Government of **Western Australia**
Department of **Health**
Purchasing and System Performance

Our Ref: REF
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Mr James Downie
Acting Chief Executive
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Downie

PUBLIC CONSULTATION PAPER 2 – DEVELOPMENT OF THE AUSTRALIAN MENTAL HEALTH CARE CLASSIFICATION

Thank you for the opportunity to comment on the Public Consultation Paper 2 on the Development of the Australian Mental Health Care Classification (AMHCC).

In general, WA Health supports the development of the AMHCC as a new classification system for mental health services. However, there are some areas of the AMHCC that still require further development and clarification. The WA Health response to the consultation questions is provided in Attachment A.

I note that the IHPA is intending to implement the AMHCC for reporting from 1 July 2016 and pricing from 1 July 2017. At a system manager level, there is a considerable amount of work that jurisdictions will need to undertake to meet the national timeframes.

WA Health is reviewing the implementation requirements and will continue to work with the IHPA on this important matter.

Yours sincerely

Angela Kelly
ASSISTANT DIRECTOR GENERAL
PURCHASING AND SYSTEM PERFORMANCE
30 December 2015

Attachment A: WA Health Response to the Public Consultation Paper 2 on the Australian Mental Health Care Classification

Government of **Western Australia**
Department of **Health**

ATTACHMENT A

WA HEALTH RESPONSE TO THE IHPA PUBLIC CONSULTATION PAPER 2 ON THE DEVELOPMENT OF THE AUSTRALIAN MENTAL HEALTH CARE CLASSIFICATION

The Western Australian Department of Health (WA Health) welcomes the opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) on the Consultation Paper 2 on the Development of the Australian Mental Health Care Classification.

Consultation question

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

Response:

- In general, WA considers the variables to be relevant to clinicians, health services and other stakeholders.
- Of the three variables tested in the Mental Health Costing Study (MHCS), WA supports the Mental Health Intervention Code and First Recent Episode of Care not being included in the AMHCC Version 1. WA supports the inclusion of Mental Health Phase of Care.
- WA considers that there are still some areas of the AMHCC Version 1 that require further development and clarification prior to the implementation of the AMHCC such as clear business rules on phase of care.

Setting

- While WA Health recognises that it may have been preferable for the AMHCC to apply to mental health care without the need to split the classification based on setting; this is not practical as not all jurisdictions have implemented the necessary unique patient identifier.
- However, under the current admitted/community split it is unclear how some services, such as outreach, day programs, and hospital-diversion based services will be classified.

Mental Health Phase of care

- As currently described, there appears to be some inconsistency between the phase name and their description. WA would like to suggest that in terms of terminology, functional gain, intensive extended and consolidating gain may

be better described as subacute, intensive rehabilitation, and recovery, respectively. These terms would be of greater relevance to clinicians.

- The AMHCC is currently unclear as to whether the phase of care is determined by the intensity of treatment or the stage in the illness, or a combination of these factors. Further examples and case studies would help to guide clinicians in determining the most appropriate phase of care to a patient.
- WA would welcome further work by IHPA on the definitions and business rules to support consistent implementation across jurisdictions and health services in how clinicians assign the phase of care.
- WA would like to highlight that adolescence is a stage of life that can be accompanied by significant volatility. Clear business rules and specific examples for adolescent consumers would assist with appropriate and consistent clinical decisions on phase of care.

Age group

- The age groupings of 0-17 years, 18-64 years and 65+ years for both the admitted and non-admitted setting are supported as the initial splitting variables. However, age classes should be considered further in later iterations of the AMHCC as highlighted in our response to Question 2.

Mental Health Legal Status

- Mental health legal status as a data class for admitted patients is supported as it is indicative of the complexity of the intervention provided.

Complexity measures

- The HoNOS complexity is a system measure and may therefore not be the most useful clinical indicator. However, as there is no other measure of complexity implemented across health systems, WA supports the data variable for both the admitted and community setting.
- The use of LSP-16 as a data class is supported in the community setting due to its usefulness to measure functioning.
- WA considers it important that appropriate measures of complexity are included in the AMHCC. Some alternative measures for assessing the complexity for children and adolescents are outlined in response to Question 2.

Consultation question

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

Response:

WA has identified the following variables for consideration in later iterations of the AMHCC.

a) Mental Health Legal Status
   - As Mental Health Legal Status is already widely collected, WA would like to suggest further consideration of this variable to all phases of care, not just the admitted, acute phase.
   - WA has a Hospital Extended Care program where a considerable number of individuals are involuntary. This site was not part of the Mental Health Costing Study. It is feasible that the MHCS did not provide sufficient data to determine how significant a cost driver legal status is for long stay inpatients.
   - WA would also like to suggest that this variable is considered further for community settings to reflect post discharge follow up and ongoing treatment of clients on Community Treatment Orders.

b) HoNOS-secure
   - The HoNOS-secure is designed to be used in secure or forensic adult settings and add to the clinical assessment by providing additional information relating to the degree of risk which an individual presents to both themselves and others. This variable can influence length of stay and limit discharge options available to the consumer. WA would like to suggest that this variable is explored as a potential cost driver for later iterations of the AMHCC.

c) Length of stay
   - In a forensic setting, length of stay may be determined by the Attorney General / Courts. In these circumstances, it is not within the power of the health service to determine when a person can be discharged.

d) Treatment resistance
   - All else being equal, some patients respond to treatment while others don't, and this may influence HoNOS-secure and length of stay.

e) Comorbidity
   - While comorbidity is already included, concurrent substance misuse disorders, cognitive disabilities, personality disorders can all combine in a patient with a psychotic condition to escalate HoNOS-secure, length of stay and treatment resilience.

f) Homelessness status
   - WA suggests that homelessness status be considered as variable for future iterations of the AMHCC as it appears to disproportionately affect cost and length of stay, more than is indicated by using item 11 on the HoNOS[i].

g) Psychosocial complexity
- Psychosocial complexity is not currently captured in the classification and can have an impact of social care services and length of stay.
- WA acknowledges that due to low samples size there was currently insufficient evidence to support the inclusion of the Global Assessment Scale (CGAS) and Factors Influencing Health Status (FIHS).
- Strength and Difficulties Questionnaire (SDQ), CGAS and FIHS could be explored further for later iterations of the AMHCC as a method of capturing psychosocial complexity for children and adolescents.
- The International Classification of Disease 10 (ICD 10) - Z Codes, could also be considered as potential variables that would allow for improved measurement of psychosocial complexity.

h) Age classes
- WA suggests that consideration be given to the inclusion of a Youth Stream service provision for 16-24 year olds. This would support the intensive treatment provided for early episode psychosis and reflect the specialized nature of treatment for the older CAMHS cohort.
- The nature of assessment, treatment and support provided to younger children and adolescents is significantly different. WA suggests that consideration also be given to further dividing the 0-17 year age group.

Consultation question

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

Response:
- In general, WA considers the final classification groups to be relevant at this initial stage of the AMHCC. WA highlighted a number of variables for further consideration in response to Question 2.
- WA considers it is important to be able to differentiate between specialist services whose costs may be increased due to the client group whom they provide a service to. An example of a Specialist Stream would be forensic mental health services.

Consultation question

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

Response:

- WA supports ongoing development and the refinement of the AMHCC and considers the priorities identified for the next stage of the AMHCC to be appropriate.

Mental Health Phase of Care

- WA supports Phase of Care as a priority for further development as a priority to support implementation of the AMHCC Version 1 from 1 July 2016.

Child and Adolescent mental health care

- WA welcomes further consideration of child and adolescent mental health care as a priority for classification development. WA Child and Adolescent Mental Health Service would be willing to participate as a pilot site to assist in developing this area of the classification.

Residential mental health care

- WA supports further work to inform the residential branch of the AMHCC.

Community-managed mental health services

- WA supports further consideration of community-mental health services and refers to points raised in response to Question 5.

Consultation question

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

Response:

Diagnostic Groups

- Consideration could be made for diagnoses which do not currently fit under ICD-10 classification but are recognised diagnostic groups by mental health clinicians for which services are currently being provided, for example “At Risk Mental State for Psychosis”. Although this diagnosis was considered for DSM-V, it was eventually placed in Section III under “conditions for further study” as “Attenuated Psychosis Syndrome” [ii].

Co-morbidities affecting length of stay

- Consideration could be made for co-morbidities that are significant factors in terms of length of stay and cost, for example co-morbid drug and alcohol issues and intellectual disability. These variables are currently not factored into the AMHCC; however they can disproportionately affect length of stay and costs.

Business rules that support shared care

- WA considers that it is important that business rules support appropriate shared care. For example, the provision of services to young people often requires working in a shared care model between child and adolescent services and adult services. Business rules should support shared care between the admitted and community settings.

Consumers receiving treatment in admitted and community settings

- WA has some concerns over the reporting and funding arrangements for consumers receiving treatment in both the admitted and community settings.
- For example, there could be the situation where community mental health is not funded for consumer focused service delivery within inpatient, and inpatient is not funded for post-discharge follow up. There may also be potential funding implications for clients who are case managed by community staff but who are at the same time an admitted patient.
- WA would welcome further consideration of this matter to ensure that all services receive the appropriate funding and consistency across jurisdictions that may have different abilities to record this type of data.

Weighted HoNOS score thresholds

- In regards to the *Weighted HoNOS score threshold for 'high complexity* (Appendix B on page 32), WA would like further clarity on how the thresholds were determined.
- The threshold for 'Acute' for a 0-17 year old admitted patient is lower than the threshold for 'Acute' for a 0-17 year old community patient. This could be interpreted as indicating that a patient should be more 'well' when discharged from an inpatient unit than when discharged from community.
- WA considers that the 'Consolidating gain' score for Community patients appears particularly high. In WA CAMHS, a score of 23 is considered clinically significant.
- WA has some concern with the appropriateness of using absolute HoNOS scores to assist with developing a costing measure, which are intended for clinical decision making.

Evidence-based relationship treatments

- WA notes the difficulties in capturing the cost of treatment when considering the child as an individual, rather than a child dependent on the quality of their caregiving environment and other social ecology factors. Costs associated with evidence based treatments to enhance relationships could be considered further.

AMHCC and NMDS

- WA suggests further consideration of the interconnection between the AMHCC which is MH patient-based (AMHCC) and the NMDS which is mental health service orientated. In particular, the activity provided by specialised community mental health services where:
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Community Mental Health services

- The episode based classification may not necessarily fit for a Community Mental Health services. WA suggests that further work be undertaken at Service Contact level to determine the cost drivers in the community setting to take into account:
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  b) Cost providing group sessions vs individual sessions;
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Pricing model

- It is unclear if the AMHCC will retain the current loadings in the AR-DRG classification. Indigenous status and remote location can be significant factors in the cost the delivering mental health services.
- Consideration could also be given to loadings for cultural and linguistic diversity and consumers with speech/hearing difficulties.

Mother and baby unit

- King Edward Memorial Hospital has a Mother and Baby Unit (MBU), which functions as a statewide authorised inpatient treatment centre for acute psychiatric conditions in the postnatal period.
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