

Small Rural Health Services Data Collection & Reporting Project

Rural & Regional Health & Aged Care
Services Division

Final Report

April 2005

1. Purpose

The purpose of this discussion paper is to present the key findings and recommendations of Stage 1 of the Small Rural Health Services (SRHS) Data Collection and Reporting (DC&R) Project for consideration and comment.

2. Project overview

Objective and scope

The project set out to investigate the potential to improve the efficiency and relevance of data collection and reporting for SRHSs through streamlining Department of Human Services (DHS) requirements. Streamlining could include reducing the number or volume of reports as well as simplifying and consolidating the data collection and reporting process (the DC&R process is represented in figure 1 on page 3).

The project scope is collection and reporting of SRHS service delivery data (not financial reporting data¹) required by DHS that relates to RRHACS' and Metropolitan Health and Aged Care Services' (MHACS') programs.

Methodology

The project team undertook in-depth consultations with six SRHSs, who provided a detailed account of their current data collection, reporting and analysis arrangements, their needs and preferences, and how they deal with data requirements from multiple DHS programs. Regions were invited to attend these consultations. Representatives from programs in SRHS scope were also consulted about elements of data collection and reporting relevant to them, use of agency information and current initiatives to streamline data collection and reporting processes for agencies.

Information collected was verified with the six SRHSs, and a discussion paper including recommendations was circulated to all 66 SRHSs as well as DHS programs and regions for comment. The recommendations were based on detailed analysis of the potential benefits to agencies, when the proposals could be implemented by, and links to other projects and initiatives. While the discussion paper did not try to address everything raised during the consultation, the recommendations were those believed to represent real opportunities for change, i.e. that are feasible for DHS and agencies to implement and will reap benefits for agencies.

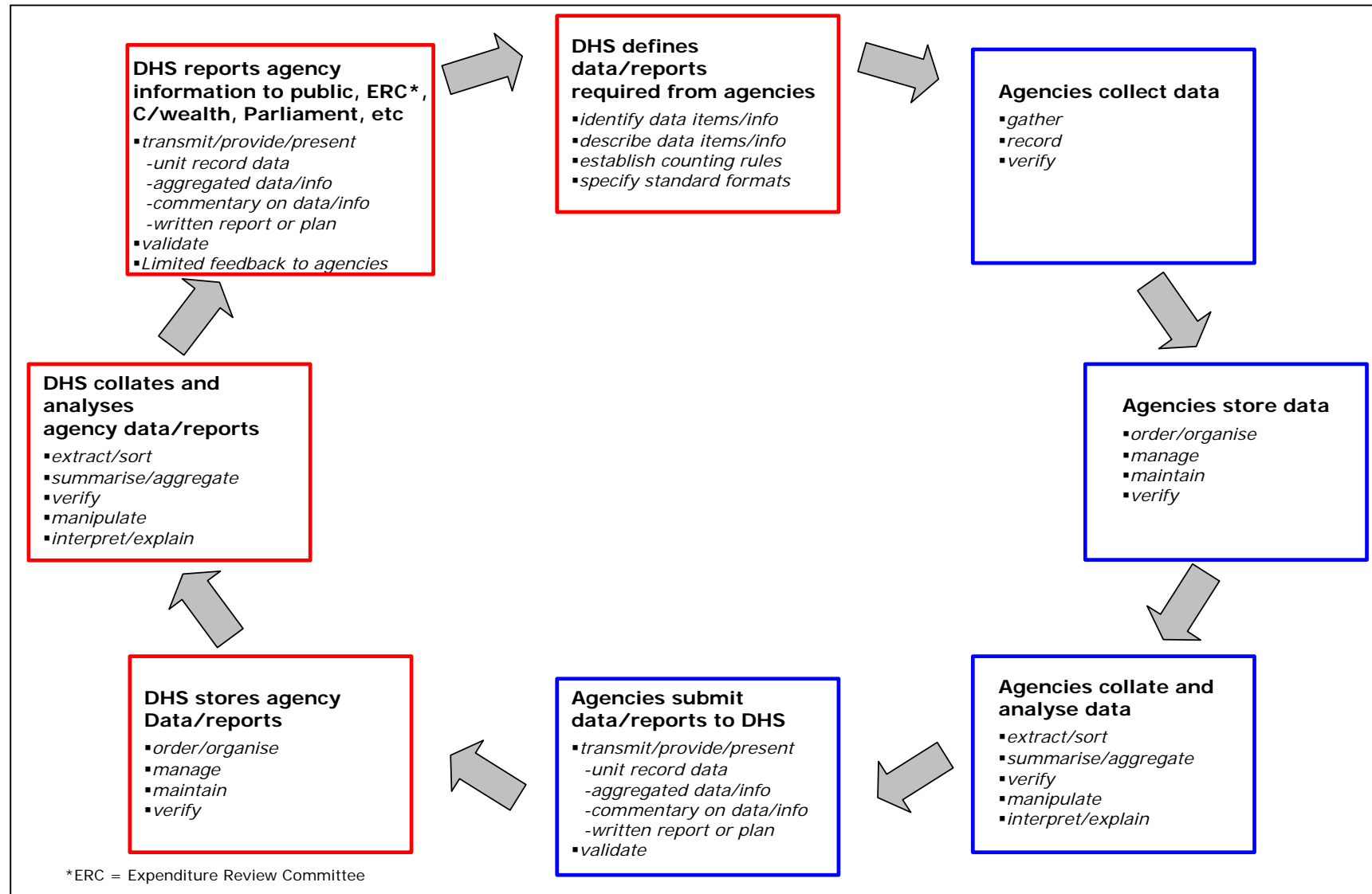
Feedback received on the discussion paper and recommendations was positive (8 SRHSs responded), and minor changes made to develop this final report.

¹ While financial reporting is outside the scope of this project, a summary of financial reporting issues raised by the six agencies has been forwarded to appropriate staff in RRHACS.

3. Data collection and reporting process and its elements

Agencies and DHS play various roles in data collection and reporting processes, illustrated in the following diagram. While this diagram is focussed on reporting to DHS, agencies also collect, store, analyse and report information for a variety of other purposes. These data collection and reporting elements underscore the fact that data collection and reporting is a complex interconnected system.

Figure 1: Key Data Collection and Reporting Elements



4. Key Findings

The key findings from consultations with agencies and DHS program representatives are outlined below. Statements made about 'agencies' or 'SRHSs' represent the views of the six volunteer agencies.

Data collected by SRHSs

- Most data collected is useful and meaningful for both agencies and DHS

Generally, the data collected as a requirement of DHS is data agencies are collecting anyway to provide services and run their organisation. It should be noted, however, that some agencies found it difficult to distinguish between DHS requirements and their own as they had built a lot of their processes and structures around what DHS requires. The reporting of agency data often differs significantly for different audiences such as internal management, boards and DHS. For example, most agencies provide separate reports to their board containing much more summarised information compared to what is provided to DHS.

- Most agencies do not receive many ad hoc requests for service delivery data.

Although some agencies receive a high number of ad hoc requests from DHS, the majority of these are for financial information, rather than service delivery data.

Relationship between DHS reporting requirements and SRHS service provision

- DHS reporting requirements do not adequately reflect SRHS service provision

Some agencies felt that the volume of reporting required by DHS was high and out of proportion to agency size and volume of service delivered, particularly in a small rural setting. Other agencies felt that the volume of reporting was not onerous, but that reporting should better reflect the actual services provided. For example Bush Nursing Centres (BNCs) undertake a variety of health promotion type activities and currently include them in HACC reports, which are not adequately set up for these types of activities. This is due to limitations associated with HACC funding and reporting under the SRHS approach

BNCs and Multi Purpose Services (MPSs) are currently providing Accident and Emergency Services which are reported reported to DHS by some MPSs but not by others and not reported at all by BNCs. The BNC and MPS agencies consulted agreed that Accident and Emergency Services data would be useful for DHS as well as agencies.

There appear to be some different understandings about DHS reporting requirements for MPSs under the SRHS approach - these require clarification.

(See recommendations 1, 2 & 3)

DHS management of data collection and reporting requirements and processes

- DHS does not view data collection and reporting requirements from an agency or cross program perspective

Agencies are very supportive of the SRHS approach and the flexibility this allows to better target funds to community need. Agencies felt, however, that DHS program specific approaches and requirements are contrary to the SRHS approach and continue to create barriers to effective integrated service delivery and streamlined reporting. Some examples of this are provided in the points below.

- Reporting requirements across DHS programs are inconsistent

Many SRHSs have a large number of funding streams and operate with limited resources which makes inconsistencies across DHS programs with respect to reporting requirements problematic. In particular, different counting rules across multi-funded

disciplines such as allied health, nursing and counselling can make reporting and data comparisons difficult for agencies. For example, an agency might have one physiotherapist funded partly through HACC and partly through Primary Health. When it comes to reporting hours of physiotherapy, the hours are split according to each funding source and each program's different definition of a service hour, and then reported to each program separately. Agencies agreed, however, that this issue can often be addressed through an IT solution. Another option under the SRHS approach is to fund the physiotherapist under either HACC or Primary Health and only report to one of these programs.

- Reporting tools and Minimum Data Sets (MDS) across DHS programs are inconsistent

The number of different reporting tools developed for different DHS programs that ask for information to be presented in different ways is an issue for agencies. Also, agencies questioned the need for DHS to collect a number of different minimum data sets (unit record level client data collections) containing essentially the same or similar information. Agencies suggested that DHS should be moving towards rationalising the many different minimum data sets that it requires from agencies, establishing core information needed from all clients and requesting it in a standard way.

- Some reporting tools require double entry of information

Agencies enter at least some of their data twice or more in order to report to DHS, which increases the workload and risk of error. For example, for some programs, DHS reporting tools and formats require data to be downloaded or printed from a client information system, then re-typed into the DHS reporting format - AIMS is an example of this. However, Funding and Financial Policy Branch in MHACS are currently undertaking a review of AIMS with a view to streamlining reporting for agencies, for example by identifying and reducing duplicate reporting and the need for double entry of data.

- In some cases DHS requests the same information in different reports

In some cases the same information is requested in different reports, sometimes at a different level of aggregation - one example of this is the *HACC Quarterly Output Data Collection* which is aggregated information that is also provided to DHS in the *HACC Minimum Data Set*. However, HACC plan to consolidate some of the fields required for the *HACC Quarterly Output Data Collection* in 2004-05, and by the start of 2005-06 to remove the requirement to submit the *HACC Quarterly Output Data Collection* (information to be derived from the *HACC National Minimum Data Set* instead).

Primary Health has developed a 'Multipurpose Report' which essentially consolidates many of the Community and Women's Health reports into one to streamline the collation, analysis and reporting process for agencies. All data collected in the Primary Care, Health Promotion, Fees, DVA, Client Type and Registered Clients reports are consolidated into the single Primary Health Multipurpose Report. The Primary Health Multipurpose Report is currently available to agencies using PJB Software but it is likely to also become available to agencies using JADE (care) and Ballarat District Nursing software.

- Changes to data collection and reporting requirements are not coordinated across programs

Programs in scope of the SRHS approach currently review data collection and reporting requirements on an individual program basis. In some cases, where there is a shared electronic application (such as SWITCH which is a reporting tool for Primary Health, HACC and Drug Services) representatives from relevant programs will meet regularly to discuss any changes. Programs also meet on an ad hoc basis around specific data collection and reporting issues.

Agencies felt that changes to data collection and reporting requirements generally involve the inclusion of additional data items rather than any data items being removed. Some agencies suggested there should be more scrutiny of changes to data collection and reporting requirements across programs within DHS to ensure items no longer required are removed, that there is a genuine business need for additional items, and that additional items are not already being collected by another program within DHS.

- Clarity and common language are important

As a general comment, agencies stressed the importance of clear requirements, with all data fields clearly explained and labelled so agencies are all counting the same thing. In addition, agencies felt that where possible, different areas of the department should use common terminology and definitions in relation to data collection and reporting. For example, currently an 'hour of service' in HACC has a slightly different meaning to an 'hour of service' in community health, even though the 'service' being provided may be the same (eg. Physiotherapy) and may be provided by the same practitioner.

(See recommendations 1 & 5)

SRHS management of data collection and reporting requirements and processes

- Agencies manage data collection and reporting requirements in different ways

There were significant differences in the way agencies manage data collection and reporting in terms of internal agency processes, systems used, the volume of resources devoted to data collection and reporting, and the level of importance attributed to meeting data collection and reporting requirements.

There was also wide variation in which elements of data collection and reporting or which particular data or reports different agencies found straightforward and which they found onerous. In part this was related to the tools that agencies use to manage information and data, which vary from manual paper-based systems to electronic integrated client and case management systems. Those using more integrated electronic systems found it much easier to manage data collection and reporting and meet DHS requirements, as did those delivering fewer service types.

Agencies cautioned that any significant changes to DHS reporting requirements should be made in a considered way as changes usually increase agency workload in the short term because of the need to alter agency processes, databases and systems.

- Some agencies would prefer more frequent reporting

Most agency reporting to DHS is currently required quarterly. Some agencies expressed a preference for monthly reporting - these agencies felt that undertaking the reporting process more regularly would increase staff familiarity with the process, systems and applications used, and increase opportunities for identifying errors in a timely manner. Other agencies and program areas consulted preferred quarterly reporting arrangements. Discussions within DHS indicated a reluctance to move to monthly reporting for all SRHSs given that some prefer quarterly, and that a mix of monthly reporting from some agencies and quarterly reporting from others would be problematic to manage. It was suggested that where preferred, a monthly reporting process could be undertaken within the agency, and reports continue to be submitted to DHS on a quarterly basis.

- Agencies would like increased support from DHS to improve internal data collection and reporting processes

While it is acknowledged that agency data collection and reporting processes are an internal agency management issue, agencies felt DHS could better support them to improve these processes. For example, DHS could improve communication with agencies about the resources and assistance available. It appears internal agency communication in relation to data collection and reporting could also be improved in some cases, so that data collection and reporting related information filters through to all relevant staff. For example, some agency staff were not aware of the Funded Agency Channel (FAC) and the type of information that could be accessed there.

Agencies felt it important for DHS to recognise that significant differences exist between agencies and some will require more support than others, or different types of support for different things.

- Data collection and reporting processes can be significantly improved through IT solutions

Agencies felt that using the appropriate hardware and software, and increasing integration within or between systems would address many of the current problems associated with the data collection and reporting process. Integrated IT systems such as PJB, BDNS and JADE (care) are the most favoured by agencies.

- In the longer term, agencies would prefer to submit data to DHS at unit record level

In general, agencies would prefer to submit information electronically at the lowest level of aggregation (unit record), and for DHS to aggregate the information as needed.

Based on consultation, the ideal data collection and reporting scenario for agencies is:

- Collect and enter client data into an electronic application once as an integral part of service delivery
- Data is stored electronically and can be easily extracted, manipulated, and analysed as needed
- Electronic application is set up to enable automatic generation of all necessary reports to meet agency needs and DHS requirements

(See recommendations 1, 5 & 6)

Use of agency data and reports

- Feedback to agencies about data submitted to DHS is low

A number of agencies commented on the importance of DHS acknowledgement that reports submitted by agencies have been received. In some cases programs do not acknowledge receipt of reports and in others programs do acknowledge receipt but it appears not all agency staff involved in the preparation of reports are aware of this feedback. The project team will further investigate the extent to which receipt of reports is acknowledged by programs and seek to improve on current arrangements.

Agencies acknowledged that current feedback reports provided by DHS on reports submitted are very useful, but felt that in general, feedback provided is low relative to the volume of information requested. Primary Health and HACC provide feedback; Acute Health, Aged Care and Drug Services currently provide little or no feedback to SRHSs on reports submitted. While these programs acknowledged the need and expressed willingness to provide feedback to agencies, they have limited resources available to do so.

Agencies would like to receive feedback reports on all service delivery data submitted, and any efforts to consolidate feedback across programs would be strongly supported. This type of information would assist agencies to plan and lead to improvements in data quality which is variable across SRHSs at the moment. Benchmarking information would also greatly assist agencies and allow them to make meaningful comparisons with other agencies. One suggestion for the longer term was to de-identify all agency service delivery data and make it available on line at a detailed level for agencies to access.

- Agency data is used for a variety of purposes

Programs use data submitted by agencies to report to the Department of Treasury and Finance (DTF) and account for expenditure of funds; monitor performance at agency, regional and state level; inform program planning and policy development; support bids to treasury for additional funding; and support and inform decisions about how funds are allocated.

There is a perception in some agencies that DHS doesn't need or use all of the data that it asks for.

Agencies see value in using their own service delivery data for internal agency management and service planning purposes. For most agencies consulted, having the resources to devote to this was an issue. Those agencies using more advanced electronic systems were better able to utilise service delivery data.

- Agencies would like assistance from DHS to access additional service planning information

In addition to service delivery data, access to other relevant service planning information such as population based data is an issue for agencies. Agencies would like more information about what is available and support to access and utilise this information. Access to this type of information is particularly important in the context of the flexibility of the SRHS approach and the opportunities it provides for agencies to reconfigure their service provision in order to meet community need.

Assistance with service planning for rural agencies is part of the role of the Rural and Regional Health Branch at DHS and the project team will ensure these issues are raised with the relevant staff.

(See recommendation 4)

5. Recommendations for DHS

Context for Recommendations - related DHS projects & initiatives

Recommendations should be considered in the context of related DHS projects and initiatives currently underway. These are summarised below:

- The SRHS Project Team are undertaking a broader Data Project which includes the collation of SRHS service delivery data and other comparative information using existing data sources. The project aims to monitor changes in SRHS service delivery and to provide SRHSs with comparative information to assist them in exploring possible change and improvement under the SRHS approach.
- The RRHACS Common Business Information Model² Project has compared client level data collections (including Minimum Data Sets) for Drug Treatment, HACC, Aged Care Assessment Program (ACAP), Victorian Admitted Episodes Data Set (VAED) and Community and Women's Health to identify commonalities and differences. In principle approval has been secured to rationalise client data in these key RRHACS Programs. As this work raises complex issues implementation plans are still being developed and once finalised will be provided to agencies. The longer-term goals of the project include, where relevant, integrating program specific data requirements.
- The MHACS Data Collection Review Project has reviewed collections managed by MHACS. The recommendations propose a cross-divisional approach, in recognition that effective reform from the agency perspective must avoid demarcations based on DHS programs. Strategies for implementing the recommendations are currently being developed.
- The Flexible Funding Models Flagship Project is conducting a series of pilots to explore the use of more flexible funding models for DHS funded agencies. The project is expected to investigate the potential to streamline reporting in line with flexible funding models.
- The Partnership Flagship Data Collection and Performance Reporting Reform Strategy Project aims to reduce reporting costs, eliminate duplication and improve the value of data through smarter deployment of information resources. A number of projects including the RRHACS Common Business Information Model project fit within this strategy.

² A business information model can be defined as the structure, content and relationships of the information used by an organisation's business

Recommendations

While this discussion paper and project are specific to the agencies and DHS programs in scope of the Small Rural Health Services funding approach, many of the recommendations could potentially have application more broadly across the Department.

The table below outlines each of the recommendations, lead responsibility for implementation, key contributors and timelines. The SRHS Steering Group will monitor overall progress, provide input and make decisions as necessary. Additional program input will be sought where relevant.

Recommendation	Lead Responsibility	Key contributors	Timelines
1. Convene a group of DHS staff across all Health and Aged Care programs to: <ul style="list-style-type: none"> ➤ Review and streamline the suite of agency reports currently required by DHS Health and Aged Care programs, ➤ Act as a governance body for any increase or changes to agency reporting required by Health and Aged Care programs, ➤ Consider SRHS reporting requirements specifically as an early project 	Planning & Resources (Information Management Strategies)	Group members	Convene group by end April 2005 to have an ongoing role
2. Review reporting requirements for Bush Nursing Centres to ensure activities such as health promotion can be appropriately reported under the SRHS model	Rural & Regional Health Services (Operations)	Planning & Resources (Divisional Projects, Strategy & Coordination), Primary & Community Health, Home & Community Care	Revised reporting implemented from July 1 2005
3. Review and clarify reporting requirements for Multi Purpose Services to ensure activities can be appropriately reported under the SRHS model	Rural & Regional Health Services (Operations)	Planning & Resources (Divisional Projects, Strategy & Coordination)	Revised reporting implemented from July 1 2005

Recommendation	Lead Responsibility	Key contributors	Timelines
4. As part of the SRHS Data Project, provide consolidated service delivery data and comparative agency information to SRHSs	Planning & Resources (Divisional Projects, Strategy & Coordination)		First release of comparative agency information by end April 2005 , supplemented by service delivery data by end July 2005 <i>Note the first release has already occurred.</i>
5. Based on outcomes of recommendation 1, evaluate the feasibility of developing a common unit record level data collection for SRHSs to replace existing multiple reporting requirements	Planning & Resources (Information Management Strategies)		Evaluation completed by end Dec 2005 (contingent on outcome of recommendation 1)
6. Support SRHSs to evaluate available electronic applications and use those that can best assist them to manage clients and information by: <ul style="list-style-type: none"> <li data-bbox="152 799 797 895">➤ Facilitating information sharing among SRHSs about electronic applications, for example through SRHS Forums <li data-bbox="152 975 797 1038">➤ Running or informing SRHSs about existing user forums for appropriate applications <li data-bbox="152 1118 797 1214">➤ Informing SRHSs about opportunities to purchase hardware and software via the whole of government licence agreement 	Rural & Regional Health Services Rural & Regional Health Services Planning & Resources (Information Systems & Services)	Regions, Planning & Resources (Info Management Strategies, Info Systems & Services) Regions, Planning & Resources (Info Management Strategies, Info Systems & Services) Planning & Resources (Information Systems & Services)	Ongoing as needed Ongoing as needed Information to SRHSs by end July 2005

Attachment 1: Small Rural Health Services consulted

Agency name	CEO name	Town(s)	DHS Region
Beaufort and Skipton Health Service	Peter Appledore	Beaufort Skipton	Grampians
Cobaw Community Health Service Inc	Alan Taylor	Kyneton Woodend	Loddon Mallee
Lake Bolac Bush Nursing Centre Inc	Lorraine Box	Lake Bolac	Grampians
Numurkah District Health Service	Trevor Carr	Numurkah	Hume
Otway Health and Community Services	Jeanette Grant	Apollo Bay	Barwon South-western
Yarram and District Health Service	Peter Craighead	Yarram	Gippsland