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

Non-Admitted Activity Reference Manual

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Table of Contents

Abbreviations and acronyms

ABF/M	Activity Based Funding / Management
AIHW	Australian Institute of Health and Welfare
AOD	Ambulatory, Other and Domiciliary (decommissioned May 2017)
ANACC	Australian Non-Admitted Care Classification
ARDT	Admissions, Readmissions, Discharge and Transfer Policy
CPAC	Clinical Priority Access Criteria
CRS	Central Referral Service
DOH	Department of Health
ED	Emergency Department
GP	General Practitioner
HCARe	Health Care and Related Information System (decommissioned 2017)
HCP	Health care provider
HITH	Hospital in the Home
HSP	Health Service Provider
ICAD	Interim Collection of Aggregate Data
ICT	Information and Communications Technology
IHPA	Independent Hospital Pricing Authority
MDC	Multidisciplinary Clinic
MCC	Multidisciplinary Case Conference
METeOR	Metadata Online Registry
NADC	Non-Admitted Data Collections
NAPAAWLDC	Non-Admitted Patient Activity and Wait List Data Collection
NAARM	Non-Admitted Activity Reference Manual
NAARRP	Non-Admitted Activity Recording and Reporting Policy
NAP DSC	Non-Admitted Patient Data Standards Committee
NGO	Non-Government Organisation
NHCDC	National Hospital Cost Data Collection
NHFB	National Health Funding Body
NHFP	National Health Funding Pool
NMDS	National Minimum Data Set
OPM	Ongoing patient management
PRNI	Privately Referred Non Inpatient
PSOLIS	Psychiatric Services On-line Information System
RITH	Rehabilitation in the Home
TOPAS	The Open Patient Administration System (decommissioned 2018)
UMRN	Unique Medical Record Number
webPAS	web-based Patient Administration System

1 Overview and scope

The WA health system has an obligation to record and report non-admitted activity in a meaningful and consistent way. The *Non-Admitted Activity Reference Manual* (NAARM) provides the framework and criteria to count and classify non-admitted patient activity correctly as required by the *Non-Admitted Activity Recording and Reporting Policy* (NAARRP).

The NAARM aims to:

- enable effective and efficient activity recording practices
- improve the consistency and completeness of activity recording and reporting
- improve the understanding and adoption of consistent business practices for non-admitted patient services
- support the alignment of State practice with national requirements.

Although Activity Based Funding (ABF) underpins most recording and reporting rules, relevant Health Service Providers and Contracted Health Entities need to be aware that reporting requirements extend beyond ABF for example reporting to the Australian Institute of Health and Welfare for publication in the Non-admitted Patient Care Australian Hospital Statistics. Also, the rules mandated in the NAARM may cover the reporting of services provided by Contracted Health Entities, some of which are not within the scope of national ABF.

The NAARM covers the two broad areas of recording data and reporting data. Relevant Health Service Providers and Contracted Health Entities are primarily responsible for recording and provision of data to the Department of Health (the Department). The NAARM does not cover recording and reporting processes that are unique to particular Health Service Providers or Contracted Health Entities. For example, the NAARM does not address recording and reporting processes required for research undertaken at Perth Children's Hospital.

The NAARM is provided for use by all relevant Health Service Providers and Contracted Health Entities that deliver publicly funded non-admitted patient care.

Specialist mental health non-admitted patient activity is not in-scope and is to be recorded in the Mental Health Information System (PSOLIS).

Community and population non-admitted activity that are not considered in-scope by Independent Hospital Pricing Authority (IHPA) are excluded from reporting but should endeavour to meet the NAARM criteria.

1.1 Accessibility

The NAARM is released in electronic format. If using a printed version, ensure it is the latest publication.

2 Information that underpins correct recording and reporting

2.1 Attended appointment

An attended appointment is defined as an event where a patient is recorded as having attended an appointment for examination, consultation, treatment or other service, in a functional health unit or hospital each time that such a service was provided.

This may include outreach clinic services, services delivered in a multidisciplinary model of care and services delivered in group sessions. The attended appointment is intended to capture instances of health care provision from the perspective of the relevant Health Service Providers and Contracted Health Entities.

The attended appointment reporting unit is to be used when conducting reporting where the intent is to include all activity at all sites, not restricted by non-admitted patient service event reporting rules.

An attended appointment may also be a non-admitted patient service event; which has additional exclusion criteria. See section 2.11 Non-admitted patient service event

2.2 Carers

Patient carers are considered to be the same as the patient themselves if they act on behalf of the patient when interacting with health care providers. This is only in situations where the patient is not able to act and/or understand for themselves (e.g. baby, young child, a person with a physical or learning disability, mental illness or chronic condition, a person who is frail and/or aged).

2.3 General List

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

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

2.4 Health care provider

Any staff member who is involved in or associated with the delivery of health care to a non-admitted patient, or caring for patient wellbeing (including medical officers, nurse practitioners, nurses, allied health professionals, health assistants or students) is considered to be a non-admitted patient health care provider. This excludes pastoral care, welfare workers and meals on wheels.

2.5 Medical record

Medical records are collections of information regarding an individual's health care, medical history, assessments and other health related documentation. A medical record is the physical record created when a patient first presents to a health care facility and for all subsequent presentations. Where an electronic record is made as a substitute for hard copy notes, it is to be viewed and treated in a similar manner to the physical record.

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

2.6 Metadata

Metadata is often called ‘data about data’ and is the underlying definition or structured description of the content, quality, condition or other characteristics of data. The *Non Admitted Patient Activity And Wait List Data Collection* (NAPAAWL DC) Data Set Specification provides the metadata for the NAPAAWL DC.

2.7 Multidisciplinary Case Conference

Where there is a model of team practice discussion and the patient and carer are not present, this is referred to as a multidisciplinary case conference (MCC).

The MCC is a discussion where there are at least three members of a multidisciplinary team communicating at the one time for the duration of the MCC, either face to face, by telephone, via video link or a combination thereof.

The MCC involves the multidisciplinary team undertaking all of the following activities:

- discussion of the patient's history
- identification of the patient's multidisciplinary needs
- identification of outcomes to be achieved by members of the team giving care to the patient
- identification of tasks to be undertaken to achieve outcomes and allocation of tasks to team members
- assessment of success or otherwise of previously identified outcomes.

2.8 Multidisciplinary Clinic

Clinics set up under the multidisciplinary approach aim to address treatment that is focused on all aspects of the needs of the person – including but not limited to physical and psychosocial needs.

Multidisciplinary care can be delivered by a range of health professionals functioning as a team either from one organisation or from a range of health organisations, including private health practice, within one multidisciplinary clinic.

Generally, multidisciplinary clinics are implemented to undertake patient assessment, and develop and trial health improvement programs that achieve the best patient outcomes in a multidisciplinary environment. As a patient's needs may change with time, the composition of the team may also change to meet these needs.

Most health improvement programs either discharge patients when health outcomes are achieved or transition from a multidisciplinary approach to being managed by individual disciplines independently. Rarely will patients be treated in a multidisciplinary clinic indefinitely.

In WA a clinic is defined as multidisciplinary when the following conditions are met:

1. There are three or more team members and the care provided by each health care provider is unique illustrated by:
    a. all members being of the same profession (medical, nursing or allied health) but each having a different speciality, or
    b. team members being of a different profession (medical, nursing or allied health) but may have the same or a different speciality.
2. Care is provided at the clinic on the same day, by multiple (three or more) health care providers, who collaborate to assess and make treatment recommendations that facilitate high quality patient care.
3. The clinic has been set up using the single service event method (mandatory from 1 July 2018).

2.9 Non-admitted outpatient

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

- the person has an appropriate referral to an outpatient clinic
- the person's referral is registered and triaged (i.e. allocated a priority code)
- the person receives care at an outpatient clinic service
- the person has not undergone a hospital's formal admission process.

2.10 Non-admitted patient

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

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

- the person receives non-admitted care at any location, e.g. outpatient clinic, emergency department, community centre, home
- the person has not undergone the hospital's formal admission process.

2.11 Non-admitted patient service event

The principle counting and reporting unit for non-admitted patient care is the "non-admitted patient service event". The service event is intended to capture instances of health care provision from the perspective of the patient.

The interaction with the patient may be for assessment, examination, consultation, treatment and/or education.

Interactions with patients via information technology (e.g. telephone, videoconference) can be service events if they substitute for face to face contact.

Information on eligibility of activity for activity based funding is available on the IHPA website.

2.11.1 Criteria

A non-admitted patient service event must satisfy all of the following criteria:

- one or multiple health care providers, providing care to a patient at the same time
    - valid exception one: patient self-administering approved treatments in the patient's own home
    - valid exception two: multidisciplinary case conference from July 2018. See section 3.1.4 Multidisciplinary case conference.
- one non-admitted 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)
- must contain clinical or therapeutic content (i.e. any preparation, travel, report writing, liaison with other health care providers etc. does not meet the definition of a non-admitted patient service event)
- must result in a dated entry to the patient's permanent medical record; whether this is paper or electronic.

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

For example: Where bereavement counselling occurs for family members/carers after the passing of the patient, a non-admitted patient service event will only occur if the family members/carers receiving the bereavement counselling are registered as patients. That is, after the passing of the patient, the non-admitted patient service events are to be recorded against those receiving the counselling and not the deceased patient.

2.11.2 Clinical or therapeutic content

Clinical or therapeutic content for the purposes of a non-admitted patient service event needs to meet the following criteria:

- it is information collected during a non-admitted patient interaction requiring consideration (of evidence) to support a diagnosis and the management of the patient

- it is expert or evidence-based clinical knowledge
- it considers the local health environment including practice, policies and availability of services.

A non-admitted patient service event will also be an attended appointment; which has less exclusion criteria. See section 2.1 Attended Appointment.

2.12 Outpatient clinic

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

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

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

2.13 Outpatient referral

An outpatient referral is the request (e.g. a written request from a General Practitioner (GP)) that includes a minimum set of patient information and is submitted to a relevant Health Service Provider or Contracted Health Entity for specialist outpatient services.

3 Activity recording

3.1 Scope

3.1.1 Not required to be recorded

Non-admitted activity that does not meet the criteria for a non-admitted patient service event may be recorded, whether or not the patient is present, as long as the attendance status and outcome are recorded to enable them to be excluded from reporting.

3.1.2 Required to be recorded

All activity undertaken in a non-admitted patient setting is in-scope and is to be recorded.

Activity will be recorded whether the non-admitted patient is or was scheduled to be present (including substitutes for face to face interactions) for consultation or treatment; or when the patient is not present (e.g. for case consultation).

Once a non-admitted patient appointment is recorded in a patient information system, it needs to have an attendance status and outcome recorded to determine whether the activity is or is not a non-admitted patient service event.

3.1.3 Health care provider and patient interaction

Each of the following interactions between a non-admitted patient health care provider and a patient in an outpatient clinic service (i.e. the patient is or was expected to be present) are to be recorded.

3.1.3.1 Pre-admission activity

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

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

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

If pre-admission activity occurred and was recorded, then the formal admission was reversed, the non-admitted activity should only be recorded as a non-admitted patient service event if it can be recorded at the outpatient clinic to which the patient was referred and where the procedure was booked to occur, as is allowed for Type C procedures (see below).

3.1.3.2 Patient already being treated

Admitted patient

An interaction between an admitted patient and a non-admitted patient health care provider during an outpatient clinic service will be recorded irrespective of whether the patient attends the clinic or the health care provider visits the ward (i.e. a scheduled appointment).

Non-admitted patient activity will not be recorded if the health care provider attends an admitted patient in a ward and the care provided is not part of an outpatient clinic service.

When a non-admitted patient clinic service is provided to a patient while they are admitted, the non-admitted patient care will not be reported as separate non-admitted activity and will instead be reported as part of the admitted episode of care. This is irrespective of whether the condition/reason for the admission and non-admitted patient care are related.

Admitted patient at public hospital and non-admitted at other public hospital

If a person is an inpatient at a public hospital and receives outpatient care at a second public hospital, their record of care at the second hospital is to indicate that they are an inpatient.

Admitted patient at private hospital and non-admitted at public hospital

If a person is an inpatient at a private hospital and receives outpatient care at a public hospital, they are to be recorded as an outpatient at the public hospital.

Admitted patient at public hospital and non-admitted at private hospital

If a person is an inpatient at a public hospital and receives outpatient care at a private hospital by another service provider (e.g. non-government organisation), they are to be recorded as an outpatient at the private hospital or other service provider.

Admitted patient at private hospital and non-admitted at private hospital (or service provider)

If a person is an inpatient at a private hospital and receives outpatient care at a private hospital or by another service provider (e.g. non-government organisation), they are to be recorded as an outpatient by the private hospital or other service provider.

Same day non-admitted procedures

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

Under the *Admission, Readmission, Discharge and Transfer (ARDT) Policy* (MP 0058/17), two types of outpatient procedures can occur:

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

Decisions on whether to admit or not admit patients are governed by explicit inclusions and exclusions for procedures/conditions set by the Commonwealth Department of Health and the ARDT Policy.

Same day non-admitted procedures (Type C)

Type C procedures are expected to be undertaken on a non-admitted basis, and although they can be performed as a same day admission if there are exceptional circumstances, they are not accepted as a reason for admission in their own right.

When a patient has been admitted in error for a Type C procedure, the admission will be reversed, necessitating business practices to be in place to ensure that the activity is recorded as a non-admitted patient service event.

The activity should only be recorded as a non-admitted patient service event at the outpatient clinic to which the patient was referred and at which the procedure was booked to occur.

See Appendix B: Flowchart for recording service events when admissions or admitted procedures are cancelled.

Same day non-admitted procedures (Type B)

Type B procedures may be provided as outpatient activity if it is safe, practical and cost-effective to do so. For further information on Type B procedures see the ARDT Reference Manual.

Cancelled Admission

Formal admissions may be reversed at any stage of the process. Patients who progress beyond the administrative process to consume clinical time, yet who are still cancelled before arrival in theatre, or commencement of procedure, may be recorded as a non-admitted patient service event. A Type C reversed admission is to be recorded as a non-admitted patient service event (see above).

Hospital in the Home (HITH) patient

HITH specifically refers to admitted patients treated in their home. HITH patients remain admitted patients until discharged from admitted care (whether in the hospital or at home).

When a patient is admitted to a hospital, is not discharged but is made a HITH patient and the HITH care is managed by a second hospital, the HITH patient is still considered to be an admitted patient.

Inappropriately classifying or labelling a non-admitted patient as a HITH patient (including naming a non-admitted patient clinic as a HITH clinic) will result in the activity not being reported as a non-admitted patient service event.

Note: Rehabilitation in the Home (RITH) has been non-admitted care since July 2013.

Emergency Department

Emergency Department refers to the service provided, not the location. Where a non-admitted patient clinic provides outpatient care in or adjacent to the area used by the Emergency Department, the activity will be recorded as non-admitted outpatient activity.

Non-admitted patient emergency care provided to a patient attending at the Emergency Department is reported under the Emergency Department episode of care.

Any non-admitted outpatient clinic service provided to a patient while they are an active attendance at the Emergency Department will be recorded. Although the activity is recorded it is not a valid non-admitted patient service event for ABF: services provided to patients in the admitted or emergency department settings must not be counted as non-admitted patient service events.

3.1.3.3 Patient attendance

Patient attendance refers to a patient being present at an appointment. This includes patient education and group sessions irrespective of the operational model of clinical practice (i.e. solitary or team practice).

Attended

A non-admitted patient who is recorded as having attended their appointment using an appropriate outcome or attended code, will be classified as an attended appointment.

Note: When a non-admitted patient commenced an appointment before midnight, and is still in the hospital after midnight, for patient safety both appointments will be recorded. The appointment after midnight is to be set to Chart Only / non-client event.

Did not attend

A non-admitted patient who does not attend (DNA) their appointment without giving the hospital or clinic prior notice will be classified as a DNA appointment.

Where a non-admitted patient attempts to cancel the appointment after the scheduled time, the appointment will be classified as a DNA appointment.

Note: For best practice, the outcome field should not to be used to record DNA. The 'non-attendance reason' field via the non-attendance screen and the appointment status (ATT/DNA button) are to be used for capturing a patient who DNA. Outcome is to be utilised for flagging the required action after the DNA (i.e. Reappoint, discharge etc.).

Attended mode

All forms of communication between a health care provider and a non-admitted patient using information technology may be eligible activity and be recorded if:

- it is a substitute for a face to face interaction
- it meets the criteria for a non-admitted patient service event
- it is interactive (i.e. continuous, responsive or mutually/ reciprocally active, involving both health care provider and patient in a short timeframe).

Assuming criteria for eligible activity is met then:

- What would be recorded:
  - Telephone
  - Videoconference (Telehealth).

- What would not be recorded:
  - SMS (short message service)
  - social media.

- What may be recorded (is likely to be in very limited circumstances and is to be confirmed with senior clinician):
  - email
  - letters.

Emails between a patient and a health care provider can be counted as non-admitted patient service events if they substitute for a face to face consultation and provided they meet all of the criteria included in the definition of a non-admitted patient service event. Substitution means that the emails must be necessary and that if the emails did not occur then the patient would have been required to receive that service in a face to face consultation.

Multiple emails between the patient and health care provider that are all part of the same conversation should be counted as one non-admitted patient service event.

The timeframe is determined objectively, that is, it needs to reflect the urgency of the situation and the technology in use but is expected to be of short duration. Where the duration becomes excessive this would not be classed as interactive and would not be recorded.

Outcoming information and communications technology interactions

Where the electronic communication occurs over more than one instance (e.g. more than one telephone call), the first such instance will be the designated date and time assigned to the appointment. The appointment will be outcomed after the last such instance.

3.1.4 Attended exceptions: Health care provider present only

The following involves a non-admitted patient health care provider undertaking patient related activity without the patient or carer being present; and may be recorded.

Non-client event/Chart only reviews

The scheduling of times for the health care provider to undertake chart reviews of the patient's medical record without the patient being present will be recorded and be classified as a non-client event (NCE).

Note: Where the review of the patient's medical record results in a non-admitted patient service event i.e. it now meets the service event criteria, the NCE can be upgraded and be recorded as a non-admitted patient service event.

When a non-admitted patient is in the hospital over midnight, the appointment after midnight is to be set to Chart Only / non-client event.

Multidisciplinary case conference

Included as a valid ABF non-admitted patient service event from 2018-19; funding still to be determined by IHPA.

A non-admitted multidisciplinary case conference (MCC) where the patient (or carer) is not present, is a meeting or discussion held concurrently between health care providers, arranged in advance, to discuss a non-admitted patient in detail and to coordinate care. Non-admitted MCCs ensure that a patient's multidisciplinary care needs are met through a planned and coordinated approach.

A non-admitted MCC must involve three or more health care providers who have direct care responsibilities for the patient discussed. The health care providers may be of the same or different profession (medical, nursing, midwifery or allied health). However, when they are of the same profession, they must each have a different speciality so that the care provided by each provider is unique.

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

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

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

Where videoconferencing is used for the MCC, only one non-admitted patient service event is to be recorded, not both ends as is done when the patient is present (Telehealth).

Where a patient is recorded at an MCC and is also present at another non-admitted patient service event on the same day, both can be reported as valid non-admitted patient service events.

Note: The webPAS Multidisciplinary Clinic (MDC) flag is only to be used for MDCs and not for MCCs. The service delivery mode of MCC is to be used to record a multidisciplinary case conference when the patient is not present; all other codes are to reflect that the patient is not present i.e. use Chart only or non-client event codes.

3.1.5 Attended exceptions: patient present only

It is a requirement that all patient self-delivered home-care services be recorded, regardless of product/equipment supplied or payment arrangements for the supplies.

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

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

3.1.6 Cancelled

The onsite health care provider (including at Outpatient Direct) may use their discretion to classify a non-admitted patient appointment as cancelled up to the time of the appointment, with the reason for cancellation recorded. This is to allow for circumstances where the non-admitted patient is unable to provide adequate warning that they will not be able to attend their appointment for reasons beyond their control.

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

4 Information systems

There is a requirement for all non-admitted patient activity to be recorded in an approved electronic patient information system; either a core or a satellite system.

The information system must also be capable of supporting the reporting requirements for Activity Based Funding and Management (ABF/M). Microsoft Excel, Access, Outlook or diaries are not considered electronic systems for the purposes of the NAARM.

Data for specialist mental health patients are to be recorded in the Mental Health Information System (PSOLIS) as this type of patient care is out of scope for the NAARRP.

4.1 Core information systems

There are currently two core WA health system information systems, which are approved for recording non-admitted non-mental patient activity. These are:

- The Open Patient Administration System (TOPAS)
- web-based Patient Administration System (webPAS)

Private hospitals and relevant Contracted Health Entities are required to use their own information systems to provide data which are incorporated into the NAPAAWL DC.

Note: Activity contracted by a Health Service Provider is to be recorded in the information system of the contracted service provider and not in the information system of the contracting Health Service Provider.

Adoption of a core patient information system for outpatient clinic management and activity recording does not preclude the use of other patient information systems for clinical, workload recording or other purposes.

4.2 Satellite information systems

Not all non-admitted patient activity is recorded in core information systems; some activity is recorded in satellite systems. As these satellite information systems (usually adopted for workload management or clinical purposes) are identified, they are reviewed to determine their suitability for providing non-admitted patient activity information. The determination of suitability, and hence approval, is based on specified essential criteria set by the NAPAAWL DC Data Custodian.

4.2.1 Approval criteria

An approved patient information system is one that meets the following essential criteria as listed in the NAPAAWL DC Data Set Specification:

- records demographic information relating to the non-admitted patient
- records all referral related information
- records appointment scheduling information and outcomes

- records all activity in such a way that related activity in another system is identifiable and is able to be reported once only
    - duplicate reporting of the same activity is not permitted
- records all activity to be identifiable in the costing applications for the purpose of billing and budget allocation
- records all activity with accurate non-admitted classification codes
- records all activity data such that it is accessible for retrieval for inclusion in the NAPAAWL DC and can be used for reporting purposes.

Approval process

The use of other electronic information systems (corporately managed or not) to record non-admitted patient activity will be considered for inclusion as an approved satellite information systems.

The Non-Admitted Data Collections (NADC) Manager is responsible for the approval process.

Data item specification for core and satellite information systems

All patient information systems that are used to record non-admitted patient activity and that are eligible to report non-admitted activity are required to document the data item specification for each hospital or unit at which the information system is used. This includes:

- the data items within the information system
- the classifications used (if applicable)
- how the data items and classifications used by the information systems will be mapped, derived or other action to meet non-admitted patient activity reporting requirements.

Once finalised, the data item specification is endorsed by appropriate delegates (i.e. the Manager, NADC and the manager/owner of the patient information system at the hospital or unit).

The data item specification is reviewed annually to cater for updated requirements or other changes necessary to achieve WA health system outcomes.

5 Outpatient clinics

It is essential that all non-admitted outpatient clinics of public hospitals be registered in a patient information system. Non-admitted outpatient clinics of Contracted Health Entities are to be registered in an approved satellite system using an appropriate clinic registration.

Each relevant Health Service Provider and Contracted Health Entity is responsible for the registration of non-admitted outpatient clinics operating at or from their hospital. This includes implementing the following rules for assigning the various classifications required to identify the clinic services. These are to be applied consistently across WA.

There are five classification codes that are mandatory for all clinic profile registrations and activity recording. Initial use and any change to the clinic profile to these five codes requires authorisation from a senior clinician and manager and consultation with the Manager NADC.

These codes are not to be changed at appointment level:

- Tier 1 NMDS
- Tier 2 NHCDC
- Referral and clinic Category
- Care type
- MDC flag.

Note: A new classification system is being developed to replace the Tier 2. This is the Australian Non-Admitted Care Classification (ANACC) and is planned to be implemented in 2025.

5.1 Tier 1 NMDS coding

The National Minimum Data Set (NMDS) Tier 1 code is allocated to each registered non-admitted outpatient clinic. Although Tier 1 NMDS is no longer being reported nationally, this code remains a mandatory item when registering non-admitted outpatient clinics.

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

The Tier 1 code descriptions may not be mutually exclusive (e.g. Obstetrics and Antenatal). The Tier 1 code attempts to cater for generalist and specialist clinics.

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

- take account of the nature of the specialty and/or the field of practice of the health care provider
- general coding practice is to 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
- general coding practice is to assign the code which has the most appropriate description. For example, if the clinic is "purely" antenatal then that is where the clinic would be coded. If the clinic is a mixture (e.g. antenatal and postnatal) then code to Obstetrics

5.2 Tier 2 National Hospital Cost Data Collection coding

The National Hospital Cost Data Collection (NHCDC) Tier 2 for non-admitted services was primarily developed to support the introduction of ABF for non-admitted hospital services in the Australian public health system.

Tier 2 is a health care 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 non-admitted services classification, each clinic has to be classified uniquely to one class so that only those clinics that perform the same range of predominant health services are brought together to form a class.

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

Every Tier 2 code is assigned a price weight by IHPA. A Tier 2 code's weight is a figure that relates to the cost of treating an average non-admitted patient in that Tier 2 category, inclusive of any ancillary services such as pharmacy, pathology or diagnostic imaging.

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

5.2.1 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 and discipline of the usual or lead health care provider).

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

5.2.2 Principal or Lead health care provider

When there is only one health care provider operating in the non-admitted outpatient clinic they are the lead health care provider. They could be a medical officer, a nurse practitioner, an allied health professional or a clinical nurse specialist.

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

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

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

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

5.2.3 Rules for assigning a Tier 2 code

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

- where a clinic is a combination of two or more specialisations, use the Principal or Lead health care provider rules above to determine which class is the most appropriate category for the clinic and hence to capture all of its non-admitted patient service events
- 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 the majority of the services provided are procedural, map the clinic to the appropriate class within the medical consultation group
- where a medical consultancy clinic regularly undertakes procedural activity, two separate clinics may be registered to record the different activity, but only where it is cost-effective in regard to overhead costs to do so
- the IHPA Non-Admitted Services Definitions Manual states in the definition of 20.11 Paediatric medicine: "Specialist paediatric operational clinics should be assigned to the relevant medical specialty. For example, paediatric respiratory is assigned to 20.19 Respiratory". The situation is similar for and paediatric surgery which is assigned to 20.17 General Surgery. Telehealth Tier 2 codes are not used by the WA health system.
    - The Service delivery mode telehealth codes are to be used.
- MCC Tier 2 codes are not used directly by the WA health system.
    - The Service delivery mode MCC code is to be used.

5.2.4 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. The Tier 2 may be altered when:

- there is no change in what a clinic undertakes, but an error was made in the original registration classifications, clinic titles or description; and
- the change is required for the "life" of the clinic (i.e. including past, present and future activity).

The Tier 2 should not be altered when there is a significant change in a clinic's operations. Best business practice is to close the existing non-admitted outpatient clinic and register a new clinic.

When there is only a need to change the Tier 2 from a point in time (i.e. only current and future), webPAS users may change the Tier 2 but must also record the Tier 2 change date.

Note: If a change is required, contact the Manager, NADC for specific system advice before proceeding as changes to values may overwrite all previous existing values.

5.2.5 Rules for re-assigning a clinic title

The clinic title 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.

The existing clinic title may be amended when an error in the original registration, clinic title or description is identified. The amendment is to be made using the correct webPAS Clinic Maintenance procedure. Note: If a change is required, contact the Manager, NADC for specific

system advice before proceeding as changes to values may overwrite all previous existing values.

5.3 Clinic and referral category

There is extreme similarity between the clinic category and referral category codes and descriptors.

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

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

These codes and descriptors are standardised and new or altered codes and descriptors require approval. See Section 10 Managing change.

5.4 Care type

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

- Rehabilitation
- Palliative care
- Geriatric evaluation and management
- Psychogeriatric care
- Mental health care—specialist (only to be used for specialist mental health clinics)
- Other care (e.g. acute care)

Note: The non-admitted patient care types are a subset of the admitted care types. Many admitted care types are not relevant to non-admitted patient care and if used are mapped to “Other care” by the NADC.

The non-admitted patient care types of Psychogeriatric care and Mental health care are excluded from all NADC reporting. These patients and their activity must be recorded in PSOLIS.

5.5 Multidisciplinary clinics

A multidisciplinary clinic (MDC) receives a special loading under ABF and must be identified using a multiple health care provider indicator. This indicator can only be correctly applied if the single service event method is used. In webPAS, all multidisciplinary clinics are to have the MDC flag set to ‘yes’.

When a non-admitted patient clinic occasionally includes the services of another health care provider(s), this does not constitute a multidisciplinary clinic and separate non-admitted patient clinics will not be registered for that appointment.

5.5.1 Single service event method

The single service event method must be used for setting up multidisciplinary clinics and multidisciplinary case conferences. This means that for each multidisciplinary interaction with a non-admitted patient:

- only one non-admitted outpatient clinic is registered in a patient information system
- only one clinic category code is allocated, usually related to the lead health care provider for the multidisciplinary clinic

- only one Tier 2 code is allocated, usually related to the lead health care provider for the multidisciplinary clinic
- only one appointment is scheduled to cover all activity undertaken by the attending health care providers.

6 Outpatient referrals

All referrals which do not contain sufficient information to allow accurate grading of the priority of the referral are to be returned to the referring health care provider.

Presentation of an unrelated illness or condition which may result in another course of treatment in another specialty will require the treating non-admitted patient health care provider to request the patient's referring health care provider (e.g. GP) for a new referral.

When a referral is received it is required that:

- all referrals to a hospital non-admitted outpatient clinic be registered in a patient information system or approved satellite system (see Section 4).
- the original referral received date remains unchanged, no matter whether the referral is actioned at the registration hospital or transferred to another hospital to ensure:
    - the Active Life of Referral requirements are upheld
    - accurate outpatient wait list reporting.

When a treating non-admitted patient health care provider refers a patient to another non-admitted patient health care provider in another specialty for continuing care (at the same hospital) a new referral(s) is created and the patient's initial referring health care provider is informed.

Note: If the initial referral was for a named non-admitted patient health care provider (e.g. Privately Referred Non Inpatient (PRNI) or Medicare billed (MBS)) then a new referral is created even if the new non-admitted patient health care provider is in the same specialty.

Patients who require to be clinically managed for extended periods will require repeat referrals. As the care is considered to be continuous, the repeat referrals may be recorded as ongoing management in the reason for referral. This will exclude the repeat referral for the outpatient wait list.

6.1 Registering and managing the outpatient wait list

Relevant Health Service Providers and Contracted Health Entities must actively manage patients to provide timely and appropriate access to clinic appointments. This will require a health service-wide approach to wait list management and coordinated care, which is cognisant of the workforce, infrastructure and case complexity considerations incumbent in outpatient wait list management.

Before any clinical interaction occurs with a potential outpatient, a referral must be received and registered in a patient information system. Patients must be registered to enable recording of appointments.

When a duplicate referral request to register a patient for the same condition at a second hospital becomes known, the request must be refused and a letter forwarded to the patient to advise them of the situation.

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

Note: In general, only one referral is to be registered with only one referral account number allocated to each referral for a particular clinic.

If more than one referral is registered for the same clinic (determined by audits or other checks) then appropriate actions are to be taken to ensure that only one is retained.

If more than one referral is registered and retained for the same clinic (e.g. where multiple services are provided at the same clinic) the rationale for the decision must be recorded in the patient's medical record. Both appointments have the outpatient visit classification of 'New'.

6.2 Removal of patients from outpatient wait lists

The hospital must have robust procedures to administratively and clinically manage patients who fail to attend. The hospital must remove patients from the wait list who fail to attend or repeatedly reschedule appointments without good cause and without prior notice.

See the *Specialist Outpatient Services Access Policy* for processes on discharging patients.

6.3 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. This includes all referrals made by medical and other health care providers from within the hospital to outpatient clinics.

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

Patients may be referred to specialist outpatient services by GPs. GP referrals are managed by the Central Referral Service (CRS) for metropolitan Health Service Providers. If a GP indicates that a patient needs immediate attention they are to be directed to contact the hospital directly.

Other sources of referral include:

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

6.4 Referral management

CRS and relevant Health Service Providers and Contracted Health Entities will ensure referrals include adequate information to allow categorisation, prioritisation and direction of patients to appropriate services as per the *Specialist Outpatient Services Access Policy*.

CRS and relevant Health Service Providers and Contracted Health Entities will implement procedures to inform referring health care providers with respect to appropriate referral content.

Referring health care providers will be encouraged to meet referral requirements through regular feedback processes (e.g. telephone, letter). Inadequate or incomplete referrals will be returned to the referrer for more complete information.

6.5 Transferring between hospitals

Patients are transferred between hospitals for many reasons. Regardless of the reason, the original referral received date is to be maintained to ensure correct reporting of outpatient waiting times.

6.5.1 Using reason for referral for transferred patients

When a patient is transferred from one hospital to another and the care provided remains under the same specialty (Tier 2 type), the following guidelines apply:

- 'Ongoing patient management' is not to be used for a first referral as the determination of extended care cannot be determined at triage.
- where the patient had a first attended appointment at the original hospital, the referral reason may be recorded as 'Ongoing patient management' at the second hospital
- where the patient had a first attended appointment at the original hospital, the appointment may be recorded as 'Follow up' and not 'New' at the second hospital.

Note: To ensure consistency of wait list reporting, when the transfer of a non-admitted patient referral is part of a system migration (i.e. from TOPAS to webPAS) or a move to a new site (e.g. a new facility is built and has a new establishment number), OPM is not to be used. Instead a cross reference file consisting of the patients' UMRNs, the referral account numbers in the current system or hospital and the referral account numbers in the new system or hospital is to be provided to NADC by the Health Support Service webPAS implementation team.

6.6 Transferring care or contracting between Health Service Providers

When one Health Service Provider contracts a second Health Service Provider to provide care or a program of care, the contracted Health Service Provider is to record the activity in their electronic system (PAS) in a manner that allows the NADC to apply the report of that care or program activity to the contracting Health Service Provider.

Note: Contact the Manager, NADC for specific system advice before proceeding.

7 Appointment scheduling

All non-admitted patient activity recorded in a core or satellite information system is to have an attendance, client type, session type and outcome recorded such that the activity can be deemed either eligible or not eligible for classification as a non-admitted patient service event.

It is assumed that all criteria for a non-admitted patient service event have been met if the activity has been outcomed as attended.

Note: When an outcome or attendance or client type or session type of unknown is recorded, that activity will not be reported and not funded.

7.1 Outpatient visits classification

Appointments shall only be classified as New, Follow-up or Non-client event/Chart only.

The determination of New or Follow-up will be based on the registered referral against which the non-admitted patient appointment is made. See Section 6.5 Transferring between hospitals.

7.1.1 New appointment

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

A New non-admitted patient service event is one where a health issue has not been previously addressed at the same clinical service, for the current referral.

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

See Section 6.1 for the rare instance where more than one referral is to be registered for the same clinic. Both appointments have the outpatient visit classification of New.

7.1.2 Follow-up (repeat appointments)

All subsequent visits for the same registered referral are classified as Follow-up.

A follow-up or repeat non-admitted patient service event is:

- one where a problem has been previously addressed for the current referral at the same clinical service – whether at the same hospital or not; that is transferred patients may be recorded as follow-up)
- any subsequent non-admitted patient service event in that given clinic for the continuing management/treatment of the same condition, and the clinician responsible for care has not discharged the patient (i.e. closed the case).

Post-discharge reviews associated with an admitted patient episode, routine review of chronic condition, monitoring results of interventions, evaluation of action plans, reassessment of patient needs, or the transfer of care to another hospital (see Section 6.5 Transferring between hospitals) are considered to be Follow-up.

7.1.3 Non-client event/Chart only

Non-client event/Chart only is to be used to allocate time for review of charts when a patient is not likely to attend or be contacted.

If a patient is subsequently contacted as a result of the chart review and the activity meets the criteria for a non-admitted patient service event, it can be recorded as a non-admitted patient service event

Note: To prevent duplicate reporting for service events that extend over midnight, set the appointment after midnight to Chart Only / non-client event.

7.2 Age of eligibility

Appropriate authorisation is required prior to processing any specialist outpatient clinic appointments at a specialist children's hospital for patients past their 16th birthday.

Patients who have been treated at a specialist children's hospital for chronic conditions may continue to be treated at that hospital for that condition until the age of 18 years. Transition to an adult facility must be completed by the patient's 18th birthday.

7.3 Clinical audit

Relevant Health Service Providers and Contracted Health Entities will manage a system of clinical audits to ensure that the patient is reviewed to determine when care is no longer required by the service so that the patient is discharged back to the referrer.

8 Clinical activity

It is a requirement that:

- where the patient interaction includes clinical/ therapeutic content, the recorded non-admitted patient activity is to have an attendance status and outcome recorded such that the activity can be deemed either eligible or not eligible for classification as a non-admitted patient service event
- all non-admitted outpatient clinics document information about storage and location of ancillary medical records that supplement/ compliment the patient's official hospital medical records
- referrals be discharged when a non-admitted patient episode of care has concluded.

8.1 Appointments

8.1.1 First assessment

The purpose of the first assessment is to identify the current needs and any underlying health issues of the non-admitted patient. This may also be referred to as New.

8.1.2 Follow-up appointments

Outpatient services will record the patient's care during the intervention (consultancy/treatment) and review the patient to determine when goals have been achieved such that the patient can be returned to the care of their referring health care provider (e.g. GP).

8.1.3 Discharging outpatient

Once the non-admitted patient episode of care has concluded, the related referral is to be discharged and a summary of discharge (e.g. reasons, outcomes, referral to another service) is to be documented in the patient's medical record.

Timely outpatient discharge will assist with non-admitted outpatient clinic effectiveness and efficiency and will enable better access for new patients.

8.2 Clinical/therapeutic content

Information will be recorded in the patient medical record for a non-admitted patient interaction that requires consideration (of evidence) to support a diagnosis and manage the outpatient.

9 Activity reporting

9.1 Scope

The scope of reporting determines what non-admitted patient activity is included or excluded from reporting for all purposes. This depends on the characteristics of the recorded non-admitted patient activity.

If the recorded non-admitted patient activity does not meet all of the criteria for an attendance it will not be reported as a non-admitted patient attended appointment.

If the recorded non-admitted patient activity does not meet all of the criteria for a service event it will not be reported as a non-admitted patient service event.

For ABF reporting, the WA health system will include in national reports all recorded activity that meets the criteria for a non-admitted patient service event, however, the final determination of what will be funded under ABF by the Commonwealth is the responsibility of the IHPA and the

Administrator of the National Health Funding Body (NHFB) that oversees the National Health Funding Pool (NHFP). In particular, ABF may not occur for:

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

Generally, if a patient attends a non-admitted outpatient clinic and the outcomed recorded activity meets the criteria for a service event, it will be reported.

Type C and B Procedures are in scope for reporting of non-admitted outpatient clinic activity.

9.2 Units of measurement

9.2.1 Activity

Two reporting units of measure are available for non-admitted patient activity:

- the non-admitted patient service event (with two versions)
- the attended appointment.

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

- MDG-10-003 Total Non-Admitted Patient Service Events
  - This definition is to be used for all non-National and non-Service Agreement reporting: this will provide activity for general reporting.

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

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

9.2.2 Waiting times

The outpatient waiting time is reported using two reporting measures: median wait time to first appointment and waiting for first appointment (on the waiting list). The median, or midpoint value, rather than the average is the standard measure utilised across Australia for the measurement of waiting times. The median is used to ensure that outlier figures do not skew the results.

The derived Reporting category and Reporting type codes are to be used when reporting the waiting times measures. Current lists for these codes are available on request to the NADC Manager.

The following definitions are to be used when reporting the waiting times measures.

- These definitions are to be used for reports that will include all clinics.
  - MDG-10-007 Patients on Outpatient Waiting List
  - MDG-10-009 Median Waiting time to First Appointment
- These definitions are to be used for reports that will include only surgical clinics.
  - MDG-10-008 Patients on Outpatient Surgical Clinic Waiting List
  - MDG-10-010 Median Waiting Time To First Surgical Outpatient Appointment

- This definition is to be used when producing reports for the Health Service Performance Report (HSPR) Performance Indicator.
    - P2-24a-c: Percentage of outpatient referrals waiting over boundary for a first attended appointment: (a) % Referral Priority 1 over 30 days; (b) % Referral Priority 2 over 90 days; (c) % Referral Priority 3 over 365 days

9.3 Official and public release of data

It is a requirement that official and public releases of information relating to non-admitted patient activity be sourced from the NAPAAWL DC and the Interim Collection of Aggregate Data (ICAD) data collections.

Non-admitted patient reports that have been produced from other data sources are to be used for internal or operational purposes only and appropriate footnotes are to be included.

9.4 Classification of patient activity

Each record of non-admitted patient activity has a number of classification-based data items associated with it. Within these classificatory data items, codes are applied which may preclude the activity from being reported as a non-admitted patient service event.

The following will not be reported as a non-admitted patient service event:

- a service that has not been provided to an individual patient (or their carer) or a group of patients
- a community, population or public health service, unless included under the General List
- specialist mental health services
- a diagnostic imaging or radiology service, other than interventional imaging
- a pathology service
- a pharmacology service, other than clinical pharmacology
- a non-clinical service e.g. pastoral care, welfare, Home and Community Care (HACC) Program.

Note: Diagnostic imaging, radiology, pathology and pharmacy activity are bundled with the originating non-admitted patient service event.

9.4.1 Missing classification codes

The Tier 2 code at this time underpins the determination of costs, prices and funding and is a mandatory item for reporting purposes. If the Tier 2 code is missing or invalid, the recorded activity will not be reported as a non-admitted patient service event.

9.5 Source of funding (payment classification)

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

9.5.1 Privately Referred Non-Inpatient (PRNI)

Generally, all outpatient costs, including the cost of the specialist appointment, pathology, pharmacy and diagnostic imaging are met by the hospital. It is possible, however, for patients to be referred by their GP or other specialist to a specific (named) specialist and that they consent to being treated as a private outpatient. With PRNI, Medicare is billed directly in respect of the specialist appointment and any pathology, pharmacy and diagnostic imaging services the patient requires.

9.6 Multidisciplinary and multiple services

9.6.1 Transition from multidisciplinary to individual health care provider clinics

When a multidisciplinary clinic transitions into individual health care provider clinics, because the interaction between health care providers and patients is no longer considered multidisciplinary, a non-admitted patient service event will be reported for each interaction at the one or more health care provider clinics, irrespective of whether they occur on the same or different days.

9.6.2 Multiple services on the same day

If a non-admitted patient has a range of conditions requiring different interventions by health care providers and they occur on the same day (usually for patient or carer convenience) then a non-admitted patient service event can be reported for each interaction provided that:

- every visit meets all criteria in the definition of a non-admitted patient service event
- the patient has attended separate clinics.

Note: Where the same or related non-admitted patient activities are recorded in more than one information system, the non-admitted patient service event will only be reported from one information system.

9.7 Patient education

Recorded patient education services can be reported as non-admitted patient service events provided they meet all of the criteria included in the definition of a non-admitted patient service event.

9.8 Services provided to groups of patients

Each attending patient that is recorded and meets the criteria for a non-admitted patient service event will be reported as a non-admitted patient service event of group type.

9.9 Services provided to carers

Where a non-admitted patient appointment is attended by a carer who is proxy for a patient, the recorded event can be reported against the patient if it meets all of the criteria for a non-admitted patient service event.

Where a non-admitted patient appointment is attended by a carer who is not acting as proxy for a patient, but is a patient in their own right, the recorded event can be reported against the carer if all of the criteria for a non-admitted patient service event are met.

9.10 Information and communications technology (ICT)

All forms of ICT (including but not limited to telephone and video link) can be reported as non-admitted patient service events if they substitute for a face to face consultation and provided they meet all of the criteria included in the definition of a non-admitted patient service event.

For Telehealth activity the non-admitted patient service event shall be recorded and reported at both the clinic providing the consultation service and the patient's location when a clinician is attending.

For Telehealth MDC activity the non-admitted patient service event shall be recorded and reported at only one clinic.

For Telehealth MCC (patient not present) activity the non-admitted patient service event shall be recorded and reported at only one clinic.

9.11 Self-administered home-delivered services

Self-administered treatments performed by the patient in their own home without the presence of a health care provider will be reported as a non-admitted patient service event, provided there is documentation of the procedures in the patient's medical record.

Home-delivered activity should be reported via the non-admitted patient activity Tier 2 method regardless of the condition/s of patients. For example if a patient is receiving services under a mental health community arrangement and requires home delivered enteral nutrition (HEN) the mental health activity is to be recorded in PSOLIS and the HEN recorded in the PAS .

Home-delivered services are accepted as non-admitted patient service events when there are no disruptions or changes to the treatment routine. When the patient is admitted to a hospital and the treatment normally undertaken at home is carried out at a health service location, any recorded home-based outpatient activity that overlaps with the admitted episode of care dates is to have a patient type (inpatient) recorded so that the outpatient activity can be excluded from reporting.

- If a patient was admitted for the whole month then no non-admitted patient service event will be reported for that month.
- If a patient was admitted for part of the month then one non-admitted patient service event will be reported for that month.
- If a patient performs multiple types of home delivered services e.g. renal dialysis and HEN, both can be recorded as separate non-admitted patient service events.

The following home-delivered services performed by the patient in their own home, without the presence of a health care provider, will be reported as a non-admitted patient service event.

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

Note: All non-admitted patient sessions performed per month for the same home-delivered service are to be bundled and reported as one non-admitted patient service event per patient per month, regardless of the number of sessions recorded.

Where multiple non-admitted patient sessions for the same home-delivered service have been recorded for a patient in the same month, only one non-admitted patient service event will be reported for the patient for that home-delivered service in that month.

Ventilation – home delivered is now block funded. All non-admitted patient sessions for this service will continue to be bundled and reported as one non-admitted patient service per patient per month. It is planned to resume as ABF activity in 2020-21.

9.12 Patient already being treated

Generally, if a patient attends a non-admitted outpatient clinic while they are being treated by another area of the hospital then the non-admitted patient activity will not be reported for ABF purposes.

9.12.1 Admitted patient

Any non-admitted patient service provided to a patient while they are admitted will not be reported as a non-admitted patient service event. Non-admitted patient care provided to an

admitted patient is included as part of the admitted care episode and will not be reported as separate activity. For example, an admitted patient that received non-admitted patient care at an outpatient clinic during their admission will not have their non-admitted patient activity reported separately as a non-admitted patient service event.

Note: Patients receiving non-admitted patient care on the same day as an admission or discharge/separation, such as when the patient has a procedure/treatment in an outpatient clinic, will be reported as non-admitted patient activity as long as the actual time of the appointment is before admission or after discharge.

9.12.2 Hospital in the Home (HITH) patient

Any service provided by non-admitted clinical staff to a HITH patient of the hospital (whether delivered at the home or at the hospital) will not be reported as a non-admitted patient service event because the patient is classified as 'admitted'.

9.12.3 Emergency Department

Any outpatient service provided to a patient while they are still registered as an attendance in the Emergency Department will not be reported as a non-admitted patient service event.

9.12.4 Patient attendance

Did not attend

An outpatient appointment that was not attended by the patient will not be reported as a non-admitted patient service event.

Cancelled

An outpatient appointment that has been cancelled (and not attended) by the patient will not be reported as a non-admitted patient service event.

Non-client event/Chart only

An outpatient appointment that is a Non-Client Event will not be reported as a non-admitted patient service event.

Not specified

An outpatient appointment that has been classified as 'Not specified' or 'Unknown' or does not have an outcome, attendance, client type or session type recorded (and subsequently is classified as Not specified) will not be reported as a non-admitted patient service event.

Non-service event

An appointment where a health care provider interacts with a non-admitted patient but does not have clinical/therapeutic content or a dated entry in the patient's medical record will not be reported as a non-admitted patient service event. In these cases, the appointment has an outcome recorded as a non-service event.

For the patients that do not meet the non-admitted patient service event criteria, the activity is still recorded but is to have the outcome recorded as a non-service event and not as an attended appointment.

Note: For patient information systems that currently do not have the non-service event option, the non-client event outcome is to be used.

Health care provider not present

A service where a health care provider is not present to interact with the attending non-admitted patient will not be reported as a non-admitted patient service event except as specified above in Section 9.11 Self-administered home-delivered services.

Patient not present

Care planning or case coordination activities conducted on behalf of a patient but without the patient being present will not be reported as a non-admitted patient service event unless they are part of a multidisciplinary case conference. See section 3.1.4 Multidisciplinary case conference.

Where an outpatient appointment is attended by a carer (as proxy for a patient) and not the patient, the recorded event can be reported as a non-admitted patient service event if it meets all of the service event criteria.

9.13 Waiting times

9.13.1 Attended appointment

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

9.13.2 Did not attend

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

9.13.3 Cancelled

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

9.13.4 Booked

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

10 Managing change

It is a requirement that any information system changes that may impact on recording or reporting of non-admitted patient activity must be considered and approved by the Non-Admitted Patient Data Standards Committee (NAP DSC) and the Executive Director, Information and System Performance (ED, I&SP), Department of Health.

See Related document: Change Request Process for Non-Admitted Data.

10.1 Scope

All information systems that provide non-admitted patient activity data to the NADC are in scope for NAP DSC / ED, I&SP governance. The following process applies:

- all planned changes to existing data items, either codes or descriptors, must be discussed with the Manager, NADC
- all changes to existing data items, either codes or descriptors, must be approved by the NAP DSC and ED, I&SP
- changes to the category code tables must be approved by the NAP DSC and ED, I&SP however re-initiation of existing codes need only be provided as advice to the NAP DSC.

10.2 Aims

The two main aims of the management of change 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 non-admitted patient activity
- minimise the impact of changes when transitioning from one information system to another.

10.3 Non-Admitted Patient Data Standards Committee

The key roles and responsibilities of the NAP DSC include but are not limited to:

- data and reporting definitions (including alignment to State and National definitions)
- business rules such as the Non-Admitted Patient Activity Recording and Reporting Policy (the Policy) that improve data quality
- creation/modification of new/existing data items with specific reference to mandatory reporting items
- data collection and reporting processes (including data extracts and extract processes from Health Service Providers and Contracted Health Entities)
- access targets and system audit findings for non-admitted patient areas.

Where advice is required beyond the Policy, the recommendations and/or solutions will be presented to the Executive Director, Information and System Performance; or in the case of long term unresolved issues, to the Data Steward.

11 Data provision and collections

All relevant Health Service Providers and Contracted Health Entities are to record non-admitted patient activity in an electronic information system in an accurate and timely manner so that the information can be accessed for inclusion into the NAPAAWL DC in accordance with agreed documented data specifications.

11.1 Non-Admitted Patient Activity and Wait List Data Collection

The NAPAAWL DC is one of the larger data collections managed by the Department. The data collection commenced in 2004 and comprises over 25,000,000 electronic non-admitted patient records. The number of records added to the collection increases every year in line with population growth as well as due to the identification and inclusion of non-admitted patient activity not previously available electronically.

The patient information systems used by relevant Health Service Providers and Contracted Health Entities have been incorporated in the NAPAAWL DC. The NADC in the Department is working towards incorporating all approved satellite patient information systems into the NAPAAWL DC.

Because not all non-admitted patient data are available electronically, an interim strategy was implemented for collecting aggregate non-admitted patient activity counts where the NADC has not finalised collection of electronic data extracts of non-admitted patient-level activity.

11.2 Interim Collection of Aggregate Data

The Interim Collection of Aggregate Data (ICAD) was developed to house aggregate data that were not otherwise available. Data are collected from specific health services using a specially designed form to enable the WA health system to report to the Commonwealth.

The aggregate data are collected monthly and classified by type of service event, Tier 2 code and source of funding.

During 2019-20 the ICAD will be decommissioned. All Health Service Providers and Contracted Health Entities providing aggregate data to ICAD will be required to provide patient-level data to NAPAAWL DC before 30 June 2020. See Section 4.2 Satellite information systems for information on the process to move from ICAD to NAPAAWL.

11.3 Standardising source information

For each record of non-admitted patient activity there can be, depending on the source patient information system, up to 120 data items available for capture. Further, those data items that include coded values may also differ.

The available data items and coded values (where applicable) are transformed (mapped) into the standardised NAPAAWL DC, comprising more than 90 data items.

The majority of these standardised data items and their coded values (where applicable) correspond to National Minimum Data Set (NMDS) and National Best Endeavours Dataset Specifications (NBEDS) as defined in the Australian Institute of Health and Welfare (AIHW) Metadata Online Registry (METeOR).

The *NAPAAWL DC Data Set Specification* provides the metadata for this collection.

11.4 NAPAAWL DC references

The NAPAAWL DC is supported by documents that need to be read in conjunction with the NAARM.

- NAPAAWL DC Data Set Specification (DSS) for non-admitted patient clinic activity which provides direction and guidelines regarding the submission and definitions of required data items
- Data item specification for the "core or satellite" information system which summarises how each non-admitted information system, core and satellite, is transformed into the standardised NAPAAWL DC. Includes assignment of variables, recoding of data item values and methods of derivation.
- Reporting Definitions (see Section 9.2).

Appendix A: Summary of recording and reporting inclusions and exclusions for ABF 2019-20

	Non-admitted Activity		
	Recorded	Reported	Eligible for national ABF
Patient already being treated			
Admitted patient	Yes	No	No
Hospital in the Home (HITH) patient	Yes	No	No
Emergency Department patient	Yes	No	No
Specialist Mental health patient	Yes	No	No
Diagnostic services	Yes	No	No
Patient attendance			
Attended In person	Yes	SE[(a)] Only	Yes
Using information technology (in place of face to face)	Possibly	SE[(a)] Only	Yes
Did not attend	Yes	No	No
Cancelled	Yes	No	No
Non-client event (patient not present) Chart review only	Yes	No	No
Multidisciplinary Case Conference	Yes	Yes	Yes[1.]
Health care provider discussion	No	No	No
Not specified	Yes	No	No
Non-service or non-client event (interaction has not met SE criteria) Patient or carer present	Yes	No	No
Patient not present: MCC only	Yes	Yes	future
Same patient activity recorded more than once			
Within same information system	Yes	SE[(a)] Only	Yes
Across two or more information systems	Yes	SE[(a)] from one information system only	Yes
Incomplete patient-level information	Yes	SE[(a)] Only	Possibly
Patient education	Yes	SE[(a)] Only	Yes
Services provided to groups	Yes	SE[(a)] Only	Yes

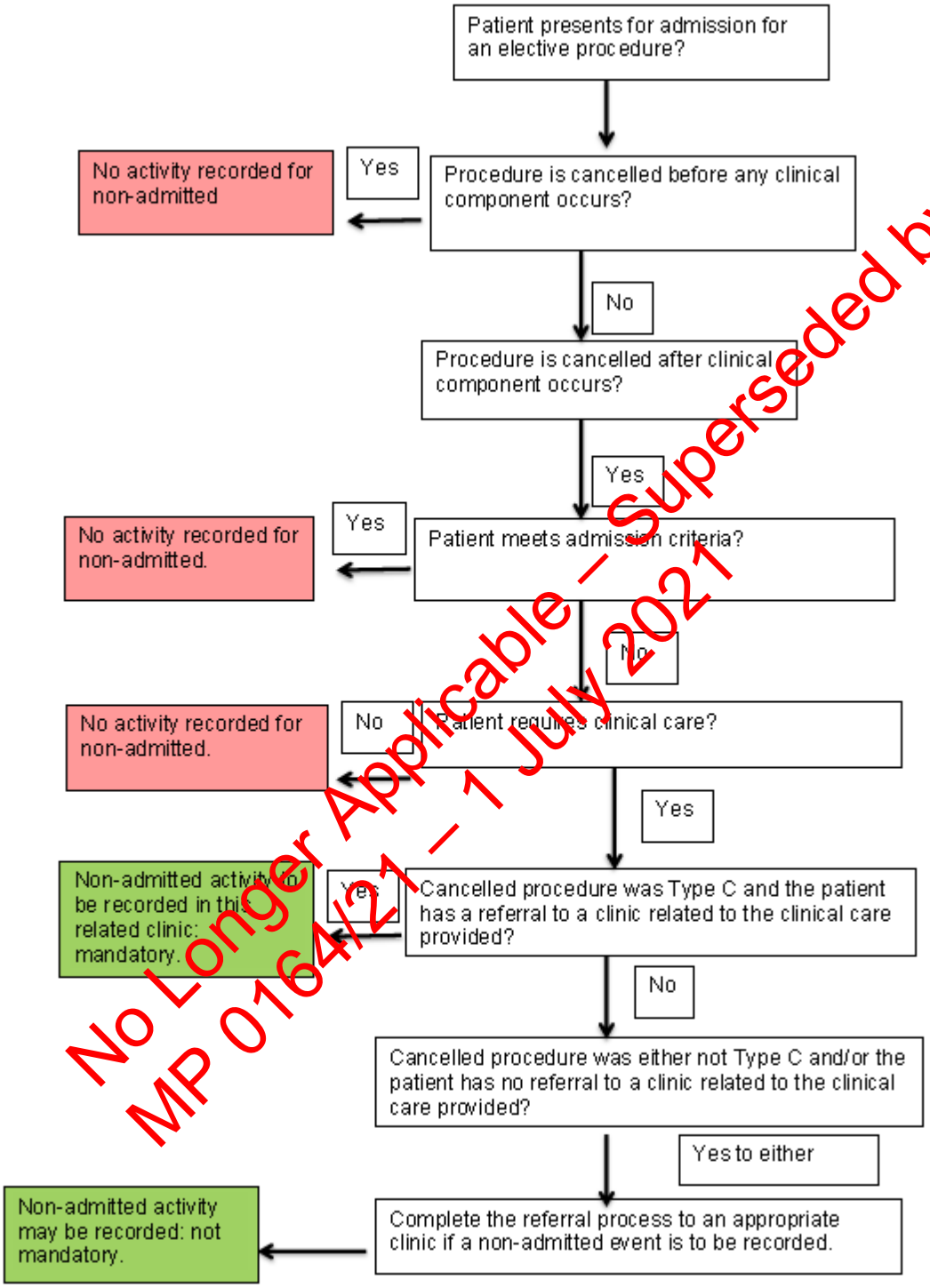
	Non-admitted Activity		
	Recorded	Reported	Eligible for national ABF
Information and Communications Technology (ICT)			
Telephone	Yes	SE[(a)] Only	Yes
Video conference (Telehealth)	Yes	SE[(a)] at both ends	Yes
Video conference (MDC)	Yes	SE[(a)] at one end	Yes
Video conference (MCC)	Yes	SE[(a)] at one end	Yes
Email	Possibly	SE[(a)] Only	Yes
Social media	No	No	No
Messaging/texting	Possibly	No	No
Letters	Possibly	SE[(a)] Only	Possibly
Self-administered home delivered services			
Renal dialysis—haemodialysis	Yes	One SE[(a)] per patient per month	Yes
Renal dialysis—peritoneal dialysis	Yes	One SE[(a)] per patient per month	Yes
Nutrition—total parenteral	Yes	One SE[(a)] per patient per month	Yes
Nutrition—enteral	Yes	One SE[(a)] per patient per month	Yes
Ventilation	Yes	One SE[(a)] per patient per month	Block funded from 2018-19
Providers			
Health care providers	Yes	SE[(a)] Only	Yes
Other providers	No	No	No
Type of service			
Consultancy	Yes	SE[(a)] Only	Yes
Procedure	Yes	SE[(a)] Only	Yes
Same day admitted cancelled procedures (Type B)	Yes	SE[(a)] Only	Yes

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

1. Included from 2018-19 by IHPA as a valid ABF non-admitted patient service event

(a) SE Non-admitted patient service event

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



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