Independent Hospital Pricing Authority

ACTIVITY BASED FUNDING MENTAL HEALTH CARE

National Best Endeavours Data Set

2017-18

Technical specifications for reporting

7 February 2017

Activity Based Funding Mental Health Care National Best Endeavours Data Set 2017-18 – Technical specifications for reporting

ABBREVIATIONS

ABF	Activity Based Funding
ABF MHC DSS	Activity based funding mental health care data set specifications
ABF MHC NBEDS	Activity based funding mental health care national best endeavours data set
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AIHW	Australian Institute of Health and Welfare
AMHCC	Australian Mental Health Care Classification
APC NMDS	Admitted patient care national minimum data set
CGAS	Children's Global Assessment Scale
CMHC NMDS	Community mental health care national minimum data set
FIHS	Factors Influencing Health Status
HoNOS	Health of the Nation Outcome Scale
HoNOS 65+	Health of the Nation Outcome Scale 65+
HoNOSCA	Health of the Nation Outcome Scale Child and Adolescent
ICD-10	International Statistical Classification of Diseases and Health Related Problems, Tenth revision
ICD-10-AM	International Statistical Classification of Diseases and Health Related Problems, Tenth revision, Australian Modification
IHPA	Independent Hospital Pricing Authority
LSP-16	Life Skills Profile (Abbreviated)
METeOR	Metadata Online Registry
MH-CASC	Mental Health Classification and Service Costs
MHIC	Mental Health Intervention Classification
MHPI DRS	Mental health phase item data request specification
MHPoC	Mental Health Phase of Care
MHWG	Mental Health Working Group
NHRA	National Health Reform Agreement
NMDS	National minimum data set
NOCC	National Outcomes and Casemix Collection
NAP NBEDS	Non-admitted patient national best endeavours data set
RMHC NMDS	Residential mental health care national minimum data set
RUG-ADL	Resource Utilisation Groups – Activities of Daily Living
UQ	University of Queensland

CONTENTS

1. BACKGROUND

In December 2012, the Pricing Authority approved the development of a new mental health classification for mental health services in Australia for the purposes of activity based funding (ABF).

The development of the Australian Mental Health Care Classification (AMHCC) will significantly improve the clinical meaningfulness of the classification of mental health services, which will improve cost predictiveness and strengthen the implementation of new models of care. There are a number of steps that need to be followed in designing the AMHCC such as defining the services provided, identifying cost drivers, conducting a patient level costing study, developing a classification system and associated infrastructure (for example, data set specifications and grouping software) and collecting ongoing activity and cost data.

In 2012, the Independent Hospital Pricing Authority (IHPA) engaged the University of Queensland (UQ) to develop a definition of mental health care for ABF purposes and to define the cost drivers associated with these services. The UQ Final Report proposed the creation of a separate care type for mental health services, an associated draft definition for classification purposes and the identification of possible cost drivers.

UQ proposed a care type definition which has been modified slightly, endorsed by IHPA's working and advisory groups and approved by the Pricing Authority on 31 May 2013.

The care type definition approved by the Pricing Authority 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.*

Whilst not specifically stated, "assessment only" activities are considered in scope for the classification.

In 2014, IHPA engaged a consortium to undertake a six month costing study in 25 hospitals across Australia including both public and private hospitals, and community mental health services. Data from the costing study was used to build the first version of the AMHCC.

In order to support the development and ongoing use of the AMHCC, IHPA developed the Activity Based Funding Mental Health Care Data Set Specification (ABF MHC DSS) for data collection in 2015-16. The intention of the ABF MHC DSS was to use existing data collections and definitions where feasible, being mindful of the 'single provision, multiple use' data principle.

The development of the ABF MHC DSS 2015-16 was undertaken during 2014 with extensive consultation through IHPA's working and advisory groups, including the Mental Health Working Group (MHWG), the National Health Information Standards and Statistics Committee (NHISSC) and the Mental Health Information Strategy Standing Committee (MHISSC).

A significantly revised version of the ABF MHC DSS was developed for 2016-17 with input from stakeholders including jurisdictional MHISSC and MHWG members at two workshops.

In 2016, the name of the DSS was revised to the Activity Based Funding Mental Health Care National Best Endeavours Data Set 2016-17 following the decision by National Health Information Standards and Statistics Committee. National Best Endeavours Data Sets describe metadata sets that are not mandated for national collection, but where there is a commitment to provide nationally on a best endeavours basis.

The ABF MHC NBEDS 2017-18 has been developed through consultation with key stakeholders and was endorsed by MHISSC in October 2016, and NHISSC in February 2017.

2. AUSTRALIAN MENTAL HEALTH CARE CLASSIFICATION

The AMHCC v1.0 has been developed as a consumer oriented classification using the setting in which the care is provided, the mental health phase of care (MHPoC) of the consumer, the age of the consumer and clinical outcomes as the key concepts.

The key concepts that are included in the AMHCC are: service setting, MHPoC and age group.

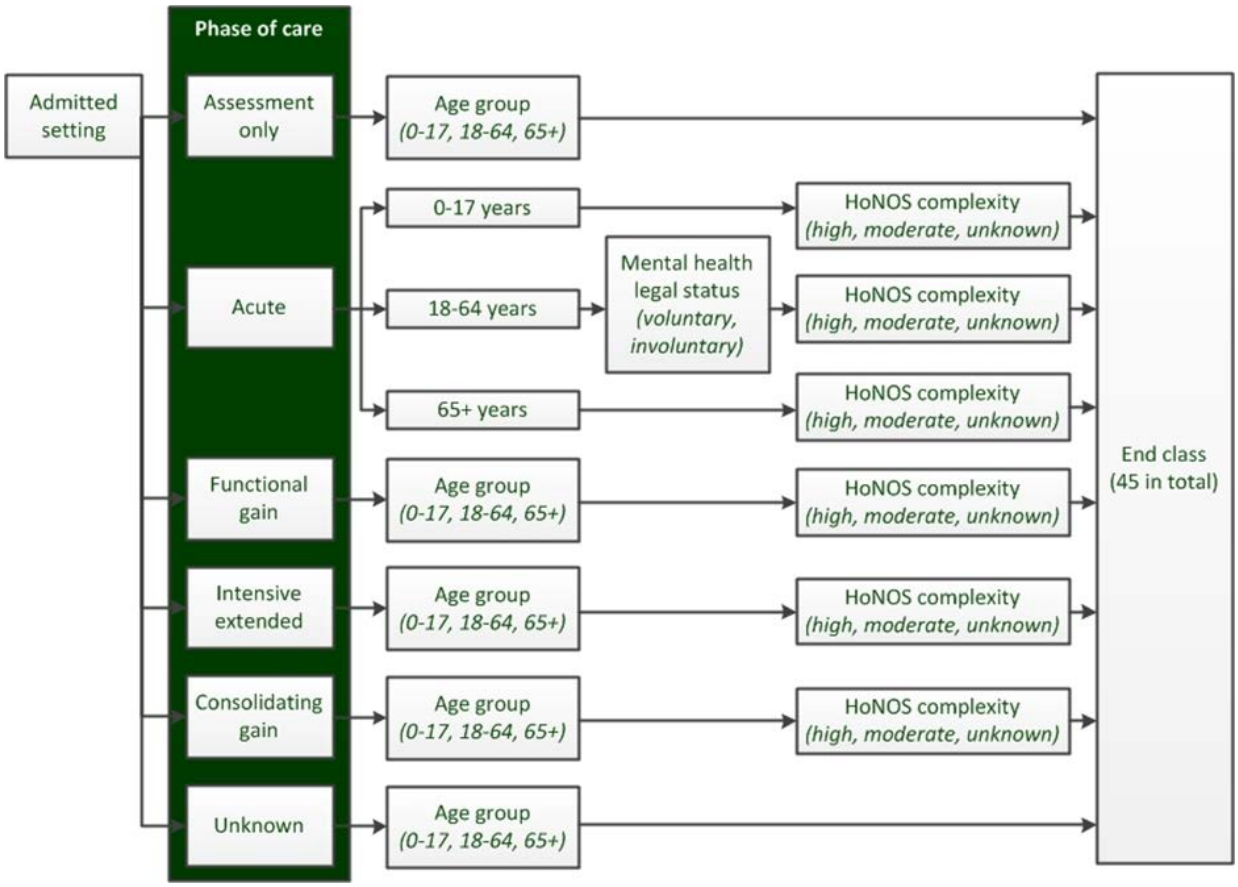

Figure 1: AMHCC - Admitted

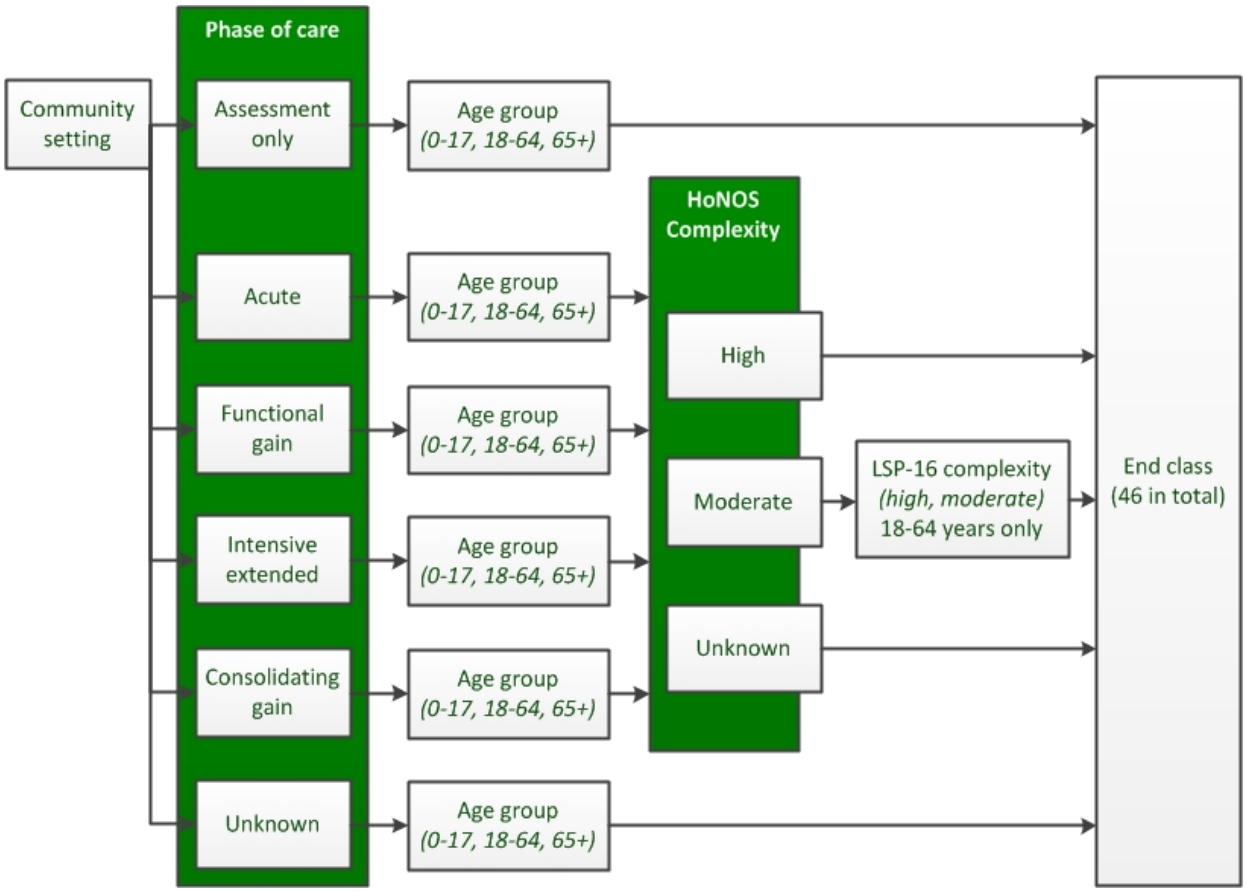

Figure 2: AMHCC – Community

3. PURPOSE AND SCOPE OF DOCUMENT

The purpose of this document is to outline the reporting requirements for the provision of data against the ABF MHC NBEDS 2017-18 by state and territory governments. This document provides details about the:

- content and key concepts included in the ABF MHC NBEDS 2017-18
- business rules relating to the reporting of the data items
- frequently asked questions relating to the ABF MHC NBEDS 2017-18.

This document is based on information in existing technical specifications, handbooks, manuals and the Australian Institute of Health and Welfare's (AIHW) Metadata Online Registry (METeOR).

The scope of this document is limited to the above and does not cover discussion or issues relating to the provision of data that is a result of, or can be resolved through, system management and design at a state and territory level.

Similarly, this document does not address the analysis and interpretation of the data gathered through this data set specification.

The reporting requirements outlined in this document represent a minimum requirement for ABF reporting purposes, and are not intended to limit the scope of data collections maintained by individual service agencies or state and territory government.

4. OVERVIEW OF THE ABF MHC NBEDS 2017-18 STRUCTURE

The ABF MHC NBEDS 2017-18 is comprised of a single data collection, which can be reported to regardless of setting. The ABF MHC NBEDS 2017-18 enables the reporting of values to occur from the derivation of existing activity data collections and the national minimum data sets (NMDS) where appropriate.

The ABF MHC NBEDS 2017-18 contains data elements which are required to be reported for all settings of mental health care and all age groups. The NBEDS requires reporting of activity according to patient episodes of mental health care and mental health phases of care. For ambulatory (community) care, individual service events or contacts are also reported.

The high level structure of the ABF MHC NBEDS 2017-18 is illustrated at Figure 3.

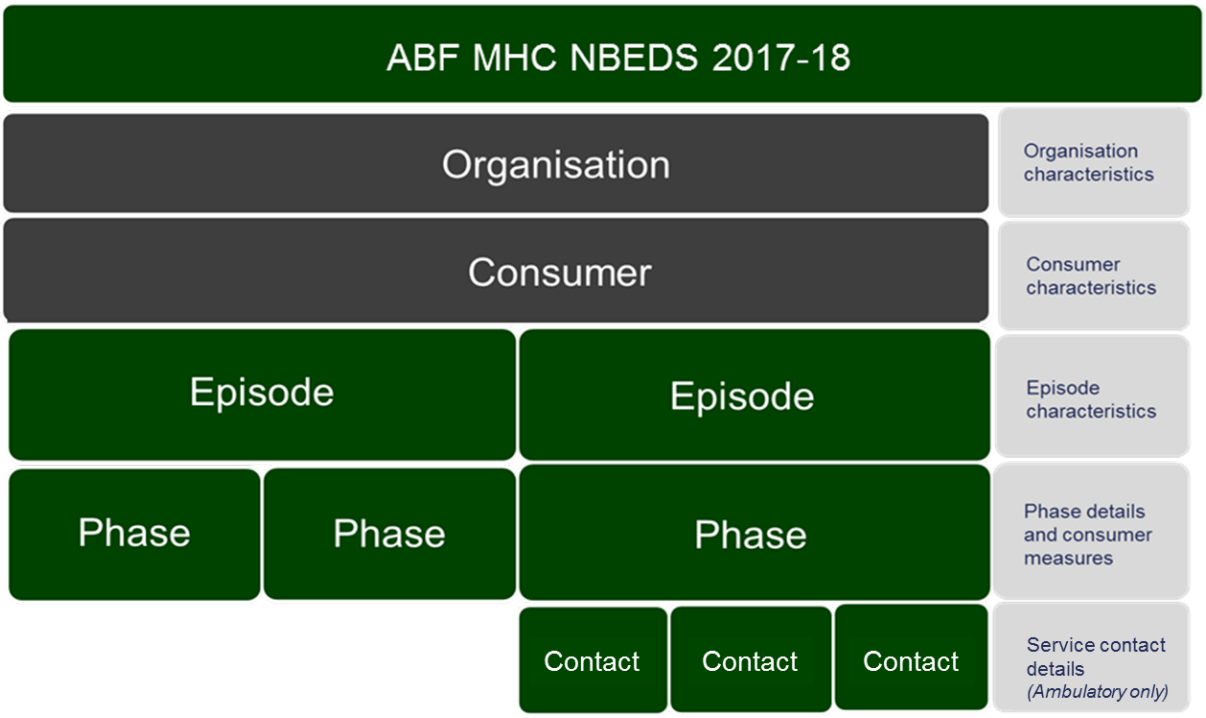

Figure 3: ABF MHC NBEDS 2017-18 high level structure

Specific data that is collected in relation to episode, a mental health phase of care and service contact (ambulatory only) are dependent on the setting and age of the consumer.

In the following chapters, the data items and key concepts contained with the ABF MHC NBEDS 2017-18 are discussed, followed by further discussion in relation to cluster specific information.

5. SCOPE OF THE ABF MHC NBEDS 2017-18

The purpose of the ABF MHC NBEDS 2017-18 is to collect information about consumers receiving mental health care, funded by the Commonwealth, state and territory government that is associated with Australian public hospitals.

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 functioning related 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 scope of the ABF MHC NBEDS 2017-18 is primarily mental health care provided by services that are in-scope public hospital services under the *National Health Reform Agreement 2011* (NHRA). This includes care delivered by specialised mental health services, public hospitals, Local Hospital Networks and non-government organisations (NGO) managed or funded by state and territory health authorities.

The scope of the ABF MHC NBEDS 2017-18 is broader than specialised mental health service and includes consumer's receiving mental health care in non-specialised settings as well.

The ABF MHC NBEDS 2017-18 has been created in the context of activity based funding, and as such its primary scope is related to those hospital services considered in-scope under the NHRA. However, as the Australian Mental Health Care Classification will have a scope that is broader than the NHRA, any mental health care services which are not in-scope public hospital services under the NHRA are encouraged to report their activity.

The ABF MHC NBEDS 2017-18 scope includes mental health care provided to consumers in admitted, ambulatory (also known as community) and residential settings.

5.1. IN-SCOPE PUBLIC HOSPITAL SERVICES

In-scope public hospital services refer to the 'General List of In-Scope Public Hospital Services' (General List) which, in accordance with Section 131(f) of the National Health Reform Act 2011 (the Act) and Clauses A9–A17 of the NHRA, defines public hospital services eligible for Commonwealth funding to be:

- all admitted programs, including hospital in the home programs;
- all emergency department services, and
- non-admitted services that meet the criteria for inclusion on the General List as published in the Pricing Framework.

5.2. SPECIALISED MENTAL HEALTH SERVICES

Specialised mental health services[1] are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

The concept of a specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget.

A service is not defined as a specialised mental health service solely because its clients include people affected by a mental disorder or psychiatric disability. The definition excludes specialist drug and alcohol services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability.

These services can be a sub-unit of a hospital even where the hospital is not a specialised mental health establishment itself (e.g. designated psychiatric units and wards, outpatient clinics).

5.3. NON-SPECIALISED MENTAL HEALTH SERVICES

Non-specialised mental health services are those services that do not identify as both specialised and serving a mental health function, may provide services to clients other than mental health clients, and may be recognised as a service that has a speciality other than mental health care.

A non-specialised mental health service may provide adjunct care and services to a specialised mental health service, or their services may encompass a consumer's entire mental health plan. However, they are not recognised as providing specialised mental health care and may provide services to clients who do not have a mental health disorder or disability.

Whilst it is acknowledged that activity meeting the definition of mental health care type is delivered in non-specialised services, it is also acknowledged that due to system capabilities there may be limited ability to report associated activity through the ABF MHC NBEDS.

5.4. NON-GOVERNMENT ORGANISATIONS

A mental health NGO[2] is a private organisation that receives Australian and/or state or territory government funding specifically for the provision of services, where the principal intent is targeted at improving mental health and well-being and delivered to people affected by a mental disorder, their families and carers or the broader community.

[1] http://meteor.aihw.gov.au/content/index.phtml/itemId/268984; accessed 24 February 2017
[2] http://meteor.aihw.gov.au/content/index.phtml/itemId/432937; accessed 24 February 2017

6. KEY CONCEPTS OF THE ABF MHC NBEDS 2017-18

The type and number of items reported for the ABF MHC NBEDS 2017-18 are dependent on the service setting, age group of the consumer and, whether it was the commencement or completion of the consumer's episode of mental health care or MHPoC.

The key concepts contained within the ABF MHC NBEDS 2017-18 are defined and discussed further below:

6.1. SERVICE SETTING

In the ABF MHC NBEDS 2017-18 there are three different service settings: admitted, ambulatory and residential. The service setting is primarily defined by the service setting in which the consumer's episode of mental health care takes place. The different service settings are defined further below.

6.1.1. Admitted

The admitted setting includes consumers that are admitted for mental health care. The consumer may be admitted to a general ward or a designated psychiatric unit in a general hospital or a psychiatric hospital. All activity reported will have a *mental health care type* for the admitted consumer episode, regardless of the mental health specialisation status of the provider.

6.1.2. Ambulatory

The ambulatory setting (also known as community) includes specialised and non-specialised mental health care services delivered to consumers who are generally not admitted to an inpatient facility or reside in a residential mental health care facility. It is recognised that mental health care can be provided to patients in an admitted, emergency department or residential setting by a mental health team from the ambulatory setting. This activity is considered an ambulatory episode.

Specialised mental health services are defined in section 5.2, and may include activity which is currently reported under the ambulatory care mental health service setting in the National Outcomes and Casemix Collection (NOCC) or the Community mental health care national minimum data set (CMHC NMDS).

Non-specialised mental health services are those services provided to consumers which meet the definition of the mental health care type, however are not provided by specialised mental health services as defined in section 5.3. These services may be currently reported through the Non-admitted patient national best endeavours data set (NAP NBEDS).

6.1.3. Residential

The residential setting refers to care provided in residential units that are staffed on a 24-hour basis by health professionals with specialist mental health qualifications or training and established in a community setting which provides specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability.

6.2. AGE GROUP

The clinical measures associated with the ABF MHC NBEDS 2017-18 are dependent on the age group of the consumer, be that child and adolescent, adult or older person.

Generally, adults are defined as persons between the age of 18 and 64 years inclusive, older persons are defined as persons aged 65 years and older, and children and adolescents are defined as persons under the age of 18 years.

It is important to note that the age group boundaries could be influenced by the clinician's decision on which clinical measure is most appropriate. There may be circumstances where the adult clinical instrument is considered most applicable to a 17 year old consumer for example, in which case the data items relevant to an adult episode of mental health care should be reported.

Clinicians will be responsible for determining whether age group, and the associated clinical measures, is determined on the basis of the actual age, condition and care needs of the consumer or on the type of service providing the treatment and care, or a mixture of both.

6.3. REPORTING UNIT OF COUNT

The overarching unit of activity within the ABF MHC NBEDS 2017-18 is episode of mental health care. Within an episode of mental health care, activity is reported according to MHPoC. In the ambulatory setting, mental health service contacts or non-admitted patient service events are reported in addition to the episode of mental health care.

6.3.1. Episode of mental health care

For the purposes of the ABF MHC NBEDS 2017-18, an episode of mental health care is defined as the period of mental health care between the formal or statistical commencement of care (such as an admission) and a formal or statistical completion of care (such as a separation) characterised by the mental health care type within a setting. An episode of mental health care reported through the ABF MHC NBEDS may differ from the clinical concept of an episode of mental health care.

Depending on the service setting and health service organisation there may be variation regarding what constitutes or equates to the period of mental health care. For example, an episode of care may vary in definition between an admitted episode of care, an ambulatory episode of care and residential episode of care.

- *Admitted episodes* – refers to the period of care provided to a consumer who is admitted for care to a specialised psychiatric inpatient service or to a general public hospital for the purposes of receiving mental health care (i.e. the consumer would have a mental health care type). The period of care is commenced when the consumer has an admission and ceases with a discharge. The admission and/or discharge may be formal or statistical.

- *Ambulatory episodes* – refers to the care provided to consumers in a non-admitted setting which can be defined by exclusion – i.e. the service does not take place in an admitted, emergency department or residential setting. The service providing the care may be a specialised community-based ambulatory mental health service or it may be a non-specialised non-admitted public hospital service. It is recognised that mental health care can be provided to patients in an admitted, emergency department or residential setting by a mental health team from the ambulatory setting. This activity is considered an ambulatory episode and may be reported through the ABF MHC NBEDS. The activity is identified through the use of patient episode setting data item.
    - The commencement of an ambulatory episode may be signalled by a new registration to community care or, if the consumer has previously been treated by the ambulatory team, the start of an episode may be the recommencement of care for a specified purpose or goal. The cessation of an ambulatory episode of mental health care may occur when the consumer's case has been closed by the mental health care team who are responsible for the development of the specialised mental health plan, or if there has been a period of inactivity which is greater than 120 days[3].
    - For the purposes of reporting ambulatory episodes of mental health care which extend beyond a reporting period, a reference period which starts on the first day of the reporting period and/or finishes on the last day of the reporting period may be used. Reference period start and end dates do not need to align with a reportable service contact.
    - With the exception of a reference period episode start or end, an episode of ambulatory mental health care must commence and cease on the same date as a reportable service contact. For ambulatory episodes of care which cease due to inactivity, the date of the last service contact in the episode of mental health care will be the episode end date.
- *Residential episodes* – refers to the period of care provided to a consumer who is admitted for care to a specialised community-based residential service. The period of care is commenced when the consumer has an admission and ceases with a discharge. The admission and/or discharge may be formal or statistical. For the purposes of reporting activity to the ABF MHC NBEDS, episodes of mental health care that extend beyond a reporting period can be reported using a reference period which starts on the first day of the reporting period and/or finishes on the last day of the reporting period.

For the purposes of the ABF MHC NBEDS 2017-18 the episode of mental health care may be derived for admitted or residential consumers from existing reported episodes of care. Therefore an admitted or residential episode of mental health care may commence with an admission to a facility or in the case of the residential setting it may be signalled by the start of a new reference period[4]. Likewise, the end of the episode for an admitted or residential episode of mental health care occurs when a consumer is discharged from the facility, at the end of a reference period or

[3] http://meteor.aihw.gov.au/content/index.phtml/itemId/653716, accessed 24 February 2017

[4] Refer to the data set specifications for the Residential mental health care national minimum data set for further information relating to reference period.

for any other reason as stated in associated activity data set specifications[5]. The ambulatory episode of mental health care is a new concept for the purposes of the ABF MHC NBEDS 2017-18 and AMHCC version 1.0 and may not be able to be derived from existing data collections.

Concurrent episodes of mental health care for a consumer within a mental health service organisation can be reported, provided the episodes of mental health care are reported for different settings. For example, a consumer receiving an ambulatory episode of mental health care who is admitted to hospital can have both the ambulatory episode and the admitted episode reported. However, a consumer receiving episodes of ambulatory mental health care from different community teams within an organisation cannot have two ambulatory episodes reported.

The patient episode setting data item identifies occurrences where the consumer was located in an admitted or residential setting but receiving a concurrent episode of mental health care from an ambulatory service provider.

6.3.2. Mental health phase of care

In addition to episode of mental health care, activity must also be reported according to MHPoC. MHPoC is a prospective description of the primary goal of care in the client's mental health treatment plan at the point in time when the data is being reported, and refers to the next stage in the consumer's care. MHPoC should be considered a subset of episode of mental health care, meaning that for each episode there can be multiple MHPoCs reported.

6.3.3. Service contact

For ambulatory episodes of mental health care, individual service contacts must also be reported. The service contact may be a mental health service contact or a non-admitted patient service event.

For ambulatory episodes reported by specialised mental health services, mental health service contact should be reported. The mental health service contact is defined in the CMHC NMDS as the provision of a clinically significant service by a specialised mental health service provider(s) for consumers, other than those consumers admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24-hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the consumer in question.

There may be occasions where a service contact occurs when a consumer has been admitted to an acute facility, or there may be multiple service contacts in one day. These service contacts should still be reported in accordance with the specifications for the CMHC NMDS.

For ambulatory episodes reported by non-specialised mental health services, non-admitted patient service events should be reported. The non-admitted patient service event is defined in the NAP NBEDS as an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

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[5] Refer to the Admitted patient care national minimum data set or the Residential mental health care national minimum data set for further information on episode of care specific to an admitted or residential patient.

6.4. UNIQUE IDENTIFICATION OF CONSUMERS

Unique identification of the consumer is an essential requirement in clinical information systems, both for ensuring that local information collections support continuity of care, as well as analysis at a state or territory and national level.

State and territory governments vary in the extent to which different mental health service units share a unique identifier for consumers under care. However, where these are not in place, state and territory governments are taking steps to establish such arrangements.

The unique patient identifier reported to the ABF MHC NBEDS 2017-18 should be in encrypted form and meet two fundamental requirements:

- The identifier should be identical to the identifier used in supplying unit record data in respect of the individual consumer in the corresponding data collections dataset.
- The encrypted identifier used to supply data should be stable over time – that is, it should allow the consumer's data to be linked across reporting years.

The ABF MHC NBEDS 2017-18 contains a data item that identifies the highest level of organisation (administrative or geographical) to which the patient identifier is unique and encompasses all health care activity specific to the individual to be captured.

6.5. ESTABLISHMENT AND SERVICE UNIT IDENTIFIERS

Establishment and service unit identifiers are used in the ABF MHC NBEDS 2017-18 to enable identification of the different levels of service units and organisations that provide mental health care services in the public system. As the ABF MHC NBEDS 2017-18 collects activity from both specialised and non-specialised services, the identifiers included may not be applicable for all settings. Table 1 provides a guide as to when an identifier may be applicable. It should be noted that this table is a guide, and local business rules may impact on when an identifier should be used.

Identifier	METeOR ID	Specialised	Non-specialised
Organisation identifier (Australian)	269973	Admitted	All settings
Local Hospital Network	584333	All settings	All settings
Specialised mental health service organisation	404186	All settings	None
Region	269940	All settings	All settings
Sector	269977	All settings	All settings
Service unit cluster	404858	All settings	None
Hospital	404239	All settings	All settings*
Admitted patient service unit	404390	Admitted	None
Ambulatory service unit	404829	Ambulatory	None
Residential service unit	404837	Residential	None

Table 1: Establishment and service unit identifiers

*Hospital Identifier is known as the organisation identifier component in the Establishment-organisation identifier (Australian)- METeOR ID 269973.

7. DATA ITEMS

7.1. CLINICAL ASSESSMENTS

7.1.1. Clinical data specific to children and adolescents

7.1.1.1. Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

The HoNOSCA is a 15 item clinician-rated measure modelled on the HoNOS and designed specifically for use in the assessment of child and adolescent consumer outcomes in mental health services. Ratings are made by clinicians based on their assessment of the consumer. In completing their ratings, the clinician makes use of a specific glossary which details the meaning of each point on the scale being rated.

Key references:

- Gowers S, Harrington R, Whitton A, Lelliott P, Beevor A, Wing J, Jezzard R (1999a) Brief scale for measuring the outcomes of emotional and behavioural disorders in children: Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). *British Journal of Psychiatry*, 174, 413-416.
- Gowers S, Harrington R, Whitton A, Beevor A, Lelliott P, Jezzard R, Wing J (1999b) Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA): Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, 174, 428-433.

7.1.1.2. Children's Global Assessment Scale (CGAS)

The CGAS was developed by Schaffer and colleagues at the Department of Psychiatry, Columbia University to provide a global measure of severity of disturbance in children and adolescents. Similar to the HoNOSCA, it is designed to reflect the lowest level of functioning for a child or adolescent during a specified period. The measure provides a single global rating only, on a scale of 1–100.

Key reference:

- Schaffer D, Gould MS, Brasic J, et al (1983) A children's global assessment scale (CGAS). *Archives of General Psychiatry*, 40, 1228-1231.

7.1.1.3. Factors Influencing Heath Status (FIHS)

The FIHS measure is a checklist of seven 'psychosocial complications' based on the problems and issues identified in the Factors Influencing Health Status chapter in International Statistical Classification of Diseases and Health Related Problems, Tenth revision (ICD-10). It is a simple checklist of the ICD factors which was originally developed for the Mental Health Classification and Service Costs (MH-CASC) project

Key reference:

- Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials.* Canberra: Commonwealth Department of Health and Family Services.

7.1.2. Clinical data specific to adults

7.1.2.1. Health of the Nation Outcome Scales (HoNOS)

The HoNOS is a 12 item clinician-rated measure designed by the Royal College of Psychiatrists specifically for use in the assessment of consumer outcomes in mental health services. Ratings are made by clinicians based on their assessment of the consumer. In completing their ratings, the clinician makes use of a glossary which details the meaning of each point on the scale being rated.

Key references:

- Wing J, Beevor A, Curtis R, Park S, Hadden S, Burns A (1998) Health of the Nation Outcome Scales (HoNOS). Research and development. *British Journal of Psychiatry*, 172, 11-18.
- Wing J, Curtis R, Beevor A (1999) Health of the Nation Outcome Scales (HoNOS): Glossary for HoNOS score sheet. *British Journal of Psychiatry*, 174, 432–434.

7.1.2.2. Abbreviated Life Skills Profile (LSP-16)

The original LSP was developed by a team of clinical researchers in Sydney (Rosen et al 1989, Parker et al 1991) and, prior to the introduction of the NOCC collection, was in fairly wide use in Australia as well as several other countries. It was designed to be a brief, specific and jargon free scale to assess a consumer's abilities with respect to basic life skills. It is capable of being completed by family members and community housing members as well as professional staff.

The original form of the LSP consists of 39 items. Work undertaken as part of the Australian MH-CASC study saw the 39 items reduced to 16 items by the original designers in consultation with the MH-CASC research team. This reduction in item number aimed to minimise the rating burden on clinicians when the measure is used in conjunction with the HoNOS. The abbreviated 16-item instrument is the version to be reported for the ABF MHC NBEDS 2017-18.

Key references:

Original 39 item version of the LSP:

- Rosen A, Hadzi-Pavlovic D, Parker G (1989) The Life Skills Profile: A measure assessing function and disability in schizophrenia. *Schizophrenia Bulletin*, 1989, 325-337.
- Parker G, Rosen A, Emdur N, Hadzi-Pavlov D (1991) The Life Skills Profile: Psychometric properties of a measure assessing function and disability in schizophrenia. *Acta Psychiatrica Scandinavica*, 83 145-152.
- Trauer T, Duckmanton RA, Chiu E (1995) The Life Skills Profile: A study of its psychometric properties. *Australian and New Zealand Journal of Psychiatry*, 29, 492-499.

Abbreviated 16 item version of the LSP-16:

- Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials*. Canberra: Commonwealth Department of Health and Family Services.

7.1.3. Clinical data specific to older people

7.1.3.1. Health of the Nation Outcome Scale 65+ (HoNOS 65+)

The 65+ variant of the HoNOS has been designed for use with adults aged older than 65 years. It consists of the same item set and is scored in the same way, however the accompanying glossary has been modified to better reflect the problems and symptoms likely to be encountered when rating older persons.

Key references:

- Burns A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J, Hadden S (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+). *British Journal of Psychiatry*, 174, 424-427.
- Burns A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J, Hadden S (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+): Glossary for HoNOS 65+ score sheet. *British Journal of Psychiatry*, 174, 435-438.

7.1.3.2. Abbreviated Life Skills Profile (LSP-16)

The original LSP was developed by a team of clinical researchers in Sydney (Rosen et al 1989, Parker et al 1991) and, prior to the introduction of the NOCC collection, was in fairly wide use in Australia as well as several other countries. It was designed to be a brief, specific and jargon free scale to assess a consumer's abilities with respect to basic life skills. It is capable of being completed by family members and community housing members as well as professional staff.

The original form of the LSP consists of 39 items. Work undertaken as part of the Australian MH-CASC study saw the 39 items reduced to 16 items by the original designers in consultation with the MH-CASC research team. This reduction in item number aimed to minimise the rating burden on clinicians when the measure is used in conjunction with the HoNOS. The abbreviated 16-item instrument is the version to be reported for the ABF MHC NBEDS 2017-18.

Key references:

Original 39 item version of the LSP:

- Rosen A, Hadzi-Pavlovic D, Parker G (1989) The Life Skills Profile: A measure assessing function and disability in schizophrenia. *Schizophrenia Bulletin*, 1989, 325-337.
- Parker G, Rosen A, Emdur N, Hadzi-Pavlov D (1991) The Life Skills Profile: Psychometric properties of a measure assessing function and disability in schizophrenia. *Acta Psychiatrica Scandinavica*, 83 145-152.
- Trauer T, Duckmanton RA, Chiu E (1995) The Life Skills Profile: A study of its psychometric properties. *Australian and New Zealand Journal of Psychiatry*, 29, 492-499.

Abbreviated 16 item version of the LSP-16:

- Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials*. Canberra: Commonwealth Department of Health and Family Services.

7.1.3.3. Resources Utilisation Groups – Activities of Daily Living (RUG-ADL)

Developed by Fries et al for the measurement of nursing dependency in skilled nursing facilities in the United States of America, the RUG-ADL measures ability with respect to 'late loss' activities – those activities that are likely to be lost last in life (e.g. eating, bed mobility, transferring and toileting). 'Early loss' activities (such as managing finances, social relationships, grooming) are included in the LSP. The RUG-ADL is widely used in Australian nursing homes and other aged care residential settings. The RUG-ADL comprises four items only and is usually completed by nursing staff.

Key reference:

- Fries BE, Schneider DP, et al (1994) Refining a casemix measure for nursing homes. Resource Utilisation Groups (RUG-III). *Medical Care*, 32, 668-685.

7.2. OTHER CLINICAL DATA ITEMS COMMON TO ALL AGE GROUPS

7.2.1. Principal and additional diagnosis

The principal diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the consumer's episode of care or presentation at a health service. In the Admitted Patient Care National Minimum Data Set, principal diagnosis is determined in accordance with the Australian Coding Standards.

Principal diagnosis is reported for an episode of mental health care that occurs in the admitted, ambulatory and residential settings.

Additional diagnoses identify secondary or other diagnoses that affected the person's care during the period in terms of requiring therapeutic intervention, clinical evaluation, extended management or increased care or monitoring.

Additional diagnoses are reported for an episode of mental health care that occurs in the admitted or residential setting and where possible the ambulatory setting.

In the admitted and residential settings, the principal and additional diagnoses are coded at the end of the episode in accordance with the Australian Coding Standards.

7.2.2. Mental health phase of care

MHPoC is a prospective description of the primary goal of care in the client's mental health treatment plan at the point in time when the data is being reported, and refers to the next stage in the consumer's care. MHPoC should be considered a subset of episode of mental health care, meaning that for each episode there can be multiple MHPoC.

MHPoC is independent of both the treatment setting and the designation of the treating service, and does not reflect service unit type. For example, an admitted episode of mental health care does not always have to have an acute MHPoC.

The five MHPoC and related definitions from METeOR[6] are described in the Table 2:

Code descriptive term	Code definition
Acute	The primary goal of care 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 of care is to improve personal, social or occupational functioning or promote psychosocial adaptation in a patient [*sic* consumer] with impairment arising from a psychiatric disorder.
Intensive extended	The primary goal of care is prevention or minimisation of further deterioration, and reduction of risk of harm in a patient [*sic* consumer] 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	The primary goal of care is to maintain the level of functioning, or improving functioning during a period of recovery, minimise deterioration or prevent relapse where the patient [*sic* consumer] has stabilised and functions relatively independently. Consolidating gain may also be known as maintenance.
Assessment only	The primary goal of care 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).

Table 2: MHPoC and related METeOR definitions

Whilst it is recognised that there may be aspects of each MHPoC represented in the consumer's mental health plan, the MHPoC is intended to identify the main goal or aim that will underpin the next period of care.

The MHPoC should be based on the goal of the consumer's mental health care plan, and as such should be agreed upon by the treating mental health team. This may mean that the MHPoC is recorded by a case manager, who may belong to any health professional discipline. However, there may be local business rules and guidelines which refer to how MHPoC is determined and who may report it. For further information relating to MHPoC, please refer to the Mental Health Phase of Care documentation[7].

[6] http://meteor.aihw.gov.au/content/index.phtml/itemId/621495; accessed 1 February 2017
[7] https://www.ihpa.gov.au/publications/mental-health-phase-care-guide; accessed 2 February 2017

7.3. OTHER DATA ITEMS

7.3.1. Service identifiers

A selection of data items which enable the identification of the establishment, organisation or service providing the episode of mental health care are included within the ABF MHC NBEDS 2017-18.

7.3.2. Consumer demographics

Data items which provide high level information on the demographics of consumers are included within the ABF MHC NBEDS 2017-18. These include:

- Date of birth
- Sex
- Marital status
- Indigenous status
- Country of birth
- Area of usual residence

These data items in most cases can be derived from existing national data collections.

7.3.3. Episode, phase and service contact details

Data items which provide descriptive information to episode and service contact activity are included within the ABF MHC NBEDS 2017-18. These include:

- Episode start date and end date
- Episode start mode and end mode
- Mental health phase of care start date and end date
- Mental health phase of care
- Leave days
- Service contact date
- Patient/client participation indicator
- Group session status
- Patient episode setting

8. COLLECTION PROTOCOL

This manual outlines the minimum requirements for the ABF MHC NBEDS 2017-18, and should not confine state and territory governments.

8.1. REPORTING OCCASIONS

8.1.1. Episode level items

The ABF MHC NBEDS 2017-18 requires reporting of some clinical and other data items at an episode level. Table 3 shows the items required to be reported at an episode level for each setting. The reporting of these data items is consistent for all age groups.

	Admitted Episode	Ambulatory Episode	Residential Episode
Person identifier	✓	✓	✓
Person identifier (organisation type)	✓	✓	✓
Sex	✓	✓	✓
Marital status	✓	✓	✓
Date of birth	✓	✓	✓
Area of usual residence	✓	✓	✓
Country of birth	✓	✓	✓
Indigenous status	✓	✓	✓
Episode start and end date	✓	✓	✓
Episode start and end mode	✓	✓	✓
Principal diagnosis	✓	✓	✓
Additional diagnoses	✓	✓	✓
Service identifiers	✓	✓	✓

Table 3: ABF MHC NBEDS 2017-18 reporting occasions for episode level items

8.1.2. Phase level items

The ABF MHC NBEDS 2017-18 requires reporting of some clinical and other data items at phase level. Table 4 shows the items required to be reported at phase level for each setting. The reporting of these data items is consistent for all age groups.

	Admitted Episode	Ambulatory Episode	Residential Episode
Mental health phase of care start and end dates	✓	✓	✓
Mental health phase of care	✓	✓	✓
Leave days	✓	✓	✓

Table 4: ABF MHC NBEDS 2017-18 reporting occasions for phase level items

8.1.2.1. Clinical measures

The ABF MHC NBEDS 2017-18 requires clinical measures to be reported in relation to the MHPoC. A new MHPoC may be considered when undertaking a review. All clinical assessments should be completed as soon as practical following the commencement of MHPoC, with the exception of the FIHS. If an episode of mental health care only contains one MHPoC, the FIHS is reported at the end of the MHPoC (on discharge).

For the purposes of the ABF MHC NBEDS 2017-18, if a consumer is discharged from an episode of mental health care and commences an episode of mental health care in a different setting, then where applicable the clinical assessment score from the last MHPoC in the previous episode of mental health care may be reported if:

- The assessment had been completed within two weeks
- The MHPoC is the same for the new episode of mental health care as it was for the discharge episode of mental health care

Table 5 shows when the clinical measures are collected and reported in the ABF MHC NBEDS 2017-18.

	Admitted Episode		Ambulatory Episode		Residential Episode	
Children/ Young Adults	**Phase 1**	**Phase 2 +**	**Phase 1**	**Phase 2 +**	**Phase 1**	**Phase 2 +**
HoNOSCA	✓	✓	✓	✓	✓	✓
CGAS	✓	✓	✓	✓	✓	✓
FIHS	×*	✓	×*	✓	×*	✓
Adults						
HoNOS	✓	✓	✓	✓	✓	✓
LSP-16	×	×	✓*	✓*	✓*	✓*
Older Adults						
HoNOS 65+	✓	✓	✓	✓	✓	✓
LSP-16	×	×	✓*	✓*	✓*	✓*
RUG-ADL	✓	✓	×	×	✓	✓

×* The FIHS is reported at the start of the second and subsequent phases within an episode. If an episode only has one phase, then the FIHS is reported at the end of the phase.

✓*The LSP-16 is assessed and reported at the start of the first phase. If an episode is longer than 3 months, than the LSP-16 score from the initial assessment is reported at the start of each new phase, however will not need to be re-assessed until the next new phase that falls after the 3 month period.

Table 5: ABF MHC NBEDS 2017-18 reporting occasions for the clinical measures

8.1.3. Service contact level items

For ambulatory episodes, the ABF MHC NBEDS 2017-18 requires reporting of some data items at an individual service contact level. Table 6 shows the items required to be reported at a service contact level. The reporting of these data items is consistent for all age groups.

	Ambulatory Episode
Service contact date	✓
Patient/client participation indicator	✓
Group session status	✓
Patient episode setting	✓

Table 6: ABF MHC NBEDS 2017-18 reporting occasions for service contact level items

8.2. RATING PERIOD

Table 7 contains a summary of the rating periods for the clinical measures:

Outcome measure	Usual rating period	Exceptions
HoNOS/ HoNOS 65+/ HoNOSCA	Previous two weeks or preceding mental health phase of care (the shorter time period)	No exceptions to rating period
CGAS	Previous two weeks	No exceptions to rating period
FIHS	Period of care bound by preceding mental health phase of care	No exceptions to rating period
LSP-16	Previous three months	No exceptions to rating period
RUG-ADL	Current status	No exceptions to rating period

Table 7: ABF MHC NBEDS 2017-18 rating periods for the clinical measures

The clinician may draw on direct observation and information from other individuals that have been in contact with the consumer during the rating period. This may include family, friends, carers and health professionals.

9. FREQUENTLY ASKED QUESTIONS

9.1. EPISODE OF MENTAL HEALTH CARE

a) Question: Can episodes overlap between settings?

Answer: Multiple episodes which occur at the same time may be reported to the ABF MHC NBEDS 2017-18, provided the episodes are reported for different settings. This may occur as a result of a consumer being admitted for mental health care, whilst in an episode of mental health care in the ambulatory or residential settings. Multiple episodes which occur at the same time cannot be reported within the same setting to the ABF MHC NBEDS 2017-18 if the services are part of the same organisation, for example, a consumer receiving multiple ambulatory episodes of care from different service providers within one organisation.

b) Question: How and when is Patient episode setting reported?

Answer: The Patient episode setting data element is intended for use within the ambulatory setting only. When patient activity is reported on the community patient administration system (PAS), the setting of the patient's service must be reported. For example, most often the community service will see patients in the community setting, and the value reported will reflect that the care has been provided in the community setting. However, if the community service sees a patient in another setting, such as the admitted patient setting (i.e. in a concurrent episode), the value reported will reflect the alternate setting. The Patient episode setting data element is not reported by the alternate setting.

Example: A patient is currently active in a community mental health service unit. The patient is admitted into a hospital's mental health ward with a mental health care type. The case manager from the community service wants to retain a pre-existing appointment with the patient and visits them in the mental health ward. In this example, the episode reported in the community PAS has a patient episode setting value reported as 1 Admitted patient – specialised mental health care unit.

c) Question: Ambulatory episodes of care may occasionally be opened prior to a service contact- how is this reported?

Answer: There may often be occurrences where an episode of care is opened administratively in the local system allowing preparatory work to occur prior to the first service contact. Whilst this is important work that is undertaken, for the purposes of reporting to the ABF MHC NBEDS 2017-18, the episode must commence on a service contact.

d) Question: There are occasions where an episode of care is formally closed, but work is still undertaken through family counselling or queries service contacts- how are these reported?

Answer: The episode of care should not be closed until care for the consumer and family has been completed. Single service contacts that occur outside of an episode of care should not be reported through the ABF MHC NBEDS 2017-18. If there are a significant number of service contacts occurring, a new episode of care may be required to be opened.

9.2. SETTING

a) Question: What is the difference between a specialised ambulatory service and a non-specialised ambulatory service?

Answer: The specialised ambulatory services are those services that identify as specialised mental health services. Their primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function[8].

A non-specialised mental health service are those mental health services which do not meet the definition of a specialised mental health service, but provide mental health services to those consumers that have a mental health care type[9].

b) Question: How are community in-reach consultation liaison services reported in the ABF MHC NBEDS 2017-18?

Answer: Those activities which are normally reported through the activity data sets (such as consultation liaison from community in-reach services) should continue to be reported as normal. Associated service contacts should indicate that the consumer location is different from that of the health service provider.

9.3. CLINICAL ASSESSMENTS

a) Question: Are clinical assessment tools required for Assessment only MHPoC?

Answer: Clinical assessment tools are not required for those episodes of care which are comprised entirely of the Assessment only MHPoC, however local clinical practice may encourage the use of clinical assessments tools.

b) Question: Does the LSP-16 need to be re-assessed if the consumer has a MHPoC change within three months of completing the tool for a previous MHPoC change?

Answer: No, as the LSP-16 is based on the previous three months it does not need to be reassessed any more frequently than three months. For example, if a consumer commences an ambulatory episode of care in July and has subsequent MHPoC changes in August and November and the episode is formally closed in January, the LSP-16 would be assessed at the start of the episode of care in July, and in November. It does not need to be re-assessed at the

[8] For further information refer to http://meteor.aihw.gov.au/content/index.phtml/itemId/268984
[9] For further information refer to http://meteor.aihw.gov.au/content/index.phtml/itemId/584081

MHPoC change in August or at the end of the episode in January. In August the LSP-16 score from July would be reported, and in January the November score would be reported.

9.4. SERVICE CONTACTS

a) Question: Are all service contacts within an episode of care reported?

Answer: Only the service contacts which occurred within the reference period are reported, not all the service contacts within an episode of care. For example, if an episode of care commenced in July 2015, and is still ongoing, the service contacts that occurred during the July-December reference period would be reported.

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