

# "It's time to remember NOCC is also about casemix: Australian casemix development in mental health"



A M H O C N

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SA Forum, 15 July 2010



A joint Australian, State and  
Territory Government Initiative

# A definition of casemix



A summary way of describing the mix of cases

The classification of patient episodes based on those patient attributes that best explain the cost of care

# Casemix Myths -1



## ***Assertion***

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casemix =  
DRGs

casemix is a  
payment  
system

## ***The facts***

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there are over 100  
casemix classifications

casemix is a tool that  
can be used for  
payment

# Casemix Myths - 2



## *Assertion*

## *The facts*

casemix is a method of cutting costs

governments and managers don't need information in order to cut costs - but they do need information to cut costs in sensible ways

# Casemix Myths - 3

## ***Assertion***

casemix is a method of reducing quality

## ***The facts***

casemix is neutral, but can help in measuring quality & looking at the relationship between quality & cost

# On understanding variation



Variation is a fact of life in the health system

We need measurement tools which help us to understand this variation

# Types of variation

Variation due to differences in the ways that health services treat patients

Variation due to differences in the kinds of patients treated

# Casemix and Variation



- We need to control for one type of variation in order to understand the other
- Casemix classifications help to control for variations between patients
- By controlling for variations between patients we produce information which helps us to understand the differences between providers

# Casemix Classification Criteria



1. iso-resource - patients in the same class 'cost' about the same amount to treat;
2. clinically sensible;
3. the right number of classes



# Developing a Casemix Classification for Mental Health Services

## Volume I Main Report

Bill Buckingham, Philip Burgess, Shane Solomon  
Jane Pirkis & Kathy Eagar  
Shane Solomon & Associates Pty Ltd  
August 1998

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health  
strategy



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# MH-CASC findings



- There is an underlying episode classification, not just in inpatient care but also community;
- Modest but acceptable levels of variation explained;
- The costs being driven by ‘casemix’ are often confounded by the costs driven by provider variations

# MH-CASC findings

- The variables driving costs in inpatient settings are also driving costs in the community but:
  - the patterns of care are different .... so  
.....
  - the importance of the variables differs across the two settings (e.g., focus of care)

# MH-CASC based on:

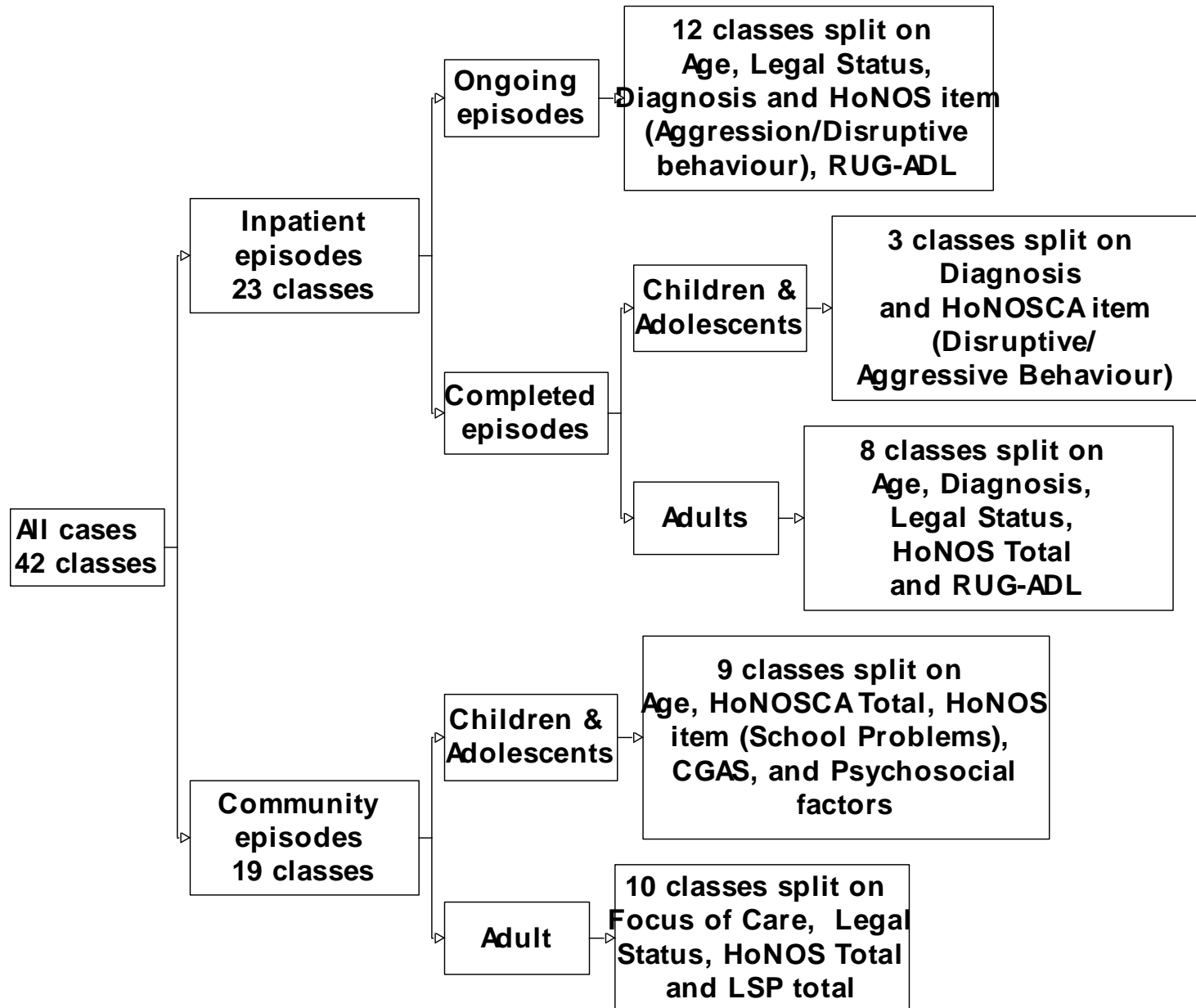
DIAGNOSIS

SEVERITY, using the HoNOS scales as the main measure

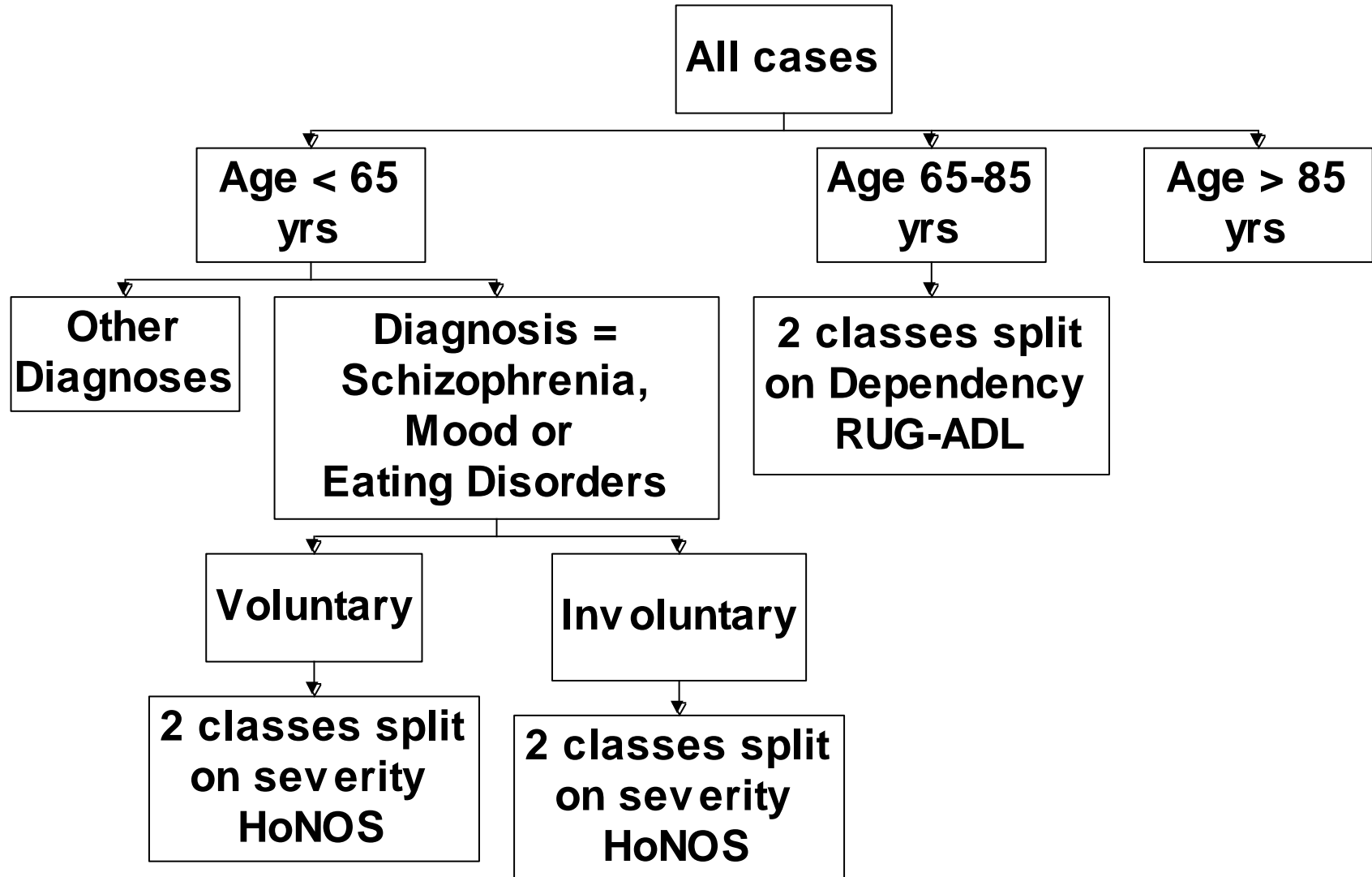
LEVEL OF FUNCTIONING, measured through an amended Life Skills Profile (adults) or child/adolescent specific measures; and

Other CLINICAL AND SOCIO-DEMOGRAPHIC characteristics e.g., age

# Summary view of MH-CASC

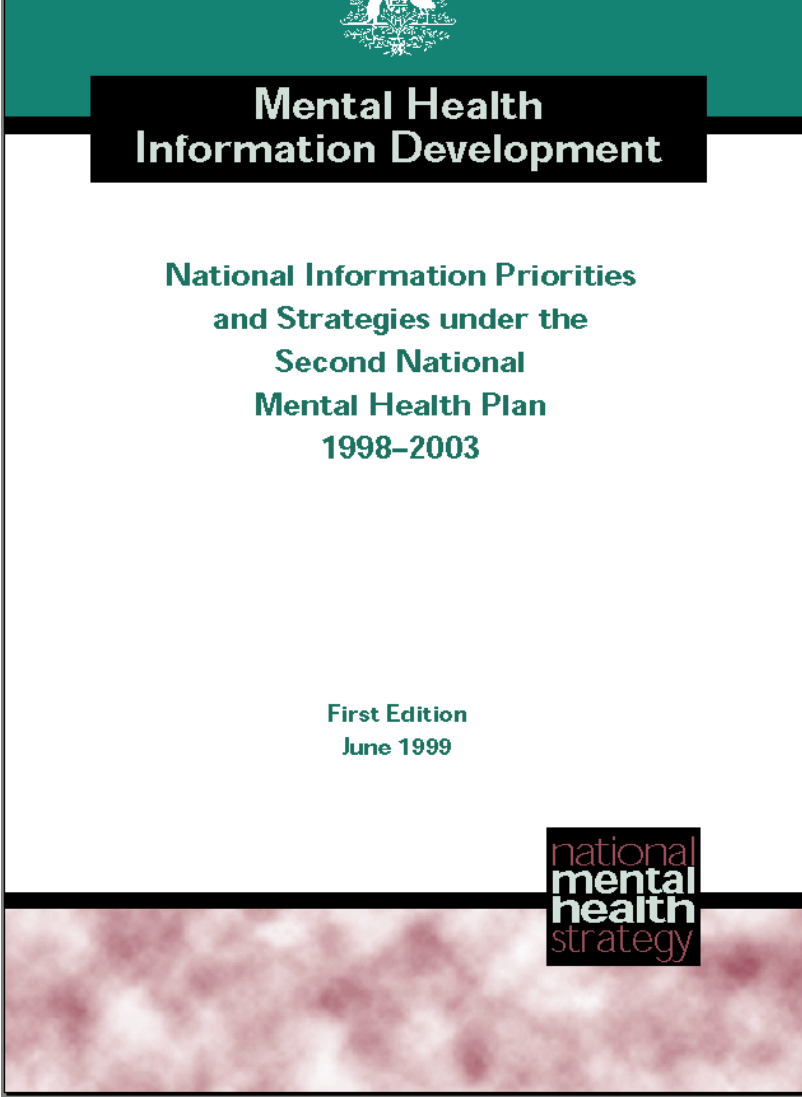


# Adult acute inpatient episodes





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# The vision



- The routine use of outcome measures (consumer and clinician rated) where such measures contribute both to improved practice and service management.
- An informed mental health sector in which benchmarking is the norm, to be used in a quality improvement cycle.
- The informed use of casemix to understand the variation in costs and outcomes.



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# Mental Health Information Development

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## National Outcomes and Casemix Collection

Technical specification of State and Territory reporting requirements for the  
outcomes and casemix components of 'Agreed Data' under  
National Mental Health Information Development Funding Agreements

Version 1.0  
Final pre-publication version

*Prepared by Technical Drafting Group  
National Mental Health Information Strategy Committee,  
AHMAC Mental Health Working Group,  
June 2002*



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# Mental Health Information Development

**National Mental Health  
Information Priorities  
2nd Edition**

June 2005

**national  
mental  
health  
strategy**



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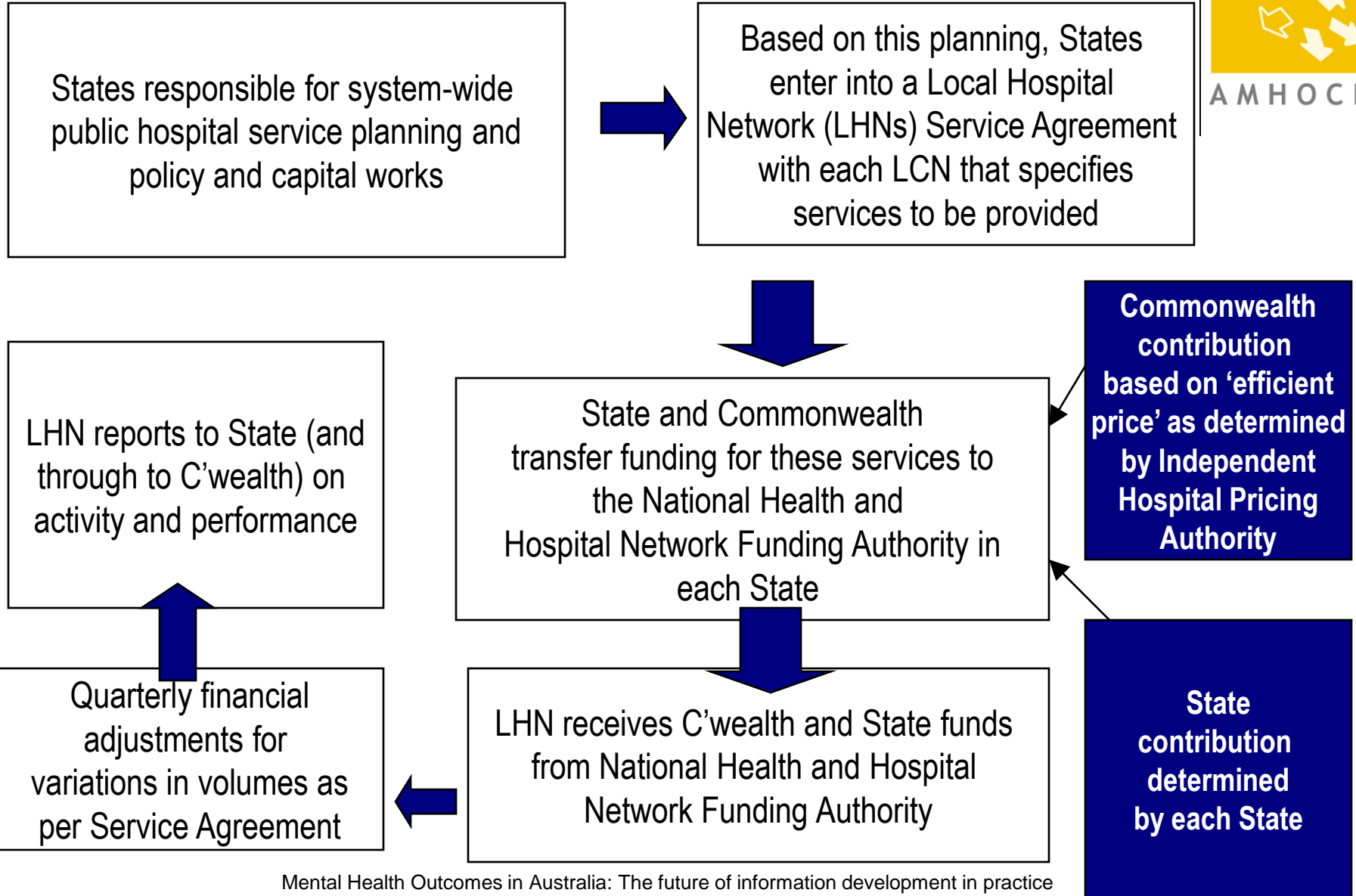
# NATIONAL HEALTH AND HOSPITALS NETWORK AGREEMENT

Council of  
Australian  
Governments

An agreement between

- the Commonwealth of Australia and
- the States and Territories, being:
  - ◆ the State of New South Wales;
  - ◆ the State of Victoria;
  - ◆ the State of Queensland;
  - ◆ the State of South Australia;
  - ◆ the State of Tasmania;
  - ◆ the Australian Capital Territory; and
  - ◆ the Northern Territory of Australia.

# Activity Based Funding!



# Progress to date ...



- Most of our efforts have been about bedding down routine outcome measurement, workforce training & information infrastructure;
- Major obstacle has been linking the NOCC (who gets) with the NMDS for Admitted Patient and Community Mental Health Care;
  - Some progress with NOCC 1.6 aligning the patient identifiers but:
    - 80% of cases in NOCC account for 67% of CMHC data

# Challenges Ahead

- Does one size fits all? Some argue strongly that AR-DRGs the way to go;
- AR-DRGs simple to administer; specialist classifications like MH-CASC more complicated

# Some indicative comparisons: % RIV Completed Inpatient Episodes



- 1997 – AR-DRGs (V3) – costs 11.3% (8 classes);
- 1997 – MH-CASC – costs 17.3% (9 classes);
  
- 2009 – AR-DRGs (V6) – LOS 15.1% (9 classes);
- 2009 – MH-CASC – LOS 22.7%

# But, for example ...

- There is a single DRG for Childhood Disorders – age is not relevant – and other DRG classes are ‘available’ (so 9 classes);
- MH-CASC has 3 classes for Child & Adolescents, and includes age, diagnosis and the single HoNOSCA scale, Aggressive Disruptive Behaviours;
- AR-DRG for Kids – 8.7% (LOS)
- MH-CASC - 3.2%
  - Potentially artefact of more DRG classes

# Challenges Ahead



- AR-DRGs are designed for acute inpatient care – much of the work in mental health occurs in ambulatory settings;
- Key issues:
  - How to deal with ‘missing’ data: no diagnosis, no classification (and worse – no payment!);
    - About 15% of completed inpatient episodes have no principal diagnosis
  - Classification development work very expensive and time consuming – years rather than months

# Challenges ahead

- Making sure we define to ‘product’ of mental health care right:
  - Person or Period of Care or Episode of Care?
- Have we got our measures right – NOCC is based on work done 15 years ago?
  - But new measures will cost!
- May be too ambitious?

# Challenges ahead



- How do we make sure the classification work proceeds balancing time constraints, funding imperatives while not compromising the goal of understanding variation?
- Perverse incentives – gaming etc – more likely to yield ‘phoney’ classifications

# Challenges ahead



- Mental health will need to demonstrate that alternative, mental health specific casemix tools justify the additional costs of collection:
  - Quality improvement;
  - Benchmarking; and
  - Demonstrating better outcomes through using these tools