ATTACHMENT B

REPORT TO THE INDEPENDENT HOSPITAL PRICING AUTHORITY

SEPTEMBER 2015

National survey of community managed mental health organisations on data capacity for the Australian Mental Health Care Classification and its suitability

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CONTENTS

BACKGROUND

This survey is part of a program of work Mental Health Australia is conducting to assist the Independent Hospital Pricing Authority (IHPA) to engage the mental health sector in the development of a classification system for the purposes of costing mental health services - the Australian Mental Health Care Classification (AMHCC).

The survey is a preliminary needs analysis of the community mental health sector's readiness to adopt and respond the AMHCC and ABF.

Mental Health Australia in partnership with Community Mental Health Australia (CMHA) held a series of national preliminary workshops to explain the background and structures of the AMHCC, discuss the terminology and concepts underlying the classification, and achieve commitment from workshop participants to complete the survey.

The survey was distributed electronically to workshop participants and to the wider mental health sector through Mental Health Australia and CMHA.

RESULTS

The preliminary workshops were held over the last two weeks of July 2015. The survey campaign then went live for a total of 14 days. As well as the invitation e-mails sent to workshop participants, invitations to participate were also sent to all members of the national, state and territory peak bodies through newsletters and standalone e-mails.

There were a total of 31 responses from member organisations. Of these, 13 CMOs responded to the open invitations, and 18 responses from CMOs that participated in the workshops. Three responses were received from branches of one of the larger organisations; with their agreement 2 responses were disqualified.

CMO DEMOGRAPHICS

FULL TIME EQUIVALENT STAFF NUMBERS

Approximate numbers of FTE staff ranged from 4 to 5000. There was a representative mix of small (<20), medium (20-100) and large (100+) CMOs. The distribution of FTE staff in responding CMOs sits on a linear trend across a logarithmic scale, which is in line with other national surveys of mental health CMOs.

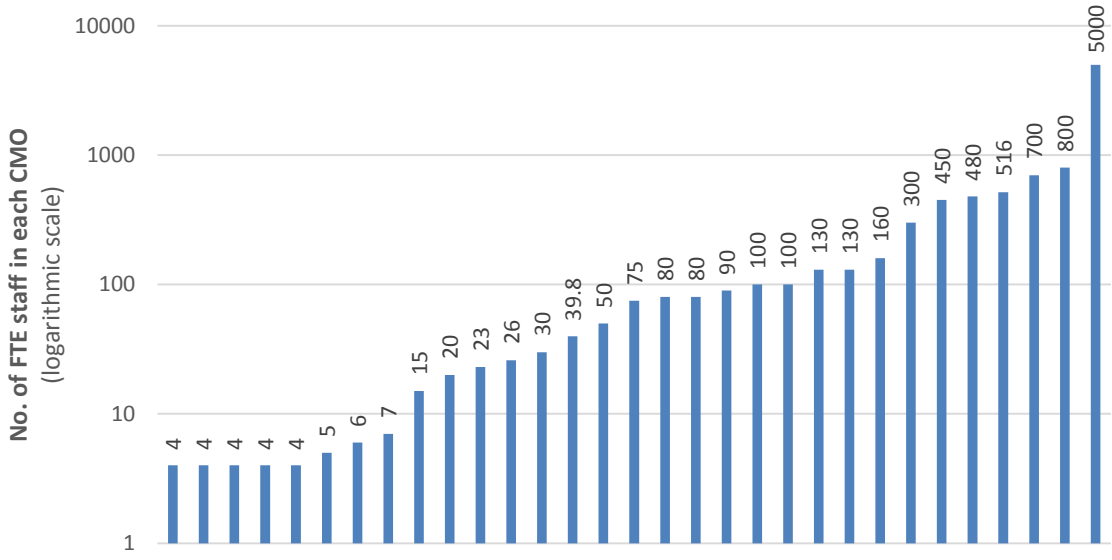


Figure 1.

SERVICE LOCATIONS BY JURISDICTION

Distribution of CMO service locations were consistent with previous consultations and the relative membership numbers of the state and territory peak bodies.

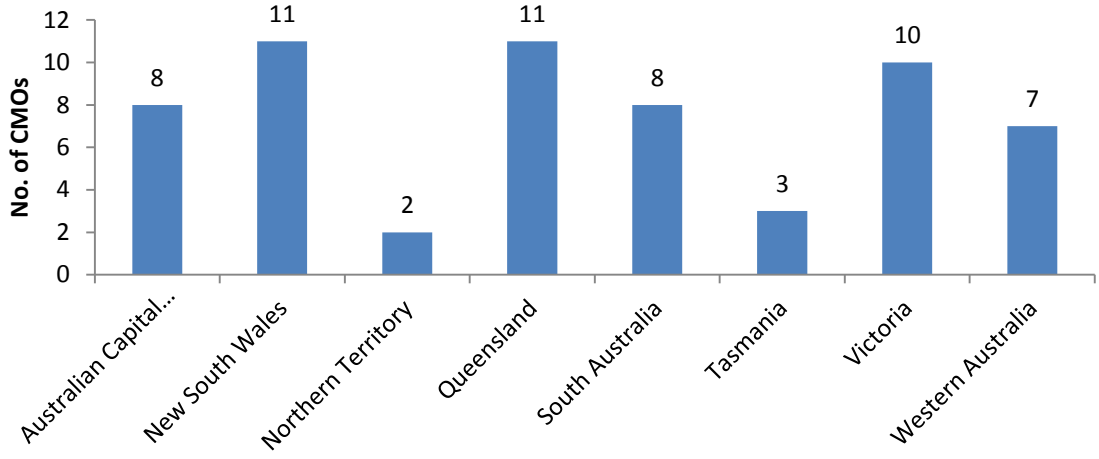


Figure 2.

LEVELS OF GOVERNMENT FUNDING

Responding organisations reported receiving mental health funding from all levels of Government, although predominantly funding was received through Health departments. A proviso to this statement is that some Commonwealth funding is known to be provided by the Department of Social Services, and in time a substantial amount may be provided by the National Disability Insurance Agency.

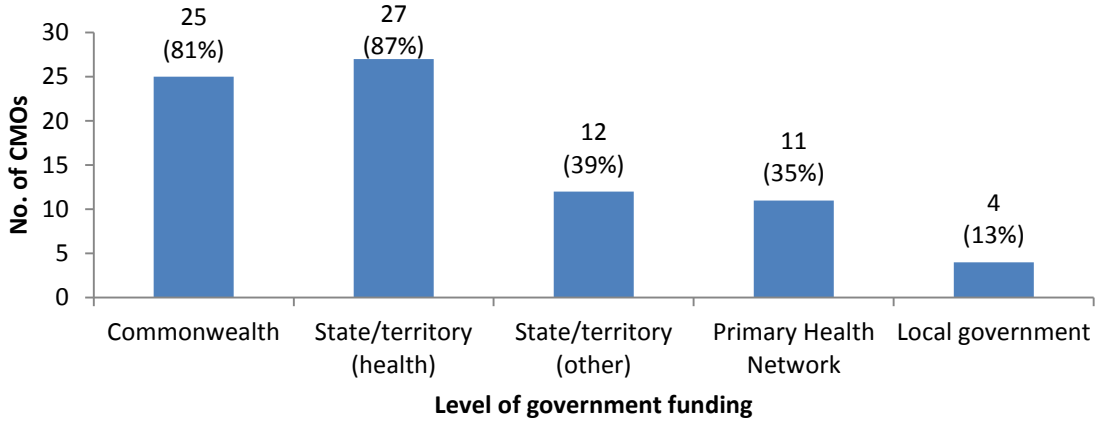


Figure 3.

TYPES OF CMO SERVICES PROVIDED

Responding organisations provide the full range of service types contained in the taxonomy of the National NGO Mental Health Establishments Data Set Specification. Other program types identified outside of the DSS were dual-disability and crisis intervention services.

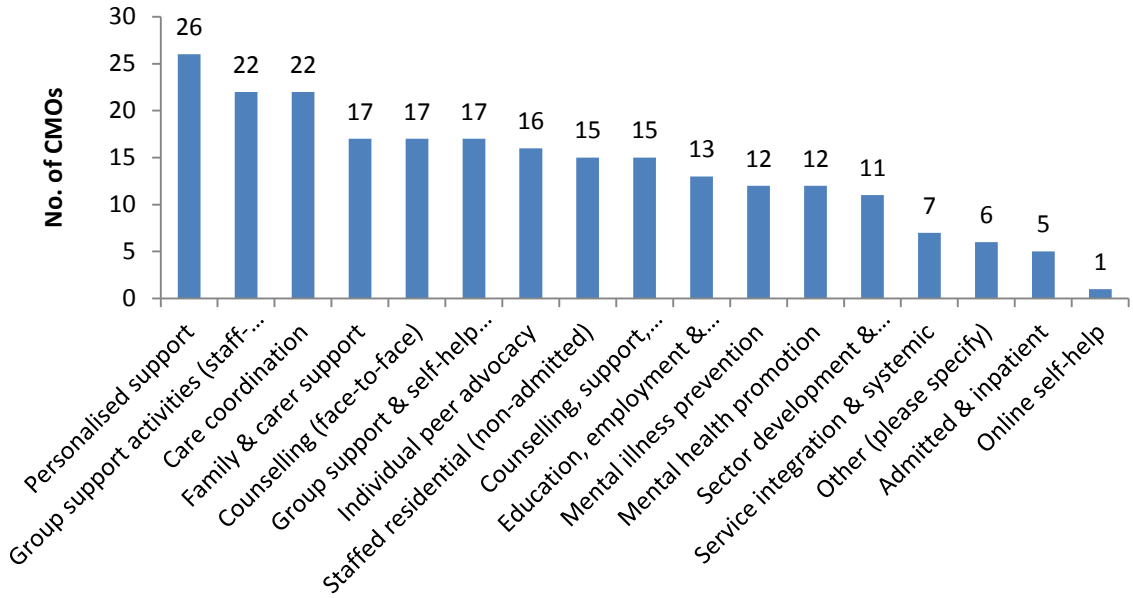


Figure 4.

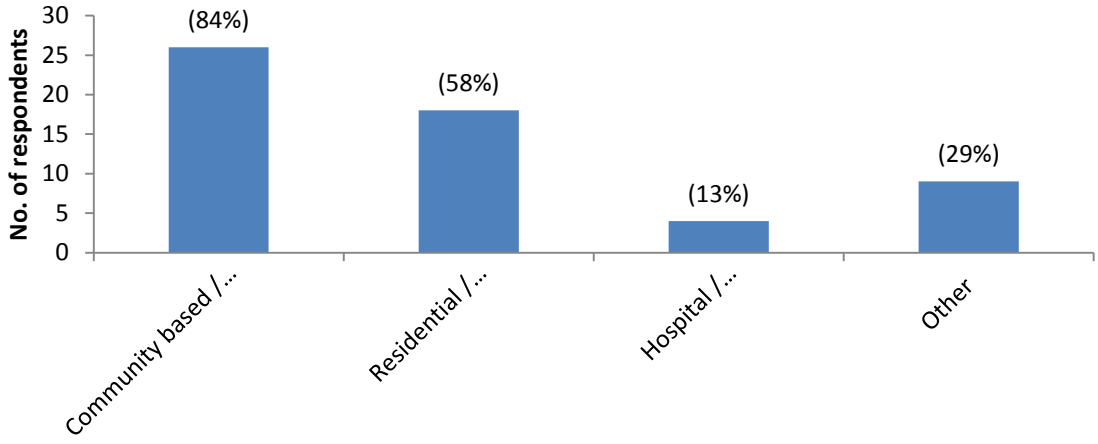
BROAD CATEGORIES OF MENTAL HEALTH SERVICE (AMHCC CLUSTER)

Categorisation of broad service types were structured around the clusters of the AMHCC. Respondents were asked which of the following broad categories of mental health service they provided:

Figure 5.

Value	No. of CMOs
Community based / drop-in *Any mental health service where a consumer is not admitted to a hospital as an inpatient and the consumer/carer is either visited by the service or they visit the service during the day.*	26
Residential / supported accommodation *Any mental health service, on or off a hospital site, where a consumer is not admitted as an inpatient and the consumer/carer stays overnight.*	18
Hospital / admitted *Any mental health service on a hospital site where a consumer is admitted as an inpatient.*	4
Other	9

Figure 6.



Most "other" responses could have been reclassified "Community based" services, however these responses came from workshop participants and there were some who maintained that the cluster definitions were too 'medical' to be inclusive of their services. The main issue with classifying within the cluster appeared to be services where there is no identified consumer or patient required for the service to be provided. Examples of these service types were:

- Family & carer support
- Education Programs
- Headspace primary mental health care services
- Systemic advocacy
- Supported employment
- Telephone support out of hours
- Advice, advocacy and sector developmen

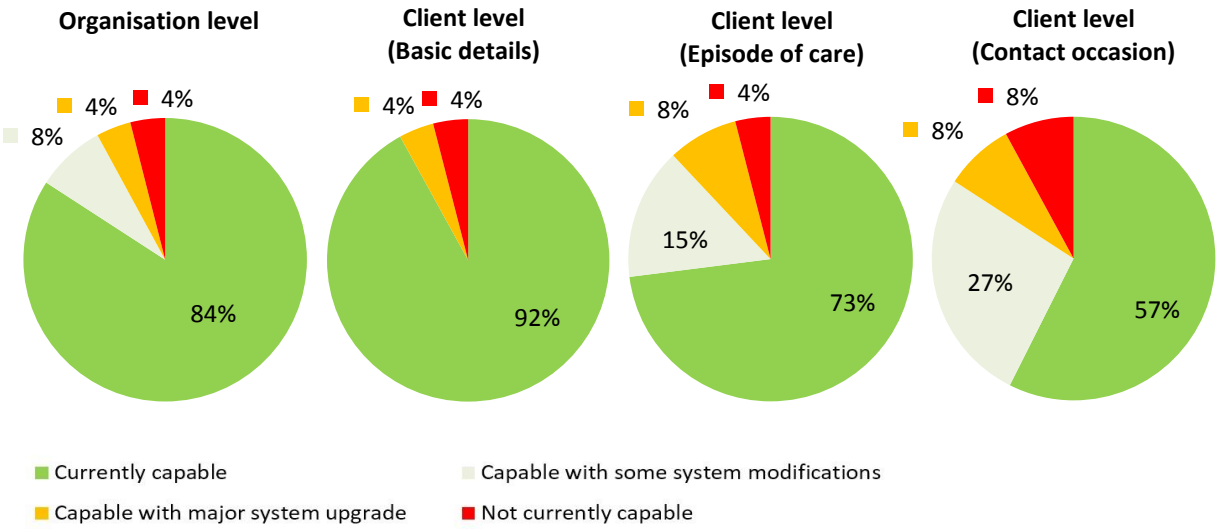
CLUSTER – COMMUNITY

26 out of 31 responding CMOs provide community based (non-admitted, non-residential) mental health services. They were asked to provide detail on the levels and types of data items they are currently capable of collecting.

CAPACITY TO COLLECT EACH LEVEL OF DATA

Most responding CMOs providing community-based mental health services are capable of collecting data at each of the levels posed in the survey. Almost half of responding CMOs providing community-based mental health services are not currently capable of collecting client data at each contact occasion.

Figure 7.



EPISODE OF CARE

Most CMOs providing community-based services are currently capable of collecting Episode of Care level data items, or could do so with some system modifications. One exception is the data item of legal status. Most organisations are not currently capable of collecting this, with many explaining that their program models allow episodes of care where diagnosis is not provided and/or diagnoses can change across the episode without the CMO being notified by the administering clinical team or funder.

	Capable	With modification	Not capable	N/A
Mental health legal status	24%	44%	20%	12%
Principal diagnosis	80%	8%	0%	12%
Additional diagnosis	64%	20%	4%	12%
Episode start date and end date	72%	12%	12%	4%
Reason for end of episode	64%	24%	8%	4%
Referral source	92%	8%	0%	0%
Referral destination	72%	16%	8%	4%

Table 1.

CONTACT OCCASION

Over half of the CMOs providing community-based mental health services are currently capable of collecting contact occasion level data items, or could with some system modifications. Of those CMOs, the data items they were least able to collect are location information and intervention.

	Capable	With modification	Not capable	N/A
Date of contact	92%	8%	0%	0%
Contact duration	83%	17%	0%	0%
Mode of contact	79%	21%	0%	0%
Location	67%	29%	4%	0%
Direct or indirect	75%	25%	0%	0%
Individual or group session	71%	29%	0%	0%
Intervention/service type provided	63%	29%	8%	0%

Table 2.

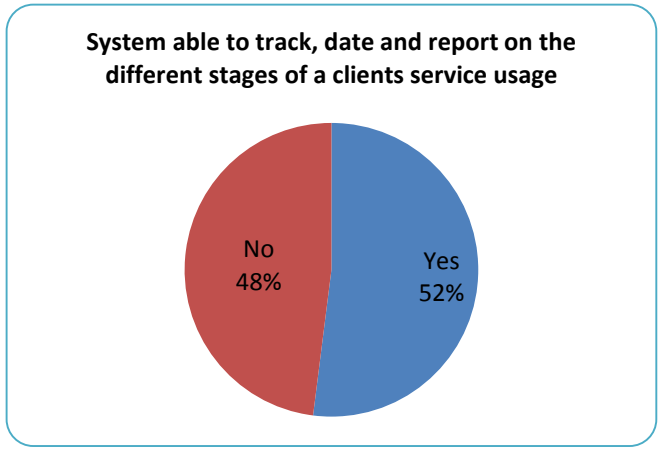
INTERVENTION / PROVIDED SERVICE

The concept of an "intervention" was challenged many times during preliminary workshops. Respondents were asked to provide detail on the types of service and/or practice methodology being provided if it is (or were) to be logged at each contact occasion. Results varied markedly and are catalogued in ***Appendix A***.

PHASE

52% of CMOs providing community-based mental health services are able to track, date and report on a change of client phase. Examples provided for possible categorisations of phase included:

- Movement between program levels of support
- No. of hours allocated per week
- Scores on recovery outcome tools
- Functional capacity
- Care plan goals
- Mutually agreed milestones
- Critical incidents and risk markers

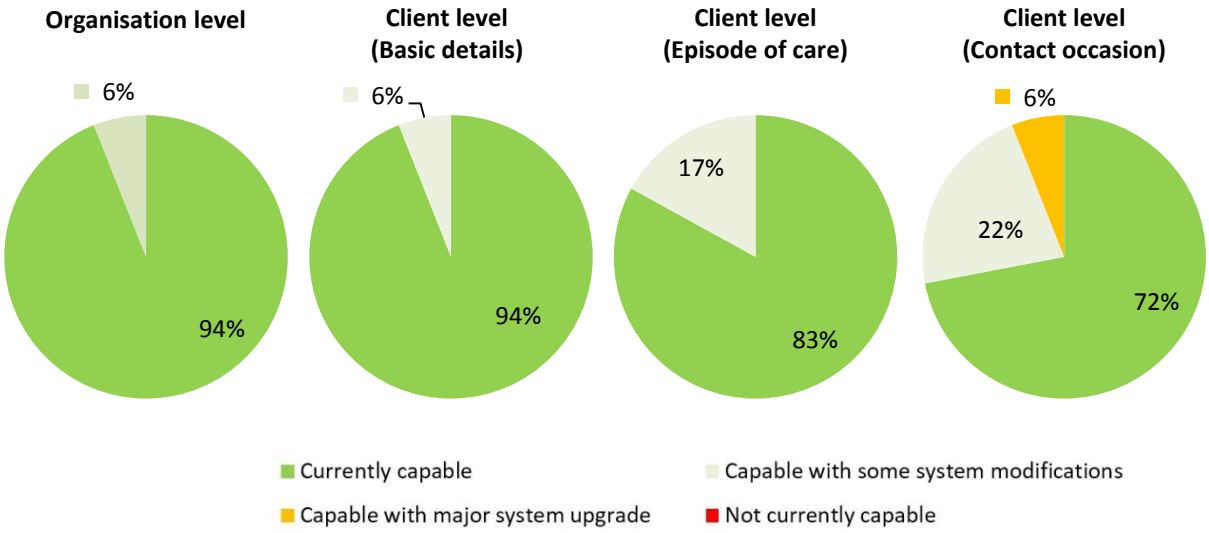


CLUSTER – RESIDENTIAL

18 out of 31 responding CMOs provide residential (non-admitted) mental health services. They were asked to provide detail on the levels and types of data items they are currently capable of collecting.

CAPACITY TO COLLECT EACH LEVEL OF DATA

Nearly all responding CMOs providing residential mental health services are capable of collecting data at each of the levels posed in the survey. Just over one quarter of responding CMOs providing residential mental health services are not currently capable of collecting client data at each contact occasion.



EPISODE OF CARE

Nearly all CMOs providing residential (non-admitted) mental health services are currently capable of collecting Episode of Care level data items, or could do so with some system modifications. One exception is the data item of legal status. Most organisations are not currently capable of collecting this, with some explaining that their program models allow episodes of care where diagnosis is not provided and/or diagnoses can change across the episode without the CMO being notified by their funder.

	Capable	With modification	Not capable	N/A
Mental health legal status	39%	33%	17%	11%
Principal diagnosis	89%	6%	0%	6%
Additional diagnosis	78%	17%	0%	6%
Episode start date and end date	94%	6%	0%	0%
Reason for end of episode	72%	22%	0%	6%
Referral source	94%	6%	0%	0%
Referral destination	67%	22%	6%	6%
Number of leave days during episode	50%	11%	22%	17%

Table 3.

CONTACT OCCASION

Nearly all CMOs providing residential mental health services are currently capable of collecting contact occasion level data items, or could with some system modifications. Of those CMOs, the data item they were least able to collect was intervention.

	Capable	With modification	Not capable	N/A
Date of contact	89%	11%	0%	0%
Contact duration	78%	11%	11%	0%
Mode of contact	78%	22%	0%	0%
Direct or indirect	72%	28%	0%	0%
Individual or group session	78%	22%	0%	0%
Intervention/service type provided	67%	22%	11%	0%

Table 4.

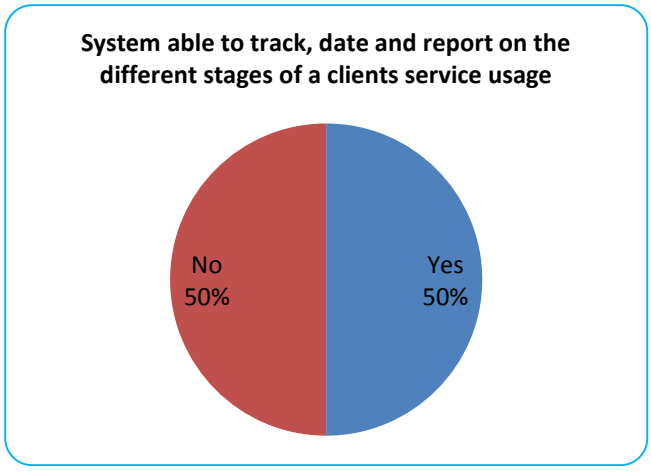
INTERVENTION / PROVIDED SERVICE

The concept of an "intervention" was challenged many times during preliminary workshops. Respondents were asked to provide detail on the types of service and/or practice methodology being provided if it is (or were) to be logged at each contact occasion. Resulted varied markedly and are catalogued in ***Appendix A***.

PHASE

50% of CMOs providing residential mental health services are able to track, date and report on a change of client phase. Examples provided for possible categorisations of phase were:

- Service levels negotiated with Local Health District
- Movement between program levels of support
- No. of hours allocated per week
- Scores on functional outcome tool
- Care plan goals

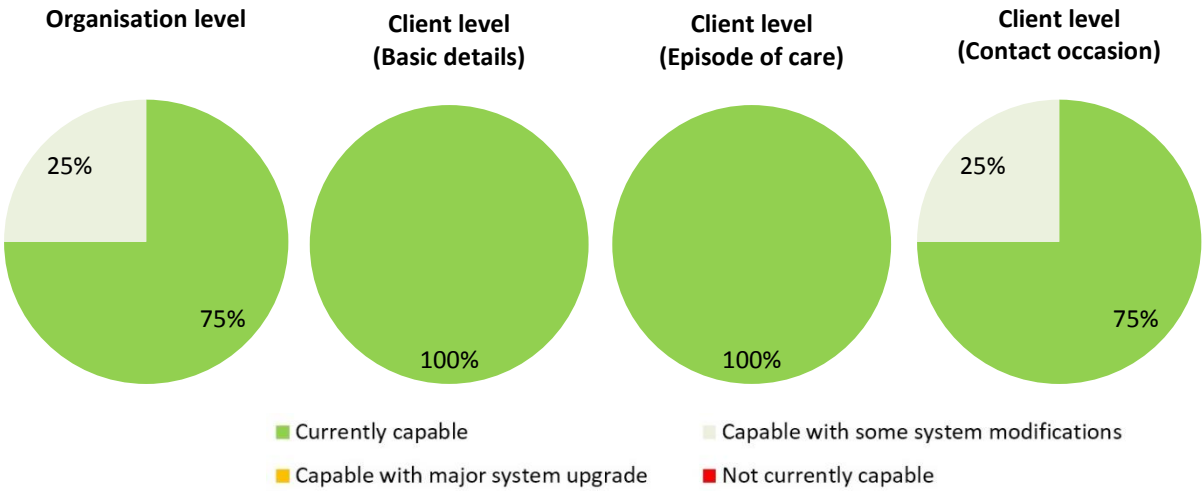


CLUSTER – HOSPITAL / ADMITTED

4 out of 31 responding CMOs provide hospital-based (admitted) mental health services. They were asked to provide detail on the levels and types of data items they are currently capable of collecting.

CAPACITY TO COLLECT EACH LEVEL OF DATA

Nearly all responding CMOs providing hospital-based mental health services are capable of collecting data at each of the levels posed in the survey. One quarter of responding CMOs providing hospital-based mental health services are not currently capable of collecting client data at each contact occasion.



EPISODE OF CARE

All responding CMOs providing hospital-based mental health services are currently capable of collecting Episode of Care level data items. One respondent was capable of collecting legal status, principal diagnosis and additional diagnoses, but noted that this was not relevant to the services they are contracted for.

	Capable	With modification	Not capable	N/A
Mental health legal status	50%	25%	0%	25%
Principal diagnosis	75%	0%	0%	25%
Additional diagnosis	75%	0%	0%	25%
Episode start date and end date	100%	0%	0%	0%
Reason for end of episode	100%	0%	0%	0%
Referral source	100%	0%	0%	0%
Referral destination	75%	25%	0%	0%
Number of leave days during episode	50%	50%	0%	0%
Psychiatric care type (e.g. acute, rehab, psychogeriatric, etc)	75%	25%	0%	0%

Table 5.

CONTACT OCCASION

Most CMOs providing hospital-based mental health services are currently capable of collecting contact occasion level data items, or could with some system modifications. One CMO noted that mode-of-contact was always direct face-to-face for their program.

	Capable	With modification	Not capable	N/A
Date of contact	75%	25%	0%	0%
Contact duration	75%	0%	25%	0%
Mode of contact	75%	0%	0%	25%
Location	50%	50%	0%	0%
Direct or indirect	75%	0%	0%	25%
Individual or group session	75%	25%	0%	0%
Intervention provided	100%	0%	0%	0%

Table 6.

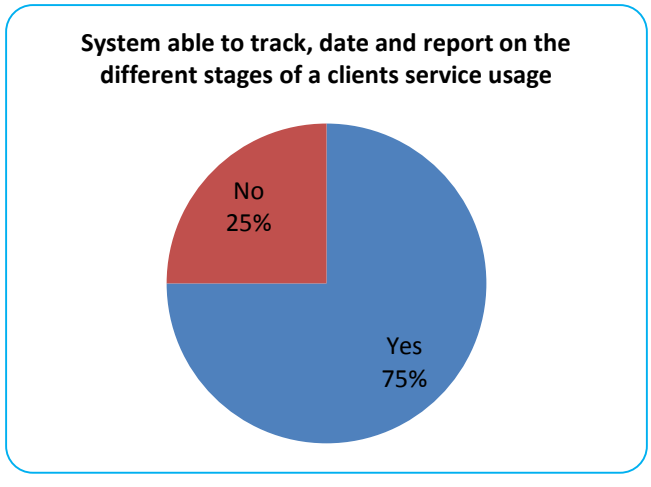
INTERVENTION / PROVIDED SERVICE

Interventions were recorded by CMOs as per hospital protocol, or in a similar fashion.

PHASE

75% of CMOs providing hospital-based mental health services are able to track, date and report on a change of client phase. Examples provided for possible categorisations of phase were:

- No. of hours allocated per week
- Scores on recovery outcome tool
- Care plan goals

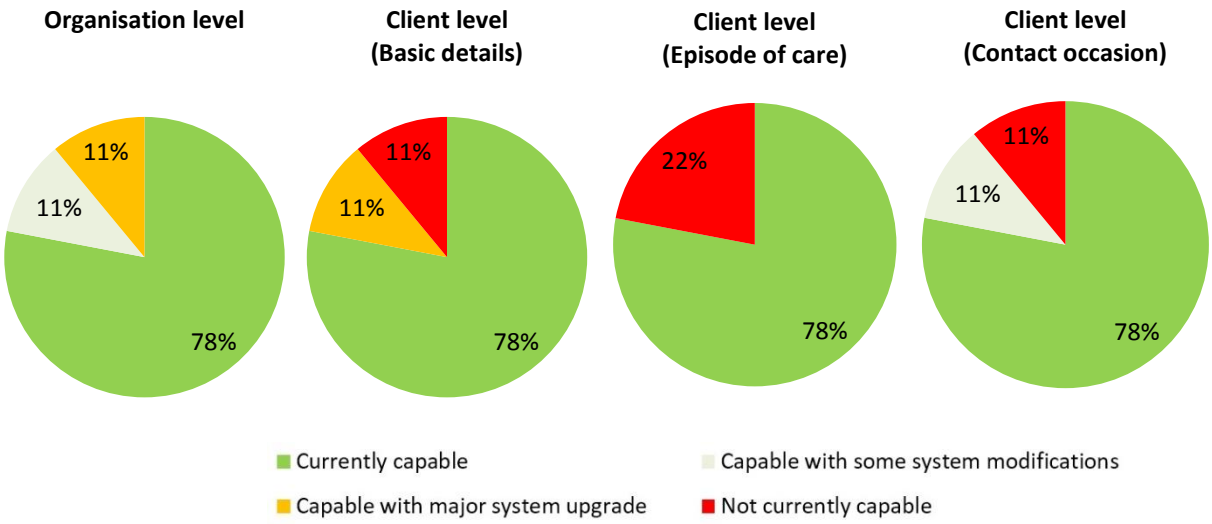


CLUSTER - OTHER / NOT CATERED FOR

9 out of 31 responding CMOs provide other (non-admitted, non-residential) mental health services. They were asked to provide detail on the levels and types of data items they are currently capable of collecting.

CAPACITY TO COLLECT EACH LEVEL OF DATA

Most responding CMOs providing other mental health services are capable of collecting data at each of the levels posed in the survey. Less than a quarter of responding CMOs providing other mental health services are not currently capable of collecting client data at each contact occasion.



EPISODE OF CARE

Nearly all CMOs providing other mental health services are currently capable of collecting Episode of Care level data items, or could do so with some system modifications. Two exceptions are the data items of legal status and number of leave days per episode.

Many organisations are not currently capable of collecting this, with some explaining that asking for many of the items, including those items they are capable of collecting, would be counter to their practice models.

	Capable	With modification	Not capable	N/A
Mental health legal status	57%	14%	29%	0%
Principal diagnosis	86%	0%	0%	14%
Additional diagnosis	71%	14%	0%	14%
Episode start date and end date	100%	0%	0%	0%
Reason for end of episode	86%	0%	14%	0%
Referral source	100%	0%	0%	0%
Referral destination	71%	14%	14%	0%
Number of leave days during episode	29%	0%	14%	57%

Table 7.

CONTACT OCCASION

Nearly all CMOs providing other mental health services are currently capable of collecting contact occasion level data items.

	Capable	With modification	Not capable	N/A
Date of contact	100%	0%	0%	0%
Contact duration	100%	0%	0%	0%
Mode of contact	100%	0%	0%	0%
Location	100%	0%	0%	0%
Direct or indirect	88%	0%	0%	13%
Individual or group session	75%	0%	0%	25%
Intervention provided	88%	13%	0%	0%

Table 8.

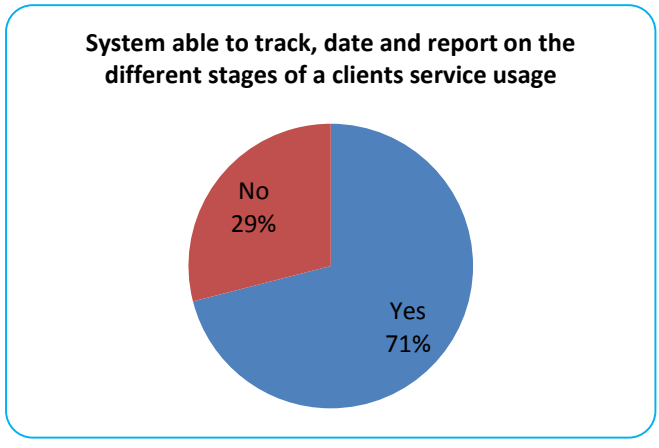
INTERVENTION / PROVIDED SERVICE

The concept of an "intervention" was challenged many times during preliminary workshops. Respondents were asked to provide detail on the types of service and/or practice methodology being provided if it is (or were) to be logged at each contact occasion. Resulted varied markedly and are catalogued in ***Appendix A***.

PHASE

71% of CMOs providing 'other' mental health services are able to track, date and report on a change of client phase. Examples provided for possible categorisations of phase included:

- Staging reports across the client journey
- Engagement, induction, education, technical skill development
- No. of hours allocated per week
- Scores on recovery outcome tools



OUTCOME MEASUREMENT TOOLS AND ADAPTATION OF SYSTEMS

A total of 27 CMOs responded to the questions on outcome measures and their plans to adapt data systems in response to major reforms.

OUTCOME MEASUREMENT TOOLS

Respondents reported using a range of different outcome measures, including those contained in both the National CMO Guidebook on measuring outcomes and the National Outcome and Casemix Collection[1].

CANSAS appears to be the most viable tool for use by CMOs if their outcomes are to be measured in the AMHCC.

The K10 ranks highly but is only being used by under a third of sampled organisations. The other NOCC tools listed below are not commonly used by CMOs

The measures marked in red are proposed for use in AMHCC Version 1.0

Table 9.

Outcome Tool	No. of CMOs	Respondent % (n = 27)	National Guidebook	NOCC Tool
CANSAS (Camberwell Assessment of Need - SAS)	17	63%	YES	
Recovery STAR	10	37%		
K10 (Kessler-10)	8	30%	YES	YES
RAS (Recovery Assessment Scale)	6	22%	YES	
(Custom tool/form)	5	19%		
DASS	5	19%		
WHOQoL (WHO Quality of Life, Brief)	5	19%	YES	
BASIS-32	4	15%		YES
LSP-16	4	15%		YES
APQ	2	7%		
HoNOS	2	7%		YES
LCQ (Living in the Community Questionnaire)	2	7%	YES	
Social Inclusion Web	2	7%		
BDI	1	4%		
BECK Anxiety and Depression scales	1	4%		
CAARS tool - The wheel	1	4%		
Carer STAR	1	4%		
Carers Experience of Service Provision	1	4%	YES	
Child PTSD Scale	1	4%		
Client & Family Experience of Service	1	4%		
DSS SCORE	1	4%		
GAF	1	4%		
GARF	1	4%		
GSES	1	4%		
Harvard Trauma Questionnaire	1	4%		
HoNOSCa	1	4%		YES

[1] Note: The majority of outcome measures in the NOCC are specifically not intended to be used in non-clinical settings and are inappropriate as they do not measure the range of outcomes that CMOs are contracted to deliver. This is why the Commonwealth Government and AMHOCN commissioned the development of the National CMO Guidebook.

Hopkins Checklist for Anxiety and Depression	1	4%		
IROC	1	4%		
Mental health literacy (children)	1	4%		
MHCSS Outcomes Tool (Vic Dept Health)	1	4%		
Motivation to Change scale	1	4%		
MSSI	1	4%		
My STAR	1	4%		
OHIO Scales	1	4%		
Personal Wellness Index	1	4%		
SDQ (Strengths and Difficulties Questionnaire)	1	4%	YES	YES
STORI (Stages of Recovery Instrument)	1	4%	YES	
WAI	1	4%		
WSAS (Work and Social Adjustment Scale)	1	4%	YES	
YES (Your Experiences of Service)	1	4%	YES	
CarerQoL (CarerQoL-7D+VAS)	0	0%	YES	

ADAPTATION TO MAJOR REFORMS

Despite the likelihood of future CMO funding to be provided within the AMHCC, most CMOs are not adapting their systems in preparation for ABF. There was a general perception in the pre-survey workshops that without a clear national agreement on ABF it was not a priority for them.

In contrast, the National Disability Insurance Scheme is seen as the highest priority for data system adaptation, with 100% of respondents indicating that they are modifying their systems in preparation.

The other reforms mentioned by one or two CMOs were E-health records, the Queensland mental health minimum data set and the NSW homelessness minimum data set.

Reform	No. of CMOs	% of respondents
Activity based funding	9	33%
National Disability Insurance Scheme	27	100%
E-health records	2	7%
Queensland mental health data set	1	4%
NSW homelessness data set	1	4%

Table 10.

COMMENTS AND FEEDBACK

Respondents were able to provide free form feedback at the survey workshop and through two open-text questions in the survey

Respondents were asked two open- text questions:

- What is the best way that IHPA, MHA or CMHA can help you develop your capacity to collect and report on service activity?
- Is there anything else you would like to say about the Australian Mental Health Care Classification?

Below is a summary of the feedback received to at the survey workshops and through the open-text questions. The complete set of responses are provided in Appendix B.

SUMMARY OF FEEDBACK TO IHPA

- The majority of comments expressed concerns about the AMHCC and ABF.
- A major theme of feedback was the need for IHPA to use terminology, classifications, interventions and outcome measures that are relevant to mental health CMOs programs.
- Language use was highlighted as an obstacle to CMO uptake (e.g. “patient”, “intervention”, etc).
- Some respondents found it difficult to see the relevance of the AMHCC given changes in the government’s policy direction on ABF, and the pressing need for CMOs to adapt to the NDIS.
- The way that IHPA has developed the AMHCC and the way the Commonwealth is providing funding, appears to incentivise hospital/inpatient mental health service provision, which is counter to most jurisdictional policies and strategies.
- Concerns were raised that the AMHCC does not seem to align with other reporting requirements of mental health CMOs, most glaringly the NDIS, which creates two largely divergent data set requirements for many CMOs (many of whom will receive funding from both sources).
- There was confusion about how the work of the NGO Establishments National Minimum Data Set was being incorporated into the AMHCC. Especially the apparent lack of use of the NGOE NMDS service classifications.
- It was suggested that a part of the AMHCC that included NGOE NMDS classifications would be a more collaborative starting point for working with the CMO sector to reflect its contribution to the specialised mental health service system.
- IT infrastructure support would be required to enable those CMOs currently unable to collect more detailed client level information. Some suggestions were to work with major software vendors to ensure ABF DSS compatibility, funding of CMO data system upgrades, and to ensure that detailed technical guidance is made available from direct funders.
- The concepts of “Episode of Care” and “phase” were especially problematic for services provided at lower levels of illness severity.

FEEDBACK TO MHA & CMHA

- Continue advocating for inclusion of appropriate terminology, relevant classifications and interventions, and outcome tools that measure appropriate domains.
- Advocate for changes to the definition of mental health care to more clearly include the work of Health-funded mental health CMO services.
- There was support for a more standardised set of outcome tools, perhaps even a NOCC, however using tools appropriate to the CMO sector.
- Promotion of further networking and collaboration on Activity Based Funding.

- Work with mental health funding agencies and software vendors to align reporting requirements and data system capacities.

WORKSHOP COMMENTS

Workshop participants made comments on a variety of conceptual issues regarding the AMHCC.

On the mental health care type definition:

- Most mental health care services would be excluded from the classification based on the mental health care type developed by the UQ
- Definition of "clinician" in mental health care type is unclear – most CMO services do not require a "clinician" to oversight. Many times they cannot get clinicians regularly involved.
- Clinician as the driver is not the model of CMOs. It sets an unprecedented narrow threshold to service access
- The mental health care type reduces the discussion to treatment and support
- CMO sector services do not necessarily need a mental health plan
- A formal mental health assessment is something someone does to you and makes a decision about what you need – this is different to a CMO service conversation between a consumer and staff member deciding what the consumer might need

On the conceptual model of the AMHCC:

- Much of the mental health sector has advanced beyond the clinical model onto recovery model – the AMHCC appears to remain dated in describing only a discrete portion of mental health care service delivery
- The ABF DSS is not inclusive of all publicly funded mental health services and not exhaustive
- There are many services/items in the NGO Establishments NMDS used for the AMHCC that are not in scope for NDIS – does this mean they are in scope for the ABF DSS? If so, where are they?
- In asking the CMO sector to collect this ABF DSS it will 're-describe' the services of CMOs in a way that is not correct
- Costs are complex – just looking a mental health is not the whole picture – employment, housing etc,
- CMOs are happy to collect data but not data that redescribes their service models

On specific data items of the ABF DSS:

- People often self-report their diagnosis – not formal diagnoses
- Some services in the CMO sector have a low informal threshold to entry – such as drop in centres – these services do not seem to be represented in the classification

On the use of "interventions" as a cost predictor

- The CMO sector does not do 'interventions' to consumers – CMO service models are based on a different logic
- CMOs would not log their 'interventions' – this is not an appropriate way to either describe their services or an appropriate way to deliver their service model
- Very problematic for the CMO sector as AMHCC is using interventions from the public clinical sector
- How do CMO services such as telephone based counselling services fit into the MHIC?

On outcome measurement tools

- The majority of NOCC outcomes are not the outcomes the CMO sector are trying to achieve, nor contracted to work toward
- LSP 16 & HoNOS were not originally designed to use for measuring the outcomes of CMO sector services

APPENDIX A – INTERVENTIONS

Despite some workshop participants and respondents disagreeing with the relevance of the concept of "intervention" in a community managed mental health service setting, many respondents provided their interpretation of the types of interventions (or services provided at a contact occasion).

The complete set of responses are provided below (blank and invalid entries have been deleted).

COMMUNITY BASED INTERVENTIONS

Response
Community based or centre based; accommodation, employment, education, support group
In home support, host care, drop in support, residential support
Individual. Group, Family, Education
Recovery star domains
Service coordination, counselling, emotional support, referral, support planning.
Types of contact can be recorded through configured "drop down" menus
group or individual; funding source
what interventions were used during the session, psychological counselling approaches used
in MFHSS, we distinguish between one off support, short term and intensive. In Carer support we elect from a list of 8 services e.g. brokerage, peer support
Type of worker intervention eg peer support; recreation specialist; community support; dual visit; 1:1 or groups; case management; assessments; Planning (MAP/PATH); phone support
Supporting / promoting self-management/health and wellbeing, developing living skills , Community Engagement, Family and Social Relationships, Legal
These are recorded in notes. They are narrative, co-authored with service-users and might include such details as what standardized tools (if any) were used, who participated in the intervention, outcomes, service-user experience.
Dependent on the service and the reporting requirements. I.e. Federal Respite services capture the nature of the outreach work within a session with a client such as Advocacy, Information & Referral, Social Activities, etc.
As per SA Health CARS database we report in categories of Independent Living, Health, Community Engagement, Family Involvement, Legal, Accommodation
accomm support, ADLs, advocacy/legal, D&A, education, family/parenting, financial mgt, gambling, mental health support and access, physical health support and access, service coord, social/recreation, travel, vocational/volunteering

RESIDENTIAL SERVICE INTERVENTIONS

Response
Living skills support, recreation, education
Refer to ambulatory care data comments
Whether a clinical appointments was required
care plans
face to face, transport, personal support, attendance at medical appointments, planning
focus of interventions, nature of work undertaken, outcomes of activity
same as community based
As per SA Health CARS database we report in categories of Independent Living, Health, Community Engagement, Family Involvement, Legal, Accommodation
Dependent on the service and the reporting requirements. E.g. SA Health funded HASP service captures "Tasks" that were completed with a client to cover the type of engagement/service provided, i.e. Family and Social Relationships, Housing, Legal etc.

INPATIENT INTERVENTIONS

Response
same as community based
At the end of each rostered shift, client file notes are updated and key activities recorded on handover sheet, e.g. did they participate in group program
Dependent on the service and the reporting requirements. E.g. capable of capturing "Tasks" that were completed with a client to cover the type of engagement/service provided, i.e. Family and Social Relationships, Housing, Legal etc.

INTERVENTIONS FOR "OTHER" SERVICE TYPES

Response
Engagement, induction, recovery education, technical skill development
For a phone line, this would primarily be details of brief counselling, and, possibly, referrals.
Support, Advocacy - System advocacy
Therapeutic types, service types (Ed, Vocation, MH plan, GP)
individual or group; peer support; worker support; education programs; funding source
referrals to different services
comprehensive assessment, identification of recovery goals, psychosocial rehabilitation support independent living skills, safety plans, advance statement preparations
Support Type - transport, appointments, interpersonal, financial, housing, relationships, community networks

APPENDIX B – FINAL COMMENTS

Respondents were asked two open-text questions:

- What is the best way that IHPA, MHA or CMHA can help you develop your capacity to collect and report on service activity?
- Is there anything else you would like to say about the Australian Mental Health Care Classification?

The complete set of responses are provided below (blank and invalid entries have been deleted).

HOW IHPA, MHA & CMHA CAN HELP COMMUNITY MANAGED ORGANISATIONS

Response
By being clear about the classification descriptors and not changing them frequently.
Develop a tool to measure the effectiveness of referrals and systemic advocacy services
Lobby for investment in systems, standardisation and expertise in outcome measurement
More collaboration through networking
Provide clear detail of what information will be required for reporting.
Work collaboratively with NDIA around collecting and reporting service activity.
clear guidelines of what reporting requirement is required
guidelines on what to collect and possibly software that we can transfer data to
share information; have consultations; deliver workshops
types of intervention classifications for NGOs would be useful
we have a CRM database - we need funds to pay for any changes to existing database
Involve us in the discussions and support a national approach to have uniformity at the jurisdictional level. More critically, recognise that the majority of persons experiencing mental illness NEVER enter a hospital or residential setting but are managed by their GP and non-clinical community services very effectively. Admission rates would be reduced if this reality was embedded into the MH system thinking with greater focus on early intervention if deterioration was identified, use of flexible model of clinical input into the home and a mutually respectful collaboration between all aspects of the clinical and non-clinical systems.
Liaise with ICON Global software developers to enable flexibility to modify software architecture to match the requirements of the reform and funding bodies. Outcome measurement training and ongoing professional development in data collection and outcome measurement

Complete the work on the NGOE National Minimum Data Set. Advocate for a more simplified and streamlined data collection strategy across all government funders to reduce the burden on CMOs
information regarding a system that would streamline to be used across multiple different service areas and sites. We have several different programs that do very different things; one system that could track everything for us would be great.
information on the changes and warning when things are changing. Training would also be beneficial.
MHA and CMHA could provide much more technical information relating to measuring service provision in the NGO mental health/disability sector - in both the Australian and the International context - particularly Consumer Outcome measures.
Provide additional funding for upgrades to software to support activity based funding data collection
Provide funds to pay for a worker to undertake this work. Create a more consumer friendly non clinical common language to undertake this work
A standardised implemented set of measures on what is good for all NGOs to collect, something like the NOCC would be good. The competitive tendering process that NGOs have to participate in doesn't encourage NGOs to share resources/measures, as individually NGOs seek to demonstrate that they/we are more innovative that other NGOs to win tenders. Competitive tendering in its current form hasn't encouraged universal data collection.

COMMENTS ON THE AMHCC

Response
For NGO's it seems the NDIS activity items will overrun the AMHCC.
Language needs to be amended to be recovery oriented and less medical in nature
Sooner the better - best development in the mental health care sector in twenty years
just the need for open communication and problem solving
The definition of clinical mental health services suggested includes improving 'environmental and physical function relating to a patient's mental disorder.' which would seem to include a lot of the non-clinical support services typically provided by CMOs often without documented mental health plans and seems to be heavily reliant on the 'medical model' .
I find this to be a very limiting/narrow way (very medically focused) that you are collecting information. I think you should consult widely with the community mental heath sector to establish agreed and respectful measures - if you take the time to undertake this process with agencies and mental health consumers I think you could find much more appropriate measures

This classification system still operates predominantly from a diagnostic paradigm. Outcomes in relation to psychosocial disability are not well recognised or utilised. There is also no nexus to the State or National based public MH data indicators, outcomes as measures of overall recovery and impact of mental illness in our community and population. Shared data sets and systems would provide a unique national opportunity. Significant investment is required to establish and maintain quality data sets that is currently not funded in the community managed sector under current contracts and not funded moving into the NDIS funding scheme.
It has been shown in other European countries that ABF does not work well in mental health and therefore the government should not progress with this.
The dollar amount of support i.e. $/hour is not necessarily something that NGOs should be competing on - it should be quality of service as determined by universal outcome and consumer satisfaction measures.
Re q 14: the term "episode of care" becomes ambiguous in the community setting - community-based outreach services work with clients not only when they are acutely unwell, but also between episodes in assisting them towards recovery and learning to manage their illness and wellness. Some clients no longer have episodes of acute illness but are obtaining support to re-establish their lives in the community. Clients move along a continuum of needs which are not always clinical or medical or episodic - there are many factors other than the illness itself that need to be considered in the community context in order to help clients move towards health and ability to manage their illness/wellness.
Although there is basis for Activity based funding, often it does not capture the work that we do effectively and devalues the service provided.
There is a lack of recognition of the role and contribution of the NGO/non-clinical sector in the current process. We experience this approach as limiting our dedicated service provision due to severely limited funding to the sector as bed-based services expand. We constantly have our resources in our Social Programs supporting persons with MH challenges. Where there is a collaboration around the care recipient by the clinical inclusive of the GP and non-clinical systems, the care recipient is much better served on their recovery journey.
We encourage ongoing consultation with CMOs, Consultations with clients to involve them in the planning, Review the recommendations outlined in the response to the AMHCC consultation Round One.

APPENDIX C – SURVEY DESIGN

The stakeholder consultation was performed with SurveyGizmo (2015 version). Page logic and hide actions were used to skip inapplicable items depending on selected options.

Introduction

Thank you for contributing to this important consultation.

***Mental Health Australia** is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. **Community Mental Health Australia** is a coalition of the eight state and territory community mental health peak bodies.*

Mental Health Australia (MHA) and Community Mental Health Australia (CMHA) are assisting Australia's Independent Hospital Pricing Authority (IHPA) to understand the capacity of Mental Health Community Managed Organisations (CMOs/NGOs) in Australia to collect data for use in future Activity Based Funding models.

This survey will take 5 - 20 minutes depending on your answers.

Here is the structure of the survey:

- **Information briefing on the Australian Classification and ABF**
- **Checks and demographics**
- **Your organisation's capacity to collect data for community-based, residential and hospital/admitted mental health services**
- **Your organisation's use of outcome measurement**
- **Future directions and opportunity for comment**

You can save this survey and return at any time by pressing the save and continue button at the top of any page.

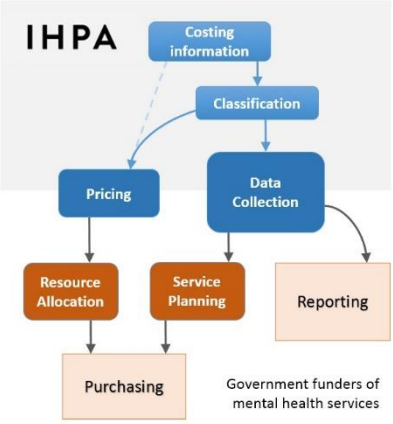
Continue to learn about the AMHCC and begin the survey

Background (1 of 2)

Health information and data are the foundation of the policy and operational levels of the health system. This consultation acknowledges and brings together the work that has already been done on ABF by MHA, on data capacity in New South Wales and Western Australia and the national outcome measurement project completed by AMHOCN/CMHA.

The planning and purchasing of mental health services in Australia rely heavily on information about the services that exist and their activities. Governments collect this information by categorising service activity and then specifying the reporting that they require through an agreed set of data items (a Data Set Specification). This forms the basis of what becomes a minimum data set for CMOs.

It is important for CMOs to be aware of health classifications and data structures as they influence the allocation of finances to different parts of the health system.



IHPA has been tasked with developing a new and separate classification for all mental health services - the Australian Mental Health Care Classification (AMHCC). The classification is intended to eventually cover all facets of admitted patient care in hospitals, as well as community and residential mental health services.

In the 2014 Budget the Federal Government indicated that it does not intend to directly fund the states and territories through an Activity Based Funding (ABF) model. However, most state and territory governments support the building of the classification framework, regardless of the status of ABF.

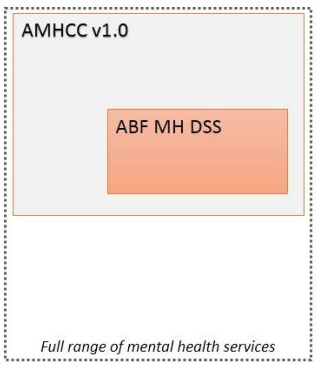
Funding based on activity will continue at the discretion of individual states and territories, and most are likely to continue using their own ABF models with reference to IHPA's work. So the development of a national mental health classification is still a very important project.

Background (2 of 2)

Building a nationally consistent classification for mental health care services will provide a mechanism to support Commonwealth and state agencies in understanding the factors that influence the cost of effective mental health care.

At present, there is no single classification used for mental health services. Since 1 July 2013, IHPA has priced admitted mental health services using Australian Refined Diagnosis Related Groups (AR-DRGs) as the classification system with a modified pricing model. This is not ideal in the longer term because diagnosis is not as strong a driver of resource utilisation for mental health services, and it can only be applied in the admitted setting. The purpose of developing the Australian Mental Health Care Classification (AMHCC) is to improve the meaningfulness of mental health classification, leading to an improvement in cost predictiveness.

In order to support the development of the AMHCC, IHPA undertook a costing study at 25 hospital and community based public mental health services. The findings from this study will inform the ongoing development of the AMHCC. In order to support the implementation of the AMHCC, IHPA will collect data from "in-scope" services from states and territories against the Activity Based Funding Mental Health Care Data Set Specification (ABF MHC DSS) from July 2015. While most CMO services are not currently "in-scope", this will change as the AMHCC is further developed.



It has been acknowledged that the next version of the AMHCC may need to cover a fuller range of mental health services, however what that will entail is yet to be determined.

This survey investigates the applicability of the AMHCC v1.0 to the CMO sector, and the capacity of the sector to collect relevant data.

Continue to begin the survey

Checks

Page exit logic: Page Logic**IF:** ((Question "My organisation is non-government / community-managed and primarily not for profit" #1 is not one of the following answers ("Yes") OR Question "I have knowledge of my organisation's (or branch's) programs, services activities and data system capacity." #2 is not one of the following answers ("Yes")) OR Question "My organisation (or branch) provides services that are funded specifically for people have experienced mental illness, their families or carers." #3 is not one of the following answers ("Yes")) **THEN:** Disqualify and display: "Sorry, you do not qualify to take this survey. Learn more about the AMHCC at the Mental Health Australia information page."

Before we begin, please answer these three questions:

1) My organisation is non-government / community-managed and primarily not for profit*

- Yes
- No

2) I have knowledge of my organisation's (or branch's) programs, services activities and data system capacity.*

- Yes
- No

3) My organisation (or branch) provides services that are funded specifically for people have experienced mental illness, their families or carers.*

- Yes
- No

Checks - representative sample

These questions help us ensure the survey is a reliable cross-section of the sector.

Responses will be de-identified during analysis of this survey and will not be passed on to funders or reported publicly.

4) What is the name of your organisation or service?*

5) If your service is a branch of a larger organisation or owned by a parent entity please provide the name of that organisations

6) What is your position?

- Director / CEO
- Manager
- Program, policy or project officer
- Team leader
- Front-line worker (e.g. Support worker, clinician, or peer worker)
- Other:

7) Roughly how many Full Time Equivalent (FTE) staff are employed for the mental services provided by your organisation or branch (incl. administrative and support staff)?*

8) Which states or territories does your organisation (or branch) operate in?*

- ☐ Queensland
- ☐ New South Wales
- ☐ Australian Capital Territory
- ☐ Victoria
- ☐ Tasmania
- ☐ South Australia
- ☐ Northern Territory
- ☐ Western Australia

9) What levels of government do you receive mental health-specific funding from?

- ☐ Commonwealth
- ☐ State/territory (health)
- ☐ State/territory (other)
- ☐ Primary Health Network
- ☐ Local government

10) What mental health services are primarily provided by your organisation / branch?

- ☐ Admitted & inpatient
- ☐ Care coordination
- ☐ Counselling (face-to-face)
- ☐ Counselling, support, information & referral (telephone or online)
- ☐ Education, employment & training
- ☐ Family & carer support
- ☐ Group support activities (staff-led)
- ☐ Group support & self-help (peer-led)

- ☐ Individual peer advocacy
- ☐ Mental health promotion
- ☐ Mental illness prevention
- ☐ Online self-help
- ☐ Personalised support
- ☐ Sector development & representation
- ☐ Service integration & systemic
- ☐ Staffed residential (non-admitted)
- ☐ Other (please specify): _____

Service clusters

The Australian Mental Health Care Classification v1.0 is organised around three traditional clusters of mental health service: Hospital (admitted), residential and community-based. This consultation will use a similar set of clusters to investigate data collection capacity.

11) Please indicate which of the following broad categories of mental health services are provided by your organisation (or branch).

Select the service areas for which you are specifically funded to provide and/or you have staff where the activity is a major component of their role. *****

- ☐ Community based / drop-in

Any mental health service where a consumer is not admitted to a hospital as an inpatient and the consumer/carer is either visited by the service or they visit the service during the day

- ☐ Residential / supported accommodation

Any mental health service, on or off a hospital site, where a consumer is not admitted as an inpatient and the consumer/carer stays overnight

- ☐ Hospital / admitted

Any mental health service on a hospital site where a consumer is admitted as an inpatient.

- ☐ Other: _____ *

Page entry logic: This page will show when: Question "Please indicate which of the following broad categories of mental health services are provided by your organisation (or branch).

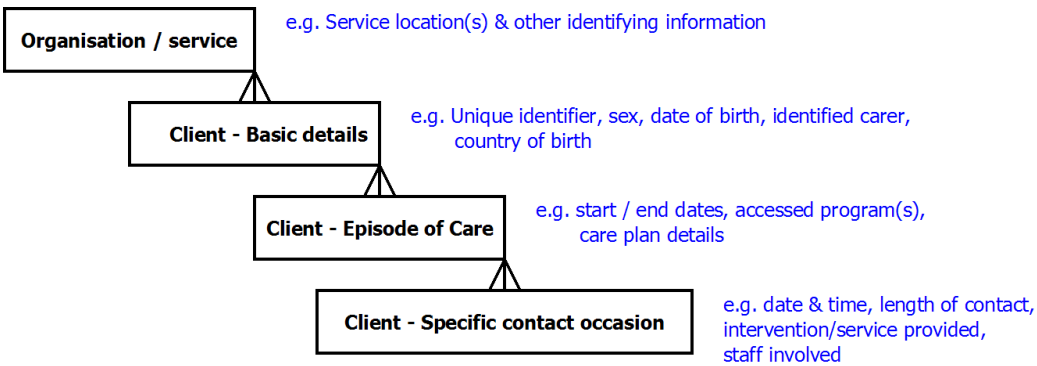
Select the service areas for which you are specifically funded to provide and/or you have staff where the activity is a major component of their role."
#11 is one of the following answers ("Community based / drop-in
Any mental health service where a consumer is not admitted to a hospital as an inpatient and the consumer/carer is either visited by the service or they visit the service during the day")

Capacity to collect data (Community based / drop in)

Please answer the questions on this page in relation to your Community-based services.

In the future, funding systems such as Activity Based Funding and the National Disability Insurance Scheme will require more detailed individual client data than CMOs have traditionally been required to report.

The differing levels of data collection and reporting capacity can be visualised as a hierarchy of information where there are many instances (or records) connected to the data level above it. This is demonstrated below.



The Australian Mental Health Care Classification involves data from all of the above levels.

Please indicate below your capacity to collect each of these levels of data.

12) Organisation / site level
e.g. Service geographical location, organisation name, service name, etc *

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

13) Client level - basic details
*e.g. unique ID, sex, date of birth, country of birth, indigenous status**

- Currently capable

- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

Logic: Show/hide trigger exists.

14) Client level - Episode of care

e.g. principal diagnosis, no. of days in care, referral source, legal status *****

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

Logic: Hidden unless: Question "Client level - Episode of care *e.g. principal diagnosis, no. of days in care, referral source, legal status* **" #14 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Which of the following Episode of care items are you able to collect and report on?*

	Capable	With modification	Not capable	N/A
Mental health legal status				
Principal diagnosis				
Additional diagnosis				
Episode start date and end date				
Reason for end of episode				
Referral source				

Referral destination	○	○	○	○

Logic: Hidden by default Hidden unless: Question "Client level - Episode of care *e.g. principal diagnosis, no. of days in care, referral source, legal status* **" #14 is one of the following answers ("Currently capable","Capable with some system modifications")**

Within an episode of care, is your system able to track, date and report on the different stages of a clients service usage (that would indicate a different level of resource or service delivery)?
e.g. high intensity/need, ready to focus on goals, low need, drop-in, etc

○ Yes (please give examples): _____

○ No

Logic: Show/hide trigger exists.

15) Client level data - Contact occasion
e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures *****

○ Currently capable

○ Capable with some system modifications

○ Capable with major system upgrade

○ Not currently capable

Logic: Hidden unless: Question "Client level data - Contact occasion *e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures* **" #15 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Which of the following Contact occasion items are you able to collect and report on?*

	Capable	With modification	Not capable	N/A
Date of contact	○	○	○	○
Contact duration	○	○	○	○

Mode of contact (e.g. face-to-face, phone, admin, etc)				
Location				
Direct or indirect				
Individual or group session				
Intervention/service type provided				

Logic: Hidden by default Hidden unless: Question "Client level data - Contact occasion *e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures* **" #15 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

If you collect data on the types of intervention/service type provided, please give examples of what you record

16) If you answered "N/A" to questions above, or have any other comment, please elaborate

Page entry logic: This page will show when: Question "Please indicate which of the following broad categories of mental health services are provided by your organisation (or branch).

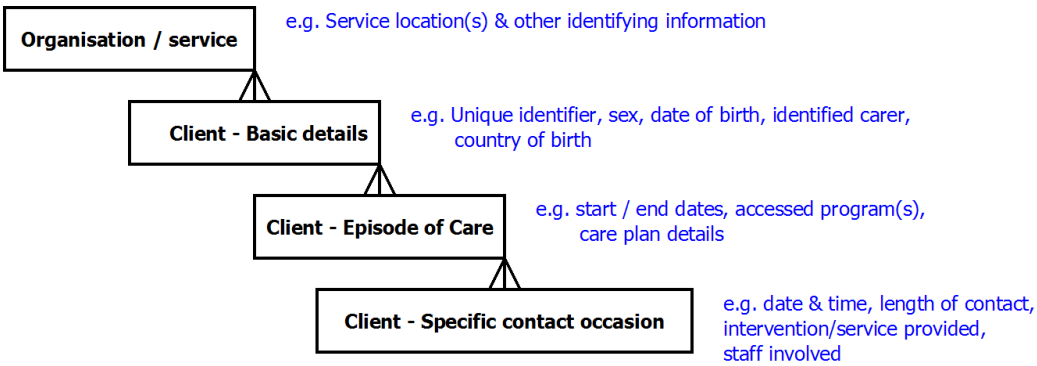
Select the service areas for which you are specifically funded to provide and/or you have staff where the activity is a major component of their role. " #11 is one of the following answers ("Residential / supported accommodation
Any mental health service, on or off a hospital site, where a consumer is not admitted as an inpatient and the consumer/carer stays overnight")

Capacity to collect data (Residential / supported accommodation)

Please answer the questions on this page in relation to your Residential / supported accommodation services.

In the future, funding systems such as Activity Based Funding and the National Disability Insurance Scheme will require more detailed individual client data than CMOs have traditionally been required to report.

The differing levels of data collection and reporting capacity can be visualised as a hierarchy of information where there are many instances (or records) connected to the data level above it. This is demonstrated below.



The Australian Mental Health Care Classification involves data from all of the above levels.

Please indicate below your capacity to collect each of these levels of data.

17) Organisation / site level

e.g. Service location, Local Hospital District, organisation name, service name *

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

18) Client level - basic details

e.g. unique ID, sex, date of birth, country of birth, indigenous status *

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade

Not currently capable

Logic: Show/hide trigger exists.

19) Client level - Episode of care
e.g. principal diagnosis, no. of days in care, referral source, legal status *****

Currently capable

Capable with some system modifications

Capable with major system upgrade

Not currently capable

Logic: Hidden unless: Question "Client level - Episode of care
e.g. principal diagnosis, no. of days in care, referral source, legal status **" #19 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Which of the following Episode of care items are you able to collect and report on?*

	Capable	With modification	Not capable	N/A
Mental health legal status				
Principal diagnosis				
Additional diagnosis				
Episode start date and end date				
Reason for end of episode				
Referral source				
Referral destination				

Number of leave days during episode				

Logic: Hidden by default Hidden unless: Question "Client level - Episode of care *e.g. principal diagnosis, no. of days in care, referral source, legal status* **" #19 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Within an episode of care, is your system able to track, date and report on the different stages of a clients service usage (that would indicate a different level of resource or service delivery)?
e.g. high intensity/need, ready to focus on goals, low need, preparing to leave, etc

- Yes (please give examples):
- No

Logic: Show/hide trigger exists.

20) Client level data - Contact occasion
e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures *****

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

Logic: Hidden unless: Question "Client level data - Contact occasion
e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures **" #20 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Which of the following Contact occasion items are you able to collect and report on?*

	Capable	With modification	Not capable	N/A
Date of contact				
Contact duration				

Mode of contact (e.g. face-to-face, phone, admin, etc)				
Direct or indirect				
Individual or group session				
Intervention provided				

Logic: Hidden by default Hidden unless: Question "Client level data - Contact occasion *e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures* **" #20 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

If you collect data on the types of intervention/service type provided, please provide examples of the interventions you record

21) If you answered "N/A" to questions above, or have any other comment, please elaborate

Page entry logic: This page will show when: Question "Please indicate which of the following broad categories of mental health services are provided by your organisation (or branch).

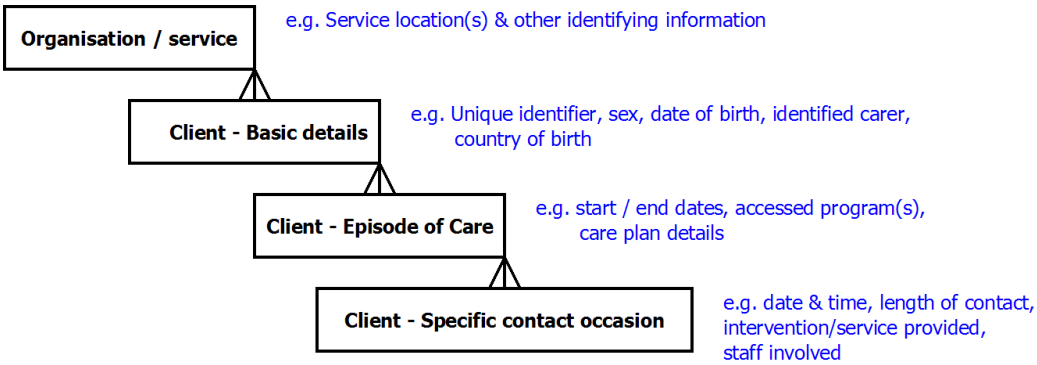
Select the service areas for which you are specifically funded to provide and/or you have staff where the activity is a major component of their role. " #11 is one of the following answers ("Hospital / admitted
Any mental health service on a hospital site where a consumer is admitted as an inpatient.")

Capacity to collect data (Hospital / admitted)

Please answer the questions on this page in relation to your Hospital / admitted services.

In the future, funding systems such as Activity Based Funding and the National Disability Insurance Scheme will require more detailed individual client data than CMOs have traditionally been required to report.

The differing levels of data collection and reporting capacity can be visualised as a hierarchy of information where there are many instances (or records) connected to the data level above it. This is demonstrated below.



The Australian Mental Health Care Classification involves data from all of the above levels.

Please indicate below your capacity to collect each of these levels of data.

22) Organisation / site level

e.g. Service location, Local Hospital District, organisation name, service name *

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

23) Client level - basic details

e.g. unique ID, sex, date of birth, country of birth, indigenous status *

- Currently capable
- Capable with some system modifications

- Capable with major system upgrade
- Not currently capable

Logic: Show/hide trigger exists.

24) Client level - Episode of care
e.g. principal diagnosis, no. of days in care, referral source, legal status *****

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

Logic: Hidden unless: Question "Client level - Episode of care
e.g. principal diagnosis, no. of days in care, referral source, legal status **" #24 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Which of the following Episode of care items are you able to collect and report on?*

	Capable	With modification	Not capable	N/A
Mental health legal status				
Principal diagnosis				
Additional diagnosis				
Episode start date and end date				
Reason for end of episode				
Referral source				
Referral destination				

Number of leave days during episode				
Psychiatric care type (e.g. acute, rehab, psychogeriatric, etc)				

Logic: Hidden by default Hidden unless: Question "Client level - Episode of care *e.g. principal diagnosis, no. of days in care, referral source, legal status* **" #24 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Within an episode of care, is your system able to track and date different stages of a clients recovery?
e.g. high need/crisis, stabilised, ready for discharge, etc

- Yes (please give examples):
- No

Logic: Show/hide trigger exists.

25) Client level data - Contact occasion
e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures *****

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

Logic: Hidden unless: Question "Client level data - Contact occasion *e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures* **" #25 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Which of the following Contact occasion items are you able to collect and report on?*

	Capable	With modification	Not capable	N/A
Date of contact				

Contact duration				
Mode of contact (e.g. face-to-face, phone, admin, etc)				
Location				
Direct or indirect				
Individual or group session				
Intervention provided				

Logic: Hidden by default Hidden unless: Question "Client level data - Contact occasion *e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures* **" #25 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

If you collect data on the types of intervention/service type provided, please provide examples of the interventions you record

26) If you answered "N/A" to questions above, or have any other comment, please elaborate

Page entry logic: This page will show when: Question "Please indicate which of the following broad categories of mental health services are provided by your organisation (or branch).

Select the service areas for which you are specifically funded to provide and/or you have staff where the activity is a major component of their role. " #11 is one of the following answers ("Other")

Capacity to collect data (Other)

Page exit logic: Skip if not Other**IF:** Question "Please indicate which of the following broad categories of mental health services are provided by your organisation (or branch).

Select the service areas for which you are specifically funded to provide and/or you have staff where the activity is a major component of their role. " #11 is not one of the following answers ("Other") **THEN:** Jump to page 11 - Outcome measurement tools

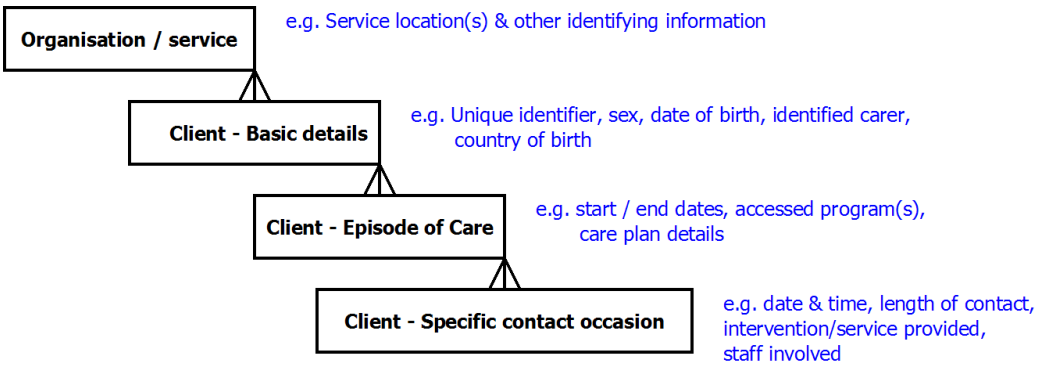
Page exit logic: Skip if not Community**IF:** Question "Please indicate which of the following broad categories of mental health services are provided by your organisation (or branch).

Select the service areas for which you are specifically funded to provide and/or you have staff where the activity is a major component of their role. " #11 is not one of the following answers ("Community based / drop-in
Any mental health service where a consumer is not admitted to a hospital as an inpatient and the consumer/carer is either visited by the service or they visit the service during the day") **THEN:**

Please answer the questions on this page in relation to your [question("option value"), id="14", option="10031"] services.

In the future, funding systems such as Activity Based Funding and the National Disability Insurance Scheme will require more detailed individual client data than CMOs have traditionally been required to report.

The differing levels of data collection and reporting capacity can be visualised as a hierarchy of information where there are many instances (or records) connected to the data level above it. This is demonstrated below.



The Australian Mental Health Care Classification involves data from all of the above levels.

Please indicate below your capacity to collect each of these levels of data.

27) Organisation / site level

e.g. Service location, Local Hospital District, organisation name, service name *

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

28) Client level - basic details

e.g. unique ID, sex, date of birth, country of birth, indigenous status *

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

Logic: Show/hide trigger exists.

29) Client level - Episode of care

e.g. principal diagnosis, no. of days in care, referral source, legal status *

- Currently capable
- Capable with some system modifications
- Capable with major system upgrade
- Not currently capable

Logic: Hidden unless: Question "Client level - Episode of care
e.g. principal diagnosis, no. of days in care, referral source, legal status **" #29 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Which of the following Episode of care items are you able to collect and report on?*

	Capable	With modification	Not capable	N/A
Mental health legal status	○	○	○	○
Principal diagnosis	○	○	○	○
Additional diagnosis	○	○	○	○
Episode start date and end date	○	○	○	○
Reason for end of episode	○	○	○	○
Referral source	○	○	○	○
Referral destination	○	○	○	○
Number of leave days during episode	○	○	○	○

Logic: Hidden by default Hidden unless: Question "Client level - Episode of care
e.g. principal diagnosis, no. of days in care, referral source, legal status" **#29 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Within an episode of care, is your system able to track, date and report on the different stages of a clients service usage (that would indicate a different level of resource or service delivery)?
e.g. high intensity/need, ready to focus on goals, low need, drop-in, etc

○ Yes (please give examples): [ ]

○ No

Logic: Show/hide trigger exists.

30) Client level data - Contact occasion
*e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures**

○ Currently capable

○ Capable with some system modifications

- Capable with major system upgrade
- Not currently capable

Logic: Hidden unless: Question "Client level data - Contact occasion *e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures* **" #30 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

Which of the following Contact occasion items are you able to collect and report on?*

	Capable	With modification	Not capable	N/A
Date of contact				
Contact duration				
Mode of contact (e.g. face-to-face, phone, admin, etc)				
Location				
Direct or indirect				
Individual or group session				
Intervention provided				

Logic: Hidden by default Hidden unless: Question "Client level data - Contact occasion *e.g. date of contact, duration, direct vs indirect, individual or group contact, outcome measures* **" #30 is one of the following answers ("Currently capable","Capable with some system modifications","Capable with major system upgrade")**

If you collect data on the types of intervention/service type provided, please provide examples of the interventions you record

31) If you answered "N/A" to questions above, or have any other comment, please elaborate

Outcome measurement tools

Second last page. Thank you for persevering.

Activity Based Funding will lead to a greater need for outcome data over time. This will support better systemic performance and assessment of need.

While standardised collection of CMO outcome data is still a way off, the following questions will assist IHPA in understanding the current status of outcome measurement in the sector.

The following outcome measurement tools will be recommended for mental health CMOs in the upcoming national AMHOCN guidebook for CMOs. This is building on the work of the National CMO Outcome Measurement Project and was based on thorough sector and government consultation.

32) Do you collect, and have the capacity to report, on any of the following outcome tools?

- ☐ RAS (Recovery Assessment Scale)
- ☐ STORI (Stages of Recovery Instrument)
- ☐ K10 (Kessler-10)
- ☐ CarerQoL (CarerQoL-7D+VAS)
- ☐ SDQ (Strengths and Difficulties Questionnaire)
- ☐ WSAS (Work and Social Adjustment Scale)
- ☐ LCQ (Living in the Community Questionnaire)
- ☐ WHOQoL (WHO Quality of Life, Brief)

- [ ] YES (Your Experiences of Service)
- [ ] Carers Experience of Service Provision
- [ ] CANSAS (Camberwell Assessment of Need - Short Appraisal Scale)

33) Are there any other tools that you use to track individual client outcomes in your services?
e.g. DASS, Recovery STAR, BASIS-32, HoNOS, LSP-16, etc

34) If you would like to be informed by AMHOCN when the national CMO mental health outcome measurement guidebook has been released, please provide an e-mail address here.
Your e-mail address will be passed on and will not be kept by this project.

Future directions and final comment

35) Are you planning to upgrade your data system to collect client-level records in response to any of the following reforms?

- [ ] Activity Based Funding
- [ ] National Disability Insurance Scheme
- [ ] E-Health Records
- [ ] Other reform process (please specify):

36) What is the best way that IHPA, MHA or CMHA can help you develop your capacity to collect and report on service activity?

37) Is there anything else you would like to say about the Australian Mental Health Care Classification?

Thank You!

Thank you for taking the time to complete this consultation. Your input will help shape the future of theAustralian Mental Health Care Classification.

Learn more about the AMHCC at the Mental Health Australia information page.