Outcome completion: how to make yours better

The purpose of this document is twofold. Firstly to communicate or explain the factors that influence completion within the revised outcomes completion report: the report was revised in April 2015 to better reflect the Information Collection Protocol (ICP). Secondly, the document can be used as a summary of the data conditions used to include or exclude episodes from completion reports. These data conditions will aid users to better understand their outcomes completion and can be used as a checklist against local data. This document can also be useful if used alongside unit record audit data available from the Ministry of Health on request.

The meaning of terms used throughout the report can be found within the definitions section.

Summary of revisions

The new specification uses a different approach to building episodes. Specifically:

- connecting community referrals that overlap
- connecting inpatient referrals that overlap.

It also addresses a set of issues with the last report:

Issue	Change
• **Concerns over the definition of overlapping referrals.**	Referrals that are open at the same time, or referrals with one day between them, are now counted as one episode.
• **Invalid outcome collections are counted in completion.**	Invalid collections are now not included (except where the Reason for Collection code is 9, 10 or 11 as it is acceptable for these collections to be incomplete).
• **Community admissions included those service users that were admitted straight into an inpatient setting.**	Community admission episodes are not counted if there was a readmission into an inpatient setting within 24 hours.
• **Community referrals that only contained one or two in scope activities were counted in the discharge tables.**	Community episodes containing less than three in scope activities are now excluded.
• **Discharge was counted as at referral end date.**	Discharge is now counted as at the last in scope activity within the episode.

The report comprises of three tables on overall completion, admission completion and discharge completion. Here are the details of each of the data conditions for each table.

Overall completion – Percentage of service users with at least one outcome collection

- Outcome collection must be valid.
- Must have an outcome collection in the three months reporting period for a service user that has an in scope activity in the reporting period.

Admission completion – Percentage of admissions in the period with an admission outcome collection completed

- Outcome collection must be valid.
- Must be an admission or assessment only collection instead of another reason for the collection.
- An outcome collection is required for inpatients within one day of the first in scope activity start date for the episode. For community, this collection occasion date must be 14 days following the first in scope activity start date for the episode.
- Community admission is excluded if there is a readmission into an inpatient setting within 24 hours. For example exclude the episode if there is an in scope activity in an inpatient setting within 24 hours of the first in scope activity start date in a community setting.
- An outcome collection date cannot be before the first in scope activity date.
- The first in scope activity must be in the three month reporting period under analysis.

Discharge completion – Percentage of discharges in the period with a discharge outcome collection completed

- Outcome collection must be valid.
- Must be a discharge collection instead of another reason for the collection.
- An outcome collection is required for inpatients within three days before or after the last in scope activity end date for the episode. Similarly, for community episodes, this collection date must be within 14 days before or after the last in scope activity end date for the episode.
- Community episodes need to include three or more in scope activities (these activities do not need to be within the reporting period).
- The last in scope activity needs to be within the three month reporting period.
- A discharge collection is not required when the referral end code is RI, RO, UN, DD, or ID.

Other issues that affect completion

- Service users who do not receive a full assessment but are being seen for triage and/or screening to see if eligible for services. T46 – triage and/or screening activity is excluded from in scope activity. Therefore no collection is required. If completing a full clinical assessment T46 should not be used. Note: in admission completion, as stated above, if the outcome collection date is before the in scope activity date, the collection will not be counted.

Definitions

Age limits – Age needs to be greater than, or equal to, four.

Episode – Connecting overlapping referrals make an episode. For example see overlapping referrals below.

In scope activity – Activity type code *not equal to* T08, T32, T33, T35, T37, T46, T47, T49, T50, TCR and Activity setting code *not equal to* WR, PH, SM, OM.

Overlapping referrals – Referrals from the same setting that are open at the same time or referrals with one day between them. For example if the second referral start date is less than or equal to one day after the first referral end date or the first referral end date time is null. All referrals that contain an in scope activity within six months before start of reporting period and six months after end of reporting period are included.

Reporting period – the three month period of the report.

Setting – Referrals are grouped into inpatient setting or a community setting. Inpatient setting: Team setting=I, Community setting: Team setting *not equal to* I.

Teams in scope – Referral was to a team type *not equal to* 03, 11, 17, 24, 26. Excludes: alcohol and drug team; co-existing problems team; need assessment and service coordination team; primary health service, intellectual disability.

Valid outcome collection – HoNOS, HoNOS65+, HoNOSCA, and HoNOS LD: A valid collection has two or fewer items unknown or missing. HoNOS secure: a valid collection has one or fewer missing items for first twelve items and one or fewer missing items for the secure items. For all tool types, collections where the reason for collection code is RC09, RC10, and RC11 (Discharge – lost to care, deceased, brief episode of care) the collection can be invalid as no outcome measure can be collected.