Australian Government
Department of Health

PRIMARY MENTAL HEALTH CARE MINIMUM DATA SET

Department response to issues raised by PHNS

16 SEPTEMBER 2016

This paper is designed to complement the document 'Primary Mental Health Care Minimum Data Set: Overview of purpose, design, scope and key decision issues'

Feedback from PHNs was received in response to an initial draft of the Overview paper, covering a wide range of issues. Around 80 issues were raised. PHNs were broadly supportive of the directions being taken, while acknowledging that considerable work will be required to establish the new arrangements.
The questions raised have been summarised into nine categories below, along with a Departmental response to all queries.

Version History

Date	Details
10 August 2016	Version prepared for initial consultation with PHN PMHC MDS Reference Group
16 September	Version prepared to accompany release of V1.0 of PMHC MDS specifications

Contents

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1. QUESTIONS ABOUT THE SCOPE OF THE MDS

PHNs raised a number of questions regarding the scope of the MDS and whether specific areas of commissioned activity were intended to be covered. The Overview paper covers the scope issue (page 4), an extract of which is copied below:

> *"The new arrangements are designed to capture data on PHN-commissioned mental health services* ***delivered to individual clients, including group-based delivery to individual clients*** *…*
>
> ***The scope of coverage will not extend to services targeted at communities****, such as the community capacity building activities previously funded under projects sourced from National Suicide Prevention Program funding. Collection and reporting of activities of this type requires a different approach to 'counting' and identification of the 'client'. PHNs commissioning activities of this type will have flexibility to establish local data reporting arrangements that suit requirements."*

PHNs raised a number of questions to further clarify the scope of the PMHC MDS, summarised below.

Issue	Question	Response
Coverage of community-based suicide prevention activities	Activities such as mental health and suicide awareness training and whole of community health promotion programs (non-clinical services) (e.g., Farm-Link). targeted at groups or whole communities, are not a good fit for the PHMC MDS They are currently reported to the National Suicide Prevention Program) MDS which finishes on the 30th June 2016. What is the mechanism for the future?	PHN-commissioned services of this type are outside the scope of the PMHC MDS. Regional whole-of-community suicide prevention activities previously funded directly by the Department and now transferred to PHNs (e.g., Farm-Link) have previously reported to the National Suicide Prevention Program MDS managed by Australian Healthcare Associates under contract to the Department. The Department is currently exploring options to continue this collection and will advise PHNs accordingly, with a view to ensuring continuity of reporting of community-based suicide prevention activities. Suicide prevention oriented services provided to individuals are in scope for collection and reporting to the PMHC MDS.
Coverage of digital health services	Are the PHNs expected to collect and upload all of the data outlined under the 6 Mental Health Priority Areas? If so it will be difficult to collect this data for referrals made to e-mental health sites such as mood gym, mind spot etc. There are also challenges around self-help groups.	As indicated, scope of coverage is all PHN-commissioned mental health services delivered to individual clients, regardless of mode of service delivery. Digital health services present particular challenges that need to be unbundled to resolve a way forward. Where PHNs refer the consumer to self-help, clinician unmoderated assistance (e.g., Mood Gym), this is not a PHN-commissioned service as such and falls outside of the scope of collection. Similarly, referral to a nationally funded clinician-moderated service such as Mindspot is not a PHN-commissioned services and falls outside of

Issue	Question	Response
		scope, bypassing the need for data collection. However, there are acknowledged issues where a PHN enters a funding agreement with a digital health provider to provide individually tailored, clinician-moderated services to specific populations within their regions. Such services clearly fall within scope. The Department is considering the options to capture the required data. These include setting up arrangements for digital providers to collect and submit data on behalf of PHNs.
Coverage of whole of region services regardless of who funds	Are we only reporting on services and processes that we are commissioning and undertaking or the region as a whole?	The PMHC MDS is designed to cover only those services commissioned by PHNs.
Appropriateness of occasions of service as a counting measure	This unit of counting is not appropriate for the full range of services that might be commissioned by PHNs, for example, whole of community-oriented prevention activities	This is agreed. The scope of the PMHC MDS does not cover every activity that a PHN may commission. Where activities are outside the scope of the PMHC MDS, PHNS are expected to set up their own arrangements to collect data suitable for reporting purposes. See also the response above regarding community-based suicide prevention activities.
Exclusion of 'non clinical' time	The MDS only captures actual clinical time. Administrative tasks such as arranging for case conferences, updating electronic health information records, undertaking program contractual management tasks, travelling to service provision venue amongst others, are currently not being captured.	The focus of the PMHC MDS collection is on clinical service delivery to individual clients. It is acknowledged that clinician have to undertake other activities to maintain their clinical work and time spent on these can be significant. However, any broadening of scope to include as mandatory other activities would create an unacceptable data reporting burden on clinical service providers, all of whom are practitioners independent of the PHN. It should be noted however that the PMHC MDS differs from the previous ATAPS collection in allowing a range of services delivered 'on behalf' of the client to be recorded. Section 4.4 of the Overview paper ('Determining what activities are in scope for reporting as service contacts") provides the relevant details.
Are headspace services covered by the requirements?	Are services funded through headspace expected to collect the PHMC MDS?	First-stage development of the MDS will not include existing youth-specific services (headspace, Early Psychosis Youth Services) that currently collect and report a standardised dataset to headspace National Office. Pending the future of these arrangements, and access to data by PHNs, the PHMC MDS can be expanded at a future stage to allow incorporation of headspace and Early Psychosis Youth Services should this be required.
Are EPYS centres	Are services funded as Early Psychosis Centres expected to	See headspace services response above.

Issue	Question	Response
covered?	collect the PHMC MDS?	

2. QUESTIONS ABOUT SPECIFIC DATA ITEMS AND DEFINITIONS

PHNs raised a number of queries about specific data items and definitions. These are listed below.

Issue	Question	Response
Diagnosis	Is this required across all service delivery areas, including low intensity services?	Yes. While low intensity workers will not be qualified to assign a clinical diagnosis, it is expected that they will be working under the supervision of a clinically qualified mental health professional.
Diagnosis - DSM-IV	Why isn't DSM-V used as the standard given that that is the most current classification system?	The DSM-IV is the diagnostic classification currently used by the majority of Australian mental health clinicians. Any move to DSM-V would require confidence that most clinicians providing services through PHN commissioning arrangements have had training in, and moved across to, the new system. The Department does not believe that this is the case. Pending uptake of DSM-V, there is scope to change to the new classification in future versions of the PMHC MDS. Additionally, as the diagnostic codes included in the PMHC MDS represent an abbreviated 'pick list', the decision to use either DSM-IV or DSM-V will not have material impact given the substantial common ground between the two classifications.
Episode-Completion Status	If the client is referred elsewhere (i.e. not suitable for this service) would this be recorded as "Episode closed administratively-other reason" or should there be an additional code to capture this information?	Under the new PMHC MDS, an episode does not formally commence until the client receives their first Service Contact. For referrals that do not lead to a Service Contact, and where the person is referred elsewhere, there is no need to open an Episode. However, based on previous experience with the ATAPS system, the Department understands that many PHNs are likely to want to do this as a means to track referrals that do not lead to Service Contacts, or to begin entering data prior to the first Service Contact. Therefore, there will be scope in the system to set up an Episode even it does not lead to a Service Contact. Standard reports to be developed will build in capacity to monitor these and ensure that they are not counted in service delivery indicators. Where a referral is followed by an initial Service Contact, and the person is referred elsewhere due to being assessed as not suitable, or requires an alternative service, a new code for Episode- Completion Status has been added

Issue	Question	Response
		('Episode closed administratively - client referred elsewhere').
Gender	Should there be consistency in how Practitioner and Client gender are collected?	Yes. The data coding options are the same for both items and based on the new standards recently released by Australian Government Guidelines on the Recognition of Sex and Gender.
GP mental health treatment plan	Can we include an item to capture whether the client has GP mental health treatment plan? Would be very useful from a planning and commissioning perspective.	The Department agrees that this is a useful item for both PHN and national purposes. It has been added to the final Version 1 specifications and is to be reported at the level of Episodes of Care.
Practitioner category	Should there be separate categories for accredited mental health social workers and occupational therapists in mental health?	The coding options allows for separate identification of social workers and occupational therapists. PHNs are free to add additional details to their local collection on the proviso that any additions are capable of being mapped to the national MDS categories.
Principal Focus of Treatment Plan – Psychological Therapy	Is the Department going to provide a firm definition of a mental health professional under the new specifications – noting the intent of increased flexibility to provide a workforce of mixed and flexible professional background?	The concept of 'mental health professionals' has a specific meaning defined in the various guidance documentation prepared to support PHNs in implementation of reforms. It refers to service providers who meet the requirements for registration, credentialing or recognition as a qualified mental health professional and includes: • Psychiatrists • Registered Psychologists • Clinical Psychologists • Mental Health Nurses; • Occupational Therapists; • Social Workers • Aboriginal and Torres Strait Islander health workers.
Provider organisation – solo practitioners	If the organisation is a sole trader private practitioner, does the organisation name become the providers name?	The sole practitioner should use the trading name against which they have registered their ABN.
Provider Organisation ABN	Why is this needed?	Understanding the characteristics and number of Provider Organisations is important for both regional and national planning purposes, and requires an approach that uniquely identifies organisations. While Provider Organisation identifiers are set up by PHNs, these are only unique at the regional level. They therefore do not allow a national picture of the number and type of organisations engaged

Issue	Question	Response
		in the delivery of primary mental health care. The ABN provides a simple and nationally unique organisation identifier. Organisation ABNs are also public domain information, being available via the Australian Business Register website.
Service contact - Definition	Does the definition extend to the writing of reports to assist the client in accessing appropriate services etc (although this may not involve 2 people)?	No. See response to "Exclusion of 'non clinical' time" under section 1 'Scope' above. As stated in the Overview paper, Service contacts are defined as "the provision of a service by a PHN commissioned mental health service provider for a client where the nature of the service would normally warrant a dated entry in the clinical record of the client and: - must involve at least two persons, one of whom must be a mental health service provider, and - can be either with the client or with a third party, such as a carer or family member, and/or other professional or mental health worker, or another service provider."
Service contact - Duration	It is unclear if the expectation is to calculate all occasions of contact for an individual consumer over an entire 24-hour day or every individual contact recorded separately. A 24-hour or full work day summation of time would be useful.	In general, it is expected that each Service Contact is reported separately. However, PHNs have discretion on how to handle multiple contacts on a single day. The approach taken will depend on how PHNs commission and remunerate service providers. We have assumed that most services will be paid on a service contacts-as-delivered basis, and thus PHNS will want to track these. But where PHNs opt to remunerate at whole-of-episode of care basis, aggregating Service Contact-Duration to whole days may be a more efficient approach.
Service contact – No Show	When item "Service Contact - No Show" is selected as "Yes", it would be useful to capture how that time of appointment was used.	The creation of the 'No Show' item represents a carry-over from the previous ATAPS collection, and was created at the request of the former Medicare Locals to monitor the extent to which this was impacting. As it does not represent a service contact as such, the Department does not believe it to be reasonable to require practitioners to report on how they used the 'no show' time.
Service Contact – Type	This item includes limited options of the actual service function delivered e.g., more detailed information - CBT, ACT, DBT, mindfulness etc. These are all grouped under the category of structured psychological	The approach taken in the PMHC MDS is to use a higher level grouping of interventions provided at each contact, designed to provide a simpler set of options for the practitioner to select from. More detailed lists of intervention types, where the provider is required to select from a long list of options, creates 'selection burden' on the provider and has proved of doubtful reliability. The former ATAPS system used a more detailed reporting on interventions, with practitioners reporting on the types of psychological interventions used, but this has not proved

Issue	Question	Response
	intervention.	to be useful for regional or national purposes.
Service Contact – Type	Is it possible to obtain further examples of "structured psychological interventions" and "other psychological interventions"? e.g., where would narrative therapy fit?	The rationale for this item is explained in the Overview paper, along with definitions of the following major categories: • Assessment • Structured psychological intervention • Other psychological intervention • Clinical care coordination/liaison • Clinical nursing services • Child or youth specific assistance NEC • Suicide prevention specific assistance NEC • Cultural specific assistance NEC Exhaustive inclusion lists are not provided, but structured psychological interventions are indicated to include, but not be limited to: • Psycho-education (including motivational interviewing) • Cognitive-behavioural therapies • Relaxation strategies • Skills training • Interpersonal therapy Narrative therapy would best fit in the category 'Other Psychological interventions', defined as those psychological interventions that do meet criteria for structured psychological intervention.
SLK	Statistical linkage keys - will these be generated in a similar manner to the ATAPS MDS?	Yes. Details on how they are created, currently available on the ATAPS website, will be included in the support resources to be progressively incorporated on the PMHC MDS website.
Source of cash income, Income range	What is the rationale for these items? They are not relevant to PHNs and providers may not be comfortable in asking the questions.	Both items were intended to address key indicators of socioeconomic disadvantage of the consumers using PHN-commissioned services. The intent is to replace the previous 'low income' data item of the previous ATAPS/MHSRRA dataset which was poorly defined and of doubtful reliability. Based on discussions we believe the intent of these data items is understood by most PHNs. 'Source of cash income' is a standard Meteor item that importantly, identifies whether the consumer is receiving government income support through a Disability Support Pension or other means. It is used in a number of data collections covering Australia Government funded human services. Income range was intended as a supplementary measure to identify low income consumers. The Department has

Issue	Question	Response
		considered the feedback and agrees this data item is not the appropriate approach. It has been replaced by an alternative item – 'Health Care Card holder'. The Department considers it essential for the data collection to have a reliable approach to identifying consumers who are economically challenged.

3. QUESTIONS ABOUT STANDARD OUTCOME MEASURES

Issue	Question	Response
Consumer experience measures	Why isn't a measure of consumer experience of services added to the PMHC MDS? This is needed to capture a person centred approach to commissioned services. Is the Department planning on developing a standard measure for use by PHNs?	The Department has previously acknowledged the importance of capturing consumer experience of service delivery as an essential measure of service quality. Considerable work has been funded by the Department since 2010 to develop the 'Your Experience of Services' (YES) consumer survey instrument that is currently being rolled out in several state and territory mental health services and non-government agencies. However, this instrument will need modification to enable a better fit to primary mental health care services and the Department will give this consideration. It is agreed that a nationally consistent tool is highly desirable. An important caveat is that, assuming a national tool is developed, any collection would sit outside a routine minimum data set collection. Consumer experience measures are usually offered to consumers on a voluntary, opt-in basis and are completed anonymously in way that is not linked to MDS data. They are also usually collected on a periodic basis (e.g., annually) rather than as a routine requirement of service delivery, unlike standard outcome measures. Further work on this will be considered as a component of establishing a quality framework for primary mental health care services.
Alternative outcome measures – for severe mental illness	The K10 has been selected as the outcome tool across all populations. Is there scope to include an alternative measure for those with severe mental illness?	The issues entailed in the specification of mandatory outcome measures are covered in section 4.7 of the Overview paper. Key selection criteria include that the core measures should be meaningful and applicable across all client groups, be capable of being used by all service providers, and reflect the client's perspective – that is, be based on self-report. The K10 is regarded as meeting all these essential elements. An important note is that the K10 is the mandatory measure used by four state and territory jurisdictions' specialised mental health services which predominantly focus on consumers with severe

Issue	Question	Response
		mental illness. Nationally, the K10+ is the consumer self-report outcome measure that has the highest level of consumer uptake across state and territory mental health services. Each PHN has the capacity to add additional outcome measures to their own regional data collection systems to meet local requirements but these are not necessary for reporting the national data PMHC minimum data set.
Alternative measures – additional measures set by PHNS	Can the measures be extended to include the Depression, Anxiety Stress Scale (DASS) and Modified Scale Suicide Ideation (MSSI)?	As per above, each PHN has the capacity to add additional outcome measures to their own regional data collection systems to meet local requirements but these are not necessary for reporting the national data PMHC minimum data set.
Mandatory measures – applicable to all priority areas?	Is the K10 and SDQ for children going to be required across all priority areas?	Yes – noting that the K5 is included as an alternative to the K10 for use with Aboriginal and Torres Strait Islander clients.
Use of collection reported by Referrer	Does the collection occasion date (for the first outcome measure) need to correspond to the first service contact date? It is possible that the referrer may have already completed this measure with the client at time of referral.	The first Collection Occasion for the outcome measure should correspond as closely as possible to the Episode Start date. If the measure has been collected and reported by the Referrer shortly before this date, it is acceptable for those scores to be used even though it will predate the Episode Start date.
K5 for Aboriginal and Torres Strait Islander population	The definitions document details the K10+, K5 and SDQ as the possible measures but the PMHC MDB overview document only mentions the K10+ for adults and the SDQ for children and young people. Is the K5 recommended for an Aboriginal and Torres Strait Islander population?	The K5 is included as an alternative to the K10 for use with Aboriginal and Torres Strait Islander clients. A version of the instrument will be made available on the PMHC MDS website. The overview document will be amended accordingly to include the K5.
SDQ for 2-4 year olds	We collect data for younger children using the SDQ 2-4 year olds. Please clarify whether we should continue this, given that the SDQ is	There are no mandated measures for children less than 4 years of age simply because there is not yet a nationally agreed standard for this age group. Work is under way to redesign the HoNOSCA but that is not yet complete. PHNs do however have the flexibility to add additional measures to meet local requirements but these are not included in

Issue	Question	Response
	listed as covering only 4-11 year olds.	the PMH MDS.
Multiple collection occasions	It is essential that the PMHC MDS have capacity for numerous outcome measure scores to be recorded against a single episode.	The new arrangements will allow this. Collection Occasions between Episode Start and Episode End are termed 'Review'. There is no limit in the number of Review Collection Occasions.
Outcome measure date	To gather meaningful clinical outcome data, the PMHC MDS needs to allow a date to be added against each measure administered	The data item Collection Occasion Date is included in the PMHC MDS to achieve this.
Low intensity workers	Use of clinical outcome measure for low intensity interventions is questionable given non-mental health professionals will deliver this service.	The mandated measures are based on consumer self-report rather than clinician-completed. They can be offered and collected by low intensity workers.
Reporting individual item scores versus subscale totals and total score	The ATAPS system only required totals and subscale scores to be reported but the PMHC MDS requires all individual scores to be reported. This may not be practical for many service providers because it adds a significant reporting burden.	The PMHC MDS requires individual item scores because these provide a stronger basis for understanding outcomes, and avoid the necessity for providers having to calculate subscale scores (on the SDQ). However, it is acknowledged that this may not be possible in the short term for all providers. Therefore, as a transitional step, reporting overall scores/subscales is allowed. This means: - For the K10+, providers can either report all 14 item scores or report the K10 total score as well as item scores for the 4 extra items in the K10+. - For the K5, providers can either report all 5 item scores or report the K5 total score. - For the SDQ, providers can either report all 42 item scores or report the SDQ subscale scores. The Department will advise PHNs of when this transitional arrangement will be ceased and individual item scores required for all measures. Additionally, the Department is giving consideration to developing a web-based reporting arrangement that would allow the client to complete and submit the outcomes data, bypassing the need for practitioners to undertake collection and reporting.
Statistical significance	Please specify whether measured changes should	No, the data required for the immediate future by the PMHC MDS are individual item scores, or as noted above,

Issue	Question	Response
	be statistically significant.	subscale scores and totals. These will be used to derive a range of change indicators.

4. QUESTIONS ABOUT PRIVACY PROTECTIONS AND PATIENT CONSENT

Issue	Question
Privacy and patient consent	(a) Can PHNs collect the data required given they are not health service providers? (b) Can data also be supplied to the Department?

Response

The Privacy Act 1988 and Australian Privacy Principles (APPs) set the overarching requirements for the collection and use of all information by organisations and entities involved in the PMHC MDS. The Department's considered view is that the PMHC MDS is fully compliant with these requirements, principally because client consent is required. Specific responses to the two issues raised are provided below.

(a) Under Australian Privacy Principle (APP) 3, an organisation can collect health information where it is reasonably necessary for its functions or activities, and the individual concerned consents to the collection. As commissioners and regional planners, PHNs require a range of data to remunerate service providers as well as monitor overall regional service provision and plan future service improvements. These are all core functions of PHNs and require that PHNs collect and analyse data on what services are delivered, to what patients, at what costs and with what outcomes. Without data, PHNs cannot undertake these functions.

Client consent is critical to the process. While APP 3 includes provision for health information to be collected without consent under the 'health management activities exception', the conditions for this are limited and not considered applicable (see https://www.oaic.gov.au/engage-with-us/consultations/health-privacy-guidance/business-resource-collecting-using-and-disclosing-health-information-for-health-management-activities). Under the previous ATAPS/MHSRRA all PHNs were required to have appropriate client consent processes in place, and for many PHNs, these have been made available on their websites for use by referrers or health practitioners. It is expected that PHNs review and update as required those consent processes to reflect the wider range of services that they are now responsible for commissioning.

(b) Supply of PMHC MDS data by PHNs to the Department of Health is dealt with by APP 6 which regulates how an organisation may use and disclose the health information that it collects. Provision of information to the Department is necessary for government to undertake its role in funding, monitoring and planning future national service delivery. Under APP 6, if an organisation collects health information for a particular or 'primary purpose', it generally cannot use or disclose that information for a 'secondary purpose' unless an exception applies. A specific exception under APP6 allows health information to be disclosed where there is client consent.

To remove any ambiguity, data passed on to the Department will require patient consent to ensure full compliance with the Privacy Act 1988. A new item has been added to PMHC MDS to confirm that client consent for data supply to the Department has been obtained.

PHNs should therefore ensure that the consent processes they establish include client consent to the provision of data to the Australian Government Department of Health. Most PHNs have included this provision in previous consent forms used for the former ATAPS/MHSRRA programs which should serve as a basis for any new forms developed. Generally, consent is obtained by the referrer or health practitioner but the specific responsibilities for this will vary according to the referral and service delivery

Issue	Question
	arrangements in each region. The Department has prepared a set of standard words that can be used, or adapted as necessary, in any locally developed forms. These are available on the resources section of the PMHC MDS website (https://www.pmhc-mds.com/resources/).

5. QUESTIONS ABOUT UNIQUE IDENTIFIERS AND 'KEYS'

PHNs raised a number of queries about the assignment of unique keys. Client Keys must be unique and persistent for an individual across the entire PHN. It is the responsibility of the PHN to derive a format for these fields to be used across their commissioned organisations.

Practitioner, Episode, Service Contact and Outcome Collection Occasion Keys will be managed by provider organisations and will be unique at the level of the provider organisation.

An important requirement to note is that Keys (or identifiers) are strings that can have a minimum length of 1 characters and a maximum length of 50 characters. Once assigned keys cannot be changed.

The purpose of keys on each of the records is to provide a unique and persistent identifier in order to allow addition, update and deletion of each individual record.

Responses to specific questions are provided below.

Issue	Question	Response
Client keys	Does the Department have any recommendations for assignment of the Client Key? Can the Department provide any further information regarding the process for allocation of region wide unique client identifiers	Client Keys must be unique and persistent for an individual across the entire PHN. It is the responsibility of the PHN to derive a format for these fields to be used across their commissioned organisations. Some PHNs have or are already implementing centralised client identifier ('key') allocation in order to facilitate services between their contracted provider organisations. For those PHNs without this capability a master client index will be created during Stage 2 of the PMHC MDS implementation. The master client index will facilitate management of the client keys within the PHN independent of the provider organisation. In the interim it is recommended that at the very least PHNs ensure that Client Keys issued by provider organisations do not overlap.
Episode keys	Could the Department provide further information about the purpose and creation of	The purpose of keys on each of the records is to provide a unique and persistent identifier in order to allow addition, update and deletion of each individual record without reference to items on that record which might need to

Issue	Question	Response
	episode Keys?	change. e.g. correcting a patient key or date. This also applies to the other record types such as client and service contact.
Manual data entry via MDs interface	Do we need to create 'keys' if we intend to enter data directly into the MDS?	Stage One of the PMHC MDS will only allow upload, not direct data entry. Upload files will either be produced automatically from client systems or by hand via Excel spreadsheet. Therefore, all organisations uploading data to the PMHC MDS will need to provide keys for each record. Where data is being exported from client systems, these keys can be auto generated, provided that a key does not change once it is assigned to an item.
Practitioner identifiers	There is currently a jumble of systems for coding service providers, making it difficult to report against the 'delivered by whom' part of the complex multi-part question posed. How will this be improved?	The new MDS specifications include separate unique keys for Provider Organisation and Practitioner which are intended to resolve this problem

6. QUESTIONS ABOUT PHN ACCESS TO DATA WAREHOUSE

Issue	Question	Response
Data warehouse	Data entered into PMHC data set will be stored in a national data warehouse. Will all of the information be accessible by PHN's for benchmarking and service development/collaborative purposes?	PHNs will have access to all de-identified data pertaining to their services but will not have access to the information of other PHNs. Benchmarking and service development reports will be developed in a subsequent development stage with input from appropriate stakeholders.

7. QUESTIONS ABOUT IMPLEMENTATION AND SUPPORT

Issue	Question	Response
Support to developers	Will the Department be providing further support to system developers to ensure that they are able to develop their clinical systems in line with the revised MDS specification?	System developers will have access to the following resources: • API documentation online • Test accounts on both staging and production systems • Offline data validation for ease of testing extracted datasets • Access to help desk via e-mail. Telephone support will be provided where the issue can't be resolved via e-mail

Issue	Question	Response
		• Developer announcement mailing list to notify developers of pending changes and issues
Staging	We would seek assurance from the Department that there is sufficient lead time for system developers to refine systems in line with these new requirements.	The Department is aware that developers will need sufficient lead time to make the required system changes and/or additions. PMHC MDS upload functionality will be separate from the existing ATAPS/MHSRRA MDS. During this initial stage the existing ATAPS/MHSRRA MDS will be kept operational so that ATAPS/MHSRRA organisations can continue to provide data through that system until they are either ready to export data to the new upload interface or until the new data entry interface is available after a later stage of development. Once all ATAPS/MHSRRA organisations are submitting data to the PMHC MDS, the ATAPS/MHSRRA MDS will be shut down. This date has not yet been specified. Data for services other than ATAPS/MHSRRA will have to be submitted via the PMHC MDS interface. Organisations should only submit data via one interface, not both. Data submitted via the existing ATAPS/MHSRRA MDS will be converted and merged with data submitted via the PMHC MDS in order to produce departmental reports.
Staging	Is year one a baseline data gathering year as opposed to there being any expectation to manage providers against levels of activity not fully understood due to the extended MDS requirements?	The Department is aware that 2016-17 is a transitional year and will not provide sufficiently comprehensive data to serve as a baseline for monitoring future activity. 2017-18 is expected to serve as the baseline year for comprehensive data collection.
Support to PHNs to engage providers	Can the Department offer assistance to PHNs in terms of creation of a spreadsheet suitable for storing and uploading collected data	Yes – Excel data entry templates for submission are provided on the PMHC MDS website.
Support to PHNs to engage providers	Will there be further clarification on how PHNs will be expected to report on provider performance to allow engagement on how best to undertake the change process?	See responses to 'Questions about standards reports'.
Data capture via	With the data being	During the initial stage of implementing the PMHC MDS,

Issue	Question	Response
the web-based portal	submitted via the web based portal – does the web based portal also allow PHN's to use this as their data capture tool as well?	PHNs and their service providers will be able to either export data from their client systems and upload to the PMHC MDS or manually create spreadsheets that can then be uploaded. Data may be uploaded in either Excel or CSV format. During phase 2 a full data entry capacity will be added. This is expected to be ready for the 2017-18 financial year.
Support to PHNs to engage providers	PHNs would desirably see the actual mechanics of the MDS hands-on prior to wider release. Successful roll-out will depend on how well PHNs are able to communicate and support providers. We suggest the department conducts PHN specific webinars and training for key nominated staff.	Online support documentation is currently being created around the data specification and online portal. In addition, the Department is currently in negotiations with external providers to supply ongoing support and training for the system. Further details of these arrangements will be made available subsequent to the finalisation of these arrangements.

8. QUESTIONS ABOUT STANDARDS REPORTS

Issue	Question	Response
Provider Organisations and Practitioners	The documentation indicates standard reports will be designed to meet PHN and departmental requirements. Will a Provider organisation or Practitioner be able to receive reports for their respective service provision?	The Department will be planning a range of standard reports and will consult with PHNs about their requirements. Standard Reports are expected to be developed for Stage 2.
Benchmarking reports	Are the PHNs going to receive reports on collated data and benchmarked against other PHNs for QI purposes?	See above response.

9. MISCELLANEOUS QUESTIONS

Issue	Question	Response

Issue	Question	Response
Clients/consumer terminology	The terms 'patient', 'client' and 'consumer' are used interchangeably in the documentation. Consultation indicates a preference for the term "consumer".	The Department acknowledges the importance of language in describing those who use mental health services and that 'consumer' is the current preferred term in the sector. However, for the purpose of specifying the PMHC MDS, the term 'client' is used in the technical specifications. This does not imply that the term 'consumer' should not be used in PHN communications with stakeholders.
Provisional Psychologists	Can provisional psychologists provide services under supervision in priority area 3?	Provisional Psychologists fall within the broader Practitioner category of 'low intensity workers'. These are defined as "individuals with appropriate competencies but who do not meet the requirements for registration, credentialing or recognition as a mental health professional". The deployment of low intensity workers is at the discretion of PHNs, but of course depends on suitable clinical supervisory arrangements being in place.
Referrer postcode	It would also be useful to collect the postcode of the referrer to understand referral patterns across and within regions.	Referrer postcode is not regarded as essential for the national data and thus not included in the PMHC MDS. However, PHNs have the discretion to add this as additional information collected at regional level.
Multiple episodes	When patients receive services under multiple funding areas is the data recorded against a separate episode of care for each service? For eg: a young person is receiving care through a headspace site (priority area 2) yet has an acute episode and requires services for a follow up around a suicide attempt- (Priority area 5) is the MDS data uploaded against both priority areas?	The business rules for Episodes are stated in the MDS specifications. Episodes are defined at the level of the Provider Organisation, not the funding source. A client can only have one episode at a time **for any given Provider Organisation**. Or course, if two Provider Organisations are delivering services simultaneously, one episode would be created by each Provider Organisation. Each Episode is classified according to a single 'Principal Focus of Treatment Plan'. This may be changed in the course of an episode if the original code entered changes during the course of treatment.
Data collection responsibility	Does the referrer of clinical provider collect the sociodemographic and clinical data? If the former, this may not be acceptable to GPs	While referrers will continue to provide some information as part of the referral process, it is the responsibility of the Practitioner and Provider Organisation to ensure the integrity of data submitted to the PMHC MDS. Most of the data required would normally be collected as part of the assessment process by the Practitioner. GPs are not expected to provide the full set of sociodemographic data.