

**Key Performance Indicators for  
Australian Public Mental Health  
Services (3<sup>rd</sup> edition): Pre-admission  
community care**

Summary paper

**March 2019**

# Background

In 2017, the National Mental Health Performance Sub-Committee (NMHPSC) recommended to the Mental Health Information Strategy Standing Committee (MHISSC) that the *Pre-admission community care* indicator be retired, noting numerous problems with the indicator in its current form. However, MHISSC requested that the indicator be redefined to better reflect its underlying purpose.

The NMHPSC subsequently established a time-limited working group to discuss and review the technical specifications of the Key Performance Indicators for Australian Public Mental Health Services (MHS KPIs). The working group reviewed the utility of the specifications for addressing contemporary mental health-related issues and considered whether new indicators were required and whether any of the existing indicators no longer warranted ongoing national monitoring and reporting.

At the February 2018 NMHPSC meeting, the full Committee discussed the recommendations from the working group, with specific focus on three indicators; *Comparative area resources*, *New client index*, and *Pre-admission community care*. The NMHPSC did not support the working group's business case for retiring the *Comparative area resources* indicator, but were unable to reach a consensus on how to resolve issues with this indicator or the other two measures.

The NMHPSC agreed to hold an out-of-session workshop in June 2018 to provide sufficient time for members to discuss the way forward with these indicators. Due to time constraints, the workshop only examined the *Comparative area resources* and *New client index* indicators. The *Pre-admission community care* indicator was discussed at the September 2018 NMHPSC meeting following the same format as the workshop. Final amendments to the specification were agreed at the March 2019 MHISSC meeting.

## Pre-admission community care

*Pre-admission community care* (MHS KPI 11) is included in the 3rd edition of the Key Performance Indicators for Australian Public Mental Health Services (MHS KPIs). It is defined as the:

*Proportion of admissions to the mental health service organisation's acute psychiatric inpatient unit(s) for which a community mental health service contact, in which the consumer participated, was recorded in the seven days immediately preceding that admission.*

This indicator maps to the 'Continuous' and 'Accessible' domains of the Tier 3 (Health System Performance) of the National Mental Health Performance Framework (see Annexes A and B). The 2018 indicator specification is at Annex C.

During the 2017 review of MHS KPIs, members identified the following issues with this indicator:

- The ideal directionality of the indicator is unclear: members disagreed on whether a higher or lower proportion of pre-admission contacts was 'good'. Some members felt that a higher proportion of admissions receiving community care may show community mental health teams are in touch with consumers in their area. Other members argued that a lower proportion of pre-admissions contact may show that community mental health clients are having their needs met in the community (i.e. community teams are helping clients to avoid hospitalisation).
- The indicator does not address the issue of readmission to hospital.
- Jurisdictions differ in how admissions are identified and therefore how the specification is applied (e.g. whether in-hospital transfers are counted).

- There are differences between consumers already receiving care through the community sector versus those whose first experience of care is through inpatient hospital admission.
- There is greater fluctuation in the smaller jurisdictions compared to the larger states/territories, which may result from differences in service models.

## Purpose of the indicator

One of the key issues for *Pre-admission community care* has been the difficulty in interpreting performance against the indicator. *Pre-admission community care* currently maps to both the 'Continuous' and 'Accessible' domains of Tier 3 of the National Mental Health Performance Framework (NMHPF). The mapping to 'Continuous' as the primary domain for the indicator reflects the concept of continuity of care; that is accessing community care before escalating to hospital-based care as the most suitable treatment option.

However, lack of the growth in the community mental health sector in some jurisdictions has led to consumers presenting to emergency departments (ED) as first port of call, rather than being assessed by the community team and admitted if appropriate. The trend towards first mental health presentations at ED represents a cultural change from when the *Pre-admission community care* indicator specification was originally developed during the National Mental Health Benchmarking Project.

NMHPSC members agreed that *Pre-admission community care* is currently more of a measure of accessibility than continuity—are consumers able to access community care prior to hospital admission? The purpose of the indicator was considered to be to drive more proactive access to comprehensive community-based care as an alternative to people going to ED or being admitted. While the indicator only examines consumers who have been admitted to hospital, it is expected that the majority of consumers should have had contact with a community team prior to hospital admission. For example, in an early psychosis service, fewer people are being admitted who have not received prior care.

## Rationale

Several issues with the Rationale were noted at the September 2018 meeting:

- The Rationale includes points not relevant to the indicator. For example, 'support and alleviate distress during a period of great turmoil' and 'relieve carer burden' do not relate to the underlying purpose of the indicator.
- The Rationale is not specific to mental health care. For example, wording from the second paragraph could be used to refer to a surgical service.
- The 'hospital' focus of the Rationale does not align with the underlying purpose of measuring access to community.

Members agreed that refinements to the Rationale would be beneficial in improving understanding of the indicator. Suggested improvements include:

- emphasising the value and accessibility of community-based care
- reflecting the purpose of community care being accessed prior to hospital admission
- being made more specific to mental health care.

Members have previously agreed that ensuring that admission to hospital is the most suitable treatment option remains a valid purpose for an indicator and should be reflected in the Rationale.

# Methodological considerations

## International indicators

To aid discussion on methodology, the NMHPSC Secretariat undertook an international literature review and identified only one comparable indicator:

### Pre-admission community care (New Zealand)

- Numerator: The number of in-scope admissions in the denominator
  1. with service user participation contact recorded in the seven days pre-admission by:
    - a. only the admitting District Health Board (DHB)
    - b. admitting DHB and Non-Government Organisation (NGO)
    - c. admitting DHB other than the one the service user initially registered with
  2. with no service user participation contact recorded in the seven days pre-admission by neither admitting DHB or NGO service.
- Denominator: Total number of in-scope inpatient admissions in the reference period.
- Source: [Key Performance Indicators for the New Zealand Mental Health & Addiction Services – Adult stream](#).

The New Zealand indicator is a core indicator in their KPI set and differentiates between the different services recording the participation contact. Members have previously suggested amending the methodology to include community contacts on the day of admission. For the New Zealand indicator, contacts on the day of admission are excluded.

Other relevant international indicators examined access to services. For example, Ireland's [Health Service Executive: National Service Plan 2016](#) indicator set used multiple indicators to track a client's progress through the mental health system, such as number and proportion of referrals offered first appointment, proportion seen, admissions to adult acute inpatient units. Canada's [Shared Health Priorities indicators](#) examine access to mental health and addictions services, and home and community care. These include:

- Wait times for community mental health services, referral/self-referral to services (services provided outside of emergency departments, hospital inpatient programs and psychiatric hospitals)
- Awareness and/or successful navigation of mental health and addictions services (self-reported)
- Rates of repeat emergency department and/or urgent care centre visits for a mental health or addiction issue.

Overall, international indicators use a broad approach for examining community care. Outside of the mental health sector, indicators on 'preventing hospitalisation' and 'community care for older people' examined the quality of care, patient satisfaction, and rates of preventable hospitalisations for ambulatory care sensitive conditions (refer to [Quality indicators for community care for older people: A systematic review](#)).

## Additional measures of access

The overall 'hospital' focus of the indicator specification was considered problematic for an indicator intended to measure access to community-based care. It was noted that the term 'pre-admission' may also be inappropriate as it usually refers to a situation where someone is about to be admitted to hospital for an elective procedure. Rather than replacing *Pre-admission community care*, complementary measures, particularly from the 'community' perspective, could improve understanding of the indicator. For example, measures of episodes started in the community, such as *Proportion of people seen by a community service admitted within the year*.

Members agreed that until alternative measures are developed, the *Pre-admission community care* indicator specification should be revised to better reflect accessibility in the community sector and ensure definitions are applied consistently between jurisdictions. This includes using an alternative term for 'pre-admission' to emphasise the community focus in the indicator specification. Members also acknowledged that work on resolving issues with other KPIs in the set may have an impact on work refining *Pre-admission community care*; for example, the decision to include contacts with the consumer's carer or support person in the scope of the related *Post-discharge community care* indicator. Decisions to disaggregate the acute-only indicators by target population also impact on the *Pre-admission community care* indicator specification.

At the March 2019 MHISSC meeting, MHISSC members suggested amending the title to 'Admission preceded by community mental health care'. MHISSC members also endorsed a range of other amendments to the indicator specification, including revised wording for the Rationale, broadening the scope to include service contacts with the consumer's carer or support person, and the removal of the indicator from the 'Continuous' domain in the NMHPF. The revised 2019 indicator specification is at Annex D.

## Other considerations

### Capacity and resourcing

There are jurisdictional differences in community capability and resourcing. In some jurisdictions, community mental health teams are based in EDs, particularly in regional areas. It is possible that this has resulted in more admissions to hospital than if the community team was located outside of ED. Another consideration is whether ED should be considered as a 'community care' location rather than 'acute care' location. However, not all consumers presenting to an ED are necessarily seen by a mental health team.

A known challenge with the *Pre-admission community care* indicator is that community mental health services have limited ability to have an impact on the indicator if they do not have the resources to implement measures known to reduce admissions (e.g. awareness campaigns, increased staff in the community care teams, provision of mental health hospital-in-the-home care).

### Mental health presentations to ED

Given the increase in mental health presentations to ED, this could be an area for further exploration in the future.

- **Bed shortages:** At present, *Pre-admission community care* is unable to examine whether or not an ED presentation leads to admission and cannot account for bed shortages at hospitals. For example, a situation where a person presents to ED following a referral by their GP but is not admitted, is not a failure of community care.
- **Repeat ED visits:** Repeat ED visits could provide another measure of access (or lack of access) to community services, with the National Integrated Health Service Information Analysis Asset linked data set as a potential data source. It should be noted that the rates of repeat ED visits is included in the 'Shared Health Priorities' pan-Canadian indicators of access to mental health and addictions.
- **Start time:** Community care should ideally be measured from when there is opportunity for care. For example, measuring from the date of admission in ED, rather than when a patient is admitted into a mental health ward.

## Next steps

Members agreed that as an interim solution, the *Pre-admission community care* indicator specification should be revised to better reflect its purpose as a measure of access to community care. Further discussion on complementary measures of access and other new indicators for the MHS KPIs set expected to form part of a proposed workshop on expanded national performance reporting for 2019.

## Annex A: National Mental Health Performance Framework

<b>Health Status and Outcomes ('TIER 1')</b>				<i>How healthy are Australians? Is it the same for everyone? Where is the most opportunity for improvement?</i>	
<b>Health Conditions</b>	<b>Human Function</b>	<b>Life Expectancy and Well-being</b>	<b>Deaths</b>		
Prevalence of disease, disorder, injury or trauma or other health-related states	Alterations to body, structure or function (impairment), activities (activity limitation) and participation (restrictions in participation)	Broad measures of physical, mental, and social wellbeing of individuals and other derived indicators such as Disability Adjusted Life Expectancy (DALE)	Age or condition specific mortality rates		
<b>Determinants of Health ('TIER 2')</b>				<i>Are the factors determining health changing for the better? Is it the same for everyone? Where and for whom are they changing for the worse?</i>	
<b>Environmental Factors</b>	<b>Socio-economic Factors</b>	<b>Community Capacity</b>	<b>Health Behaviours</b>	<b>Person-related Factors</b>	
Physical, chemical and biological factors such as air, water, food and soil quality resulting from chemical pollution and waste disposal	Socio-economic factors such as education, employment per capita expenditure on health, and average weekly earnings	Characteristics of communities and families such as population density, age distribution, health literacy, housing, community support services and transport	Attitudes, beliefs knowledge and behaviours (e.g. patterns of eating, physical activity, excess alcohol consumption and smoking)	Genetic related susceptibility to disease and other factors such as blood pressure, cholesterol levels and body weight	
<b>Health System Performance ('TIER 3')</b>				<i>How well is the health system performing in delivering quality health actions to improve the health of all Australians? Is it the same for everyone?</i>	
<b>Effective</b>		<b>Appropriate</b>		<b>Efficient</b>	
Care, intervention or action achieves desired outcome		The care, intervention or action provided is relevant to the consumer's and/or carer's needs and based on established standards		Achieving desired results with most cost effective use of resources	
<b>Responsive</b>		<b>Accessible</b>		<b>Safe</b>	
Service provides respect for persons and is consumer and carer orientated: respect for dignity, confidential, participate in choices, prompt, quality of amenities, access to social support networks, and choice of provider		Ability of people to obtain health care at the right place and right time irrespective of income, geography and cultural background		Potential risks of an intervention or the environment are identified and avoided or minimised	
<b>Continuous</b>		<b>Capable</b>		<b>Sustainable</b>	
Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.		An individual or service's capacity to provide a health service based on skills and knowledge		System or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring)	

# Annex B: National Mental Health Performance Framework domains, indicators and benchmarking usage

Mental Health Services Key Performance Indicators	Effective	Appropriate	Efficient	Responsive	Accessible	Sustainable	Capable	Safe	Continuous	Level at which indicators can be used for benchmarking			
										State and Territory	Regional Group of Services	MHSOs	Service Units
MHS PI 1: Change in consumers' clinical outcomes	▲									✓	✓	✓	✓
MHS PI 2: 28 day readmission rate	▲								■	✓	✓	✓	✓
MHS PI 3: National Service Standards compliance		▲						■		✓	✓	✓	○
MHS PI 4: Average length of acute inpatient stay		■	▲							✓	✓	✓	✓
MHS PI 5: Average cost per acute admitted patient day			▲							✓	✓	✓	✓
MHS PI 6: Average treatment days per three month community care period		■	▲							✓	✓	✓	✓
MHS PI 7: Average cost per community treatment day			▲							✓	✓	✓	✓
MHS PI 8: Proportion of population receiving care					▲					✓	✓	✓	✘
MHS PI 9: New client index					▲					✓	✓	✓	○
MHS PI 10: Comparative area resources					▲	■				✓	✓	✓	✘
MHS PI 11: Rate of pre-admission community care					■				▲	✓	✓	✓	✓
MHS PI 12: Rate of post-discharge community care					■			■	▲	✓	✓	✓	✓
MHS PI 13: Consumer outcomes participation				▲				■		✓	✓	✓	✓
MHS PI 14: Outcomes readiness	■							▲		✓	✓	✓	✓
MHS PI 15: Rate of seclusion		■						▲		✓	✓	✓	✓

▲ = Primary domain  
 ■ = Secondary domain

✓ = Valuable at this level  
 ○ = Limited value at this level  
 ✘ = Not useful at this level



## Annex C: 2018 Pre-admission community care specification

### Pre-admission community mental health care, 2018

#### Identifying and definitional attributes

<i>Metadata item type:</i>	Indicator
<i>Indicator type:</i>	Indicator
<i>Short name:</i>	Pre-admission community mental health care, 2018
<i>METeOR identifier:</i>	692993
<i>Registration status:</i>	Health, Candidate 09/08/2018
<i>Description:</i>	<p>The percentage of <b>admissions</b> to state/territory public acute admitted patient mental health care service unit(s) for which a community mental health service contact, in which the consumer participated, was recorded in the 7 days immediately preceding that admission.</p> <p><b>NOTE:</b> This specification has been adapted from the indicator <i>Pre-admission community mental health care, 2018- (Service level)</i> using terminology consistent with the National Health Data Dictionary. There are no technical differences in the calculation methodologies between the Service level version and the Jurisdictional level version of this indicator.</p>
<i>Rationale:</i>	<ul style="list-style-type: none"><li>• To monitor the continuity/accessibility of care via the extent to which public sector community mental health services are involved with consumers prior to the admission to hospital to:<ul style="list-style-type: none"><li>* support and alleviate distress during a period of great turmoil</li><li>* relieve carer burden</li><li>* avert hospital admission where possible</li><li>* ensure that admission is the most appropriate treatment option</li><li>* commence treatment of the patient as soon possible where admission may not be averted.</li></ul></li><li>• The majority of consumers admitted to state/territory public acute admitted patient mental health care service units are known to public sector community mental health services and it is reasonable to expect community teams should be involved in pre-admission care.</li></ul>
<i>Indicator set:</i>	Key Performance Indicators for Australian Public Mental Health Services (Jurisdictional level version) (2018) Health, Candidate 09/08/2018

#### Collection and usage attributes

<i>Computation description:</i>	<p>Coverage/Scope:</p> <p>State/territory public acute admitted patient mental health care service units in scope for reporting as defined by the Mental Health Establishments National Minimum Data Set (NMDS) (admissions data).</p> <p>State/territory specialised community mental health care service unit(s) in scope for reporting as defined by the</p>
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Community Mental Health Care NMDS (pre-admission community contact data).

The following admissions are excluded:

- same-day admissions
- statistical and change of care type admissions
- admissions by transfer from another acute or psychiatric inpatient hospital
- admissions by transfer from a residential mental health care service
- separations where length of stay is one night only and procedure code for Electroconvulsive Therapy (ECT) is recorded.

The following community mental health service contacts are excluded:

- service contacts on the day of admission
- contacts where a consumer does not participate.

Service contacts can be provided by any community mental health care service within the state/territory.

Methodology:

Reference period for 2018 performance reporting: 2016–17

- Implementation of this indicator requires the capacity to track service use across inpatient and community boundaries and is dependent on the capacity to link patient identifiers.
- For the purpose of this indicator, when a mental health service organisation has more than one unit of a particular admitted patient care program, those units should be combined.
- The categorisation of the specialised mental health admitted patient service unit is based on the principal purpose(s) of the admitted patient care program rather than the classification of individual consumers.
- All acute admitted mental health service units reporting to the Mental Health Establishments NMDS are in scope for this indicator, including short-stay units and emergency acute mental health admitted units.
- One of the following Australian Classification of Health Interventions (ACHI) ECT procedure codes are recorded:
  - \* ACHI 5th edition use procedure codes 93340-02 and 93340-03.
  - \* ACHI 6th to 9th editions use procedure codes 93341-00 to 93341-99.
  - \* ACHI 10th edition use procedure codes 14224-00 to 14224-06.
  - \* ACHI 5th to 10th editions ECT Block 1907 may be selected to capture all data regardless of code changes over time.

Different results for the 7-day pre-admission community care indicator will be achieved depending on whether the indicator is based on organisation-level or state-level analysis. The key difference between the two approaches concerns whether pre-admission community care is regarded to have occurred only

when the person is seen by the discharging organisation, or by any public mental health service within the jurisdiction. The preferred approach is for state-level analysis to be used, and for contacts provided by any public mental health service to be counted. This will depend however, on the capacity of jurisdictions to track service use across multiple service organisation providers and will not be possible for all jurisdictions, the details of which are explored in the data quality statement for this indicator.

*Computation:*

$(\text{Numerator} \div \text{Denominator}) \times 100$

*Numerator:*

Number of in-scope admissions to state/territory public acute admitted patient mental health care service unit(s) for which a community mental health service contact, in which the consumer participated, was recorded in the 7 days immediately preceding that admission.

*Numerator data elements:*

**Data Element / Data Set**  
**Data Element**

Specialised mental health service – number of admissions in which there was a community mental health service contact recorded 7 days preceding an admission

**Data Sources**

[State/territory community mental health care data](#) 2016–17

[State/territory admitted patient data](#) 2016–17

*Denominator:*

Number of in-scope admissions to state/territory public acute admitted patient mental health care service unit(s) occurring within the reference period.

*Denominator data elements:*

**Data Element / Data Set**  
**Data Element**

Specialised mental health service – number of admissions

**Data Source**

[State/territory admitted patient data](#) 2016–17

*Disaggregation:*

Service variables: nil.

Consumer attributes: age, sex, Socio-Economic Indexes for Areas (SEIFA), remoteness, Indigenous status.

Disaggregated data excludes missing or not reported data.

All disaggregation data are to be calculated as at admission to the admitted mental health care service unit, even if the value is null.

*Disaggregation data elements:*

**Data Element / Data Set**  
**Data Element**

Person – age

**Data Source**

[State/territory admitted patient data](#) 2016–17

**Guide for use**

Data source type: Administrative by-product data

**Data Element / Data Set**  
**Data Element**

Person – sex

**Data Source**

[State/territory admitted patient data](#) 2016–17

**Data Element / Data Set**

**Data Element**

Address – statistical area level 2 (SA2) code

**Data Source**

[State/territory admitted patient data](#) 2016–17

**Guide for use**

Used for disaggregation by remoteness and SEIFA

**Data Element / Data Set**

**Data Element**

Person – Indigenous status

**Data Source**

[State/territory admitted patient data](#) 2016–17

**Representational attributes**

<i>Representation class:</i>	Percentage
<i>Data type:</i>	Real
<i>Unit of measure:</i>	Service event
<i>Format:</i>	N[NN].N

**Indicator conceptual framework**

*Framework and dimensions:* [Continuous](#)

[Accessible](#)

**Accountability attributes**

*Benchmark:* State/territory level

*Further data development / collection required:*

This indicator cannot be accurately constructed using the Admitted Patient Care and Community Mental Health Care NMDSs because they do not share a common unique identifier that would allow persons admitted to hospital to be tracked in the community services data. Additionally, states and territories vary in the extent to which state-wide unique identifiers are in place to that would allow accurate tracking of persons who are seen by multiple organisations.

There is no proxy solution available. To construct this indicator at a national level requires separate indicator data to be provided individually by states and territories.

Development of a system of state-wide unique patient identifiers within all mental health NMDSs is needed to improve this capacity.

*Other issues caveats:*

- The reliability of this indicator is dependent on the implementation of state-wide unique patient identifiers as the community services may not necessarily be delivered by the same mental health service organisation that admits the consumer to hospital care. Access to state-wide data is required to construct this indicator accurately.
- This measure does not consider variations in intensity or frequency of contacts prior to admission to hospital.
- This measure does not distinguish qualitative differences between phone and face-to-face community contacts.

When data for this indicator are requested, jurisdictions are required to answer 'yes' or 'no' to the question "Seven day pre-admission contact based on tracking pre-admission service contacts across all state/territory public mental health services?". A 'yes' response implies that a state-wide unique client identifier system is in place, or some comparable approach has been used in the data analysis to allow tracking of service utilisation by an individual consumer across all public mental health services in the jurisdiction. Collection of this information is aimed at assessing the degree of consistency between jurisdictions in data reported.

## **Source and reference attributes**

*Submitting organisation:*

Australian Institute of Health and Welfare on behalf of the National Mental Health Performance Subcommittee

*Reference documents:*

National Mental Health Performance Subcommittee (NMHPSC) 2013. Key Performance Indicators for Australian Public Mental Health Services, 3rd edn. Canberra: NMHPSC.

## **Relational attributes**

*Related metadata references:*

Supersedes [KPIs for Australian Public Mental Health Services: PI 11J - Rate of pre-admission community care, 2017](#) Health, Standard 14/06/2017

## Annex D: 2019 Pre-admission community care specification

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### Admission preceded by community mental health care, 2019

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#### Identifying and definitional attributes

<i>Metadata item type:</i>	Indicator
<i>Indicator type:</i>	Indicator
<i>Short name:</i>	Admission preceded by community mental health care, 2019
<i>METeOR identifier:</i>	709384
<i>Registration status:</i>	No registration status
<i>Description:</i>	<p>The percentage of <b>admissions</b> to state/territory public acute admitted patient mental health care service unit(s) for which a community <a href="#">mental health service contact</a>, in which the consumer or their carer/support person participated, was recorded in the 7 days immediately preceding that admission.</p> <p><b>NOTE:</b> This specification has been adapted from the indicator <i>Admission preceded by community mental health care, 2019– (Service level)</i> using terminology consistent with the National Health Data Dictionary. There are no technical differences in the calculation methodologies between the Service level version and the Jurisdictional level version of this indicator.</p>
<i>Rationale:</i>	<ul style="list-style-type: none"><li>• Public sector community mental health services deliver a broad spectrum of services to consumers living in the community. Access to community mental health care can help avert hospital admissions and ensure that hospitalisation only occurs when it is the most suitable treatment option.</li><li>• Monitoring public sector community mental health service contacts with consumers followed by admission to hospital serves as a proxy measure of access to community mental health care.</li><li>• It is reasonable to expect that for consumers known to community mental health services, the community team has been involved the consumer’s care prior to admission to hospital.</li><li>• Both local and national legislation and policies support the engagement of carers of people with mental illness in all levels of service delivery. Families and carers are the backbone of community mental health support, and play a critical role in the process of recovery and relapse prevention.</li></ul>
<i>Indicator set:</i>	Key Performance Indicators for Australian Public Mental Health Services (Jurisdictional level version) (2019) No registration status

## Collection and usage attributes

### *Computation description:*

### Coverage/Scope:

State/territory public acute admitted patient mental health care service units in scope for reporting as defined by the Mental Health Establishments National Minimum Data Set (NMDS) (admissions data).

State/territory specialised community mental health care service unit(s) in scope for reporting as defined by the Community Mental Health Care NMDS (admission data preceded by community contact).

Participation by a consumer or their carer/support person in the community mental health service contact are in scope.

The following admissions are excluded:

- same-day admissions
- statistical and change of care type admissions (e.g. in-hospital transfer from another unit)
- admissions by transfer from another acute or psychiatric inpatient hospital
- admissions by transfer from a residential mental health care service
- separations where length of stay is one night only and procedure code for Electroconvulsive Therapy (ECT) is recorded.

The following community mental health service contacts are excluded:

- service contacts on the day of admission
- contacts where neither a consumer or their carer/support person participated.

Service contacts can be provided by any community mental health care service within the state/territory.

### Methodology:

Reference period for 2019 performance reporting: 2017–18

- Implementation of this indicator requires the capacity to track service use across inpatient and community boundaries and is dependent on the capacity to link patient identifiers.
- For the purpose of this indicator, when a mental health service organisation has more than one unit of a particular admitted patient care program, those units should be combined.
- The categorisation of the specialised mental health admitted patient service unit is based on the principal purpose(s) of the admitted patient care program rather than the classification of individual consumers.
- All acute admitted mental health service units reporting to the Mental Health Establishments NMDS are in scope for

this indicator, including short-stay units and emergency acute mental health admitted units.

- 'Carer/support person' is defined by local legislation and policies for the relevant jurisdiction.
- One of the following Australian Classification of Health Interventions (ACHI) ECT procedure codes are recorded:
  - \* ACHI 5th edition use procedure codes 93340-02 and 93340-03.
  - \* ACHI 6th to 9th editions use procedure codes 93341-00 to 93341-99.
  - \* ACHI 10th edition use procedure codes 14224-00 to 14224-06.
  - \* ACHI 5th to 10th editions ECT Block 1907 may be selected to capture all data regardless of code changes over time.

Different results for the *Admission preceded by community mental health care* indicator will be achieved depending on whether the indicator is based on organisation-level or state-level analysis. The key difference between the two approaches concerns whether community mental health service contact is regarded to have occurred only when the person is seen by the discharging organisation, or by any public mental health service within the jurisdiction. The preferred approach is for state-level analysis to be used, and for contacts provided by any public mental health service to be counted. This will depend however, on the capacity of jurisdictions to track service use across multiple service organisation providers and will not be possible for all jurisdictions, the details of which are explored in the data quality statement for this indicator.

*Computation:*

$(\text{Numerator} \div \text{Denominator}) \times 100$

*Numerator:*

Number of in-scope admissions to state/territory public acute admitted patient mental health care service unit(s) for which a community mental health service contact, in which the consumer or their carer/support person participated, was recorded in the 7 days immediately preceding that admission.

*Numerator data elements:*

**Data Element / Data Set**  
**Data Element**

Specialised mental health service – number of admissions in which there was a community mental health service contact recorded 7 days preceding an admission

**Data Sources**

[State/territory community mental health care data](#) 2017–18

[State/territory admitted patient data](#) 2017–18

*Denominator:*

Number of in-scope admissions to state/territory public acute admitted patient mental health care service unit(s) occurring within the reference period.



*Denominator data elements:*

**Data Element / Data Set**  
**Data Element**

Specialised mental health service – number of admissions

**Data Source**

[State/territory admitted patient data](#) 2017-18

*Disaggregation:*

Service variables: target population of the admitted unit.

Consumer attributes: age, sex, Socio-Economic Indexes for Areas (SEIFA), remoteness, Indigenous status, person present in the mental health service contact.

Disaggregated data excludes missing or not reported data.

All disaggregation data are to be calculated as at admission to the admitted mental health care service unit, even if the value is null.

*Disaggregation data elements:*

**Data Element / Data Set**  
**Data Element**

Person – age

**Data Source**

[State/territory admitted patient data](#) 2017-18

**Guide for use**

Data source type: Administrative by-product data

**Data Element / Data Set**  
**Data Element**

Person – sex

**Data Source**

[State/territory admitted patient data](#) 2017-18

**Data Element / Data Set**  
**Data Element**

Address – statistical area level 2 (SA2) code

**Data Source**

[State/territory admitted patient data](#) 2017-18

**Guide for use**

Used for disaggregation by remoteness and SEIFA

**Data Element / Data Set**  
**Data Element**

Person – Indigenous status

**Data Source**

[State/territory admitted patient data](#) 2017–18

**Data Element / Data Set**  
**Data Element**

Specialised mental health service – target population group

**Data Source**

[State/territory admitted patient data](#) 2017–18

**Data Element / Data Set**  
**Data Element**

Mental health service contact – person present

**Data Source**

[State/territory admitted patient data](#) 2017–18

**Guide for use**

The person present in the mental health service contact may be one of the following: the consumer only, the carer/support person only, or both the consumer and carer/support person.

**Representational attributes**

<i>Representation class:</i>	Percentage
<i>Data type:</i>	Real
<i>Unit of measure:</i>	Service event
<i>Format:</i>	N[NN].N

**Indicator conceptual framework**

*Framework and dimensions:* [Accessible](#)

**Accountability attributes**

*Benchmark:* State/territory level

*Further data development / collection required:* This indicator cannot be accurately constructed using the Admitted Patient Care and Community Mental Health Care NMDSs because they do not share a common unique identifier that would allow persons admitted to hospital to be tracked in the community services data. Additionally, states and territories

vary in the extent to which state-wide unique identifiers are in place to that would allow accurate tracking of persons who are seen by multiple organisations. Data on carer/support person contacts and the target population of the admitting unit are not also currently available in national datasets.

There is no proxy solution available. To construct this indicator at a national level requires separate indicator data to be provided individually by states and territories.

Development of a system of state-wide unique patient identifiers within all mental health NMDs is needed to improve this capacity.

Collection of carer/support person contacts has been added in the 2019 indicator specifications. Data development work to consistently capture information about carers in state/territory data systems is necessary to allow further development of this indicator.

*Other issues caveats:*

- The reliability of this indicator is dependent on the implementation of state-wide unique patient identifiers as the community services may not necessarily be delivered by the same mental health service organisation that admits the consumer to hospital care. Access to state-wide data is required to construct this indicator accurately.
- This measure does not consider variations in intensity or frequency of contacts prior to admission to hospital.
- This measure does not distinguish qualitative differences between phone and face-to-face community contacts.

When data for this indicator are requested, jurisdictions are required to answer 'yes' or 'no' to the question "Seven day pre-admission contact based on tracking pre-admission service contacts across all state/territory public mental health services?". A 'yes' response implies that a state-wide unique client identifier system is in place, or some comparable approach has been used in the data analysis to allow tracking of service utilisation by an individual consumer across all public mental health services in the jurisdiction. Collection of this information is aimed at assessing the degree of consistency between jurisdictions in data reported.

## **Source and reference attributes**

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare on behalf of the National Mental Health Performance Subcommittee
<i>Reference documents:</i>	National Mental Health Performance Subcommittee (NMHPSC) 2013. Key Performance Indicators for Australian Public Mental Health Services, 3rd edn. Canberra: NMHPSC.

## **Relational attributes**

<i>Related metadata references:</i>	See also <a href="#">Post-discharge community mental health care, 2019</a> No registration status
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Supersedes [Pre-admission community mental health care, 2018](#)  
Health, Candidate 09/08/2018