Non-Admitted (Acute) Frequently Asked Questions

Updated – June 2016

Scope of Services

What is the scope of non-admitted Activity Based Funding (ABF)?

The scope of services to be included for national activity based funding purposes is determined by the Independent Hospital Pricing Authority (IHPA). The IHPA's determination about the scope of non-admitted services for ABF is contained in Section 3 of the Pricing Framework for Australian Public Hospital Services.

There are two broad categories of in-scope public hospital non-admitted services:

1. Specialist Outpatient clinics - comprises all clinics in the Tier 2 Non-admitted Services classification, classes 10, 20, and 30, with the exception of the General Practice and Primary care (20.06) class.
2. Other Non-admitted Patient Services – includes:

- all clinics in the 40 class in the Tier 2 Non-admitted Services classification
- other non-admitted public hospital services and
- services on the A17 list - a list of services which would not normally be considered a public hospital service, but which IHPA is satisfied were provided by a particular hospital in 2010. The services on this list are eligible for Commonwealth funding only at the Local Hospital Network indicated in the list. The Victorian list includes Family Planning clinics (at specified LHN's), Child and adolescent community based mental health services, Alcohol and drug services and Adult Continuing care at all LHN's.

To be eligible for Commonwealth funding a service must be:

- directly related to an inpatient admission or an emergency department attendance; or
- intended to substitute directly for an inpatient admission or emergency department attendance; or
- expected to improve the health or better manage the symptoms of people with physical or mental health conditions who have a history of frequent hospital attendance or admission.

The following non-admitted acute services are in scope for ABF under the National Health Reform Agreement (NHRA) – acute outpatients (specialist clinics), post natal domiciliary services, home dialysis, home delivered HEN and TPN, Integrated Hepatitis C and Genetics.

Services that are not within scope for ABF include Home and Community Care (HACC) funded services, Aged Care Assessment Services, and services funded via the Community Health Program.

If a health service is unsure whether a non-admitted service is in scope, they should email their query to abf@dhhs.vic.gov.au

When will ABF take effect for non-admitted services?

- National activity based funding arrangements took effect for non-admitted acute health funded activity from 1 July 2012.
- In Victoria, non-admitted acute service budgets continue to be set according to Victorian funding models. However, health services need to be able to count and cost non-admitted activity according to the national ABF model in order for the Commonwealth to calculate and acquit its funding contribution.
- National ABF arrangements took effect for non-admitted subacute from 1 July 2013.
- In Victoria, non-admitted subacute service budgets continue to be set according to Victorian funding models. However, health services need to be able to count and cost non-admitted subacute activity according to the national ABF model in order for the Commonwealth to calculate and acquit its funding contribution.
- Non-admitted mental health services will remain block funded in the short term.

Under ABF will all non-admitted activity be activity funded or will there be a base grant?

Under national ABF the majority funding for in-scope non-admitted services will be linked to activity.

Will all clinics classifiable under Tier 2 be eligible for national ABF?

The IHPA may determine that some Tier 2 classes will not be funded under the NHRA (i.e. excluded from scope). Where this is the case, there will be no price weight listed against the relevant Tier 2 class in the IHPA National Efficient Price Determination.

Are staff clinics in scope for ABF?

No. Staff clinics (for example Influenza clinics) are considered an overhead cost so health services should not register staff clinics or report service events for activity that occurs in staff clinics.

Classification

What is the classification system that will be used for non-admitted clinics?

The Tier 2 Non-admitted Services Definitions Manual provides a national framework for classifying non-admitted service events.

The most recent manual can be found at : www.ihpa.gov.au/publications?f[0]=field_publication_section%3A2

What is the Tier 2 Non-admitted Services National Index?

This document, produced by IHPA is designed to provide a way of navigating the Tier 2 classification to ensure all health services are classifying non-admitted hospital services to an appropriate Tier 2 class, in a consistent manner. The index can be found at: www.ihpa.gov.au/publications?f[0]=field_publication_section%3A2

What is the Tier 2 Non-admitted Services Compendium?

The IHPA developed the Compendium to provide guidance on the counting and classification rules associated with the Tier 2 non-admitted services classification. The Compendium provides business rules and examples to assist with consistent counting, classification and reporting of non-admitted activity. The Compendium can be found at: www.ihpa.gov.au/publications?f[0]=field_publication_section%3A2

If a clinic is run by a nurse practitioner, where is the clinic classified under Tier 2?

A clinic that is conducted by an endorsed nurse practitioner can be allocated to the 20.xx series.

What Tier 2 class should a pre-admission clinic be assigned to?

In addition to the assessment and consultation with a surgeon or surgical registrar that is part of the patient's overall episode of outpatient care, patients booked for surgery are often assessed in a preadmission clinic.

For activity to be considered 'pre-admission' rather than part of the relevant specialty (e.g. orthopaedics), patients should be attending for one or more of the following purposes:

- to assess their fitness to undergo a scheduled general anaesthesia and surgery (e.g. respiratory function is checked, relevant blood tests are taken).
- to discuss anaesthetic options e.g. spinal block & sedation vs general anaesthetic, epidural vs general anaesthetic etc.
- to advise them on preparations for the surgery (e.g. nothing to eat beforehand, stop taking certain medications etc).

A pre-admission clinic should be assigned to:

- 40.07 Pre-admission and pre-anaesthesia - If the clinic is nurse or allied health led.
- 20.02 Anaesthetics - if the clinic is run by a specialist. The Tier 2 definitions suggest that the "usual provider" would be an anaesthetist, as this is normally the case. However, we believe it is acceptable to use this code in the event that a surgeon or other medical specialist is leading the preadmission clinic (as defined in the second paragraph) rather than, or in addition to, an anaesthetist.

If the clinic's purpose is more general (e.g. providing advice about what is involved in knee reconstruction surgery, and its risks and rehabilitation path), the contact should be coded to the relevant code for that specialty (e.g. 20.29 Orthopaedics).

In summary, pre-admission clinics should be assigned to 40.07 if nurse or allied health led, or 20.02 if led by an anaesthetist and/or another specialist. Surgery-related assessment and information provision that is not part of a specific pre-admission clinic should be coded to the relevant specialty.

How should allied health activity performed in the Radiotherapy program be classified?

Activity should be classified to the relevant Allied Health Tier 2 class.

Should separate clinics for allied health activity undertaken in the Radiotherapy program be registered on the Non-Admitted Clinic Management System?

The department does not require health services to register separate allied health clinics specifically for the reporting of activity within the Radiotherapy program. However, a health service may choose to register separate clinics so they can differentiate the allied health activity undertaken in the Radiotherapy program from other allied health activity.

Can dispensing medication be classified to Tier 2 class 40.04 Clinical Pharmacy?

In order to report activity under Tier 2 class 40.04, a consultation between a patient and a pharmacist must occur that is above and beyond the normal conversation that occurs when a Pharmacist dispenses medication.

Counting

What is the unit of count for non-admitted ABF activity reporting?

The unit of count is a "service event". A service event is defined as "an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record."

What activity can be counted against a clinic in Tier 2 class 10.17 Total parenteral nutrition – home delivered or 10.18 Enteral nutrition – home delivered?

Health services should count (and report) one service event for each calendar month that a patient undertakes TPN or HEN in their own home, without a healthcare provider present, provided there is documentation in the patient's medical record.

Example: A health service with 10 patients who self-administer HEN at home in July 2015 would report 10 service events under a HEN clinic (Tier 2 class 10.18) in the July 2015 S10. If all patients are public patients, they would be reported as 10 public service events in the S10.

If the HEN consumables for a patient are funded via another funding source e.g. DVA those service events should be reported under the relevant column in the S10. If 9 patients are public and 1 is funded via DVA the service event count for the HEN clinic for July would be 9 public service events and 1 DVA service event.

If a patient is admitted to hospital for a complete calendar month, that patient should not be included in the service event count reported via the S10. However, if a patient is admitted to hospital for only a portion of a month, that patient should be included in the service event count reported via the S10.

The Tier 2 Non-admitted Services Compendium provides more detailed advice and examples. The Compendium can be found at: www.ihpa.gov.au/publications?f[0]=field_publication_section%3A2

If a healthcare provider, such as a Dietician/Nutritionist conducts a consultation over the phone (and the phone call substitutes for a face-to-face consultation) or in person, this activity must not be counted or reported under Tier 2 class 10.17 or 10.18. Tier 2 classes 10.17 and 10.18 are procedure classes and are exclusively for counting TPN or HEN that a patient undertakes in their own home. Consultations with healthcare providers should be reported under the appropriate Medical consultation or Allied Health/Clinical Nurse Specialist intervention classes.

How many service events should be counted for a post-natal domiciliary visit?

A home visit that involves an interaction between a nurse/midwife and more than one non-admitted patient (i.e. mother and baby) can be counted as two service events (or three service events for twins etc). This is providing that all aspects of the service event definition are met for each non-admitted patient:

- the interaction is between a healthcare provider and a non-admitted patient
- the interaction is clinical or therapeutic in nature
- there is a dated entry in each patients medical record

This advice is supported in the Tier 2 Non-admitted Services Compendium (Section 2.7 - Services provided to Groups, example 2) which advises that two children attending a single outpatient appointment can be counted as two service events. The post-natal domiciliary visit is a similar situation - one visit, multiple patients.

Home based post-natal visits should be reported under Tier 2 class 40.28 Midwifery and Maternity.

What activity can be counted against a clinic in Tier 2 class 10.15 Renal dialysis – haemodialysis – home delivered

Health services should count (and report) one service event for each calendar month where a patient undergoes haemodialysis (Tier 2 class 10.15) in their own home, without a healthcare provider present, provided there is documentation in the patient's medical record. Example: A health service with 5 patients who self administer haemodialysis at home 3 times a week (Mon, Wed and Fri) in July would report 5 service events under a haemodialysis clinic (Tier 2 class 10.15) in the July S10. If all patients are public patients, they would be reported as 5 public service events in the S10.

If the haemodialysis consumables for a patient are funded via another funding source e.g. DVA those service events should be reported under the relevant column in the S10. If 4 patients are public and 1 is funded via DVA the service event count for the HEN clinic for July would be 4 public service events and 1 DVA service event.

If a patient is admitted to hospital for a complete calendar month there should not be a service event reported for the patient in that month via the S10. However, if a patient is admitted to hospital for only a portion of a month, that patient should be included in the service event count reported via the S10.The Tier 2 Non-admitted Services Compendium provides more detailed advice and examples. The Compendium can be found at: www.ihpa.gov.au/publications?f[0]=field_publication_section%3A2

If a healthcare provider, such as a Nurse conducts a consultation over the phone (and the phone call substitutes for a face-to-face consultation) or in person, this activity must not be counted or reported under Tier 2 class 10.15. Tier 2 class 10.15 is a procedure class and is exclusively for counting haemodialysis that a patient undertakes in their own home. Consultations with healthcare providers should be reported under the appropriate Medical consultation or Allied Health/Clinical Nurse Specialist intervention classes.

What activity can be counted against a clinic in Tier 2 class 10.16 Renal dialysis – peritoneal dialysis – home delivered

Health services should count (and report) a service event for each calendar month that a patient undertakes peritoneal dialysis (Tier 2 class 10.16) in their own home, without a healthcare provider present, provided there is documentation in the patient's medical record. Example: A health service with 10 patients who self-administer peritoneal dialysis at home in July would report 10 service events under a home PD clinic (Tier 2 class 10.16) in the July S10. If all patients are public patients, they would be reported as 10 public service events in the S10.

If the peritoneal dialysis consumables for a patient are funded via another funding source e.g. DVA those service events should be reported under the relevant column in the S10. If 9 patients are public and 1 is funded via DVA the service event count for the HEN clinic for July would be 9 public service events and 1 DVA service event.

If a patient is admitted to hospital for a complete calendar month, there should not be a service event reported for the patient in that month via the S10. However, if a patient is admitted to hospital for only a portion of a month, that patient should be included in the service event count reported via the S10.

The Tier 2 Non-admitted Services Compendium provides more detailed advice and examples. The Compendium can be found at: www.ihpa.gov.au/publications?f[0]=field_publication_section%3A2

If a healthcare provider, such as a Nurse conducts a consultation over the phone (and the phone call substitutes for a face-to-face consultation) or in person, this activity must not be counted or reported under Tier 2 class 10.16. Tier 2 class 10.16 is a procedure class and is exclusively for counting haemodialysis that a patient undertakes in their own home. Consultations with healthcare providers should be reported under the appropriate Medical consultation or Allied Health/Clinical Nurse Specialist intervention classes.

There is a Tier 2 class for home delivered ventilation - should a clinic for ventilator dependent patients be registered on the Non-Admitted Clinic Management System?

No. Service events that meet the definition of home delivered ventilation should be reported on the AIMS S11 form. Therefore a clinic does not need to be registered.

Is a dated entry in the Patient Master Index (PMI) equivalent to a dated entry in the patient's medical record?

No. To count as a service event for ABF purposes, all elements of the service event definition must be met. There must be a dated entry in the hard copy of the patient's medical record or the electronic version of the patient medical record. The PMI is not considered to be part of the patient's medical record and a note in the PMI only would therefore not meet that part of the service event definition.

Can telephone calls be counted as a service event for non-admitted ABF purposes?

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

Can emails or text messages be counted as service events for non-admitted ABF purposes?

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

Multiple emails or text messages between the patient and healthcare provider that are all part of the same conversation should be counted as **one** service event.

Can a spontaneous or ad hoc consultation with a patient in an outpatient clinic be counted?

Spontaneous or ad hoc consultations provided by a healthcare provider to a patient attending an outpatient clinic should not be counted as an additional service event. Irrespective of whether the patient was seen jointly or separately by the healthcare providers, only one non-admitted service event may be counted for a patient at a clinic on a given day.

Should radiotherapy treatment review consultations be counted and reported under ABF?

Yes. Under ABF radiotherapy treatment review consultations can be counted and reported on the AIMS S10. These interactions are classified to Tier 2 class 20.43 Radiation oncology (consultation), assuming the provider is a radiation oncologist and providing the interaction meets the definition of a service event.

Are interpreter services counted as a service event for non-admitted ABF purposes?

No. Where interpreter costs are incurred as part of a non-admitted service event, they should be linked back to the requesting service event via the health services costing system. Where this occurs, it will help to influence the cost weights and the level of funding received by the health service

Can activity undertaken by allied health assistants working under the direction of a supervising professional be counted as a service event?

Yes. An allied health assistant is a healthcare provider and can therefore participate in the delivery of a non-admitted service event.

Are diagnostic/ancillary services counted as non-admitted service events for ABF activity reporting?

No. Diagnostic or ancillary services such as radiology, pathology, imaging and medical photography are not reported as service events for ABF activity purposes. These services do not have a cost weight and are not directly funded under ABF.

The cost of these services are incorporated as part of the total cost incurred by the requesting service event (e.g. relevant outpatient medical consultation clinic) and should be linked back to the requesting service via the health service's costing system. This allows all the costs involved in providing care in a particular clinic to be reflected in the price weight of the Tier 2 class and hence the level of funding received by the health service.

Are services funded via an alternative funding source (eg Jane McGrath Foundation, Pharmaceutical companies etc) counted as non-admitted service events for ABF?

No. If a health service is funded for a non-admitted service via an alternative funding source, it is not eligible for funding under ABF as well.

Are clinics where the user pays to attend counted as non-admitted service events for ABF?

No. If a user pays to attend a clinic (for example childbirth education classes), it is not eligible for funding under ABF.

Can the two telehealth classes within Tier 2 be used to count activity where a patient arrives at an Urgent Care Centre (UCC) and telehealth is used to link with the emergency department of a larger health service?

No. The Tier 2 classification is used to classify non-admitted outpatient clinics or ambulatory care clinics. Activity in UCC and emergency departments is not part of the non-admitted ABF stream.

Reporting

Which non-admitted acute services should report patient level activity data for ABF purposes via VINAH?

Specialist clinic activity at 26 specific health services should be reporting patient level data via VINAH. The department will provide separate advice about when other programs (such as Post-natal domiciliary, Integrated Hepatitis C etc) are expected to move to patient level data reporting. These other programs should report aggregate activity via the S10 until advised by the department.

What is a Group?

A group must have two or more persons attending in the capacity of patients in their own right.

A group may involve care that has been provided to two or more patients by the same healthcare provider(s) at the same time.

Patients in a group receive precisely the same service.

A group session may be delivered by more than one healthcare provider. This may be multidisciplinary care within one clinic appointment as part of a group e.g. a group session jointly delivered by a physiotherapist and an occupational therapist.

How should a health service report group activity on the AIMS S10 or S11 form?

One service event is recorded for each patient who attends a group session.

If the patients in the group are receiving precisely the same services (for example patients may be part of a movement or hydrotherapy class where all participants are following the same intervention at the same time) then for reporting purposes this is considered a group. Therefore the number of group sessions should be reported in the column ‘number of group sessions’ and the service events will be reported in the applicable ‘group service events’ column/s.

For example, a group with 10 participants – 7 are public, 2 are DVA and 1 is TAC, would appear as follows on the S10 or S11.

- number of group sessions = 1
- number of public group service events = 7
- number of DVA group service events = 2
- number of other funded group service events = 1

If care is delivered to a number of patients in the same physical space at the same time but the patients are not receiving precisely the same services (that is, where a clinician works one-on-one with several different patients in the same space over a period of time but each patient is following their own personalised program) for reporting purposes this is not considered a group. Therefore the ‘number of group sessions’ column will be blank. The service events will be reported as an individual service event in the applicable ‘individual service events’ column.

For example, six patients in the physiotherapy gym at the same time (4 are public, 1 is DVA, and 1 is TAC) where a physiotherapist is supervising all six patients and each patient is following their own personalised program is not reported as a group and would appear as follows on the S10 or S11.

- number of public individual service events = 4
- number of DVA individual service events = 1
- number of other funded individual service events = 1

Note, when reporting group contacts through VINAH, follow the VINAH Contact Session Type reporting guide which specifies that in situations where a clinician is working one-on-one with several different patients in the same space over a period of time and each patient is following their own personalised program each of these patients

should be coded as having a contact session type of '4 – Group – Individual program' as the services provided to each patient are not the same but rather individualised programs.

What is the deadline for the submission of the S10 form each month?

Hospitals must submit data to the department via the HealthCollect Portal by the 15th day following the end of the reporting month. A tick in the Completed field indicates to the department that the form is complete.

What should a health service do if they are unable to meet the S10 reporting deadline?

A health service should notify the HDSS helpdesk hdss.helpdesk@dhhs.vic.gov.au if they are unable to meet the S10 reporting deadline.

How will the Department of Health and Human Services monitor non-admitted activity?

The department will use aggregate data submitted via the S10 for monitoring non-admitted acute activity ie. The only exception to this is where a health service has received written approval from the department to move to reporting of activity via VINAH only for particular services.

The department will also use the aggregate data submitted via the S10 for reconciliation purposes where full patient level coverage is not available.

How long does a health service have to continue dual reporting via AIMS and VINAH?

The department has developed a process and criteria to help determine when a health service may be approved to reduce dual reporting. Details can be found at the HDSS website www.health.vic.gov.au/hdss

What data items reported via the S10 are used to determine National Weighted Activity Unit (NWAU) for ABF purposes and to monitor activity against targets?

Data in the Public Individual Service Events field and the Public Group Service Events field on the S10 are used to calculate NWAU for ABF purposes and to monitor activity against targets.

What is the purpose of the Multiple Healthcare Provider data element?

The Independent Hospital Pricing Authority (IHPA) introduced an additional data element in the national non-admitted data sets for 2015-16 to identify activity that is delivered by multiple health care providers.

The national definition that has been developed by the IHPA for this data element is as follows "..in the context of reporting non-admitted data for activity funding 'Multiple healthcare provider' means three or more healthcare providers who deliver care either individually or jointly within a non-admitted patient service event. The healthcare providers may be of the same profession (medical, nursing, or allied health). However, they must each have a different specialty so that the care provided by each provider is unique and meets the definition of a non-admitted patient service event".

The link to the Meteor data element is http://meteor.aihw.gov.au/content/index.phtml/itemId/584616

What non-admitted reports are available to health services on the AIMS portal?

Compliance reports – lists submission status for health services

Non-admitted clinic reports – a detailed or summary list of clinics registered by a health service

Year to date reports – activity data reported by health services on the S10 form

Governance

How does a health service register a new non-admitted clinic or make changes to an existing clinic?

New clinics are registered via the Non-Admitted Clinic Management System in AIMS. Each health service has staff that are authorised to access the clinic management system in AIMS. If additional staff require access to AIMS you should contact: hdss.helpdesk@dhhs.vic.gov.au

Limited changes to existing clinic details (e.g. contact details and clinic name) can be made by a health service once a clinic has been reviewed or approved. If you have any queries about this process please contact hdss.helpdesk@dhhs.vic.gov.au

If a registered clinic is Approved, does this mean a health service will receive additional funding?

No. Registration of a clinic on the Non-Admitted Clinic Management System is for classification and reporting purposes only. Registration and approval of a non-admitted clinic does not mean that additional funding will be allocated to a health service. If a clinic requires funding beyond that available within the health service's existing budget, then the health service needs to identify that as a priority in the annual budget setting process and/or performance meetings with the Department of Health and Human Services.

Is funding for non-admitted service activity capped?

Health services need to continue to operate within their total health service budget and agreed targets. Health services should refer to the relevant year's Victorian health policy and funding guidelines for details of funding parameters.

What is the Non-Admitted Clinical Classification Committee (NACCC)?

The Non-Admitted Clinical Classification Committee (NACCC) has been established to provide the department with advice on non-admitted classifications issues and make recommendations on the most appropriate Tier 2 classes for individual clinics. NACCC members are drawn from a range of professional backgrounds, roles, and health services within Victoria. The NACCC meets up to four times per annum.

For further information, please contact abf@dhhs.vic.gov.au

To receive this publication in an accessible format email <abf@dhhs.vic.gov.au>

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