IHPA

# Development of the Australian Mental Health Care Classification

## Public consultation paper 1

January 2015

**Development of the Australian Mental Health Care Classification – public consultation paper 1**

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# Glossary

| | |
|---|---|
| ABF | Activity Based Funding |
| ABF MHC DSS | ABF Mental Health Care Data Set Specification |
| AIHW | Australian Institute of Health and Welfare |
| AMHCC | Australian Mental Health Care Classification |
| AN-SNAP | Australian National Subacute and Non-acute Patient classification |
| AR-DRG | Australian-Refined Diagnosis Related Groups |
| HoNOS | Health of the Nation Outcome Scales |
| IHPA | Independent Hospital Pricing Authority |
| MHCT | Mental Health Care Type |
| MH-CASC | Mental Health Classification and Service Costs project |
| MHCERG | Mental Health Classification Expert Reference Group |
| MHIC | Mental Health Intervention Classification |
| MHWG | Mental Health Working Group |
| NDIS | National Disability Insurance Scheme |
| NHRA | National Health Reform Agreement |
| NMDS | National Minimum Data Set |
| NMHSPF | National Mental Health Service Planning Framework |
| NOCC | National Outcomes and Casemix Collection |
| UQ | University of Queensland |

# Executive summary

This is the first in a series of public consultation papers to inform the final stage in the development of the first iteration of the Australian Mental Health Care Classification (AMHCC). It builds on consultations undertaken by the University of Queensland (UQ) in the early stages of this project, and through targeted consultation undertaken by IHPA through the AMHCC Mental Health Costing Study.

This paper sets out work undertaken to date and seeks stakeholders' views on the approach to the classification's development and its proposed structure.

At present, there is no single classification used for mental health services. Since 1 July 2013, IHPA has priced admitted mental health services using Australian Refined Diagnosis Related Groups (AR-DRGs) as the classification system with a modified pricing model. This is not ideal in the longer term because diagnosis is not as strong a driver of resource utilisation for mental health services as it is in other acute services, and it can only be applied in the admitted setting.

The purpose of developing the AMHCC is to improve the clinical meaningfulness of mental health classification, leading to an improvement in the cost predictiveness, and to support the new models of care being implemented in all states and territories with a classification that can be applied in all settings.

An effective way of classifying mental health care across settings will be of use to many different levels of the health system. The AMHCC will allow individual services and service systems such as state and territory health departments, Local Health Networks, non-government and private organisations to better understand how their mental health services work and where clinical, financial and other resources are applied, and will enable performance benchmarking across similar services.

Development of the AMHCC commenced in 2012. To date, IHPA has commissioned UQ to develop a Mental Health Care Type to determine the scope of the AMHCC, and a proposed architecture for the classification based on a detailed analysis of available data, international literature and stakeholder input to determine what the most significant cost drivers may be for providing mental health care.

UQ proposed an architecture for the classification which includes some new data elements which might provide a way of determining how care is classified: the 'phase of care' that a consumer is in, whether this is the consumer's first contact with mental health care services, and the types of mental health interventions provided, as well as consideration of existing outcome measures. These are currently being tested through a Mental Health Costing Study operating in a variety of mental health care settings.

In developing the AMHCC, IHPA has accepted UQ's recommendation that, consistent with the principal of 'single provision, multiple use', the dataset to be developed by IHPA be derived from existing data collections which can be reported by states and territories where possible. Version 1.0 of the Data Set Specification has since been developed and will be refined as the AMHCC development progresses.

As with other classification systems, development of the AMHCC will take time. The initial version to be implemented in 2016-17 is unlikely to apply to all types of mental health care service settings or providers, as data to support classification development will need to be developed over coming years. The consultation processes and developmental work for the 2016-17 revision will include the identification of areas of focus for future work.

This paper seeks stakeholders' views on the approach to the classification's development and its proposed structure. Pricing of mental health care is a separate and later matter. IHPA consults on approaches to pricing health care services through its annual consultation on the Pricing Framework for Australian Public Hospital Services. Following development of the AMHCC, IHPA will seek views on pricing through this process.

Following this consultation on the classification structure, IHPA will commence development of the classification itself and undertake further rounds of consultation from later in 2015.

## Consultation questions

IHPA is seeking comments on the following areas:

1. What are the most important factors to draw from international experiences in classifying mental health care?
2. What are the most important considerations in the national context?
3. Are there any other principles that should be considered in developing the AMHCC?
4. Are there further data or other limitations of which the AMHCC should be aware?
5. Are there any other key considerations that should be taken into account in developing the AMHCC?
6. Are there other cost drivers that should be considered in the development of the AMHCC?
7. Are there any further considerations in relation to the proposed architecture?
8. Is there any further evidence that should be considered in testing the proposed architecture?
9. Which psychological interventions, if any, may be of significant in understanding the cost of care?
10. Are there particular aspects or areas of the AMHCC that should be prioritised in its development, or aspects that should be developed at a later stage?
11. Are there any further considerations that should be taken into account when developing the AMHCC?

## Submissions

Submissions should be sent as an accessible Word document to submissions.ihpa@ihpa.gov.au or posted to "Submissions" PO BOX 483 Darlinghurst NSW 1300. **Submissions close at 5pm on Friday 13 February 2015**.

All submissions will be published on the IHPA website unless respondents specifically identify any sections that they believe should be kept confidential due to commercial or other reasons.

## More information

The Mental Health Care page on the IHPA website provides up to date information on the development of the AMHCC, including links to key documents referred to in this public consultation paper.

# Introduction

## What are classifications?

Classifications are comprised of codes that provide clinically meaningful ways of relating the types of patients treated by a health service to the resources required. They enable hospital and health service provider performances to be measured by creating a link between the patients treated and the resources consumed for providing those treatments. This allows hospital and health service provider output to be measured, which forms the crucial data for policies on funding, budgeting and setting costs.

Classification systems enable clinical information that is written in medical charts to be converted into manageable data categories. Rules for collecting and coding clinical data need to be the same across Australia to ensure that all jurisdictions are obtaining and providing information the same way. Effective clinical classification systems ensure that hospital data is grouped into appropriate classes, which in turn contributes to the determination of a national efficient price for public hospital services.

IHPA uses the classification systems to determine the cost of treatment and care, using it as one of the determinants for calculating the national efficient price. There are six patient service categories in Australia currently which have classifications being used nationally or in development stage: admitted acute care; subacute and non-acute care; non-admitted care; mental health care; emergency care; and teaching, training and research.

IHPA undertakes reviews and updates of existing classifications and is also responsible for introducing new classifications for those service categories without an existing classification.

## Why is the Australian Mental Health Care Classification being developed?

As part of the National Health Reform Agreement (NHRA), IHPA is required to price public hospital services on an activity basis “where ever practicable” (Clause A2). The NHRA recognised that some classification systems were less developed than others and allowed for a phased introduction of Activity Based Funding (ABF).

At present, there is no single classification used for mental health services. Since 1 July 2013, IHPA has priced admitted mental health services using Australian Refined Diagnosis Related Groups (AR-DRGs) as the classification system with a modified pricing model.

The AR-DRG system is not the ideal classification in the longer term for mental health services. This is primarily because diagnosis is not as strong a driver of resource utilisation for mental health services as it is in other acute services, and it can only be applied in the admitted setting.

The purpose of developing the Australian Mental Health Care Classification (AMHCC) is to improve the clinical meaningfulness of mental health classification, leading to an improvement in the cost predictiveness, and to support the new models of care being implemented in all states and territories with a classification that can be applied in all settings.

In the *Pricing Framework for Australian Public Hospital Services 2014-15* which was released in December 2013, IHPA foreshadowed that it expects to begin pricing mental health services using the AMHCC from 1 July 2016.

IHPA will use the AMHCC to enable more accurate pricing of mental health services under the NHRA; however, the development of the AMHCC will have much broader utility.

An effective way of classifying mental health care across settings will be of use to many different levels of the health system. The AMHCC will allow individual services and service systems such as state and territory health departments, Local Health Networks, non-government and private organisations to better understand how their mental health services work and where clinical, financial and other resources are applied, and will enable performance benchmarking across similar services.

### IHPA's ongoing role, ABF and the AMHCC

On 13 May 2014, the Commonwealth Treasurer delivered the Commonwealth Government's Budget 2014-15. The Commonwealth Government announced its intention to work with states and territories during 2014-15 with the intention to create a new Health Productivity and Performance Commission. Subject to consultation, the new Health Productivity and Performance Commission would be formed by merging the functions of the Australian Commission on Safety and Quality in Health Care, the Australian Institute of Health and Welfare (AIHW), IHPA, the National Health Performance Authority, the National Health Funding Body and the Administrator of the National Health Funding Pool.

Whilst the Government undertakes these consultations, IHPA will continue to deliver the program of work laid out in the *IHPA Work Program 2014-15*, including development of the AMHCC.

In the Budget 2014-15, the Commonwealth Government also announced its intention that, from 2017-18, the Commonwealth will index its contribution to hospital funding by a combination of the Consumer Price Index and population growth, rather than through ABF.

A number of states and territories have signalled that the development of the AMHCC remains a priority for them irrespective of its association with pricing for Commonwealth funding, noting the benefits of the classification still apply at a local level.

## How will the AMHCC be developed?

There are a number of stages in the development of a new classification:

1. define the services to be covered;
2. identify the cost drivers;
3. conduct a patient level costing study;
4. develop the classification system and associated infrastructure (data set specifications, grouping software, etc); and
5. maintain ongoing activity and cost data collection.

To date IHPA has completed steps one and two, with step three nearing completion and step four underway. Step four includes the planning, design, development, testing, and transition of the AMHCC for the purposes of pricing mental health services from 1 July 2016.

## What is the scope of the AMHCC?

In 2012, IHPA engaged the University of Queensland (UQ) to develop a definition of mental health care – a 'Care Type' – which sets the scope of the AMHCC. The Mental Health Care Type (MHCT) proposed by UQ was modified slightly and approved by the Pricing Authority on 31 May 2013. It is:

> *Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical function relating to a patient's mental disorder.*
>
> *Mental health care:*
> - *is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health;*
> - *is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and*
> - *may include significant psychosocial components including family and carer support.*

It should be noted that 'assessment only' activities are considered in scope for the classification.

As the definition states, a clinician is someone with specialised expertise in mental health, and is not limited to a specific professional background.

The MHCT does not specify or limit the setting in which mental health care is provided. The AMHCC will operate across settings, including, for example, admitted, community (including hospital avoidance) and residential mental health care and is concerned with the care provided, rather than the identity of the provider.

In developing the AMHCC, IHPA will consider all services that fall under the broader MHCT. For example, child and adolescent community mental health services are not currently considered in scope for Commonwealth funding under the NHRA; however, these services will be included within the AMHCC.

As such, the AMHCC will have utility beyond ABF and IHPA's work. The AMHCC is agnostic as to the service provider or setting; however, the extent to which the AMHCC is applied for funding or counting purposes is determined by the relationship between funder and provider.

As such, the classification may be adopted by any relevant organisation which collects the required data items.

## Governance of the project

IHPA's Mental Health Working Group (MHWG) will oversee the development of the AMHCC.

The MHWG advises IHPA on matters relevant to mental health and includes representatives from all jurisdictions including the Commonwealth, as well as the representatives of the National Mental Health Commission, Mental Health Australia, the Royal Australian and New Zealand College of Psychiatrists, the Australian College of Mental Health Nurses, Allied Health Professions Australia, the Royal Australian College of General Practitioners, the

Australian Private Hospitals Association, Private Healthcare Australia, the National Disability Insurance Agency, Community Mental Health Australia, the IHPA Clinical Advisory Committee, mental health consumer and carer representatives and individual experts.

The project is supported by a Mental Health Classification Expert Reference Group (MHCERG) which includes mental health subject matter experts, classification system development experts and data analysis experts. The MHCERG reports to the IHPA Chief Executive Officer through the MHWG.

In undertaking its work, the MHCERG will convene smaller clinical, technical and other specialist expert meetings as required.

# Background

This chapter provides a summary of the way in which mental health care services are currently classified in Australia, approaches to classification that have been taken in other countries, and the significant systems and reforms have been undertaken in Australia and which are important to consider in the development of the AMHCC.

## How is mental health care currently classified in Australia?

### Admitted services

Since 1 July 2013, IHPA has priced admitted mental health services using AR-DRGs as the classification system. Under this system, mental health consumers are defined as only those acute admitted patients that are in Major Diagnostic Categories 19 and 20 (Mental Diseases and Disorders, and Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders respectively) and those patients in other Major Diagnostic Categories that have recorded psychiatric care days.

IHPA modified the pricing model on the basis that AR-DRGs do not predict resource consumption for mental health care as well as they do for other medical and surgical services.

### Emergency department services

Mental health care provided in Emergency Departments are classified using Urgency Related Groups and will continue to be after the implementation of the AMHCC.

### Non-admitted services

General non-admitted services are classified using the Tier 2 Non-admitted Care Services classification. Some mental health care may be classified using Tier 2; however the classification does not include a comprehensive list of non-admitted mental health care.

### Subacute and non-acute services

Mental health care is excluded from the Australian National Subacute and Non-Acute Patient (AN-SNAP) classification system, with the exception of psychogeriatric care. Noting that there is clearly a crossover with mental health care, the Psychogeriatric Care Type will be reviewed following the implementation of the AMHCC.

## International approaches to mental health care classification

Internationally, a number of jurisdictions have developed mental health-specific casemix classification systems. The following provides a summary of different approaches to provide context to the development of the AMHCC. The AMHCC developers will give consideration to these approaches in determining how the classification might be structured.

**England** uses Mental Health Care Clusters to classify adult mental health services for funding under the Payment by Results system. A cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the Mental Health Clustering Tool, which is a needs assessment tool based on the Health of the Nation Outcome Scales (HoNOS) and additional ratings of historical events designed to

rate the care needs of a consumer . The clusters were developed based on patient observations rather large scale data analysis.

Initially, care professionals assign the consumer to one of three super classes: non-psychotic, psychosis or organic. Each super class is further segregated into semi-super clusters and finally into the cluster type allocated to the consumer, each of which represents a subgroup of mental illnesses. A consumer's cluster allocation is determined at the point of referral but, also re-assessed and re-clustered periodically at formal review sessions and any point where a significant change in planned care is deemed necessary.[1] It should be noted that while Australia has adopted the HoNOS, it uses a broader range of assessment tools than England, and as such the Mental Health Clustering Tool could not be directly applied in Australia.

In **New Zealand**, the 2003 Mental Health Classification and Outcomes Study (NZ CAOS) was undertaken to develop a casemix classification for mental health care that was developed for the purposes of benchmarking. The classification builds on Australia's Mental Health Classification and Service Costs (MH-CASC) prototype. It consists of 42 classes that were developed based on statistical analysis of activity, outcome and cost data that was collected over a six month period at eight District Health Boards covering approximately 22.44% of New Zealand mental health services.

Each class is a description of a group of people with similar characteristics and costs as identified by age, legal status, ethnicity, outcomes and length of stay and in some cases, diagnosis. The classification is applicable across both admitted and community settings, child and youth, adult and forensic mental health services. The inclusion of classes defined by ethnicity of the consumer would need to be considered in an Australian context.

Initially consumers are classified by service setting and age, then split based on complete and incomplete episodes, with the final classification determined by consumer characteristics and HoNOS ratings.[2]

In **Ontario, Canada**, the System for Classification of In-Patient Psychiatry (SCIPP) is used to group and develop weighted patient days for designated adult admitted mental health care beds. There are nine SCIPP categories based on mental health diagnoses with up to 18 groups within each category. Categories are ordered in a clinical hierarchy based on resource intensity. In addition, episodes of care are weighted depending upon the day of stay to further account for resource intensity. SCIPP explains approximately 26% of the variable portion of per-diem resource utilisation for all psychiatric inpatients.[3]

**The Netherlands'** reimbursement system for admitted and non-admitted mental health services is known as "Diagnose Behandleling Combinatie" (DBC) or "Diagnostic Treatment Combination". The DBC identifies the type of care being provided (emergency, regular or

[1] Mason, A, Goddard, M, Myers, L, Verzulli R 2011, 'Navigating uncharted waters? How international experience can inform the funding of mental health care in England', *Journal of Mental Health*, vol. 20, no. 3, pp. 234-48.

[2] Gaines, P, Bower, A, Buckingham, B, Eagar, E, Burgess, P, Green, J 2003, *New Zealand Mental Health Classification and Outcomes Study: Final Report*, Health Research Council of New Zealand, Auckland, p. 118.

[3] Saxena, S, Esparza, P, Regier, DA, Saraceno, B, Sartorius N (eds) 2012, *Public Health Aspects of Diagnosis and Classification of Mental and Behavioral Disorders: Refining the Research Agenda for DSM-5 and ICD-11*, American Psychiatric Publishing, Virginia, p. 219.

chronic), the diagnosis and the treatment (including setting). There is a DBC for each diagnosis/treatment combination. As at 2013, there were 140 DBCs for treatment with an additional seven DBCs for accommodation. Consumers can be assigned to more than one DBC therefore allowing flexibility for co-morbid consumers. A quality element is also included in the outcome measurement system which is used by health insurers during the purchasing process.

Care in the admitted or non-admitted setting (excluding the community setting) of more than 365 days is considered 'long term' and is funded under the Exceptional Medical Expenses Act (AWBZ) based on a care intensity package which takes into account consumer profile, function/ weekly consumer hours and care setting characteristics.

In the **United States**, federally funded providers are paid prospectively using a Prospective Payment System (PPS), with treatments and procedures defined by the Diagnosis Related Groups (DRG) classification. PPS was implemented in admitted psychiatric facilities in 2004 with a base rate of payment for patient days on the basis of a standard per diem rate. There are then consumer- and facility-level adjustments applied on the basis that there are certain consumer and facility factors that impact on the cost of service delivery, including age, DRG assignment, comorbidities, and variable per diem adjustment, wage index, rurality, teaching status, qualifying emergency department, and cost of living for certain states. There are additional policies that impact on the payment including outlier patients, interrupted stays and Electro Convulsive Therapy (ECT) treatments. In addition, quality measures data is submitted to the Department of Health and Human Services, with failure to submit data resulting in a payment reduction.[4]

Noting the different health care system structures and data collections and processes, none of these approaches can be directly implemented in Australia. However, there are aspects of each which will be important to consider. For example, the use of existing outcome measures, splits be resource intensity, variation in approach depending on whether the length of stay or care is short, medium or long term, or weighting for particular types of treatment or comorbidities.

## Mental Health Classification and Service Costs project

Prior to the application of ABF in Australia, over 1995-98, the Commonwealth Department of Health & Family Services funded the MH-CASC project under the National Mental Health Strategy. This was a one-off project, with the aim to develop the first version of a national casemix classification, with associated cost weights, for specialist mental health services. The developers found that:

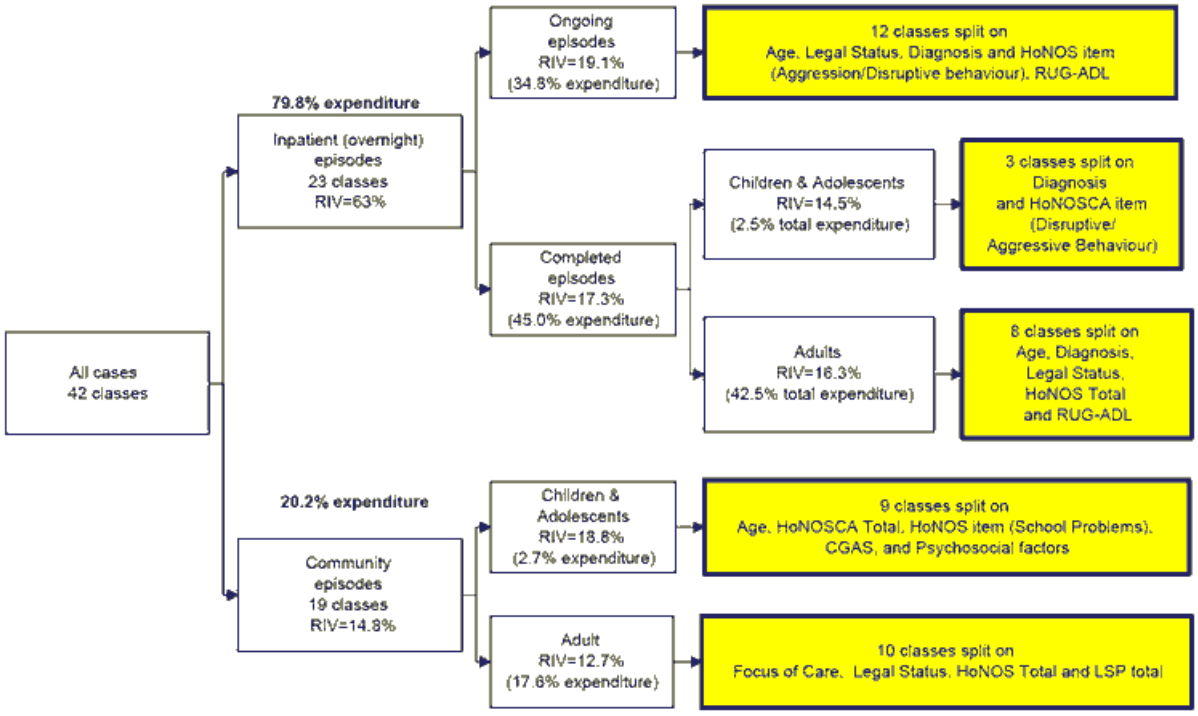
> *"…there is an underlying episode classification, not just in inpatient services but also in community mental health care. The level of service provided to patients does in fact bear a clinically and statistically logical relationship to the patient's clinical status. However, the relationship between clinical factors and cost is often confounded by variations in the practice of different providers. Some of these provider factors may*

[4] Federal Register 2014, *Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System-Update for Fiscal Year Beginning October 1, 2014 (FY 2015)*, vol. 79, no. 151, Washington, viewed 10 December 2013, http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18329.pdf

*be structural or financial, and others may be under the control of individual clinicians. Further work is required disentangle these factors."*[5]

The developers recommended a casemix model across admitted and community mental health episodes, based on 42 patient classes, as set out at Figure 1. They acknowledged that this should be considered as 'version 1.0', which considerable ongoing refinement required.

Figure 1: Summary of MH-CASC setting-specific classification[6]




The developers found that explanation of variation in the community is more difficult, probably because of the more complex care provided, and fewer controls on care.[7]

While MH-CASC was not progressed to national roll out, it remains the most comprehensive attempt to date to classify mental health services in Australia, and has been a reference point for UQ's initial work to support the development of the AMHCC.

## Other considerations in the Australian system

### National Mental Health Plan

The *Fourth National Mental Health Plan*[8] is the most recent publication under the National Mental Health Strategy and sets out eight key principles for mental health policy in Australia. The AMHCC should align with these principles:

[5] Buckingham, W, Burgess, P, Solomon, S, Pirkis, J, Eagar, K 1998, *Developing a Casemix Classification for Mental Health Services: Summary*, Commonwealth Department of Health and Family Services, Canberra, p. 7.

[6] Ibid., p. 18.

[7] Ibid., p. 18.

- respect for the rights and needs of consumers, carers and families
- services delivered with a commitment to a recovery approach
- social inclusion
- recognition of social, cultural and geographic diversity and experience
- recognition that the focus of care may be different across the life span
- services delivered to support continuity and coordination of care
- service equity across areas, communities and age groups
- consideration of the spectrum of mental health, mental health problems and mental illness.

## National Mental Health Service Planning Framework

In 2011, the Commonwealth Government contracted the NSW Ministry of Health to develop a population-based National Mental Health Service Planning Framework (NMHSPF) based on modelling with epidemiological data, to improve strategic and coordinated approaches to mental health planning and service delivery.

It is important to note that the NMHSPF is a planning tool designed to describe what "should be". A classification system provides a consistent method of classifying patients, their treatment and associated costs. The role of the AMHCC will be to reflect the services that are provided, rather than drive service design. However, it will be important to ensure that, consistent with the design principles, the new classification is designed in such a way that it can improve over time, for example, to reflect new practices, new models of care or improved knowledge about cost drivers.

While the NMHSPF project is currently ongoing, work-to-date provided in confidence to IHPA will be considered in the development of the AMHCC to ensure that there is consistency between the two tools.

## National Disability Insurance Scheme

The scope and approach of the National Disability Insurance Scheme (NDIS) will be important considerations in the development of the AMHCC. While the two systems are not intended to overlap, some people with a mental illness will be able to access services under the NDIS. The access requirements include people with a psychiatric condition who have significant and permanent functional impairment. The Productivity Commission estimated this to be 12 per cent of adults with severe mental disorders.

The NDIS will not fund clinical mental health services or medical treatment. Rather, it will provide supports that assist a person to undertake activities of daily living, including:

- assistance with planning and decision making and household tasks;
- assistance to build capacity to live independently and achieve their goals, such as building social relationships, as well as financial management and tenancy management skills; and
- supports to engage in community activities such as recreation, education, training and employment.

[8] Commonwealth of Australia 2009, *Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014*, Commonwealth of Australia, Canberra, 2009.

The health system will continue to provide health care to NDIS clients. However, some of the daily living supports listed above are also provided by community mental health services (for example, through adult integrated community mental health services and hospital avoidance programs), and are therefore within the scope of the AMHCC.

As such, consideration needs to be given to how the two systems will work together, or alongside each other. The National Disability Insurance Agency is represented on IHPA's MHWG, which has oversight of the AMHCC.

## Consultation questions

1. What are the most important factors to draw from international experiences in classifying mental health care?

2. What are the most important considerations in the national context?

# Key considerations in building a mental health classification

In addition to learnings from other classification systems, there should be core principles applied to the development of the AMHCC. Every classification system should have a set of principles underlying; however, these will vary depending on the nature of the classification and the services it is grouping.

In addition, there are limitations on the resources that a classification can draw on, for example the data that can be provided by all organisations required to participate in the classification, and this will necessarily affect the way in which the classification can be designed.

## What are the principles for developing a classification?

Classification systems group together patients who are clinically relevant (i.e. have similar conditions) and resource homogenous (i.e. cost similar amounts per episode). At each level of the classification, children categories are mutually exclusive and jointly exhaustive of their parent.

Through the development and review of other classifications, IHPA has developed nine principles which may also be applied in the development of the AMHCC. These have been reviewed against the principles outlined in other relevant mental health projects including MH-CASC, the Mental Health Intervention Classification (MHIC); NZ-CAOS, and the approaches are considered to be consistent.

Table 1: Principles for classification development

| Principle | Description |
|---|---|
| **1. Comprehensive, mutually exclusive and consistent** | The classification is comprehensive, with all possible cases (episodes) within the scope of the classification able to be grouped to a class.<br>The classification should be able to be applied to all services in scope for the MHCT and perform similarly (clinically and statistically) when applied to different models and/ or settings of care.<br>The classification should be scalable to take account of lower levels of detail required by settings at a lower role level.<br>Classes within the classification are mutually exclusive, with every case (episode) in scope only be able to be grouped to a single class.<br>Class definitions and assignment to classes are clear, consistent and unambiguous. |
| **2. Clinical meaning** | The underlying data elements are useful for clinical management purposes in addition to funding purposes.<br>Should group patients/ consumers with similar clinical and other characteristics and/ or requiring similar treatment.<br>The data element makes sense to clinicians, and aligns with the language used by clinicians for clinical management of patients/ consumers. |

| Principle | Description |
|---|---|
| **3. Resource use homogeneity** | Events (episodes) should be assigned to classes with similar levels of resource use.<br>Estimates of resource use within classes should be stable over time.<br>When applied prospectively, the classification should explain a substantial level of the cost variation between classes, while minimising the variability of costs within each class.<br>When assessing an individual data element for its inclusion in the classification, there is strong evidence that the data element explains variation in costs over and above other cost drivers. |
| **4. Patient/ consumer based** | The classification should be based on data elements that reflect the characteristic of patients/ consumers, rather than characteristics of the service provider or inputs to care.<br>Classification should be able to be applied consistently across different settings. |
| **5. Simple and transparent** | The classification has as many classes as are needed for its purpose and no more.<br>Assignment of cases to classes should occur through a process that is transparent and able to be understood by clinicians and health service managers. |
| **6. Minimising undesirable and inadvertent consequences** | The classification relies on data elements that are collected consistently and uniformly.<br>The classification minimises the reliance on data elements that are open to local interpretation and/or provide incentives to change reporting to optimise funding.<br>The classification should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.<br>The underlying data contributing to the classification are able to be audited. |
| **7. Capacity for improvement** | The classification and the underlying data elements should provide information of sufficient granularity to facilitate improvement in the classification over time, for example, to reflect changes in practice patterns and technological advances, and to incorporate emerging knowledge about cost drivers.<br>The system should be sufficiently flexible to adapt to such change without requiring major restructuring. |
| **8. Utility beyond activity based funding** | The classification and the underlying data elements should allow the analysis of best practice and facilitate benchmarking.<br>The data elements required for the classification are useful for purposes other than funding. These may include health services management, monitoring of quality and safety, epidemiological monitoring, understanding practice and cost variation, health services planning and performance reporting. |

| Principle | Description |
|---|---|
| **9. Administrative and operational feasibility** | The benefits of the data collected for the classification outweigh the administrative cost and burden of collection.<br>The additional cost of systems to maintain integrity of data required for classification is negligible or reasonable.<br>The collection of data utilises approaches that assist with or consistent with the implementation of the electronic health/medical record.<br>The cost to establish/ purchase and maintain the classification system is balanced by the benefits that it offers, and is affordable to the health system relative to other priorities. |

## Data that can be used in the AMHCC

In developing the AMHCC, IHPA has accepted UQ's recommendation that, consistent with the principal of 'single provision, multiple use', the dataset to be developed by IHPA be derived from relevant minimum data sets, the National Outcomes and Casemix Collection (NOCC), mental health interventions and the national hospital cost data collection. Importantly, in order for the AMHCC to be used by IHPA and for it to have national applicability, the data needs to be able to be collected by states and territories.

As such, version 1.0 of the ABF Mental Health Care Data Set Specification (ABF MHC DSS) uses existing data collections and definitions where feasible, noting the addition of the three new data elements proposed by UQ (explained in more detail below). In order for any additional data items to be included beyond those existing and specified new items specified in the ABF MHC DSS, all states and territories would need to be able to collect and report them.

### Consultation questions

3. Are there any other principles that should be considered in developing the AMHCC?
4. Are there further data or other limitations of which the AMHCC should be aware?
5. Are there any other key considerations that should be taken into account in developing the AMHCC?

# Work undertaken to date

As outlined in the Introduction, signification work which will inform the development of the AMHCC has already been undertaken. Of the five stages set out in the Introduction, IHPA has already carried out work to define the services in scope for the AMHCC, identify cost drivers, and test these cost drivers through a patient level costing study.

## Development of a Mental Health Care Type

In 2012, IHPA engaged UQ to develop a definition of mental health care for ABF purposes and to define the cost drivers associated with these services.

UQ proposed the creation of a separate Care Type for mental health services. The following definition was approved by the Pricing Authority on 31 May 2013. It is also set out and described in the Introduction to this paper:

> *Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical function relating to a patient's mental disorder.*
>
> *Mental health care:*
> - *is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health;*
> - *is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and*
> - *may include significant psychosocial components including family and carer support.*

The MHCT will be collected for admitted patients from 1 July 2015. Those jurisdictions that have been able to do so have been collecting the MHCT for non-admitted patients since 1 July 2014, with the remainder starting from 1 July 2015. The collection of the MHCT is in advance of the implementation of the AMHCC to enable as much time as possible for jurisdictions to identify any issues with the new Care Type. The Admitted Patient Care Types have been modified to explicitly exclude patients who meet the definition of the MHCT from the Acute and Subacute Care Types.

This mirrors the recommendation in the UQ Final Report[9], in that the MHCT is effectively the first Care Type to be allocated if the conditions of its definition are met. There are notes in each of the other Care Type definitions to this effect.

## Cost drivers and recommended classification architecture

Under commission from IHPA, UQ also undertook a comprehensive literature review, wide ranging stakeholder consultation, and quantitative analysis using data obtained from Queensland, Victoria and New South Wales to consider potential cost drivers for mental health care.

[9] Whiteford, H, Eagar, K, Harris, M, Diminic, S, Burgess, P, Stewart, G 2013, *Stage A Final Report: Defining mental health services for classification purposes for the Definition and Cost Drivers for Mental Health Services project*, The University of Queensland, Brisbane, p. 53.

The results of the quantitative analysis are consistent with the literature and confirm that mental health costs are driven by multiple factors, including (but not limited to) complications and comorbidities, symptom severity and function as well as some contribution from patient diagnosis as a lesser contributing factor.

Based on their analysis, UQ proposed a classification architecture which included some new data elements and broke a patient episode of care into one of these – a Mental Health Phase of Care. The architecture proposed in the UQ report is being further considered and testing through the Mental Health Costing Study and is detailed in the next chapter.

## Mental Health Costing Study

A key finding of the UQ report was that the costing data submitted to the National Hospital Cost Data Collection by jurisdictions for mental health services "was patchy at best". UQ proposed that IHPA commission a one-off study or series of one-off studies to develop the AMHCC.

In February 2014, IHPA engaged a consortium led by HealthConsult to undertake a six month costing study at health services across Australia including both public and private hospitals, and community mental health services. The study includes collection of consultation liaison and in-reach/out-reach service data. The purpose of the study was to test the new data elements proposed by UQ and collect cost data to support the development of the AMHCC.

25 sites are participating in the study in New South Wales, Queensland, South Australia and Western Australia, and a private health care facility in Victoria. Sites comprise a range of public and private admitted and community mental health services, including specialist child and adolescent, older persons, forensic and consultation liaison services. Services provided by community managed organisations are captured where these services are contracted by the study sites. The profile of mental health consumers accessing services, including gender, age and indigenous status at the study sites is similar to those reported by jurisdictions in relevant data sets.

Data collection commenced at study sites on 1 July 2014 and concluded on 31 December 2014, with final activity and cost data due to be submitted by sites to IHPA in February 2015. More information about the Mental Health Costing Study including a full list of participating sites is available on the Mental Health Costing Study website.

The Mental Health Costing Study will be used to inform the development of the AMHCC, but it will not be the sole source of data used. The development of the AMHCC is an iterative process with later versions expected to broaden the range of services included within the classification. For example, where community managed organisations or some specialist services are not captured in the Mental Health Costing Study, or in any subsequent one off studies prior to July 2016, these will be identified as areas of the AMHCC for ongoing development and refinement.

## Development of a data set specification

In order to support the development of the AMHCC, IHPA commenced the development of the ABF MHC DSS in early 2014 for data collection in 2015-16. The ABF MHC DSS is based

on existing mental health National Minimum Data Sets (NMDS) and also includes the new data elements proposed by UQ.

The 2015-16 ABF MHC DSS will be an activity DSS for best efforts collection, developed in accordance with the standards set out by the National Health Information Standards and Statistics Committee. The intention of the ABF MHC DSS is to use existing data collections and definitions where feasible, always being mindful of the 'single provision, multiple use' of data principles.

The ABF MHC DSS is based on data items from the:

- admitted patient care NMDS;
- admitted patient mental health care NMDS;
- community mental health care NMDS;
- mental health establishments NMDS;
- non-admitted patient DSS; and
- residential mental health care NMDS.

The ABF MHC DSS is also closely associated with the NOCC and aligns with NOCC reporting protocols where possible.

Collection of the ABF MHC DSS will commence in 2015-16 prior to implementation of the AMHCC to enable as much time as possible for jurisdictions to identify any issues with the ABF MHC DSS.

The new data elements included in the 2015-16 ABF MHC DSS have been tested through the Mental Health Costing Study. This data will be analysed in early 2015, and following this the ABF MHC DSS will be reviewed with any changes made ahead of full implementation for the AMHCC in 2016-17.

The DSS may be viewed on the Australian Institute for Health and Welfare's Metadata Online Registry.

# Cost drivers of mental health care

## Analysis by the University of Queensland

As part of the UQ project commissioned by IHPA, the UQ project team was required to provide recommendations for the most appropriate cost drivers and preferred options for classification development for mental health services in Australia.

UQ undertook a comprehensive literature review, wide ranging stakeholder consultation, and quantitative analysis using data obtained from Queensland, Victoria and New South Wales to consider potential cost drivers for mental health care.

UQ's review of the international literature found that the most commonly identified patient-level cost drivers were patient illness factors and patient characteristics, with variation across service settings, noting that the most commonly examined factors were principal diagnosis, patient age and sex. Treatment history was also one of the more commonly investigated patient illness factors; however, a range of variables were used for this purpose.[10]

UQ identified potential cost drivers as falling into five categories, and made the following commentary:

- **Consumer-related factors** (such as diagnosis): these can predict both the need for and cost of mental health services. These factors may or may not be amendable to incorporation in a patient classification system.
- **Service factors**: these are more problematic for a casemix classification because they can create undesirable incentives; however, they need to be fully analysed to understand variations.
- **Treatment factors**: there is currently little reliable data on this.
- **Legal status, safety and emergency care**: these are factors in about half of all stays in public admitted patient care and are significant because they demand such a high utilisation of cost.
- **Chronic disease management**: the lifetime impacts of chronic disease on mental health patients are significant, and it is important that "the cost drivers for the aggregate consumption of healthcare are separately identified and considered as well as those applicable to the individual components of care."[11]

The UQ researchers concluded that, consistent with the literature, "mental health costs are driven by multiple factors, including (but not limited to) diagnoses, complications and comorbidities, symptoms severity and function".

[10] Whiteford, H, Eagar, K, Harris, M, Diminic, S, Burgess, P, Stewart, G 2013, *Stage A Final Report: Defining mental health services for classification purposes for the Definition and Cost Drivers for Mental Health Services project*, The University of Queensland, Brisbane, pp. iii-iv.

[11] Ibid., pp. 2-3.

However, they cautioned that since much of the data is of poor quality and cannot be linked, results were indicative only.[12] In particular, they found that cost data was not reliable and that using 'length of stay' or the number of contacts as proxies for cost does not allow for varying intensity of treatment; considerable amounts of data was lost in the linkage process, or in analysis because of missing value; and that the quality of some other variables was poor (for example, there were discrepancies between the age-specific tools used and the actual age of the patient. But, "despite the shortcomings of the data, the results were quite consistent with those found in earlier work on mental health cost drivers."[13]

These proposed cost drivers will be test through analysis of the final Mental Health Costing Study data set in early 2015, and will inform the final AMHCC framework.

## Consultation question

6. Are there other cost drivers that should be considered in the development of the AMHCC?

[12] Eagar, K, Green, J, Lago, L, Blanchard, M, Diminic, S, Harris, M 2013, *Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project, volume 1*, The University of Queensland, Brisbane, pp. 1-2.

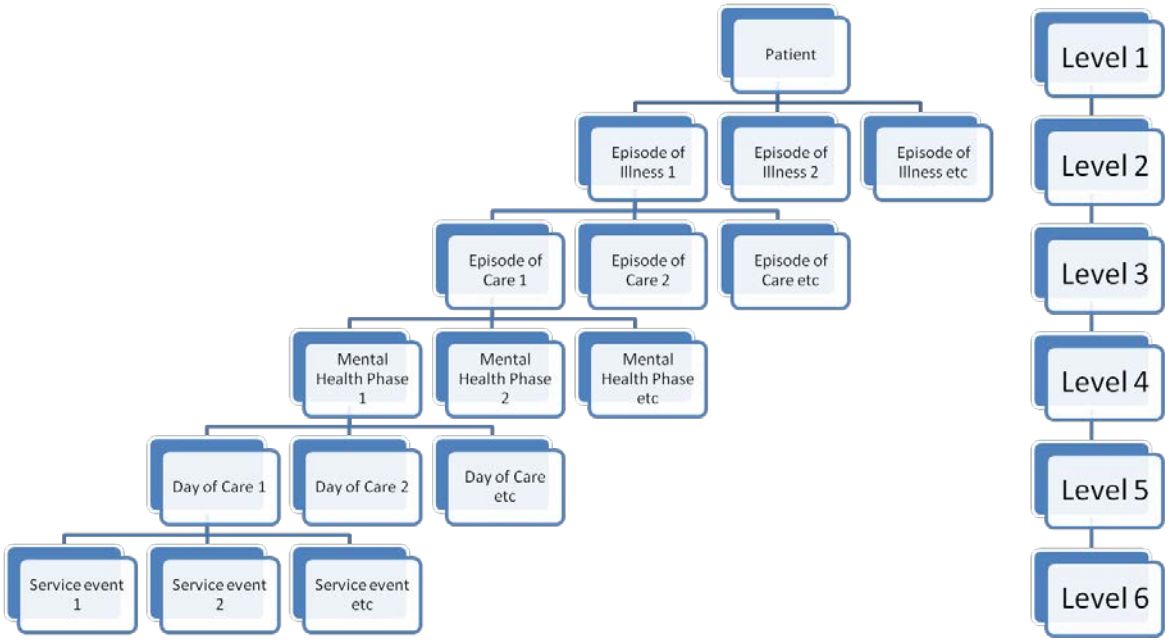
[13] Ibid., p. 39.

# Proposed approach

## The University of Queensland's proposal

Having considered the scope of the MHCT and likely cost drivers for the provision of care, and following further consultation, UQ proposed a high level classification architecture for the AMHCC. Their proposed approach breaks a patient Episode of Care into mental health 'phases', as set out at Figure 2.

Figure 2: UQ's proposed mental health information architecture[14]




The proposed classification architecture is setting and provider agnostic. Primary mental health care services that meet the requirements of the MHCT definition are in scope.

Level 1 is the consumer, who during their life may have more or more Episode of Illness which meets the MHCT (Level 2). Concurrent with their mental health episode, a patient may have other non-mental health related Level 2 Episodes of Illness, e.g. breaking a leg. These would be dealt with by a separate classification.

At Level 3 are Episodes of (Mental Health) Care. These are defined by setting (admitted, community, residential) and begin and end with events such as hospital admissions, discharges and transfers. A consumer who is discharged from hospital to a community program has two Episodes of Care, one admitted and one community episode.

Classifications are usually developed using levels 1 to 3. UQ proposed a further split within an Episode of Care called a Mental Health Phase of Care – this is Level 4. The concept of Phase is discussed further below. A Phase may in turn consist of a number of Days of Care (Level 5), and a number of Service Events within each Day (Level 6).

[14] Eagar, K, Green, J, Lago, L, Blanchard, M, Diminic, S, Harris, M 2013, *Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project, volume 1*, The University of Queensland, Brisbane, p. 43.

In considering each of these levels, UQ proposed that the AMHCC developers allow that, for classification purposes, mental health care be bundled up to the highest level at which the package of care (or cost of the care) is predictable.[15]

## Phase of care

The key part of UQ's proposed architecture is the new concept of Mental Health Phase of Care. UQ recommended that IHPA explore whether the Phase of Care that a consumer is in is a legitimate cost driver that might be used in a new classification.

Phase of Care is a prospective assessment of a patient's needs defined by patient characteristics and the associated goals of care (the 'patient journey') rather than solely by the physical location of treatment (e.g., acute unit, rehabilitation unit) or the treating clinical team (e.g., acute team, rehabilitation team).

A change of Phase would therefore trigger a new collection of outcomes measures and, in the ABF context, potentially a new ABF payment. However, Phases may be bundled, with care bundled up to the highest level at which the package/cost of care is predictable – this could be at the Phase level, or above or below it, dependent on the outcome of further testing.

UQ proposed that the Mental Health Phases replace or complement the current Focus of Care data element (as defined in the NOCC) and are an alternative to Mental Health Subtypes that are currently in place in some jurisdictions.

In order to test the UQ hypothesis, HealthConsult developed a definition of Phase of Care and the data domain definitions for the five phases of care, for application through the Mental Health Costing Study.

The proposed definition and data domains were developed in consultation with a small group of clinical and technical experts. The definition and data domains were based on a modified NOCC 'Focus of Care' approach to Phase of Care with an additional data domain for 'initial assessment / brief intervention'.

The definition of Phase of Care for the purposes of the Mental Health Costing Study was:

> *The phase of care identifies the primary goal of care that is reflected in the client's mental health treatment plan at the time of collection, for the next stage in the patient's care. It reflects the prospective assessment of the primary goal of care, rather than a retrospective assessment.*

The data domains detailed in Table 2 incorporate the four Focus of Care categories and an additional code for 'initial assessment'. The other amendment was to change the title of "Maintenance" to "Consolidating gain (also known as maintenance)".

[15] Eagar, K, Green, J, Lago, L, Blanchard, M, Diminic, S, Harris, M 2013, *Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project, volume 1*, The University of Queensland, Brisbane, p. 43.

Table 2: Data domains for Phase of Care in the Mental Health Costing Study

| Descriptive term | Definition |
|---|---|
| Initial assessment | The primary goal is to obtain information, including collateral information where possible, in order to determine the intervention/treatment needs and to arrange for this to occur (includes brief history, risk assessment, referral to treating team or other service). |
| Acute | The primary goal is the short term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a psychiatric disorder. |
| Functional gain | The primary goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a patient with impairment arising from a psychiatric disorder. |
| Intensive extended | The primary goal is prevention or minimisation of further deterioration, and reduction of risk of harm in a patient who has a stable pattern of severe symptoms, frequent relapses or severe inability to function independently and is judged to require care over an indefinite period. |
| Consolidating gain (also known as maintenance) | The primary goal is to maintain the level of functioning, or improving functioning during a period of recovery, minimise deterioration or prevent relapse where the patient has stabilised and functions relatively independently. |

For the purposes of the Mental Health Costing Study, the data element was collected at each point of service delivery in the community setting, and at regular intervals in the admitted setting. Therefore, the point at which Phase of Care was collected differed based on the setting.

In the admitted setting, Phase of Care is collected on day of admission, then every subsequent 14 days post admission, then at discharge. If there is a Phase change during the admission (e.g. a change from acute to consolidating gain) then there will be a requirement to submit other specified data such as NOCC clinical ratings.

Only one Phase of Care can be reported at each collection point. The clinician determines the Phase at the time of collection, for the next stage of the consumer's care. It reflects the prospective assessment of the primary goal at the time of assessment, rather than a retrospective assessment.

In the community / non-admitted setting, Phase of Care is collected for all contacts or service events provided by mental health services. The clinician decides the Phase at each contact or service event. The Phase identifies the primary goal of care that is reflected in the consumer's mental health treatment plan at the time of collection. As is currently the case, clinical rating data only needs to be submitted every 91 days (as the minimum requirement) or when there is a significant change (e.g. change of care team).

## First episode of mental health care

UQ found some evidence in the literature to suggest that the first occasion of mental health care that a consumer receives may be different to subsequent occasions of care in terms of

both costs and outcomes, and recommended that this be explored in the development of the AMHCC. For this reason, data relating to this was collected as part of the Mental Health Costing Study.

It was initially proposed by UQ that the 'first episode psychosis' be collected in the Mental Health Costing Study. However, following consultation with a number of mental health experts, it was agreed that there were practical difficulties associated with collecting this data, and it was agreed that the alternative options of the 'first episode of any mental health condition' and 'the availability of a patient's detailed history' be considered as factors which could influence the cost of care.

Where the date of the last contact a mental health service had with a consumer cannot easily be extracted from the patient administration system, services were asked whether the consumer was known to the service in the previous five years for care that meets the definition of the MHCT.

## Mental health interventions

UQ also recommended that data be captured on the mental health interventions that consumers receive, to determine whether particular interventions, or types of interventions are significant in determining the costs of providing care and how the AMHCC is developed. It is however important to note that understanding the type of care provided will help build a better understanding of consumer profiles, but the inputs (the interventions) themselves will not determine the structure of the classification.

Due to the extensive work previously undertaken by the AIHW in the development of the prototype Mental Health Intervention Classification 1.0 (MHIC), this compendium of classifications was used in the Mental Health Costing Study to report interventions. In addition, study sites were able to add additional interventions to reflect particular practices at their service.

The MHIC describes and captures information on selected mental health interventions provided to mental health consumers under four categories: assessment and review interventions, therapeutic interventions, emergency interventions and service coordination interventions. Each type of intervention within the category is then given a code, which is used by staff to record care provided to consumers. For example, assessment and review interventions include activities such as 'triage or initial assessment' and 'physical assessment', and therapeutic interventions include structured psychological therapies such as 'cognitive and/or behavioural therapies' and 'family/carer-focused therapy and interventions'. The full list of codes is available on the website.

Experiences and feedback from implementing the MHIC through the Mental Health Costing Study will also be captured for use in any future interventions compendiums.

## Outcome measures

In addition to these new data elements, UQ also proposed that business rules be established to require the NOCC to become a data collection at the Phase level. Collecting the NOCC at this level in the Mental Health Costing Study will enable consideration of whether measures of outcome may be linked to the cost of providing services and considered a cost driver.

The NOCC is a collection of clinical outcome measures and protocol for when each measures should be collected, dependent on the age group of the consumer, the service setting, and whether the consumer is being admitted, reviewed or discharged. The measures capture the symptoms and functioning of the consumer at key points within an episode (or Phase) of mental health care. The specific NOCC measures are set out in Table 3.

Table 3: NOCC measures[16]

| Age group | Measures |
|---|---|
| **Child and adolescent** | Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA)<br>Strengths and Difficulties Questionnaire (SDQ)<br>Children's Global Assessment Scale (CGAS)<br>Factors Influencing Health Status (FIHS) |
| **Adult** | Health of the Nation Outcome Scales (HoNOS)<br>Life Skills Profile 16 (LSP-16)<br>Focus Of Care (FOC)<br>*Consumer-rated measures:*<br>Mental Health Inventory (MHI-38)<br>Behaviour and Symptom Identification Scale 32 (BASIS-32)<br>Kessler 10 Plus (K10+) |
| **Older persons** | Health of the Nation Outcome Scales for Elderly Persons (HoNOS65+)<br>Life Skills Profile 16 (LSP-16)<br>Resource Utilisation Groups – Activities of Daily Living (RUG-ADL)<br>Focus Of Care (FOC)<br>*Consumer-rated measures:*<br>Mental Health Inventory (MHI-38)<br>Behaviour and Symptom Identification Scale 32 (BASIS-32)<br>Kessler 10 Plus (K10+) |

## Testing of the proposed framework through the Mental Health Costing Study

The purpose of the Mental Health Costing Study is to test the UQ framework. As at the end of December 2014, the first tranche of activity data has been received from study sites, with analysis underway.

IHPA will use the full activity and cost data from the study, due to be submitted in early 2015, to test whether the new concepts can be applied in different settings and to different

[16] National Mental Health Information Development Expert Advisory Panel 2013, *Mental Health National Outcomes and Casemix Collection: NOCC Strategic Directions 2014 – 2024*, Commonwealth of Australia, Canberra, p. 20.

consumer cohorts, and whether they are determining factors in the cost of providing mental health care. This analysis will be used to inform version 1.0 of the AMHCC.

## Consultation questions

7. Are there any further considerations in relation to the proposed architecture?
8. Is there any further evidence that should be considered in testing the proposed architecture?
9. Which psychological interventions, if any, may be of significant in understanding the cost of care?

# Next steps and further opportunities to participate

As with other classification systems, development of the AMHCC will take time and a number of iterations. The version to be implemented in 2016-17 is unlikely to apply to all types of mental health care service settings or providers, as data to support classification development will need to be sourced over the coming years, with data collection mechanisms built up. Part of the consultation processes and developmental work for the 2016-17 iteration will be identifying areas of focus for future work.

The following steps will guide the development of the 2016-17 AMHCC; however, consultation will continue on its ongoing development beyond this.

## Refine and finalise the AMHCC framework

Once **public consultation 1** has concluded in February 2015, IHPA will consider the feedback received and publish the final framework on the IHPA website.

IHPA will undertake further targeted consultation with clinicians, service providers, consumer and carer groups, and classification and funding specialists on specific issues as needed throughout this process.

The IHPA Activity Based Funding Conference 2015, which will take place from 27-29 May 2015, will include a workshop on the development of the AMHCC.

## Develop AMHCC version 1.0

With oversight from the MHCERG, in early 2015 IHPA will commence development of version 1.0 of the AMHCC. This will be informed by the final framework incorporating feedback from this consultation paper, and the Mental Health Costing Study data and analysis.

Based on the quality and breadth of the data from the Mental Health Costing Study, IHPA will consider whether there are branches of the AMHCC which require more data in order for them to further developed, for example, a particular service setting or patient cohort. IHPA will then undertake further one-off studies as required, or may propose a staged process for AMHCC development.

Version 1.0 of the AMHCC will be released for **public consultation 2** in mid-2015.

Concurrent with this, IHPA will pilot version 1.0 of the AMHCC from mid-2015, to test the concepts and provide data to refine the classification.

IHPA will again undertake further targeted consultation on specific issues as needed throughout this process.

## Develop AMHCC version 2.0

From late 2015, guided again by the MHCERG, IHPA will consider feedback from the public consultation on AMHCC version 1.0 and the results of the pilot to start development of version 2.0 of the AMHCC.

Version 2.0 of the AMHCC will be released for **public consultation 3** in early 2016.

IHPA will consider the feedback from this consultation and again undertake further targeted consultation on specific issues as needed and use this to finalise AMHCC version 2.0.

The ABF MHC DSS will also be updated to reflect AMHCC version 2.0.

The final AMHCC will then be released for implementation from 1 July 2016.

## Consultation questions

10. Are there particular aspects or areas of the AMHCC that should be prioritised in its development, or aspects that should be developed at a later stage?

11. Are there any further considerations that should be taken into account when developing the AMHCC?