Implementing National Mental Health Key Performance Indicators in Australian States and Territories

2011

A report by the National Mental Health Performance Subcommittee

Mental Health Information Strategy Subcommittee

AHMAC Mental Health Standing Committee

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A summary of Implementing National Mental Health Key Performance Indicators in Australian States and Territories 2011

A report produced by the National Mental Health Performance Subcommittee.

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Introduction

The original National Mental Health Plan in 1992 placed a strong emphasis on reporting indicators of mental health reform. Health ministers imposed on themselves the discipline of public reporting on reform progress through the National Mental Health Report. Subsequent National Mental Health Plans drove a number of major initiatives, including the implementation of routine outcome measurement for all consumers receiving care through the state and territory mental health services, the introduction of service level benchmarking and the establishment of national minimum data sets to cover all aspects of the public sector mental health delivery.

The first edition of *Key Performance Indicators for Australian Public Mental Health Services* [1] was released in 2005 and describes the National Mental Health Performance Framework (NMHPF). The first edition introduced an initial set of key performance indicators (KPIs) specific to public sector mental health services. All States and territories made a commitment to the implementation of the NMHPF and associated national KPIs to support service improvement and benchmarking activities. A second edition is due for release in 2011 with a revised indicator set, which will update the specifications of the original indicators, include three new indicators added since 2005, and remove one indicator.

The National Mental Health Performance Subcommittee (NMHPSC) was established by the Mental Health Information Strategy Subcommittee (MHISS) to oversee the development, enhancement and implementation of the NMHPF to support benchmarking for mental health service improvement, and provide national information on mental health system performance.

The NMHPSC regularly surveys States and Territories on the progress of implementing the NMHPF and the national KPIs to better support the implementation process and inform indicator development.

The survey was completed by the mental health branch (or appropriate oversighting area) of each State and Territory central health authority[2] and provided information related to activity being undertaken, led and/or facilitated by the central health authority as at March 2011.

This is the first public report to inform stakeholders of the progress of implementation of the NMHPF and performance reporting against the national KPIs. It provides a point in time update on the status of activity by States and Territories and highlights the challenges experienced.

National KPI implementation and reporting

All States and Territories have begun to construct and utilise the national KPIs and are progressively incorporating them into regular performance reporting and information dissemination. Table 1 highlights three different reporting avenues that States and Territories utilise:

- Public reporting;
- Internal departmental reporting; and
- Reporting to mental health service organisations (MHSOs).

[1] *Key Performance Indicators for Australia's public mental health services 2005*, Australian Government, Canberra, available at www.health.gov.au/mhsc

[2] For the purposes of this document this term includes the Western Australia Mental Health Commission

Table 1: Reporting by States/Territories

Indicator	NT			TAS			SA			QLD			NSW			WA			ACT			VIC		
	Public	Internal	MHSO	Public	Internal	MHSO	Public	Internal	MHSO	Public	Internal	MHSO	Public	Internal	MHSO	Public	Internal	MHSO	Public	Internal	MHSO	Public	Internal	MHSO
28 day readmission rate	■	■	✔	■	▲	✔	■	●	✔	■	▲	▲	✔	✔	✔	-	-	-	✔	✔	✔	✔	✔	✔
National Service Standards compliance	■	■	✔	-	-	-	-	-	-	-	▲	▲	-	✔	-	-	-	-	✔	✔	■	-	-	-
Average length of acute inpatient stay	-	-	✔	-	■	✔	■	●	✔	-	▲	▲	-	✔	✔	-	-	-	✔	▲	■	✔	✔	✔
Average cost per acute inpatient episode	-	-	✔	-	-	-	-	-	-	-	▲	▲	-	✔	✔	-	-	-	-	■	-	-	-	-
Average treatment days per three month community care period	-	-	✔	-	■	✔	-	–	-	-	▲	▲	-	-	-	-	-	-	✔	▲	-	✔	✔	✔
Average cost per three month community care period	-	-	-	-	●	✔	-	-	-	-	▲	▲	-	-	-	■	-	-	✔	▲	-	-	-	-
Population receiving care	-	■	✔	-	●	✔	-	-	-	-	▲	▲	■	✔	-	-	-	-	✔	●	✔	-	-	-
New client index	-	-	-	-	●	✔	-	–	-	-	▲	▲	-	–	-	-	-	-	-	■	■	■	✔	-
Local access to acute inpatient care	-	-	-	-	-	-	-	-	-	-	▲	▲	✔	✔	✔	-	-	-	✔	✔	■	✔	✔	✔
Comparative area resources	-	●	✔	-	-	-	-	-	-	-	▲	▲	-	✔	✔	-	-	-	✔	✔	■	-	-	-
Pre-admission community care	-	-	-	-	●	✔	-	●	✔	-	▲	▲	-	-	-	■	-	-	✔	✔	■	✔	✔	✔
Post-discharge community care	■	■	✔	-	●	✔	■	●	✔	■	▲	▲	✔	✔	✔	■	■	✔	✔	✔	✔	✔	✔	✔
Consumer outcomes participation	-	-	-	-	-	-	-	●	✔	-	-	-	-	–	-	-	-	-	✔	●	■	✔	✔	✔
Outcomes readiness	-	●	✔	-	–	-	-	●	✔	-	-	-	-	✔	✔	-	-	-	✔	✔	▲	✔	✔	✔
Rates of seclusion	-	●	✔	-	●	✔	■	✔	✔	■	-	-	-	✔	✔	-	-	-	✔	✔	▲	✔	✔	✔
Change in consumers clinical outcomes	-	-	-	-	●	✔	-	–	-	-	-	-	-	●	✔	-	-	-	-	-	-	✔	✔	✔

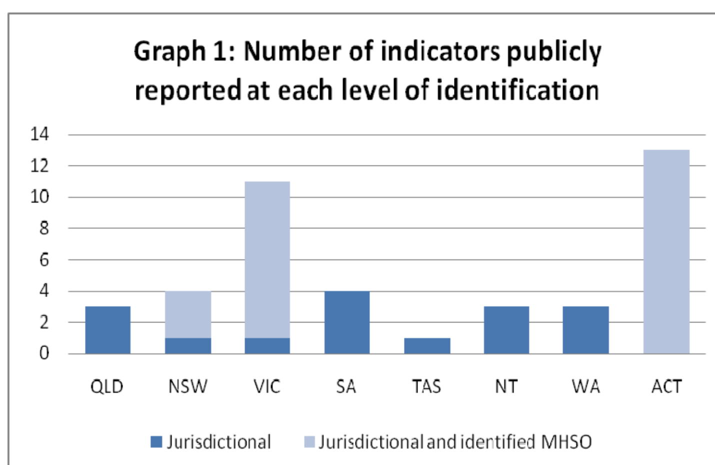
Key		
Public Reporting	✔	The KPI is reported publicly with jurisdiction-level data and identified MHSO data
	▲	The KPI is reported publicly with jurisdiction-level data and unidentified MHSO data
	■	The KPI is reported publicly with jurisdiction-level data
	-	The KPI is not reported publicly
Internal departmental reporting	✔	Reported internally to Minister and/or Cabinet
	▲	Reported internally to the department Secretary/Director General
	■	Reported within health central administration
	●	Reported within mental health central administration
	-	Not reported internally
MHSO Reporting	✔	MHSOs are provided with own and identified peer results
	▲	MHSOs are provided with own and unidentified peer results
	■	The MHSO is provided with own results only
	-	MHSOs are not provided with results

Table 1 highlights that States and Territories are at different stages of progress in performance reporting utilising the NMHPF. For example, the newly-established Western Australian Mental Health Commission, in partnership with the Department of Health, plans to review their mental health indicators in the coming year. Currently WA reports publicly against a number of indicators similar to the national KPIs, however there is variance in terms of the definitions and specifications utilised. In comparison, Victoria, which has a strong history in performance reporting, provides performance information utilising national KPIs to MHSOs quarterly, and significantly, reports the same results to the public.

The timeliness and frequency of reporting varies between States and Territories. The delay between the end of reporting periods and information being available is impacted by a wide range of factors, including information systems and the level of analysis required to transform raw data into indicator results, as well as the capacity of analyst resources.

Public reporting

Overall, public reporting against the national KPIs remains limited. The ACT publicly reports against 13 of the 16 national KPIs at the jurisdiction and MHSO levels, and Victoria reports against 11 as a web release. The majority of public reporting by other states and territories remains seated within Health Department annual reports. Graph 1 highlights that the level of disaggregation continues to vary, with publicly reported figures either at the jurisdiction level or with identified MHSO data. No State or Territory publicly reports de-identified MHSO data.

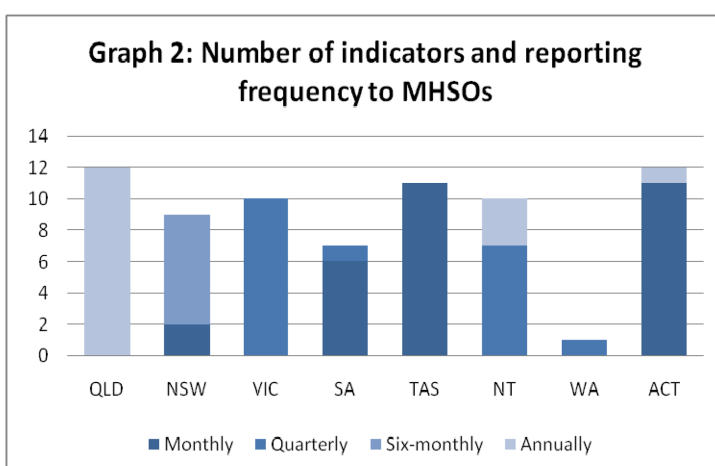


Internal departmental reporting

Indicators are utilised to report internally within health departments (or their equivalents) and up to Minister or Cabinet. As highlighted in Table 1, the majority of States and Territories report a selection of indicators to their minister, whilst all States and Territories utilise at least a sub-set of the KPIs for internal reporting. Queensland has introduced one national mental health KPI (post-discharge community contact) in Performance Agreements between District Chief Executive Officers and the Director-General for 2011-12.

Reporting to MHSOs

All States and Territories utilise a sub-set of National KPIs for performance reporting to MHSOs. However, there is variance in the number of indicators and frequency of reporting (Graph 2), and the level of MHSO identification (Table 1).



All National KPIs can be constructed with stratification by target population. When States and Territories report to

MHSOs, two-thirds (66%) are stratified by target population, compared to less than half (42%) when reported publicly.

In NSW, three main reports are regularly prepared at the State level and disseminated internally: a monthly Health Service Performance Report by NSW Health; a six-monthly Mental Health Performance Report; and additional six-monthly reports are generated for MHSOs utilising the Clinical Information Benchmarking Reporting Engine (CIBRE). The ability of MHSOs to replicate the same results that are produced centrally, are impacted on due to slight variations in interpretation and coding; utilising different data sources; and variability of data depending on extraction dates/times.

In Queensland, annual performance reporting from corporate office to MHSOs is through a relatively manual process undertaken by central office staff (including data extraction, data linkage, production of data output and then production of reports). Queensland aims to move to quarterly reporting in the next 12 months, however the manual process impacts on the timeliness of reporting and increases the cost of production. Queensland's focus over the past three years has been on improving reporting capacity and supporting the use of performance information within MHSOs, utilising national KPIs as the basis of performance reports.

In the ACT access to components of financial reporting, accuracy, quality control and auditing of systems are limited due to resources. There has been limited exploration of indicators that are not currently reported.

In the South Australian model central office provides high level peer reporting to regions, however most performance reporting is constructed at the region-level for MHSOs.

In Tasmania, the Department of Health and Human Services publishes a quarterly report that includes three mental health indicators, of which one is a national KPI (28 day readmission rate).

Issues and barriers experienced to implementing National KPIs

States and Territories identified a range of issues that impact on their implementation of the NMHPF and national KPIs. For the purposes of this document issues have been broadly grouped together in five themes.

Information systems

Each State and Territory has their own mental health information system and processes to collect source data. State-wide information technology (IT) systems are costly to develop, implement and train users on. Some States and Territories have invested heavily to introduce new solutions to enhance data collection, sharing and reporting, whilst others report that their current IT systems' capacity is limited.

The growth in utilisation of mental health performance information has often out-paced the capacity and functionality of some systems. Table 2 illustrates that at March 2011, five of the eight States and Territories' mental health information systems generate unique consumer identifiers that enable the capacity to match data between settings or across MHSOs. Queensland has a state-wide unique identifier, however inpatient services utilise a different information system, and data matching approaches to manually link data sets are utilised. South Australia is investigating potential solutions to achieve a unique identifier, and Tasmania is implementing a solution later in 2011.

Although not necessarily affecting the construction or use of the current national KPIs, States and Territories identified integration and compatibility issues between mental health and general or acute health IT systems, such as in emergency departments and when mental health consumers are admitted to general hospital wards. These issues may impact on future KPIs that attempt to measure continuity of care across different areas of health.

Business practices

Each State and Territory utilises different accounting and funding systems that effect the availability of data for cost/expenditure indicators. Additionally, State and Territory business rules governing data collection practices vary, however there has been significant work by States and Territories to improve consistency and comparability of data within national collections.

Each State and Territory identified a range of compliance issues with the collection of activity data, and are implementing a range of strategies to address them. In addition to the work being progressed nationally, all States and Territories are working to improve data quality through a variety of initiatives, including attempting to reduce collection burden through easier-to-use information systems and increasing literacy in the use of mental health information within clinical settings, so that users may place greater value on collecting accurate and quality information.

Table 2 illustrates that there can be variance in quality between indicators within a jurisdiction, depending on the data source.

Table 2: Data quality and unique identifier

Indicator	NT		TAS		SA		QLD		NSW		WA		ACT		VIC	
	Data Qual	Unique ID	Data Qual	Unique ID	Data Qual	Unique ID	Data Qual	Unique ID	Data Qual	Unique ID	Data Qual	Unique ID	Data Qual	Unique ID	Data Qual	Unique ID
28 day readmission rate	▲	✔	✔	✔	✔	-	▲	▲	▲	✔	✔	✔	✔	✔	✔	✔
National Service Standards compliance	✔	✔	■	✔	✔	✔	▲	✔	-	✔	▲	✔	✔	✔	✔	✔
Average length of acute inpatient stay	✔	✔	✔	✔	✔	✔	▲	▲	▲	✔	✔	✔	✔	✔	✔	✔
Average cost per acute inpatient episode	▲	✔	✔	✔	✔	✔	▲	▲	■	✔	▲	✔	-	✔	✔	✔
Average treatment days per three month community care period	■	✔	✔	✔	▲	✔	▲	✔	■	✔	✔	✔	▲	✔	✔	✔
Average cost per three month community care period	-	✔	✔	✔	▲	✔	▲	✔	■	✔	▲	✔	▲	✔	✔	✔
Population receiving care	✔	✔	✔	✔	▲	-	▲	✔	▲	✔	✔	✔	▲	✔	✔	✔
New client index	■	✔	✔	■	▲	-	▲	▲	■	✔	✔	✔	✔	✔	✔	✔
Local access to acute inpatient care	▲	✔	▲	■	✔	✔	▲	▲	▲	✔	✔	✔	✔	✔	✔	✔
Comparative area resources	▲	✔	✔	✔	✔	✔	▲	✔	■	✔	■	✔	✔	✔	✔	✔
Pre-admission community care	▲	✔	▲	■	▲	▲	▲	▲	▲	✔	✔	✔	▲	✔	✔	✔
Post-discharge community care	✔	✔	▲	■	▲	▲	▲	▲	▲	✔	✔	✔	✔	✔	✔	✔
Consumer outcomes participation	▲	✔	▲	✔	✔	✔	▲	✔	■	✔	■	✔	✔	✔	✔	✔
Outcomes readiness	▲	✔	▲	▲	✔	✔	▲	✔	■	✔	✔	✔	■	✔	✔	✔
Rates of seclusion	✔	✔	✔	✔	■	✔	■	✔	■	✔	-	✔	▲	✔	✔	✔
Change in consumers clinical outcomes	-	✔	▲	▲	✔	✔	▲	✔	■	✔	▲	✔	■	✔	✔	✔

Key		
Data quality	✔	Data quality is satisfactory
	▲	Data quality is satisfactory however issues are still being addressed
	■	There are significant data quality issues currently being addressed
	–	There are significant data quality issues not currently being addressed
Unique identifier	✔	A unique identifier is generated at the jurisdiction level
	▲	A combination of state-wide unique identifiers and local-level identifiers can be linked at a jurisdiction-level using data matching approaches
	■	Local-level identifiers can be linked at a jurisdiction-level using data matching approaches
	–	Unique identifiers are generated at the local-level and cannot be linked at a jurisdiction-level using data matching approaches

Access to required expertise

The majority of States and Territories identified that they can access the expertise to construct indicators, however the capacity of these resources to conduct all required analyses is limited. States and Territories are required to focus their specialist resources on a broad range of activity for both operational and strategic purposes. Generally, there is greater capacity within central mental health administrations than within MHSOs to construct indicators and analyse results.

Technical specifications

Three States and Territories describe all 16 national KPI specifications as sufficiently detailed for their use at both the jurisdiction and MHSO levels. Other States and Territories modify national KPI specifications to fit local requirements. For example, States and Territories hold a greater degree of outcome data than reported to the National Outcome and Casemix Collection (NOCC), and are not subject to a limitation of utilising a set episode for community consumers. This results in a more meaningful indicator for those jurisdictions, however limits the comparability between States and Territories.

Information literacy

Although there are examples of excellence, and champions exist, each State and Territory identified an overall deficit in data and indicator literacy amongst clinical managers, clinicians and other stakeholders. As noted above, there are ongoing efforts to improve literacy. Computer literacy and access may be an issue for a number of individuals and services. The dominant theme emerging was also identified by the National Mental Health Benchmarking Project Evaluation Report [3] that data and indicator literacy requires extensive support from central authorities and local management, and utilises considerable resources.

Summary

States and Territories have embarked on a range of reforms to their mental health sectors that have had a subsequent impact on the collection and use of information. Broader national health reforms through COAG emphasise the importance of performance monitoring and influence the need for embedding this activity within mental health service delivery and policy development.

States and Territories all have systems of reporting mental health system performance information to government, departmental officials, MHSOs and the public; and although the approaches vary, there is a focus on increasing comparability. All States and Territories have incorporated national KPIs into their mental health performance measurement and reporting approaches in one form or another.

The survey identified a range of issues experienced by States and Territories related to implementing national mental health KPIs. Some issues are unique to a single jurisdiction whilst others are common across many or all jurisdictions.

Data and indicator development activities take time and are expensive. All States and Territories reported ongoing work to refine their data collection and quality. Considerable work has been undertaken to progress and develop the mental health performance agenda, to provide a platform for nationally comparable information for mental health services to utilise in benchmarking activity to inform quality improvement, and shape a more accountable and transparent mental health system.

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[3] The National Mental Health Benchmarking Project Evaluation Report is available from the MHSC website at www.health.gov.au/mhsc

Next steps

Work on improving standardisation of data within the National Minimum Data Sets is continuing under the leadership of the Mental Health Information Strategy Subcommittee, to enable more accurate comparison and support benchmarking activity.

A second edition of *Key Performance Indicators for Australian Public Mental Health Services*, to be released in 2011, will place revised KPI specifications into the public domain in a single document, superseding both the first edition and the 2008 technical specifications summary.

Under the Fourth National Mental Health Plan, governments agreed to further develop the *National Mental Health Performance and Benchmarking Framework*. The NMHPSC will lead this work, and consider the role of national benchmarking and additional indicators.

There have been a number of policy announcements impacting on the mental health sector, and as additional funding and resources are allocated, there will be an associated increase in focus and scrutiny on the performance of the sector.

Under COAG reforms of the broader health sector announced in April 2010 and February 2011, a National Health Performance Authority (NHPA) will be established. Under a Performance and Accountability Framework the NHPA will develop and produce performance reports which will help Australians make more informed choices about their health services, and help ensure the standard of care across hospital, general practice and primary health services continues to improve.

In the 2011 federal budget, the Australian Government announced the establishment of a National Mental Health Commission, who will monitor the performance of the mental health sector and produce an Annual National Report Card on Mental Health and Suicide Prevention.

It is anticipated that the extensive work already undertaken by the mental health sector will contribute to the work of the National Health Performance Authority and the National Mental Health Commission once they are established.

www.health.gov.au/mhsc

All information in this publication is correct as of May 2011

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