

**National Mental Health
Information Strategy
Implementation Plan 2006**

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MANATŪ HAUORA

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Introduction

This Implementation Plan for the National Mental Health Information Strategy outlines the future actions needed to address information gaps and move the mental health sector closer to the ideal of an integrated network of service providers, especially in the non-governmental organisation (NGO) sector.

The need for good-quality information to support the development of health services generally, and mental health services specifically, has been recognised in several reports. However, these documents also acknowledge that the use of information in the health sector in New Zealand is not ideal, and that ‘better means of organising health information need to be employed’ (Ministry of Health 2001a).

Mental health service providers have already invested substantially in the collection and use of current information, so this Implementation Plan suggests activities to enhance what has already been accomplished, using resources that are already in place and focusing on areas requiring further work.

The next stage of information development in mental health in five years time will hopefully be quite different to what is expressed in this Implementation Plan, principally because providers will be able to build on the infrastructure that has been established as a result of the successful implementation of the activities outlined here. By 2010 technology will have inevitably progressed, making possible what is barely conceivable today. These rapid advances in technology, coupled with increasing demands by both consumers and their whānau for shared power in the therapeutic relationship,

expressed in the form of shared information, will drive a revolution in the creation of ‘new’ knowledge – ‘new’ in the sense that the various individuals who participate in the consumers’ system of care rediscover, critically evaluate and then apply the information that is already available to them.

It may be that this is the single most important change that needs to occur in the mental health system with regard to mental health information development. The people who interact with consumers on a daily basis want to know if what they provide to consumers really contributes to the process of recovery and, on the basis of their findings, are willing to change what they do in order to improve that contribution.

This human and organisational challenge is fundamental to the development of a high-quality mental health system, and all of the priority areas in this Implementation Plan depend on demonstrated leadership in this area.

On a purely technical level, the actions in this Implementation Plan are located within the broader range of national health information initiatives outlined in the Health Information Strategy for New Zealand (Ministry of Health 2005a). Synergies between both strategies are expressed later in the document, so that the information priorities that have been identified in the wider health sector will engender an increased focus on the same priority areas for mental health.



National Mental Health Information Strategy

Aim

The aim of the National Mental Health Information Strategy is to improve the collection and use of the two types of mental health information.

- Information collected to support the delivery of care to individual consumers (commonly collected by patient management information systems).
- Information collected to support the management of mental health service systems (eg, for funding, planning, monitoring and policy development).

Principles

The ongoing development of information systems offers stakeholders an opportunity to share information in such a way that ensures consumers can be confident they will receive the best care regardless of which provider they see. Three core principles are proposed to guide the ongoing development of mental health information systems:

- partnership – active engagement of consumers in the therapeutic relationship and greater access to areas such as records and recovery plans
- protection – privacy and security of information
- participation – connectivity between individuals and agencies.

These principles support the development of an information base (monitoring, research, evaluation, resource allocation, outcome and performance information) that will contribute to achieving whānau ora.

The Strategy represents more than a set of technical activities to support the collection of mental health information. Providers have already invested significant sums of money into developing information systems to meet their own and national requirements. The task ahead is to reach a consensus on how to improve the systems already in place.

Drivers for change

The health and disability sector, like other sectors, continues to increase its investment in information systems in response to an increasing demand for better information on which to base decisions. Investments such as the National Health Index to provide a unique consumer identifier, National Minimum Data Set for inpatient services, Mental Health Information National Collection (MHINC) and Mental Health Standard Measures of Assessment and Recovery (MH-SMART) have all significantly increased the sector's capacity to describe the services that are being delivered, to whom and to what effect.

Linkages between the National Mental Health Information Strategy and the Health Information Strategy

As noted above, the Mental Health Strategy is one of a number of health care strategies developed to address growing demand, and to direct the delivery of services to those most in need. Quality information is required in order to make effective, informed decisions about service delivery for individuals, communities and populations.

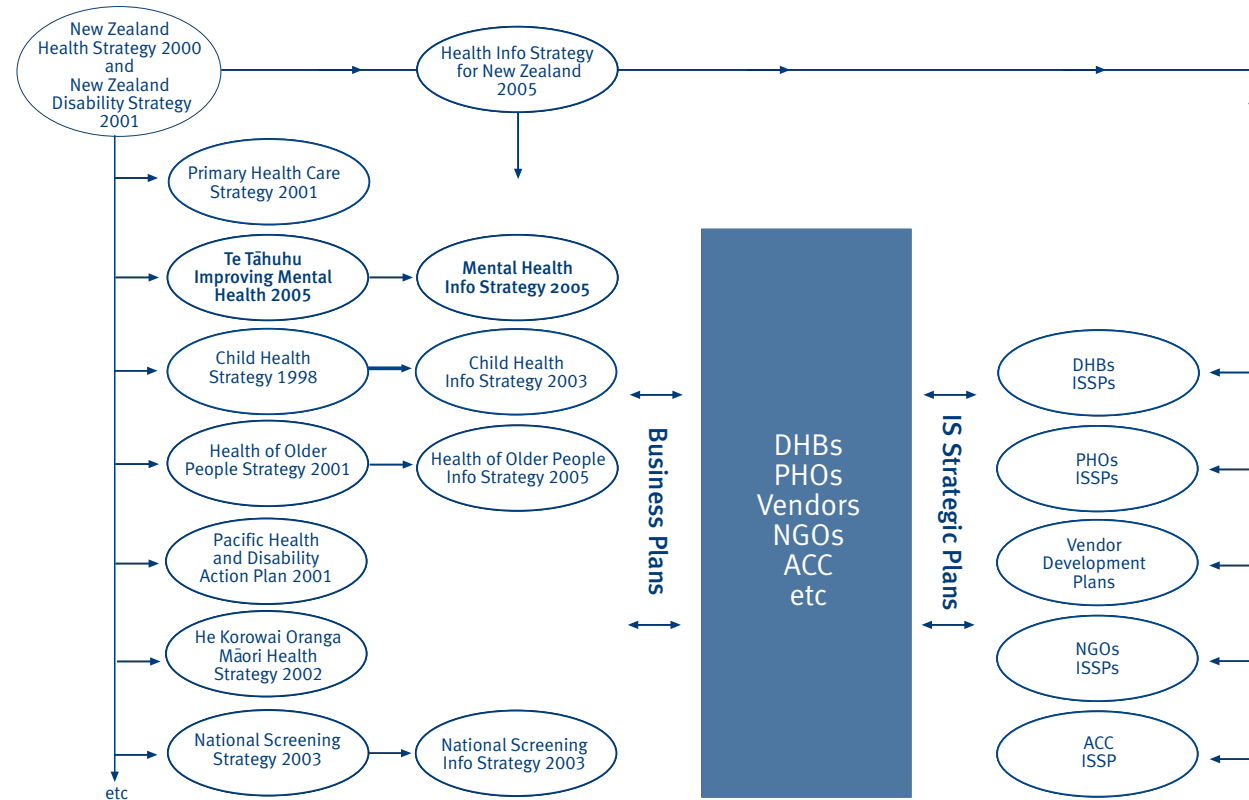
To facilitate this process at a national level, the Health Information Strategy for New Zealand (HIS-NZ) has been developed to provide a context to support the New Zealand Health Strategy and the New Zealand Disability Strategy to use information in innovative ways to improve the health and independence of New Zealanders.

HIS-NZ provides a direction for the health and disability sector to make better decisions about how to improve the quality and availability of health information. The linkages between health strategies and information strategies are illustrated in Figure 1.

In approving the HIS-NZ, the Minister also established the Health Information

Strategy Action Committee to provide governance, oversight and leadership for the implementation of the Strategy. The Strategy and the Committee reflect the trend towards joined-up service delivery, where health care is planned and delivered by a mix of parties, including District Health Boards (DHBs), public health organisations, primary, secondary and community providers, professional associations, government departments, iwi authorities, local authorities and researchers.

Figure 1: The linkages between health strategies and information strategies



The HIS-NZ identifies 12 information management and technology initiatives known as ‘action zones’ as the priorities for collaborative sector activity over the next three to five years. These priorities evolved from a stocktake of the sector’s current capabilities and practices against the information management capabilities required to deliver New Zealand’s seven major health and disability strategies.

This Implementation Plan acknowledges that HIS-NZ is the overarching information strategy for the health sector, and the specific projects and initiatives contained in this Plan can be aligned with HIS-NZ and its action zones (see ‘Interdependencies and Constraints’).

Non-governmental organisations’ development

Many of the activities given in the Plan are particularly relevant to the NGO sector, because most NGO providers have limited capability to connect with and participate in a local information system, let alone a national one. Given that the level of mental health services funding to be provided to the NGO sector is around 28 percent of the total, it is important that NGOs as well as DHB provider arms provide information on the consumer utilisation of services to support comparisons between regions about the effectiveness, efficiency, quality and coverage of their mental health services.

Currently only 32 NGOs out of an estimated total of 350 providers are reporting data to the MHINC, either by paper or from their own electronic systems. The Ministry has recently undertaken a substantive analysis of the MHINC and contract data in an effort to

provide an informed estimate of how much data from unique mental health consumers is not currently being captured. The analysis shows that data from approximately 19 percent of consumers may not be captured at the national level.

The Ministry is increasingly reliant on the accuracy and completeness of the MHINC data set to assess the overall performance of the mental health sector. Without complete NGO data, neither DHBs nor the Ministry will be able to provide a comprehensive picture of mental health service provision to consumers. This is a serious constraint to the nation’s understanding of the mental health sector, especially when progress is predominantly assessed on the basis of how many of the 3 percent of the population with severe mental illness are able to gain access to specialist mental health services. For this reason, this Plan has identified the development of an information system for NGOs to report MHINC data to the New Zealand Health Information Service (NZHIS) as one of the highest priority projects.

It is recommended that any additional activity for NGOs focus on the priority areas that will have the most benefit for the majority of NGO providers, instead of developing isolated points of excellence or attending to the requirements of only a few NGO providers with high information needs. In particular, there is a need to develop an outcomes-focused culture and a common understanding about outcome measurement throughout the NGO sector.



Implementing the Plan

Working collaboratively and co-operatively

Mental health and wellbeing is complex, and a wide range of stakeholders are involved. Agencies from both the government and non-government sectors have a significant involvement across the mental health and addiction services continuum. In promoting an integrated approach to improving mental health and addiction services, Te Tāhuhu – Improving Mental Health and this Implementation Plan aim to encourage and assist government and non-government service providers to work more closely together, to jointly develop solutions to problems and work towards improving outcomes for people with mental illness and addiction problems.

Leadership for implementation

Te Tāhuhu – Improving Mental Health and this Plan provide a tool for the Ministry of Health, DHBs and key stakeholders to take the lead in addressing mental health and addiction in New Zealand. The Ministry of Health will provide overall leadership to DHBs, monitor and review the implementation of this Plan, and foster collaboration and co-ordination across all levels of the mental health and addiction sector. DHBs will also provide direction through funders, providers, primary health organisations (PHOs) and engaging communities to participate in implementing this Plan.

Ministry of Health

As the chief advisor to the Government on health, the Ministry's primary responsibility is to ensure that the health and disability support system works well. Across its many functions the Ministry works to shape the health and disability system to be fair, and ultimately to make a significant contribution to achieving the Government's desired outcome of healthy New Zealanders.

The Ministry is responsible for overseeing the implementation of the Plan for the National Mental Health Information Strategy, working alongside DHBs and key organisations. At a higher level however, the Health Information Strategy Action Committee will monitor and review the implementation of HIS-NZ.

District Health Boards (DHBs)

DHBs are required by government statute to effectively fund and manage health and disability services to improve the health status of populations. In doing this, they are guided by the objectives of the New Zealand Health Strategy and the New Zealand Disability Strategy.

DHBs are involved in the delivery of services across many aspects of the mental health and addiction services continuum. In their roles as funders and planners of services, DHBs will be expected to have a major role in implementing this Implementation Plan.

Resourcing the Plan

The ability to make progress on the priority areas described in this Plan requires resources to be available and assumes that the key stakeholders will continue to work together to develop a coherent national approach to mental health information development. This approach also includes other directorates within the Ministry of Health that are developing strategic plans for information development in areas of common interest to mental health (eg, primary health care and older people).

As a benchmark, this Plan details the current human resource and patient management information systems used by each DHB in the Appendix. It is the expectation that providers will collaborate and form alliances where they either use the same IT system or are considering changing systems.

Evaluation, monitoring and review

This Plan forms a subset of activities to be undertaken under Te Tāhuhu – Improving Mental Health (Ministry of Health 2005f), so the Ministry will monitor the implementation of this Plan utilising the mechanisms already in place for monitoring the mental health sector. Relevant updates on progress will be made available on the Ministry's website (www.moh.govt.nz) as part of the proposed reporting of progress for Te Tāhuhu – Improving Mental Health.

The Mental Health Commission has an important role to play in monitoring the mental health sector and reporting to government on the implementation of the Government's National Mental Health

Strategy, of which both Te Tāhuhu and the National Mental Health Information Strategy form a part.

Priorities may change because of trade-offs between competing priorities, the costs of change outweighing the benefits, or other opportunities that may arise that offer even greater gain to multiple providers. For example, it is important for the Ministry to identify possible outcome measures for national collection by the NGO sector under the MH-SMART initiative. However, it may be more pressing to address the lack of information system development in the NGO sector as the most important issue to resolve, so that NGO providers are enabled to capture and report the current national mental health data set (MHINC).

In 2008 the Ministry of Health will undertake a review of progress towards implementing the National Mental Health Information Strategy. This Implementation Plan will also be reviewed as the result of funding approvals and any changes to HIS-NZ priorities brought about as a result of evolving health strategies.



The Priority Areas

Priority areas for action

All activities have been grouped into the following nine priority areas:

1. Shift the focus from information collection to information use
2. Minimise the cost of collecting information
3. Increase opportunities for consumer input
4. Extend the coverage of mental health data to primary care
5. Support Māori goals for whānau ora
6. Support information sharing among providers (eg, District Health Boards, non-governmental organisations and primary health care providers)
7. Use information as a quality improvement tool
8. Use information for research and development
9. Fill data gaps and improve data quality.

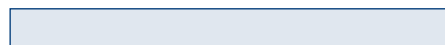
Fix and renovate

The actions in this Plan are mostly drawn from those actions that were included in the National Mental Health Strategy, and all relate to the leading challenge ‘trust and transparency’ from *Te Tāhuhu – Improving Mental Health* (Ministry of Health 2005f). A number of additional actions have been included in the Implementation Plan that offer greater levels of detail than in either the draft action plan for Te Tāhuhu or the National Mental Health Information Strategy.

This Plan prioritises activities for the short to medium term under the headings ‘Fix’ and ‘Renovate’. Those activities listed under ‘Fix’ within a priority area will occur from 1 July 2005 to 1 July 2007 and will occupy most (90 percent) of the work programme. Activities listed under ‘Renovate’ are likely to take longer (until 2010), because they depend on the completion of ‘Fix’ activities or they rely on wider health information developments.

Gaps and fundamental areas

In those cases where a project is deemed to be fundamental to either furthering the sector or measuring progress on Te Tāhuhu, this project has been highlighted in blue.



Where there are gaps in the current work plan, these projects are highlighted in yellow.



Interdependencies and constraints

The effectiveness of the actions outlined in this Implementation Plan depend on the timing of other information-related developments across the health sector – they cannot be implemented successfully in isolation. These dependencies have been taken into account in the development of this Implementation Plan and are demonstrated in diagrammatical form in the section on ‘Interdependencies and Constraints’.



Priority Area 1: Shift the Focus from Information Collection to Information Use

From information collection to information use

We cannot build on the sector's achievements over the last few decades without considering what needs to be done to improve the dissemination and use of information that forms the evidence base for planning, delivering and monitoring services for mental health consumers.

Electronic decision support systems are becoming increasingly sophisticated in their ability to directly aid clinical decision-making. One of the aims of these systems is for consumers, carers and service providers to have access to the best available evidence that will help them to make good decisions about a person's care and treatment.

There is some evidence to suggest that the mental health sector's reluctance to use the information it already has available to it by electronic means will not be solved by the application of yet more technology (NICS 2002). The better use of information by all stakeholders relies much more on developing an environment that supports a change in individual and organisational behaviour and encourages all stakeholders to recognise the value of the information available to them (in whatever form it is presented).

Objectives

Long-term

- Improve the dissemination and use of evidence-based information to inform the planning, delivery and monitoring of services for mental health consumers.

Next five years

- Establish an episodic view of mental health consumer interactions.
- Develop an environment that supports the mental health workforce to use information to improve the quality of care.
- Provide better access to evidence-based information for consumers, carers and service providers.
- Ensure funders and providers can use information to better understand the effectiveness of services in order to make decisions about how they can be improved in the future.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/measures/ phasing/status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
1 (Fix) Shift the focus from information collection to information use					
1.1 (Fix) National data collection development					
Investigate the feasibility of merging MHINC and MH-SMART data into one extract to reduce costs for providers and increase opportunities for the analysis of both data sets.	A business case and feasibility study have been conducted for the Integrated Mental Health Data Collection to determine the costs and benefits of integrating the MHINC and MH-SMART data elements.	MoH, DHBs, NGOs, Mental Health Commission (MHC)	Feasibility study Completed (June 2005) Business case Completed (Dec 2005) Funding Approved; system design and development commenced (2006)	Propose Integrated Mental Health Data Collection solution.	Participate in the review and implement suggested changes.
1.2 (Fix) Workforce development					
Provide training programmes to extend the skills of the current workforce so that staff at all levels are better equipped to interpret and apply information based on best practice, outcomes, etc.	The Core Competencies Framework and the National Training Plan will both support the shift in focus from information collection to information use, signalled in the National Mental Health Information Strategy 2005-2010, as well as the challenge to develop a culture of continuous quality improvement in which information and knowledge are used to enhance recovery and service development.	MoH, DHBs, NGOs, professional and industrial workers' organisations, MHC	Include in Workforce Development Strategy Completed (Nov 2005) Core competencies framework To be completed July 2007	Scope the requirements for enhanced decision-making via the Mental Health Workforce Development Programme.	Ensure staff have basic skills as a core competency for their work.
Develop training programmes to address the needs of recruits entering the mental health workforce.	The National Training Plan will involve a review of mental health and addiction components of undergraduate health training and the curriculum, and development of clinical placements to reinforce the specialist training.	Mental Health Directorate, supported by the national workforce development centres, training programmes, the Pacific Workforce Development programme (PAVA) and the MHC	National Training Plan To be developed by December 2007	Liaise with national training organisations, professional bodies and the Clinical Training Agency to determine how best to influence and enable the education sector to meet requirements for information management and methodologies in mental health services.	Ensure provider staff orientation programmes include an information management module.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/measures/ phasing/status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
Develop an accreditation system that offers the sector confidence in the standard and quality of training in information management.	Identified gap: currently no steps have been taken to investigate the development of an accreditation system for professional trainers in information management.	MoH, DHBs, NGOs, professional and industrial workers' organisations, education providers and framework owners, MHC	To be progressed under the Mental Health Workforce Plan.	Investigate developing an accreditation system for professional trainers.	Ensure staff have access to courses provided by accredited trainers and education providers.
Renovate					
1.3 (Renovate) National data collection development					
Develop an information-literate sector which collects and analyses outcome data as part of its routine quality improvement activity.	Additional data elements in the Integrated Mental Health Data Collection system will allow fairer comparisons of providers through case-mix adjustment.	MoH, DHBs, NGOs, MHC	Integrated Mental Health Data Collection System completed (July 2007)	Refine and implement the mental health case-mix classification to enable analysis of outcome data.	Commit to incorporating outcome measurements into routine quality improvement activities within services.
	The NZ Classification and Outcomes Study (CAOS) suggests that case mix is useful for interpreting variation in consumer outcomes, cost benchmarking and the development of best practice	MoH, DHBs, NGOs, MHC	CAOS Study Completed (July 2003). Development of a case-mix grouper to occur as part of the Integrated Mental Health Data Collection system (2006)	Use case-mix adjusted data when benchmarking at a national level.	Use case-mix adjusted outcome data when analysing aggregated outcome data and when benchmarking services.
1.4 (Renovate) Collaboration frameworks					
Develop an evaluative framework that includes cost-effectiveness.	Nationally agreed standards and formats for national data collection will permit cost comparisons between services and the establishment of best-practice benchmarks.	MOH, DHBs	2005–2010 Robust pricing developed	Develop nationally agreed standards and formats to permit cost comparisons between services. Continue the mental health sector contribution to the national DHB benchmarking pricing and common costing projects.	Consider expanding the current work programme to prioritise work on common costing standards and common counting from a mental health perspective.



Priority Area 2: Minimise the Cost of Collecting Information

Best use of limited resources

Given the diverse nature of mental health providers and the decentralisation of decision-making, the National Mental Health Information Strategy aims to help align local-level decision-making with national policy. As a small nation New Zealand does not have the financial resources to continue to approach information system development in a localised way. We need to co-ordinate our efforts as much as possible to make sure that IT developments are not duplicated and that different IT systems support the easy exchange of mental health information across the sector.

The Ministry of Health is promoting a ‘Leading for Outcomes’ approach for all who are involved in the health system, whether in actual health care delivery, administration or policy, to help maintain a focus on the overall results of the sector’s collective actions – in other words, on outcomes. The mental health sector needs to be able to demonstrate that services operate effectively, and that the development of the information infrastructure is shaped by the outcomes the sector seeks to achieve; namely, mental health services helping to reduce the impact of severe mental illness and supporting the consumer’s process of recovery.

Objectives

Long-term

- Improve the co-ordination of IT developments for national data collections.

Next five years

- Ensure that IT developments are not duplicated among providers of mental health services (DHBs and NGOs).
- Ensure that different IT systems support the easy and efficient exchange of clinical and management mental health information across the sector within the privacy rules.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
2 (Fix) Minimise the cost of collecting information					
2.1 (Fix) Align sector capital investment					
Adopt a more formal approach for co-ordinating investment in IT that includes DHB, NGO and primary care providers.	The Capital Investment Guidelines have been developed for DHBs for funding over \$500,000 for IT.	MoH, DHBs	Capital Investment Guidelines for DHBs Completed (Oct 2004).	Monitor and evaluate use of the guidelines.	DHBs will adhere to the National Capital Committee guidelines for investment in IT.
	Identified gap: the guidelines do not cover investment by NGO or primary care providers.	MoH, NGOs, primary care providers, DHBs (Funding & Planning, PHOs)	Not currently on MoH work programme.	Investigate mechanisms to support collaboration in development of IT systems among NGO and primary care providers.	Participate in formal forums to share ideas and collaborate on IT initiatives where common interests exist.
2.2 (Fix) Accountability framework					
Rationalise data for national contract and service-monitoring purposes to streamline reporting and reduce duplication.	The Monitoring System Rationalisation Project provides a stocktake of all the 2004/05 key performance indicator (KPI) reports the Ministry collects from DHBs. Feedback on the report did not suggest the sector had significant issues or suggestions in relation to any specific strands of information currently being collected. However, the current collection process through the main Crown Funding Agreement reporting mechanism adds to DHB perceptions of increased compliance costs adding to the burden of reporting.	MoH, DHBs, MHC	Monitoring System Rationalisation Project Completed (Sept 2005).	Address perceptions of increased compliance costs associated with reporting.	Participate in discussions on monitoring and rationalisation to streamline reporting requirements.
	The Ministry's Statement of Intent outcomes framework forms the basis for the performance framework for DHBs. The performance framework consists of headline indicators for the sector (health sector performance). Currently there are two headline indicators relating to mental health.	MoH, DHBs	Headline indicators To be delivered by Dec 2005 In DHB planning documents To be delivered by 2006/07	Communicate headline indicators to sector.	Include headline indicators in DHB planning documents.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
	<p>The Nationwide Service Framework (NSF) including mental health service specifications is being revised to:</p> <ul style="list-style-type: none"> – support innovation, integration and flexibility – promote recovery – support continuity of care and seamless service delivery – update reporting requirements. 	MoH, DHBs, NGOs	Between 1 July 2006 and 30 June 2007 all service specifications will be fully revised and entered into the accountability framework.	<p>Lead the review ensuring that both policy and reporting requirements are considered.</p> <p>Monitor uptake of the revised specifications.</p>	<p>Participate in the review for all NSF mental health services</p> <p>Implement revised mental health service specifications.</p>



Priority Area 3: Increase Opportunities for Consumer Input

Consumer recovery

The increasing emphasis on consumers' active participation in their care and treatment presents some challenges for the mental health sector. Many clients are disempowered either through lack of information about their illness or lack of access to the information that is held about them and their care and treatment. In the future, clinical information systems will need to be developed with a view to incorporating direct input from consumers and their nominated carers.

The Internet offers considerable opportunities in this regard, but access to consumer health records need to be considered in the light of Privacy Act 1993 requirements as well as the development of technical standards.

Objectives

Long-term

- Increase consumers' active participation in their care and treatment.

Next five years

- Electronic clinical information systems will need further technical development so that consumers and their nominated carers can provide direct input.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
3 (Fix) Increase opportunities for consumer input into clinical information systems					
3.1 (Fix) Collaboration					
Develop information systems that support active participation and collaboration between providers and consumers in the management of mental illness for practitioners involved in their care.	Currently there are no electronic information systems projects within the Ministry of Health that address the ability of consumers to have direct input into electronic clinical records.	MoH, vendors, providers and consumers, MHC	Not currently on MoH work programme. Refer to 'Gaps in the Work Programme'.	Promote the benefits and value of enabling consumer input into clinical records. Ensure standards and systems are technically enabled for this to occur.	Upgrade electronic information systems to enable consumers' active participation. Encourage changes in clinical practice that will take advantage of this opportunity.
All service providers will implement collaborative note-taking and recovery planning for mental health service users, and treatment/ intervention planning for addiction service users.	There is variable activity in this area with a number of providers still to develop a process for making sure that consumer recovery plans are in place.	All providers, clinicians, service users, family, whānau	2005–2007 Recovery plans will be in place and evidenced through case notes and audit processes.	Monitor via the results of audit and certification processes.	Led by providers.
Service users, family, whānau and other agencies know and understand what they can expect from mental health and addiction services.	There is variable practice among DHBs.	DHBs, MOH, NGOs, service users, family, whānau, professional associations, clinicians, and other government agencies.	2005–2007 Each DHB at service locations and on their websites has information on the range of contracted services mental health services, referral criteria and processes, complaints procedures, access to consumer and family advisors, and mechanisms in place for feedback.	Review implementation.	DHBs to improve the accessibility of information about their services



Priority Area 4: Extend the Coverage of Mental Health Data to Primary Health Care

Primary mental health

The Primary Health Care Strategy (Minister of Health 2001) and the establishment of primary health organisations (PHOs) provide a unique opportunity to develop mental health services in relation to population needs. One study has offered some useful insights into the incidence, severity and patterns of treatment for mental health conditions at the level of primary care (MaGPIe Research Group 2003). Given the prevalence of mental health conditions in the general population and the pivotal role of primary health care as the first point of contact, we now need better information at a national level about the use and effectiveness of primary care services for mental health consumers.

Te Tāhuhu – Improving Mental Health (Ministry of Health 2005f) emphasises the need for good links between primary health care and specialist mental health services for the provision of co-ordinated care for people with severe or enduring mental illness. This link involves expanding the level of electronic communication and co-ordination between primary and secondary care, particularly in the areas of referrals, discharges and the transfer of relevant clinical reports.

Objectives

Long-term

- Improve information at a national level about the use and effectiveness of primary care services for mental health consumers.

Next five years

- Establish better linkages between primary health care and specialist mental health services for the provision of co-ordinated care for people with severe or enduring mental illness.
- Expand the level of electronic communication and co-ordination between primary and secondary care, particularly in the areas of referrals, discharges and the transfer of relevant clinical reports.
- Providers to conform to common information standards, where they are available.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
4 (Fix) Extend the coverage of mental health data to primary health care					
4.1 (Fix) National data collection development					
Develop a primary health care minimum data set that is inclusive of mental health requirements.	Develop the primary care minimum data set to capture mental health information on consumers as they move through the continuum of care.	MoH, providers, researchers, vendors MHC, GPs, PHOs		Develop the primary care minimum data set in line with the HIS-NZ.	Participate in developing a minimum data set for primary care inclusive of mental health requirements, and implement.
	Develop clinical and key performance indicators at the primary care level for mental health (Clinical Services Directorate).	MoH, providers, researchers, MHC	2007 Indicators are included in phase 2 of the PHO Performance Management Programme.	Take the lead role in facilitating development of clinical indicators in primary care. Ensure this is addressed through one of the Mental Health Primary Care pilots.	Participate in the development of clinical indicators.
Extend the focus of chronic disease management in primary care to explicitly include mental health.	Indicators are included in phase 2 of the PHO Performance Management Programme.	MOH, DHBs, primary care providers	2005–2008 The treatment of depression is considered as part of the chronic disease management approach.	Take the lead role.	Implement identified indicators.



Priority Area 5: Support Māori Goals for Whānau Ora

Māori: whānau ora

Perhaps the biggest challenge to developing a culturally competent mental health information system is the very nature of the mental health sector. Who collects what information, in what way and how it is analysed are all key determinants of the cultural relevance of the eventual findings, especially to the population under consideration. For this reason, the development of cultural competence at the clinical and administrative levels continues to be important for achieving whānau ora, as outlined in He Korowai Oranga: Māori Health Strategy (Minister of Health and Associate Minister of Health 2002).

Whānau ora is a dimension of wellbeing that is gaining acceptance in the mental health sector, as it best encapsulates a Māori world view of total wellbeing and ‘recovery’. Although more work is required to define ‘whānau ora’ within the context of a mental health information system, it is clear that this concept is broad in scope, focuses on recovery, and requires innovative and extensive approaches to data collection. The definition will be key to the development of outcome measures for Māori and, when monitoring, determining whether or not the desired outcomes have been achieved. This is not to say that existing information systems will be unhelpful, but that measurement processes should reflect the outcomes desired by Māori.

Most importantly, from an information perspective it will involve providing the information that enables effective Māori participation at all levels of the sector, including decision-making, planning and development, and the delivery of mental health and addiction services (Ministry of Health 2004).

Objectives

Long term

- Improve the collection and provision of information that enables effective Māori participation at all levels of the sector, including decision-making, planning and development, and the delivery of mental health and addiction services.

Next five years

- Support the development and collection of data that can be used to improve service delivery from a cultural perspective.
- Develop cultural competence in the interpretation of data by the mental health workforce at both clinical and administrative levels.
- Define ‘whānau ora’ within the context of mental health information.
- Develop outcome measures for Māori and monitor whether or not the desired outcomes have been achieved.
- Encourage research in areas important to Māori, and develop information systems that fit with a Māori world view.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
5 (Fix) Support Māori goals for whānau ora					
5.1 (Fix) Workforce development					
Enhance skill and expertise in the non-Māori and Māori mental health sector workforce to understand, produce and analyse Māori mental health information for the benefit of Māori.	The National Mental Health Workforce Development Centres address workforce development issues and information management training needs of the sector in their work programmes.	MoH, DHBs, NGOs, kaupapa Māori services, service users, whānau, hapū, iwi, Māori community, MHC	Years 1–3 The requirements for workforce development to enable Māori providers to actively participate in data collection will be identified and addressed.	Scope the requirements for national information training initiatives for the mental health workforce through the national Mental Health Workforce Development Programme.	Ensure staff have basic information management skills as a core competency for their work.
5.2 (Fix) Cultural responsiveness					
Improve the recording and reporting of ethnicity to enable better decision-making on appropriate service provision for Māori.	The Ethnicity Protocol prescribes how health providers should record ethnicity. As part of the National Health Index (NHI) upgrade project, ethnicity training materials were produced to enable a range of training events, such as ‘train the trainer’ or end-user training to be presented. NZHIS is currently monitoring the quality of ethnicity data captured from providers, and has recently compared the ratio of Māori ethnicity collected against census levels. Results will be collated and analysed in order to target training and awareness programmes in the future.	MoH, providers, consumers, researchers, other Crown policy makers (eg, Ministry of Social Development)	Ethnicity Protocol Completed (Nov 2004) Monitoring quality of ethnicity data capture Ongoing	Continue to support the implementation of the Ethnicity Protocol and to monitor the quality of ethnicity data capture.	2005–2010 Use reliable ethnicity data to inform DHB funding and planning. 2010 onwards Develop the capacity and capability to effectively collect ethnicity data, for NGO services in particular.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
5.3 (Fix) National data collection development					
Ensure the National Mental Health Information System can capture data on the cultural context of mental illness and recovery.	A feasibility study into the Integrated Mental Health Data Collection has recently been completed. This study has consulted widely with mental health stakeholders, including the Māori Monitoring and Review Group and Te Taiwhenua o Heretaunga. The study has identified the need to include new data items for iwi. Also, the SP code T32 was introduced in 2002 to code for mental health contact with family/whānau.	MoH, providers, consumers, researchers, other Crown policy makers (eg, Ministry of Social Development, MHC)	<p>Review of cultural relevance of MHINC Completed (Jun 2005)</p> <p>Integrated Mental Health Data Collection solution To be completed by July 2007</p>	<p>Review the cultural relevance of the MHINC to include modifications as part of the MHINC feasibility study.</p> <p>Propose a new Integrated Mental Health Data Collection solution.</p>	Participate in the review and implement suggested changes.
5.4 (Fix and Renovate) Quality improvement					
Focus research activities on service quality/improvements that are of high national priority and consistent with national policy directions.	<p>Māori Mental Health Research and Development Strategy</p> <p>Sector development initiatives have focused on:</p> <ul style="list-style-type: none"> developing a database of all previous research on Māori mental health issues understanding patterns of service utilisation of tangata whai ora using MHINC data. 	MoH, all providers, Māori, consumer groups, researchers, MHC	<p>2005–2008 A Māori mental health research agenda is developed.</p> <p>2005–2010 Research programmes are implemented and results disseminated to the sector to inform service planning and delivery.</p>	Develop and support the implementation of a Māori mental health research and development agenda that promotes kaupapa Māori methodologies and whānau ora approaches to mental health and addiction.	Incorporate research and development findings into routine practice.



Priority Area 6: Support Information Sharing Among Providers

System or sector development

Sharing information in a safe and appropriate way across different care delivery settings is critical to the effective delivery of an integrated continuum of care for consumers. Innovation and excellence in isolation will not produce the benefits required across the sector. Mental health providers need to operate as part of an interactive sector, with their sole focus being the seamless delivery of care to consumers to produce the best possible outcomes. This means developing IT systems that, at the very least, conform to national standards that permit the easy and efficient transfer of information.

The mental health sector also needs to consider its relationships to the wider health sector and other sectors, including the social (general health care, education and training, justice), environmental (housing), economic (income and employment) and cultural sectors. Given the significance of these other sectors' contribution to improved health outcomes, it is important for mental health information systems to match data across sectors.

The importance of a systems approach is recognised in Improving Quality (IQ) (Minister of Health 2003) and the consultation document for Improving Mental Health (Ministry of Health 2004), which suggested that DHBs be asked to report on how they integrate and co-ordinate the services they fund. DHBs have a key role as part of their role in implementing the Primary Health Care Strategy (Minister

of Health 2001) and Te Tāhuhu – Improving Mental Health 2005–2015 (Minister of Health 2005f) in helping to improve the information systems interface between the primary and NGO providers.

Objectives

Long-term

- Enable safe and appropriate information sharing across different care delivery settings.

Next five years

- Develop IT systems that conform to national standards and permit the easy and efficient transfer of clinical client-level information between providers, within the privacy rules.
- Consider the relationships the mental health sector has with the wider health sector and other sectors, including the social (general health care, education and training, justice), environmental (housing), economic (income and employment) and cultural sectors.
- Share appropriate aggregated clinical and service delivery information across sectors to improve service planning and the provision of care.
- Improve how information systems interface among primary, DHB and NGO providers with the objective of improving the delivery of care to individual consumers.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
6 (Fix) Support information sharing among providers					
6.1 (Fix) Applications					
Develop or modify applications to provide a standardised output that supports common business processes.	Identified gap – the Ministry of Health needs to initiate a project with HIS-NZ that covers the development of applications to provide a standardised output that supports common business process.	MoH, providers, vendors	Not currently on the HIS-NZ work programme. Refer to ‘Gaps in the Work Programme’.	Implement the HIS-NZ.	Implement national applications to support common business processes.
6.2 (Fix) Standards					
Develop and implement information management and technology standards for the sector.	Identified gap – the Ministry of Health needs to initiate a project that covers the development and implementation for specific information management and technology standards for the sector with the Health Information Standards Committee.	MoH, providers, vendors	Not currently on the HISO work programme. Refer to ‘Gaps in the Work Programme’.	Participate in developing and implementing the Health Information Standards Organisation (HISO) work programme.	Participate in developing and implementing the HISO work programme.
6.3 (Fix) Collaboration frameworks					
Providers work collaboratively on integrated information system development and issues of common interest.	Use the e-government programme to support and enable collaboration on inter-agency information systems.	MoH, providers, vendors	Ongoing	Use the e-government programme to support and enable collaboration on inter-agency information systems.	DHBs and NGO providers with more sophisticated information systems, or experience in information management, take a leadership role in developing capability in other parts of the sector.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
Renovate					
6.4 (Renovate) Standards					
Develop standards that permit electronic patient records to be shared among providers using different systems.	The project initiated under HIS-NZ covers standardising the format of the electronic record so information can be shared among providers.	MoH, providers, vendors	Not currently on the HIS-NZ work programme. Refer to 'Gaps in the Work Programme'.	Lead development of national standards and formats for the electronic health record.	Incrementally develop electronic clinical records that align with national standards and formats.
Spread information throughout several different physical information systems, but link and reference data electronically.	The HIS-NZ work programme is under development. The Ministry of Health needs to initiate a project with HIS-NZ that covers spreading information throughout several different physical information systems, but linking and referencing data electronically.	MoH, providers, vendors	Not currently on the HIS-NZ work programme. Refer to 'Gaps in the Work Programme'.	Lead development of national standards and formats for the electronic health record.	Develop incrementally electronic consumer records to ensure alignment with national standards and formats.
Share information across sectors.	The HIS-NZ work programme is under development. The Ministry of Health needs to initiate a project with HIS-NZ that covers sharing information across sectors.	MoH, providers, vendors	Not currently on the HIS-NZ work programme. Refer to 'Gaps in the Work Programme'.	Lead the development of agreed data formats and establish protocols for what constitutes appropriate information sharing and monitor provider compliance.	Comply with agreed data formats and protocols.



Priority Area 7: Use Information as a Quality Improvement Tool

Quality improvement

The quality dimensions described in *Improving Quality (IQ)* (Minister of Health 2003) provide a framework for measuring the mental health sector's overall performance. *Improving Quality (IQ)* illustrates how several dimensions of quality are common to a range of key stakeholders, and how 'quality improvement needs to encapsulate all levels of the sector and the interactions between them' (Minister of Health 2003).

At the service provider level, clinical and management staff are interested in obtaining information about how to improve their practice on the basis of what is known to work best for consumers. Although there are numerous references relating to 'best practice', there is no single repository of information where staff can easily learn about the latest research, and no single agency supporting providers in their attempts to incorporate research findings into routine practice.

At the national level, key performance indicators are a central component of any health service quality improvement process because they provide a basis for accountability and monitoring. The Ministry of Health is expanding the current dimensions of quality (access and equity, safety, effectiveness and efficiency) to form a framework for the development of national key performance indicators for the mental health sector to use at provider and national levels. It is proposed that this framework include a further

five domains (services that are appropriate, continuous, responsive, capable, and sustainable), as identified in the performance framework for Australian public mental health services (National Mental Health Information Strategy Committee 2004).

One of the proposed activities is to engage a group of providers in the development of key performance indicators using current data, and then use those indicators as part of a benchmarking activity whereby providers can learn from each other about the practices and processes that best contribute to improved outcomes for consumers.

Objectives

Long term

- Improve provider practice on the basis of what is known to work best for consumers.

Next five years

- Use key performance indicators as part of a benchmarking activity whereby providers can learn from each other about the practices and processes that best contribute to improved outcomes for consumers.
- Develop a 'best practice' repository where providers can easily learn about the latest research and support their attempts to incorporate research findings into routine practice.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
7 (Fix) Use information as a quality improvement tool					
7.1 (Fix) National connectivity					
Develop a coherent national strategy to maximise the benefits of broadband, high-speed internet access to the sector.	<p>The National Network Strategy Action Zone (HIS-NZ) will implement a national approach to improving the quality and speed of sector communications, which includes:</p> <ul style="list-style-type: none"> confirming a national approach for the provision of secure network services that defines what will be provided nationally and what can be provided at a regional or local level reviewing, developing and encouraging opportunities to reduce the cost impact of secure broadband networks on coalface providers by volume discounts and the sharing of costs across the sector. 	MoH, providers, vendors	<p>National Network Strategy Action Zone Initiated with HIS-NZ (Aug 2005)</p> <p>Work is ongoing.</p>	Implement the HIS-NZ.	Gain access to secure email and the internet.
7.2 (Fix) Quality improvement					
Create an environment that enables DHBs to demonstrate that their investments in mental health and/ or addiction deliver value for money, are results focused, and have regard to service impacts on people who are severely affected by mental illness, addiction and problem gambling.	Develop a first version national key performance indicator set for use in New Zealand mental health services.	MoH, NZHIS, DHBs, NGOs, MHC, service users.	<p>Jan 2006 – Dec 2008 First version of generic KPI indicators developed.</p> <p>Jan 2008 – Dec 2010 Active and appropriate benchmarking is used to improve services.</p>	Lead the establishment of a mental health sector working group to develop a national set of key performance indicators.	Participate in a mental health sector working group to develop a national set of key performance indicators based on current provider capacity to produce the necessary data.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
	Develop benchmarking workshops utilising the service profile information developed on the basis of a complete national data set.	MoH, DHBs, NGOs, professional associations	Jan 2008 – Dec 2010 Workshops developed and information used to improve services.	Establish a mechanism for making the DHB service profile information available for use by DHBs. Work with DHBs to help support the establishment of benchmarking workshops.	DHBs actively use the DHB service profile information as part of its quality improvement programme. Establish and participate in benchmarking workshops.
	Further develop and co-ordinate a set of national indicators for mental health and addiction workforce development, including specific indicators for Māori, Pacific, child and adolescent, and addiction workforces.		A set of formal indicators integrated with the Key Performance Indicators (KPI) project and Nationwide Mental Health Service Framework. To be delivered June 2009.	Mental Health Directorate to implement with all national centres and programmes.	Participate in the development of national indicators for the mental health and addiction workforce.
Develop a co-ordinated national approach to telepsychiatry to increase consumer access to services.	Telepsychiatry Report (Mental Health Workforce Development Programme) Delivery of the Telepsychiatry Strategy over 2004 has seen the establishment of a central repository website for the project, with various supporting materials and information, followed up with regional support through the input of co-ordinators towards determining how best to increase and/or encourage the use of videoconferencing regionally and nationally within the mental health sector.	MoH, providers, consumer advocacy groups	Delivery of Telepsychiatry Strategy Completed (2004) 2005–2010 Ongoing development under the telehealth initiative.	2006 Support the posting of the revised Guidelines for the Use of Telepsychiatry on the RANZCP website. 2006–2008 Support the ongoing development of telepsychiatry as part of wider developments in the area of telehealth.	Use telepsychiatry as part of a wider strategy by DHBs for the use of telemedicine as a mechanism to increase consumer access to high-quality care and treatment.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
	Recommendations for the future of videoconferencing within the mental health sector have been made suggesting that the most cost-effective solution would be as part of a regional/national solution for the wider health sector.	MoH, providers, vendors		Implement the recommendations of the Telepsychiatry Project under the Ministry's Telehealth Report.	Rationalise and upgrade videoconferencing equipment as part of a regional/national strategy designed to increase the availability of telemedicine.
Develop a culture of continuous improvement in which information and knowledge are used to enhance recovery and service delivery.	Implement the priorities identified in HIS-NZ.	MoH, DHBs, NGOs.	Jan 2006 – Dec 2008 Facilitate workshops for DHBs and NGOs on service improvement tools and techniques under the Workforce Development Programme.	Provide funding support under the Workforce Development Programme for the Service Improvement workshops.	Support teams develop improved consumer care pathways utilising a variety of approaches, including the Service Improvement approach.
7.3 (Renovate) Quality improvement					
Create an environment where mental health workers and service users can readily use information to support and enhance evidence-based practice.	Roll out the national service user satisfaction survey tool using the hospital benchmarking process used/developed by Ministry hospital benchmarking indicators. This will also help to create a cultural shift about using information, and ownership in the generation of useful data.	MoH, DHBs, NGOs, service users, family, whanau, mental health workforce, MHC	Jan 2006 – Dec 2008 The tool rolled is out and the information is used by DHBs to inform improvements in the quality of services.		



Priority Area 8: Use Information for Research and Development

Role of information in mental health research and development

The role of information in mental health research is critical to the sector's ability to respond to the needs of consumers using the most effective interventions and models of service delivery.

Although the National Mental Health Information Strategy focuses on the routine collection of information, it is anticipated that a national approach to information development will also support the mental health sector's capacity to conduct research into priority areas. A national approach to information development will not only increase the range, volume and quality of data to meet identified immediate clinical and planning requirements, but it will also provide opportunities for the additional evaluation of services in a research and development framework.

Objectives

Long-term

- Improve the sector's ability to respond to the needs of consumers using the most effective interventions and models of service delivery.

Next five years

- Develop a national approach to information development to increase the range, volume and/or quality of data to meet identified clinical and service planning requirements.
- Provide an opportunity for the additional evaluation of services in a research and development framework.
- Develop a culture of inquiry where evidence-based practice is integrated into the routine functioning of the mental health service.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
8 (Fix) Use information for research and development					
8.1 (Fix) Quality improvement					
Create opportunities for all key stakeholders to have easy access to up-to-date information about effective programmes and practices.	Scope a proposal by the Mental Health Research and Development Strategy (MHRDS), which includes a mechanism to support the dissemination and uptake of information about effective programmes and practices. This will be part of the new work programme for the Mental Health Research and Development Strategy for 2006 and going forward.	MoH, providers, consumer advocacy groups, professional bodies, educational institutions, MHC, Mental Health Programmes Ltd (MHP)	2006 Proposal completed	Scope area under the MHRDS.	Work with the MHRDS and the Workforce Development Programme to identify mechanisms to support the translation of evidence-informed practice findings into routine practice.
	Develop a website to provide access to up-to-date information about effective programmes and practices.	MoH, providers, consumer advocacy groups, professional bodies, educational institutions, MHC, MHP	Website live To be delivered by July 2007	Scope area under the MHRDS.	Work with the MHRDS and WDP to identify mechanisms to support the translation of evidence-informed practice findings into routine practice.
Continue to invest in the implementation of mental health outcome measurement and management.	Continue with the implementation of consumer outcome measures under MH-SMART. It is proposed that the Mental Health Integrated Data Collection will collect and report outcome data along with MHINC data.	MoH, providers, consumer advocacy groups, professional bodies, educational and research institutions, MHC, MHP	Ongoing	Continue to support (through the MHRDS) projects that build on previous work in outcome measurement.	Implement outcome tools and develop expertise in outcome measurement and outcome management.
Develop a Pacific mental health research agenda.	Develop a Pacific mental health research agenda as part of the MHRDS.	MoH, DHBs, NGOs, Pacific providers, educational and research institutions, MHC, MHP	Jan 2006 – Dec 2008 Research agenda is established. Jan 2006 – Dec 2010 Specific research projects are undertaken and the results disseminated to the sector for use in service planning and delivery.	Support the development of a Pacific mental health research agenda under the MHRDS framework and work programme.	Providers implement results of research findings into routine practice.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
Focus research activities on service quality/ improvements that are of high national priority for Māori and consistent with national policy directions.	<p>Māori Mental Health Research and Development Strategy</p> <p>Sector development initiatives have so far focused on:</p> <ul style="list-style-type: none"> • developing a database of all previous research on Māori mental health issues • understanding patterns of service utilisation of tangata whai ora using MHINC data. 	MoH, all providers, Māori, consumer groups, researchers, MHC, MHP	<p>Years 1–3</p> <p>A Māori mental health research agenda is developed.</p> <p>Years 1–5</p> <p>Research programmes are implemented and results disseminated to the sector to inform service planning and delivery.</p>	Develop and support the implementation of a Māori mental health research and development agenda that promotes kaupapa Māori methodologies and whānau ora approaches to mental health and addiction.	Implement research and development findings into routine practice.
Increase understanding of the mental health and addiction needs of refugee and migrant communities.	To be incorporated into the development of the MHRDS.	MHP, MOH, DHBs, NGOs, refugee and migrant peoples with experience of mental illness, communities, networks of service users and families	<p>2006–2009</p> <p>A mental health and addiction research agenda for refugee and migrant peoples is developed.</p>	Support the development of a refugee and migrant mental health research agenda under the MHRDS framework and work programme.	Providers implement the results of research findings into routine practice.
Increase understanding of the mental health and addiction needs of Asian and other ethnic communities.	This will be incorporated into the development of the MHRDS.	MHP, MOH, DHBs, NGOs, Asian and other ethnic peoples with experience of mental illness, communities, networks of service users and families	<p>2006–2009</p> <p>A profile of Asian peoples' mental health is developed.</p> <p>A mental health and addiction research agenda for Asian peoples is developed</p>	Support the development of a mental health profile and mental health research agenda for Asian people under the MHRDS framework and work programme.	Providers implement the results of research findings into routine practice.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
Increase information about the prevalence of mental illness in the general population as well as their use of mental health services.	Complete the National Mental Health Epidemiology Study	MOH, MHRDS, Health Research Council, ALAC, research team, MHP	Completed by mid-2006	MOH currently funds the study under the MHRDS. 2006–2010 Policy development and further research based on the findings.	No service provider input is required for the actual study, but service provision at both the primary and secondary levels will need to be examined in the light of the findings.
Develop a knowledge base on effective interventions for problem gambling	The Ministry has entered into a procurement process and preferred providers have been selected for this work.	MOH, research institutions, problem gambling service providers	2006–2009 The Ministry of Health will report through quarterly contract reviews and auditing process.	Lead role	Participate in the process of identifying best practice interventions; implement best practice.
Develop outcome measurement tools for evaluating problem gambling services.	The Ministry has entered into a procurement process and preferred providers have been selected for this work.	MOH, research institutions, problem gambling providers	2006–2009 Ministry of Health will report through quarterly contract reviews and auditing process.	Lead role	Participate in the development process and implement the eventual outcome measures.
Develop and implement a programme of research and evaluation for problem gambling .	The Ministry has entered into a procurement process and preferred providers have been selected for this work.	MOH, research institutions, problem gambling providers, professional associations, service users, family, whānau, people with experience of addiction	2006–2009 Research programme established and results used to inform further service development.	Lead role	Participate in the development and implementation of the research and evaluation programme for problem gambling.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
Increase the availability of information and information systems to underpin service development decision-making.	Implement the Mental Health Research and Development Strategy.	MoH, Mental Health Research and Development Committee, MHC, MHP, Health Research Council, researchers	Jan 2006–Dec 2010 Research strategy development; results of research disseminated for consideration and action by providers.	Led by the Ministry of Health under the MHRDS.	Implement research findings into routine practice.
	Mechanisms for gaining feedback on the responsiveness of services are in place and used for making services more responsive.	MoH, DHBs (funders and provider), NGOs, other providers, service users, family, whānau, clinicians, professional associations, MHC	Jan 2008–Dec 2010 All providers have mechanisms to receive and use feedback from service users. Jan 2008–Dec 2010 Regular assessment of service user and family/whānau satisfaction shows sustained improvement.	The Ministry of Health has led the development of a national DHB consumer satisfaction survey.	All providers have mechanisms to receive and use feedback from service users.
	Establish a mechanism for co-ordinating and disseminating innovative and effective practice across the mental health and addiction sector, including primary mental health care.	MoH, DHBs, NGOs, PHOs, primary care, professionals, research & evaluation organisations, training providers, MHC, MHP	Jan 2006–Dec 2008 Scoping completed on a potential mechanism. Jan 2008–Dec 2010 Establishment phase.	Led by the Ministry of Health under the MHRDS.	Participate in the development and implementation of a mechanism for the dissemination of best practice.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities			
				Ministry of Health	DHBs (DHB providers and NGOs)		
Develop outcome measures for routine use in mental health services under the MHRDS.	Work is being done to determine a process to develop a national suite of standard outcome measures to be implemented under MH-SMART.	MoH, providers, researchers, service users, consumer advocacy groups, MHC, MHP	Development and implementation timetable below	Provide funding and support for the development of national outcome measures under the MHRDS.	Implement consumer outcome measures into routine practice.		
	Health of the Nation Outcomes Scale (family of outcome measures)	MoH, providers, researchers, service users, consumer advocacy groups, MHC, MHP	Local DHB collection Started 1 July 2005 under the MH-SMART Initiative.			Support the sector to collect, analyse and use outcome data to improve the quality of service delivery to consumers.	Introduce new outcome measurement tools as they are introduced. Continue to upskill the workforce to use outcome data to improve their practice.
	Focus of Care – Australia and New Zealand to work together to refine the Focus of Care.	MoH, providers, researchers, service users, consumer advocacy groups, MHC, MHP	Refine definitions Due to be delivered by end of 2006.				
	Hua Oranga (Māori mental health outcome measure)	MoH, providers, Māori researchers, service users, consumer advocacy groups, MHC, MHP	Due to be delivered by July 2007.				
	Preliminary Work Towards the Development of a Self-Assessed Measure of Consumer Outcomes	MoH, providers, researchers, service users, consumer advocacy groups, MHC, MHP	Due to be delivered by October 2008.				
	Outcome Measurement for Pacific Islands People – Preliminary Report	MoH, providers, Pacific peoples, researchers, service users, consumer advocacy groups, MHC, MHP	Preliminary work to be completed by Dec 2005.				

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
	Alcohol and Drug Outcome Project Develop addiction-related outcome measures for addiction treatment services.	MoH, A&OD providers, researchers, service users, consumer advocacy groups, MHC, MHP	2005–2010 Outcome measures developed. 2007–2015 Measures implemented		
	NGO outcome development	MOH, DHBs, NGO, service users, MHC, MHP	2006 Implementation Plan for NGOs developed 2007 Pilot measures with a view to incorporating them within Mental Health Information Reporting System (MHIRS).		
	Level of functioning measure	MoH, providers, researchers, service users, consumer advocacy groups, MHC, MHP	Preliminary work completed in Dec 2005.		



Priority Area 9: Fill Data Gaps and Improve Data Quality

Data quality

Poor-quality data is a significant barrier to effective service delivery and limits the government's ability to monitor service delivery and to develop good policy. Providing high-quality information helps to support the provision of efficient and cost-effective care, and to improve consumer health outcomes. The Ministry of Health's Data Quality Improvement Programme seeks to provide the health and disability sector with a common understanding and philosophy about data quality.

One of the requirements of the Ministry's Data Quality Improvement Programme's is that data quality and integrity are first and foremost the provider's responsibility. The Ministry of Health's role is to manage the data provided to it and maintain its integrity.

For all stakeholders to be able to rely on the national Mental Health Information Collection (MHINC) as a reliable source of data, service providers and the Ministry of Health need to devote more effort towards improving data quality. Providers need to commit to having a data quality strategy, whereby action is taken as a result of the data that staff collect, and data quality is monitored as an integral part of a provider's quality improvement processes. At a transaction level, improvements are required around providers' ability to load their data, and around NZHIS's capacity to verify the quality of the data upload.

Data collection must be recognised as a dynamic process that reflects changing information needs in response to clinical, social/cultural, business and environmental/demographic movements and knowledge. Consequently, this Plan represents a snapshot of the work required

to meet current and projected information requirements. There may be an increasing need to improve the range and quality of statistical information on, for example, the use of compulsion (eg, seclusion and restraint) in clinical care. We would expect information requirement changes at this level of detail to be covered as part of the normal development and management of the National Data Collection.

Objectives

Long-term

- Improve the quality of information provided to front-line staff, designed to support the delivery of effective and cost-effective care.
- Delivery of evidence-based care results in improved consumer health outcomes.
- Improve consumer knowledge about what interventions work best under what circumstances.

Next five years

- The mental health sector demonstrates a common understanding and philosophy about data quality.
- Data quality is monitored as an integral part of service provider's routine quality improvement processes.
- NZHIS provides timely feedback to service providers on the quality of data provided.
- There is a better match between mental health service delivery and population need.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
9 (Fix) Fill data gaps and improve data quality					
9.1 (Fix) National data collection development					
Review MHINC data items, business processes and provider reports as part of a five-yearly review.	MHINC data items have been reviewed as part of the Integrated Mental Health Data Collection feasibility study, including feedback from the sector. The resulting data model will be ratified with the sector as part of the design and development of the Integrated Data Collection system in 2006.	MoH, all providers, MHC	Review of MHINC data items Completed (June 2005) as part of feasibility study. Next review due in 2010.	Review MHINC data items as part of MHINC/MH-SMART feasibility study. Initiate and lead the future review process. Next review due in 2010.	Participate in any review, and demonstrate a commitment to implementing changes and monitoring event-level data quality at the local level.
Develop national consistency in the data collection of older people's access to mental health and addiction services.	At present the policy direction for the mental health of older people is extrapolated from the Nationwide Service Framework, the Blueprint and the Health of Older People Strategy. This process has contributed to inconsistencies in the way services are planned, resulting in possible variances and gaps in actual service provision.	MOH, DHBs, NGOs	2005–2008 Options for developing national consistency are developed. By 2010 Agreed systems are implemented.	Lead the development of the policy framework for a nationally consistent approach to the planning and delivery of services for older people with a mental illness.	Policy development is led by the sector, with providers clearly identifying the issues that require resolution.
Develop a mechanism for all NGO alcohol and other drug providers to report the national minimum data set within the MHINC.	The Ministry will develop a discussion paper on data development for the A&OD sector for presentation to the National A&OD Treatment forum.	MOH, DHBs, NGO A&OD providers	2006–2008 Mechanism developed. By 2010 All A&OD NGOs are reporting to the MHINC.	Lead the development of a mechanism to report data.	Participate in a process to identify and implement the best solution for the sector.
Review the findings of the epidemiology study.	Review the findings of the New Zealand Mental Health Epidemiology Study with a view to creating a better match between mental health service delivery and population need.	MOH, DHB funders and planners, providers	2006–2009 Review papers and disseminate information to the sector	Further analyse the data set at the national level.	Review the findings and demonstrate service changes based on population needs.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
Develop a national Mental Health Workforce Information System to collect workforce information from several different providers.	The Health Workforce Information Project builds on the lessons learned by the Mental Health Workforce Information System project.	MOH, District Health Boards New Zealand, MoH, all providers	Jan 2006–Dec 2008 Develop and implement the Health Workforce Information Project solution.	Review options for collecting accurate mental health workforce information.	Support the collection of data on the mental health workforce via implementation of the final Health Workforce Information Project solution.
Survey the NGO sector to assess information capacity and capability (which are unknown).	The Ministry has commissioned Platform to undertake a national survey of all mental health NGO providers to assess their information system capacity and capability. Outcome measurement for NGOs is to be progressed under MH-SMART. The findings are to be used to inform the development of the NGO Mental Health Information Reporting System (MHIRS).	MoH, NGOs, Platform, MHC	Survey NGO sector To be delivered by April 2006. Develop a scoping document for developing an outcome measurement in the NGO sector by the end of 2006	Survey the NGO sector.	Support the roll-out and ongoing maintenance of a NGO mental health information solution that includes both MHINC and outcome data.
Encourage the sector to value data as a critical component of a quality improvement process, and monitor data quality accordingly.	The NGO MHIRS is a proposed software application that will enable NGOs to report MHINC and MH-SMART data to NZHIS. 28 NGOs currently submit results manually, which are keyed into MHINC via the Ministry Mental Health Online Data Entry system. The MHIRS Project will provide feedback from an additional 300 NGOs, filling current data gaps.	MoH, DHBs, NGOs, NCAT, MHRDS, MHC, vendors.	Jan 2006 – Dec 2007 A mechanism is developed and distributed to providers. Jan 2008–Dec 2010 Reporting and benchmarking are implemented.	Lead the development and design of MHIRS in accordance with the business requirements of the Integrated Mental Health Data Collection System. Distribute MHIRS to mental health NGO providers to enable them to report MHINC and MH-SMART data.	NGO providers participate in the design and development of MHIRS. NGO providers report the integrated data set to NZHIS.
NZHIS expands the roles and responsibilities associated with maintaining MHINC to encompass MH-SMART data.	The Integrated Mental Health Data Collection will provide a clearer picture of the relationship between consumer utilisation of services and consumer outcomes by combining MHINC and MH-SMART data sets into an integrated data collection.	MoH, providers, research institutions, training organisations, MHC	Jan 2006 Project starts. Mid-2007 Local DHB data is reported to the NZHIS.	The NZHIS develops analytical capacity and capability, including case-mix expertise, to support the analysis of outcome data at the national level	Participate in the design and development of the Integrated System. Report the integrated data set to NZHIS.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
Improve the recording and reporting of patient ethnicity to enable better decision-making.	See 5.2 (Fix) regarding the Ethnicity Protocol. The NZHIS is currently monitoring the quality of ethnicity data captured from providers and has recently compared the ratio of Māori ethnicity collected against census levels. Results will be collated and analysed in order to target training and awareness programmes in the future.	MoH, providers, research and training organisations, MHC	Ethnicity Protocol Completed (Nov 2004).	Developed Ethnicity Protocol.	2005–2010 Reliable ethnicity data will be used to inform DHB funding and planning.
			Monitoring the quality of ethnicity data capture Ongoing	Continue to implement the ethnicity and data protocols for the health and disability sector, and monitor the quality of ethnicity data capture.	Collect ethnicity data according to the ethnicity protocols.
Implement the collection of consumer outcome data into routine practice under MH-SMART.	The national MH-SMART implementation team has supported DHB site coordinators to prepare staff for the collection and use of outcome data.	MoH, DHBs, MHC	2004–2005 Ministry of Health to fund MH-SMART co-ordinator positions 2006 onwards DHBs to support the collection of data	Support service provider capability development through the national MH-SMART implementation team.	Participate in national training workshops and incorporate ongoing training on outcome measurement into routine information management modules.
9.2 (Fix) Privacy and security					
Put in place privacy, security and authentication frameworks to provide a sound environment for information sharing.	A Privacy, Authentication and Security (PAS) guide has been developed by the Ministry and DHBs, and is currently under sector consultation. The PAS guide will bring existing documents together and specify a consistent level of security and privacy for the sector.	MoH, providers, vendors, consumer advocacy groups	Sector consultation Progressing. PAS implementation To be scheduled.	Develop, with the ACC, the PAS guide that brings existing documents together and specifies a consistent level of security and privacy for the sector.	Implement and monitor information systems to ensure they comply with relevant legislation.

Solution from MHIS	Current state and specific actions	Key stakeholders	Milestones/ measures/ phasing/ status	Relative roles and responsibilities	
				Ministry of Health	DHBs (DHB providers and NGOs)
Improve the availability of information about the application of the Health Information Privacy Code 1994.	Although no specific work has been done to monitor provider compliance with legislation and standards, a number of providers were contacted during a review of the Health Information Privacy Code 1994, which led to changes to the Code being proposed to the Privacy Commissioner in July 2005. No action has been taken by the Privacy Commissioner in following up these proposals.	MoH, providers, consumers, Privacy Commissioner	Privacy Code changes proposed to Commissioner Completed (July 2005).	Monitor provider compliance with legislation and standards.	Ensure all staff know what consumer health information they are able to share and under what circumstances.
	The NZ-HIS and policy group (within the NZHIS) supports the DHB Privacy Officers Forum, which meets three times a year and considers ways of sharing knowledge and improving best practice. General understanding of the Code by DHB privacy officers appears to be good.	MoH, DHBs	Privacy Officers Forum Meets three times a year.		
9.3 (Fix) Governance					
Develop a stakeholder governance framework to ensure effective stakeholder management of all national mental health information.	The National Governance Framework is currently under development to ensure effective stakeholder management of all national mental health information.	All stakeholders, MHC	Governance Framework To be developed by the Ministry by Dec 2006.	Review the governance arrangements for the MHINC as part of the Ministry's wider National Data Collection Framework project (the responsibility of the Health Information Strategy Action Committee's National Collections Subcommittee).	Participate in developing a sector-wide governance framework for managing the national mental health data collection.



Interdependencies and Constraints

Overview

This section describes the relationship between the different initiatives identified in the various priority areas in terms of how the activities are currently phased and the expected timeframes. The aim is to highlight those areas in which progress in one initiative depends on successfully completing work in another. Identifying these constraints is essential to manage the risks associated with the different work streams - and to manage expectations.

The following section also indicates the relevant HIS-NZ action zone (AZ) or building guide (BG) for the identified projects.

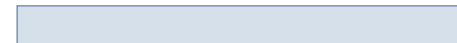
The 12 action zones in the HIS-NZ are:

1. National Network Strategy
2. National Health Index
3. Health Provider Index
4. ePharmacy
5. eLabs
6. Hospital discharge summaries
7. Chronic care and disease management
8. Electronic referrals
9. National outpatient collection
10. National primary and community care collection
11. National system access
12. Anchoring framework.

The HIS-NZ also identifies eight building guides, which set out the key structural components required to deliver integrated information systems to the sector:

- A. National connectivity
- B. Applications
- C. National data collections
- D. Standards
- E. Privacy and security
- F. Governance and accountability frameworks
- G. Collaboration frameworks
- H. Investment management framework.

In those cases where a project is deemed to be fundamental to either furthering the sector or measuring progress on Te Tāhuhu, this project has been highlighted in blue.



Priority projects have been identified on the basis of common themes regarding the drivers underlying the National Mental Health Information Strategy. These common themes may be summarised as:

- a desire to integrate (data and services)
- a desire to lower the compliance overhead for providers

- a desire to achieve a longitudinal view of care provision and consumer outcome, regardless of service setting (with a particular focus on NGOs)
- an increased focus on demonstrating ‘value for money’.

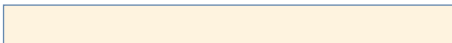
Four priority projects

The four priority projects are the:

1. Mental Health Integrated Data Collection (PRIMHED)
2. Mental Health Information Reporting System (MHIRS)
3. development of a key performance framework for mental health services
4. development of standards (to support both PRIMHED and MHIRS).

It is important to note that sharing information across multiple systems requires common standards and common processes. The development of standards is not a stand-alone project, but is inherent in a number of projects, including PRIMHED and MHIRS.

Where there are gaps in the current work plan, the projects are highlighted in yellow.



There are also some projects that do not have any reference to HIS-NZ because they have more to do with information use rather than system development.

It is recognised that the sector faces considerable constraints regarding the financial and human resources that will be required to implement the full Implementation Plan within the timeframes indicated. How these constraints affect individual projects or initiatives is difficult to assess and quantify because different organisations are not only in different stages of clinical practice and business development, but also vary in their capability to find and fund the staff with the appropriate skills to implement these initiatives. For this reason it will be important to review the Implementation Plan in 2008 to align it with any changes in the sector and to changes in the priority areas in HIS-NZ.

Key for the abbreviations used in the following section

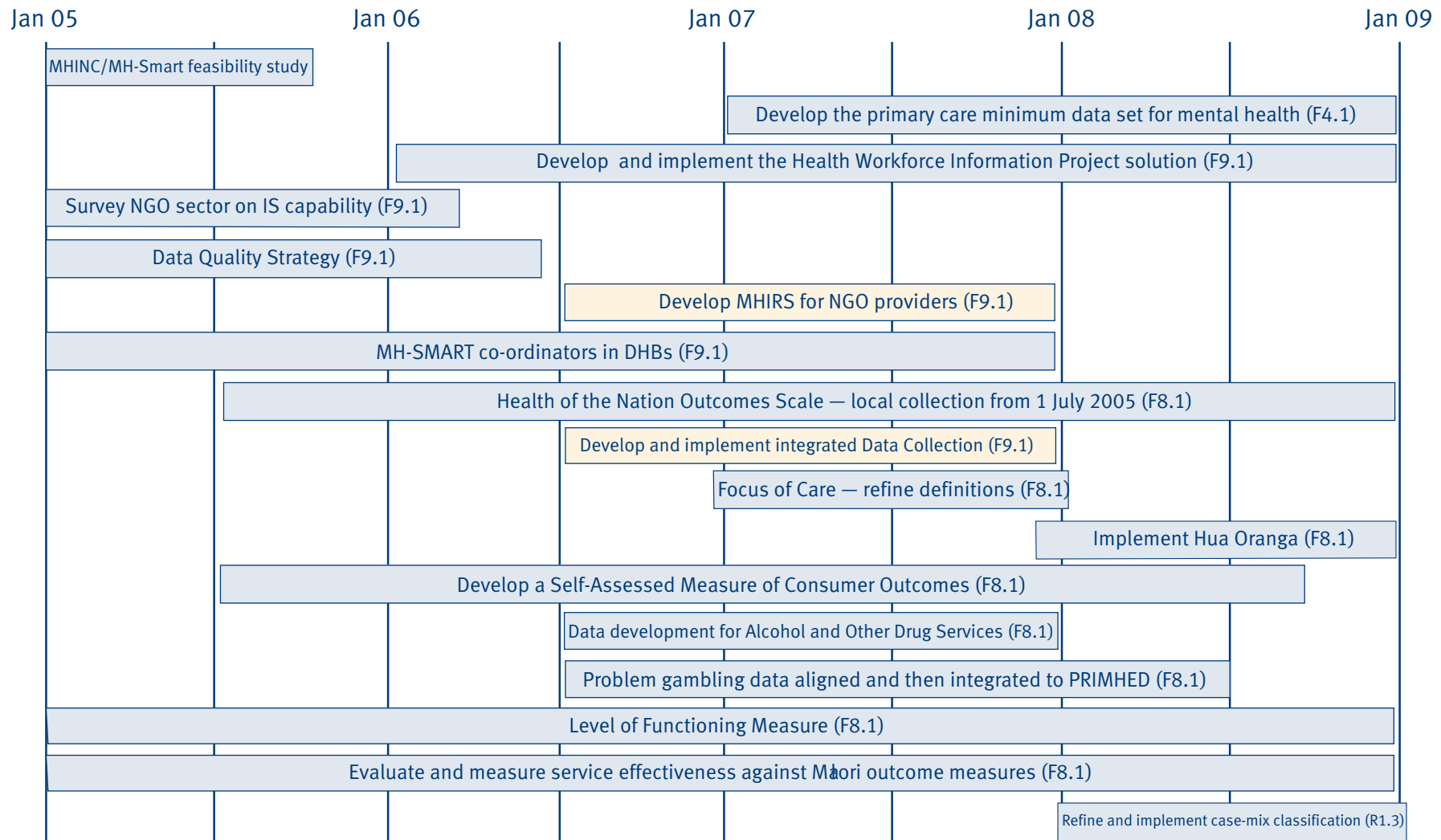
Action zones: **AZ** (followed by the relevant number of the action zone in HIS-NZ)

Building guides: **BG** (followed by the letter of the relevant building guide in HIS-NZ)

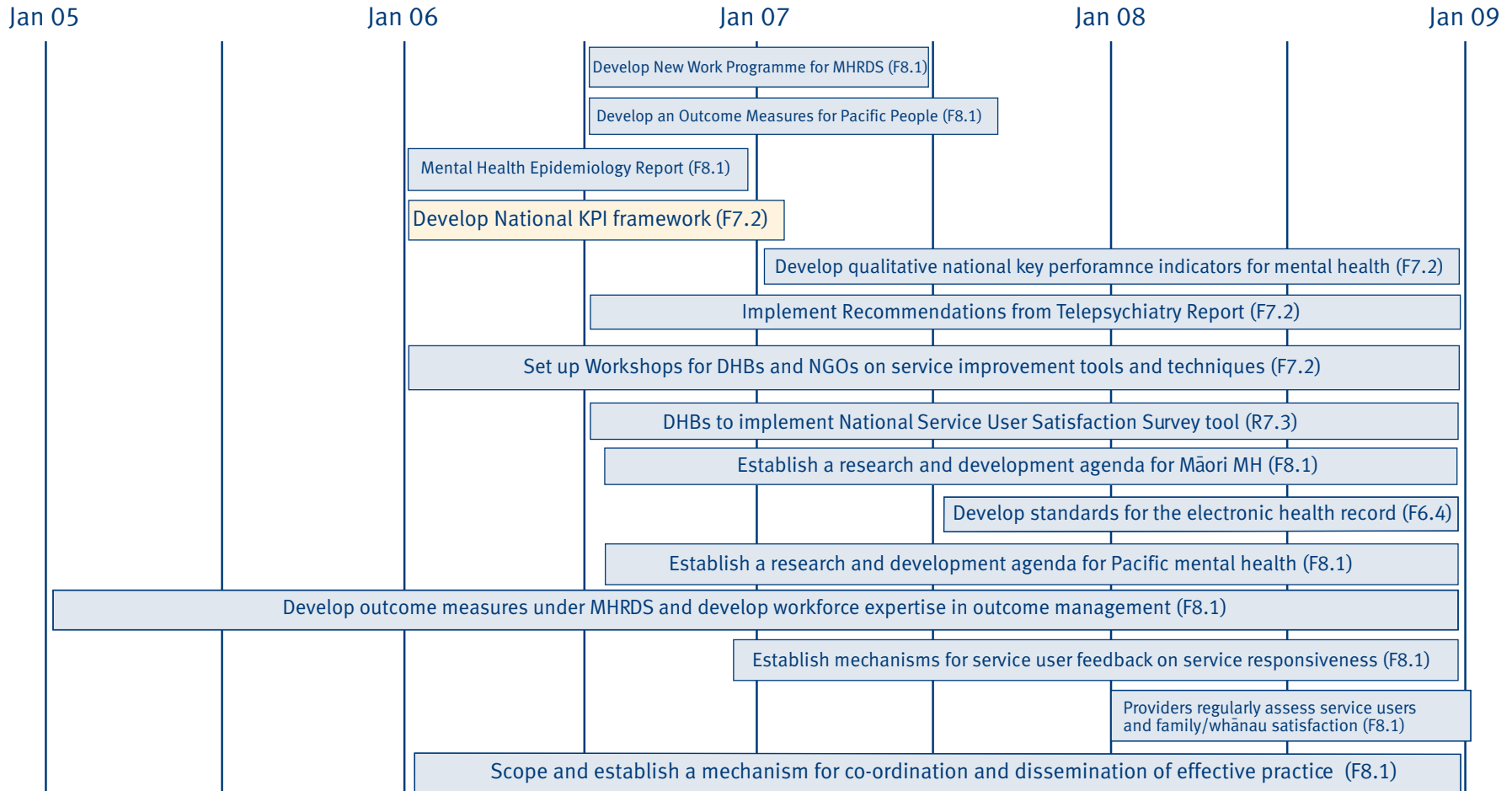
Fix: **F** (followed by the relevant reference to the numbered priority area in the National Mental Health Information Strategy Implementation Plan)

Renovate: **R** (followed by the relevant reference to the numbered priority area in the National Mental Health Information Strategy Implementation Plan)

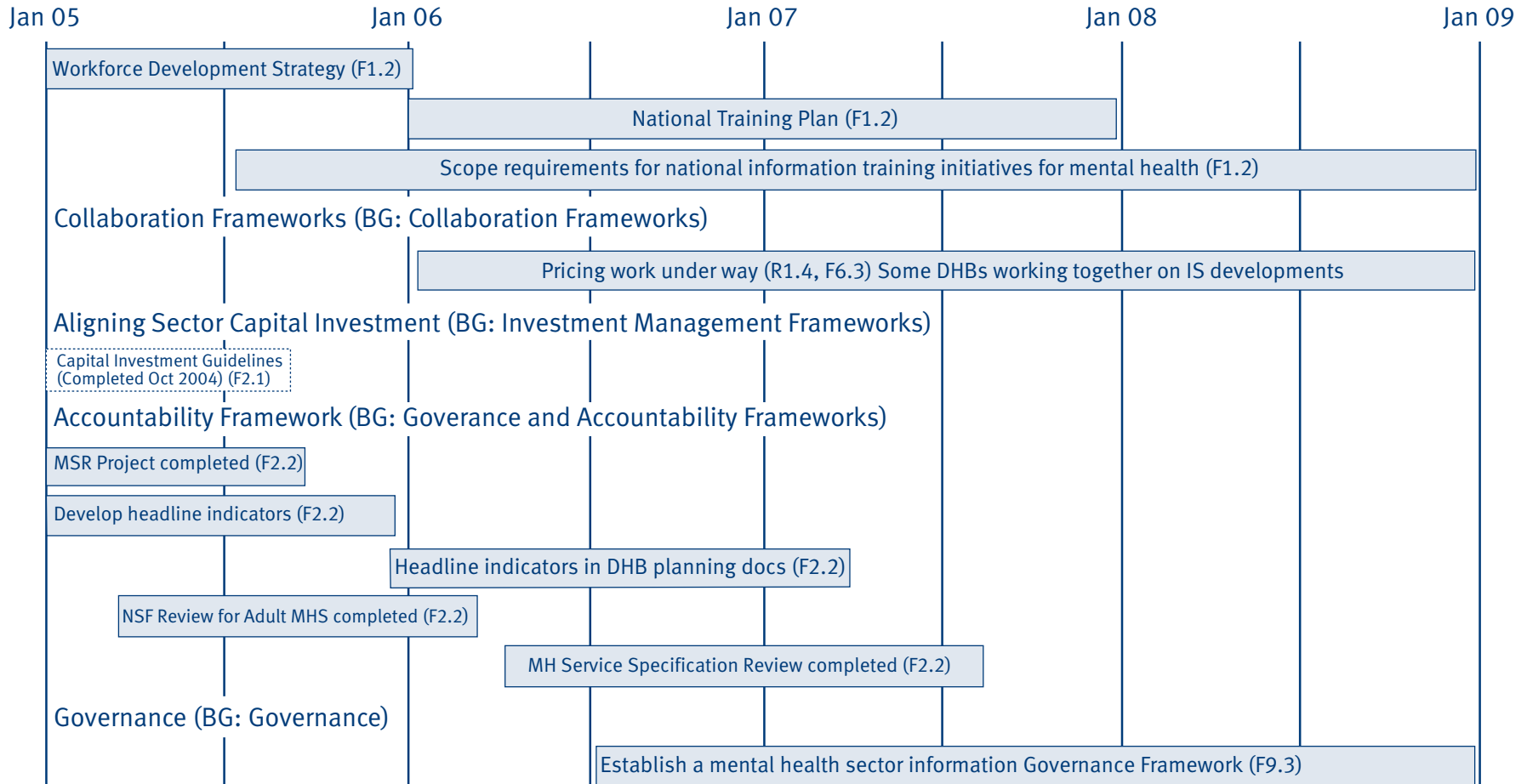
National Data Collection Development (Action Zones 9 and 10)



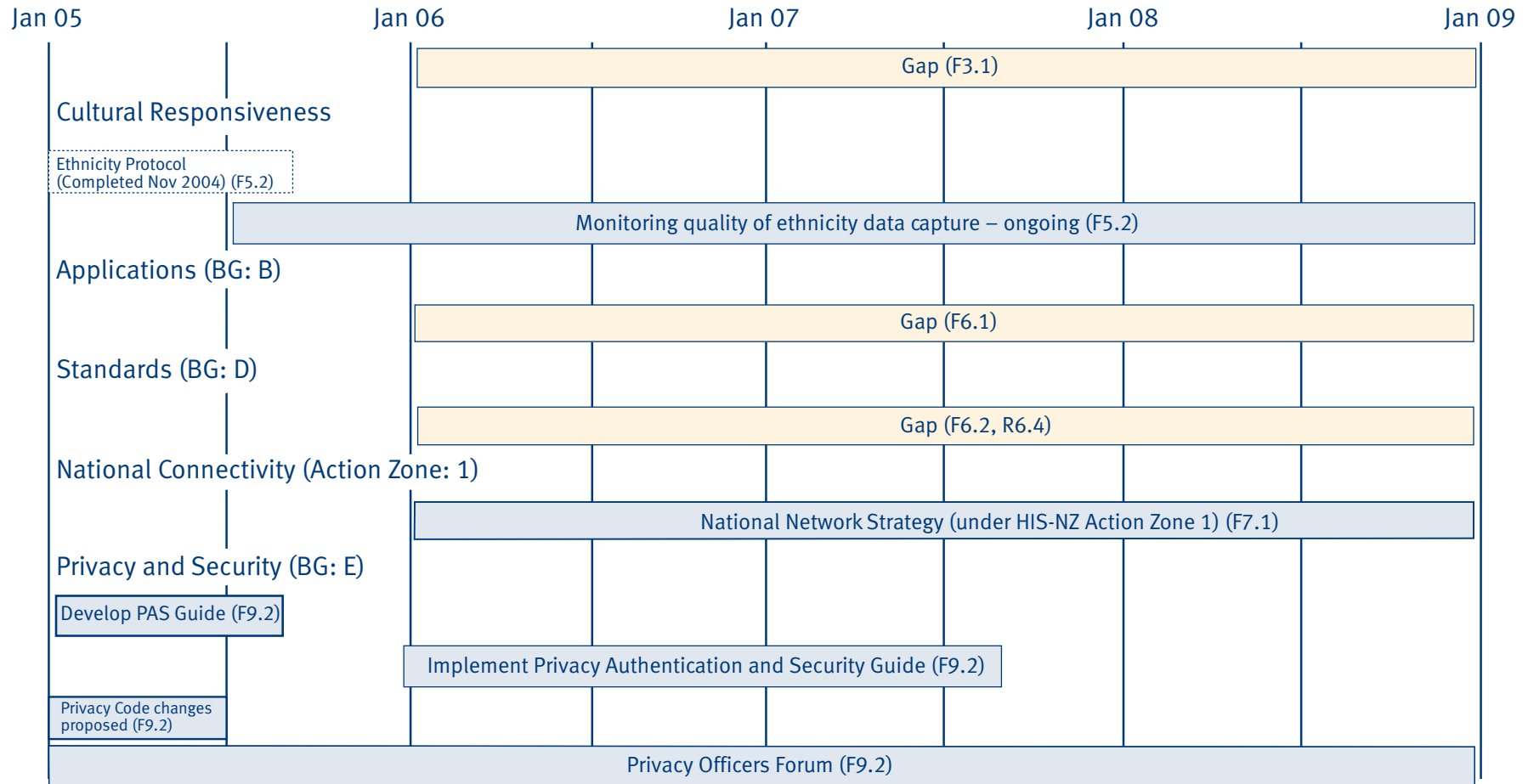
Quality Improvement (BG: National Data Collections and Standards)



Workforce Development



Consumer Input into Records (BG: G)





Gaps in the Work Programme

Overview

This section identifies the areas in which work has been identified as being necessary, but has yet to be established as a formal initiative. Where possible, for each area that needs a work programme, an indication will be provided of the:

- scope of effort required
- priority
- scale of resources likely to be needed
- stakeholders and lead agency responsible
- interdependencies with the established work programmes and how it constrains or enables these activities
- technology requirements.

Fix

2.1 Align sector capital investment: Adopt a more formal approach for co-ordinating investment in IT that includes DHB, NGO and primary health care providers.

Capital investment guidelines have been developed for DHBs but do not cover investment by NGO or primary health care providers.

Action required: Although the Ministry of Health is not directly involved in the capital investment of primary care or NGO providers, it does so indirectly by funding services these providers are contracted to deliver. It remains important, therefore, to investigate how best to extend the lessons learned in the DHB sector to NGO and primary care providers with respect to capital investment.

Priority: Moderate. Providers are already investing capital and introducing technology, and the Ministry needs to facilitate an appropriate mechanism that would help smaller organisations to optimise both technology selection and investment decisions.

Resources: Moderate to low. Ministry resources will be focused on facilitation and co-ordination.

Stakeholders: IT vendors, Ministry of Health Funding and Performance, NGO and primary care providers, DHBs.

Lead agency: Ministry of Health

Interdependencies: All projects that involve data collection.

Technology: Nil specific.

3.1 Collaboration: Develop information systems that support active participation and collaboration between providers and consumers in the management of mental illness for practitioners involved in their care.

Currently there are no information system projects within the Ministry of Health that address the ability for consumers to have direct input into electronic clinical records (see priority area 3.1)

Action required: The Ministry of Health needs to ensure the opportunity for consumer input into clinical records is actively encouraged and built into application selection decisions, and that appropriate standards and security controls are developed that will permit this to occur.

Priority: Low to moderate. The ability to achieve this objective is predicated on the introduction of web-based technology, with the appropriate security functionality that can enable this to occur.

Resources: Low. Ministry resources will be focused on establishing standards and inter-operability.

Stakeholders: IT vendors, Ministry of Health, providers, HISO, consumers.

Lead agency: Ministry of Health.

Interdependencies: All projects involving client-centred records.

Technology: Nil specific.

4.1 National data collection development: Develop a primary care minimum data set that is inclusive of mental health requirements.

Currently there is an emphasis on the development of indicators for primary care that include mental health. The second stage of information development is to develop a primary care minimum data set that also addresses mental health requirements.

Action required: The Mental Health Directorate needs representation on the steering committee of the project developing the primary care minimum data set.

Priority: High. The Mental Health Directorate needs to have direct representation on any project that involves data collection in the primary care sector.

Resources: Low.

Stakeholders: Ministry of Health, primary care providers.

Lead Agency: Ministry of Health (Clinical Services Directorate and NZHIS).

Interdependencies: All projects involving collection of data in the primary care sector.

Technology: Nil specific

6.1 Applications: Develop or modify applications to provide a standardised output that supports common business processes.

Identifying and documenting common business processes embodying best practice within mental health providers, and capturing this electronically, is not on the HIS-NZ work programme.

Action required: Develop an integrated approach that recognises the wide variety of providers and the different business processes that might be relevant for DHBs, NGOs, and primary providers. Step 1 is to identify and agree common business processes. Step 2 is to translate the business processes into meaningful and appropriate inputs that can be integrated and recognised by operational systems and data collection applications.

Priority: Moderate. This is important in the longer term but does not require immediate attention.

Resources: Moderate. Ministry resources will be focused on facilitation and co-ordination of standards and system requirements within the HIS-NZ framework.

Stakeholders: Ministry of Health, providers, consumers.

Lead agency: Ministry of Health.

Interdependencies: All projects that support operational processes.

Technology: Nil specific.

Renovate

6.4 Standards: Develop standards that permit electronic patient records to be shared among providers using different systems.

Inter-operability is a critical success factor and a major reason for introducing electronic health records. Ensuring that there is an agreed format for electronic records is not currently on the HIS-NZ work programme.

Action required: The Ministry of Health needs to take a leadership role in the development of national standards and formats for the electronic health record.

Priority: High. Providers are already incrementally introducing technology that will lead to a full electronic health record, and the Ministry needs to facilitate the development of standards that will be adopted nationally before making adverse investment decisions.

Resources: Moderate. Ministry resources will be focused on facilitation and co-ordination.

Stakeholders: IT vendors, Ministry of Health, providers, HISO.

Lead agency: Ministry of Health

Interdependencies: All projects that require data sharing between agencies, especially the Integrated Mental Health Data Collection and MHIRS

Technology: Nil specific



Appendix: DHB PMS and HRIS Profiles

In referring to this Appendix it should be noted that software applications are subject to frequent change. Each year the NZHIS undertakes a survey of all DHBs, which identifies both the software and the version that each DHB uses for every service across the organisation. The following tables reflect the environment as at March 2006.

Table A1: HRIS applications, by region and DHB as at March 2006

Region	DHB	Product	Comment
Northern	Auckland	AMS Leader	Payroll implemented; online leave request, CPE (CME/CMNE), OSH due in 2006.
Northern	Counties-Manukau	AMS Leader	Supplied by Health Alliance
Northern	Northland	PS 2000+	Midland 'Health Vanilla'
Northern	Waitemata	AMS Leader	Supplied by Health Alliance
Midland	Bay of Plenty	PS 2000+	Midland 'Health Vanilla'
Midland	Lakes	PS 2000+	Midland 'Health Vanilla'
Midland	Tairāwhiti	PS 2000+	Midland 'Health Vanilla'
Midland	Taranaki	StarGarden	
Midland	Waikato	HRIS (PeopleSoft)	
Central	Capital and Coast	AMS Leader	
Central	Hawke's Bay	AMS Leader	
Central	Hutt	PayGlobal	
Central	MidCentral	PS 2000+	Midland 'Health Vanilla'

Region	DHB	Product	Comment
Central	Wairarapa	AMS Leader	
Central	Whanganui	PS 2000+	Midland 'Health Vanilla' (TBV)
Southern	Canterbury	StarGarden	
Southern	Nelson-Marlborough	AMS Leader	
Southern	Otago	People Manager (Datacom)	
Southern	South Canterbury	AMS Leader	
Southern	Southland	CHRIS	
Southern	West Coast	StarGarden	Operates from Canterbury DHB infrastructure

Table A2: PMS applications, by region and DHB as at March 2006

Region	DHB	PMS software		Comments
		Inpatient data collection	Community	
Northern	Auckland	HCC/CHIPS	HCC	
Northern	Counties-Manukau	PIMS 1.81	PIMS 1.81	
Northern	Northland	Alpha	JCC	
Northern	Waitemata	PIMS	PIMS	
Midland	Bay of Plenty	IBA PMS	IBA Eclipse	
Midland	Lakes	Isoft	Isoft	
Midland	Tairāwhiti	Galen	CHIPS	
Midland	Taranaki	IBA PMS	IBA PMS + in house-built SQL database (for crisis team, legal status and diagnosis)	
Midland	Waikato	Hospro-w (changing to iSOFT iPM late in 2006)	Hospro-w (changing to iSOFT iPM late in 2006)	
Central	Capital and Coast	IBA	IBA	Allegra is the current PMS but will be replaced mid-2006 by IBA for inpatient and community as part of the systems replacement project moving to IBA (PMS) and Orion (Clinical).
Central	Hawke's Bay	IBA	Eclipse	
Central	Hutt	IBA	Eclipse	
Central	MidCentral	CHIPS	MS Access	
Central	Wairarapa	Galen (InteHealth)	Galen and CAMHS in Mental Health (inhouse Access/SQL)	
Central	Whanganui	Oracare	Oracare	

Region	DHB	PMS software		
		Inpatient data collection	Community	Community
Southern	Canterbury	SAP ISH / ISMED	SAP ISH / ISMED	
Southern	Nelson-Marlborough	Oracare	Oracare	
Southern	Otago	Oracare	Oracare	
Southern	South Canterbury	Ajexus	Ajexus	
Southern	Southland	IBA/Oracare (MHS) migrating to iSOFT in April 2006	IBA/Oracare (MHS) migrating to iSOFT in April 2006	
Southern	West Coast	IBA	In House	



Glossary

Access	A potential consumer's ability to obtain a service when they need it and within an appropriate time.	Consumer	A person with experience of mental illness who uses mental health services. This term is often used interchangeably with 'service user' and/or 'tangata whai ora'.
Assessment	A service provider's systematic and ongoing collection of information about a consumer to form an understanding of consumer needs. A clinical assessment forms the basis for developing a diagnosis and an individualised treatment and support plan with the consumer, their family/whānau and significant others.	Evidence-based practice	An approach to decision-making in which the clinician uses the best evidence available, in consultation with the consumer, to decide on a course of action that suits the consumer best.
Blueprint (for mental health services)	The document the Mental Health Commission developed that defines the levels of specialist mental health services as well as the changes required to implement the Government's National Mental Health Strategy (Mental Health Commission 1998).	Family	The consumer's whānau, extended family, partners, friends or other people the consumer has nominated.
Care providers	All professionals who provide consumers with clinical and/or social support.	Health Information Strategy for New Zealand (HIS-NZ)	The broad range of national health information initiatives (Ministry of Health 2005a).
Carer	A family/whānau member or friend who cares for or supports a consumer, either voluntarily or for a nominal payment.	Health outcome	A change in an individual's or group's health status attributable to one or more interventions.
		Information systems	In its broadest sense, a term used to cover all processes, information, communication and technology.
		Mental Health Commission (MHC)	A statutory agency reporting to the Minister of Health on the implementation of the Mental Health Strategy and the performance of the Ministry and providers in relation to this.

Mental Health Information National Collection (MHINC)	The national database of mental health information held by the New Zealand Health Information Service (NZHIS) to support policy formation, monitoring and research.	Mental illness	Any clinically significant behavioural or psychological syndrome characterised by distressing symptoms or significant impairment affecting a person's ability to function.
Mental health sector	The organisations and individuals involved in mental health to any degree and at any level.	Pacific peoples	A diverse group of people from the Pacific region, including Tongan, Samoan, Fijian, Cook Island, Tokelauan and Niue peoples.
Mental health service provider	An organisation providing, as its core activity, assessment, treatment or support to consumers with mental illness and/or alcohol and drug problems.	Policy	A written statement that reflects an organisation's or service's position and values on a given subject. These may also be called protocols, standards or codes of practice.
Mental Health Standard Measures of Assessment and Recovery (MH-SMART)	The Mental Health Standard Measures of Assessment and Recovery initiative, referred to as 'MH-SMART', was established to assist DHBs in outcome collection processes. MH-SMART will support the implementation of a suite of standard outcome tools to measure changes in the health status of mental health service users. These tools will help consumers, clinicians, service providers and funders to identify the possible contribution mental health services have made to recovery.	Recovery	Living well in the presence or absence of mental illness and the losses that can be associated with mental illness.
		Standard	An identified level of performance, made up of specific criteria, against which performance is measured.
		Strategic plan	An organisation-wide plan that establishes an organisation's overall objectives and positions the organisation in respect of its environment.
		Tangata whai ora	A person with experience of mental illness. This term is often used interchangeably with 'service user' and/or 'consumer' The translation of the term from Māori means 'a person seeking wellbeing'.

Te tāhuhu	The ridgepole that provides essential support to the meeting house
Telemedicine	The use of information communications technology to deliver health care services to recipients in different physical locations from the provider. Examples include telepsychiatry, teleradiology, and clinical decision support with reminders and alerts.
Whānau	Includes kuia, koroua, pakeke, rangatahi, tamariki. The use of the term Whānau in this document is not limited to traditional definitions, but recognises the wide diversity of families represented within Māori communities. It is up to each Whānau and each individual to define for themselves who their Whānau is.
Whānau ora	Families supported to achieve their maximum health and wellbeing, individually and collectively.



Abbreviations

A&OD	Alcohol and other drug	NZHS	New Zealand Health Information Service
AZ	Action Zone	PAVA	Pacific Workforce Development Programme
BG	Building Guide	PHO	Primary Health Organisation
CFA	Crown Funding Agreement	PMS	Patient Management System
CSD	Clinical Services Directorate	PRIMHED	Project for the Integration of Mental Health Data
DHB	District Health Board	WDP	Workforce Development Programme
HISO	Health Information Standards Organisation		
HRC	Health Research Council of New Zealand		
HRIS	Human Resource Information System		
KPI	Key Performance Indicator		
MHC	Mental Health Commission		
MHINC	Mental Health Information National Collection		
MHIRS	Mental Health Information Reporting System		
MHP	Mental Health Programmes Ltd		
MHRDS	Mental Health Research and Development Strategy		
MH-SMART	Mental Health Standard Measures of Assessment and Recovery		
MoH	Ministry of Health		
NGO	Non-Government Organisation		
NHI	National Health Index		



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