



Information Directorate



Programme for the Integration of Mental Health Data

NGO Implementation of PRIMHD:

Strategy and Approach

Programme for the Integration of Mental Health Data

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1.0 Introduction to PRIMHD

1.1 Purpose

The purpose of this document is to recommend an approach to the implementation of the Project for the Integration of Mental Health Data (PRIMHD) in the mental health and addiction non-government (NGO) sector. Once this approach is approved by the PRIMHD Executive the Ministry will develop a more detailed implementation plan that will specify the roles and responsibilities of the various parties as well as an accompanying communications plan.

1.2 Introduction

Significant change has been a feature of New Zealand's public health and disability system since the late 1980s. The introduction of a quasi-market model in the 1990's saw a sharp separation between purchasers and providers in the public health sector as well as the emergence of legally binding contracts between the two parties. The use of contracts to purchase public health services led to increased compliance costs associated with much higher levels of accountability and increased inter-agency competition for resources¹. However, the new contractual arrangements coupled with annual increases in mental health 'Blueprint' funding also opened up opportunities for the development of some newer NGO organisations, including Māori and Pacific providers.

This period of change has had a major impact on the nature and focus of NGO activity in New Zealand and this impact continues to be felt in the new millennium. By 2006/07, the NGO sector claimed around 29% of mental health funding nationally, up from around 10% at the beginning of 1995/96². The range of services include residential support, vocational training, advocacy, counselling, community support, a range of alcohol and other drug services, kaupapa Maori services, community services for Pacific, employment options, drop-in centres, peer support, carer support and recreation programmes.

As the principle funder of mental health and addiction services, the government (in the form of DHBs) has had a significant influence on the business operations of NGOs. Some NGOs have struggled to maintain a sense of independence as self governing entities because their business has become increasingly orientated towards meeting their contractual responsibilities in return for public funding. Increasingly NGOs experience a tension between the move towards national standardisation and the necessity to support the development of innovative responses to the needs of their local communities. This tension is evidenced in the number of contracts that now contain provider specific service specifications in addition to the service specifications listed in the Nationwide Service Framework. It is also widely acknowledged that the current reporting requirements that form part of the Nationwide Service Framework offer limited information with which to inform service planning or to assist with the monitoring of the effectiveness and efficiency of NGO services. The current review of the Nationwide Service Framework has been established, in part, to address these concerns.

¹ Tennant M. et al (2006) *Defining the Nonprofit Sector: New Zealand*. Working Papers of the John Hopkins Comparative Nonprofit Sector Project, No 45. Baltimore: The Johns Hopkins Centre for Civil Society Studies, 2006.

² Source: Mental Health Group, Population Health, Ministry of Health

1.3 Background

The need for good quality information to support the future development of mental health services has been recognised as a leading challenge in *Te Tahuu: Improving Mental Health 2005 – 2015* (2005) as well as the *National Mental Health Information Strategy* (2005).

The development of an information reporting system for NGOs was one of four priority projects outlined in the *Implementation Plan for the National Information Strategy* (2006) and forms part of the programme of activity under the Project for the Integration of Mental Health Data (PRIMHD).

Given that the level of funding provided to the non government sector is around 29% of the total funding for mental health and addiction services, it is important that NGOs as well as District Health Board services provide information on consumer utilisation of services.

In 2005 Platform Inc published the results of the NgOIT Landscape Survey. The survey was distributed to 365 NGO providers that were identified as receiving mental health funding, with a response rate of 65.3% (NB: The number of contracted providers in 2007 is closer to 423, which is much higher than the figure reported in 2005).³

This survey was the first of its kind and provided the sector with valuable information about the current NGO information infrastructure as well as the models that were already being used by NGO services to measure consumer outcomes within the sector. The findings from this survey indicate that many NGOs are already collecting valuable data about the consumers that they serve, from both administrative and clinical viewpoints. The survey also showed that many NGOs have multiple contracts with a number of different government agencies and provide different reports against each of these contracts.

1.4 Benefits

The vision for PRIMHD is to assist in the improvement of health outcomes for all Mental Health consumers in New Zealand by providing a single rich data source of National Mental Health information that can be used for multiple purposes. Over time the amount of duplicate reporting will be eliminated as the data set could be used to inform contractual reporting as well as reporting to the New Zealand Health Information Service (NZHIS).

PRIMHD proposes to increase the coverage of the national collection so that there is a broader view of consumer utilisation of services across a number of different mental health providers (including DHBs and NGOs).

The Ministry estimates that up to 12.5% of mental health consumers seen by NGO services are not currently captured in the national mental health information collection (MHINC). This is a significant number of consumers for which there is no client level detailed service activity information recorded. Please note that previous estimates of 19% included older persons' mental health services funded by aged care in the Central and Southern regions, as well as clients receiving methadone treatment and currently reported via the DHBs.

The acquisition of this missing information is of obvious benefit to the Ministry of Health but, just as importantly, there are also benefits for consumers, service providers and

³ The Ministry has identified 423 NGO providers in its contract management database with current contracts for Blueprint services as at 13 August 2007.

DHB funders and planners. Table 1 summarises some of these benefits for the various stakeholder groups.

Table 1: Stakeholder requirements for information

Information needs	Consumer	Family/ Whanau	Provider	Funder	Ministry
To facilitate consumer participation in services -	√				
To benchmark services - how does this service compare to others?	√	√	√	√	√
To provide feedback to consumers	√	√	√		
To inform organisational business decisions			√		
One core data set that can be used for multiple reporting purposes			√	√	√
To support whanau ora	√	√	√	√	√
To inform workforce development activities			√	√	√
To inform improvements in the quality of services	√	√	√	√	√
To further develop services			√	√	
To support governance accountability			√		
To monitor service performance			√	√	√
To inform future planning			√	√	√
To inform policy development					√

1.5 Problems identified with other implementations

As part of the implementation phase for MHINC in 2000 the Ministry decided to develop and supply an information system for those NGOs that could not afford an information system of their own. This system was called the Community Reporting System (CRS) and a few NGO providers received some funding as part of pilot for this project. However, for various reasons the system did not eventuate. This development was then replaced by a proposed development called the Mental Health Information Reporting System (MHIRS) which was delayed because it was considered that the needs of the sector had changed since the inception of CRS and that any information system development would need to be future proofed in order for it to have any value.

The development of a patient management system is still considered to be outside the role of the Ministry of Health, not least because it raises questions about which agency would take responsibility for its deployment, which agency would take responsibility for maintaining it and which agency would manage any further upgrades. In particular the issue regarding the 'ownership' of the system is not straightforward and carries with it potential financial liability for any further development work.

For the above reasons the Ministry is revisiting what was originally proposed for MHIRS with a view to gathering the views of DHB funders about applying the funding in a way that benefits the maximum number of NGO providers. The ultimate objective of the MHIRS funding is that it be used to assist NGO providers to improve their information infrastructure, to better utilise web based technology and to report the new national data collection called PRIMHD.

NZHIS has, in the past, had minimal ability to offer support services to the sector in regard to MHINC, resulting in a common perception that the national data collection does not have much local utility. PRIMHD is in a different position to MHINC in that it does have resources attached to it that will enable access to ongoing support services to the sector in the form of a dedicated FTE liaison for NGO providers as well as improved access to a new suite of standardised and ad hoc reports.

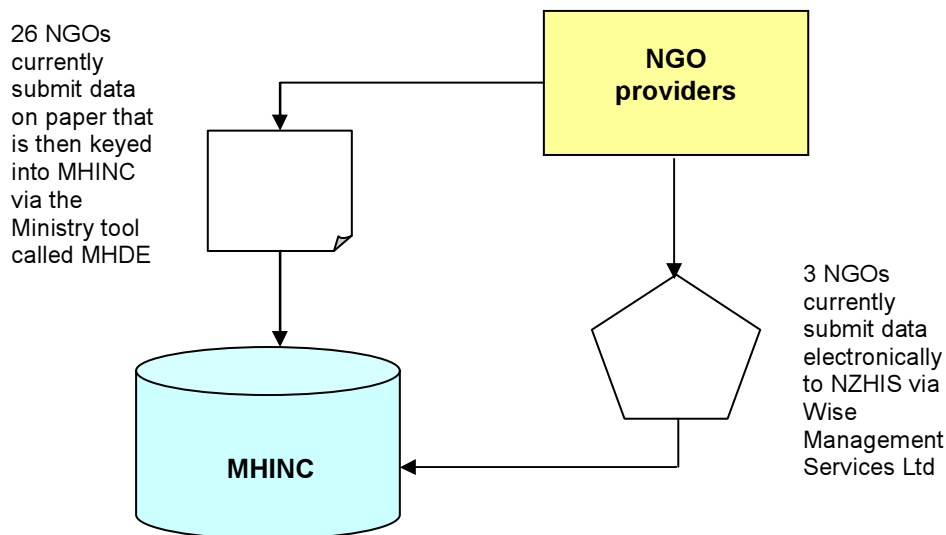
2.0 Current Situation

Since the demise of the Community Reporting System some NGOs have elected to either develop their own information system or have decided to purchase an off-the-shelf product that best meets their own business requirements.

Some DHB funders and planners have also started to progress local information developments with the NGO providers that they fund, with a view to obtaining a comprehensive picture of consumer utilisation of mental health and addiction services in their local DHB area.

Currently only 29 NGOs out of a total of 423 NGO providers are reporting data to the Mental Health Information National Collection (MHINC). Three NGOs submit electronic data extracts to NZHIS via a data management service offered by Wise Management Services Ltd and the remaining twenty six NGOs submit paper records which the Ministry then manually enters into the data warehouse using an existing tool called the Mental Health Data Entry System or MHDE (see Figure 1).

Figure 1 - The Current State of NGO provider reporting to MHINC



3.0 Options for the delivery of data

General approach

The project needs to:

- build on the capabilities already in place within the sector,
- provide solutions to help bridge the gap in capabilities and

- make sure that the approach takes into consideration emerging technological opportunities under the Ministry's National Services Development Programme.

Privacy Considerations

Regardless of the option that is selected by individual NGO providers for the delivery of data to NZHIS most providers will still need to make amendments to their current policies and procedures in order to comply with legislative requirements under the Privacy Act (1993) and the Health Information Privacy Code (1994). In particular, attention will need to be focused on the following:

- Data security (access, control and prevention of data loss)
- Privacy assurance/data ownership and data use
- Compliance and data management
- Error management (particularly in relation to errors reported by NZHIS).

Options

The options available to the sector for the delivery of PRIMHD data to NZHIS will include the following (see Figure 2):

Option	Description
1	Submission of NGO data via a host agency (data management service)
2	Submitting NGO data via the DHB
3	Direct electronic reporting to NZHIS
4	Submission of paper based reporting (hard copy initially but rapidly moving towards the use of a web based form).

Option 1: Submission of NGO data via a host agency (data management service)

As previously stated 3 NGO providers already submit MHINC data electronically to NZHIS utilising a data management service. This option presents some economies of scale for NGOs if enough providers utilise this type of service. It also offers NZHIS one point of contact.

Option 2: Submitting NGO data via the DHB

This option is very similar to the data hosting service option outlined above but the DHB is the host agency. This solution is already utilised by some DHBs at a local level and is enabling the DHB funders and planners to easily match data from the DHB provider arm with data from NGO services. In this way they are forming a picture of service delivery to consumers across the continuum of care.

In some cases this option may not be supported by the NGO providers or the DHB.

Option 3: Direct electronic reporting to NZHIS

Direct file transfer remains an option for those providers that have electronic information systems and are able to meet the file specification and messaging requirements of NZHIS. This could include a variety of mechanisms for transporting the data including direct file submission. This method is suited to providers who have the capability (internally, or through external contractors) to amend their information systems to interoperate with the NZHIS's systems, as well as permitting collection of the data in the first place.

It may also be that, where a number of providers use the same software package from a single vendor, the vendor may be open to amending the package so that it suits a collective purpose. Such a vendor may find a market for the amended package amongst providers who currently have no information system, and amongst those who are prepared to migrate from their existing information systems.

A software package could be developed which would cover all of the requirements for the collection and transmission of data for PRIMHD. This is what was originally envisaged for MHIRS.

As previously stated, if this issue is widely supported there will be issues of:

- version control, so that the providers are always using the latest version
- resources required to create, maintain and support the package
- variety of platforms on which providers would wish to run it (eg different operating systems).

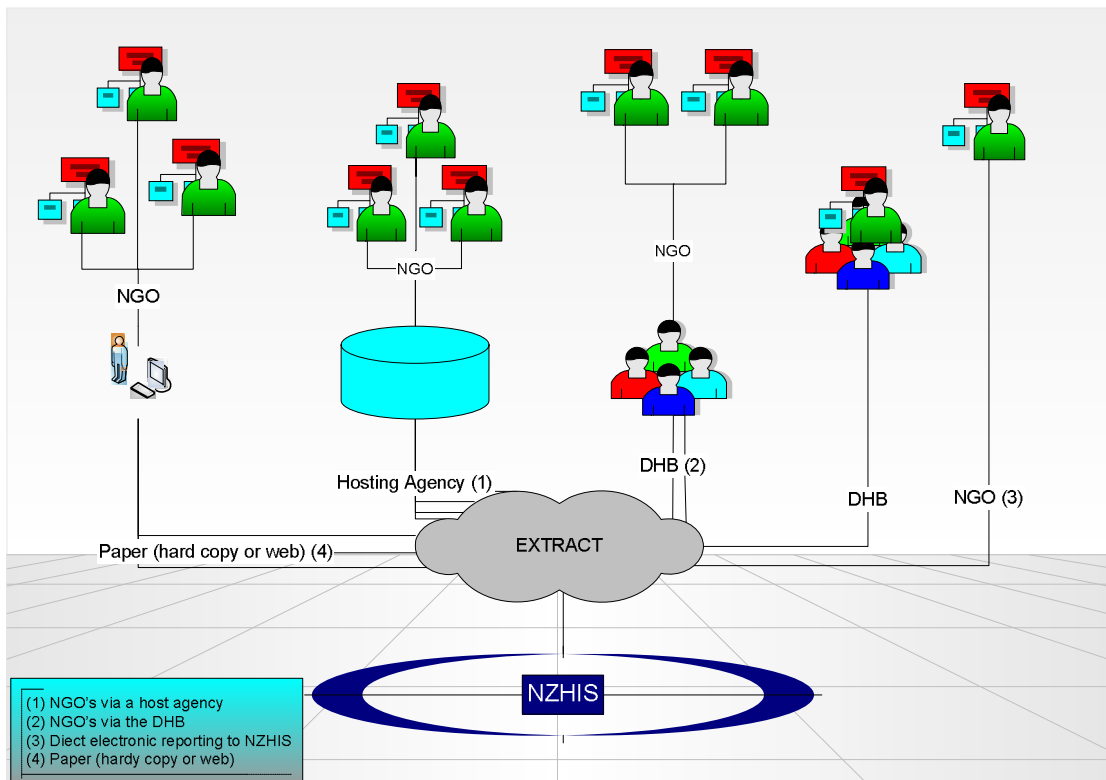
For providers with the simplest requirements (eg; a provider with only a few consumers), and who may not have any information systems at present, it is possible that a package may provide all the functionality they need to run the consumer side of their business as well as collect and transmit PRIMHD information. For other providers this would be highly unlikely; they would be faced with running the package alongside their existing information systems. This will necessitate double-keying of much data, which will be unpopular, and will likely lead to poor quality of the PRIMHD information that is collected.

Option 4: Submission of paper based reporting (hard copy or web based)

This option is used by 29 NGOs at the moment and should remain an option for smaller providers (especially those without electronic systems) in the first year of implementation only. During the first year the expectation is that a web based form will replace any paper based reporting to NZHIS for those NGO providers that want to use this method of reporting their data.

It is also a good option for those providers where the provision of mental health and addiction services is not their core business and where they provide services for only a few consumers. These providers may want to submit a report to NZHIS using the easiest method possible for them.

Figure 2 - Options for the delivery of mental health PRIMHD data to NZHIS



Utilising the funding for the Mental Health Information Reporting System

The Mental Health Information Reporting System (MHIRS) was initially conceived of as an information system that the Ministry would develop to give to those NGOs that did not have one. At face value this appears to be an attractive option, but software development is not part of usual Ministry business and presents some issues for the Ministry regarding ownership and ongoing maintenance as well as the management of any associated upgrades. In addition, there is also a requirement to provide some sort of support function to make sure that the NGO workforce receives the technical training and ongoing advice that they need in order to effectively use the product.

Given these difficulties, as well as the fact that the NgOIT survey indicated that some NGOs already have an information system of one kind or another, the funding for MHIRS has been put on hold until such time as a clear direction emerges from the planning process for the implementation of PRIMHD with NGOs.

One of the proposed alternatives that has already emerged during discussions about PRIMHD is that the Ministry uses the MHIRS funding to support NGO information developments in other ways that best meets local/regional information requirements for NGOs. The difficulty with this approach is that the amount of central funding under consideration is small and would become even smaller if it was to be divided up on a pro rata basis. Another suggestion is that it is best invested in the development of a central electronic mechanism to report data and which would replace the paper form.

The final decision will be informed by a process of consultation with DHB funders and planners via their regional networking forums that started in December 2007.

4.0 Suggested approach

The Ministry intends that the implementation of PRIMHD for NGOs will be in five stages that extend over a three year timeframe starting on 1 July 2008 (Table 2). The Ministry is focused on collecting information about those service types where it is possible to report service activity for each consumer using a unique national health index number (NHI). The rationale for adopting this approach is that all national health collections rely on the reporting of the consumer NHI as an integral part of the anchoring framework under the Health Information Strategy for New Zealand (2005).

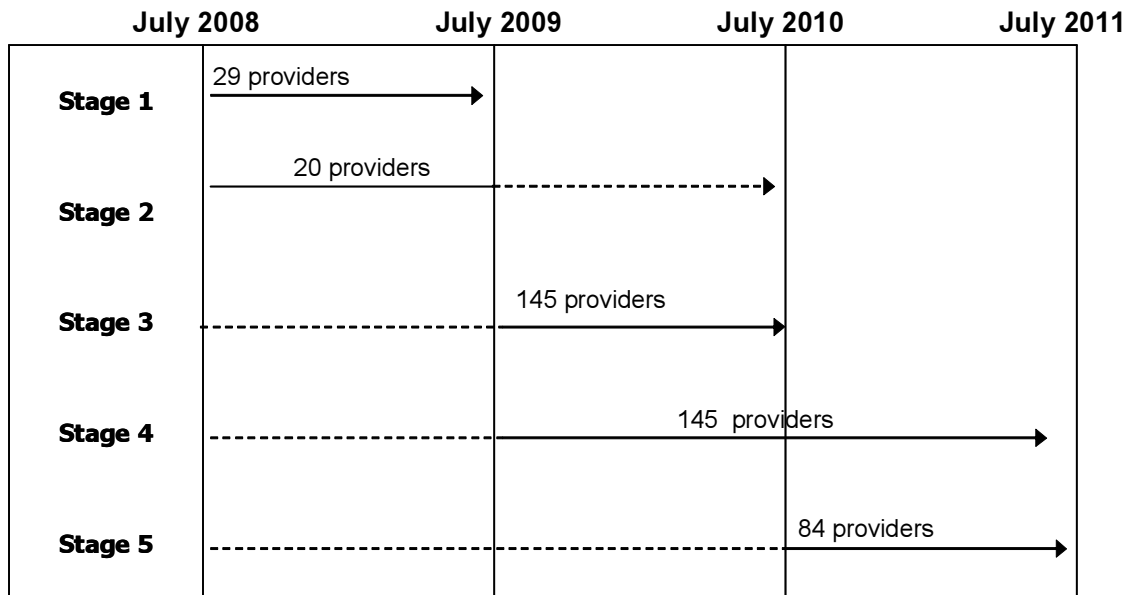
Table 2: Proposed stages for the national rollout for NGOs

Stage	Which NGOs	% Total NGO Mental Health funding (cumulative %)
1	Transitioning of those 29 NGO providers that currently report MHINC data	18% (18%)
2	20 NGO providers with large volume contracts that are not currently reporting to MHINC	33% (51%)
3	NGO providers with supportive DHB funders and planners that are willing and ready to submit PRIMHD data to NZHIS.	21% (72%)
4	Remaining NGOs that are able to report service activity against the consumer NHI number.	23% (95%)
5	NGOs that are currently out of scope for PRIMHD	5% (100%)

The expectation is that all NGO providers that are able to report service activity against the consumer NHI will be reporting to NZHIS at the end of the three year period.

The five stages will run concurrently thereby enabling any NGO provider to start reporting their information to NZHIS at any time. This approach is reflected in figure 3. The solid line indicates the Ministry's particular area of focus for each of the stages but does not preclude any provider being part of the implementation process starting 1 July 2008.

Figure 3: Concurrent proposed stages of NGO rollout of PRIMHD



The Ministry will conduct an internal review at the end of each stage to help inform the next stage. This reflects a commitment to a process of continuous learning and ongoing improvement by the Ministry.

The NZHIS national rollout team has a dedicated NGO resource to assist providers with any issues that they may encounter over the period of implementation.

The following section provides more detail about each of the five stages.

N.B: Please note that all tables exclude funding for child and youth day programmes, methadone places and non-blueprint services.

1. Stage one – transitioning of current NGO providers reporting to MHINC

Stage one is focused only on the 29 mental health NGO providers that are already reporting information to the Mental Health Information National Collection (MHINC) with the intention that all of these providers will begin reporting PRIMHD data to NZHIS from 1 July 2008.

Analysis shows that these providers cover 18% of the total funding for Mental Health and Addiction services. This funding is further broken down in Table 3:

Table 3 – Summary of mental health funding for stage 1 NGOs (those NGOs currently reporting to MHINC)

Mental Health Commission Group Description	Sum of 2006/07 Total funding \$M for stage 1 NGOs	Total NGO mental health Funding \$M	Percentage of Total NGO mental health Funding
A&D Beds	3.3	13.3	25%
A&D Community FTEs	5.8	30.3	19%
Adult Residential Beds	6.6	72.3	9%
Community MH FTEs	4.5	19.4	23%
Community Support FTEs	25.1	98.8	25%
C&Y Community FTEs	0.4	12.4	3%
Specialist Community FTEs	0.1	1.1	5%
Adult Inpatient Beds	0	1.9	0%
Forensic Beds	0	2.8	0%
Forensic Community FTEs	0	0.5	0%
Specialist Beds	0	0.1	0%
Total	45.8	252.9	18%

Criteria for stages 2, 3, 4 and 5:

A staged approach is planned for those NGOs currently not reporting to MHINC. The staged approach is based on the following criteria:

1. Size (based on those providers that have larger contracted volumes)
2. Service type (all NGO services that are able to report service activity against the consumer's NHI)
3. Selection of data delivery mechanism
4. Current service capability – level of 'readiness' to report to NZHIS
5. Willingness to report data
6. Level of DHB funder and planner support

Initial consultation with the sector indicates that 'willingness' and 'service readiness' will be the biggest factors that dictate when a NGO provider might be able to engage with their DHB funder and planner and with the national NZHIS rollout team.

Issues that NGOs will face include IT infrastructure, workforce development/training, quality assurance processes, information utility, privacy assurance and change management. There are opportunities for some NGO providers with greater capacity and capability to offer advice to other NGO providers that require assistance with one or more of the above issues.

2. Stage two – NGO providers with larger contracted volumes that are not currently reporting to MHINC

The emphasis in stage two will be on those twenty NGOs that deliver mental health and addiction services to a large group of consumers and that do not currently report their service activity to MHINC.

Currently 33% of mental health funding for mental health and addiction NGO providers is directed towards twenty large mental health & addiction NGO providers that deliver a wide range of services to a significant number of consumers and do not report on that activity to NZHIS (see Table 4).

Further work will be required (in conjunction with their DHB funder and planner) to identify to what extent each of these 20 providers meet the other five criteria before developing a more detailed implementation plan with each NGO provider that specifies

activities designed to increase 'service readiness' to report and that specifies the timeframes for reporting.

Table 4 – Summary of mental health funding for stage 2 NGOs (20 mental health & addiction NGO providers with greatest contracted volumes)

Mental Health Commission Group Description	Sum of 2006/07 Total funding \$M for stage 2 NGOs	Total NGO mental health Funding \$M	Percentage of Total NGO mental health Funding
A&D Beds	3.3	13.3	24%
A&D Community FTEs	6.5	30.3	22%
Adult Inpatient Beds	1.9	1.9	100%
Adult Residential Beds	31.9	72.3	44%
C&Y Community FTEs	5.1	12.4	41%
Community MH FTEs	5.4	19.4	28%
Community Support FTEs	26.2	98.8	26%
Forensic Beds	2.8	2.8	100%
Forensic Community FTEs	0.5	0.5	100%
Specialist Beds	0.1	0.1	100%
Specialist Community FTEs	0	1.1	0%
Total	83.6	252.9	33%

Whilst this stage will be predominately focused on working with the larger NGO providers to develop implementation plans it does not preclude the inclusion of any other NGO that is able and willing to report data to NZHIS. The expectation is that these providers will indicate their interest either directly to NZHIS or, via their DHB funder and planner, and that they will develop an implementation plan detailing the timeframe for reporting in conjunction with the DHB funder and the NZHIS national rollout team.

It is important to note that the timing is not only dependant on NGO readiness but that it is also dependant on NZHIS resources, especially with regard to the receipt of any further paper based reporting up to 1 July 2009. At this date all paper based reporting will have been replaced by provider access to the NZHIS web based form.

3. Stage three:

The scope of stage three will be dependant on the results of the communication and engagement process undertaken as part of the DHB funders and planners initial scoping exercise. Again provider willingness and capability issues will influence decisions about which providers are included in this stage of the national rollout. In addition, the reporting mechanism that is selected by each NGO to deliver data will have a direct impact on the resources required by the DHB and by NZHIS to manage the increased reporting. For this reason it is suggested that each DHB funder and planner work with their contracted NGO providers to establish the degree of 'readiness' and the most likely method of reporting with a view to developing a more detailed implementation plan in conjunction with the DHB funder, each provider and with NZHIS.

4. Stage four:

The fourth stage aims to obtain the data from the remaining NGOs that are able to report service activity against the consumer NHI number. These NGOs currently receive a further 23% of Mental Health and Addiction Services (Table 5).

These four stages combined will succeed in capturing data from NGOs that currently receive 95% of the total funding on mental health and addiction services in the NGO sector.

Table 5 – Summary of mental health funding for stage 4 NGOs

Mental Health Commission Group Description	Sum of 2006/07 Total funding \$M for stage 4 NGOs	Total NGO mental health Funding \$M	Percentage of Total NGO mental health Funding
Community Support FTEs	15.4	98.8	16%
A&D Beds	2.5	13.3	19%
A&D Community FTEs	8.6	30.3	28%
Adult Residential Beds	21.5	72.3	30%
Community MH FTEs	6.4	19.4	33%
C&Y Community FTEs	3.7	12.4	30%
Specialist Community FTEs	0.5	1.1	47%
Adult Inpatient Beds	0	1.9	0%
Forensic Beds	0	2.8	0%
Forensic Community FTEs	0	0.5	0%
Specialist Beds	0	0.1	0%
Total	58.6	252.9	23%

5. Stage five:

The funding for those NGOs that are currently out-of-scope for PRIMHD is summarised in Table 6. The service types covered by these NGOs mostly include drop-in centres and other community day programmes where it is not practical to report service activity on the basis of the consumer NHI.

Table 6 – Summary of mental health funding for stage 5 NGOs

Mental Health Commission Group Description	Sum of 2006/07 Total funding \$M for stage 5 NGOs	Total NGO mental health Funding \$M	Percentage of Total NGO mental health Funding
Community Support FTEs	12.5	98.8	13%
A&D Beds	0	13.3	0%
A&D Community FTEs	0	30.3	0%
Adult Residential Beds	0	72.3	0%
Community MH FTEs	0	19.4	0%
C&Y Community FTEs	0	12.4	0%
Specialist Community FTEs	0	1.1	0%
Adult Inpatient Beds	0	1.9	0%
Forensic Beds	0	2.8	0%
Forensic Community FTEs	0	0.5	0%
Specialist Beds	0	0.1	0%
Total	12.5	252.9	5%

NB: Appendix C identifies how many NGO's are involved in each of the 5 stages above and identifies which DHBs hold the contracts for those NGO's. It is important to acknowledge the DHB that holds the contract with the NGO if the DHB funders are to be involved in bringing each NGO on board to report to PRIMHD.

Regional analysis

The Ministry has also completed some preliminary analysis that focuses on the number of NGO providers in each of the four regions given that DHB funders may choose to develop a more regional approach towards implementation (see appendix B). The total mental health and addiction funding represented by these providers per region is also broken down in Table 7.

Table 7 – Total NGO provider mental health and addiction funding per region (2006/07)

Region	Total \$M 2006/07	% total funding
Central	39.3	16%
Midland	52.3	21%
National	20.6	8%
Northern	85.1	34%
Southern	55.6	22%
Total	252.9	

5.0 Engagement with Maori NGO providers

Maori health providers deliver a range of services that are tailored to respond to their communities needs and which may be funded by a number of different agencies. Mental health and addiction services may only make up a small part of their overall service delivery.

Maori organisations affiliate to diverse regional and national networks and therefore it is critical that any communication strategy will incorporate culturally appropriate methods for engaging and working with this part of the sector. NZHIS will consult with the Maori Mental Health team within the Ministry to decide on the best way forward.

Table 8 outlines the numbers of Maori providers over the five different stages. These providers have been identified by either the contracted service type or the GL code and not by the name of the organisation.

Table 8 – Number of Maori NGO providers by stage

	Stage 1 (current MHINC submitters)	Stage 2 (largest 20 NGOs)	Stage 3	Stage 4	Stage 5	Grand Total
Maori providers	5	5	40	39	15	104

6.0 NGO data requirements for PRIMHD

There will be minimal changes to the actual data items that are currently reported by NGOs to the national collection as most of the enhancements that were made to MHINC in the development of PRIMHD do not apply to NGOs (e.g. reporting of ECT events and the use of seclusion). Most of the changes that have been made are in the area of the business rules and the file specification. NZHIS will develop some user guidelines and offer training to assist NGOs to report their data in the new format.

The national collection integrates service activity and consumer outcome data. At present only DHBs are required to collect outcomes data unless the lead clinician is situated within the NGO. Approximately five NGO providers have been identified as potentially employing a lead clinician on the basis of the following purchase unit types: employing a medical FTE, providing inpatient beds or offering clinical forensic services.

7.0 Technical solutions supporting the delivery of data

In addition to considerations about which agency is best placed to deliver the data there are also a number of technical solutions that the Ministry is considering as part of its PRIMHD developments that would help facilitate the transfer of data from NGO providers to NZHIS. These technical developments are twofold:

- (a) the development of a web form for those providers that wanted to submit 'paper' records and;
- (b) a web based service model for providers that want to electronically transmit their data.

A web service model has the advantage that it does not mandate the use of one specific network provider. It can also interact with different electronic information systems used by different NGO providers and can deal with a range of data hosting arrangements as long as the xml script identifies the agency that actually produced the data as well as the agency submitting it. The intention is to move from a FTP to a more secure connection over time.

7.1 Web enabled access to National Systems

This type of technical development aligns with the web enabled access to National Systems that is signalled under the Health Information Strategy for New Zealand (HIS-NZ). The Strategy highlights that an improvement in the ability of stakeholders to access national systems is required under Action Zone 11: National System Access.

The National Systems Development Programme is a four-year initiative that has been established by the Ministry to meet the objectives of HIS-NZ. Specifically, the Programme has been established to deliver improved and sustainable national payment, information and connectivity systems that interact more efficiently in the health and disability sector.

One of the tasks under this programme of activity is to design and develop the technical infrastructure that will facilitate secure controlled access to the suite of national data collections for a number of authorised stakeholders (Ref: Action Zone 11 in the Health Information Strategy for New Zealand). HIS-NZ signals that a web based portal is one of the options that would offer authorised stakeholders secure access to a cross sector view of consumer utilisation of health and disability services, including mental health.

If this type of web based infrastructural development is approved it will affect how NGO providers will interact with the Ministry of Health in the future with regard to their reporting of PRIMHD data as well as what level of secure access they will have to any information stored in the national systems.

The successful operation of the NZHIS national database systems is dependent upon the efficient exchange of information between the heterogeneous systems operated by the various health organisations connected to the NZHIS Data Network. The technical solution for PRIMHD considered three types of message formats for reporting purposes and eventually settled on the use of xml, given that a schema could be provided to the sector with some validation rules already included.

Access to broadband remains an issue for NGO providers that deliver a service in remote geographical locations and this issue needs to be factored into any local and national planning.

8.0 Impact of selected options

8.1 Impact on NGO providers

Two goals of the project include “Keep it Simple” and “Reduce maintenance overheads”. The impact to organisations will vary depending on the current status of their information infrastructure. Any impact will need to be managed and agreed through the local DHB funders.

8.2 Impact on Ministry of Health and NGO Providers

The impact of implementing PRIMHD on NGO providers and the Ministry of Health is summarised below (Table 9). The impact on District Health Boards from the NGO rollout is not listed and is dependant to a large extent on the mechanism that is selected at the local DHB level for reporting NGO data to NZHIS. If the DHB is selected as the preferred data hosting agency there are significant implications for the DHB with regards to managing the associated changes in business processes, putting in place the necessary technical infrastructure and training the workforce to deal with the changes.

Table 9: Impacts on NGO providers and the Ministry of Health

	NGO Providers	Ministry of Health
MHIRS	<ul style="list-style-type: none"> • Significant flexibility with regards to local application of MHIRS funding for operational costs. • Workforce Development • Change management regarding the use of information • Benefit realisation 	<ul style="list-style-type: none"> • Development of a web service model • Provision of support services • Development of Service Level Agreements • Benefit realisation • Relationship management
Via host agency	<ul style="list-style-type: none"> • Operational and capital costs • Workforce Development • Change management regarding the use of information • Benefit realisation 	<ul style="list-style-type: none"> • Development of a web service model • Establishment of contracts with host agencies • Provision of support services • Help desk / account management • Benefit realisation • Relationship management
Via DHB	<ul style="list-style-type: none"> • Operational and capital costs • Workforce Development • Change management regarding the use of information • Benefit realisation 	<ul style="list-style-type: none"> • Development of a web service model • Establishment of contracts with DHBs • Provision of support services • Help desk / account management • Benefit realisation • Relationship management

	NGO Providers	Ministry of Health
Direct	<ul style="list-style-type: none"> Operational and capital costs Workforce Development Change management regarding the use of information Benefit realisation 	<ul style="list-style-type: none"> Development of a web service model Development of Service Level Agreements with NGO providers Provision of support services Help desk / account management Benefit realisation Relationship management
Paper Based	<ul style="list-style-type: none"> Minimal disruption Minimal cost Workforce Development Change management regarding the use of information Benefit realisation 	<ul style="list-style-type: none"> Development of a web form Additional personnel to manage extra 'paper' based reporting Establishment of Service Level Agreements Provision of support services Help desk / account management Benefit realisation Relationship management

8.3 Impact on NZHIS Business Operations

The impact on NZHIS is significant and includes changes to both the technical architecture and to business operations. The impacts on business operations are outlined below (Table 10).

Table 10: Impacts on NZHIS Business Operations

Option	Impacts
Via host agency	<p>Assumes access to NZHIS will be via the host agency's FTP.</p> <ul style="list-style-type: none"> Business Operations will set up each agency with its own FTP access and do the work to maintain the FTP directory. Business Operations will provide each Agency with information packs to help them get a digital certificate. Business Operations will run compliance tests for each NGO within each Agency and issue them with compliance certificates. Business Operations will provide a helpdesk service and ongoing support for loading provider files and returning error files. The Data Quality team will provide relationship management services - chasing up missing data and NGOs that have stopped reporting and following up on data quality issues. The Data Quality team can provide reconciliation reports so that each NGO can see summaries of their data that has been successfully loaded. (If they have web access this may not be required). The Data Quality team and Business Operations will work to maintain code tables to ensure that data from new teams can be reported. There is an ongoing relationship management function that is required for new NGOs reporting for the first time, and those that are changing their reporting. The Data Quality team will set up mapping documents for each of the NGOs and get them signed off.

Via DHB	<p>Assumes access will be via the existing DHB's FTP.</p> <ul style="list-style-type: none"> • Business Operations will do the work to maintain each DHBs FTP directory, building new folders for each NGO as required. • Business Operations will run compliance tests for each NGO within each DHB and issue them with compliance certificates. • Business Operations will provide a helpdesk service and ongoing support for loading provider files and returning error files. • Data Quality Team will provide relationship management services - chasing up missing data and NGOs that have stopped reporting and following up on data quality issues. • Data Quality Team can provide reconciliation reports so that each NGO can see summaries of their data that has been successfully loaded. (If they have web access this may not be required). • Data Quality Team and Business Operations will work to maintain code tables to ensure that data from new teams can be reported. • There is an ongoing relationship management function that is required for new NGOs reporting for the first time, and those that are changing their reporting. • Data Quality Team will set up mapping documents for each of the NGOs and get them signed off.
Direct	<p>Assumes access to NZHIS is via the FTP directory (i.e. they send in their own extract file)</p> <ul style="list-style-type: none"> • Business Operations will set up each NGO with its own FTP access and do the work to maintain the FTP directory. • Business Operations will provide each NGO with information packs to help them get a digital certificate. • Business Operations will run compliance tests for each NGO and issue them with compliance certificates. • Business Operations will provide a helpdesk service and ongoing support for loading provider files and returning error files. • Data Quality Team will provide relationship management services - chasing up missing data and NGOs that have stopped reporting and following up on data quality issues. • Data Quality Team can provide reconciliation reports so that each NGO can see summaries of their data that has been successfully loaded. (If they have web access this may not be required). • Data Quality Team and Business Operations will work to maintain code tables to ensure that data from new teams can be reported • There is an ongoing relationship management function that is required for new NGOs reporting for the first time, and those that are changing their reporting. • Data Quality Team will set up mapping documents for each of the NGOs and get them signed off.
Paper based	<p>Access to PRIMHD will be via NZHIS's FTP directories (i.e. Data Management Services creates the load file from paper and puts it in the FTP directory for processing)</p> <ul style="list-style-type: none"> • Business Operations will set up FTP directories for groups of NGOs and they will do the work to maintain the FTP directories. • Business Operations will provide each NGO with information packs to help them get a digital certificate. • Business Operations will run compliance tests for MHDE (the software that generates the load files) when it is upgraded. • Business Operations will provide a helpdesk service and ongoing support for loading provider files and returning error files. • Data Quality Team will provide data entry services - quality assuring paper reports from NGOs and creating the PRIMHD load files from them.

	<p>Access to PRIMHD will be via NZHIS's FTP directories cont.</p> <ul style="list-style-type: none"> • Data Quality Team will provide relationship management services - chasing up missing data and NGOs that have stopped reporting and following up on data quality issues. • Data Quality Team can provide reconciliation reports so that each NGO can see summaries of their data that has been successfully loaded. (If they have web access this may not be required). • Data Quality Team and Business Operations will work to maintain code tables to ensure that data from new teams can be reported. • There is an ongoing relationship management function that is required for new NGOs reporting for the first time, and those that are changing their reporting. • Data Quality Team will set up mapping documents for each of the NGOs and get them signed off.
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8.4 Impact on roles and responsibilities

Personnel impacts make up the largest change associated with this implementation. This project once implemented will change the way that data is collected at the NGO level, may also impact on DHBs if they elect to host NGO data, and will also change what happens at the NZHIS level.

The role of NZHIS will include offering additional support services which will require Service Level Agreements to be developed including:

- Ad Hoc Reporting
- Ad Hoc Extracts

The existing PRIMHD site coordinators continue to play a key part in transition planning for the new collection, and are required to continue managing outcome developments within their DHBs whilst transitioning their role into an information specialist and support role for the new PRIMHD collection.

Te Pou will continue to provide the sector with expert advice on the outcome measures (as they become available), provide training for the NGO workforce and offer advice and expertise to NGO providers in the use of information. This is a significant new area of development but much has already been learned from the MH-SMART initiative with regard to supporting the roll-out of outcome measures in the DHBs that can also be applied to the PRIMHD information collection and use by NGOs.

Platform Inc is a national body for NGOs. The Ministry has funded this organisation to support the implementation of the PRIMHD project at a national and at a local NGO level and to participate in the national planning process.

8.5 Impact on accountabilities

There is a current requirement in all mental health and addiction contracts that NGO providers report information to MHINC.

The reporting requirements are as follows (see Part 3, 8.1) *“Service providers must establish and maintain an information system that complies with the requirements of the NZHIS, this must be capable of measuring health outcomes as well as the utilisation of services. The system will maintain records of consumer ethnicity, presenting problem, service utilisation data, demographic information, outcome and evaluation data.*

The information system will be NHI based and consumer centred, with accurate collection and recording of consumer ethnicity seen as a priority”.

Any impact to existing accountabilities will be with the agreement of the impacted parties and will include DHB funders and NGO providers (external to the Ministry) and the NZHIS Business Intelligence Unit and the Mental Health Group (internal to the Ministry).

8.6 Impact on technology

Technology impacts will include other initiatives within the Ministry including any enterprise architecture plans and major infrastructure projects over the next two years.

There is less of a focus now on the type of electronic information system that providers have chosen to use and more of a focus on their capacity to engage with a high speed secure network. The NgOIT survey indicated that most NGO providers already utilise broadband but that they may not have the applications to make the most of the opportunities that are presented by new technology.

9.0 Summary

This paper reflects a number of issues that have already been raised by NGO service providers via the NGO Advisory Group regarding the implementation of PRIMHD. The Ministry has developed a FAQ sheet to address the most commonly asked questions but the most difficult issues to be addressed by NGO providers cannot be covered in a FAQ and are more long-standing and systemic in nature. These include:

- Lack of an information infrastructure
- Lack of capacity and capability
- Lack of workforce development
- Issues with privacy and security of information
- Issues with benefit realisation at a provider level
- NGO business processes are underdeveloped in some cases.

It should also be noted that this project will not address the different reporting requirements that are stipulated in the different contracts that NGO providers hold with various government agencies. However, what is able to be addressed through this project is the amount of reporting to both HealthPAC and to NZHIS. For those NGO providers delivering mental health and addiction services and implementing PRIMHD, one of the benefits will be a decrease in their reporting to HealthPAC over time.

The ideal arrangement for providers is that PRIMHD forms the core data set for reporting purposes and that any additional reporting (both quantitative and qualitative) is based on clearly understood requirements that are meaningful to both the NGO provider and to the funder. This issue will be addressed as part of the current review of the Nationwide Service Framework.

Appendix A

List of NGO's that currently report to NZHIS using paper forms. NZHIS then manually enters the data into MHINC using the MHDES tool:

Auckland City Mission
Bay of Plenty Community Homes Trust
Caroline House Inc Society
Cheviot Rest Home
Christchurch City Mission
Claire House
EQUIP
Forbury House Trust
HealthCare NZ
Like Minds Taranaki
Mahia Mai A Whai Tara Trust (under Tui Ora contract)
Manaaki Oranga Ltd (under Tui Ora contract)
Mt View Residential Trust
Northpoint Trust
Raumano Health Trust (under Tui Ora contract)
Salvation Army Bridge Program
Sarona Community Trust
Seedel Homes
Te Ihi Rangi Trust (under Tui Ora contract)
Te Rau Pani Maori MH Trust (under Tui Ora contract)
Te Whare Puawai O Te Tangata (under Tui Ora contract)
Te Toka O Maru O Taranaki Trust
Tu Tama Whaine O Taranaki (under Tui Ora contract)
Tranx Inc
Waiheke Island Supported Homes Trust
Wairarapa Addiction Services

NGOs that currently report to NZHIS electronically:

Pathways
Work Wise
IRIS (under the Mental Health Solutions contract)

Appendix B

Number of NGO mental health and Addiction providers involved in each implementation stage by region

Region	Stage 1 (current MHINC submitters)	Stage 2 (largest 20 NGOs)	Stage 3 & 4		Stage 5		Grand Total
			Large	Small	Large	Small	
Northern	7	10	18	24	0	14	73
Midland	10	3	19	53	1	23	109
Central	4	2	19	38	0	22	85
Southern	7	4	24	95	0	24	154
National (MOH)	1	1	0	0	0	0	2
Total	29	20	80	210	1	83	423

*Note: * 'Region' is the region of the DHB where the largest contract is held*

Large denotes a contract of \$500,000 and over

Small denotes a contract of under \$500,000

Appendix C

Number of NGO mental health and addiction providers by DHB at each implementation stage

DHB	Stage 1 (current MHINC submitters)	Stage 2 (largest 20 NGOs)	Stage 3 and 4		Stage 5		Grand Total
			Large	Small	Large	Small	
Auckland	4	4	4	8		7	27
Bay of Plenty	1		6	21		13	41
Canterbury	5	2	13	50			70
Capital and Coast	1	1	7	22			31
Counties Manukau	1	2	3	2		3	11
Hawkes Bay			5	7		2	14
Hutt			4	3		8	15
Lakes	1		6	17			24
Mid Central	1	1	2	3		4	11
Nelson Marlborough			4	5		7	16
Northland	1		4	4		4	13
Otago	1	1	4	16		11	33
South Canterbury	1			5		5	11
Southland		1	3	19			23
Tairāwhiti			2			4	6
Taranaki	5			4			9
Waikato	3	3	5	11	1	6	29
Wairarapa	1			2		3	6
Waitemata	1	4	7	10			22
West Coast						1	1
Whanganui	1		1	1		5	8
Ministry of Health	1	1					2
Grand Total	29	20	80	210	1	83	423

Note:

* 'DHB' is the DHB where the largest contract is held

* If an NGO holds a contract with a specific DHB they are counted under that DHB rather than the DHB with the largest contract

* Large denotes a contract of \$500,000 and over

* Small denotes a contract of under \$500,000