

Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care

2015 Edition

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Introduction

The private sector provides a range of mental health services that are delivered by a variety of service providers and across a number of service settings including community, office and hospital-based. Payment for private mental health services and treatments is made through a variety of mechanisms including the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme, private health insurance arrangements, individuals who fund their own care, and third party payers, including the Australian Government Department of Veterans' Affairs and compensation insurers.

Services provided by psychiatrists, GPs, psychologists, nurses, occupational therapists and social workers in private practice may attract Medicare benefits. Private health insurers may also pay benefits for a range of ancillary services. Overnight, admitted day only, outreach, outpatient and community patient services, provided by private hospitals, may attract benefits paid by private health insurers and third party payers, whilst the private medical practitioner component of services delivered while a patient receives hospital-based care and services, may continue to attract benefits through the MBS. Private health insurers also provide medical benefits for inpatient care.

These Guidelines have been endorsed by the Private Mental Health Alliance (PMHA)¹ and were developed by the PMHA's Collaborative Care Models Working Group.² They include advice that is applicable to private hospital-based psychiatric services and in some instances to those services that substitute for traditional admitted patient treatment. The Guidelines should be read in conjunction with the National Standards for Mental Health Services and the Australian Commission on Safety and Quality in Healthcare National Safety and Quality Health Service Standards.

The Guidelines cannot be prescriptive and, at present, are primarily intended to provide guidance for hospitals and private health insurers in determining health insurance benefits for private patient hospital-based mental health care. This includes same-day, half-day, overnight and services that substitute for traditional admitted patient treatment, as well as community and outpatient services, where applicable. The Guidelines may also be of assistance to State/Territory health authorities and their public hospitals in the treatment of Medicare and privately insured patients and to office-based practitioners.

1 The PMHA is a national industry alliance that resulted from the 2007 restructure of its antecedent, the Strategic Planning Group for Private Psychiatric Services (SPGPPS). This industry alliance has been operating since 1996 to address issues related to funding, classification, quality of care, outcome measurement, consumer and carer participation and related topics as they affect the private mental health sector. PMHA is currently comprised of representatives of the Australian Medical Association, Private Healthcare Australia, Australian Private Hospitals Association, the Private Mental Health Consumer Carer Network (Australia), and the Australian Government Department of Health and the Department of Veterans' Affairs.

2 Since the 2007 restructure, the PMHA has been further expanded to include a Collaborative Care Models Working Group. In addition to the organisations participating on PMHA, the CCMWG includes representatives from The Royal Australian and New Zealand College of Psychiatrists, the Royal Australian College of General Practitioners, the Australian College of Mental Health Nurses, the Australian Psychological Society, the Australian Association of Social Workers, and Occupational Therapy Australia.

Principles

The following key principles underpin these Guidelines.

- 1.1. Private patients have a right to high quality private mental health services focused on symptomatic and functional recovery.
- 1.2. Private patients have the right to the Doctor of their choice.
- 1.3. Health Insurance benefits and funding models will support the provision of high quality, evidence-based care.
- 1.4. It is a shared responsibility of funders, providers and treating doctors to assist consumers and carers in establishing the extent of the consumer's private health insurance cover and potential out-of-pocket expenses.
- 1.5. Consumer, carer and family participation will be included in all aspects of private mental health service provision, with the specific permission of the consumer.
- 1.6. Consideration must be given to the most appropriate, evidence-based³ and cost-effective recovery oriented treatment options delivered in the most appropriate environment.
- 1.7. The Guidelines support private mental health care services being delivered in accordance with a continuum of care and encourage hospitals and appropriately qualified practitioners to provide care in this manner.
- 1.8. Private health insurers, hospitals and mental health professionals should be strongly encouraged to co design funding models in support of the continuum of care.
- 1.9. Private mental health services should comply with the following, where applicable.
 - National Health Act 1953
 - Health Insurance Act 1973
 - Private Health Insurance Act 2007
 - Disability Discrimination Act 1992
 - Australian Government Privacy Act 1998
 - Private Health Insurance (Accreditation) Rules 2008
 - National Mental Health Policy and Plan
 - National Standards for Mental Health Services (NSMHS)

³ While it is acknowledged that evidence-based practice can be applied in the majority of cases, there will be situations where evidence-based practice cannot be applied, due to the complexity of some psychiatric problems and the nature of some forms of psychotherapeutic treatment.

- A model for data collection and analysis that enables the monitoring and evaluation of improvement in the quality of services, in accordance with the NSMHS. It is strongly recommended that such data be analysed and used within a collaborative framework that enables benchmarking with best practice.⁴
 - National Health Data Dictionary
 - National Practice Standards for the Mental Health Workforce
 - Australian Commission on Safety and Quality in Healthcare (ACSQHC) National Safety and Quality Health Service Standards
 - PMHA Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers
 - Relevant State and Territory Mental Health Acts
 - State and Territory Private Hospital and Day Hospital Facility Licensing Acts
 - Guidelines for Approved Outreach Service under the Health Legislation Amendment Act (No 1) 2001
 - RACGP Standards for general practices
- 1.10 Hospitals, private health insurers and appropriately qualified practitioners are encouraged to develop the appropriate expertise to implement these Guidelines to achieve cost effective high quality, consumer and service outcomes, in accordance with best practice.
- 1.11 Applications for funding of private hospital-based mental health services must demonstrate there is a need for such services. Decisions regarding approval and level of funding remain a matter for negotiation between hospitals and private health insurers, and the Australian Government through its regulatory function.
- 1.12 Private hospital-based mental health services should actively engage in recognised quality assurance processes, including review of services against the National Standards for Mental Health Services, by an independent accreditation agency and implementation of quality assurance plans arising from such external review.
- 1.13 University affiliation and collaboration are encouraged in relation to research, education and training.

Service Provision

People with a mental illness or mental disorder, require access to a comprehensive range of services, with an emphasis on coordination, integration and individualised care. Mental health services should be funded and delivered according to a continuum of care model and a range of specialist treatment and support services should be available.

⁴ National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Hospital-based Psychiatric Services.

Such services may include the following.

- Early intervention.
- Crisis assessment.
- Domiciliary/community care
- Outpatient services
- Day, half-day, partial-day and evening services
- Hospital programs
- Admitted overnight services
- Maintenance and supportive care
- Patient and carer education
- Discharge planning and preventative care
- Leave as part of the process for preparing for discharge
- Self-management and recovery focussed treatment
- Hospital treatment services provided outside the hospital setting

Funding for some of these services will be provided by private health insurers, while other services will be funded through the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme, the Australian Government, State and Territory and Local Governments, third party funders, and by the patients themselves.

Private Hospital-based Services

Section 121.5 of the *Private Health Insurance Act 2007* (Act), which commenced on 1 April 2007, describes the meaning of *hospital treatment* as follows.

- (1) *Hospital treatment* is treatment (including the provision of goods and services) that:
 - (a) is intended to manage a disease, injury or condition; and
 - (b) is provided to a person:
 - (i) by a person who is authorised by a hospital to provide the treatment; or
 - (ii) under the management or control of such a person; and
 - (c) either:
 - (i) is provided at a hospital; or
 - (ii) is provided, or arranged, with the direct involvement of a hospital.

The Act also provides a platform for private health insurers to cover a wide range of services provided outside the hospital including hospital-substitute treatment, and programs that help their members better manage their health, such as chronic disease management programs.

Under the Act, services are classified as either *hospital treatment* or *general treatment*.

Hospital treatment is defined under Section 121-5 of the Act as treatment that is intended to manage a disease, injury or condition that is provided to an insured person by a hospital, or arranged with the direct involvement of a hospital.

General treatment is defined under Section 121–10 of the Act as treatment that is intended to manage or prevent a disease, injury or condition, and is not *hospital treatment*.

Hospital–substitute treatment is a subset of *general treatment* and is defined under Section 69–10 of the Act. It is treatment provided by a provider that is not a declared hospital, but which substitutes for an episode of hospital treatment, i.e. it is the same treatment that is usually provided by a hospital. It is not mandatory for private health insurers to cover *Hospital–substitute treatment*. It is up to private health insurers to decide the services they pay benefits for and to determine that the services provide value for money in terms of cost outlays and health outcomes for their members. Providers that wish to provide services outside of hospital must contact private health insurers and establish an agreement before health insurance benefits can be paid.

1. Care delivery

It is strongly recommended that hospitals, where applicable to privately insured patients, meet the principles for guiding the delivery of care as recommended by the National Standards for Mental Health Services.⁵ This should include the following.

- Choice and access to a range of treatment options in consultation with the patient and, where nominated and clinically appropriate, their family or carer(s).
- Reference to the patient’s social, cultural and developmental context.
- Continuous and coordinated care delivered via a range of services across a variety of care settings.
- Comprehensive individualised care, access to treatment and support services able to meet specific needs during the various stages of the individual’s illness.
- Treatment in the most facilitative environment appropriate for the individual patient.
- Care provided must also be documented in an individual care plan and be transparent based on, for example, the use of Clinical Care Pathways, Clinical Practice Guidelines,⁶ and Clinical Notes.
- Priority must be given to the most appropriate evidence based, recovery oriented, and cost-effective treatment options for each individual patient. While it is acknowledged that Evidence-based practice can be applied in the majority of cases, there will be situations where evidence does not exist for the level of complexity of some psychiatric problems and the nature of some forms of psychotherapeutic treatment.

5 PMHA has endorsed the National Standards for Mental Health Services, where applicable, for implementation in private sector mental health services.

6 Clinical Practice Guidelines (or CPGs) are systematically developed statements intended to assist practitioners in making decisions about appropriate health care for specific clinical circumstances. Their main purpose is to improve health outcomes for patients by improving the practice of clinicians. As they become available, CPGs for psychiatric disorders are placed on the internet at <http://www.ranzcp.org>.

2. Choice of setting

The following factors need to be considered when selecting the most appropriate setting for care delivery.

- Patient acuity, level of distress and disability.
- Level of social support in the home.
- Geographical considerations.

3. Patient acuity, level of distress and disability

Patients should have:

- a diagnosed psychiatric illness classified by either ICD–10–AM or DSM–5 and have a level of distress and/or disability that demonstrably impacts on their ability to function in day–to–day living and their relationships with others; and
- require specialised intervention, treatment or support in an appropriate care setting or range of settings, with an expected measurable outcome.

It is acknowledged that early intervention for people with a mental illness, or mental disorder, is particularly important in minimising the impact of first episodes, the incidence of relapse, maximising recovery and reducing the length of hospital stay.

Direct admission to an appropriate same–day program (half or full–day), or attendances at outpatient services, where available, should be considered as an alternative to admitted overnight patient services.

3.1 Admitted overnight services

After mental health assessment by the treating psychiatrist, level of distress and/or disability is assessed as acute, severe, or serious as evidenced by but not confined to, the following.

- High risk of harm to self, or others.
- Incapacitating symptoms or distress. This may be evidenced by a highly disorganised state impacting on self–care and/or physical health, including inability to comply with treatment, resulting in a need for 24 hour care.
- The need to establish the nature of a disorder, initiate and/or stabilise complex treatment modalities, such as pharmacotherapy and Electroconvulsive Therapy (ECT).
- Significant problems in initiating treatment, or continuing treatment, in another setting. As patient acuity, dysfunction and available support change the patient should, as soon as possible, be relocated to an appropriate level in the continuum of care, in consultation with the patient and, where nominated and clinically appropriate, his or her family/carer.

Admitted overnight length-of-stay should be determined by the patient's treating psychiatrist in accordance with individual patient clinical need, and clinical best practice⁷, not by length of program.

3.2 Admitted same-day patient services

Admitted same-day services should be the setting of choice for early intervention and when the patient exhibits a level of acuity, distress, or disability that is assessed as:

- manageable risk of harm to self, or others; and
- lower indicators of severity and complexity than those necessitating admitted overnight stay; and
- able to comply with treatment and self-care; or
- able to cope with their usual environment.

As patient acuity, level of functioning and disability and available supports change, the patient should, as soon as possible, be relocated to an appropriate level in the continuum of care, in consultation with the patient and, where nominated and clinically appropriate, their family/carer(s) and with consideration of funding options.

All occasions of service must be determined on an individual basis. This may include participation in a structured program of defined interventions and duration, where it is indicated by Best Practice.

Admitted same-day services should only be provided when that treatment environment is the best for the individual patient.

3.3 Community, hospital-in-the-home, and outreach type services

Community, hospital-in-the-home and outreach type services that are provided by private hospitals should meet all applicable guidelines and be delivered by appropriately trained and qualified health professionals. Patients can receive such services as a direct substitution for admitted overnight, or admitted same-day care. It is expected that psychiatrists and hospitals will regularly communicate with each other to reassess the appropriateness of this level of care for the patient.

4. Treatment and care options

Treatment and care options should comply with any relevant clinical guidelines regarding treatment of any specific disorders (see Footnote 6).

At all times, in the selection of treatment options, the focus needs to be on individual needs and restoration or stabilisation of function, taking into account environmental factors for the patient, patient preferences and the patient's support systems.

⁷ Clinical best practice is defined in this context as those clinical interventions that have been judged to be most effective at delivering a particular clinical outcome, such as the RANZCP Clinical Practice Guidelines.

Phases of treatment include pre-admission assessment, admission, immediate assessment and intervention, continued diagnostic evaluation and refinement of treatment, clarification of treatment goals and discharge criteria, progress towards and achievement of goals, discharge, and transition to appropriate aftercare or follow up.

A full continuum of care ranges from intensive/high dependency admitted overnight treatment to day hospital, outpatient, rehabilitation, office-based, and community care.

It is expected that program modules designed to develop/increase skill levels to prevent or minimise relapses will be primarily conducted on a same-day, outpatient, half or full-day basis, where possible and clinically appropriate.

Admission, treatment and care must be under the supervision of the attending psychiatrist irrespective of care setting. Treatment and care options based on biopsychosocial principles, should be negotiated with the patient and, where nominated and clinically appropriate, their family/carer(s). It is acknowledged that there will be two possible scenarios:

1. the patient is able to make an informed decision regarding the involvement of their family/carer(s) in their treatment and care options;
- or
2. the patient is unable to make an informed decision concerning the involvement of their family/carer(s).

In the second situation, the attending psychiatrist is responsible for determining the level of involvement of family/carer(s) in the consideration of treatment and care options.

A care plan should be developed as part of the assessment process and documented prior to commencement of specialist treatment. Regular reviews of the care plan should occur at intervals appropriate to the care setting and include those members of the multidisciplinary team involved in the treatment. Care plans and reviews must always reflect the needs of the patient and include those members of the multidisciplinary team and appropriate and relevant families/carers.

The care plan should:

- document chosen treatment and care options;
- take into account transitions in levels of care;
- include discharge planning;
- clearly state goals and outcomes, including detailed functional improvement or decline and an estimate of length/duration of treatment(s);
- be developed collaboratively and regularly reviewed with the patient, and with the patient's informed consent, their carers, and be available to them.

Care and treatment options should be selected from Evidence-based treatment choices, within a recovery oriented framework such as the following.

- Individual, group, family and other psychotherapies.
- Psychopharmacotherapy.
- Electroconvulsive Therapy (in accordance with guidelines of the RANZCP and the Australian and New Zealand College of Anaesthetists).⁸
- Specific post-natal mental health services where babies should usually accompany their mother during her admission.⁹
- Other Evidence-based treatment modalities.
- Specific rehabilitation and education services to facilitate return of function.
- Outreach services to facilitate return of function, maintain function or prevent relapse.
- Education, promotion, prevention and support services.
- Drug and alcohol program following assessment (and treatment if necessary) by a psychiatrist.

5. Quality standards

Hospitals should implement appropriate quality improvement processes taking account of relevant sections of the *National Safety and Quality Health Service (NSQHS) Standards*, the *National Standards for Mental Health Services* and the *National Practice Standards for the Mental Health Workforce* including but not limited to, the following.

- Recognised by the Australian Government Department of Health for private health insurance purposes.
- Licensed by a State/Territory as a Private Psychiatric Facility.
- Accreditation by an industry recognised body.
- Demonstrated quality improvement activities.
- Ongoing collection and benchmarking of industry agreed and validated outcome measures, both patient and clinician rated.

8 The Royal Australian and New Zealand College of Psychiatrists, Guidelines on the Administration of Electroconvulsive Therapy (ECT), can be obtained from their website at: <http://www.ranzcp.org/resources/clinical-memoranda.html>. The Australian and New Zealand College of Anaesthetists, T1 Recommendations of Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations – Interim Review 2008, are available from their website at: <http://www.anzca.edu.au/resources/professional-documents/pdf/T1.pdf>

9 Royal Australian and New Zealand College of Psychiatrists Position Statement #57 – Mothers, Babies and Psychiatric Inpatient Treatment.

- Data collected are stored and reported in a manner, which ensures confidentiality and complies with relevant legislation and the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital-based Psychiatric Services*.
- Mechanism for clinical case review of patients.
- Ongoing peer review and/or clinical supervision as appropriate for all health professionals involved in patient care.
- Quality initiatives ratified from time-to-time by the PMHA

6. Staffing

All treatment, irrespective of care setting, is to be provided by appropriately trained and qualified health professionals who are registered, where registration is required, or otherwise members of their relevant professional bodies, with substantiated and relevant clinical experience in the forms of treatment, therapy and care they provide. These may include the following.

- *General Practitioners (GPs) and GP Registrars*, registered with Australian Health Practitioner Regulation Agency (AHPRA).
- *Psychiatrists and Psychiatric Registrars* registered with AHPRA
- *Psychologists* registered with AHPRA, including those endorsed to practice as a Clinical Psychologist.
- *Registered and Enrolled Nurses and Nurse Practitioners* registered with AHPRA.
- Mental Health Nurses credentialed by the Australian College of Mental Health Nurses (ACMHN).
- *Occupational Therapists* registered with AHPRA
- *Accredited Mental Health Social Workers* accredited with the Australian Association of Social Workers (AASW).

It is acknowledged that the medical practitioner component (for example Psychiatrist, General Practitioner, Anaesthetist, Physician) of private hospital-based treatment is provided by a private medical practitioner operating under the MBS.

6.1 Staffing levels

Each mental health unit/service will be staffed according to occupancy rates, the current severity of illness experienced by patients, special individual needs and age-specific needs and vulnerabilities.

Appropriately trained Mental Health Professionals will make up the majority (minimum 60%) of the staffing numbers.

Hours per patient day will be an average of 4 hours, with the aim of achieving 4.2 hours, per patient day over 7 days.

Therapy services provided by Mental Health Professionals should be available seven days a week for Admitted Overnight patients.

Twenty four hour cover for Admitted Overnight patients, through a roster for Consultant Psychiatrists, or hospital registrars/medical officers or both, are encouraged.

6.2 Professional Development

There must be a continuing education and development program for staff, which takes cognisance of the *National Standards for Mental Health Services* and *National Practice Standards for the Mental Health Workforce*. It is recognised that private hospitals provide training and clinical placements for a range of students including Nurses, Allied Health and Medical.

All clinical staff must be credentialed by the service and participate in regular peer evaluations and reviews. Clinical case assessments must be performed where appropriate and documented. Clinical supervision of all nursing and allied health professional staff must be undertaken on a regular basis.

All staff must be aware of, and comply with, the obligations specified under the Privacy Act 1998 (as amended).

6.3 Admitted Overnight Patient Services

Admitted Overnight Patient Services must be delivered by appropriately trained and qualified health professionals. Patients should have a structured therapeutic plan that is tailored to meet their individual and group therapy requirements.

6.4 Admitted Same-day Patient Services

Services must be delivered by appropriately trained and qualified health professionals for specific contact hours. Contact hours include:

- Participation in specialised group therapy programs that have clearly defined clinical outcome goals.
- One-to-one counselling/therapy sessions.

Contact hours should not include time allocated for meal and tea breaks, unless they are part of an eating disorders program.

Same-day Programs – full-day

A minimum number of four and a half hours of structured therapeutic contact hours per day, except where agreement has been reached for alternative arrangements.

Same-day Programs – *half-day*

A minimum number of two and a half hours of structured therapeutic contact per day, except where agreement has been reached for alternative arrangements.

7. Facilities

Facilities must be licensed by the relevant State/Territory health authority or approved as equivalent by the Australian Government Department of Health. Licensing arrangements vary significantly from one jurisdiction to another. The following minimum requirements are strongly recommended.

7.1 Hospitals

A hospital building or unit designed and built specifically for the purpose of providing psychiatric care, or another type of hospital building which has been converted or modified to specifically provide psychiatric care and incorporates the following.

Therapy rooms There should be sufficient purpose designed rooms to cater for the needs of all admitted overnight and same-day patients.

Therapy Group Size The **maximum** size of groups should not exceed 12 participants, unless additional facilitators are involved.

Lounge/recreation rooms Properly furnished rooms and/or areas should be set aside for admitted overnight patients and same-day patient's relaxation. Access to a safe outside leisure area. Private areas should also be set aside for admitted overnight patients to meet with relatives and friends.

Interview rooms There should be an adequate number of rooms provided for use by clinicians to interview/consult with patients on a confidential basis.

Dining rooms Fully equipped dining rooms should be provided adequate to meet the needs of the total service including admitted overnight patients and same-day patients, day patients and staff.

Electroconvulsive Therapy (ECT) If ECT is administered, separate preoperative, procedure, and post-operative rooms must be available. Hospitals must comply with State and Territory licensing requirements for ECT, where they exist, the guidelines for ECT of the Royal Australian and New Zealand College of Psychiatrists, and those of the Australian and New Zealand College of Anaesthetists (see Footnote 9).

Facilities for specialist programs Hospitals providing specialist programs, e.g. High Dependency Units, Parent/Infant Units, Alcohol Detoxification Programs must be able to demonstrate the existence of appropriate facilities and equipment. In some cases this may require the designation of specific special purpose areas within the hospital.

Wards Wards should be comfortable with adequate bathroom facilities and, in shared wards, must include screens or curtains to ensure individual privacy for each patient. Each facility should have an appropriate number of single bed wards designed and

positioned to permit observation and monitoring of progress of high risk patients.

Smoking areas Where permitted, dedicated smoking areas for patients should be functional but discourage lengthy personal interactions or individual isolation. Nicotine Replacement Therapy should be routinely offered to all patients who smoke and dedicated program/s should promote withdrawal, assist abstinence and encourage alternatives within the context of the management of their mental illness.

Alternatives to In Hospital Treatment

Under Australian legislation, contractual arrangements can be established in the private sector between providers and private health insurers for the provision of service models that substitute for traditional admitted patient treatment, overnight and day only hospital-based care (*hereafter* traditional admitted patient treatment).

These transitional models constitute a form of substitute service delivery that can improve the quality of health outcomes for some people living with a mental illness in the community. Such acute care services aim to reduce the severity of illness over time, reduce hospital admissions, re-admissions and the length of hospital stay. They include, but are not limited to such models as Hospital-in-the-Home (HITH), Outreach, and Hospital-substitute type services. These services are time limited and focus on integrating the patient back into the community with the relevant community-based supports. They are not a substitute for community-based care and care should be taken to make sure the patient does not become inappropriately dependent on these, particularly when socially isolated.

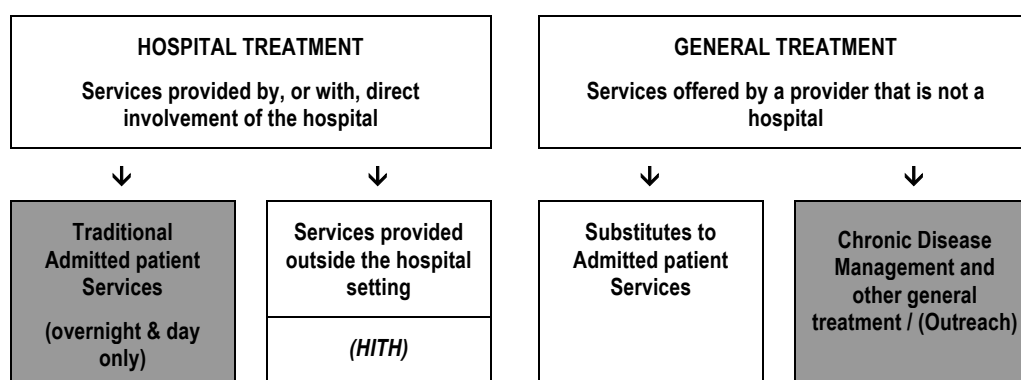
To facilitate the delivery of such services, a central lead agency that is responsible and accountable for the services provided is required. Within the private sector, the lead agency is more likely to be a private hospital. There is, however, sufficient flexibility under the legislation to enable providers that are not hospitals to undertake the provision of such services.

This section of the Guidelines is intended to assist providers, payers, consumers and carers, better understand the nature of these services and the terminology involved.

1. Legislation

As detailed earlier in these Guidelines, the *Private Health Insurance Act 2007* (the Act) is intended to provide a platform for private health insurers to provide benefits for a wide range of services and programs including those that can be substituted for traditional admitted patient treatment, and those that can help their members better manage their health, such as chronic disease management programs.

Figure 1: Comparison of Models under Hospital Treatment and General Treatment



1.1 Hospital Treatment

Under current legislation, *hospital treatment* is defined under Section 121–5 of the Act as treatment that is intended to manage a disease, injury or condition that can be provided to an insured person by a hospital, or arranged with the direct involvement of a hospital.

Two distinct models of service provision can be provided under *hospital treatment*.

- (1) Traditional overnight and day only admitted patient treatment that is conducted to achieve a continuum of care for the patient *within* the hospital setting.

Private health insurers for the purpose of paying benefits **may** consider the patient to be admitted.

- (2) Substitution of traditional admitted patient treatment with an alternative service model able to achieve a continuum of care for the patient *outside* the hospital setting.

These services are usually delivered to the patient at their home or in another appropriate setting. While a range of terms exist for these alternative models, such as HITH, the hospital is the lead agency that is both responsible and accountable for the provision of the services.

These services are usually provided by hospital-based personnel, or by personnel subcontracted by the hospital. The services include clinical assessment, monitoring, support and interventions to assist to maximise recovery and prevent relapse.

Under this model, while the hospital does not consider the patient to be an in-patient of the hospital, they are considered to be an admitted patient. This ensures continuity of care and enables the hospital to meet its clinical responsibilities and legal obligations to the patient.

Private health insurers, for the purpose of paying benefits, **may** consider the patient to be admitted.

1.2 General Treatment

General treatment is defined under Section 121–10 of the Act as treatment that is intended to manage or prevent a disease, injury or condition, and is not hospital treatment. However, while the service provider is **not** a hospital, a subset of the Act (Section 69–10), does facilitate the provision of what is described formally in the Act as *hospital-substitute treatment*. *Hospital-substitute treatment* can be offered by a provider or agency that is not a declared hospital in substitution for an episode of hospital treatment. In other words, it is intended to give providers and private health insurers the flexibility to provide the same treatment that would normally be provided by a hospital without the direct involvement of a hospital.

Under *hospital–substitute treatment*, the provider(s) would be considered both responsible and accountable for the provision of the services, but the patient is not considered to be admitted in the hospital. *Hospital–substitute treatment* may be undertaken by the provider, or by personnel subcontracted by the provider.

These services include clinical assessment, monitoring, support and interventions to assist to maximise recovery and prevent relapse. Under this model, the provider would be responsible for ensuring there is continuity of care and that the relevant clinical responsibilities and legal obligations to the patient and their health records are met.

2 Funding

It is not mandatory for private health insurers to cover these services. It is up to private health insurers to decide the services they pay benefits for and to determine that the services provide value for money in terms of cost outlays and health outcomes for their members. Providers that wish to provide services that substitute for traditional admitted patient treatment must contact private health insurers and establish an agreement before health insurance benefits can be paid. There may be agreement for a variety of different funding models to be used in these circumstances within the overall funding of the service. Insurers, for example, may consider alternative funding arrangements, such as providing benefits for a finite number of visits or alternatively having a step down arrangement for such services.

Under *hospital–substitute treatment*, services that substitute for traditional admitted patient treatment are able to be covered by the MBS. A private health insurance member may also be entitled to receive higher than 100% of the MBS fee under their membership, depending on what medical no gap arrangement they have with their insurer. The MBS is able to cover up to 75% of the MBS fee and health insurers cover the remaining gap of 25%. However, insured persons receiving hospital substitute treatment may instead elect to be billed the 85% MBS fee, and cover any gap.

3. Approaches to service delivery

Services that substitute for the traditional admitted patient treatment will vary in how they are structured and operate. They are not a substitute for community–based care.

It is critically important that substitute services for people with a mental illness are able to provide continuity of care and clear lines of communication so that multiple sources of possibly differing treatment and advice are avoided.

Cooperation with other treatment services and providers is also critical to ensure a person with a mental illness receives not only an appropriate mix of services, but is also able to transition appropriately between other services including inpatient, day only, outpatient and substitute treatment services, without unnecessary overlap or duplication. This will require appropriate linkages to be established with a variety of public sector and Non Government Organisations.

It may also require agreement between providers and the person receiving treatment about the use and sharing of their health record.

Substitute services include clinical assessment, monitoring, support and interventions to assist to maximise recovery and prevent relapse. The service is then delivered on a face-to-face basis either at the patient's home, or in another appropriate setting. Such services should be directed toward integrating the patient back into the community with the relevant community-based supports. Visits should involve face-to-face contact with an appropriately trained mental health professional and be of a clinically appropriate duration. Each visit should be recorded in the medical record. These services should generally not be conducted whilst a patient is participating in a day only program, unless under short-term exceptional circumstances.

4. Quality and Standards

Services that substitute for traditional admitted patient treatment should comply with the National Standards for Mental Health Services and the ACSQHC National Safety and Quality Health Service Standards, particularly in relation to person centred care in relation to the following.

- Services are evidence-based and directed at supporting recovery.
- Consultation with the patient and family/carer, where nominated by the patient, regarding choice of access to support and treatment services.
- Provision of services in a manner that respects social and cultural values, beliefs and practices.
- Provision of co-ordinated care across a range of settings and service providers, as appropriate.
- Provision of individualised care to meet specific needs during various stages of the patient's illness.

They should aim to meet the principles guiding care delivery recommended by the National Practice Standards for Mental Health Workforce and other relevant professional standards.

Services should collect and benchmark against agreed and validated outcome measures, both patient and clinician rated. Data collected should be stored and reported in a manner, which ensures confidentiality and complies with relevant legislation and the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital-based Psychiatric Services*.

Consumer feedback should be sought regarding the quality of service provision.

Substitute services should also comply with any local requirements of the lead agency providing the service and any relevant Commonwealth, State or Territory legislation.

5. Entry and Duty of Care

Patients who are assessed as appropriate for referral to a private hospital for services that substitute for the traditional admitted patient treatment following an inpatient stay should be under the care of private psychiatrist who is accredited to practice at that hospital. The treating psychiatrist should then be responsible for prescribing and reviewing the substitute treatment service.

The hospital is responsible for providing the range of services including assessment, monitoring, support, risk assessment and information on sources of emergency support, after hours support and integration back to living as independently as possible in the community. Throughout each episode of care, patients are considered to be concurrently patients of the hospital and of the treating psychiatrist.

When patients are being supported by services external to the hospital, the duty of care for those services lies with the treating psychiatrist and the external service provider.

A tracking system should be maintained that ensures all patients referred to a substitute service are followed up within 5 working days of referral.

6. Care Plan

A written Care Plan outlines the goals and strategies for management, support, and rehabilitation for the patient's particular identified mental health problem.

Following the initial assessment and referral to a substitute service, a care plan should be completed in collaboration with the patient and members of the treating team, and where nominated and clinically appropriate, the carer(s). The treating team is usually comprised of the treating psychiatrist and other clinical, medical or allied health personnel involved in the patient's regular mental health care. The multi-disciplinary nature of the team ensures the staff delivering the substitute service, have access to a range of personnel with expertise in a variety of areas. In addition, the patient's carer(s) should be consulted, where nominated, as should personnel from other support agencies to ensure information sharing, continuity of care, and transfer of care, when and if applicable. Discharge planning should be undertaken as part of the assessment and admission process and should form part of the care plan.

Services that substitute for traditional admitted patient treatment should be part of a patient's overall Care Plan. Substitute services should receive a copy of the Care Plan, which should include documentation of the following.

- Chosen treatment and care options.
- Other services/providers the patient has attended, or is currently attending.
- Goals for initial referral to the substitute service.
- Results achieved to date.
- Number of any additional visits deemed appropriate.

- Strategies to be implemented.
- Evaluation of progress.
- What community support services have been initiated, where appropriate.
- Mechanism for review by the treating psychiatrist.
- Next review by the treating psychiatrist.
- Transitions in levels of care.
- Discharge planning.
- Functional improvement.
- Estimate of length/duration of treatment(s).
- Management of crisis intervention.

Care plans should be regularly reviewed with the patient at appropriate intervals [monthly]. The review should include those members of the treating team involved in providing the substitute treatment. A care plan tracking system should be used to assist all the members of the treating team to maintain consistency in the review process.

7. Review

It is critical that the review of the patient's progress is embedded in the cycle of the substitute treatment. This will involve both the usual ongoing review at each contact with the patient and more formal regular reviews by treating team, including the psychiatrist. The care plan should be adjusted accordingly.

All members of the treating team should have an opportunity to contribute to the review and the development of the subsequent plan. Where required, the patient and their nominated carer(s) should be consulted, as should personnel from other support agencies.

The methods of review for services that substitute for traditional admitted patient treatment should be similar to those that are available to in-patients and should be geared toward addressing whether this level of care, or type of service, is still appropriate for the patient. Where this level of care is not appropriate, alternative forms of maintenance or chronic disease management should be considered. It is expected that psychiatrists and hospitals will regularly communicate with each other to reassess the appropriateness of this level of care for the patient.

8. Discharge

A patient should not be discharged from a substitute type service until alternative external support services have been put in place as required and the discharge has been approved by the treating psychiatrist.

Discharge planning is undertaken from initial contact with the development of the care plan with any specific discharge policies and procedural processes detailed therein.

While specific discharge policies and procedural processes will differ from service provider to service provider they commonly include documentation of at least the following.

- Follow-up and support arrangements including referrals to other services.
- Notification of the treating psychiatrist of discharge arrangements.
- Contact procedure to be followed if the patient fails to attend a follow-up visit.
- Transition to another level of care, such as admission to traditional admitted patient treatment, should be considered as a separate episode of care.

9. Governance

Substitute services governed by a hospital must comply with the relevant by-laws of that facility.

Services should have an integrated risk management framework in place and a formal quality assurance process.

Policies should be in place to ensure the safety of patients and staff, and to support them during and post, critical incidents.

10. Staffing

Mental Health Professionals providing the service should be experienced and competent to practice within their scope of practice. Targeted recruitment should be undertaken to ensure the service is able to maintain high quality delivery of care to mental health patients and their families outside of the hospital setting.

There should be mandatory training and education to ensure staff are familiar with evidence-based care and contemporary evidence-based practices.

Guidelines Review

These Guidelines shall be reviewed on a biennial basis by the PMHA in consultation with the following organisations.

- Private Healthcare Australia
- Australian Private Hospitals Association Australian
- Australian Medical Association
- The Royal Australian and New Zealand College of Psychiatrists
- The Royal Australian College of General Practitioners
- Australian College of Mental Health Nurses
- Australian Psychological Society
- Australian Association of Social Workers
- Occupational Therapy Australia
- Australian Government Department of Health
- Australian Government Department of Veterans' Affairs
- Private Mental Health Consumer Carer Network (Australia)

References

1. Australian Commission on Safety and Quality in Health Care. *National Safety and Quality Health Service Standards*. Sydney. ACSQHC, 2011
2. Commonwealth of Australia. *National Standards for Mental Health Services 2010*. Canberra. Commonwealth of Australia, 2010.
3. Victorian Government, *National Practice Standard for Mental Health Workforce 2013*. Melbourne. State of Victoria, Department of Health 2013.
4. *The Health Insurance Act 1973* (Cwlth)
5. *Private Health Insurance Act 2007* (Cwlth)
6. *Private Health Insurance (Health Insurance Business) Rules 2013* (Cwlth)
7. *Private Health Insurance (Accreditation) Rules 2011* (Cwlth)
8. *Health Practitioner Regulation National Law Act*, as in force in each Australian state and territory.