

Performance Indicators Certification Statement

**PEEL HEALTH SERVICES
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2004**

I hereby certify that the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the Peel Health Services and fairly represent the performance of the Health Service for the financial year ending 30 June 2004.



**Mike Daube
Director General of Health
Accountable Authority for Peel Health Services**

31 August 2004

Performance Indicators Audit Opinion



AUDITOR GENERAL

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

PEEL HEALTH SERVICES PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2004

Audit Opinion

In my opinion, the key effectiveness and efficiency performance indicators of the Peel Health Services are relevant and appropriate to help users assess the Health Services' performance and fairly represent the indicated performance for the year ended June 30, 2004.

Scope

The Director General, Department of Health's Role

The Director General, Department of Health is responsible for developing and maintaining proper records and systems for preparing performance indicators.

The performance indicators consist of key indicators of effectiveness and efficiency.

Summary of my Role

As required by the Financial Administration and Audit Act 1985, I have independently audited the performance indicators to express an opinion on them. This was done by looking at a sample of the evidence.

An audit does not guarantee that every amount and disclosure in the performance indicators is error free, nor does it examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the performance indicators.

A handwritten signature in black ink, appearing to read 'D D R Pearson'.

D D R PEARSON
AUDITOR GENERAL
November 16, 2004

INTRODUCTION

Health is a complex area and is influenced by many factors outside of the provision of health services. Numerous environmental and social factors as well as access to, and use of, other government services have positive or negative effects on the health of the population.

The Performance Indicators outlined in the following pages, address the extent to which the strategies and activities of the Health Services contribute to the broadly stated health outcome which is, through the delivery of its Health Services, the improvement of the health of the Western Australian community by:

- A reduction in the incidence of preventable disease, injury, disability and premature death and the extent of drug abuse.
- The restoration of the health of people with acute illness.
- An improvement in the quality of life for people with chronic disease and disability.

Different divisions of the Health Services are responsible for specific areas of the three outcomes. The largest proportion of Health Services activity is directed to Outcome 2 (Diagnosis and Treatment). To ascertain the overall performance of the health system all reports must be read. All entities contribute to the whole of health performance.

These reports are:

- **Department of Health (Royal Street)**
- **Metropolitan Health Service**
- **Hawthorn Hospital**
- **South West Area Health Service**
- **Peel Health Services**
- **WA Country Health Service**

The different service activities, which relate to the components of the outcome, are outlined below.

Prevention and Promotion

- Community and public health services.
- Mental health services.
- Dental health services.

Diagnosis and Treatment

- Hospital services (emergency, outpatient, inpatient and rehabilitation).
- Nursing posts.
- Community health services (post discharge care).
- Mental health services.
- Dental health services.
- Obstetric services.

Continuing Care

- Services for frail aged and disabled people (eg Aged Care Assessments).
- Services for those with chronic illness.
- Mental health services.

There are some services, such as community health, which address all three of the components.

Note

Results are presented as Aboriginal and non-Aboriginal population figures where appropriate. Comparisons across time are provided where possible and appropriate.

TREASURER'S INSTRUCTION 904

Amendments to Treasurer's Instruction 904 'Performance Indicators' specify requirements for performance reporting by departments, statutory authorities and agencies effective 25 May 1999.

For clarification, the Department of Health is required to report:

- key efficiency indicators for each output, relating outputs to inputs consumed; and
- key effectiveness indicators for each outcome, relating outputs to outcomes achieved.

The four output measures are of quantity, quality, timeliness and cost. These are direct measures of performance, but are not to be confused with Key Performance Indicators of Efficiency and Effectiveness.

Quantity	Measures describe outputs in terms of how much, or how many are performed and require a unit of measurement to be defined.
Quality	Measures usually reflect service standards based on customer needs. The dimensions of quality as an output measure include accuracy; completeness; accessibility; continuity and a customer acceptability of the output.
Timeliness	Measures provide parameters for how often, or within what time frame, outputs will be produced.
Cost	Measures reflect the full accrual cost to an agency of producing each output.

CONSUMER PRICE INDEX (CPI) DEFLATOR SERIES

The index figures are derived from the CPI all groups, weighted average of the eight capital cities index numbers. For the financial year series the index is the average of the December and March quarter and is rebased to reflect a mid year point of the five year series that appears in the annual reports. The average of the December and March quarter is used, because the full year index series is not available in time for the annual reporting cycle.

The calendar year series uses a similar methodology but is based on the average of the June and September quarter.

The financial year costs for the annual report can be adjusted by applying the following formula. The result will be that financial data is converted to 2001-02 dollars:

$Cost_n \times (100/Index_n)$ where n is the financial year or calendar year where appropriate.

Table 9: Index figures for the financial and calendar years

Calendar year	1998	1999	2000	2001	2002	2003
Index (Base 2001)	90.41	91.68	95.93	100.00	103.02	105.75
Financial year	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
Index (Base 2001-02)	89.60	91.65	97.06	100.00	103.24	105.48

OUTCOME 1: Reducing the incidence of preventable disease, injury, disability and premature death and the impact of drug abuse

The services (outputs) of all parts of the Department of Health contribute to the outcome above. The achievement of this component of the health objective includes activities that reduce the likelihood of disease or injury and reduce the risk of long-term disability or premature death. Strategies include prevention, early identification and intervention and the monitoring of the incidence of disease in the population to ensure primary health measures are working. The impact of drug abuse is also monitored.

The outputs of the Peel Health Services as well as the other divisions of the Department of Health are contained on the table below. The greatest proportion of the services provided by the Peel Health Services in this outcome is directed to children. Other health services and divisions of Department of Health, for example Royal Street Division provide more services directed to prevention and surveillance of disease including those affecting the adult population.

Table 10: Respective Indicators by health sector for Outcome 1

	Metropolitan Health Service	Peel Health Services	South West Area Health Service	WA Country Health Service	Royal Street Division
The achievement of this component of the health objective involves activities which:					
1. Reduce the likelihood of onset of disease or injury by:					
• Immunisation programs	101	101	101	101	
• Childhood screening & appropriate referrals	105 106				
• Safety program					R101
2. Reduce the risk of long term disability or premature death from injury or illness through:					
• Surveillance					R101
3. Monitoring the incidence of disease in the population to ensure primary health measures are effective:					
	103 104	103 104	103 104	103 104	
4. Monitoring and surveillance of suicide rates and drug and alcohol use:					
					R101

101A: Rate of fully immunised children 0-6 years

This indicator reports the rate of fully immunised children 0-6 years who reside in the Peel Health Services catchment area.

Rationale

The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore them to good health when they become ill but also to maintain a state of 'wellness' that allows them to develop to full potential. One of the key components of this is to attempt to ensure that every child experiences the full benefit provided by appropriate and timely immunisation against disease provided by internationally recognised vaccination practices.

Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

The agreed targets in the Public Health Funding Agreement are as follows:

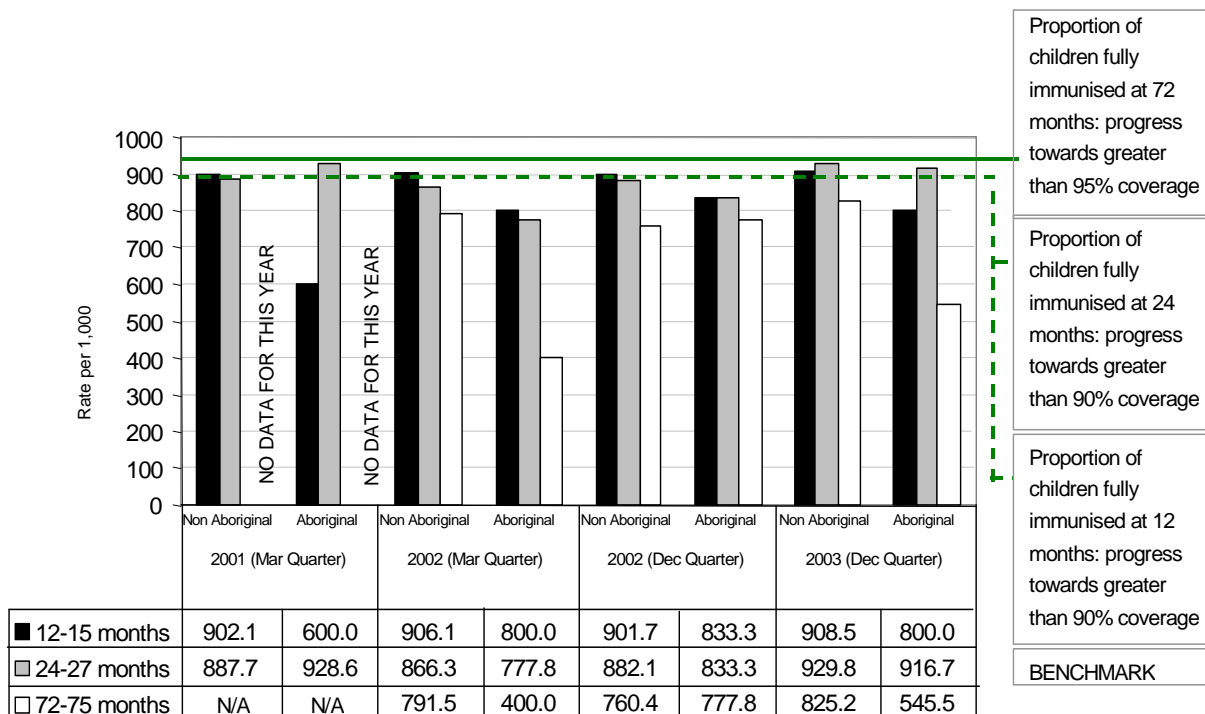
- Proportion of children fully immunised at 12 months – progress towards greater than 90% coverage.
- Proportion of children fully immunised at two years – progress towards greater than 90% coverage.
- Proportion of children fully immunised at six years - progress towards greater than 95% coverage.

Results

In 2003 the target was reached in the non-Aboriginal 12-15 month age group and the 24-27 month age group for both ethnic groups.

The Public Health Funding Agreement targets have never been reached for the 72-75 month age bracket in the Peel area. These results however are inconclusive as the numbers were small: in the December 2003 quarter there were only eleven children in this grouping, six of whom were immunised.

Figure 1: Rate of fully immunised children



Data Sources

Australian Childhood Immunisation Register (ACIR).
Australian Bureau of Statistics (ABS) population figures.

101B: Rate of hospitalisations with an infectious disease for which there is an immunisation program

This indicator reports the rate of hospitalisations with an infectious disease for which there is an immunisation program.

Rationale

There are specific communicable diseases which are preventable by vaccine and thus routine vaccination or immunisation is recommended by the National Health and Medical Research Council (NHMRC).

To provide additional information about the effect of immunisation programs, the rates of hospitalisation for treatment of the infectious diseases of measles, mumps, rubella, diphtheria, pertussis, poliomyelitis, hepatitis B and tetanus are reported.

The first three conditions are reported by 0-17 year old age groups while the remaining are reported by 0-12 year old age groups. There should be few or no individuals hospitalised for infectious diseases when an immunisation program is effective.

Results

Since 2000, no vaccine-preventable diseases have been reported in the Peel Health Services Area. This provides an indication of the effectiveness of the vaccination and immunisation schedules.

103: Rate of hospitalisation for gastroenteritis in children 0-4 years

This indicator reports the rate of hospitalisation for gastroenteritis in children 0-4 years.

Rationale

Gastroenteritis is a condition for which a high number of patients are treated either in the hospital or in the community. It would be expected that hospital admissions for this condition would decrease as performance and quality of service in many different health areas improves.

The rate of children who are admitted to hospital per 1,000 population for treatment of gastroenteritis may be an indication of improved primary care or community health strategies - for example, health education. Programs are delivered to ensure there is an understanding of hygiene within homes to assist and prevent gastroenteritis.

It is important to note, however, that other factors such as environmental issues will also have an impact on the prevalence of transmissible diseases like gastroenteritis.

The Royal Street Division of the Department of Health is also engaged in the surveillance of enteric diseases. Some forms of gastroenteritis for example salmonellosis and shigellosis are notifiable diseases and infection rates are monitored.

Note

This indicator measures hospital separations of children living in a given location who may attend a hospital close to home or in another Health Service area. This indicator is not necessarily a measure of the performance of the Health Service providing the hospitalisation.

Map 2: The Peel Health Services area

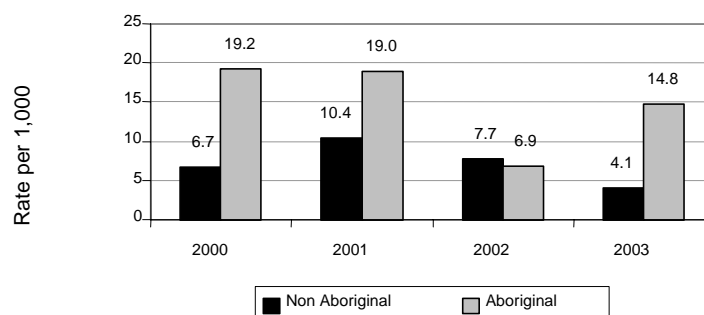


Results

During 2003, the gastroenteritis hospitalisation rate for Aboriginals was 14.8 per 1,000 while the non-Aboriginal rate was 4.1 per 1,000. The high Aboriginal hospitalisation rate may be misleading, as it represents only two episodes of an Aboriginal population of 135 for this age group.

The small hospitalisation numbers indicate that there is good access to primary health care and community health programs in the area.

Figure 2: Rate of hospitalisation for gastroenteritis in 0-4 years



Data Source

Hospital Morbidity Data System (HMDS).

104: Rate of hospitalisation for respiratory conditions

This indicator reports the rate of hospitalisation for respiratory conditions.

Rationale

The rate of children aged 0-4 years who are admitted to hospital per 1,000 population for treatment of respiratory conditions such as acute bronchitis, bronchiolitis and croup and the rate of all persons admitted for the treatment of acute asthma may be an indication of primary care or community health strategies - for example, health education.

It is important to note however, that other factors may influence the number of people hospitalised with these respiratory conditions. The conditions are ones which have a high number of patients treated either in hospital or in the community. It would be expected that hospital admissions for these conditions would decrease as performance and quality of service increases in primary or community health.

Results of Acute Asthma

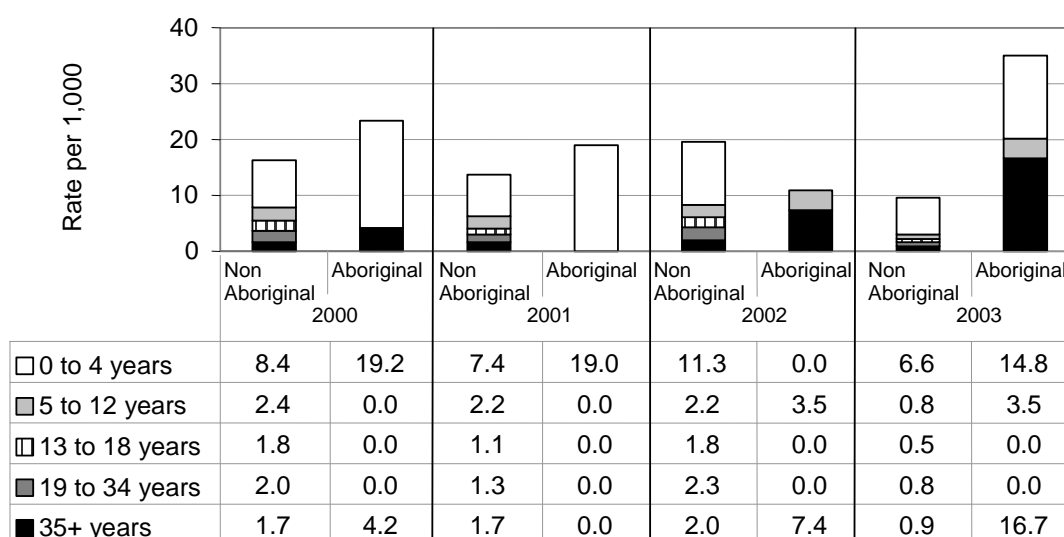
In 2003, hospital rates for asthma significantly increased in the Aboriginal 0-4 and 35+ age groups compared with the previous year. However the numbers contributed to this increase are in fact small, with only two hospitalisations in the 0-4 year group and an increase from two admissions in 2002 to five admissions in 2003 for the 35+ age group. The rates for the other Aboriginal age groups have remained similar since 2002.

Non-Aboriginal admission rates have seen significant decreases between 2002 and 2003, particularly in the 0-4 age group where the number of admissions dropped from 41 in 2002 to 24 in 2003, and the 35+ age bracket where hospitalisations dropped from 72 to 34.

Note

This indicator measures hospital separations of individuals living in a given location who may attend a hospital in their own or another Health Service. The performance of the Health Service providing the hospitalisation is not being measured.

Figure 3: Rate of hospitalisation for acute asthma



Data Sources

Hospital Morbidity Data System.
Australian Bureau of Statistics (ABS) population figures.

104: Rate of hospitalisation for respiratory conditions (cont)

Map 3: The Peel Health Services area

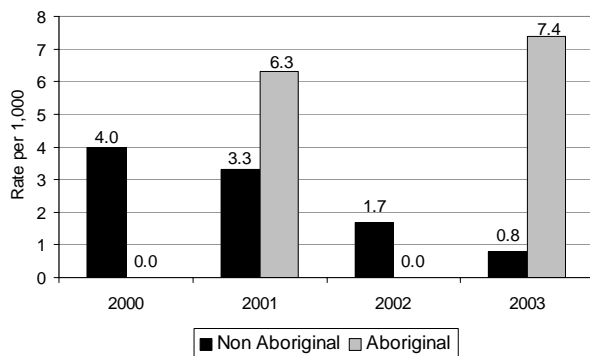


Results of Croup

There were three non-Aboriginal and one Aboriginal croup admissions in 2003. The sole Aboriginal admission resulted in the dramatic 2003 rate increase, while the drop from six to three non-Aboriginal hospitalisations in 2003 resulted in the halving of the non-Aboriginal rate.

In general the rates for respiratory conditions in the Peel Health Services area are low, indicating good access to primary health care.

Figure 4: Rate of hospitalisation for croup in 0-4 years



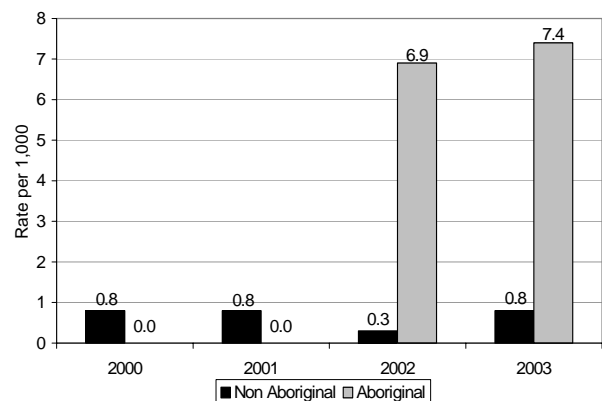
Data Sources

Hospital Morbidity Data System.
Australian Bureau of Statistics (ABS) population figures.

Results of Acute Bronchitis

While the high Aboriginal admission rate for acute bronchitis in 2003 was much higher than the non-Aboriginal population (7.4 per 1,000 and 0.8 per 1,000 respectively), these hospitalisation rates represent one episode for each ethnic group in the Peel Health Services area.

Figure 5: Rate of hospitalisation for acute bronchitis in 0-4 years

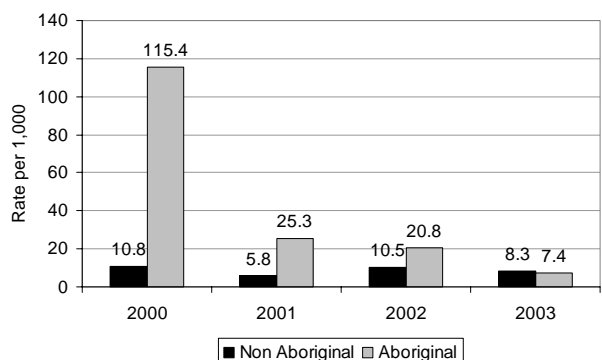


Results of Bronchiolitis

Bronchiolitis hospitalisation rates for young children are comparable between Aboriginals and non-Aboriginals in 2003. There were 30 non-Aboriginal and one Aboriginal bronchiolitis admissions in 2003.

While admission rates appear to have declined slightly for non-Aboriginals and significantly for Aboriginals, the actual numbers of admissions are comparable over the two years (a decrease of 38 to 30 and three to one for respective ethnic groups).

Figure 6: Rate of hospitalisation for bronchiolitis in 0-4 years



110: Cost per capita of the Population Health Unit

This indicator reports the cost per capita of the Population Health Unit.

Rationale

Population health considers the health of individuals, groups, families and communities by adopting an approach that addresses the determinants of health. With the aim of improving health, population health works to integrate all activities of the health sector and link them with broader social and economic services and resources. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Population health unit supports individuals, families and communities to increase control over and improve their health. These services and programs include:

- Supporting growth and development, particularly in young children (community health activities).
- Promoting healthy environments.
- Prevention and control of communicable diseases.
- Injury prevention.
- Promotion of healthy lifestyle to prevent illness and disability.
- Support for self-management of chronic disease.
- Prevention and early detection of cancer.

Results

In 2003-04, the per capita cost of Population Health Units for the Peel Area Health Service was \$47.39.

Table 11: Cost per capita of the Population Health Unit

	2003-04
Actual cost	\$47.39

Data Source

Local Health Service Data Systems.

Note

As this is the first year this indicator has been reported previous years' comparisons are not available.

OUTCOME 2: Restoring the health of people with acute illness

The achievement of this component of the health objective involves activities which ensure that people have appropriate and timely access to acute care services when needed so that intervention occurs as early as possible. Timely and appropriate access ensures that the acute illness does not progress or the effects of injury do not progress further than necessary, increasing the chance of complete recovery from the illness or injury (for example access to elective surgery).

The services provided include:

- Quality diagnostic and treatment services which ensure the maximum restoration to health after an acute illness or injury.
- After-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible.
- Obstetric care during pregnancy and the birth episode to both mother and child.

Table 12: Respective Indicators by Health Sector for Outcome 2

	Metropolitan Health Service	Peel Health Services	South West Area Health Service	WA Country Health Service	Royal Street Division
The achievement of this component of the health objective involves activities which:					
1. Ensures that people have access to acute care services by:					
• Prioritizing access to elective surgery.	200		200	200	R207
• Providing timely transport to hospital.					R206
• Prioritizing access to dental services.	212 213				R202
2. Provide quality diagnostic services and treatment by:					
• Providing appropriate and quality admitted patient services when people are ill or injured.	201	204	201	204	R201
	204	205	204	205	R204
	205		205	206	R205
	206		206	208	
	208		208		
• Providing timely and appropriate ambulatory services for people who do not require admitted patient care.			202	202	
• Providing appropriate obstetric and neonatal care.	207		207	207	

204: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

This indicator reports the rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition.

Rationale

Good medical and/or surgical intervention together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. An unplanned readmission is an unplanned return to hospital as an admitted patient for the same or a related condition as the one for which the patient had most recently been discharged. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Although there are some conditions that may require numerous admissions to enable the best level of care to be given, in most of these cases readmission to hospital would be planned. A low unplanned readmission rate suggests that good clinical practice is in operation.

Results

The 2003 readmission percentages for the Peel Health Services are high due to the small inpatient numbers of the hospital being small.

The reduction in the rate from 2002-03 to 2003-04 demonstrates that management plans introduced to manage ongoing chronic conditions have been effective. Evaluation will continue in an attempt to further reduce the rate.

Table 13: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

	2001-02	2002-03	2003-04
Unplanned readmissions rate	7.5%	11.1%	7.6%

Data Source

Hospital Morbidity Data System.

205: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

This indicator reports the rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition.

Rationale

An unplanned readmission for a patient with a mental health condition is an unplanned return to hospital, as an admitted patient, for the same condition as the one for which the patient had most recently been discharged.

While it is inevitable that some patients will need to be readmitted to hospital with 28 days, a high percentage of readmissions may indicate that improvements could be made to discharge planning or to aspects of inpatient therapy protocols. Appropriate therapy, together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. Unplanned readmissions necessitate patients

spending additional periods of time in hospital as well as utilising additional hospital resources.

Although there are some mental health conditions that may require numerous admissions to enable the best level of care to be given, in most of these cases, readmission to hospital would be planned. A low unplanned readmission percentage suggests good clinical practice is in operation.

Results

The 2003-04 readmission percentages for Peel Health Services hospitals fall within the 10% Australian Council on Healthcare Standards (ACHS) threshold.

These results suggest that good clinical practice and discharge planning are in place.

Table 14: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

	2001-02	2002-03	2003-04
Unplanned readmissions rate	17.6%	11.0%	10.0%

Data Source

Hospital Morbidity Data System.

225: Average cost per non-admitted hospital based service

This indicator reports the average cost per non-admitted hospital based service.

Rationale

The efficient use of hospital resources can help minimise the overall costs of providing health care, or mean that more patients can be treated for the same amount of resources.

Because of variations in patient characteristics and clinic types between sites and across time, there may be differences in service delivery costs. It is important to monitor the unit cost of this non-admitted component of hospital care in order to ensure their overall quality and cost effectiveness.

Results

Since 2001-02, the average cost per non-admitted hospital based service has decreased significantly. In 2003-04 the average cost was \$62.84.

A corporate review of Murray District Hospital services was undertaken in 2003. Early evaluation has demonstrated maintenance of service provision with an overall reduction in hospital based service costs.

The improved outcome for 2003-04 is a result of the implementation of a number of strategies including restructuring of outpatient activity and redeployment of staff.

Table 15: Average cost per non-admitted hospital based service

	1999-00	2000-01	2001-02	2002-03	2003-04
Actual cost	\$90.36	\$58.04	\$93.90	\$84.32	\$62.84
CPI adjusted	\$98.59	\$59.80	\$93.90	\$81.67	\$59.58

Data Source

Local Health Service Data Systems.

227: Average cost per bed-day for admitted patients

This indicator reports the average cost per bed-day for admitted patients.

Rationale

While the use of casemix is a recognised methodology for measuring the cost and complexity of admitted patients in hospitals where there is a wide range of different medical and surgical patients it is not the accepted method of costing patients in small rural hospitals.

Most small hospitals do not have the advantage of economies of scale. Minimum nursing services may have to be rostered for very few patients. Accordingly the hospitals with limited

beds which provide acute and Nursing Home Type Patient (NHTP) care report patient costs by bed-days.

Results

The average cost per bed-day for admitted patients dropped in 2003-04 to \$683, a significant drop from the 2002-03 average of \$870.

Evaluation of 2002-03 costing KPIs progressed the implementation of a number of cost reducing strategies, effectively resulting in an approximate 20-25% reduction in average cost per bed day for admitted patients.

Table 16: Average cost per bed-day for admitted patients

	1999-00	2000-01	2001-02	2002-03	2003-04
Actual cost	\$582	\$543	\$682	\$870	\$693
CPI adjusted	\$636	\$560	\$682	\$843	\$657

Data Source

Local Health Service Data Systems.

228: Average cost of Patient Assisted Travel Scheme (PATS)

This indicator reports the average cost of Patient Assisted Travel Scheme (PATS).

Rationale

The aim of PATS is to allow permanent country residents to access the nearest medical specialist and specialist medical services.

Subsidy is provided towards the cost of travel and accommodation for patients and where

necessary an escort for people. Assistance is provided to Peel residents living between 70kms and 100kms from Perth, subject to certain conditions.

Without travel assistance many people would be unable to access the services needed to diagnose or treat some conditions.

Table 17: Average cost of Patient Assisted Travel Scheme (PATS)

	2002-03	2003-04
Actual cost	\$30.33	\$27.10
CPI adjusted	\$29.38	\$25.69

Data Source

Local Health Service Data System.

OUTCOME 3: Improving the quality of life of people with chronic illness and disability

The achievement of this component of the health objective involves provision of services and programs that improve and maintain an optimal quality of life for people with chronic illness or disability.

If a client suffers from a chronic illness they have access to services and supports through a range of organisations, including non-government organisations, which are managed through the DOH (Royal St). The effectiveness and efficiency measures for those supports are reported by DOH (Royal St).

The Health Services in general will only come into contact with those clients when they become acute and require acute care. When this care is completed they are returned to the community where they can again receive ongoing (continuing) care through the other agencies and services provided.

To enable people with chronic illness or disability to maintain as much independence in their every day life as their illness permits, services are provided to enable normal patterns of living. Supports are provided to people in their own homes for as long as possible but when extra care is required long term placement is found in residential facilities. The intent is to support people in their own home for as long as possible. This involves the provision of clinical and other services which:

- Ensure that people experience the minimum of pain and discomfort from their chronic illness or disability.
- Maintain the optimal level of physical and social functioning.
- Prevent or slow down the progression of the illness or disability.

- Make available aids and appliances that maintain, as far as possible, independent living (eg wheelchairs, walking frames).
- Enable people to live as long as possible in the place of their choice supported by, for example, home care services or home delivery of meals.
- Support families and carers in their roles.
- Provide access to recreation, education and employment opportunities.

The significant areas of continuing care provided by the Health Services are in the areas of Mental Health Community Care and Aged Care. The Mental Health Community Care consists of multi-disciplinary teams including mental health nurses providing continued and regular contact with clients to ensure, prevent or delay the onset of acuity and thereby allowing them to continue to maintain as close to normal lifestyles as possible.

An important part of ensuring that services are provided to those frail aged who need them is assessment by Aged Care Assessment Teams (ACAT). Without equal access to ACAT assessments appropriate services/aged care may not be provided.

Where a person has a disability, including a younger person, they will receive support through a number of agencies including Disability Services Commission and the Quadriplegic Centre. The DOH also provides assistance to those with disabilities through the provision of Home and Community Care (HACC) services. The HACC program is administered through the DOH (Royal St). The effectiveness and efficiency indicators for HACC are reported by DOH (Royal St). The Health Services will provide acute services to those with disabilities under Outcome 2.

Table 18: Respective Indicators by Health Sector for Outcome 3

	Metropolitan Health Service	Peel Health Services	South West Area Health Service	WA Country Health Service	Royal Street Division	Hawthorn Hospital
The achievement of this component of the health objective involves activities which:						
1. Supporting people with chronic and terminal illness by:						
<ul style="list-style-type: none"> ▪ Providing palliative care services. 					R304	
<ul style="list-style-type: none"> ▪ Providing support services to people with chronic illnesses and disabilities. 	304	304	304	304		See Hawthorn Hospital report
<ul style="list-style-type: none"> ▪ Providing appropriate home care services for the frail aged. 					R302 R303	
<ul style="list-style-type: none"> • Providing community support for those with mental illness. 	301 302	301 302	301 302	301 302		

301: Percent of contacts with community-based public mental health non-inpatient services within seven and fourteen days post discharge from inpatient units

This indicator reports on clients with a principal diagnosis of schizophrenia or bipolar disorder who had contact with a community-based public mental health non-inpatient services within seven and fourteen days following discharge from hospital.

Rationale

A large proportion of people with a severe and persistent psychiatric illness generally have a chronic or recurrent type illness that results in only partial recovery between acute episodes and a deterioration in functioning that can lead to problems in living an independent life. As a result, hospitalisation may be required on one or more occasions a year with the need for ongoing clinical care from community-based non-inpatient services following discharge.

These community services provide ongoing mental health treatment and access to a range of rehabilitation and recovery programs outside of the hospital setting that reduce the length of hospital stays, thereby improving the patient's independent functioning and quality of life.

This type of continuing care for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential after

discharge to maintain or improve clinical and functional stability. Community psychiatric services can provide effective treatment in circumstances that would otherwise require hospitalisation should relapse occur, reducing the frequency of planned and unplanned hospital admissions.

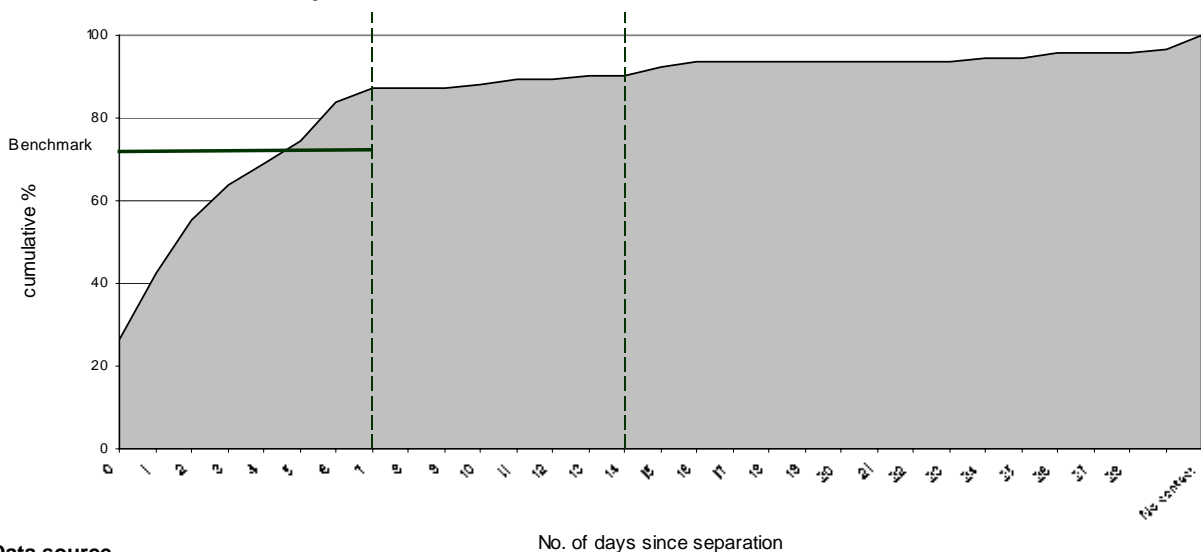
A severe and persistent mental illness refers to clients who have psychotic disorders with severe and chronic impairment in the conduct of daily life activities. It includes those with a diagnosis of schizophrenia or bipolar disorder.

The time period of seven days was recently recommended nationally as an indicative measure of follow up with non-inpatient services for people with a severe and persistent mental illness.

There is currently no agreed target benchmark figure for the proportion of clients to be seen within a seven-day period. At this stage, there appears to be some consensus among clinicians in Western Australia that a reasonable target is around 70%. The seven-day threshold and 70% target benchmark figure are pending an empirical review on their appropriateness.

Results

Figure 7: Cumulative percentage of schizophrenic and bipolar disorders separations from public designated mental units having contact with a community-based public mental health non-inpatient service



Data source

Mental Health Information System, Health Information Centre, Department of Health WA.

Performance Indicators

In 2003, 87% of discharges with a principal diagnosis of schizophrenia or bipolar disorder resulted in contact with a community-based public mental health non-inpatient service within 7 days of discharge within Peel Health Services. Of this group 27% had contact on the day of discharge. A further 3% had contact within 8 to 14 days following discharge, which gives a total of 90% of contacts within a two-

week period. Three percent did not have any contact within a given year.

No contact may indicate that referrals, following discharge, were made to the private sector (e.g. General Practitioners, Private Psychiatrists, Private Psychologists) for which data on contacts is not available.

Explanatory notes

1. Target Group: WA residents discharged from inpatient units with a principal diagnosis of schizophrenia or bipolar disorders (ICD-10-AM range of codes F20 to F29 or F31).
2. Inpatient units: includes all Child and Adolescent, Adult, and Older Person programs at specialised public mental health inpatient units at the following hospitals:
 - Graylands Hospital.
 - Selby Lemnos.
 - Fremantle Hospital.
 - Bentley Hospital.
 - Armadale/Kelmscott Hospital.
 - Swan District Hospital.
 - Osborne Park Hospital.
 - Princess Margaret Hospital.
 - Sir Charles Gairdner Hospital.
 - Royal Perth Hospital.
3. Excludes people who:
 - Died in hospital.
 - Were transferred to another inpatient unit.
 - Re-admitted on the same day (includes statistical separations and intra hospital transfer).
 - Left against medical advice.
 - Had a same day admission or were admitted, treated and discharged on the same day.

302: Median bed-days for persons under mental health community management who were admitted to hospital

This indicator reports median bed-days for persons under mental health community management who were admitted to hospital.

Rationale

The aim of community management of people with mental illness is to provide the treatment and support required to prevent the recurrence of an acute episode that may result in extended hospitalisation. People with mental illness have improved quality of life if their condition is managed with few admissions to hospital. Maintenance of good mental health which may include community mental health management is preferred to hospitalisation. This indicator shows the extent to which community mental health services have achieved this aim, by measuring the number of median bed-days of people under mental health community management.

This indicator consists of all overnight psychiatric (mental health diagnosis) admissions to public hospitals.

An indication of good performance would be admissions that require fewer bed days. If mental health clients are managed appropriately through community psychiatric services, the length of each hospitalisation is reduced as both clients and clinicians have confidence in the clients ability to manage in the community.

This performance indicator should be considered in conjunction with performance indicator 205.

Table 19: Median bed-days for persons under mental health community management who were admitted to hospital

	1999	2000	2001	2002	2003
Median bed-days	14	12	12	14	14

Data Source
Mental Health Information System.

304: Completed assessments as a proportion of accepted ACAT referrals

This indicator reports the completed outcomes against the total number of accepted referrals to an ACAT.

Referred ACAT Clients

An ACAT client is usually an older person who is experiencing difficulty managing at home and/or is considering admission to residential care. However on occasion a younger person may seek ACAT assessment due to long term disability where residential care or community support is considered appropriate.

ACATs receive referrals from any source including self referral. The ACAT intake process determines the appropriateness of the referral as per the program guidelines. An ACAT comprehensive assessment will determine the older person's eligibility for services including Commonwealth subsidised aged care services. An ACAT client is not a person who requires acute medical services, post acute services or rehabilitation.

Rationale

An ACAT assessment will identify those clients who are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living and whose needs fall within the capacity of subsidised aged care services.

The assessment is the first step in ensuring the ACAT clients gain access to the appropriate services and receive care either in the community or in an institutional setting.

The range of services are available to people requiring support to improve or maintain their optimal quality of life. There are supports available to people living in their own homes as well as supported accommodation options.

A completed assessment is when a comprehensive assessment has been undertaken (and full information on the client is recorded) and has resulted in recommendations being made. This includes approvals to access Commonwealth funded programs (eg residential care, community aged care packages and some flexible care options).

If during an assessment the older person is found to require acute medical services, post acute services or rehabilitation services the assessment is recorded as incomplete. The record is also incomplete if during the process the person withdraws, moves to another services or dies before a comprehensive assessment has been completed and recommendations have been made.

Note

Commencing in 2003-04 the ACAT Program made significant amendments to the minimum data set Aged Care Assessment Teams collect on their activities. The new data set is being evaluated and revised as the new data is compiled. As a result only interim data is available for the period July-December 2003. Data collected in prior formats are not available in 2003-04 nor is the data presented in the new format comparable to previous years.

Table 20: Completed assessments as a proportion of accepted ACAT referrals

	2003
Completed assessments as a proportion of accepted ACAT referrals	100%

Data Source

Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to September 2003 and October to December 2003.

Notes

In 2003 the ACAT Program amended to the minimum data set, so only interim data is available for the period July – December 2003.

As the data is based on ACAT team coverage rather than statistical local areas, this indicator includes ACAT assessment data from Rockingham and Peel.

As this is the first year this indicator has been reported previous years' comparisons are not available.

303: Average cost per person with mental illness under community management

Rationale

The majority of services provided by community mental health services are for people in an acute phase of a mental health problem or who are receiving post-acute care. This indicator gives a measure of the cost effectiveness of treatment for public psychiatric patients under community management (non-admitted/ambulatory patients).

During the last four financial years, the increase in average cost has been statistically significant and may be attributed to an increase in Peel Mental Health FTE.

Evaluation of services demonstrated that as an area the service was under resourced in staffing per 1,000 population.

Results

In 2003-04, the average cost per person with mental illness under community management was \$3,010.

The service framework is now more equitable with other regions.

Table 21: Average cost per person with mental illness under community management

	2000-01	2001-02	2002-03	2003-04
Actual cost	\$1,629	\$1,849	\$2,504	\$3,010
CPI adjusted	\$1,679	\$1,849	\$2,426	\$2,854

Data Source

Local Health Service Data Systems.

311: Average cost per ACAT assessment

This indicator measures the average cost per ACAT assessment.

A range of services are available to people requiring support to improve or maintain their optimal quality of life.

Rationale

People within targeted age groups are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living.

The Commonwealth funds the Aged Care Assessment Program based on state health service assessments which determine eligibility for and the level of care required by these aged care services.

Table 22: Average cost per ACAT assessment

	2003-04
Actual cost	\$299

Data Sources

Local Health Service Financial System.

Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to September 2003 and October to December 2003.

Note

As the data is based on ACAT team coverage rather than statistical local areas, this indicator includes ACAT assessment data from Rockingham and Peel.

As this is the first year this indicator has been reported previous years' comparisons are not available.