Primary Care Partnerships

Information Management Strategic Directions

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Aged, Community and Mental Health Division
Department of Human Services, Victoria

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Further Information

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Contents

Executive Summary v

Section 1: The Policy 1
1.1 Primary Care Partnerships
1.2 Service Coordination within Primary Care Partnerships 1

Section 2: The Operational Framework 3
2.1 The Better Access to Services Model 3
2.2 Desired IM/IT Capabilities 5
2.3 An Incremental Approach to Developing IM/IT Capabilities 8
2.4 Manage an Ongoing Change Program 9

Section 3: Key Strategies 13
3.1 Develop PCP Capabilities 13
3.2 Protect Consumer Information 18
3.3 Link State and National Initiatives 21
3.4 Improve Planning, Funding and Reporting Arrangements 24
3.5 Establish Common Infrastructure 28
3.6 Key Elements of an Electronic Information Sharing Environment 30

Appendix A Process Maps 37

Appendix B Information Management Strategic Plan Template 47

Appendix C Generic Planning Templates To Support the Development of Information Management Strategic Plans 49
C1 Scoping Template 50
C2 Model of Operation 51
C3 Management Considerations 52
C4 Current IT Audit Template 54
C5 Target IT Requirements Template 56
C6 Project Brief Template 59
C7 Financial Templates 60
C8 Project Management Template 61

Draft

Figures

Figure 1 Better Access To Services Operational Framework. 1
Figure 2 Systems Required To Support Primary Care Providers 5
Figure 3 Incremental Approach To Acquiring IM/IT Capabilities. 8
Figure 4 The Underlying Change Management Framework 10
Figure 5 Managing the Relationship between the Partnership and its Suppliers 14
Figure 6 Elements of IM/IT Governance 15
Figure 7 Typical Structure for IM/IT Governance 15
Figure 8 Responsibilities of the Working Group. 16
Figure 9 The IM/IT Acquisition Process 17
Figure 10 Approach To Simplify the Department's Data Collection Requirements 27
Figure 11 Role of a Shared Health Record To Coordinate Services 31
Figure 12 Securing Communications between Providers 34
App Figure 1 Process Map Conventions 38
App Figure 2 High Level View 39
App Figure 3 Initial Contact 40
App Figure 4 Initial Needs Identification 41
App Figure 5 Comprehensive, Service Specific and Specialist Assessment 42
App Figure 6 Care Planning (1). 43
App Figure 7 Care Planning (2). 44
App Figure 8 Provide Services 45
App Figure 9 Swimlane Process Mapping Technique 52

Tables

Table 1: Indicative Evolutionary Pathway viii
Table 2: Funding Structure for PCP Information Management ix

Draft

Executive Summary

The Primary Care Partnership strategy aims to create a cohesive primary care system working to improve the health and wellbeing of Victorians. Primary care providers have been encouraged to form alliances, called Primary Care Partnerships (PCPs), to develop cooperative strategies that address the needs of their local communities. There are now 32 PCPs that cover rural Victoria and most of metropolitan Melbourne.

This document outlines the directions for development of information management and information technology (IM/IT) capacities in PCPs and the broader primary care sector in Victoria. It details the expected areas of IM/IT development and an evolutionary pathway to achieve the developments. The Strategic Directions take into account developments and trends that are occurring across Victoria, nationally and internationally.

This document contains practical tools and guidance to enable PCPs to begin developing IM/IT strategic plans. On the basis of these plans, the Department of Human Services will work in partnership with PCPs to guide the development of and investment in IM capabilities over the coming years.

Effective and efficient coordination of services requires the use, among other things, of improved IM practices and appropriate IT. There is widespread desire amongst providers to improve their IM/IT capabilities. There is also general recognition that demographic and technological change is putting pressure on the primary care sector. Both consumers and providers want to use new technologies to integrate services into a cohesive system. This will enable providers to efficiently deliver a coordinated range of services to meet individual consumer needs. Achieving this change requires consumers, providers and planners to utilise a sophisticated suite of systems—a vision that can only be achieved as providers address IM issues and develop IT capabilities. Providers will also need to work with consumers to ensure the IM/IT systems that are developed support improved care for consumers in appropriate ways.

> Connectivity between providers is a key factor in enabling this vision to be achieved. Connectivity can only be achieved if providers develop systems based on common business processes and utilise data and transmission standards endorsed at a State or national level.

Affordability of establishing the necessary management processes and appropriate technology, funding to enable agencies to participate effectively, and organisational readiness, will be critical in establishing the pace at which this change occurs. As PCPs progressively develop their capabilities, statewide infrastructures will be developed. This will enable communication and information sharing across PCPs in Victoria, linking them into an evolving national health IM/IT structure. A critical feature of this will be a very strong interface between the primary care sector and the acute and residential care sectors, underpinned by joint initiatives.

Addressing IM Issues To Build a Cohesive Primary Care System

Investment in IM capacity for PCPs is fundamental to achieving the objectives of the strategy. Industries outside of the human services sector have demonstrated that investment in IM is a catalyst for ongoing change. The real benefits are achieved when organisations invest in IM by developing new processes, building skills, and changing work practices. The implication for the primary care sector is that significant improvements in quality, accessibility, efficiency and health outcomes can be achieved by adopting work practices based on the increased understanding of the importance of IM in contemporary human services delivery.

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The management of information will need to be founded in the work processes of individual agencies and PCPs as a whole. The development of new work processes based on the Better Access to Services (BATS) policy directions promises to deliver benefits to consumers and providers. The BATS framework is aimed at assisting service providers to improve practice within, and the interface between, existing assessment processes with an emphasis on consumers' initial contact with the service system, initial needs identification, referral and feedback.

Development needs to be based on real, practical solutions addressing identified local requirements. PCPs need to maximise the value of the development by targeting high priority local needs. Initial development needs to establish the partnership's profile and a base for future expansion. As progress is made, the capabilities will gradually expand to establish an IM environment to support the communication of health information among all primary care providers and consumers across the State.

The main benefit of improvements in IM/IT capacity will be to enable services to be delivered more effectively. Many agencies have identified a real and significant administrative burden in current paper-based systems. This includes finding and waiting for files, completing documentation after a service event, unproductive time spent in travel or meetings, and collection of data to fulfil funding and service agreement reporting requirements. Freeing this unproductive time will allow providers to deliver improved services to consumers. In addition, the lack of cohesion in the sector can mean that providers unnecessarily duplicate assessments and repeatedly collect the same information from those seeking to use services. Sharing trusted information between providers within a privacy protection regime could create efficiencies for providers and result in a more positive experience and better care for consumers.

Addressing IM issues, supported by the efficiency gains delivered by IT, will provide a base for substantial improvements in the health and wellbeing of the community. It is generally accepted that large gains can be made when consumers take more responsibility for their care. The key opportunities are to reduce risk factors, make more astute use of health care services, and develop systems that enable compliance with advice given by providers. IM and IT development can be used to:

- Encourage healthier lifestyles by providing health and lifestyle information.
- Encourage use of the appropriate health and community services.
- Enable remote access to services and information using Internet communications.
- Support self-management of care, especially for people with chronic conditions.
- Encourage and enable compliance with care advice, especially by using follow-up contacts.
- Enable extended hours of support and advice.
- Publish service availability and eligibility information to assist consumers and providers in decision making.
- Enable more effective coordination of care and information sharing to support improved health and wellbeing outcomes.

While it is expected that these capabilities will provide substantial benefits in the longer term, realisation will depend on their availability and uptake by the community. Continued promotion and encouragement by both Government and providers will be necessary to create consumer acceptance. Consumer involvement in the development of such systems will enable the establishment of appropriate and acceptable systems.

Basis for the Strategic Directions

This document provides practical approaches to guide PCPs in developing their IM capabilities. The Strategic Directions have been built on the following foundations that reflect the nature of the sector and the issues it faces:

- Primary care providers provide a wide range of health and community support services.

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- There is a large variation in the relative size and scope of primary care agencies, ranging from single provider agencies to agencies employing hundreds of staff delivering a wide range of services.
- Providers are starting from different capability levels, but share a common vision. This includes raising the visibility of services, facilitating access for disadvantaged groups, providing continuity of care, achieving efficiencies in service delivery, and maintaining sustainable funding levels for primary care.
- Improving linkages between primary care providers is a key requirement.
- In general, there has been a low level of investment in IM/IT capabilities, with most providers consequently lacking skills and experience in developing IM/IT capabilities.
- Agencies are likely to take a greater interest in successful IM/IT capability development if they share responsibility for investment, are accountable for its success within their agency, and receive benefits above a reasonable threshold of expected funding.
- Investment risk can be managed by PCPs developing sophisticated and coordinated management practices and employing appropriately skilled personnel.

> Given the complexity of the primary care system, it is necessary to define common business processes, using the BATS framework, for IM/IT development. This approach emphasises connectivity between providers and partnerships based on common standards and practices rather than common IT systems.

Consultations have been held with consumers and providers across Victoria to understand IM issues and identify desired capabilities. Workshops to frame potential solutions were held with advisory group members who had knowledge of IM/IT requirements and had participated in IM/IT trials or developed IM/IT capabilities for relevant primary care organisations.

The key strategies developed through this process are outlined below. The objective of these strategies is to improve the use and value of information within the primary care system. These are the principal mechanisms through which the Strategic Directions will be achieved.

Incremental Development of Partnership IM/IT Capabilities

The challenge for primary care providers is to develop their collective IM/IT management skills and sophistication. This will be achieved using a ‘learning by doing’ approach. Partnerships will be able to undertake small, targeted projects that bring the main participants together to solve a common service need. The lessons learned from this project will be re-applied in a succession of projects that expand to include all services and all providers delivering services to consumers from the PCP’s catchment area.

Develop Information Management Practice and User Capacity

The objective is to establish a broad base of information management capacity and skills in each partnership.

Partnerships will:

1. Establish IM/IT governance mechanisms encompassing involvement from all participating agencies and consumers, including mechanisms to develop practices and protocols. They will specify application requirements, agree on implementation standards, and assist in steering projects to successful completion.
2. Enter contractual arrangements to concentrate IM/IT expertise and purchasing power in accordance with the terms and conditions set out in each PCP’s partnering agreement or Memorandum of Understanding (MoU).
3. Invest in information and communications infrastructure through arrangements established by the the Department of Human Services to ensure value for money and best practice purchasing.
4. Develop and implement a balanced multi-year IM investment plan for the partnership (Information Management Strategic Plan). This plan will identify and prioritise projects to enhance and implement the partnership IM capabilities.

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5 Foster and encourage relationships with the private sector to leverage available expertise and funds.

Develop and Implement a Strategic Plan
Partnerships will develop a five-year IM strategic plan to support the establishment of a functionally integrated service system based on the operational framework set out in *Better Access to Services: A Policy and Operational Framework*. This will be achieved by selecting a business requirement that can be significantly improved through project work on IM processes, practices and systems with a small investment in IT. Initially the work of PCPs will focus on:

- IM and IT to support initial contact (including the development and implementation of a local services directory and coordinated telecommunications arrangements).
- Piloting an initial needs identification tool (including management of issues around consent, privacy and confidentiality of information and duty of care).
- Piloting a care planning tool (dealing with privacy and duty of care issues and addressing mechanisms for review and reassessment).

Table 1: Indicative Evolutionary Pathway

July 2000 – June 2001 Partnership Development Plan	**July 2001 – June 2002 Community Health Plan 1**	**July 2002 – June 2003 Community Health Plan 2**	**July 2003 – June 2004 Community Health Plan 3**	**July 2004 – June 2005 Community Health Plan 4**
Service coordination management established involving full range of stakeholders. Identified and analysed current practices, processes and infrastructure for service coordination. Develop service coordination model. Develop BATS and IM strategy. Develop local services directory. Develop telecommunications plan to support the service coordination model. Input into the development of INI and care plan tools, core consumer information standards and statewide service directory. Address privacy/consent issues with service coordination model.	Participate in first year evaluation – partnership change. Input into competencies development for components of BATS. Implement local services directory. Implement telecommunications plan to support service coordination model. Pilot and implement initial needs identification and care plan tools.	Participate in second year evaluation – consumer experience and process change. Develop a coordinated platform for supporting clinical and care decision making. Participate in workforce capacity building to achieve competencies in the elements of the assessment process. Pilot other tools as required such as comprehensive assessment, service specific assessment and specialist assessment.	Participate in third year evaluation – consumer outcomes. Accredited staff with defined competencies delivering a fully operational service coordination model. Functional integration between residential care and acute including streamlined discharge and admission processes. Incorporate a rationalised client records environment into the service coordination model.	Operate within a rationalised electronic client record environment integrated across all sectors delivering health care.

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- The development of consistent IM practices and processes around comprehensive assessment, for those PCPs piloting integrated disease management.

The rate of implementation of IM/IT capabilities across the PCP will depend on many factors including the availability of infrastructure and resources, the current level of capability in each participating agency, and the readiness of the PCP to undertake IT investment projects.

As a guide, it is expected that PCPs will reach the levels of capability set out in Table 1.

Collaborate with the Department and Other PCPs
Collaboration will enhance the development of IM sophistication and skills, and support the coordinated development of IT infrastructure in the primary care sector.

This will be achieved by the Department establishing a series of focused working groups to provide a governance structure for PCP development and simplification of the Departmental reporting requirements for agencies.

The Department's Contribution to Assist Partnerships
In recognition of the challenge to reach these objectives and the size of the financial investments, the strategy has been developed to address both the management and technical dimensions of IT supply and demand. Emphasis has been given to providing the sector with the skills and experience in the early years to minimise investment risk.

The Department has contributed to the developments with funding commitments over a three-year time frame. These funding commitments are tied to specific outcomes for the strategy. The funding structure is outlined in Table 2.

In **1999–2000**, the sum of $960,000 for Information Management Establishment Grants consisted of a payment of $30,000 per PCP. This was to develop a strategy for coordinated telecommunications access to the local service system through which consumers and providers can obtain comprehensive and accurate information about all the services available. The amount of $856,000 for Information Management Strategic Planning was a pro rata payment of $27,000 per PCP to support the commencement of work on the development of a local IM strategic plan.

In **2000–01**, PCPs receive the full year funding of $107,000 per PCP (for a total of $3.424 million) to support the development of local IM strategic plans in the context of the development of Community Health Plans (CHPs) by the end of 2000–01

In **2001–02**, PCPs will be required to submit project proposals in line with the *Community Health Planning Template* and the requirements set out in Appendix B of this document. This requires PCPs to:

- Work within the standard infrastructure specified by the Department (as per Section 3 of this document).
- Work with key stakeholders (including consumers and acute and residential care sectors).
- Conform with the Department's purchasing requirements for Information and Communications Technology (ICT) infrastructure investment.
- Demonstrate how they have addressed a range of critical issues (including privacy and confidentiality, definition of roles and responsibilities, and project evaluation).

The timing and level of investment will be staged depending on each PCP's level of readiness and the nature of their project proposals.

Table 2: Funding Structure for PCP Information Management

	1999–2000 ($millions)	2000–2001 ($millions)	2001–2002 ($millions)	**Total** ($millions)
Information Management Grant	0.960	0	0	**0.960**
Information Management Planning	0.856	3.424	0	**4.280**
IM/IT Investment and Training Development	0	0	5.313	**5.313**

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Improve Planning, Funding and Reporting Arrangements

The Department is working to improve its approach to planning, funding and reporting of services by primary care providers, including the development of IM/IT capabilities by PCPs.

The Department will:

1 Specify datasets for services information, initial needs identification and care planning as building blocks in the development of a common PCP dataset.

- These datasets will support consistent information sharing to assist service coordination.
- They will also enable consistent data collection to assist integrated service planning.

2 Develop a simpler, streamlined funding strategy, with a range of funding mechanisms.

3 Develop a data reporting framework that will define a common approach to the Department's data reporting requirements.

Link State and National Initiatives

The Department will facilitate the development of partnership IM/IT capabilities while ensuring that they operate within statewide and national frameworks.

To achieve this, the Department will:

1 Establish a peak body of information managers from each partnership to steer the ongoing development of IM/IT capabilities.

2 Establish an advisory committee consisting of leaders in the use of IM/IT in health care to provide advice to the Department regarding IM/IT in the health industry.

3 Establish an information standards group and a series of working groups to address the development and implementation of information standards in the primary care sector.

4 Facilitate collaboration with partnerships to address issues as and when they arise.

5 In collaboration with primary care providers and other sectors, develop an agreed approach to the security of health information when electronically transmitted between agencies. This will include developing a position on security infrastructure such as Public Key Infrastructure (PKI).

6 In collaboration with primary care providers and other sectors, establish an agreed approach to identify common clients and patients in an electronic health environment.

Protect Consumer Information

Partnerships need to establish confidence about the privacy and confidentiality of consumer information held by primary care providers and effectively manage this information within a legislative privacy protection regime.

The Department will:

1 Develop guidelines to assist primary care providers to satisfy privacy legislation requirements.

2 In collaboration with providers, consumers and carers, support the development of mechanisms for informed consumer consent to support the management and communication of personal information.

3 Promulgate national guidelines for the secure management of health information and conduct education sessions with primary care providers across the State.

Establish Common Infrastructure

The objective is to address common IM requirements by establishing a statewide approach to IT infrastructure.

The Department will:

1 Develop an approach to enable primary care providers to use the Better Health Channel to inform their clients and patients about health and lifestyle matters.

2 Establish a statewide service directory infrastructure to enable partnerships to develop local service directories within a common statewide structure.

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3 Through the BATS project, develop tool templates that will provide standardised datasets for information collected and used as part of initial needs identification and care planning processes (refer to *Better Access to Services: A Policy and Operational Framework* for further detail).

4 Develop a framework for comprehensive assessment.

5 Put in place purchasing arrangements to ensure value for money and effective use of purchasing power for investment by PCPs in information and communications technology.

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Section 1: The Policy

1.1 Primary Care Partnerships

The PCP strategy aims to enable primary care services to achieve high quality outcomes for consumers and deliver improved health and wellbeing for the community. This strategy, broadly outlined in the document *Primary Care Partnerships: Going Forward* (Department of Human Services, April 2000[1]) provides a framework for improving the planning and delivery of primary care services and for ensuring they work effectively together.

To achieve these goals, funding has been provided to groups of primary care providers that have formed voluntary alliances in their local communities. These alliances, or PCPs, include agencies with a wealth of knowledge and practical day-to-day experience in meeting their community's needs. A core group of services are typically included in each PCP; these services are outlined in the Going Forward document.

The voluntary nature of partnerships without mandated administrative integration creates the opportunity for a range of agencies to be involved throughout the public and private sectors. The voluntarism imbedded in this process also creates specific challenges in defining service environments and undertaking system enhancements.

This core group of services provides an opportunity to create a comprehensive and local primary care response to consumers. (This is particularly critical given that a single organisation cannot provide for the total care of a consumer alone.) This is not to say, however, that PCPs are exclusive to the core set of services outlined. The vision for PCPs is to align the systems and processes across the many primary care agencies that impact on the health and wellbeing outcomes of consumers. This means that some PCPs will include other service agencies such as dentists and pharmacists to achieve their aims, while other PCPs will reach out to services from sectors such as community care, housing and emergency services. The fact that there are finite resources will encourage exploration of alternatives and collaboration within these other organisations and sectors.

Whatever the local alliance makeup, the PCP will provide a vehicle for relationship building and service development and will work towards a shared vision and shared community responsibility. The approach will be underlined by development of community, individual and corporate relationships, a corresponding respect for dissent and diversity, and a view that process is as important as outcome. The change intended through the PCP strategy is significant and requires a degree of organisational, cultural, professional and personal change. In this sense then, PCPs won't fix all the problems or issues of the current primary care service system. What PCPs will provide is a planning framework to assist this broader work. This planning framework referred to as Community Health Plans (CHPs), will address the following three key areas:

1. Partnerships, defining how the partnership will engage the relevant stakeholders and work together.
2. Service coordination, describing how local systems and processes, such as information management and assessment will enable services to be better coordinated.
3. Service planning, identifying the population health needs of the community and proposing strategies to address these needs, such as integrated, multi-sectoral health promotion and disease management programs.

PCPs will work with consumers, their local communities and government to develop and implement CHPs. These plans will identify the priority primary care needs of the local area and describe how the range of providers in the PCP will work with each other and with other key stakeholders to collectively respond to these needs.

1.2 Service Coordination within Primary Care Partnerships

The service coordination element of CHPs provides a framework whereby PCP can work towards functional integration across the range of services. This means that while services remain independent of each other in a

1 http://www.dhs.vic.gov.au/acmh/ph/pcp/forward/index.htm

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structural sense, they work in a cohesive and coordinated way so that the consumer experiences a seamless and integrated response.

Within the service coordination component of CHPs, there are three initiatives that provide the infrastructure. These initiatives are Better Access to Services (BATS), Information Management (IM) and Local Services Information. These three initiatives are interdependent. There is little point in changing assessment practice and service delivery if they are not supported by consistent and quality IM practices and underpinned by accessible and relevant services information. There is a need to progress the development and implementation of these three initiatives systematically at a statewide level while supporting local accomplishments.

While these initiatives will improve service coordination, the impact will not be confined to service coordination alone. The three initiatives support the service planning component of the CHP by facilitating service delivery processes and practices that focus on health promotion, early intervention and disease management. They also provide the infrastructure for collecting consistent client information that can be aggregated for population health planning.

Clearly, all three elements of the CHP are critically linked and must take account of the others in their evolution and implementation. PCPs will be able to utilise the *Information Management Strategic Directions*, and the *Better Access to Services: A Policy and Operational Framework* to contribute to, and interconnect, the strategies within their CHP and enable changes to current roles, responsibilities, practices and approaches.

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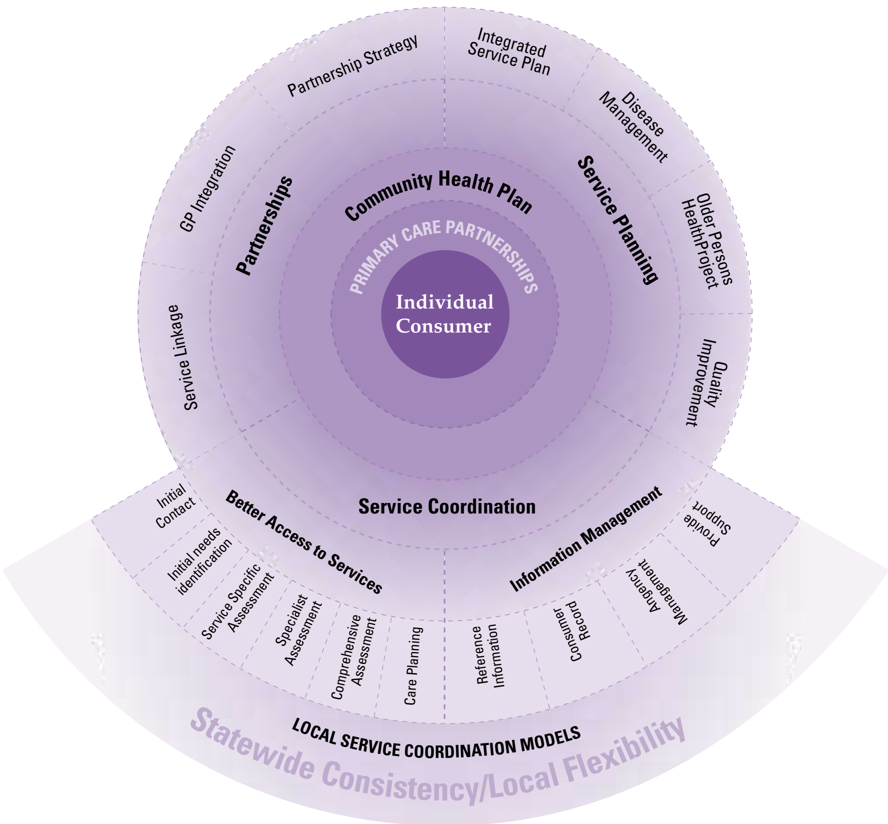
Section 2: The Operational Framework

2.1 The Better Access to Services Model

The model for BATS is important to consider in developing IM strategic directions because PCPs' IM practices and IT solutions should be developed to support the key business processes contained in the BATS operational framework.

Figure 1 BATS Operational Framework



This operational framework does not prescribe a model of service delivery. Rather, the intent is for PCPs to develop their own local models of assessment and service delivery that operationalise each of these six elements. Whichever way partnerships elect to construct the elements, the end result will be that people who use services and people who provide services have a common framework that enables a statewide application of the process. This approach is referred to as functional integration, because each of these six elements describes functions that will be carried out in an integrated way within each PCP.

The companion document to these strategic directions, *Better Access to Services: A Policy and Operational Framework*, sets out a common language and framework for assessment and access to services. It describes access and assessment processes as six operational elements:

1 Initial contact

2 Initial needs identification

3 Service specific assessment

4 Specialist assessment

5 Comprehensive assessment

6 Care planning.

> Given the complexity of the primary care system, it is necessary to define common business processes, utilising the BATS framework, for IM/IT development. This approach emphasises connectivity between providers and partnerships based on common standards and practices rather than common IT systems.

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Initial Contact

Initial contact is the point of first contact with the service system. It is anticipated that initial contact will continue to be initiated by consumers in a variety of ways (including by telephone or in person). Regardless of the way in which initial contact occurs, PCPs provide an opportunity to improve access through a range of coordinated, responsive and innovative initial contact initiatives.

Initial Needs Identification

Initial needs identification is an initial assessment process where the consumer's risk, eligibility and priority for service is determined. The consumer's needs and health promotion opportunities are broadly identified and consumers are subsequently informed about the range of service options available to meet their needs.

Tools to Support Initial Needs Identification

The Department of Human Services, in collaboration with PCPs and other key stakeholders, will develop a tool template for initial needs identification. Each PCP will build on the template and implement its own initial needs identification tool. This tool, combined with the care planning template, will support consistent referral for providers within and external to the partnership. The tool will support consistency in access and priority setting for service provision. When administered by appropriately skilled staff, it will also assist in identifying the range of a consumer's needs, and assess their urgency, priority and eligibility for access to services and referrals. The tool template will incorporate common core consumer information and will build on and incorporate the range of tools, guidelines and principles that currently exist, including tools developed for specific services, such as drug treatment services.

Service Specific Assessment

Service specific assessment is a face-to-face interaction with a consumer and occurs where a service need is identified following initial needs identification. It is conducted by the provider responsible for delivering the service and occurs as part of the service delivery.

Specialist Assessment

Specialist assessment is a face-to-face interaction with a consumer and occurs where a specialist need is identified following initial needs identification. It is conducted by a provider who has specialist skills and expertise and usually occurs as part of specialist service delivery.

Comprehensive Assessment

Comprehensive assessment is a face-to-face interaction with a consumer and involves the most intense level of inquiry including history taking, examination, observation, measurement and testing. It occurs where consumers have multiple, complex or unclear needs or where they need long term or intensive service provision.

Care Planning

Care planning is a process of deliberation that incorporates a range of existing activities such as development of clinical plans, service plans and individual treatment plans.

Tools to Support Care Planning

The Department, in collaboration with PCPs and other key stakeholders, will develop a tool template for care planning. Each PCP will build on the template and implement its own care planning tool. This tool, combined with the initial needs identification template, will support consistent referral for providers within and external to the PCP, and reflect the working arrangements within partnerships building on the current examples of good practice.

Broadly, the care planning tool will take account of the range of processes explicit in care planning (care coordination, case management, monitoring, review, referral and feedback) and include:

- The identified needs and capabilities of the consumer (and where relevant, the carer).
- A service plan that includes services to which the consumer will be referred, service providers currently involved, and interim management and support plans for consumers awaiting service availability.
- Informal and formal support arrangements.
- Identified health promotion activities.

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- Desired goals and outcomes.
- A nominated care coordinator and case manager where required.
- Time frame for review and nominated reviewer.
- Care plan evaluation and re-assessment requirements.

For further detail about these six elements and the overall operational framework, refer to *Better Access to Services: A Policy and Operational Framework*.

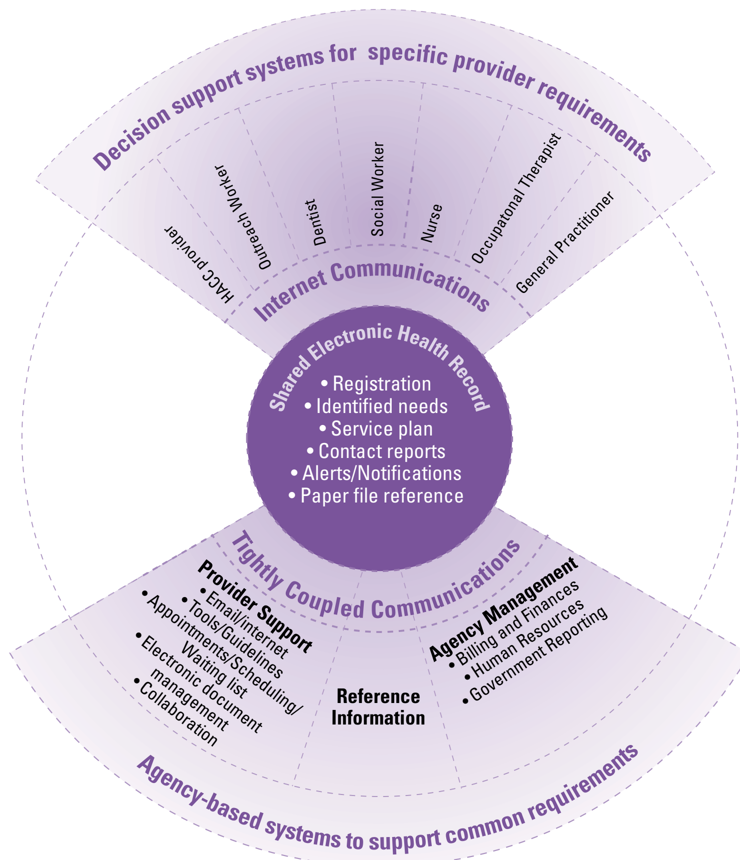
2.2 Desired IM/IT Capabilities

Using a technique known as business process mapping, it is possible to determine the information management needs of providers to enable them to deliver high quality care. The operational framework described above has been mapped with the assistance of primary care providers (see Appendix A). The desired IM/IT capabilities required by providers to support this operational environment can be summarised as follows:

- IM systems to support individual providers in their professional decision making processes.
- Shared information about the consumer's health and wellbeing to coordinate services.
- Shared information about services to support provider and consumer navigation and information requirements and to support referral and planning activity.
- Reference information to guide care and treatment decisions including support tools such as schedules and templates to assist practitioners.
- Planning and management information and administrative functions such as billing and reporting.

Diagrammatically, these elements can be summarised as follows:

Figure 2 Systems Required to Support Primary Care Providers



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Business process mapping should be undertaken by PCPs to document the interaction within the local service system and obtain a clear understanding of the information requirements. The business processes should inform the establishment of appropriate IM practices and a supportive IT infrastructure. This process should involve and address the concerns of consumers regarding the electronic transfer of their information.

> The establishment of IT applications and systems without a thorough understanding of the business processes and the necessary IM practices threatens to limit the effectiveness of any investments. Appropriate staff skill development is required to most effectively use any IT investment.

Information Management to Support Work Processes

Primary care providers should have appropriate technology to support their work. Generally this will be a personal computer (PC) with relevant office and professional support software. This will vary according to the requirements of particular staff and workplaces.

These requirements can be summarised as follows:

- Scheduling functions for allocating appointments to consumers and convening meetings between staff.
- Case notes to document the activity undertaken by a provider and the assessment and response of a consumer to the services provided.
- Recording of results of tests or procedures (pathology, radiology).
- Treatment records (care plans, medication records).

The general requirements of all service providers need to be considered as well as the specific requirements of individual types of service providers. For example, most service types will require the capacity to schedule appointments, whereas only a few practitioners (medical practitioners and dentists) will require capacity to provide medication prescriptions.

Sharing of Health and Care Information

To achieve functional integration across the six elements of the BATS operational framework, PCPs will need to share health and care information to:

- Support consumers with complex needs who require care coordinated across a number of services or agencies.
- Meet the needs of consumers with straightforward requirements who need to be referred to another provider or who have repeated contact with the service system over an extended period.

To address this need, PCPs will be asked to pilot initial needs identification and care planning tools in the first half of 2001–02 and to implement a consistent approach to initial contact. This work will require the sharing of personal and health information between agencies within the PCP. Whether this information is shared electronically or by traditional means, there is a range of IM issues that will need to be addressed, including privacy and duty of care.

A capacity to share health and care information is essential for the implementation not only of initial needs identification and care planning tools, but also for service specific, specialist and comprehensive assessment, where these relate to the coordinated delivery of care by multiple providers (either concurrently or consecutively over time).

Initial contact also requires information sharing, but for the most part this will be demographic and personal information, rather than health information. While privacy considerations still apply, this information may not be as sensitive as health and care information and is governed by different legislation (see section 3.2 Protection Consumer Information).

Sharing of Services Information

The development of the service directory is a key tool for managing service information. The directory needs to contain information on health and community-based services available in PCP catchments. PCPs, agencies and consumers can then use their directory as a local information resource and a tool to support referral.

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Further information on service directory development is contained in the *Service Directory Discussion Paper and Data Fields* document and section 3.5.

Reference and Support Tools

Providers need access to a range of basic information management tools to enable them to coordinate and deliver care simply and effectively. These tools need to support the many ways that providers work individually and with each other. Examples of the tools needed include:

- Electronic mail.
- Knowledge base. For example: templates and guidelines and common sources of reference information.
- Appointments, scheduling, waiting list.
- Document management.

Email is usually one of the first tools agencies provide for their staff. The ability to communicate quickly, easily and conveniently has been a powerful driver of growth of the Internet.

Websites for use within an agency (Intranet) are a second priority. Intranets contain tools and information useful to providers within the agency. They usually evolve from providing basic information (for example, organisational structures, staff and service descriptions, operating procedures) to processing self-service applications (for example, human resource forms such as annual leave, purchasing goods and services such as office products, and delivering on-line training).

In primary care, Intranets could be used to store tools and templates such as initial needs identification and care planning tools. Additional content could include:

- Clinical medicine information knowledge bases including protocols, guidelines and standards.
- Drug information knowledge bases, such as MIMS.
- Analytic information resources, such as the Cochrane collaboration.
- Comparative benchmarking and clinical outcomes data.
- Consumer health and care education and management information.
- Health prevention and promotion information.

Action will need to be taken in a number of areas:

- Providers need to identify and assure themselves that they are using reliable sources of information.
- Agencies need to establish standards, and perhaps preferred sources of information, to ensure the quality of services delivered by their staff.
- Professional bodies need to endorse sources of information suitable for use by their members.
- Partnerships need to undertake work with consumers and carers in developing methods and processes on how to make information available to them.

Planning and Management Capacity

All businesses need to manage their finances and people. Most primary care agencies are small and therefore require bookkeeping, payroll and other human resources functions. These fundamental requirements need to be met when acquiring IM systems.

PCP agencies also need the following:

- Reporting systems to provide performance and accountability information to funding providers.
- Planning capabilities to support integrated service planning using population based data and service delivery data including, over time, data aggregated (in a suitably de-identified form) from service directories and from initial needs identification, care planning and initial contact processes.

2.3 An Incremental Approach to Developing IM/IT Capabilities

Development of IM capability and investment in IT needs to be made on an incremental basis that demonstrates achievement of goals. Partnerships are expected to develop a strategy for IM and IT investment targeting high priority projects. Each investment project should be scoped to take about three months in order to minimise its risks

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and should be evaluated to ensure continual learning and realisation of benefits.

After completion of each project, providers are expected to continue to develop improved processes based on the new IM capabilities. Partnerships need to continually monitor these process changes to ensure that the full benefits are realised from their IT investment and development of IM capabilities.

The key steps in this process are summarised in figure 3 and described in the following sections.

Establish the Partnership

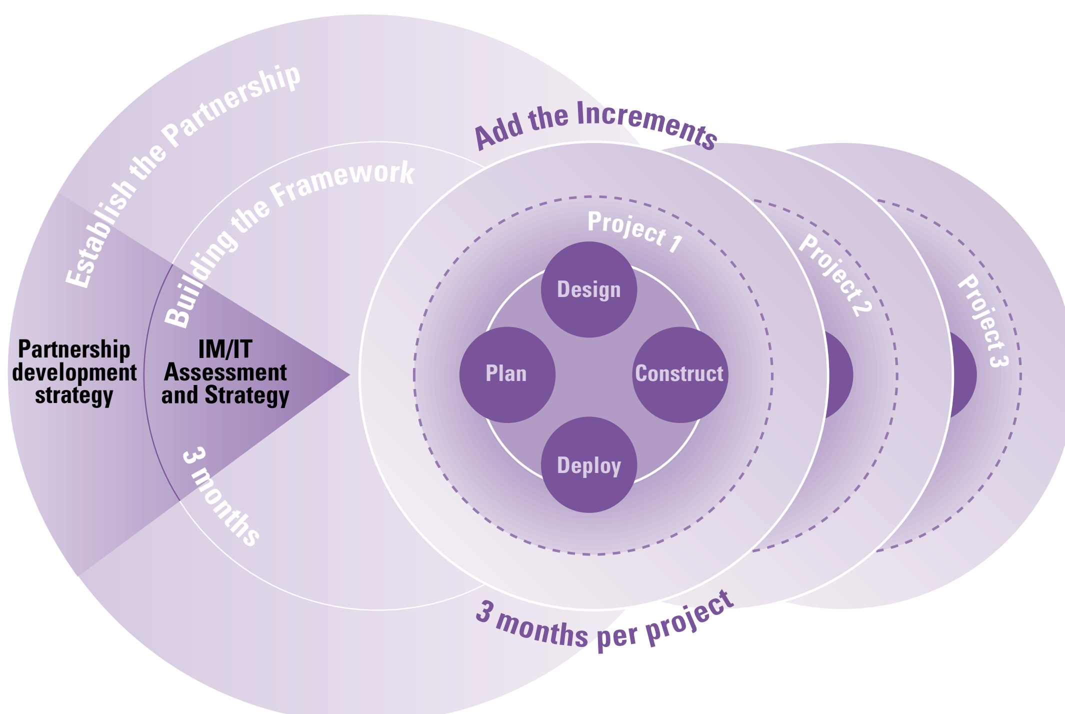
Acquisition of IM/IT capabilities is one of the major activities to be undertaken by partnerships. IM and IT purchasing power in primary care is often diminished because of the large number of low volume users who often have fragmented requirements. To overcome these issues and increase the appeal of primary care to the information technology and telecommunications industry, a consolidated approach to acquisition is required.

> Partnerships, because of their size relative to individual agencies, are in a position to maximise purchasing power for IM and IT capability. The success of the rural alliances of hospitals demonstrates this approach.

The challenge for partnerships is to develop a consistent approach to the acquisition of IT products and services within the context of a statewide purchasing framework. Partnerships need to:

- Establish a functionally integrated approached to IM that can be supported by common IT infrastructure.
- Deliver IT infrastructure to all primary care providers regardless of location.
- Consolidate purchasing power of primary care providers and minimise ICT overhead costs, (such as technical support), within a statewide purchasing framework.
- Present viable options to attract government and private sector funding.

Figure 3 Incremental Approach to Acquiring IMIT Capabilities



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In consultations with a variety of sector representatives, it has been accepted that consolidation of purchasing power is necessary. From our discussions with primary care providers, it seems reasonable to conclude that:

- PCPs need a wide range of IT capabilities from communications networks through PCs and LANS to service focused applications.
- IT capabilities could be purchased as managed services from more than one vendor, for example network service, desktop service or application service. It is possible for service pricing to be usage-based so there are no up-front capital costs.
- Partnerships can purchase IT capabilities on behalf of their member agencies.
- Partnerships can increase their purchasing power by working with other organisations, such as hospital alliances. This process should support and encourage participation by smaller primary care agencies.

See section 4.1 for further information on partnership arrangements for collective IM and IT acquisition.

Build the Framework

Realising maximum benefit requires synchronised investment in IM and IT. Development of an IM strategic plan allows partnerships to explore their business processes and requirements, agree on processes that offer the greatest potential with least risk, and develop implementation plans which address both IT and work practice change. The strategic plan enables partners to work together to identify and achieve agreed goals. Without the strategic plan there will be confusion and disagreement over the best options for investment of scarce resources.

Add the Increments

Develop projects for the implementation of the IM strategic plan in incremental stages. In 2001–02, these projects should, at a minimum, address the following:

- A functionally integrated approach to initial contact.
- Piloting the use of initial needs identification and care planning tools.
- A functionally integrated approach to comprehensive assessment (only for partnerships conducting integrated disease management pilots).

2.4 Manage an Ongoing Change Program

Increasing the sophistication of IM/IT capabilities in the primary care sector is not an objective in its own right. It is an essential element in achieving one of the key objectives of PCPs, that is, to establish a functionally integrated service system that meets consumers' needs.

Experience from other industries has shown that change management is an essential factor in the success of complex, large-scale IM/IT developments. Change management will also be a critical success factor for PCP development. These cannot be seen, nor managed, as two different processes.

There are a number of elements which must all be in place to ensure successful change. These underlying elements for managing change are shown in figure 4 (on page 10).

- **Leadership**
  This element is concerned with who will lead change and what structures and systems can be put in place to make and implement decisions. It also focuses on the clarity of the vision, the degree to which this is communicated and promoted by leaders, and the extent to which the vision is communicated and shared.
- **Compelling case for change**
  This element is concerned with the strength of the case for change and the extent to which people understand what is driving the change.
- **Strategy development**
  This element looks at the strategy to implement the change. It focuses on the extent to which the strategy is defined and integrated and the depth of understanding of stakeholders as to how the change will be achieved.

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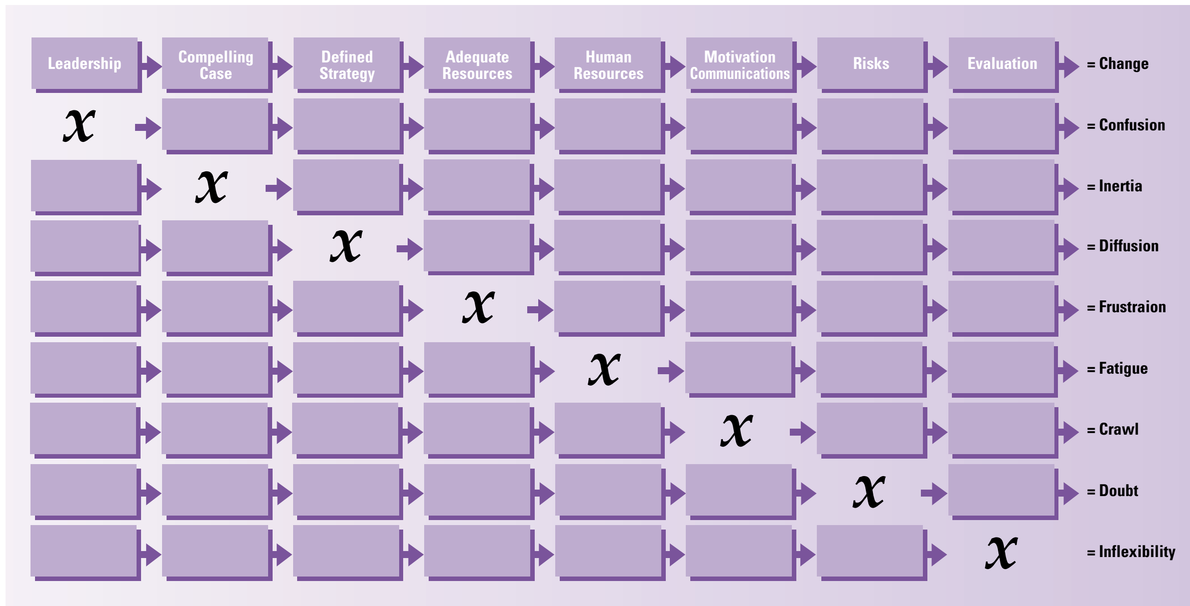
Figure 4 The Underlying Change Management Framework



- **Adequate resources**
  This element focuses on the amount of resources that will be available to bring about change.

- **Human resources**
  This element focuses on the skills and abilities of the individuals involved with the change and the infrastructure supporting the new way of practice. It includes base skill levels and access to training, equipment and information.

- **Motivation and communication**
  This looks at the motivation of individuals to undertake the change. It includes the extent to which people understand what is expected of them, performance management and the strength of commitment from leaders. It also includes how well information about the change is being communicated.

- **Managing risks**
  This element concerns the extent to which risks have been identified, acknowledged and planned for.

- **Monitoring and evaluation**
  This element focuses on the systems in place to determine how the change is progressing and to make adjustment to the change process on the basis of feedback from stakeholders.

Figure 4 also shows some of the outcomes that may occur if one of more of the elements is missing. For example, if there is not a clear vision then people become confused. If there is not a clear strategy, then actions are diffused. If two or more elements are missing then change is less likely to be successful.

For partnerships to achieve the envisaged change, leaders need to be identified at the statewide, regional, PCP and agency level. Leaders at each of these levels will have different functions to perform but need to share the same vision. Leadership functions include promoting the change, building the case for change, creating the constituency for change, and developing strategies for change at their level of the system.

People throughout the entire system must believe there is a compelling case for change. To date the case for change has been presented primarily by the Department. Consultations indicate that ongoing work is needed to ensure that this case is widely agreed and understood. One way of achieving this is to continue to build the vision for change on the basis of achieving gains to service delivery

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for consumers (that is better access and improved outcomes). Presenting case studies and examples of where this has occurred and how changes in information management have also assisted agencies and partnerships to attract funding and improve sustainability will also assist in building the case. Leaders have a central role in presenting the case for change.

There is need for a clear, coordinated approach to achieve the desired objectives. To date, IT developments in primary care have been ad hoc and opportunistic and there has been no coordinated approach to the development of IM capabilities. This approach has generally reflected the lack of resources and the development of systems that are based on the need to meet funding and accountability requirements as opposed to supporting the business requirements of providers.

> If the envisaged PCP development is to succeed, partnerships will need to develop coordinated IM strategic plans that encompass the activities of each participating agency. These plans must be staged to allow progressive development as and when resources are available. They must start with steps that can be taken now, recognising the broad nature of the strategic directions and that critical future activities will be mapped out as they arise.

An absolutely critical element of all changes is to ensure that it is inclusive of all participants. This means that all primary care providers and much of the community need to be included in the change management process. Change must be based on good understanding of its impact on individuals. For IM, the key question is how it affects providers and consumers. The participation of the range of providers and consumers will be necessary to convince people that there is something in it for them. To achieve this, managers must understand how IM/IT capabilities fit in to their processes and how they deliver benefits, such as simplified access for consumers, better informed decisions and better services.

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Section 3: Key Strategies

3.1 Develop PCP Capabilities

The Department is taking a **whole of health sector** approach to the development of ICT infrastructure and capabilities within the funded sector.

This means that the needs of the acute and primary care sectors are also being considered and a strategic approach will be taken to investment in ICT to support a quality health and care system for all Victorians.

Included in this is not only the infrastructure requirement to support connectivity, but the ongoing investment required to support that infrastructure, the applications needed to support care, the training and skills development requirements for working within this environment, and the governance and change management needed to steer the implementation.

Initial investment in PCPs is supporting the development of IM strategic plans. In line with the objectives of the PCP strategy, these plans need to identify how IM and ICT priorities will contribute to integration in primary care and between the primary care and acute sectors. The Department will also be supporting PCPs to undertake project work in priority areas related to the implementation of IM strategic plans.

> A total of $5.313 million is available in 2001–02 to support this work. PCPs will be required to submit project proposals in line with the community health planning template and the requirements set out in **Appendix B** of this document. The timing and level of investment will be staged depending on each PCP's level of readiness and the nature of their project proposals.

Developing an Information Management Strategy

Development of IM processes and practices, and effective investment in IT, requires careful planning and prioritisation. Partnerships are required to develop an IM strategy that addresses the needs of primary care providers in the PCP over five years. The strategy needs to map out a multi-year plan of how IM/IT capabilities will be acquired. It needs to take into account the range of providers in the partnership, the range of services delivered by members, and the quality of existing processes and infrastructure, to determine priorities for development. The strategy needs to identify the IM/IT capabilities to be established at each stage through the five-year period, including which agencies will be using them.

The Department will use these plans to monitor the progress of each partnership and support PCPs in problem solving as the need arises. Templates to assist partnerships develop their plans are included in the appendices. They provide a guide for partnerships to ensure that all aspects of the strategy are appropriately considered and that there is conformity between partnership strategies.

It is important for partnerships to consider that significant improvements in IM capacity can occur without funding of additional IT. Partnerships need to detail the IM issues that need to be addressed together with the strategies to be undertaken. For example:

- Establishing and developing trust relationships between providers and the community.
- Implementing procedures to ensure the privacy of personal and health information.
- Developing business processes according to the BATS framework.
- Defining the information to be exchanged between agencies in referral processes.

The sections below address the main issues that will need to be addressed in developing and implementing information management projects as part of a CHP (as set out in the template in Appendix B).

Managing Implementation of the Local Information Management Strategic Plan

This section outlines an approach to IM/IT governance which is considered best practice. While PCPs are not

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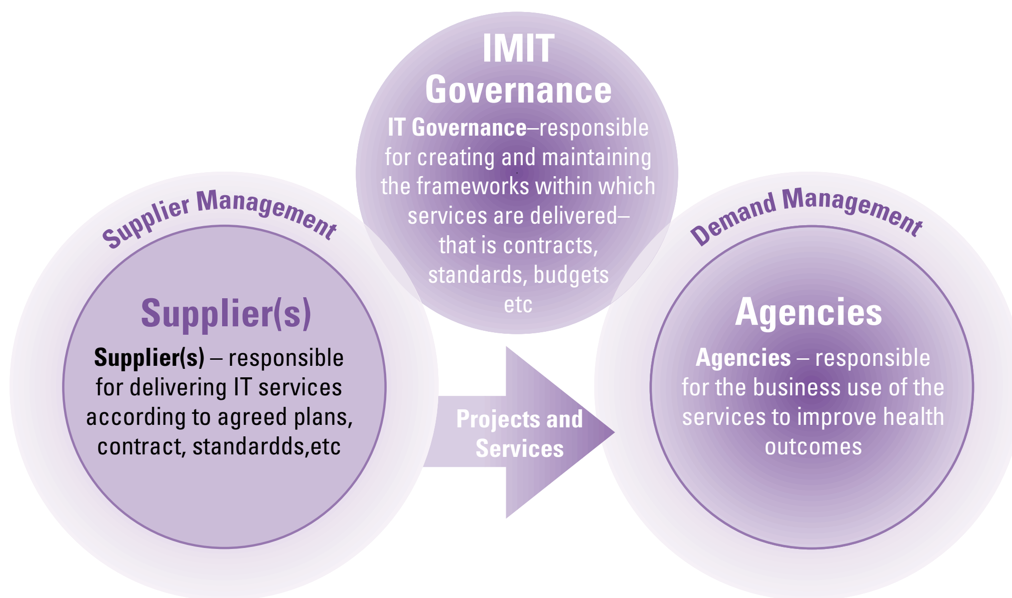
required to adopt the structure outlined below, it is important that partnerships agree on an approach to IM/IT implementation that supports effective governance.

As previously mentioned (section 2.3), there are significant benefits to be obtained by PCPs cooperating in the acquisition of IM and IT capability. PCPs can join with other partnerships or acute care providers to create regional IT alliances or they can implement an independent IT strategy within their own PCP. If partnerships choose to enter into a regional alliance, all participants will need to enter into a contractual alliance to purchase IM and IT services. The contract will need to specify the parties to the alliance and the processes by which members can join and resign from it. All members of the alliance will need to agree to be bound by their obligations under the alliance agreement. In particular, each member will need to agree how it will contribute to the alliance and how it will access its services.

Any collaborative purchasing or contractual arrangements entered into by Partnerships must occur within the statewide Department of Human Services purchasing arrangements for ICT infrastructure (refer to Section 3.5).

Figure 5 Managing the Relationship between the Partnership and its Suppliers



Partnerships that choose to create an IT strategy independent of other partnerships and agencies can effectively use the governance structures outlined in their partnering agreements or MoU to purchase IM and IT services (see *Information Resource: Partnership Issues*, October 2000). In the case of regional alliances, one member should be appointed as the contact agency to be responsible for the formal elements of IM/IT governance as shown in the diagram below. This will include framing strategies to meet the demand from all agencies, coordinating the development of agreed IM processes and practices, managing the relationships with suppliers, and assisting agencies to maximise the benefits from their investment in IM/IT. The contact agency will have responsibility for employing the management team for the alliance, acting as fund-holder, and entering into contracts on behalf of the alliance.

The PCP steering committee could form the governing body for partnerships undertaking an independent IM/IT strategy. The responsibilities in relation to employment, contracting and the provision and distribution of resources would be set out in the PCP's partnering agreement or MoU.

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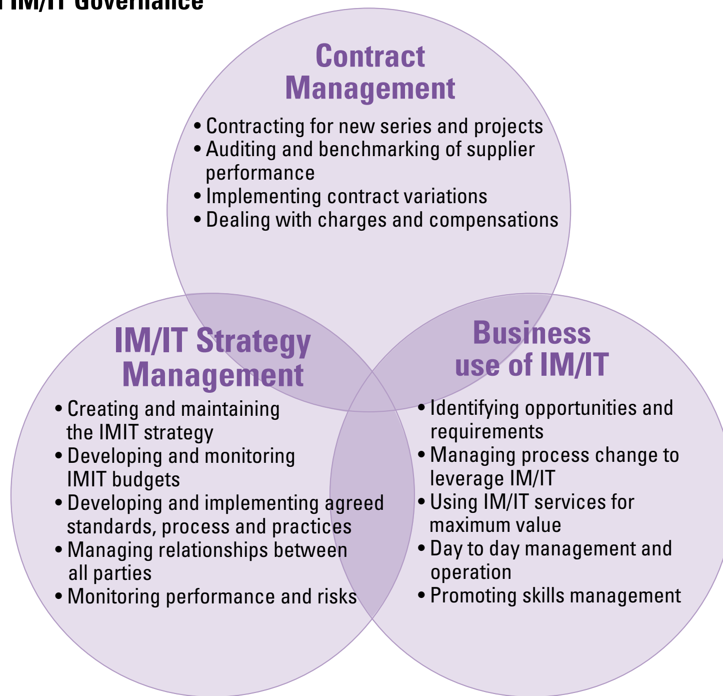
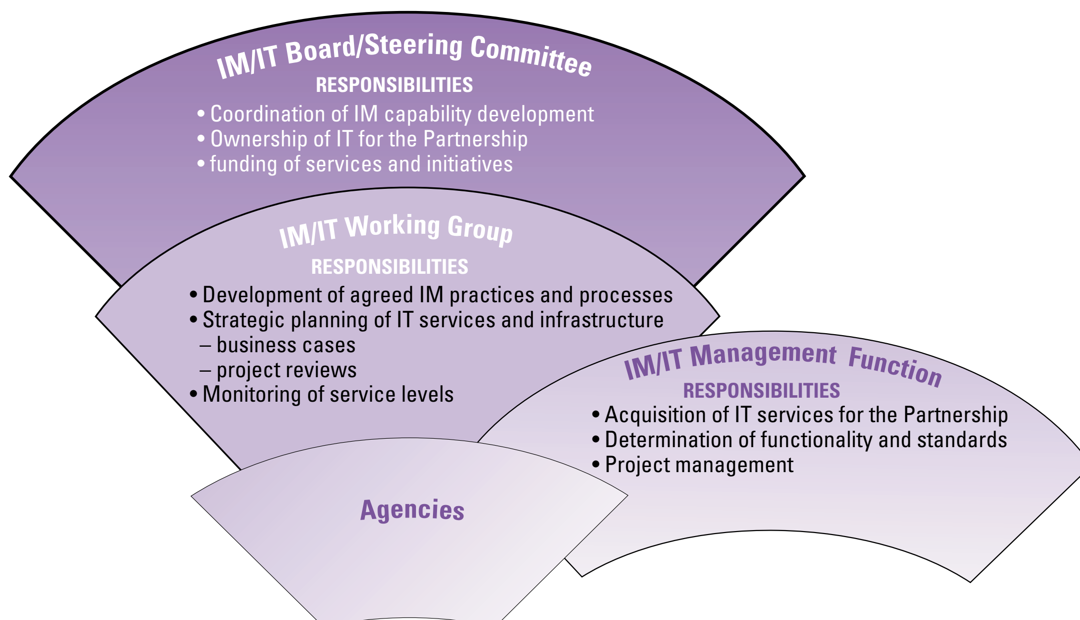
Figure 6 Elements of IM/IT Governance



A critical aspect for good governance is an appropriate management structure. Figure 7 presents the typical structure of best practice governance arrangements. The Board of Governance represents the joint ownership in the development of IM capabilities for regional IM/IT alliances. In the case of independent partnerships, this role will generally be adopted by the PCP's steering committee. A working group (or reference group) under the board or steering committee takes more interest in what is planned and how the development is progressing. An IM/IT

Figure 7 Typical Structure for IM/IT Governance



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management function is required to acquire IM/IT services, manage projects and assist agencies to develop their requirements. Finally, each agency is responsible for using the IM/IT services and implementing the information management processes to maximum benefit for themselves and for consumers.

Information Management Governance
In an alliance with many stakeholders, it is essential that the development of IM capabilities and investment in IT be orchestrated in a manner that allows all stakeholders to participate in the decision making process. Developing the strategy involves identifying the future ways that new practices, processes and technologies should serve the alliance and its stakeholders, and formulating these in terms of the services required and the means of delivering them.

There are two elements that need to considered in gaining stakeholder buy-in:

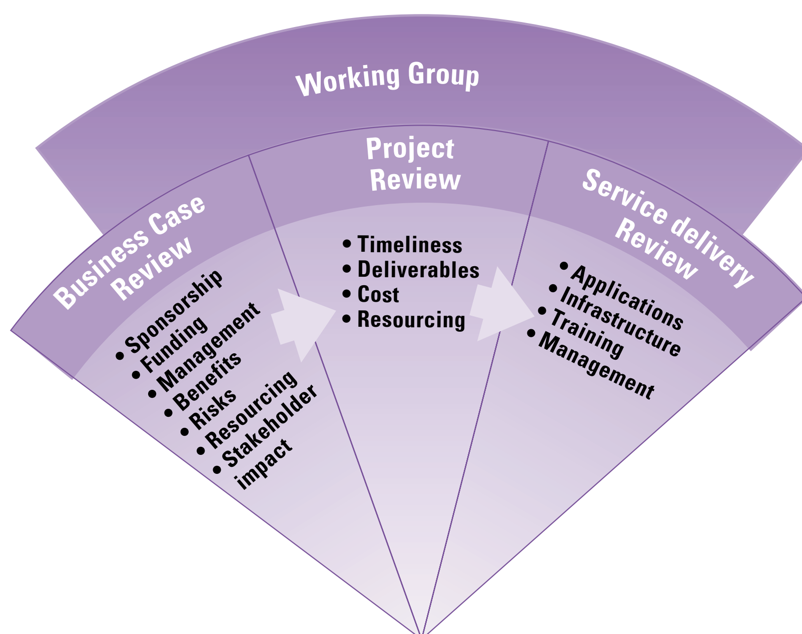
- Benefits Allocation.
  The extent to which the benefits are equitably distributed across all stakeholders. Identifying benefits per stakeholder and then tracking those benefits will assist in demonstrating equity and identifying any need for correction during implementation.
- Pace of Change.
  All stakeholders must be comfortable with the pace at which new systems are implemented and business processes are changed. This pace needs to be justified, well planned and executed. Tracking and reporting the changes, and particularly any variation to the original plan, is critical to maintaining acceptance.

An information management board, or steering committee, would typically consist of representative CEOs of the participating members of the PCP. Its role is to manage the stakeholder interests in the IM/IT investment. Typical terms of reference for a board or steering committee would include responsibility to:

- Approve the IM strategic plan.
- Approve and monitor budgets for IM/IT expenditure.
- Agree and approve contractual relationships between Partnerships or Partnership members.
- Approve and monitor all contracts for services delivered to the Partnership.

Working Groups
The Partnership or alliance will probably require an IM/IT working group. The working group would consist of

Figure 8 Responsibilities of the Working Group



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representatives of the participating members of the PCP, including consumers. Its role is to manage the process of investing in IM/IT and developing agreed IM processes and practices. It would meet more regularly than the board or steering committee.

Typical terms of reference for a working group would include responsibility to:

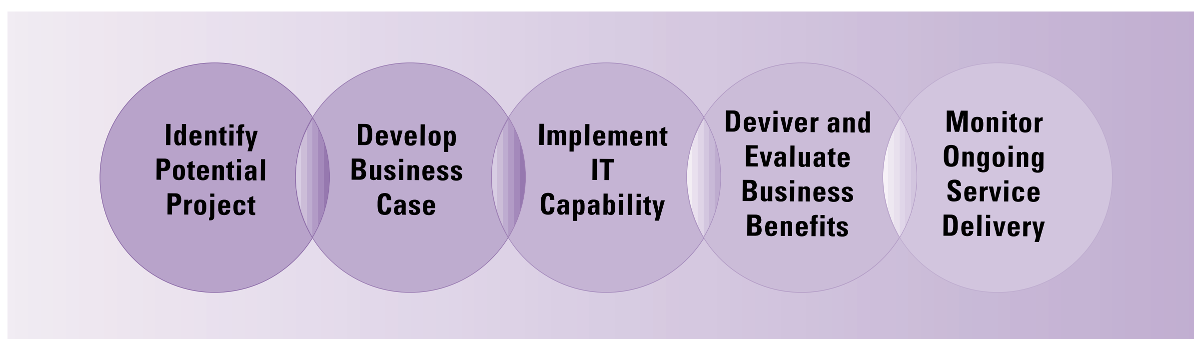
- Consider changes to IM practices and processes and assess, prioritise and approve proposals to implement new approaches.
- Assess, prioritise and approve all new proposals for IM/IT investment.
- Approve projects and allocate resources to projects.
- Assess results and monitor progress of all projects.
- Monitor service delivery against agreed service levels.
- Review efficiency and effectiveness of IM/IT use within the Partnership.
- Submit regular activity reports to the board or steering committee.

A number of sub-groups may also be established under the working group to address specific issues, such as specifying requirements for a particular process, or setting of information and technology standards. Generally these groups will have a lifetime related to a specific project. However, some groups may have longer lifetimes to address ongoing requirements such as technology standards or requirements for specific professional disciplines. Typical terms of reference for such a sub-group would include responsibility to:

- Develop and agree on IM approaches for particular business processes.
- Identify and agree on business requirements for investment in IT.
- Specify information and technical standards.

IM/IT Management Function
The regional alliance's contact agency or, in the case of independent partnerships, the member agency responsible for engaging personnel, needs to identify a management team. The IM/IT management function should be carried out by a small group of people with relevant experience in IM/IT management disciplines. Its role is to manage the investment in IM/IT under the authority delegated by the board or steering committee and the working group. It would be responsible for day-to-day operational management issues supporting the acquisition of IM/IT capabilities, including chairing the reference groups.

Figure 9 The IM/IT Acquisition Process



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Typical terms of reference for an IM/IT management function would include responsibility to:

- Assist agencies identify and specify their requirements.
- Develop business cases for new projects.
- Provide project management support for all projects.
- Ensure all projects adhere to agreed standards.
- Develop contractual specifications with vendors.
- Monitor services delivered by vendors against agreed service levels.
- Agree contract variations within agreed limits.

Capacity Building—Staff Training and Development

Consultations with representatives across the primary care sector have indicated that provider training and skills development is a major issue. Projects in the sector have indicated that the training and development effort is often under estimated. One reason is the anxiety that individuals often have about the implications of using IT in their jobs. In particular there is concern about the legal liability relating to their responsibilities under 'duty of care' when information is transmitted electronically.

Allaying these concerns requires a considered plan covering a wide range of actions, including:

- Developing an understanding of the new business processes.
- Encouraging users to participate in designing new work practices.
- Explaining the business direction and how it affects their area.
- Developing expertise in general IT skills (such as word processing, spreadsheets, email, graphics and the Internet) and specific business applications.
- Exploring and addressing specific concerns relating to the introduction of new business processes and practices.

Consumer Involvement

Implementation of the desired capabilities over the full range of stakeholders will take many years to complete and will need to involve consumers at each step of the process. Consumer engagement will be critical in managing a continuous process of change as more services use electronic information sharing to coordinate the service delivery process. Most notably, consumers need to be involved in the development of consent mechanisms and will need to provide consent prior to their information being shared across more providers. Maintaining consumer involvement in these changes will underpin the success of the implementation of the strategy.

Consideration needs to be given to:

- How consumers will be engaged in the development of IM capabilities.
- How consent will be sought from consumers.
- What mechanisms need to be established to ensure that consumers are able to control the use of information collected about them.
- How to engage consumers to minimise the impact of change.
- What approach should be adopted to phase the implementation, for example by consumer group, type of service or agency.
- How to handle and address consumer concerns.

3.2 Protect Consumer Information

For Partnerships to be effective, providers need to share consumer information in a way that ensures consumer privacy and confidentiality. The issues pertaining to privacy and confidentiality of information are well known, particularly in the health care setting.

Assisting Providers To Satisfy the Legislative Requirements

The Victorian Parliament passed the *Information Privacy Act 2000* on 30 November 2000. This Act is the second part of the Government's legislative package to boost e-commerce and the partner to the *Electronic Transactions Act 2000*.

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The Act was based on the Data Protection Bill 1999, which was introduced by the previous Government and amended to apply to the public sector only, in recognition that the Commonwealth had committed to a national private sector scheme.

The Information Privacy Act creates a scheme for the responsible collection and handling of personal information across the public sector in Victoria. Important things to note about the Act are:

- It creates binding obligations with respect to the collection, use and disclosure of personal information as well as setting access rights (although Freedom of Information obligations take precedence). The Act is available on the Victorian Parliamentary Website at http://www.dms.dpc.vic.gov.au/pdocs/bills/B00596/index.html
- It does **not** cover the non-government sector. Recent amendments (6 December 2000) made to the Commonwealth Privacy Act will create a national privacy scheme for the non-government sector. The Victorian Act is compatible with the Commonwealth Act, using substantially the same privacy principles for its own default obligations.
- The Information Privacy Act commences on 1 September 2001 and will be administered by the Department of Justice. By that time the Victorian Government will have appointed the first State Privacy Commissioner. The Commonwealth provisions will commence on 22 December 2001.
- The Minister for Health is sponsoring the Health Records Bill, which provides specific protection to health records held either in the public or private sectors. Accordingly, the Information Privacy Act does not apply to health records. The two Acts will work together to create a sound framework for the protection of privacy in Victoria.

The Health Records Bill (2000) sets out 11 Health Privacy Principles, which will establish the scope of what information can be collected, the circumstances in which it can be collected, together with the protocols and safeguards regarding access to that information and its application. Comments were sought on this draft in August 2000 and the Bill was introduced into Parliament in November.

The legislation will obviously impact on the information shared across the range of agencies that form a Partnership. With the codification of practice will come a legal responsibility. The Department will produce guidelines for funded agencies to assist in the implementation of the Act and adherence to the privacy principles.

More information can be obtained at:

- http://www.dhs.vic.gov.au/corpres/privacy/
- http://www.dhs.vic.gov.au/ahs/healthrecords/index.htm
- http://www.dhs.vic.gov.au/ahs/privacy/index.htm

PCPs are expected to outline in their strategic plans how they will undertake to comply with the relevant privacy requirements.

Assisting Providers To Obtain Consumer Consent

Over the past ten years, ensuring that consumers understand and consent to the care they access has come to be considered integral to service delivery. The increasing importance of consumer consent has meant that service delivery is no longer a 'top-down' process with the consumer simply being a passive recipient of services, instead the consumer has come to be considered as having the right to fully participate in the choices about their health and care. It is critical that consumers are involved in the development of consent mechanisms, to ensure that they are meeting the goal of informed consent.

> The most important goal of informed consent is that the consumer has an opportunity to be an informed participant in their care decisions. It is generally accepted that 'complete' informed consent involves consumers being made aware of the following:
>
> - The nature of the decision/process.
> - Reasonable alternatives to the proposed action (if that exists).
> - The relevant risks, benefits and uncertainties related to each alternative.

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It also requires providers to assess consumers' understanding of what information they are being given as well as ensuring acceptance of proposed action by the consumer. In order for a consumer's consent to be valid, they must be considered competent to make the decision at hand and their consent must be voluntary.

Various services or groupings of services (for example, North East Coordinated Care Trial, Maroondah HACC referral system) have already implemented arrangements for the collection and sharing of client information as dictated by client need. These 'networks' of providers have achieved agreement regarding data standards, information transmission and so on, with consumer consent for such sharing occurring at point of intake.

Consent in the PCP Environment

The Health Records Bill 2000 sets out principles that govern the activities of organisations in relation to the collection, use, disclosure, storage and destruction of health information. PCPs are not considered as organisations for the purposes of this legislation. Under the proposed Act, each agency or practitioner (if operating as a sole provider) within the PCP is considered to be a separate organisation. This means that the sharing of health information within PCPs is governed by the provisions for use and disclosure of health information by individual organisations.

Under the legislation, each agency (organisation) within a PCP that is providing health services to an individual can share information within the agency either with the consent of the individual, or where the sharing is necessary to ensure that health services are provided safely and effectively to the individual. However, information sharing between agencies would require the consent of the individual concerned unless the sharing is necessary to prevent a serious and imminent threat to the individual's life or health.

The development of processes and protocols around consent is one of the most important areas PCPs will need to address in protecting the privacy of consumers. Given the range of agencies and services involved in PCPs, and the unlikelihood that a large number of them will be involved in the care of any one individual, it is unreasonable for consumers to be asked to give blanket consent to sharing sensitive health information between all agencies within a PCP. On the other hand, PCPs, in collaboration with consumers, need to consider a consent mechanism that will support continuity of care and care coordination without unrealistic administrative overheads and repeated consent requests for consumers.

One possible approach would be to use the initial needs identification and care planning tools to establish the initial limits of consent for the use and disclosure of an individual's health information. For individuals with complex needs requiring a range of services, one of the outcomes of the initial needs identification is likely to be referral of the individual to other agencies for further assessment and care. Similarly, the care planning process will refine care requirements and define the responsibilities of particular agencies. Both of these processes provide opportunities to seek consumer consent for information sharing with a limited and defined range of agencies, linked to their current identified needs. Consent would only need to be reobtained if the person's needs changed or if the care plan changed as a result of a review or reassessment.

Another important consideration in terms of consent is information sharing that supports the goal of an integrated service system that consumers can enter at multiple points and in a variety of ways. This will require consent processes and protocols around the sharing of core consumer information collected at initial contact or during initial needs identification. The sharing of this 'registration information' across the PCP will reduce repeated information collection, increase scope for more coordinated care, and support streamlined processes for gaining consent for the disclosure of health information held by other agencies within the PCP.

Clearly there will be instances where consent to the sharing of personal or health information will not be forthcoming or expected (especially when the information is considered especially sensitive, for example clients of sexual assault

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services, mental health services or drug treatment services). Partnerships will need to develop information management processes (including protocols for the provision of information to consumers about the potential risks of withholding consent) to address this situation.

Assisting Providers To Manage Information Securely
In the current system, consumer information is held in paper-based records. Without adequate security and authentication measures, electronic IM systems are open to inappropriate use and easier abuse.

> Consumers need to feel confident that information about them held by agencies and in computer systems is securely managed. The greatest concern is that personal and health information is only accessible by people they have authorised. If this confidence does not exist, then sharing of information electronically cannot occur.

Information security measures need to be based on a risk management approach. This means that security controls are selected based on the likelihood and the extent of potential harm that could occur to the consumer or the agency from a security failure. Potential security breaches include inappropriate access to information and sending information to the wrong person.

Information security controls need to address:

- Authentication—the ability to confirm that someone is who they claim to be.
- Confidentiality—information is only made available to authorised persons.
- Integrity—nothing gets changed between sending and receiving.
- Non-repudiation—no-one having sent or received a message can later deny having sent or received it.
- Availability—information is readily accessible by authorised users.
- Auditability—records of access and changes to information is kept.

The key objective is to ensure that personal information held in electronic form is securely managed. The security safeguards must be acceptable to consumers and providers, allaying concerns about privacy.

Standards Australia International Ltd (Standards Australia) has developed a generic Information Security Management Standard (AS/NZS4444). The Standards Australia Health Information Security Working Party (IT14/4) is currently developing an implementation guide to that standard for the health industry. This is planned to be available in July 2001. When that occurs, health and community service organisations will be able to seek accreditation under that standard. Being accredited under that standard will mean that consumers and health service providers will have a means for assessing the trust they can place in an organisation managing individual health care information.

3.3 Linking State and National Initiatives

The PCP strategy exists within a health care system that is funded and regulated at a public and private level and also between the State and Commonwealth Governments. Achieving connectivity between agencies requires a process of participation in statewide and national initiatives and forums that specify technical and data standards. This commitment to an open systems approach is essential.

Achieving Statewide Collaboration

Primary care providers have expressed the need for statewide coordination and integration with the national approach to health information management. The identified benefits of a statewide approach included:

- Maximise the benefits of IM/IT expenditure, including acute sector expenditure.
- Enable interaction between providers by adhering to common national and international standards.
- Encourage commercial development of products and services for a small, fragmented market.

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- Build on the lessons learned in different parts of the health care system.
- Establish the legal and privacy frameworks to enable sharing of personal information.
- Ensure consistency across state and sector boundaries.

One of the strongest calls on the Department by primary care providers has been for the establishment of a coordination process to minimise duplication of effort across partnerships. The objectives of a coordinating body would be:

- To champion the improvement of IM capabilities by primary care providers.
- To consolidate common requirements and sponsor initiatives to develop statewide capabilities.
- To establish a statewide coordinated approach to the acquisition of IT by the primary care sector.
- To increase the linkage and synergy between IM initiatives for primary care, other Divisions in the Department (acute health, public health, community care and housing), and other relevant Victorian Government departments.
- To establish a strong linkage between Victorian and national primary care information management initiatives.

Each partnership has been funded to facilitate and coordinate the development of the PCP strategy in its catchment. The partnership managers, or information managers where they exist, need to meet regularly to coordinate their activities across the State. The Department will convene a forum with similar terms of reference to the Victorian Health Chief Information Officers' Forum. It would act as a coordination body for primary care initiatives and provide advice to the Department of Human Services.

PCPs should also consider establishing coordination mechanisms at a regional level in conjunction with the Department's Regional Offices.

Implementing National Standards

Standards can be defined as agreements between all the stakeholders in a process to share common methods and techniques to achieve common goals that would not otherwise be achievable if the stakeholders acted individually.

IM and data standards are concerned with the content and meaning of data, while IT standards are required for the development of hardware and software, communication and security protocols.

The National Health Information Standards Advisory Committee (NHISAC) oversees the national development and implementation of health information standards. Victoria is represented on this group through the Department of Human Services.

The *National Standards Plan for Australia*, developed by the Commonwealth Department of Health and Aged Care in partnership with Standards Australia, identifies the standards required at a national level and sets out priorities and the time scale needed to develop and implement them.

Widely accepted and implemented standards are needed for the effective management and sharing of information between the different providers and agencies. As indicated in the National Standards Plan for Australia, without agreed national standards, health and community services information would break down into smaller, isolated networks.

There are two streams of standards development work relevant to health and community services information systems that may be used by PCPs in Victoria. The streams are data standards for health information reporting and technical standards for health information systems development.

Data Standards Development in Australia

The development of data standards for health information is under the control of the National Health Information Management Group (NHIMG). This group is comprised of representatives from the Commonwealth, State and

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Territory health authorities and has largely focused on developing national comparative data standards to support reporting for service evaluation, funding and planning purposes under the auspices of the National Health Information Agreement.

The development of health standards is delegated to the National Health Data Committee and standards in community services is delegated to the National Community Services Data Committee. These groups respectively produce the *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

Victoria is represented on these groups through the Department of Human Services. PCPs can best provide input and influence into this process by working through existing Victorian Department of Human Services representation on national health information standards development activities.

Health Information Systems Standards Development

Standards Australia has been active for several years in the development of health information technology and telecommunications standards. Standards Australia's work in these fields is highly regarded, both nationally and internationally. Their work in health information technology is carried out by the IT-14 Health Informatics Committee, which is made up of representatives from Commonwealth and State health authorities, professional organisations such as the College of General Practitioners, the AMA, the Medical Software Industry Association, pathology and radiology industry representatives and, unlike the NHIMG, there is strong private sector representation. IT-14 work is divided across a number of specialist working groups with similar ranges of representation.

Establishing Standards for Primary Care

The activities of Standards Australia are relevant to the goals and requirements of the PCP strategy and the activities of PCPs.

Traditionally, a clear demarcation has existed between Standards Australia and NHIMG in the field of health information data and technology standards. NHIMG has focused on data standards and has no requirement to address health information technology or telecommunications standards. However, Standards Australia is responsible for developing technical standards including the Australian implementation versions of the Health Level 7 (HL7) Standards. HL7 is a standards developing organisation that develops specifications, the most relevant being a messaging standard to enable communication of clinical and administrative data between disparate health care applications. The data elements contained in the Australian HL7 implementation standards will most likely become part of the information architecture for the Health Information Network for Australia (Health*Connect*).

Standards Australia has a number of working groups addressing a range of standards relevant for primary care. These groups include the Security and Privacy, Electronic Health Records, Patient Identification and Linkage, and the Referral Information working groups.

Although there has been considerable development of IM and IT standards in Australia, there is also considerable work that still needs to be done, particularly to support community health and primary care. Standards Australia is active in this development, with work continuing on developing HL7 implementation standards for:

- Community-based electronic messages.
- Electronic referrals and discharge summaries.
- Electronic orders and observations.
- Electronic notification of immunisations.
- Community-based health services.
- Mental health services.

All of the IT-14 Working Groups are open to anyone within the relevant industry to attend and contribute. The Department will facilitate the establishment of a PCP Standards Working Group (linked to the PCP Information Managers Forum proposed above) to work on common implementation standards for PCPs. This would include deciding whether PCPs should be represented on any of the Standards working groups and, if so, how they should be represented.

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The PCPs can provide input and influence the NHIMG by working through existing Victorian Department of Human Services representation on its standards development activities.

3.4 Improve Planning, Funding and Reporting Arrangements

The IM systems developed by PCPs should contribute not only to improvements in service coordination, but also to deliver better service data to support integrated service planning.

Integrated Service Planning

One of the goals of the PCP strategy is to build a population health approach into primary care planning in Victoria. A population health approach emphasises a view of the community as a whole, in addition to treating and supporting individuals. It also recognises that achieving improvements in the health and wellbeing of the population as a whole requires an understanding of the different needs and circumstances of particular subgroups of the population.

Each PCP will develop an Integrated Service Plan, as an element of its broader CHP. They will identify the health and wellbeing needs of the community and develop collaborative strategies to address these needs, such as health promotion and disease management programs and services.

Collaborative planning will enable primary care services to respond in a more coordinated fashion to community needs, leading to more effective use of resources and better health outcomes for the community. Integrated Service Plans developed by PCPs will inform the Department's priorities and future decisions about the application of growth funding and funding for new initiatives. Interim guidelines for Integrated Service Planning will be released early in 2001.

The information management systems being developed as part of the PCP strategy will help in improving the quality and utility of service data.

The data elements identified within the service directory template are intended to capture information that can support both referral and integrated service planning. Service directories can provide information on the location and distribution of services, as well as opening hours, disabled access, assessment types delivered, age groups catered for, language services, eligibility and waiting list information, which helps to build a detailed picture of service availability and accessibility.

The information collected through the initial needs identification tool, in a de-identified form, can inform about the expressed needs of consumers and the capacity of the service system to meet those needs. This information can be mapped against population data to determine the relationship between projected levels of need (based on population characteristics) and identified levels of need. This can help to identify the proportion of the expected target group that has actually come into contact with the service system.

Information gathered from initial needs identification can also be mapped against service utilisation data to determine the relationship between identified levels of need and the corresponding level of service delivery, which can help identify how effectively services are meeting known demand.

Future Funding Directions

Under the current funding approach, ACMH's service definitions, funding rules and processes sometimes limit providers' ability to package different services (funded by ACMH or other Divisions) to meet individual and local community needs. As a result, service users don't necessarily receive the best possible mix of services. In addition, reporting requirements do not significantly enhance management information for providers or achieve adequate accountability for the Department.

ACMH is working to develop a simpler, streamlined funding strategy, with a range of funding mechanisms including both output and program/block funding. A mix of funding mechanisms is considered the best way to accommodate the diversity of ACMH service users and providers and to take account of current service delivery systems.

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Under this strategy, many agencies will receive funding under several service groups and across several priority groups, with a mix of output-based and program-based funding. For example, in future a community health centre might receive funding for allied health on an item funding basis (for example, price per hour) and health promotion on a program funding basis (funds for specific health promotion outputs or outcomes), rather than both types of funding being provided based on hours of direct service.

> Developing this new funding approach will be accompanied by a focus on strengthening the links between funding and planning, developing a streamlined set of performance measures, enhancing information management and information and communications technology to support funding and planning, and promoting quality and outcome measurement, including consumer satisfaction and experience measures.

Streamlining of ACMH's funding strategy will use a staged approach. Before developing funding models, work will be done to enhance service definitions and collect better information on service provision and service costs. Analysis of that information will then determine if and how it can be used to inform funding decisions and develop new funding models. For each proposed new funding mechanism, the development phase will be followed by trial, review and modification (as appropriate) prior to implementation. Consultation will occur at all stages and PCPs and their member agencies will be involved in that process.

Streamlined Data Collection and Reporting

Integrated service planning requires each agency within a partnership to record and report its activities in a way that can be 'summed' across the PCP to develop a coherent and consistent picture of activity. During consultations with partnerships there has been widespread call for the development of a common data set for reporting to State and Commonwealth funding programs.

The Raysmith Review found that 'service providers bear the cost of multiple and incompatible data collections'. Internal analysis by the Department has found that:

- There are multiple unique collections with differing reporting frequencies, with multiple data reception points, different data media and transmission methods, and differing data transmission pathways.
- Even where there is similarity in data collection characteristics, there is little consistency in the way requirements are expressed or presented.
- The majority of data collections are paper-based (74 per cent of collections) with significant manual processing from agencies through Regions to various Head Office locations.
- The complexity of these approaches is further magnified as approximately 40 per cent of collections have no supporting documentation.
- The result is that most agencies are required to adhere to large numbers of different data collections.

Concepts Underpinning the Collection of Data
The data collected from service providers facilitates two key objectives:

- To ensure that agencies have appropriately delivered the desired services to the desired target populations. This addresses agencies' need to be **accountable**, ensuring that they comply with the terms specified in their service delivery agreements.
- To understand service and service system utilisation. This **service planning** information is used to monitor overall service system performance and to provide a basis for the allocation or re-allocation of funding.

Agencies should be capturing reliable client and service data as part of their normal business activities. This should include a minimum dataset on client profile, targeting and delivery of services to clients that will enable measurement of patterns of demand and outcomes to adequately inform service planning. Simply put, it is

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reasonable to assume that agencies should be collecting data regarding the delivery of services to individual clients.

Streamlining Data Collection and Reporting
Increasing demand on health care services requires that Government and providers plan programs and services that deliver appropriately targeted, effective and efficient services. The measurement of key information items such as customer profile, service demand patterns and consumer outcomes provides essential indicators to inform planning of future health care services. Consequently, informed decision making is heavily reliant on the collection of pure and reliable client and service data.

There are two factors that need to be addressed to streamline data collection and data reporting. The first is for providers to acquire the technology needed to support service delivery including the collection of data during service events. The second is for the Department to specify core program reporting requirements and establish business rules to underpin data management that enables reporting of agency data in a timely and efficient manner.

At the moment there is wide disparity between the 'ideal' and actual practice of service delivery. Since the capture of information about core services can be considered good management practice, it is assumed that providers are collecting data during service events and recording such information in their case notes or consumer management systems. In other words, the required data should be collected as a by-product of delivering services. If the data was collected in a standardised way, then it could be reported directly from the information system in any format required. The initial needs identification and care planning tool templates for PCP are an important step in achieving this goal (see Section 3.5).

> Electronic collection and transmission of information will be a key factor in the effective management and reporting of data. Agencies will need to acquire capabilities to enable electronic capture of data at the point of care delivery. In addition, partnerships will need to address the capabilities of member agencies as they develop their IM/IT capabilities.

To address issues relating to the collection and management of client and service data, the Department will develop a data reporting framework that will:

- Identify core data requirements to enable program planning at a government level and PCP service planning.
- Provide a data dictionary, aligned as far as possible with National Health and Community Services Data Dictionary, that establishes a core set of consistent definitions relating to the data elements required to meet performance measures; determines mandatory and discretionary data reporting; and provides identifying, definitional, relational and administrative attributes to clarify and manage information.
- Establish IM business rules that specify principles around the collection, storage, transfer and security of client information that will form part of the core data collection, in accordance with the Department's Privacy Principles and relevant legislation.
- Specify interim reporting arrangements and collection methodology for 2001–02 to enable all PCP agencies to meet reporting requirements based on minimal IT capabilities.

The Department is developing a common approach to the specification of its data reporting requirements, as shown in Figure 10. It has identified more than 111 different data collections across the Department. The Department has developed a Common Code Set that establishes common definitions for the data elements collected by the Department. All data collections are expected to conform

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to agreed standards over time. Initially data collections will incorporate the Common Data Set standards that will, at a minimum, comprise standard agency and service activity details.

Implementation of the Common Code Set will be determined after consultation with partnerships. It is recognised that a phased approach will be needed, especially where Commonwealth collections are also involved. Adequate notice needs to be given and previous commitments honoured, such as the period in which no change to the HACC collection will be made.

The intention is that eventually all collections will conform to a common framework for consistently classifying activities (into item, episode, case and program).

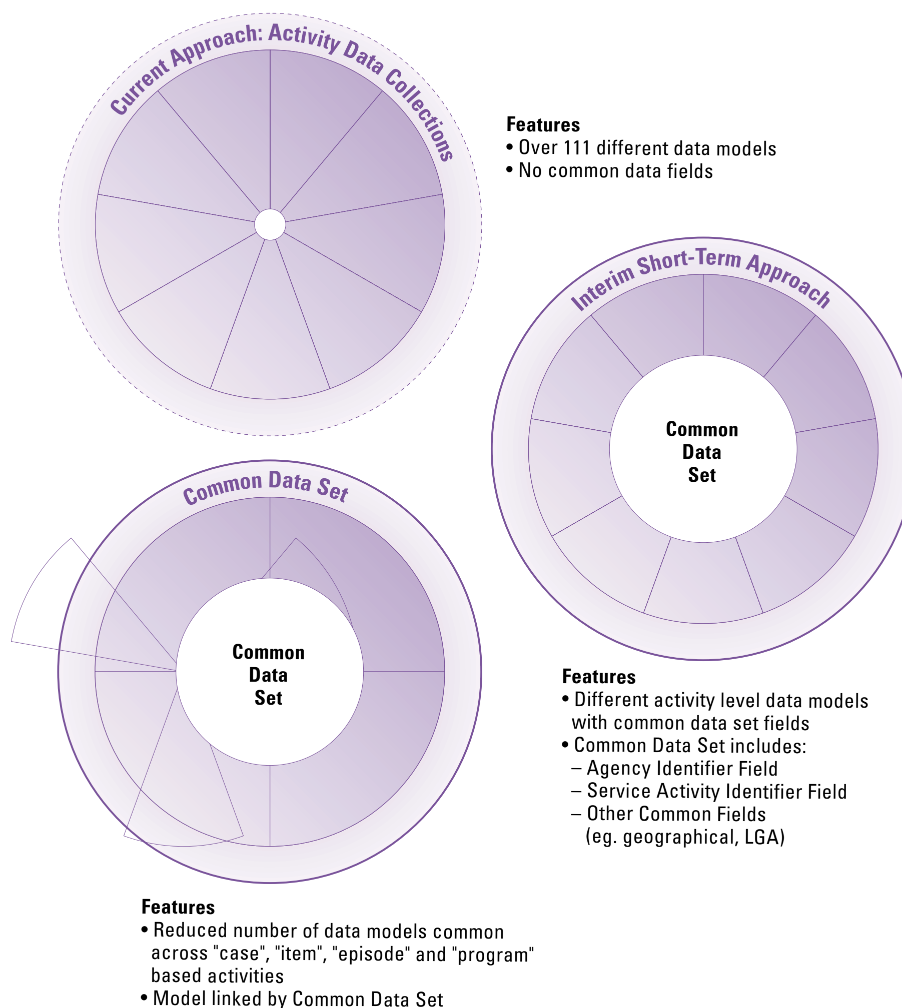
Development of common data models that reflect each classification is proceeding. This activity will be done in conjunction with partnerships to ensure that they conform with service delivery practice. In this way the Department's requirements for data to support its decision making processes can be progressed without placing extra burden on providers.

3.5 Establish Common Infrastructure

There are some IM/IT capabilities needed by the primary care sector which are most sensibly developed on a statewide basis. Key requirements are:

- A mechanism to ensure the quality of health and lifestyle information to be promoted to Victorians.

Figure 10 Approach To Simplify the Department's Data Collection Requirements



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- A knowledge base and information sharing facility for primary care providers.
- A directory of services available in the State.
- Tool templates to support the implementation of the operational framework for BATS.
- Purchasing arrangements for investments in information and communications technology.

The Department has established a number of initiatives to address these requirements.

3.5.1 Health and Lifestyle Information for Consumers—The Better Health Channel

Providing information is one way for providers to strengthen their relationships with consumers. Consumers increasingly expect health and care information to be available 24 hours a day, seven days a week, wherever they are. New intermediaries are emerging to provide customised information about healthy lifestyle options, care plans, appropriate services, and so on.

There are many sources of health and care-related information ranging from call centres to Web sites. The main concern for providers is to be able to recommend sites to consumers that present information that is reliable, useful, current, accurate, understandable and appropriate for consumers to act upon. This can only be achieved if there are quality control processes in place which 'certifies' information acceptable to primary care providers.

The key objective for primary care in Victoria is to certify information sources and sites that provide high quality information suitable for consumers to act upon to maintain or improve their health and wellbeing.

The Victorian Department of Human Services has developed the Better Health Channel (http://www.betterhealth.vic.gov.au/) as a communication vehicle to provide reliable, high quality health information to Victorians.

The Better Health Channel was developed with the objective of improving the health and wellbeing of Victorians. It provides an easy way for consumers to access information about health and related matters. It is managed by a steering committee within the Department, comprised of senior staff from various Divisions. Content is developed in conjunction with the Better Health Channel partners who are respected health advocacy or representation bodies.

Information on the site is divided into the sub-categories of: healthy living, health conditions, support and advice, and life events. Articles are sourced according to demand, typically being written in conjunction with a relevant third party. The content of these articles is assured via the requirement for all content to be authorised by the Department and by the partner organisation. Partner organisations review the content for currency on a regular basis, generally every six months.

The Channel has more than 220 links to other sites, grouped into Australian health sites, Better Health Channel partners, health reference sites, international health sites, other Victorian Government sites, and other related sites. A policy to determine which sites should be linked is currently being developed. The Department checks the links on a three-monthly basis.

The Department of Human Services needs to encourage the participation of partnerships and primary care agencies to identify information that should be published on the site and to promote the use of the site by consumers.

Primary Health Knowledge Base

The Primary Health Knowledge Base is an innovative Web-based information repository which was established in May 2000.

This facility became immediately available to all Victorian primary health service providers and allowed all primary health service agencies to participate in the electronic exchange of information and the facilitation of knowledge build-up at a single, easily accessible location. While the Primary Health Knowledge Base is managed and supported by the Department, content is provided by both primary health service providers and the Department's staff.

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In this way, the Primary Health Knowledge Base promotes a better understanding of primary health services among service providers, government staff and private sector professionals.

The Primary Health Knowledge Base is also an integral 'voice' for PCPs that provides a vital source of information and electronic documentation in relation to the PCP Strategy. Some of these sources include:

CHP Resource
The CHP Resource forms part of an overall strategy to ensure that PCPs have access to timely and up-to-date information required for developing Community Health Plans.

Primary Health Datamart Online (PHDO)
This Web-based data repository allows the provision of electronic forms and reporting methods, while providing PCPs and service providers with data reports from data they have provided to the Department.

Primary Health Datamart Online also provides data sources and links vital to the development of CHPs by PCPs.

PCP Web Pages
A Web page for each PCP has been set up within the Primary Health Knowledge Base to provide a simple and easily accessible location for PCPs to communicate, share and exchange information. This facility, which is called 'PCPs—*Making It Happen*', will allow easy access to PCP information by Departmental staff and Victorian service providers.

3.5.2 Service Directory

A key undertaking of the PCP strategy is the development of service directories. Directories need to contain information on health and community-based services available in PCP catchments. PCPs, agencies and consumers can then use their directory as a local information resource and tool to support referral.

The establishment of PCP service directories is a key stage in developing an integrated primary care service system and promoting the role and presence of PCPs to the community. The directories provide comprehensive information on the range and scope of services available to consumers. This information is essential for agencies to work together to deliver improved care for consumers. The service directory can also be used when PCPs undertake integrated service planning, because it will provide a picture of the services currently available in the catchment.

Service directories will be important tools for achieving a common approach to initial contact as part of the operational framework for BATS. They will also be important in assisting consumer entry and navigation. Service directories will need to be linked into broader processes to support consumer access, including recognising the diversity of consumers and providing a range of options for accessing services information.

A major feature of cooperation and coordination through partnerships is increasing the value and ease of use of health and community services information through presentation in a consistent format that is accurate, current and readily available. Involving local agencies and consumers will ensure that the range of services in the area is accurately documented and that the information contained is relevant to users' needs.

> A standard format for the structure and content of service directories is needed to enable directories to be combined on a regional or statewide basis, and facilitate ease of use for people who utilise more than one directory. Draft data fields have been constructed to ensure consistency of this information. Common data fields will also enable data interchange with the statewide local Services Directory on the Better Health Channel.

Further information on service directory development can be obtained from the *Service Directory Discussion Paper and Draft Data Fields* (http://www.dhs.vic.gov.au/phkb/).

3.5.3 Tool Templates for Initial Needs Identification and Care Planning

To support the operational framework for BATS, the Department is contracting the development of tool templates for initial needs identification and care planning.

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Under this contract, draft tool templates will be piloted in all PCPs in the second half of 2001. Part of the development of these templates will be the specification of datasets (including core consumer information) to standardise the information collected through the use of the tools. As far as possible, these tool templates will be consistent with, and build upon, existing standards and tools in current practice (for further information, refer to *Better Access to Services: A Policy and Operational Framework*).

3.5.4 Common PCPs Dataset

A common dataset for services information, and data elements to support initial needs identification and care planning tool templates (incorporating core consumer information), represent the core of a common dataset for PCPs. This work is being pursued with work on a Common Code Set for the Department (see Secton 3.4) and the implementation of the HACC Minimum Dataset, to ensure that common data standards and definitions are adopted across the board.

3.5.5 Statewide Information and Communications Technology Purchasing Arrangements

The Department of Human Services has in place a number of contracts for the purchase of PCs and has negotiated with our suppliers to allow hospitals to purchase this equipment at the same price. The Department will work to extend its existing IT purchasing contracts to the PCPs to enable them to obtain similar prices, thereby increasing the effectiveness of their purchasing power and their investment in ICT infrastructure. The purchasing arrangements will include a recommended system configuration to support day-to-day use and enable electronic interaction with the Department.

The primary consideration in the development of these arrangements will be to ensure that PCPs have access to the economies of scale and streamlined purchasing arrangements that the Department can provide.

3.6 Key Elements of an Electronic Information Sharing Environment

This section sets out the key elements expected to evolve in the primary care environment over the next five years to support electronic information sharing. While the Department is developing policy positions in these areas, and is participating in developments, the fluid nature of the environment makes it impossible to provide definitive advice on the implementation of these capabilities in PCPs.

3.6.1 Electronic Health Records

To coordinate care within a partnership environment, each provider needs to understand the care requirements of their consumers. To achieve this, they need to share with other providers some common information about the needs and care provided for each consumer.

This can be implemented through the development of electronic health records. An electronic health record has been defined by the National Electronic Health Records Taskforce as:

> *An electronic longitudinal collection of personal health information, usually based on the individual, entered or accepted by health care providers, which can be distributed over a number of sites or aggregated at a particular source. The information is organised primarily to support continuing, efficient and quality health care. The record is under the control of the consumer and is stored and transmitted securely.*[2]

The way in which an electronic health record could operate is depicted in Figure 11. The transition from paper-based records into an electronic environment is likely to take some time because of the complexity of the issues involved, but this needs to be factored into PCP planning processes.

In its simplest form, an electronic health record would include information such as the consumer's details, their needs as identified or assessed, what services are planned and when they are required, relevant data collected (for example, test results) and summary reports from each contact with the consumer. The record should also have the capability to notify providers and consumers when actions,

2 A Health Information Network Australia. Report to Health Ministers by the National Electronic Health Records Taskforce. July 2000; page.xv

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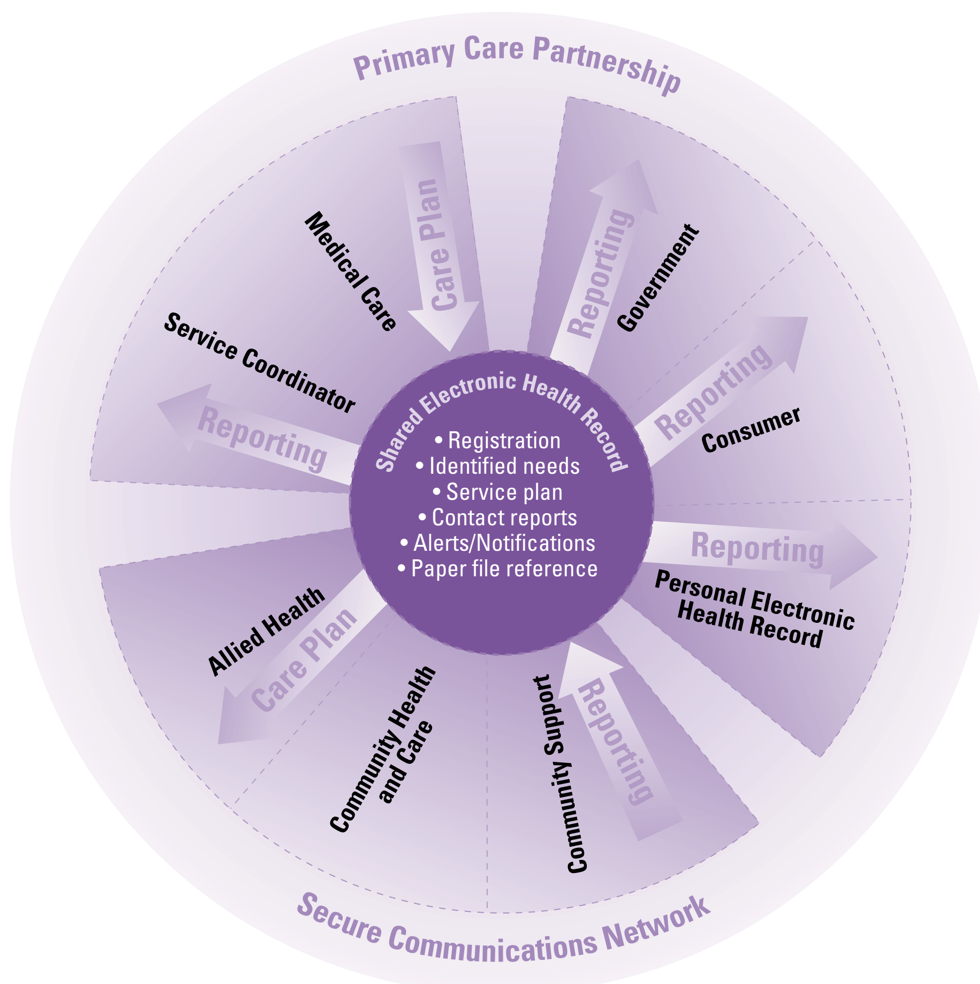
such as service reviews, scheduled appointments or proposed remedial action, are required and to notify consumers when scheduled self-management activity should occur.

The purpose of the electronic health record is to assist with the coordination of the interactions between consumers and providers. Electronic health records act as a centrally held master file which is available to all authorised staff immediately—negating the wait for a paper file to be retrieved from the filing system or passed across by another staff member. This allows the agency to provide a cohesive and coordinated service regardless of which providers actually deliver the service.

To achieve this level of coordination, electronic health records need certain communications capabilities. Providers must be able to view consumer's information or download it into their personal technology or system. In turn, these personal systems need to be able to submit summarised contact reports back to the record. It is also important that these systems synchronise essential details, such as the consumer's name and address, to ensure that information held about consumers is correct and up-to-date.

It is also desirable that the electronic health record enables coordination of services with providers in different agencies that may use a different electronic health record system. As a result, there is a need to be able to send parts or the whole record to other providers or agencies. Ideally, they should also be updated by the addition of contact reports received back from other agencies to which the consumer has been referred. The result will then be a

Figure 11 Role of a Shared Health Record To Coordinate Services



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smooth interaction of agency-based electronic health records that will enable the primary care sector to operate as a cohesive and coordinated system.

The development of initial needs identification and care planning tools will provide some of the core data that would need to be part of any electronic health record in the PCP environment. At this stage, PCPs need to be wary of becoming locked into a system that cannot accommodate new tools and datasets and the evolution of policy and approaches to electronic health records at a national level.

3.6.1.1 Consumer's Personal Electronic Health Record
Consumers prefer to act for themselves. They will want to record and own their health and care information so that it is accessible when and where they need it, such as when they're away from home or in an emergency. Some new information intermediaries do offer this service. These sites often contain options to store consumer's personal details, emergency contacts, medications and the like. However, most consumers may be cautious of locating their information where they cannot control it.

Smartcards were originally seen as the solution as they can store personal information, have a high level of security and are controlled by the consumer. However, the cost of the infrastructure is currently seen as too prohibitive to support widespread use of smartcards across the primary care system. As a result, other information intermediaries can be expected to provide safe and secure storage for personal information on the Web.

The utility of personal health records will be based on a number of key features:

- Consumers maintain their own health and lifestyle information such as demographics, provider and carer contact details, problems, allergies, immunisations, medications, prescriptions, family histories, calendars and reminders, test results and comments.
- Information is held in an electronic record to allow access for relevant providers (for example, GP, nurse, carer, emergency contact) from their place of work.
- The electronic record must be secure and include privacy options to allow consumers to grant different levels of access to their personal providers.
- The electronic record provides links to health and care information (for example, personalised information for a chronic condition such as diet and nutrition, preventative care plans, activity and exercise regimes) and to services they need (such as local pharmacist, care monitoring).

Personal electronic health records have the potential to improve the quality of life for consumers who need long term care. The primary care sector needs to be aware of these developments and recognise the implications for their services, particularly when they become widely deployed across Australia.

3.6.2 Identifying Common Consumers
The unique identification of consumers is a critical element for the coordination of services across care settings and health jurisdictions.

A means of uniquely identifying consumers is an essential component of the IM/IT infrastructure needed to enable the sharing of consumer information between provider systems. Consumers can be identified by using a range of demographic data, and it is possible to have reasonable statistical certainty of uniqueness (up to about 90 per cent) through the use of a statistical linkage algorithms (such as used for the HACC Minimum Dataset) for planning and analysis purposes.

Alternatively, consumers can be provided with a single means of unique identification (such as a unique number) which can be used for both care delivery and planning and analysis purposes. This approach provides more certainty and longer term viability than the use of demographic data (which can be subject to data quality problems and can change over time).

Inextricably linked to the issue of consumer identification is a number of sensitive privacy and confidentiality issues and concerns widely held throughout the community. A primary concern for consumers is the need for confidence

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and certainty with regard to what the identifier will be used for (and what it won't be used for). Consumers need to be assured that adequate safeguards are built in to prevent broader use of the identifier outside its primary, specific use in the provision of health care.

The ideal identifier must minimise or eliminate the risk of misidentification and meet certainty requirements. In *Health Data in the Information Age—Use, Disclosure, and Privacy* (Institute of Medicine, 1994), a number of critical certainty requirements of a unique consumer identifier are described. These requirements can be summarised as follows:

- The transition from current to the future record keeping environment must be seamless, transparent and assured.
- The identifier must have error-control features to ensure data entry errors are unlikely.
- The identifier must have separate identification and authentication elements.
- The identifier must operate in any situation in which health care services are delivered, whether or not the situation was anticipated in the design of the identification system.
- The identifier must function anywhere in the jurisdiction and in any provider's facilities and settings within the jurisdiction.
- The identifier must minimise opportunities for criminal use or abuse.

The National Electronic Health Records Taskforce recommended in their HealthConnect report that Health Ministers should agree to the establishment of a national health identifier to be used only in the health sector under strict privacy protocols. They also recommended that providers and agencies be reliably identified to eliminate any uncertainty about who was involved in an episode of care and where the care was provided.

In advance of clearer direction and a supportable national approach, PCPs should use demographic data to identify consumers within their PCP and should adopt the use of a statistical linkage key (such as used for the HACC Minimum Dataset) for the purposes of planning and analysis.

3.6.3 An Infrastructure for Security and Authentication

In the current system, minimal personal information is transferred between providers. When it is, it is usually a printed referral or a test result which is either sent with the consumer or faxed to the provider.

Using information systems, it is possible to send more detailed personal information directly between providers. Without adequate security and authentication measures, electronic transmission is open to inappropriate use and abuse.

There are a number of options to manage the security of information transmitted across computer networks and the Internet:

- Unsecure email—many health and primary care agencies currently use unsecure email to send client record information. While in some senses it is more secure than paper, the ease with which it can be intercepted, read and altered makes it an unacceptable option.
- Secure Web Email Services—using end-to-end encryption between the PC and a Secure Web Server is effective in ensuring confidentiality (Secure Socket Layer encryption).
- Secure email—the use of digital certificates at the computer device level can be quite effective in ensuring confidentiality and message integrity, depending on how much trust is attached to the certificate. This includes S/MIME using digital certificates, Pretty Good Privacy (PGP), and Virtual Private Network (VPN).

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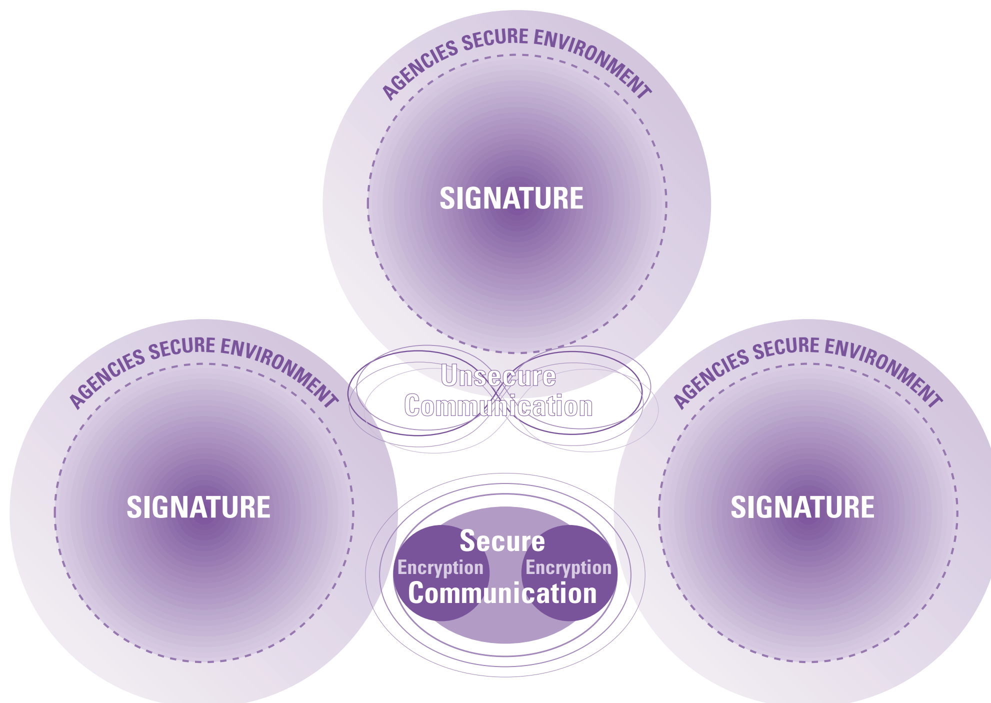
- Public Key Infrastructure (PKI)—the use of digital certificates issued by trusted Certification or Registration Authorities (a combination of technical and administrative approaches) ensures authentication, integrity, confidentiality, integrity and non-repudiation. While it provides the safest approach, it is also the most complex, requiring a management infrastructure to be developed.

3.6.3.1 Public Key Infrastructure

Primary care providers and consumers need to be assured that electronic transmission of health information is secure. The greatest concern is that personal information will not be secure when it is sent over the Internet. It is critical that some means be established that ensures that information can be passed securely over the Internet and that someone can be held accountable for this security.

Figure 12 Securing Communications between Providers



Secure communication of information over the Internet requires security controls that address:

- Authentication—the ability to confirm the identity of the provider or agency.
- Encryption—information is not readable by unauthorised people during its transmission.
- Integrity—nothing gets changed between sending and receiving.
- Non-repudiation—no-one having sent or received a message can later deny having sent or received it.

The development of PKI is a means to improving the security of Internet transferred information. PKI addresses the requirements for secure Internet communications. The first is to know who is sending, or receiving, the information (authentication and non-repudiation). The second requirement is to ensure the confidentiality of the information while it is in transit between the agencies (encryption and integrity).

A PKI uses a set of protocols and a matching key pair, one private and held by the user and one made available on a public directory. Each key performs a one-way transformation of data that can only be reversed by its matching key. The 'Public' key is made available to

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everyone, a bank for example, while the 'Private' key is kept secret and only accessible by the user. By matching these key pairs and using them to decrypt information, or using them to create a digital signature, a user can be authenticated. Such encryption can be used as proof of identity when using the Internet.

PKI protocols define the basis by which digital certificates are issued by a Certifying Authority (CA). The CA vouches for the certificate holder under a policy that specifies registration conditions, such as a '100 point' passport check. Widespread use of digital certificates in primary care will require either one super health care CA or each health care CA to 'trust' other CAs. Protocols are also required to define the trust relationship between CAs.

In Australia, the Gatekeeper strategy has been adopted by the Commonwealth Government as the security standard for the electronic transfer of information. This standard has been adopted by the Health Insurance Commission to support the transmission of administrative health data for the Medicare and Pharmaceutical Benefits Schemes.

The National Health Electronic Records Taskforce has recommended a PKI-based security approach for the Health Information Network for Australia initiative. Obtain further information on PKI at:

- http://www.hic.gov.au ;
- http://www.govonline.gov.au/projects/publickey/Gatekeeper.htm ; and
- http://www.medisafe.com.au/ .

3.6.3.2 Establishing a PKI for Health Care
It is recognised that secure communications is a prerequisite in gaining consumer and provider confidence in the security of personal information. Some agencies are trialing, or are considering trials, of secure electronic communication. While there are several alternatives for secure information between small, defined groups of users, the deployment of PKI appears to be the only satisfactory solution for widespread networking across the health care sector.

However, there are a number of issues that need to be resolved prior to a widespread PKI implementation, including:

- The Gatekeeper strategy was primarily designed for the transfer of administrative and financial data. The relevance of the strategy to the transfer of sensitive personal health information is yet to be determined.
- The willingness of a CA to trust and accept certificates from other CAs is yet to be tested.
- The cost of implementation and maintenance of an extensive PKI system in the primary care system is yet to be determined.

While PKI may be a goal for the development of secure information exchange in the primary care sector, the infrastructure, skills base, protocols, practices and systems architecture will take time to develop across the State. PCPs are encouraged to consider a range of approaches in the short term (and specifically with reference to piloting initial needs identification and care planning tools in 2001–02). These can range over:

- Paper-based trials of information sharing with practices and processes to protect the security and confidentiality of information in transit and when it is collected, used and stored.
- Secure email backed up by agreements between agencies regarding authentication.
- Secure email and the use of digital certificates, or the use of localised PKI trials.

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Appendix A Process Maps

The following process maps have been developed to identify the information needs of primary care providers. They have been developed with the Department of Human Services after wide consultation with a cross-section of providers across the primary care sector.

These process maps assist in determining the information and communication needs of primary care providers. They provide important input to the development of IM practices and the specification of IT capabilities needed by providers, and they are a useful guide. They do not, however, capture the full variety and complexity of approaches adopted in delivering primary care services.

IT applications and infrastructure specifications based on these process maps provide a generic guideline to the capabilities needed by primary care providers. Detailed business requirements need to be developed through more formal techniques by providers or groups of providers (such as that undertaken by the GP Computing Group).[2]

3 See GPCCnCore data model and core data set project. http://www.gpcg.org/data model.htm

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App Figure 1 Process Map Conventions

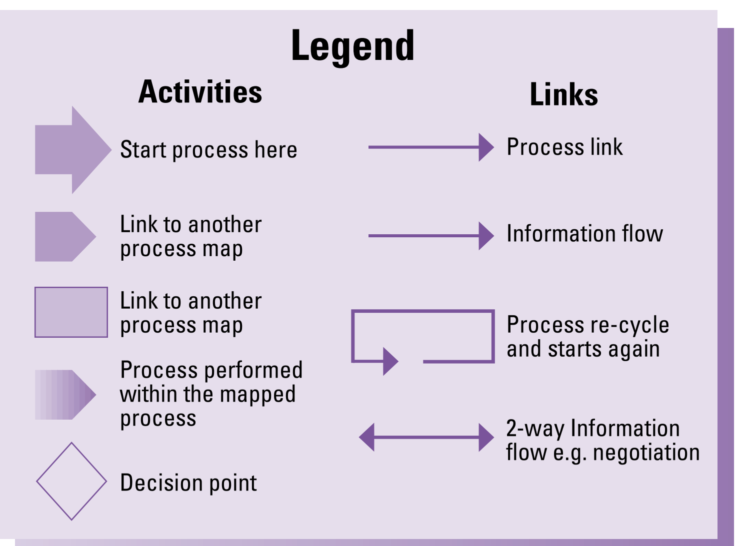
Processes consist of activities which are performed in sequence following the connecting arrows. Usually the process proceeds from left to right.

All activities are performed, but may be implicit (skipped) in certain circumstances. What shown as sequential, some activities may be performed concurrently or in an iterative manner. Where possible, these are shown insidea dotted-line box.

The focus of these maps is to highlight those activities which have implications for information management, particularly those that create, send or receive information or are associated with its use e.g. analysis or security.

Activities are performed by people who performed by peoples "role" in the process. Activities performed by a roles are drawn on the same horizontal row on the process map. This method is used to highlight where information is passed from one role to another i.e. vertically. A person may perform more than one role, in which case there is an implied transfer of information as they change role.˚

Information flows between roles in different organisations (agencies) must obey clearly defined protocols to ensure the information is received correctly (not scrambled), in context (the recipient knows why they are receiving it) and is meaningful (the recipient knows what they should do).



Roles performed in primary care

Role	Description
Consumer/carer	The consumer and/or their representative
Service provider	Service Provider is used to denote a person involved with the delivery of service to a consumer
Care Coordinator	Care ocordinator is a person delegated to coordinate and monitor the delivery of services to a consumer
Information source	An external source and/or provider of information
Agency Management	A person performing a managerial or administrative function within an agency

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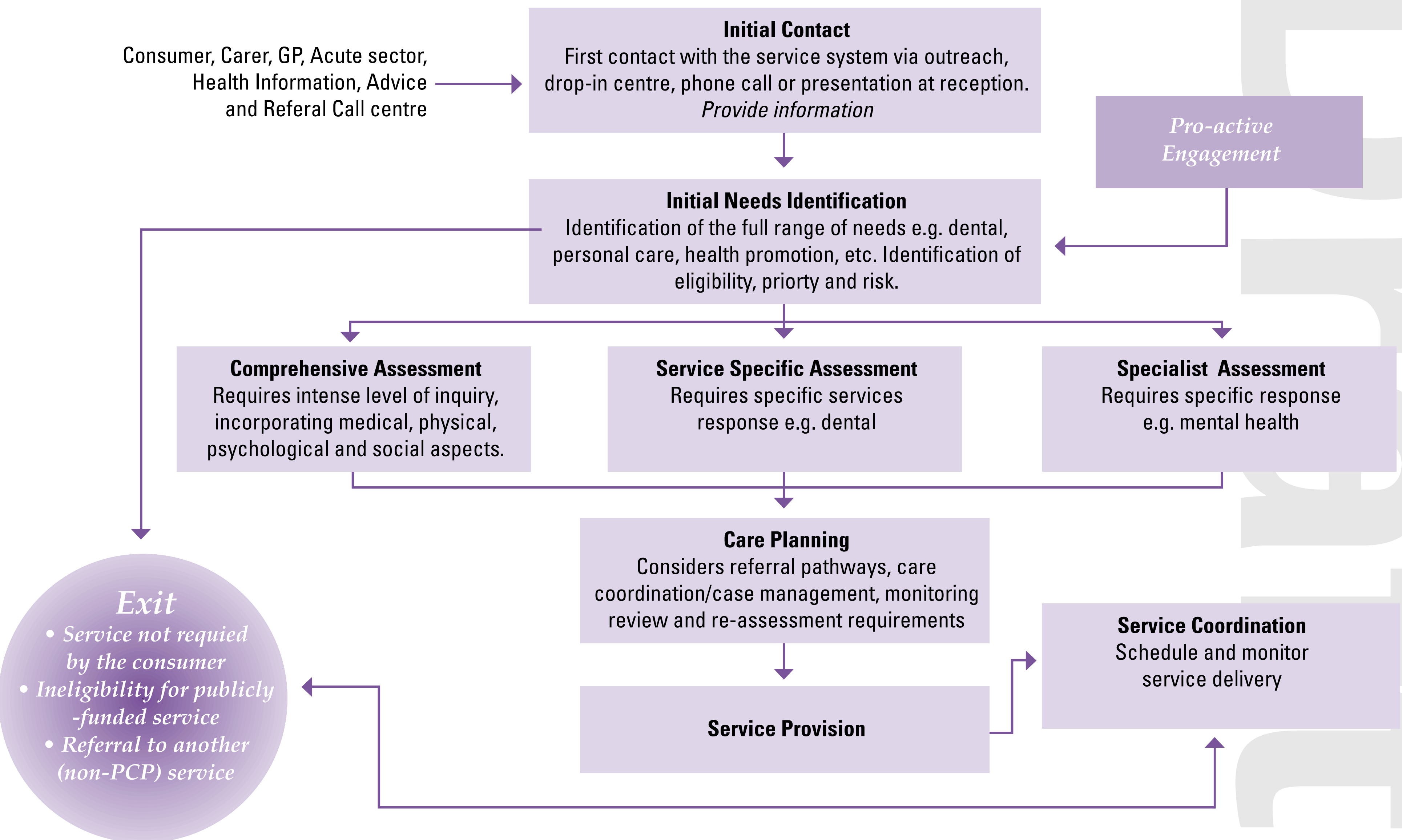
App Figure 2 High Level View



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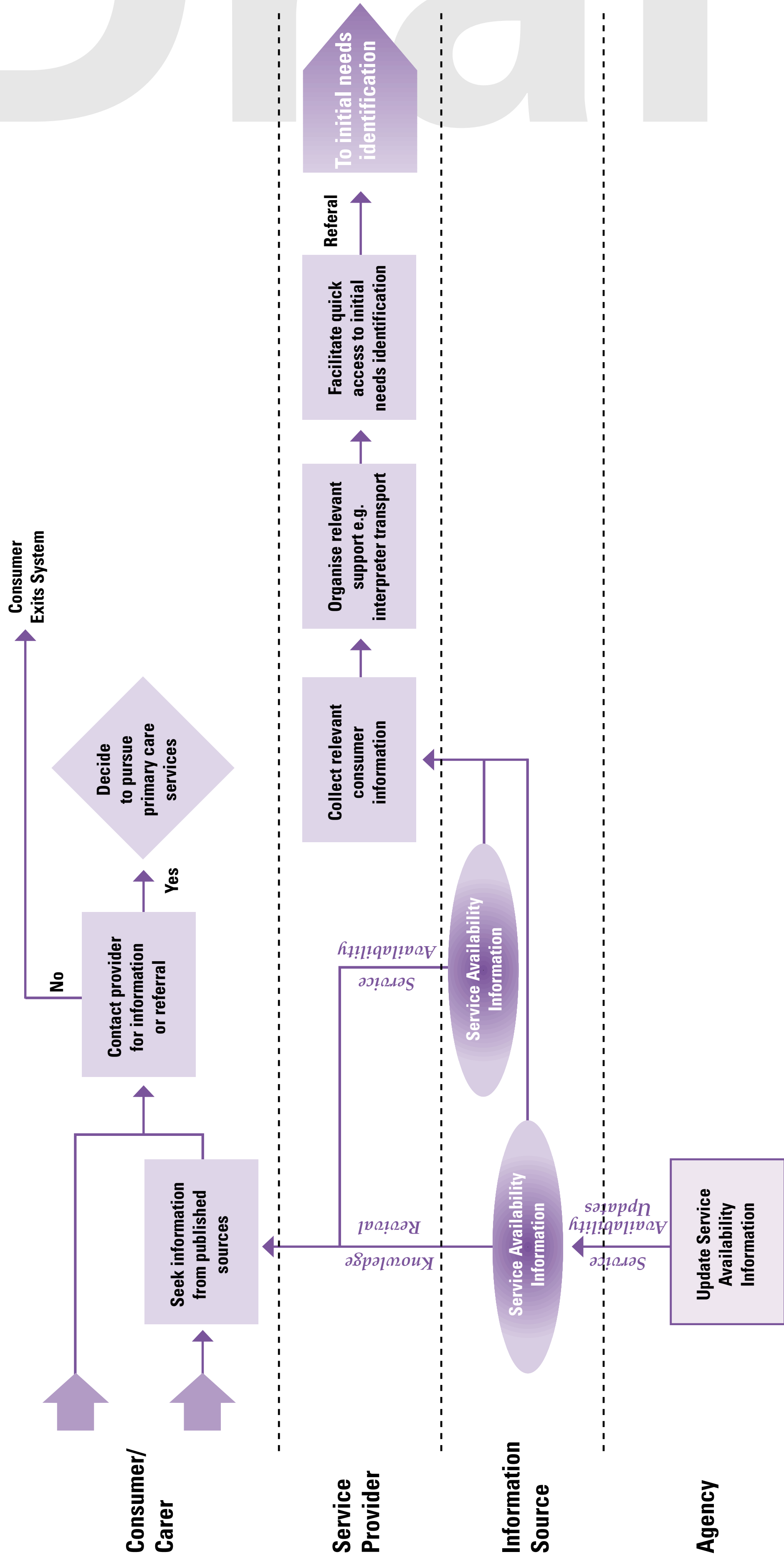
App Figure 3 Initial Contact



Service Provider can be a receptionist, volunteer, or qualified service provider such as intake worker, GP, outreach worker

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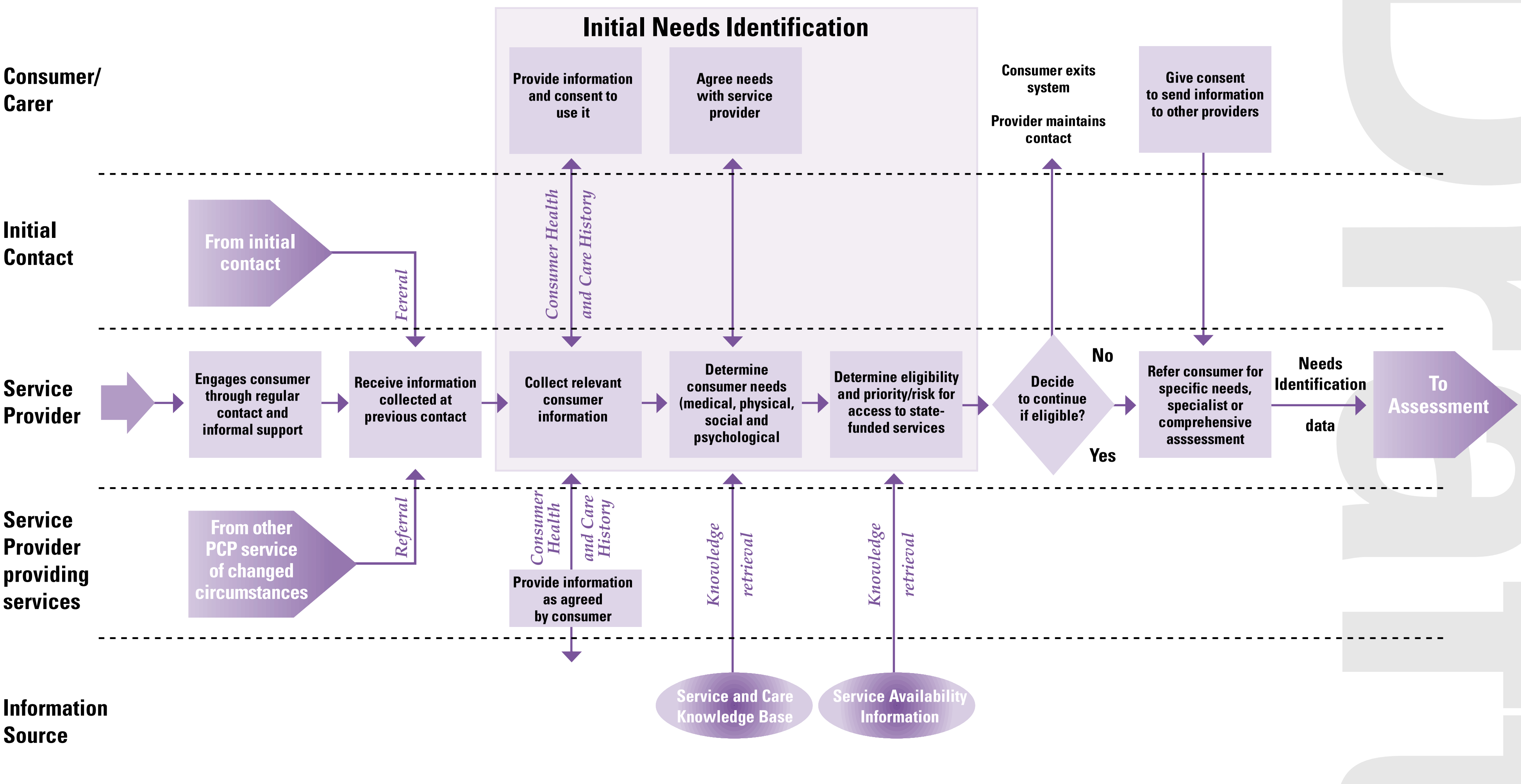
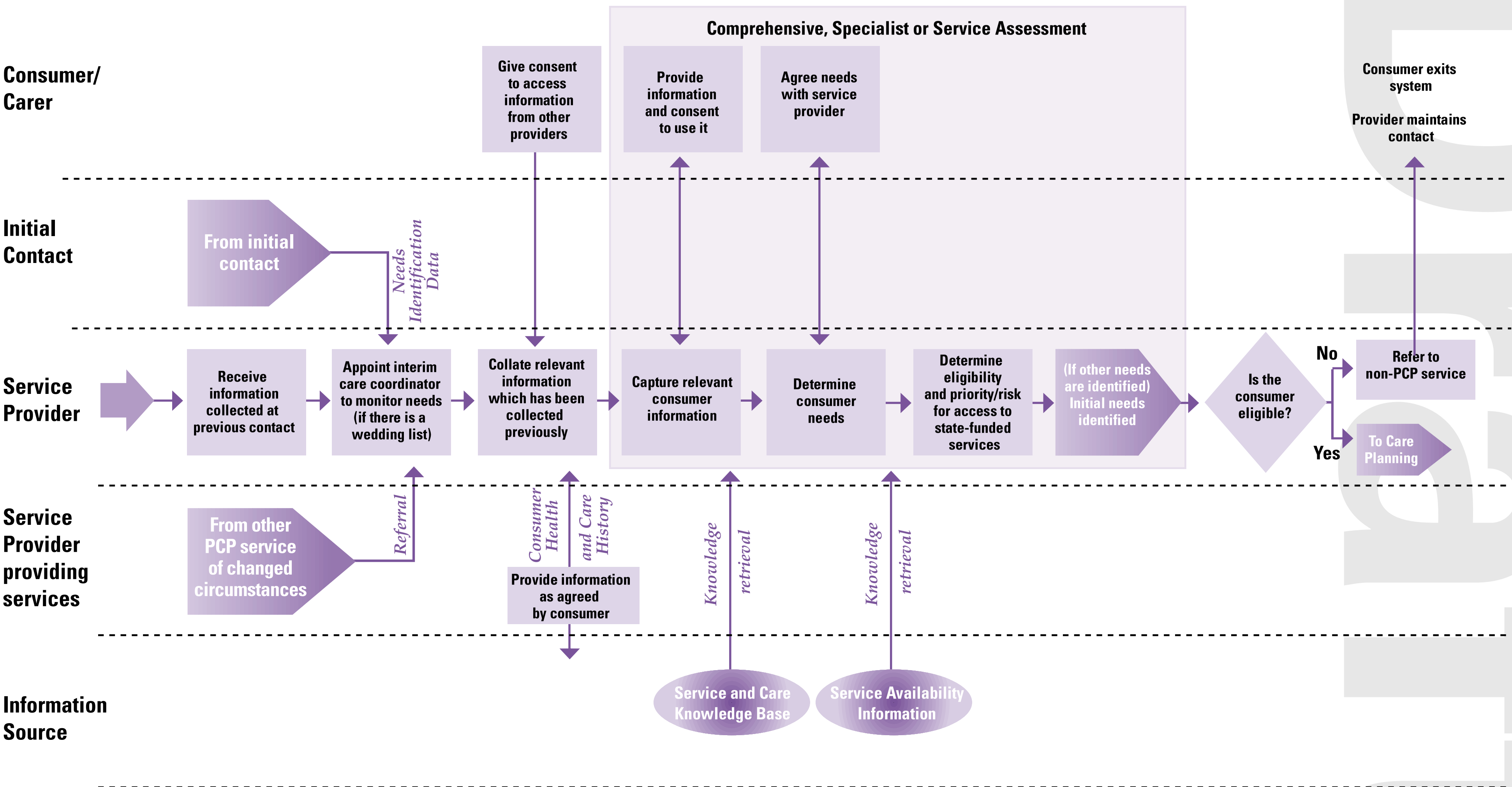
App Figure 4 Initial Needs Identification



Service Provider is a health professional where the consumer has an unstable health or personal care need

App Figure 5 Comprehensive, Service Specific and Specialist Assessment



Comprehensive assessment – Requires intensive level of inquiry, incorporating medical, physical, psychological and social aspects.
Service specific assessment – Requires specific service response e.g. dental.
Specialist assessment – Requires specialist response e.g. mental health.

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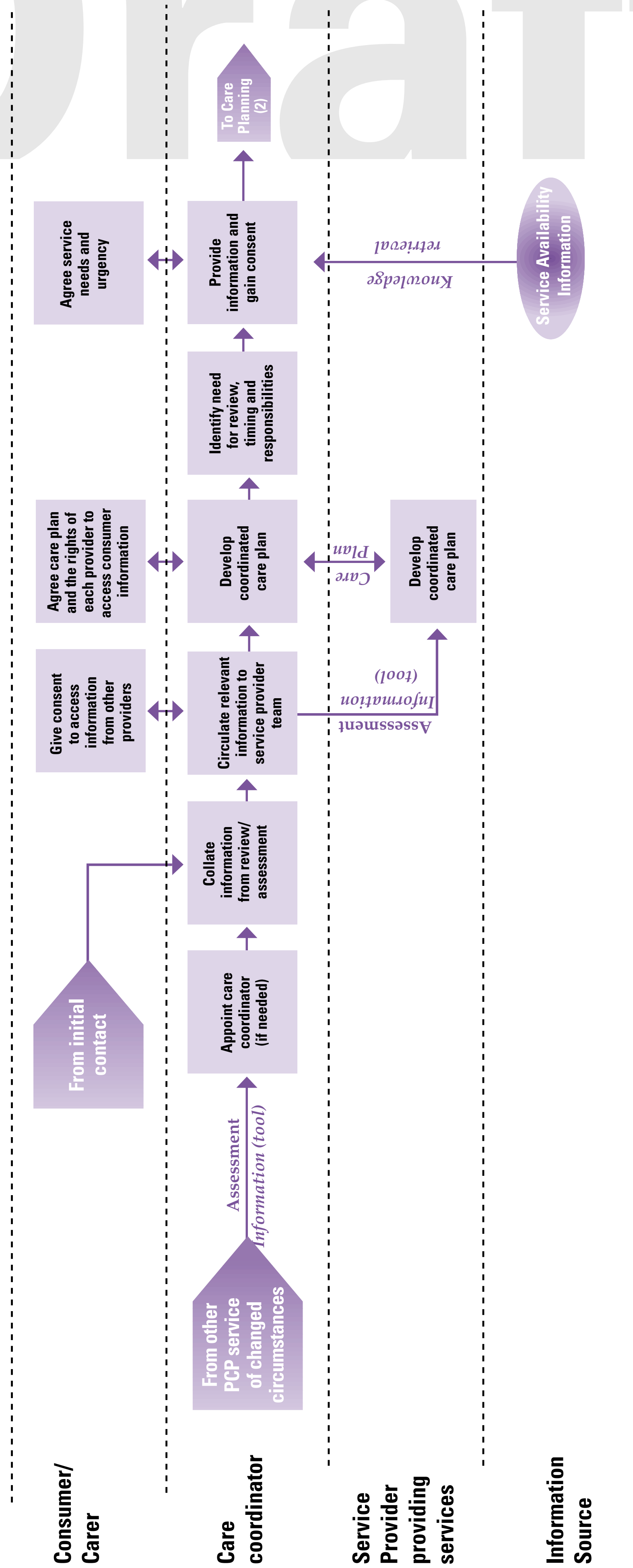
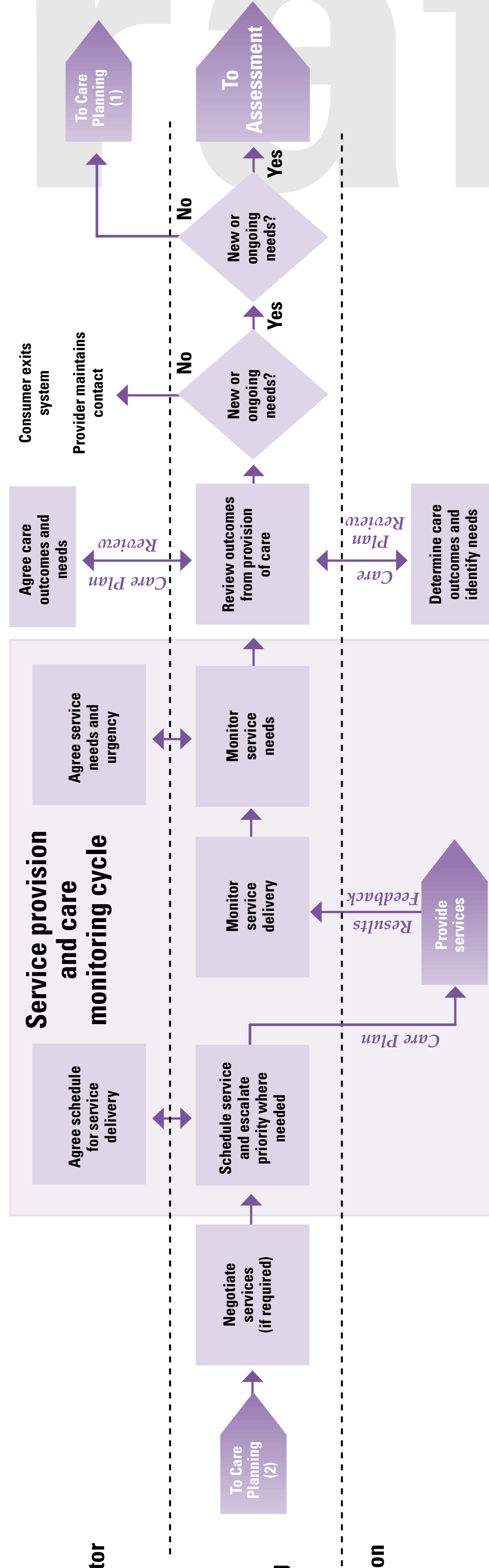
App Figure 6 Care Planning (1)



App Figure 7 Care Planning (2)



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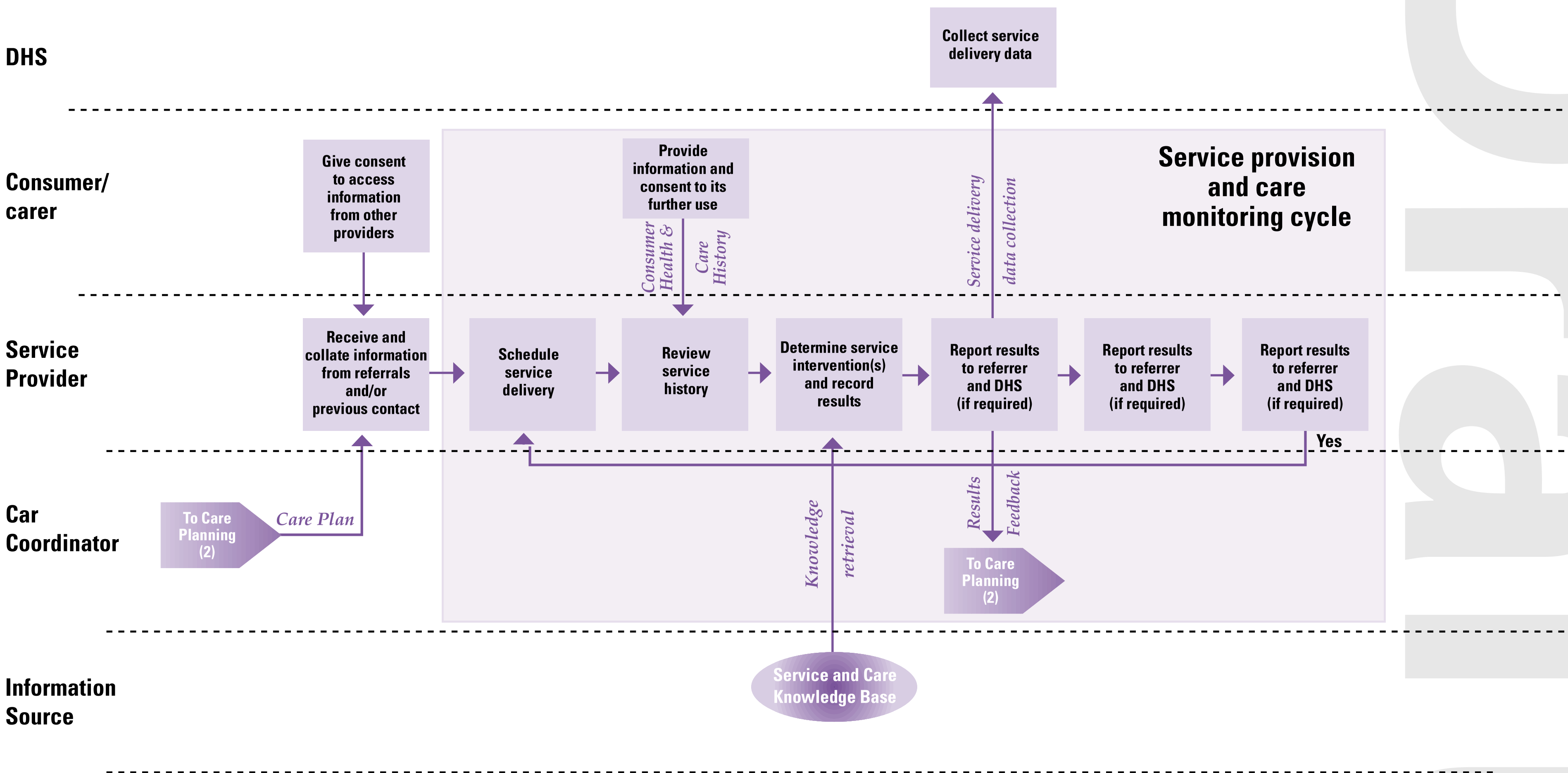
App Figure 8 Provide Services



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Appendix B Information Management Strategic Plan Template

Partnerships will work with the community and the Department to develop and implement CHPs.

The purpose of the CHP is to communicate the Partnership's development, service coordination and service planning objectives to the Department and interested stakeholders. See the latest version of the *PCPs Community Health Plan Template*.[3]

This appendix provides further detail to sections 2.2 (Information Management Strategic Plan) and 2.3 (Local Service Information Strategy) of the *PCPs Community Health Plan Template*. **This appendix specifies what the Department expects PCPs to address in their IM strategic plans as a component of their CHPs.**

The information management strategic plan consists of two parts, B1 and B2, as detailed below.

B1 Information Management Strategic Plan

PCPs need to present an IM strategic plan that describes at a local level how the PCP will implement the *Information Management Strategic Directions*. The plan should identify the IM practices, protocols, processes and systems needed to support the functional integration described in the PCP's model for BATS. The plan should identify how key stakeholders (including consumers and carers) have been involved in its development.

The plan must describe the IM capabilities which the PCP will develop to support the implementation of the operational framework for BATS (as described in *Better Access to Services: A Policy and Operational Framework*). Specifically, it must describe the IM practices, protocols, processes and systems to support:

- Individual providers in their **professional decision making processes** (to support INI, care planning and service specific, specialist and comprehensive assessment).
- The **sharing of health and care information** relating to individual consumers (to support INI, care planning and service specific, specialist and comprehensive assessment).
- The **sharing of services information** to assist consumer entry and navigation and provider navigation, referral and coordination (to support all six elements of the BATS operational framework).
- The **provision of reference information** (including health prevention and promotion information) for use by providers and consumers and their carers (to support all six elements of the BATS operational framework).
- **Planning and management capacity**, including financial management and the aggregation of data to contribute to integrated service planning (to support the implementation and development of all six elements of the BATS operational framework).

The strategic plan must identify priorities for the development of information management capabilities and specify project activity to contribute to this development in 2001–02. At a minimum, the plan must identify projects in the following areas:

- Initial contact
- Initial needs identification pilots
- Care planning pilots
- **Comprehensive assessment** (for PCPs undertaking integrated disease management pilots).

3 Final template will be produced following the Ministerial Forum on the Primary Care partnership Strategy in March 2001.

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For each project, the plan must address how information is collected/stored/used in relation to each process; information sharing and consent mechanisms; roles and responsibilities in relation to the management of information collected or used; and the infrastructure and skills development requirements to support the management of this information. The project should demonstrate how key stakeholders (including consumers and carers and acute and residential care sectors) will be involved in the development of the information management practices, protocols, and systems to support each process. Project proposals should also demonstrate how the project will be evaluated to support shared learning with other PCPs.

Each project should identify the proposed project management arrangements as well as the budget and other resources required to support the project.

B2 Local Services Information Strategy

Present a strategy for the delivery of local services information which is aligned with the local IM strategic plan and supports the implementation of a local operational framework for BATS as identified by the PCP's BATS model and strategy.

This strategy must specifically support the goals of the IM strategic plan in relation to the sharing of services information to assist consumer entry and navigation and provider navigation, referral and coordination.

The strategy should identify priorities for the development of capabilities for the management (including collection, sharing, use and updating) of services information within the partnership. It should also demonstrate how all stakeholders (including consumers and carers) have been involved in the development of the strategy.

The strategy should identify projects to support the development of capabilities for the management of services information. At a minimum, project work for 2001–02 should include:

- **Services Directory:** implementation of an electronic services directory incorporating the information about primary care services within the partnership collected according to the statewide data standards identified by the Department, which can support initial contact and initial needs identification and care planning pilots. The project should address how the information contained in the service directory is accessed (by consumers, carers and providers) and in what form; how the directory is managed including content management (accuracy and data quality issues); the roles and responsibilities of providers in relation to the service directory; the infrastructure and skills development required to implement the service directory; and how its effectiveness will be evaluated. The project must identify how key stakeholders (including consumers and carers and acute and residential care sectors) will be involved in the implementation of the services directory.
- **Telecommunications:** implementation of a coordinated approach to telecommunications for the partnership that supports the provision of information about services to providers, consumers and carers at their first point of contact with the partnership. The project should address how telecommunications can support the visibility and accessibility of the PCP as a functionally integrated service system; the roles and responsibilities of providers; the infrastructure and skills development required to implement a coordinated approach to telecommunications; how it will be managed and how its effectiveness will be evaluated. The project must identify how key stakeholders (including consumers and carers and acute and residential care sectors) will be involved in the implementation of a coordinated approach to telecommunications.

Each project should identify the proposed project management arrangements and identify the budget and other resources required to support the project. Each project proposal should also identify how the project will be evaluated to support shared learning with other PCPs.

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Appendix C Generic Planning Templates to Support the Development of Information Management Strategic Plans

This appendix provides a number of generic templates that PCPs may use to assist them in the development of their information management strategic plans. **While PCPs are not required to use these templates, they address the range of information that the Department will expect to be covered in IM strategic plans.**

Each element of the service coordination strategy should cover:

- What the partnership is trying to achieve.
- What capabilities are needed and by when.
- How the capabilities will be developed, including acquisition of information systems.
- How much it will cost, including both capital and recurrent costs.
- How it will be funded.

This template provides an outline of the issues to be addressed in the Service Coordination section of the CHP.

Scope

An incremental approach is recommended to minimise risks involved for partnerships. The partnership needs to structure each element in a series of projects of about three months duration. This can be achieved by limiting what is to be achieved by the project in terms of either the number of participants or the capabilities to be delivered. Expansion of these numbers or capabilities can then be achieved through successive iterations of similar projects.

Model of Operation

The model of operation addresses how each operational element of the BATS framework will function. The model for each element needs to address the processes, protocols, practice and systems to support the development of a functionally integrated primary care system.

Management Considerations

A number of management considerations need to be addressed in order to provide IM support to the local operational framework for BATS. Building on the *Information Management Discussion Paper*, partnerships should describe how the management considerations would be addressed.

Information Systems

The information systems needed by the partnership should be described. The following details should be summarised for each system to be acquired or developed:

- A description of the current IT environment.
- A description of the requirement.
- How the system will be acquired, maintained and operated.
- What training and skills development will be provided for affected staff.
- Project timelines and estimated costs.

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Implementation Projects

Implementation projects of about three months duration should be specified to achieve the desired model of operation and acquire the supporting information systems. An implementation plan should be developed showing all projects, their priority/prerequisites and their staging to achieve desired capabilities. This forms the master plan for the partnership.

It is equally important to address how the projects will be managed. Descriptions should be given of what management structures and responsibilities will be put in place, how the project will be monitored and how its ongoing operations will be managed. Risk factors should be identified as part of the development of a risk management plan. Projects should be structured to minimise the impact of risk.

Costs and Funding

An overall summary of costs and description of benefits should be developed. Sources for funds needed to develop and operate the new IT capabilities must be clearly established. Agreement to these commitments is essential before the partnership can proceed to implement the strategic plan.

C1 Scoping Template

The purpose of this template is to identify and agree on the scope for each element of the strategic plan. The partnership should establish objectives that can be achieved within a few years. Consideration needs to be given to which members will participate in the development activities and which projects will be undertaken in the first three months. This template should then be reviewed each quarter to monitor progress and develop the next three months' work schedule. Detailed project briefs should be prepared for all projects to be undertaken in the following three months, and less detailed ones for projects to be commenced in the next six to 12 months.

Objectives

What is the partnership trying to achieve?

What is the target population group?

What are the improvements for providers and consumers?

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Participants

Which agencies, sites and providers will be participating in this development program?

Agency	Town/Site	Address	Number of Staff (EFT)	Number of Staff (People)

Three-Month Goals

What will the partnership be doing (projects)?

What will be completed?

Who is responsible for each activity?

How will we measure achievements?

Project Name	Project Objectives	Project Tasks	Project Manager	Project Key Performance Indicators

C2 Model of Operation

The first step for each project is to develop a model for the operation of the relevant element of BATS at the local level. Process mapping is a good technique to assist a group of people to agree on how the process should work. A number of different conventions can be used for mapping processes. One of the simplest to use is the 'swimlane' technique shown in the following diagram (App figure 9).

The 'swimlane' technique maps out activities (rectangles) in a sequential, time-based order. Decisions can be shown (diamonds) to identify where alternative paths can be followed. The strength of this mapping technique is the identification of who is responsible for each activity, shown as a swimlane. This technique enables the roles of each party to be clearly identified, including different providers, the consumer and, where relevant, the carer. Information sources (electronic or otherwise) can be shown as a separate swimlane to assist in specifying information systems needed to support the process.

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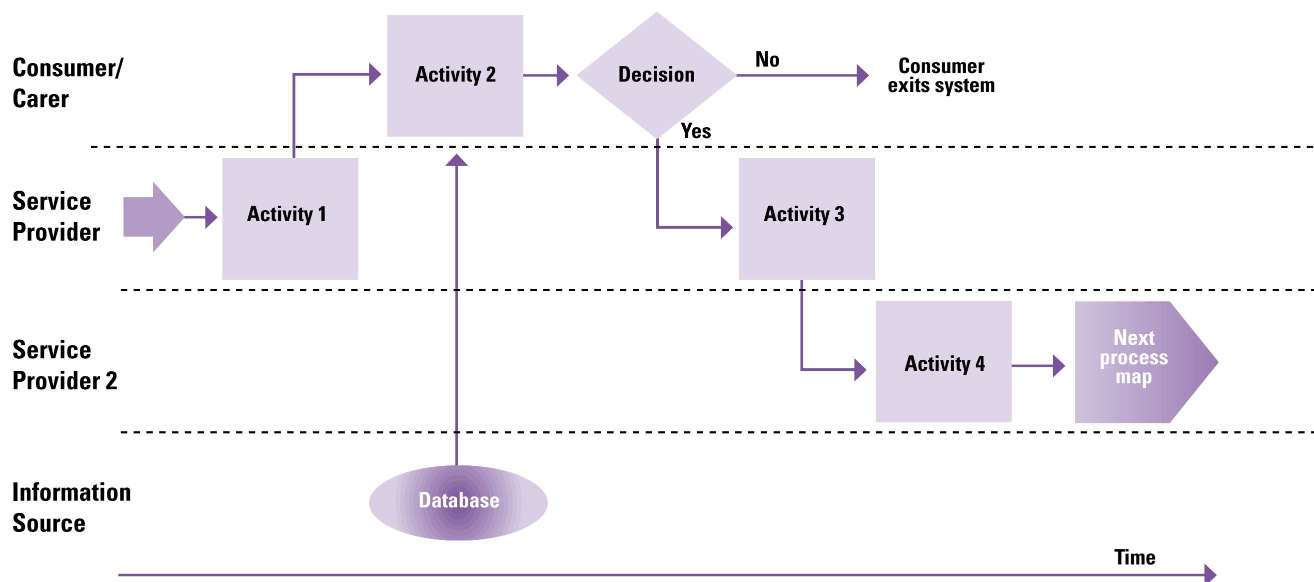
App Figure 9 Swimlane Process Mapping Technique



A representative group of providers who will be engaged in the new process should be convened, preferably under the guidance of a leader who has experience in process mapping. The team should agree how the process will work, including specifying the roles and responsibilities for providers from each agency involved.

Transfer of information between providers will be a critical element of the process. Initially, the most likely ways of transferring information will be by using a paper-based process. Other methods for information transfer could include sending data between systems or using a shared system. Using a shared system requires clear specification of responsibilities to ensure the consumer is not 'lost' in the system, nor receives inadequate or inappropriate care. Specification of data interfaces is critical if communications between systems is to be used. Obviously standard message formats should be used where they exist.

At the end of this step, the partnership should have an agreed protocol for how the interaction of consumers with the service system will be managed including an outline of the roles and responsibilities for each participant, an outline of systems required and specification of data flows to support the process.

C3 Management Considerations

The purpose of this template is to describe how the partnership will address the management considerations in order to implement the local operational framework for BATS. The Information Management Discussion Paper provides further detail and context to the considerations listed below.

Considerations for Consumers

How will consumers participate in the development of the information management practices, protocols, processes and systems to support the local framework for BATS?

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How will the partnership engender consumer confidence about the privacy and confidentiality of their information?

How will the partnership educate consumers about the local BATS model and how to navigate the system?

Considerations for Providers

How will the partnership engender confidence between providers sharing information?

How will the partnership meet the training and skills development needs of providers?

How will the partnership seek agreement with providers on new responsibilities derived from the local operational framework for BATS?

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C4 Current IT Audit Template

This template is to be used by agencies to identify how their current IT environment supports the processes developed for the future model of operation.

This table should be completed for each system used by an agency. (Text in *italics* is for guidance and should be deleted).

System Name	
Name of current system	*Name of current system which best matches the functional requirements for this target system.*
Details	*Relevant details about the system such as vendor, current installed version, when it was installed, its current operating environment, etc.*
Extent to which this application meets current business needs	*How well does this system meet the current user requirements?*
Extent to which this application meets future business needs	*How well does this system meet the functionality requirements of the target system?*
Maintenance and operation	*How much does it cost to maintain and operate? How easy is it to maintain and operate? Is maintenance timely? Is there adequate support for this system (within the agency and/or from the appropriate vendor)?*
Suitability for upgrades	*Is it a good technical platform for further upgrades? Does it have a continuing life cycle?*
Other/comments	*Are there any other issues which are relevant to the applicability of this system to meet future needs?*
Upgrade needed	*Describe what upgrade is needed to meet the target system requirements. In particular, identify if the system is fully capable now, needs enhancement or should be replaced. If it is to be replaced, the table in Appendix C should also be completed for this system.*

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This table summarises all systems used by an agency (or agency location for agencies which have more than one location within the PCP).

Current IT Environment **Agency (Location) Name** **Summary Table**			
IT Capability	**System Name**	**Suitability**	**No. of Staff Trained**
Cabling			N/A
Local area networking, file servers			N/A
PCs, office systems (word, spreadsheet, graphics, etc.)			
Electronic mail (email)			
Web browser			
Intranet/Internet access			
Appointments, booking or scheduling system			
Electronic Health Record (registration, needs, contact summaries, etc.)			
Case notes, case documentation system			
Financial management system			
Human resources system			
Activity reporting and costing system			
Department of Human Services reporting systems ■ SWITCH ■ ADIS ■ Others			

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C5 Target IT Requirements Template

This template is to be used to identify what IT capabilities are required and how they will be sourced.

This table is to be completed for each system needed by each agency and /or by the partnership (e.g. service directory and security management). (Text in *italics* is for guidance and should be deleted.)

System Name	
Name	*Name of the product or system to be developed (ie. Financial management system)*
Source	*How will the system be acquired? (e.g. purchase package, develop/build by preferred vendor, use system from a 3rd party, tender for solution)*
Hardware required: Specify configuration	Cost $,000 *Identify all hardware that needs to be acquired*
Software required: Application and databases operating system, utilities, etc. Security management	Cost $,000 *Identify all software that needs to be acquired*
Implementation	*Identify all implementation considerations including how long it will take, what training is required and the estimated cost.* ($,000)
Usage costs	*Identify all costs that are to be charged on a usage basis (e.g. per user, per Mb storage) and the total cost* ($,000)
Operating and maintenance costs	*Identify all costs that will be incurred to maintain and/or operate the system e.g. telecommunications.* ($,000 p.a)
Business prerequisites	*Identify anything which must be done before this system can be implemented.*
Other/comments	*Identify any other considerations that may need to be taken into account in the planning and scheduling of the implementation of this system.*

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This table summarises all systems to be acquired by each agency in the partnership.

Target IT Environment **Agency (Location) Name** **Summary Table**				
System Required	**Capital Cost**	**Ongoing Costs p.a.**	**No. Staff To Be Trained**	**Comments**
Cabling				
Local area networking				
File servers				
PCs, office systems (word, spreadsheet, graphics, etc.)				
Web browser				
Internet access				
Appointments, booking or scheduling system				
Case notes, case documentation system				
Financial management system				
Human resources system				
Activity reporting and costing system				

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This table summarises all systems to be acquired collectively for all agencies in the partnership.

Target IT Environment **Shared Services** **Summary Table**				
System Required	**Capital Cost**	**Ongoing Costs p.a.**	**No. Staff To Be Trained**	**Comments**
File servers				
Electronic mail server				
Service directory				
Internet access				
Security infrastructure				
Appointments, booking or scheduling system				
Shared Electronic Health Record (registration, needs, contact summaries, etc.)				
Case notes, case documentation system				
Financial management system				
Human resources system				
Activity reporting and costing system				
Reference information databases				

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C6 Project Brief Template

This template is to be used to define each project to be undertaken by the partnership. Each project should be structured to take about three months to ensure that achievable targets are set, and to develop a momentum of successful projects. Each project should have a clear deliverable at its completion, such as the implementation of an IT capability or a modification to improve the way a process works. Projects should be broken into stages to start with a simple capability for a small target group and progressively extend it to include more agencies or capabilities.

Project Name	
Objective	*Why this project is being done?*
Description	*What is being done in this project?*
Deliverables	*What business capabilities are being delivered by this project (infrastructure, applications, people skills)?*
Benefits	*What benefits can be expected to be delivered by this project? Benefits can be either qualitative or quantitative.*
Stakeholders	*Which stakeholders are affected and what is the extent of their involvement?*
Work Practices	*What changes to work practices are needed to implement this project?*
Accountability	*Who carries responsibility for each part of the project?*
Key Tasks	*What needs to be done to complete this project?*
Timeline	*When will this project start? How long will it take to develop and implement? When will it be completed? What are the major milestones?*
Resourcing	*Who should perform the tasks in this project? Where will they come from?*
Costs	*How much does this project cost to complete? What will be the ongoing cost of maintenance and operation of the new environment?*
Alternatives considered	*What alternatives are there to this project e.g. continue with current state? Why is the proposed alternative preferred?*

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C7 Financial Templates

These templates are to be used to cost each project and a cash flow summary to enable preparation of the partnership's budget.

Project Costing Model

This costing model can be used to determine the costs to complete the project plus any ongoing costs incurred (such as systems maintenance and support). Benefits include any cost reductions which can be directly attributed to the project such as support costs for replaced systems.

	Year 1		Year 2		Ongoing
Item	**Capital**	**Recurrent**	**Capital**	**Recurrent**	**Recurrent**
Technology					
Hardware					
Software					
Maintenance					
Services					
Communication					
Other Contracts					
Personnel					
Salaries					
Contractors					
Other Costs					
Benefits					
Current Systems					
Cash Flow					

Cash Flow Summary

The cash flow summary establishes the total costs to be incurred by the partnership over time.

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Project #1						
Project #2						
Project #3						
Project #4						
Project #5						
Total Cash Flow						

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C8 Project Management Template

This checklist is provided to assist partnerships to ensure that they have the necessary IM/IT management processes in place to successfully manage projects and implement the strategic plan.

Management Practice	Objective
Strategic Management	
Strategy Development	How are investment proposals developed and agreed by the partnership?
Financial Management	How are the costs of projects and services managed and apportioned?
Benefit Allocation and Management	How are the benefits of IT investment returned to stakeholders?
Priority Setting	How are projects prioritised?
Service Delivery Management	
Project Management	How are new services or changes implemented across all partnership stakeholders?
Vendor Relationship Management	How are products and services purchased? How are relationships with vendors maintained?
Information and Security Management	How is information managed and security is maintained?
Risk Management	How are risks identified and mitigation strategies implemented?