National Mental Health Benchmarking Project Adult

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 Adult 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 Adult 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 Adult 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 Adult 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 general adult mental 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 Adult Mental Health Benchmarking Forum are primarily based on the expert opinion and majority consensus of participants. Where available literature has been utilised to support defined targets.

Identifying thresholds for investigations – 'alert targets'

The Adult 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 Adult Forum, no organisations from two jurisdictions (Tasmania and the Northern Territory) participated.

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.

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 Adult 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	22 June 2007

LEARNINGS

- The 28 day readmission rate indicator says 'something' about services, it is not diagnostic of a particular problem but rather identifies the potential existence of issues associated with system functioning and that further investigation of some component of the system may be necessary, without necessarily directing the investigation.
- Not all readmissions to psychiatric care are failures of care.
- Planned readmissions that are genuinely scheduled in advance are believed to be relatively infrequent in the general adult sector.
- 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.
- Additionally, a lower readmission rate does not necessarily indicate better practices or outcomes than a higher readmission rate.
- The establishment of Psychiatric Emergency Care Centres (PECCs) and Prevention and Recovery Care (PARC) services has the potential to impact on the interpretation of readmission rates. The inclusion or exclusion of these services needs to be transparent to ensure that the readmissions are not being hidden due to the specifications utilised.
- 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 readmission rates. 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).
- This indicator is useful where multiple inpatient units exist for comparing internally within an organisation, and also has merit in comparing across 'like' services.
- The readmission rate can fluctuate on a monthly basis. Therefore the reference period for analysing and reporting the data can be useful in guiding or directing any investigation or activity.
- The Adult forum researched current literature and interrogated a range of factors that have the potential to impact on readmission rates to determine the capacity of organisations to influence performance. Further details can be found within the 'Good Practice Guidelines' developed by the Adult Forum.
- The Adult forum investigated readmission rates with varying time periods (7 days, 28 days and 180 days). Initial analysis suggested that 7 days could be reflective of issues within the inpatient unit, 28 days of issues associated with either or both the inpatient unit and the community mental health service, and 180 days was potentially linked to the chronic nature of mental illness. However, the forum did not fully discuss or investigate the potential interpretation and utility of 7 day and 180 day readmission rates and the initial discussions should not be considered the consensus view of the forum. Further analysis of this information could inform future refinement of specifications.

For the ADULT PROGRAM AREA this indicator is RELEVANT **YES**

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

For the ADULT 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 ADULT PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate **YES**

- Given the current technical inability to accurately and consistently identify planned readmissions, the Adult 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 Adult 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 ADULT 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 a mental health service organisation should be able to achieve **10 percent or below** on this indicator.

Alert target

- Where an organisation reaches **20 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. Further discussion and consideration of what constitutes 'good practice' is required. This absolute target is based upon expert opinion and consensus of participants in the Adult 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.
- Contextual information:
  - service structure, practices and resources (such as FTE);
  - casemix factors (including HoNOS and diagnosis profiles).

	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 ADULT PROGRAM AREA

- The indicator **28 day readmission rate** can be utilised for benchmarking general adult mental health services as nationally defined and specified.
- A preliminary good practice target (*10 percent or below*) and a preliminary alert target (*20 percent or above*) should be considered for use with general adult mental health services.
- Although the Adult Forum agreed that the specifications should continue to look at all readmissions, it was highlighted that further work should be progressed to address and fix the current technical limitations for distinguishing between planned and unplanned readmissions.
- Research into the utility of an additional indicator focusing on readmission within 180 days should be considered for future investigation.

National Service Standards Compliance

PRIMARY DOMAIN	Appropriate
SUB-DOMAIN	Compliance with standards
SECONDARY DOMAIN	Capable
INITIAL REVIEW DATE	16 – 17 June 2007

LEARNINGS

- The Adult 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, however it may be more useful to be able to distinguish between where organisations are at within the accreditation and continuous quality improvement cycle.
- 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.
- The review process is not necessarily consistent across surveyors or accreditation agencies.
- 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.
- There are additional standards (such as the National Mental Health Practice Standards) that are relevant to mental health services that are not measured by this indicator.
- The use of expenditure to distribute compliance across the service complicates understanding of the indicator and the increasing trend for services to be accredited as a 'whole' rather than as individual units or settings further diminishes the utility of the indicator at the service level.
- The Adult Forum briefly discussed options for revision of the definition and specification, such as number of recommendations and length of time accreditation was granted, however it was noted that a range of factors other than service appropriateness potentially had greater influence over the result.
- Further discussion and investigation is required to develop a more appropriate indicator for this domain.

For the ADULT PROGRAM AREA this indicator is RELEVANT	**YES**
For the ADULT PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**NO**

- 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.

For the ADULT PROGRAM AREA the NATIONAL DEFINITION is appropriate	**NO**
For the ADULT PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**NO**
For the ADULT PROGRAM AREA UNIFORM TARGETS can be set	**NO**
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	**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 ADULT PROGRAM AREA

- The indicator **National Service Standards Compliance** should not be used to benchmark the appropriateness of general adult 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	22 June 2007

LEARNINGS

- 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.
- This indicator must be interpreted within the context of the service and other indicators as it is susceptible to a range of clinical and non-clinical factors including as changes in medical and nursing leadership and practice, discharge practices, bed occupancy, community resources and so on.
- 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.
- The median and mode will provide additional contextual information to enable more accurate description of the typical length of stay of most consumers.
- The mean is impacted on by extreme outliers (e.g. consumer needing extended treatment care receiving care within acute unit as no beds available). It was noted that the greater the difference between the mean and median, the more the average length of stay is affected by outliers.
- The establishment of alternatives to admission to acute psychiatric inpatient units (such as Psychiatric Emergency Care Centres (PECCs) and Prevention and Recovery Care (PARC) units will have an impact on the interpretation of length of stay. The Adult forum agreed that these units should remain in-scope for the calculation of the indicator but further investigation of their impact should be undertaken, potentially through supplementary indicators that exclude the alternative services.

For the ADULT PROGRAM AREA this indicator is RELEVANT	**YES**
For the ADULT PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**YES**
For the ADULT PROGRAM AREA the NATIONAL DEFINITION is appropriate	**YES**
For the ADULT PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**YES**
For the ADULT PROGRAM AREA UNIFORM TARGETS can be set	**YES**

- Although there is agreement that this indicator should primarily be looked at through efficiency, targets would best be set looking through the appropriateness domain.
- It is not sensible to set an absolute average length of stay as 'best' or 'good' practice. Instead, it is more meaningful to identify the upper end of the 'good practice' range – i.e. a limit below which organisations should strive to achieve.

Good practice target

- With the presence of agreed good practices and sufficient resources, an organisation should be able to achieve an average length of stay of **12 days or less**.

NOTE: Any target determined is preliminary and may change as more evidence is available. Further discussion and consideration of what constitutes 'good practice' is required. This absolute target is based upon expert opinion and consensus of participants in the Adult 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:
  - post-discharge community care.
- Additional and supplementary indicators:
  - median and mode length of stay (utilising the definition and specification of length of stay used to calculate average length of stay, i.e. in-scope separations and so on);
  - 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 ADULT PROGRAM AREA.

- The indicator **average length of acute inpatient stay** can be utilised for benchmarking general adult mental health services as nationally defined and specified.
- A preliminary good practice target (*12 days or less*) from the appropriateness domain should be considered for use with general adult mental health services.

Average cost per acute inpatient episode

PRIMARY DOMAIN	Efficient
SUB-DOMAIN	Inpatient
INITIAL REVIEW DATE	22 June 2007

LEARNINGS

- Inpatient episode cost is utilised within the general health sector.
- 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.
- 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. Consequently there is potential for the indicator to mislead analysis of an organisations efficiency and performance.
- The bed day cost, which is a component of episode costs, is generally more relevant at the organisational level.

For the ADULT PROGRAM AREA this indicator is RELEVANT	**YES**
For the ADULT PROGRAM AREA this indicator MEASURES WHAT IS INTENDED?	**YES**
For the ADULT PROGRAM AREA the NATIONAL DEFINITION is appropriate	**YES**
For the ADULT PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**YES**
For the ADULT 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?	**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 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 stay.
- Additional and supplementary indicators:
  - bed occupancy;
  - cost per bed day;
  - annual average cost per bed;
  - clinical hours 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	**YES**	**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 ADULT PROGRAM AREA

- Although the **average cost per acute inpatient episode** indicator meets the specified criteria, the Adult Forum recommends that the **average cost per bed day** be used for benchmarking general adult mental health services.

Average treatment days per three month community care

PRIMARY DOMAIN	Efficient
SUB-DOMAIN	Community
SECONDARY DOMAINS	Appropriate
INITIAL REVIEW DATE	16 – 17 October 2007

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). However, the output at the organisational level potentially averages out any variation between models utilised by different teams and service models.
- 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.
- 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 their time.
- The indicator has the potential to highlight issues at the level of the team or individual clinician.
- An exceedingly high number of average treatment days and a low average number of treatment days are both of concern and may warrant investigation by organisations.
- 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.
- It was noted that utilisation of treatment days is a method to account for reporting variation associated with occasions of service or service contacts, both within and between jurisdictions.
- It was acknowledged that the concept of treatment days was complex and would require education and training of staff to interpret and utilise the information.
- Although the pattern across the three years of data has remained relatively stable, the forum agreed that under-reporting of ambulatory contacts continues to be a significant issue impacting on the interpretability and reliability of the indicator.
- The construction of this indicator is complex and would benefit from more definite specifications and explanations, such as computational specifications or clarity around the determination of the three calendar month community care periods (i.e. days are counted regardless of where a consumer's episode begins or ends within (or outside) the reporting period).

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

- Ideally each episode should be counted as beginning when it commences for each individual consumer, however the Adult forum acknowledges the limitations of current systems and technology.
- Further clarification of the specifications regarding the determination of periods of care would facilitate the construction of this indicator.

For the ADULT PROGRAM AREA UNIFORM TARGETS can be set **YES**

Alert targets

- **Lower Alert:** The average is **equal to or less than 6 treatment days**.
- **Upper Alert:** The average is **equal to or more than 18 treatment days**.

NOTE: Any target determined is preliminary and may change as more evidence is available. This absolute target is based upon expert opinion and consensus of participants in the Adult Mental Health Forum.

The indicator 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 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

- Additional and supplementary indicators:
  - proportion of assessment only cases.
- Contextual information:
  - available resources (such as FTE per 100,000);
  - 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 ADULT PROGRAM AREA

- The indicator **average treatment days per three month community care period** can be utilised for benchmarking general adult mental health services as nationally defined, noting that refinements are required to clarify some aspects of the indicator specifications.
- Alert targets (an average of *six treatment days [lower]* and an average of *18 treatment days [higher]*) should be considered for use with general adult mental health services.

Average cost per three month community care period

PRIMARY DOMAIN	Efficient
SUB-DOMAIN	Community
INITIAL REVIEW DATE	16 – 17 October 2007

LEARNINGS

- The indicator is susceptible to poor compliance by clinicians with local information reporting requirements, particularly contact reporting (i.e. low reporting rates increases costs).
- 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. Consequently there is potential for the indicator to mislead analysis of an organisation's efficiency and performance.
- At the organisational level there is a need to unpack costs and identify associated issues (such as FTE and staffing profile) to enable understanding of efficiency.
- Average cost per treatment day may be more useful when benchmarking at the mental health service organisation level.

For the ADULT PROGRAM AREA this indicator is RELEVANT	**YES**
For the ADULT PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**YES**
For the ADULT PROGRAM AREA the NATIONAL DEFINITION is appropriate	**YES**
For the ADULT PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**YES**
For the ADULT 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 be INTERPRETED AND UNDERSTOOD by people who need to act	**YES**
Performance on the indicator 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.
- 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 ADULT PROGRAM AREA

- Although the **average cost per three-month community care period** indicator meets the above criteria, the Adult Forum recommends that the **average cost per treatment** day be used for benchmarking general adult mental health services.

Population under care

PRIMARY DOMAIN	Accessible
SUB-DOMAIN	Access for those in need
INITIAL REVIEW DATE	19 -20 February 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.
- 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.
- As a measure of performance this indicator cannot be looked at in isolation of other initiatives, such as those funded through Commonwealth of Australian Government (COAG) National Action Plan on Mental Health. These initiatives 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).
- 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 inaccuracies caused by different registration activities across community services. To be nationally comparable the data must be consistently recorded and counted. This must be considered in the interpretation and comparison of the indicator.
- The model of service, particularly where some components of the service are provided outside of the organisations (such as external or shared triage model), will impact on the interpretability and comparability of the indicator.
- 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.

For the ADULT PROGRAM AREA this indicator is RELEVANT	**YES**
For the ADULT PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**YES**
For the ADULT 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 ADULT 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 is more appropriate and useful.

For the ADULT PROGRAM AREA UNIFORM TARGETS can be set	**YES**

- Epidemiological evidence, such as that identified in the Mental Health Clinical Costing Project (MH-CCP) in New South Wales, indicates that approximately 2.6 percent of the population have a serious mental illness that would require access to mental health services. However, setting the target at this level assumes all persons with a severe mental illness have to access the public sector and does not take account of private sector services.

Good practice target

- For ambulatory services, **approximately 2 percent or higher** of the catchments population should access services from the local public sector mental health service.

NOTE: Any target determined is preliminary and may change as more evidence is available. This absolute target is based upon initial epidemiological evidence as it applies to general adult ambulatory mental health services in Australia.

The indicator be INTERPRETED AND UNDERSTOOD by people who need to act	**YES**
Performance on the indicator 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

- Additional and supplementary indicators:
  - proportion of consumers from catchment area receiving care outside local catchment (noting this indicator requires access to state-wide data); and
  - proportion of consumers from outside catchment area receiving services from local service.
  - FTE per 100,000 population.
- Contextual information:
  - model of service;
  - population characteristics (such as demographic and epidemiological profiles);
  - staffing profile;
  - local prevalence of mental illness.

	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 ADULT PROGRAM AREA

- The indicator **population under care** can be utilised for benchmarking at general adult mental health services as currently defined and specified for the National Benchmarking Project.
- Focus of analysis and investigation should be on ambulatory population under care as these services undertake the majority of activity within the public sector and given adequate resources has the capacity to minimise/alleviate admissions to inpatient care. Based on current epidemiological evidence, a preliminary good practice target (*2 percent or higher*) should be considered for use with general adult ambulatory mental health services.

Local access to inpatient care

PRIMARY DOMAIN	Accessible
SUB-DOMAIN	Local access
INITIAL REVIEW DATE	19 – 20 February 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 and/or clinician may not be 'local'.
- For services whose inpatient catchment stretches a large geographic region the concept of 'local' as defined for this indicator is not meaningful.

For the ADULT PROGRAM AREA this indicator is RELEVANT	**NO**
For the ADULT PROGRAM AREA this indicator is MEASURES WHAT IS INTENDED	**NO**
For the ADULT PROGRAM AREA the NATIONAL DEFINITION is appropriate	**N.A.**
For the ADULT PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**N.A.**
For the ADULT PROGRAM AREA UNIFROM TARGETS can be set.	**N.A.**
The indicator be INTERPRETED AND UNDERSTOOD by people who need to act	**N.A.**
Performance on the indicator 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.**
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 ADULT PROGRAM AREA

- The indicator **local access to acute inpatient care** should not be utilised for benchmarking at the general adult mental health services as a measure of access as currently defined and specified in the National Mental Health Performance Framework.

New Client Index

PRIMARY DOMAIN	Accessible
SUB-DOMAIN	Access for those in need
INITIAL REVIEW DATE	16 – 17 October 2007

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').
- 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.
- The Adult Forum constructed the indicator as defined within the national indicator framework (that is, new to mental health care by the organisation). Organisation's had variable capacity to identify 'new', with the reference period varying. The change was informative and provided broader contextual information as to consumer throughput, however the benchmarking definition was considered appropriate for defining access to care as even if consumers do have a history with a mental health service there will be a need to re-engage or re-connect for consumers who have not accessed public mental health services for an extended period of time.
- There are likely to be strong regional differences in the performance of this indicator, particularly where there are alternate (non-public sector) services available.

For the ADULT PROGRAM AREA this indicator is RELEVANT	**YES**
For the ADULT PROGRAM AREA this indicator MEASURES WHAT IS INTENDED	**YES**
For the ADULT 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 adult program area.

For the ADULT 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 adult program area.

For the ADULT PROGRAM AREA UNIFORM TARGETS can be set	**NO**
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 (new to mental health care);
  - case closure or throughput index (a measure of discharge).
- Contextual information:
  - population demographics.

	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 ADULT PROGRAM AREA

- The indicator **new client index** as defined and specified for the National Mental Health Benchmarking Project is appropriate for benchmarking general adult mental health services.
- Where possible, the new client index as defined within the National Mental Health Performance Framework should be utilised as a supplementary indicator for benchmarking general adult mental health services.

Comparative area resources

PRIMARY DOMAIN	Accessible
SUB-DOMAIN	Access for those in need
SECONDARY DOMAIN	Sustainable
INITIAL REVIEW DATE	16 – 17 October 2007

LEARNINGS

- The Forum considered that this was not necessarily 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, population and service) that may not be within the control of the service.
- 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.

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

- The national definition looks at the overall organisation and does not allow consideration of different catchment populations between service components.
- The definition utilised as part of the National Mental Health Benchmarking Project is more appropriate and useful (splitting between three main settings [acute inpatient, community residential and community mental health]).

For the ADULT PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**NO**

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

For the ADULT PROGRAM AREA UNIFORM TARGETS can be set	**NO**
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

- 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 ADULT PROGRAM AREA

- The indicator **comparative area resources** can be utilised for benchmarking at the mental health service organisation level as currently defined and specified for the National Mental Health Benchmarking Project.

Pre-admission community care

PRIMARY DOMAIN	Continuous
SUB-DOMAIN	Cross-setting continuity
SECONDARY DOMAIN	Accessible
INITIAL REVIEW DATE	16 – 17 October 2007

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 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.
- The Forum discussed the potential for the 'primary' domain of the indicator to be 'access' rather than continuous and noted that it could also map strongly to responsiveness.
- The Adult Forum investigated the construction of this indicator for 'open cases' (that is, existing consumers) and all consumers (i.e. existing and new consumers). However it should be noted that the definition of 'case' varied between participating organisations (even within jurisdictions).
- Performance for services improved when the specifications were restricted to open cases, but the current lack of consistent definitions of what constitutes an 'open case' limited comparability and utility within a benchmarking context.
- Additionally, focussing the indicator only on 'open cases' was seen to be inconsistent with the aim of mental health services to treat consumers in the least restrictive environment appropriate and to intervene as early as possible to prevent or ease admissions into acute care.
- 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.

For the ADULT PROGRAM AREA the indicator is RELEVANT **YES**

For the ADULT PROGRAM AREA the indicator MEASURES WHAT IS INTENDED **NO**

- The Adult forum determined that the primary domain should be access and the secondary domains: continuous, appropriate and responsiveness.

For the ADULT PROGRAM AREA the NATIONAL DEFINITION is appropriate **YES**

For the ADULT PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate **YES**

- Further work is required to appropriately define a 'case' and the criteria for commencing and stopping a 'case' (and subsequently identifying a 'case'), as this will enable the most appropriate specifications for this indicator to be identified

For the ADULT 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 **75 percent or above** on this indicator.

Alert target

- An alert target of **50 percent or less** could be utilised to trigger potential investigation or action for general adult mental health services.

NOTE: Any target determined is preliminary and may change as more evidence is available. These absolute targets are based upon expert opinion and majority consensus of participants in the Adult 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**

- Decisions regarding a range of factors such as collaboration between service components, partnerships within primary care, private sector or non-government mental health services will impact on 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

- National indicators:
  - new client index.
- Additional and supplementary indicators:
  - new client index (new to inpatient care);
  - FTE per 100,000 population;
  - beds per 100,000 population;
  - bed occupancy.
- Contextual information:
  - service model, for example, is relevant community team an acute assessment team or a case management team?;
  - population demographics;
  - 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**	**NO**

RECOMMENDATIONS for the ADULT PROGRAM AREA

- The indicator **pre-admission community care** can be utilised for benchmarking general adult mental health services as defined and specified in the National Mental Health Performance Framework.
- However, the Adult Forum determined that the primary domain should be access and the secondary domains continuous, appropriate and responsiveness.
- A preliminary alert target (*50 percent or less*) and preliminary good practice target (*75 percent and above*) should be considered for use with general adult mental health services.
- Further work is required to appropriately and consistently define a 'case' and the criteria for commencing and stopping a case, to determine a more appropriate specification for the indicator.

Post-discharge community care	
PRIMARY DOMAIN	Continuous
SUB-DOMAIN	Cross-setting continuity
SECONDARY DOMAINS	Accessible, Safe
INITIAL REVIEW DATE	16 – 17 October 2007

LEARNINGS

- The indicator is a direct measure of good clinical practice. It has clinical meaning and relevance at the individual clinician level and can drive practice improvement and change.
- 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.
- 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.
- 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).
- The indicator is vulnerable to poor ambulatory data collection compliance.

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

- The indicator specifications should refer to where the ambulatory contact occurred (i.e. not whilst in an inpatient unit) not who performed the contact.
- The Adult Forum agreed that the specifications should be modified to only count follow-up contacts where the consumer participated.

For the ADULT PROGRAM AREA UNIFORM TARGETS can be set	**YES**

- Ideally 100 percent of all persons discharged to the public community mental health service would be seen within seven days, however there is a need to recognise that a proportion of consumers are appropriately followed up by alternate and/or 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 **90 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. This absolute target is based upon expert opinion and consensus of participants in the Adult 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**

- 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

- Additional and supplementary indicators:
  - FTE per 100,000 population;
  - bed occupancy;
  - referral destination.
- Contextual information:
  - service model, for example, is relevant community team an acute assessment team or a case management team?;
  - population demographics;
  - 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 ADULT PROGRAM AREA

- The indicator **post-discharge community care** can be utilised for benchmarking general adult mental health services as defined in the National Mental Health Performance Framework, noting refinements to specifications to only include contacts where the consumer participated.
- A preliminary good practice target (*90 percent and above*) should be considered for use with general adult mental health services.

Outcomes readiness

PRIMARY DOMAIN	Capable
SUB-DOMAIN	Outcomes orientation
SECONDARY DOMAIN	Effective
INITIAL REVIEW DATE	19 – 20 February 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 services can have 150% participation). In particular, it is skewed in the favour of residential or long-stay services.

For the ADULT PROGRAM AREA this indicator is RELEVANT	**YES**
For the ADULT PROGRAM AREA this indicator is MEASURES WHAT IS INTENDED	**NO**
For the ADULT PROGRAM AREA the NATIONAL DEFINITION is appropriate	**N.A.**
For the ADULT PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate	**N.A.**
For the ADULT PROGRAM AREA UNIFROM TARGETS can be set.	**N.A.**
The indicator be INTERPRETED AND UNDERSTOOD by people who need to act	**N.A.**
Performance on the indicator 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.**
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 ADULT PROGRAM AREA

- The indicator **outcomes readiness** should not be utilised as a measure of capability as currently defined and specified in the National Mental Health Performance Framework.
- An indicator utilising mental health clinical outcomes (such as change scores over time) should be developed to measure the effectiveness of mental health services.

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 Adult 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 general adult mental health services, and whether or not it was feasible to collect the data and construct the indicator.

The Adult Forum identified that there was potentially a need to develop a set of national contextual indicators that, although not measures of performance, were critical to facilitating the understanding, interpretation and utilisation of performance indicators. This section identifies the contextual indicators that the Adult Forum considered should be included within a national indicator set of contextual information.

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. • 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.	**YES**
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'.	**YES**

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.	**NO** • 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. This limits the capacity to accurately specify and interpret this indicator. • The use of alternate data should be scoped to provide more appropriate information about accessibility of community residential beds.	**NO**
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.	**NO** • Different accounting practices and costing methodologies limit the utility and comparability of this indicator.	**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.	**YES**
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**
Staffing mix per acute patient day	Total direct care staffing hours for nursing/medical/allied health 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** • Although staffing mix is under the control of each organisation to an extent, the overall mix of the different disciplines may be dictated by industry requirements which may differ across jurisdictions.	**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 grouped as percentage within each of the major diagnostic groupings (using ICD-10-AM codes) during the reference period.	**YES**	**NO**
Mental Health Outcomes Profile (HoNOS)	The Adult Forum considered the following HoNOS information: • Total HoNOS Score at Admission. • Average HoNOS Item Score by Item at Admission. • Percentage of clinically significant items by item at Admission.	**YES**	**NO**
Proportion of out-of-scope overnight separations	Number of overnight separations deemed out-of-scope from acute psychiatric inpatient units within the reference period **over** the total number of overnight separations from acute psychiatric inpatient units during the reference period.	**YES**	**NO**

SUPPLEMENTARY PERFORMANCE INDICATORS

The following section briefly summarises the recommendations and key comments made by the Adult 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 general adult 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 ≥ 35 days	Efficient	Number of in-scope overnight separations with length of stay ≥ 35 days during the reference period **over** the number of in-scope overnight separations during the reference period.	**NO**	**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. • Although there was some divergent views the Adult Forum generally considered that action could be taken to influence performance on bed occupancy, although resource availability was a significant influence. • 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 replacement 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**	**YES** • This indicator should be considered as a replacement for the indicator *average cost per three-month community care period.*
Average annual cost per residential bed	Efficient	Total expenditure on residential mental health services during the reference period. Total number of available beds in the residential mental health service during the referee period.	**YES**	**NO**
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**	**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**	**NO**
Average contacts per treatment day	Efficient	Total community ambulatory service contacts within the reference period **over** the total community treatment days within the reference period.	**NO**	**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**

INDICATOR	DOMAIN	DEFINITION and SPECIFICATIONS	RELEVANT, USEEFUL and FEASIBLE	NATIONAL INDICATOR
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**	**NO**
Average contacts per three month community care period	Efficient	Total community ambulatory service contacts within the reference period **over** the total 3-month community care periods during the reference period.	**NO**	**NO**
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**
Consumer outcomes participation	Responsive	The number of National Outcomes and Casemix Collection (NOCC) ambulatory care setting collection occasions with a valid consumer self-assessment outcome measure during the reference period **over** the number of NOCC ambulatory care setting collection occasions during the reference period.	**YES** • The indicator constructed for the Adult Forum required a 'valid' measure: K10+ (minimum 9 items completed), MHI (minimum 30 items completed), BASIS-32 (minimum 24 items completed). • The Adult Forum was supportive of the revision of the specifications of the *consumer outcomes participation* indicator endorsed for inclusion in the *National Mental Health Performance Framework* to count all measures with at least one item completed as a measure of the responsive of mental health services.	**YES**
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**