

...and after Tuesday lunch



Benchmarking, outcomes and their impact on
service delivery, funders and policy development

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Background

- Outcomes
- Benchmarking
 - Can be criticised for involving
 - Much effort
 - Oversimplifying
 - Decontextualising
 - But most tellingly
 - Changing nothing of any importance

On the benchmarking adventure

- 6 CAMHS nominated by States for
 - Preparedness and history of being informed by data
 - 2 year project
 - Aim was to inform National KPIs for mental health

- EH CAMHS aka Sneezy
 - Peter Brann, Sue Quartermain, Peter Birleson, Leanne Beagley, Paul Leyden
 - Support from Jenny Galloway, Jacinta Jolly, Richard Gornall, Christina Doyle, Cheryl Nickels-Beattie

Benchmarking CAMHS in Australia



- **Sneezy** – OP Adol. IP and Day Program
- Sleepy – OP plus Adol. IP
- Happy – OP and Adol. IP
 - Doc – OP teams only
 - Grumpy – OP only
 - Bashful – OP and for younger age weekday IP
- More details at AMHOCN www.amhocn.org/training-service-development

National Framework

Health System Performance

Effective

28 Day re-admission rate

Appropriate

National Service Standards Compliance

Efficient

Cost per acute inpatient episode
Average length of acute inpatient stay
Cost per 3 month community care period
Treatment days per 3 month community care period

Responsive

★

Accessible

Population receiving care
New client index
Comparative area resources
Local access to inpatient care

Safe

★

Continuous

Pre-admission community care
Post discharge community care

Capable

Outcomes readiness

Sustainable

★

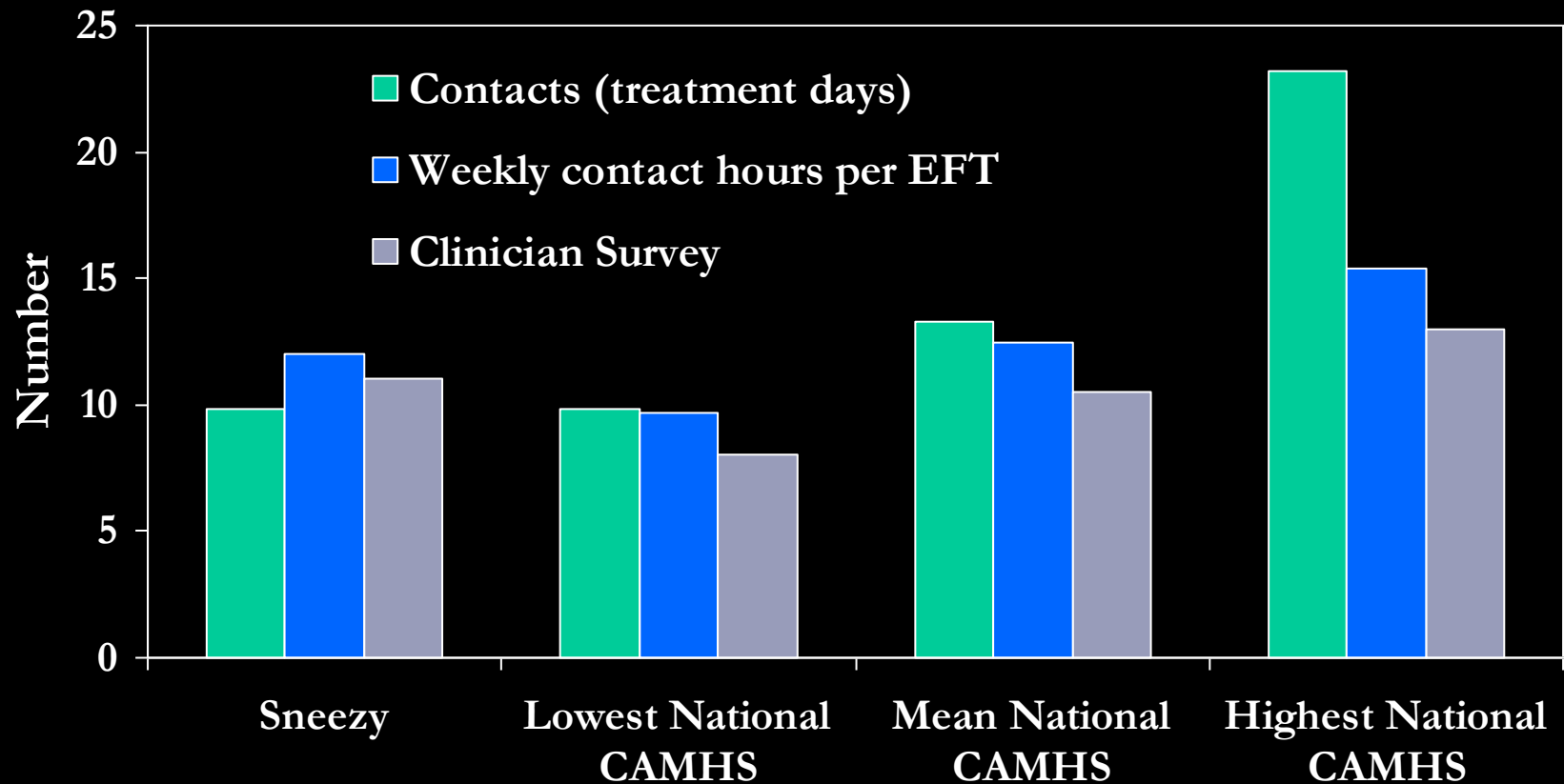
★ Indicator to be developed

KPIs

- Core set from the 13 indicators
 - Others derived from the raw data
- Two additional projects
 - Aside from the understandable defensiveness, I really think we do lots of stuff
 - Staff survey “Where did my day go?”
 - And that stuff is useful
 - Discharges project
 - Are we effective, accessible, responsive and appropriate?

-
- This presentation will provide an example of the impact of benchmarking on service culture, expectations and functioning

How many clients are seen per week?



-
- Different methods still suggest that if you put these clients back to back, then...
 - What do you do after lunchtime Tuesday?

□ Back at Sneezy

- This number of clients was hard to justify
 - But staff appeared very busy and worked hard
- Where did the rest of the day/week go?

Back at Sneezy

- History of increasing organisational expectations with no limits provided
- Department exploring workload expectations
- History of increasing complexity of cases
- Increased proportions of part time staff
- The impact of FTA (17%)
- Community team clinicians highlight lack of clarity in expectations at Benchmarking – What makes management happy?

The journey and the solution

- The tension within the service
 - Clinicians should work harder
 - They are overworked already
- And missing the point
 - Organisational expectations are unlimited
 - Productive EFT is important
- It took months to work this through

The proposal

- Defend clinical and community time
 - 50% expectation
 - Management's role to defend that time against committees, email, etc
 - Organisational activities have to fit within remaining time
 - Include what is required to provide a contemporary CAMHS (e.g. supervision, co-therapy, intra-agency liaison)
 - There will be variation
 - Team Managers enquire below 25% and above 75%
 - Makes it obvious that can't just keep handing out tasks

Online reporting

Program Finance Group

1 of 1 100% Find | Next Select a format Export



Clinical Contact Hours

MENT

Data Source: CMI, as at 13/07/2010 01:31 and Payroll data as produced by EH F

CAMHS - ALL Totals Fortnight Ending

| Team / Clinician | 21/02/10 | 07/03/10 | 21/03/10 | 04/04/10 | 18/04/10 | 02/05/10 | 16/05/10 | 30/05/10 | 13/06/10 | 27/06/10 | Avg | Latest |
|------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|------|----------|
| Total Hrs | 408 | 419 | 360 | 368 | 219 | 224 | 346 | 299 | 295 | 278 | 321 | 01/06/10 |
| % Contact | 32 % | 30 % | 21 % | 22 % | 26 % | 35 % | 29 % | 24 % | 21 % | 19 % | 26 % | |
| Total Hrs | 568 | 578 | 520 | 531 | 458 | 488 | 601 | 535 | 490 | 427 | 520 | 17/02/10 |
| % Contact | 31 % | 34 % | 31 % | 31 % | 31 % | 34 % | 33 % | 33 % | 36 % | 36 % | 33 % | |
| Total Hrs | 510 | 519 | 498 | 426 | 359 | 523 | 472 | 471 | 397 | 337 | 451 | |
| % Contact | 29 % | 32 % | 36 % | 32 % | 37 % | 27 % | 33 % | 21 % | 30 % | 27 % | 30 % | |
| Total Hrs | 322 | 398 | 379 | 422 | 364 | 399 | 451 | 450 | 434 | 314 | 393 | 05/02/10 |
| % Contact | 28 % | 42 % | 31 % | 35 % | 39 % | 42 % | 47 % | 42 % | 48 % | 41 % | 40 % | |
| Total Hrs | 610 | 562 | 506 | 515 | 547 | 557 | 608 | 577 | 591 | 374 | 545 | |
| % Contact | 30 % | 37 % | 42 % | 37 % | 26 % | 34 % | 33 % | 25 % | 33 % | 32 % | 33 % | 07/05/10 |
| Total Hrs | 208 | 202 | 178 | 178 | 165 | 170 | 208 | 204 | 122 | 114 | 175 | |
| % Contact | 49 % | 53 % | 48 % | 12 % | 13 % | 50 % | 60 % | 57 % | 58 % | 34 % | 44 % | |
| Total Hrs | 144 | 144 | 152 | 162 | 151 | 128 | 183 | 187 | 166 | 176 | 159 | 10/02/10 |
| % Contact | 58 % | 73 % | 70 % | 59 % | 39 % | 64 % | 62 % | 64 % | 60 % | 42 % | 59 % | |
| Total Hrs | 312 | 341 | 304 | 200 | 224 | 308 | 304 | 296 | 320 | 272 | 288 | |
| % Contact | 16 % | 30 % | 36 % | 22 % | 20 % | 35 % | 38 % | 88 % | 131 % | 92 % | 52 % | 10/02/10 |
| Total Hrs | 270 | 249 | 248 | 214 | 203 | 220 | 211 | 260 | 256 | 222 | 235 | |
| % Contact | 14 % | 13 % | 11 % | 15 % | 25 % | 19 % | 28 % | 24 % | 14 % | 16 % | 18 % | |

Note -
 a) Total hours obtained from payroll. It excludes annual, sick, pub hol leave and ADOs, b) Contacts hours obtained from CMI - All A, B, C and D contacts are included, & c) Admin staff excluded.

Online reporting

| ian | 21/02/10 | 07/03/10 | 21/03/10 | 04/04/10 | 18/04/10 |
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- ❑ Can choose individual teams and then see % by clinicians name
- ❑ Hours derived from payroll which everyone has an interest in keeping accurate
- ❑ Led to simplified rules re contacts
- ❑ Supervision KPI

Eastern Health Mental Health Programs (EH MHP) Contact Flowchart

Should I record a contact in CMI?

Is the activity clinically meaningful or significant in terms of client or consumer activity/ consultation/ community development/ education/ review/ supervision/ report writing/ travel?

Yes

No

Are there any non EH MHP employees present? (e.g. family member, client, outside agency, private practitioner)

No contact recorded

Yes

No (It is only EH MH staff)

Are you the sole **or** primary clinician providing this contact?

Yes

No (I'm the 2nd or 3rd etc) clinician.

Client/ Consumer Related Activity
(Registered, Unregistered, Community Agency)

Tertiary Consultation, Community Development/ Education

Consumer Review / Supervision/ Report Writing/ Travel Time

Contact type either 'A' registered, 'B' unregistered or 'C' community primary/ secondary consultation.

Contact type will be 'C' community activity

Contact type will be 'D'. All other fields (UR number, duration etc) filled in as if this were an 'A', 'B' or 'C' contact.

NB: Where a code is applicable, write in Research Field 1:

PC (Primary Consultation), **SC** (Secondary Consultation), **TC** (Tertiary Consultation)
CD (Community Development), **CE** (Community Education), **SG** (Supervision Given), **SR** (Supervision Received), **CR** (Clinical review/ Team review/ Peer review) **RW** (Report Writing), **TT** (Travel Time)

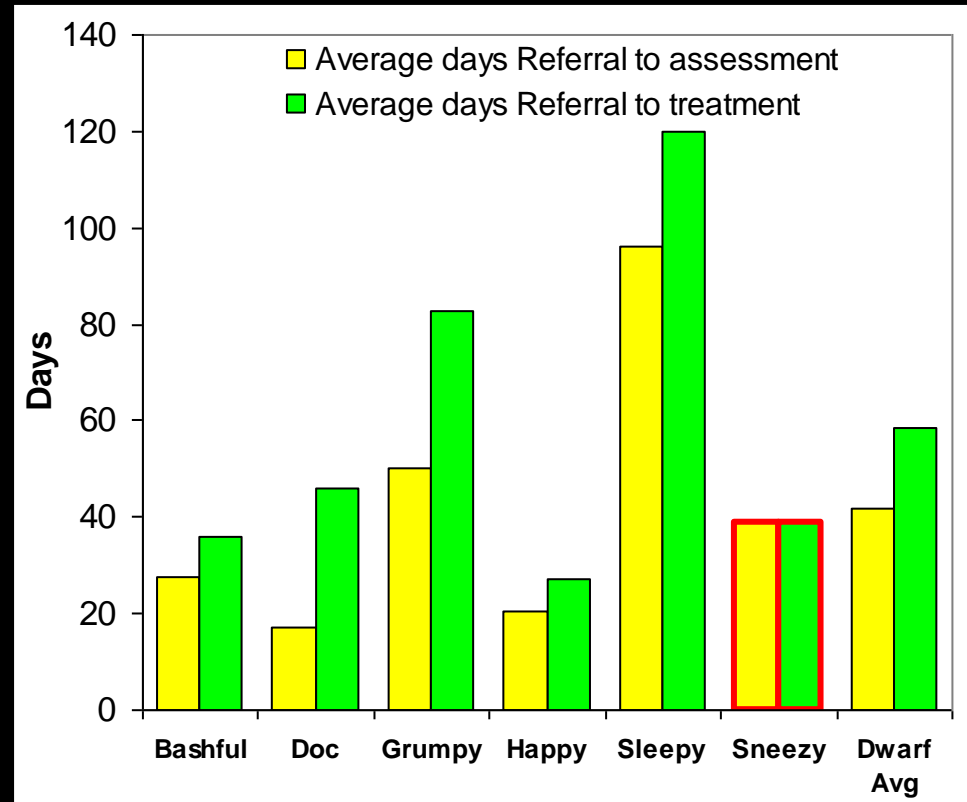
Why do CAMHS keep clients waiting?

Lessons for funders

- ❑ Waiting lists a magnet for complaints about services
- ❑ The urban myth and the horror of those who wait a long time
- ❑ Always a tool for departments and management suggesting services are non-responsive
- ❑ Always a lingering pressure for clinicians on throughput and case loads

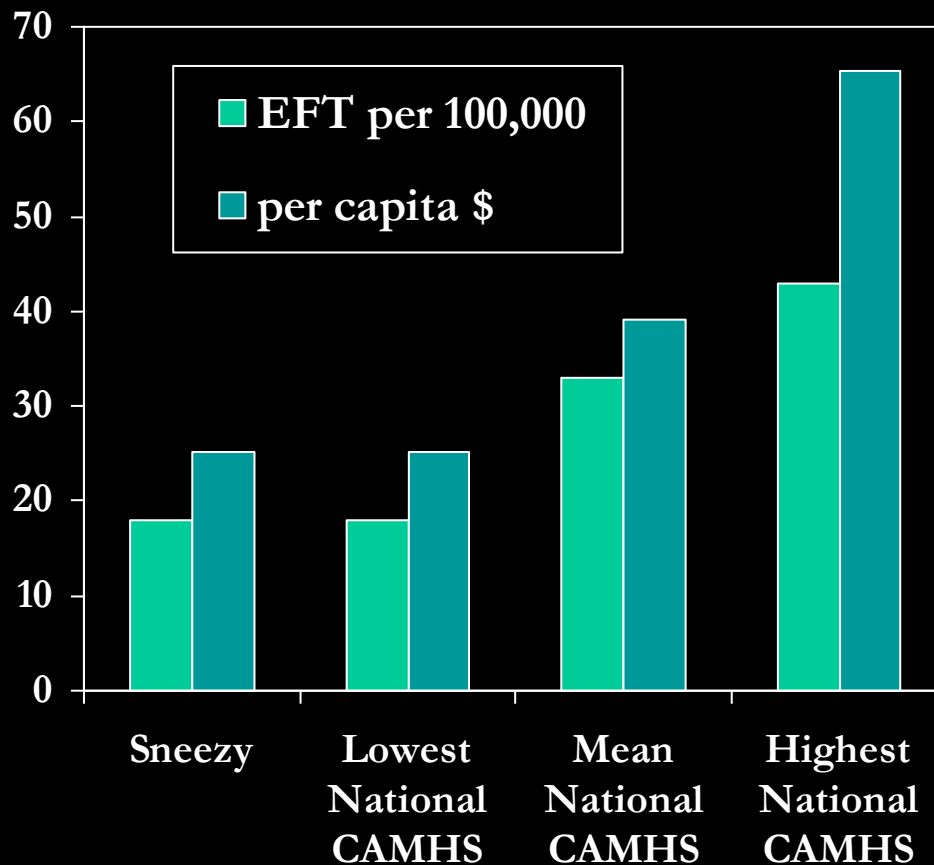
Access

- Waiting time for Sneezzy average at about 40 days
 - Includes crises, priorities etc
 - This can't be right! I've heard people wait for months.
- Still, why are we less responsive than eg Happy?



Money?

- Some variation in funding
 - Correlation between waiting for assessment and per capita \$ of 0.5
 - Correlation between waiting for treatment and EFT per 1000,000 population of 0.6
- Funding and resources are very important



The journey and the solution

- Apples and oranges can be compared
- But need to keep reminding those comparing, that available resources are important
- In all forums, request per capita \$ or per capita EFT be put on the table
 - Otherwise it's a contest of impression management and spinning with marginalised groups
- Victoria now has \$ per 100,000 population as part of community KPI set

Doing things with outcomes

- Previous presentations have focussed on how we have used outcomes
 - And some evolving directions
- From benchmarking
 - Those with the greatest number of clients seen were seeing less severe clients
 - It's a model choice and temptation to follow models of others must be tempered by their effectiveness and the severity of who they see

Conclusion

- Benchmarking provides a wealth of material that can change a service culture, functioning and tools
 - But an accessible, responsive, efficient etc etc service without effective outcomes is pointless
 - And comparisons without \$ or resources in the discussion are ungrounded
- Thank you