

# 5 Comments on data elements

This chapter brings together summary information on the utility and importance of the NMDS data elements, comments and suggestions from both the utility and compliance evaluations, and other comments obtained during the NMDS evaluation. The order of data elements in this section largely follows the order in which the data elements are presented in tables 3.5 and 4.3. Data elements relating to continuity of care have been grouped together from page 110.

## Existing data elements and data element concepts

### Establishment data elements

#### Establishment identifier

Ninety-four per cent of respondents rated this data element as either important (38%) or highly important (56%), and 94% rated it as either useful (38%) or highly useful (56%). Six per cent were unsure of its importance and usefulness.

Respondents indicated the importance and usefulness of this data element in allowing comparisons to be made across states and territories for other data elements. Inconsistency between jurisdictions in the level at which establishments are identified was seen to limit its usefulness.

Another issue raised was that the approach used to report establishments in the NMDS varies from that used in the National Survey of Mental Health Services and the NOCC, limiting the ability to integrate the NMDS data with data from these sources. The DoHA commented that this issue is of high priority.

#### Establishment number

Eighty-one per cent of respondents rated this data element as either important (31%) or highly important (50%), and 88% rated it as either useful (38%) or highly useful (50%). Thirteen per cent did not think the data element was important and 6% not useful. Six per cent were unsure of both its usefulness and importance.

There were no comments about this data element.

#### Establishment sector

Eighty-eight per cent of respondents rated this data element as either important (44%) or highly important (44%), and 75% rated it as either useful (38%) or highly useful (38%). Thirteen per cent did not think the data element was useful and a further 13% were unsure of its usefulness.

A recommendation from the evaluation of the APC NMDS, relevant to the current evaluation, was that the informal collection of information on whether the hospital is a public psychiatric, other public, private free-standing day hospital facility or other private hospital using this data element should be replaced with either an appropriate revision of the data domain for *Establishment sector* or the creation of a new data element on hospital type. This is currently being considered as part of the AIHW's work program for the development of the APC NMDS.

### **Region code**

Seventy-five per cent of respondents rated this data element as either important (44%) or highly important (31%), and 63% rated it as either useful (31%) or highly useful (31%). Six per cent did not think the data element was important and 12% not useful. Another 19% were unsure of its importance and 25% of its usefulness.

Comments included that it would be preferable to define the location of health services in terms of their SLA; and that because a region means completely different things in different jurisdictions, inter-jurisdictional comparisons of other data elements on the basis on this data element are not possible. However, it was noted that this data element is used at the local level within jurisdictions.

Another comment was that while *Region code* may have little value for the general health sector, it is still useful to collect as mental health services are organised on a catchment population basis; for all states and territories, *Region code* points to the geographic populations served. It was also noted that there is a need to align any replacement concept with the concept in the NOCC and the National Survey of Mental Health Services.

This data element has been deleted from the APC NMDS, subsequent to a recommendation of the evaluation of that NMDS. However, given its usefulness in identifying catchment populations, it was thought useful to retain it in the APMHC NMDS. However, it should be revised to clarify how it would be used for this NMDS to indicate catchment areas and/or align with the region concept in the NOCC.

### **State identifier**

Sixty-nine per cent of respondents rated this data element as either important (25%) or highly important (44%), and 69% rated it as either useful (25%) or highly useful (44%). Only 6% rated it as not important or not useful. Twenty-five per cent were unsure of its importance and usefulness.

There were no comments on this data element.

## **Demographic data elements**

### **Area of usual residence**

Ninety-four per cent of respondents rated this data element as either important (6%) or highly important (88%), and 94% rated it as either useful (19%) or highly useful (75%). Only 6% were unsure about its importance and usefulness.

It was commented that this data element is important for service delivery planning.

### **Country of birth**

Eighty-eight per cent of respondents rated this data element as either important (44%) or highly important (44%), and 75% rated it as either useful (50%) or highly useful (25%). Twelve per cent rated it as not useful and 12% were unsure.

Generally, there was concern about the lack of data collected on the cultural and linguistic diversity of patients, with *Country of birth* generally regarded as a necessary but insufficient element to measure cultural and linguistic diversity.

The ABS has identified a minimum recommended core set of cultural and language indicators comprising *Indigenous status*, *Main language other than English spoken at home*, *Country of birth* and *Proficiency in spoken English*.

### **Date of birth**

Eighty-eight per cent of respondents rated this data element as either important (6%) or highly important (81%), and 88% rated it as either useful (25%) or highly useful (63%). Twelve per cent were unsure about its importance and usefulness.

Generally comments related to the need for clarification on how to report an unknown date of birth if only day is known, month is known, or year is known. There is no estimated date of birth flag in the NMDS at present to indicate which part(s) of the date was estimated.

Comments included that work underway by the AIHW to achieve consensus on how missing data are handled needs to be pursued.

### **Employment status—acute hospital and private psychiatric hospital admissions**

Only 57% of respondents rated this data element as either important (31%) or highly important (25%), and only 31% rated it as either useful (19%) or highly useful (13%). Twenty-five per cent rated it as not important and 31% as not useful. Another 19% were unsure of its importance, and 38% of its usefulness.

There were a number of comments relating to this data element and to *Employment status – public psychiatric hospital admissions*. Many respondents expressed concern regarding the existence of two separate data elements to collect information on employment status. There was also general concern expressed that the data domains are not clearly defined or mutually exclusive and that the data are difficult to collect.

Another problem raised as an issue to be resolved is that there is no definition of 'employed' in the data element. The ABS classifies a person as employed if they work 1 hour or more a week for the calculation of the unemployment rate.

In addition, information under the collection method refers to the current or last occupation of the patient, which is not descriptive of the data domain.

It was indicated that local users rarely request information on employment status, and that it is already possible to examine relationships between socioeconomic status

and the use of mental health based services at the SLA level, using Census and local administrative data.

It was noted that the different data domains in *Employment status – acute hospital and private psychiatric hospital admissions* and *Employment status – public psychiatric hospital admissions* result in incomparable data collected using the two data elements and are causing confusion for data collectors.

Possible solutions to the problems discussed above involve forming a new ‘merged’ data element or deleting the two employment status data elements from the NMDS altogether. It was suggested that a merged data element could use the data domain from *Employment status – public psychiatric hospital admissions*, but incorporate a separate pension category. Further work would need to be done on clarifying the definition of employed for the purposes of this NMDS.

As a first step, it needs to be decided why employment status information is collected. Although employment status is often included with a range of other data elements to provide information on socioeconomic status, it was suggested that employment status on its own is not a good indicator of socioeconomic status. It was also noted that information on employment status is important to collect for use as a correlate for a range of other data elements and development of socioeconomic profiles of ‘at risk’ groups. However, if the purpose is to measure an aspect of functioning of the patient, then an alternative data element that better measures this concept may need to be developed.

It was also stated that the measurement of socioeconomic status of psychiatric patients is a highly complex and resource-intensive task. For this reason, measurement of concepts contributing to measurement of socioeconomic status may be better collected in a sample survey or limited-time in-depth study. For example, it could be collected on a sample basis at selected hospitals using the assistance of social workers.

The AIHW in the past has only requested data for one data element *Employment status*. The data domain from *Employment status – public psychiatric hospital admissions* has been used, but the scope has not been limited to public psychiatric hospitals.

### **Employment status—public psychiatric hospital admissions**

Only 53% of respondents rated this data element as either important (33%) or highly important (20%), and 27% rated it as either useful (20%) or highly useful (7%). Thirteen per cent rated it as not important and 33% as not useful. Another 33% were unsure of its importance and 40% of its usefulness.

See previous data element for detailed comments.

### **Indigenous status**

Eighty-eight per cent of respondents rated this data element as either important (13%) or highly important (75%), and 88% rated it as either useful (31%) or highly useful (56%). Thirteen per cent were unsure of its importance and usefulness.

One respondent indicated the need for a Declined/unable to respond category, to separately measure Declined/unable to respond from other reasons for which data are not available.

The AIHW has no information on whether *Indigenous status* is collected independently for each episode of care for mental health patients, or if it is recorded only once and then replicated for repeat admissions. Ideally, information should be collected at each admission.

In addition, the AIHW has no specific information on the quality of the Indigenous data collected in the APMHC NMDS. For quality information on data collected for the APC NMDS for 2002-03, see page 70.

The National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Data has improvement of the quality of Indigenous identification in hospital morbidity data as part of its work program.

The AIHW, in collaboration with the National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Data, is currently undertaking work aimed at improving the identification of Indigenous patients in admitted patient care data. The specific outcomes for this work are:

- description of the completeness of Indigenous identification in work undertaken to date
- outline of methods used by jurisdictions to improve identification, including examples of best practice and examples of those methods that have not worked
- development of analysis guidelines to support the consistent and appropriate analysis of *Indigenous status* in hospital morbidity data.

### **Marital status**

Only 50% of respondents rated this data element as either important (44%) or highly important (6%), and only 44% rated it as either useful (31%) or highly useful (13%). Thirty-one per cent rated it as not important and 38% not useful. A further 19% were unsure about its importance and usefulness.

Many respondents questioned the importance and usefulness of the collection of marital status. It was noted that information on marital status is rarely requested at the local level. It was also stated that categories are not mutually exclusive, for example, a person can be divorced and currently married at the same time.

Some respondents questioned the use of marital status as a measure of the level of social support patients receive at home, as stated in the context of the data element. It was suggested as not being useful in this role, as a person's marital status does not necessarily reflect the level of support they receive. For example, a person who is married could have an invalid dependent spouse for whom they provide care but do not receive any in return. Marital status is also a mix of legal and social concepts, so the categories, even if defined better, will always mean different things to different users. The respondents who commented generally suggested that a new data element should be developed to collect the type of information that is actually required.

Another problem raised was the lack of apparent relevance of collection of these data to the provision of health care services, which makes this data element a candidate for review under privacy legislation.

However, it was also commented that information on marital status is important to collect for use as a correlate for a range of other data elements and for the development of socioeconomic profiles of 'at risk' groups. Comments included that marital status combined with other sociodemographic data is known to be a predictor of psychiatric service utilisation and has been used by numerous Australian and international studies, and that marital status is a proxy for social isolation/connectedness.

It was also suggested that the collection of the data element to measure the association of marital status with the need for and use of services, and for epidemiological analysis may be better met by in-depth short-term studies at selected sites.

### **Sex**

Eighty-eight per cent of respondents rated this data element as either important (13%) or highly important (75%), and 94% rated it as either useful (19%) or highly useful (75%). Only 6% rated it as not important. A further 6% were unsure about its importance and usefulness.

No comments were received on this data element.

## **Length of stay data elements**

### **Admission date**

Eighty-eight per cent of respondents rated this data element as either important (13%) or highly important (75%), and 88% rated it as either useful (19%) or highly useful (69%). Thirteen per cent were unsure about its importance and usefulness.

Comments on this data element referred to the addition of admission time to the NMDS. This has been proposed as an effective method of monitoring the use of the data element concepts *Overnight stay patient* and *Same-day patient* and would allow more accurate measures of length of stay.

It was also recommended in the evaluation of the APC NMDS that consideration be given to the addition of admission time to the APC NMDS.

### **Separation date**

Ninety-four per cent of respondents rated this data element as either important (19%) or highly important (75%), and 94% rated it as either useful (19%) or highly useful (75%). Six per cent were unsure about its importance and usefulness.

Similar to *Admission date*, comments on this data element referred to the addition of separation time to the NMDS. This has been proposed as an effective method of

monitoring the use of the data element concepts *Overnight stay patient* and *Same-day patient* and would allow more accurate measures of length of stay.

It was also recommended in the evaluation of the APC NMDS that consideration be given to the addition of separation time to the APC NMDS.

### **Total leave days**

Eighty-eight per cent of respondents rated this data element as either important (31%) or highly important (56%), and 81% rated it as either useful (25%) or highly useful (56%). Another 13% were unsure of its importance and 19% of its usefulness.

Comments were made on the need for clarity and consistency in leave day rules, particularly in relation to involuntary patients who cannot be separated or discharged for legal reasons. There was also a proposal to redefine the concept to total leave nights and to not record absences during the day.

In the evaluation of the APC NMDS, it was recommended that this data element be changed to total leave hours. This change could be accompanied by the introduction of data elements for time of admission and time of separation, to allow yet more accurate measurement of length of stay in hours. In general, there were concerns about the difficulties in implementing this approach for mental health patients and the usefulness of doing so.

### **Total psychiatric care days**

Eighty-one per cent of respondents rated this data element as either important (6%) or highly important (75%), and 81% rated it as either useful (6%) or highly useful (75%). Another 19% were unsure of its importance and usefulness.

Some respondents indicated difficulty in collecting this data element and concern regarding the accuracy of data currently collected.

The recording psychiatric care in hours was suggested. However, given the high proportions of respondents reporting high levels of usefulness and importance of this data element it was considered that it should be retained in its current form.

## **Clinical and related data elements and data element concepts**

### **Diagnosis**

Seventy-five per cent of respondents rated this data element concept as either important (13%) or highly important (63%), and 75% rated it as either useful (19%) or highly useful (56%). Another 25% were unsure of its importance and 19% of its usefulness.

There were no comments from respondents in relation to this data element concept.

## **Additional diagnosis**

Ninety-four per cent of respondents rated this data element as highly important, and 94% rated it as either useful (6%) or highly useful (88%). Another 6% were unsure of its importance and usefulness.

It was noted that *Additional diagnosis* is useful to signify additional complexity in the episode of care.

There were also comments that the quality of additional diagnosis data should be assessed to ensure that its usefulness was not compromised.

## **Care type**

Eighty-eight per cent of respondents rated this data element as either important (31%) or highly important (56%), and 75% rated it as either useful (31%) or highly useful (44%). Six per cent did not think the data element was important and 13% not useful. Another 6% were unsure of its importance and 13% were unsure of its usefulness.

Many respondents were concerned about the appropriateness of the data domain as it is currently designed for mental health. They commented that the current code set is acute-hospital care orientated and does not take into account the type of care provided to many psychiatric patients, particularly long-stay rehabilitation patients and psychogeriatric patients.

The separation of psychogeriatric care as a separate category from acute care was considered problematic, as psychogeriatric care may also be acute care. The data domain does not allow this to be recognised and has possibly contributed to (or reinforced) existing conceptualisations that mental health care to the elderly ('psychogeriatric') is subacute. It was commented that, although usually having a longer length of stay, the older patient requiring mental health hospitalisation often has multiple active comorbidities and requires an acute level of care. Similarly, older patients with mental health problems may require other types of care, for example, rehabilitation.

It was suggested that mental health should perhaps have its own specific set of care types that do not overlap the non-mental health care types.

The recommendation of the DoHA is to replace *Care type* with separate data elements that distinguish clinical intent from type of service. Clinical intent would be the basis for separating acute from subacute episodes. Such an approach has the following advantages from the mental health services perspective:

1. It would provide a basis for consistency with the service type classification that has been implemented within the National Survey of Mental Health Services since 1994, and which is in the Mental Health Establishments National Minimum Data Set. This classification distinguishes services on the basis of main program type (acute, other) and target population (child and adolescent, older persons, forensic, general).

2. It would allow scope for a fuller elaboration of the concept of clinical intent. For example, there is value in distinguishing intensive psychiatric care as a subcategory of 'acute'.

In the evaluation of the APC NMDS it was recommended that *Care type* be comprehensively reviewed with input by clinicians. The limitations of this data element for psychiatric care were particularly noted. A number of new data domains including Psychiatric care and Acute psychiatric care were suggested, as was splitting the data element into two – one for clinical intent and the other for 'service type'.

*Care type* is currently being reviewed as part of the APC NMDS data development work program of the AIHW.

### **Diagnosis Related Group**

Eighty-one per cent of respondents rated this data element as either important (19%) or highly important (63%), and 75% rated it as either useful (13%) or highly useful (63%). Only 6% did not think the data element was important and 13% not useful. Another 13% were unsure of its importance and usefulness.

No comments were received on this data element.

### **Principal diagnosis**

Ninety-four per cent of respondents rated this data element as either important (6%) or highly important (88%), and 94% rated it as either useful (13%) or highly useful (81%). Another 6% were unsure of its importance and usefulness.

There were no detailed comments received on this data element.

### **Major Diagnostic Category**

Ninety-four per cent of respondents rated this data element as either important (38%) or highly important (56%), and 88% rated it as either useful (38%) or highly useful (50%). Another 6% were unsure of its importance and 13% of its usefulness.

No comments were received on this data element.

## **Continuity of care data elements**

The group of data elements that relate to continuity of care are those relating to care prior to admission: *Previous specialised treatment*, *Source of referral to public psychiatric hospital*, *Type of accommodation* and *Type of usual accommodation*; and those relating to care following separation: *Mode of separation* and *Referral to further care*.

### **Previous specialised treatment**

Only 44% of respondents rated this data element as either important (13%) or highly important (31%), and only 50% rated it as either useful (13%) or highly useful (38%).

Nineteen per cent did not think the data element was important and 13% not useful. Another 38% were unsure of its importance and usefulness.

The original purpose of this data element for the NMDS was to assess continuity of care, that is, whether a patient has received similar treatment in the past or is known to the health service, or has been admitted for specialised mental health care for the first time.

Several respondents were unsure as to how well the data element is being collected or how often it is being used.

It was commented that since its introduction, this item has had little attention in terms of analysis and reporting. However, its importance has increased as it is fundamental to the 'New Client Index' indicator included in the recently agreed the recently agreed *Key Performance Indicators for Australian Public Mental Health Services* (DoHA 2005). A new patient is thought to be more resource-intensive than patients who have previously received admitted care, community care or both.

It was suggested that the definition and data domain for this data element require review to make clear that specialised mental health service contacts are included in scope. It was stated that staff don't understand 'service contact' as a concept and it is difficult for them to explain this concept to a mental health patient. More explanation may be required in the guide for use.

The *Mental health service contact* data element concept was endorsed by the National Health Information Group in December 2004 for inclusion in the NMDS for Community Mental Health Care from 1 July. This new data element concept replaced the previous *Service contact* data element concept and provided clarification of the definition, context and guide for use to improve consistency in data collected across states and territories and more accurately reflect clinical practice. Hence, the *Previous specialised treatment* data element should be revised to reflect that new data element.

The question of 'how recent is relevant' was raised. At present, the guide for use refers to previous hospital admission(s) and/or service contact(s) at any time in the past. It was suggested that this data element should have further definition of periodicity to improve its usefulness. Its appropriateness should also be reviewed, given that it is currently described generically rather than being specific to mental health care, and this review should consider whether it or a new data element is required to capture the intent of the 'New Client Index' indicator.

### **Source of referral to public psychiatric hospital**

Seventy-five per cent of respondents rated this data element as either important (33%) or highly important (33%), and 75% rated it as either useful (40%) or highly useful (27%). Seven per cent did not think the data element was important or useful. Another 27% were unsure of its importance and usefulness.

Comments included that the value of this data element is limited due to its restriction to public psychiatric hospitals, and also that it is unlikely that redefinition of the data element to meet the generic needs of the overall admitted patient collection will provide reliable and useful data. It should therefore be removed from the NMDS. However, it was recommended in the evaluation of the APC NMDS that the

feasibility of expanding this data element for collection in all public hospitals is investigated.

It was also suggested to combine *Source of referral to public psychiatric hospital* with *Mode of admission*. Some respondents commented that work on the data domain is needed. One suggestion was that the data domain should include 'Other public hospital', and perhaps 'Residential aged care facility'. 'Other health care establishment' is quite vague and it is probably better to be specific rather than general.

New South Wales commented that they cannot apply one classification to public psychiatric hospitals and another to other public hospitals as they share the same patient administration system.

### **Type of accommodation**

Sixty-nine per cent of respondents rated this data element as either important (38%) or highly important (31%), and 56% rated it as either useful (38%) or highly useful (19%). Thirteen per cent rated it as not important and 19% as not useful. Another 19% were unsure of its importance and 25% of its usefulness.

Similar to the employment status data elements, several respondents indicated concern over the existence of two separate data elements collecting information on accommodation status. A number of respondents suggested merging *Type of accommodation* with *Type of usual accommodation*. There was also support for using the data domain from *Type of accommodation* for the new merged data element, as it is the most useable.

It was commented that the continuing prominence of accommodation issues in mental health highlight the importance of retaining such an item in the NMDS. There are links with the issue of 'extended stay' patients (see below) and the availability of housing after separation from hospital. However, limited analysis of these data elements has been reported, making it difficult to comment on data quality.

Comments included that it was difficult to see the relevance of collecting information on accommodation status in a patient administration system. It may more logically sit with information held by a social worker, who works with the patient for transition back to the community and assesses the appropriateness of their accommodation. For this reason, the item may be better collected in a small sample survey or in an in-depth study over a short period of time, rather than for every separation.

Some noted that information on *Type of accommodation* and *Type of usual accommodation* was considered important to collect for use as a correlate for a range of other data elements and development of socioeconomic profiles of 'at risk' groups.

As with the employment status data elements and *Marital status*, a first step is to decide why accommodation data are collected in the NMDS. Once the purpose is clarified, the definition and data domains will require further work. Possible purposes include to measure post-discharge continuity of care, and access carer availability, develop socioeconomic profiles of at-risk groups, or to assess quality of care across the health care system.

The AIHW is currently undertaking data development work to capture information about 'extended stay' patients (that is, patients who had an extended stay in hospital after being ready for discharge), and the results may inform this work.

### **Type of usual accommodation**

Only 56% of respondents who provided a rating for the importance of this data element rated it as either important (31%) or highly important (25%), and only 44% rated it as either useful (25%) or highly useful (19%). Twenty-five per cent rated it as not important and not useful. A further 19% were unsure about its importance and 31% about its usefulness.

See previous data element for detailed comments.

### **Mode of separation**

Ninety-four per cent of respondents rated this data element as either important (63%) or highly important (31%), and 88% rated it as either useful (63%) or highly useful (25%). Another 6% were unsure of its importance and 13% of its usefulness.

It was noted that this data element is currently a combination of non-mutually exclusive codes that describe patient destination or patient status. Consideration should be given to *Referral to further care* during any development of *Mode of separation* to ensure the data elements can be used together (that is, compatibility between codes, definitions and guides for use).

Work is continuing by the AIHW to refine this data element. The proposed approach involves separating the mode and destination.

### **Referral to further care (psychiatric patients)**

Seventy-five per cent of respondents rated this data element as either important (25%) or highly important (50%), and 63% rated it as either useful (25%) or highly useful (38%). Six per cent did not think the data element was important or useful. Another 19% were unsure of its importance and 31% of its usefulness.

It was commented that this data element, developed in 1989, has the important objective of gathering information about post-discharge continuity of care and referral pathways, but has not been subject to a detailed analysis. Comments also included that the data domain is outdated and requires review.

Respondents also commented that a patient may be referred to several different services after separation. Acknowledgment of this is required in the data element, along with rules clarifying what should take precedence if multiple referrals occur.

It was also suggested that the data domains covering both mental health and drug and alcohol facilities should be split. These can be quite different services, and the category label is far too long to display in a drop-down menu in a patient administration system. It was noted that there is sometimes confusion at the point of collection between *Referral to further care (psychiatric patients)* and *Source of referral to public psychiatric hospital*.

Respondents also commented on the overlap between *Referral to further care (psychiatric patients)* and *Mode of separation*. For example, discharge/transfers to acute hospitals are collected in both data elements. This needs to be considered in any redevelopment so as to not duplicate what is being collected between two data items.

## **Administrative data elements**

### **Mental health legal status**

Eighty-eight per cent of respondents rated this data element as either important (19%) or highly important (69%), and 81% rated it as either useful (19%) or highly useful (63%). Six per cent did not think the data element was important and 13% not useful. Another 6% were unsure of its importance and usefulness.

New South Wales commented that patients can be involuntary and not admitted to designated psychiatric units because there are more patients than designated beds. They suggested that consideration should be given to whether this data element should be included in the APMHC NMDS or the APC NMDS, where it would be used to identify involuntary patients who are not receiving specialised psychiatric care.

For the APC NMDS data for 2002-03, South Australia reported 2,123 separations in the public sector with a *Mental health legal status* of involuntary and no psychiatric care days.

The recommendation arising from the evaluation of the APC NMDS was that *Mental health legal status* be deleted from the APC NMDS and retained in the APMHC NMDS. A reversal of this recommendation may need to be considered.

### **Person identifier**

Seventy-five per cent of respondents rated this data element as either important (13%) or highly important (63%), and 69% rated it as either useful (25%) or highly useful (44%). Nineteen per cent did not think the data element was important or useful. Another 6% were unsure of its importance and 13% of its usefulness.

It was noted that *Person identifier* is only useful in longitudinal studies, and then only within the context of the treatment provided at a single hospital (except if a single jurisdiction-wide patient identifier is introduced).

It was commented that lack of compliance by several jurisdictions limits the utility of this key item and that this should be given prominence in this evaluation. It has been expected that, for public specialised mental health services, *Person identifiers* would correspond with clients of area-based specialised mental health services that integrate admitted, ambulatory and residential care.

It is anticipated that this data element will be useful for data linkage across the NHMD, the National Community Mental Health Care Database, the National Residential Mental Health Care Database and the National Outcomes and Casemix Collection Database, to assess service utilisation and outcomes for mental health

patients. The extent to which *Person identifiers* match across these data collections requires investigation.

For more information on this data element as provided for 2002–03, see page 81.

## Data element concepts

### Acute care episode for admitted patient

Seventy-five per cent of respondents rated this data element concept as either important (25%) or highly important (50%), and 63% rated it as either useful (31%) or highly useful (31%). Thirteen per cent did not think the data element concept was important and 19% not useful. Another 13% were unsure of its importance and 19% of its usefulness.

Several respondents suggested that this data element concept is covered by *Care type* and should be deleted. The recommendation arising from the evaluation of the APC NMDS was that this data element concept be reconsidered with *Care type*. Data development work on *Care type* is currently being undertaken as part of the APC NMDS data development work program.

### Admission

Seventy-five per cent of respondents rated this data element concept as either important (19%) or highly important (56%), and 69% rated it as either useful (19%) or highly useful (50%). Only 6% did not think the data element concept was important or useful. Another 19% were unsure of its importance and 25% of its usefulness.

Respondents indicated general concern about this data element concept. They acknowledged its importance but agreed that work needs to be done on the distinction between 'admitted' and 'non-admitted', and that rules need to be standardised and applied consistently across Australia for data comparisons to have real meaning.

The DoHA noted that the admission concept is critical but, as currently defined, only recognises admitted patient care. They commented that, within the mental health sector, 'admission' to non-admitted patient care (that is, commencement of an episode of non-admitted patient care) is substantially more frequent and needs to be incorporated in future revisions of the NHDD. The DoHA suggested that this data element concept be retitled 'Admission to Admitted Patient Care', to be consistent with the recent revision of the *Episode of care* data element concept.

The DoHA discussed the inclusion of same-day admissions within the admitted patient data and the particular problem this creates for the mental health field. They commented that same-day separations usually have a different meaning in mental health than in general health. In the latter case, there are procedural events associated with such admissions which are detailed in the data element *Same-day patient*. Based on those criteria, the DoHA noted that most same-day admissions in mental health do not meet the definition of a same-day patient.

The DoHA noted that many same-day separations are better considered as a series of treatment events occurring during a period of ambulatory care. Typically, they involve daily attendance by patients at a variety of day and group-based programs that could otherwise be provided in community settings. The continued inclusion of same-day patients within the admitted patient mental health data may misrepresent the nature of the care actually involved.

This issue has been acknowledged in the AIHW report *Mental Health Services in Australia 2001–02* (AIHW 2004b) where same-day separations considered to be ambulatory-equivalent care were reported separately for the first time. The DoHA commented that this new approach to reporting is a major advance over previous reports but it needs to be recognised that such approaches do not deal with the fundamental problem.

The solution offered by the DoHA to the problem of same-day patients in the mental health data is twofold:

1. Better definition and agreement within the mental health service industry regarding the events that should be classed as genuine same-day separations
2. A clear distinction between intended same-day patients from those who were discharged on the same day when the original intent was an overnight admission. The introduction in 2001 of the data element *Intended length of hospital stay* within the APC NMDS provided the potential for this, but full compliance has not been reached. Work needs to be done to promote the full implementation of this data element by the mental health sector.

The DoHA commented that *Intended length of hospital stay* was recommended for removal from the APC NMDS following the 2004 evaluation, pending consultation with the mental health sector. The DoHA recommended that, although the data element has had poor compliance to date, it is retained as it provides the means to address problems that arise for the sector as a result of the inclusion of same-day patients within the admitted patient collection.

The AIHW suggested that same-day separations considered to be ambulatory-equivalent care continue to be reported separately in the *Mental Health Services in Australia* reports.

The AIHW notes that variations in admission practices affect other types of health care and not just mental health. For example, chemotherapy is undertaken on an admitted basis in some state and territories and on a non-admitted basis in others. It is currently undertaking work for the HDSC to document admission practices and policies comprehensively and to propose greater standardisation.

It was noted that in the context of a co-located specialist mental health acute care admitted patient unit/ward, admission may frequently be via other, general wards. The definition may need to include a concept of an 'administrative' admission due to action to transfer patients between wards/units within multi-unit facilities. However, this could also be addressed through consideration of the types of triggers used for statistical separation, and in the related consideration of the *Care type* data element.

The recommendation arising from the evaluation of the APC NMDS in relation to mental health-related care was that some types of mental health admitted patient care be regarded as non-admitted, particularly non-procedural same-day admissions that had not been intended to be overnight admissions. It was suggested that the issue be resolved through revision of the data element concept, or the use of a data analysis solution.

### **Admitted patient**

Eighty-one per cent of respondents rated this data element concept as either important (13%) or highly important (69%), and 75% rated it as either useful (19%) or highly useful (56%). Only 6% did not think the data element concept was important or useful. Another 13% were unsure of its importance and 19% of its usefulness.

Similar to the comments for *Admission*, it was suggested that one of the major areas of work required for the NMDS is to define more consistently and accurately the boundaries between admitted overnight, same-day and non-admitted care, including in relation to hospital-in-the-home care.

It was suggested that within the mental health sector, patients treated in the home environment are best not described as 'admitted patients' as currently defined, as they may fall within the category of ambulatory care.

The DoHA suggested that this element be retitled 'Admitted Hospital Patient', reflecting the use of the term 'admission' for non-admitted care in the mental health sector.

### **Episode of admitted patient care**

Seventy-five per cent of respondents rated this data element concept as either important (13%) or highly important (63%), and 75% rated it as either useful (13%) or highly useful (63%). Another 25% were unsure of its importance and usefulness.

The DoHA noted that the concept *Episode of care* was recently redefined as *Episode of admitted patient care* to accommodate other episode types, for example, episodes of residential care. They acknowledged this to be a positive development and consistent with recommendations submitted by the National Mental Health Working Group's Information Strategy Committee to the evaluation of the APC NMDS.

The DoHA commented that improvement in the utility of *Episode of admitted patient care* will rest upon redefining the *Care type* definition, given that, under current arrangements, a change of care type precipitates a new episode.

The recommendation arising from the evaluation of the APC NMDS was that the concept of an episode of care be reviewed along with the data element *Care type*.

It was also recommended that consideration be given to amending the APC NMDS data collection arrangements to change the statistical unit for longer term care, for selected analysis applications. This 'long stay' issue derives from the separation-based definition of the NMDS. A significant proportion of patient care in designated mental health units (and for extended stay or nursing home type patients) is longer term care which remains invisible to the current NMDS approach. Acknowledging

that the scope would be difficult to define in many cases, it was suggested that the concept of a 'statistical separation' should be extended to accommodate these groups of patients whereby a NMDS record of the ordinary kind is generated, but is separately identified. This approach has recently been adopted for the Residential Health Care National Minimum Data Set.

## **Hospital**

Seventy-five per cent of respondents rated this data element concept as either important (25%) or highly important (50%), and 69% rated it as either useful (25%) or highly useful (44%). Another 25% were unsure of its importance and 31% of its usefulness.

It was noted that the concept of a 'hospital' is continually changing in reality, as new methods of service delivery emerge.

The DoHA commented that the current definition, by its acceptance of multi-campus reporting under a single hospital, allows considerable imprecision in identifying specific hospitals. It is inconsistent with the approach taken to hospital reporting under the National Survey of Mental Health Services, where separate campuses are reported as discrete hospital entities. Additionally, the current approach allows public psychiatric hospitals managed by 'parent' public acute hospital to be reported as part of the public acute hospital.

See comments under *Establishment identifier* above.

Work to develop *Establishment type* is continuing by the HDSC and with the APC NMDS data development work program of the AIHW.

## **Patient**

Seventy-five per cent of respondents rated this data element concept as either important (19%) or highly important (56%), and 75% rated it as either useful (25%) or highly useful (50%). Another 25% were unsure of its importance and usefulness.

It was commented that boarders should be separately classified from patients in the NMDS. The issue of clarifying the scope of the APC NMDS in relation to boarders was also raised in the evaluation of the APC NMDS.

## **Separation**

Eighty-one per cent of respondents rated this data element concept as either important (19%) or highly important (63%), and 81% rated it as either useful (13%) or highly useful (69%). Another 19% were unsure of its importance and usefulness.

No comments were received on this data element concept.

See comments under *Episode of admitted patient care* above.

## Proposed new data elements

There were some concerns raised by respondents about the idea of introducing new data elements (or modifying existing data elements) into the NMDS. A business case is required for changes to NMDSs.

Despite the concerns raised by a number of respondents, a number of new data elements (or suites of data elements) were suggested.

### Consultation–liaison

Some respondents suggested the need for information on consultation–liaison services provided, for example, to people with psychiatric comorbidity and physical disorders.

### Language spoken and Need for an interpreter

It was suggested that it would be useful to have data elements to capture language spoken at home/preferred language and the need for an interpreter. The need for an interpreter could be organised with the categories ‘no’, ‘occasionally’, ‘usually’, ‘always’; or ‘no’, ‘for complex information’, ‘for most communication’ and ‘for all communication’ (rather than yes/no).

It was indicated that such items would be valuable in analysing the resources required to deliver mental health services within a multicultural environment, and to assess the effectiveness of mental health services in delivering care within this environment. Information on need for interpreters was noted as also relating to access to services. It was also considered useful to have information on whether an interpreter was used. The broader issue of cultural and linguistic diversity is discussed on page 104 under *Country of birth*.

### Carer availability

It was suggested that a data element for carer availability could allow the analysis of carer availability in relation to discharge destination and length of stay. It would provide information on the level of support available to the patient when leaving hospital. This item could be considered together with other relevant data elements such as *Marital status* and *Type of accommodation*.

### Procedure

This data element is currently being collected for the APC NMDS and recommended for inclusion in the APMHC NMDS, if the latter continues to be defined to overlap with the APC NMDS.

See also ‘Intervention classification for mental health’, page 13.