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

Non-Admitted Patient Activity Data

Business Rules

July 2024

health.wa.gov.au

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

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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
NAP	Non-Admitted Patient
NADC	Non-Admitted Data Collection
NAP SE	Non-Admitted Patient Service Event
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 Patient (NAP) 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.

For the purposes of this document, the terms “patient” and “client” are used interchangeably. In the non-admitted setting there is a shift towards using the term “client” as an acknowledgement that some services provided are not for direct treatment of a health condition, but rather involve collaboration with a person to empower them as individuals.

3. Contact Details

Queries and feedback on the Business Rules can be submitted to the Department of Health via 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 NAP 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.

5. Definitions

5.1 Attended appointment

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

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

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

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

5.2 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, submissions to be forward to the National Activity Based Funding (ABF) team of WA npaisc@health.wa.gov.au for review in early April, prior to submission to Independent Health and Aged Care Pricing Authority (IHACPA) by the 31 May each year.

5.3 Healthcare provider

A person 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 NAP is a non-admitted patient healthcare provider.

This includes: medical or nurse practitioners, clinical nurse specialists, liaison nurses (recognised in WA only) and allied health professionals. Pastoral care, welfare workers and meals on wheels staff are not recognised as a non-admitted patient healthcare provider.

Clinics where the usual healthcare provider is a healthcare professional support staff, such as a therapy aide, should be classified to the relevant allied health and/or CNS interventions class that reflects the discipline of the healthcare provider under whose guidance they are working.

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

5.4 Non-admitted patient

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

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

5.4.1 Non-admitted outpatient

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

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

5.5 Outpatient clinic

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

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

- medical practitioners, 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.

5.6 Outpatient referral

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

5.7 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 and/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.

All NAP events must be supported by documentation and a record of treatment and/or care that includes:

- administrative documentation (e.g. registration on the Patient Administration System (PAS) and referral)
- documentation in the medical record by a medical practitioner or authorised clinician to evident compliance with the definition of non admitted activity, 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
    - factors/exceptional patient circumstances contributing to the event
    - conditions identified and treated/care provided.

Information not written or recorded within a conventional paper-based or digital medical record but captured electronically via a supporting administrative and/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. Documentation must be clearly delineated, with information recorded according to the type of activity being undertaken.

5.8 Multidisciplinary Case Conference – patient not present

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

MCCs are recorded by the service delivery mode selection of 'MCC' to allow for analysis of activity and reporting. The healthcare providers involved in the MCC may be of the same or different profession. However, when they are of the same profession, they must each be from a different specialty so that the care provided by each healthcare provider is unique. Alternatively, the healthcare providers may be of different professions (medical, nursing, midwifery or allied health) but of the same specialty (for example, oncologist, oncology registered nurse, physiotherapist).

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 patient's medical record:

a) 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

b) the names of the participants involved in the discussion relating to the patient and their designations and clinical backgrounds

c) a description of the non-admitted patient's problems, goals and strategies

relevant to that MCC

d) 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).

The healthcare providers participating in the MCC may attend in person or via an Information Communication Technology platform (ICT) (including but not limited to telehealth). 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 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 in which the patient was discussed 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.

A non-admitted MCC service event is counted for each patient, not by the number of healthcare providers present or number of MCCs discussed.

Where the non-admitted MCC includes healthcare providers billing under a different funding arrangement (for example, the Medicare Benefits Scheme), the non-admitted MCC should still be reported.

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

For example: A MCC is held by one Plastic Surgeon, one General Surgeon and one Vascular Surgeon to discuss a patient's upcoming surgery in detail and coordinate the treatment plan. The patient is not present for the meeting. A management plan is developed at the conference which includes detailed documentation of the patient condition, goals and strategies relevant to the upcoming admission and post admission care plan. A dated summary of the outcomes, duration and attendees names and clinical backgrounds are documented in the Medical Record by one of the participants. Once the meeting was closed one of the participants phoned the patient to advise the plan for the upcoming surgery and this event was recorded in the PAS under the MCC Clinic.

Outcome: this would meet the criteria for a MCC event and an additional NAP event and result in both events eligible for funding.

5.9 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 different profession (e.g. a medical practitioner, a nurse and an allied health professional all from specialty A)
- different specialties: healthcare providers can be of the same profession (e.g. a nurse from specialty A, a nurse from specialty B and a medical practitioner

from specialty B)

- the contribution of each healthcare provider must meet the definition of a service event in its own right
- the one organisation or from a range of health organisations including private healthcare providers that provide publicly-funded services.

Where healthcare providers from multiple clinics, establishments, or locations are present at a service event, only one service event should be recorded.

The aim of an MDC is to provide Multidisciplinary care to a NAP on the same day within a single clinic by collaborating together to assess and make treatment recommendations that facilitate patient care. MDCs must be set up with the multidisciplinary flag set to 'yes.' Please see Multidisciplinary Clinic flag for further information on MDC set up.

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

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

6. Rules for non-admitted patient service event

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

This may be for assessment, examination, consultation, treatment and/or education.

One service event must be recorded for each interaction, regardless of the number of healthcare providers present.

Consultations delivered via information and communication technology (ICT) (including but not limited to telehealth and where the patient is participating via a video conferencing platform) must be equivalent to a face to face consultation to be counted as a non-admitted patient service event. That is, the event must be necessary and if the event were not delivered via ICT then the patient would have been required to receive that service in a face to face consultation. See Interactions via information and communications technology.

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

The Service Event reporting definition (see MDG-10-004 Total Non-admitted Patient Service Events definition) is to be used for a range of reporting including national funding and health service planning.

A NAP service event must satisfy all of the following criteria:

- an interaction between one or more healthcare providers and one NAP (e.g. each patient receiving care is recorded as an individual event regardless of whether they receive care as an individual or as part of a group)
    - valid exception one: patient self-administering approved treatments in the patient's own home 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 NAP service event)
- must result in a dated entry in the patient's medical record. The dated entry is documentation that supports the patient's attendance to the appointment as well as provide record of treatment and/or care plans.

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

- work related services provided in clinics for staff
- non attendances for a booked non admitted service or booked non admitted services that did not go ahead.

6.1 Events broken in time

The period of interaction can be broken but still regarded 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, for example, 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 considered to be a service event only if the definition of service event (above) is met.

6.2 Clinical or therapeutic content

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

- it is information recorded during a NAP interaction requiring consideration (of evidence) to support a diagnosis and the management of the patient
- it is expert or evidence-based clinical knowledge
- it may also restore a person's health or provide healing from an injury
- it may prevent a specific illness from occurring or after the diagnosis has already been established to treat the diagnosis or provide healing
- it considers the local health environment including practice, policies and availability of services.

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

6.3 Self-administered home-delivered services

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

- 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.

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

Home-delivered services are accepted as NAP service events if the patient performed at least one session of the home-delivered service in their own home as a non-admitted patient. When, for an entire month, the patient is admitted to a hospital or is an admitted Hospital in the Home (HITH) patient, all home-based outpatient activity that occurred whilst the patient was admitted will be excluded from reporting:

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

and HEN, both can be recorded as separate NAP service events provided the patient performed at least one session of each type of home-delivered service as a non-admitted patient.

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

For example, if a patient is:

i. receiving services under a mental health community arrangement and

ii. requires home delivered enteral nutrition.

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

6.4 Services provided to groups

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

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

The '*Group Client Present*' service delivery mode is recorded for this type of NAP service event and is used to derive the session type of 'Group'.

The counting rules that are to be applied are:

- a NAP service event is to be counted for each member of the group that receives a service containing therapeutic/clinical content
- the interaction must be documented in the patient medical record in order to be counted as a NAP service event
- family members seen together are each to be counted as non-admitted patient service events as long as each family member was provided with therapeutic/clinical input and a dated entry was made in each family member's medical record
- family members and/or carers accompanying a patient to an appointment must not be counted as additional non-admitted patient service events when they did not receive a service meeting the definition of a non-admitted patient service event.

7. Rules for outpatient clinic registrations

A NAP service event is funded based upon the Tier 2 Non-Admitted Services Classification Code and must be assigned by HSPs and CHEs when registering their non-admitted outpatient clinics.

A clinic must:

- have a unique identification number and title e.g. ENT123
- be assigned to a Clinic Category (see Appendix A)
- be classified according to the predominant activity undertaken
- have the lead healthcare provider designated if managed by two or more healthcare providers (refer to principal or lead healthcare provider)
- have the following mandatory classification codes assigned. These codes are not to be changed at appointment level:
    - Tier 1 National Minimum Data Set (NMDS) Code
    - Tier 2 Non-Admitted Services Classification Code
    - Referral and Clinic Category
    - Care type
    - Multidisciplinary Clinic (MDC) flag.

Initial registration or any changes to the clinic, involving these five fields, require authorisation from a manager at site before notifying the 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 historical 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 are no longer reported nationally, as Tier 2 is the current classification system for NAP activity, this code remains a mandatory item when registering non-admitted outpatient clinics and is used to identify national service events which may 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

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

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

mixed patient clinic) then code to ‘group’ level only

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

7.1.1 Block funded clinics

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

If a new block funded clinic is to be created in the PAS, the appropriate Tier 1 NMDS code must be allocated to ensure the activity is correctly reported. Consultation with the 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).

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

7.2.2 Principal or lead healthcare provider

When there is only one healthcare provider operating in the non-admitted outpatient clinic, they are the lead healthcare provider. 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 the majority of services are provided by specialist nurses. The most suitable nursing qualifications/titles are to be determined by the jurisdiction. WA includes liaison nurses as suitably qualified to be allocated a Tier 2 code clinic.

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

- where there are two healthcare providers and one is a nurse practitioner and the other a medical practitioner, the lead healthcare provider will be the medical practitioner
- where there is either one medical practitioner or one nurse practitioner, along with other healthcare providers, the medical practitioner or nurse practitioner is deemed to be the lead healthcare provider
- where there are two or more medical practitioners, (or two or more nurse practitioners) a decision about the lead healthcare provider needs to be agreed. This may sometimes be subjective, but could be related to the underlying condition, symptoms or diagnosis or which healthcare provider spends more time with each patient (i.e. where one clinician performs greater than 50% of the service provision)
- where there are two or more allied health professionals, or a combination of allied health professionals and clinical nurse specialists, a decision about the lead healthcare provider needs to be agreed. This will be based on the diagnosis, procedure and/or intervention associated with the patient 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 determination of the Tier 2 code is as follows:

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

  See Section 5.8 Multidisciplinary Case Conference – patient not present for further information.
- Telehealth clinics must have the Tier 2 of the leading healthcare provider assigned as well as the relevant telehealth service delivery mode.
- the following Telehealth Tier 2 codes are not to be used within the WA health system:
    - 40.61 Telehealth – patient location
    - 20.55 Telehealth – patient location.

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

For example:

- clinics where the usual healthcare provider is an endorsed midwife practitioner, or a nurse practitioner should be classified to the relevant class within the 20 series - Medical consultation rather than to a class within the 40 series - Allied health and/or CNS intervention
- a nurse practitioner is a registered nurse, educated and authorised to

function autonomously in an advanced and extended clinical role. The title of nurse practitioner is protected by state and territory legislation and only those authorised by their nursing and midwifery regulatory authority are able to call themselves nurse practitioners

- an endorsed midwife practitioner is a registered midwife that is qualified to prescribe schedule 2, 3, 4 and 8 medicines and to provide associated services for midwifery practice in accordance with relevant state and territory legislation
- where there is a mix of medical practitioners, allied health personnel and/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 to an allied health and/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 re-assign 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 re-assigning a clinic title

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

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

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

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

7.4 Care type

Care type refers to the overall nature of a clinical service provided to a NAP 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 NAP care types are a subset of the admitted care types. Many admitted care types are not relevant to NAP care and if used are mapped to ‘Other care’.

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

7.5 Multidisciplinary clinic flag

When a clinic meets the Multidisciplinary Clinic (MDC) definition, the MDC flag must be set to ‘yes’ in the clinic registration in the PAS. By ensuring the MDC flag is set to ‘yes’, MDC activity can be correctly identified 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.’

7.5.1 Single service event method

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

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

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

7.6 Voluntary assisted dying

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. Rules for managing outpatient referrals

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

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

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

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

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

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

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

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

8.1 Registering referrals

HSPs and CHEs must actively manage patients 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, that is, requires consideration by more than one specialty or discipline (i.e. referral category) at a hospital, and multidisciplinary care is not indicated, separate referral registrations are required for each referral category and condition combination.

Only one referral per referral category per condition 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 referral), 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 - with the exception of pre-approved and arranged circumstances 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.

Patients 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 specialist nurses)
- individual self-referral or referral by a carer or family member. This may occur in very limited circumstances. It is expected that referrals are mainly raised by healthcare providers
- specialists referring back to themselves for ongoing patient management.

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

8.3 Referral reason

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

- assessment

- chart review
- education
- ongoing patient management
- other
- research trial
- treatment or intervention.

8.3.1 Ongoing Patient Management

Ongoing Patient Management must only be utilised 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.

Scenarios:

- The service is moving from one Hospital to another which requires all referrals to be transferred. The patient received their first appointment at Hospital A, the service is being transferred to Hospital B. As a result, all referrals will be moved from Hospital A to Hospital B.

  A new referral is created with ‘Ongoing patient Management’ as the referral reason.

  If the patient was on the waiting list without having attended a first appointment, this referral would be added with a referral reason of ‘Assessment’.

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

  For patients who attended their first appointment under General Surgery, the new referral is created with a referral reason of ‘Ongoing patient Management’.

  For the patients still on the waiting list to attend a first appointment, a new referral would be created with a referral reason of ‘Assessment’.

Please note: A patient who requires an appointment after 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 is to have the referral reason as ‘Ongoing patient management’.
    - the first appointment from the transferred referral is to then be recorded as ‘Follow-up.’
- the original referral must be closed with the referral closure reason as ‘*Transfer and Close.*’

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

8.5 Rules for closing referrals

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 NAP attended appointment is ‘discharge’, the PAS referral must be closed to reflect the reason for closure as ‘treatment complete’ – provided there are no further appointments linked to the referral.

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

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

  The referring healthcare provider must be notified of this action.
- When a referral is transferred to a new referral, the old PAS referral must be closed to reflect a reason for closure as ‘Transfer and Close’.
- When notification of a deceased patient is received, all PAS referrals must be closed to reflect a reason for closure as ‘Deceased.’

HSPs and CHEs are required to conduct routine audits to manage accessibility to outpatient services by assessing long waiting open referrals. As part of this, sites are required to assess referrals which have been waiting beyond their triaged timeframe without activity recorded against the referral. If an audit deems the referral no longer requires an appointment as per patient consent or clinical decision, the patient is to

be returned to the referring healthcare providers care. The referral is to be closed with a reason for closure as ‘Audit’.

Auditing long waiting open referrals is also a data quality practice that ensures Key Performance Indicators (KPIs) and public reporting are accurately presented. Advice for 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:

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

8.6 Reactivating referrals

Referrals must not be reactivated. If a referral is closed, it should remain closed and a new referral created unless:-

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

9. Rules for managing appointments

NAP appointments are deemed either eligible or not eligible for classification as a NAP 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 reported or funded.

9.1 Appointment classification

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

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

MCC appointments must use ‘Non-client event/Chart Only’ Appointment Type.

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

The following are not considered to be ‘New’ service events and must be entered as a Follow-up:

- post-discharge reviews associated with an admitted patient episode for conditions that have been previously addressed under the same clinical service
- services for clinical review.

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

9.1.2 Follow-up

All subsequent appointments for the same registered referral must be classified as ‘Follow-up.’

A ‘Follow-up’ or repeat NAP appointment is:

- one where a condition has been previously addressed for the current referral at the same clinical service – whether at the same hospital or not

  Transferred patients may be recorded as ‘Follow-up’
- any subsequent NAP appointment in that given clinic for the continuing management or treatment of the same condition, and where the healthcare provider responsible for care has not discharged the patient (i.e. closed the case). This includes:
  - post-discharge reviews associated with an admitted patient episode
  - routine review of a chronic condition
  - monitoring results of interventions
  - evaluation of action plans
  - reassessment of patient needs.

9.1.3 Non-client event/Chart only

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

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

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

A Non-client event/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;

- clinician advises the patient is to be discharged as no further treatment required - Non-client event/Chart only is processed as ‘discharge’ and the referral closed
- clinician advises the patient is to be seen in the next available appointment slot – Non-client event/Chart only is processed as ‘reappoint’ and a follow up appointment booked.

9.2 Services extended over midnight

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

9.3 Appointment attendance

9.3.1 Attended

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 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 Did not attend

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

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

9.3.3 Interactions via information and communications technology

Consultations delivered via ICT 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 patient interacting in a mutually responsive manner within a short timeframe.

Consultations delivered via ICT must be a substitute for a face-to-face consultation to be counted as a non-admitted patient service event. That is, the consultation must contain therapeutic/clinical content and be equivalent in content in the sense that if the consultation could not be provided via ICT, a face-to-face consultation would have occurred.

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

Consultations delivered via ICT 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).

Examples:

1. During an outpatient visit involving an elderly patient at hospital A, a neurologist in hospital B assesses tremors and gait problems using teleconferencing, video link, telemetry or other resources. A nurse is with the patient during the outpatient visit at hospital A. Hospital B has determined the clinic providing the service is most appropriately classified to Neurology.

   Outcome: this consultation is equivalent to the patient attending an

appointment in person with the neurologist at hospital B. It meets the definition of the non-admitted patient service event and is counted as a non-admitted patient service event for the clinic at hospital B classified under Neurology and service delivery mode Telehealth at a WA Health site (THS) and for hospital A under Neurology and service delivery mode Telehealth support clinician (THC).

2. An asthma clinic has implemented a secure smartphone application which enables communication between patients and healthcare providers. A patient receives a notification through the application asking them to send through a video of them taking their inhaled medication and detailing any symptoms or illness exacerbations or improvements. A nurse reviews the video and written information, assessing for technique, medication tolerance and adverse reactions. The nurse sends a reply message to the patient letting them know of any changes to the care plan or notifying them that they will need to come into the clinic for a detailed assessment by another healthcare provider. The communication messages are automatically downloaded into the electronic medical record.

   Outcome: The interaction substitutes for a face to face consultation at the clinic. The multiple interactions through the smartphone application would be counted as one service event, as the exchange in its entirety is a substitute for a single face to face service event at the clinic.

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

Non-admitted services events delivered via telehealth where two public hospital service non-admitted clinics are involved are counted twice. One service event is counted at the clinic where the patient attends, and one service event is counted at the clinic providing the consultation.

9.4 Attended exceptions

9.4.1 Healthcare provider present only

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

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

9.4.2 Patient present only

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

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

- 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.

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 a NAP service event. Regardless of the service delivery mode, all NAP service events must result in a dated entry in the patient's medical record.

9.5.1 Client present (face to face)

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

Exception: Self-administered home-delivered services, where 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 this service where multiple patients 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 if there are various healthcare providers or specialties involved in the MCC or whether the meeting was held via an alternative platform from in-person, only a single service event is to be recorded per NAP with the service delivery mode set to '*MCC*.'

9.5.5 Other

A service delivery mode of 'other' must be assigned when the service involves a direct interaction with a healthcare provider and therapeutic content is provided via a means not covered by any other service delivery mode.

Exception: Service delivery mode of 'other' is to be used for appointment classifications of '*Chart only.*' to ensure that the patient is not notified of the appointment.

9.5.6 Telephone

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

9.5.7 Telehealth

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

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

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

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

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

Note: A telehealth service delivery mode can be selected for MDC appointments.

For MCC appointments, the healthcare providers participating in the MCC may attend via ICT (including but not limited to telehealth). Only one MCC should be recorded regardless of the number of sites involved. The most appropriate site to report the MCC should be based where the majority of the healthcare providers and services are located.

Telehealth service delivery modes cannot be selected as only one appointment is to be recorded for the MCC clinic and the service delivery mode of 'MCC' must be selected.

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/clinical backgrounds, are documented in the patient's medical record by the respiratory physician.

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

The three telehealth service delivery modes which can be used for NAP service excluding MCCs:

9.6 Telehealth at Non-WA health site

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

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

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

9.7 Telehealth at WA health site

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

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

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

9.8 Telehealth Support Clinician

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

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

Both events are valid NAP service events recognised by IHACPA, 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 WAH site*' service delivery mode. Example: a healthcare provider is located at a metropolitan hospital (A) and a 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 WAH site'* and the regional site (B) records the activity against '*TH Support Clinician*.'

9.9 Cancelled appointments

An appointment can be cancelled on the PAS:

- when a patient declines treatment or advises of receiving treatment elsewhere, in this scenario the referral must also be closed
- when the patient is currently attending the Emergency Department or is an Inpatient
- by the HSP/CHE as the clinician is unavailable.

In these scenarios, an appointment request must be made to ensure the appointment will remain in the system and can be picked up and re-booked from the pending reschedule list.

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 Business Rules for instructions on the cancellation process of appointments.

10. Rules for 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.

For a snapshot of the following, please refer to the flowchart for recording service events (Appendix B) and the summary of recording and reporting inclusions and exclusions for ABF 202-24 (Appendix C).

10.1 Required to be recorded

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

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

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

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

10.1.1 Deceased patient activity

Patients with a status of ‘deceased’ in the PAS can have retrospective NAP 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 limits the number of unnecessary open referrals in the system.

10.2 Multiple services on the same day

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

The counting rules that are to be applied are:

- for multiple non-admitted patient 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 patient service event.
- if the non-admitted patient 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 patient service event must be counted.
- appointments at clinics where services are provided by multiple healthcare providers must not be counted as separate non-admitted patient service events in order to count increased non-admitted patient service events.
- clinics where services are provided by multiple healthcare providers must not be registered as separate clinics in order to count increased non-admitted patient service events.
- patients whose care is discussed at a MCC occurring immediately prior to, or immediately following, an outpatient clinic to which the same patients discussed attend, may be counted separately as a non-admitted MCC service event.

10.3 Pre-admission

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

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

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

10.4 Admitted patient

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 patients during receipt of publicly-funded admitted or active emergency care are not valid NAP 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 NAP service event.

The following are examples of activity that must be recorded:

- interaction between an admitted patient and a NAP healthcare provider for an outpatient clinic service, irrespective of whether the patient physically attends the clinic location or if the NAP healthcare provider visits the ward
- admitted patient at one hospital and attends a non-admitted service at a second hospital

- outpatient clinic services provided by a NAP healthcare provider to a patient who is an admitted Hospital in the Home (HITH) patient.

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

10.5 Same day NAP procedure

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

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

- same day non-admitted procedures (Type C) provided in an outpatient setting must always be recorded as a NAP service event unless there is a documented clinical reason for admission or the service was provided in an Inpatient ward or unit
- 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.

Same day NAP procedures are generally recorded under a 10 series Tier 2 clinic.

10.6 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 outpatient activity.

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

10.7 Emergency Department

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

11. High-cost therapy

Access to new, high cost, highly specialised and potentially curative therapy treatments are an emerging option for patients in WA. A small number of patients are expected to benefit from access to 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, and Tecartus and other specialised therapies including Qarziba® and Luxturna™.

IHACPA has developed guidelines for the costing, counting and reconciliation of funding. In order to comply, all HSP's must provide patient level activity recording of highly specialised therapies to the DoH 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 requires HSP's 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.

12. Activity reporting

12.1 Scope

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

For NAP service event reporting, the WA health system will include all recorded activity that meets the reporting definition of a national service event (see MDG-10-004 Non-Admitted Patient National Service Event Definition), 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 has already been funded from another source
- other activity that is out-of-scope for activity based funding.

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

12.2 Units of Measurement

12.2.1 Activity

WA uses two reporting units of measurement for reporting NAP activity:

- the NAP service event and
- the 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 to be used when producing reports that are to include all activity at all sites, not restricted by service event reporting rules i.e. includes all appointment types, category codes, professions and Tier 2 codes.

12.2.2 Waiting times

The outpatient waiting time is reported using two reporting measures:

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

The median, or midpoint value, rather than the average is the standard

measure utilised across Australia for the measurement of waiting times. The median is used to ensure that outlier figures do not skew the results.

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

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

    (a) % Referral Priority 1 over 30 days

    (b) % Referral Priority 2 over 90 days

    (c) % Referral Priority 3 over 365 days.

12.3 Classification of patient activity

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

- services that have not been provided to an individual patient or a group of patients; with the exception of MCCs
- community, population or a public health service, unless included under the General List
- specialist mental health services, 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.

12.4 Source of funding – payment classification

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

12.5 Multiple services on the same day

Where multiple non-admitted services are recorded for the same patient at the same clinic on the same day, only the first NAP service event for that day will be counted for national reporting. Local reporting on attended appointments will include all appointments. The exception is:

- if a Multidisciplinary Case Conference – patient not present (MCC) is reported

and an additional appointment is attended the same day and meets the service event definition then two service events are eligible for National Reporting.

Where multiple non-admitted services are recorded for the same patient at the same clinic on the same day at the same time, only the first NAP record will be loaded into the NADC, as the other records are considered true duplicates.

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

12.6 Wait list

12.6.1 Attended appointment

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

12.6.2 Did not attend

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

12.6.3 Cancelled 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.

12.6.4 Booked

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

12.6.5 Non-client event/Chart only

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

13. Rules for managing change

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

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

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

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

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

- data and reporting definitions (including alignment to State and National definitions)
- compliance with the Non-Admitted Patient Activity Business Rules to ensure data quality
- creation 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 NAP areas.

14. Information Systems

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

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

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

Note: As of 31st of March 2021 the WA Department of Health ceased the collection of aggregate level NAP data. All NAP data must be recorded at a patient level.

15. Compliance and audits

15.1 Audit of Business Rules

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

15.2 Validation and compliance monitoring

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

Validations are used to support:

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

16. Glossary

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

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

Term	Definition
	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.

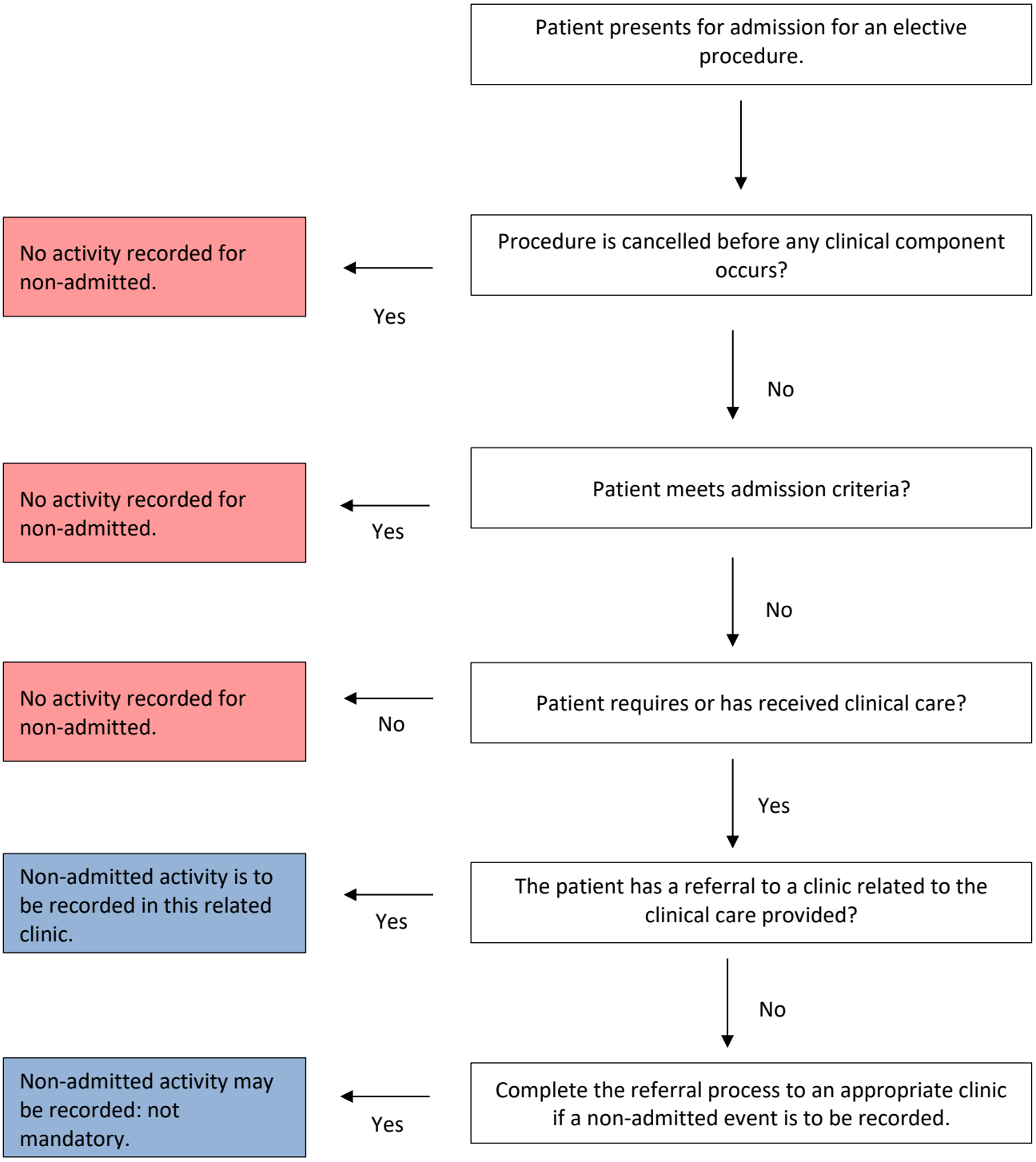
Appendix A – Current referral categories listed by reporting category type

Reporting Type	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 Managment
	Occupational Therapy	OCC=Occupational Therapy
	Physiotherapy	PHY=Physiotherapy
	Podiatry	MFC=Multidisciplinary Foot Ulcer
		OTC=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
		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=Neurogeneti
	Gerontology	ACA=Aged Care Assessment Team

Reporting Type	Reporting Category	PAS Referral Category Codes
		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
		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

Reporting Type	Reporting Category	PAS Referral Category Codes
		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
		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 2023-24

	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) patient	Yes	No[(d)]	No
Non-admitted services provided to Emergency Department patients	Yes	No[(d)]	No
Specialist Mental health patient	Yes	No[(d)]	No
Diagnostic services -Tier 2 codes 30.01 to 30.08	Yes	Yes[(b)]	No
Patient attendance			
Patient attended in person	Yes	SE[(a)] Only	Yes[(c)]
Patient attended via information technology (in place of in-person) as selected via service delivery mode	Yes	SE[(a)] Only	Yes[(c)]
Patient did not attend; did not provide notification of non-attendance	Yes	No	No
Appointment cancelled	Yes	No	No
Non-client event/Chart review only (patient not present) selected via service delivery mode '*other*'	Yes	No	No
Medical consultation undertaken in a Multidisciplinary Case Conference (MCC) clinic, as selected via service delivery mode '*MCC'*	Yes	One SE[(a)] per MCC appointment Only	Yes[(c)]
Allied health and/or clinical nurse specialist interventions undertaken in a Multidisciplinary Case Conference (MCC) clinic, as selected via service delivery mode '*MCC'*	Yes	One SE[(a)] per MCC appointment Only	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
Providers			
Healthcare providers	Yes	SE[a] Only	Yes[c]
Other providers	No	No	No
Type of service			
Consultancy	Yes	SE[a] Only	Yes[c]
Procedure	Yes	SE[a] Only	Yes[c]
Same day cancelled admitted procedures (Type B)	Yes	SE[a] Only	Yes[c]
Same day non-admitted procedures (Type C)	Yes	SE[a] Only	Yes[c]
Telehealth	Yes	SE[a] Only	Yes[c]

	Non-admitted Activity		
	Recorded in PAS	Reported by DOH	Eligible for national ABF
Specific programs			
Aged Care Assessment (ACAT)	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)]
Stroke clinics	Yes	SE[(a)] Only	Yes[(c)]
Parkinson's clinics	Yes	SE[(a)] Only	Yes[(c)]
Residential Care Line (RCL)	Yes	SE[(a)] Only	Yes[(c)]

(a) SE = NAP activity that meets the WA MDG-10-004 Non-Admitted Patient 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 NAP service event will only be eligible for activity-based funding if it has both a funding source and a Tier 2 code that are in-scope and the service is provided from an in-scope establishment. Block-funded establishments are not eligible for activity-based funding.

(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 re-opened. 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

Produced by:
Information and Performance Governance
Information and System Performance Directorate
Purchasing and System Performance Division
The Department of Health Western Australia

Ref: F-AA-74148
Mandatory Policy: MP 0164/21

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