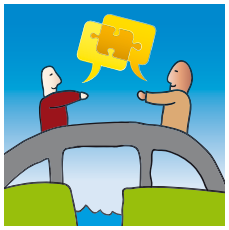
Outcome measurement in mental health services Frequently asked questions – some sticky points

Factsheet 4

Acronyms and initialisms used in this document

AMHS	area mental health service
APATT	aged persons assessment and treatment team
BASIS-32®	Behaviour and Symptom Identification Scale
CATT	crisis and assessment team
CCT	continuing care team
CCU	continuing care unit
CMI	client management interface
CTO	community treatment order
ECT	electroconvulsive therapy
FOC	focus of care
GP	general practitioner
HoNOS	Health of the Nation Outcome Scale
HoNOSCA	Health of the Nation Outcome Scale Child and Adolescents
HoNOS65+	Health of the Nation Outcome Scale 65+
HOPS	homeless outreach psychiatric services
IPU	inpatient psychiatric unit
LOS	length of stay
LSP-16	Life Skills Profile-16
MST	mobile support team
NOCC	National Outcomes and Casemix Collection
OM	outcome measurement
PARC	prevention and recovery centres
SDQ	Strengths and Difficulties Questionnaire



1. General issues

1.1 How do I rate items such as problems with drinking/drug taking and living conditions for consumers in an inpatient unit?

The HoNOS rating period is the two weeks prior to admission to an inpatient unit and the three days prior to discharge from an inpatient unit (provided the length of stay is longer than 72 hours). It is important to rate according to the glossary for the rating period. It is **inappropriate** to rate according to the environment or condition the consumer is returning to.

It is likely that for some consumers the inpatient environment and factors would mean that the ratings would be uncharacteristically low compared with when they are in the community. Therefore, it is imperative that the outcome measures are considered with all available information.

1.2 What are the implications for teams that see people from across the age ranges (child and adolescent, adult, aged)?

Training – Some services, such as CATT and PMHEI teams, work with consumers of all ages. It is expected that clinicians in these teams be trained to use all suites of measures.

Collection complexities – ORYGEN Youth Health (OYH), Youth Early Psychosis (YEP) and PMHEI provide targeted age appropriate services and, rather than arbitrarily defining all OYP, YEP and PMHEI consumers as adults for OM, it was decided that for consumers accessing these specific programs that the CAMHS measures would be used until the consumer turns 18 then the adult measures would be collected.

However, there is some flexibility and discretion to accommodate clinical judgement; for example, a 17-year-old may have the adult measures used provided they are assigned to the adult OM setting. The correct OM setting is required for subcentres to ensure that the CMI can automate the appropriate suite of measures.

State Government Victoria

However, there are a small number of consumers who access services outside of their age range, for example, a 16-year-old admitted to an adult acute inpatient unit. In order for the collection of measures to not be overly complicated and burdensome for these consumers the decision was made that the setting rule (dictating that in this instance the adult NOCC measures be used) would stand.

Subcentre set up – To manage the age split requirements in CMI for outcome measurement, separate subcentres are required where services are provided across the age boundary (CAMHS – adult, Adult – older person). This most heavily affects OYH, YEP and PMHEI.

1.3 When and how should a consumer's mental health legal status be recorded for OM purposes?

The NOCC protocol makes clear that the purpose of collecting a consumer's mental health legal status is to ascertain whether 'the person was treated on an involuntary basis under the relevant State or Territory mental health legislation, at some point during the period preceding the [OM] collection occasion'. In order to minimise data entry, there is no need to enter a consumer's legal status each time an OM rating is made.

A certain amount of additional information is required in order to interpret OM data. This contextual information includes the FOC as well as the consumer's principal and additional diagnosis and their mental health legal status. However, when analysing OM data, that information can be derived from other modules of CMI, linking each OM data collection occasion with the consumer's legal status during the episode covered by the OM rating. This means that there is no need to change your current practice in this area.

1.4 For the occasional consumer who has refused to engage with us for two or three months before we finally agree to discharge them – what 'discharge' OM is expected?

It is appreciated that the practice of collecting 'discharge' OM for consumers who are not accessible is difficult. The measures referenced here are for an adult consumer in a community team.

All consumers who are in an open case and who have had 'admission/intake' outcome measures completed require 'discharge' outcome measures, except inpatients with a length of stay less than 72 hours. Which outcome measures are required will depend on the setting (**inpatient**, **ambulatory** or **community residential**) and the age of the consumer (child and adolescent, adult, aged).

The decision to discharge a consumer from a service should be a clinical decision and, where possible, done following a face-to-face assessment. However, the decision may well be made on the basis of second- or third-hand information, for example, communication with a GP, family member or partner. Therefore, the clinician-rated 'discharge' OM can be completed on all available information sources. As a general rule, there should be no missing data; however, if it is not possible to make an informed estimate of the severity of an item there is capacity to enter a rating of 9 (for HoNOS or LSP-16). It is important to remember that ratings of 9 are treated as if they were zeroes (no problems) when total scores are calculated. The FOC requires the clinician to make a judgment about the primary goal of care by identifying which of one of four types of care focus best describes the care provided to their consumer over the recent period – acute, functional gain, intensive extended or maintenance. For all clinician-rated measures, clinicians need to refer to the individual measure rating guidelines.

In addition to the clinician measures, clinicians are also required to offer the consumer self-rating measure at 'discharge' and consumers have the option to complete it or not. Recognising that offering is not always appropriate there are both temporary contraindications and general exclusion criteria.

1.5 Isn't the FOC rated more frequently in Victoria than is required by the NOCC protocol?

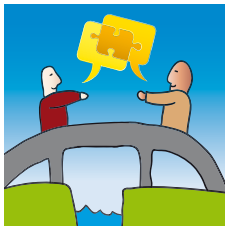
Yes. In a minor change to the protocol Victoria requires that the FOC also be rated at 'review' in **inpatient** and community residential settings for adults and in **inpatient** settings for aged persons. The effect of these changes is to simplify the protocol and training, as the FOC is rated at 'review' and 'discharge' in all adult and aged persons mental health services. As the FOC is a single-item tick box, the impact of this change is minimal. The Overview of Suites and Data Collection Occasions – *Overview of data collection occasions for each measure (July 2007), Appendix 2 (PDF file 269KB)* has been updated to reflect these changes.

1.6 How strict is the interpretation of a two-week rating period for the HoNOS?

The ratings from any measure are only as good as the rating rules applied. In this case, it is rating according to the glossary as well as the rating period. The HoNOS is a psychometrically tested instrument and the point of using standardised measures is to enable consistency and comparison. So, the rating period needs to be strictly interpreted!

1.7 What suites of measures are required with the following setting changes?

Requirements if:	OM required:
Ambulatory consumer is admitted to an **acute inpatient** unit	**Ambulatory** 'discharge' OM *and* **inpatient** 'admission' OM
Ambulatory consumer is admitted to a **community residential** unit	**Ambulatory** 'discharge' OM *and* **community residential** 'admission' OM
Consumer is discharged from an **inpatient** unit to return to an **ambulatory** team	**Inpatient** 'discharge' OM *and* **ambulatory** 'intake' OM
Consumer is discharged from an **inpatient** unit and admitted to a **community residential** unit	**Inpatient** 'discharge' OM *and* **community residential** 'admission' OM
Consumer is discharged from a **community residential** unit and admitted to an **inpatient** unit	**Community residential** 'discharge' OM *and* **inpatient** 'admission' OM
Consumer is discharged from a **community residential** unit and returns to an **ambulatory** team	**Community residential** 'discharge' OM *and* **ambulatory** 'intake' OM
Consumer is discharged from a service (and has no further service setting involvement)	**Inpatient, community residential** or **ambulatory** 'discharge' OM (from either, as appropriate)
PMHEI or youth services **ambulatory** consumer turns 18 during their period of care	At next review: CAMHS **ambulatory** 'discharge' OM *and* adult **ambulatory** 'intake' OM
PMHEI **ambulatory** consumer turns 65 during their period of care	At next review: Adult **ambulatory** 'discharge' OM *and* aged **ambulatory** 'intake' OM
Existing **ambulatory** consumer ceases case management and is referred to the clozapine coordinator	**Ambulatory** 'discharge' OM



2. Common scenarios

A range of common scenarios (as they apply in Victoria) are available separately (Scenario 1 – New CAMHS consumer, Scenario 2 – New child (multiple teams), Scenario 3 – Youth consumer (youth service, turns 18), Scenario 4 – New adult consumer, Scenario 5 – Existing adult consumer, Scenario 6 – Aged consumer). See *Victorian specific scenarios PDF*.

2.1 When a current community-case-managed consumer gets admitted, why do we have to collect measures for the two settings at the same time?

The common suggestion is we should just copy these ratings, rather than filling in two different forms for the same measure on the same date. There are some very practical issues with adopting this approach:

- Often the staff involved are different (inpatient staff and community staff).
- The quality of the assessment, relationship with the consumer and capacity to elicit information will have an impact on the ratings, that is, it would be likely that a case manager who knows a consumer would gather more information and possibly rate higher.
- The rating timeframes vary for the HoNOS/CA/65+ on discharge from inpatient (previous three days) and intake to community/admission to community residential (previous two weeks).

Therefore as a rule, when there is a change in setting this usually indicates an increase or decrease in treatment intensity and a vital point for collection. It is appropriate for the admitting clinician to review the discharge ratings (if available) and consider if these are still current. But, by nature of reviewing these (and hopefully also considering additional sources of information/collateral), the clinician has made a judgement and so it is not straight copying of the ratings.

The *Outcome measurement program management circular (07/2007)* reinforces that 'the Department of Human Services does not support the practice of *deeming* and will not support CMI changes to facilitate this. Deeming refers to the practice of entering the same rating twice for contiguous episodes, for example the discharge HoNOS from an **inpatient** unit cannot also be entered as the 'intake' HoNOS to an **ambulatory** setting.'

The only exception

This would be when an existing community consumer is admitted to a PARC service because more often than not the same case manager would be responsible for:

- completing the discharge from ambulatory
- completing the admission to inpatient
- their care while in PARC.

Provided that there was some way of identifying on the form that this was both a discharge from ambulatory and an admission to inpatient (PARC only), then copying these ratings would be acceptable. It would, however, be **unacceptable** for the same process to be used on discharge from inpatient (PARC only) as the rating time periods vary.

2.2 So if the OM program management circular outlines the 'what and when' how do we determine the 'who' for teams like CATT?

It is complicated because a high number of the consumers seen by CATT are existing ambulatory consumers and so a change in setting requirement is not triggered. However, CATT as a general rule are in-scope, that is, they form a treatment and intervention function within the ambulatory setting.

If the consumer is an existing ambulatory consumer then there is no change in setting and no OM required, unless the consumer is admitted into the inpatient unit. Determining who completes the OM in this instance (the ongoing case manager or the CATT clinician) needs to be resolved locally. How the episodes are created in CMI will determine who the automated tasks are attributed to.

If the consumer is not an existing consumer a decision to collect should be based on a decision to undertake treatment or interventions. That is, while there is no provision within the current collection protocol for short-stay ambulatory consumers, assessment-only consumers are excluded, thereby making a component of CATT activity out of scope. **This is a clinical decision and cannot be narrowly defined as 'x' number of visits.**

2.3 With the establishment of the Mental Health and Drug Division, the alcohol and other drug (AOD) sector have been asking: *What is the plan for outcome measurement in AOD?*

Victoria has implemented the nationally mandated suite of outcome measures NOCC in clinical mental health services. While this focus is on clinical services and there is no capacity within our existing agreements with the Commonwealth to develop additional measures for alcohol and drugs or PDRSS, we have explored ways to enhance the use of the measures already collected in clinical services with PDRSS staff for consumers accessing both services.

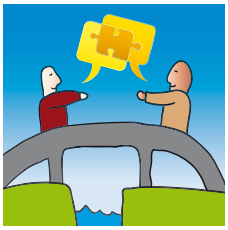
In relation to questions regarding the usefulness of measuring changes in mental health consumers' co-occurring substance use disorders, it would be difficult to say conclusively but if the glossaries and rating guidelines were being used (clinician measures) there is a very good chance of capturing the impact of the co-occurring disorder. For example, HoNOS items:

- (1) overactive, aggressive, disruptive or agitated behaviour
- (3) problem drinking or drug-taking
- (4) cognitive problems (so long as not temporary or transient)
- (5) physical illness or disability problems
- (9) problems with relationships
- (10) problems with activities of daily living
- possibly items (11) and (12).

In relation to corresponding activity for suites of measures for AOD clinicians and services to measure mental health status, it is worth considering the lessons learnt with implementing the NOCC protocol in clinical mental health services:

- It had a significant gestation period (health ministers signed it off in 1992 and implemented it in 2003) not least of which was because the measures needed to be identified then trialled and endorsed as well as developing a collection protocol and a building data system to record the measures.
- We have a target of 85 per cent compliance with the NOCC protocol and, for a number of services (especially ambulatory), there is a long way to go to reach this target.
- The information system needs to be able to support the collection of measures, including the capacity to provide useful, relevant and timely reports (individual and aggregate).
- There are significant workforce development and training requirements.
- There is the ongoing tension and challenge between a focus on compliance (getting the data in) and on clinical utility (using the measures in clinical practice).
- There is the challenge of engaging consumers in the agenda (all states and territories have very low completion rates of the consumer self-assessment measure).

In recognition of these challenges there has been considerable financial investment, predominately from the Commonwealth Government, to progress this initiative. All of the above would need to be considered to inform any activity in the AOD sector.



3. Specific issues

3.1 CCU consumers attending for ECT are separated and readmitted on CMI, despite it being of only some hours' duration. Are 'discharge' and 'admission/intake' OM required?

CMI coordinators have directed services to not close residential episodes for consumers having same-day ECT. This would mean that services would not record the ECT same-day procedure in the CMI for residential consumers; however, this data can be collected on the local CMI. As there has been no episode end, an OM does not need to be collected.

3.2 Are we required to complete 'discharge' measures for an adult consumer who dies while receiving acute inpatient treatment?

The trauma and distress associated with a consumer death on an inpatient unit cannot be overlooked and as such we would not expect the discharge measures to be completed.

Given that death in an inpatient unit is not a common event, and recording of death in CMI is sometimes delayed while waiting for root cause analysis to occur and paperwork for the Chief Psychiatrist, our recommendation is for administrative staff to enter 9's for all of the items.

This will mean that:

- compliance is not adversely effected
- the measure is invalid and therefore discarded from any analysis.

3.3 For consumers who are on a leave of absence from the acute IPU and go on leave under a restricted CTO, they remain registered to the IPU on the CMI, however, are clinically reviewed/managed by the MST. What should occur for OM?

If they have short periods of leave (less than 7 days) the episode for the IPU remains open with no need for OM collection. If MST are following these consumers up while they are out, the MST can record them as contacts; however, they should not create the episode unless they are intending to maintain follow-up after they are discharged. Once the consumer is discharged from the IPU then OM are required. If the MST team has created an episode or the consumers are already within an **ambulatory** episode then OM will need to be done by the **ambulatory** team responsible (depending on local business rules) once the consumer is discharged from the IPU.

3.4 What are the OM requirements for clozapine-only consumers who are discharged from CCT and reviewed only by their GP but remain registered with an AMHS for review by a clozapine coordinator?

Consumers of a clozapine program who are not receiving case management are 'out of scope' for OM. The frequency of their contact with the clozapine coordinator is determined by their progress. To ensure that clozapine-only consumers are excluded from protocol requirements and subsequent OM compliance reports, they must be allocated to the local clozapine subcentre.

If an existing **ambulatory** consumer (CATT, MST or CCT) was transferred to the clozapine coordinator with no further **ambulatory** case management, 'discharge' **ambulatory** OM would be required. This is provided that:

- the clozapine subcentre has the OM setting 'adult not applicable'
- the consumer is registered against the clozapine subcentre.

However, if a consumer in an open case continues to receive case management follow-up in addition to contact with the clozapine coordinator then the relevant **ambulatory** team responsible for managing the consumer will continue as per protocol. 'Who' completes the relevant OM is determined by local business rules.

As a result of the 2007 CMI release, services can utilise the screening registration rather than episode creation for clozapine-only consumers.

3.5 Which measures are completed when a person aged 60 is admitted to an aged person acute inpatient unit?

Use the suite for aged persons, as that is the applicable service setting. Conversely, the suite for adults would be used by CATT to rate a 69-year-old person admitted to an adult mental health service over the weekend. Service setting overrides biological age in determining which suite to apply (except in relation to specified youth services).

3.6 The APAT asks the CATT to visit a case managed consumer over the weekend. Does CATT need to complete outcome measures and, if so, which suite?

There is no need under the NOCC protocol for the CATT to complete any outcome measures unless the consumer is subsequently admitted to an inpatient unit. As the service with case management responsibility, the APAT will undertake the relevant ratings. The NOCC protocol makes clear that the involvement of a second service component does not constitute a change of NOCC episode. In this instance both teams are ambulatory so there is no change of service setting.

3.7 At Spectrum (residential), a statewide service for borderline personality disorders, consumers are given extended leave (over Easter/Christmas). After seven days this leave becomes a statistical separation on the CMI and a statistical admit upon their return. In effect, this generates a 'false' review for OM ratings. Does this subcentre need to generate an OM upon each statistical separation or is the subcentre able to complete their three-monthly reviews as necessary?

Basically, if the consumer has been statistically discharged and not admitted to an acute mental health acute unit, then an OM is not required.

'91-day reviews' should be calculated from the genuine admission date (not the statistical admission/separation).

However, if a Spectrum consumer is discharged because they are admitted to an acute inpatient unit, then a 'discharge' OM would be required. When they return to Spectrum, 'admission' ratings would be required. The '91-day review' would then be required 91 days from the 'admission' OM.

3.8 What if a consumer is admitted to a CCU for assessment?

Encourage the CCU staff to consider the potential value of the consumer outcomes as part of the assessment process.

The NOCC requirement makes allowance for brief inpatient admissions by changing the rating timeframe on discharge for HoNOS/CA/65+ from two weeks to the previous three days, and no discharge measures if LOS is less than 72 hours. Unfortunately the NOCC protocol does not make allowances for ambulatory and community residential service settings for a short-term/brief stay.

In relation to completion, it is recommended that ratings are made based on all available information – collateral from consumer, family/carer, GP or case manager. If a clinician really cannot make an assessment and is therefore unable to attribute a rating then they can give a rating of 9 – though this should only be used if absolutely necessary.

3.9 What if a HOPS team is providing in-reach treatment for inmates?

First, current practice suggests that this is uncommon. Therefore, the decision to apply the OM collection protocol is dependent on the nature of the incarceration:

- If it is a short-term type, such as custody awaiting bail or committal hearing, then it is appropriate for clinical services to continue liaison with the prison/family at a minimum and sometimes visits to support legal advocacy etc. Given jail would not be defined as a home and it is possible the consumer will be homeless on release, it makes sense for HOPS to continue their involvement or to consider transferring the care at a suitable time based on clinical criteria (depending on the length of sentence etc). Therefore, for the purposes of OM, the consumer would remain an ambulatory consumer receiving outreach services.
- In the case of a longer term sentence the consumer would be discharged from the service and a 'discharge' OM would apply; an 'intake to community' would be required on their release from prison.

The collection occasion would be 'ambulatory setting, review' (either 91 days or discretionary) and would include the full suite of measures. The completed measures are a summary record completed following an assessment.

It would be likely that due to environmental factors and containment that the ratings would be uncharacteristically low compared with those in the community. It is imperative that the outcome measures are considered with all available information. For example, just as incarceration is important here, for another consumer, it is recognising that the CTO is mandating treatment and that it is a contributing factor to why they are scoring low.

3.10 Are there measures available for children under four years of age?

There are no measures required or available under NOCC for this age group and so there is no departmental requirement.

If there are measures deemed suitable these could be manually added at interested services using the 'additional measure' function in the CMI task list.

None of this data would be reported to the department or analysed by the department. However, the new release allows for all measures (mandated and additional) to be exported to Excel.

3.11 What's wrong with this picture?

A consumer is:

- admitted to an inpatient unit with HoNOS score of 20 by our Acute Response Service
- discharged 48 hours later with HoNOS score of five by inpatient staff
- admitted to community team HoNOS score 17 by case manager.

The discharge from inpatient unit ratings **is not** required where the length of stay is less than 72 hours. This is because the discharge from the inpatient rating timeframe for the HoNOS is the previous three days, and so collection within this timeframe is not useful.

3.12 How do I complete the Focus of Care (FOC) for a disengaged consumer?

'Disengaged' could refer to somebody who hasn't been seen in the preceding 91 days, not seen at all/ever or not seen for a couple of weeks.

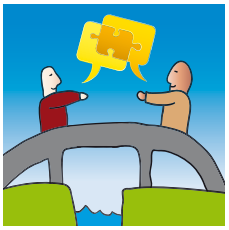
Not so much a measure of outcome but an important aid to understanding the other outcome measures, FOC is used to identify 'markers' or time points within episodes at which significant changes may have occurred in the consumer's clinical status and treatment goals. It requires the clinician to make a judgement about the consumer's primary need for care and treatment.

Unlike the other measures used in the NOCC suite, the FOC does not have a specific time-defined rating period such as two weeks or three months; rather, it looks for the preceding period of care, that is, from the last NOCC collection occasion which could have been days, weeks or months before. FOC is identifying the main treatment goal or focus identified by the clinician for the preceding period not necessarily whether this goal was achieved.

Therefore, if the client had only been 'disengaged' for a short period prior to review it would be possible to allocate a FOC based on what the 'main' goal of care/treatment had been for 'most' of the preceding period since their admission or review.

Even if the client had not been seen for the entire 91-day period, consider the decisions made during this time about care/treatment. For example, if there had been no active follow-up then one would anticipate a 'maintenance' focus for the FOC.

In the unlikely event that a clinician could not identify one of the four FOC for a consumer, the collection occasion would be counted as 'partially complete' in the CMI task list and reports, as there is no provision for missing data for the FOC.



4. Client Management Interface (CMI)

Client Management Interface–Operational Data Store (CMI-ODS) is a database used to record clinical service activity and mental health legal information for consumers of public mental health services in Victoria. CMI-ODS has been in use by all public hospitals in Victoria since October 2000. It records both inpatient and community activity. Upgrades occur one to two times each year following any legislative changes, application enhancement or technical refresh.

The *Mental Health Act 1986* and the *Health Records Act 1986* allow for the recording of selected information on CMI-ODS. Consumers must have an identified mental illness and been the recipient of a clinical mental health service before registration occurs on CMI-ODS. This registration generates a unique record number that is used for all subsequent activities recorded on CMI-ODS.

4.1 Where is the OM data entered?

In September 2008 Victoria undertook an OM-focused releaseof the CMI. The enhancement provided the capacity to automate the mandated NOCC measures. The functional enhancement enables the automation of the relevant suite of measures for a service setting, age group and collection occasion.

The enhancement also enables the clinician- and consumer-rated outcome measures to be completed directly from the task screen. In addition, it also provides capacity for charting of single or up to three time points for each measure, as well as providing an export function for recorded measures. This release provides the opportunity for other functions of clinical practice to be considered.

4.2 What if another staff member enters the outcome measures I have completed onto the CMI?

You need to make sure the forms are:

- complete – do not leave clinician measure items empty as these forms are clinical documents and it is not appropriate for administrative staff to be making a judgement attributing a code for incomplete measures with missing items
- legible to ensure accurate data entry
- timely.

If administrative or medical records staff are responsible for inputting the data into CMI, it needs to be clear who completed the measure/s. That is, it cannot be assumed that the case manager is the rater. If in doubt, check it out!

4.3 How do I know what measures to collect and when?

The NOCC protocol sets the minimum requirement for the nationally mandated measures. The September 2009 CMI release 3.4 has provided opportunities for any of the NOCC measures or for services to complement the NOCC measures with another locally constructed instrument by selecting 'additional measures' from the task list drop down.

4.4 Why doesn't the CMI automate collection of the SDQ on discharge from an inpatient unit?

The NOCC protocol, technical specifications detail that:

'Discharge ratings for the SDQ are not required for any episode of less than 21 days duration because the rating period used at discharge (previous month) would overlap significantly with the period rated at admission.'

Therefore, the SDQ has not been automated for discharge from a child and adolescent inpatient unit as we anticipate the usual length of stay is less than 21 days. An SDQ can be collected and recorded as an 'additional measure' if:

- length of stay greater than 21 days
- you believe there is sufficient change and therefore merit in collecting again.

4.5 What do I do when OM data have been entered incorrectly into the CMI?

Historically OM data could be amended if entered incorrectly. However, this is clinical information and as such the capacity to delete or amend easily has been tightened up. If the ratings are entered incorrectly you will need to speak with your local CMI system administrators.

4.6 How do I know that an OM is required?

The enhancements made in September 2008 included the CMI task list which, on the basis of the subcentre outcomes setting assigned, will link to the relevant suite of measures per age group (child and adolescent, adult, aged), setting (inpatient, ambulatory, community residential) and reason for collection (admission, review, discharge).

4.7 Is it possible to determine whether the self-rating instrument has been offered to a consumer?

Selecting the BASIS-32® as an outcome measure in the CMI Wellbeing component brings up two tick boxes in the *Wellbeing detail* dialogue box, where the rater or data entry person can indicate whether the BASIS-32® was offered to and accepted by the consumer. The default setting on the 'BASIS offered' tick box is a tick enabling scores from a completed form to be entered against each individual item.

Alternatively, the 'refused' box must be ticked. Unchecking 'BASIS offered' confirmation box brings up a further dialogue box, which prompts the user to explain *why* the self-rating instrument was not offered to the consumer.

There are four choices here: burden to consumer, cognitive functioning, illness acuity and language.

Note that the BASIS-32® has been translated into a number of community languages and, where the translated versions are completed, ratings should be entered into CMI in the usual way as the translations all follow the same scale and ordering.

4.8 Can I get OM reports off the CMI?

The 2009 enhancements to the CMI has created reporting functionality including graphs and a written summary. In addition to this, all OM ratings can be exported into Excel for local analysis and reporting.

Some services utilise other reporting tools and if this is the case please refer to any relevant documentation on these systems.

4.9 How do I ensure that the OM suite for ambulatory consumer is complete?

The most common measure left outstanding or incomplete is the BASIS-32®. It is critical if you have offered the BASIS-32® that you, as the clinician, follow up as soon as possible after offering it.

An entry on CMI is required if:

- there is a completed measure – enter the ratings
- the consumer refused – ensure that 'refusal' is selected.

If the OM ratings are not entered directly by you but rather by administrative staff please make sure you follow up and ensure that the OM suite dataset is complete.