PMHA | PRIVATE MENTAL HEALTH ALLIANCE

Australian Medical Association

Australian Private Hospitals Association

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Private Mental Health Consumer Carer Network (Australia)

beyondblue – the national depression initiative

THE PMHA QUALITY IMPROVEMENT PROJECT

PROJECT BRIEF 2010

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PURPOSE OF THE PROJECT BRIEF

The purpose of this Project Brief is to provide a full and firm foundation for the scope and management of the PMHA Quality Improvement Project (hereafter QIP or Project). It specifically sets out the following.

- What the PMHA requires the Project to deliver.
- The requirements of the Project
- The scope of the Project in terms of what is to be included.
- The outcomes of the Project so that all PMHA stakeholders fully understand what the Project will deliver within the context of available funding and resources.
- The benefits that can be realised through delivery of the outcomes.

This Brief provides a base document that includes the objectives, work programs and deliverables for the QIP. It provides a shared and common understanding, which has been endorsed by the PMHA.

THE PMHA QUALITY IMPROVEMENT PROJECT

In 2010, an anonymous donor provided $250,000 of financial support 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 funding is 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). In welcoming this anonymous offer, the PMHA designed a *PMHA Quality Improvement Project* (hereafter QIP or Project), which contains a suite of four complementary activities to be undertaken within the context of the available funding.

1. Implementation of Consumer Perceptions of Care (CPoC) 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.

2. Outcomes in Private Psychiatry Practice

Work on this second activity will establish a research network of psychiatrists evaluating outcomes 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.

3. 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.

4. 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.

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.

1. Implementation of Consumer Perceptions of Care Measure

There is a wealth of evidence available to demonstrate that consumer involvement in the evaluation of mental health services is an essential part of improving the quality of those services for consumers. The information that is derived can help to structure changes not only within the services that are provided, but also in the area of staff attitudes towards consumers and their carers. The *Fourth National Mental Health Plan 2009–2014* (Plan) has been developed to further guide reform of Australia's mental health services. It identifies key actions that can make meaningful progress towards fulfilling the vision of the agreed *National Mental Health Policy* for Australia. The Plan clearly identifies the need for accountability in Priority area 5 where it states:

> *Consumers and carers have access to information about the performance of services responsible for their care across the range of health quality domains and are able to compare these to national benchmarks.*

Over the life of the Plan, the key gaps in regularly available national data are to be corrected, including the collection of data on consumers' experiences of the services that are provided.

Australia's mental health sector has been a world leader in the establishment of routine collection of clinical outcome measures and the private mental health sector has been instrumental in this process. All private hospital–based psychiatric services in Australia have now implemented a *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures* (hereafter, National Model). Under the National Model standardised measures of consumers' clinical status are collected at key occasions in the clinical path: at admission and discharge from episodes of overnight inpatient care, and from both home and hospital–based ambulatory care. Analyses of changes from one occasion to the next enable consumer outcomes throughout the clinical path to be reported on and evaluated. The one component missing, however, is data on the consumers' perceptions of care (CPoC). CPoC data is of great interest to all stakeholders concerned with the assurance of service quality and effectiveness, and is a critical component of an effective quality improvement process.

CPoC Pilot Study

In 2005, a pilot study was conducted to assess the feasibility and utility of implementing a data collection and reporting process for CPoC that was similar to the existing processes for the collection and reporting of outcome measures under the National Model. The pilot was funded by the Australian Government and Queensland Health. The principal investigator was the Director of the PMHA's CDMS, Mr Allen Morris-Yates. The indirect cost of Mr Morris-Yates' salary whilst he worked on the study and its' final report was borne equally by the PMHA-CDMS's three financial stakeholders: the Australian Private Hospitals, Association, the Australian Health Insurance Association, and the Australian Government Department of Health and Ageing. The portion of the pilot pertaining to the private sector was overseen by PMHA's CDMS Management Committee. Use was made of the Consumer Surveys developed in the United States of America under the auspices of the Mental Health Statistics Improvement Program (MHSIP) and the National Research Institute of the National Association of State Mental Health Program Directors. The MHSIP Consumer Surveys include versions suitable for use in all service settings. The original development process for the Surveys included a high level of consumer and care involvement and consultation. The Private Mental Health Consumer Carer Network (Australia) [the Network] was instrumental

in obtaining feedback from seventy private sector consumers and carers who reviewed the surveys and found them to be largely acceptable for use in Australia.

Eight of the private hospitals with psychiatric beds participated in the pilot. The pilot study showed that the routine collection of a measure of perception of care was possible within the private sector. Not only was it possible, but the results indicated that both hospitals and consumers felt the information that was collected was useful and would be used to improve services within these facilities. The APHA Psychiatry Sub–committee has given strong support to the establishment of a national system for benchmarking consumers' perceptions of care through a routine data collection and reporting process.

CPoC Work Program and Deliverables

It is proposed that in this part of the QIP, CPoC data be collected from all consumers on discharge from Hospitals participating in the PMHA's CDMS and entered by those Hospitals in the same manner as they currently do for the clinical outcome measures they collect under the National Model. The CDMS Standard Quarterly Reports would then report on the Hospitals' performance benchmarked against the national average. This is new ground for any health service in Australia and will take considerable time and input to ensure that the collection and reporting process is robust and meaningful. While the full implementation of the CPoC measure will add a much stronger consumer perspective to assist Hospitals quality improvement cycle, it needs to be approached with care, and in three stages.

First, an agreed survey suite needs to be developed. Whilst the two MHSIP surveys used in the CPoC Pilot Study worked very well, both consumers and Hospital managers identified issues that were missed and wording that could be made more appropriate to the Australian context.

Second, given an agreed suite of surveys, hospitals should then be asked to agree on a standard collection protocol. In addition to issues about when the surveys are to be offered, this protocol will need to also recommend mechanisms for ensuring anonymity of respondents. In particular, as it became clear to the CPoC Pilot Study research team that hospital staff were able to identify many consumers by their handwriting and style of written response, written complaint and other comment processes will need to be clearly separated from the CPoC survey administration and collection process.

Third, the CDMS will need to implement the suite of CPoC measures within the existing outcomes measures collection, analysis and reporting framework. That work will entail the specification and implementation of changes to:

1. the data submission formats;

2. the data entry, data submission and analysis reporting functions with the HSMdb software now provided by the CDMS to participating hospitals; and,

3. the CDMS data warehouse data processing, analysis and reporting functions.

Deliverables: (1) An agreed survey suite and standard collection protocol.

(2) Implementation the suite of CPoC measures within the existing outcomes measures collection, analysis and reporting framework.

2. Outcomes in Private Psychiatry Practice (OPPP)

This part of the QIP is focussed on better involving psychiatrists in private office–based practice in the data collection and outcome measurement processes of the PMHA and its CDMS. It not only complements the Work Program for the implementation of the CPoC measure detailed above, but would also establish an ongoing Research Network of psychiatrists interested in using outcome measures within the context of their practice.

OPPP Work Program and Deliverables

The purpose of this program of work is to establish a Research Network of psychiatrists across Australia. Psychiatrists participating in the Research Network will have to be willing to:

(a) give time at no cost;

(b) collaborate with one or more private hospital facilities in their state or territory; and

(c) remain involved in the their Research Network beyond the duration of the QIP.

To establish the Research Network, the Senior Research Officer for the QIP will work with the AMA Psychiatrists' Group (AMAPG) to recruit psychiatrists in private practice willing to participate. AMAPG has psychiatrist representatives in most state and territory jurisdictions who have indicated they are prepared to foster the formation of the Research Network. The jurisdiction–based groups within the Research Network would function in a similar way to current peer review groups of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). Their focus, however, would be active research, with the first two years of their function likely to be taken up almost entirely by the OPPP Work Program. The RANZCP would be approached to suggest appropriate Continuing Professional Development recognition for the psychiatrists involved in the Research Network.

The actual substance of the OPPP Work Program would involve three key phases, which are intrinsically linked, and sequential. It is envisaged that peer reviewed papers will arise from each phase.

Phase One

Establishment of the Research Network in Phase One would enable a survey involving a larger group of psychiatrists to be undertaken. The purpose of the survey would be to define the full spectrum of the population currently served by the private psychiatrist sector. It would also provide a reference against which the clinical needs, patterns of service utilisation, and outcomes of the sub–set of patients seen by private hospital-based psychiatric services, can be compared and contrasted. Importantly, this research will provide insight into the combinations of providers who are now working with patients receiving specialist psychiatric care in the private sector. This also provides a fitting informational adjunct for the PMHA's Collaborative Care Models Working Group.

Deliverable: A report on the survey of private psychiatrists' caseload suitable for publication in a peer review journal.

Phase Two

The second phase of the OPPP Work Program will more directly involve the Research Network set up in Phase One. Using a peer review approach, the Research Network will examine the issues encountered in the treatment of patient groups with complex needs for care (using criteria suggested by consumers and carers, private health insurers, private hospital–based psychiatric services, and the psychiatrists themselves). Those patients studied within the peer review process will not be personally identified to the Research Network members. Discussion will occur in an ordered way so that the conclusions of the members can be tabulated by the diagnostic complexity of the patients, and the treatments provided. In addition, the peer review process will be supported by the PMHA's CDMS through the provision of aggregate statistics regarding the pattern of service utilisation and outcomes for the patient groups identified by the Research Network.

Deliverable: A final report that answers the following questions.

- **How do we identify patients with complex needs?**
- **What clinical paths should they follow?**
- **What issues are likely to be encountered in the treatment of those patients groups?**
- **Recommendations regarding indicators of outcomes for those patient groups.**

Phase Three

The third component of the OPPP Work Program is a longitudinal study, which would commence after the QIP had ended and last for approximately one year. Phase Three would be geared towards the active continuation of the Research Network, building on significant expertise gained during the OPPP Work Program. This Phase would involve a group of psychiatrists willing to commit to a one year period of more intense follow–up of a small group of patients in their practices. It is envisaged that perhaps twenty four individual psychiatrists will follow–up at least ten patients each (achieving a minimum sample size of 240 cases). Psychiatrists who regularly admit patients to private hospital–based psychiatric care will be encouraged to participate.

Two patient groups will be focused on. Approximately half of the patients followed–up should be in the high utiliser group. Whilst it would be unlikely that each psychiatrist would have five patients who were in the high utiliser group, as defined by most health insurers, the group of five patients could be based on the five patients who have utilised private psychiatric hospital facilities to the greatest extent in their practices. Such selection could be based on hospital or health insurer information, which could influence the selection of that group of patients. The other five patients that the psychiatrist would follow–up would be a control, or comparison group. Ideally, those patients should be selected randomly from those psychiatrist's practices. The patients enrolled in the study would be followed reasonably intensively. Besides baseline information concerning diagnosis, and ongoing information concerning all the other detectable healthcare practitioners involved in that patient's care, there would also be outcome measurement, and possibly other types of clinical indicator measurements undertaken with that group. This would then provide a much more detailed longitudinal picture of the diagnoses, care provided, and healthcare community working

around the patients needs over the course of at least one year. Such an in–depth view of patients' treatment would provide another very useful piece of information for all the PMHA's stakeholders.

The final component of Phase Three, concerns the feedback about outcome measurement data to the patient. It is intended that, with this small longer term follow–up group, outcome measurement data would be collected in all cases. This may provide an interesting comparison sub–group within the overall study for there to be feedback of the outcome measurement information to the patient, in half the cases involved in the OPPP. Incorporation of this sub–stratification would allow some comparison of quantitative data between a group of people that are given outcome measurement feedback, and a group that are not. It also suggested that some qualitative assessment be made, perhaps with phone call feedback through a set of questions, and analysis of the relatively free form commentary gained from such feedback. It would be intended that the feedback would be obtained from both the treating psychiatrist, and the consumer.

Deliverable: A study protocol for Phase Three developed in consultation with the Research Network.

3. Internet–based Access to the PMHA's CDMS (IAPC)

The content of the current Standard Quarterly Reports provided to Hospitals and Payers by the PMHA's CDMS is severely constrained by their publication format. The recently initiated provision of extracts of the statistical information in an XML format can enable interested users to interrogate the statistics in new ways. Nevertheless, however useful the extracts may be, they are still a relatively limited subset of the clinically oriented information that could be derived from the data held by the CDMS. Provision of an internet–based interface to the aggregate statistics held by the CDMS, similar to the Clinical Review functions already made available to Hospitals within the HSMdb software, would provide CDMS participants with a substantially more flexible and timely method of obtaining a greatly enhanced array of information.

Access to the CDMS data for clinical research purposes could also be provided through such an internet–based analysis system. At present, using the HSMdb software's clinical review functions, Hospitals do already have access to a very flexible system for investigating their own data. Development of an internet–based system could provide a similar highly flexible mechanism for gaining access to aggregate statistical information based on all CDMS data. The development of such a system would have immediate benefits for the CDMS's principal stakeholders and could also greatly enhance the capacity of the CDMS data to be used for clinical purposes to improve patient care.

IAPC Work Program and Deliverables

This part of the QIP is a first step toward enabling internet–based access to be properly undertaken. The Work Program would involve a scoping exercise directed toward clearly specifying the requirements for a model Agreement that can address the following for stakeholders.

1. Privacy and confidentiality protocols consistent with the National Model's information access guidelines.

2. Protocols for the protection of intellectual property (principally that of the Hospitals that contribute the data) and the publication of information derived from the CDMS.

3. Reliable and cost–effective systems for granting and revoking authenticated user access.

As the information is owned by participating private Hospitals, their requirements with respect to these issues must be clearly identified and addressed.

Deliverables: (1) Specifications of what is required for a model Agreement for internet based access to the PMHA's CDMS that addresses the following for PMHA stakeholders.

- **Privacy and confidentiality protocols consistent with the National Model's information access guidelines.**
- **Protocols for the protection of intellectual property and the publication of information derived from the CDMS.**
- **Reliable and cost–effective systems for granting and revoking authenticated user access.**

(2) A model Agreement for internet-based access that each organisation whose staff are granted access will be required to sign.

4. Borderline Personality Disorder (BPD)

Currently, treatment options for people with BPD vary between services. There has been consistent lobbying for the last 18 months to have the treatment and care for people with BPD better recognised, resourced and coordinated. The Senate Community Affairs Report of September, 2008 made a Recommendation to establish a national initiative which would be overseen by a Taskforce to include amongst other things;

- the establishment of designated BPD outpatient care units in selected trial sites in every jurisdiction to provide assessment, therapy, teaching, research and clinical supervision; and

- training program for mental health services and community–based organisations in the effective care of people with BPD.

BPD Work Program and Deliverables

Under the QIP, the Work Program for this activity would take the form of a scoping exercise to determine what models of care are currently being used for people with a BPD in private sector settings. Some aspects of this scoping exercise would be able to be undertaken as part of the other aspects of the QIP described above. In the program of work required for the OMPPP, for example, questions could be included to elicit information on the following.

- Diagnosis of BPD

- Number of people being treated for BPD

- Types of treatments being used for BPD

- What other health professionals are involved in the care of people with BPD

Private hospital-based psychiatric services could also be asked to provide similar information on what they are able to offer and any difficulties they may have encountered.

This information could then be further developed into a guide for consumers on what to currently expect at each stage of the clinical care pathway.

The findings from this scoping exercise would also help to determine what might be required for the more in–depth work that would be necessary to establish a consistent approach for treatment.

Deliverable: A report on current practice and what to expect at each stage of the clinical care pathway for BPD.

PROJECT MANAGEMENT

While the PMHA is the overarching group responsible for QIP a small sub–committee has been established to act as a reference group and to assist with steering and managing the Project.

PMHA-QIP Sub Committee

The PMHA's QIP Sub–committee is comprised of the following representatives.

Ms Moira Munro	PMHA Deputy Chair and APHA representative
Dr Bill Pring	PMHA AMA representative (private psychiatrist)
Ms Janne McMahon OAM	PMHA Consumer representative and Network Chair
Ms Andrea Selleck	PMHA AHIA representative
Professor Andrew Page	Expert Adviser
Mr Allen Morris–Yates	PMHA–CDMS Director
Mr Phillip Taylor	PMHA Director

Crucial to the success of the QIP will be the appointment of a Senior Research Officer of sufficient calibre and independence to be able to undertake the four Work Programs described in this Project Brief. The Sub-committee is well placed to assist with the management of the selection process for the SRO in consultation with the AMA.

PMHA Senior Research Officer

The PMHA's Senior Research Officer (SRO) for the Project will be employed by the AMA and located Research Office, Kahlyn Day Centre, 40 Briant Road, Magill, South Australia, for the two year period of the QIP.

The SRO will work under the general supervision of the PMHA–CDMS Director, Mr Allen Morris–Yates and in consultation with the PMHA-QIP Sub-committee.

The PMHA meets in Adelaide and the Independent Chair of the PMHA, Mr Philip Plummer, is also located in Adelaide. This facilitates the SRO attending meetings of the wider PMHA to formally report on progress with the QIP.

The SRO will hold primary responsibility for undertaking and successfully completing the Project's suite of four work programs and their deliverables.

The SRO will be required to review the Project Brief and develop the detailed research design for each of the four work programs in consultation with the PMHA–QIP Sub–committee.

TIMEFRAME

The PMHA-QIP is a two year project and would commence as soon as the SRO is appointed.