Government of Western Australia
Department of Health

Non-Admitted Patient Activity Data

Business Rules

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Links to:	Information Management Policy Framework https://ww2.health.wa.gov.au/About-us/Policy-frameworks/InformationManagement

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Abbreviations

ABF	Activity Based Funding
ACAT	Aged Care Assessment Team
AIHW	Australian Institute of Health and Welfare
CAR-T	Chimeric Antigen Receptor Therapy
CHE	Contracted Health Entities
ED	Emergency Department
GP	General Practitioner
HEN	Home delivered Enteral Nutrition
HITH	Hospital In The Home
HSP	Health Service Provider
ICT	Information and Communications Technology
IHACPA	Independent Health and Aged Care Pricing Authority
MCC	Multidisciplinary Case Conference
MDC	Multidisciplinary Clinic
NADC	Non-Admitted Data Collection
NHRA	National Health Reform Agreement
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 (WA) health system.

The Non-Admitted Patient Activity Data Business Rules is a related document mandated under 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 Data Collection Data Specifications*
- *Non-Admitted Data Collection Data Dictionary*
- *Patient Activity Data Policy Information Compendium*.

2. Background

Business rules ensure that the collection of non-admitted data is standardised across the WA health system, and ensures that Health Service Providers (HSPs) and Contracted Health Entities (CHEs) record, count and classify 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 Non-Admitted Data Collection (NADC) 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 non-admitted services involving the provision of clinical care:

- irrespective of location (includes on-campus and off-campus)
- regardless of the source from which the entity derives activity funding (Department of Veterans' Affairs, compensable, Medicare and other patient funding sources are included) regardless of setting or mode.

Excluded from the scope are services:

- for the delivery of non-clinical care, i.e. activities such as home cleaning, meals on wheels or home maintenance
- Primary health services, e.g. General Practitioner (GP).

5. Definitions

5.1 Activity

Non-admitted activity occurs when a patient receives specialised care outside of emergency and admitted settings. In general, non-admitted care is 'simpler,' less prolonged treatment, monitoring, and evaluations than same day or overnight admitted care.

Prior to any non-admitted activity occurring, a patient must have an appropriate referral to a specialised healthcare provider which must be registered, triaged, and allocated a clinical urgency.

5.2 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. All attended appointments must have the outcome recorded within five days.

The attended appointment is intended to capture instances of healthcare provision from the perspective of the relevant HSP and CHE.

Note: If a patient is accompanied by a carer/relative, or the carer/relative acts on behalf of the patient with or without that patient present (e.g. the mother of a two-year-old, or the carer for an incapacitated patient), only the referred patient's service event is recorded unless the carer or relative's interaction meets the definition of a service event. The term carer refers to an informal carer only.

5.3 Clinical or therapeutic content

Clinical or therapeutic content needs to meet the following criteria:

- supports a diagnosis and the management of the patient
- is expert or evidence-based clinical knowledge
- may also restore a patient's health or provide healing from an injury
- may prevent a specific illness from occurring or after the diagnosis has already been established to treat the diagnosis or provide healing
- considers the local health environment including practice, policies and availability of services.

5.4 General List

The General List refers to the list of activity that is in-scope for Commonwealth funding under the National Health Reform Agreement (NHRA). The General List Determination is guided by the framework entitled Annual Review of the General List of In-scope Public Hospital Services. Assessment is performed a year in advance by the Independent Hospital Pricing Authority (IHACPA). Submissions are to be forwarded to the WA National Activity Based Funding (ABF) team npaisc@health.wa.gov.au for review in early April, prior to submission to Independent Health and Aged Care Pricing Authority (IHACPA) by 31 May each year.

5.5 Healthcare provider

A non-admitted healthcare provider is a person who is registered to practice under The Australian Health Practitioner Regulation Agency (AHPRA) or other applicable governing body or national professional organisation and whose primary employment role is to:

- diagnose and treat physical and mental illnesses and conditions or
- recommend, administer, dispense, and develop medications and treatment to promote or restore good health to a patient.

Non-admitted healthcare providers are university qualified practitioners with expertise in their specialty and work autonomously providing direct clinical care. Recognised non-admitted healthcare providers who are eligible to record activity under the IHACPA Tier 2 code classification code include:

- Medical Practitioners
- Dental Practitioners
- Nurse Practitioners
- Clinical Nurse Specialists
- Midwives
- Endorsed Midwives
- Liaison Nurses (recognised in WA only)
- Allied Health Practitioners
- Aboriginal Health Practitioners

Healthcare providers may be accompanied by health assistants and students. This activity must be recorded against the leading healthcare provider's registered clinic only.

Pastoral care, welfare or liaison workers, meals on wheels staff, allied health assistants and Enrolled Nurses are not recognised as a non-admitted healthcare provider. These providers work within a multidisciplinary team and provide support to the leading healthcare provider.

5.6 Medical record

Medical records are formal collections of information regarding an individual's healthcare plan, medical history, assessments and other health related documentation. A medical record can exist in physical, digital or electronic form and is typically created when a patient first presents to a healthcare facility. The medical record is also used to document care in all subsequent presentations. Where an electronic record is made as a substitute for a physical record, it is to be viewed and treated in a similar manner to the physical record. While the medical record primarily serves the patient as a documented history of their care interactions, it is also a necessary evidentiary record for mandatory audit purposes, to meet legislated funding agreements and record keeping requirements. Entries must be made by the healthcare provider during the event or directly after within a reasonable timeframe.

All non-admitted events must be supported by documentation and a record of treatment or care that includes:

- administrative documentation (e.g. registration on the Patient Administration System (PAS) and referral)

- written documentation in the medical record by the non-admitted healthcare provider to evident compliance with the definition of a service event, including:
    - the date and time of the non-admitted event
    - the reason for the non-admitted event
    - the intended clinical treatment plan for the non-admitted event
    - follow up instructions
    - factors and exceptional patient circumstances contributing to the event
    - conditions identified and treatment or care provided
    - name of the healthcare provider who is providing the service and their designation.

Information not written or recorded within a conventional paper-based or digital medical record but captured electronically via a supporting administrative or clinical application (e.g. eReferrals, iCM) may, by definition, be considered an extended part of the medical record. Where such an application is used to document any decision in relation to the non-admitted event, local procedures must evidence this as standard practice, and the information must be documented consistently. A copy of a dictated letter from the healthcare provider does not substitute as evidence of the event. Documentation must be clear and legible, with information relevant to the type of activity being undertaken. For more information on managing health records, refer to Australian Health Practitioner Regulation Agency - Managing health records.

5.7 Service event

Activity which meets national criteria and counting rules and is reported nationally for inclusion in the Non-admitted patient National Best Endeavours Dataset.

See Section 12. National reporting for more information.

5.8 Outpatient clinic

An outpatient clinic is a specialty unit or organisational arrangement under which a HSP or CHE provides non-admitted services.

These services are an important interface in the health system between primary care services and hospital services including acute care admissions. They provide people seeking healthcare with access to:

- medical practitioners, nurses, midwives 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 admission care
- related diagnostic services such as pathology, pharmacy and diagnostic imaging
- time limited and goal orientated care planning services in an ambulatory setting to reduce unplanned admissions and readmissions.

5.9 Referrals

A referral is a service request that includes a minimum set of information about a patient and the reason why specialised care is required. A referral can be completed by a WA Health recognised referral source. If a referral is accepted by a relevant HSP or CHE it provides the patient with access to specialised non-admitted services.

6. Recording activity

HSPs and CHEs are responsible for ensuring that data are entered correctly in a timely manner in an approved PAS (e.g. appointments attended) so that up-to-date data can be provided for reporting purposes.

Data can be retrospectively entered to ensure all activity is included in data submissions to IHACPA and the AIHW.

Data entry and corrections for the previous quarter must be entered by the second month of the current quarter.

- 1st Quarter – 15th November
- 2nd Quarter – 15th February
- 3rd Quarter – 15th May
- 4th Quarter – 15th August.

Refer to Appendix C Summary of recording and reporting inclusions and exclusions for ABF 2025-26.

6.1 Required to be recorded

For operational requirements any activity undertaken in a non-admitted setting is in-scope and is able to be recorded. This includes activity where the patient is:

- present or the interaction is equivalent to an in-patient consultation or treatment (e.g. telehealth and telephone appointments)
- not present (e.g. Non client event (NCE), Chart Only (C/O) or Multidisciplinary Case Conference - patient not present (MCC) appointments).

Once an appointment is recorded in the PAS, it needs to meet the WA MDG-10006 Non-Admitted Patient Attended Appointment Definition and other additional criteria to determine whether the activity is or is not a service event for reporting and funding purposes.

Activity which does not meet the service event criteria may also be recorded regardless of if the patient is present or not. To exclude this from reporting the appropriate criteria must be enabled.

6.2 Admitted patient

The NHRA and the *Health Insurance Act 1973* requires all components of care (including non-admitted care) provided to an admitted public patient to be provided free of charge as a public hospital service, regardless of the setting. This includes any care provided to the patient by Contracted Health Entities.

While non-admitted services provided to people during receipt of publicly funded admitted or active emergency care are not valid service events, they must still be recorded.

If the patient is admitted as a private patient at a private hospital at the time of receiving a public outpatient clinic service, then their public outpatient activity can be counted as a service event.

The following are examples of activity that must be recorded:

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

Activity will not be reported if the healthcare provider interacts with an admitted patient in a ward as the care provided is not part of an outpatient clinic service (valid outpatient clinic).

6.3 Emergency Department

A non-admitted service provided to a patient whilst in active emergency attendance must be recorded, as per the Emergency Department Patient Activity Data Business Rules.

6.4 Deceased patient activity

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

HSPs and CHEs are responsible for managing the status of a referral if the referral is reactivated to enter retrospective activity. The referral must be closed, and the original closure date is to be inserted after data entry is completed. This avoids accidental communication with deceased patients' families and to limit the number of unnecessary open referrals in the system.

6.5 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 service event. Documentation of these services must be in the medical record:

- 10.15 Renal dialysis - Haemodialysis - home delivered
- 10.16 Renal dialysis - Peritoneal dialysis - home delivered
- 10.17 Total parenteral nutrition - home delivered (TPN)
- 10.18 Enteral nutrition - home delivered (HEN)
- 10.19 Ventilation - home delivered
- 10.22 Subcutaneous immunoglobulin (SCIg) infusion therapy - home delivered

All sessions performed per month for the same home-delivered service will be bundled and reported as one non-admitted service event, regardless of the number of sessions performed. These services must have the service delivery mode of 'Client Present' assigned.

Note: Bundling rules do not apply for Tier 2 code 10.22 Subcutaneous immunoglobulin (SCIg) infusion therapy - home delivered. Each self-administered delivery of SCIg by the patient or healthcare provider is to be recorded and is eligible for funding when documented in the medical record. These services must have the service delivery mode of 'Client Present' assigned.

Any self-administered home-delivered activity that occurred whilst the patient was admitted will be excluded from reporting.

When there are multiple types of home delivered services (e.g. renal dialysis and HEN), both can be recorded as separate non-admitted service events provided the patient performed at least one session of each type of the home-delivered service.

Home-delivered activity must be classified via the Tier 2 Non-admitted services classification regardless of the conditions of patient.

For example, if the patient is:

- receiving services under a mental health community arrangement and
- 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.

6.5.1 Home Enteral Nutrition

Home Enteral Nutrition (HEN) services encompass both specialised nutrition products which includes any substance with nutritional value used for HEN and any consumables e.g. feeding sets, syringes required to administer HEN. Activity is to be recorded under Tier 2 code 10.18 Enteral nutrition – home delivered into an approved PAS and is reported nationally.

Only one HSP or CHE is eligible to record the HEN activity for the same patient in the same month. The site which is funding the nutritional products or consumables is to record the activity. When transferring a patient between sites, a discussion between the referring and receiving Dietitian should occur to determine which site should record the HEN activity for any given month.

Activity may be entered on the assumption that HEN is occurring and continuing as instructed. If HEN did not occur, then the event is to be cancelled, in a timely manner to ensure that accurate data is available in NADC for reporting.

HEN activity must satisfy the criteria for a service event. See Section 11.1 Criteria

Activity that occurs in relation to the HEN which meets the criteria for a service event is to be recorded under the appropriate Tier 2 code of the leading healthcare provider e.g. interactions that occur when there is a change to the patient's prescription.

- HEN-specific reporting criteria: A patient needs to be on HEN for at least ≥1 day per month to qualify for entering activity into the PAS
- One day or multiple days in a single month equate to one service event to be entered into the PAS
- If the person is an inpatient at the time the HEN event is recorded the HEN will not be eligible for funding.
- It is recommended that the day allocated for recording HEN be the last Friday or Saturday of the month
- Appointment types are to be assigned to each service event as follows:
    - NEW: patients on their first month of HEN

- FOL: patients on subsequent months of HEN

Activity should be recorded in a timely manner so that the information can be accessed for inclusion into NADC. Data should be entered retrospectively on a monthly basis to ensure that it is available for reporting.

Documentation provided in addition to the entry made by the healthcare provider must include:

- HEN prescription including product/consumables, volume and frequency e.g. brand, volume and number of times per day or week HEN is consumed
- expiry date of HEN registration
- timeframe for patient review
- Healthcare Practitioner's full name, designation and date of entry
- outcomes or changes to HEN prescriptions.

Any subsequent reviews must include clear documentation in the medical record detailing any changes to the HEN prescription, frequency, expiry date or if HEN is ceased.

A clinical review between the patient and the healthcare provider is recommended within the first month after HEN commences to ensure the patient is compliant with the prescription. Each patient should then be reviewed based on clinical need to determine ongoing requirements for HEN. If the patient is well established on HEN a review with the healthcare provider every three months is recommended unless clinically indicated.

6.6 Multiple services on the same day

If a patient has a range of conditions requiring different interventions by healthcare providers and they occur on the same day (usually for the patient or carers' convenience), then each service event must be recorded. Only the first event for the day per clinic will be reported nationally. For local reporting multiple events are within scope.

The counting rules that are to be applied are:

- for multiple non-admitted service events to be counted on a given day, the patient must have attended separate clinics where they received a service that meets the definition of a non-admitted service event.
- if the non-admitted service event was intended to be unbroken, but due to circumstances the healthcare provider was called away and returned later, then only a single non-admitted service event must be counted.
- appointments at clinics where services are provided by multiple healthcare providers must not be counted as separate non-admitted service events in order to count increased non-admitted service events. This activity may meet the criteria for a multidisciplinary clinic.
- clinics where services are provided by multiple healthcare providers must not be registered as separate clinics in order to count increased non-admitted service events. This activity may meet the criteria for a multidisciplinary clinic.

- a patient whose care is discussed at an MCC occurring immediately prior to, or immediately following an outpatient clinic to which the same patient attends, is counted separately as a non-admitted service event.

6.7 Pre-admission

HSPs or CHEs may report pre-admission 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 on the same day as the admission, as long as the event occurred before the admission starts, this will be reported as activity.

6.8 Same day non-admitted procedure

A non-admitted procedure is a procedure that does not require the patient to be admitted for inpatient care. To minimise hospital costs and with improved technology, the frequency of non-admitted procedures has increased, with shorter procedure duration and fewer complications.

See Same-day ACHI Procedure Codes for list of Type C and B Procedures that are in scope for reporting of non-admitted outpatient clinic activity. These procedures are generally recorded under a 10 series Tier 2 clinic.

6.9 Cancelled and rescheduled 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 non-admitted activity.

See Flowchart for recording service events (Appendix B) for recording service events when an admitted event is cancelled.

6.10 Multidisciplinary case conference – patient not present

A Multidisciplinary Case Conference (MCC) is an appointment type where the patient (or their carer) is not present, and a meeting is arranged in advance and held concurrently between three or more healthcare providers who have direct responsibilities for the patient and coordinate a treatment plan. MCCs ensure that a patient's multidisciplinary care needs are met through a planned and coordinated approach.

The healthcare providers involved in the MCC may be of the same or different profession. When they are of the same profession, they must each be from a different specialty so that the care provided by each healthcare provider is unique. Alternatively, the healthcare providers may be of different professions (medical, nursing, midwifery or allied health) but of the same specialty (e.g. cardiology). While support staff such as Aboriginal Liaison Officers can participate, they are not counted as one of the healthcare providers in the criteria.

For each non-admitted patient discussed - a multidisciplinary management plan must be in place or developed at the MCC, and one participating healthcare provider must record the following items in each medical record:

- the name of the MCC, the date of the MCC, and the start and end times (or duration) of the MCC at which each patient was discussed
- the names of the participants involved in the discussion relating to the patient and their designations and clinical backgrounds
- a description of the patient's problems, goals and strategies relevant to that MCC
- a summary of the outcomes of the MCC.

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

Each participating healthcare provider must also have a separate entry into the medical record defined in Section 5.6 Medical record.

MCCs are recorded by the service delivery mode selection of 'MCC' to allow for analysis of activity and reporting. The MCC must be recorded under the leading healthcare providers Tier 2 code. The following Tier 2 codes are not permitted for use in WA:

- 40.62 Multidisciplinary Case Conference (MCC) – patient not present
- 20.56 Multidisciplinary Case Conference (MCC) – patient not present.

MCC appointments must use 'Non-client event or chart only' Appointment Type.

The healthcare providers participating in the MCC may attend in person or via an approved 'Virtual care' delivery mode, however the service delivery mode is to remain as 'MCC' and only one MCC should be recorded regardless of the number of sites involved. The most appropriate site to report the MCC should be based on where the majority of healthcare providers and services are located. Healthcare providers can attend from the one organisation or from a range of health organisations including private healthcare providers that provide publicly funded services.

For Example:

> A MCC is held by a cardiologist, respiratory physician, haematologist and a physiotherapist to discuss a patient in detail and coordinate their care. The patient is not present in the MCC. The cardiologist and respiratory physicians are located at hospital A whilst the haematologist and physiotherapist are located at hospital B. All four healthcare providers participate in the MCC via videoconference. A multidisciplinary management plan is developed at the conference which includes a documented description of the patient's problems, goals and strategies relevant to that conference, and a summary of outcomes of the conference. A summary of the details including the date, duration, and the attendee's names and designations or clinical backgrounds, are documented in the medical record by the respiratory physician. In this instance, the healthcare providers agreed that the cardiologist and respiratory physician (from hospital A) were providing the majority of the services to the patient therefore would report the non-admitted MCC using service delivery mode - MCC.

Outcome: this would be counted as one non-admitted MCC service event, even though all four healthcare providers were providing the MCC via videoconference.

For multiple MCCs to be counted for the same patient on a given day, the patient must have been discussed in separate MCCs where each of the different MCCs meets the definition of a non-admitted MCC service event, e.g. on the same day, a patient may be discussed separately in an oncology MCC and in a musculoskeletal MCC, both of which had a different and unique focus on the patient's issues. One service event is to be recorded for each patient discussed at the MCC regardless of the number of healthcare providers are participating. Refer to the Section 7.5 Single service event method.

6.11 Subcutaneous Immunoglobulin (SCIg) Infusion Therapy

When reporting activity for Tier 2 code 10.22 Subcutaneous Immunoglobulin (SCIg) Infusion Therapy, every occasion of service, regardless of frequency, is counted as a service event, provided there is documentation of the SCIg in the medical record. The SCIg can be administered by the patient or the healthcare provider and the event recorded under the Tier 2 code 10.22.

Although the SCIg is self-administered by the patient with or without the presence of a healthcare provider the service delivery mode must be recorded as 'Client present'.

For example: a follow up appointment by the healthcare provider was made by telephone with the patient to discuss any issues or concerns when self-administering SCIg infusion therapy at their home for the last 8 weeks. The patient has been prescribed SCIg 3 times a week for 8 weeks and every dosage has been documented by the patient in their diary which the healthcare provider confirmed with the patient. The following requirements where completed:

1. A copy of the patients' diary and SCIg prescription was filed in the medical record.
2. A dated written entry was made by the healthcare provider in the medical record confirming the patients' diary entries were correct, and any issues or concerns and recommendations provided by the healthcare provider to the patient.
3. Each procedure date was then recorded in the PAS.

Outcome: a non-admitted service event would be counted for each procedure on the day it was delivered and a second event recorded for the interaction between the patient and the healthcare provider using the appropriate Tier 2 code.

6.12 High-cost therapy

Access to new, high cost, highly specialised and potentially curative therapy treatments are an emerging option for patients in WA. A small number of people are expected to benefit from access to highly specialised therapies each year. This includes, but is not limited to, the provision of Chimeric Antigen Receptor Therapy (CAR-T) such as Yescarta®, Kymriah®, Tecartus, and other specialised therapies including Qarziba® and Luxturna™.
IHACPA has developed guidelines for the costing, counting and reconciliation of funding. To comply, all HSPs must provide patient-level activity data on highly specialised therapies to the Department of Health on a quarterly basis through NADCdata@health.wa.gov.au.

The specifications are available on the IHACPA website, under Alternative funding source. However the Department of Health, as the System Manager, requires HSPs to provide the patient UMRN, activity type, and date of event to identify activity within central records.

This will enable the required reporting to IHACPA and will ensure that highly specialised therapy can be identified and reported for a range of purposes, including patient safety, research and funding.

7. Outpatient clinic registrations

When registering an outpatient clinic, the clinic must include:

- a unique identifier (Clinic ID) allocated by Health Support Services (HSS) for webPAS sites
- a description which states the purpose of the clinic and the lead healthcare provider designated if managed by two or more healthcare providers (refer to Section 7.2.2 Principal or lead healthcare provider)
- 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 mandatory fields, require authorisation from a manager at site before notifying the NADC Data Custodian via email at NADCdata@health.wa.gov.au.

The NADC Data Custodian will review clinic registrations and changes to clinics and will provide specific system advice if further actions are required, including any impact on data.

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 codes are no longer reported nationally, as Tier 2 is the current classification system for non-admitted activity, this code remains a mandatory item when registering non-admitted outpatient clinics and is used to identify national service events which may or may not qualify for activity based funding.

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 Clinic - outpatient clinic Tier 1 type list.

Non-clinical care, ancillary services and services provided in community health settings (e.g. community and child health centres) can be recorded and reported using out-of-scope Tier 1 codes to ensure this activity is not reported nationally.

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 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 e.g. 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 NADC Data Custodian is required prior to establishing a block funded clinic in the PAS so the correct advice on which Tier 1 NMDS code to use 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 ABF 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 service.

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

Each financial year the price 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 IHACPA 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).

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. Guidance on which discipline and healthcare providers that usually deliver the Tier 2 services can be found in the IHACPA Tier 2 Non-Admitted Services Definitions Manual.

Note: While Tier 2 codes in the 40 series specify the nurse to be a clinical nurse specialist, the use of the terminology ‘clinical nurse specialist’ is intended to reflect that services are provided by specialist nurses. 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 lead healthcare provider for Tier 2 coding purposes is determined as follows:

- where 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 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 or which healthcare provider spends more time with each patient (i.e. where one clinician provides greater than 50% of the services)
- 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 or intervention associated with the cohort.

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 cannot be changed without significant objective reasons.

7.2.3 Rules for assigning a Tier 2 code

For the WA health system, the Tier 2 code is determined 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 to capture all of its NAP service events e.g. 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.

For example:

- clinics where the usual healthcare provider is an endorsed midwife practitioner, or a nurse practitioner the clinic should be classified to the relevant class within the 20 series - Medical consultation
- where there is a mix of medical practitioners, allied health professionals or CNS in the one clinic for a specific service, the clinic should be classified to the Tier 2 group most relevant to the usual healthcare provider of the clinic's services. Spontaneous or ad hoc consultations provided by a medical practitioner within an allied health professional or CNS clinic should not result in a reassignment to a class within the 20 series - Medical consultation
- the 10 series deliberately omits the 'usual provider' field in class definitions. Clinics that provide procedural services should be classified within this series based on the usual procedure the clinic delivers, rather than who is the usual healthcare provider of the clinic's services.

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 reassign a Tier 2 code the NADC 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
- new Tier 2 codes become available or are decommissioned from IHACPA.

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 NADC Data Custodian for specific system advice before proceeding as changes to values may overwrite all previous existing values.

7.2.5 Rules for reassigning 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 sent to the NADC 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 patient 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 WA health system.

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

7.4 Care type

Care type refers to the overall nature of the clinical service provided to the patient during a consultation 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)
- acute care
- other care (e.g. maintenance care).

Note: The non-admitted care types are a subset of the admitted care types. Many admitted care types are not relevant to non-admitted care and if used are mapped to ‘Other care’.

The care types of Psychogeriatric care and Mental Health care are excluded from all non-admitted reporting. These care types are recorded in PSOLIS and reported by the Mental Health Data Collection for funding; however, the non-admitted activity is to be recorded as the activity will continue to be collected in the NADC for internal purposes. Please refer to current referral categories (Appendix A) for activity reporting exclusions.

7.5 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.

7.6 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 healthcare providers functioning as a team. The healthcare providers within an MDC can be from:

- the same specialty: healthcare providers must be of a different profession (e.g. a medical practitioner, a clinical nurse specialist and an allied health practitioner all from specialty A)
- different specialties: healthcare providers can be of the same profession (e.g. a clinical nurse specialist from specialty A, a clinical nurse specialist from specialty B and a clinical nurse specialist from specialty C)
- the contribution of each healthcare provider must meet the definition of a service event. See Section 11.1 Criteria.

Where healthcare providers are from multiple clinics, establishments, or different locations and are present at the MDC, only one service event should be recorded. The exception to this rule is when the patient is attending the MDC with a support clinician at one site and the other healthcare providers are located at another site as part of a telehealth consultation.

Although there are three or more healthcare providers contributing to an MDC, only a single service event must be recorded for each patient. See Section 7.5 Single service method.

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 with two healthcare providers whilst the third healthcare provider attends via telephone). MDCs are permitted to use virtual care service delivery modes.

The aim of an MDC is to provide Multidisciplinary care to a patient on the same day within a single clinic by collaborating to assess and make treatment recommendations that facilitate patient care. MDCs must be set up with the multidisciplinary flag set to 'yes.' By ensuring the MDC flag is set to 'yes', MDC activity can be correctly identified and used for planning and funding purposes.

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

7.7 Voluntary assisted dying clinics

When setting up a clinic relating to voluntary assisted dying, please contact the NADC Data Custodian NADCdata@health.wa.gov.au for specific registration requirements.

8. Managing referrals

Accurate recording of referral data is important as it marks the commencement of the non-admitted journey and dictates how subsequent appointment activity is classified and reported. All accepted referrals to a non-admitted outpatient clinic must be registered in a PAS.

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

Referrals which do not contain sufficient information to allow accurate triage of the referral or do not meet the 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 healthcare provider.

If a treating healthcare provider refers a patient to another 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.

For more information regarding referral requirements refer to the *Specialist Outpatient Services Access Policy.*

8.1 Registering referrals

HSPs and CHEs must actively manage referrals to provide timely and appropriate access to clinic appointments.

Before any clinical interaction occurs, a referral must be received, triaged by a healthcare provider 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 an appointment within 30 days
- semi urgent: priority 2 an appointment within 90 days
- routine: priority 3 an appointment within 365 days.

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

Where a single referral letter covers more than one condition and requires consideration by more than one specialty, separate referral registrations are required for each referral category and condition combination.

Only one referral per referral category per condition per treatment phase is to be registered and open in the PAS at any given time. If the patient is required to be seen

by sub-specialty healthcare 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 or condition combination is clearly documented in the 'presenting complaint' field of the PAS 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), this requires the referral request to be declined or rejected in the PAS with a letter forwarded to the patient and issuing referrer advising of the situation, except when pre-approved arrangements have been made between HSPs.

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 contact the hospital directly.

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

- their general practitioner
- healthcare provider within the hospital (e.g. Emergency Department, admitted units)
- medical practitioners, private rooms
- healthcare providers in other hospitals
- other healthcare providers where appropriate (e.g. optometrists, dental practitioners, midwives, audiologists, Aged Care Assessment Teams (ACATs) and Nurse Practitioners)
- 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
- specialists referring back to themselves for ongoing care.

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:

8.3.1 Assessment

A comprehensive evaluation of the patient's health status, medical history, symptoms or condition.

8.3.2 Chart review

A review of the patient's medical record is required by the healthcare provider, the patient is not present.

8.3.3 Education

The patient only requires education regarding a health condition.

8.3.4 Other

The referral reason does not fit into any option.

8.3.5 Research trial

The patient is part of a research trial only.

8.3.6 Treatment or intervention

The patient only requires a diagnostic procedure.

8.3.7 Ongoing Patient Management

Ongoing Patient Management must only be used when a patient has attended an appointment for the original referral and there is a technical reason for the referral to be transferred to a newly created referral.

- Scenario one:

  The service is moving from Hospital A to Hospital B, which requires all referrals to be transferred to Hospital B. This scenario includes when a patient is transitioning from a paediatric hospital to an adult hospital.

  If the patient has attended a first appointment at Hospital A, the new referral at Hospital B must use the 'ongoing patient management' as the referral reason.

  For a patient still awaiting their first appointment at the paediatric hospital, the new referral at the adult hospital must use 'assessment' as the referral reason.

- Scenario two:

  The service is moving from one specialty to another. This often occurs when a new clinic specialty is created e.g. the original referral is under General Surgery. The request to create an Upper GI Specialty is approved and requires all General Surgery referrals to be moved to Upper GI on the PAS.

  If the patient has attended a first appointment at the General Surgery clinic, the new referral at Upper GI must use the 'ongoing patient management' as the referral reason.

  For a patient still awaiting their first appointment at Upper GI, the new referral must use 'assessment' as the referral reason.

  Note: A patient who requires an appointment post discharge does not meet the requirements for 'ongoing patient management'. For this

scenario, an existing referral can be utilised, or a new referral with referral reason of ‘Assessment’ is to be created.

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 Tier 2 code for reasons approved by sites. 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 must use referral reason ‘ongoing patient management’ and appointment type ‘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

HSPs and CHEs 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 last attended appointment is ‘discharge’, the PAS referral must be closed to reflect the reason for closure as ‘treatment complete’ – if no further appointments linked to the referral.

  The referring healthcare provider must be notified of this action, including the reason.

- When a patient ‘did not attend’ an appointment(s) and the healthcare provider advises the patient is 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, including the reason.

- When a patient requiring non-urgent care advises they no longer want to receive care or routinely reschedules or cancels consecutive appointments and the healthcare provider has agreed, then the referral can be closed and the reason ‘Declined Treatment’, as guided by the *Specialist Outpatient Services Access Policy*.

The referring healthcare provider must be notified of this action, including the reason.

- When a patient requiring urgent care advises they no longer want to receive care or routinely reschedules or cancels consecutive appointments and the healthcare provider has agreed, then the referral can be closed and the reason 'Declined Treatment', as guided by the *Specialist Outpatient Services Access Policy*.

  The referring healthcare provider must be notified of this action, including the reason.

- When a referral is transferred to a new referral, the original referral must be closed to reflect a reason for closure as 'Transfer and Close'.
- When notification of a deceased patient is received, all 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 no longer requires an appointment as requested by the patient or clinical decision, the patient is to be returned to the referring healthcare provider and the referring healthcare provider notified of the reason. The referral is to be closed with a reason for closure as 'Audit'.

Auditing long waiting open referrals is also a data quality practice that ensures Key Performance Indicators (KPIs) and public reporting are accurately presented. Advice on data quality measures can be obtained by consultation with the NADC Data Custodian.

8.5.1 Cancelling referrals

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

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

8.6 Reactivating referrals

Referrals must not be reactivated. Closed referrals should remain closed, unless in specific circumstances including:

- link or unlink referrals to appointments
- referral was closed in error
- requires further review prior to a procedure or a planned admission
- as a result of an audit, and the patient fulfils all requirements set out by the health service provider to reactivate the referral.

9. Managing appointments

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

- establishment code
- attendance code
- client type
- appointment type
- session type
- clinic category code
- Tier 1 NMDS code
- Tier 2 code
- care type
- 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 used for standard reporting or submitted for ABF.

9.1 Appointment type

Appointments must only be classified as 'New,' 'Follow-up' or 'Non-client event or Chart only' Appointment Type.

The determination of 'New' or 'Follow-up' must be based on the registered open referral against which the appointment is made.

Note: Appointment Type is synonymous with visit type in webPAS.

9.1.1 New appointment

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

A 'New' appointment type is one where a health issue or condition has not been previously addressed at that clinic for that referral.

See Section 8.1 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 appointment type of 'New'.

9.1.2 Follow-up

All subsequent appointments for the same registered referral must be classified as follow-up. This includes:

- post-discharge reviews associated with an admitted patient episode
- routine review of a chronic condition
- monitoring results of interventions
- evaluation of action plans
- reassessment of patient needs.

9.1.3 Non-client event or Chart only

'*Non-client event or Chart only'* is to be used to allocate time for review of a patient's medical record. As there is no patient interaction, the patient is not contacted under this appointment classification.

To ensure a patient is not mistakenly notified of the '*Non-client event or Chart only'* appointment, the service delivery mode of this appointment classification must be set to 'Other.'

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

A Non-client event or Chart only must be processed to reflect the outcome or 'next step' in the patients care plan, processing the appointment outcome as 'chart only' is not advised.

For example:

- The clinician advises the patient is to be discharged as no further treatment required. The Non-client event or Chart only appointment is processed with an outcome of 'discharge' and the referral is closed. The referring healthcare provider is to be notified of this action, including the reason.
- The clinician advises the patient is to be seen in the next available appointment slot. The Non-client event or Chart only appointment is processed with an outcome of 're-appoint' and a follow up appointment is booked.

9.2 Services extended over midnight

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

9.3 Appointment attendance

9.3.1 Attendance

An appointment is recorded as being attended when the patient is present for their appointment or was recorded as being discussed at an MCC. An attendance is determined by using an appropriate attendance code 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 recording inclusions and exclusions for appointment attendances.

9.3.2 Non-attendance

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

If notification of a 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*.' In webPAS 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 used for flagging the required action after the '*Did Not Attend'* (i.e. the next step - reappoint, discharge etc.).

9.4 Attended exceptions

9.4.1 Healthcare provider present only

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

- chart reviews which result in a written entry in the patient's medical record.
- multidisciplinary case conferences.

9.4.2 Self-administered treatments

It is a requirement that all self-delivered events are recorded, regardless of any products or equipment supplied or payment arrangements for the supplies.

9.5 Service delivery modes

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

9.5.1 Client present (face to face)

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

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

9.5.2 Group client present (face to face)

The healthcare provider delivers the service to multiple people who are present for a group session and therapeutic content is provided.

9.5.3 Home visit

The healthcare provider delivers the service at the patient's own home and therapeutic care is provided.

9.5.4 Multidisciplinary case conference

When an appointment meets the Multidisciplinary case conference (MCC) definition the appointment must have '*MCC'* selected as the service delivery mode.

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

9.5.5 Other

A service delivery mode of 'Other' must be assigned when there is a service provided that does not involve any interaction between the patient and the healthcare provider.

Example: A 'Non-client event or Chart only' appointment must use this service delivery mode to ensure that the patient is not notified of the appointment. Note: this is specific for webPAS users.

9.6 Virtual care

Virtual care (also known as telehealth) is the use of technology to enable care when a healthcare provider and patient are in different locations. Virtual care consultations must involve an interaction between at least one healthcare provider and the patient. The interaction must be the equivalent of a face-to-face consultation. That is, both healthcare provider and the patient are interacting in a mutually responsive manner within a short timeframe.

Virtual care consultations must be a substitute for a face-to-face consultation to be counted as a non-admitted service event. That is, the consultation must contain therapeutic or clinical content and be equivalent in content in the sense that if the consultation could not be provided via virtual care, a face-to-face consultation would have occurred.

Administrative phone calls such as booking or rescheduling appointments, must not be counted as non-admitted service events. 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).

Virtual care consultations may be counted by the public hospital service providing the consultation service (provider end), and by the public hospital service where the patient is present (receiver end) and a healthcare provider is present.

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.

Virtual care activity must use the Tier 2 code of the leading healthcare provider assigned and the relevant service delivery mode.

9.6.1 Telehealth at Non-WA health site

Service delivery mode of *'TH at Non-WA Health 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. home or workplace, GP surgery, community resource centre or prison.

Example: the patient attends a telehealth service from their home using their personal device and the healthcare provider is located at any WA health site. The healthcare provider records this service event under *'TH at Non WA health site'.*

9.6.2 Telehealth at WA health site

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

- 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.)

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

9.6.3 Telehealth Support Clinician

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

- healthcare provider is located at WA health site (A)
- patient attends WA health site (B) and is accompanied by a support healthcare provider at WA health site (B).

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

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

Example: a healthcare provider is located at a metropolitan hospital (A) and the patient attends a regional hospital (B) to use their videoconferencing facilities and is accompanied by a support healthcare provider. The metropolitan site (A) records the activity against '*TH at WA Health site'* and the regional site (B) records the activity against '*TH Support Clinician*.'

9.6.4 Telephone

The healthcare provider delivers the service to the patient using a telephone and the service meets the definition of a service event.

9.7 Cancelled appointments

An appointment can be cancelled on the PAS when the patient:

- declines treatment or advises of receiving treatment elsewhere.
  - In this scenario, the referral must also be closed and the referring healthcare provider notified, including the reason.
- is currently attending the Emergency Department or is an inpatient.
  - In this scenario, another appointment is to be made, or
- the HSP or CHE as the clinician is unavailable.
  - In this scenario, another appointment is to be made.

When an appointment is cancelled, the cancellation reason must be clearly recorded.

Note: the following information is specific to webPAS.

When a patient requests to 'cancel' an appointment, unless the patient states the reason is due to declining treatment or receiving care elsewhere, a reschedule function must be followed for the appointment by allocating a new booking date and time. The *Specialist Outpatient Access Policy* must be read in conjunction with the *Non-Admitted Patient Activity Data Business Rules* for instructions on the cancellation process for appointments.

10. Managing change

Non-admitted activity data 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 NADC Data Custodian be notified of any information system changes that may impact recording or reporting of non-admitted activity. The NADC Data Custodian will then consult with stakeholders of the WA health system to progress changes.

The main aims of this process are to:

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

The key roles and responsibilities of 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 Data Business Rules to ensure data quality
- creation or modification of new and existing data items with specific reference to mandatory reporting items
- data collection and reporting processes (including data extracts and extract processes from HSPs and CHEs)
- access targets and system audit findings for non-admitted data providers.

10.1 Standard reporting

The WA health system uses non-admitted data for a wide range of reporting including:

- performance measures (for example, HSPR indicators P2-24a-c)
- Parliamentary questions
- media enquiries
- requests for data from WA health teams to support planning, monitoring, evaluation and funding of health services.

The characteristics of recorded non-admitted activity determines what is included or excluded from reporting. Activity is categorised as follows:

10.1.1 Standard exclusions

Non-clinical care, ancillary services, services provided in community health settings, specialised mental health, and poor quality data.

10.1.2 Attended appointments

Appointments that did occur and have been appropriately processed.

10.1.3 First appointments

The first attended appointment recorded against a referral.

10.1.4 Multidisciplinary case conferences

Multidisciplinary case conferences that did occur and have been appropriately processed.

10.1.5 Public hospitals

Activity reported by establishments listed as a public hospital in Schedule 2 of the *Health Services (Health Service Providers) Order 2016*.

Activity can be categorised into more than one category. Activity will generally be included or excluded from reporting based on these categories and depending on the specific requirements of a report or request for data.

10.2 Units of Measurement

10.2.1 Activity

WA uses the following two reporting units of measurement for reporting non-admitted activity:

- non-admitted service event
- attended appointment.

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

- MDG-10-004 Non-Admitted Patient National Service Event Definition: National Version: this definition is to be used for all National reports and submissions. Further criteria are then applied to determine what activity is eligible for ABF.
- MDG-10-006 Non-Admitted Patient Attended Appointment Definition: this definition is 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.

10.2.2 Waiting times

The outpatient waiting time is reported using two reporting measures:

1. time waited for first appointment and
2. waiting time for first appointment (on the waiting list).

Reporting category codes are used when reporting the waiting times measures. Current lists for these codes are located in Appendix A. The following definitions are used when reporting the waiting times measures:

- MDG-10-007 Patients on Outpatient Waiting List
- MDG-10-009 Median Waiting time to First Appointment

Definitions 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.

10.2.3 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.

10.2.4 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.

10.2.5 Cancelled and rescheduled

An outpatient appointment that has been cancelled by the patient or HSP (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.

10.2.6 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.

10.2.7 Non-client event or Chart only

A Non-client event or Chart only or MCC appointment that has been booked for the patient (i.e. a first appointment has not been attended for that referral) will not be excluded from the wait list. They are considered to be still waiting.

10.3 Classification of non-admitted activity

Each record of non-admitted 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 service event. The following will not be reported as a non-admitted service event:

- services that have not been provided to an individual patient or a group of patients, except for MCCs
- community, population or a public health service, unless included under the General List
- specialist mental health services, these are to be recorded in PSOLIS
- ancillary services such as issuing pharmacy scripts and dispensing medications
- non-clinical services e.g. pastoral care, welfare, Home and Community Care (HACC) Program.

10.3.1 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 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.

10.3.2 Multiple services on the same day

Where multiple non-admitted services are recorded for the same patient at the same clinic on the same day, only the first service event for that day will be counted for national reporting. The exception is when a Multidisciplinary Case Conference - patient not present (MCC) is reported and an additional appointment is attended on the same day and meets the service event definition then both events are eligible for National reporting.

Local reporting on attended appointments will include all appointments.

11. National reporting

The principal counting unit for nationally reported non-admitted activity is the service event.

All activity that meets the nationally defined criteria and counting rules of a service event will be reported nationally. However, the final determination of what will be funded under ABF by the Commonwealth is the responsibility of the IHACPA and the Administrator of the National Health Funding Pool. In particular, ABF will not occur for:

- incomplete activity records
- activity that is nationally funded by alternative sources (e.g. Department of Veterans' Affairs, Medicare Benefits Scheme, Insurance Commission of Western Australia)
- out-of-scope activity.

11.1 Criteria

A service event must satisfy all of the following criteria:

- an interaction between one or more healthcare providers and one patient (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 without the presence of a healthcare provider;
    - valid exception two: multidisciplinary case conference without the patient present.
- 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 non-admitted service event)
- must result in a dated entry in the medical record including the healthcare providers name and designation. The dated entry is documentation that supports the patient's attendance to the appointment as well as provide a record of the treatment and/or care plans.

11.2 Exclusions

Any activity that does not meet the above criteria is not considered a service event such as:

- work related services provided in clinics for staff
- non-attendances for booked non-admitted services that did not go ahead or when the patient left early
- travel by a health professional
- services provided to inpatients (including services provided by staff working in non-admitted clinics who visit admitted patients in wards, or other types of consultation and liaison services provided to inpatients)
- medical record reviews (e.g. chart only)
- patients who are currently attending an Emergency Department event
- report writing
- healthcare provider interactions where the patient or carer is not present (multidisciplinary case conferences are an exception)

- email correspondence to the patient or between healthcare providers regarding the patient
- transportation of a patient
- provision of equipment
- triage of referrals

11.3 Counting rules

Rules for counting service events are determined by national requirements. These rules include:

11.3.1 Multiple healthcare providers

All non-admitted services that meet the criteria of a non-admitted service event should be counted, and be counted only once regardless of the number of health-care providers present. The multiple health-care provider indicator can be used to identify service events with three or more health-care providers.

11.3.2 Multiple services on the same day

A patient can be counted as having multiple non-admitted service events in one day, provided that every visit meets each of the criteria in the definition of a non-admitted service event.

11.3.3 Education services

Education services provided to a patient can be counted as non-admitted service events, provided that they meet the criteria included in the definition of a non-admitted service event.

11.3.4 Group sessions

Each patient attending a group session is counted as a non-admitted patient service event, provided that the session included the provision of therapeutic/clinical advice for each patient and that this was recorded using a dated entry in each patient's medical record.

11.3.5 Information and communication technology

Consultations delivered by information and communication technology (ICT), including but not limited to virtual care and where the patient is participating via a video link consultation, can be counted as service events if they substitute for a face-to-face consultation, provided that they meet all the criteria included in the definition of a non-admitted service event. A telephone consultation is only counted as one non-admitted patient service event, irrespective of the number of health professionals or locations participating in the consultation. A telehealth consultation has service events counted at the location of the healthcare provider and the location of the patient.

11.3.6 Funding source

All non-admitted services that meet the criteria in the definition of non-admitted service events must be counted, irrespective of funding source (including Medicare Benefits Schedule) for the non-admitted service.

11.3.7 Diagnostic services

For activity-based funding purposes, diagnostic services are not counted as non-admitted service events; these are an integral part of the requesting clinic's non-admitted service event.

11.3.8 Self-administered treatment

Renal dialysis, total parenteral nutrition, home enteral nutrition and home ventilation performed by the patient in their own home without the presence of a health-care provider may be counted as a non-admitted service event, provided there is documentation of the procedures in the medical record. For activity-based funding purposes, all non-admitted sessions performed per month are to be bundled and counted as one non-admitted service event per patient per calendar month regardless of the number of sessions.

11.3.9 Multidisciplinary case conferences

Multidisciplinary case conferences – patient not present; whilst not meeting the definition of a non-admitted service event, are reported for activity-based funding purposes, provided there is documentation of the conference and associated outcomes in the medical record.

11.3.10 Events broken in time

The period of interaction can be broken but is still counted as one service event if it was intended to be unbroken in time. This covers those circumstances in which treatment during a service event is temporarily interrupted for unexpected reasons. E.g. a healthcare provider is called to assess another patient who requires more urgent care.

Where a healthcare provider is unable to complete the interaction, it is if the definition of service event (above) is met.

11.3.11 Services provided to groups

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

Where the definition of a non-admitted 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 Group Client Present service delivery mode is recorded for this type of A non-admitted service event and is used to derive the session type of 'Group'. The counting rules that are to be applied are:

- a service event is to be counted for each member of the group that receives a service containing therapeutic or clinical content
- the interaction must be documented in the medical record in order to be counted as a service event
- family members seen together are each to be counted as service events if each family member's service meets the definition of a service event

- family members or carers accompanying a patient to an appointment must not be counted as additional service events when they did not receive a service meeting the definition of a non-admitted service event.

12. Information Systems

The flow of information to the NADC begins at the health service when the patient is referred, and the patients' registration information is entered in the PAS.

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

- records demographic information relating to the 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 can be counted once only
- does not permit duplicate counting of the same activity
- records all activity to be identifiable in the costing applications for the purpose of billing and budget allocation
- records all activity with the permitted non-admitted classification codes
- records all activity data such that it is accessible for retrieval for inclusions in the NADC and can be used for reporting purposes.

Note: As of 31st of March 2021 the Non-Admitted Data Collection ceased the collection of aggregate-level non-admitted data. All data must be recorded at a patient level.

13. Compliance and audits

13.1 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 WA Health System. Audit findings will be communicated to the WA health entity, the Director General and other relevant persons.

HSPs and CHEs 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.

13.2 Validation and compliance monitoring

Data quality and validation processes are essential tools used to ensure the accuracy and appropriateness of data submitted to the NADC. 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.

For further information on data quality and validation processes and timeframes, refer to the *Patient Activity Data Policy Information Compendium.*

Validations are used to support:

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

14. Glossary

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

Term	Definition
Contracted Health Entity	A non-government entity that provides health services to the State under a contract or other agreement entered into with (a) a Health Service Provider; or (b) the Department CEO, the Minister or the Premier on behalf of the State
Custodian	A custodian manages the day-to-day operations of the information asset(s) and implements policy on behalf of the Steward and Sponsor.
Health Service Provider	A Health Service Provider established by an order under section 32(1)(b) of the *Health Services Act 2016* and includes North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, WA Country Health Service, East Metropolitan Health Service, PathWest Medicine WA, Quadriplegic Centre and Health Support Services.
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.
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, as the System Manager.
System Manager	The term used to describe the Department CEO's role in managing the WA health system to the extent necessary to provide stewardship, strategic leadership and direction and to allocate resources for the provision of public health services in the State under section 19 of the *Health Services Act 2016*.

WA health system	The WA health system is comprised of: (i) the Department of Health; (ii) Health Service Providers (North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, WA Country Health Service, East Metropolitan Health Service, PathWest Laboratory Medicine WA, Quadriplegic Centre and Health Support Services); and (iii) contracted health entities, to the extent they provide health services to the State.

Appendix A – Current referral categories listed by reporting category type

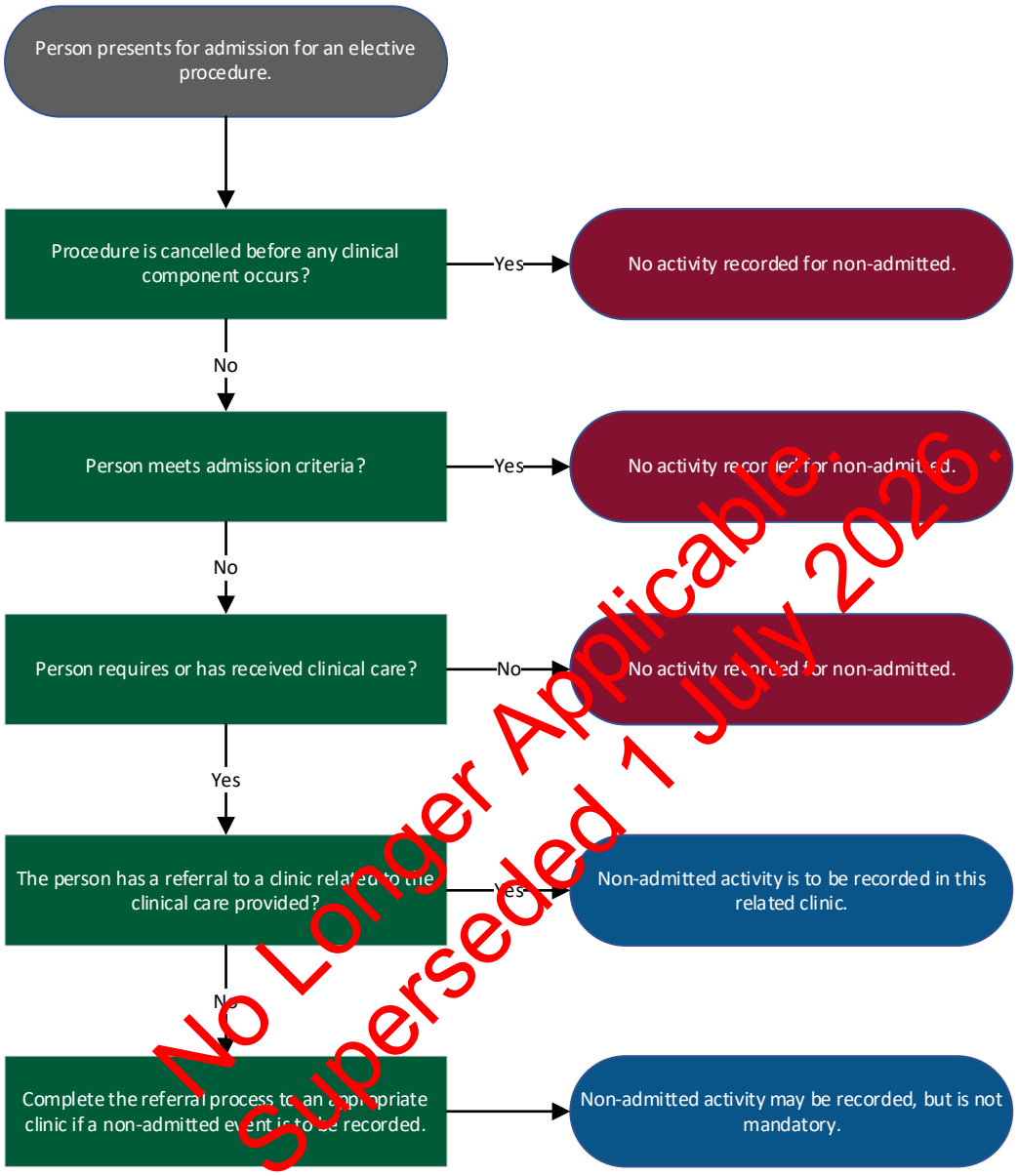
Reporting Type	HSPR Reporting Category	PAS Referral Category Codes
Allied Health & Nursing	Allied Health	ALI=Allied Health
	Audiology	AUD=Audiology
	Dietetics	DIE=Dietetics
	General nursing	CMN=Community Nursing
		CON=Continence Enuresis
		COT=Continence
		EME=Emergency
		GNU=General Nursing
		STM=Stomal Therapy
		WOU=Wounds Dressings Management
	Occupational Therapy	OCC=Occupational Therapy
	Physiotherapy	PHY=Physiotherapy
	Podiatry	MFC=Multidisciplinary Foot Ulcer
		ORT=Orthotics
		POD=Podiatry
	Social Work	CHP=Child Protection Medicine
		SOW=Social Work
	Speech Pathology	SPP=Speech Pathology
Medical	Cardiology	CAR=Cardiology
		CMB=Cardiometabolic
		CRE=Cardiac Rehabilitation
		CTE=Cardiology Technical Service
	Dermatology	DER=Dermatology
	Diagnostic Imaging	NUC=Nuclear Medicine
		RAD=Radiology
	Endocrinology	ABH=Aboriginal Health
		DAE=Diabetic Education
		DIA=Diabetes
		END=Endocrinology
	Gastroenterology	GAS=Gastroenterology
	General Medicine	ADO=Adolescent Medicine
		AMA=Acute Medical Assessment
		DAA=Drug And Alcohol

Reporting Type	HSPR Reporting Category	PAS Referral Category Codes
		GDS=Gender Diversity Service
		GPM=General Medicine
		HYP=Hyperbaric Medicine
		LYM=Lymphoedema Service
		MET=Metabolic Medicine
		PIC=Peripherally Inserted Central Catheter Services
	Genetics	GEN=Genetics
		NGE=Neurogenetics
	Gerontology	ACA=Aged Care Assessment Team
		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=Neurology Technical Service
	Obstetrics	ANT=Antenatal
		OBS=Obstetrics
	Oncology	ICS=Integrated Cancer Service
		ONC=Oncology
		RAO=Radiation Oncology
		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
		REH=Rehabilitation Medicine
		RET=Rehabilitation Technology

Reporting Type	HSPR Reporting Category	PAS Referral Category Codes
		RIT=Rehabilitation In The Home
	Renal	DIS=Dialysis
		REM=Renal Medicine
	Respiratory Medicine	PUP=Pulmonary Physiology
		RES=Respiratory Medicine
		SLP=Sleep
	Rheumatology	RHE=Rheumatology
Surgical	Anaesthetics	ANA=Anaesthetics
		PRE=Pre Admission and Pre Anaesthetic
	Breast Service	BRE=Breast Service
	Burns	BUR=Burns
	Cardiothoracic Surgery	CTS=Cardiothoracic Surgery
	Dental	DEN=Dental
		ORA=Oral Surgery
	Ear, Nose and Throat	ENT=Ear, Nose and Throat
	General Surgery	COL=Colorectal Surgery
		GES=General Surgery
		MTO=Major Trauma Outcome
	Neurosurgery	NES=Neurosurgery
	Ophthalmology	OPH=Ophthalmology
		OPT=Optometry
		ORP=Orthoptics
	Orthopaedics	HAN=Hand Surgery
		ORT=Orthopaedics
		OTT=Orthopaedic Trauma
		SPS=Spinal and Scoliosis
	Pain Management	PAI=Pain Management
	Plastics	PLA=Plastic Surgery
	Urology	URO=Urology
	Vascular	VAS=Vascular Surgery
		VTE=Vascular Technical 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 Medicine

Reporting Type	HSPR Reporting Category	PAS Referral Category Codes
		GHP=General Health Psychology
		MMH=Midland Mental Health
		MPG=Midland Psychiatric Geriatric
		PSG=Psychogeriatrics
		PSY=Psychiatry Adult
		PYO=Psychiatry Youth
		SAM=Statewide Aboriginal Mental Health
	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 reporting 2025-26

	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(d)	No
Hospital in the Home (HITH)	Yes	No(d)	No
Non-admitted services provided to Emergency Department patients	Yes	No(d)	No
Specialist Mental health	Yes	No(d)	No
Diagnostic services -Tier 2 codes 30.01 to 30.08	Yes	Yes(b)	No
Patient attendance			
Client present	Yes	SE(a) Only	Yes(c)
Patient attended via information technology (in place of Client present) as selected via service delivery mode	Yes	SE(a) Only	Yes(c)
Did not attend; did not provide notification of nonattendance	Yes	No	No
Appointment cancelled	Yes	No	No
Non-client event/Chart review only (no interaction between the healthcare provider and the patient) selected via service delivery mode '*other*'	Yes	No	No
Multidisciplinary Case Conference (MCC), as selected via service delivery mode '*MCC*'	Yes	One SE(a) per MCC appointment Only	Yes(c)
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 - home delivered	Yes	One SE[(a)] per patient per month	Yes[(c)]
Renal dialysis-peritoneal dialysis - home delivered	Yes	One SE[(a)] per patient per month	Yes[(c)]
Total parenteral nutrition - home delivered	Yes	One SE[(a)] per patient per month	Yes[(c)]
Enteral nutrition - home delivered	Yes	One SE[(a)] per patient per month	Yes[(c)]
Ventilation - home delivered	Yes	One SE[(a)] per patient per month	No - Block funded
Subcutaneous immunoglobulin (SCIg) infusion therapy - home delivered	Yes	SE[(a)] Only	Yes[(c)]
Providers			
Healthcare providers	Yes	SE[(a)] Only	Yes[(c)]
Other providers	No	No	No

	Non-admitted Activity		
	Recorded in PAS	Reported by DOH	Eligible for national ABF
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)]
Virtual care	Yes	SE[(a)] Only	Yes[(c)]
Specific programs			
Aged Care Assessment (ACAT)	Yes	SE[(a)] Only	No
State funded	Yes	SE[(a)] Only	Yes[(c)]
Block funded	Yes	No	No
Family Planning	Yes	SE[(a)] Only	No
Primary Health Care	Yes	SE[(a)] Only	No
General Counselling	Yes	SE[(a)] Only	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)]

	Non-admitted Activity		
	Recorded in PAS	Reported by DOH	Eligible for national ABF
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 = non-admitted activity that meets the WA MDG-10-004 Non-Admitted Patient National Service Event Definition

(b) Services provided from these clinics will be reported nationally if they meet the WA MDG-10-004 Non-Admitted Patient National Service Event Definition but will be bundled with the originating NAP service event for national activity-based funding purposes.

(c) A 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.

(d) Exception being services from a COVID-19 vaccination clinic (Tier 2 code: 10.21), which may be reported as non-admitted patient service events if they are provided to a patient while they are admitted or registered in an emergency care setting.

Appendix D – Summary of revisions

Date Released	Author	Approval	Amendment
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).
1 July 2022	Lorinda Bailey Shani Shiham Rachael McGuire	Rob Anderson, Assistant Director General, Purchasing and System Performance	Included a new section on appropriate recording of COVID-19 specific non-admitted appointments. Emphasised the need to audit long waiting open referrals. Added rules for when referrals can be reopened. Added confirmation that private patients in private hospitals who receive a public outpatient service can be counted as a NAP service event. Included information for the collection of high cost therapy data.
1 July 2023	Daniel Bonner Rachael McGuire	Rob Anderson, Assistant Director General, Purchasing and System Performance	Chart-only appointments must now be recorded with a factual outcome.
1st July 2024	Daniel Bonner Rachael McGuire	Rob Anderson, Assistant Director General, Purchasing and System Performance	Alignment of business rules to National definitions. Removed COVID-19 section. Included information on creation of voluntary assisted dying clinics. Added new Category Code - Gender Diversity Service Revised Appendix A – Current referral categories listed by reporting type

30 June 2025	Daniel Bonner Rachael McGuire	Rob Anderson, Assistant Director General, Purchasing and System Performance	Alignment of business rules to National definitions. Updated links and dates. Grammar, spelling and format updated. Increased clarification and content for all sections. Amalgamated and aligned sections for: - Multidisciplinary case conference – patient not present - Multidisciplinary Clinics - Virtual care - National reporting Created new sections for: - Tier 2 code 10.22 Subcutaneous - immunoglobulin therapy Embedded Recording Instructions for Home Enteral Nutrition (HEN) activity.

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