National Mental Health Benchmarking Project

Older Persons

Review of Key Performance Indicators

A joint Australian, State and Territory Government Initiative

June 2008

Contents

Background

During 2006-07 and 2007-08 the National Mental Health Benchmarking Project, a collaborative initiative between State, Territory and Australian Governments, convened benchmarking forums in four program areas (general adult, child and adolescent, older persons and forensic) of public sector mental health services. The project aimed to:

1. promote the sharing of information between organisations to increase understanding and acceptance of benchmarking as a key process to improve service quality.
2. identify the benefits, barriers and issues arising for organisations in the mental health field engaging in benchmarking activities.
3. understand what is required to promote such practices on a wider scale.
4. evaluate the suitability of the National Mental Health Performance Framework (domains, sub domains and key performance indicators) as a basis for benchmarking and identifying areas for future improvement of the framework and its implementation.

To facilitate the evaluation of the suitability of the 13 national indicators for benchmarking mental health services, each forum completed a comprehensive review of the national Key Performance indicators (KPIs) utilising the criteria outlined in Table 1 and made recommendations regarding their definition, specification, targets and appropriateness for benchmarking at the mental health service organisation level. Part one provides an overview of the discussion and recommendations made by the Older Persons Forum in relation to the nationally agreed KPIs.

In addition to the 13 national KPIs each forum looked at a range of additional and supplementary performance and contextual indicators. These indicators were reviewed against their relevance, utility, feasibility and interpretability. Recommendations were made in regards to the appropriateness of each indicator for benchmarking and for performance indicators if the indicator should be considered for inclusion within the national indicator set (either in addition to or as replacement for an existing indicator). The outcomes of the discussion from the Older Persons Forum are in Part Two of this document.

Table 1: National Key Performance Indicator Review Criteria

1. Is the indicator relevant to the program area? Is the underlying concept and intent of the indicator relevant to the program area? Does it provide information about an aspect of performance that is important to the program area?
2. Does the indicator MEASURE WHAT IS INTENDED within the program area? Is it an appropriate indicator for the nominated performance domain and subdomain? Or is it better mapped to another primary domain? Does it inform about an organisation's performance on the domain?
3. Is the national indicator DEFINITION appropriate to the program area? Is the current national definition suitable? Or is some variation needed to better define the underlying concept so that it is more appropriate to your program area?
4. Are the NATIONAL DATA SPECIFICATIONS for the indicator appropriate to your program area? Is the way in which the technical data inclusions and exclusions are specified meaningful to the program area? Are there specific technical issues that need to be better reflected in the way data are manipulated to produce the indicator?
5. Can UNIFORM TARGETS be set for this indicator? Can performance be meaningfully compared using the same 'benchmark' or target? What might be the appropriate targets to define 'minimally acceptable' and 'best practice' standards in your program area? What might be appropriate targets that set an 'alert threshold' for further investigation? Are targets set in the basis of RELATIVITIES (who's the best of the group) or ABSOLUTES (based on some standard such as evidence, expert opinion or stakeholder consensus?
6. Can the indicator be INTERPRETED AND UNDERSTOOD by people who need to act? Does it give an unambiguous signal or can it be interpreted in multiple ways? (e.g. are higher scores indicative of better or worse performance?) Does interpretation of performance depend on the domain being considered?
7. Can performance on the indicator be INFLUENCED BY LOCAL DECISIONS by people who have the power to act? Is performance on the indicator under the control of people with power to act? Or is it mainly the result of factors outside the control of the organisation?
8. Is it FEASIBLE to collect the required data and report at an organisational level, on a regular basis? Can the indicator be produced regularly, in a timely way, and within current resources?
9. What CONTEXTUAL INFORMATION is critical to the interpretation of an organisation's performance on this indicator? What other important information or indicators are needed to make sense of an organisations performance on this indicator?
10. Is the indicator relevant at the SERVICE UNIT and INDIVIDUAL CLINICIAN levels? The service unit generally refers to individual wards of an inpatient service or teams of the ambulatory service within an overarching mental health service organisation. For some services the service unit is equivalent to the mental health service organisation (e.g. where an organisation only has one inpatient ward).

Key issues

The following section outlines key issues considered relevant to interpretation, utility and comparison of most or all of the indicators and recommendations made by the Older Persons Forum. The issues should be considered in conjunction with the information provided in the detailed reviews outlined in parts one and two of this document.

No indicator in isolation

A single indicator cannot provide sufficient information to explain and monitor the performance of a mental health service organisation or the mental health system. It is important to ensure that in the interpretation, utilisation and comparison of performance indicators that other related indicators and contextual information is also considered. The required information may differ depending upon the indicator, the organisational context, program area and so on.

Model of service

The model of service adopted by organisations is a significant influence on many of the indicators. Differences between organisations with different service models may be an artefact of the model rather than differences in performance.

Available resources

Organisations generally provide services within the resources available to them. Differences between organisations may be due to differences in available resources rather than differences in performance.

Data compliance and quality

The data required to construct the indicators is primarily drawn from electronic information systems used within each jurisdiction. Although, the systems make the collection of data and construction of indicators more feasible, the accuracy and representativeness of the output is dependent upon service compliance with data entry. This is particularly of significance in relation to contact reporting for ambulatory services. Poor coding practices or poor data entry practices also limit the utility of the data used to construct the indicators.

The quality of expenditure data is a significant issue due to the lack of a consistent costing methodology across health services, within and across jurisdictions. Additionally, different input costs such as wage rates further limit the comparability of expenditure data across jurisdictions.

The Older Persons Forum indicated that although these issues are of concern and should be considered when interpreting the indicators, the use and reporting of the data at the service level has the potential to improve both compliance and quality.

Jurisdictional differences

Across jurisdictions there are small differences in the definitions and protocols used which will potentially impact on the comparability of indicators across. For example, the threshold for registration differs in each jurisdiction which may impact on the number of consumers counted in the construction of the population under care indicator. One service may appear to have with a higher population under care than another service however it could potentially be an artefact of the differences in practices around registration thresholds.

Defining good practice – 'good practice targets'

Further discussion and investigation by stakeholders is required to establish what constitutes 'good practice' across older persons health services. This will enable the appropriateness of any of the recommended targets to be determined and will assist in the refinement and development of appropriate good practice targets for other indicators as appropriate.

It is important to note that the targets set by the Older Persons Mental Health Benchmarking Forum are primarily based on the expert opinion and majority consensus of participants.

Identifying thresholds for investigations – 'alert targets'

The Older Persons Forum has set 'Alert Targets' for a number of the indicators. These targets are not intended to identify poor practices but rather aim to identify a threshold that could potentially trigger an investigation of a range of factors that may be influencing the output (including data compliance, consumer profiles, service models, clinical practices and so on).

Indicator literacy

A key issue that has both hindered and helped participants in the National Mental Health Benchmarking Project is the issue of indicator literacy. Sufficient understanding of the technical specifications, construction and applicability of the indicators is essential to enable appropriate interpretation and utilisation of the data. The understanding of indicators requires significant investment so that the information can be used to appropriately highlight successes, identify quality improvement needs and inform resources allocation.

Representation of services

The participants in the National Mental Health Benchmarking Forum represent approximately 10 per cent of mental health services in Australia. In the Older Persons Forum no organisations from three jurisdictions (Tasmania, Northern Territory, and the Australian Capital Territory) participated. Additionally, the participants in the Older Persons Mental Health Benchmarking Forum were representatives of services that provide sub-specialist older persons services. The discussion and recommendations are specific to these specialist services and may not be applicable to older persons receiving treatment from general adult services. Applicability to the broader population requires further analysis and discussion with all relevant services.

The information provided in this review is based upon the considered experience of two years of benchmarking activity. However, there is still much to be learnt about the indicators and benchmarking mental health services that can only be enhanced through participation by a greater proportion of the sector.

Finally, a potential bias in the selection of participating services, who were generally nominated by jurisdictions as being high performing services, may also impact on the results of the indicators and discussions.

Guide for reading review documentation

Throughout this document, references are made to the *National Specifications* and the *Project Specifications*. The National Specifications refer to the specifications published in the document *Key Performance Indicators for Australian Public Mental Health Services* (2005). The Project Specifications refer to the detailed specifications developed for the Benchmarking Project (published as Part 3 of the Project Manual). Both specifications are required to interpret the comments and recommendations of each of the forums. These documents are available at www.mhnocc.org/benchmarking.

Please note these documents were developed for each forum as part of the evaluation process. The feedback from the Older Persons Forum provides one source of information and advice around the national indicators. Once there is agreement by all participants these documents will be consolidated.

Comments and further information

Any comments or requests for further information regarding the contents of these documents should be forwarded to the evaluation project officer via email: kristen_breed@health.qld.gov.au.

PART ONE

REVIEW OF AGREED NATIONAL KEY PERFORMANCE INDICATORS

28 day readmission rate

PRIMARY DOMAIN	Effective
SUB-DOMAIN	Community Tenure
SECONDARY DOMAINS	Continuous
INITIAL REVIEW DATE	4 – 5 March 2008

LEARNINGS

- The concept of readmission is clinically valid as a measure of effectiveness that warrants monitoring and investigation by older person mental health services. It is important to note that **not** all readmissions to psychiatric care are failures of care.
- There appears to be a relationship between 28 day readmission rates and length of acute inpatient stay, as services under pressure to reduce length of stay have shown an increase in readmission rates. However, this is not a consistent pattern across all participating services.
- The most appropriate length of time between discharge and readmission was discussed, however the forum did not reach a decision regarding extending the 28 days timeframe. Further analysis and discussion would be required before changing the timeframe for older persons services
- The capacity of the community mental health service to provide adequate care will impact on organisational performance (that is, it should not be seen as an inpatient issue, but rather as a system issue).
- A range of factors influence the indicator, including: bed availability; experience and skill mix of staff (inpatient and community); bed demand, degree of social integration; service practices, such as use and reporting of leave, discharge planning; service context such as structural issues, resources and so on.
- Analysis and identification of appropriate allied indicators (such as average length of stay and post-discharge community care) and contextual factors is essential to accurately interpret the output, as the same result may have different causes across organisations. For example, a low readmission rate may be a factor of lack of access to beds, poor community resources, or the geographic location of discharge destination in one organisation but due to concerted action to lower rates or improve staff skill base in another organisation.
- The number of separations and readmission in older person mental health services is generally small, which inturn impacts of the stability of the indicator (one or two additional readmissions can significantly increase the readmission rate).
- Performance on this indicator is impacted on by the capacity of each organisation to link data and is sensitive to interpretation of data definitions and specifications.
- The model of care and other indicators (especially length of stay), and ideally measures of consumer outcome, should be considered in the interpretation of readmission rates as a lower readmission rate does not necessarily indicate better clinical practices or outcomes than a higher readmission rate.
- Although not all factors influencing readmission rates are in the control of service organisations, there is work that can be undertaken locally to impact on an organisations performance. Specific action or inaction can be linked to a high or low readmission rate.
- There is the potential to utilise the information gained from the indicator to reinforce arguments regarding factors outside an organisations control (such as resources).
- The forum agreed that a supplementary indicator looking at a readmission to a medical ward is of use when benchmarking older person services, as the target population has higher medical needs that should also be a focus of inpatient care. Additionally, it was seen that the supplementary indicator would recognise the importance of the interface between medical and psychiatric wards for the older population. However, it was noted that there was varying capacity between organisations to provide the required medical care in the psychiatric unit and to identify readmissions between psychiatric and general medicine units.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT **YES**

For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED **YES**

For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate **YES**

- The distinction between planned and unplanned readmissions is important and should remain within the definition. However, the technical difficulties associated with consistent and reliable collection of planned readmissions is acknowledged and further work is needed to address this issue.

For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate **YES**

- Given the current technical inability to accurately and consistently identify *planned* readmissions, the Older Persons Forum agreed that the specifications should continue to look at all readmissions (rather than distinguishing between planned and unplanned readmissions). However, further work should be progressed to address and fix the current technical limitations for the construction of this indicator.
- The forum indicated that the specifications used for the benchmarking project (i.e. admissions to same organisation rather than any organisation within jurisdiction) were less reliable as a measure of efficiency, particularly for metropolitan organisations where there is considerable cross boundary flows. The Older Persons forum agreed that the indicator is best calculated on the basis of readmissions to any hospital within the jurisdiction, although it was acknowledged that this is information difficult for individual organisations to access.

For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set **YES**

- An absolute target of zero is not appropriate given: (i) inability to distinguish between planned and unplanned readmissions, and (ii) not all readmissions are failures of care.
- An evidence-base should be built to support the ongoing development of appropriate targets, eg audit of readmissions to determine percentage that could have been avoided.

Good practice target

- Given adequate resources and good practices an older persons mental health service organisation should be able to achieve **7 percent or below** on this indicator.

Alert target

- Where an older persons mental health service organisation reaches **10 percent or above** on this indicator, the contributing factors should be flagged as requiring priority investigation and / or intervention.

Note: *Any target determined is preliminary and may change as more evidence is available. The participants in the Older Persons Mental Health Forum manage sub-specialist psychogeriatric services. The proposed targets only apply to sub-specialist services and may not be applicable for the 65+ population receiving acute inpatient care in General Adult acute psychiatric inpatient units. Applicability to the broader population requires further analysis and discussion with those services. This absolute target is based upon expert opinion and consensus of participants in the Older Persons Mental Health Forum.*

The indicator can be **INTERPRETED AND UNDERSTOOD** by people who need to act **YES**

Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act **YES**

It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis **YES**

- For most jurisdictions, individual organisations cannot easily access information regarding readmissions to any mental health service organisation within a jurisdiction and assistance from state and territory health authorities will be required.

CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator

- National indicators:
  - average length of acute inpatient stay;
  - post-discharge community care.
- Additional and supplementary indicators:
  - bed occupancy;
  - readmission to hospital (non-psychiatric).
- Contextual information:
  - community and inpatient service structure, practices and resources (such as FTE);
  - availability of non-mental health community resources;
  - consumer profile (including outcomes and diagnosis).

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**YES**	**YES**
The national definition is meaningful	**YES**	**YES**
The national data specifications can be applied without modification	**YES**	**YES**
The targets set for higher levels are also applicable at this level	**YES**	**YES**

RECOMMENDATIONS for the OLDER PERSONS PROGRAM AREA

- The indicator **28 day readmission rate** can be utilised for benchmarking older persons mental health services as nationally defined and specified.
- Preliminary good practice (*7 percent or below*) and Alert targets (*10 percent or above*) should be considered for use with older persons mental health services.
- The Older Persons forum agreed that the distinction between planned and unplanned readmissions is important and should remain within the definition. However, the technical difficulties associated with consistent and reliable collection of planned readmissions is acknowledged and further work is needed to address this issue.

National Service Standards Compliance

PRIMARY DOMAIN	Appropriate
SUB-DOMAIN	Compliance with standards
SECONDARY DOMAIN	Capable
INITIAL REVIEW DATE	4 – 5 March 2008

LEARNINGS

- The Older Persons Forum agreed that all mental health services should comply with National Service Standards and that it is good to acknowledge an external review of processes.
- There are differences in the way that organisations are accredited against the standards, e.g. some organisations are accredited as part of a larger organisation (such as an Area or District) and results may be dependent upon other units or services within the organisation.
- At the organisational level this indicator has a tendency to produce a '*Yes'* or '*No'* output and as such does not provide information about incremental improvement by an organisation.
- Compliance with National Service Standards is relevant and important for mental health services. However, compliance as shown through this indicator does not necessarily equal appropriate service delivery. The review process is not necessarily consistent across surveyors or accreditation agencies.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT	**YES**
For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**NO**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate	**NO**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**NO**
For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set	**NO**
The indicator can be **INTERPRETED AND UNDERSTOOD** by people who need to act	**N.A.**
Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act	**N.A.**
It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis	**N.A.**

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**NO**	**NO**
The national definition is meaningful	**NO**	**NO**
The national data specifications can be applied without modification	**N.A.**	**N.A.**
The targets set for higher levels are also applicable at this level	**N.A.**	**N.A.**

RECOMMENDATIONS for the OLDER PERSONS PROGRAM AREA

- The indicator **National Service Standards Compliance** should not be used to benchmark the appropriateness of older persons mental health services.
- Future activity should consider the development of a more appropriate indicator for this domain.

Average length of acute inpatient stay

PRIMARY DOMAIN	Efficient
SUB-DOMAIN	Inpatient
SECONDARY DOMAIN	Appropriate
INITIAL REVIEW DATE	4 – 5 March 2008

LEARNINGS

- This indicator needs to be interpreted within the context of the service's model of care, other indicators (such as 28 day readmission rate) as it is susceptible to changes in medical and nursing leadership and practice, discharge practices, bed occupancy, community resources and so on.
- Performance on this indicator may be a factor of resources and model of service rather than the failure of the service to perform appropriately or to provide efficient services.
- The mean is impacted on by extreme outliers (e.g. consumer needing extended treatment care receiving care within acute unit as no beds available). The small numbers of 'in-scope' discharges from older persons acute units also impacts on the stability of the indicator and analysis of the trend-series.
- The profile of consumers, particularly consumers with dementia and behavioural issues that cannot be adequately cared for at home or in a nursing home, will increase length of stay.
- Although the average length of stay is influenced by demographics, casemix, clinical care / processes, rurality, and staff / service philosophies (e.g. discharge as soon as risk is minimised), there are range of activities can be undertaken to influence performance, such as patient flow practices. Ideally measures of consumer outcomes should also be considered in the interpretation of average length of acute inpatient stay.
- Access to nursing home places and lack of community resources (for both mental and physical health resources) limits capacity to discharge when consumer no longer requires acute psychiatric inpatient care. The need to wait for placement will inflate length of stay.
- There is often a lack of support to facilitate the transition from general adult to older person services, which has the potential to complicate and lengthen treatment.
- The median provides additional contextual information to enable more accurate description of the typical length of stay of most consumers.
- General adult and older persons units should not be compared given the higher prevalence of physical co-morbidities which have the potential to extend length of stay within acute settings. The Older Persons Forum suggested the utilisation of a supplementary indicator that measures the proportion of consumers who are ready to be discharged but are awaiting placement (either in nursing homes or in the community) would further inform practice and resource debates. The change of care type from acute to non-acute could potentially provide a proxy measure of discharge readiness.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT	**YES**
For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**YES**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate	**YES**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**YES**

For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set	YES

- It is not sensible to set an absolute average length of stay as 'good' practice as there are many variables that may impact on the average and it is highly susceptible to outliers (due to small numbers of discharges). The Older Persons agreed that it would be more meaningful to identify upper and lower 'alert' thresholds that could be utilised to trigger investigation by services. The Older Persons Forum recommended that if a 'good practice' target was to be set then the median should be utilised as the measure rather than the mean.

Alert targets

- An organisation with an average length of stay in its specialist older persons acute psychiatric inpatient unit of **more than 50 days** should potentially investigate potential causes of performance to ensure it is not adversely impacting on the model of clinical care and consumer outcomes.
- An organisation with an average length of stay in its specialist older persons acute psychiatric inpatient unit of **less than 35 days** should potentially investigate potential causes of performance to ensure it is not adversely impacting on the model of clinical care and consumer outcomes.

Note: *Any target determined is preliminary and may change as more evidence is available. The participants in the Older Persons Mental Health Forum manage sub-specialist psychogeriatric inpatient services. The proposed targets only apply to sub-specialist services and may not be applicable for the 65+ population receiving acute inpatient care in General Adult acute psychiatric inpatient units. Applicability to the broader population requires further analysis and discussion with those services. This absolute target is based upon expert opinion and consensus of participants in the Older Persons Mental Health Forum.*

The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act	YES

Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act	YES

It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis	YES

CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator

- National indicators:
  - length of stay by diagnosis (dementia, depression, and psychosis);
  - 28-day readmission rate.
- Additional and supplementary indicators:
  - proportion of consumers awaiting placement or length of stay of acute inpatients;
  - median and mode length of stay;
  - minimum and maximum lengths of stay;
  - bed occupancy.
- Contextual information:
  - casemix factors (including HoNOS and diagnosis profiles).
  - available resources (such as beds per 100,000, availability and appropriateness of discharge destination or alternate accommodation options, issues of carer burden and / or safety).

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**YES**	**NO**
The national definition is meaningful	**YES**	**NO**
The national data specifications can be applied without modification	**YES**	**N.A.**
The targets set for higher levels are also applicable at this level	**YES**	**N.A.**

RECOMMENDATIONS for the OLDER PERSONS PROGRAM AREA.

- The indicator *average* **length of acute inpatient stay** can be utilised for benchmarking older persons mental health services as nationally defined and specified.
- Preliminary Alert targets (*less than 35 days* and *greater than 50 days*) should be considered for use with older person mental health services. The median length of stay should be utilised to facilitate interpretation of the average.

Average cost per acute inpatient episode

PRIMARY DOMAIN Efficient

SUB-DOMAIN Inpatient

INITIAL REVIEW DATE 22 June 2007

LEARNINGS

- As calculated for the national project inpatient episode costs are largely driven by the number of episodes and length of stay, therefore the influences on length of stay also impact on the costs. The double counting of length of stay the complexity of the interpretation.
- At the organisational level there is a need to unpack costs and identify associated issues (such as staff hours per day) to enable understanding of efficiency.
- The reliability of indicator is dependent upon good quality, accurate and consistent financial reporting (especially regarding organisational overheads).
- There are significant concerns regarding the accuracy and consistency of mental health expenditure data, particularly differences in the apportioning of indirect costs (e.g. costs associated with stand-alone hospitals versus units aligned to general hospitals). Consequently there is potential for the indicator to mislead analysis of an organisations efficiency and performance.
- The indicator is skewed for services that have a greater proportion of out-of-scope separations. The link to the separated episode limits comparability and is misleading as an indicator of inpatient efficiency.
- Changing of accounting practices, costing methodologies and other financial rules within organisations limits the utility of trend analysis. Additionally, there is significant difficulty in determining causes of differences with financial data. For example, a single organisation with three units was unable to accurately determine the causes of the differences in results on this indicator.
- A range of factors outside the control of individual organisations (or for which the organisations have limited capacity to influence), such as staffing mix, wage rates, organisational changes and restructures, accounting practices (such as how costs are apportioned and distributed), recruitment practices (e.g. number of overseas trained staff) will impact on the output of this indicator and limit the comparability and trend analysis,
- The Older Persons Forum identified that the average cost per bed day, which is a component of episode costs, is generally more relevant at the organisational level.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT	**YES**
For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED?	**NO**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate	**NO**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**NO**
For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set	**NO**

- Considerable work is required to develop consistent costing methodology across mental health services, both within and across jurisdictions.
- Different input costs (especially wage rates) make the development of a national standardised target irrelevant and misleading. However, there is some potential and merit in individual organisations setting local targets.

The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act **NO**

- Due to differences in costing methodologies and funding allocations it is difficult to interpret this indicator across organisations and jurisdictions.

Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act **NO**

- Although expenditure is primarily within the control of the individual organisations, funding allocations, costing methodologies and apportioning of indirect costs are generally managed within the broader organisations, which the mental health service component may have limited capacity to influence

It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis **YES**

- The data is feasible to collect, however it is difficult to access financial inputs and the quality of financial data varies significantly both across and within jurisdictions.

CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator

- National indicators:
  - average length of acute inpatient stay.
- Additional and supplementary indicators:
  - bed occupancy;
  - cost per bed day.
- Contextual information:
  - staffing mix.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**YES**	**NO**
The national definition is meaningful	**NO**	**NO**
The national data specifications can be applied without modification	**NO**	**N.A.**
The targets set for higher levels are also applicable at this level	**N.A.**	**N.A.**

RECOMMENDATIONS for the OLDER PERSONS PROGRAM AREA

- The indicator **average cost per acute inpatient episode** is not suitable for benchmarking older persons mental health services as nationally defined and specified.
- The inclusion and utilisation of **average cost per bed day** should be considered for benchmarking older persons mental health services.

Average treatment days per three month community care

PRIMARY DOMAIN	Efficient
SUB-DOMAIN	Community
SECONDARY DOMAINS	Appropriate
INITIAL REVIEW DATE	4 – 5 March 2008

LEARNINGS

- The indicator needs to be interpreted within the service context as it is influenced by the model of service adopted (e.g. case management versus assessment or acute treatment). Although it was noted that the output generally averages out any variation between models utilised by different teams and service models. However, there is no standardised concept or definition of what makes up an episode of ambulatory mental health care. The same number of treatment days does not imply the same type of care was provided to consumers.
- Treatment days can be influenced by a range of factors outside the control of the local services, such as staff experience, service models, rurality, access to inpatient services, access to NGO services. Additionally, the average can be impacted on by extreme outliers, particularly in smaller services.
- The indicator is not a measure of FTE productivity and is not intended to account for how clinicians spend there time. The indicator provides an average and should not be considered as a guide for each individual consumer (ideally clinical judgement on the intensity of treatment should dictate the care provided to consumers).
- The forum found the inclusion of all forms of contacts in the construction of a treatment day to be acceptable as a high-level measure as it accounted for a large proportion of variation in costs and had less variability than contact reporting. However, it was acknowledged that the indicator is not a measure of the quality of the treatment provided as differences between the quality of the services provided cannot be determined without outcomes-based information.
- The under-reporting of ambulatory contacts continues to be a significant issue impacting on the interpretability and reliability of the indicator.
- The capacity to collect data on duration of contacts is variable but would be useful in determining the efficiency of community care.
- As a high-level indicator average treatment days has use in identifying a potential issue for a service, but further information is required to understand the issues at the service level, particularly in relation to duration of contacts.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT	**YES**
For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**YES**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate	**YES**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**YES**

For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set **YES**

Alert targets

- If the average treatment days per three month community care period is **equal to or less than 8 treatment days** the service should consider investigating potential causes of the results.

Note: *Any target determined is preliminary and may change as more evidence is available. As the participants provide specialist older persons services, the proposed targets only apply to sub-specialist services and may not be applicable for the 65+ population receiving ambulatory care from general community mental health services. Applicability to the broader population requires further analysis and discussion with those services.*

The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act **YES**

- The underlying concepts of this indicator are complex and there is generally a scarcity of the skills required to conduct the data analysis.

Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act **YES**

It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis **YES**

CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator

- National indicators:
  - comparative area resources;
  - population under care;
  - new client index.
- Additional and supplementary indicators:
  - proportion of direct contacts;
  - average contact duration;
  - community contribution to new client index.
- Contextual information:
  - service models;
  - available resources (such as FTE per 100,000);
  - geographic size of catchment;
  - staffing mix;
  - consumer profile (such as HoNOS and diagnostic profiles).

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**YES**	**YES**
The national definition is meaningful	**YES**	**YES**
The national data specifications can be applied without modification	**YES**	**YES**
The targets set for higher levels are also applicable at this level	**YES**	**YES**

RECOMMENDATIONS for the OLDER PERSONS PROGRAM AREA

- The indicator **average treatment days per three month community care period** can be utilised for benchmarking older persons mental health services as nationally defined and specified.
- An alert target (*equal to or less than an average of eight treatment days per three month community care period*) should be considered for use with older persons ambulatory mental health services.

Average cost per three month community care period

PRIMARY DOMAIN Efficient

SUB-DOMAIN Community

INITIAL REVIEW DATE 4 – 5 March 2008

LEARNINGS

- The Older Person Forum identified that it was important not to look at the concept of efficiency in isolation of the context and what factors influence an indicator. For example, a single clinician that provides services to 100 consumers may be able to provide cheaper period of care costs but it may not be efficient as the level of care is unlikely to be meeting the needs of the consumers.
- It is difficult to define efficient community care as there are substantial differences in service models, staffing mix, target populations and so on that it cannot be assumed that an episode of community care in Service A is the same or even similar to an episode of community care in Service B.
- As calculated for the national project community care period costs are largely driven by the number of episodes and number of treatment days, therefore the influences on treatment days also impact on the costs. The double counting of treatment days increases the complexity of the interpretation.
- At the organisational level there is a need to unpack costs and identify associated issues (such as staff hours per day) to enable understanding of efficiency.
- The reliability of indicator is dependent upon good quality, accurate and consistent financial reporting (especially regarding organisational overheads). Additionally, the indicator is susceptible to poor compliance by clinicians with local information reporting requirements, particularly contact reporting (i.e. low reporting rates increases costs).
- There are significant concerns regarding the accuracy and consistency of mental health expenditure data, particularly differences in the apportioning of indirect costs. Consequently there is potential for the indicator to mislead analysis of an organisations efficiency and performance.
- Changing of accounting practices, costing methodologies and other financial rules within organisations limits the utility of trend analysis. However, it was agreed that the complexity of the financial system was less for ambulatory services than inpatient services.
- A range of factors outside the control of individual organisations (or for which the organisations have limited capacity to influence), such as staffing mix, wage rates, organisational changes and restructures, accounting practices (such as how costs are apportioned and distributed), recruitment practices (e.g. number of overseas trained staff) will impact on the output of this indicator and limit the comparability and trend analysis,
- The average cost per treatment day, which is a component of episode costs, is generally more relevant at the organisational level.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT	**YES**
For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**NO**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate	**NO**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**NO**
For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set	**NO**

- Considerable work is required to develop consistent costing methodology across mental health services, both within and across jurisdictions.
- Different input costs (especially wage rates) make the development of a national standardised target irrelevant and misleading. However, there is some potential and merit in individual organisations

setting local targets.

The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act	**NO**
Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act	**NO**
It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis	**YES**

- The data is feasible to collect, however it is difficult to access financial inputs and the quality of financial data varies significantly both across and within jurisdictions.

CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator

- National indicators:
  - comparative area resources;
  - average treatment days per three month community care period.
- Additional and supplementary indicators:
  - average cost per treatment day;
  - annual average cost per consumer treated.
- Contextual information:
  - staffing mix.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**NO**	**NO**
The national definition is meaningful	**NO**	**NO**
The national data specifications can be applied without modification	**N.A.**	**N.A.**
The targets set for higher levels are also applicable at this level	**N.A.**	**N.A.**

RECOMMENDATIONS for **OLDER PERSONS PROGRAM AREA**

- The indicator **average cost per three-month community care period** should not be utilised for benchmarking older persons mental health services as nationally defined and specified.
- The Older Persons Forum recommends that the **average cost per treatment day** is a more appropriate measure for benchmarking older persons mental health services.

Population under care

PRIMARY DOMAIN	Accessible
SUB-DOMAIN	Access for those in need
INITIAL REVIEW DATE	4 – 5 March 2008

LEARNINGS

- Access to mental health services is an ongoing issue for most services and capacity to monitor and improve access (where necessary) is relevant. Although this is an indicator of access it does not account for population demand for services.
- There are a range of issues (structural, population and service) that impact on this indicator that are not necessarily in the direct control of the mental health service organisation, such as catchment size, proportion of *vulnerable* groups, such as Indigenous populations and the level of available resources.
- There is a need to be clear that it is not about the percentage of the catchment population receiving mental health care, but rather the percentage of catchment population receiving mental health care from local services.
- The output is susceptible to and impacted upon by:
  - inaccuracies caused by different registration activities across community services. To be nationally comparable the data must be consistently counted;
  - changes in catchment boundaries and how the catchment population is counted (particularly in the interpretation of the trend series);
  - the amount of productive versus unproductive FTE within the services
- It is essential that the indicator be split into the three service settings (acute inpatient, residential and ambulatory) to enable accurate interpretation, analysis and action.
- In conjunction with the *average treatment days per three month community care period* and *new client index* this indicator provides a relatively sound picture of community mental health care.
- As a measure of performance this indicator cannot be looked at in isolation of other government, non-government and private sector services. Initiatives, such as those funded through Commonwealth of Australian Government (COAG) National Action Plan on Mental Health, have the potential to reduce the output without it being an indication of service performance (e.g. more people contact General Practitioners or psychologists rather than the local mental health service).
- Services can restrict access to care to manage the capacity of its resources to provide appropriate clinical care.
- It is important to note that this is not an indicator of intensity or type of service provided to consumers of public sector mental health services.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT	**YES**
For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**YES**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate	**NO**

- The national definition looks at the overall organisation and does not allow for the different catchments between service components.
- The definition utilised as part of the National Mental Health Benchmarking Project is more appropriate and useful.

For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**NO**

- The national specifications construct the indicator for the overall organisation and does not allow for the different catchments between service components.
- The specifications utilised as part of the National Mental Health Benchmarking Project are more appropriate and useful.
- Alternate specifications of the indicator, such as a rate per 100,000 population may be utilised to provide different perspectives and additional information.

For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set	**NO**

- The Older Persons Mental Health Benchmarking Forum does not have all the epidemiological expertise required to determine an appropriate target.

The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act	**YES**

Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act	**YES**

It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis	**YES**

CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator

- National indicators:
  - average treatment days per three month community care period;
  - new client index.
- Additional and supplementary indicators:
  - FTE per 100,000 population.
- Contextual information:
  - population characteristics (such as demographic and epidemiological profiles);
  - availability of alternate services (community and residential);
  - consumer profile (particularly diagnosis);;

	SERVICE UNIT	**INDIVIDUAL CLINICIAN**
The indicator is relevant to understanding performance	**YES**	**NO**
The national definition is meaningful	**YES**	**NO**
The national data specifications can be applied without modification	**N.A.**	**N.A.**
The targets set for higher levels are also applicable at this level	**N.A.**	**N.A.**

RECOMMENDATIONS for **OLDER PERSONS PROGRAM AREA**

- The indicator **population under care** can be utilised for benchmarking older persons mental health services as defined and specified for the National Mental Health Benchmarking Project.
- Focus of analysis and investigation should be on ambulatory population under care as these services aim to minimise admission to inpatient care.
- Further epidemiological evidence is required to develop an appropriate indicator for use with older person ambulatory mental health services.

Local access to inpatient care

PRIMARY DOMAIN Accessible
SUB-DOMAIN Local access
INITIAL REVIEW DATE 8 May 2008

LEARNINGS

- The concept of 'local' is difficult to define, therefore the indicator looks at local as being within the defined catchment area of the service, which from the perspective of the consumer, carer. clinician and/or service may not be 'local'. In regards to catchments 'local' is generally defined at a level broader than mental health service organisation.
- The differences between how 'local' is defined between organisations will impact on the comparability of this indicator. Additionally, proximity to alternative acute inpatient service services and arrangements (such as general aged care beds with input from the mental health service or access to general adult psychiatric inpatient service) impacts on how this indicator can be interpreted and compared.
- The inability to count psychiatric patients admitted to general aged care wards (for various reasons such as lack of beds within the specialist units) limits the utility of this indicator. There may be a benefit in specifying the indicator for different programs and stakeholders, for instance older person mental health services would benefit from the capacity to identify psychiatric patients in aged care wards.
- Changes to catchment boundaries through jurisdictional and organisational restructuring will also impact on trend analysis. Additionally, services whose inpatient catchment stretches a large geographic region the concept of 'local' as defined for this indicator is not meaningful.
- Local information systems impact on the capacity to collect this consistently between and within jurisdictions.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT	**YES**
For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**NO**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate	**NO**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**NO**
For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set	**N.A.**
The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act	**NO**
Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act	**NO**
It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis	**YES**
CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator	**N.A.**

	SERVICE UNIT	**INDIVIDUAL CLINICIAN**
The indicator is relevant to understanding performance	**NO**	**NO**

The national definition is meaningful	**NO**	**NO**
The national data specifications can be applied without modification	**N.A.**	**N.A.**
The targets set for higher levels are also applicable at this level	**N.A.**	**N.A.**

RECOMMENDATIONS for **OLDER PERSONS PROGRAM AREA**

- The indicator **local access to acute inpatient care** should not be utilised for benchmarking older persons mental health services as a measure of access as nationally defined and specified.

New Client Index

PRIMARY DOMAIN Accessible

SUB-DOMAIN Access for those in need

INITIAL REVIEW DATE 8 May 2008

LEARNINGS

- Access (or lack thereof) to mental health services is an ongoing issue for most services and capacity to monitor and improve access (where necessary) is relevant. The proportion of 'new' clients enables the first part of an organisations throughput to be considered.
- This is a conceptually complex indicator, primarily because defining 'new' has many interpretations and definitional approaches, such as new to service versus new to setting versus new to program versus new to diagnostic group and so on. The indicator looks at who is new to an organisation, regardless of setting or program (i.e. if come from other program not considered 'new').
- The definition of 'new' may need to vary depending upon the level of analysis (new to setting for inpatient units only, new to team etc).
- Although the indicator can identify issues associated with access it does not identify the cause of access issues. Further analysis of structural, population and practice issues is required to interpret the indicator.
- The indicator does not specify that the client needs to be an 'active' or ongoing client of the service (i.e. includes assessment only) as the indicator is about access and getting an assessment is about accessing the service.
- It was acknowledged that the use of 'new' as 365 days prior to first contact with any component of the mental health service organisation is arbitrary and an attempt to deal with information system constraints rather than determining that whether or not a consumer is actually new to the overall system. However, it is possible that a consumer re-presenting after a two or three year absence may be presenting with different issues or diagnosis.
- Organisational restructure and boundary changes will impact on the time series associated with the indicator.
- The *point of entry* (that is the setting where the consumer first contacted the organisation) is important supplementary information that needs to be considered in the interpretation of the indicator.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT **YES**

For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED **YES**

For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate **NO**

- The definition of 'new' as defined for the National Mental Health Benchmarking Project, i.e. 365 days without contact with the mental health service organisation, is appropriate for benchmarking in the older person program area.

For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate **NO**

- The specification of 'new' as defined for the National Mental Health Benchmarking Project, i.e. 365 days without contact with the mental health service organisation, is appropriate for benchmarking in the older person program area.

For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set **YES**

Alert targets

- An organisation with a new client index of **less than 50 percent** or a new client index of **more than 80 percent**, should potentially investigate potential causes of performance.

Note: *Any target determined is preliminary and may change as more evidence is available. The participants in the Older Persons Mental Health Forum provide specialist older persons services. The proposed targets only apply to sub-specialist services and may not be applicable for the 65+ population receiving ambulatory care from general community mental health services. Applicability to the broader population requires further analysis and discussion with those services. This absolute target is based upon expert opinion and consensus of participants in the Older Persons Mental Health Forum.*

The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act **YES**

Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act **YES**

It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis **YES**

- The feasibility of data collection is varied within and across jurisdictions due to system issues and requirement of unique identification at the individual consumer level across organisations.
- There are technical and practical issues that impact on the capacity to collect 'new' as 'new' rather than 'new in the last 365 days'.

CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator

- National indicators:
  - population under care.
- Additional and supplementary indicators:
  - new client index (point of entry);
  - new client index (new to acute inpatient care);
  - new client index (new to ambulatory mental health care).
- Contextual information:
  - population demographics.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**YES**	**NO**
The national definition is meaningful	**YES**	**NO**
The national data specifications can be applied without modification	**YES**	**N.A.**
The targets set for higher levels are also applicable at this level	**YES**	**N.A.**

RECOMMENDATIONS for the OLDER PERSONS PROGRAM AREA

- The indicator **new client index** can be used for benchmarking older persons mental health services as defined and specified for the National Mental Health Benchmarking Project.
- Preliminary Alert targets of *less than 50 percent* (as an indication of poor throughput) and *more than 80 percent* (as an indication of assessment only focus and issues with service models) should be considered for use with older person mental health services.
- A supplementary new client index (new to setting [acute inpatient or ambulatory mental health care]) should be utilised when benchmarking older person services at the mental health service organisation level.

Comparative area resources

PRIMARY DOMAIN	Accessible
SUB-DOMAIN	Access for those in need
SECONDARY DOMAIN	Sustainable
INITIAL REVIEW DATE	8 May 2008

LEARNINGS

- This is not an indicator of service performance as funding allocation is not completely within the control of individual mental health service organisations. However, it has the potential to provide: (i) significant leverage for influencing policy and funding decisions; and, (ii) information to service managers to assist in the interpretation of other indicators.
- Access is impacted on by a range of issues (structural changes, population and service) that may not be within the control of the service. Although the concept that is being measured is relevant it is difficult to interpret data as a measure of access.
- The reliability of output is dependent upon good quality, accurate and consistent financial reporting (especially regarding organisational overheads). Considerable work is required to develop consistent costing methodology across mental health services, both within and across jurisdictions.
- The interface with aged care services is important when identifying resources for older person mental health services.
- The inability to count consumers who access aged care services underestimate the resources utilised for the population.
- Comparison of beds and FTE (standardised) is potentially more informative given issues with accounting practices and costing methodology across and within jurisdictions.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT — **YES**

For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED — **YES**

For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate — **NO**

- The national definition looks at the overall organisation and does not allow for the different catchments between service components.
- The definition utilised as part of the National Mental Health Benchmarking Project is more appropriate and useful.

For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate — **NO**

- The national specifications look at the overall organisation and does not allow for the different catchments between service components.
- The specifications utilised as part of the National Mental Health Benchmarking Project are more appropriate and useful.

For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set — **NO**

The indicator can be **INTERPRETED AND UNDERSTOOD** by people who need to act — **YES**

- With consistent accounting practices and costing methodology this indicator could be interpreted and understood, however there is significant work required to consistently count financial data.

Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act — **NO**

It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis	**YES**

- The data is feasible to collect, however it is difficult to access financial inputs and the quality of financial data varies significantly both across and within jurisdictions.

CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator

- Additional and supplementary indicators:
  - FTE per 100,000 population (noting issues with defining FTE);
  - beds per 100,000 population.
- Contextual information:
  - staffing mix;
  - population demographics.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**YES**	**NO**
The national definition is meaningful	**YES**	**NO**
The national data specifications can be applied without modification	**YES**	**N.A.**
The targets set for higher levels are also applicable at this level	**N.A.**	**N.A.**

RECOMMENDATIONS for the OLDER PERSONS PROGRAM AREA

- There is value in comparing the indicator at both jurisdictional and organisational levels, however caution is required due to significant issues identified regarding accounting practices and costing methodology.
- The indicator **comparative area resources** can be utilised for benchmarking older persons mental health services as defined and specified for the National Mental Health Benchmarking Project.
- The supplementary indicators **FTE per 100,000 population** and **Beds per 100,000 population** should be considered for benchmarking older persons mental health services.

Pre-admission community care

PRIMARY DOMAIN	Continuous
SUB-DOMAIN	Cross-setting continuity
SECONDARY DOMAIN	Accessible
INITIAL REVIEW DATE	8 May 2008

LEARNINGS

- This indicator is based on the concept that pre-admission community care can potentially (i) ease transition into acute care, (ii) reduce the length of stay (limited evidence-base for this argument), (iii) reduce the times that the inpatient setting is used as the 'front-door', or entry point to a mental health service organisation.
- The indicator provides information about the mental health service organisation as a whole, not just the inpatient setting or just the community setting.
- The Older Persons Forum considered that an increase in emergency admissions could be an indication of poor resources in the community.
- The indicator counts all service contacts which is appropriate for older persons mental health services.
- The indicator is not about identifying proportion of admissions that could have been prevented or averted and does not assume that a high percentage pre-admission community care is an indication of failure of community care. It attempts to identify those consumers who are not seen – i.e. those who are not receiving a service or are falling through 'the gaps' in community care prior to admission.
- It was noted that there will always be a small proportion of people who escalate so quickly that pre-admission contact is unlikely, but that overall systems should be set up in a way that means the community is aware of services, and that services are accessible in a timely manner.
- The indicator is vulnerable to poor community data collection adherence. Participants suggested that it is possible that ambulatory contacts in the week prior to admission are less likely to be recorded into electronic information systems due to the crisis nature of the work, for example, a crisis team may be seeing a consumer on a daily basis but not recording the contacts.
- The indicator is sensitive to demographic factors, such as rurality (where consumers may wait longer for admission due to distance and so on) and transient population, and the threshold for admission.
- Differences in admission practices, such as assessment of all consumers physical problems prior to admission to acute psychiatric service, will impact on the comparability of the indicator. The practice used in relation to recording of triage contacts will also impact upon the interpretability of the indicator. Further discussion is required to more effectively, consistently and accurately capture data regarding triage related contacts.
- The indicator could be stratified to focus on specific populations, such as consumers with dementia related diagnoses to identify issues and risks associated with particular consumer groups.

For the **OLDER PERSONS PROGRAM AREA** the indicator is **RELEVANT**	**YES**
For the **OLDER PERSONS PROGRAM AREA** the indicator **MEASURES WHAT IS INTENDED**	**YES**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate	**YES**

- Further work is required to more effectively, consistently and accurately capture data regarding triage related contacts.
- Potential combined admission or intake processes with general aged care may impact on the definition and utility of the indicator.

For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate **YES**

- The indicator specifications refer to where the ambulatory contact occurred (i.e. not whilst in an inpatient unit) not who performed the contact.
- Further work is required to more effectively, consistently and accurately capture data regarding triage related contacts.
- Potential combined admission or intake processes with general aged care may impact on the specification and utility of the indicator.

For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set **YES**

- It was agreed that given current definition and specifications it is not realistic to aim for 100 percent pre-admission care because there will always be consumers whose first presentation to public sector services is to the acute inpatient unit (including consumers who receive ongoing care from general practitioners, private psychiatrists and so on).

Good practice target

- Given adequate resources and good practices a mental health service organisation should be able to achieve **80 percent or above** on this indicator.

Note: *Any target determined is preliminary and may change as more evidence is available. The participants in the Older Persons Mental Health Forum provide specialist older persons services. The proposed targets only apply to sub-specialist services and may not be applicable for the 65+ population receiving ambulatory care from general community mental health services. Applicability to the broader population requires further analysis and discussion with those services. This absolute target is based upon expert opinion and consensus of participants in the Older Persons Mental Health Forum.*

The indicator can be **INTERPRETED AND UNDERSTOOD** by people who need to act **YES**

Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act **YES**

- The clinical relevance of this indicator means that decisions regarding a range of factors such as collaboration between service components or with non-public mental health services impacts on the services performance.

It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis **YES**

- Construction is feasible but difficult as it requires unique identification and/or linkage between inpatient and community systems that is not available in all jurisdictions.

CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator

- Contextual information:
  - service model, for example, links with aged care services;
  - consumer profile (demographics, outcomes and diagnosis);
  - community data compliance / coverage
  - Intake / triage processes and data collection protocols.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**YES**	**YES**
The national definition is meaningful	**YES**	**YES**
The national data specifications can be applied without modification	**YES**	**NO**
The targets set for higher levels are also applicable at this level	**YES**	**NO**

RECOMMENDATIONS for the OLDER PERSONS PROGRAM AREA

- The indicator **pre-admission community care** can be utilised for benchmarking older persons mental health services as defined and specified in the National Mental Health Performance Framework.
- A preliminary good practice target (*80 percent and above*) should be considered for use with older person mental health services.
- Further work is required to more effectively, consistently and accurately capture data regarding intake and triage related contacts.

Post-discharge community care

PRIMARY DOMAIN	Continuous
SUB-DOMAIN	Cross-setting continuity
SECONDARY DOMAINS	Accessible, Safe
INITIAL REVIEW DATE	8 May 2008

LEARNINGS

- The indicator measures good practice directly. It has clinical meaning and relevance at the individual clinician level and can drive practice improvement and change.
- The indicator is vulnerable to poor ambulatory data collection compliance.
- Public mental health services cannot be expected to see everyone discharged from public inpatient units as some consumers are appropriately followed up by GPs, private psychiatrists or other services.
- The indicator provides a good indication of what is happening in relation to post-discharge follow-up. Further analysis and stratification by client participation, diagnosis groups and so on, may be of use to individual services.
- As the indicator is currently specified there is no differentiation between people who are not contacted versus those where contact is attempted by service but refused or failed (due to movement from jurisdiction). However, the Forum acknowledged the current limitations of information systems to capture the appropriate data.
- The model of care adopted by the service will impact on the output and comparability of the indicator.
- The indicator is appropriately inclusive of all service contacts as follow-up care in older person mental health services is often about the co-ordination of post-discharge care, for example, the most appropriate follow-up for a consumer with a low mental status may be with the residential aged care facility rather than the consumer themselves.
- The indicator does not distinguish between (nor is it intended to) the intensity or quality of treatment provided. It is important to acknowledge that the follow-up is inclusive of all contacts, including team reviews etc.
- It was acknowledged that the seven day parameter was chosen due to substantial literature indicating increased risk of suicide within the first seven days following discharge from acute care. However, there is less evidence that follow-up within seven days makes a difference for the consumer in regards to community tenure. The seven days relates to the consumer not the service hours (i.e. seven days from the time the consumer was discharged not seven working days).
- The Older Persons Forum discussed the appropriateness of utilising seven days within older person services. It was agreed that further analysis of different reference periods is required before any decisions or recommendations can be presented.

For the **OLDER PERSONS PROGRAM AREA** the indicator is **RELEVANT**	**YES**
For the **OLDER PERSONS PROGRAM AREA** the indicator **MEASURES WHAT IS INTENDED**	**YES**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate	**YES**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**YES**

For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set	**YES**

- Ideally 100 percent of all persons discharged to the public community mental health service, however would need to recognise that a proportion of consumers are appropriately followed up by alternate and private sector services. Future work could investigate how to appropriately identify consumers referred to the public mental health services rather than to no further care (i.e. outside jurisdiction or service catchment) or to the private sector.

Good practice target

- At least **80 percent** of consumers should be contacted in the seven days following discharge from an acute inpatient unit.

Note: *Any target determined is preliminary and may change as more evidence is available. The participants in the Older Persons Mental Health Forum provide specialist older persons services. The proposed targets only apply to sub-specialist services and may not be applicable for the 65+ population receiving ambulatory care from general community mental health services. Applicability to the broader population requires further analysis and discussion with those services. This absolute target is based upon expert opinion and consensus of participants in the Older Persons Mental Health Forum.*

The indicator can be **INTERPRETED AND UNDERSTOOD** by people who need to act	**YES**

Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act	**YES**

- The clinical relevance of this indicator means that decisions regarding a range of factors such as collaboration between service components or with non-public mental health services impacts on the services performance.

It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis	**YES**

- Construction is feasible but difficult as it requires unique identification and/or linkage between inpatient and community systems that is not available in all jurisdictions.

CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator

- Contextual information:
  - model of care;
  - discharge destination;
  - consumer profile (demographics, outcomes and diagnosis);
  - community data compliance / coverage.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**YES**	**YES**
The national definition is meaningful	**YES**	**YES**
The national data specifications can be applied without modification	**YES**	**YES**
The targets set for higher levels are also applicable at this level	**YES**	**YES**

RECOMMENDATIONS for the OLDER PERSONS PROGRAM AREA

- The indicator **post-discharge community care** can be utilised for benchmarking older persons mental health services as defined in the National Mental Health Performance Framework.
- A preliminary good practice target (*80 percent and above*) should be considered for use with older person mental health services.

Outcomes readiness

PRIMARY DOMAIN	Capable
SUB-DOMAIN	Outcomes orientation
SECONDARY DOMAIN	Effective
INITIAL REVIEW DATE	8 May 2008

LEARNINGS

- Compliance with data collection protocols is not an indication of data quality. As currently defined and specified this is not a measure of capability.
- The indicator is overly generous in its calculation of participation, which causes some difficulty in interpretation and face validity (eg when have 150% participation). In particular, it is skewed in the favour of residential or long-stay services.

For the OLDER PERSONS PROGRAM AREA this indicator is RELEVANT	**YES**
For the OLDER PERSONS PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**YES**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DEFINITION is appropriate	**YES**
For the OLDER PERSONS PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**NO**

- The Older Persons Forum considered that the specifications do not allow for compliance with specific measures to be identified. The national specifications are unclear on whether consumer self-assessment measures are included in the construction of compliance. Given the significant low rate of offering and completion of these measures inclusion would significantly impact on the output and utility of the indicator.
- The Older Persons Forum would recommend that compliance with the consumer self-report measure be reported separately to compliance with clinician measures.

For the OLDER PERSONS PROGRAM AREA UNIFORM TARGETS can be set	**NO**

- The Older Persons Forum considered that given the lack of clarity regarding what is included in the construction of the national definition it was not sensible to set a target.
- It was noted that the national target for compliance with the National Outcomes and Casemix Collection was 85 per cent.

The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act	**YES**
Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act	**YES**
It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis	**YES**

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	**YES**	**NO**
The national definition is meaningful	**YES**	**NO**
The national data specifications can be applied without modification	**N.A.**	**N.A.**
The targets set for higher levels are also applicable at this level	**N.A.**	**N.A.**

RECOMMENDATIONS for **OLDER PERSONS PROGRAM AREA**

- The indicator **outcomes readiness** *care* can utilised for benchmarking older persons mental health services as a measure of capability as defined and specified in the National Mental Health Performance Framework.

PART TWO

REVIEW OF ADDITIONAL AND SUPPLEMENTARY PERFORMANCE AND CONTEXTUAL INDICATORS

SUPPLEMENTARY CONTEXTUAL INDICATORS

The following section briefly summarises the recommendations and key comments made by the Older Persons Forum regarding the supplementary contextual indicators used within the National Mental Health Benchmarking Forum. These indicators were considered to provide **context** to the service and other indicators but were not deemed to be a measure of a service's performance (that is, services would not necessarily be able to influence the results due to changes in clinical or administrative practices).

The Forum considered whether or not the information was relevant and useful for benchmarking older persons mental health services, and whether or not it was feasible to collect the data and construct the indicator.

INDICATOR	DEFINITION and SPECIFICATIONS	RELEVANT, USEEFUL and FEASIBLE	NATIONAL INDICATOR
Total in-scope expenditure	Sum of all in-scope expenditure during the reference period.	**YES** • Although there are considerable differences in costing methodologies which impact on the comparability of this data it was informative in estimated overall size of resource bucket.	**NO**
Community ambulatory mental health services direct care FTE per 100,000 population	Number of community ambulatory mental health services direct care FTE within the reference period **over** the total catchment population for in-scope community ambulatory mental health services during the reference period.	**YES** • FTE information is more comparable than financial data as it is less susceptible to different accounting practices and overcomes many of the issues that arise with comparisons of the financials. • Variation in staffing mix will impact on the indicator, eg medical staff are more expensive which may lower FTE for same level of expenditure as another service with more overall FTE. • This indicator provides more information about expenditure rather than basic financial information. • Consideration should be given to stratifying the indicator by productive and unproductive (that is, paid but not working) FTE.	**POTENTIAL** Further consideration of strengths and weaknesses of indicator is required.
Acute beds per 100,000 population	Number of in-scope acute inpatient psychiatric beds available during the reference period **over** the total catchment population for in-scope acute inpatient mental health services during the reference period.	**YES** • Bed information is more comparable than financial data as it is less susceptible to different accounting practices. Although there are potential differences in counting what is considered a 'bed'. • Has more operational meaning and provides a better basis for jurisdictional comparisons.	**POTENTIAL**

INDICATOR	DEFINITION and SPECIFICATIONS	RELEVANT, USEEFUL and FEASIBLE	NATIONAL INDICATOR
Community residential beds per 100,000 population	Number of in-scope community residential psychiatric beds available during the reference period **over** the total catchment population for in-scope community residential mental health services during the reference period.	**YES** • Community residential services often have broad catchments and a mental health service organisation may not be responsible for the functioning of a service but is able to access its services. • Potentially useful to advocate for resources.	**POTENTIAL**
Proportion of indirect expenditure	Total indirect expenditure for all in-scope services during the reference period **over** the total expenditure for all in-scope services during the reference period.	**YES** • Conceptually this is useful information, however different accounting practices and costing methodologies limit the utility and comparability of expenditure data. • Useful for service managers but not clinicians as it can potentially help to explain variation in expenditure based indicators (however dependent upon quality of expenditure data and differences between costing methodologies).	**NO**
Proportion of expenditure on salaries and wages	Total salaries and wages expenditure for all in-scope services during the reference period **over** the total expenditure for all in-scope services during the reference period.	**YES** • Although there are limitations on comparison of actual expenditure, the proportion of expenditure of salaries and wages provides information on how services are expending their funds. This allows some comparison and understanding of resource availability and allocation.	**NO**
Full year cost per acute inpatient bed	Total expenditure for all in-scope acute psychiatric inpatient units during the reference period **over** the number of in-scope acute psychiatric inpatient beds available during the reference period.	**YES**	**NO**
Full year cost per community residential bed	Total expenditure for all in-scope community residential services during the reference period **over** the number of in-scope community residential beds available during the reference period.	**YES** • It is useful to ensure that contextual data for acute units is also provided for community residential.	**NO**
Full year cost per community ambulatory direct care FTE	Total expenditure for in-scope community ambulatory services within the reference period **over** the total community ambulatory mental health direct care FTE within the reference period.	**YES**	**NO**

INDICATOR	DEFINITION and SPECIFICATIONS	RELEVANT, USEEFUL and FEASIBLE	NATIONAL INDICATOR
Proportion of consumers who reside outside community ambulatory catchment	Number of people receiving one or more community ambulatory service contacts who resided outside of the community ambulatory mental health services designated catchment during the reference period **over** the number of people receiving one or more community ambulatory service contacts from the community ambulatory mental health service during the reference period.	**YES**	**NO**
Proportion of acute inpatient separations where the consumer resides outside acute inpatient catchment	Number of separations from the acute inpatient psychiatric unit for people who reside outside the designated acute psychiatric inpatient unit's catchment during the reference period **over** the total number of separations during the reference period.	**YES**	**NO**
Diagnosis Profile	• Diagnosis (*at separation for inpatient, and 'most recent' for ambulatory settings*) at separation grouped as percentage within each of the major diagnostic groupings (using ICD-10-AM codes) during the reference period. • Percentage of overnight separations with diagnosis data. • Percentage of ambulatory consumers with diagnosis data.	**YES**	**NO**
Mental Health Outcomes Profile (HoNOS65+ and RUG-ADL)	The Older Persons Forum considered the following information, by acute inpatient and ambulatory settings: • Total HoNOS65+ Score (*Admission for Inpatient, Review for Ambulatory settings*). • Average HoNOS65+ Item Score by Item (*Admission for Inpatient, Review for Ambulatory settings*). • Percentage of clinically significant items by item (*Admission for Inpatient, Review for Ambulatory settings*). • Percentage of overnight separations with HoNOS65+ data. • Percentage of ambulatory consumers with HoNOS65+ data. • Average RUG-ADL score at admission. • Average RUG-ADL score at admission as percent of maximum score.	**YES** • The trend data is important in looking at outcomes information. • When building casemix profiles it is important to identify the proportion of the consumers represented.	**NO**
Proportion of out-of-scope	Number of overnight separations deemed out-of-scope from acute	**YES**	**NO**

INDICATOR	DEFINITION and SPECIFICATIONS	RELEVANT, USEEFUL and FEASIBLE	NATIONAL INDICATOR
overnight separations	psychiatric inpatient units within the reference period **over** the total number of overnight separations from acute psychiatric inpatient units during the reference period.		
Categorisation of diagnosis at separation	The proportion of separations from acute inpatient units with: Mood Disorders; Dementia; and Psychosis	**YES** • The Older Persons Forum identified that the stratification of a range of information by diagnostic groupings enabled the performance of the services to be unpacked. In particular: - 28 day readmission rate; - Average length of acute inpatient stay; - Median length of stay; - Pre-admission community contact; - Post-discharge community contact.	**N**

SUPPLEMENTARY PERFORMANCE INDICATORS

The following section briefly summarises the recommendations and key comments made by the Older Persons Forum regarding the additional and supplementary **performance** indicators used within the National Mental Health Benchmarking Forum.

The Forum considered whether or not the information was relevant and useful for benchmarking older persons mental health services, whether or not it was feasible to collect and construct and if the indicator should be considered for inclusion in the *National Mental Health Performance Framework*, either in addition to or as a replacement for an existing indicator.

INDICATOR	DOMAIN	DEFINITION and SPECIFICATIONS	RELEVANT, USEEFUL and FEASIBLE	NATIONAL INDICATOR
Median Length of Stay	Efficient	The middle score within the distribution of length of stay during the reference period.	**YES** • The median provides additional information that is important in understanding the average length of acute inpatient stay.	**NO**
Proportion of overnight separations with acute length of stay ≥ 60 days	Efficient	Number of in-scope overnight separations with length of stay ≥ 60 days during the reference period **over** the number of in-scope overnight separations during the reference period.	**YES**	**NO**
Acute bed occupancy	Safe Efficient	Total accrued mental health patient days for in-scope acute psychiatric units during the reference period **over** the number of available beds days during the reference period.	**YES** • Bed occupancy is important in understanding a range of indicators and can have significant impact on a services performance on those indicators, such as readmission rates. • Can map to a number of domains including safety and efficiency.	**YES**
Cost per acute inpatient bed day	Efficient	Total expenditure for in-scope acute psychiatric inpatient units during the reference period **over** the total accrued mental health patient days for in-scope acute psychiatric units during the reference period.	**YES**	**YES** • This indicator should be considered as a complement for the indicator *cost per acute inpatient episode*.

INDICATOR	DOMAIN	DEFINITION and SPECIFICATIONS	RELEVANT, USEEFUL and FEASIBLE	NATIONAL INDICATOR
Average direct care staff hours per acute inpatient day	Efficient	Total accrued mental health patient days for in-scope acute psychiatric units during the reference period **over** the total direct care staffing hours for in-scope acute psychiatric units during the reference period.	**YES**	**NO**
Average cost per community treatment day	Efficient	Total expenditure on community ambulatory mental health services during the reference period. Total number of treatment days during the reference period.	**YES** • This information can also be used to identify issues around underreporting of ambulatory collections.	**YES** • This indicator should be considered as a complement to the indicator *cost per three-month community care period.*
Average weekly contacts per direct care FTE	Efficient	Total community ambulatory service contacts within the reference period **over** the total number of community ambulatory direct care FTE within the reference period multiplied by 44 (assuming annual reporting period).	**YES** • This information can also be used to identify issues around underreporting of ambulatory collections. • Identifies some aspects of intensity of service (although duration is would provide the most accurate measure of intensity). • Highlights that not all services provided are in-person.	**NO**
Average weekly treatment days per direct care FTE	Efficient	Total community treatment days within the reference period **over** the total number of community ambulatory direct care FTE within the reference period multiplied by 44 (assuming annual reporting period).	**YES** • The different perspectives on ambulatory activity combine to provide a more detailed picture of the services provided.	**NO**
Average number of persons seen per year per ambulatory direct care FTE	Efficient	Number of persons receiving one or more service contacts from in-scope community ambulatory services during the reference period **over** the total number of community ambulatory direct care FTE during the reference period.	**YES**	**NO**
Proportion of single treatment day consumers per three month community care period	Efficient	Number of consumers receiving one treatment day only per three month community care period during the reference period **over** the total 3-month community care periods during the reference period.	**YES** • Provides additional information about the services provided and the investment of resources.	**NO**

INDICATOR	DOMAIN	DEFINITION and SPECIFICATIONS	RELEVANT, USEEFUL and FEASIBLE	NATIONAL INDICATOR
Overnight separations per 100,000 population	Efficient	Total number of overnight separations from acute psychiatric inpatient units during the reference period **over** the total population of acute psychiatric inpatient units designated catchment during the reference period.	**NO**	**NO**
Proportion of same day separations from acute psychiatric inpatient units		Number of same day separations from acute psychiatric inpatient units within the reference period **over** the total number of separations from acute psychiatric inpatient units during the reference period.	**YES**	**NO**
Rate of falls	Safe	The number of falls in the acute psychiatric inpatient unit during the reference period **over** the total number of consumers in the acute psychiatric inpatient unit during the reference period.	**YES** • Falls in the elderly is a significant indicator to increased length of stay. • A fall is defined as an event that results in a consumer coming to rest inadvertently on the ground or floor or other lower level. Including staff finding the consumer on the floor but did not witness the event.	
Proportion of consumers who fall	Safe	The number of consumers of the acute psychiatric inpatient unit who fell during the reference period **over** the total number of total number of consumers in the acute psychiatric inpatient unit during the reference period	**YES** • Although the indicator provides useful information the capacity to construct it varies significantly across services	**NO**
Proportion of consumers who fall three or more times	Safe	The number of consumers who have had three or more episodes of falls in the acute psychiatric inpatient unit during the reference period **over** the number of consumers within the acute psychiatric inpatient unit who have had at least one fall during the reference period.	**YES** • Although the indicator provides useful information the capacity to construct it varies significantly across services	**NO**
Rate of unwitnessed falls without injury	Safe	The number of unwitnessed falls with no injury in the acute psychiatric inpatient unit **over** the number of falls in the acute psychiatric inpatient unit during the reference period.	**NO** • Although the indicator provides useful information the capacity to construct it varies significantly across services.	
Rate of witnessed	Safe	The number of witnessed falls with no injury in the	**NO**	

INDICATOR	DOMAIN	DEFINITION and SPECIFICATIONS	RELEVANT, USEEFUL and FEASIBLE	NATIONAL INDICATOR
falls without injury		acute psychiatric inpatient unit **over** the number of falls in the acute psychiatric inpatient unit during the reference period.	• Although the indicator provides useful information the capacity to construct it varies significantly across services.	
Proportion of falls leading to hospitalisation	Safe	The number of falls in the acute psychiatric inpatient unit where the client required hospitalisation **over** the number of falls in the acute psychiatric inpatient unit during the reference period.	**NO** • Although the indicator provides useful information the capacity to construct it varies significantly across services.	
Proportion of falls resulting in injury	Safe	The number of falls in the acute psychiatric inpatient unit resulting in injury to consumer during the reference period **over** the number of falls in the acute psychiatric inpatient unit during the reference period.	**NO** • Although the indicator provides useful information the capacity to construct it varies significantly across services.	
Proportion of falls resulting in a fracture	Safe	The number of falls in the acute psychiatric inpatient unit that result in a fracture during the reference period **over** the total number of falls in the acute psychiatric inpatient unit during the reference period.	**NO** • Although the indicator provides useful information the capacity to construct it varies significantly across services.	
Proportion of consumers with multiple admissions		The number of consumers with more than one separation from the acute psychiatric inpatient unit during the reference period **over** the total number of consumers within the acute psychiatric inpatient unit during the reference period.	**NO**	**NO**
Community Tenure	Effective	The number of consumers registered in the mental health service organisations community ambulatory mental health service with no admissions to acute psychiatric inpatient care (following registration with ambulatory service) during the reference period **over** the number of consumers registered in the mental health service organisations community ambulatory mental health service during the reference period.	**??**	**??**