funded).
- Patients needs can be addressed by physiotherapy

Hospital Based Outpatient Rehabilitative Care

- Includes programs that may delivered by a single or multiple disciplines. Also provide access to adjunctive services (e.g., chiropody, dietetics) and specialty clinics (e.g., seating and positioning, splinting, spasticity, prosthetics and orthotics).

Response Rates

A total of 282 surveys were distributed to providers across the province.

- 113 Health Service Provider (HSP) corporations* offering outpatient/ambulatory rehabilitative care
- 165 Community Physiotherapy Clinics (CPCs) across Ontario.

A total of 160 surveys were returned to the RCA

- 58% total response rate
  - 75 HSP corporations returned a survey to the RCA
    - 66% response rate across hospitals
  - 85 CPCs returned a survey to the RCA
    - 52% response rate across CPCs

*HSP corporations can include multiple hospital sites

Results from Hospital Based Providers

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Based on the 75 completed surveys…

- **95 sites** offering outpatient/ambulatory rehabilitative care services based on the completed surveys.
- **357 programs** offering outpatient/ambulatory rehabilitative care.
- **230, 803 patients** were served in 2013/2014
- **1,321,217 health discipline attendances** were provided in 2013/2014
- **258,039 nursing visits** were provided in 2013/2014

Considerations and Limitations

Based on the 75 completed hospital based surveys…

- 357 outpatient/ambulatory rehabilitative care programs
  - 55 programs indicated that estimates were used when reporting volumes/attendances/visits
  - 6 programs did not report any patient volumes
  - 2 programs did not report any nursing visits

- Community Physiotherapy Clinics were not asked to report volumes as these are reported to the MOHLTC.

Breakdown of Hospital Based Outpatient Rehabilitative Care Programs

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Primary Objective*	Number of Programs	% of Total Programs
Restore or optimize function	251	70%
Maintain function	16	4%
Education, Peer Support, Self-Management	27	8%
Primarily consultative or assessment-based: Assistive devices needs	16	4%
Primarily consultative or assessment-based: Other	47	13%

*Primary Objectives as categorized within the RCA MDS

Most Frequently Reported "Restore or Optimize Function" Programs Within the Hospital Based Outpatient Sector

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- Outpatient Physiotherapy Programs
- Hand and Upper Limb Clinics
- Orthopedic Rehabilitation (Including Post-Op Joint Programs)
- Cardiac Rehabilitation Programs
- Neurological Rehabilitation and Stroke Programs
- Outpatient Speech Language Pathology Programs
- Multidisciplinary Outpatient Rehabilitation Programs
- Outpatient Occupational Therapy Programs
- Pediatric Rehabilitation (Including Speech Therapy Programs)
- Prosthetics and Amputee Rehabilitation Programs
- Pulmonary and Respiratory Rehabilitation Programs
- Geriatric Rehabilitation

Overview of Current State Collection of Data Elements within the Financial Performance & Access and Transition Quadrant

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The 'Access and Transition' & 'Financial Performance' Quadrants are comprised of 33 data elements.

- Current state collection of these data elements ranges from 20% to 99% of providers, depending on the data element.
- 90% of the data elements within the 'Access and Transition' and 'Financial Performance' quadrants are collected by the majority of providers (i.e., >50%).
- None of the data elements within the 'Financial Performance' & 'Access and Transition' Quadrants are **new** elements for **all** providers
  - Refer to Appendix A for a detailed analysis of the current state collection of data elements.

Financial Performance & Access and Transition Quadrant: CPCs vs. Hospital Based Providers

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Current state collection of data elements is similar between CPCs and Hospital Based Providers with the following exceptions:

- Hospital based providers collect the following data elements more consistently:
  - Service Recipient Time (82%) vs. CPCs (52%)
  - Declined Referrals (62%) vs. CPCs (28%)
  - Reasons for Declined Referrals (54%) vs. CPCs (26%)
- CPCs collect the following data elements more consistently:
  - Unplanned Discharge (94%) vs. Hospital based providers (64%)
  - Reason for Discharge (97%) vs. Hospital based providers (74%)
  - Primary Diagnosis Code* (89%) vs. Hospital based providers (15%)

*CPCs mandated to report through TPA with MOHLTC

Current State collection of Patient Experience and Clinical Outcome Measures

Proposed Data Element	Percentage of Programs
Measure of Caregiver Burden	4%
Measure of Patient/Caregiver Experience	40%

Frequency of Patient/Caregiver Experience Surveys

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	Caregiver Burden	Patient Experience
Each Attendance		3
Admission	1	2
Discharge	1	34
Admission & Discharge	1	1
Optional		3
Monthly		2
Quarterly	1	7
Bi-Annually		4
Annually		8

Clinical Outcomes

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Based on the 75 completed surveys from hospital based providers:

- 107 different clinical outcome measures are currently collected
  - Appendix C outlines the most frequently collected clinical outcome measures reported in the validation survey.
- There were only 4 providers across the province who indicated that they are currently collecting one clinical outcome measure to “evaluate functional change across outpatient/ambulatory rehab programs”
  - Berg Balance Scale x 2
  - Reintegration to Normal Living Index (RNLI)
  - FIM ®

Clinical Outcomes

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Community Physiotherapy Clinics are required to submit the score from an outcome measure obtained at the commencement and conclusion of the episode of care.

- Appendix D outlines the outcome measures to be used by CPCs as indicated in the transfer payment agreements with the MOHLTC.

4. Summary of Implementation Considerations and Key Findings of the OP/AMB Minimum Data Set Validation Survey

Implementation Considerations for 'Financial Performance' and 'Access & Transition Quadrants'

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Key Themes Across Responses

"Reporting on the proposed data elements within the 'Access and Transition' and 'Financial Performance' quadrants through a standardized data collection and patient classification system would bring value to the data elements that are currently collected and would require IT solutions, and decision support/information management."

"Proposed data elements within the 'Access and Transition' and 'Financial Performance' quadrants would require additional resources or would decrease the amount of therapy time for each patient due to increased therapist time spent on indirect care."

"Proposed data elements within the 'Access & Transition' and 'Financial Performance' quadrants are well aligned with the current state of data collection, and would not be a significant burden to our organization."

Implementation Considerations for Patient Experience and Caregiver Burden

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Key Themes Across Responses

"Collecting a measure of caregiver burden and patient experience would require the identification/standardization of a sensitive tool(s), training for staff, and purchasing of materials"

"Collecting a measure of caregiver burden and patient experience would have a significant impact on resources available to provide direct care"

"A measure of caregiver burden is not relevant to all patient populations who are served in the outpatient/ambulatory rehabilitative care setting."

"Measures of caregiver burden and/or patient experience are already being collected and there would be no significant challenges with implementation"

Implementation Considerations for Clinical Outcome Measures

Key Themes Across Responses

"Collecting a single clinical outcome measure would require training, and possibly funding for purchasing tool/software but is manageable and would provide a significant benefit to the sector."

"Collecting a clinical outcome measure would be a significant burden to the care team and would potentially decrease resources available for patient care"

"Identifying a single clinical outcome measure to demonstrate functional change for all patients that access outpatient/ambulatory care is a concern."

"Collecting a clinical outcome measure at admission and discharge would be challenging due to the frequency of incomplete episodes of care."

Minimum Data Set Validation Survey: Stratified Analysis

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In review of respondents who reported the top 80% of patient volumes:

- 79% (26/33) of data elements within the 'Access and Transition' and 'Financial Performance' quadrants are collected by the majority of providers (>50%)

- 74% indicated that: "Reporting on the proposed data elements within the 'Access and Transition' and 'Financial Performance' quadrants through a standardized data collection and patient classification system would bring value to the data elements that are currently collected and would require IT solutions, and decision support/information management."

Minimum Data Set Validation Survey: Summary of Results and Next Steps

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- None of the proposed data elements within the MDS are new data elements for all providers.
- 90% (30/33) of the data elements within the 'Access and Transition' and 'Financial Performance' quadrants are collected by the majority of providers (i.e., >50%).
- However, there is variability in the approaches used to collect data by outpatient/ambulatory rehabilitative care providers.
- A summary analysis of the completed surveys within each LHIN has been distributed to LHIN Leads across the province.
- As anticipated, a change management strategy will be required to mitigate implementation challenges and capitalize on the opportunities throughout implementation (e.g., training, standardized data collection, a patient classification system, etc.).

Minimum Data Set Validation Survey: Summary of Results and Next Steps (cont'd)

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Given the status of data collection observed across health service providers, implementation of a standardized outpatient/ambulatory minimum data set is required to:

- Reduce lost opportunity costs associated with the current state of data collection in the outpatient/ambulatory rehab sector (i.e., a high percentage of the data elements are collected by the majority of providers – the variation lies in the approach to the collection and in definitions of the data elements).
- Ensure consistency in performance reporting;
- Support MOHLTC directions in HSFR/QBP implementation; and
- Inform capacity planning and enable LHINs to maximize the value of community based rehabilitative care

For More Information

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5. Appendices

Appendix A: Current State collection of Financial Performance and Access & Transition Quadrants by CPC and Hospital Based Providers

Appendix A: Current State Collection of Financial Performance and Access & Transition Quadrants

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Proposed Data Element	Percentage collecting element	% Collected by Administrative Support Staff	% Collected by Healthcare Provider	% Stored in Patient's Chart	% Stored in Spreadsheet	% Stored in Software
Patient Level: Number of attendances per health professional functional cost centres*	83%	54%	41%	13%	9%	75%
Provider Level: Number of attendances per health professional functional cost centres	86%	46%	49%	7%	11%	80%
Patient Level: Number of visits per nursing functional cost centres	59%**	39%	48%	9%	9%	74%
Provider Level: Number of visits per nursing functional cost centres	64%**	28%	64%	0%	12%	70%
Patient Level: Service recipient time - individual session/each health profession	61%	40%	57%	7%	8%	76%
Provider Level: Service recipient time-individual session/each health profession	67%	29%	63%	7%	9%	74%

Current State Collection of Financial Performance and Access & Transition Quadrants

Rehabilitative Care Alliance

Proposed Data Element	Percentage collecting element	% Collected by Administrative Support Staff	% Collected by Healthcare Provider	% Stored in Patient's Chart	% Stored in Spreadsheet	% Stored in Software
Patient Level: Service recipient time - group therapy sessions/each health profession	55%**	11%	83%	9%	3%	80%
Provider Level: Service recipient time - group therapy sessions/each health profession	73%**	11%	83%	9%	2%	79%
Reason for Referral	95%	60%	37%	43%	13%	44%
Date Referral is Received	90%	78%	20%	29%	18%	44%
Referral Declined	44%	58%	38%	26%	49%	11%
Reasons for Declined Referral	39%	56%	42%	30%	50%	9%

Current State Collection of Financial Performance and Access & Transition Quadrants

Rehabilitative Care Alliance

Proposed Data Element	Percentage collecting element	% Collected by Administrative Support Staff	% Collected by Healthcare Provider	% Stored in Patient's Chart	% Stored in Spreadsheet	% Stored in Software
Referral Cancellation	63%	75%	21%	14%	33%	34%
Reasons for Cancellation	58%	74%	22%	22%	33%	40%
Date of visits/attendances*	99%	63%	36%	25%	6%	65%
Missed Appointments	87%	53%	45%	29%	6%	53%
Reasons for Missed Appointments	60%	68%	32%	33%	4%	58%
Discharge Destination	56%	10%	84%	73%	3%	15%

Current State Collection of Financial Performance and Access & Transition Quadrants

Rehabilitative Care Alliance

Proposed Data Element	Percentage collecting element	% Collected by Administrative Support Staff	% Collected by Healthcare Provider	% Stored in Patient's Chart	% Stored in Spreadsheet	% Stored in Software
Unplanned Discharge/Incomplete Episode of Care	80%	33%	67%	59%	10%	28%
Reason for Discharge from Program	86%	25%	74%	66%	3%	29%
Health Card Number*	99%	88%	9%	29%	1%	67%
Patient Date of Birth*	99%	86%	9%	30%	3%	63%
Province/Territory Issuing Health Card	91%	84%	12%	30%	2%	64%
Postal Code	97%	86%	10%	31%	2%	66%

Current State Collection of Financial Performance and Access & Transition Quadrants

Rehabilitative Care Alliance

Proposed Data Element	Percentage collecting element	% Collected by Administrative Support Staff	% Collected by Healthcare Provider	% Stored in Patient's Chart	% Stored in Spreadsheet	% Stored in Software
Sex	96%	75%	11%	31%	1%	62%
Primary Diagnosis Code [ICD-10]	20%	42%	52%	36%	0%	52%
Primary Diagnosis Code [OHIP]*	54%	48%	48%	25%	0%	73%
Primary Diagnosis Description	86%	34%	63%	46%	6%	44%
Most responsible/primary health condition for which patient is seeking rehabilitative care	93%	34%	64%	54%	6%	38%
Referral From (type of provider and/or facility name/number) *	94%	71%	26%	33%	13%	50%

Current State Collection of Financial Performance and Access & Transition Quadrants

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Proposed Data Element	Percentage collecting element	% Collected by Administrative Support Staff	% Collected by Healthcare Provider	% Stored in Patient's Chart	% Stored in Spreadsheet	% Stored in Software
Date of discharge from acute care (if applicable)	64%	44%	54%	51%	5%	42%
Date of First Appointment*	99%	68%	31%	30%	6%	61%
Date of Discharge from Program*	95%	56%	44%	36%	5%	57%

*CPCs mandated to report through TPA with MOHLTC

** Based on programs that offer nursing services or group therapy programs, and not relevant to CPCs

- 39 programs offering nursing services
- 64 programs that offer group therapy programs

Appendix B: Software Information

- A wide variety of software is currently being used to collect/store the proposed data elements.
- Many surveys indicated that data elements were stored on a software, but did not specify which software was used.
- Organizations with a number of CPCs across the province have developed proprietary software to implement electronic records and scheduling systems.

Software Information – The Most Frequently Reported Software

Software	# of Providers Reported Using
Meditech	32
Practice Perfect	26
Infomed	16
LifeMark Patient System	15
AbleMed	7
STAR McKessen	7
Cerner	5
Workload EH3	4

- Other software (EPIC, PhysioPlus, Antibex, Clinic Server Flex, Anzer, Emerald, Quadramed) were reported as being used by 3 or less providers.

Appendix C: Clinical Outcomes Measures Currently Collected – Hospital Based Providers

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Clinical Outcome Measure	# of Providers Reported Collecting Measure
Timed Up and Go (TUG)	26
Lower Extremity Functional Scale (LEFS)	25
Berg Balance Scale	25
Disabilities of the Arm, Shoulder and Hand (DASH)	22
Roland Morris Disability Questionnaire	16
Neck Disability Index (NDI) ©	14
6 Minute Walk Test	13
Range of Motion (ROM)	12
Upper Extremity Functional Index (UEFI)	11
2 Minute Walk Test	9

Clinical Outcomes Measures Currently Collected – Hospital Based Providers (cont'd)

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Clinical Outcome Measure	# of Providers Reported Collecting Measure
FIM ®	8
Chedoke McMaster Stroke Assessment ©	8
Grip Strength	8
Visual Analogue Scale (VAS)	7
Patient Rated Wrist Evaluation (PRWE) ©	7
Montreal Cognitive Assessment (MoCA) ©	7
Numeric Pain Rating Scale (NPRS)	7
Patient Specific Functional and Pain Scale (PSFS)	6
4-Item Pain Intensity Measure (P4)	5
Western Ontario and McMaster Universities Arthritis Index (WOMAC)	4

Clinical Outcomes Measures Currently Collected – Hospital Based Providers (cont'd)

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Clinical Outcome Measure	# of Providers Reported Collecting Measure
Reintegration to Normal Living Index (RNLI)	4
10 Meter Walk Test	3
Geriatric Depression Scale (GDS)	3
Rivermead Behavioural Memory Test (RBMT) ©	3
Borg Rating of Perceived Exertion (RPE) Test	3
Mini-Mental State Examination (MMSE)	3
Motor Free Visual Perceptual Test (MVPT) ©	3

Appendix D: Clinical Outcomes Measures Currently Collected - CPCs

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- Community Physiotherapy Clinics are required to submit the score from an associated outcome measure, selected from the list, obtained at the commencement and conclusion of the episode of care.

Diagnostic Group	Outcome Measure
Acute Arthritis (flare up)	. Numerical Pain Rating Scale (NPRS) . Timed up and Go test (TUG) . Health Assessment Questionnaire – II (HAQ) ©
Acute low back pain	. Roland Morris Disability Questionnaire . Numerical Pain Rating Scale (NPRS)
Acute neck pain/ headache	. Numerical Pain Rating Scale (NPRS) . Neck Disability Index ©
Balance: Any diagnosis that affects 'high level' balance and mobility deficits.	. 2 Minute Walk Test . Short Form Berg Balance Scale 3 Point
Mild stroke	. Timed up and Go test (TUG) . Barthel Index

Clinical Outcomes Measures Currently Collected – CPCs (cont'd)

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Diagnostic group	Outcome measure
Mild traumatic brain injury	• The Rivermead Post-Concussion Symptoms Questionnaire © • The RAND 36-Item Health Survey (SF 36)
Musculoskeletal lower extremity disorders or injuries (including ankle and knee pain and /or injuries)	• Lower extremity functional scale LEFS • Numerical Pain rating scale NPRS • Timed up and Go test (TUG)
Musculoskeletal upper limb disorders or injuries (including shoulder, elbow, wrist or hand injuries).	• Quick DASH disabilities/symptom score • Numerical Pain Rating Scale NPRS
Physical Function: Any diagnosis that affects loss of physical function in daily living	• Patient Specific Functional Scale
Other diagnostic condition not listed	• Goal Attainments Scale (GAS)