

Development of the Australian Mental Health Care Classification: Public Consultation Paper 2

NSW HEALTH SUBMISSION

This submission provides comments on the Independent Hospital Pricing Authority's (IHPA) Public Consultation Paper 2 on the development of the Australian Mental Health Care Classification (AMHCC).

Developing the AMHCC version 1.0

Consultation question:

1. Are the variables included in the draft AMHCC version 1.0 relevant to clinicians, health service managers and other stakeholders?

NSW Health agrees that the variables included in the draft AMHCC version 1.0 are relevant to clinicians, health service managers and other stakeholders. The variables with AMHCC version 1.0 provide a stable base to the process of implementation and the agreed continual review and refinement of the classification. The following comments are made.

Setting

NSW Health supports setting as a logical splitting variable. There is a resource differential in servicing admitted patients (and residential patients) compared to ambulatory care patients and therefore they should be identified separately as per the AMHCC.

Mental Health Phase of Care

NSW Health will provide data on a best efforts basis to meet phase of care requirements. The mental health phase of care data item is not currently routinely collected in NSW Mental Health Information Systems. Significant development time to update systems is required to capture and report the variables, plus time for education and change management processes to be put in place for clinicians.

Clinicians have informed NSW Health that there is no clear delineation or guidance within the definitions, and an extensive overlap exists between phases, particularly between Functional Gain, Intensive Extended, and Consolidating Gain. NSW Health acknowledges that IHPA has undertaken additional work to refine the definitions of the mental health phases of care for the AMHCC pilot and that further work will be undertaken prior to implementation in July 2016 including an inter-rater reliability validation.

As the mental health phase of care (and outcome measures) is a subjective measure (i.e. depending on the individual judgement of a clinician concerning the nature of care they provide), NSW Health recommends that a third-party inter-rater reliability study be undertaken to ensure an independent assessment.

The draft AMHCC version 1.0 has extensive end-classes based on “unknown” mental health phase of care. Clinicians noted a concern that this could be used as a “way out” resulting in relevant assessments not being undertaken. These classes should be phased out in AMHCC version 2.0.

Additionally, clinicians support the intention to document phase of care in the care plan.

Age Group

Age is a logical splitting variable noting that those patients at either end of the age spectrum (<17 years age group and 65+ age group) attract more intensive care and more service coordination between various providers than typical adult patients.

Mental Health Legal Status

Mental health legal status is appropriate as a splitting variable, as additional resources are often involved in the care of these patients, which should be identified and recognised within the AMHCC.

HoNOS Complexity and LSP-16 Complexity

NSW Health supports the inclusion of these variables at this stage, noting there are mixed views from the clinical community regarding the appropriateness of a HoNOS complexity and an LSP-16 complexity inclusion in the draft AMHCC version 1.0.

Current collection regimes, i.e. National Outcomes and Casemix Collections (NOCC), are based on episode timings and would need to be modified to link to phase of care changes. NSW Health notes that significant time will be required to embed the collection of all NOCC items including the HoNOS and LSP-16 in everyday practice, as well as significant education for clinicians.

Consultation question:

2. Are there other variables that should be considered in later iterations of the AMHCC?

NSW Health notes and supports future iterations of the AMHCC consideration of the ongoing refinement of phase of care, child and adolescent mental health care, older person community mental health care and complexity and comorbidities, including how significant chronic physical health comorbidities can be incorporated into the classification and costing model.

NSW Health suggests considering the following variables:

- Clinical complexity and comorbidities: further investigation of other indicators of clinical complexity and comorbidities is required. Clinicians have indicated that phase of care and HoNOS may explain some of the variation between patients; however, there could be a significant cost difference based on complexity or comorbidities including chronic physical health conditions.

- Patient living arrangements and other social factors: many mental health patients have unstable accommodation and other social factors which contribute to cost as their recovery and length of stay is often prolonged by these factors.
- CALD backgrounds: IHPA should further investigate the impact of additional costs of providing interpreters, social workers etc.
- Mental health legal status in the community setting: this is already an indicator of resource use in the admitted setting, and clinicians have indicated that this should also be the case in the community and residential settings.

Draft AMHCC version 1.0

Consultation question:

3. Do the final classification groups have relevance to clinicians, health service managers and other stakeholders?

In general, the feedback from clinicians and health service managers in NSW Health is that the classification groups are relevant.

The use of diagnostic classes will remain central to clinical practice and planning and any classification that does not include diagnosis will not be applicable or relevant for clinical purposes. Diagnoses remain critical to training, service planning, treatment planning, treatment choice, prognosis and access to a wide range of supports.

Clinicians noted a concern with the community branch of the classification on patients who have LSP-16 scores that are not either “high” or “moderate”. This requires addressing in the grouping process as a number of patients who have a “low” score do not appear to be grouped to a class.

The draft AMHCC version 1.0 does not clearly identify the grouping practice for patients who have an “unknown” HoNOS but a known LSP score, or known HoNOS but an “unknown” LSP-16 score. For those patients with an “unknown” HoNOS but a known LSP, NSW Health notes that additional end-classes may be warranted as known LSP scores may explain some of the complexity related to these patients. If “unknown” LSP scores are grouped to the “moderate” class then NSW Health recommends that this class be re-named “Other” as it is misleading.

In relation to the HoNOS complexity, NSW Health suggests that IHPA consider the number of completed questions required to group to a known HoNOS class (“High” or “Moderate”). NSW Health understands that up to two scales can be missing for the collection to be considered ‘valid’ and therefore group to a known HoNOS class. NSW Health conducted preliminary analysis and suggests that a significant number of additional records would be grouped to known HoNOS classes if the number of completed questions required was lowered.

Ongoing development of the AMHCC

Consultation question:

4. Are the priorities for the next stages of development of the AMHCC appropriate?

NSW Health agrees, in general, with the priorities for the next stages of AMHCC development. The priorities identify gaps in version 1.0 and necessary refinements to capture data from all classification groups.

NSW Health supports the proposed ongoing review of clinical complexity and comorbidities, as these can be key contributors of cost and extended length of stay. There are a number of issues with using HoNOS as a proxy for alternative means of measuring clinical complexity which are more precise. Clinician feedback acknowledges that the HoNOS is a complicated tool which often does not match the clinical judgement processes and forces clinicians to make ratings on items in isolation, rather than in the context of other patient information. They also consider that it is still problematic with inter-rater reliability and its precision in identifying problems. For example, it is possible for a patient to score low on the HoNOS yet still have valid reasons to be in care. NSW Health would like IHPA to consider these views in the communication and supporting materials that will be required for the change management process.

NSW Health strongly recommends that IHPA's proposal to undertake an inter-rater reliability study in relation to phase of care be completed independently.

Refinement of the classification for older and younger persons, and the further exploration of clinical complexity and comorbidity measures are important and appropriate future priorities.

Developing a classification for the NGO/CMO sector is not a marginal change. There are major policy, conceptual and resource implications which require consideration. It is not clear that there has been any policy discussion or agreement between governments that an ABF approach is appropriate to the CMO sector. Piloting this approach in NSW is likely to require very substantial financial enhancements to NGO services for data collection infrastructure and capacity building.

NSW Health seeks further information from IHPA on the implementation of the mental health phase of care for patients who are awaiting permanent placement in the community/nursing home/group home.

NSW Health is of the view that strategies be implemented to address:

- Active clinical engagement and leadership champions
- An education and change management process for correct implementation of the AMHCC
- Timely use of the data to refine the AMHCC, including classifications on physical health care that can be also present in any episode of care.

Consultation question:

5. Are there any other issues which should be taken into account in the next stages of development?

Data Preparation and modelling

The data preparation process has not been adequately explained in the public consultation paper. Whilst the supplement released on 15 December 2015 provides some information it remains unclear why certain data was or was not removed from the data sets used for the purpose of modelling. In particular, there is minimal explanation as to why the final data set used to develop the AMHCC only included 20,934 episodes of a possible 52,219 episodes.

The public consultation paper refers to statistics including sample sizes, mean costs, coefficient of variation (CV), reduction in deviance (RID) and reduction in variation (RIV). However, only RIV results are outlined in the paper. NSW Health acknowledges that the CV of the end-classes is provided in the supplement along with some explanation regarding the performance of mental health phase of care. Further analysis regarding the performance of mental health phase of care is requested.

The public consultation paper states that “only public mental health services were included in the mental health costing study” (pg. 13). NSW Health notes that there were four private hospital sites in the mental health costing study, and seeks clarification as to whether these facilities were included in classification development. If they were not, NSW Health believes that this is a missed opportunity in building a whole-of-health mental health classification, and IHPA should ensure that the inclusion of the private hospital sites should be taken advantage of in future iterations.

The public consultation paper is silent on the process used to determine the duration of a mental health phase of care in the community setting. NSW Health notes that in the mental health costing study, phase of care was collected at each service contact. NSW Health requests IHPA make available further details in relation to how the phase of care as a unit of count was developed within the community setting.

Classification Structure

In relation to Mental Health Legal Status, the public consultation paper states that “In the admitted, acute, 18-64 years age group only, there is an additional split based on the MHLS of the patient (involuntary or voluntary)” (pg. 19). However, Figure 1 Admitted Setting Structure (pg. 20) does not reflect this.

Implementation

NSW Health notes that there is an ongoing body of work relating to the refinement of the ABF MHC DSS for 2016-17. It is unclear from the public consultation paper how the AMHCC will be implemented in relation to non-specialised mental health care. This is particularly evident in the community setting. It is NSW Health’s understanding that non-specialised mental health services were still to be reported using NAP DSS. However, the AMHCC is intended to apply to both specialised and non-specialised mental health care services.

NSW Health notes that significant system changes are required to implement the AMHCC prior to 1 July 2016 due to the change in counting unit. The implementation of the mental health phase of care concept is both costly and time consuming. A short term solution may be possible however feedback from the NSW AMHCC pilot site was that this process proved difficult and required additional staffing resources unless a fully electronic solution is provided. Notwithstanding system changes, the pilot site found the need for a clinical coordinator to prompt completion of the required data items however this need may reduce over time.

Pricing

NSW Health requests that the same pricing adjustments and loadings that are applied in the acute care setting be applied to the AMHCC, particularly the Indigenous and patient remoteness area adjustments.

Specific Comments Regarding Other Issues for Consideration

NSW Health suggests that the issues outlined below be taken into consideration in the next stages of AMHCC development:

- How Psychiatric Emergency Care Centres (PECC) and Mental Health ICU's are dealt with as they do not appear to be adequately addressed in the draft AMHCC. NSW Health advocates for the inclusion of a PECC in the Emergency Department costing study if they are considered out of scope for the AMHCC.
- The application of the AMHCC to forensic patients.
- The delineation between the Mental Health and Psychogeriatric Care Types is unclear and inconsistent. This definitional issue should be resolved. NSW Health suggests that the psychogeriatric care definition should be amended by removing the following statement "excludes care which meets the definition of mental health care". NSW Health recommends that IHPA seeks the appropriate clinical input into this decision.