Government of **Western Australia**
Department of **Health**

Non-Admitted Patient Activity Data

Business Rules

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Contents

Abbreviations

ABF	Activity Based Funding
ACAT	Aged Care Assessment Team
ED	Emergency Department
GP	General Practitioner
HEN	Home delivered enteral nutrition
HITH	Hospital In The Home
IHPA	Independent Hospital Pricing Authority
MCC	Multidisciplinary Case Conference
MDC	Multidisciplinary Clinic
NAP	Non-Admitted Patient
NAPDC	Non-Admitted Patient Data Collection
NAP SE	Non-Admitted Patient Service Event
NMDS	National Minimum Data Set
PAS	Patient Administration System
PSOLIS	Psychiatric Services On-line Information System
SMS	Short Message Service
TPN	Total parenteral nutrition
WA	Western Australia
webPAS	Web-based Patient Administration System

1. Purpose

The purpose of the Non-Admitted Patient Activity Data Business Rules is to outline criteria to correctly record, count and classify non-admitted patient activity within the Western Australian health system.

The Non-Admitted Patient Activity Data Business Rules is a Related Document mandated under the *MP 0164/21* *Patient Activity Data Policy*.

These Business Rules are to be read in conjunction with this policy and other Related Documents and Supporting Information as follows:

- *Non-Admitted Patient Data Collection Data Specifications*
- *Non-Admitted Patient Data Collection Data Dictionary*
- *Patient Activity Data Policy Information Compendium*.

2. Background

Business rules ensure that the collection of Non-Admitted Patient (NAP) data is standardised across the WA health system, and to ensure that Health Service Providers and Contracted Health Entities record, count, classify and record activity correctly for the services they provide. High quality information is required to inform the planning, monitoring, evaluation and funding of health services.

These Business Rules are revised annually, with reference to national policy and legislation, to ensure relevance and currency. Revisions are made following extensive consultation with stakeholders.

3. Contact Details

Queries and feedback on the Business Rules can be submitted to the Department of Health via the Non-Admitted Patient Data Collection (NAPDC) Data Custodian at NADCdata@health.wa.gov.au.

4. Scope

The type of activity in-scope for the Non-Admitted Patient Activity Data Business Rules includes all arrangements made to deliver NAP services:

- irrespective of location (includes on-campus and off-campus)
- whose treatment has been funded through the jurisdictional health authority, regardless of the source from which the entity derives these funds: Department of Veterans' Affairs, compensable and other patient funding sources via the hospital including Medicare ineligible patients
- regardless of setting or mode.

Excluded from the scope are all services covered by:

- services which deliver non-clinical care, i.e. activities such as home cleaning, meals on wheels or home maintenance.
- COVID-19 testing and vaccination activity conducted by HSPs. This activity has specific rules for recording and reporting which instructions can be found via the

COVID-19 Activity Data Recording document.

A non-admitted service is where a recognised clinical team of one or more healthcare providers within an organisational arrangement under a jurisdictional health authority, Health Service Provider or contracted health entity, provide non-admitted services.

Mental health, community and population NAP activity that are not considered in-scope at this time by the Independent Hospital Pricing Authority (IHPA) are excluded from Activity Based Funding (ABF) reporting but should endeavor to meet recording criteria as the activity will be collected in the NAPDC and reported on by the Department of Health.

5. Definitions

5.1 Attended appointment

An attended appointment is defined as an event where a patient is recorded as having attended an appointment: the appointment is completed by allocating an outcome code.

The attended appointment is intended to capture instances of healthcare provision from the perspective of the relevant Health Service Provider and contracted health entity.

The attended appointment definition (see MDG-10-006 Non-Admitted Patient Attended Appointment Definition) is to be used for baseline reporting by the Department of Health when the reporting intent is to include all activity at all sites; not restricted by NAP service event counting rules.

An attended appointment may also be a NAP service event; which has additional exclusion criteria. See NAP service event.

5.2 General List

The General List refers to activity that is not directly identifiable as non-admitted outpatient clinic activity but is assessed by IHPA to be in the scope of NAP activity reporting. Assessment is performed a year in advance, with submissions due to IHPA by 31 May each year.

The General List Determination is guided by the framework entitled Annual Review of the General List of In-scope Public Hospital Services.

5.3 Healthcare provider

Any staff member who is involved or associated with the delivery of healthcare to a NAP is a non-admitted patient healthcare provider. This includes: medical or nurse practitioners, clinical nurse specialists, liaison nurses (recognised in WA only) and allied health professionals. Pastoral care, welfare workers and meals on wheels staff are not recognised as a non-admitted patient healthcare provider.

Note: Healthcare providers may have accompanying health assistants and students present. This activity will be recorded against the healthcare provider only.

5.4 Medical record

Medical records are collections of information regarding an individual's healthcare, medical history, assessments and other health related documentation. A medical record is the physical record created when a patient first presents to a healthcare

facility and for all subsequent presentations. Where an electronic record is made as a substitute for hard copy notes, it is to be viewed and treated in a similar manner to the physical record.

The medical record primarily serves the patient by documenting patient care interactions. As such, healthcare providers rely on the medical record as the principal means of communication and information exchange regarding patients under their care. The medical record is also used to support additional clinical and administrative decision making and planning processes.

5.5 Multidisciplinary Case Conference

A Multidisciplinary Case Conference (MCC) is an appointment type where a patient (or carer) is not present and a meeting is arranged in advance and held concurrently between three or more healthcare providers to discuss a NAP to coordinate care. MCCs ensure that a patient's multidisciplinary care needs are met through a planned and coordinated approach. MCCs are recorded by the service delivery mode selection of 'MCC.'

The healthcare providers involved in the MCC may be of the same or different profession. However, when they are of the same profession, they must each be from a different specialty so that the care provided by each provider is unique.

5.6 Multidisciplinary clinic

A Multidisciplinary Clinic (MDC) is a clinic set up for appointments where a patient is present, and treatment is delivered by three or more health professionals functioning as a team. The health professions within an MDC can be from:

- same specialty: healthcare providers must be of different profession (e.g. a medical practitioner, a nurse and an allied health professional all from specialty A)
- different specialty: healthcare providers can be of the same profession (e.g. a nurse from specialty A, a nurse from specialty B and a medical practitioner from specialty B)
- one organisation or from a range of health organisations including private health providers that provide publicly-funded services.

The aim of an MDC is to address treatment that is focused on all aspects of the needs of the NAP – including but not limited to physical and psychosocial needs. Care must be provided to a NAP at the clinic on the same day and all MDCs must be set up with the multidisciplinary flag set to 'yes.' Please see Multidisciplinary Clinic flag for further information on MDC set up.

Although there are three or more healthcare providers contributing in an MDC, only a single service event must be recorded for a NAP.

MDCs can be delivered via a range of settings. The correct service delivery mode must be selected to reflect how the appointment was primarily delivered to the patient (e.g. the service delivery mode of 'client present' is to be used when a patient is present in-person with two healthcare providers whilst the third healthcare provider attends via the telephone).

5.7 Non-admitted patient

A person is a non-admitted patient if they do not meet the *Admitted Patient Activity Business Rules* admission criteria and do not undergo a hospital's formal admission process. In general, NAPs receive 'simpler,' less prolonged treatment, monitoring and evaluations than same day or overnight admitted patients.

A person is a non-admitted patient when a person receives non-admitted care at any location, e.g. outpatient clinic, emergency department, community centre, home.

5.7.1 Non-admitted outpatient

A person is a non-admitted outpatient if all the following apply:

- the person has an appropriate referral to an outpatient clinic
- the person's referral is registered and triaged (i.e. allocated a priority code)
- the person receives care at an outpatient clinic service.

5.8 Outpatient clinic

An outpatient clinic is a specialty unit or organisational arrangement under which a hospital provides outpatient clinic services.

Outpatient clinics provide non-admitted services that require the focus of a specialist healthcare provider to ensure the best outcome for the patient. These services are an important interface in the health system between acute admitted patients and primary care services. They provide access to:

- medical practitioners, nursing/midwifery and allied health professionals for assessment, diagnosis and treatment
- ongoing specialist management of chronic and complex conditions in collaboration with community providers
- pre- and post-hospital care
- related diagnostic services such as pathology, pharmacy and diagnostic imaging.

5.9 Outpatient referral

An outpatient referral is required for the patient to commence receiving NAP outpatient services. An outpatient referral is a request that includes a minimum set of patient information and is accepted by a relevant Health Service Provider or contracted health entity to access specialist outpatient services. An outpatient referral can be completed by a WA Health recognised referral source which can be found via source of specialist outpatient referrals.

6. Rules for non-admitted patient service event

The principal counting unit for NAP care is the 'NAP service event.' The service event is intended to capture instances of healthcare provision from the perspective of the patient.

Interactions with patients via information and communication technology (including but not limited to telehealth, where the patient is participating via a video conferencing platform) can be service events if they substitute for in-person contact.

For ABF purposes, ancillary services such as the issuing of pharmacy script and the dispensing of medication, diagnostic imaging, radiology and pathology are bundled with the originating NAP service event.

As not all NAP service events are eligible for ABF, information on eligibility is available on the IHPA website.

A NAP service event must satisfy all the following criteria:

- an interaction between one or more healthcare providers and one NAP (e.g. each patient receiving care is recorded as an individual event regardless of whether they receive care as an individual or as part of a group)
    - valid exception one: patient self-administering approved treatments in the patient's own home
    - valid exception two: multidisciplinary case conference.
- must contain clinical or therapeutic content (i.e. any preparation, travel, report writing, liaison with other healthcare providers etc. does not meet the definition of a NAP service event)
- must result in a dated entry in the patient's medical record; physical or electronic medical record. The dated entry is documentation that supports the patient's attendance to the appointment as well as provide record of treatment and/or care plans.

Any activity that does not meet all these criteria will be referred to as a non-service event.

6.1 Clinical or therapeutic content

Clinical or therapeutic content for the purposes of a NAP service event needs to meet the following criteria:

- it is information recorded during a NAP interaction requiring consideration (of evidence) to support a diagnosis and the management of the patient
- it is expert or evidence-based clinical knowledge
- it considers the local health environment including practice, policies and availability of services.

A NAP service event will also be an attended appointment, which has less exclusion criteria. See Attended Appointment.

6.2 Self-administered home-delivered services

The following home-delivered services performed by the patient in their own home, without the presence of a healthcare provider, will be counted as a NAP service event. Documentation of these services must be in the patient's medical record:

- Renal dialysis — Haemodialysis – home delivered

- Renal dialysis — Peritoneal dialysis – home delivered
- Nutrition — Total parenteral nutrition – home delivered (TPN)
- Nutrition — Enteral nutrition – home delivered (HEN)
- Ventilation — home delivered.

All NAP sessions performed per month for the same home-delivered service are to be bundled and counted as one NAP service event per patient per month, regardless of the number of sessions recorded. These services must have the service delivery mode of 'Client Present' assigned.

Home-delivered services are accepted as NAP service events when there are no disruptions or changes to the treatment routine. When, for an entire month, the patient is admitted to a hospital or is an admitted Hospital in the Home (HITH) patient, all home-based outpatient activity that occurred whilst the patient was admitted will be excluded from reporting.

- if a patient was admitted for the whole month then one appointment is recorded in the PAS for the home-delivered service with the patient type set to 'inpatient'. No NAP service event will be reported for that month.
- if a patient was admitted for part of the month but also performed at least one session of the home-delivered service in their own home as a non-admitted patient, one appointment is recorded in the PAS with the patient type of OP (outpatient). One NAP service event will be reported for that month.
- if a patient performs multiple types of home delivered services e.g. renal dialysis and HEN, both can be recorded as separate NAP service events provided the patient performed at least one session of each type of home-delivered service as a non-admitted patient.

Home-delivered activity must be classified via the non-admitted patient activity Tier 2 Non-Admitted Services Classification method regardless of the condition/s of patients.

For example, if a patient is:

i. receiving services under a mental health community arrangement and
ii. requires home delivered enteral nutrition.

The mental health activity must be recorded in the Psychiatric Services On-line Information System, PSOLIS, and the HEN activity recorded in the patient administration system webPAS. Both are valid reportable activity.

6.3 Services provided to groups

Care provided to two or more patients by the same service provider(s) at the same time can be referred to as a group session when the patients within the group receive the same service.

Where the definition of a NAP service event is met, one service event and a dated entry in the medical record is to be recorded for each patient who attends a group session regardless of the number of healthcare providers present.

The session type is derived from the '*Group Client Present'* service delivery mode of the appointment to count this type of NAP service event.

7. Rules for outpatient clinic registrations

A NAP service event is funded based upon the Tier 2 Non-Admitted Services Classification Code and must be assigned as part of the registration process for non-admitted outpatient clinics at Health Service Providers and Contracted Health Entities.

A clinic must:

- have a unique identification number and title
- be classified according to the predominant activity undertaken
- have the lead healthcare provider designated if managed by two or more healthcare providers (refer principal or lead healthcare provider)
- have the following mandatory classification codes assigned. These codes are not to be changed at appointment level:
    - Tier 1 National Minimum Data Set (NMDS) Code
    - Tier 2 Non-Admitted Services Classification Code
    - Referral and Clinic Category
    - Care type
    - Multidisciplinary Clinic (MDC) flag

Initial registration or any changes to the clinic, involving these five fields, require authorisation from a manager at site before notifying the NAPDC Data Custodian via email.

The NAPDC Data Custodian will assess clinic registrations and changes to provide specific system advice if further actions are required. The NAPDC Data Custodian will assess the changes made for potential impacts on historical data.

Consultation with the NAPDC Data Custodian via email communication is recommended for guidance on clinic registration or changes.

7.1 Tier 1 National Minimum Data Set (NMDS) Codes

The Tier 1 NMDS code is allocated to each registered non-admitted outpatient clinic. Although Tier 1 NMDS is no longer reported nationally, as Tier 2 is the current classification system for NAP activity, this code remains a mandatory item when registering non-admitted outpatient clinics.

The Tier 1 code has a two-level structure. The digits preceding the decimal point are the 'group' code. More refined 'class' codes replace the .000 with a value (e.g. 010.000 Medical and 010.001 Aged care).

The Tier 1 code descriptions may not be mutually exclusive (e.g. Obstetrics and Antenatal). The Tier 1 code attempts to cater for generalist and specialist clinics. A Complete list of Tier 1 codes can be found in the *Non-Admitted Patient Data Collection Data Dictionary*.

In most cases, reference to the permissible values will be adequate to code hospital non-admitted outpatient clinics to an appropriate code. If not, general principles for coding non-admitted outpatient clinics are:

- take account of the nature of the specialty and/or the field of practice of the healthcare provider
- code to 'class' level and if that is not possible (e.g. not enough information,

mixed patient clinic) then code to 'group' level only

- for the purposes of Tier 1 coding of non-admitted outpatient clinics, the 'group' code level is acceptable
- assign the code which has the most appropriate description. For example, if the clinic is 'purely' antenatal then that is where the clinic would be coded. If the clinic is a mixture (e.g. antenatal and postnatal) then code to Obstetrics.

7.1.1 Block funded clinics

Block funding supports teaching, training and research in public hospitals and public health programs. It may also be used for certain public hospital services and smaller rural or regional hospital services where block funding is more appropriate. Current categories of approved block funding are established annually by the National Health Funding Body.

If a new block funded clinic is to be created in the PAS, the appropriate Tier 1 NMDS code must be allocated to ensure the activity is correctly reported. Consultation with the NAPDC Data Custodian is required prior to establishing a block funded clinic in the PAS so the correct advice on which Tier 1 NMDS code can be provided.

7.2 Tier 2 Non-Admitted Services Classification code

The Tier 2 Non-Admitted Services Classification (Tier 2 code) for non-admitted services was primarily developed to support the introduction of Activity Based Funding for non-admitted hospital services in the Australian public health system.

The Tier 2 code is a healthcare provider-based classification. It provides a standard framework within which clinics providing similar health services can be grouped together, with each resultant group being referred to as a class. Each individual class is defined in terms of a specific range of activities. The Tier 2 code assumes that the type of clinic where the health service is provided is a proxy for the patient's clinical condition.

In the Tier 2 code, each clinic must be classified uniquely to one class so that only those clinics that perform the same range of predominant health services are brought together to form a class.

It is important to recognise the need for accuracy when allocating an appropriate Tier 2 code to the activity undertaken by an outpatient clinic.

Tier 2 codes that are in-scope for ABF are assigned a price weight by IHPA. The price weight of a Tier 2 code relates to the cost of treating an average NAP in that Tier 2 code category, inclusive of any ancillary services such as pharmacy, pathology or diagnostic imaging.

Each financial year the weights associated with each Tier 2 code are updated based on changing costs and efficiencies across jurisdictions over time.

Current Tier 2 code definitions can be found via the IHPA Non-Admitted Services Definitions Manual.

7.2.1 Determining the Tier 2 code

A 'top-down' approach is recommended to classify clinics. There are two main factors that will determine the Tier 2 code allocated to the non-admitted outpatient clinic and the activity undertaken, namely:

- group classification—the predominant nature (type) of health service provided by the clinic
- class classification—the most appropriate for the clinic's specialisation (often reflective of the specialty or discipline of the usual or lead healthcare provider).

Note: Where an activity is provided for more than 50% of the services, more than 50% of the time, that activity is used to determine the Tier 2 code and the lead healthcare provider.

7.2.2 Principal or lead healthcare provider

When there is only one healthcare provider operating in the non-admitted outpatient clinic, they are the lead healthcare provider. Details on which healthcare providers are assigned to Tier 2 services can be found via the IHPA Non-Admitted Services Definitions Manual.

Note: While the Tier 2 code 40 series clinics specify the nurse to be a clinical nurse specialist, the use of the terminology 'clinical nurse specialist' is intended to reflect that the majority of services are provided by specialist nurses. The most suitable nursing qualifications/titles are to be determined by the jurisdiction. WA includes liaison nurses as suitably qualified to be allocated a Tier 2 code clinic.

For the WA health system, when two or more healthcare providers work together in a non-admitted outpatient clinic, the determination of the lead healthcare provider for Tier 2 coding purposes is as follows:

- where there are two healthcare providers and one is a nurse practitioner and the other a medical practitioner, the lead healthcare provider will be the medical practitioner
- where there is either one medical practitioner or one nurse practitioner, along with other healthcare providers, the medical practitioner or nurse practitioner is deemed to be the lead healthcare provider
- where there are two or more medical practitioners, (or two or more nurse practitioners) a decision about the lead healthcare provider needs to be agreed. This may sometimes be subjective, but could be related to the underlying condition, symptoms or diagnosis of the patient; or which healthcare provider spends more time with each patient (i.e. where one clinician performs greater than 50% of the service provision)
- where there are two or more allied health professionals, or a combination of allied health professionals and clinical nurse specialists, a decision about the lead healthcare provider needs to be agreed. This will be based on the diagnosis, procedure and/or intervention associated with the NAP.

Note: One criterion that must not be considered when determining the lead healthcare provider is the potential funding that may derive from the decision. The funding may change (sometimes substantially) year-to-year and once a lead healthcare provider is designated for a non-admitted outpatient clinic it will not be changed without significant objective reasons.

7.2.3 Rules for assigning a Tier 2 code

For the WA health system, the determination of the Tier 2 code is as follows:

- where a clinic is a combination of two or more specialties or disciplines, use the principal or lead healthcare provider rules above to determine which class is the most appropriate category for the clinic and hence to capture all of its NAP service events, for example, paediatric medicine
- where a clinic performs a range of health services wider than those designated as belonging to a particular class, the clinic must be classified based on its predominant activity
- activities undertaken that belong to classes other than that to which the clinic is classified are described as its 'secondary activities'. The secondary activities of a clinic play no part in assigning the class to which the clinic is classified
- in some settings, there may be a combination of procedural and consultation services within the one clinic. In this scenario, unless most of the services provided are procedural, map the clinic to the appropriate class within the medical consultation group
- where a medical consultancy clinic regularly undertakes procedural activity, two separate clinics may be registered to record the different activity, but only where it is cost-effective in regard to overhead costs to do so
- MCC clinics must have the Tier 2 code of the leading healthcare provider assigned as well as the service delivery mode of 'MCC.'
- The following MCC Tier 2 codes are not to be used by the WA health system:
    - 40.62 Multidisciplinary Case Conference (MDCC) – patient not present
    - 20.56 Multidisciplinary Case Conference (MDCC) – patient not present
- Telehealth clinics must have the Tier 2 of the leading healthcare provider assigned as well as the relevant telehealth service delivery mode.
- The following Telehealth Tier 2 codes are not to be used within the WA health system:
    - 40.61 Telehealth – patient location
    - 20.55 Telehealth – patient location.

See Tier 2 Non-Admitted Services Classification Code for further information.

7.2.4 Rules for re-assigning a Tier 2 code

The Tier 2 code assigned to a registered non-admitted outpatient clinic is to be fixed for the lifetime of that clinic unless it can be demonstrated that an error has occurred when the clinic was set up.

To re-assign a Tier 2 code the NAPDC Data Custodian must be consulted via

email communication to approve of the update. A Tier 2 code change may be considered when:

- there is no change in the operation the clinic undertakes, but an error was made in the original registration classification
- the change is required for the ongoing 'life' of the clinic (i.e. including past, present and future activity) from an identified point in time.

The Tier 2 code for a clinic must not be altered when there is a significant change in a clinic's operations. The clinic is to be closed and a new clinic with the correct Tier 2 code is to be registered and created.

Please contact the NAPDC Data Custodian for specific system advice before proceeding as changes to values may overwrite all previous existing values.

7.2.5 Rules for re-assigning a clinic title

The clinic title can be re-assigned from the registered clinic title when there has been a rotation or change in workforce or when the title re-assignment is due to an error from when the clinic was initially set up. When a clinic title is reassigned, the date of change must be recorded in the PAS and an email notification to the NAPDC Data Custodian detailing the changes.

7.3 Referral and clinic category

Clinic category is a code and descriptor that reflects the specialty of the clinic.

Referral category is a code and descriptor that reflects the specialty to which a person is being referred.

In the WA health system, Clinic Category and Referral Category codes and descriptors have been aligned.

These codes and descriptors are standardised and form the foundational structure to which all non-admitted services are grouped, reported and visible in applications across the health system.

Sites may only have certain categories activated and available for use, therefore if a new category is required, sites must consult with the NAPDC Data Custodian.

7.4 Care type

Care type refers to the overall nature of a clinical service provided to a NAP during a consultancy or treatment appointment. The following are the only valid care types for non-admitted outpatient clinics:

- rehabilitation
- palliative care
- geriatric evaluation and management
- psychogeriatric care
- mental health care— (only to be used for specialist mental health clinics)
- other care (e.g. acute care).

Note: The NAP care types are a subset of the admitted care types. Many admitted care types are not relevant to NAP care and if used are mapped to 'Other care'.

The NAP care types of Psychogeriatric care and Mental Health care are excluded from NAP IHPA and AIHW submissions as these care types are reported by the Mental Health Data Collection for funding. However, the NAP activity is to be recorded as the activity will continue to be collected in the NAPDC for internal reporting purposes. Please refer to current referral categories (Appendix A) for NAP activity reporting exclusions.

7.5 Multidisciplinary clinic flag

When a clinic meets the Multidisciplinary Clinic (MDC) definition, the MDC flag must be set to 'yes' in the clinic registration in the PAS. By ensuring the MDC flag is set to 'yes', MDC activity can be correctly identified for special loading under ABF.

Note: MCC clinic registrations do not meet the definition of a multidisciplinary clinic therefore must have the MDC flag set to 'no.'

All appointments under an MDC are mapped to a value of 'yes' for the multiple healthcare provider indicator for national reporting. The multiple healthcare provider indicator can only be correctly applied if the single service event method is used when setting up multidisciplinary clinics.

7.5.1 Single service event method

The single service event method must be used when recording activity for MDCs. This means that for each multidisciplinary appointment:

- only one non-admitted outpatient clinic is registered in a PAS against the lead healthcare provider's clinic category code
- only one Tier 2 code is allocated, usually related to the lead healthcare provider for the multidisciplinary clinic
- only one appointment is scheduled to cover all activity undertaken by the attending healthcare providers.

Note: MCC appointments must also follow the single service event method for clinic set up and appointment scheduling.

8. Rules for managing outpatient referrals

Accurate recording of referral data is important as it marks the commencement of the NAP journey and dictates how subsequent appointment activity is classified and reported.

All referrals to a hospital non-admitted outpatient clinic must be registered in a PAS.

All NAP appointment activity must be linked to a valid referral (except in exceptional circumstances with approval from the NAPDC Data Custodian).

Referrals which do not contain sufficient information to allow accurate triage of the referral or meet the specialty defined referral access criteria, must be returned to the referring healthcare provider.

The original referral received date must not be changed, no matter whether the referral is actioned at the registration hospital or transferred to another hospital, to ensure accurate outpatient waitlist reporting.

If an unrelated illness or condition arises, which may require a course of treatment in another specialty, a new referral to that specialty must be sought from the patient's referring healthcare provider (e.g. GP) or current treating NAP healthcare provider.

If a treating NAP healthcare provider refers a patient to another NAP healthcare provider in another specialty at the same hospital (internal referral) a new referral(s) must be created, and the patient's initial referring healthcare provider informed.

8.1 Registering referrals

Health Service Providers and Contracted Health Entities must actively manage patients to provide timely and appropriate access to clinic appointments.

Before any clinical interaction occurs, a referral must be received and registered to a patient in the PAS to enable recording of appointments.

The healthcare provider will allocate a referral priority at the point of triaging the referral and this referral priority must be entered in the PAS referral. The referral priority determines the urgency of care required and provides a timeframe for when the patient is to attend an appointment:

- urgent: priority 1 within 30 days
- semi urgent: priority 2 within 90 days
- routine: priority 3 within 365 days.

The referral category selected in the PAS referral, will determine the appointment category in which the outpatient appointment is booked against. The referral and appointment category cannot differ from one another.

Where a single referral letter covers more than one condition, that is, requires consideration by more than one specialty or discipline (i.e. referral category) at a hospital, and multidisciplinary care is not indicated, separate referral registrations are required for each referral category and condition combination.

Only one referral per referral category per condition is to be registered and open in the PAS at any given time. If the patient is required to be seen by sub-specialty providers within the referral category to address the condition identified on the referral, the same referral is to be used to book these appointments.

Multiple referrals can be registered for a category when each referral category/condition combination is clearly documented in the 'presenting complaint'

field of the PAS referral to allow the site system administrator to differentiate true duplicate referrals from valid referral registrations.

In general, if more than one referral is registered and open for the same referral category and condition (determined by audits or other checks) then appropriate actions are to be taken to ensure that only one referral remains open. Where a referral request to register a patient for the same condition at a second hospital becomes known (i.e. duplicate referral), this requires the referral request to be declined and/or rejected in the PAS with a letter forwarded to the patient and issuing referrer advising of the situation - with the exception of pre-approved and arranged circumstances between HSP services.

8.2 Source of specialist outpatient referrals

The clinical assessment criteria and the administrative requirements for referring a patient to specialist outpatient services are the same irrespective of the source of referral.

Referrals requesting a specialist outpatient appointment must follow the Specialist Outpatient Services Access Policy.

If the referrer indicates that a patient needs immediate attention they are to be directed to contact the hospital directly.

Patients may be referred to specialist outpatient services by internal and external healthcare providers, including:

- healthcare provider within the hospital (e.g. Emergency Department, admitted units)
- medical practitioners' private rooms
- healthcare provider in other hospitals
- other healthcare providers where appropriate (e.g. optometrists, dental practitioners, midwives, audiologists, Aged Care Assessment Teams (ACATs) and specialist nurses)
- individual self-referral or referral by a carer or family member. This may occur in very limited circumstances. It is expected that referrals are mainly raised by healthcare providers
- specialist referring back to themselves for ongoing patient management.

Referral sources must be captured in the PAS accordingly when referrals are registered.

8.3 Referral reason

The referral reason must be selected in the PAS to identify the intended service as per the referral. The following referral reasons can be used:

- assessment
- education
- ongoing patient management
- research trial.

8.3.1 Ongoing Patient Management

The referral reason Ongoing Patient Management is only to be used in the PAS when:

- a referral is transferred from one hospital to another, the patient has attended a first appointment under the original referral and the care provided remains under the same class Tier 2 code
- a referral is transferred to a new clinic category as part of a clinic reconfiguration and the patient has attended a first appointment under the original referral.

The original referral information is to be transferred to the new referral on the PAS. 'Ongoing patient management' referral reason then indicates a referral is not for new activity within a category and enables the referral to be excluded from any reporting related to outpatient waiting times for new appointments.

'Ongoing patient management' must not be used for new referrals where a first appointment has not been attended by a patient. This includes the scenario when a new referral is created as a result of an admitted or emergency event where the patient is required to be reviewed in an outpatient clinic.

'Ongoing patient management' must not be used if a patient has been formally discharged from a Health Service and a second referral has been received for the same condition. This second referral must be treated as a new referral and entered onto the PAS as any other new referral.

8.4 Transferring a referral

Referrals can be transferred to a different clinic category as part of a clinic reconfiguration or between hospitals under the same class Tier 2 code for reasons approved by sites. The NAPDC Data Custodian is to be notified of these transfers. Regardless of the reason, the original referral received date is to be maintained in the PAS to ensure correct reporting of outpatient waiting times.

When a referral is transferred:

- referral reason 'ongoing patient management' is not to be used for a first appointment as the determination of extended care cannot be determined at triage
- where a first attended appointment has occurred from the original referral, the transferred referral is to have the referral reason as 'ongoing patient management'
  - the first appointment from the transferred referral is to then be recorded as 'Follow-up'
- the original referral must be closed with the referral closure reason as '*Transfer and Close.*'

Note: Large scale referral transfers (in cases of system migration, closure or creation of hospital establishments) are to be managed by Health Support Services and the Department of Health. This is due to the referral files requiring to be cross referenced to maintain the consistency of waitlist reporting. Referral reason 'ongoing patient management' is not used for these transfers.

8.5 Rules for closing referrals

Health Service Providers and Contracted Health Entities must ensure outpatient referrals are managed routinely, promptly and correctly by closing referrals to assist with non-admitted outpatient clinic effectiveness and efficiency, enabling better access for new patients.

- when the healthcare provider determines completion of care and the outcome from the NAP attended appointment is 'discharge', the PAS referral must be closed to reflect the reason for closure as 'treatment complete' – provided there are no further appointments linked to the referral.

  The referring healthcare provider must be notified of this action.

- when a patient 'did not attend' an appointment(s) and is required to be returned to the care and management of the referring healthcare provider (e.g. GP) as per the *Specialist Outpatient Services Access Policy*, the PAS referral must be closed to reflect a reason for closure as 'Discharge Policy'.

  The referring healthcare provider must be notified of this action.

- when a patient requiring non-urgent care consents to no longer wanting to receive care or routinely reschedules or cancels consecutive appointments, the PAS referral must be closed to reflect a reason for closure as 'Declined Treatment', as guided by the *Specialist Outpatient Services Access Policy*. If the patient requires urgent care, before any action on the PAS referral, the NAP healthcare provider is to be notified to determine if the patient will continue to be treated or return to be managed by the referring healthcare provider.

  The referring healthcare provider must be notified of this action.

- when a referral is transferred to a new referral, the old PAS referral must be closed to reflect a reason for closure as 'Transfer and Close'

- when notification of a deceased patient is received, all PAS referrals must be closed to reflect a reason for closure as 'Deceased.'

HSPs and CHEs are required to conduct routine audits to manage accessibility to outpatient services by assessing long waiting open referrals. As part of this, sites are required to assess referrals which have been waiting beyond their triaged timeframe without activity recorded against the referral. If an audit deems the referral to no longer require an appointment as per patient consent or clinical decision, the referral is to be returned to the referring healthcare providers care. The referral is to be closed with a reason for closure as 'Audit.'

Auditing long waiting open referrals will also provide sites access to any potential data quality issues and data entry errors, providing an opportunity for sites to correct the data. Advice for data quality measures can be obtained by consultation with the NAPDC Data Custodian.

If sites do not routinely audit, performance indicators and public reporting may be impacted as the data may not be valid.

8.5.1 Cancelling referrals

Cancelling a referral on the PAS is only to be actioned when the referral was entered as a:

- direct duplicate of an existing open referral. The cancellation reason of 'duplicate' is to be used
- complete error by the data entry user of the PAS. The cancellation reason of 'user error' is to be used.

9. Rules for managing appointments

NAP appointments are deemed either eligible or not eligible for classification as a NAP service event based on the:

- attendance code,
- client type,
- appointment type,
- session type,
- service delivery mode,
- clinic category code,
- Tier 1 NMDS code,
- Tier 2 code,
- care type and
- outcome code.

When an outcome, attendance code, appointment type, client type or session type are missing or a value of 'unknown' is recorded, the activity will not be reported or funded.

9.1 Appointment classification

- appointments must only be classified as 'New,' 'Follow-up' or 'Non-client event/Chart only'
- the determination of 'New' or 'Follow-up' must be based on the registered open referral against which the NAP appointment is made

9.1.1 New appointment

The first attended appointment for a registered referral is classified as 'New'.

A 'New' NAP appointment is one where a health issue/condition has not been previously addressed at the same clinical service, associated admitted or emergency department event for the current referral category.

Post-discharge reviews associated with an admitted patient episode for conditions that have been previously addressed under the same clinical service, and services for clinical review, are not considered to be 'New'.

See Registering Referrals for the scenario where more than one referral is to be registered for the same clinic; both appointments (from each separate referral) are to have the outpatient visit classification of New.

9.1.2 Follow-up

All subsequent visits for the same registered referral must be classified as 'Follow-up.'

A 'Follow-up' or repeat NAP appointment is:

- one where a condition has been previously addressed for the current referral at the same clinical service – whether at the same hospital or not
  - that is transferred patients may be recorded as 'Follow-up'
- any subsequent NAP appointment in that given clinic for the continuing management/treatment of the same condition, and the healthcare provider responsible for care has not discharged the patient (i.e. closed the case). This includes:
  - post-discharge reviews associated with an admitted patient episode
  - routine review of chronic condition
  - monitoring results of interventions
  - evaluation of action plans
  - reassessment of patient needs.

9.1.3 Non-client event/Chart only

'*Non-client event/Chart only*' is to be used to allocate time for review of a patient's medical record. The patient is not present or contacted under this appointment classification.

To ensure a patient is not mistakenly notified of the '*Non-client event/Chart only*' appointment, the service delivery mode of this appointment classification must be set to 'other.' This will ensure a patient will not receive an SMS notification of the appointment as the patient is not present.

If a patient is subsequently contacted as a result of the chart review and the activity meets the criteria for a NAP service event, it can be recorded as a NAP service event by updating the appointment type on the appointment record from '*Non-client event*' to '*New*' or '*Follow-up.*'

9.1.3.1 Services extended over midnight

To prevent duplicate reporting for service events that extend over midnight, the after midnight appointment is to be recorded as '*Non-client event/Chart Only*' with the outcome allocated to '*Chart only*'.

9.2 Appointment attendance

9.2.1 Attended

An appointment is recorded as being attended, when the patient is present for their appointment or if an MCC occurred. An attendance is determined, by using an appropriate attendance and outcome code as well as additional criteria for the activity to meet the WA MDG-10-006 Non-Admitted Patient Attended Appointment Definition.

Appendix C provides a summary of appointment attendances.

9.2.2 Did not attend

A NAP who '*Did Not Attend'* their appointment, did not give the hospital or clinic prior notice of non-attendance, will be classified as a '*Did Not Attend'* appointment.

If notification of a NAP non-attendance is provided prior to the scheduled appointment time, sites are to operationally manage the rescheduling or cancellation of the appointment as per the *Specialist Outpatient Services Access Policy*.

Note: The outcome field is not to be used to record '*Did Not Attend*.' The 'non-attendance reason' field via the non-attendance screen and the appointment status is to be used for capturing a patient who '*Did Not Attend*.' The outcome field is to be utilised for flagging the required action after the '*Did Not Attend'* (i.e. the next step - reappoint, discharge etc.).

9.2.3 Interactions via information and communications technology

Interactions between a healthcare provider and a NAP using information and communications technology may be eligible activity if:

- it is a substitute for an in-person interaction
- it meets the criteria for a NAP service event
- it is interactive (i.e. continuous, responsive or mutually/ reciprocally active, involving both healthcare provider and patient in a short timeframe).

Please refer to Service Delivery Modes for instruction on appropriate use of codes when recording information and communications technology interactions.

Where electronic communication occurs over more than one interaction (e.g. more than one telephone call or multiple emails) which are all part of the same conversation, only one NAP service event is to be recorded for the overall interaction. The first such interaction will be the designated date and time assigned to the appointment. The appointment outcome will be after the last such interaction.

9.3 Attended exceptions

9.3.1 Healthcare provider present only

The following involves a NAP healthcare provider undertaking patient related activity without the patient or carer being present; these must be recorded:

- appointments with a classification type of Non-client event/Chart only
- appointments with the service delivery mode of Multidisciplinary Case Conference (MCC).

9.3.2 Patient present only

It is a requirement that all patient self-delivered home-care services are

recorded, regardless of product/equipment supplied or payment arrangements for the supplies.

Each of the following relates to approved patient-administered home delivered services that do not include the presence of a non-admitted healthcare provider; and are to be recorded.

- Renal dialysis — haemodialysis – home delivered
- Renal dialysis — peritoneal dialysis – home delivered
- Nutrition — Total parenteral nutrition – home delivered (TPN)
- Nutrition — Enteral nutrition – home delivered (HEN)
- Ventilation — home delivered.

9.4 Service delivery modes

The service delivery mode, collected as 'appointment delivery mode', describes the method of communication that occurred between a patient and a health service provider for a NAP service event. Regardless of the service delivery mode, all NAP service events must result in a dated entry in the patient's medical record.

9.4.1 Client present

The healthcare provider delivers the service in the physical presence (in-person) of the patient and therapeutic content is provided.

Exception: Self-administered home-delivered services, where the only the patient is present, is an exception where *'client present'* service delivery mode must be used.

9.4.2 Group client present

The healthcare provider delivers this service where multiple patients are present for a group session where therapeutic content is provided.

9.4.3 Home visit

The healthcare provider delivers the service at the patient's own home, where therapeutic content is provided.

9.4.4 Multidisciplinary case conference

When an appointment meets the Multidisciplinary case conference (MCC) definition, the appointment must have *'MCC'* selected as the service delivery mode. This will ensure MCC appointments can be identified, as MCCs are excluded from some reports.

Regardless if there are various healthcare providers or specialties involved in the MCC or whether the meeting was held via an alternative platform from in-person, only a single service event is to be recorded per NAP with the service delivery mode set to '*MCC*.'

For each NAP discussed, a multidisciplinary management plan must be in place or developed at the MCC with documentation of the following items in the patients' medical record:

i. the name of the MCC event, the date of the event, and the start and

end times (or duration) at which each patient was discussed during the case conference

ii. the names of the participants involved in the discussion relating to the patient and their designations/clinical backgrounds

iii. a description of the NAP's problems, goals and strategies relevant to that MCC

iv. a summary of the outcomes of the MCC.

Note: Items iii. and iv. may be completed through documentation (or revision) of a multidisciplinary care plan completed after each non-admitted MCC where the patient is not present.

Where a patient is discussed at an MCC and is also present at another NAP service event on the same day, both can be counted as valid NAP service events.

9.4.5 Other

The service delivery involving a direct interaction with a healthcare provider via a means not covered by any other service delivery mode e.g. email interactions, when activity meets the eligibility criteria, must be assigned a service delivery mode of 'other'.

Exception: Service delivery mode of 'other' is to be used for appointment classifications of '*Chart only*' for the purpose of ensuring appointment notification is not sent to the patient.

9.4.6 Telephone

The healthcare provider delivers the service using a telephone, where therapeutic content is provided.

9.4.7 Telehealth

This model of delivery occurs where a healthcare provider is in a different location to that of the patient and delivers the appointment via a WA health system approved video conferencing platform.

The patient may attend the appointment at a public hospital facility with or without a supporting healthcare provider present, in their own home or at a non-public health facility (e.g. GP practice, a prison, or community resource centre).

The following Telehealth Tier 2 codes are not to be used within the WA health system:

- 40.61 Telehealth – patient location
- 20.55 Telehealth – patient location.

See Tier 2 Non-Admitted Services Classification Code for further information.

Note: A telehealth service delivery mode can be selected for MDC appointments. However, for MCC appointments, if a healthcare provider attends the meeting via a video conferencing platform, a telehealth service delivery mode cannot be selected as only one appointment is to be recorded for the MCC clinic and the service delivery mode of 'MCC' must be selected.

There are three telehealth service delivery modes which can be used for NAP services that are not provided in MCC clinics.

9.4.7.1 Telehealth at Non- WA health site

Service delivery mode of 'TH at Non WAH Site' is used by the healthcare provider site when the:

- healthcare provider is located at any WA health site
- the patient is located at a non-WA health location e.g. patient's home or workplace, GP surgery, community resource centre or prison.

9.4.7.2 Telehealth at WA health site

Service delivery mode of '*TH at WAH Site*' is used by the healthcare provider site (A) when:

- healthcare provider is located at WA health site (A)
- patient attends WA health site (B), to use the facilities (consulting room, computer monitor, camera and microphone etc.) to attend an appointment.

Example: a healthcare provider is located at a metropolitan hospital and a patient attends a regional hospital to use their videoconferencing facilities to attend the telehealth appointment. The activity is recorded against the metropolitan site by using '*TH at WA Site'* service delivery mode.

9.4.7.3 Telehealth Support Clinician

Service delivery mode of '*TH Support Clinician'* is used by the support healthcare provider site (B) when:

- healthcare provider is located at WA health site (A)
- patient attends WA health site (B)
- the patient must have a support healthcare provider at WA health site (B) appointment.

In addition, WA health site (A) must record this activity against '*TH at WAH site*' service delivery mode.

Both events are valid NAP service events recognised by IHPA, provided all of the conditions for a service event have been met.

Example: a healthcare provider is located at a metropolitan hospital and a patient attends a regional hospital to use their videoconferencing facilities and is accompanied by a support healthcare provider to attend the telehealth appointment. The metropolitan site records the activity against '*TH at WAH site'* and the regional site records the activity against '*TH Support Clinician*.'

9.5 Cancelled appointments

The onsite healthcare provider may use their discretion to classify a NAP appointment as cancelled up to the time of the appointment, with the reason for cancellation recorded. This is to allow for circumstances where the NAP is unable to provide adequate warning that they will not be able to attend their appointment for reasons beyond their control (e.g. patient is currently in the emergency department or is an inpatient).

All attempted cancellations by a patient after the scheduled appointment time has passed must be classified as 'Did Not Attend' with the reason for non-attendance recorded.

10. Rules for recording activity

Health Service Providers and Contracted Health Entities are responsible for ensuring that data are entered correctly in a timely manner in a PAS (e.g. appointments attended) so that up to date data can be provided for reporting purposes.

Data can be retrospectively entered. However, data entry and corrections for the previous quarter must be entered by the second month of the current quarter (e.g. for July – September quarter, data entry and correction cut off is 30 November) to ensure activity is included in data submissions to the IHPA and Australian Institute of Health and Welfare.

For a snapshot of the following, please refer to the flowchart for recording service events (Appendix B) and the summary of recording and reporting inclusions and exclusions for ABF 2020-21 (Appendix C).

10.1 Required to be recorded

All activity undertaken in a NAP setting is in-scope and is to be recorded. This includes NAP activity when:

- the patient is present in-person or the interaction is equivalent to an in-person consultation or treatment (e.g. telehealth and telephone appointments)
- the patient is not present (e.g. NCE/chart only or MCC appointments).

Once a NAP appointment is recorded in the PAS, it needs to meet the WA MDG-10-006 Non-Admitted Patient Attended Appointment Definition and other additional criteria to determine whether the activity is or is not a NAP service event.

NAP activity which does not meet NAP service event criteria may also be recorded, whether the patient is present or not, as long as the appropriate appointment characteristics are recorded to enable its exclusions from reporting.

10.1.1 Deceased patient activity

Patients with a status of 'deceased' in PAS can have retrospective NAP activity entered.

Health Service Providers and Contracted Health Entities are responsible for managing the status of a referral if the referral is reactivated to enter retrospective activity. The referral must be closed immediately after data entry is completed to avoid accidental communication with deceased patients' families and to limit the number of unnecessary open referrals in the system.

10.2 Multiple services on the same day

If a NAP has a range of conditions requiring different interventions by healthcare providers and they occur on the same day (usually for patient or carer convenience), then each NAP activity must be recorded provided that:

- each NAP activity meets all criteria for the definition of a NAP service event
- the patient has attended separate clinics

10.3 Pre-admission

Relevant Health Service Providers or Contracted Health Entities may undertake activity prior to the formal admission of a patient (e.g. for elective surgery). This pre-admission activity may occur on the same day or in the days prior to the admission.

When the pre-admission activity is undertaken in a registered pre-admission outpatient clinic, the activity will be recorded as NAP activity.

When the pre-admission activity is undertaken on the same day as the admission, as long as the event is recorded before the admission occurs, the activity will be reported as NAP activity.

10.4 Admitted patient

Any non-admitted service provided to a patient while they are admitted or in active emergency care, whilst not a valid NAP service event for national ABF reporting, must be recorded. The following are examples of activity that must be recorded:

- interaction between an admitted patient and a NAP healthcare provider for an outpatient clinic service, irrespective of whether the patient physically attends the clinic location or if the NAP healthcare provider visits the ward
- admitted patient at one hospital and is a NAP at a second hospital
- outpatient clinic services provided by a NAP healthcare provider to a patient who is an admitted Hospital in the Home (HITH) patient.

NAP activity will not be recorded if the NAP healthcare provider interacts with an admitted patient in a ward and the care provided is not part of an outpatient clinic service (valid outpatient clinic).

10.5 Same day NAP procedure

A NAP procedure is a procedure that does not require inpatient care: i.e. the patient does not need to be admitted. To minimise hospital costs and with improved technology, the frequency of NAP procedures has increased, with shorter procedure duration, fewer complications and lower cost.

Under the *Admitted Patient Activity Data Business Rules*, two types of outpatient procedures can occur:

- same day non-admitted procedures (Type C) provided in an outpatient setting must always be recorded as a NAP service event unless there is a documented clinical reason for admission
- same day admitted procedures (Type B) may be provided in a non-admitted setting and recorded as outpatient activity if it is safe, practical and cost-effective to do so.

10.6 Cancelled admission

Formal admissions may be reversed at any stage of the process. Patients who progress beyond the administrative process to consume clinical time, yet who are still cancelled before arrival in theatre, or commencement of procedure, may be recorded as outpatient activity.

See Flowchart for recording service events (Appendix B) when admissions of admitted procedures are cancelled.

10.7 Emergency Department

An outpatient clinic service provided to a patient whilst in active emergency attendance must be recorded, as per the *Emergency Department Patient Activity Data Business Rules*.

11. High-cost therapy

Access to high-cost, cutting edge and potentially curative therapy treatments are an emerging option for patients in WA. A small number of patients are expected to benefit from access to high-cost therapies each year. This includes, but is not limited to, the provision of CAR-T therapy.

IHPA has developed guidelines for the costing, counting and reconciliation of its funding and in order to comply, all HSPs must discuss activity recording of high-cost therapies with the DoH, to ensure it is appropriately captured. Additionally, this will ensure that high-cost therapy can be identified and reported for a range of purposes, including patient safety, research and funding.

12. Activity reporting

12.1 Scope

The characteristics of the recorded NAP activity determines what is included or excluded from reporting. If the recorded NAP activity does not meet all of the criteria for an attendance it will not be reported as a non-admitted patient attended appointment. If the recorded non-admitted patient activity does not meet all of the criteria for a service event it will not be reported as a non-admitted patient service event.

For ABF reporting, the WA health system will include all recorded activity that meets the WA definition of a national service event (see MDG-10-004 Non-Admitted Patient Service Event Definition), however, the final determination of what will be funded under ABF by the Commonwealth is the responsibility of the IHPA and the Administrator of the National Health Funding Body that oversees the National Health Funding Pool. In particular, ABF will not occur for:

- incomplete activity records
- activity that has already been funded from another source
- other activity that is out-of-scope for activity based funded.

If a patient attends a non-admitted outpatient clinic and the activity meets the criteria for a NAP service event, it will be reported. Type C and B Procedures are in scope for reporting of non-admitted outpatient clinic activity.

12.2 Units of Measurement

12.2.1 Activity

Two reporting units of measurement are available for NAP activity:

- the NAP service event (with two versions: the WA definition and IHPA's definition)
- the attended appointment.

Determination of which definition is to be used depends on the reporting requirements.

- MDG-10-004 Non-Admitted Patient Service Event Definition: National Version. This definition is to be used for all National reports and submissions.

Note: Further criteria are then applied to determine what activity meets IHPA's definition of a NAP service event.

- MDG-10-006 Non-Admitted Attended Appointment Definition: This definition is to be used when producing reports that are to include all activity at all sites, not restricted by service event reporting rules i.e. includes all appointment types, category codes, professions and Tier 2 codes.

12.2.2 Waiting times

The outpatient waiting time is reported using two reporting measures:

- median wait time to first appointment and
- waiting time for first appointment (on the waiting list).

The median, or midpoint value, rather than the average is the standard measure utilised across Australia for the measurement of waiting times. The median is used to ensure that outlier figures do not skew the results.

The derived Reporting category and Reporting type codes are to be used when reporting the waiting times measures. Current lists for these codes can be located via Appendix A. The following definitions are to be used when reporting the waiting times measures.

- these definitions are to be used for reports that will include all clinics:
  - MDG-10-007 Patients on Outpatient Waiting List
  - MDG-10-009 Median Waiting time to First Appointment
- this definition is to be used when producing reports for the Health Service Performance Report (HSPR) Performance Indicator:
  - P2-24a-c: Percentage of outpatient referrals waiting over boundary for a first attended appointment:

    (a) % Referral Priority 1 over 30 days

    (b) % Referral Priority 2 over 90 days

    (c) % Referral Priority 3 over 365 days.

12.3 Classification of patient activity

Each record of non-admitted patient activity has a number of classification-based data items associated with it. Within these classificatory data items, codes are applied which may preclude the activity from being reported as a non-admitted patient service event. The following will not be reported as a non-admitted patient service event:

- services that have not been provided to an individual patient) or a group of patients; with the exception of MCCs
- community, population or a public health service, unless included under the General List
- specialist mental health services
- diagnostic imaging or radiology services, other than interventional imaging
- pathology services

- pharmacology services, other than clinical pharmacology
- non-clinical services e.g. pastoral care, welfare, Home and Community Care (HACC) Program.

12.4 Source of funding – payment classification

Irrespective of the source of funding (payment classification) nominated for the recorded activity, it will be reported as a non-admitted patient service event if it satisfies all of the service event criteria. Not all sources of funding are in scope for ABF, but it is a requirement to report them.

12.5 Multiple services on the same day activity

Where the same NAP activities are recorded at the same clinic on the same day, only the first NAP service event for that day will be counted for national reporting. Local reporting on attended appointments will include all appointments.

Where the same NAP activities are recorded at the same clinic on the same day at the same time, only the first NAP service event will be loaded into the NAPDC, as the other records are considered true duplicates.

Where the same or related NAP activities are recorded in more than one information system, the NAP service event will only be counted from one information system.

12.6 Wait list

12.6.1 Attended appointment

A referral is excluded from the wait list from the date on which a patient is recorded as having attended a first appointment for that referral. They are considered to be no longer waiting.

12.6.2 Did not attend

A referral is not excluded from the wait list when a patient is recorded as having not attended a first appointment for that referral. They are considered to be still waiting.

12.6.3 Cancelled

An outpatient appointment that has been cancelled by the patient (i.e. not attended a first appointment for that referral) will not be excluded from the wait list. They are considered to be still waiting

12.6.4 Booked

An outpatient appointment that has been booked for the patient (i.e. a first appointment for that referral) will not be excluded from the wait list. They are considered to be still waiting.

13. Rules for managing change

NAP activity is used for a range of reporting, including performance reporting and reporting to the Commonwealth. Changes to recording and reporting of data can have financial implications.

It is a requirement that the NAPDC Data Custodian be notified of any information system changes that may impact recording or reporting of NAP activity. The NAPDC Data Custodian will then consult with NAP stakeholders of the WA health system to progress changes.

The main aims of the management of change process is to:

- ensure changes are compatible and consistent with reporting requirements across the various core and satellite information systems that are used to record NAP activity, and
- minimise the impact of changes when transitioning from one information system to another.

The key roles and responsibilities of NAP stakeholders include, but are not limited to, supporting:

- data and reporting definitions (including alignment to State and National definitions)
- compliance with the Non-Admitted Patient Activity Business Rules to ensure data quality
- creation/modification of new/existing data items with specific reference to mandatory reporting items
- data collection and reporting processes (including data extracts and extract processes from Health Service Providers and Contracted Health Entities)
- access targets and system audit findings for NAP areas.

14. Information Systems

The flow of information to the NAPDC begins at the health service when the patient is referred, and the patient registration information is entered on the health service's PAS.

An approved PAS is one that meets the following essential criteria as listed in the *Non-Admitted Patient Data Collection Data Specifications*:

- records demographic information relating to the non-admitted patient
- records all referral related information
- records appointment scheduling information and outcomes
- records all activity in such a way that related activity in another system is identifiable and is able to be counted once only
- duplicate counting of the same activity is not permitted
- records all activity to be identifiable in the costing applications for the purpose of billing and budget allocation
- records all activity with accurate non-admitted classification codes
- records all activity data such that it is accessible for retrieval for inclusions in the NAPDC and can be used for reporting purposes.

Note: As of 1 July 2020, the WA Department of Health ceased the collection of aggregate level NAP data. All NAP data collection must be recorded at a patient-level.

15. Compliance and audits

15.1 Audit of Business Rules

The System Manager, through the Purchasing and System Performance Division, will carry out audits to ascertain the level of compliance with the business rules contained in this document. The purpose of the audit program is to add value, improve performance and support the business objectives of the Department of Health. Audit findings will be communicated to the health system entity, the Director General and other relevant persons.

WA health system entities are required to facilitate these audits by providing the required information and resources to the audit team.

Further information regarding audits conducted by the Health Information Audit Team is contained in the Health Information Audit Practice Statement.

15.2 Validation and compliance monitoring

Data quality and validation processes are essential tools used to ensure the accuracy and appropriateness of data submitted to the NAPDC. Validations are applied to individual data elements and reflect national reporting obligations, best practice and compliance with policy requirements, as well as the five data quality principles of relevance, accuracy, timeliness, coherence and interpretability.

Validations are used to support:

- key performance indicators
- Activity Based Funding
- clinical indicators developed by the Office of Patient Safety and Clinical Quality
- health service monitoring, evaluation and planning
- reporting to the Federal Government
- research
- response to Parliamentary requests/questions.

16. Glossary

The following definition(s) are relevant to this document:

Term	Definition
Contracted Health Entity	As per section 6 of the *Health Services Act 2016*, a non-government entity that provides health services under a contract or other agreement entered into with the Department Chief Executive Officer on behalf of the State, a Health Service Provider or the Minister.
Custodian	A custodian manages the day-to-day operations of the information asset(s) and implements policy on behalf of the Steward and Sponsor.
Data Collection	Refer to Information Asset.
Health Service Provider	As per section 6 of the *Health Services Act 2016*, a Health Service Provider established by an order made under section 32(1)(b).
Information asset	A collection of information that is recognised as having value for the purpose of enabling the WA health system to perform its clinical and business functions, which include supporting processes, information flows, reporting and analytics.
Information Management Policy Framework	The Information Management Policy Framework specifies the information management requirements that all Health Service Providers must comply with in order to ensure effective and consistent management of health, personal and business information across the WA health system.
Medical record	A documented account, in any format, of a client's/patient's health, illness and treatment during each visit or stay at a health service.
Non-admitted patient	A person who does not meet the admission criteria and does not undergo a hospital's formal admission process.
Non-admitted patient service event	An interaction between one or more health-care provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

Term	Definition
Patient Activity Data Business Rules	Patient Activity Data Business Rules mandate the rules, scope and criteria to be used when recording health service patient activity data and reporting to the Department of Health.
Sponsor	A Sponsor's role is to execute leadership over allocated information asset(s) functions on behalf of the Steward.
Steward	A Steward's role is to implement the strategic direction of information management governance as recommended by the Information Management Governance Advisory Group and manage the information asset(s) under their control to ensure compliance in line with legislation, policies and standards.
WA health system	Pursuant to section 19(1) of the *Health Services Act 2016*, means the Department of Health, Health Service Providers and to the extent that Contracted Health Entities provide health services to the State, the Contracted Health Entities.
WA health system entities	• All Health Service Providers as established by an order made under section 32(1)(b) of the *Health Services Act 2016*; • The Department of Health as an administrative division of the State of Western Australia pursuant to section 35 of the *Public Sector Management Act 1994*. Note: Contracted health entities are not considered WA health system entities.

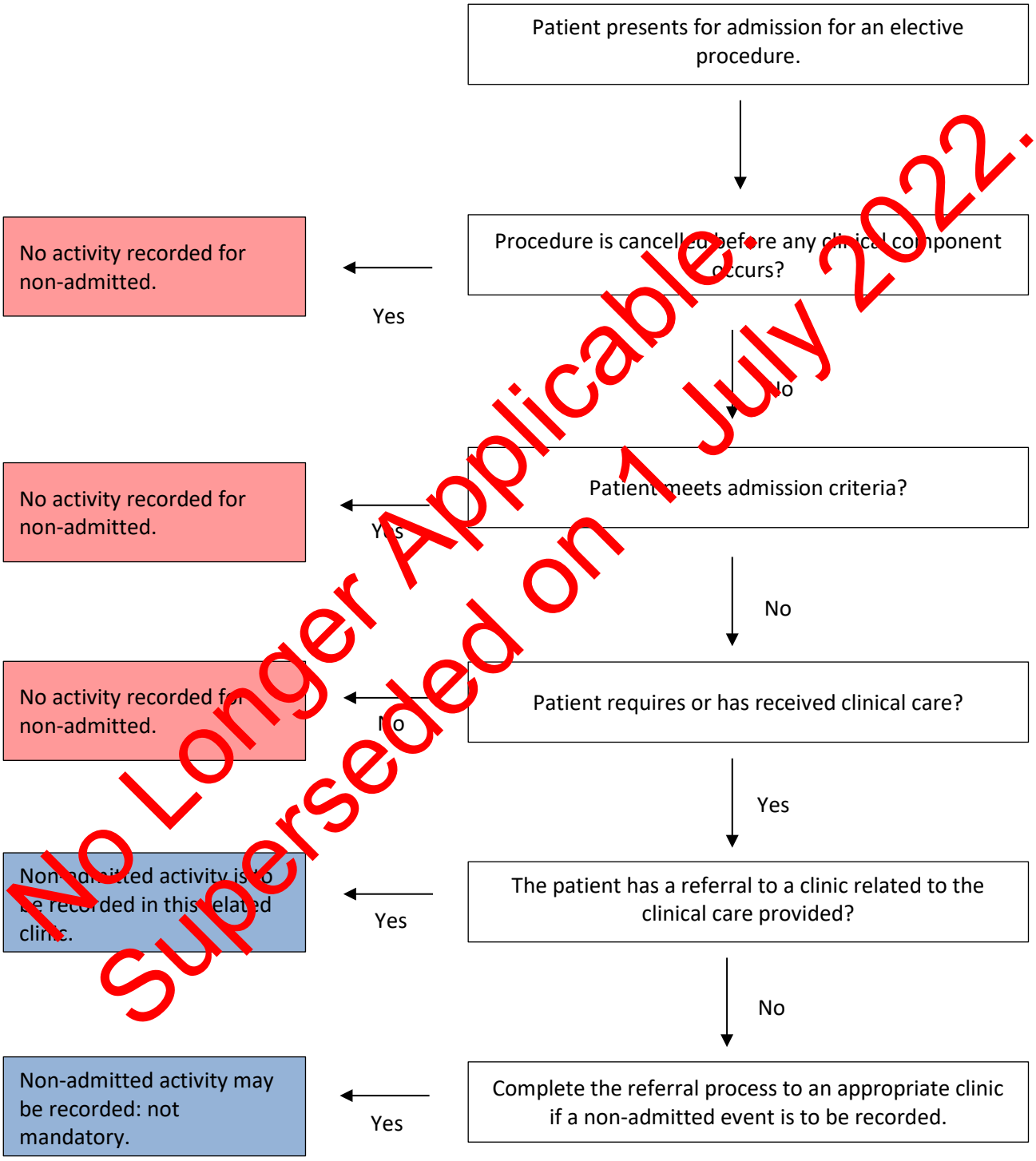
Appendix A – Current referral categories listed by reporting category type

Reporting Type	Reporting Category	PAS Referral Category Codes
Allied Health & Nursing	Allied Health	ALI=Allied Health
	Audiology	AUD=Audiology Clinic
	Dietetics	DIE=Dietetics
	General Nursing	CCT=Care Coordination Team
		CMN=Visiting Nurse
		CON=Continence Enuresis
		COT=Continence
		EME=Emergency
		GB1=Plastic Dressings Clinic
		GNU=General Nursing
		STM=Stomal Therapy
		WOU=Wounds/Dressings Mgt
	Occupational Therapy	OCC=Occupational Therapy
		OCC=Occupational Med
	Physiotherapy	PHY=Physiotherapy
	Podiatry	MFC=Multidisciplinary Foot Ulcer
		POD=Podiatry
		POE=Podiatry
	Social Work	CHP=Child Protection
		SOW=Social Work
	Speech Pathology	SPH=Speech Pathology
Medical	Cardiology	CAR=Cardiology
		CMB=Cardiometabolic
		CRE=Cardiac Rehab
		CTE=Cardiology Technical Services
	Dermatology	DER=Dermatology
	Diagnostic Imaging	NUC=Nuclear Medicine
		RAD=Radiology
	Endocrinology	ABH=Aboriginal Health
		DAE=Diabetic Education
		DIA=Diabetes
		DIAB=Diabetic
		END=Endocrinology
		EVE=Eveline Centre
	Gastroenterology	GAS=Gastroenterology
	General Medicine	ADO=Adolescent
		AMA=Acute Medical Assessment Clinic
		DAA=Drug And Alcohol
		DMU=Disease Management Unit
		GME=General Medicine
		GPM=General Medicine

Reporting Type	Reporting Category	PAS Referral Category Codes
		HYP=Hyperbaric Medicine
		LYM=Lymphoedema Service
		MET=Metabolic
		NRT=Nrt Clinic
		PIC=PIC
	Genetics	GEN=Genetics
		NGE=Neurogenetic Clinic
	Gerontology	ACA=Aged Care Assessment Team
		ECD=Gerontology
		EQU=Gerontology
		GER=Gerontology
	Gynaecology	GYN=Gynaecology
	Haematology	HAE=Haematology
	Hepatobiliary	HEP=Hepatobiliary
		LIV=Liver Service
	Immunology	IMM=Immunology
	Infectious Diseases	COM=Communicable Disease
		INF=Infectious Medicine
	Neonatal	NEO=Neonatology
	Neurology	NEU=Neurology
		NIS=Neurological Intervention
		NTE=Neuro Trac Service
	Obstetrics	ANT=Antenatal
		OBS=Obstetrics
		VCM=Visiting Clinical Midwives
	Oncology	CCO=Chemotherapy Outpatients
		CCS=Cancer Service
		ONC=Oncology
		RAO=Radiation Oncology
		RAT=Radiotherapy
		YAC=Young Adult Clinic
		YCS=Youth Cancer Service
	Paediatrics	PAE=Paediatric Medicine
		PAS=Paediatric Surgery
	Palliative Care	PAL=Palliative Medicine
	Pharmacy	PHA=Pharmacy
	Rehabilitation	ACA=Aged Care Assessment Team
		AMP=Amputee
		HLK=Home Link
		RAC=Rehab And Aged Care
		REH=Rehab Medicine
		RET=Rehabilitation Technology
		RIT=Rehabilitation In The Home
	Renal	DIS=Dialysis
		REM=Renal Medicine
	Respiratory Medicine	PUP=Pulmonary Physiology

Reporting Type	Reporting Category	PAS Referral Category Codes
		RES=Respiratory Medicine
	Rheumatology	RHE=Rheumatology
Surgical	Anaesthetics	ANA=Anaesthetics
		PAC=Pre-admission Clinic
		PRE=Pre Admiss Pre Anaes
	Breast Service	BRE=Breast Service
	Burns	BUR=Burns
	Cardiothoracic Surgery	CTS=Cardiothoracic Surg
	Dental	DEN=Dental
		ORA=Oral Surgery
	Ear, Nose And Throat	ENT=Ear, Nose And Throat
	General Surgery	COL=Colo Rectal Surgery
		GES=General Surgery
		GSU=General Surgery
		MTO=Major Trauma Outcome Clinic
	Neurosurgery	NES=Neurosurgery
	Ophthalmology	OPH=Ophthalmology
		OPT=Optometry
		ORP=Orthoptics
	Orthopaedics	ORT=Orthopaedics
		OTT=Orthopaedic Trauma
		SPS=Spinal Injury
		SPS=Spinal and Scoliosis
	Pain Management	PAI=Pain Management
	Plastic Surgery	HAN=Hand Clinic
		PLA=Plastic Surgery
	Urology	URO=Urology
	Vascular	VAS=Vascular Surgery
		VTE=Vascular Tech Service
Z: Not to be reported	Hospital in the Home	HIT=Hospital In The Home
	Mental Health	APY=Adult Psychology
		CHI=Child Psychiatry
		CPY=Child Psychology
		FRM=Forensic Psychiatry
		GHP=General Health Psych
		MMH=Midland MH
		MPG=Midland Psych Geri
		PSG=Psychogeriatrics
		PSY=Psychiatry Adult
		PYO=Psychology - Youth
		SAM=SW Aboriginal MH
	Research	RSH=Research

Appendix B – Flowchart for recording service events when admissions or admitted procedures are cancelled



Appendix C – Summary of recording and reporting inclusions and exclusions for ABF 2020-21

	Non-admitted Activity		
	Recorded in PAS	Reported by DOH	Eligible for national ABF
Patient already being treated			
Non-admitted services provided to admitted patients	Yes	No	No
Hospital in the Home (HITH) patient	Yes	No	No
Non-admitted services provided to Emergency Department patients	Yes	No	No
Specialist Mental health patient	Yes	No	No
Diagnostic services -Tier 2 codes 30.01 to 30.08	Yes	Yes[b]	No
Patient attendance			
Patient attended in person	Yes	SE[a] Only	Yes[c]
Patient attended via information technology (in place of in-person) as selected via service delivery mode	Yes	SE[a] Only	Yes[c]
Patient did not attend, did not provide notification of non-attendance	Yes	No	No
Appointment cancelled	Yes	No	No
Non-client event/Chart review only (patient not present) selected via service delivery mode *'other'*	Yes	No	No
Medical consultation undertaken in a Multidisciplinary Case Conference (MCC) clinic, as selected via service delivery mode *'MCC'*	Yes	One SE[a] per MCC appointment Only	Yes[c]
Allied health and/or clinical nurse specialist interventions undertaken in a Multidisciplinary Case Conference (MCC) clinic, as selected via service delivery mode *'MCC'*	Yes	One SE[a] per MCC appointment Only	No
Not specified	Yes	No	No
Same patient activity recorded more than once			

	Non-admitted Activity		
	Recorded in PAS	Reported by DOH	Eligible for national ABF
Within same information system/site	Yes	First SE[a] of the day Only	Yes[c]
Across two or more information systems	Yes	SE[a] from one information system only	Yes[c]
Incomplete patient-level information	Yes	SE[a] Only	Yes[c]
Patient education	Yes	SE[a] Only	Yes[c]
Services provided to groups	Yes	SE[a] Only	Yes[c]
Self-administered home delivered services			
Renal dialysis—haemodialysis	Yes	One SE[a] per patient per month	Yes[c]
Renal dialysis—peritoneal dialysis	Yes	One SE[a] per patient per month	Yes[c]
Nutrition—total parenteral	Yes	One SE[a] per patient per month	Yes[c]
Nutrition—enteral	Yes	One SE[a] per patient per month	Yes[c]
Ventilation	Yes	One SE[a] per patient per month	No - Block funded
Providers			
Healthcare providers	Yes	SE[a] Only	Yes[c]
Other providers	No	No	No
Type of service			
Consultancy	Yes	SE[a] Only	Yes[c]
Procedure	Yes	SE[a] Only	Yes[c]
Same day cancelled admitted procedures (Type B)	Yes	SE[a] Only	Yes[c]
Same day non-admitted procedures (Type C)	Yes	SE[a] Only	Yes[c]
Telehealth	Yes	SE[a] Only	Yes[c]

	Non-admitted Activity		
	Recorded in PAS	Reported by DOH	Eligible for national ABF
Specific programs			
Aged Care Assessment (ACAT)			
State funded	Yes	SE[a] Only	Yes[c]
Commonwealth funded	Yes	No	No
Family Planning	Yes	Yes	No
Primary Health Care	Yes	Yes	No
General Counselling	Yes	Yes	No
Rehabilitation in the Home (RITH)	Yes	SE[a] Only	Yes[c]
Falls clinics	Yes	SE[a] Only	Yes[c]
Memory clinics	Yes	SE[a] Only	Yes[c]
Day Therapy Units	Yes	SE[a] Only	Yes[c]
Stroke clinics	Yes	SE[a] Only	Yes[c]
Parkinson's clinics	Yes	SE[a] Only	Yes[c]
Residential Care Line (RCL)	Yes	SE[a] Only	Yes[c]

(a) SE = NAP activity that meets the WA MDG-10-004 Non-Admitted Patient Service Event Definition
(b) Services provided from these clinics will be reported nationally if they meet the WA MDG-10-004 Non-Admitted Patient Service Event Definition but will be bundled with the originating NAP service event for national activity-based funding purposes.
(c) A NAP service event will only be eligible for activity-based funding if it has both a funding source and a Tier 2 code that are in-scope and the service is provided from an in-scope establishment. Block-funded establishments are not eligible for activity-based funding.

Appendix D – Summary of revisions

Version	Date Released	Author	Approval	Amendment
1.0	1 July 2021	Lorinda Bailey	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document created. Content adapted from the Non-Admitted Activity Reference Manual (NAARM).

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