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| Clinical mental health services: changes to registration and updates to outcome measurement |
| **Frequently asked questions**  Updated 30 August 2021 (Original issued 25 May 2021) |
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# What is changing

The approach to registration of mental health consumers is currently variable across the state. Registration of a consumer on the Client Management Interface/Operational Data Store (CMI/ODS) will now be required where a person receives a face-to-face mental health assessment. The process also requires a case and episode be opened at that time. It will continue to be required in a range of other circumstances, for example when a consumer is admitted. Consistent registration practices support safety; coordinated care centred on the person; and sharing of relevant information.

In addition, a new outcome measure (Phase of Care) is being introduced for adults and older adults, replacing an existing measure (Focus of Care). The Phase of Care element is new for child and adolescents. Finally, services are being reminded about the importance of collecting outcome measures as required under national agreements. Three new program management circulars (PMCs) outline the changes in detail.

# Registration

## Why change the approach to registration now?

Under the current approach, consumers might be seen multiple times but not registered. If this occurs at different services, then clinicians may have incomplete information for decision-making. Both intentional self-harm and some mental illnesses are associated with a higher risk of suicide. A number of coronial recommendations in Victoria have noted that improving the information available to treating mental health clinicians about previous presentations is important to improve safety. Consistent registration of consumers who receive a face-to-face mental health assessment, (including family, children and carer information as per the Chief Psychiatrist’s guidelines) will improve the availability of information to mental health clinicians on second or subsequent presentations.

The new approach to registration will also allow a better assessment of demand for mental health services. A better understanding of those seeking access to care will support improved planning to meet demand.

## What do the registration changes mean for area mental health services?

Under the new PMC business rules, the scope of registration is expanded to include people who have received services, including assessment, from a public clinical mental health service. This is a similar approach to other Australian states and territories. Previously, registration scope was focussed on people receiving ongoing mental health treatment, but varied in practice across services.

Area mental health services (AMHS) need to prepare to implement these changes. Each service will be different— for some services the changes will be substantial, for others they may not be as significant, depending on current registration practices. Planning to meet local needs will be required, and discussion with clinical staff, information staff, administration staff and educators. Forms and systems may also need to be changed.

These changes mean that some services, such as consultation-liaison psychiatry, that may have not previously registered consumers, will now need to do so. A list of services that are in-scope is in the registration PMC.

## Does face-to-face assessment include videoconferencing?

Yes.

## If a program is not listed in the scope section of the registration PMC and we currently register consumers, do we stop?

No. To improve safety and quality, the registration changes are intended to increase the scope of registration to collect information on all consumers who receive services, including assessment. The program management circular’s advice on the scope of registration is not exhaustive. We have tried to be explicit but inevitably not every type of program (or program name) will have been included. Services should not reduce their scope of reporting.

## What about programs that aren’t specifically listed in the scope section of the registration PMC?

Clients using early intervention and diversion programs, including triage-type services delivered face-to-face, should be registered, even though this may not have occurred previously. For example, consumers of programs such as: CYMHS and Schools Early Action (CASEA), Perinatal Emotional Health (PEHP), and Mental Health and Response Service (MHARS) should be registered if they receive a face-to-face mental health assessment. For MHARS this would include the Court Liaison Service (CLS) function and the Community Corrections Order Screening (CCOS) function. Not every type of program that meets the criteria for registration in the PMC (like face-to-face assessment) can be listed individually.

## For some clients, there is a check of the ODS only, looking for previous activity- what to do in this instance?

In this situation, use the Triage Minimum Data Set (TMDS), and specifically Triage category G “ODS lookup only.” Do not register the person, and report data only to TMDS.

## With the changes to registration, when is data recorded in the Triage Minimum Data Set?

Most phone contacts to mental health triage services will result in data being recorded in the TMDS. If the person is seen face-to-face then they will be registered on CMI/ODS. TMDS should **not** be used to record consultation-liaison data or MHARS data, as these clients must now be registered. It is expected that all services will have moved to using the TMDS for phone triage and look ups only, by the end of quarter 1, 2021-22.

## Why should consultation-liaison psychiatry patients be registered?

Consultation-Liaison Psychiatry (C-L) is a subspecialty that provides care to inpatients under medical, surgical or other non-psychiatric care. Comorbid mental and physical illnesses are common, and it is not surprising that some people with, for example, heart problems or kidney disease should experience issues with anxiety, depression or other mental illness. The physical health of people with severe mental illness is often poor, and someone with schizophrenia may also have, for example, lung disease or diabetes. The prevalence of mental illness among hospital inpatients has been estimated to range from 26.1 to 38.7%[[1]](#endnote-2).

Patients admitted to inpatient wards are registered on the local Patient Administration System (PAS). They also need to be registered on CMI/ODS, if they meet the registration criteria in the PMC, for example, face-to-face assessment by mental health clinicians. Documentation is part of patient safety, as noted in the National Safety and Quality Health Service Standards- see <https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/documentation-information>.

Although C-L psychiatry has been shown to improve outcomes for patients, some medical staff may be reluctant to refer patients to C-L. Stigma can play a part in this reluctance, and both stigma and patient preference have been raised as referral barriers by hospital doctors. However, as illustrated by Klein’s study on medical inpatients, patients often do not hold the same view as their treating professionals[[2]](#endnote-3). Referrals should not be obstructed by the perception of mental illness stigma by hospital staff. Klein found that medical inpatients are generally accepting of psychiatric consultation, that consultation does not pose a threat to the doctor-patient relationship, and that careful preparation of the patient by the provider can improve patients' attitudes toward the consultation.

## What about clients on clozapine?

These consumers must be registered.

## What do the registration changes mean for consumers?

Consumers of public clinical mental health services will be registered in the CMI/ODS and issued a mental health state-wide patient identifier number at the point of face-to-face assessment, rather than when a decision is made to provide ongoing treatment. For consumers who are admitted there is no change in practice. In both cases, registration should improve continuity of care; safety and improved planning. Services should have systems in place to identify carers and dependents, and to discuss and encourage use of consumer tools including Advance Statements and Nominated Persons as part of registering clients.

## Is people’s information protected and secure?

Maintaining the privacy and confidentiality of people’s personal and health information is important. The law governs how this information must be collected, used, disclosed and stored. People with a mental illness have a right to privacy, and in most cases their health information must not be disclosed without their consent.

The CMI/ODS has audit trails in place to pick up unauthorised activity. The data store has controlled access with procedures and controls in place. Designated mental health services (including staff members) are only permitted to disclose health information about consumers under specific circumstances outlined in the *Mental Health Act 2014*, such as for the purposes of providing treatment. A Privacy Impact Assessment found that existing privacy controls were current and working well.

## What privacy laws protect the information in CMI/ODS?

The following privacy and health record laws apply to use of CMI/ODS:

* the Health Records Act 2001 (Vic) (*HRA*); and
* the Privacy and Data Protection Act 2014 (Vic) (*PDP Act*);
* the Mental Health Act 2014 (Vic) (*Mental Health Act*), (together, the Privacy Laws).

## Will there be funding support for services to implement the registration, phase of care and updated outcome measurement program management circulars?

The impact of implementation of the program management circulars will vary across services. Some services may already largely meet the revised requirements for registration, for example, but others will have substantial work to do. Funding support for data quality and integrity was provided during 2020-21 as part of the Adult Intensive Complex Care Packages funding. In addition, the department has provided further funding for dedicated resources and technical improvements to existing data and information systems in 2020-21.

The dedicated funding is provided for health services to improve their data and information management quality and integrity, including implementation of changes for Registration, Episodes of Care, Phase of Care and Outcome Measures, and to support general upgrades to the collection, management and reporting of mental health data. Health services will be required to complete a transition plan and demonstrate progress toward improving data management capabilities.

## Do I need to register a consumer if it is a one-off assessment?

Yes. All face-to-face consultations meeting the criteria/threshold for registration must be registered.

## Do I have to open a case and episode if it is an assessment only case?

Yes. All face-to-face consultations or other presentations meeting the criteria/threshold for registration must have an episode and case opened. Otherwise information does not flow to the Operational Data Store, and will not be visible to other clinicians on second or subsequent presentations.

## Can I register the consumer on the second or subsequent contact following assessment?

No. A consumer who receives face-to-face mental health treatment, care or support must be registered at the time of the contact. Timelines are specified at the end of the registration PMC.

## Do I have to register an infant or child aged 0-11 years?

Yes. Consumers who receive a face-to-face contact will be required to be registered irrespective of age. This means that consumers of programs such as CASEA will now need to be registered.

## What is the approach to accompanying family members or carers?

Family members or carers who accompany a consumer who receives mental health treatment, care or support do not need to be registered if they are not receiving mental health treatment and care. For example, a mother and baby may be admitted to a parent-infant unit. If both mother and baby receive mental health treatment, both are to be registered. However, if only the mother receives mental health treatment, the baby is considered a boarder and is not registered.

## What is the approach with support groups for carers that are run by the AMHS?

If the participants meet the registration criteria they should be registered. Carers can carry a heavy burden and have legitimate health needs of their own.

## Do I have to register a consumer who presents to an ED and receives mental health treatment as they are already registered as part of the emergency department care?

Yes. If mental health services are provided to a consumer who presents to ED, they must be registered on CMI/ODS and a case and episode opened accordingly.

## Do I need to register the consumer within 24hrs?

Yes. To enable continuity of care, CMI/ODS client registration, case and episode data must be entered into CMI/ODS close to real time. At a minimum this data must be entered within the following timeframes, including afterhours and weekend presentations:

* within 24 hours of mental state assessment being completed for Emergency Mental Health presentations,
* within 24 hours of mental state assessment being completed for other ambulatory Mental Health services
* as close to real time as possible for residential and admitted services (must be within 24 hours).

A key reason for the timeline is that there have been occasions where a person has had multiple presentations to one or more ED but not been registered. Victorian coronial recommendations have supported mental health clinicians having access to information on previous mental health presentations, to improve safety.

## Does a consumer need to provide consent to be registered?

No. As with the provision of any health service, a person must be advised of their registration under the provisions of HPP 1.4 of the *Health Records Act 2001.* However, they do not need to provide consent to registration. Authority to register is expressly permitted under the provisions of s.347 (1) of the *Mental Health Act 2014*.

## How do we configure our ECATT subcentres on CMI/ODS to be able to record multiple same day presentations and with episode end times on the same date?

CMI/ODS subcentres for episodes that commence in Emergency Departments can be configured with an OM rating of “Generalist Not Applicable", and all outcome measures completed by these teams can be recorded against the “Additional measures” task.

## Our service previously reported Consultation Liaison and ECATT activity through Triage Minimum Dataset (TMDS), submissions, however from 01/07/2021 are now reporting this through CMI/ODS episodes, registrations and  outcome measures. Are we required to report these services through both?

No, from 01 July 2021, community mental health teams that provide in person assessment services should be reported through CMI/ODS, and should not report through TMDS.

## Our CL service and ECATT teams work across multiple hospital campuses. Is it acceptable if we create different subcentres for each hospital campus?

The department recommends that services create a separate subcentre for each hospital campus that your ECATT or Consultation Liaison service operates across, however this is not a mandatory requirement.

# What is Phase of Care?

Mental health phase of care is defined as the primary goal of treatment within the episode of care in terms of the recognised phases of mental health care. It is the prospective (or forward looking) description of the primary goal of care for a consumer at a point of time.

Mental health phase of care is intended to identify the primary goal of care by the treating professional(s) through engagement with the consumer. The mental health phase of care is independent of both the treatment setting and the designation of the treating service and does not reflect service unit type.

A new mental health phase of care may begin either when a consumer commences an episode of care or when the primary goal of care changes in an existing episode of care.

The mental health phase of care should therefore be considered as a subset of an episode of care, meaning that for each episode there can be multiple mental health phases of care.

## What are the possible phases of care?

There are five mental health phases of care:

Table1: Phases of care

| Phase | Primary goal |
| --- | --- |
| Assessment only | The primary goal is to obtain information including collateral information where possible, in order to determine the intervention/ treatment needs and to arrange for this to occur (includes brief history, risk assessment, referral to treating team or other service). |
| Acute | The primary goal is the short-term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a psychiatric disorder. |
| Functional gain | The primary goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a consumer with impairment arising from a psychiatric disorder. |
| Intensive extended | The primary goal is prevention or minimisation of further deterioration and reduction of risk of harm in a consumer who has a stable pattern of severe symptoms, frequent relapses or severe inability to function independently and is judged to require care over an indefinite period. |
| Consolidating gain | The primary goal is to maintain the level of functioning or improving functioning during a period of recovery, minimise deterioration or prevent relapse where the consumer has stabilised and functions relatively independently. Consolidating gain may also be known as maintenance. |

## What happens to Focus of Care?

From 1 July 2021, focus of care will no longer be collected by Victorian Area Mental Health Services. Other states and territories have already made the change from Focus of care to Phase of Care. For most adult and older adult services, this is a change of an existing data element and is not an additional collection requirement.

## Can lived experience team members assign phase of care measures?

Peer workers can do the online training to understand phase of care, however, it is not their role to complete the phase of care measure. The training can and should support peer workers to work with the case manager and the consumer in a collaborative process.

## Will Phase of Care be built into Client Management Interface/Operational Data Store collection occasions?

The process to add Phase of Care into outcome measure collection occasion workflows is underway. At present, it is in Client Management Interface as an additional measure and must be manually created and recorded.

## When is Phase of Care collected?

Phase of care is collected at first assessment, and each time the client’s phase of care changes. Please refer to the outcome measurement PMC for further information on which outcome measures are to be collected when. Please refer to the Phase of Care PMC for further information.

## Will validations still occur for the Focus of Care?

Yes, in the short term. The CMI/ODS application will still prompt FoC collection, however, the prompts are in the process of being removed. From 1 July 2021, Focus of Care will remain in the Client Management Interface/Operational Data Store but will no longer be required to be entered.

The department will remove it from CMI prompts. In the interim, collection occasions that require Focus of Care, like discharge from community, will be marked as "incomplete", which services will not need to remediate.

The department will work with the Mental Health Applications Team to ensure collection requirements associated with the Focus of Care element are removed from the system. CMI is difficult to change, so this may take some time.

## Are assessment only cases required to report outcome measures?

Assessment only cases are only required to report Phase of Care, and are not required to report the full suite of outcome measures.

## Will the department monitor compliance?

Yes. The department will support compliance by providing services with the relevant SQL scripts to monitor activity. Services should be able to see where, for example, Phase of Care and HoNOS are being reported and the proportion of consumers who are having these and other measures completed as expected. The department through the Performance and Accountability framework will also report compliance with outcome measures.

## If phase of care changes, do we have to do the other outcome measures?

Yes. If there has been a sustained and significant change in the consumer's presentation then the phase of care changes. This can occur within the same setting, such as when a consumer is being case managed in the community. For example, moving from an acute phase to functional gain phase you would expect to see changes in some HoNOS scales, perhaps lower scores on scales 1, 2 and 6. Alternatively, moving from intensive extended phase to acute phase you might expect increasing scores across the board.

## When will the CMI training databases be updated to reflect the changes?

Updating CMI and updating the 18 CMI training databases is complex. It was decided to focus on updating CMI as soon as possible to reflect the new PMC requirements, in particular to support Phase of Care as part of the auto-prompted outcome measures.

The eighteen CMI training databases will be updated subsequently to reflect current requirements. Ideally updating the training databases would have occurred sooner, however this has not been possible.

# What are outcome measures?

The National Outcomes and Casemix Collection (NOCC) is the national specification of a set of standardised measures of consumer symptoms and functioning, and a protocol for their collection at key points of care within public specialised clinical mental health services. The NOCC supports clinical care, dialogue and assessment of progress for individual consumers, carers and clinicians. The purpose of the NOCC is also to support service managers and leaders to implement reflective care, effective management and the identification and exploration of variations in clinical practice or outcomes.

## What ages can HoNOSCA be reported for in relation to young people?

Some services that may begin work with a young person when the consumer is aged under 18, and continue work with the young person after they turn 18, prefer to continue to use HoNOSCA and SDQ rather than switch to the adult suite of measures. The department is currently consulting with stakeholders including AMHOCN, departmental staff (Victorian Agency for Health Information, Health Services Data), and the Independent Hospital Pricing Authority to understand the reporting requirements/system restrictions. NOCC is by definition a national collection, and there are business rules that need to be adhered to.

However, the Royal Commission has recommended Youth Area Mental Health Services are available for young people aged 12 to 25 (until a person’s 26th birthday) with age boundaries and transitions to be applied flexibly by services in partnership with young people and their families, carers and supporters. A more definitive response will be provided when it is possible to do so.

Existing local AMHS practice for reporting HoNOS or HoNOSCA should continue until further direction is provided by the department.

## Once the protected industrial action is resolved, will I need to retrospectively apply outcome measurements? E.g. 91 day review?

No. Services are not expected to retrospectively determine and apply outcome measurement to cases where the 91 day review occurred during the protected industrial action period. Following cessation of the protected industrial action, services are required to ensure the relevant outcome collection occurs. Guidance will be provided by the mental health applications team on how to recommence recording of outcome measurements within CMI/ODS.

## Is there an alternative to BASIS-32?

No. Victoria chose to use BASIS-32 as the adult consumer-rated measure some years ago, and pays a fee for the instrument each year. BASIS is a required measure under the NOCC and supported by health ministers. In the future, Victoria may choose or develop a new consumer-rated measure but this will take some time.

## Are specialist services required to open episodes and report outcome measures?

All community MH teams that provide a face-to-face assessment service are in scope for CMI/ODS registration, episode creation, and outcome measurement reporting as outlined in the recently published PMCs. For specialist services that undertake a secondary consult, to determine if outcome measurements are required for a specific consumer, they must consider if the consumer is in an open case at their campus and engaged with another community MH treating team that is primarily treating the consumer and completing community MH outcome measures. In this case, the specialist service only needs to complete concurrent episode creation and confirm registration details are current, and play a supporting role in helping determine appropriate OM rating for the case management team. In all other situations, specialist services are required to complete full registration, episode creation, and outcome measurement reporting. When the specialist service is involved with a subcentre in the role of capacity building, no registration or episode creation is required.

## If a person has a brief ambulatory episode, do outcome measures need to be recorded at discharge from the service?

Under the NOCC protocol, there are limited exceptions in relation to discharge ratings not being required and one is due to episode brevity.

On discharge from ambulatory care, where the episode was brief (14 days or less in duration) discharge ratings for clinician and consumer-rated measures are not required. The 14 days means the number of days from admission to and discharge from the NOCC ambulatory episode. Mental health legal status and principal and additional diagnoses still need to be captured. Please note that if the person is transferred to an inpatient service then discharge OM are required.

## Once the industrial bans are lifted, how do services go about recommencing the reporting of outcome measures for consumers?

Within 30 days of industrial bans being lifted, mental health services must put processes in place to ensure that all consumers missing outcome measures due to the bans, have a discretionary review completed by the clinicians, and reported into CMI/ODS as a discretionary review. This will retrigger the outcome measurement cycle in CMI/ODS and enable services to realign with outcome measurement reporting requirements.

## If we have a community team that crosses multiple age groups, are we required to split the subcentres according to age groups to generate the appropriate Outcome measures?

If currently subcentres are not split across age groups, change is not mandatory at this time, while Royal Commission recommendations about age groups are still being worked through. Ideally yes, subcentres should be split across the CAMHS/Adult/Older Persons age groups to generate the appropriate outcome measures, and to attribute the activity against the appropriate performance measures within the Performance and Accountability Framework (PAF).

## Do AOD services under the governance of Mental Health Programs, such as dual diagnosis AOD residential services, need to report outcome measures to CMI/ODS if they report outcome measures within VADC submissions?

No, dual diagnosis residential services, and other AOD programs can continue to report the VADC suite of outcome measures, and are out of scope for CMI/ODS adult residential service outcome measures.

## Are older person’s residential services in scope?

Older Person’s Residential service placements remain out of scope of National Outcomes and Casemix Collection (NOCC) reporting, and are not required to report phase of care or other outcome measures. Current usual CMI/ODS data reporting should continue for these services. Appendix 2 of the outcome measure PMC confirms that residential services are out of scope.

# Scenarios relating to implementation

It is not possible to cover off every type of scenario that services may encounter. The following scenarios are provided as a guide only. Clinicians need to use the information provided in the PMCs and to use the training resources available. See for example www.amhocn.org

## Scenario 1: Consumer presents to the Emergency Department (not case-managed)

* Face-to-face mental health assessment occurs, but consumer assessed as appropriate for follow up in primary care
* Register client on CMI – Statewide unit record number (SW UR number) assigned/ current SW UR number updated
* Case and episode opened on CMI to Emergency Department Mental Health team
* Assessment Only PoC recorded
* No outcome measures required
* Client D/C home and referred to GP
* Case and episode closed on CMI (no outcome measures required as less than 14 days)

## Scenario 2: Consumer referred directly to a Community Care Team from another AMHS

* Register client on CMI – Statewide number assigned/ current SW UR number updated
* Open episode to CCT on CMI
* Decision to provide further service delivery
* New PoC selected e.g. Functional Gain, Acute, Intensive extended or Consolidating Gain PoC as appropriate
* Full suite of outcome measures required
* 91day review scheduled automatically

## Scenario 3: Case-managed consumer in the community

* Intake completed, PoC assigned as Intensive Extended and full suite of outcome measures completed
* Client is reviewed regularly and the PoC has remained the same for several 91 Day Reviews. Documented in CMI and medical record
* Clients symptoms and functioning improve the client is reviewed outside of the 91 day review cycle. A Discretionary Review is entered in CMI and a new PoC is assigned as Functional Gain in line with the new treatment plan
* 91 Day review has been pushed out

## Scenario 4: Consumer presents to the Emergency Department (currently case-managed)

* Face to face mental health assessment occurs
* Current SW UR number updated
* Concurrent episode opened on CMI to Emergency Department Mental Health team (displays service need)
* PoC recorded as determined by the ED clinician as follows:
  + PoC recorded if the PoC changes, in consultation with the treating team
  + Additional PoC not required if the phase has not changed from the last recorded by the treating team
* Client D/C home and referred back to CCT
* ED team episode closed on CMI,( no outcome measures required) CCT episode remains open

## Scenario 5: Case-managed consumer commences a secondary consultation service from a specialist team

* Client has a current episode opened to CCT
* Concurrent episode opened on CMI to the specialist team, e.g. FAPMI, Family Violence, SUMMIT (displays consumer and service need)
* PoC recorded as determined by case managing clinician
* Specialist episode closed on CMI, (no outcome measures required) CCT episode remains open

## Scenario 6: Consumer is case-managed in the community, with services provided by multiple mental health teams

* Open concurrent community episodes in CMI
* The PoC should be agreed upon by the various treatment providers
* PoC and outcome measures to be recorded by primary team

# Glossary

**Case**- From July 1 2021, a case will be defined as a period of clinical care that commences from the point of assessment within a mental health service, and may progress to include a period of ongoing care within a framework of multidisciplinary care in community, outpatient/ambulatory, inpatient and/or residential mental health service settings.

**Secondary consultation**- a discussion, usually via phone, between a specialist team clinician and a mental health service clinician about a specific client. The client is not present during the consultation. The aim of the discussion is to clarify relevant issues and provide advice from the specialist team about the client’s ongoing management or treatment options. Questions about clinical formulation or crisis management may also be addressed. At times a secondary consultation may lead to a primary consultation, when appropriate.

**Specialist team**- A range of specialist mental health services provide highly specialised treatment and care to Victorians with severe and complex illnesses. These services include but are not limited to perinatal mental health services, personality disorder services (Spectrum), eating disorder services and a dual disability service (for people with both mental illness and an intellectual disability or Autism Spectrum Disorder).

# Note re new or amended questions

The following questions have had amendments or clarifications made: 13 (funding support); 42 (subcentres); scenario 4 (case-managed consumer presents to ED)

The following questions have been added since the first edition of the FAQs on 25 May 2021: 7 (triage data set); 23 (ECATT subcentres); 24 (C-L and ECATT activity); 25 (C-L and ECATT); 34 (phase of care); 35 (CMI/ODS training databases); 39 (specialist services); 40 (brief ambulatory episodes and outcome measures); 41 (recommending measures); 42 (age groups and subcentres); 43 (AOD services and outcome measures); 44 (older person’s residential services); Glossary (definition of secondary consultation).

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