

The future of mental health information development in Australia: What do we want to achieve?



A M H O C N

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Australian Mental Health Outcomes
and Classification Network



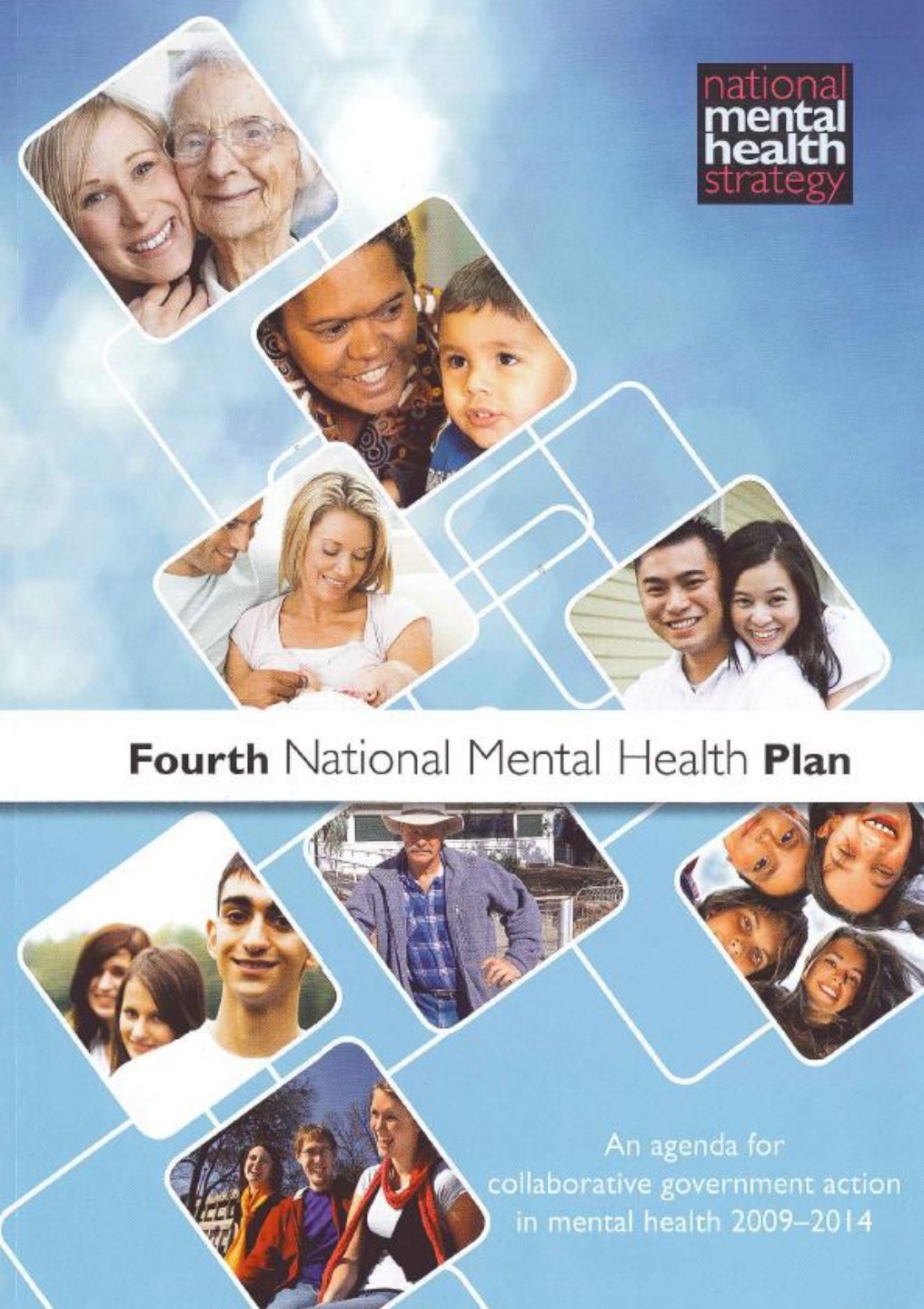
A joint Australian, State and
Territory Government Initiative

The 4th National Mental Health Plan

5 Priority Areas for reform

1. Social inclusion and recovery
2. Prevention and early intervention
3. Service access, coordination and continuity of care
4. Quality and innovation
5. Accountability

Fourth National Mental Health Plan



An agenda for
collaborative government action
in mental health 2009–2014

Quality improvement and innovation



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Outcome

- The community has access to information on service delivery and outcomes on a regional basis. This includes reporting against agreed standards of care including consumers' and carers' experiences and perceptions. Mental health legislation meets agreed principles and is able to support appropriate transfer of civil and forensic patients between jurisdictions.
- There are explicit avenues of support for emerging and current leaders to implement evidence based and innovative models of care, to foster research and dissemination of findings, and to further workforce development and reform.

Indicators

- Proportion of total mental health workforce accounted for by consumer and carer workers
- Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards
- Mental health outcomes for people who receive treatment from state and territory services and the private hospital system
- Proportion of consumers and carers with positive experiences of service delivery

Quality improvement and innovation



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Accountability—measuring and reporting progress



Outcome

- The public is able to make informed judgements about the extent of mental health reform in Australia, including the progress of the Fourth Plan, and has confidence in the information available to make these judgements. Consumers and carers have access to information about the performance of services responsible for their care across the range of health quality domains and are able to compare these to national benchmarks.

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- Proportion of services publicly reporting performance data

Accountability—measuring and reporting progress



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Indicators

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National Mental Health Reports



National Mental Health Report

Monitors progress of national reform

Dept of Health & Ageing

Mental Health Services in Australia

Presents descriptive data on activity of mental health services

Aust. Institute of Health & Welfare

COAG National Action Plan on Mental Health (2006 – 2011)

Reports on indicators across a variety of priority areas

Dept of Health & Ageing

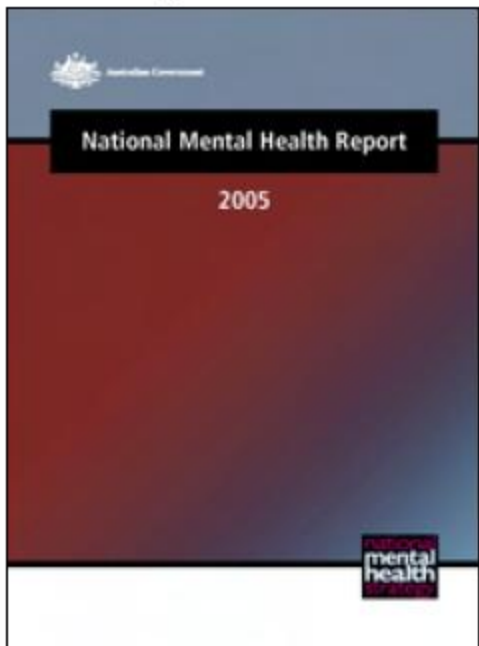
Report on Government Services

Reviews the management of government services, including mental health

Productivity Commission

National Mental Health Report 2000

National Mental Health Report 2005

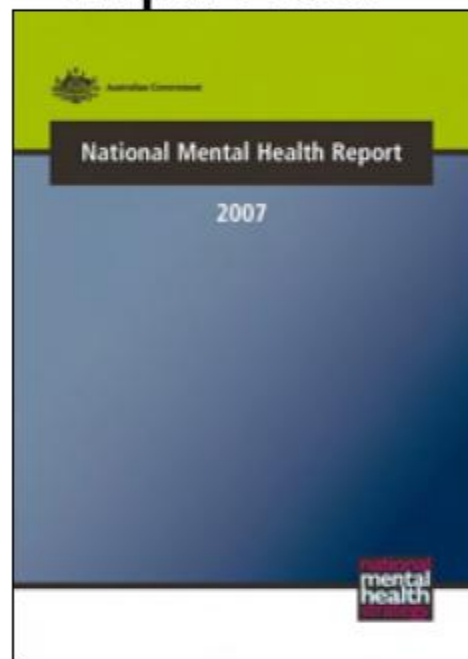


Released:
Coverage:

Released: December 2005
Coverage: Progress to 2002-03

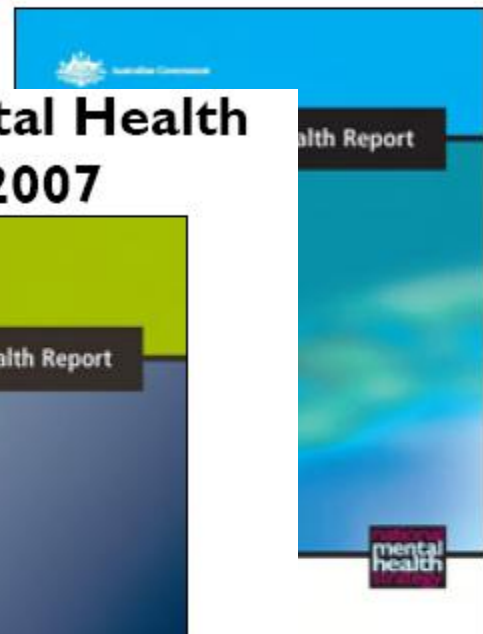
National Mental Health Report 2

National Mental Health Report 2007



Released: February 2008
Coverage: Progress to 2004-05

National Mental Health Report 2004



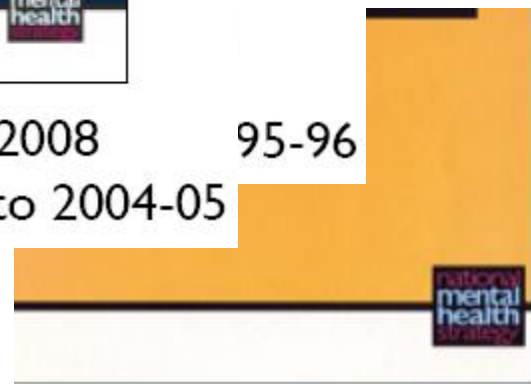
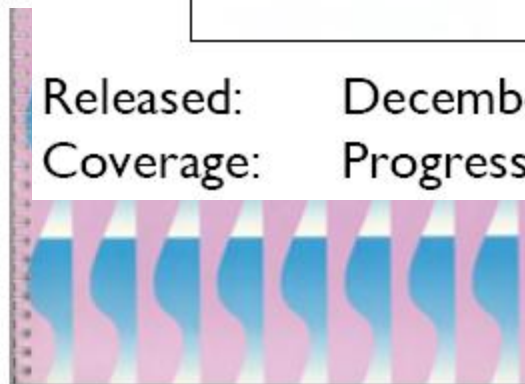
Released: November 2004
Coverage: Progress to 2001-02

Released: 1995-96

Released: March 1994
Coverage: 1992-93 'base'

Released: July 1996
Coverage: Progress to 1994-95

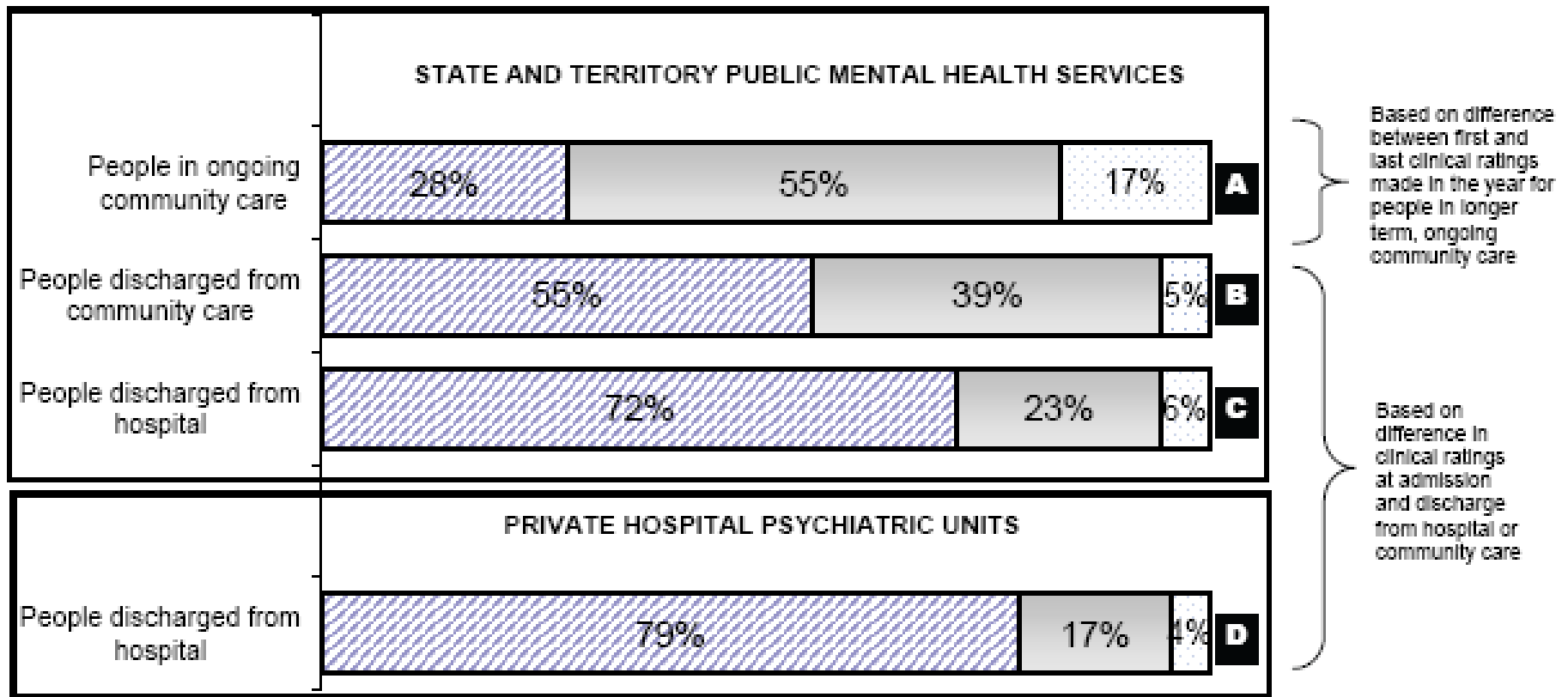
Released: May 1995
Coverage: Progress in 1993-94





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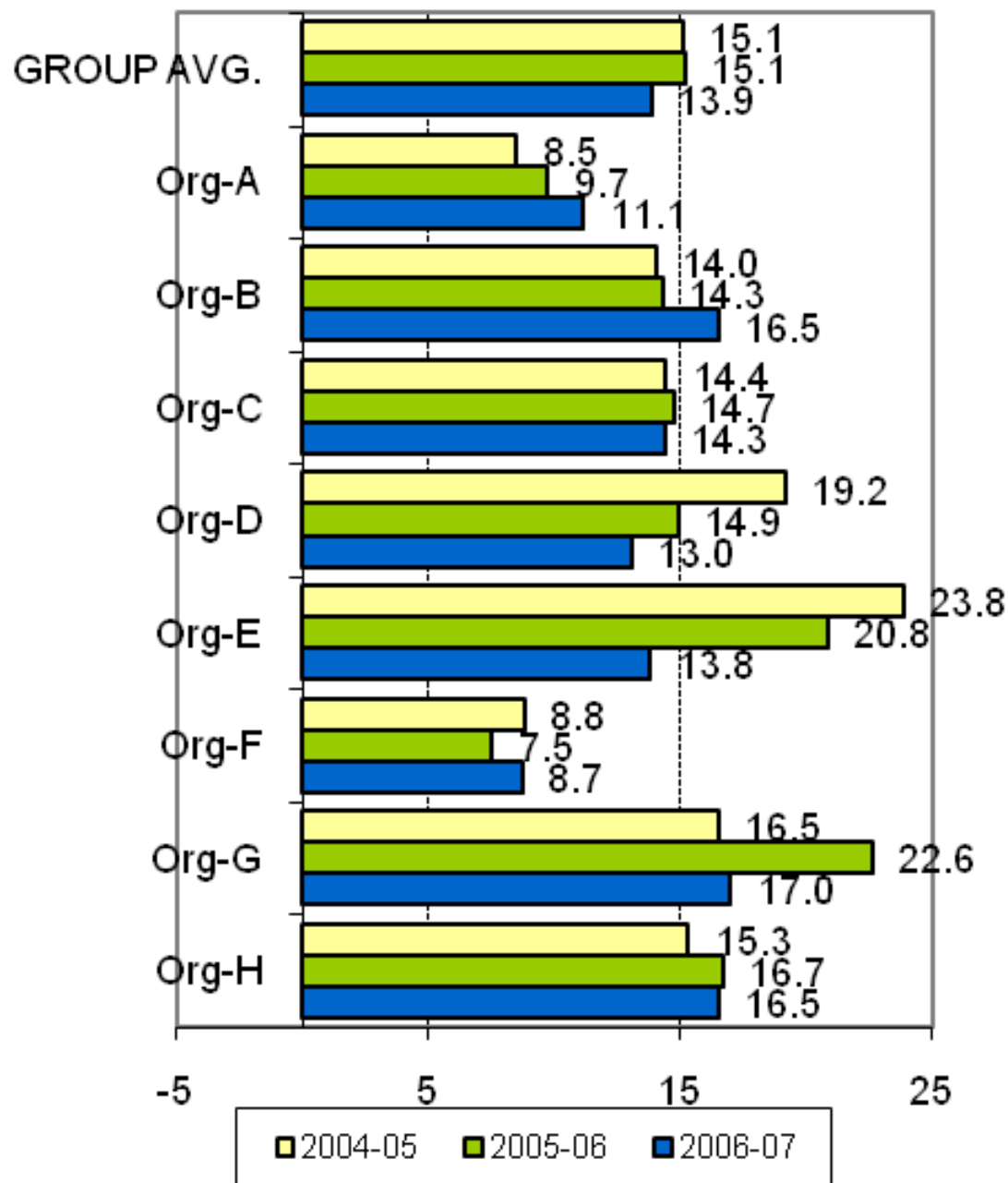
Figure 19: Clinical outcomes of people receiving various types of mental health care, 2006-07



- Significant improvement
- No significant change
- Significant deterioration

Note: Indicators for all groups based on changes in ratings on the Health of the Nation Outcome Scale "family" of measures (HoNOS and HoNOSCA), completed by clinicians at various points over the course of a consumer's treatment and care.

KPI#3 Average acute length of stay



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Examples Public Reporting



- New York State: Office of Mental Health
 - <http://bi.omh.state.ny.us/scorecard/index>
- Hospital Compare (USA)
 - <http://www.hospitalcompare.hhs.gov/Hospital/Home2.asp>
- Medicare “Home Health Compare” (USA)
 - <http://www.medicare.gov/HHCompare>
- Online GP practice results database (United Kingdom)
 - <http://www.qof.ic.nhs.uk/index.asp>
- The Leapfrog Group (USA)
 - http://www.leapfroggroup.org/about_us

Australian Public Reporting



- All states and territories are publicly reporting some Hospital data.
- Wide variation in what and how information is reported



Mental Health Admissions

What do these figures show?

In the September 2009 quarter, there was an increase of 238 (or 10.8%) public mental health admissions compared with the same quarter in the previous year.

For the same period, metropolitan public hospital mental health admissions increased by 234 (or 12.0%). For country public hospitals there were 4 (or 1.6%) more mental health admissions for the September 2009 quarter compared with the September 2008 quarter.

Figures include mental health admissions at all authorised hospitals and designated mental health inpatient units at public hospitals and the authorised mental health inpatient unit at Joondalup Health Campus. Peel Health Campus is excluded as it is not a designated mental health facility.

Admissions to mental health services can vary from year to year. Factors that can impact on admissions during any year include availability of beds and staffing levels.

Figure 9: Number of public mental health admissions (WA State)

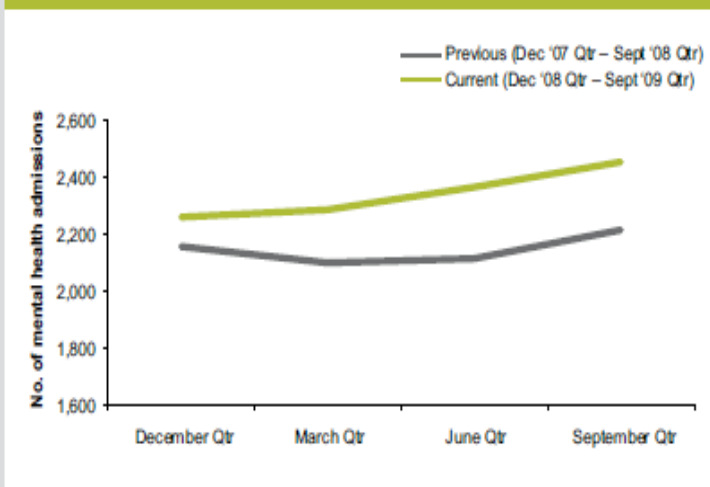


Table 9: Number of public mental health admissions*

Area	December 2007 Quarter	March 2008 Quarter	June 2008 Quarter	September 2008 Quarter	December 2008 Quarter	March 2009 Quarter	June 2009 Quarter	September 2009 Quarter	% change Sept 08 to Sept 09 Quarters
Metropolitan	1,956	1,898	1,881	1,958	1,963	2,005	2,095	2,192	12.0%
Country	198	199	231	254	294	278	267	258	1.6%
WA State	2,154	2,097	2,112	2,212	2,257	2,283	2,362	2,450	10.8%

*Figures are preliminary. Figures may change within the 2007-08 and 2008-09 reporting period due to timing of coding and editing.

HOSPITAL PERFORMANCE - CLINICAL (TABLE)
Risk Adjusted Rate per 100 Separations



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Medical	Surgical	Gynaecology/Obsetric	Mental Health
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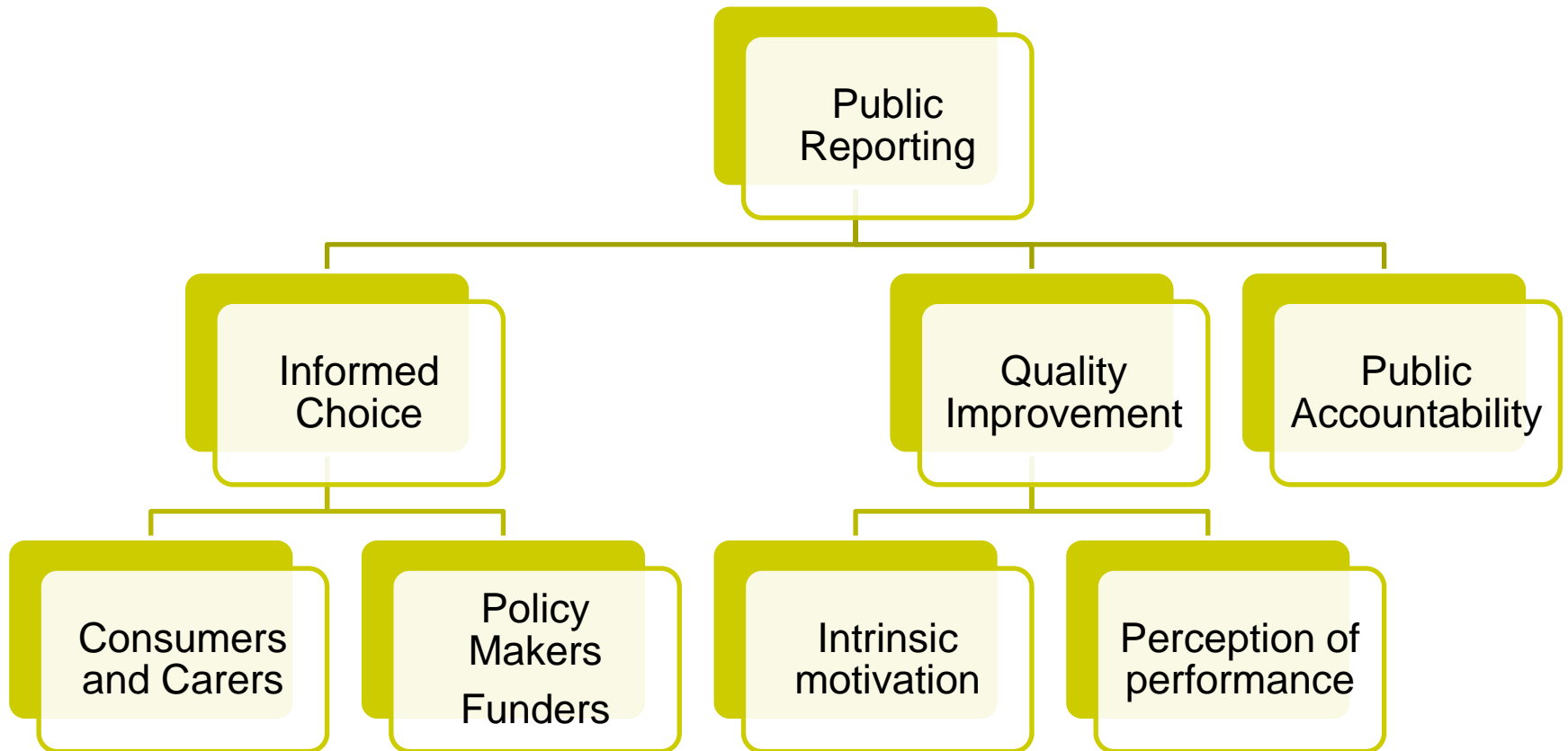
Principal Referral and Specialised
Large
Medium and small

Hospital Name	Mental Health			
	Depression Readmission	Depression Long stay	Schizophrenia Readmission	Schizophrenia Long stay
MATER CHILDRENS PUBLIC HOSPITAL				
MATER MOTHERS PUBLIC HOSPITAL				
THE PRINCE CHARLES HOSPITAL	11.91	5.42	18.10	14.00
ROYAL CHILDRENS HOSPITAL				
PRINCESS ALEXANDRA HOSPITAL	7.98	11.82	13.80	26.29
NAMBOUR GENERAL HOSPITAL	9.00	14.66	18.55	14.41
GOLD COAST HOSPITAL	6.74	9.81	11.05	28.58

Legend	
Public Hospitals that have a statistically significantly lower rate than Private	↓
Public Hospitals that have a statistically significantly higher rate than Private	↑
Variation is not statistically significantly different	■
Not applicable	

- Notes:**
1. This is a state-wide comparison of Public and Private Hospital clinical performance results
 2. Significant variations are highlighted where there is a 95% statistical certainty that public and private results are different
 3. No risk adjustment for age, sex or comorbidities/complications has been made in this comparison
 4. Public Hospitals tend to treat higher than average complexity of cases than in Private. Patients also generally have a different demographic that cannot be adjusted for in these comparisons

Rationale



Stakeholder Views



- Consumers:
 - Want information that is readily accessible and updated
 - Sufficient detail to make choices
 - Includes process, impact and outcomes
- Clinicians
 - Hostile
 - Misinterpreted when limitations aren't understood
- Managers
 - Mixed, some positive views when combined with internal quality improvement processes

Impact: Four Systematic Reviews



- Marshall (2000) and Schaufler and Mordavsky (2001)
 - Encouraged hospitals to respond with internal changes but little evidence of other impacts
- Fung et al (2008) and Shekelle et al (2008)

	Impact		
Consumer selection of health plans	Light Green	Light Yellow	Light Yellow
Consumer selection of hospitals and providers	Light Yellow	Yellow	Light Yellow
Quality improvement at a hospital level	Green	Light Yellow	Light Yellow
Improved effectiveness of treatment	Light Yellow	Light Yellow	Red

- Both warn that absence of evidence isn't evidence of absence

Unintended consequences



Tunnel Vision	Here faced with many different targets managers choose the one easiest to measure and ignore the rest
Sub-optimisation	Here managers operate in ways that benefit their own operation but impact on the overall system performance in a negative way
Myopia	Managers for whatever reason focus on short term targets at the expense of longer term goals
Measures fixation	Outcomes can sometime be difficult to measure and managers may focus on indicators rather than the desired outcomes
Misrepresentation	Data is either misreported or distorted to create a good impression
Misinterpretation	Here reported differences in organisational performance may be more measurement error and there may be o difference in organisational performance
Gaming	Here managers manipulate data to achieve their own ends
Convergence	They place greater emphasis on not being exposed as an outlier rather than a desire to be outstanding
Ossification	The indicator has past its use by date for whatever reason but it continues to be reported

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Specific advice on the “What and How to report”



- Clear and explicit definitions
- High quality and timely
- Disclosure of methods
- Uncertainty of observations
- Presentation of reported data
 - Style (stars, ticks and thumbs)
 - Mindful of cognitive burden
 - Framework
 - Personally relevant
 - Knowledge construction rather than information telling



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Australian Mental Health Outcomes and Classification Network
SHARING INFORMATION TO IMPROVE OUTCOMES



- Home
- Training & Service Development
- Analysis & Reporting
- Data Bureau
- Expert Panels
- Special Projects

AUSTRALIAN MENTAL HEALTH OUTCOMES AND CLASSIFICATION NETWORK

The Australian Mental Health Outcomes and Classification Network (AMHOCN) was established by the Australian Government in December 2003 to provide leadership to the mental health sector to support the sustainable implementation of the outcomes and casemix collection as part of routine clinical practice.

AMHOCN aims to support states and territories and to work collaboratively with the mental health sector to achieve the vision of the introduction of outcomes and casemix measures. AMHOCN consists of three components: a data bureau responsible for receiving and processing information; an analysis and reporting component providing analysis and reports of submitted data; and a training and service development component supporting training in the measures and their use for clinical practice, service management and development purposes.

Currently, the Australian Government has contracted the following organisations to undertake these roles: Strategic Data Pty Ltd - [Data Bureau](#); The University of Queensland - [Analysis & Reporting](#); and The NSW Institute of Psychiatry - [Training & Service Development](#).

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ONLINE REPORTING

LATEST NEWS
[National Forum](#)

For information, news and an online forum see www.amhocn.org

Mental health outcomes in Australia: the