Australian Health Ministers' Advisory Council

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MENTAL HEALTH, DRUG AND ALCOHOL PRINCIPAL COMMITTEE
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Mental Health Information Strategy Standing Committee
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12 February 2015

Dr Sherbon
Chief Executive Officer
Independent Hospital Pricing Authority
P.O. Box 483
DARLINGHURST NSW 1300

Dear Dr Sherbon,

Re: Development of the Australian Mental Health Care Classification – Public Consultation paper 1 – February 2015

Thank you for the opportunity to provide further feedback on the development of the Australian Mental Health Care Classification (AMHCC). As you know the Mental Health Information Strategy Standing Committee (MHISSC) brings together consumers, carers, peak mental health bodies, NGOs, state/territory and national governments, private hospitals and organisations involved in collection, analysis and reporting of Australian mental health data.

The development of a better funding model for mental health which supports the important shared directions for reform is also a priority of the MHISSC. We acknowledge that the developments of the AMHCC and of subsequent funding models are distinct and should be conducted in discrete stages. Effective mental health services need to be strongly focused on the needs of consumers, supporting personal recovery as well as effective clinical care. They should always involve families and carers, and properly record this work. They should provide care as early as possible and in community settings. They should also work to avoid hospital admission, but when this occurs they should ensure maximum integration and continuity of care. They should encourage a diversity of providers, and develop systems for good communication between those providers. An effective classification will support the development of funding models which support these objectives.

MHISSC anticipates that individual MHISSC members' organisations will respond separately to IHPA's consultation call and address broader clinical and service delivery and policy issues. This submission aims to summarise areas of common concern to MHISSC members. In keeping with MHISSC's role, the submission focuses on technical and data aspects of the proposed AHMCC. The feedback below builds on and is consistent with feedback MHISSC provided in response to earlier IHPA consultations.

Our feedback falls into three main areas:

a. Purpose and scope of the AMHCC.
b. Clarifying the assumptions and design principles of the AMHCC.
c. Specific issues within the proposed AMHCC.

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A: Purpose and scope of the AMHCC

MHISSC appreciates that the purpose of the AMHCC has changed since IHPA's initial consultation. The AMHCC was initially intended to enable accurate pricing of mental health services under the National Health Reform Agreement (NHRA). However, changes to the NHRA mean 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 Activity Based Funding (ABF). Therefore the AMHCC's function is no longer tied directly to that purpose, or to the scope of services and populations that were included in the NHRA.

A number of states and territories have indicated that they are committed to including mental health services within ABF models. A consistent national AMHCC would benefit states and territories, and help to avoid the development of many different classifications. However states and territories will now have greater discretion regarding either the adoption of a national classification model or whether they progress with other models currently being developed and tested in various locations. To be of value to states and territories, the scope of AMHCC should ideally include the full range of populations seen by mental health services, the full range of settings in which mental health services are provided (including ambulatory and community residential settings) and the full range of providers funded by governments (including, increasingly, non-government organisations).

IHPA's proposed timelines and structures reflect the original goals and scope of the NHRA. We submit that to maximise the validity of the AMHCC and its take-up by states and territories, IHPA needs to ensure strong representation and detailed consultation with states and territories beyond its current arrangements. IHPA should ensure that its Mental Health Working Group and Mental Health Classification Expert Reference Group include expertise relevant to (i) the range of populations included in the classification and (ii) the jurisdictional agencies responsible for adopting and implementing any proposed classification.

Against this background, MHISSC queries the timing and purpose of the review more broadly. MHISSC was of the understanding from previous IHPA advice that members would provide feedback on Version 0.1 of the AMHCC with the pilot data collection informing Version 0.2 and leading to further stakeholder consultations. Given that the Data Set Specification (DSS) has already been developed, it is unclear how the current feedback will inform the proposed AMHCC development.

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B: Clarifying the assumptions and design principles of the AMHCC

The consultation paper includes a number of assumptions that are either ambiguous or not clearly stated. It would help the clarity of future development if some of these underlying assumptions could be stated or clarified as design principles. These include:

Is AMHCC setting-specific?
The consultation paper summarises a range of international approaches to mental health classification. A number of the models described are "bundled" models which aim to define and cost a single episode of mental health care which spans inpatient and community settings. The proposed AMHCC appears not to take this approach; however, this is somewhat ambiguous in early stages of the paper, and described as a detail of the definition of episodes of care (page 25) rather than as a high-order design principle. MHISSC supports the development of separate inpatient and community approaches, while acknowledging the design challenge of avoiding price signals which encourage inpatient care. However, we suggest that this principle should be more clearly articulated and that IHPA make it clear that the model will segment into settings with a single cost differing between these settings.

How will AMHCC approach specialist children and adolescent services?
MHISSC members support the scope of the AHMCC which has broadened to include mental health services for children and adolescents. However, the model proposed in the consultation paper is silent on how the particular issues affecting this population will be reflected.

Children and adolescent services use tailored treatment programs for their clients that are likely to have different mental health treatment costs and cost drivers. The current data architecture (p25) does not distinguish children and adolescent services as a separate category, implying that the data items needed to develop or implement a classification will be shared with those of adult services, and that drivers of cost difference will apply equally across the two types of services. These assumptions may not be correct: for example if outcome measures are included in the model as proposed, child/adolescent services use different symptom, disability and functional measures (the HONOS-CA is used instead of the HONOS, etc).

MHISSC proposes that children and adolescent services be identified as a separate branch within the model, mirroring the proposed structure for the general adult model but allowing differing data inputs to be collected generating unique children and adolescent costs. It would be helpful for there to be further development of the approach to this issue, and for the basis of the approach to be explicitly declared in the model.

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How will AMHCC balance expert and empirical evidence in further development?

The consultation paper notes that in addition to the Mental Health Costing Study, additional data will be used to inform the development of the AMHCC. A clearer understanding of the range of other inputs that will inform the next stages of development would be helpful. The Mental Health Costing Study may be unable to resolve a number of the important questions, either because of limitations in the study or because some issues cannot be derived empirically from such a study but require consensus positions on clinical or service standards. For example, the clusters which form the basis of the UK funding approach have not been empirically derived but are "crafted" on the basis of expert opinion, and are still being tested and refined. IHPA should articulate (i) what issues it saw as requiring further development through expert consultation and (ii) how that consultation would occur. MHISSC does not believe that the current Mental Health Working Group would provide a sufficient basis for such consultation.

How will AMHCC treat demographic or regional differences which influence cost?

A number of demographic (patient variables) and regional differences (system variables) will significantly drive differences in the cost of care. The consultation paper is silent on the fundamental design approach to this issue. Clarification should be provided on whether these issues would be considered as falling within the classification, or would instead be seen as pricing issues, reflected in the subsequent establishment of different price loadings after implementation of the classification.

As an example, it is likely that costs of service may be higher for Aboriginal and Torres Strait Islander Australians, for a range of reasons. The New Zealand costing model has included ethnicity as a variable in its classification. An alternative would be to apply the same classification, but to apply a price loading for services for Indigenous people, in effect crafting the funding model on the basis of subject matter expertise. The former approach is more complex, but allows the development of models which may also include the application of different cost drivers for different populations.

Similar issues may apply to regional differences (e.g. state and territory differences due to variations in health systems or staffing costs). For example, when undertaking the Mental Health Classification and Service Costs (MH-CASC) project, it became apparent that mental health costs differed between jurisdictions potentially masking the contribution of other variables. For example, all else being equal, the cost of a clinical visit would differ between the Northern Territory and Victoria purely due to location. Thus jurisdictional price variations would need to be taken into account in the funding model to ensure an accurate price was obtained. MHISSC proposes that these non-patient variables be removed from the classification (i.e. standardise unit costs) and be attended to in the subsequent 'funding' model to remove their potential confounding effect.

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C: Specific issues within the proposed AMHCC

This section discusses a number of specific issues within the proposed AMHCC of concern to MHISSC members.

Phase of care

As flagged in MHISSC's earlier correspondence with IHPA, MHISSC is anticipating that IHPA's costing study will shed light on the validity and utility of the proposed concept of "phase of care" and that the DSS will be adjusted to reflect its findings. While the concept has face validity, there are several significant issues which remain to be resolved. First, the current descriptions/definitions are ambiguous and have the potential to confuse clinicians. There is a need to thoroughly test the feasibility and inter-rater reliability of these definitions. Our brief desktop review of these showed very significant differences in interpretation between readers. Issues which were interpreted variably included: the boundary between initial assessment and acute treatment (for example, are first two weeks of an acute hospital admission "initial assessment" or "acute treatment"?); the meaning of "functional gain" (is this intended to capture care which is short-term but less intense, or only apply to longer term care?); the blurring of dimensions of intensity, duration and focus in several categories; and the rules that might apply when a person in long term care needs a brief period of more acute or intensive support.

If inter-rater reliability is low, as we suspect it would be, this would need resolution either by refinement of the definitions and descriptors or significant investment in staff training. Even with well-defined items, we remind IHPA that introduction of this new data concept will require considerable investment by states and territories. The requirement to train clinician staff in the collection of these data will place both financial and time burdens on jurisdictions.

Second MHISSC is concerned at a possible intrinsic disincentive for accurate collection of the data. The model requires clinicians to make a clinical decision on "phase of care". This change in phase will trigger a requirement for a potentially significant data collection (new outcome measures, diagnoses etc.), often by the same clinician. Therefore it is very likely that many clinicians will seek to avoid recording a change in "phase of care", in order to avoid a time-consuming data collection.

MHISSC recommends that testing of these concepts continue and include test-retest and inter-rater reliability assessments to ensure that the model and data being collected are accurate and robust.

Inclusion of MHIC classification

IHPA has included the Mental Health Intervention Classification 1.0 (MHIC) within the proposed DSS, but does not propose to include it within the AMHCC, writing "*understanding the type of care provided will help build a*

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better understanding of consumer profiles, but the inputs (the interventions) themselves will not determine the structure of the classification" p28.

MHISSC does not understand IHPA's position on this issue. Despite its clearly expressed reservations about the generalisability of the MHIC in its current form across settings and jurisdictions, MHISSC questions why IHPA would not include interventions in the AHMCC if they prove to be predictive of costs.

MHISSC's earlier concerns about the inclusion of MHIC within the current DSS have not been allayed. As previously advised, the current MHIC was developed before consideration of ABF development, and was not designed to reflect cost-related issues. The development of MHIC followed earlier unsuccessful attempts to build comprehensive intervention classifications capturing all mental health activity. MHIC in its current form is deliberately aimed to capture only selected, clearly identifiable interventions. Therefore it is not surprising that services have felt the need to add to or modify MHIC as part of the current costing study. However, these modifications have not been standardised and have not been through the same process of testing as other MHIC codes. MHISSC still maintains that further refinement of the current MHIC is required and that IHPA should identify an appropriate entity to undertake this work on a long term basis.

In conclusion, MHISSC is hopeful that the AMHCC has the potential to be a beneficial tool for all jurisdictions. However, further testing and refinement of the classification's model is indicated before it can be considered fit for purpose. Significant investment in staff training and developing a consistent implementation approach will be required by jurisdictional authorities to ensure the tool is valid and reliable and that it provides consistent data across jurisdictions.

MHISSC remains committed to working with IHPA to further develop and refine the proposed AMHCC to enhance its utility for jurisdictional mental health authorities. We are grateful for Ms Jennifer Nobbs continued representation on our committee and will continue to work closely with her. Please don't hesitate to contact me (02-8877 5120 or Grant.Sara@health.nsw.gov.au) should you wish to discuss this matter in more detail.

Warm regards

Dr Grant Sara
Chair
Mental Health Information Strategy Standing Committee

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