

18 December 2015



Australian Health Ministers'
Advisory Council

James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
P.O. Box 483
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Dear Mr Downie, *James*.

**Re: Development of the Australian Mental Health Care Classification
Public consultation paper 2**

Thanks for the opportunity to comment on the draft Mental Health Care Classification (AMHCC). MHISSC members acknowledge the extensive and detailed work done by IHPA in developing the classification to date, and recognise the need to start with a “good enough” classification and improve this incrementally.

In previous submissions we have documented MHISSC members’ concerns about conceptual, technical and practical issues with the classification development. This submission focuses on the specific questions asked in the Consultation Paper, but starts with several broad issues that should be considered in further development of the classification (Question 5).

The consultation paper starts by outlining some of the significant benefits to be gained from an effective classification, including improved understanding of cost and better transparency of reporting. These are important benefits. However in our view the paper overstates other potential benefits of AMHCC. It is by no means certain that AMHCC “promotes integrated service delivery” (p7). No funding model intrinsically promotes service integration, and an ineffective model could equally discourage community care. AMHCC can “enable performance benchmarking” (p7), however only for benchmarking on specific issues of cost and technical efficiency rather than on broader issues of clinical performance which have been the focus of much national and state benchmarking activity.

On the other hand, the paper does not acknowledge that the benefits of implementation of AMHCC are also balanced by significant risks and costs, for states and territories required to implement the classification and for staff and consumers of those services. These include substantial potential impacts on workforce, clinical processes and information systems. We won’t detail these as they have been discussed in earlier submissions. However, in the early stages of implementation these costs and risks may outweigh any benefits realised, and so it is essential that the classification be as ‘fit for purpose’ as possible.

A major issue for MHISSC members in weighing up these benefits and risks is that the current paper provides insufficient information to allow an objective or independent view of the technical performance of the draft AMHCC. A technical paper was released on 15 Dec, unfortunately only days before the deadline for comment and after initial submissions had been prepared. We appreciate the complexity of IHPA’s work on this issue, but there remain several important issues on which more information is required. These include

- **Costing methodology and accuracy:** preliminary IHPA documentation on the costing study included limited information on costing



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methodology, and suggested up to three-fold variation between states and study sites in final 'product' costs. The costing data used as the main dependent variable in the classification has not been standardised in a way that could reduce the impact of this variation. Unless addressed, this risks compromising class findings by confounding site variation with patient-driven variation. *We would recommend that IHPA consider testing the robustness of the draft classification by conducting further analysis using standardised cost data.*

- **Reliability of the allocation of mental health phase.** The paper acknowledges significant concerns about the clarity and inter-rater reliability of the current definitions. Many of the costs and risks for state/territory implementation are related to the implementation of the phase concept into clinical and data systems, and it is critical that these phases can be validly and reliably defined. This issue is discussed in more detail below.
- **Possible bias due to the exclusion of open episodes.** The draft classification has been based on only a small and probably unrepresentative minority of the episodes collected. The costing study collected data on 58,209 episodes. Of these, only 20,934 episodes (36%) were examined for classification development: the remainder were excluded because phase of care commenced outside the reference period. Only 14,592 episodes (25%) were included in calculating the performance of the classification. No information is provided to allow comparison of the included and excluded episodes, but it is highly likely that they would differ systematically from each other. Many episodes of community care are long, and many will span more than one reference period. These episodes are likely to be longer in duration and higher in cost than episodes which begin and end in a reference period (particularly the brief reference period of the costing study). They will differ systematically in clinical features and complexity from briefer episodes. Therefore classification development may be based on a subset of episodes which are highly unrepresentative of the normal range of community mental health episodes. The apparent performance of the classification may also be inflated by being tested only in a minority of episodes where much variability in length of episode, and therefore cost, has already been excluded.
- **Applicability to episodes of care occurring outside of specialised mental health service settings.** These episodes are an intended target of the current classification. The consultation and technical papers do not quantify this issue, but we understand that very few of such episodes were included in the costing study and classification development. These episodes are likely to differ significantly in diagnosis, complexity and cost from episodes in designated mental health services. Their inclusion or exclusion could have major impacts on the broader classification, for example the absence of diagnosis as predictive factor may partly reflect the selection of only very severe and complex cases of some disorders (e.g. depression, anxiety) for admission to acute mental health units.
- **Defining the appropriate unit of counting.** The summary table on comparative RIV of the AMHCC (p23) compares performance in explaining variation at episode level. Given the costed product used for AMHCC is phase, it is not clear how this episode analysis has been undertaken. The reported performance advantage of AMHCC shown in that table suggests that episode may be the appropriate classification unit. There have been previous calls for IHPA to establish a strong case for the relative superiority of phase over episode as the costed unit by providing the technical data and to demonstrate that the substantial additional cost and complexity involved in implementing phase is accompanied by an incremental improvement in the predictive power of the classification. This table reinforces previous proposals for a reanalysis to be based on episode units rather than on phase.

MHISSC concurs with other commentators that it would be highly desirable for IHPA to subject the costing study data to independent analysis to verify the approach taken. Given

the potential impact of introducing the AMHCC, a second check would be a sensible approach to build confidence that we do in fact have the best possible solution.

Regarding IHPA's specific questions:

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

Most variables included (setting, age group, HONOS) are widely used and understood, and would form part of routine clinical or management consideration. There are also many other variables that clinicians and managers would see as relevant and important to understanding differences in clinical complexity or service use, including diagnosis, comorbidity, social and family supports, service alliance or engagement, risk and so on. Other outcome measures not included in the classification are also often relevant.

The inclusion of the Life Skills Profile (LSP) is of arguable clinical relevance. The issues that the measure addresses are important, however efforts to implement this measure nationally have produced only limited uptake and support. The quality and completeness of LSP data is variable and often poor. The recent review of the National Outcome and Casemix Collection conducted extensive national consultations with consumers, carers and clinicians. It recommended that a new measure of functioning and ability be developed to replace the LSP. Reliance on the LSP within the classification therefore risks short term problems by attaching financial and administrative incentives to a measure with only limited clinical buy in, and may also be a barrier to the development of more contemporary measures.

The concept of "phase" has clinical face validity. The change in terminology from "Initial assessment" to "Assessment only" is an improvement and reduces some former ambiguity (noting that the paper still uses the terminology "Initial assessment" in Appendix C). However, we remain concerned that overall the Phase definitions remain poorly operationalised, with unclear and overlapping definitions. Because the implementation of Phase is one of the major areas of risk and cost for states and territories, the following section describes our concerns in more detail.

The Consultation Paper includes for the first time a paragraph within each phase definition describing an expected frequency and duration of contact (p 18-19). This is conceptually extremely confusing. Are these statements intended as definitional attributes of the phases, or as more aspirational or advocacy statements about minimum or desirable standards of care? Regardless of intent, the lack of clarity of the definitions means that many readers/users will be likely to rely on these additional and specific statements to assist with definition. What is the origin of these statements? It seems circular and inconsistent with the goals of AMHCC to include statements of resource use (frequency of contact) within a variable used for classification: this seems akin to including length of stay as a defining variable for inpatient classes – that is, it confuses the dependent and independent variables. The statements of resource use appear to have little relationship to clinical reality. For example, the acute treatment phase is described as involving (or possibly requiring) daily contact. Most episodes of acute community treatment involve assessment and then a period of regular contact, but most do NOT involve daily contact. For example a person referred for community treatment of significant depression or early psychosis may receive 1-2 x weekly contact with a psychiatrist or psychologist, but may never require daily contact. If frequency of contact is seen as a definitional attribute then there will also be a large number of "orphan" phases which cannot be classified: they will be of insufficient frequency to be defined as "Acute", but because they are focused on treatment of symptoms they do not fit definitions of other classes. The same issue applies to all phase definitions, and if taken narrowly, a person being seen less than monthly would not fit the definition of any phase. Has IHPA undertaken any analysis of its data to test for alignment between these "expected frequency"

statements and the actual frequency of service contact? Unless this analysis has been done and supports these statements, we would strongly urge that these statements not form part of any future definitions or documentation.

The table below summarises the definitions of phase included in the paper. Significant overlap between definitions remains. For example, the goal of the *functional gain* phase is to improve functioning, while an aim of the *intensive extended* phase is to “assist return to functional capacity”. The *acute* phase has a goal of “reduction in symptoms and distress” while the *intensive extended* phase includes the aim of “assertively manage symptoms or disturbance”. *Functional gain* includes the aim of improving “self-management and adaptation”, while *consolidating gain* has an aim of “promoting recovery, assisting integration and independence”. These distinctions are too poorly defined and open to different interpretations to form the basis for reliable classification.

Table 1 : Attributes of Phases of care (wording shortened from Consultation Paper)

Phase	Goal	Aim	Clinical features	Expected frequency of contact
Acute	Reduction in symptoms or distress	-	Recent onset or exacerbation	Daily
Functional gain	Improve functioning, promote adaptation	Self-management, adaptation, skills	Impairment arising from psychiatric disorder	Multiple contacts per week for an extended period (> 2 weeks)
Intensive extended	Prevent/ minimise deterioration. Reduce risk of harm	Assist return to functional capacity, assertively manage symptoms or disturbance	Stable pattern of severe symptoms, relapse or inability to function	At least weekly over an extended period (>1 month)
Consolidating gain / Maintenance	Maintain or improve functioning, prevent relapse	Promote recovery, assist integration and independence	-	Weekly to monthly

A further issue regarding clinical relevance concerns the approach the AMHCC takes to HoNOS and LSP scores. These two measures are widely used and clinically understood. However, the AMHCC proposes using them in a way that differs dramatically from their current clinical use. As outlined in Appendix B, the AMHCC weights individual HoNOS and LSP items, and applies a different weighting to each item depending on setting, phase and age-group. Without more detailed technical papers, it is not possible to assess the rationale for this approach. However, even if statistically justified, this approach means that the scores and groupings (moderate, severe etc.) used in AMHCC will differ in complex ways from those used by clinicians. This will make the use of the measures within AMHCC largely clinically irrelevant.

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

AMHCC should further explore other variables already included within national datasets, including diagnosis and measures of clinical complexity and comorbidity. Because of the substantial impact of the introduction of new data items, AMHCC should only consider other variables not already included in national datasets if there is strong and independent evidence of a requirement to do so.

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

The broad logic of the classification structure has face validity for the prediction of cost. However, the final classification groups are very unlikely to have clinical utility, or be adopted for any purpose other than costing. The large number and complex nature of the nomenclature of the end-classes means that these have very little chance of use outside specific costing applications.

The use of diagnostic classes will remain central to clinical practice and planning and any classification that does not include diagnosis will not be applicable or relevant for clinical purposes. Diagnostic groups may not predict cost differences, and there are important limits to diagnoses and ongoing debates about diagnostic systems. However, diagnoses remain critical to clinical understanding, treatment planning, communication with consumers and families, prognosis, training, service planning, and access to a wide range of supports. When discussing DRGs, the Paper comments to the effect that “many mental health clinicians” believe that “the use of diagnoses to describe patient grouping has little clinical relevance when compared with other measures such as HoNOS”(p22). This statement lacks credibility and doesn't accord with the experience of MHISSC members involved in implementation of HoNOS in clinical services.

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

The Paper identifies refinement of Phase of Care as a priority. As discussed above, MHISSC is of the opinion that addressing current problems with the phase definitions is an urgent precondition to any initial implementation, rather than a priority for future development.

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

MHISSC strongly supports information development in the NGO/CMO sector. The consultation paper proposes expansion of the AMHCC to include non-government services, presenting this as a marginal or incremental change. In our view there are major policy, conceptual and resource implications which require further, detailed consideration before this expansion could be considered. It is not clear that there has been any policy discussion or agreement between governments that an ABF approach is appropriate to the CMO sector. The range of services provided by the sector is diverse, and a range of funders and funding models exist. Only a small proportion of mental health CMO activity would currently involve episodes of care of the type to be captured by adoption of the AMHCC. Additionally, there are no nationally consistent data sources that would support the development or implementation of a classification for the sector.

Once again, thanks for the opportunity to comment. We remain happy to work closely with IHPA to support this important work.

Yours sincerely



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Chair, Mental Health Information Strategy Standing Committee