STRATEGIC PLANNING GROUP FOR

SPGPPS

PRIVATE PSYCHIATRIC SERVICES

News

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Introduction

This is the last edition of the SPGPPS News for the year, and we have included some reviews of the work to date of some of the major projects undertaken by the SPGPPS. I think you will agree that there has been a great deal of work generated by this group, and finally there is some significant evidence of results of that hard work.

All those involved in the projects should be congratulated for their efforts. Much of the work is groundbreaking, and has helped to put the private psychiatric sector firmly within the overall National Mental Health policy agenda. Not everyone will agree with all aspects of the SPGPPS projects, and certain concerns have been expressed about the practicality of the outcomes in particular of some of the projects. The representatives of the various stakeholder groups would very much welcome feedback and constructive criticism. Please feel free to get in touch with your own representatives if there are queries, or if you have comments to make.

I wish all our readers the very best for the season and the coming New Year. I believe that the year 2000 is going to be another busy year for the SPGPPS and for all those involved in these projects.

Dr Bill Pring
Editor

Update on the SPGPPS Data Collection and Analysis Project

Mr Allen Morris Yates

The SPGPPS Data Collection and Analysis Project seeks to develop a national model for the collection and analysis of a minimum data set with outcome measures for private psychiatric services.

The aim is to put in place systems for the routine collection of data that will enable the relative effectiveness of various models of service delivery in the provision of mental health care services in private hospitals to be determined. The Project also aims to simplify overall hospital data collection requirements.

COMPLETION OF STAGE ONE

Stage One of this Project is nearing completion and the Discussion Paper titled, *A National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services*, was widely distributed throughout the private sector for review and comment earlier this year.

Extensive feedback was received from both Hospitals and Funds. Overall, there was strong support for the proposed model. However, both Hospitals and Funds did have some specific concerns, primarily with the selection of the SF-12 as the self-report measure. The Commonwealth also provided independent feedback, giving strong support for the proposed model, with the exception that some concern was expressed regarding our recommendation that AR-DRG 4.1 be used as an interim patient classification.

Finally, the Working Group had asked all stakeholders to carefully consider the alternative routes by which the data should be submitted to the proposed Centralised Data Management Service (CDMS).

THREE ISSUES

These three issues - the selection of a self-report measure, the selection of a standard patient classification, and the identification of the most appropriate routes by which data should be submitted - have since been carefully reconsidered by the Working Group in the light of the feedback received. The Discussion Paper has been revised accordingly. The nature and rationale for these revisions is outlined below.

1. Selection of a self-report measure of consumer outcome

A number of concerns were expressed by Hospitals and Funds with respect to the Working Group's recommendation that the SF-12 be used as the standard self-report measure of consumer outcome. The project team were also made aware of developing concerns regarding the scoring of the instrument. The principal problems identified were that:

a) the instrument addressed disability but not distress;

b) half the questions addressed physical health problems which were unlikely to be seen as relevant by consumers with mental health problems;

c) the scoring algorithm applied to SF-12 results in less weight being applied to mental health problems in the presence of physical health problems, so that in psychogeriatric settings patients mental health may not be correctly reported; and

d) the scoring algorithm used for the SF-12 requires that all items are completed by the patient.

With respect to the selection of a self-report measure for routine use in the private sector, the Working Group now recommends that the 14 items constituting the Mental Component Summary (MCS) of the SF-36 be used. A copy of the full text of the revised section of the Discussion Paper regarding the selection of the

self-report measure together with the SF-36-MCS questionnaire can be obtained by emailing Allen Morris-Yates at the address given below.

The key issues in the argument for the use of the MCS component of the SF-36 are that it allows us to have the best of both the MHI and the SF-36 (the 5 item short form of the MHI is the Mental Health subscale of the SF-36), without the disadvantages of the SF-12 (questions on physical health seen as less relevant to consumers, limited questions on distress, and a complex scoring procedure that is vulnerable to missing data) or the limitations of the MHI-5 (no questions on mental health-related disability), whilst still being a very short measure (14 items) having an accessible and broad, Australian and international, base of benchmark data.

2. Selection of a standard patient classification

Both Hospitals and Funds expressed agreement with the selection of the AR-DRG 4.1 casemix classification as the interim standard patient classification to be used in reporting the results of analyses of the data collected.

The Commonwealth however, expressed some concern at that recommendation, suggesting that it could have the effect of indicating that the private sector also intended to use it as the basis for funding private psychiatric services. Unfortunately, although the Discussion Paper did make it clear that this was not the case, the Working Group nevertheless become aware that some sectors of the industry have in fact formed such a view.

The Commonwealth was also concerned that even provisional endorsement of AR-DRG 4.1 for mental health services could deflect attention away from its serious limitations and the need to further develop and test the MH-CASC classification. They therefore put the suggestion that rather than using AR-DRG 4.1 as an interim classification, the ICD-10 Diagnostic Groups classification developed by the MH-CASC project team in collaboration with National Centre for Classification in Health, be utilised as the interim classification. The Working Group considered this recommendation and believes it has considerable merit.

Apart from avoiding any misapprehensions regarding funding models, the ICD-10 Diagnostic Groups classification has a number of other advantages for private sector hospital-based psychiatric services.

First, it is very simple to implement, being based only on the grouping of patients in accordance with their principal diagnosis.

Second, it does not force the aggregation of a number of clinically diverse patient groups. For example, unlike AR-DRG 4.1, Eating Disorders and Personality Disorders are assigned separate categories.

Third, unlike AR-DRG4.1, it can be applied without modification in ambulatory care settings.

The Working Group therefore recommends that the ICD-10 Diagnostic Groups classification be utilised as the interim standard patient classification.

A copy of the full text of the revised section of the Discussion Paper regarding the selection of the standard patient classification, which includes tables showing the mapping between the ICD-10 and the recommended classification, can be obtained by emailing Allen Morris-Yates at the address given below.

3. Identification of the most appropriate routes by which data should be submitted

Hospitals expressed a preference for data to be submitted directly to the proposed Centralised Data Management Service (CDMS), however most also noted that submission of the data to Funds would also be acceptable. Funds expressed a strong preference that data regarding their members should be submitted to them, following which they would submit it to the CDMS.

In reviewing stakeholders comments, the Working Group gave careful consideration to three major sets of issues:

a) Funds legitimate need to implement valid means to evaluate hospital quality and health outcomes for their members;

b) the need to maintain patients' privacy and confidentiality; and

c) the technical problem of maintaining data integrity whilst keeping costs to a minimum.

After careful consideration of stakeholders concerns and the likely feasibility of various technical options, the Working Group concludes that the most practical, reliable and cost-efficient solution is to recommend that Hospitals submit data by the following routes:

- Hospitals submit to each Fund both the HCP Data Set and Outcome Measures records for

those Patients who are members of that given Fund.

- Hospitals directly submit both the HCP Data Set and Outcome Measures records for all Patients to the Centralised Data Management Service.
- Funds submit to the Centralised Data Management Service the HCP Data Set records, to which have been added information regarding benefits paid, for all members' admissions to identified private psychiatric Hospitals.

PUBLICATION OF THE DISCUSSION PAPER AND DEVELOPMENT OF AN IMPLEMENTATION PLAN

The revised Discussion Paper, which includes the major revisions identified above, together with a number of minor revisions and corrections will be published and widely distributed early in the New Year.

After reviewing the current state of development of the private psychiatric hospital sector and the technical requirements of the proposed National Model the Working Group has recommended to the SPGPPS that the initially planned pilot test phase need not be undertaken. Instead, it is recommended that the Working Group reconvene in February and begin work on the development of an implementation plan.

To that end, the Commonwealth has committed funds to enable the project manager, Mr Allen Morris-Yates, to continue work on the project until the end of April 2000. The brief is to develop a detailed phased implementation plan which includes detailed specifications of:

a) the functional requirements for operation of the Centralised Data Management Service;

b) the steps needed to implement the collection of outcome measures in Hospitals, including training;

c) the functional requirements of the basic software likely to be required by Hospitals to facilitate the collection and submission of data;

d) the process by which the Centralised Data Management Service is to be set up and run; and

e) the initial and recurrent costs of operating that Service.

The Implementation Plan will pass through the same review and revision process as that applied in the development of the Discussion Paper. However, given our funding constraints, the Working Group proposes to have the Plan completed and published by the end of May 2000 so that, assuming all goes well, implementation may begin in July 2000.

The SPGPPS considered developments with the Project at its December meeting and adopted resolutions adopted to enable to the Project to proceed.

The first meeting of the Working Group is scheduled for 17 February 2000.

For further information contact

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Guidelines for Determining Benefits for Private Hospital-Based Psychiatric Care

Dr Robert Broadbent

The RANZCP and private health insurance funds met in February 1999 to expedite the review and update of the RANZCP document originally titled *Guidelines for Determining Benefits for Psychiatric Inpatients*.

A Working Party comprised of representatives from the RANZCP, health insurance funds and private hospitals was subsequently established. New Guidelines, titled *Guidelines for Determining Benefits for Private Hospital-Based Psychiatric Care*, were drafted and then circulated for comment to constituent groups of the RANZCP, funds and private hospitals.

The Working Party met again in August 1999 and further revised the new Guidelines for circulation of the final draft version to constituent groups for comment.

The revised Guidelines were tabled at the last meeting of the SPGPPS and Members were asked to forward any comments they might wish to make to the relevant representatives on the Working Party.

Ms Janne McMahon provided comments from a consumer perspective that were supportive of the revised guidelines.

The RANZCP College General Council has endorsed the Guidelines. Health Funds and Private hospitals have also endorsed the new guidelines.

Guidance is currently being sought from the Commonwealth Private Health Industry Branch concerning implementation of the new Guidelines by the industry.

The SPGPPS endorses the Guidelines for Determining Benefits for Private Hospital-Based Psychiatric Care, and requests that the necessary consultations and negotiations be undertaken with the Commonwealth Department of Health and Aged Care, Private Health Industry Branch, to enable the Guidelines to be implemented.

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Development & Implementation of Clinical Practice Guidelines Project

Ms Meredith Harris

The following article provides an update on the progress of the Clinical Practice Guideline project. First drafts of the guidelines for Depression and Panic Disorder and Agoraphobia are expected to be circulated for review in early 2000.

PRESENTATIONS

Prof. Philip Boyce (Project Chair) has presented the Project in a number of forums over the past three months, including:

- World Psychiatric Association, Hamburg, August 1999.
- RANZCP New Zealand National Conference, Dunedin, September 1999.
- RANZCP Branch CME meetings in Tasmania, Victoria, NSW, Queensland and WA.
- TheMHS Conference, Melbourne, September 1999.

More presentations will be scheduled in the coming year.

ECONOMIC ANALYSIS FOR CLINICAL PRACTICE GUIDELINES

A workshop was held on Thursday December 9, 1999, at the College's NSW Branch in Rozelle, for the guideline teams to discuss techniques for economic analysis in clinical practice guidelines.

Presentations were given by:

- Prof. Jane Hall and Dr. Philip Haywood (Centre for Health Economic Research and Evaluation (CHERE), University of Sydney), presenting their draft toolkit for economic analysis for clinical practice guidelines for the NH&MRC.
- Dr. James Butler (National Centre for Epidemiology and Population Health, ANU), presenting preliminary work on modelling the costs of diagnosing and treating depression, and the effect of changing practice patterns on costs.

CLINICAL PRACTICE GUIDELINES SURVEY

In early October the RANZCP conducted a survey to explore the views of psychiatrists about clinical practice guidelines. All College Fellows, Trainees and Affiliates were invited to complete the survey.

The responses to this survey will help inform the guideline developers about the formats and attributes of guidelines preferred by psychiatrists, and to guide the development of effective strategies for the dissemination, implementation and evaluation of the guidelines.

Responses are presently being analysed and we expect the results to be available on the RANZCP website in early 2000.

STEERING & IMPLEMENTATION COMMITTEE

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A/Prof. Fiona Judd	RANZCP
Dr. Josh Geffen	Assn Psychs in Training
Dr. Bill Pring	SPGPPS
Ms. Merinda Epstein	Consumer rep.
Mr. John McGrath	Carer rep.
Mr. Paul Gross	HAC, NH&MRC
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National Demonstration Projects in Integrated Mental Health Care An Update

Associate Professor Kathy Eager

The first round of National Demonstration Projects in Integrated Mental Health Services (MHIP) are now in the detailed design and planning phase. This phase involves approximately six months for consultation and for the development of a detailed design plan. At the end of this period, project groups will be submitting a detailed implementation plan. Subject to the development of a satisfactory plan and to the agreement of local consumers, providers and State Health Authorities, the Commonwealth will approve each project and provide project funds for a period of two years. Approval to progress to the 'live' phase is not automatic and is subject to satisfactory progress being made during the planning phase. The four projects in the first round are Far West (NSW), Illawarra (NSW), Inner Urban East Melbourne (Victoria) and the Grampians (Victoria). Other projects are likely to be approved for a further round of trials in 2000.

The Centre for Health Service Development (CHSD) at the University of Wollongong is providing technical assistance in relation to design, management, financial and monitoring arrangements and site selection. They have released 8 discussion papers that address the key issues that demonstration sites are considering during the planning phase. The discussion papers are:

1. Planning issues in designing national demonstration projects in integrated mental health
2. Issues in the establishment of the funding pool
3. Payment options for private providers
4. Payment options for public providers
5. Clinical issues and planning for patient care
6. Evaluation guidelines
7. Guidelines for managing the project in the live phase
8. MHIP is not managed care.

A National Reference Group will be established to oversee the projects in the live phase. The RANZCP, the SPGPPS and other key stakeholder groups have been invited to participate as members of the National Reference Group. Dr Yvonne White will represent the SPGPPS, with Dr Bill Pring as alternate delegate.

For further information contact

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SPGPPS News provides a brief summary of issues being progressed under the auspice of the SPGPPS process. Copies of full draft reports on the most recent meetings of the SPGPPS can be viewed on the internet at:

http://domino.ama.com.au/DIR0103/MentalH.nsf/Mental+Health