PMHA | PRIVATE MENTAL HEALTH ALLIANCE

TENTH MEETING

HELD ON

FRIDAY, 26 FEBRUARY 2010

AT

ADELAIDE CLINIC
33 PARK TERRACE
GILBARTON
SOUTH AUSTRALIA

REPORT AND RESOLUTIONS

Glossary of Acronyms and Terms
used in this Report

AHIA	Australian Health Insurance Association
AHMAC	Australian Health Ministers Advisory Council
AMA	Australian Medical Association
APHA	Australian Private Hospitals Association
APS	Australian Psychological Society
CPoC	Consumer Perceptions of Care Project
DoHA	Australian Government Department of Health and Ageing
DVA	Australian Government Department of Veterans' Affairs
HCP	Hospital Casemix Protocol
Health Insurer(s)	Private Health Insurers that pay benefits for psychiatric care
Hospital(s)	Private Hospital(s) with psychiatric beds
MHSC	Mental Health Standing Committee of the AHMAC Health Priorities Principal Committee
MHISS	Mental Health Information Strategy Sub–committee of the MHSC
Network	Private Mental Health Consumer Carer Network (Australia)
PMHA	Private Mental Health Alliance
PMHA–CCMWG	PMHA Collaborative Care Models Working Group
PMHA–CDMS	PMHA–Centralised Data Management Service
PMHA–CDMS MC	PMHA–CDMS Management Committee
SQPS	Safety and Quality Partnership Sub–committee of the MHSC

1. OPENING AND WELCOME

The Private Mental Health Alliance (PMHA), Independent Chair, Mr Philip Plummer, opened the Tenth (10th) Meeting of the PMHA (the Meeting) at 9:00 AM on Friday, 26 February 2010. The Meeting was kindly hosted by the Adelaide Clinic, 33 Park Terrace, Gilberton, in South Australia.

1.1 Present

The following representatives were in attendance.

1.	Mr Phillip Plummer	PMHA Independent Chair
2.	Ms Moira Munro	PMHA Deputy Chair and APHA Representative
3.	Ms Janne McMahon	PMHA Consumer Representative
4.	Ms Ruth Carson	PMHA Carer Representative
5.	Dr Bill Pring	Australian Medical Association (AMA)
6.	Ms Carole Turnbull	Australian Private Hospitals Association (APHA)
7.	Ms Andrea Selleck	Australian Health Insurance Association (AHIA)
8.	Ms Robyn Milthorpe	Australian Government Department of Health and Ageing (DoHA) Mental Health Reform Branch
9.	Mr Peter Callanan	DoHA Private Health Insurance Branch
10.	Mr Wayne Penniall	Australian Government Department of Veterans' Affairs (DVA)
11.	Mr Allen Morris–Yates	PMHA–CDMS Director
12.	Phillip Taylor	PMHA Director (Secretary)

1.2 Apologies

1.	Dr Choong–Siew Yong	AMA
2.	Ms Helen Eriksson	AHIA
3.	Mr Greg Kovacs	AHIA

1.3 Invited Guest (from 12:30 to 1:45 PM)

1.	Ms Amanda Price	Consultant, National Service Planning Framework (Refer to Agenda Item 9)

1.4 Changes in representation

The Chair welcomed the incoming Chair of the AHIA Mental Health Committee, Ms Andrea Selleck, replacing Mr Greg Kovacs on the PMHA as one of the two Health Insurer Representatives nominated by the AHIA.

The Chair reported that DVA has accepted the invitation to participate on the PMHA. DVA has agreed that the balance of votes on the PMHA should be preserved, by the Australian Government retaining two votes with it being left in the hands of the three Government representatives to discuss and decide how those two votes should be caste on any particular issue. The Chair welcomed Mr Wayne Penniall, National Manager for DVA Community Care Policy, to the Meeting.

RESOLVED (UNANIMOUS)

1. *The PMHA endorses the nomination of Ms Andrea Selleck to replace Mr Greg Kovacs as one of the two Health Insurer representatives on the PMHA. The PMHA notes that Ms Selleck can be contacted at the following address:*

   Ms Andrea Selleck
   Executive Officer
   Australian Regional Health Group Limited
   PO Box 185
   DONCASTER EAST VIC 3109
   P: 03 9894 5362
   F: 03 9894 5365
   E: aselleck@arhg.com.au

2. *The PMHA extends its appreciation to Mr Greg Kovacs for participating in and supporting the work of, the PMHA as the Health Insurer representative, and wishes Greg well in his continuing role with the AHIA.*

3. *The PMHA welcomes the Department of Veterans' Affairs as part of the Australian Government contingent on the PMHA and notes that its current representative can be contacted as follows.*

   Mr Wayne Penniall
   National Manager, Community Care Policy
   Australian Government Department of Veterans' Affairs
   PO Box 21
   WODEN ACT 2606
   P: 02 6289 6014
   F: 02 6289 6712
   E: wayne.penniall@dva.gov.au

2. REPORT OF THE LAST (NINTH) PMHA MEETING

The PMHA adopted the report of its last meeting without amendment.

Resolved (unanimous)

1. *That the Private Mental Health Alliance (PMHA) adopts the Report of the Ninth PMHA Meeting held on Friday, 2 October 2009 in Adelaide, as a true and accurate record of proceedings.*

2. *That the PMHA directs that the Report of the Ninth PMHA Meeting be made available on the PMHA website at: www.pmha.com.au.*

Action: PMHA Director

3. PROGRESS REPORT ON MATTERS ARISING

The Meeting updated the following Table of Progress on actions arising from the 9th PMHA Meeting.

Item #	TABLE OF PROGRESS	RESPONSIBILITY	STATUS
2	PMHA MEETING REPORTS		
	Post Report of 8th PMHA Meeting and PMHA Workshop on PMHA Website.	PMHA Director	Done
	Draft and circulate for comment Report of 9th PMHA Meeting held on 2 October 2009.	PMHA Director	Done
	Revise Report of 9th PMHA Meeting and prepare final.	PMHA Director	Done
	Agenda Item 10th PMHA Meeting.	PMHA Director	Done
4	AMA FINANCIAL STATEMENTS		
	Agenda Item 10th PMHA Meeting.	PMHA Director	Done
5	PMHA PROGRESS REPORT 2008–09		
	Ms Milthorpe to provide material expanding on the work of MHISS	Ms Milthorpe	Done
	Complete Audit of PMHA/CDMS/Network Accounts and append Letters of Aquittal to Report.	AMA	Done
	Circulate final version of Progress Report to Parties to AMA Agreement for Services 2008–09	PMHA Director	Done
	Post Progress Report on PMHA website.	PMHA Director	Done
6	PMHA WORK PLAN		
	Revise based on deliberations of 9th PMHA Meeting	PMHA Director	Done
	Agenda Item 10th PMHA Meeting.	PMHA Director	Done
7	PMHA COLLABORATIVE CARE MODELS WORKING GROUP		
	Agenda Item 10th PMHA Meeting.	PMHA Director	Done
8	PMHA–CDMS		
8.2	Risk Management for the PMHA's CDMS		
	Develop a Draft Disaster Recovery Plan for PMHA–CDMS	PMHA–CDMS Director	Done
8.3.1	Annual Statistical Report		
	Release Annual PMHA–CDMS Statistical Report as follows:		
	▪ PMHA Press Release (electronic)	PMHA Director	Suspended
	▪ PMHA Newsletter (electronic)	PMHA Director	Done
	▪ PMHA Website (electronic)	PMHA Director	Done
	▪ CEOs Participating Hospitals (electronic)	PMHA Director	Done
	▪ Chairs of MHSC/MHISS/SQPS/AHIW (hard copy)	PMHA Director	Done
	▪ CEOs APHA/AHIA/AMA and Health Insurers (hard copy)	PMHA Director	Done
8.3.3	Revision of the National Model		
	APHA Psychiatry Committee to meet with PMHA–CDMS Director to discuss Reporting Framework Version 3	Ms Munro/MsTurnbull	Done
	AHIA Mental Health Committee to meet with PMHA–CDMS Director to discuss Reporting Framework Version 3	Ms Erikkson/Mr Kovacs	Pending
8.4	Enabling Greater of the data held by the CDMS		
	Further develop and cost suggestions for inclusion in overarching proposal for Mr Plummer	Ms Munro/Dr Pring/Ms McMahon	Done
	Meet as a PMHA Sub–committee to discuss priorities within the context of available funding	Ms Munro/Dr Pring/Ms McMahon	Done
8.6	Consumer Perceptions of Care (CPoC)		
	Complete final report for private sector on CPoC Pilot Study by 19/20 November 2009	PMHA–CDMS Director	Done
8.7	AIHW Request		
	Provide data for inclusion in National Healthcare Agreement Performance Indicators Report 2007–08 by 16/10/09	PMHA–CDMS Director	Done

Item #	TABLE OF PROGRESS (continued)	RESPONSIBILITY	STATUS
9	PMHA COMMUNICATIONS		
	Draft and circulate 4th Edition of the Newsletter to PMHA for approval	PMHA Director	Done
	Circulate 4th Edition with a copy of the PMHA–CDMS Annual Statistical Report	PMHA Director	Done
	Agenda Item 10th PMHA Meeting.	PMHA Director	Done
10	NETWORK REPORT		
	Agenda Item 10th PMHA Meeting.	PMHA Director	Done
11	MHSC REPORT		
11.4	Seclusion and Restraint		
	Circulate materials developed during Seclusion and Restraint Project	PMHA Director	Done
11.8	Meetings of the MHSC 2009–10		
	Dr Bill Pring and Ms Munro to attend 23 November 2009 MHSC Meeting in Melbourne	Dr Pring/Ms Munro	Done
	Agenda Item 10th PMHA Meeting.	PMHA Director	Done
12	MHSC SQPS REPORT		
12.7	Next SQPS Meeting		
	Dr Pring to attend 19/20 November 2009 SQPS Meeting in Melbourne	Dr Pring	Done
	Agenda Item 10th PMHA Meeting.	PMHA Director	Done
13	MHSC MHISS REPORT		
13.4	Next MHISS Meeting		
	Ms Munro to attend 19/20 MHISS Meeting in Melbourne	PMHA Director	Done
	Agenda Item 10th PMHA Meeting.	PMHA Director	Done
14	OTHER BUSINESS		
	Agenda Item 10th PMHA Meeting	PMHA Director	Done
15	NEXT MEETING		
	Organise 10th PMHA Meeting for 26 February 2010 @ The Adelaide Clinic	PMHA Director	Done
	Prepare and circulate Agenda and Papers for 10th PMHA Meeting	PMHA Director	Done

3.1 Annual Statistical Report

Mr Phillip Taylor reported that subsequent to the last PMHA Meeting it was agreed that a press release for the first PMHA–CDMS Annual Statistical Report was not required.

4. AMA FINANCIAL STATEMENTS

The Meeting adopted the AMA Statements of Income and Expenditure for the PMHA, its CDMS, and the Network, for the period 1 July 2009 to 31 December 2009, as they appear at **Appendix A** of this Report.

Resolved (unanimous)

That the PMHA adopts the AMA Statement of Income and Expenditure for the Private Mental Health Alliance, its Centralised Data Management Service, and the Private Mental Health Consumer Carer Network (Australia), for the period 1 July 2009 to 31 December 2009.

5. PMHA WORK PLAN FOR FINANCIAL YEARS 2009–11

The last (9th) PMHA Meeting, held on 2 October 2009 in Adelaide, requested that the PMHA Director develop a work program for the PMHA Strategic Plan for the two financial years 2009–11, based on the suggestions put forward at the 9th Meeting.

The Meeting then considered and amended a copy of the draft PMHA Work Plan 2009–11, which had been circulated with the agenda and papers for the meeting.

A copy of the final version of the Work Plan appears at **Appendix B** of this Report.

Resolved (unanimous)

That the PMHA adopts the Work Plan for the PMHA for Financial Years 2009–11 as amended by the 10th Meeting of the PMHA held in Adelaide on 26 February 2010.

6. PMHA COLLABORATIVE CARE MODELS WORKING GROUP (CCMWG) REPORT

The Chair of the CCMWG, Mr Phillip Taylor, summarized the tasks that had been undertaken by the CCMWG at the request of the PMHA, in 2009.

1. Development of a set of *General Principles for the Funding Private Mental Health Services* that were subsequently endorsed by the PMHA.
2. The review and update of the 2006 Discussion Paper *Underlying Principles for Funding Psychiatric Care*, prepared by the PMHA's antecedent the Strategic Planning Group for Private Psychiatric Services.

   The Meeting noted that this review is now largely completed. A copy of the revised Discussion Paper now titled, *Update on Funding Service Delivery for Private Mental Health Services*, was circulated with the agenda and papers for this Meeting with a view to obtaining PMHA endorsement. After discussion, the Meeting endorsed the Paper, noting some additional material was yet to be included from the Occupational Therapists, DoHA and DVA. The completed Paper will be circulated to PMHA for final sign–off prior to its release electronically.
3. The review and update of the 2007 Edition of the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–Based Mental Health Care* (Guidelines).

   Mr Taylor reported that the revision of the Guidelines is nearing completion. The next meeting of the CCMWG will be largely devoted to section *6 Staffing Levels, Supervision and Contact Hours*, and the section of the Guidelines currently titled, *Services Provided Outside the Private Hospital Setting*.

   The last meeting of the CCMWG, requested that the Addendum to the Guidelines titled, *Guidelines for Assessment and Recognition of Alcohol and Drug Programs and Services for Hospital–based Private Patients*, (Alcohol and Drug Guidelines) be removed and referred to the PMHA for possible revision and adoption as a policy statement of the PMHA. A copy of the Addendum was circulated with the agenda and papers for this Meeting with some preliminary suggested revisions included. After discussion, it was agreed that these Alcohol and Drug Guidelines had served

their purpose. There is now a wealth of detailed guidelines available on what constitutes good clinical care for people with drug and alcohol problems.

Resolved *(unanimous)*

1. *That the Private Mental Health Alliance (PMHA) adopts the Report of the Fourth Meeting of the PMHA's Collaborative Care Models Working Group (CCMWG) held on Friday, 11 September 2009 in Canberra and notes the draft Report of the Fifth CCMWG Meeting held on Friday, 26 November 2009 in Canberra.*

2. *That the PMHA endorses the paper titled, Update on Funding of private Mental health Services: Discussion Paper 2010, prepared by the PMHA Collaborative Care Models Working Group, and requests that any outstanding or additional material for inclusion be forwarded to the PMHA Director, as soon as possible. The Paper should be released, electronically following final approval by the PMHA, via email.*

Action: PMHA Director/PMHA

7. PMHA QUALITY IMPROVEMENT PROJECT

In 2009, the PMHA Chair, Mr Philip Plummer, advised that an offer from an anonymous donor of financial support was made toward work that the PMHA might undertake to improve mental health outcomes for consumers within the context of the mental health services that are provided by private hospital–based psychiatric services (Hospitals) and psychiatrists in private practice. The intention is for the funding available to be used to help achieve that goal by making better use of the mechanism of the PMHA and its Centralised Data Management Service (CDMS). The funding will be something of the order of $250,000 that may be made available before June 2010.

Mr Taylor reported that, in response, a Project Brief for a PMHA Quality Improvement Project (or PQI Project) has been developed that contains a suite of four complementary activities to be undertaken within the context of the available funding. Work Programs for each of these activities have been developed based on achieving demonstrable improvements in the quality and effectiveness of mental health service provision in private sector.

- **Implementation of Consumer Perceptions of Care Measure**

  This first activity involves the implementation of a standardised measure of CPoC in all private hospital–based psychiatric services across Australia. This is the component missing from the outcomes data that is currently collected and reported by the PMHA's CDMS, under the PMHA's National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures. Collection of this measure will be a critical part of the quality assurance processes that operate in private hospitals to improve patient care.

- **Outcome Measures in Private Psychiatry Practice**

  Work on this second activity will establish a research network of psychiatrists using outcome measures within the context of their private psychiatry practice. This would be an important first step toward demonstrating how outcome data can

be used in private psychiatry practice to better involve consumers and improve outcomes of care.

- **Internet Access to the PMHA's CDMS**

  This third activity involves a scoping exercise to determine the requirements for a model Agreement that would enable appropriate and secure internet–based access for participating stakeholders to the data currently held by the PMHA's CDMS. Internet–based access would not only streamline the provision of CDMS Standard Quarterly Reports, but also greatly enhance the capacity of the CDMS data to be used for clinical purposes to improve patient care.

- **Borderline Personality Disorder (BPD)**

  This activity involves preliminary work to scope what models of care are currently being used for people with a diagnosis of BPD. This would include information such as diagnosis of BPD, number of people being treated, types of treatment being used, involvement of other health professionals, and any difficulties that might have been encountered. This exercise will provide information on what can currently be expected at each stage of the clinical care pathway and help to determine what might be required for the more in–depth work that would be necessary to establish a consistent approach for treatment.

The Meeting then considered a copy of the Project Brief, which had been circulated with the agenda and papers for this Meeting.

Ms McMahon reported that the meeting of the Private Mental Health Consumer Carer Network held on 18/19 February 2010 had considered and endorsed the PQI Project proceeding.

Mr Taylor reported that the AMA Psychiatrists' Group (AMAPG) had considered and endorsed the PQI Project proceeding at the AMAPG Teleconference held on Monday, 22 February 2010.

Mr Plummer reported that the offer of free office space at HLB Mann Judd in Adelaide, to accommodate a Senior Research Officer for the Project, will expire on 30 June 2011.

After a long discussion, the Meeting endorsed the Project Brief and agreed that the following should now be undertaken to progress the Project.

- The AMA formally advise Mr Plummer how it wishes to receive the bequest on behalf of the PMHA for the PQI Project.

- PQI Project Funding should be reported as a separate line item within the context of the PMHA Income and Expenditure Statement prepared by the AMA.

- The PMHA establish a PQI Project Steering Group to prepare a detailed document for the PMHA to consider that:

(a) breaks down and clearly specifies the deliverables and timelines for each work program for the Project, and

(b) identifies the core responsibilities of the Senior Research Officer to be employed by the AMA.

Resolved (unanimous)

1. *That the Private Mental Health Alliance (PMHA) endorses the PMHA Quality Improvement (PQI) Project brief.*

2. *That the PMHA requests that the Federal Australian Medical Association (AMA) advise the PMHA Chair, Mr Phillip Plummer, as to how the AMA wishes to receive the bequest of funding for the PQI Project.*

Action: PMHA Director /AMA (Mr Howard Pickrell)

3. *That the PMHA requests the AMA to manage the funding for the PQI Project and report it as a separate line item within the context of the PMHA Income and Expenditure Statement.*

Action: PMHA Director/AMA (Mr Howard Pickrell)

4. *That the PMHA directs that a small PQI Project Steering Committee be established to comprised of the following representatives*

   - *Ms Moira Munro*
   - *Dr Bill Pring*
   - *Ms Janne McMahon*
   - *Mr Allen Morris–Yates*
   - *Mr Phillip Taylor*

Action: PMHA Director

5. *That the PMHA requests the PQI Steering Committee prepare a detailed document for the PMHA to consider that:*

   (a) clearly specifies the deliverables and timelines for each work program for the PQI Project, and

   (b) identifies the core responsibilities of the Senior Research Officer to be employed by the AMA to conduct the PQI Project.

Action: PQI Project Steering Committee

6. *That the PMHA and the Private Mental Health Consumer Carer Network (Australia) thanks Mr Phillip Plummer for making the PQI Project possible.*

8. PMHA'S CENTRALISED DATA MANAGEMENT SERVICE (PMHA–CDMS) REPORT

The last meeting of the PMHA requested that the following be included in the PMHA–CDMS Work Plan for Financial Years 2009–11.

Core Tasks (ongoing)

1. Preparation of SQRs for Hospitals and Payers.

2. Revision of the National Model's Analysis and Reporting Framework.

3. Revision of the HSMdb database applications.

4. Provision of electronic training materials for Hospitals.

Additional Tasks (in order of priority)

1. Contribute data for the National Healthcare Agreement Performance Indicators 2007–08 Report by 16 October 2009.

2. Complete the final report for the private sector on the pilot study of NRI/MHSIP Inpatient Consumer Survey (CPoC Pilot Study) before 19/20 November 2009.

3. Develop a PMHA–CDMS Disaster Recovery Plan by the end of 2009 for consideration by PMHA at its first meeting in 2010.

The PMHA invited Mr Morris–Yates to report on progress with the current activity of the PMHA's CDMS.

8.1 Preparation of SQRs for Hospitals and Payers.

Preparation and distribution of SQRs in respect of the period July to September 2009 has been delayed due to very late submission of data by a number of hospitals and the need to deal with changes in the way some hospitals that provide high volumes of outreach care use the Hospital Casemix Protocol (HCP) to code that type of care. With respect to late submission of data, the following Figure illustrates the state of play as of Wednesday 10 February. Just over 50% of hospitals were able to meet the standard submission within 10 weeks of quarter end requirement. A further 20% were able to submit their data within the extended deadline of Friday, 22 January, and as of 10 February 20% have still not been able to submit their data. Discussion with the staff responsible for the preparation of the submissions has indicated that the root causes of the delay have been that new personnel have taken on the task without adequate handover and that changeover to new Patient Administration Systems has made the timely extraction of HCP data difficult. In several cases both problems have arisen together.

With respect to the coding of outreach care, the July–September quarter for which we are still now waiting on submissions is also the quarter when the full effect of bringing 13 hospitals on board has become most apparent. Whilst on leave in December and early January, the CDMS Director fielded many requests for assistance with the submission of data. During the course of those discussions he was alerted to the fact that several large hospitals that provide very high volumes of outreach care

changed their HCP extract practices in 2008 to exactly conform to the Australian Governments requirements. Previously no hospital had actually done that. The paper presented to the APHA Psychiatric Hospitals Committee by Betty Cooper from New Farm Clinic clearly highlighted the problems that attempting to do so would entail. The fears she expressed have now been realised in practice. This full implementation of DoHA's requirements in concert with the wide variation in health insurers interpretation of those requirements has severely corrupted the meaning, if not the actual content, of the data to the point that for their own internal purposes some of the affected hospitals have to calculate their average lengths of stay by hand. In the past the CDMS dealt with the few problematic outreach records by excluding them. The volume of such records now being submitted means that the CDMS must now implement an exact solution within the data processing steps prior to analysis. This will involve implementing a level of imputation previously considered but avoided because of its complexity. Now, however, if such a solution is not implemented the national average length of stay for overnight episodes will soon be quite inaccurate. At present it only contains one quarter's worth of problematic data so the effect of that data is not as noticeable as it will soon be.

Mr Morris–Yates then provided a PowerPoint presentation on the complexity of the current situation, which is largely a result of the interaction between Hospitals billing systems and Health Insurer contract requirements, and the way they have used the HCP. Data extracted from the CDMS is demonstrating that volume of outreach type care is increasing significantly over time. Some of the outreach care is being coded as a same–day admission, which is preferable for CDMS purposes, because it allows the CDMS to identify each occasion of service. This is useful in determining such issues as the average interval between visits, which is relevant both clinically and in the evaluation of the service model. Some outreach care, however, is still being coded as overnight for same–day or overnight. The CDMS has had to implement an imputation in order to deal with this problem and obtain an accurate Overnight and outreach care records that can be treated distinctly. This will enable the CDMS to:

- report much more accurately on how much outreach care has been provided historically and currently, and
- definitively remove the corruption of overnight in–patient records with outreach care, so that the Average Length–of–Stay can be reported accurately.

Standard Quarterly Reports (SQRs) for the July–September 2009 period will be prepared and distributed as soon as the above changes have been completed and tested. These changes will also be included in the next release of the HSMdb (see Agenda Item 8.3 below).

After discussion, the Meeting agreed that a reminder email should be sent to all Hospitals advising why the SQRs are delayed.

Resolved *(unanimous)*

That the Private Mental Health Alliance (PMHA) requests that a reminder email be sent to all Hospitals participating in the PMHA's CDMS advising as to why the Standard Quarterly Reports are delayed.

Action: PMHA and PMHA–CDMS Directors

8.2 Revision of the National Model the National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures (National Model)

Included in the work program for the PMHA's CDMS is the task of revising the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital–based Psychiatric Services* (National Model). The PMHA's CDMS has prepared two papers regarding these revisions, which the PMHA is currently looking at. The first paper titled, *Revision of the stratification framework used in Hospitals' and Payers' Standard Quarterly Reports,* addresses the stratification scheme used in the PMHA's CDMS Standard Quarterly Reports (SQRs). The second paper titled, *Reporting Framework, Version 3–0*, details a new version of the framework for the content and layout of SQRs.

8.2.1 Paper 1: Revision of the stratification framework used in Hospitals' and Payers' Standard Quarterly Reports

This Paper discusses changes to the diagnostic classification used in the stratification of statistics in both Hospitals' and Payers' SQRS. The recommendations include the following.

1. Simplification of the classification to remove rarely occurring diagnostic groupings from reports.

2. Renaming of certain major groupings to improve the accuracy with which they identify the diagnoses covered by the group.

3. Inclusion of two clinical co–morbidity groups.

The revised classification would be as follows.

(0) All patients regardless of Principal or Secondary Diagnosis.
(1) Schizophrenia, Schizoaffective and Other Psychotic Disorders.
(2) Major Affective and Other Mood Disorders.
(3) Anxiety Disorders.
(4) Post-Traumatic Stress and Other Adjustment Disorders.
(5) Personality Disorders.
(6) Alcohol or Other Substance Use Disorders.
(7) Eating Disorders.
(8) All Patients with Co–morbid Personality Disorder.
(9) All patients with Co–morbid Alcohol or Other Substance Use Disorder.

So far, Hospitals and Health Insurers do not see any major problems with the revised classification as presented above.

Further discussions are underway with the Commonwealth to enable the development of an additional class that identifies patients with co–morbid non–psychiatric illnesses (e.g. diabetes, heart disease etc). The Meeting noted the response to questions from Mr Kelvin King, Director, Classification Development Section, Healthcare Services Information Branch Acute Care Division, DoHA, which detailed the analyses necessary to enable the development of that class. Mr King was subsequently provided with some additional information and responded to Mr Morris–Yates via email as follows.

> *The Department has existing contracts in place with only four software companies to obtain and use the material you have requested. Therefore, the material you require cannot be provided to you. Please note that we are currently implementing recommendations from a review of work in the area of classification development and one of these recommendations will allow other software companies to obtain these materials. Once this particular recommendation is implemented I shall contact you as you may wish to then follow the process that will be put in place to enable any software company to obtain the material.*

Mr Morris–Yates will respond to ascertain the DoHA position, if this is to be used purely for research.

8.2.2 Paper 2: Reporting Framework Version 3

This Paper details proposed new formats for both Hospitals and Payers SQRs. The objective of the revisions is to substantially improve both the accessibility and content of the SQRs without obscuring the inherent complexity of the problems for which care is provided. This second Paper also includes a detailed discussion of the issues involved in reporting on Ambulatory Care and proposes a new episode–based model for reporting Ambulatory Care that should meet both Hospitals and Payers needs. This will be a substantial improvement in what Hospitals are currently receiving.

The Meeting noted that the process for reviewing and finalising this Paper is underway. So far, discussions have taken place with the members of the APHA Psychiatry Committee, and the AHIA Mental Health Committee will provide its comments within the next two weeks. A revised version of the discussion paper will then be made available for broader comment by all stakeholders.

8.3 Development and distribution of a revised version of the HSMdb database application

A revised version of HSMdb must be provided to all participating Hospitals by the beginning of June 2010. The emergence of the problems with increased complexity in the coding of outreach care will mean that significant additional time will need to be devoted to the development and testing of this next release. Accordingly, the Meeting noted that, apart from the preparation of SQRs and some time devoted to the preparation of draft electronic materials (see Agenda Item 8.4 below) the remainder of the PMHA–CDMS Director's time between now and the end of June will be largely devoted to work on HSMdb.

8.4 Provision of electronic training materials for Hospitals.

This work has been put to one side for some time. The PMHA–CDMS Director proposes to devote time in March 2010, after the SQR run, to developing a draft introduction to the HoNOS suitable for use as orientation for new staff.

8.5 National Healthcare Agreement Performance Indicators 2007–08.

The PMHA's CDMS contributed data for the National Healthcare Agreement Performance Indicators 2007–08 Report on 16 October 2009.

8.6 Pilot Study of NRI/MHSIP Inpatient Consumer Survey (CPoC Pilot Study).

The final report for the private sector on the pilot study of NRI/MHSIP Inpatient Consumer Survey (CPoC Pilot Study) was completed before 19/20 November 2009.

8.7 PMHA–CDMS Disaster Recovery Plan

The Meeting discussed a copy of the detailed Disaster Recovery Plans (DRP) for the CDMS, which had been prepared at the request of the last PMHA Meeting, by the PMHA–CDMS Director in consultation with the PMHA Chair, PMHA Director and the AMA. The Chair reported he had conducted a site visit of the current location of the PMHA's CDMS on Wednesday, 24 February 2010.

The PMHA noted the DRP document reveals a number of choke points – issues that if addressed would reduce the impact of disaster and speed recovery. The two key choke points that were discussed by the Meeting have been briefly summarised below.

1. Reliance on a single individual

The CDMS relies on a single individual. The backup operator proposed in the DRPs, the only person available under the current *AMA Agreement for Services 2009–11* (Agreement), is the PMHA Director. The provision of backup services to the CDMS falls outside the scope of his current duties or, indeed, of his available time. If the PMHA Director is to fulfil the role of backup operator for the CDMS he will need provided with a detailed manual outlining his tasks and time to learn and practise those tasks on a regular basis. Under the current Agreement, the development of those materials and the provision of that training are not included in the *Schedule of Services* to be provided by the CDMS.

In considering this choke point, there was consensus that having the PMHA Director act as the backup operator was not an appropriate solution and would cause significant delays with that Director's PMHA, CDMS and Network responsibilities. The Meeting agreed that the role of the PMHA Director should be rather, to clearly understand what steps need to be taken to hand over to an appropriately qualified person (or organisation), if the current PMHA–CDMS Director is not available in the long term. This will require the current PMHA–CDMS Director to be given the time to develop a comprehensive PMHA–CDMS Operations Manual.

2. Reliance on a single location for core CDMS computing equipment

The core CDMS computing equipment is housed within the offices of Data Systematics Pty Ltd in a building that is located within a high bushfire–risk zone. Re–location of core CDMS infrastructure to a secure data centre within the Adelaide CBD would greatly reduce the likelihood of CDMS equipment being lost through bushfire. It would also greatly ease and facilitate any handover should the CDMS Director become unable to fulfil his duties for an extended period or resign. The total cost of that re–location is estimated to be $32,000 in the first year and $18,000 per annum thereafter. Alternatively, the provision of a backup server in Canberra within the Federal Offices of the AMA could provide a less costly, but also less capable solution in the event of disaster. The total cost of implementing this solution is estimated to be between $28,000 to $33,000 in the first year and $3,200 per annum thereafter.

The Meeting discussed this choke point and agreed that the PMHA should consider the option of relocating the CDMS infrastructure to a secure data centre within the Adelaide CBD. Mr Morris–Yates indicated that there is a current surplus of approximately $20,000 in the CDMS budget that has been carried over from previous years of unspent funds. The PMHA might wish to consider using this funding for the initial relocation, to take effect from the beginning of the next Financial Year (1 July 2010). The recurrent funding for the ongoing management of data centre (approximately $18,000 per annum) would then be able to be factored into the proposed budgets for the PMHA's CDMS for beyond 30 June 2011.

Mr Morris–Yates responded to several questions regarding the security and other arrangements that are already in place for the CDMS. An external audit of security of internet access has been undertaken, which reported that the set–up was very secure. Mr Morris–Yates was asked to provide a copy of that report for the next meeting, so it can be properly documented.

Under this Agenda Item, Mr Morris–Yates raised the related issue of the current accommodation of the CDMS within the offices of his company Data Systematics Pty Ltd. At present that accommodation is provided to stakeholders at no charge. Currently the AMA charges a reduced rate of $350 per square metre (ex GST) per annum for the space occupied by the PMHA Director in the Federal Offices of the AMA. At present, the CDMS occupies 28 square metres across three rooms: a temperature controlled computer room, a main office and a storage room. Given the increasing reliance placed on the CDMS by both hospitals and payers, Mr Morris–Yates requested that anomalous situation be addressed. At the current AMA rate these offices should be charged at a minimum of $9,800 per annum.

After discussion of the history of this issue, it was agreed that this was matter that would need to be addressed as part of the funding negotiations for PMHA's CDMS beyond 30 June 2011. Ms Munro pointed out that there is no funding available under the current *AMA Agreement for Services 2009–11* to meet such costs.

In drawing this Agenda Item to close, the Chair felt that the accommodation charge and many of the other issues raised warranted consideration of whether, after 30 June

2011, Mr Morris–Yates should continue to be employed by the AMA, or work as a consultant through a contract with his company Data Systematics. Mr Plummer agreed to undertake a cost analysis for presentation at the next PMHA Meeting.

Resolved *(unanimous)*

1. *That the Private Mental Health Alliance (PMHA) requests that the surplus funds that may be available at 30 June 2010 in the budget for the PMHA's Centralised Data Management Services (CDMS) be accurately determined.*

Action: PMHA–CDMS Director

2. *That the PMHA consider the surplus and, if sufficient, agree that it be used to relocate the CDMS infrastructure to a secure data centre within the Adelaide CBD with the ongoing costs of managing the data centre being factored into the proposed budgets for the PMHA's CDMS for beyond 30 June 2011.*

Action: PMHA

3. *That the PMHA requests that an Operations Manual be developed that clearly and comprehensively documents the operation of the PMHA's CDMS.*

Action: PMHA–CDMS Director

4. *That the PMHA requests that a copy of the internet security audit of the PMHA's CDMS be included with the CDMS Report for the next PMHA meeting.*

Action: PMHA and PMHA–CDMS Directors

5. *That the PMHA requests that the PMHA Chair prepare a preliminary cost analysis between the PMHA–CDMS Director being employed by the AMA, versus working as a consultant through a contract with his company Data Systematics from 1 July 2011.*

Action: PMHA Chair

9. PMHA COMMUNICATION

PMHA Communication is an ongoing Standing Item on the PMHA Agenda not only for discussion of issues related to the PMHA Newsletter, but also to consider what other strategies might be used to beyond the Newsletter to promote the private sector.

The Meeting noted a copy of the Fourth Edition of the PMHA Newsletter, which had been circulated with the agenda and papers for this Meeting. Mr Taylor reported that the next Newsletter is due for publication in March/April 2009. Possible articles were discussed and it was agreed that the next Edition should include the following.

- Funding of Private Mental Health Services.
- PMHA Quality Improvement Project.
- National Standards for Mental Health Services.

- Consumer Perceptions of Care
- Stakeholder Round–Up
- Fact Sheet

Resolved *(unanimous)*

That the Private Mental Health Alliance (PMHA) requests that the PMHA Director draft the Fifth Edition of the PMHA Newsletter for circulation to members of the PMHA for comment.

Action: PMHA Director

10. PRIVATE MENTAL HEALTH CONSUMER CARER NETWORK (AUSTRALIA) [NETWORK] REPORT

The Meeting noted that the last meeting of the Network's National Committee (NC) was held on 18/19 February 2010 in Melbourne. The Chair of the Network, Ms Janne McMahon, briefed the Meeting in detail on the following.

- Network Work Plan 2009–11.
- Procedures and processes for the Network. A set of operating guidelines have been endorsed.
- The appointment of the Deputy Chair, Ms Kim Werner. Kim has a legal background, which is proving very useful to the Network.
- Network policies on smoking, consent, and a media protocol have been endorsed. Policies on privacy and confidentiality, and health information sharing are in the pipeline.
- The Network Carer Project.
- Carer Consultants.
- The issue of the listing of the newer a–typical anti psychotic medications of the PBS. There are a number of diagnoses which respond well to a small amount of anti–psychotic medications, which are not listed on the PBS and are therefore not available to consumers. The Network is considering approaching the PBAC concerning this issue.
- The Network has been successful in having a psychiatrist appointed to the PBAC, which was a significant achievement.
- The Network has been involved with the RANZCP project on Chronic Disease Self–Management. The views of NC Members concerning the terms Chronic, Disease, and Recovery have been recorded electronically and will be included with other training materials being developed for psychiatrists.
- The use of restraint in Emergency Departments (ED). A survey is to be conducted by the Australasian College of Emergency Medicine, due to the lobbying of the

Network. This survey will scope how many ED staff are trained in de–escalation techniques and the level of use of physical and chemical restraint.

- Progress with the Recommendations 24 and 25 of the Senate Community Affairs Committee concerning the long–term mental health implications for victims of childhood sexual and other abuse.

- That Network has endorsed the PMHA Quality Improvement Project proceeding.

The Chair thanked Ms McMahon for her report and it was noted that the next meeting of the NC will be held in Melbourne on 30/31 August 2010.

11. MENTAL HEALTH STANDING COMMITTEE (MHSC) REPORT

The MHSC reports to the Australian Health Ministers' Conference (AHMC) through the Australian Health Ministers' Advisory Council (AHMAC) and the Health Policy Priorities Principal Committee (HPPPC).

The last meeting of the MHSC was held in Sydney on Friday, 29 January 2010. The PMHA Chair and Deputy Chair both attended that meeting and reported verbally on some of the matters that are being progressed by the MHSC, which have been summarised below.

11.1 Seclusion and Restraint

Ms McMahon's work in this area was recognised by the MHSC.

11.2 Outcomes in Mental Health

Representatives from the Mental Health Council of Australia continue to claim that there is no outcome measurement going on in the private sector. Mr Morris–Yates agreed to prepare a presentation for the next MHSC Meeting on the work of the PMHA's CDMS..

11.3 National Service Planning Framework

The MHSC has agreed that all jurisdictions need to be involved in progressing action 16 of the Fourth National Mental Health Plan, which is set out below.

> *Develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models.*

This is a foundation action which will lead the implementation of other actions, and DoHA has engaged a consultant, Ms Amanda Price, to undertake a scoping study to inform the actual development of the planning framework. DoHA currently has funding available to support the implementation of this action and, with the time imperatives associated with progressing the implementation of the Plan, there is impetus to commence the actual development of the framework before mid 2010.

The proposed development of a national service planning framework is essentially a two staged approach with the scoping study as an initial stage. Its outcomes, including a literature review and report on targeted stakeholder consultation, will inform the next phase, which is proposed to involve an open tender process to develop the national framework. The findings from a literature review of national and international models and the targeted consultation will result in a report that the DoHA will present to MHSC to inform the next phase of work (including tender specifications) in consultation with the subgroup that will progress this action. The reporting on consultation findings will preserve the anonymity of contributors.

The Chair reported that Ms Price had accepted an invitation to attend this PMHA Meeting to gather information on current service planning models, and perceived challenges to be overcome in achieving a national approach to mental health service planning. A later stage of the scoping study will involve a half–day forum to be held on 16 March 2010 at the Melbourne Airport Hilton Hotel for contributors to discuss the collated stakeholder and research findings.

The Chair welcomed Ms Price to the Meeting and the following issues were discussed.

The key priority areas in mental health that need to be taken into account include the following.

- Early Intervention and the promotion of mental health "wellness".
- Consumers and Carers are supportive of early intervention and other support services provided by some health insurers, and the outreach programs provided by some private hospitals.
- Long–term care in the community, particularly for complex cases and the elderly.
- Continuity of care *across* the public and private sectors.
- Lack of acute care beds is currently affecting both the public and private sectors.
- Mental health workforce issues need to be considered, including the implications of an ageing workforce, and the possible inclusion of consumers and carers as possible mental health workers.
- The need for transitional step–down type care between hospital–based services and community–based services.
- There is a lack of access to public sector services for private patients, particularly in relation to long–term care and community follow–up.
- Collaboration, coordination, and communication, *within* and *across* sectors needs to be improved.
- The understanding of mental illness in subsidiary services such ambulance and police need to be addressed.

- There is lack of developed service standards in the public sector.

- Provision of services in rural areas of Australia.

- A unique patient identifier capable of tracking patients across public and private sectors would be useful.

The Meeting agreed that these priority areas would benefit from a national planning framework, but only if it included the private sector. This would help to acknowledge that it is useful to have the combination of the public and private sector working together. Countries that have a relatively well balanced public and private sectors deliver services to their population more effectively than either a totally privatised, or nationalised system, can. Some of the results of the National Demonstration Projects on public private partnerships conducted in Victoria and the Illawara would verify this. MHIPS is also important. What needs to be determined at the national level is what each sector should be concentrating on to get the balance right. There needs to be an understanding of severity and clinical pathways built into any national planning framework that acknowledges the way mental illnesses evolve when people receive appropriate care, *and* when they do not.

In relation to how planning for mental health services are currently being approached by the various jurisdictions, it was felt that the following was important.

- Planning is often reactive and ad hoc.

- Tolkien II is a start.

- Planning at the national level needs to translate and match what is planned at the state and territory level. For example, while the Commonwealth's Better Access Initiative has brought psychologists in under Medicare, in at least one jurisdiction, decisions taken at the local area health service level are making it very hard to get *any* public mental health community–based services to see people in the longer term. It is assumed that GPs and psychologists will manage these people.

- Public and private mental health services that demonstrate good outcomes in a cost efficient manner should be more closely analysed with a view to sharing information and potential models on the understanding that what works well in one area may not in another.

- The broad directions determined at the national planning level should be reflected in jurisdictional level plans.

In the private sector the planning approach for private hospitals is usually done on an annual basis at the facility level and on a slightly longer term basis at the corporate level.

The PMHA is the vehicle through which the private sector is linked into the key national planning activities, such as the revision and implementation of the National Standards for Mental Health Services.

There would be huge benefits to the involvement of the private sector in adopting a

national approach to the planning of mental health services.

Ms Price thanked members for their feedback and left the Meeting.

It was agreed that Dr Bill Pring would attend the 16 March 2010 Forum on behalf of the PMHA.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that Dr Bill Pring attend the National Service Planning Framework Forum to be held on 16 March 2010 at the Melbourne Airport Hilton Hotel on behalf of the PMHA.

Action: Dr Bill Pring

11.4 Meetings of the MHSC 2010

The MHSC meeting schedule is as follows for the remainder of 2010.

- Thursday, 13 May 2010 Perth
- Friday, 17 September 2010 Melbourne

Mr Plummer reported that he would be unable to attend on 13 May. The PMHA agreed that Ms Moira Munro should attend as the proxy for Mr Plummer and Ms McMahon agreed to attend as the PMHA Observer.

Resolved (unanimous)

1. *That the Private Mental Health Alliance (PMHA) requests that Ms Moira Munro attend the meeting of the Mental Health Standing Committee to be held in Perth on Thursday 13 May 2010, as a proxy for the PMHA Chair. Ms Janne McMahon will attend as the PMHA Observer.*

Action: Ms Moira Munro/Ms Janne McMahon

2. *That the PMHA requests a presentation on the use of outcomes measures in the private sector be prepared for the 13 May MHSC Meeting.*

Action: PMHA–CDMS Director

12 MHSC SQPS REPORT

The SQPS is responsible for taking the Australian Government mental health safety and quality agenda forward. While the Australian Commission for Safety and Quality in Health Care (ACSQHC) leads the national effort to improve the safety and quality of health care provision in Australia generally, the SQPS has a defined focus on safety and quality in mental health care. It is intended that the SQPS and the ACSQHC work in partnership. The SQPS brings together key stakeholders in the mental health field, from both the public and the private sectors that are relevant to implementation of national priorities. The PMHA is represented on the SQPS by Dr Bill Pring.

Dr Pring reported on the following issues that were discussed at the most recent meeting of the SQPS, which was held in Melbourne on 19/20 November 2009

conjointly with the MHSC Mental Health Information Strategy Sub–Committee (MHISS).

12.1 National Standards for Mental Health Services.

The National Standards Implementation Steering Committee (NSISC) has been overseeing the significant work required to prepare for implementation of the Standards. It has established seven working groups to assist in the preparation work including one on office–based practice. The objective of all this work is to most effectively implement the Standards.

12.2 Seclusion and Restraint Working Party (SRWP)

SQPS is exploring options to extend the focus on seclusion and restraint reduction initiatives through the drafting and publication of articles and literature. It is likely a national seclusion and restraint forum will be held in the second half of 2010.

12.3 Reducing Suicide and Deliberate Self Harm in Mental Health Services

SQPS has discussed the work of the Australian Suicide Prevention Advisory Council and the Department of Health and Ageing. In relation to the alignment of suicide prevention across the jurisdictions (Action 13 under priority Area 2 of the Fourth Plan) Ms Colleen Krestensen, DoHA, and Dr Aaron Groves, Chair of MHSC, will be writing to jurisdictions to formalise collaboration and jurisdictional agreement towards a national mental health suicide prevention framework.

There was also discussion of how to take forward SQPS work in the area of suicide prevention. It was suggested that consumers are most at risk during the 28 day post discharge timeframe. Victoria has done some work on post discharge follow–up best practice guidelines based on a rigorous Scottish methodology. The guidelines, which include some reference to deliberate self harm are expected to be finalised in early 2010. It was agreed that SQPS could build on this work.

12.4 Safe transport of people with mental health problems

The lead group investigating the safe air transport of consumers has almost completed the review of existing air transport guidelines. Jurisdictions are being asked to contribute information related to air transportation of consumers in each jurisdiction. The final report will provide a baseline to identify issues and inform SQPS on work that could be taken forward.

SQPS also discussed the feedback from jurisdictions on Memorandums of Understanding between mental health services and police and ambulance services. Problematic issues identified in the responses and discussion relate to quality and safety. Jurisdictional members will take issues back to jurisdictions to follow–up with Police Services and Ambulance Services.

12.5 SQPS linkages with MHISS and Australian Council on Safety and Quality in Health Care (ACSQHC)

Ms Milthorpe spoke to this item and reported on the following.

SQPS has established greater linkages with MHISS and formed a Joint SQPS/MHISS Subgroup which is looking at areas of joint action. So far, a quality framework to balance the safety aspects of what MHISS looks after, and the involvement of SQPS in the next edition of the Information Priorities, have been identified as areas for MHISS and SQPS to work on conjointly.

Ms Milthorpe reported that ACSQHC agenda is moving forward fairly rapidly now. ACSQHC has a work plan mapped out and there are areas that the SQPS will be able to work effectively with ACSQHC on.

Consumer Perceptions of Care (CPoC) type measures, is another area SQPS wants to work with MHISS on, in terms of what might be reported at the national level. In response to a question from Mrs Carson, Ms Milthorpe confirmed that the work undertaken by the Network on CPoC is being reported on through MHISS.

Under this Agenda Item, Ms McMahon revisited the issue raised in the Network Report (see Agenda Item 11 above), concerning the listing of the newer a–typical anti psychotic medications on the PBS and whether the Network should approach SQPS concerning this matter. Dr Pring and Ms Milthorpe advised that the appropriate groups to approach would be PBAC and the Therapeutic Goods Administration. Both require a strong evidence base concerning the safety and efficacy of a medication before it can be considered for listing on the PBS.

12.6 Next SQPS Meeting

The next meeting of SQPS is scheduled to be held in Sydney on Friday, 12 March 2010. Dr Pring will be able to attend.

Ms McMahon agreed to provide an update for Dr Pring to present at SQPS on the Network's Carer Project.

Dr Pring also agreed to provide SQPS with an update on PMHA activities.

13. MHSC MENTAL HEALTH INFORMATION STRATEGY SUB–COMMITTEE (MHISS)

MHISS provides expert technical advice and recommendations on initiatives to address the information requirements for MHSC.

The Meeting noted a copy of the draft minutes of the meeting of MHISS held in Melbourne on 19/20 November 2009.

The PMHA Deputy Chair, Ms Moira Munro, represents the PMHA on MHISS. Ms Munro reported on the following issues that were discussed at the most recent meeting of the MHISS, which was held in Hobart on 11/12 February 2010.

13.1 Indicators and targets for the Fourth National Mental Health Plan – National Mental Health Performance Subcommittee (NMHPSC) preliminary review

A great deal the current work of MHISS involves the review 25 indicators identified for monitoring the progress of the Fourth National Mental Health Plan. This is proving a lengthy and complex task with multiple inter–linked issues that have substantial implications for the national mental health information development

agenda over the next few years. In summary, the review has identified that 14 indicators are currently being reported and 11 require new data collections (7 through state and territory mental health services) at costs varying from low to high. Priority area 1 (social inclusion and recovery) requires the most effort and cost to deliver meaningful indicators for monitoring the progress of the Plan. The indicators, when mapped to the National Mental Health Performance Framework, covered all tiers.

MHISS has requested that the PMHA consider both the feasibility and benefit of the private sector collecting the following indicators.

Indicator 1: Participation rates by people with mental illness of working age in employment.

Indicator 2: Participation rates by young people aged 16–30 with mental illness in education and employment.

Indicator 4: Percentage of mental health consumers living in stable housing.

Indicator 5: Rates of community participation by people with mental illness.

Indicator 17: Proportion of specialist mental health sector consumers with a nominated GP.

Indicator 24: Proportion of consumers and carers with positive experiences of service delivery.

Mr Morris–Yates indicated the only way this level of national reporting could be undertaken by the PMHA's CDMS would be to either have the relevant data elements included in the HCP, or to have them manually collected as part of the current outcome measures collection through the HoNOS.

The complexities involved in collecting each of these indicators at the private hospital level using the mechanism of the PMHA's CDMS was discussed at length. Mr Morris–Yates indicated a preference for the use of the proposed recovery measure as a means for capturing most of these issues. It would also be amenable to routine collection.

After further discussion, it was agreed that the PMHA should advise the next meeting of MHISS of the following.

- The private sector is not adverse to participating in the collection of some of the indicators once further work has been done to develop what the collection will actually look like and mean.

- In the interim, information could be gathered on whether any of this information is being collected in the state–level collections.

- The private sector would want to be closely involved in the development of the recovery measure.

- The CPoC component of the PQI Project should place the PMHA in a position to regularly report on Indicator 24, but this would take a year to implement.

13.2 Consumer Perceptions of Care (CPoC)

MHISS has now received final reports on the use of CPoC measures from the private sector, Queensland (QLD), and Western Australia (WA). After a report has been received from New South Wales, MHISS will do a summary on the use of those measures. PMHA noted that in WA the CPoC study was done in a cost effective manner externally via a telephone interview, which excluded detained patients. QLD is implementing their CPoC measure across the state.

13.3 Australian Institute of Health and Welfare (AIHW) Mental Health Interventions Classification (MHIC) Project

MHISS discussed the proposed AIHW project plan and agreed that it would be prudent to run a small 'proof of concept' trial within one community mental health care service, in the ACT prior to conducting a wider pilot across multiple services and service settings. The 'proof of concept' trail will commence in February 2010.

13.4 Next MHISS Meeting

The next Meeting of MHISS will be held in Adelaide on 22/23 April 2010 in Adelaide. Ms Munro will overseas at the time of this meeting and Mr Morris–Yates agreed to attend as proxy for Ms Munro representing the PMHA.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that Mr Allen Morris–Yates attend the 22/23 April 2010 meeting of the Mental Health Information Strategy Sub–Committee to be held in Adelaide on 22/23 April 2010, as a proxy for the PMHA Deputy Chair, Ms Moira Munro.

Action: PMHA–CDMS Director

13.5 National Mental Health Information Development Expert Advisory Panel

PMHA noted that Mr Morris–Yates, has accepted the invitation from the MHISS Chair, Dr Aaron Groves, to be a member of the National Mental Health Information Development Expert Advisory Panel. After discussion, it was agreed that Ms Rosemary Dickson should be advised that the PMHA has no capacity to fund Mr Morris–Yates attendance at meetings of the Panel.

13.6 Other Issues

Ms Milthorpe reported that a scoping exercise is being conducted on the developing systems for public reporting under the Fourth National Mental Health Plan and there is another MHISS working group discussing how the National Mental Health Reports can be restructured and modernised. The Commonwealth is also funding a scoping exercise for the NGO sector data. Ms Munro indicated a confidential paper was also presented at MHISS on the Recovery Measure.

Mr Wayne Penniall explained what DVA is doing in relation to CPoC and other outcome measures.

14. OTHER BUSINESS

Dr Bill Pring reported that the meeting of the AMA Psychiatrists' Group, held on Monday, 22 February 2010, had raised the following issues.

- There are concerns, especially among psychiatrists working with older people, that there are moves toward improving service efficiencies in the private sector that might result in it being less financially attractive to accommodate psychiatric patients with particularly chronic and complex conditions. Many of these patients will be elderly and may require a lengthy hospital admission to receive proper treatment and care.

  Mr Callanan felt this may be related to the issue of acute care certificates. Dr Pring agreed to follow this–up.

- Ethical and professional indemnity concerns are arising again in relation to the way in which people with a mental illness are currently being recruited by health insurers into telephone–based and other advisory type services without close collaboration with the patient's psychiatrist. There is no scientific evidence that these services result in better outcomes, despite the claims that have been made in an article that appeared in the RANZCP Journal of Psychiatry in 2009.

Dr Pring indicated that he would seek further information concerning these matters for the next PMHA meeting.

15. NEXT PMHA MEETING

It was agreed that the next two face–to–face meetings of the PMHA would be held as follows.

11th PMHA Meeting 9:00 AM to 5:00 PM Friday, 18 June 2010	**12th PMHA Meeting** 9:00 AM to 5:00 PM Friday, 22 October 2010
The Adelaide Clinic 33 Park Terrace Gilberton South Australia	

16. CLOSE

There being no further business, the Chair closed the Meeting at 4:00 PM.

Mr Philip Plummer
Independent Chair

Mr Phillip Taylor
PMHA Director (Secretary)

PMHA INCOME (Stakeholder Contributions)	Contribution		
1. Australian Medical Association	53,576		
2. Australian Private Hospitals Association	53,576		
3. Australian Health Insurance Association	53,576		
4. Australian Government Department of Health and Ageing	61,576		
Transfer of PMHA balance from 1 July 2008 to 30 June 2009	*14,989*		
Total	**237,293**		
PMHA EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	162,377	71,821	90,557
Infrastructure	0	0	0
Recurrent and other expenses	19,626	17,301	2,324
Meetings of PMHA	9,852	2,828	7,024
Meetings of PMHA Working Groups	2,999	5,831	–2,832
Other Meetings	7,239	449	6,790
Total before AMA Administration charge	202,093	98,230	103,863
AMA Administration Charge of 10%	20,209	20,209	0
Total	**222,303**	**118,439**	**103,863**
Total PMHA Funds Remaining	***118,854***		

PMHA–CDMS INCOME (Stakeholder Contributions)	Contribution		
1. Australian Private Hospitals Association	65,204		
2. Australian Health Insurance Association	65,204		
3. Australian Government Department of Health and Ageing	65,204		
Transfer CDMS Balance From 1 July 2008 to 30 June 2009	*27,898*		
New Hospital Enrollments and re–enrollments	*10,500*		
Total	**234,010**		
PMHA–CDMS EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	144,972	61,650	83,322
Infrastructure	18,495	14,980	3,515
Recurrent and other expenses	14,363	7,042	7,321
Attendance at PMHA and other stakeholder's meetings	0	0	0
Workshops and Training	0	11,468	–11,468
Total before AMA Administration charge	177,830	95,141	82,689
AMA Administration Charge of 10%	17,783	17,783	0
Total	**195,613**	**112,924**	**82,689**
Total CDMS Funds Remaining	***121,086***		

NETWORK INCOME (Stakeholder Contributions)	Contribution		
1. Australian Medical Association	11,598		
2. Australian Private Hospitals Association	11,598		
3. Australian Health Insurance Association	11,598		
4. Beyondblue	11,598		
5. Australian Government Department of Health and Ageing	100,500		
Donation from the RANZCP	*11,598*		
Transfer of Network Balance from 1 July 2008 to 30 June 2009	*10,336*		
Transfer McMahon Petty Cash Advance for Network from 15/07/09	*–2,000*		
Total	**166,826**		
NETWORK EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	98,935	41,765	59,326
Infrastructure for Network Chair	536	1,452	–916
Meetings of the Network	38,505	13,021	25,484
Attendance of Network Representative at Other Meetings	8,497	10,112	–1,615
Total before AMA Administration charge	146,473	66,351	82,278
AMA Administration Charge of 10%	14,647	14,647	0
Total	**161,120**	**81,214**	**82,278**
Total Network Funds Remaining	***85,828***		

PRIVATE MENTAL HEALTH ALLIANCE
STRATEGIC PLAN 2009–11

PRINCIPLES	PRIORITIES	WORK PLAN	SCHEDULE	RESPONSIBILITY
REPRESENTATION AND PROMOTION OF THE PRIVATE MENTAL HEALTH SECTOR	1 Sustain a coherent position when representing the private mental health sector	The PMHA Chair, or in their absence, a PMHA agreed delegate, to provide the position of the PMHA and all its Parties as a whole. Where this conflicts with the position held by any individual Party, then the PMHA may not represent the Parties. Where the Parties are unable to formulate an agreed PMHA position, the Parties cannot speak on the matter as representatives of the PMHA.	At all times	PMHA Chair
		The Chair, or in their absence a PMHA agreed delegate, takes a pro–active role in representing a consolidated private sector position and ensures that relevant input is provided into key forums and meetings.	At all times	PMHA Chair
	2 Promote the work of the PMHA and its CDMS	Follow PMHA Communication Plan 2009–2011	2009–11	PMHA
		Quarterly electronic PMHA Newsletter.	2009–11	PMHA Director/PMHA
		Promulgate the revised version of the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–based Mental Health Care Guidelines for Determining Benefits*	2010	PMHA
		Promulgate the PMHA Discussion Paper, *Update On Funding Service Delivery For Private Mental Health Services*	2010	PMHA
		Utilisation of PHI Circulars.	Ongoing	PMHA Director
	3 Engagement with key national bodies involved in mental health	Represent the PMHA on the following key National Committees and their relevant sub–committees.		
		▪ Australian Health Minister's Advisory Council (AHMAC) Health Policy Priorities Principal Committee (HPPPC), Mental Health Standing Committee (MHSC).	2009–11	PMHA Chair PMHA Deputy Chair
		▪ MHSC Mental Health Information Strategy Sub–committee (MHISS)	2009–11	PMHA Deputy Chair
		▪ National Healthcare Agreement Performance Indicators 2007–08.	2009–10	PMHA Deputy Chair
		▪ MHSC Safety and Quality Partnership Sub–committee.	2009–11	Dr Bill Pring
		Maintain a watching brief of the measures being developed by the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011 and consider the implications for the private sector. Seek to provide representation for the PMHA.	2009–11	PMHA

PRIVATE MENTAL HEALTH ALLIANCE STRATEGIC PLAN 2009–11				
PRINCIPLES	PRIORITIES	WORK PLAN	SCHEDULE	RESPONSIBILITY
CARE FOCUS	3 Ensure participation of the private sector in relevant national mental health committees, reviews, and activities	Continued representation for the private sector in the development and implementation of measures directed toward achieving consistency in the provision of safe high quality mental health care. This includes, but is not limited to, the following.	2009–11	PMHA
		▪ National Mental Health Policy and Fourth National Mental Health Plan 2009–2014.	2009–11	PMHA Deputy Chair Dr Bill Pring
		▪ National Comorbidity Collaboration.	2009–10	Ms Carol Turnbull
		▪ National Perinatal Depression Initiative Working Group.	2009	Dr Choong–Siew Yong
		▪ Nationally Agreed Building and Design Guidelines.	2009–11	Ms Carol Turnbull
		▪ Active involvement and input into consultation and implementation of the revised National Standards for Mental Health Services (NSMHS) through the NSMHS Implementation Steering Committee and the Implementation Working Groups.	2009–10	PMHA Deputy Chair Dr Bill Pring Ms Carol Turnbull Ms Janne McMahon
		▪ Mental Health Workforce Advisory Committee.	2009–11	Ms Carol Turnbull
		▪ National Mental Health Workforce Strategy and Plan.	2009–11	Dr Bill Pring
		▪ National Mental Health Information Development Expert Advisory Panel	2009–11	PMHA–CDMS Director
		Review of Guidelines For Determining Benefits For Health Insurance Purposes For Private Patient Hospital Based Mental Health Care.	2009–10	PMHA–CCMWG

PRIVATE MENTAL HEALTH ALLIANCE STRATEGIC PLAN 2009–11				
PRINCIPLES	PRIORITIES	WORK PLAN	SCHEDULE	RESPONSIBILITY
PMHA–CDMS	4 Ensure that the PMHA–CDMS is the mechanism for monitoring and accountability and change under the governance of the PMHA	Incorporate the role of the PMHA–CDMS Management Committee into the core business of the PMHA with teleconferences conducted as required between face–to–face Meetings of the PMHA to discuss issues relevant to the governance of the PMHA's CDMS.	2009–11	PMHA
		Annual Review of the PMHA–CDMS reports.	Ongoing	PMHA
		Ensure ongoing improvement in the quality of data collection, analysis and reporting by the CDMS.	Ongoing	PMHA
		Ensure the wide dissemination of information from the PMHA–CDMS to highlight the achievements and work undertaken by the sector, including demonstrating the differences between the private and public sectors.	Ongoing	PMHA
		Use available CDMS data to promote a sector wide perspective for individual Hospitals and Health Insurers on what CDMS does, how it is does it, and how well it is done.	Ongoing	PMHA PMHA–CDMS Director
		Facilitate the greater utilisation of CDMS data at a national level directed towards better understanding and improving clinical outcomes.	Ongoing	PMHA PMHA–CDMS Director
FUNDING REFORM	5 Examine and monitor models service delivery and their funding that emerge under private health insurance legislation	Continue the work of the PMHA Collaborative Care Models Working Group (PMHA–CCMWG) to assist in opening up discussion on the following. ▪ Innovative models of service delivery and their funding. ▪ Integration of different types of service delivery between the public and private sectors. ▪ The shift toward prevention and promotion, particularly in relation to community based services.	Ongoing	PMHA–CCMWG
		Participate in the development of uniform quality and safety provisions for models of service delivery that emerge under private health insurance legislation.	Ongoing	PMHA–CCMWG
		Continue to examine models of funding and service delivery that emerge outside of the Hospital setting that Health Insurers are able to fund under Hospital and General Treatment.	Ongoing	PMHA–CCMWG
FUTURE WORK PROGRAMS BUDGETS	6 Develop proposed work programs and budgets 6 months prior to 30 June 2011	Conduct a PMHA Workshop toward the end of 2010 to discuss the future work programs and budgets for PMHA, PMHA–CDMS and Network and any areas of concern that need to be addressed in their development.	2010	PMHA