

# Performance Indicators Certification Statement

## **CERTIFICATION OF PERFORMANCE INDICATORS**

for the year ended 30 June 2005

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 South West Health Board and fairly represent the performance of the health service for the financial year 30 June 2005.



Dr Neale Fong  
**Acting Director General**  
**Accountable Authority**

30 August 2005

# Performance Indicators Audit Opinion



AUDITOR GENERAL

## INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

**SOUTH WEST HEALTH BOARD  
PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2005**

### **Audit Opinion**

In my opinion, the key effectiveness and efficiency performance indicators of the South West Health Board are relevant and appropriate to help users assess the Board's performance and fairly represent the indicated performance for the year ended 30 June 2005.

### **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  
10 October 2005

# Performance Indicators

## *Introduction*

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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**
- **Metropolitan Health Service**
- **South West Area Health Service**
- **Peel Health Service**
- **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, rehabilitation and community-based post discharge care).
- Community health services (Nursing Posts).
- Mental health services.
- Dental health services.
- Obstetric services.

### Continuing care

- Services for frail aged and disabled people (eg Aged Care Assessments, outpatient services for chronic pain and disability, Nursing Home Type hospital care).
- Services for those with chronic illness.
- Mental health services.

There are some services, such as Community Health, which address all three of the components.

Results in this section are presented as both Aboriginal and non-Aboriginal population figures where appropriate.

Comparisons across time are provided where possible and appropriate.

# Performance Indicators

## 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 2002-03 dollars:

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

**Table 7: Consumer price index figures for the financial and calendar years**

| Calendar year        | 2000    | 2001    | 2002    | 2003    | 2004    |
|----------------------|---------|---------|---------|---------|---------|
| Index (Base 2002)    | 93.118  | 97.006  | 100.000 | 102.644 | 105.107 |
|                      |         |         |         |         |         |
| Financial year       | 2000-01 | 2001-02 | 2002-03 | 2003-04 | 2004-05 |
| Index (Base 2002-03) | 94.017  | 96.866  | 100.000 | 102.172 | 104.701 |

## Efficiency Indicator Note

All calculations for efficiency indicators include administrative overheads in accordance with relevant Treasurer's Instructions for annual reporting purposes only. These figures are not to be used for any other comparative purpose.

# Performance Indicators

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

The services, or outputs, of all parts of the Department of Health contribute to the above outcome. 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 Metropolitan Health Service as well as the other divisions of the Department of Health are contained on the table below. The greatest proportion of outputs provided by the South West Area Health Service in this outcome is directed to children. Other health services and divisions of the Department of Health provide more services directed to prevention and surveillance of disease, including those affecting the adult population.

**Table 8: Respective Indicators by Health Sector for Outcome 1**

|   | Metropolitan Health Service | Peel Health Service | South West Area Health Service | WA Country Health Service | DOH  |
|---|-----------------------------|---------------------|--------------------------------|---------------------------|------|
| The achievement of this component of the health objective involves activities which:                          |                             |                     |                                |                           |      |
| <b>Reduce the likelihood of onset of disease or injury by:</b>  |                             |                     |                                |                           |      |
| Immunisation programs   | 101A<br>101B                | 101A<br>101B        | 101A<br>101B                   | 101A<br>101B              |      |
| Dental screening  | 105<br>106                  |                     |                                |                           |      |
| Safety program  |                             |                     |                                |                           | R101 |
| <b>Reduce the risk of long term disability or premature death from injury or illness through:</b>             |                             |                     |                                |                           |      |
| Surveillance  |                             |                     |                                |                           | R101 |
| <b>Monitoring the incidence of disease in the population to ensure primary health measures are effective:</b> |                             |                     |                                |                           |      |
|   | 103<br>104                  | 103<br>104          | 103<br>104                     | 103<br>104                |      |
| <b>Monitoring and surveillance of suicide rates and drug and alcohol use:</b>                                 |                             |                     |                                |                           |      |
|   |                             |                     |                                |                           | R101 |

# Performance Indicators

## 101A: Percentage of fully immunised children 0-6 years

This indicator reports the rate of fully immunised children 0 to 6 years.

### 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

The coverage of completely immunised children for the 12 to month non-Aboriginal and the 24 to 27 month Aboriginal and non-Aboriginal age groups maintained results in 2004 that exceeded the agreed targets. While a comparable result to 2003 for Aboriginal children 12 to 15 months was achieved in 2004, the coverage still fails to reach the required target.

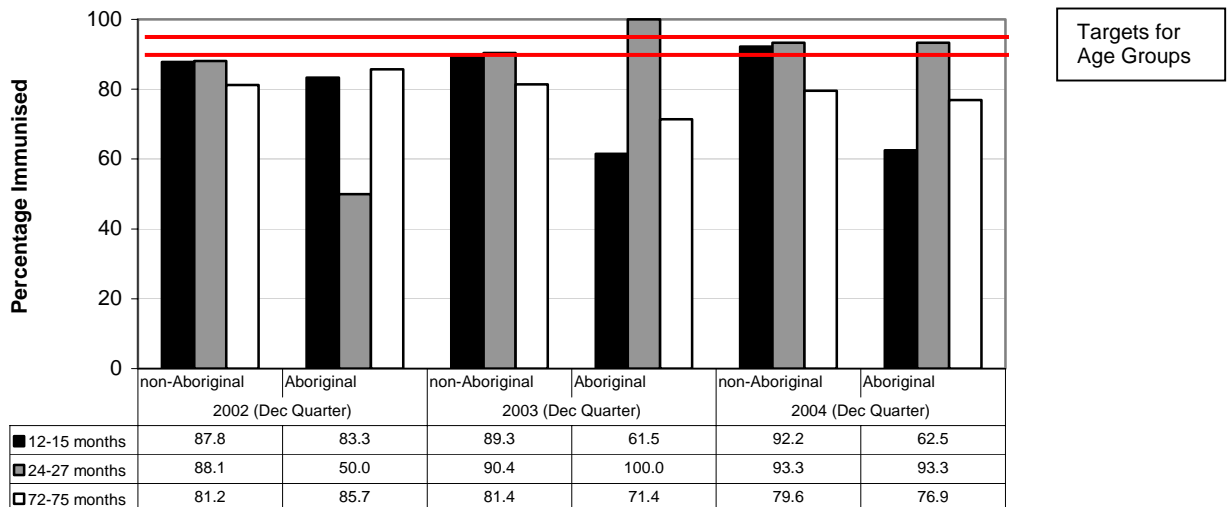
The immunisation coverage achieved in 2004 for the Aboriginal and non-Aboriginal 72 to 75 month age group did not reach the agreed target but maintained similar results to 2003. However this result is consistent with other health areas in Western Australia.

Comparable results across Aboriginal and non-Aboriginal children in the 24 to 27 and 72 to 75 month age groups was achieved while the coverage for Aboriginal children in the 12 to 15 month age group remains lower than that achieved for non-Aboriginal children.

### Note

Actual numbers in the Aboriginal cohorts are not large in the South West and as a result small movements in numbers can cause significant fluctuations in rate.

Figure 2: Rate of fully immunised children



### Data Sources

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

# Performance Indicators

## **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 to 17 year old age groups while the remaining are reported by 0 to 12 year old age groups. There should be few or no individuals hospitalised for infectious diseases when an immunisation program is effective.

In 2004 there were four whooping cough (pertussis) hospitalisations reported in the South West Area Health Service. No other hospitalisations for these infectious diseases were reported.

The occurrence of whooping cough is reflective of a general increase in the occurrence of this disease in Western Australia in 2004. The Department of Health responded to the increased occurrences with an additional whooping cough vaccination program targeting high school students.

However the overall results achieved in the South West Area Health Service for hospitalisations for infectious diseases subject to targeted immunisation programs still reflects effective vaccination and immunisation programs provided in the Health Service.

**Table 9: Rate of hospitalisations per 1,000 with an infectious disease for which there is an immunisation program – 0 to 12 years**

|                       | 2002           |            | 2003           |            | 2004           |            |
|-----------------------|----------------|------------|----------------|------------|----------------|------------|
|                       | Non-Aboriginal | Aboriginal | Non-Aboriginal | Aboriginal | Non-Aboriginal | Aboriginal |
| <b>Diphtheria</b>     | 0.00           | 0.00       | 0.00           | 0.00       | 0.00           | 0.00       |
| <b>Hepatitis B</b>    | 0.00           | 0.00       | 0.00           | 0.00       | 0.00           | 0.00       |
| <b>Whooping Cough</b> | 0.08           | 2.90       | 0.00           | 0.00       | 0.16           | 0.00       |
| <b>Poliomyelitis</b>  | 0.00           | 0.00       | 0.00           | 0.00       | 0.00           | 0.00       |
| <b>Tetanus</b>        | 0.00           | 0.00       | 0.00           | 0.00       | 0.00           | 0.00       |

**Table 10: Rate of hospitalisations per 1,000 with an infectious disease for which there is an immunisation program – 0 to 17 years**

|                | 2002           |            | 2003           |            | 2004           |            |
|----------------|----------------|------------|----------------|------------|----------------|------------|
|                | Non-Aboriginal | Aboriginal | Non-Aboriginal | Aboriginal | Non-Aboriginal | Aboriginal |
| <b>Measles</b> | 0.00           | 0.00       | 0.00           | 0.00       | 0.00           | 0.00       |
| <b>Mumps</b>   | N/A            | N/A        | N/A            | N/A        | 0.00           | 0.00       |
| <b>Rubella</b> | N/A            | N/A        | N/A            | N/A        | 0.00           | 0.00       |

N/A Not reported in this year

### **Data Sources**

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

# Performance Indicators

## 103: *Rate of hospitalisation for gastroenteritis in children 0 to 4 years*

This indicator reports the rate of hospitalisation for gastroenteritis in children 0 to 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 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.

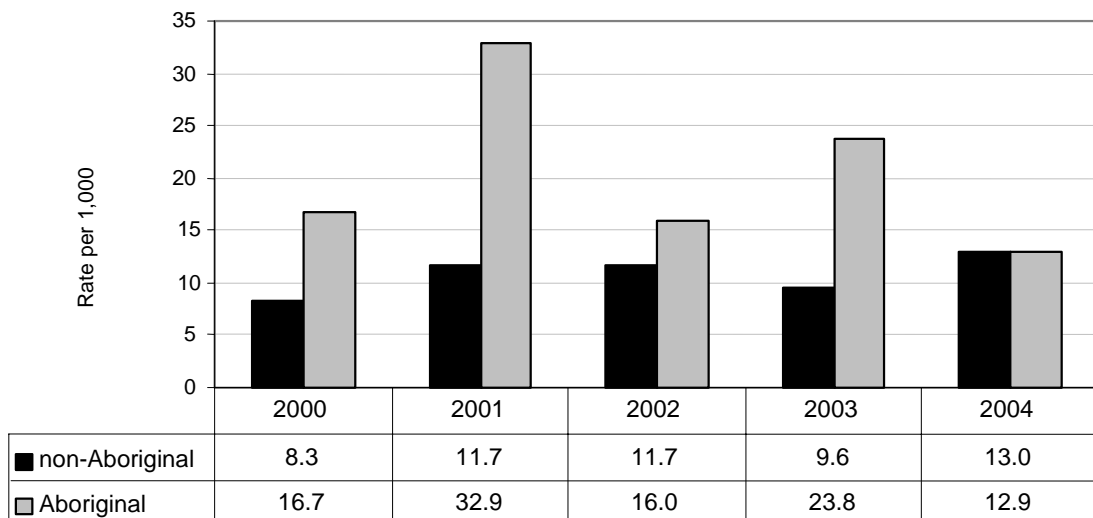
### Results

The rate of hospitalisation for gastroenteritis in 2004 for the Aboriginal population has shown a decrease compared to 2003 and the result for non-Aboriginals has slightly increased compared with previous years. The results demonstrate sustained community participation in public and community health programs provided in the South West Area Health Service.

### 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.

**Figure 3: Rate of hospitalisation for gastroenteritis 0 to 4 years**



### Data Sources

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

# Performance Indicators

## 104: Rate of hospitalisation for respiratory conditions

This indicator reports the rate of hospitalisation for respiratory conditions.

### Rationale

The rate of children aged 0 to 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 services or community health strategies, such as 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 those that have a high number of patients treated either in hospital or in the community. It

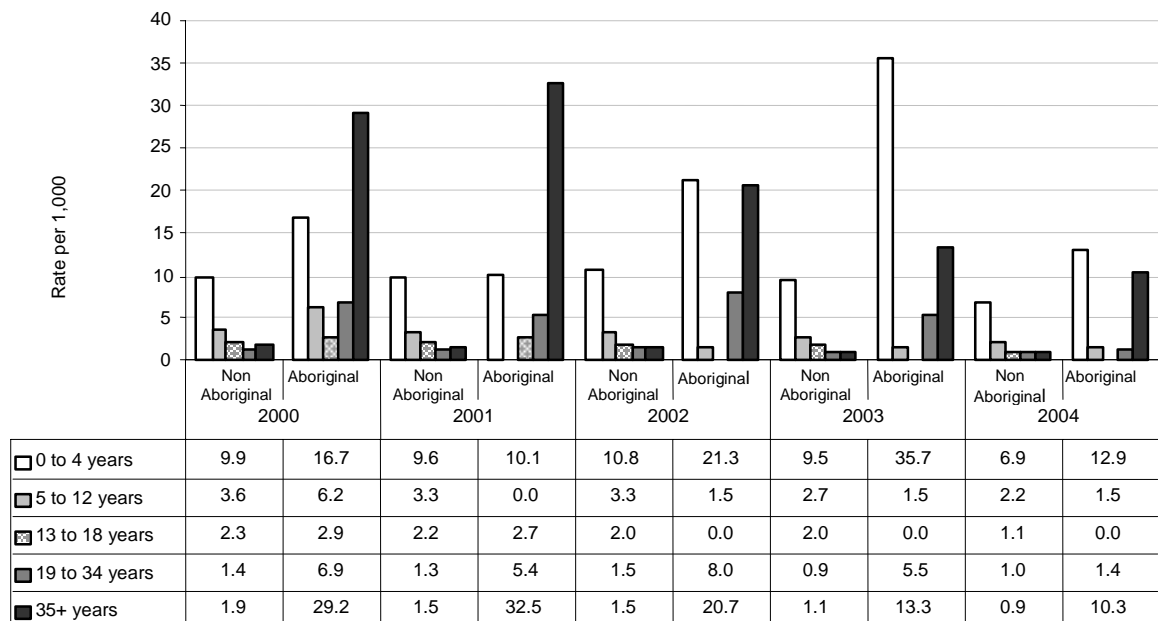
would be expected that hospital admissions for these conditions would decrease as performance and quality of service increases in primary or community health.

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.

### Note

Population numbers in the Aboriginal cohorts are not large in the South West and as a result small movements in actual numbers can cause significant fluctuations in rates.

**Figure 4: Rate of hospitalisation for acute asthma (all ages)**



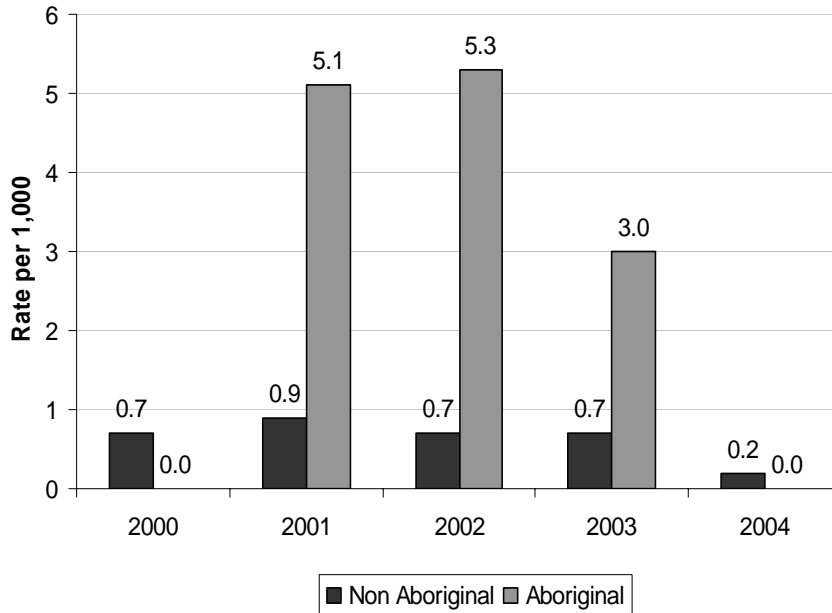
### Results – Acute Asthma

The results reported for all ages remain comparable to previous years or show a reduction in the hospitalisation for acute asthma. While the South West Area Health Service continues to report higher rates of hospitalisations for Aboriginal people for acute asthma in 0 to 4 yrs and 35+ yrs in comparison

to non-Aboriginal populations in 2004 there were only 12 Aboriginal admissions to hospital for acute asthma in these age cohorts during the capture period. However these rates are consistent with results occurring across the State.

# Performance Indicators

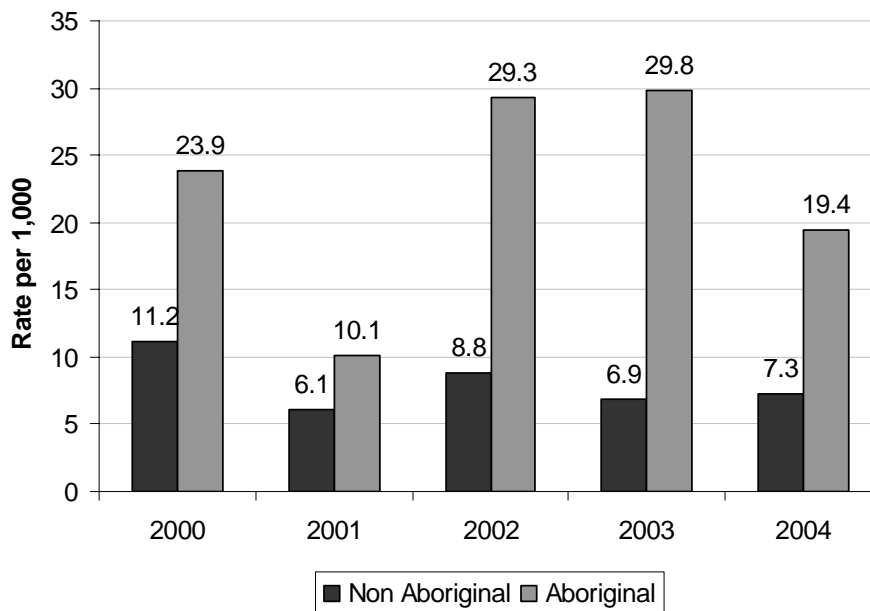
**Figure 5: Rate of hospitalisation for acute bronchitis (0 to 4 yrs)**



**Results**

As in previous years the number of admissions to hospital for acute bronchitis for 0 to 4 year olds remains very low. In 2004 there were only 2 non-Aboriginal admissions to hospital for this condition with none occurring in the Aboriginal population compared to 6 non-Aboriginal and 1 Aboriginal hospitalisation in 2003.

**Figure 6: Rate of hospitalisation for bronchiolitis (0 to 4yrs)**

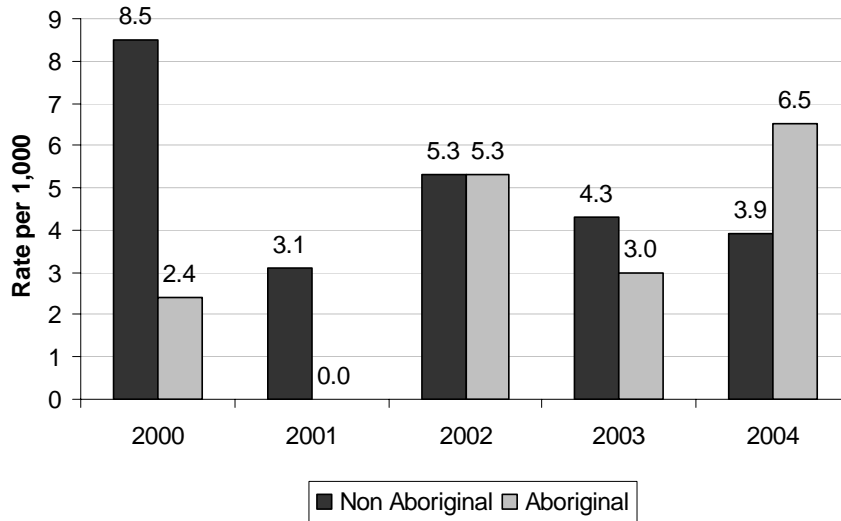


**Results**

The rates of hospitalisation for bronchiolitis for 0 to 4 year olds remain comparable to those achieved in previous years. In 2004 there were 6 admissions of Aboriginal children and 62 admissions for non-Aboriginal children with the Bunbury area recording the most hospitalisations

# Performance Indicators

Figure 7: Rate of hospitalisation for croup (0 to 4yrs)



### Results

Reported rates of hospitalisation for croup remain comparable to previous years. However actual hospital admissions for croup are low with only 6 Aboriginal and 33 non-Aboriginal admissions for South West Area Health Service.

### Data Sources

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

# Performance Indicators

## **110: Average cost per capita of Population Health Unit**

This indicator reports the cost per capita of 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.

**Table 11: Cost per capita of Population Health Unit**

|                     | <b>2003-04</b> | <b>2004-05</b> |
|---------------------|----------------|----------------|
| <b>Actual Cost</b>  | \$80.27        | \$97.00        |
| <b>CPI adjusted</b> | \$78.56        | \$92.64        |

### **Data Sources**

Health Information Centre (ABS data).  
SWAHS Financial Systems.

# Performance Indicators

## ***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 they are in need of them 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 is acceptable, increasing the chance of complete recovery from the illness or injury (for example access to elective surgery);

Provide quality diagnostic and treatment services which ensure the maximum restoration to health after an acute illness or injury:

- Provide appropriate after-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible.
- Provide appropriate 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 Service | South West Area Health Service  | WA Country Health Service | DOH                          |
|---|---------------------------------|---------------------|---------------------------------|---------------------------|------------------------------|
| <b>The achievement of this component of the health objective involves activities which:</b>               |                                 |                     |                                 |                           |                              |
| <b>Ensures that people have access to acute care services by:</b>   |                                 |                     |                                 |                           |                              |
| Prioritising access to elective surgery.  | 200                             |                     | 200                             | 200                       |                              |
| Providing timely transport to hospital.   |                                 |                     |                                 |                           | R206                         |
| Prioritising access to dental services.   | 212<br>213                      |                     |                                 |                           | R207                         |
| <b>Provide quality diagnostic services and treatment by:</b>  |                                 |                     |                                 |                           |                              |
| Providing appropriate and quality admitted patient services when people are ill or injured.               | 201<br>204<br>205<br>206<br>208 | 204<br>205          | 201<br>204<br>205<br>206<br>208 | 204<br>205<br>206<br>208  | R201<br>R202<br>R204<br>R205 |
| Providing timely and appropriate ambulatory services for people who do not require admitted patient care. |                                 |                     |                                 |                           |                              |
| Providing appropriate obstetric and neonatal care.  | 207                             |                     | 207                             | 207                       |                              |

# Performance Indicators

## 200: Elective surgery waiting times

This indicator reports elective surgery waiting times.

### Rationale

For health services to be effective, access needs to be provided on the basis of clinical need. If patients requiring admission to hospital wait for long periods of time, there is the potential for them to experience an increased degree of pain, dysfunction and disability relating to their condition. After some types of surgery patients will be restored to health, while other surgery will improve the quality of life.

Patients who are referred for elective surgery are classified by senior medical staff into one of

the following urgency categories based on the likelihood of the condition becoming an emergency if not seen within the recommended time frame. The categories are listed below:

- Category 1: Admission desirable within 30 days
- Category 2: Admission desirable within 90 days
- Category 3: Admission desirable within 365 days

### Note

This reporting rationale conforms with the Australian Council on Healthcare Standards reporting requirements and is reported for all of the SWAHS.

**Table 13: People admitted from the waiting list during 2004-05**

|   | Category 1 |     |                             | Category 2 |     |                             | Category 3 |     |                             |
|---|------------|-----|-----------------------------|------------|-----|-----------------------------|------------|-----|-----------------------------|
|   | Cases      | %   | Median waiting time in days | Cases      | %   | Median waiting time in days | Cases      | %   | Median waiting time in days |
| Percentage admitted within desirable time     | 832        | 91% | 7                           | 813        | 87% | 22                          | 1710       | 98% | 22                          |
| Percentage not admitted within desirable time | 83         | 9%  |                             | 117        | 13% |                             | 34         | 2%  |                             |

**Table 14: People admitted from the waiting list during 2003-04**

|   | Category 1 |    |                             | Category 2 |    |                             | Category 3 |    |                             |
|---|------------|----|-----------------------------|------------|----|-----------------------------|------------|----|-----------------------------|
|   | Cases      | %  | Median waiting time in days | Cases      | %  | Median waiting time in days | Cases      | %  | Median waiting time in days |
| Percentage admitted within desirable time     | 795        | 94 | 7                           | 1230       | 93 | 16                          | 2206       | 98 | 29                          |
| Percentage not admitted within desirable time | 54         | 6  |                             | 98         | 7  |                             | 37         | 2  |                             |

# Performance Indicators

## 200: Elective surgery waiting times (cont)

Table 15: People remaining on the waiting list as at 30 June 2005

|  | Category 1 |     |                             | Category 2 |     |                             | Category 3 |     |                             |
|--|------------|-----|-----------------------------|------------|-----|-----------------------------|------------|-----|-----------------------------|
|  | Cases      | %   | Median waiting time in days | Cases      | %   | Median waiting time in days | Cases      | %   | Median waiting time in days |
| Percentage not admitted (still on the waiting list) but waiting time within desirable time   | 32         | 60% | 23                          | 134        | 63% | 56                          | 471        | 81% | 120                         |
| Percentage not admitted (still on the waiting list) and waiting time over the desirable time | 21         | 40% |                             | 80         | 37% |                             | 113        | 19% |                             |

Table 16: People remaining on the waiting list as 30 June 2004

|  | Category 1 |    |                             | Category 2 |    |                             | Category 3 |    |                             |
|--|------------|----|-----------------------------|------------|----|-----------------------------|------------|----|-----------------------------|
|  | Cases      | %  | Median waiting time in days | Cases      | %  | Median waiting time in days | Cases      | %  | Median waiting time in days |
| Percentage not admitted (still on the waiting list) but waiting time within desirable time   | 42         | 76 | 12                          | 82         | 56 | 83                          | 414        | 86 | 90                          |
| Percentage not admitted (still on the waiting list) and waiting time over the desirable time | 13         | 24 |                             | 65         | 44 |                             | 70         | 14 |                             |

**Data Source**

Central Waitlist Bureau, WA Department of Health.

# Performance Indicators

## **201: Proportion of emergency department patients seen within recommended times**

This indicator reports the proportion of emergency department patients seen within recommended times.

### **Rationale**

When patients first enter an Emergency Department, they are assessed by specially trained nursing staff who judge how urgently treatment should be provided. The aim of this process known as triage is to ensure treatment is given in the appropriate time. This should prevent adverse conditions arising from deterioration in the patient's condition. Treatment within recommended times should assist in the restoration to health either during the emergency visit or the admission to hospital which may follow Emergency Department care.

A patient is allocated a triage code between 1 and 5, which indicates their urgency (see table).

The triage process and scores are recognised by the College of Emergency Medicine and recommended for prioritising those who present to an Emergency Department. In a busy Emergency Department when several people present at the same time, the service aims for the best outcome for all. Treatment should be within the recommended time of the triage category allocated.

This indicator measures the percentage of patients in each triage category who were seen within the time periods recommended by the Australasian College for Emergency Medicine (ACEM).

**Table 17: Proportion of emergency department patients seen within recommended times**

|                                       | <b>Threshold</b> | <b>2000-01</b> | <b>2001-02</b> | <b>2002-03</b> | <b>2003-04</b> | <b>2004-05</b> |
|---------------------------------------|------------------|----------------|----------------|----------------|----------------|----------------|
| Triage category 1 (immediately)       | 100%             | 100.00%        | 100.00%        | 100.00%        | 100.00%        | 98.8%          |
| Triage category 2 (within 10 minutes) | 80%              | 82.70%         | 69.30%         | 84.10%         | 80.92%         | 71.2%          |
| Triage category 3 (within 30 minutes) | 75%              | 81.50%         | 78.00%         | 83.80%         | 84.03%         | 79.5%          |
| Triage category 4 (within 60 minutes) | 70%              | 78.30%         | 76.80%         | 83.30%         | 84.95%         | 85.2%          |
| Triage category 5 (within in 2 hours) | 70%              | 91.20%         | 92.20%         | 96.10%         | 96.61%         | 96.5%          |

### **Data Source**

TOPAS Bunbury Regional Hospital.

# Performance Indicators

## **202: *Rate of emergency presentations with a triage score of 4 and 5 not admitted***

This indicator reports the rate of emergency presentations with a triage score of 4 and 5 not admitted.

### **Rationale**

When patients attend hospital they are initially assessed in emergency departments where treatment and a decision on whether to admit for further care takes place.

Triaging is an essential function of the emergency department where many people may present simultaneously. The aim of triage is to ensure that patients are treated in order of their clinical urgency and that patients receive timely care. While urgency refers principally to time-critical intervention and is not synonymous with severity, more patients triaged 1 and 2 are admitted to hospital than those with a score of 4 and 5.

Without care provided by staff in an emergency department, the restoration to health of people with an injury or a sudden illness may take longer or result in death. This indicator reports the rate of people presenting to the emergency department given a triage score of 4 or 5 who were assessed, and treated but did not need admitted hospital care ie were restored to health. These are the people who receive primary care in the emergency department. It does not include patients whose sickness or injury requires admitted hospital care.

The indicator reports the number of patient presentations to hospitals where the emergency department does not have 24 hour cover by doctors who are trained in emergency medicine. The numbers of presentations include doctor attended assessments and treatment as well as nursing assessment and treatment.

### **Results**

The results indicate comparable emergency presentation outcomes with prior years.

**Table 18: Rate of emergency presentations with a triage score of 4 and 5 not admitted**

|                          | 2002-03 | 2003-04 | 2004-05 |
|--------------------------|---------|---------|---------|
| <b>Triage Category 4</b> | 85%     | 90%     | 89%     |
| <b>Triage Category 5</b> | 93%     | 95%     | 96%     |

### **Source**

HCARE Activity Data Systems.

# Performance Indicators

## **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**

While the result for the rate of readmission to hospital for a related condition has increased for South West Area Health Service hospitals it is comparable to other non-metropolitan locations and indicates the health service continues to use appropriate clinical interventions and effective discharging practices. It should be noted however that the readmission rates at some smaller service centres can be influenced by the availability of community support services during the health condition episode.

### **Note**

A return to hospital is a readmission only if the reason for this admission is the same or is related to the condition treated in the previous admission.

**Table 19: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition**

|                            | 2002-03 | 2003-04 | 2004-05 |
|----------------------------|---------|---------|---------|
| Unplanned readmission rate | 1.6%    | 2.0%    | 4.0%    |

### **Data Source**

Hospital Morbidity Data System.

# Performance Indicators

## **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 within 28 days, in an unplanned way, 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**

Results for the rate of readmission to hospital for a mental health condition remains at the same level as reported in 2003 and is below the ACHS standard. This indicates that the South West Area Health Service has adopted appropriate multidisciplinary clinical interventions and discharging practices.

### **Note**

The numbers of patients who receive inpatient mental health care are very low, hence small numbers of patients who have unplanned re-admissions can result in large variations to the annual percentage. The Australian Council on Healthcare Standards (ACHS) considers that a threshold of 10% is an acceptable rate of unplanned re-admissions within 28 days, for patients receiving inpatient mental health services.

A return to hospital is a readmission only if the reason for this admission is the same or is related to the condition treated in the previous admission.

**Table 20: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition**

|                            | 2002-03 | 2003-04 | 2004-05 |
|----------------------------|---------|---------|---------|
| Unplanned readmission rate | 2.7%    | 5.7%    | 5.7%    |

### **Data Source**

Hospital Morbidity Data System.

# Performance Indicators

## **206: Rate of post-operative pulmonary embolism**

This indicator reports the rate of post-operative pulmonary embolism.

### **Rationale**

Patients post-operatively can develop a blood clot in the deep veins of the leg. This can travel to the lungs and cause circulatory problems. This is known as a pulmonary embolism and is one of the main preventable causes of death in fit people undergoing elective surgery.

Hospital staff can take special precautions to decrease the risk of this happening. A low percentage of cases developing pulmonary embolism post-operatively suggests that the appropriate precautions have been taken.

This indicator measures the percentage rate of patients who underwent surgery and subsequently developed pulmonary embolism. By monitoring the incidence of post-operative pulmonary embolism, a hospital can ensure clinical protocols that minimise such risks are in place and are working. The monitoring of post-operative complications is important in ensuring the optimum recovery rate for people with acute illness.

### **Results**

The SWAHS has experienced a notable increase in the number of cases of post-operative pulmonary embolism with six cases in 2004 compared to only one in 2003. As a consequence, the rate has exceeded the ACHS Clinical Indicator threshold.

Accordingly, processes have been established to reinforce the application of current prevention and treatment policies and practices based on risk assessment. Reported cases will be audited to ensure compliance.

### **Note**

Cases are selected for reporting using the criteria defined by the ACHS. The ACHS standard for good practice is a rate less than 0.8%. Cases are reported for pulmonary emboli if the post-operative length of stay is at least seven days.

The data capture period for this performance indicator is the 2004 calendar year.

**Table 21: Rate of post operative pulmonary embolism**

|                                   | 2000-01 | 2001-02 | 2002-03 | 2003  | 2004  |
|-----------------------------------|---------|---------|---------|-------|-------|
| Post operative pulmonary embolism | 1.52%   | 0.96%   | 0.51%   | 0.28% | 1.35% |

### **Data Source**

Hospital Morbidity Data System.

## Performance Indicators

### **207: Survival rate of live born babies with an APGAR score of four or less five minutes after delivery**

This indicator reports the survival rate of live born babies with an APGAR score of four or less five minutes after delivery

#### **Rationale**

A well managed labour will normally result in the birth of a minimally distressed infant. The level of foetal well-being (lack of stress or other complications or conditions) is measured five minutes post delivery by a numerical scoring system (APGAR) through an assessment of heart rate, respiratory effort, muscle tone, reflex irritability and colour.

A high average APGAR score in a hospital will generally indicate that appropriate labour management practices are employed and is also an indication of the wellbeing of the baby.

This indicator reports the survival rates of babies with low APGAR scores at birth (an APGAR score of four or less at five minutes post delivery). A baby with a low APGAR is more likely to have been affected by antenatal or intrapartum events such as maternal haemorrhage, preterm labour, or infection. This indicator measures the survival rate of babies with a low APGAR score and is an elementary measure of how the care in hospital restores the sick or premature baby to health.

#### **Results**

As in 2003 there was only a very small number of babies born in South West Area Health Service hospitals with an APGAR score of 4 or less five minutes after delivery. Both babies born meeting this criteria in 2004 survived.

**Table 22: Survival rate of babies born with an APGAR score of four or less**

| Gestation period in weeks | 2003              |                   | 2004              |                   |
|---------------------------|-------------------|-------------------|-------------------|-------------------|
|                           | Babies born (no.) | Survival rate (%) | Babies born (no.) | Survival rate (%) |
| 20-28                     | no event          |                   | no event          |                   |
| 29-32                     | no event          |                   | no event          |                   |
| 33-36                     | no event          |                   | no event          |                   |
| 37-41                     | 3                 | 100               | 2                 | 100               |
| over 41                   | no event          |                   | no event          |                   |
| <b>Total all periods</b>  | 3                 | 100               | 2                 | 100               |

#### **Data Source**

WA Midwives' Registry.

# Performance Indicators

## 208: *Survival rates for sentinel conditions*

This indicator reports the survival rates for sentinel conditions.

### Rationale

The survival rate of patients in hospitals can be affected by many factors. This includes the diagnosis, the treatment given or procedure performed, the age, sex and condition of each individual patient including whether the patient had other co-morbid conditions at the time of admission or developed complications while in hospital.

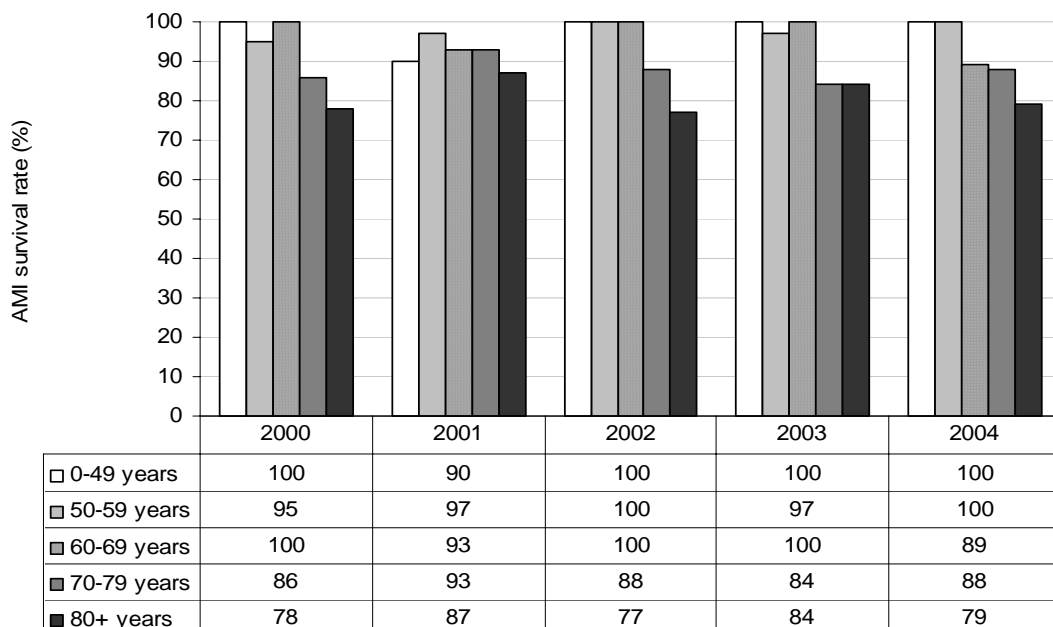
The comparison of 'whole of hospital' survival rates between hospitals may not be appropriate due to differences in mortality associated with different diagnoses and procedures. Three 'sentinel' conditions, therefore, are reported for which the survival rates are to be measured by specified age groups.

For each of these conditions – stroke, heart attack (also known as acute myocardial infarction - AMI), and fractured hip (also known as fractured neck of femur - FNOF), a good recovery is more likely when there is early intervention and appropriate care. Additional co-morbid conditions are more likely to increase with age therefore better comparisons can be made if comparing age slices rather than the whole population.

This indicator measures the hospitals' performance in restoring the health of people who have had a stroke, AMI, or FNOF, by measuring those who survive the illness and are discharged well. Some may be transferred to another hospital for specialist rehabilitation or to a hospital closer to home for additional rehabilitation at the end of the acute admission.

The survival rates for stroke and AMI decline as expected in the older age groups. High survival rates indicate effective clinical care.

**Figure 8: Survival rate for acute myocardial infarction (AMI)**



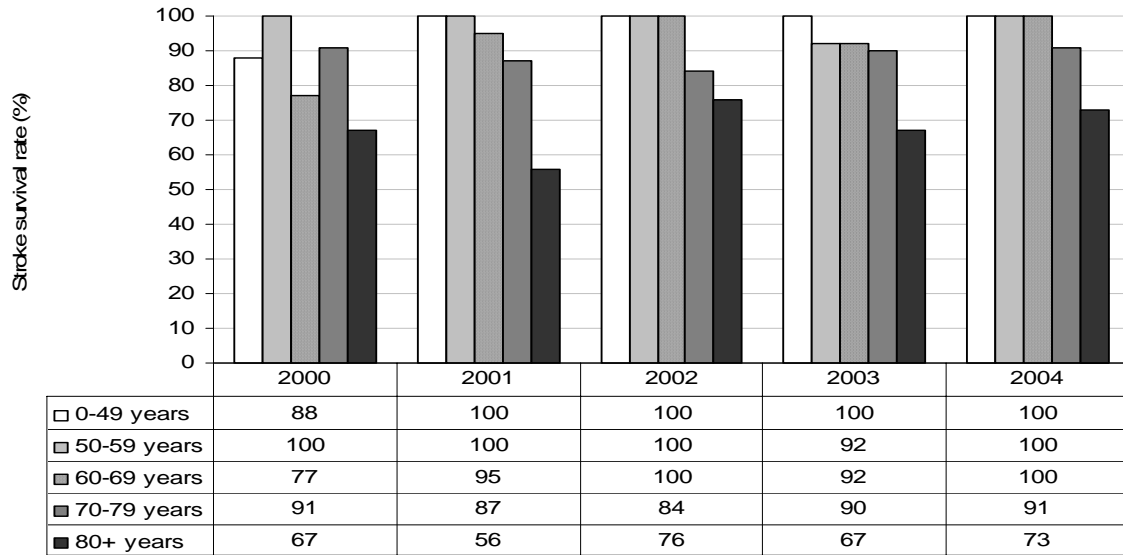
### Results

The rates of survival for the different age cohorts for AMI has remains comparable with previous years except for the age group 60 to 69 years which has shown a decrease in the reported rate.

# Performance Indicators

## 208: Survival rates for sentinel conditions

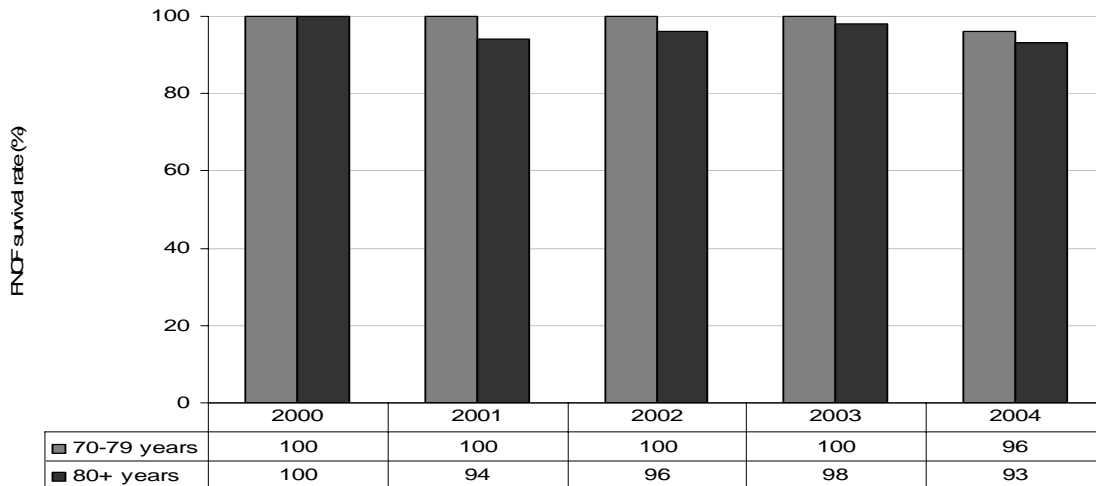
Figure 9: Survival rate for stroke



### Results

The rates of survival for the different age cohorts for stroke remains comparable or has improved against results recorded in previous years.

Figure 10: Survival rate for fractured neck of femur (FNOF)



### Results

The rates of survival for the two age cohorts for fractured neck of femur remains comparable with the results recorded in previous years.

### Data Source

Hospital Morbidity Data System.

# Performance Indicators

## **221: Average cost per casemix adjusted separation for non-teaching hospitals**

This indicator reports average cost per casemix adjusted separation for non-teaching hospitals.

### **Rationale**

The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provision and

the use of resources. Hence the number of separations in a hospital may not necessarily equal the number of casemix adjusted separations. The magnitude of the difference will depend on the complexity of the services provided.

**Table 23: Average cost per casemix adjusted separation**

|                     | 2001-02 | 2002-03 | 2003-04 | 2004-05 |
|---------------------|---------|---------|---------|---------|
| <b>Actual Cost</b>  | \$2,728 | \$3,330 | \$3,367 | \$3,080 |
| <b>CPI adjusted</b> | \$2,816 | \$3,330 | \$3,295 | \$2,942 |

### **Data Sources**

Hospital Morbidity Data System (HMDS).  
SWAHS Financial System.

# Performance Indicators

## ***225: Average cost per non-admitted hospital based occasion of service***

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

### **Rationale**

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

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. However, due to variations in patient characteristics and clinic types between sites and across time, there may be differences in service delivery costs.

**Table 24: Average cost per non-admitted hospital based occasion of service**

|                     | 2001-02 | 2002-03 | 2003-04 | 2004-05 |
|---------------------|---------|---------|---------|---------|
| <b>Actual Cost</b>  | \$128   | \$106   | \$128   | \$122   |
| <b>CPI adjusted</b> | \$132   | \$106   | \$125   | \$117   |

### **Data Sources**

TOPAS and HCARE Data System.  
SWAHS Financial System.

# Performance Indicators

**226: Average cost per non-admitted occasion of service in a nursing post**

This indicator reports the average cost per non-admitted occasion of service in a nursing post.

**Rationale**

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

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

**Table 25: Average cost per nursing post based non-admitted occasion of service**

|                     | 2001-02 | 2002-03 | 2003-04 | 2004-05 |
|---------------------|---------|---------|---------|---------|
| <b>Actual Cost</b>  | \$71.00 | \$151   | \$143   | \$153   |
| <b>CPI adjusted</b> | \$73.30 | \$151   | \$140   | \$146   |

**Data Sources**

HCARe (local) activity data systems.  
SWAHS Financial Systems.

# Performance Indicators

## **227: Average cost per bed-day for admitted patients (selected small rural hospitals)**

This indicator reports the average cost per bed-day for admitted patients (selected small rural hospitals).

### **Rationale**

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. However it is not the accepted method of costing admitted patient activity in a small rural hospital.

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

**Table 26: Average cost per bed-day for admitted patients in a small hospital**

|                     | 2001-02 | 2002-03 | 2003-04 | 2004-05 |
|---------------------|---------|---------|---------|---------|
| <b>Actual Cost</b>  | \$349   | \$498   | \$527   | \$532   |
| <b>CPI adjusted</b> | \$360   | \$498   | \$516   | \$508   |

### **Data Sources**

HCARE activity data systems.  
SWAHS Financial Systems.

# Performance Indicators

## **228: Average cost per trip of Patient Assisted Travel Scheme**

This indicator reports the average cost per trip of Patient Assisted Travel Scheme.

### **Rationale**

The Patient Assisted Travel Scheme assists permanent country residents to access the nearest medical specialist and specialist medical services.

A subsidy is provided towards the cost of travel and accommodation for patients and where necessary an escort for people who have to travel more than 100 kilometres one way to attend medical appointments. Without this assistance many people would be unable to access the services needed to diagnose or treat some conditions.

**Table 27: Average cost per trip of the Patient Assisted Travel Scheme**

|                     | 2002-03 | 2003-04 | 2004-05 |
|---------------------|---------|---------|---------|
| <b>Actual Cost</b>  | \$89.00 | \$90.62 | \$88.33 |
| <b>CPI adjusted</b> | \$89.00 | \$88.69 | \$84.36 |

### **Data Sources**

Local activity data systems.  
SWAHS Financial Systems.

## Performance Indicators

### ***229: Average cost per bed-day in an authorised mental health unit***

This indicator reports the average cost per bed-day in an authorised mental health unit.

#### **Rationale**

The efficient use of hospital resources can help minimise the overall costs of providing health care, or allow more patients to be treated with a similar amount of resources.

Variations in patient characteristics between sites and across time may result in differences in service delivery costs.

In order to ensure quality and cost effectiveness, it is important to monitor the unit cost per bed-day of admitted patient care in authorised mental health units. These are hospitals or hospital wards devoted to the treatment and care of patients with psychiatric, mental or behavioural disorders that are by law able to admit people as involuntary patients for psychiatric treatment.

In the South West Area Health Service there is one authorised mental health unit situated in the Bunbury Regional Hospital.

**Table 28: Average cost per bed-day in an authorised mental health unit**

|                     | 2003-04 | 2004-05 |
|---------------------|---------|---------|
| <b>Actual Cost</b>  | \$995   | \$1,035 |
| <b>CPI adjusted</b> | \$974   | \$989   |

#### **Data Sources**

Mental Health Information System.  
SWAHS Financial Systems.

# Performance Indicators

## **Outcome 3: *Improving the quality of life of people with chronic illness and disability***

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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. The effectiveness and efficiency measures for those supports are reported by DOH.

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. The effectiveness and efficiency indicators for HACC are reported by DOH. The Health Services will provide acute services to those with disabilities under Outcome 2.

# Performance Indicators

**Table 29: Respective Indicators by Health Sector for Outcome 3**

|  | Metropolitan Health Service | Peel Health Service | South West Area Health Service | WA Country Health Service | DOH          |
|--|-----------------------------|---------------------|--------------------------------|---------------------------|--------------|
| The achievement of this component of the health objective involves activities which: |                             |                     |                                |                           |              |
| <b>Supporting people with chronic and terminal illness by:</b>                       |                             |                     |                                |                           |              |
| Providing palliative care services.  |                             |                     |                                |                           | R304         |
| Providing support services to people with chronic illnesses and disabilities.        | 301                         | 301                 | 301                            | 301                       | R301         |
| Providing appropriate home care services for the frail aged.                         | 304                         | 304                 | 304                            | 304                       | R302<br>R303 |

# Performance Indicators

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

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

### **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-admitted services following discharge.

These community services provide ongoing mental health treatment and access to a range of rehabilitation and recovery programs that aim to reduce hospital readmission and maximise an individuals independent functioning and quality of life.

This type of care for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential after discharge to maintain or improve clinical and functional stability and to reduce the likelihood of an unplanned readmission.

A severe and persistent mental illness refers to clients who have psychotic disorders that result in 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 has been recommended nationally as an indicative measure of follow up with non-admitted services for people with a severe and persistent mental illness.

There is currently no agreed target benchmark 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 of their appropriateness.

### **Results**

In 2004, 54.2% of discharges with a principal diagnosis of schizophrenia or bipolar disorder from public mental health inpatient units resulted in contact with a community-based public mental health non-admitted service within seven days of discharge. Approximately 10% of discharges did not have contact within the year. No contact may indicate that referrals, following discharge, were made to the private sector (eg General Practitioners, Private Psychiatrists, Private Psychologists etc) for which data on contacts is not available.

While the findings indicate that the target benchmark for a seven-day threshold has not as yet been achieved, over 68% of contacts are taking place within a fortnight.

This KPI was developed for the first time in 2003 and results indicate that the percent of contacts within seven days post discharge for 2004 has decreased since 2003.

Caution should be used when interpreting these figures due to the small numbers involved. This can result in significant variability between years.

# Performance Indicators

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

**Table 30: Percent of contacts with community-based public mental health non-admitted services within seven and fourteen days post discharge from public mental health inpatient units**

| Days to first contact | 2003   | 2004   |
|-----------------------|--------|--------|
| 0 to 7 days           | 60.43% | 54.17% |
| 8 to 14 days          | 16.55% | 14.17% |
| 15 to 28 days         | 2.88%  | 7.50%  |
| 29 + days             | 12.23% | 14.17% |
| No contact            | 7.91%  | 10.00% |

### **Data source**

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

### **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:
  - Bunbury Regional 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.

# Performance Indicators

## 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 service or dies before a comprehensive assessment has been completed and recommendations have been made.

### Note

Commencing in 2003-04 the WA ACAT Program made significant amendments to how ACAT teams collect and report their minimum data set on their activities. As described in the 2003-04 annual report the minimum data set for calculating this performance indicator was revised. As a result of evaluation the operational definition of an accepted ACAT referral has been revised and now includes all referrals.

Previously only those referrals, which resulted in a comprehensive assessment, were included. This change in methodology now aligns WA with national reporting methodologies.

**Table 31: Completed assessments as a proportion of accepted ACAT referrals**

|  | 2003  | 2004  |
|--|-------|-------|
| Completed assessments as a proportion of accepted ACAT referrals | 98.7% | 93.5% |

### Data Source

Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports July to December 2004.

# Performance Indicators

## **303: Average cost per person receiving care from public community-based mental health services**

This indicator reports the average cost per person with mental illness under community care.

### **Rationale**

The majority of services provided by community mental health services are for people in an acute

phase of a mental illness or who are receiving post-acute care. This indicator gives a measure of the cost effectiveness of treatment for public mental health patients under community care (non-admitted/ambulatory patients).

**Table 32: Average cost per person with a mental illness under community care**

|                     | 2002-03 | 2003-04 | 2004-05 |
|---------------------|---------|---------|---------|
| <b>Actual Cost</b>  | \$2,316 | \$3,791 | \$3,375 |
| <b>CPI adjusted</b> | \$2,316 | \$3,710 | \$3,223 |

### **Data Sources**

Mental Health Information System, HIC.  
SWAHS Financial Systems.

# Performance Indicators

## **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 33: Average cost per aged care assessment**

|                     | 2003-04 | 2004-05 |
|---------------------|---------|---------|
| <b>Actual cost</b>  | \$349   | \$300   |
| <b>CPI adjusted</b> | \$342   | \$287   |

### **Data Sources**

Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to December 2004.  
SWAHS Financial Systems.