submissions ihpa

From: Jerry Burong [redacted]
Sent: Friday, 13 February 2015 12:49
To: submissions ihpa
Subject: Mental Health primary carer: Submission Australian Mental Health Care Classification - Public Consultation Paper 1 [SEC=No Protective Marking]

Submission's Officer
Independent Hospitals Pricing Authority

RE: Public Consultation Paper 1: Development of the Australian Mental Health Care Classification

Submission AMHCC

The AMHCC relies on semantically defined classifications that lends itself to opinionated application and will be unnecessarily complex.

Any complex project requiring success outcomes, be it designing a process or services, require robust and standardised taxonomies to facilitate measurements of desired outcomes, followed by ongoing improvement reviews, the application budget planning/review/discipline and clear metrics to measure and track efficient use of time/resources/people/costs.

Furthermore, the above structured definitions should also facilitate user friendly global benchmarking between different organisations and operational settings.

Proposed strategies to develop AMHCC as a diagnostic and operating management tool

Use project planning and execution strategies by clearly defining the desired front end objectives involving the following consideration:

- ***The clinician and healthcare professionals jointly define desired objectives as a scoping document***

  Collaborate with information engineer or systems analyst or experienced business manager with operations experience to provide informed implications to further refine the conceived and execution strategy.
  It is analogous to the prospective home owner appointing an architect to design the home to desired outcomes and constraints.

- ***Project objectives for consideration***

  - What are the desired clinical and healthcare criteria's (psycho-social) that will be the basis for mental health diagnosis and psycho-social recovery/rehabilitation/support improvements?

- Will the criteria's change over time as medical insights/techniques improve (say DSM changed by NIH or others) as well as future improved designs of psycho-social innovations – if so in what way and what is its nature?
- How can we define the criteria to ensure it is user friendly at the coal face.
- Is there a possibility that desired clinical and psycho-social s recovery/rehabilitation/support criteria for, say, a particular patient may be revised?

- ***Enhancing MH (Mental Health) healthcare delivery cost efficiencies and optimising coal face and consumer benefit outcomes***

  Design the system to reduce data transaction steps (bums on seats and why repeat data entry that resides in the database?); apply and operate based on Management by Exception principles requiring authority levels matched to responsibility benchmarked to metrics on budgeted cost and resources incurred basis.

- ***Improve on the present organisational, management, decision making and informational flow***

- ***Is it necessary for the system be migrate-able and reconfigured-able to a future new institutional structure?***

  What are the desired trade-offs, and options, in terms of cost versus convenience and flexibility?

- ***Will the system be patched into portable in-the-field applications such as tablets using Wi-Fi and will it require internet access?***

- ***What are the specific data to be compiled on the patient***

  Will the AMHCC system be linked to legacy in-house mainframe or server databases (medical, personal, accounting, mapping etc.) as well as external departments (police and Centrelink and corrective services).
  Can the system help ensure continued medication and psycho-social support by tracking homeless or "nomadic" consumers by having the AMHCC digital system networked to Centrelink - since such clients are likely to need continued access to pensions in their moments post psychosis? Presumably by requiring periodic visits to Centrelink thus providing the consumer to visit the nearest MH clinic should there be Missed appointments.
  What will the level of authorised access be by job title and how much can be linked to tiered echelon authority levels on the basis of need to know?
  What amount of information can be shared by whom across the organisation and at what echelon levels?
  Will AMHCC benefit by including ethnic background to help develop greater insights into cultural and genetic effects of treatment and support.

  Reduce coal face input by ensuring healthcare professionals access to meta database.

- ***What is the specific information needed by each authorised echelon user***
  Required for the purposes of diagnosis; assessment on individual progress (per visit or periodic); operations management to track various MH programs in order to assess its progress or budgetary constraints, program resource and cost utilisation, program planning and budgeting submissions.

- *System design parameters*
  Will it be to be scalable; require migrate-able capabi8lity using off the shelve systems that is compatible to existing legacy mainframe (is this desirable?) and in-house servers and systems.
  OR is it better to use, say, open systems like Unix for future upgrades?
  Perhaps, migrate the mainframe legacy data to the new system?
  How can the system workload be minimised to reduce capital costs in terms of software and hardware computing power?

- Does it need to include “google type” mapping and the mapping system proposed by Connetica?
- What will be the desired initial budgetary estimate and time frame?

Basically we need clarity of what is wanted in order to assess its systemic implications within that MH organisational universe that in turn simplifies its design and to better understand the complexity and criteria’s required.
From that clarity will come the various flowcharts on decision tree, information flow, and how it fits into the present or future organisational structures.
It will help ensure operational convenience and accommodate future structural and criteria changes.

The world is full of developed systems in this networked digital information based socio-economic world.
For example, there exists a huge amount of mapping applications even for field use by geologists, forestry, utilities using RFID to read meters etc. that already possess the systems capability for of the shelf use and same may apply with the above.
No doubt the same applies to above with modifications of coursre.5he

The conceptual phase does not require much money and time because it is a mud map to arrive at a strategic approach and better understand the degree of risk and challenges involved.

General comments of the MH healthcare delivery and MH research in both State and Federal Level

Australia faces at least one decade of austerity because we frittered away the Once-in-a-Century mining revenue windfall and the global economy is experiencing structural economic declines as well as geopolitical risks as the new multi-polar world emerges. Our living standards will fall until Canberra is in a position to increase aggregate productivity and create new economic sectors to replace lost revenue from lower mining and hydrocarbon demands AND lower export prices.

Our MH healthcare delivery sector is cost inefficient and absorbs too much of the annual budgets allocated by both State and Federal governments.
There a literally AUD billions of savings that can be unlocked for better investment at the coal face.

Australia has insignificant (by global and export revenue basis) pharmaceutical business processing medication.
The Psychiatric DSM criteria used to justify basic research is an ideology with very few biological origins prompting the US NIH to fund a USD100 million research effort to replace it.
Furthermore, the antipsychotics presently used will not be replaced for at least another decade and perhaps longer.

It is a business reality that Australian patents on new potential drugs, for example, are sold or funded by mezzanine venture capitalists and international big pharma for a pittance because of the huge costs and risks when it is being developed into saleable medication in which few are realised.
Most basic research involves public finds directly or indirectly and patented discovery represent an Australian subsidy that when commercially success makes huge profits for offshore big pharma only.

Given the commercial reality it is suggested that applied research based on commercially realistic risk/rewards should be funded in this era of austerity based on prospective practical outcomes possible within, say, a 5 year time frame.

Sincerely,

Jerry and Nancy Burong
Primary carers