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| Outcome measurement in clinical mental health services |
| Program management circular 2021  26 March 2021 |
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# Key message

The Department of Health (the department) requires all clinical mental health services to collect outcome measures using the protocol outlined in this circular.

Services are responsible for ensuring the integrity, quality and timeliness of outcome measurement (OM) data.

It is expected that OM ratings and data will be used at an individual level in dialogue with consumers and carers to inform clinical decisions and at service level for quality improvement.

Routinely offering and encouraging consumers to complete self-assessment measures is an integral part of the OM process.

# Purpose

The measurement of consumer outcomes in public mental health services is a key mental health priority for both State and Commonwealth Governments. Reporting of outcomes data to the Commonwealth is a requirement of the National Healthcare Agreement.

The department is committed to improving the quality, clinical utility and accessibility of information on consumer outcomes for consumers, carers, clinicians and health services. This is being completed through a range of initiatives as part of an activity-based funding model for clinical mental health services.

Enhanced reporting needs to be underpinned by data that is as consistent as possible in its compilation. This circular has been developed in collaboration with sector representatives and provides guidance to the sector on departmental requirements for OM and the Commonwealth’s direction to transition to Activity Based Funding (ABF) to link consumer outcomes with funding.

# Guiding principles

1. The clinical mental health sector is divided into three types of service setting:
   1. **Acute Inpatient** (admitted overnight)
   2. **Community Residential** (staffed 24 hours)
   3. **Ambulatory (community** treatment teams)

\*NB: A consumer can move between **Ambulatory** teams within a service without triggering a change of setting. *Appendix 1 outlines Victorian service types and the applicable setting for each one.*

1. There are three fundamental business rules:
   1. One episode at a time
   2. A change of setting = a new episode
   3. A change of Phase of Care = a new outcome measure collection occasion
2. Outcome Measurement collection occasions:
   1. ‘intake’
   2. ‘discharge’ (Phase of Care not required)
   3. ‘91-day review’
   4. ‘discretionary review’
3. Different measures are collected for different age groups (CAMHS, Adult, Aged). Appendix 2 outlines which measures are required per collection occasion for each age group.

# Protocol application in Victoria

The key general protocol principles and service-specific protocol requirements are outlined here. More information can be found in *Technical specification of state and territory reporting requirements for the outcomes and casemix components of ‘Agreed data’* Version 2.02.

## 1. Compliance with NOCC protocol

1.1 DHHS requires all clinical mental health services in Victoria to comply with the National OM protocol.

1. Compliance requires the completion of all measures specified for each service setting and reason for collection (refer to Appendix 2).
2. It involves the completion of relevant clinician-rated measures as well as the offering of the relevant consumer self-assessment measure and the carer version of the consumer self-assessment measure in child and adolescent or youth services.
3. Clinicians are required to offer the self-assessment measure (BASIS-32® or SDQ for children and young people) at ‘admission/intake’, ‘review’ and ‘discharge’ in **Ambulatory** and **Community Residential** settings, unless contra-indicated.
4. It is essential that accurate ratings are entered onto the Client Management Interface (CMI) in a timely manner (refer to Appendix 3).

## 2. Outcome measurement Reviews – ’91-day review’ and ‘discretionary review’

2.1 The department requires all consumers who remain continuously in an Inpatient, Ambulatory and Community Residential setting in public clinical mental health services, to have OM reviews completed at least every 91 days. The ‘91-day review’ requirement is consistent with the *National Standards for Mental Health Services 2010*, which require consumers of public clinical mental health services to have a comprehensive clinical review by a multi-disciplinary team at least every three months. This requirement is not intended to restrict more frequent OM reviews.

2.2 A ‘discretionary review’ allows for review ratings before 91 days have elapsed, for example, when clinical factors indicate that a review is necessary, and a consumer enters a new Phase of Care.

2.3 Both ‘91-day’ and ‘discretionary’ OM reviews require the full suite of measures for a review collection occasion for the relevant age group (refer to Appendix 2).

## 3. Consumer movement between setting

3.1 As a general rule, the setting dictates the choice of measures (CAMHS, Adult or Aged). Outcome measures are collected in *matched pairs*, so when:

1. An exiting CAMHS consumer is referred to an Adult service, both ‘discharge’ CAMHS measures and ‘intake/admission’ Adult measures need to be completed;
2. An exiting Adult consumer is referred to an Aged service, both ‘discharge’ Adult measures and ‘intake/admission’ Aged measures need to be completed.

Youth Services are an exception to this rule – refer: ‘Service-specific protocol requirements’ item 5.

3.2 When an existing **Ambulatory** consumer transfers between **Ambulatory** teams in the same health service, OM is not required because there is no change in setting except if a consumer’s Phase of Care changes. However, if services wish to track ratings at transfer points, the relevant suite of measures can be completed as a ‘discretionary review.’

3.3 The table below outlines OM requirements relevant for particular setting changes (refer to Appendix 2 for further details):

| Requirements if: | OM required: |
| --- | --- |
| **Ambulatory** consumer is admitted to an **Acute Inpatient** unit | **Ambulatory** ‘discharge’ OM and **Inpatient** ‘admission’ OM |
| **Ambulatory** consumer is admitted to a **Community Residential** unit | **Ambulatory** ‘discharge’ OM **and Community Residential** ‘admission’ OM |
| Consumer is discharged from an **Inpatient** unit to return to an **Ambulatory** team | **Inpatient** ‘discharge’ OM and **Ambulatory** ‘intake’ OM |
| Consumer is discharged from **Inpatient** unit and admitted to a **Community Residential** unit | **Inpatient** ‘discharge’ OM and **Community Residential** ‘admission’ OM |
| Consumer is discharged from a **Community Residential** unit and admitted to an **Inpatient** unit | **Community Residential** ‘discharge’ OM and **Inpatient** ‘admission’ OM |
| Consumer is discharged from **Community Residential** unit and returns to an **Ambulatory** team | **Community Residential** ‘discharge’ OM and **Ambulatory** ‘intake’ OM |
| Consumer is discharged from a service (and has no further service setting involvement) | **Inpatient, Community Residential** or **Ambulatory** ‘discharge’ OM (from either, as appropriate) |
| PMHEI or youth services **Ambulatory** consumer turns 18 during their period of care | At next review: CAMHS **Ambulatory** ‘discharge’ OM and Adult **Ambulatory** ‘intake’ OM |
| PMHEI **Ambulatory** consumer turns 65 during their period of care | At next review: Adult **Ambulatory** ‘discharge’ OM and Aged **Ambulatory** ‘intake’ OM |
| Existing **Ambulatory** consumer ceases case management and is referred to Clozapine co-ordinator | **Ambulatory** ‘discharge’ OM |
| Consumer enters a new Phase of Care during an episode | **Inpatient, Community Residential** or **Ambulatory** ‘discretionary review’ OM |

* 1. The department does not support the practice of deeming and will not support CMI changes to facilitate this. Deeming refers to the practice of entering the same rating twice for contiguous episodes, for example the discharge Health of the Nation Outcomes Scales (HoNOS) from an **Inpatient** unit cannot also be entered as the ‘intake’ HoNOS to an **Ambulatory** setting.

## 4. Recording Phase of Care (PoC)

4.1 The PoC is defined as the prospective primary goal of treatment within the episode of care in terms of the recognised phases of mental health care. Whilst it is recognised that there may be aspects of each mental health PoC represented in the consumer’s mental health plan, the PoC is intended to identify the main goal or aim that will underpin the next period of care. The mental health PoC is independent of both the treatment setting and the designation of the treating service and does not reflect service unit type.

4.2 PoC is to be collected and recorded by all clinical mental health teams in conjunction with the associated age required outcome measures **(not required for “Assessment only”)** on admission/registration, at every 91-day review, where there has been a transfer of care between service settings or when there is a significant or substantial change to the consumer’s symptoms and/or psychosocial functioning that requires a change to the mental health care plan (discretionary review).

(Refer to Appendix 4 *Mental Health Phase of Care program management circular* for details.)

## 5. Assessment-only teams

5.1 OM is not required for *assessment-only Phase of Care* situations. *Assessment-only* involves one or a number of assessments or follow up activities (including brief interventions) but excludes the commencement of treatment (refer to Appendix 1).

1. Teams are not required to complete OM if they are seeing a consumer in an assessment-only Phase of Care.
2. If these teams/functions are providing treatment to a consumer in a Phase of Care outside of an assessment only, then full OM measures are required.

(Refer to Appendix 4 *Mental Health Phase of Care program management circular* for details.)

## 6. Local business rules

The National and Victorian protocols indicate which measures are required and when they are required. Local services need to determine who is responsible for completing OM at specific service junctures, particularly where there are multiple teams involved within the same setting. Services also need to determine and communicate local business rules detailing who is responsible for data entry (refer to Appendix 3).

# Service-specific protocol requirements

## 1. Crisis Assessment and Treatment Team (CATT)

CATT must collect OM using the **Ambulatory** protocol.

## 2. Hospital in the Home (HITH)

HITH must collect OM using the **Inpatient** protocol.

## 3. Secure Extended Care Units (SECU)

Secure Extended Care should follow the **Community Residential** protocol. Services at Forensicare are assigned as either subacute or acute units, so acute units should follow the **Inpatient** protocol and subacute units should follow the **Community Residential** protocol.

## 4. Hospital Outreach Post-suicidal Engagement (HOPE) Program

Where there is a decision to treat an individual consumer, HOPE programs are to follow the Ambulatory protocol using the CAMHS suite of measures for consumers aged 15–18 years, the Adult suite of measures for consumers aged 18–65 years and the Aged suite of measures for consumers aged 65+ years. This includes the self-assessment measures, Strengths and Difficulties Questionnaire (SDQ) for child and adolescent consumers and the BASIS-32 for adult and aged consumers. The K-10 is not supported in Victoria.

OM is collected in matched pairs – this means that if a consumer turns:

* 18 during a period of care, both the ‘discharge’ ratings for the child and adolescent measures and the ‘intake’ ratings for the adult measures need to be completed at the next OM collection occasion
* 65 during a period of care, both the ‘discharge’ ratings for the adult measures and the ‘intake’ ratings for the aged measures need to be completed at the next OM collection occasion. (Refer to Table 3.3 on page 4)

## 5. Prevention and Recovery Care (PARC)

PARC services should follow the **Inpatient** protocol.

## 6. Youth services/Youth Early Psychosis (YEP)

Generally, the choice of measures follows the service setting except for youth services. Youth services should utilise the CAMHS suite of measures for consumers aged 15–18 years, and the Adult suite of measures for consumers aged 18+ years.

OM is collected in *matched pairs* – this means that if a consumer turns 18 during a period of care, both the ‘discharge’ ratings for the child and adolescent measures and the ‘intake’ ratings for the adult measures need to be completed at the next OM collection occasion. (Refer to Table 3.3 on page 4)

## 7. Clozapine-only consumers

Consumers of Clozapine program who are not receiving case management are “out of scope” for OM. To ensure that Clozapine-only consumers are excluded from protocol requirements and subsequent OM compliance reports they must be allocated to the local Clozapine subcentre.

If an existing **Ambulatory** consumer (CATT, Mobile Support Team, Continuing Care Team, Integrated Community Team) is transferred to the Clozapine co-ordinator with no further **Ambulatory** case management, ‘discharge’ **Ambulatory** OM would be required. However, if a consumer in an open case continues to receive case management follow-up in addition to contact with the Clozapine co-ordinator then the relevant **Ambulatory** team responsible for managing the consumer will continue as per protocol. “Who” completes the relevant outcome measurements is determined by local business rules. As a result of the 2007 CMI release, services can utilise the Screening Registration rather than episode creation for Clozapine only clients.

## 8. Emerging service types/programs

As the mental health sector responds to emerging needs with new program approaches, additional program

types will develop. The Department of Health and Human Services will provide clarification and direction on the application of outcome measures for emerging program types in public clinical mental health services.

## 9. Mental Health Community Support Services (MHCSS)

Generally, MHCSS are out of scope. Where clinical in-reach is provided in MHCSS by area mental health services, clinical service staff will be responsible for completing the required OM (refer to Appendix 1).

# Use of Outcome Measurement (OM) data

## Clinical application of individual OM data

Each suite of measures can be used to facilitate and inform the dialogue between clinicians, consumers and carers, and to assist decision making on treatment and care. Regular outcomes assessment in public sector clinical mental health services will augment clinical practice and provide valuable information for quality assurance activities. At each collection occasion it is important to review all relevant measures together, including mental health act status, diagnosis and clinical interventions provided, in addition to other relevant information about a consumer. Data entered onto CMI can be used to generate individual consumer reports. These reports represent change over time and can be helpful in reviewing outcomes with consumers and carers as well as with peers (for example, clinical review).

## Application of aggregate (team/service level) OM data

The ultimate aim of collecting OM is to apply the information to improve and enhance mental health services for consumers. Aggregated OM data provides invaluable information for managers to consider when making decisions about service profiling or reviewing service or program effectiveness. The data collected can be used to better identify and understand differences between groups of consumers. OM data can also be used to review the relative effectiveness of different services, service components or models.

The department will generate a range of reports, with each mental health service receiving reports for the three service settings (**Inpatient, Ambulatory** and **Community Residential**) and for each age grouping (CAMHS, Adult, Aged).

# Clinician responsibilities

## OM rating

The collection of OM is fundamentally a clinical activity that supports clinical decision making, and enhances the planning, implementation and review of care plans.

### Ensuring the reliability of data collected

All clinicians completing OM, or offering self-assessment measures to consumers, require training in both rating the individual measures and offering the relevant self-assessment measure. When rating the measures, clinicians should refer to the relevant glossary or rating rules for each measure bearing in mind that:

* Outcome measures have different prescribed rating periods for particular settings (refer Appendix 3, Table 3).
* In teams where a number of staff members are familiar with an individual consumer, a comparison of different clinicians’ ratings for that consumer can be a useful refresher activity. Similarly, discussion of ratings in the course of clinical reviews and between teams can also assist with rating consistency (inter-rater reliability).

### Data entry

Clinicians must comply with their local business rules for the accurate and timely entry of OM data.

# Consumer self-assessment

Consumer self-assessment is an integral component of the OM process in mental health. Offering a self- assessment measure can be useful for engagement as well as collaboration between consumers, carers and clinicians. Also, discussion of self-assessment ratings with consumers (and where appropriate with carers) can enrich treatment and care planning. Self-assessment provides the opportunity for consumers, carers and clinicians to track progress through comparison of ratings over time. The incremental nature of progress can sometimes be difficult to monitor without measurement tools.

As a general rule, the consumer self-assessment measure should always be offered according to the protocol unless contra-indications are present. The offering of the consumer self-assessment measure must be recorded on the CMI (refer Appendix 3). **Completion by the consumer is always voluntary.** Clinicians need to consider how they will explain OM concepts to consumers and carers, as well as how they will provide specific feedback.

There are a number of training materials available to assist clinicians with this process. Clinicians need to be familiar with the consumer self-rated measures. When offering the consumer self-assessment, it is important to explain why it is being offered and how the information will be used.

The department has commissioned translations of BASIS-32 or SDQ for children and young people into a number of community languages. Clinicians should also consider using interpreters to assist culturally and linguistically diverse consumers to complete the BASIS 32 and SDQ.

Consumers and their families should be provided with verbal and written information on OM to enable them to make an informed decision on whether to participate. Information brochures are available from <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality/measuring-outcomes-in-mental-health>. These have also been translated into many community languages.

# Privacy and confidentiality

OM is governed by the same legislation and considerations as other clinical activities; including privacy and confidentiality of medical records and personal information and freedom of information.

# About program management circulars

The information provided in this circular is intended as general information and not as legal advice. Mental health service management should ensure that policies and procedures are developed and implemented to enable staff to collect and use health information in accordance with relevant legislation.

# References and Resources

Independent Hospital Pricing Authority. (2016). *Australian Mental Health Care Classification. Mental health phase of care guide*. Retrieved from https://www.ihpa.gov.au/publications/mental-health-phase-care-guide

# Appendix 1

Compliance encompasses application of all measures required within the national protocol for that age group, service setting and the reason for collection, including the completion of relevant clinician-rated measures and offering of relevant consumer self-assessment measure (and carer measure in child and adolescent services).

Table 1: “In Scope” Victorian teams/programs and corresponding national age grouping and setting

|  |  |  |
| --- | --- | --- |
| **National age group** | **Victorian team/program** | **National setting** |
| Child and adolescent (0-18 years) | - Acute Mental Health Inpatient Units  - State-wide services | **Inpatient** |
| - Community teams (case management)  - Day programs  **Youth (15–18 years)**  - Primary Mental Health and Early Intervention Services\*  - Youth Access Team (YAT)  - Early Psychosis Prevention and Intervention Centre (EPPIC)  outpatient case management  - Youthscope  - Youth Early Psychosis (YEP)  - Intensive Mobile Youth Outreach Service (IMYOS) | **Ambulatory** |
| Adult (18-65 years) | - Acute Inpatient units (including PICU)  - Forensicare acute beds  - Statewide services (including parent/infant unit)  - Eating Disorders units  - Veteran psychiatry unit  - Prevention and Recovery Centres (PARC) | **Inpatient** |
| **Youth (18–25 years)**  - Primary Mental Health and Early Intervention Services\*  - Youth Access Team (YAT)  - Early Psychosis Prevention and Intervention Centre (EPPIC)  outpatient case management  - Youthscope  - Youth Early Psychosis (YEP)  - Intensive Mobile Youth Outreach Service (IMYOS)  **Adult**  - Primary Mental Health and Early Intervention Services\*  - Integrated Community Teams  - Crisis Assessment and Treatment Teams (CATT)  - Continuing Care Teams (CCT)  - Mobile Support and Treatment services (MST)  - Eating disorders outpatient services  - Day programs  - Veteran psychiatry | **Ambulatory** |
| - Community Care Units/Community Residential Care Units | **Community Residential** |
| - Secure Extended Units (including AMHRU, Forensicare subacute beds) | **Community Residential** |
| Aged (65+ years) | - Acute Inpatient units (including Forensicare acute beds) | **Inpatient** |
| - Primary Mental Health and Early Intervention Services\*  - Aged Persons Assessment and Treatment Teams (APATT)  - Behavioural disturbance assessment and treatment services  - Hospital substitution teams | **Ambulatory** |

Note: \*Only consumers with an open case who are receiving treatment are “in scope”, **not** *assessment-only* consumers.

Victorian public clinical mental health services that are **“out of scope”:**

* Secondary consults provided to a consumer currently receiving treatment from an area mental health service (out of area as well as in the same service). OM would be completed by the consumers’ primary treatment service.
* Community residential for child and adolescent services and aged services
* Generally, MHCSS sector are out of scope except where clinical in-reach is provided by area mental health services. In these instances, clinical staff will complete the required OM.
* Consumers of Clozapine program who are not receiving case management are “out of scope” for OM.
* To ensure that Clozapine-only consumers are excluded from protocol requirements and subsequent OM compliance reports they must be allocated to the local Clozapine subcentre.

# Appendix 2

Table 2: Overview of data collection occasions for each measure (NOCC protocol)

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Age Group** | **Mental health service setting** | | **Inpatient** | | | **Residential** | | | **Ambulatory** | | | |
| **CMI/ODS AUTOGENERATED TASK** | | ADMINP | ISPREV | DISINP | ADMRES | ISPREV | DISRES | AXCOM | INTCOM | ISPREV | DISCOM |
| **Measure** | **Purpose** |  | | | | | | | | | |
| **Children and adolescents** | **CAMHS CMI/ODS Subcentre OM Setting** | | 9 CAMHS Inpatient | | | Not applicable in Victoria | | | 8 CAMHS Community | | | |
| HoNosca | Symptoms |  |  |  |  | | |  |  |  |  |
| Phase of Care | Contextual info |  |  | - | **** |  |  | - |
| CGAS | Functioning |  |  | - |  |  |  | - |
| FIHS | Contextual info | - |  |  |  | - |  |  |
| SDQ | Consumer self-rating |  | - |  |  |  |  |  |
| Principal & add. diagnoses | Contextual info | - |  |  | **** | - |  |  |
| MH legal status | Contextual info | - |  |  | **** | - |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Adults** | **Adult CMI/ODS Subcentre OM Setting** | | 2 Adult Inpatient | | | 4 Adult Residential | | | 1 Adult Community | | | |
| HoNOS | Symptoms |  |  |  |  |  |  |  |  |  |  |
| LSP-16 | Functioning | - | - | - |  |  |  |  |  |  |  |
| BASIS-32 | Consumer self-rating | - | - | - |  |  |  |  |  |  |  |
| Phase of Care | Contextual info |  |  | - |  |  | - | **** |  |  | - |
| Principal & add. diagnoses | Contextual info | - |  |  | - |  |  | **** | - |  |  |
| MH legal status | Contextual info | - |  |  | - |  |  | **** | - |  |  |
| **Aged** | **AGED CMI/ODS Subcentre OM Setting** | | 6 Aged Inpatient | | | Not applicable in Victoria | | | 5 Aged Community | | | |
| HoNOS 65+ | Symptoms |  |  |  |  | | |  |  |  |  |
| LSP-16 | Functioning | - | - | - |  | - |  |  |
| RUG-ADL | Dependency |  |  | - |  | - | - | - |
| BASIS-32 | Consumer self-rating | - | - | - |  |  |  |  |
| Phase of Care | Contextual info |  |  |  | **** |  |  | - |
| Principal & add. diagnoses | Contextual info | - |  |  | **** | - |  |  |
| MH legal status | Contextual info | - |  |  | **** | - |  |  |

|  |  |
| --- | --- |
| **Legend** | **ADM** = Includes ‘admission’ for **Inpatient** **(INP)** and **Community Residential** **(RES)**  **INT** = ‘Intake’ for **Ambulatory (COM)**  **AX** = Assessment Community for **Ambulatory (COM)** |
| **ISP** = Individual Service Plan Review includes ’91-day review’ and ‘discretionary review’ |
| **DIS** = ‘discharge’ refers to a change of setting as defined under the national OM collection protocol, specifically ‘discharge’ from an **Inpatient (INP)** or **Community Residential (RES)** unit or from an **Ambulatory** **(COM)** setting (consumer either exits ambulatory service or changes setting e.g. admitted to an *Inpatient* or *Community Residential* unit) |
|  = Collection of data on this occasion is mandatory (to be interpreted as ‘to be offered’ unless contra-indicated in the case of consumer self-rating) |
| - = No collection requirements apply |

# 

# Appendix 3

Table 3: Overview of measures and rating periods

(Rating periods by measure at each required collection occasion)

**Items in orange are self-rating measures**

**Items in green are not outcome measures as such but are important for the interpretation of outcome data.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Age group** | **Name of measure** | **Description of measure** | **Rating period** | |
| **Usual rating period** | **Exceptions** |
| **Child and**  **adolescent**  **mental**  **health services** | **Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)** | Child and adolescent equivalent to the HoNOS. Contains 15 items. | Previous 2 weeks | Previous 72 hours on ‘discharge’ from **Inpatient** psychiatric care |
| **Children’s Global Assessment Scale (CGAS)** | A single global measure of level of functioning, rated 0–100 in order of improved functioning. | Previous 2 weeks | No exceptions |
| **Factors Influencing Health Status (FIHS)** | Checklist of ‘psychosocial complications’ based on ICD–10 Factors Influencing Health Status. | Preceding period\* | No exceptions |
| **Strengths and Difficulties Questionnaire (SDQ)** | A parent and adolescent-completed brief behavioural questionnaire administered on admission and follow up to health services for 4–17-year-olds. It includes 25 items on psychological attributes for five scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. It also includes items on the impact of these attributes. | At ‘admission/intake’ to a service, the previous six  months  At ‘review’ and  ‘discharge’, the previous one month | No exceptions |
| **Adult mental health service** | **Health of the Nation Outcome Scales (HoNOS)** | An instrument developed in the UK for use by clinicians in routine clinical work to measure consumer outcomes. Contains 12 items across four outcome domains: behaviour, impairment, symptoms and social. | Previous 2 weeks | Previous 72 hours on ‘discharge’ from **Inpatient** psychiatric care |
| **Life Skills Profile (LSP-16)** | A clinician-completed rating scale designed to assess abilities with respect to basic life skills over the preceding three months. | Previous 3 months | No exceptions |
| **The Behaviour and Symptom Identification Scale (BASIS-32)** | Thirty-two questions that assess the extent to which consumers are experiencing difficulties in relation to managing day-to-day life; relating to other people; self-esteem; motivation; clinical symptoms; drug and alcohol use; and level of satisfaction with life. | Previous 2 weeks | No exceptions |
| **Aged**  **persons**  **mental**  **health services** | **Health of the Nation Outcome Scales for Older People (HoNOS 65+)** | A modified version of the HoNOS for people 65+. | Previous 2 weeks | Previous 72 hours on ‘discharge’ from **Inpatient** psychiatric care |
| **Life Skills Profile (LSP-16)** | A clinician-completed rating scale designed to assess abilities with respect to basic life skills over the preceding three months. | Previous 3 months | No exceptions |
| **Resource Utilisation Groups. Activities of Daily Living (RUG–ADL)** | An instrument for measuring nursing dependency in skilled nursing facilities.  Measures the consumer’s need for assistance in activities of daily living (bed mobility, toileting, transfer and eating). | Current status | No exceptions |
| **The Behaviour and Symptom Identification Scale (BASIS-32)** | Thirty-two questions that assess the extent to which consumers are experiencing difficulties in relation to managing day-to-day life; relating to other people; self-esteem; motivation; clinical symptoms; drug and alcohol use; and level of satisfaction with life. | Previous two weeks | No exceptions |
| **All Age Groups** | **Principal and additional diagnoses** | The principal diagnosis’ is the diagnosis established after study to be chiefly responsible for occasioning the patient or client’s care in the period of care preceding the *Collection O*ccasion. Additional diagnoses identify main secondary diagnoses that affect the person’s care during the period in terms of requiring therapeutic intervention, clinical evaluation, extended management or increased care or monitoring. Up to two additional diagnoses may be recorded. | Previous two weeks | No exceptions |
| **Phase of Care (POC)** | The PoC is defined as the prospective primary goal of treatment within the episode of care in terms of the recognised phases of mental health care. Whilst it is recognised that there may be aspects of each mental health phase of care represented in the consumer’s mental health plan, the PoC is intended to identify the main goal or aim that will underpin the next period of care. 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. | Current status | No exceptions |
| **Mental health legal status** | This item is used to indicate where the person was treated on an involuntary basis under the relevant State or Territory mental health legislation, at some point during the period preceding the *Collection* Occasion*.* | Preceding period\* | No exceptions |

Source: 2003, Victorian Outcome Measurement Training Manual, 2nd edition, page 18-19 (modified version)

\*In accordance with the NOCC protocol, the ‘preceding period’ refers to ‘the period of care bound by the current Collection Occasion and the preceding Collection Occasion.’ (NOCC *Technical Specifications*, Version 2.02, page 46).

# Appendix 4

## Key message

* Victoria is moving to collect and record phase of care as a required data component for Commonwealth funding of mental health services. The concept of Phase of Care provides information, in addition to outcome measures, that describes the complexity of the consumer’s presentation and the primary goal of care.
* Services must cease collecting and recording Mental Health Focus of Care.
* Services must commence collecting and recording Mental Health Phase of Care (PoC) items-*Acute, Functional gain, Intensive extended, Consolidating gain and Assessment only,* for ALL age groups across clinical public mental health settings as per the Mental Health National Outcomes and Casemix Collection Version 2.02 (NOCC 2.02).
* PoC is to be collected and recorded by all clinical mental health programs in conjunction with current outcome measures on admission/registration, at every 91-day review, where there has been a transfer of care between service settings or when there is a significant or substantial change to the consumer’s symptoms and/or psychosocial functioning that requires a change to the mental health care plan (discretionary review).
* Any change in a consumer’s PoC should also be clearly documented in the consumer’s medical record.
* A PoC can last up to 91 days and must be reviewed at this time. A consumer can continue in the same PoC **(except Assessment Only)** but this must be entered into the CMI/ODS.
* *Assessment Only* PoC can be used when a consumer presents seeking assessment or has been referred from another agency.
* *Assessment Only* PoC can be used if on first contact with a service where a mental health assessment is conducted to determine if any further intervention is needed, and the clinician is unable to determine, based on information available an alternative PoC.
* *Assessment Only* PoC **does not require outcome measures to be completed**, however all other mental health phases of care require the completion of outcome measures.
* When an *Assessment Only* PoC is recorded in a setting, then Assessment Only phase cannot be recorded again within the same episode of care.
* *Assessment Only* PoC is not intended to capture regular review as part of a standard clinical workflow routine.

## Purpose

To provide advice to the sector to commence recording Phase of Care (prospective measure) and identify the relevant business rules to support the collection of Phase of Care in CMI/ODS for persons receiving treatment in public mental health services. Clinicians will cease recording Mental Health Focus of Care (retrospective measure) as part of this process. The introduction of Phase of Care will support the shift towards activity-based funding for Victorian mental health services.

Enhanced reporting needs to be underpinned by data that is as consistent as possible in its compilation. This circular has been developed in collaboration with sector representatives and provides guidance to the sector on departmental requirements for Phase of Care and the Commonwealth’s direction to transition to Activity Based Funding (ABF) to link complexity of consumer presentation and primary goal of care with funding.

## Background

CMI/ODS is the Victorian public mental health client information management system and comprises:

* Client Management Interface (CMI). The CMI is the local consumer information system used by each public mental health service
* Operational Data Store (ODS). The ODS manages a set of select data items from each CMI and is used to:
  + allocate a unique (mental health) registration number for each consumer, known as the state-wide unit record (UR) number
  + share select client-level data between Victorian public area mental health services (AMHS) to support continuity of treatment and care
  + ensure the legal basis for providing treatment is evident to all public mental health service providers where a client may be unable or unwilling to consent to treatment
  + meet the various reporting requirements of the Department of Health and Human Services
  + support the statutory functions of the Chief Psychiatrist and the Mental Health Tribunal.

Victorian Area Mental Health services have followed the Mental Health National Outcomes and Case mix Collection (NOCC) 1.9 using Focus of Care (FoC). FoC is a data item developed in the Australian Mental Health Classification and Service Costs (MH-CASC) study that requires the clinician to make a judgement about each consumer’s primary goal of care over the preceding period (i.e. retrospectively).

The current revision (Version 2.02) has resulted from identification of the need to have closer alignment between the NOCC and the Australian Mental Health Care Classification, which was developed by the Independent Hospital Pricing Authority (IHPA) and is based upon the collection of the Mental Health Phase of Care (PoC).

The PoC concept was developed in 2012, through a project commissioned by the IHPA. This project identified possible cost drivers for further examination and considered options for a classification architecture. It is an attempt to bring together two related concepts of the “consumer’s needs” and “goal of care”. Each phase of care involves the provision of resources aimed at meeting individual consumer need. The mental health phase of care is a simple tool designed to qualify a complex concept. Consumers may move between any of the phases of care in any order. Identification of the mental health phase of care is aligned to the contemporary recovery-orientated mental health practice where the goals of care are collaboratively generated and are responsive to the needs of the consumer at the time.[[1]](#footnote-1)

## Recording Phase of Care

The PoC is defined as the prospective primary goal of treatment within the episode of care in terms of the recognised phases of mental health care. Whilst it is recognised that there may be aspects of each mental health phase of care represented in the consumer’s mental health plan, the PoC is intended to identify the main goal or aim that will underpin the next period of care. 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.

PoC is to be collected and recorded by all clinical mental health teams in conjunction with the associated age required outcome measures **(not required for “Assessment only”)** on admission/registration, at every 91-day review, where there has been a transfer of care between service settings or when there is a significant or substantial change to the consumer’s symptoms and/or psychosocial functioning that requires a change to the mental health care plan (discretionary review).

Please refer *to Guiding principles for use in practice for details*.

### Domains

Moving forward, all clinicians in bed based, community residential and ambulatory will commence recording PoC.

| FoC (Cease) | PoC (Commence) |
| --- | --- |
| 1 – Acute  2 – Functional gain  3 – Intensive extended  4 - Maintenance | 1 – Acute  2 – Functional gain  3 – Intensive extended  4 – Consolidating gain  5 – Assessment only |

### Definitions

| FoC Permissible value definitions (Cease) | PoC Permissible value definitions (Commence) |
| --- | --- |
| **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 | **Acute** The primary goal of care 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 patient with impairment arising from a psychiatric disorder. | **Functional gain** The primary goal of care is to improve personal, social or occupational functioning or promote psychosocial adaptation in a patient 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 patient 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 | **Intensive extended** The primary goal of care is prevention or minimisation of further deterioration, and reduction of risk of harm in a patient 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. |
| **Maintenance** The primary goal is to maintain the level of functioning, minimise deterioration or prevent relapse where the patient has stabilised and functions relatively independently. | **Consolidating gain** The primary goal of care is to maintain the level of functioning, or improving functioning during a period of recovery, minimise deterioration or prevent relapse where the patient has stabilised and functions relatively independently. Consolidating gain may also be known as maintenance. |
|  | **Assessment only** The primary goal of care 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). |

## Guiding principles for use in practice[[2]](#footnote-2)

1. The rating of the mental health Phase of Care should be undertaken by the clinician with the best understanding of the consumer’s presentation and need for intervention. This would typically be the case manager or primary/key clinician.
2. The mental health Phase of Care should be assessed on:
   1. admission/registration to a service
   2. where there has been a transfer of care between service settings or
   3. when there has been a change to the mental health care plan as outlined in 3.
3. When there is a significant or substantial change to the consumer’s symptoms and/or psychosocial functioning that requires a change to the mental health care plan, a review of the mental health Phase of Care should occur.
4. Mental health services should conduct regular reviews of the consumer’s treatment, care and recovery plan, as per clinical standards. This includes change of mental health legal status, transfer between service sites and deterioration in symptoms/ functioning.
5. The mental health Phase of Care does not need to be assessed and identified at every contact made with the consumer by a care provider.
6. If a change in mental health Phase of Care is required, this should be accompanied by a change to the mental health recovery/ treatment/care or management plan and be clearly documented in the consumer’s medical record.
7. At the commencement of, or a change in a mental health Phase of Care, an outcome measures collection is required in all mental health service settings as per the Outcome Measurement PMC (reference to be added).
8. There is no set time period for the length of a mental health Phase of Care, however regular reviews of a consumer’s mental health Phase of Care should occur as clinically appropriate and at a minimum every 91 days. The mental health Phase of Care does not need to be changed at each review when the main goal of treatment remains the same, but it does need to be entered.
9. A consumer will only have one mental health Phase of Care at any time. When care is co-managed or provided by multiple mental health services in the same setting, the mental health Phase of Care should be agreed upon by the various treatment providers. The mental health care plan should include all activity undertaken by all relevant treatment providers caring for the consumer, and the mental health phase of care should align with this care plan.
10. Mental health Phase of Care cannot be changed whilst a consumer is on leave from a health care service (i.e. when a consumer is on holidays).
11. As the mental health Phase of Care is prospective the reporting of discharge PoC measures is not required in relation to the AMHCC.
12. There is no limit on the number of mental health Phase of Care that can be completed within an episode of care. An episode of care may contain one or multiple mental health Phase of Care.

**Assessment Only Phase of care**

1. If a consumer is referred to another setting, the “Assessment Only” mental health Phase of Care may be reported to capture the work undertaken at the service in conducting the brief triage assessment or initial assessment.
2. Although a consumer is reviewed regularly throughout an episode of care, “Assessment only” can only ever be the first or only mental health Phase of Care in an episode.
3. The AMHCC does not require the completion of outcome measures for an “Assessment Only” mental health Phase of Care, however all other mental health phases of care require the completion of outcome measures.
4. If outcome measures are completed at the commencement of an “Assessment only” mental health Phase of Care, then these can be deemed completed for the first collection of a subsequent mental health Phase of Care if considered appropriate.

## About program management circulars

The information provided in this circular is intended as general information and not as legal advice. Mental health service management should ensure that policies and procedures are developed and implemented to enable staff to collect and use health information in accordance with relevant legislation.

## References and Resources

Independent Hospital Pricing Authority. (2016). *Australian Mental Health Care Classification. Mental health phase of care guide*. Retrieved from https://www.ihpa.gov.au/publications/mental-health-phase-care-guide

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1. Independent Hospital Pricing Authority. (2016). *Australian Mental Health Care Classification. Mental health phase of care guide*. Retrieved from https://www.ihpa.gov.au/publications/mental-health-phase-care-guide. [↑](#footnote-ref-1)
2. Independent Hospital Pricing Authority. (2016). *Australian Mental Health Care Classification. Mental health phase of care guide*. Retrieved from https://www.ihpa.gov.au/publications/mental-health-phase-care-guide. [↑](#footnote-ref-2)