## CHAPTER 22 - STATISTICS

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22.1 INCLUSION OF COMMUNITY HEALTH STATISTICS IN HOSPITAL MANAGEMENT REPORTS

The Provision of community health services falls into one of the following categories:
(a) Those provided by a hospital using hospital staff.
(b) Those provided by a hospital on behalf of the Department.
(c) Those provided by the Department using hospital staff.

For the purpose of reporting community health statistics as hospital non-inpatient statistics, the primary criterion should be that the cost of providing the service (other than salaries and wages costs) is met through the hospital’s General Fund Account. A second criterion is that the statistics are collected in accordance with the provisions of Section 22.1.2.1.

Hospitals should examine any community health services being provided by the hospital to determine whether or not the non-inpatient statistics are being reported correctly in the hospital’s Monthly, Quarterly and Annual reports to the Department. If the statistics have not been correctly reported in the past, hospitals should inform the Department for determination of action to be taken.

NON-ADMITTED PATIENT ACTIVITY REPORTING REQUIREMENTS (PD2013_010)


PURPOSE

The purpose of this policy is to mandate the requirement for NSW health services to report non-admitted patient activity to the Ministry of Health. This reporting requirement underpins the activity based funding model that is being implemented at the state and national level. The document outlines the requirements for reporting both summary level and patient unit record level non-admitted patient data. The activity covered by this policy includes hospital emergency department services, hospital outpatient care services and non-residential community health services.

MANDATORY REQUIREMENTS

All non-admitted patient service units providing services from 1 July 2013 must be registered and aligned with recognised clinical teams in both HERO and WebNAP. Service units must be appropriately classified to the revised HERO establishment type classification applicable to the 2013/14 financial year.

All pathology testing services, radiology imaging services, and pharmacy dispensing services pertaining to non-admitted patients must be reported at the summary level to WebNAP. Any requirement to report patient level data for these services will be issued in a separate policy.

All Emergency Department (ED) services provided to patients on a non-admitted patient basis that are not reported to the Emergency Department Data Collection at the patient level must be reported at the summary level via WebNAP. ED patient level data is not in scope of the reporting requirements to WebNAP.

All other non-admitted patient services containing clinical and/or therapeutic content that warrant a note being made in the patient’s medical record that are delivered on or after 1 July 2013 must be reported:

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- as a monthly occasion of service summary count until 30 June 2014, or the date patient level data is reported and reconciles with summary counts for all non-admitted patient service units using the same source system build and extract for a period of 6 months; and
- as an occasion of service patient level record via WebNAP until 30 June 2014; and
- as a patient level service record via EDWARD from 1 July 2014; and
- at the patient level to any other data repository as required by other policies until such time that they are rescinded. See Section 6.4 to 6.8 of the Non-admitted Patient Policy and Procedures (Attachment 1) for further details.

All data elements in the minimum data set prescribed in Section 2 of the Non-admitted Patient Policy and Procedures (Attachment 1) must be reported in compliance with the classification standards issued in the relevant data dictionary (EDWARD or WebNAP) and the “Non-admitted Patient Activity Reporting Business Rules” guidelines.

Data reported via WebNAP or EDWARD must be submitted, and be of acceptable quality, by the 15th working day of the month following the delivery of the service.

When reporting to EDWARD Local Health Districts (LHDs) and Specialist Health Networks (SHNs) must report client/patient characteristics via the client/patient registration data extract (from iPM or Cerner PAS), and patient level service details via one of the two community heath and outpatient care service event data extract formats. A period of parallel reporting of patient level data to both WebNAP and EDWARD is expected prior to 30 June 2014.

LHDs/SHNs must reconcile both the summary and patient level data reported to WebNAP and EDWARD against the source system, ensure the mandatory reporting requirements have been met, ensure all in-scope activity has been reported, and ensure that the data quality is fit for purpose (which includes activity based funding).

Where the patient level data from a source system build is reported to EDWARD, HIE or other Ministry of Health data repository, and the data has been determined by the LHDs/SHNs to be of equal or superior quality to WebNAP, the LHDs/SHNs using that source system build may, as a group, apply to the Health System Information and Performance Reporting Branch for an early exemption from reporting to patient level and/or summary level data to WebNAP.

IMPLEMENTATION

It is the responsibility of LHDs/SHNs to fund, specify, develop, test and implement:

1. WebNAP summary level and patient unit record level extracts from all non-admitted patient source systems by 1 July 2013.
2. EDWARD patient level extracts (either minimum or maximum format) from all non-admitted patient source systems by 1 July 2014.
3. Modifications to source systems, such that they fully comply with the minimum data set requirements for reporting to WebNAP and EDWARD.

LHDs/SHNs must ensure that all non-admitted services provided from 1 July 2013:
- are either recorded on a source system with a fully functional non-admitted patient level extract OR manually entered into WebNAP; and
- the patient unit record level data occasions of service reconciles with summary level occasions of service counts; and
- are reported under service units registered in HERO and WebNAP that align with recognised clinical teams, and are correct classified to the most appropriate 2013/14 ‘establishment type’ in HERO.
See Section 11 of the Non-admitted Patient Policy and Procedures (Attachment 1) for the roles and responsibilities of the LHD/SHN Chief Executive and Non-Admitted Patient Data Steward/Coordinator, and the Health System Information and Performance Reporting Branch.

All associated documentation is available via the NSW Health Intranet from the following URL:


1. **Background**

1.1 **About this document**

The purpose of this policy and procedure document is to:

- Prescribe the minimum data set to be reported for all non-admitted patient services at both the summary and patient level.
- Prescribe the data repositories to which data must be reported, and the formats it must comply with.
- Prescribe the due dates for reporting.
- Prescribe the roles and responsibilities for implementation and on-going management of the policy and reporting procedures.

The activity covered by this policy includes hospital emergency department services, hospital outpatient care services, outreach services and non-residential community health services provided by NSW Health Services.

This document is relevant to NSW Health and affiliated health organisations:

- LHD/SHN/SVHN chief executives.
- LHD/SHN/SVHN non-admitted patient data collection stewards/coordinators.
- Hospital general managers and community health service managers.
- Managers of NSW Health non-admitted patient service units.
- Non-Admitted patient source system administrators.
- Chief Information Officers.

1.2 **Key definitions**

1.2.1 **Definition: Non-admitted patient service**

A *non-admitted patient service* is an interaction between a healthcare provider and a person who is not formally admitted to a hospital or multi-purpose service, that contains clinical and/or therapeutic content that results in a dated entry being made in the person’s physical or electronic medical record. The interaction may be for an assessment, examination, consultation, treatment and/or education.

1.2.2 **Definition: Non-admitted patient support activity**

A *non-admitted patient support activity* is an activity or interaction that supplements and/or supports the health or health care of a non-admitted person, personal carers or the community generally, but does not contain clinical and/or therapeutic content that results in a dated entry being made in the person’s physical or electronic medical record.
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1.2.3 Definition: Non-admitted patient appointment

A non-admitted patient appointment is a planned or walk-in visit time slot allocated for one person to receive a non-admitted patient service through an interaction with one or more healthcare provider at the same time or in succession on the same calendar day. One non-admitted patient appointment may consist of one or many non-admitted patient occasions of service. A non-admitted patient appointment may or may not result in a non-admitted patient service being provided.

1.2.4 Definition: Non-admitted patient occasion of service

A non-admitted patient occasion of service is a non-admitted patient service or a non-admitted patient support activity reported for each provider type and service type combination on each occasion a service is provided to the patient within one non-admitted patient appointment on one calendar day.

1.2.5 Definition: Non-admitted patient (national) service event

A non-admitted patient (national) service event is an interaction between one non-admitted patient and one or more healthcare provider(s) who are working within the context of one service unit on one calendar day. The interaction must contain clinical and/or therapeutic content (i.e. an assessment, examination, consultation, treatment and/or education), that results in a dated entry being made in the patient’s medical record. Non-admitted patient (national) service events exclude services provided by stand-alone diagnostic service units, travel by the healthcare provider or patient, services where the patient is not present, or services provided to persons who are admitted patients at the time of service provision.

Note: One non-admitted patient (national) service event may consist of one or more non-admitted patient occasion of service records, and one or more non-admitted patient appointments. Non-admitted patient support activity does not meet the definition of a non-admitted patient (national) service event, and is therefore excluded.

Source: Compiled from the Tier 2 Non-Admitted Services Compendium 2013-2014, Independent Hospital Pricing Authority.

1.2.6 Definition: Emergency Department non-admitted patient service

An Emergency Department non-admitted patient service is a non-admitted patient service provided by a hospital’s Emergency Department team.

1.2.7 Definition: Ancillary occasion of service

An ancillary occasion of service is a service provided to one patient who is the subject of:
- one pathology diagnostic test, or a simultaneous set of related pathology tests, provided by a hospital’s pathology service unit;
- one radiology/imaging diagnostic test, or a simultaneous set of related radiology/imaging services, provided by a hospital’s radiology and organ imaging service unit;
- the filling of one order/script of pharmaceuticals, regardless of the number of items dispensed per script, provided by a hospital’s pharmaceutical dispensing service unit.

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1.2.8 Definition: Non-admitted patient service unit

A non-admitted patient service unit is a recognised clinical team of one or more healthcare providers within a hospital, multi-purpose service or community health service that provides non-admitted patient services and/or non-admitted patient support activities in defined locations, at regular or irregular times. A non-admitted patient service unit generally consists of multiple healthcare providers, who may be practicing the same or different disciplines or specialties. In some health services a service unit may consist of only one individual healthcare provider.

1.2.9 Definition: Service unit level ‘establishment type’

The service unit level ‘establishment type’ is NSW Health’s classification of service units that aligns to the National Tier 2 Clinic Type classification.

1.2.10 Definition: National Weighted Activity Unit (NWAU)

The National Weighted Activity Unit (NWAU) is a measure of Health Service activity expressed as a common unit, against which the National Efficient Price (NEP) is paid. It provides a way of comparing and valuing each public hospital service (whether they be admissions, emergency department presentations or outpatient episodes), by weighting for its clinical complexity. The average hospital service is worth one NWAU – the most intensive and expensive activities are worth multiple NWAUs, the simplest and least expensive are worth fractions of an NWAU.


1.2.11 Definition: Local Health Districts (LHDs)

Local Health Districts (LHDs) means the following local health districts constituted under Section 17 and specified from time to time in Schedule 1 of the Health Services Act 1997:

- Central Coast Local Health District
- Illawarra Shoalhaven Local Health District
- Nepean Blue Mountains Local Health District
- Northern Sydney Local Health District
- South Eastern Sydney Local Health District
- South Western Sydney Local Health District
- Sydney Local Health District
- Western Sydney Local Health District
- Far West Local Health District
- Hunter New England Local Health District
- Mid North Coast Local Health District
- Murrumbidgee Local Health District
- Northern NSW Local Health District
- Southern NSW Local Health District
- Western NSW Local Health District

Note: For the purpose of this policy and procedures, with the exception of organisations prescribed for reporting under the “St Vincent’s Health Network”, affiliated health organisations prescribed under Schedule 3 of the Health Services Act 1997 that are located within the boundaries of a Local Health District are in scope of the Local Health District’s reporting requirements.
1.2.12 Definition: Specialty Health Networks (SHNs)

Specialty Health Networks mean the following statutory health corporations prescribed under Schedule 2 of the Health Services Act 1997:

- The Sydney Children’s Hospital Network (Randwick and Westmead)
- Justice Health and Forensic Mental Health Network

1.2.13 Definition: St Vincent’s Health Network (SVHN)

The St Vincent’s Health Network means the following affiliated health organisations prescribed under Schedule 3 of the Health Services Act 1997:

- St Vincent’s Hospital, Darlinghurst
- Sacred Heart Hospice, Darlinghurst
- St Joseph’s Hospital, Auburn

1.3 Diagram of conceptual relationships

The diagram below shows the conceptual relationships between service units, patients, appointments, occasion of service, service type, provider type, national service event and the National Weighted Activity Unit (NWAU) for funding.

1.4 Statutory reporting obligations

This policy supports onward reporting to a number of non-admitted patient activity related national data sets:


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- Non-admitted Patient Activity Based Funding Data Set, Independent Hospital Pricing Authority.
- Non-admitted Patient Activity Costs Data Collection, Independent Hospital Pricing Authority.

The policy makes reference to the additional requirements for onward reporting to the following non-admitted patient activity national data sets:
- Home and Community Care National Minimum Data Set, Australian Institute of Health and Welfare.
- Aged Care Assessment Program National Minimum Data Set, Australian Department of Health and Ageing.

2. Non-admitted Patient Data Collection Coverage

2.1 Coverage statement

The policy and procedures covered by this document apply to all activity that meets the definition of a non-admitted patient service provided by, or contracted out by, any of the following:
- Local Health District
- Specialty Health Network
- An affiliated health organisation, prescribed under the Health Services Act, 1997.

All non-admitted patient services provided by the above organisations are in scope of the reporting requirements regardless of the patient service billing arrangement (i.e. non-charge, privately referred, compensable, Medicare ineligible, patient fee co-contribution etc.) and funding program or funding source.

All non-admitted patient support activities are non-mandatory reporting requirements, which may be reported at the discretion of the LHD/SNH.

2.2 Coverage Clarification: Services provided by external parties under a contract with a NSW Health organisation

Non-admitted patient services that are contracted out to any private sector organisation, not for profit organisation, or Visiting Medical Officer that are paid for by a NSW Health organisation under a fee for service or sessional service contract are in scope of the reporting requirements of the non-admitted patient activity reporting requirements prescribed by this policy and procedures document.

Privately referred activity provided under these contractual arrangements where a NSW Health organisation bills the patient, or a 3rd party organisation, are in scope of the reporting requirements.

Note: Contracts need to include a clause that requires the contracted service provider to make available to the purchasing organisation the data/information required to fully comply with the minimum data set and reporting requirements outlined in this document. The activity is to be reported against a 'virtual' service unit that is to have the purchasing hospital or community health services as the parent organisation.

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2.3 Coverage Clarification: Services provided by a private practice, hospital or day procedure centre

Non-admitted patient services that are provided by a private practice, private hospital or private day procedure centre that rents space to operate on NSW Health property under a commercial contract and directly bills the patient or a 3rd party organisation (other than a NSW Health organisation) under their own Australian Business Number are not in scope of the non-admitted patient activity reporting requirements prescribed by this policy and procedures document.

2.4 Coverage Clarification: Services provided to a patient of a private practice, hospital or day procedure centre

Non-admitted patient services that are provided by a NSW Health organisation to a patient of a private practice, private hospital or private day procedure centre under a fee for service or sessional service contract basis, or where the NSW Health organisation directly bills a 3rd party insurer, Medicare or the patient to recover full cost of providing the service (such as pathology services), are not in scope of the non-admitted patient activity reporting requirements prescribed in this document.

3. Minimum data set for all non-admitted patient services

3.1 Overview

This section prescribes the minimum data set that must be reported for all non-admitted patient services, regardless of their clinical specialty.

The following standards have been used in the tables to indicate the requirements:

- “#” Indicates a field that is in scope of national reporting requirements to the Independent Hospital Pricing Authority, or used to derive or map to a data element in scope of those requirements.
- Where the WebNAP and EDWARD data repositories have a different concept name, both descriptions have been provided.
- In terms of mandatory status:
  - “Yes” means the data element is available and must be reported.
  - “Conditional” means that the data element is mandatory for reporting under particular conditions. These conditions are clarified below each table.
  - “No” means the data element is available in the system, but optional for reporting. Such data element may support local reporting.
  - “n.a.” means ‘not applicable’, that is, the data element is not in scope of the data repository.

There are additional requirements to report non-admitted patients services to other data collections where they are of the following type:

- alcohol and other drug services (PD2015_014),
- mental health services (PD2006_041 & PD2006_042),
- emergency department services (PD2005_198),
- home and community care services (PD2008_050), and
- aged care assessment program services (PD2007_080).

The additional requirements for reporting to these data collections are prescribed in separate policies shown above. The requirement for NSW Health Services to report to those separate data collections will continue until such time that those policies are rescinded and/or all non-admitted patient data collections have been migrated to EDWARD.
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3.2 Non-admitted patient service unit characteristics

3.2.1 Mandatory data elements - service unit

The table below shows the business mandatory status of characteristics about non-admitted patient service units that must be reported to the Ministry of Health.

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Mandatory for WebNAP</th>
<th>Mandatory for HERO/EDWARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Unit HERO Identifier #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Unit WebNAP Code</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Service Unit Name</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Unit Establishment Type Code #</td>
<td>n.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Unit First Open Date</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Unit Permanent Closure Date</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Unit Address - Physical</td>
<td>n.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative Parent Facility HIE Facility ID</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Administrative Parent Facility HERO ID #</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Health District/Specialty Health Network HIE Facility ID</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Local Health District/Specialty Health Network HERO ID #</td>
<td>n.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Health District Physical Location Boundary</td>
<td>n.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Unit Source System</td>
<td>n.a.</td>
<td>No</td>
</tr>
</tbody>
</table>

3.2.2 Optional data elements - service unit

The table below shows the optional characteristics about non-admitted patient service units that may be recorded (for example, to support local reporting requirements).

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Available in WebNAP</th>
<th>Available in EDWARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Unit Division Name</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Service Unit Division Code</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Service Unit Cost Centre</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Unit Community Health Service Flag</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

3.2.3 Mandatory data elements - service option

The registration of “service options” is only relevant to services reported using WebNAP and is a requirement that enables loading and data entry of summary level data.

Note: The Service Option is reported on the same file as the Service Unit. Therefore the mandatory fields for both Service Unit (above) and Service Option (below) must be reported in the extract file submitted to WebNAP.

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Mandatory for WebNAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Unit WebNAP Code</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Option – Effective From Date</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Option – Effective To Date</td>
<td>No</td>
</tr>
<tr>
<td>Service Option – Provider Type Code</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Option – Service Type Code</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Option – Setting Code</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Option – Modality Code</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Option – Funding Source Code</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### 3.3 Non-admitted patient level data

#### 3.3.1 Overview

Non-admitted patient level data consists of patient characteristics, and service characteristics. When reporting activity to WebNAP the unit record level data is an occasion of services. When reporting non-admitted patient activity to EDWARD or HIE, the unit record level data reported varies according to the source system and data collection data is reported to, and includes appointments, encounters, service episodes or service contacts.

**Note:** The concept that must be reported to the Independent Hospital Pricing Authority for activity based funding - a nationally defined ‘service event’ - will be derived by the Ministry of Health when preparing the data for national reporting, based on the national business rules.

#### 3.3.2 Mandatory data elements - patient characteristics

The table below shows the patient characteristics that are in scope of reporting and their mandatory status for reporting via WebNAP and EDWARD for services provided on or after 1 July 2013.

For variable patient characteristics, such as address of usual residence, the characteristics at the time the service was provided must be reported.

**Note:** Patient characteristics must be recorded in either the iPM or Cerner HNA Millennium patient registration module, and should be transferred to other non-admitted patient source systems as HL7 messages. Updates and corrections must always be made in iPM and Cerner HNA Millennium. See the Client Registration Policy and Client Registration Guidelines for further details on these requirements.

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Mandatory for WebNAP</th>
<th>Mandatory for EDWARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient – Identifier Type Flag #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Identifier Issuing Authority</td>
<td>N.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Identifier #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Area Unique Person Identifier</td>
<td>No</td>
<td>n.a.</td>
</tr>
<tr>
<td>Patient – Facility Medical Record Number</td>
<td>No</td>
<td>n.a.</td>
</tr>
<tr>
<td>Patient – First Name (WebNAP) *1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Given Name (EDWARD) *1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient – Last Name (WebNAP) *1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Family Name (EDWARD) *1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient – Gender (WebNAP)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Sex Code (EDWARD) #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient – Date of Birth #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Country of Birth Code #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Aboriginality Code (WebNAP)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Indigenous Status Code (EDWARD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient – Street Address of Usual Residence #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Suburb / Locality of Usual Residence #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient – Postcode of Usual Residence #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – State of Usual Residence #</td>
<td>N.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient – Country of Usual Residence #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient – DVA Card Type *2</td>
<td>Conditional</td>
<td>Conditional</td>
</tr>
<tr>
<td>Patient – DVA File Number *2</td>
<td>Conditional</td>
<td>Conditional</td>
</tr>
</tbody>
</table>

*1 – See Client Registration Policy and Client Registration Guidelines for standards for registering clients as anonymous patients.

*2 – DVA Card Type and File Number is required when the Financial Group/Financial Class/Billing Category indicates the service costs are the responsibility of the Department of Veterans’ Affairs.

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### 3.3.3 Mandatory data elements - service characteristics

The table below shows the service characteristics that are in scope of reporting and their mandatory status for reporting via WebNAP and EDWARD for services provided on or after 1 July 2013.

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Mandatory for WebNAP</th>
<th>Mandatory for EDWARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Event Source System Identifier</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Encounter Record Identifier</td>
<td>N.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Event Record Identifier</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Source of Referral Code (WebNAP) #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Request Source Type Code (EDWARD) #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WebNAP Source of Referral Name</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Referral Issue Date/Time (WebNAP)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Request Correspondence Date/Time (EDWARD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral Receipt Date (WebNAP)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Request Received Date (EDWARD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Booking Create Date/Time (WebNAP)</td>
<td>Yes (*1)</td>
<td>Yes (*1)</td>
</tr>
<tr>
<td>Offer Issue Datetime (EDWARD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Event Start Date/Time</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Provider Type Code (WebNAP)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Individual Provider Speciality / Discipline Code (EDWARD)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Setting Type Code (WebNAP) #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Primary Setting Type Code (EDWARD) #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modality of Care Code (WebNAP) #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Contact Mode Code (EDWARD) #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial or Subsequent Service Code</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Group Session Flag #</td>
<td>N.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Group Session Identifier #</td>
<td>N.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Client Participated Flag</td>
<td>N.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Financial Group Code (WebNAP) #</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Billing Category Code (EDWARD) #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding Source Code (WebNAP)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Primary Program Funding Source Code (EDWARD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Type Code (WebNAP)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>NAP Service Type Code (EDWARD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Type NHDD Code #</td>
<td>N.a.</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicare Benefit Scheme Item Number(s) (WebNAP)</td>
<td>Conditional (*1)</td>
<td>Conditional (*1)</td>
</tr>
<tr>
<td>Service Activity Reference Source Identifier (EDWARD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Activity Reference Domain Identifier (EDWARD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Activity Code (EDWARD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Event End Date/Time</td>
<td>Yes (*1)</td>
<td>Yes (*1)</td>
</tr>
<tr>
<td>Direct Contact Time Band</td>
<td>N.a.</td>
<td>No</td>
</tr>
</tbody>
</table>

**Note:** (*1) These data elements become mandatory for reporting from 1 July 2014.
3.4 Non-admitted patient summary level data

3.4.1 Mandatory data elements

The table below shows the data elements that are mandatory for reporting summary level occasion of service counts to WebNAP.

<table>
<thead>
<tr>
<th>Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Unit WebNAP Code</td>
</tr>
<tr>
<td>Service Unit HERO Identifier</td>
</tr>
<tr>
<td>Service Unit Name</td>
</tr>
<tr>
<td>Administrative Parent Facility HIE Facility ID</td>
</tr>
<tr>
<td>Service Type Code</td>
</tr>
<tr>
<td>Setting Type Code</td>
</tr>
<tr>
<td>Provider Type Code</td>
</tr>
<tr>
<td>Modality of Care Code</td>
</tr>
<tr>
<td>Funding Source Code</td>
</tr>
<tr>
<td>Reporting Month</td>
</tr>
<tr>
<td>Reporting Year</td>
</tr>
<tr>
<td>Occasion of Service Count – Department of Veterans’ Affairs Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Department of Veterans’ Affairs (Contracted) Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Department of Veterans’ Affairs (Privately Referred) Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Ineligible Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Lifetime Care and Support Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Motor Accident Authority Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Motor Accident Authority (Driver at Fault) Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Motor Accident Authority (Not Driver at Fault) Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Workcover Compensable Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Transcover Compensable Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Other Compensable Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Non-Chargeable Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Private Contract Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Private Referred Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Special Purposes Trust Financial Group</td>
</tr>
<tr>
<td>Occasion of Service Count – Total Group Sessions</td>
</tr>
<tr>
<td>Occasion of Service Count – Total Group Patients</td>
</tr>
</tbody>
</table>

4. Requirement to register and classify service units

4.1 Requirement to register non-admitted patient service units

All non-admitted patient service units must be registered in HERO. Where activity is reported via WebNAP, an equivalent service unit must also be setup in WebNAP.

4.2 Requirement to ensure registered non-admitted patient service units align with clinical service teams and structures

Historically some health services created non-admitted patient service units in WebNAP that do not align with recognised clinical service teams and structures. These historical service units may have been established to simplify summary level statistical reporting.

To support the activity based funding model from 1 July 2013, and support reporting at the patient level, registered non-admitted patient service units must be a reflection of the recognised clinical teams within a single hospital or community health service.
Any service unit that has does not reflect a recognised clinical team within a single hospital or community health service must be closed by 30 June 2013 and replaced by service units that are recognised clinical service teams within a single hospital or community health service.

### 4.3 Requirement to classify non-admitted patient service units

Each service unit must be appropriately classified to an ‘establishment type’.

The ‘establishment type’ classification (categories and definitions) has changed to align with the 2013/14 IHPA Tier 2 Clinic Type classifications. This classification is expected to change each year as non-admitted patient activity based funding matures. A review of the assigned ‘establishment type’ must therefore be undertaken in June every year.

Where the service unit registered in HERO and WebNAP meets the definition of multiple ‘establishment type’ categories it should be flagged for a more detailed review. If the service unit aligns with only one recognised clinical team within a single hospital, multi-purpose service or community health service, the service unit must be allocated to the category that represents the majority of services provided (i.e. 50% or more of the services provided).

If a service unit registered in HERO and WebNAP aligns with two or more recognised clinical teams within a single hospital, multi-purpose service or community health service the service unit registration should be end dated as a reporting entity, and new service units should be registered for reporting that align with the recognised clinical teams. Each new service unit should be assigned the appropriate establishment type. Activity should thereafter be reported under those replacement service units.

Historical data may be used to assist in the allocation of the service unit’s ‘establishment type’ in HERO. However, as historical data may be unreliable, an independent review of the provider type/discipline/speciality of the individual healthcare providers and clinical services provided should be conducted to identify the correction service unit level ‘establishment type’.

**Note:** The classification of a service unit to the most appropriate service unit level ‘establishment type’ category is essential because it is a key factor in determining the levels of Activity Based Funding.

### 4.4 Requirement to report summary level and patient level data under the same service unit

From 1 July 2013, it is a mandatory requirement to report the summary level total occasion of service counts to WebNAP under the same service unit as used for reporting the patient level data that make up that total.

### 4.5 Requirement to automate calculation of summary level occasions of services based on patient level data

The summary counts reported to WebNAP must be based on automated aggregation of the patient level data to ensure front line staff do not have to separately record data at both the patient level and summary level.

### 4.6 Requirement to align service units in source systems, HERO and WebNAP

From 1 July 2013, it is a requirement for service units to align in source systems, HERO and WebNAP.
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There must be a one to one relationship between the service units registered in HERO and WebNAP. Service units registered in HERO must align with the service units (clinics) as created in source systems. There should generally be a one to one relationship between the service unit created in a source system and the service unit registered in HERO and WebNAP.

When activity is reported to EDWARD the source system service unit must be aliased with the HERO Identifier assigned to the service unit by HERO during the registration process. This ensures data quality issues can be communicated to the clinical team that provided the services.

One service unit in a source system may not be created as two or more service units in HERO or WebNAP.

Note: If reporting activity via EDWARD any activity reported for a service unit that is not aliased with the HERO Identifier will be excluded from reporting – these records are hidden from end users by the EDWARD security framework as the source of the data cannot be determined.

4.7 Requirement to record the HERO Identifier against the service unit in WebNAP

The HERO Identifier must be reported against every WebNAP service unit. This is required to support the linkage of WebNAP service units to the HERO service unit where the service unit level ‘establishment type’ will be maintained.

4.8 Data quality audits

The Ministry of Health will undertake data quality audits. These may focus on the following:

- the structure of service units, to ensure against the splitting of service unit structures merely to increase the number of national service event records per patient per calendar day;
- the ‘establishment type’ that service units have been assigned in HERO, to assure against the assignment of an establishment type that attract a higher NWAU and does not accurately reflect the majority of services provided by the service unit;
- the quality and completeness of data reported for specific data elements (e.g. the Service Type is appropriate for the Provider Type reported); and
- source system functionality and build compliance with the mandatory reporting requirements, including the availability of all mandatory fields, availability of all categories within a standard classification and mappings to the State level standard classification code set.

To support the data quality audits, where a service unit can be classified to more than one establishment type or the service unit name does not clearly match one establishment type, LHDs/SHNs/SVHN must document the justification for the final classification decision in HERO in the entity registration “Comments” or “Services Provided” field.

5. Requirement to report summary occasion of service counts

From 1 July 2013, all non-admitted patient services provided within each calendar month must continue to be reported via WebNAP at the summary level as a monthly total occasion of service count for each unique combination of the following attributes:

- Service unit
- Service option, that is a combination of:
  - Provider Type Code
Summary counts may either be reported via the WebNAP Version 2.0 data extract summary file format or directly entered into WebNAP.

Monthly occasion of service summary counts must be reported to WebNAP until 30 June 2014, or the date approved by the Director, Health System Information & Performance Reporting Branch. Prior to 30 June 2014, summary counts must reconcile with the patient level data reported via WebNAP for at least 6 months.

LHDs/SHNs may apply to the Director, Health System Information & Performance Reporting Branch for an early exemption from summary level reporting for all non-admitted patient service units using the same source system build and extract where they can demonstrate that the equivalent patient level data has reconciled with summary counts for a period of 6 months.

Note: There is no requirement or facility to report summary level non-admitted patient data to EDWARD.

6. Requirement to report patient level data

6.1 Requirement to report non-admitted patient occasion of service unit record level data to WebNAP

WebNAP has been established as an interim patient level reporting system.

The following non-admitted patient services are not required to be reported to WebNAP at the patient level under this policy:
- Emergency Department services,
- Pathology testing services,
- Radiology imaging services, and
- Pharmacy dispensing services.

Any requirement to report pathology testing, radiology imaging and pharmacy dispensing services at the patient level will be prescribed in a separate policy.

All other services that meet the definition of a non-admitted patient service that are provided up to and including 30 June 2014 must be reported via WebNAP at the patient level.

Where a source system is used to record non-admitted patient services via WebNAP the activity must be reported via the WebNAP Version 2.0 patient level extract format. See the “WebNAP Version 2.0 extract requirement specification” guideline document for detailed requirements.

Where a source system is not used, each patient level occasion of service record must be entered into WebNAP via direct data entry screens, or otherwise prepared in the WebNAP Version 2.0 patient level extract format and uploaded.
6.2 Reporting patient level data via EDWARD

It is NSW Health’s strategic direction to move to non-admitted patient level reporting via EDWARD from 1 July 2014. LHDs/SHNs/SVHN must take the necessary steps to move to reporting via EDWARD by this date.

To report data to EDWARD the following must be in place by 1 July 2014:
- All patient/clients must be registered in either the iPM or Cerner HNA Millennium patient registration module, in line with the Client Registration Policy Directive; and
- All patient/client identifiers must be recorded in the iPM or Cerner HNA Millennium patient registration module, in line with the Client Registration Policy Directive; and
- The EDWARD Client Characteristics Interface from the iPM or Cerner HNA Millennium patient registration module must be in production and report data daily to EDWARD; and
- Either:
  - the EDWARD Community Health and Outpatient Care Maximum Data Set Interface must be in production and report data daily (or at least monthly) to EDWARD from the relevant non-admitted patient source system build OR
  - the EDWARD Community Health and Outpatient Care Minimum Data Set Interface must be in production and report data daily (or at least monthly) to EDWARD from the relevant non-admitted patient source system build.
The Ministry of Health will consider requests from Local Health Districts and Specialty Health Networks to report patient level data via EDWARD instead of WebNAP prior to 1 July 2014 if the all of the above is in place and the LHD/SHN/SVHN has:

- Resolved any source system build non-compliance with the EDWARD data dictionary and interface requirement specifications for data elements within scope of the non-admitted patient minimum data set prescribed in this policy; and
- Reconciled the data in EDWARD against source systems; and
- Provided written confirmation to the Health System Information and Performance Reporting Branch that the data reported via EDWARD is reconciled with the source and meets the minimum data set requirements; and
- Formally requested an exemption from reporting patient level data to WebNAP via written correspondence from the Chief Executive to the Director, Health System Information and Performance Reporting Branch.

Parallel reporting to WebNAP is expected until such time that the Local Health District or Speciality Health Network has fully complied with the above.

**Note:** There are a number of advantages of EDWARD over WebNAP, including more streamlined data submission, safeguards against duplicate records, a dedicated reporting area, and server capacity.

### 6.3 Reporting of Emergency Department services

Summary level counts of non-admitted patient occasion of service delivered on or after 1 July 2013 must be reported to WebNAP for all emergency department services where:

- the patient is not formally admitted to the hospital, and
- the service is not reported at the patient level to the Emergency Department Data Collection.
Non-admitted patient services that are delivered in Emergency Departments must be reported at the patient level to HIE (Health Information Exchange)/EDWARD in compliance with the reporting requirements of the Emergency Department Data Collection policy.

Emergency Department presentations delivered on or after 1 July 2013 that are in scope of patient level reporting to the Emergency Department Data Collection must not be reported to WebNAP at either the summary level or patient level.

**Note:** The total number of services provided by Emergency Departments provided on or after 1 July 2013 will be the sum of the summary level occasions of service reported to WebNAP and the total presentations (admitted and non-admitted) reported at the patient level to the Emergency Department Data Collection.

### 6.4 Reporting of mental health services

Non-admitted patient mental health services must be reported as follows:
- At the summary level occasion of service counts to WebNAP; AND
- At the occasion of service patient level to WebNAP (or EDWARD if exemption to report to WebNAP has been requested and granted) to 30 June 2014; AND
- At the patient level to EDWARD from 1 July 2014; AND
- At the service event patient level to HIE in accordance with the Community Mental Health Ambulatory (CHAMB) Data Collection and Mental Health Assessment and Outcomes Team (MHOAT) Data Collection requirements.

**Note:** Mental health services recorded on CHIME are also in scope of reporting of service events to EDWARD.

### 6.5 Reporting of alcohol and other drug services

Non-admitted patient alcohol and other drug services must be reported as follows:
- At the summary level occasion of service counts to WebNAP; AND
- At the occasion of service patient level to WebNAP (or EDWARD if exemption to report to WebNAP has been requested and granted) to 30 June 2014; AND
- At the patient level to EDWARD from 1 July 2014; AND
- At the service episode level to HIE in accordance with the requirements of the Alcohol and Other Drugs Data Collection.

### 6.6 Reporting of home and community care services

All non-admitted patient home and community care (HACC) program services, including services delivered under the program that contain no clinical or therapeutic content, must be reported at the service event patient level to HACCIRS data repository.

Non-admitted patient service units that deliver services that contain clinical and/or therapeutic content to HACC program eligible clients/patients only, or to a mix of HACC eligible and HACC ineligible clients/patients, must also report the services:
- At the occasion of service summary level to WebNAP; AND
- At the occasions of service patient level to WebNAP (or EDWARD if exemption to report to WebNAP has been requested and granted) to 30 June 2014; AND
- At the patient level to EDWARD from 1 July 2014.

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Note: HACC eligible patients need to be reported to WebNAP with a Funding Source Code of ‘5; (Federal) and to EDWARD with a Primary Program Funding Source Code of ‘01’ (Home and Community Care Program).

6.7 Reporting of oral health services

Non-admitted patient oral health services must be reported as follows:
- At the occasion of service summary level to WebNAP; AND
- At the occasions of service patient level to WebNAP (or EDWARD if exemption to report to WebNAP has been requested and granted) to 30 June 2014; AND
- At the patient level to EDWARD from 1 July 2014; AND
- At the visit level to the NSW Oral Health Data Collection via the ISOH extract files set.

6.8 Reporting of aged care assessment program services

Non-admitted patient aged care assessment program services must be reported as follows:
- At the occasion of service summary level to WebNAP; AND
- At the occasions of service patient level to WebNAP (or EDWARD if exemption to report to WebNAP has been requested and granted) to 30 June 2014; AND
- At the patient level to EDWARD from 1 July 2014; AND
- At the assessment process and care/plan outcome level to the Aged Care Assessment Program Minimum Data Set.

6.9 Reporting of ancillary services

Pathology testing services, radiology imaging services, and pharmacy dispensing services pertaining to non-admitted patients must be reported as summary level occasion of service counts to WebNAP.

Medical consultation services provided by ancillary services are in scope of the reporting requirements described in this policy and procedures document and must be reported at both the summary and patient level.

Note: Any requirement to report Pathology testing services, radiology imaging services, and pharmacy dispensing services at the patient level will be issued in a separate policy.

6.10 Reporting of transport services

Community transport services provided to clients/patients should be reported to the NSW Health Integrated Community Transport Data Set (ICTDS).

6.11 Reporting of services to clients/patients who are not registered

Non-admitted patient services that are provided to clients/patients in the community who are not registered because they are receiving a community group immunisation/screening service, health promotion service, needle exchange service, or services where registration may inhibit their participation in the service (such as supervised injecting room services) must be reported at the summary level but patient level reporting is optional.

Where such activity is reported at the summary level only they must be reported under a service unit setup for the reporting of this summary level activity only – no patient level activity should be reported under these service units.
6.12 Requirement to comply with business rule guidelines

All non-admitted patient activity data reported to EDWARD or WebNAP must be reported in compliance with the non-admitted patient activity reporting business rules guidelines.

The guidelines provide detailed level information about the data collection’s scope (inclusion and exclusions). In addition, the reporting requirements for specific scenarios are provided.

Access to the business rules is provided via the following URL:


6.13 Requirement to comply with data dictionary classifications

Data reported via WebNAP must comply with the WebNAP Data Dictionary for 2013/14 published on the NSW Health Intranet.

Data reported via EDWARD must comply with the Client Characteristics, Individual Service Provider Characteristics, Community Health and Outpatient Care Service Event Maximum Data Set and Community Health and Outpatient Care Minimum Data Set EDWARD Data Dictionaries published in HIRD (Health Information Resources Directory).

Access to these data dictionaries are provided via the following URL:


Compliance means all the relevant classification categories (or local equivalents) must be available in source systems and be mapped to the appropriate state code.

**Note:** The classification standards between WebNAP and EDWARD differ. This can be handled in source systems by using the more detailed classification (usually EDWARD) and mapping the classification to the relevant WebNAP or EDWARD code as an outbound alias/alternative identifier code.

7. Requirement to register source system build used for recording non-admitted patient services

It is a mandatory requirement for Local Health Districts and Specialty Health Networks to identify and register each build/instance of each source system used for recording non-admitted patient services with the Ministry of Health.

**Note:** The register of the source system builds will be maintained by the Health System Information and Performance Reporting Branch. A unique source system build identifier will be assigned and this unique source system build identifier must be reported on each patient unit record submitted to WebNAP and EDWARD. This information will be used to monitor completeness of the data collection across the relevant data repositories, and identify data quality or non-compliance issues relating to a specific build of a source system.

8. Requirement to provide status report of source system extract implementation

A monthly status report of the progress of modifications to each source system build to comply with the minimum data set and the classifications prescribed in the data dictionaries, and the development of the source system’s WebNAP and EDWARD extracts, must be provided to the Health System
Information and Performance Reporting Branch by the Local Health District/Specialty Health Network until such time that both the WebNAP Version 2.0 extracts and, following this, the EDWARD extracts, are delivered and installed in production environments.

9. Due dates for reporting

Non-admitted patient activity data at both the summary level and patient level must be submitted, and be of acceptable quality, by the 15th working day of the month after the month the service was delivered.

Data reported via EDWARD from strategic source systems, such as iPM, CHIME and the Cerner HNA Millennium Electronic Medical Record, is expected to be transferred automatically on a daily basis.

10. Quality and completeness of data

The quality of non-admitted patient activity data will be assessed through a set of data validation rules.

Data must be reported in a form compliant with the codes published in the WebNAP data dictionary (where activity is reported to WebNAP) or EDWARD data dictionaries (where activity is reported to EDWARD).

It is the source system administrator’s responsibility, and the LHD/SHN non-admitted patient data steward/coordinator’s responsibility, to ensure the local categories displayed to source systems users align with state standard categories and map to the appropriate state code. There must be at least one local classification category for each state classification category. Local categories that do not map to one state category in the WebNAP or EDWARD classification (that is they map to two or more categories), should be end dated so that they can no longer be selected by source system users from 1 July 2013.

For all data elements reported as a code, the local classification to state standard classification mappings must be submitted to the Data Quality Unit of the Health System Information and Performance Reporting Branch for a quality review prior to the production implementation of each extract and following any major change to local classifications.

11. Implementation

11.1 Source system and extract development

It is the responsibility of Local Health Districts and Specialty Health Networks to fund, specify, develop, test and implement:

- WebNAP Version 2.0 summary level and patient level extracts from all source systems.
- EDWARD extracts from source systems (other than iPM and CHIME which have been delivered).
- Changes to existing EDWARD iPM, CHIME and Cerner source system extracts to accommodate local variations of source system builds.
- The addition of all data elements in scope of the minimum data set into their source systems if they currently do not exist.
- The alignment of classifications and code mappings in source systems for all in scope data elements in compliance with the WebNAP, HIE and EDWARD data dictionaries.
- The creation of business rules, such as mandatory status on fields, within source systems to ensure completeness and accuracy of data.
Local Health Districts and Specialty Health Networks should liaise with the HealthShare Community Health and Outpatient Care Program regarding any shared services and IT capital program funding that may provide to assist health services comply with the statutory reporting requirements outlined in this policy.

11.2 Non-Admitted Patient Data Set Sponsor Responsibilities

By default, the Chief Executive of each LHD/SHN/SVHN is the Non-Admitted Patient Data Set Sponsor for the data pertaining to services provided by hospitals, multi-purpose services and community health services of the LHD/SHN/SVHN. The data sponsor role is responsible for:

- directing the resources required to comply with the reporting obligations prescribed by this policy;
- reporting on progress and issues relating to the reporting requirements at the executive level; and
- authorising access to data relating to services provided by their Local Health District/Specialty Health Network within the constraints of NSW Health Privacy Policy and legislation.

The Chief Executive may formally delegate the responsibilities of this role within the Local Health District or Specialty Health Network.

11.3 Non-Admitted Patient Data Steward/Coordinator Responsibilities

The Chief Executives of Local Health Districts and Specialty Health Networks must nominate a position for the role of Non-Admitted Patient Data Steward/Coordinator, and advise the Health System Information & Performance Reporting Branch of the incumbent’s details.

The Non-Admitted Patient Data Steward/Coordinator role is responsible for:

- Ensuring all non-admitted patient service units are registered in HERO and WebNAP and that they align.
- Ensuring all non-admitted patient service units are correctly classified in HERO to the service unit level ‘establishment type’, which will be a key factor in cost weight assignment under the activity based funding model.
- Ensuring all service units have reported both summary level and patient level data to the Ministry of Health each month.
- Ensuring all source system builds used by service units within their Local Health District have classifications that comply with the relevant data dictionary and are correctly mapped to the relevant state categories and codes.
- Ensuring data reported to WebNAP and/or EDWARD is reconciled against source systems.
- Ensuring all service units are reporting all in scope services.
- Ensuring that non-admitted patient reporting business rules are being complied with by all services.
- Ensuring there are procedures in place for all new non-admitted patient services to be registered in HERO and WebNAP, and that they are informed of their reporting obligation.
- Ensuring there are procedures in place for all closed service units to be registered as closed in HERO and WebNAP.
- Ensuring that the summary level occasion of service count reported match the number of patient level data records reported each month.
- Ensuring data has been uploaded into WebNAP by the due date and that there a mitigation procedures in place to avoid the risk of creating duplicate records in data resubmissions.
- Reporting on progress made towards the establishment of production quality extracts of both summary level and patient level data to WebNAP and EDWARD.
11.4 Health System Information and Performance Reporting Branch Responsibilities

The Health System Information and Performance Reporting Branch is responsible for:

- Compiling the data from EDWARD, HIE and WebNAP into a single standardised data set and making it available in a secure way to Local Health Districts and Specialty Health Networks for their local analysis and reporting purposes.
- Transforming occasion of service records into service events that comply with the Independent Hospital Pricing Authority unit record counting rules.
- Providing end user orientation/training for WebNAP, HIE and EDWARD.
- Providing clarifications or reporting rules for particular scenarios in response to requests from Local Health Districts/Specialty Health Networks.
- Reviewing, and authorising, requests to migrate from reporting occasions of service via WebNAP to service events via EDWARD.
Attachment 1: Implementation checklist

<table>
<thead>
<tr>
<th>LHD/SHN/SVHN/Facility:</th>
<th>Date of Assessment:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>IMPLEMENTATION REQUIREMENTS</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Register all non-admitted patient service units in HERO and WebNAP</td>
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</tr>
</tbody>
</table>

Notes:

2. Align source system, HERO and WebNAP Service Units.

Notes:

3. Record HERO Identifier of Service Unit against Service Unit registration in WebNAP

Notes:

4. Review establishment type classification of Service Unit registrations in HERO against new definitions and classification changes implemented to align with Independent Hospital Pricing Authority requirements.

Notes:

5. Conduct survey of source systems used to record non-admitted patient services, and obtain unique identifier for each source system build from Ministry of Health.

Notes:

6. Modify source systems to comply with non-admitted patient minimum data set requirements.

Notes:

7. Modify source systems to comply with non-admitted patient minimum data set requirements.

Notes:
### IMPLEMENTATION REQUIREMENTS

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
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<tbody>
<tr>
<td>8. Modify existing WebNAP extracts to comply with the Version 2.0 interface format at both summary level and patient level.</td>
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<td>Notes:</td>
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<tr>
<td>9. Create new WebNAP extracts to comply with the Version 2.0 interface format at both summary level and patient level for source systems that don’t yet have an extract by 30 June 2013</td>
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<td>Notes:</td>
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<tr>
<td>10. Establish policy and process to register all new service units prior to service commencement.</td>
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<td>Notes:</td>
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<tr>
<td>11. Establish processes to train all service units, including new service units prior to service commencement, on the mandatory minimum data set reporting requirements.</td>
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<td>Notes:</td>
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<tr>
<td>12. Identify all users that required WebNAP accounts (e.g. for file upload or direct data entry for reporting of patient level data, complete application form and establish access.</td>
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<td>Notes:</td>
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<tr>
<td>13. Train service units without source systems on unit record level data entry directly into WebNAP.</td>
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<td>Notes:</td>
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<tr>
<td>14. Establish policy and process to register all new service units prior to service commencement.</td>
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<td>Notes:</td>
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<tr>
<td>15. Identify all users that required EDWARD accounts (e.g. for reconciling iPM/CHIME data or statistical reporting), complete application form and establish access.</td>
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<td>Notes:</td>
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</table>
## IMPLEMENTATION REQUIREMENTS

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>16.</strong> Review/reconcile non-admitted patient service event data in EDWARD for iPIM and CHIME. Resolve data quality issues and compliance gaps.</td>
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<td>Notes:</td>
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<tr>
<td><strong>17.</strong> Establish processes for approval of access to non-admitted patient (de-identified) data.</td>
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<td>Notes:</td>
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<tr>
<td><strong>18.</strong> Review resourcing for the collection – consider establishment of hospital level data stewards to support Local Health District data steward.</td>
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<td>Notes:</td>
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180(06/06/13)
ACCOMMODATION OF PARENTS, RELATIVES OR FRIENDS OF PATIENTS IN ALL PUBLIC HOSPITALS (SECOND, THIRD AND FIFTH SCHEDULE)

Inpatient bed day statistics and morbidity details should only relate to persons who are formally admitted as inpatients. Parents, relatives and friends of inpatients are boarders (not inpatients) and should not be counted in hospital statistics or morbidity details. They are to be treated as “boarders”.

MENTAL HEALTH OUTCOMES AND ASSESSMENT TOOLS (MH-OAT) DATA COLLECTION - REPORTING AND SUBMISSION REQUIREMENTS - 1ST JULY 2006 (PD2006_041)

1. Introduction


It relates to the ongoing collection of clinician and self rated client outcome measures for mental health clients according to the Mental Health Outcomes and Assessment Tools (MH-OAT) protocol in NSW.

1.1 Changes in this update:

- Weekly extraction of MH-OAT data to the Area Health Information Exchange from source systems
- Weekly extraction of MH-OAT data from Area HIE to State HIE (Section 6)
- General clarification in all sections
1.2 The purpose of the collection is to:
   - Provide information about the clinical/psychological status of clients treated by all public specialist mental health services in NSW. Rating is done before, after and during the episode of care. These outcome measures can be linked for an individual to the activity components of that client’s journey across a variety of settings to provide information about the effectiveness of care and change in client status over time.
   - Linkage is achieved by using a unique person identifier.

Details of the following issues are included
1. Introduction
2. Scope of Collection
3. Mandatory Recording Requirements
4. Reporting
5. Data Submission
6. Compliance Monitoring
7. Data Quality
8. Privacy
9. Security of the data
10. MH-OAT data collection information - access and dissemination
11. Contact Information
12. Appendix - Required Data Items for the MH-OAT Data Collection
13. Glossary

1.4 It is essential that this Policy Directive be distributed to all staff involved in the collection and supply of data for the MH-OAT data collection. These include:
   - All mental health staff in public mental health services in NSW.
   - Area Mental Health Information Staff
   - Area Directors of Mental Health
   - Area and State Health Information Exchange Coordinators
   - Staff of State and Mental Health Unique Patient Identifier Facilities
   - Central Office NSW Department of Health
   - Health Technology

2. Scope of Collection

The MH-OAT data collection is an ongoing statewide collection, which is managed on a financial year basis but which reports to the HIE weekly and generates a continuous client record over time.

2.1 The MH-OAT data collection applies to:
   - The capture of outcomes and casemix data for clients of specialist mental health services that report to the National Survey of Mental Health Services.
   - These services may be for Admitted Patient Care which includes care at a public psychiatric facility or a designated psychiatric unit in a public hospital; or Community Residential Care (clinically staffed 24hr or less); or ambulatory care where the client is not concurrently an admitted or community residential client. A change between any of these settings indicates a new episode of care for the data collection.
   - Specialist mental health services that are not funded under the mental health financial program are in scope but participation is currently by negotiation.
   - Consultation Liaison services may choose to record MH-OAT measures where relevant.
22. STATISTICAL INFORMATION AND DATA

22.12

2.2 Mental Health Funded Private Organisations and NGOs

While there is no mandate for these services to participate, individual contracts with NGOs under future partnership arrangements may include provision to report MH-OAT data.

3. Mandatory Recording Requirements

- Recording of MH-OAT data in NSW is a requirement under the Quality Through Outcomes (QTO) contract under the Australian Health Care Agreement between the NSW Department of Health and the Commonwealth Department of Health and Ageing.

- Mental Health Service Agreements between Areas and the Director-General of Health, require Areas to improve compliance with the recording of MH-OAT collection occasions according to set targets based on other service activity and population numbers.

- The appropriate MH-OAT Standardised Measures Module SM1 or SM2 or electronic equivalents, and other MH-OAT data items must be completed on admission, review and discharge from NSW mental health services according to the specifications, definitions and business rules in the most current version of Data Collection and System Requirements NSW Mental Health Outcomes and Assessment Tools (MH-OAT).

- The adult self-report measures (SR1 and SR2), parent-report measures (PC1, PC2, PY1, PY2) and youth measures (YR1, YR2) must also be offered in accordance with the protocols in Data Collection and System Requirements NSW Mental Health Outcomes and Assessment Tools (MH-OAT).

- Item definitions are also included in the NSW Department of Health Information Resource Directory (HIRD) on the Intranet. This incorporates the requirements of the National Outcomes and Casemix Collection (NOCC).

- The required items are listed in the Appendix to this document.

- The specific measure to be used at a particular instance is decided by a combination of Age Group of client, treatment setting and reason for collection. It is expected that where direct entry into an electronic system is undertaken, the system will assist clinicians to select the appropriate standard measure for the circumstances.

- Direct clinician entry of these ratings into an electronic system is recommended so clinicians may also access the available client reports in the system.

- Measures must be rated and recorded at least on a paper form by the responsible clinician. Further data entry may be done by a clerical assistant on behalf of the clinician.

4. Reporting from MHOAT

4.1 Supported Collections

MH-OAT data in NSW supports the following Commonwealth and NSW reporting requirements:

- Provision of the National Outcomes and Casemix Collection (NOCC) required under the Quality Through Outcomes Funding Agreement.

5. Submission of Data

- Data are to be extracted from SCI MH-OAT or equivalent system to the Area Health Information Exchange (HIE) at least weekly. A further extract from Area to State HIE occurs after encryption of identifiers and exclusion of names.
22. STATISTICAL INFORMATION AND DATA

- Data are to be extracted according to the MH-OAT extract file format specified in the latest version of Fujitsu Document HIE Mental Health MH-OAT Extract Format PO 3496.
- The extracts are to be submitted weekly on a day to be arranged. Area HIE co-ordinators are to ensure that feeds will be sent to the State HIE in the standard weekly feed.
- Extracts are to include all new and updated records for the extract period.
- Full financial year electronic unit record data by service unit for the MH-OAT collection must be submitted to the Area HIE and have passed data quality checks and Mental Health Unique Patient Identifier (MHUPI) reconciliations by no later than two months following the end of a financial year.
- For quarterly performance monitoring, complete MH-OAT data for each quarter needs to reach the State HIE by the end of the second month following the end of the quarter as below:

<table>
<thead>
<tr>
<th>Quarter of Financial Year</th>
<th>Due date in State HIE</th>
</tr>
</thead>
<tbody>
<tr>
<td>July - September</td>
<td>30 November</td>
</tr>
<tr>
<td>October - December</td>
<td>28 February</td>
</tr>
<tr>
<td>January to March</td>
<td>31 May</td>
</tr>
<tr>
<td>April to July</td>
<td>31 August</td>
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</tbody>
</table>

6. Compliance Monitoring

- The NSW Department of Health will monitor compliance with the reporting requirements set in this Policy Directive and will produce compliance reports for each reporting period. The compliance will be based only on the data in the NSW Department of Health’s HIE (Health Information Exchange).
- The quarterly compliance reports will be distributed to the Health Service Chief Executives, Area Directors of Mental Health, the Director, Centre for Mental Health and are the basis for contract reporting to the Commonwealth.

7. Data Quality

- An electronic data quality checking utility will be made available for identifying errors and omissions in the extracts from collection systems. This utility will be independent of the collection system.
- Data errors and missing data identified by this utility, the HIE or the MHUPI reconciliation checks are to be corrected and records resubmitted to the Area HIE within 2 months of the end of the month in which the activity took place.
- MHUPI reconciliation checks will occur in accordance with the Mental Health UPI Reconciliation Guidelines and Procedures and the current agreement between the Area Health Service and the Department.
- It is mandatory that Area Health Services undertake data quality checks to ensure that all fields are complete and that inconsistencies in the data within a particular record are identified and corrected.
8. Privacy

See the Privacy Manual for Health Information (March 2015).

9. Security of the data

9.1 Hard Copy

Data submitted in hard copy (paper) format for batch entry within an Area must be kept secure at all times. This means records must be sent by secure post (or courier) using a service that records the name of the persons handling the data.

9.2 Electronic Copy

Data sent in electronic format should not be sent by Internet e-mail unless authorised in advance. Data submitted by e-mail within the Health Network is to be encrypted and password protected. The password must be provided separately to the email containing the data.

10. MH-OAT data collection information - access and dissemination

10.1 Source Systems

Area source systems provide a series of reports to assist clinicians with patient management and care planning using the results of the measures.

10.2 Area

Identified client outcome data at Area level is available in Area Health Information Exchanges (AHIE) after signing confidentiality agreements and undertaking suitable HIE training. These data can be linked across the Area and to other client activity data for the same client using the Mental Health Unique Patient Identifier or the State Unique Patient Identifier.

10.3 State

Linkage between the outcome data set and other client activity datasets will be undertaken by a qualified Biostatistician so that linked datamarts can be made available. These will be identified at Area level and de-identified at State level.

Deidentified statewide data will be available from:

- Health Outcomes Information Statistical Toolkit (HOIST) that is accessible by staff of the Department and Area Health Services on signing a confidentiality agreement.
- NSW Statewide Health Information Exchange on signing confidentiality agreements.
- Written request to the Director, Centre for Mental Health.

10.4 National

Deidentified data sets of MH-OAT information will be provided to the Commonwealth for inclusion in the National Mental Health Outcomes and Casemix Collection (NOCC) by December following the financial year of collection.
Up to date information about the MH-OAT data collection will be available on the MH-OAT website: http://internal.health.nsw.gov.au/policy/cmh/MH-OAT

11. Contact Information

- For further information about this Policy Directive and the MH-OAT data collection, contact:
  Carolyn Muir, Principal Information Officer
  Centre for Mental Health
  Phone: 02 9391 9237
  E-mail: cmuir@doh.health.nsw.gov.au
- Requests for further information about this Policy Directive may also be faxed to the MH-OAT Project Officer at InforMH on 02 9887 5722

12. APPENDIX: Required Data Items for the MH-OAT Data Collection

Rating response and summary score data items as specified in age specific standardised measures

**Children**
- HoNOSCA (Health of the Nation Outcome Scales for Children)
- ICD10 Factors influencing health status
- CGAS (Children’s Global Assessment Functioning Scale)
- SDQ (Strengths and Difficulties Questionnaire)

**Adults**
- HoNOS (Health of the Nation Outcome Scales)
- LSP-(an abbreviated version of the Life Skills Profile)
- K10+-LM or K10-L3D (two versions of the Kessler-10).

**Older people**
- HoNOS 65+ (an alternative version of the HoNOS)
- RUG-ADL (Resource Utilisation Groups - Activities of Daily Scale)
- LSP-16 (an abbreviated version of the Life Skills Profile)
- K10+-LM or K10-L3D (two versions of the Kessler-10).

**Data items identifying the Person**
- Family name
- First given name
- Date of birth
- Sex
- Person identifier

**Data items identifying the Collection occasion**
- Area Health Service
- Mental Health Service Setting
- Collection Date
22. STATISTICAL INFORMATION AND DATA

- Responsible service unit
- Responsible staff member
- Facility/location at time of collection occasions
- Age group
- Reason for collection

Data Items about preceding period of care
- Principal Diagnosis
- Focus of care
- Mental Health Legal Status

Other Indicators
- Previous specialised treatment
- Early psychosis intervention eligibility
- Collection Status for each measure

13. GLOSSARY

<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td>MH-AMB</td>
<td>Mental Health Ambulatory data collection</td>
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<tr>
<td>AHCA</td>
<td>Australian Health Care Agreement</td>
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<tr>
<td>HIE</td>
<td>Health Information Exchange (data warehouse)</td>
</tr>
<tr>
<td>DOHRS</td>
<td>Department of Health Reporting System</td>
</tr>
<tr>
<td>MHEC</td>
<td>Mental Health Emergency Care program</td>
</tr>
<tr>
<td>CAMHSNET</td>
<td>Child and Adolescent Mental Health Services Network</td>
</tr>
<tr>
<td>PECC</td>
<td>Psychiatric Emergency Care Centre</td>
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<tr>
<td>PAS</td>
<td>Patient Administration System</td>
</tr>
<tr>
<td>MHUID</td>
<td>Mental Health Unique (patient) Identifier</td>
</tr>
<tr>
<td>SUID</td>
<td>State Unique (patient) Identifier</td>
</tr>
<tr>
<td>NAPOOS</td>
<td>Non Admitted Patient Occasions Of Service</td>
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<tr>
<td>ECT</td>
<td>Electro Convulsive Therapy</td>
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<tr>
<td>NSMHS</td>
<td>National Survey of Mental Health Services</td>
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<td>PPCDC</td>
<td>Program and Product Cost Data Collection</td>
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<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
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MENTAL HEALTH AMBULATORY (MH-AMB) DATA COLLECTION - REPORTING AND SUBMISSION REQUIREMENTS - 1ST JULY 2006 (PD2006_042)

PD2006_042 rescinds PD2005_325.

1. Introduction

It relates to the continuation of the NSW Mental Health Ambulatory Data Collection (MH-AMB) that began in July 2000 to meet minimal Mental Health reporting requirements for NSW under the Australian Health Care Agreement (AHCA) 1998-2003.

MH-AMB was upgraded from July 2003 to satisfy NSW reporting requirements and revised national requirements for the AHCA 2003-2008.

Electronic unit records provide the basis for counts of non admitted mental health activity under a variety of reporting requirements met by this collection.

1.1 Changes in this update:

- Weekly extraction of CHAMB2 data to the Area Health Information Exchange from source systems.
- Weekly extraction of CHAMB2 data from Area HIE to State HIE (Section 6)
- General clarification in all sections.
- Specific inclusion of Mental Health Emergency Care activity and CAMHSNET activity.
- Identification of data items that must be completed to satisfy AHCA requirements (section 4).

The purpose of the collection is to:
22. STATISTICAL INFORMATION AND DATA

- Provide statewide information about the clients, the care they receive and the clinicians delivering that care for ambulatory Specialist mental health services in NSW.
- Provide statewide information about ambulatory mental health care delivered to clients by clinicians who work for non ambulatory mental health services.
- Provide statewide information about non client activity by staff employed by ambulatory mental health services where Areas wish to collect this information.
- Provide the ambulatory component of a series of linked databases in the HIE which will enable the generation of the continuous client journey over time and service settings, for any individual who has had contact with a public mental health service since June 2000. This linkage is achieved by using a unique person identifier.
- Provide a data source which satisfies the conditions of the Australian Health Care Agreement in relation to the National Minimum Dataset Community Mental Health Care.

Details of the following issues are included:

1. Introduction
2. Scope of Collection
3. Definitions
4. Mandatory Recording Requirements
5. Reporting
6. Submission of Data
7. Compliance Monitoring
8. Data Quality
9. Privacy
10. Security of the Data
11. MH-AMB data collection information - access and dissemination
12. Contact Details
13. Appendix - Data items in subject area order
14. Glossary

1.4 It is essential that this circular be distributed to all staff involved in the collection and supply of data for the MH-AMB data collection. These include:
- All mental health staff in public mental health services in NSW.
- Area Mental Health Information Staff
- Area Directors of Mental Health
- Health Information Exchange (HIE) Coordinators
- Staff of the State and Mental Health Unique Patient Identifier Facilities
- Area DOHRS and casemix co-ordinators
- Central Office NSW Department of Health
- Health Technology

2. Scope of Collection

MH-AMB is a NSW statewide non admitted data collection which is managed on a financial year basis but which extracts data to the HIE weekly.

2.1 MH-AMB includes:
- All client related activity delivered by ambulatory specialist mental health service units in any location and to any client, including prevention and promotion activities.
22. STATISTICAL INFORMATION AND DATA

- All activity delivered by inpatient or residential specialist mental health service units to non admitted and non residential clients.
- All client related activity delivered by specialist mental health consultation liaison teams or providers regardless of client treatment setting.
- All client related activity delivered by specialist mental health staff in Emergency Departments and PECC units until they achieve inpatient unit status whence the mandated admitted patient data must be collected in PAS systems.
- All client related activity delivered by mental health CAMHSNET supported bed staff.
- It MAY INCLUDE activity delivered to mental health clients by providers external to the mental health program.
- It MAY INCLUDE any non client activity performed as part of their employment by staff of ambulatory specialist mental health service units.

2.2 MHAMB excludes:
- Services provided by inpatient specialist mental health service unit staff to admitted patients in mental health inpatient units.
- Services provided by residential specialist mental health staff to patients admitted to residential mental health services.
- Services provided by PECC unit staff to patients who have been admitted to the PECC inpatient unit. (If the beds are not specifically mental health beds in an identified location then the unit is still considered ambulatory and providing consultation liaison to the ED.)

3. Definitions

3.1 Clients

- A client may be identified or unidentified and need not be registered by the service unit or accepted for ongoing treatment. Any person who receives any level of clinical care/advice/support that is more than brief information only is deemed to be a client for this collection. Persons who are triaged by phone and referred elsewhere are considered clients. The degree of information collected for such clients will vary.
- Identified Clients are those for whom sufficient identifying information is recorded to allow Client Data Linkage processes and the assignment of a Mental Health Unique Patient Identifier (MHUID) or a State Unique Identifier (SUID) for their continuous electronic record.
- Unidentified clients include a wide range of other people who receive services as unidentified individuals or receive mental health promotion and prevention services as members of groups or organisations or target populations. This includes all situations where the creation or updating of an individual client record is either impossible or clinically unnecessary.
3.1.1 Client related activity includes:

- **Direct care** where a client is present by any means of communication.

- **Indirect care** where the client is not present by any means of communication but an activity is performed for/on behalf of that particular client. This may or may not be a contact with another provider or family member and the client may not be identified.

3.2 Ambulatory specialist mental health care

This includes but is not limited to the assessment, treatment, rehabilitation or other care of non-admitted patients that has historically been captured as Non Admitted Patient Occasions of Service (NAPOOS).

It also includes:
- mental health promotion and illness prevention;
- day programs;
- psychiatric outpatient and outreach services (eg, home visits);
- care provided by hospital-based or other consultation-liaison services to admitted patients in non-psychiatric and hospital Emergency Department settings;
- care provided by community workers to admitted patients and to clients in community residential settings where the worker is not employed by the residential service unit as a residential staff member;
- same-day admitted patient care is also included in the “ambulatory” definition, except for defined same day procedures such as Electroconvulsive Therapy (ECT) which is recorded in PAS systems as part of the Admitted Patient Data Collection. All same-day admitted patient care is recorded in PAS systems as part of the inpatient statistics collection.

Care may be direct (client present) or indirect (client not present).

3.3 Specialist Mental Health Services

- **Specialist Mental Health Services** are defined for the National Minimum Data Set-Community Mental Health Care as those services providing mental health care that Areas designate for reporting in the National Survey of Mental Health Services (NSMHS) each year. This may include services not currently reporting in Financial Program 3.1 (Mental Health). The MH-AMB supports reporting from all Financial programs and Sub-programs recognised in the Product and Program Cost Data Collection (PPCDC).

- The MH-AMB data collection supports the recording of care activity for identified clients by NSW Health services outside the Mental Health Financial Program, and by other human services agencies operating in partnership with specialist mental health service providers (eg, Department of Housing, NGO’s, GP’s).

3.4 Mental Health Funded Private Organisations and NGOs

Where private organisations and NGOs are contracted to supply services within the scope of this collection on behalf of Area Health Services, it is the responsibility of the AHS to ensure that it can meet the reporting requirements.
4. Mandatory Recording Requirements

4.1 Definitions of Data Items?

Data in the format defined in the current version of the New South Wales Mental Health Data Dictionary (as documented in the Health Information Resource Directory HIRD on the Health Intranet) are to be recorded by all in scope service units for all in scope clients. A list of required items in subject order is in the Appendix to this document.

Where NMDS appears after a data item, this item is mandatory to comply with AHCA requirements. These items must be completed with a valid value and must not be left blank.

4.2 What Activity is Recorded?

All services under the Mental Health Financial Program (3.1 or DOHRS program 8) which provide ambulatory mental health care must:

- Record all direct client care activity (client present) provided by any means of communication to individuals, whether they are identified clients or not.
- Record all indirect client care activity (client not present) that can be attributed to an individual identified client. This includes travel time, report writing, care conferences, and other defined indirect care activity identified in the current Mental Health Data Dictionary.
- Record all care activity provided in group situations for each identified client.
- Record all other direct care activity provided in group situations to other clients.

4.3 Who is responsible for Recording activity?

Every provider is responsible for recording their own involvement in ambulatory mental health activity. This includes multi-provider activities.

4.4 Must All Activity be Recorded?

Provider activity that is not directed towards specific clients, such as training courses, clinical supervision, attendance at conferences etc may be recorded but is not mandatory.

General administrative and other activity such as service planning and management may be recorded but is not mandatory.

4.5 How is the Activity Recorded?

The preferred method for recording activity under the MH-AMB collection is by direct clinician entry into the Department’s interim system, SCI MH-OAT or equivalent system. Recording on paper forms that are then entered into the electronic system may also be used but this form of entry is not recommended because reports in the system are not immediately available to the clinician.

5. Reporting from MH-AMB

5.1 Supported Collections

MH-AMB data in NSW supports the following Commonwealth and NSW reporting requirements:
22. **STATISTICAL INFORMATION AND DATA**

- Provision of the National Minimum Dataset - Community Mental Health Care as required under the Australian Health Care Agreement (AHCA) with NSW, and the National Health Information Agreement (NHIA).
- Honouring of the commitment to NSW Treasury to provide a resource weighted activity measure for ambulatory mental health (client related provider time).
- Provision of data as required for the Department of Health Reporting System (DOHRS).
- Provision of ambulatory mental health care activity data to support Targets and Indicators under the Health Service Performance Agreements and Mental Health Service Agreements.
- State-wide planning activities for mental health services according to the Mental Health Clinical Care and Prevention model (MHCCP).

6. **Submission of Data**

- Data are to be extracted from SCI MH-OAT or equivalent system to the Area Health Information Exchange (HIE) at least weekly. A further extract from Area to State HIE occurs after encryption of identifiers and exclusion of names.
- Data are to be extracted in the CHAMB2 extract format which is defined in the current version of HIE Mental Health Feed Scope PO 3201.
- The data items required for collection to produce the CHAMB2 extract may vary depending on the source system and its ability to generate and display particular fields, but the final extract must conform to CHAMB2 definitions and format.
- The extracts are to be submitted at least weekly on a day to be arranged. Area HIE Co-ordinators are to ensure feeds will be sent to the State HIE in the standard weekly feed.
- Extracts are to include all new and updated records for the extract period
- Full financial year electronic unit record data by service unit for the MH-AMB collection must be submitted to the Area HIE and passed data quality checks and MHUPI reconciliations by no later than two months following the end of a financial year.

7. **Compliance Monitoring**

- The NSW Department of Health will monitor compliance with the reporting requirements set in this Circular and will produce compliance reports on a regular basis. The compliance will only be based on accessible data in the NSW Department of Health HIE.
- The compliance reports will be distributed to the Health Service Chief Executives, Area Directors of Mental Health and the Director, Centre for Mental Health.
- Compliance and Performance Reporting will be based only on data which can be accessed from the State HIE.

8. **Data Quality**

- An electronic data quality checking utility will be made available for identifying errors and omissions in the extracts from collection systems. This utility will be independent of the collection system.
- Data errors and missing data identified by the MHAMB collection system the HIE or the MHUPI reconciliation checks are to be corrected and records resubmitted to the Area HIE within 2 months of the end of the month in which the activity took place.
22. STATISTICAL INFORMATION AND DATA

- MHUPI reconciliation checks will occur in accordance with the Mental Health UPI Reconciliation Guidelines and Procedures and the current agreement between the Area Health Service and the Department.

- It is mandatory that Area Health Services undertake data quality checks to ensure that all fields are complete and that inconsistencies in the data within a particular record are identified and corrected.

9. Privacy

The Health Records and Information Privacy Act 2002 and Privacy Manual for Health Information (March 2015) must be observed for all data relating to the MH-AMB data collection. The NSW Health Privacy Manual provides operational guidance for health service staff to the legislative obligations imposed by the Health Records and Information Privacy Act 2002. The document outlines procedures to support compliance with the Act in any activity that involves personal health information.

10. Security of the data

10.1 Hard Copy

Data submitted in hard copy (paper) format for batch entry within an Area must be kept secure at all times. This means records must be sent by secure post (or courier) using a service that records the name of the persons handling the data.

10.2 Electronic copy

Data sent in electronic format should not be sent by Internet e-mail unless authorised in advance. Data submitted by e-mail within the Health Network should be encrypted and password protected. The password must be provided separately to the email containing the data.

11. MH-AMB data collection information - access and dissemination

11.1 Source Systems

Area source systems provide a series of reports to assist Area staff to manage clients and services at local level.

11.2 Area

Datamarts will be constructed in all HIEs so that identified Area-wide data can be accessed from Area Health Information Exchanges in accordance with predetermined access arrangements on signing confidentiality agreements as required by the Area. Persons accessing the HIE will be required to undergo suitable training prior to access being granted by an Area.

11.3 State

State-wide de-identified data sets of MH-AMB information are available in the State HIE from 2000/01 onwards but require datamarts to be constructed for ease of use.

State-wide de-identified data will be accessible from:
- Business Objects reports in the State and Area HIEs.
- Health Outcomes Information Statistical Toolkit (HOIST) which is accessible by staff of the Department and Area Health Services on signing a confidentiality agreement.
22. STATISTICAL INFORMATION AND DATA

- NSW State-wide Health Information Exchange for appropriate staff on signing confidentiality agreements.
- Written request to the Director, Centre for Mental Health.

11.4 National

De-identified data will be provided as required by the Commonwealth according to agreed specifications for inclusion in the National Minimum Dataset - Community Client Mental Health Care by December following the end of each financial year.

12. Contact Information

- For further information about this Policy Directive and the MH-AMB collection, contact:
  Carolyn Muir
  Principal Information Officer
  Centre for Mental Health
  Phone: 02 9391 9237
  E-mail: cmuir@doh.health.nsw.gov.au

- Requests for further information about this Policy Directive may also be faxed to the Performance Management and Monitoring Unit c/o Centre for Mental Health on 02 9391 9041.

- All definitions and metadata documentation for this collection can be found in the Health Information Resource Directory (HIRD) via the NSW Health Intranet.
## 13. Appendix: List of MH-AMB Data Items by Subject

### Individual client
- Aboriginal and Torres Strait Islander Origin (NMDS)
- Address of usual residence:
  - Building/property name
  - Postcode
  - State/Territory
  - Street Name
  - Street Number
  - Town/Suburb (NMDS)
- Client’s alias family name
- Client’s alias given name
- Client’s family name
- Client’s given name
- Client’s middle name
- Centrelink number
- Country of birth (NMDS)
- Date of birth (NMDS)
- Department of Veterans’ Affairs:
  - File number (NMDS)
  - Health card type (NMDS)
- Early intervention flag
- Estimated date of birth flag (NMDS)
- HASI flag
- IGOS flag
- Local person identifier (NMDS)
- Marital status (NMDS)
- Medicare number
- MRN facility ID
- Next of kin family name
- Next of kin given name
- Preferred language (NMDS)
- Previous specialist treatment (NMDS)
- Sex (NMDS)
- Telephone number - business
- Telephone number - home
- Unique person identifier - AHS
- Unique patient identifier - State

### Group Client
- Mental health target group type
- Number of clients

### CDL Items
- Client’s maiden name
- Father’s family name
- Father’s given name
- Mother’s family name
- Mother’s given name
- Mother’s maiden name

### Service delivery
- Activity code mental health
- Activity codesetActivity duration (NMDS)
- Activity qualifier
- Activity start date (NMDS)
- Activity start time
- Additional diagnosis
- Allocated provider time
- Client present status
- Financial class
- Flag activation date
- Legal status (NMDS)
- Mental health clinical intervention code
- Mental health diagnosis group (NMDS)
- Mental health principal service category
- Mental health service referred from
- Mental health service referred to
- Multidisciplinary flag
- Number of providers
- Referred to further care (NMDS)
- Service contact duration
- Service contact mode
- Service delivery location type
- Service delivery location
- Service event ID
- Service recipient type
- Service request ID
- Source of referral

### Service provider
- Area identifier (NMDS)
- Individual provider identifier
- Mental health provider role
- Mental health provider type
- Provider award (State)
- Provider financial program PPDC
- Provider financial subprogram/category PPDC
- Service unit identifier (NMDS)

### Extract processing items
- CDL flag
- Database Identifier
- DOHRS flag
- Extract end date
- Extract generation date
- Extract generation time
- Extract identifier
- Extract start date
- MDS flag
- NAPOOS Flag
- Record count
- Record identifier
- Transaction type
### 14. GLOSSARY

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>MH-AMB</td>
<td>Mental Health Ambulatory data collection</td>
</tr>
<tr>
<td>AHCA</td>
<td>Australian Health Care Agreement</td>
</tr>
<tr>
<td>HIE</td>
<td>Health Information Exchange (data warehouse)</td>
</tr>
<tr>
<td>DOHRS</td>
<td>Department of Health Reporting System</td>
</tr>
<tr>
<td>MHEC</td>
<td>Mental Health Emergency Care program</td>
</tr>
<tr>
<td>CAMHSNET</td>
<td>Child and Adolescent Mental Health Services Network</td>
</tr>
<tr>
<td>PECC</td>
<td>Psychiatric Emergency Care Centre</td>
</tr>
<tr>
<td>PAS</td>
<td>Patient Administration System</td>
</tr>
<tr>
<td>MHUID</td>
<td>Mental Health Unique (patient) Identifier</td>
</tr>
<tr>
<td>SUID</td>
<td>State Unique (patient) Identifier</td>
</tr>
<tr>
<td>NAPOOS</td>
<td>Non Admitted Patient Occasions Of Service</td>
</tr>
<tr>
<td>ECT</td>
<td>Electro Convulsive Therapy</td>
</tr>
<tr>
<td>NSMHS</td>
<td>National Survey of Mental Health Services</td>
</tr>
<tr>
<td>PPCDC</td>
<td>Program and Product Cost Data Collection</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HIRD</td>
<td>Health Information Resource Directory</td>
</tr>
<tr>
<td>NMDS</td>
<td>National Minimum Dataset</td>
</tr>
<tr>
<td>SCI MH-OAT</td>
<td>Service Contact Information Mental Health Outcomes and Assessment Tools interim data collection system</td>
</tr>
<tr>
<td>NHIA</td>
<td>National Health Information Agreement</td>
</tr>
<tr>
<td>MHCCP</td>
<td>Mental Health Clinical Care and Prevention service planning model</td>
</tr>
<tr>
<td>CHAMB</td>
<td>Community Health Ambulatory Extract to the HIE from July 2000</td>
</tr>
<tr>
<td>CHAMB2</td>
<td>Community Health Ambulatory Extract to the HIE Version 2 from July 2003</td>
</tr>
<tr>
<td>HOIST</td>
<td>Health Outcomes Information Statistical Toolkit</td>
</tr>
</tbody>
</table>
This document defines the procedure that must be followed for the establishment of new data collections or modification of existing collections based in the Department. It also establishes a procedure for the ongoing review of all these data collections.

This policy aims to support and regulate the establishment of central data collections in NSW Health. The process will:

- formalise the implementation of key aspects of the Information Policy in regard to new data collections;
- ensure all new data collections are developed with regard to other health information developments;
- prevent further uncontrolled central collecting of data and minimise unnecessary requests for data;
- promote a cultural change within NSW Health whereby information is seen and managed as a valuable resource;
- enable a current and detailed catalogue of the Department’s data collections to be maintained;
- ensure that demands made on data providers are fully justified.

The process for approval documented in these guidelines applies to all data collections. Data collections maintained by individual health services, administrative registers based in the Department of Health, operational collections and data access mechanisms as defined in the guidelines are not within the scope of this process. A list of currently approved data collections and registers has been included with the guidelines. These collections will be issued with an Accreditation reference number, but will be required to undertake a review and complete a business case. Any other current data collections that do not appear on this list will require a business case to be developed to justify their ongoing collection after 1 July 2000.

This process is mandatory for all current and proposed central data collections.

The main changes introduced by this policy are:

- All new data collections must be approved by a delegated officer on the advice of the Information Management Committee before data collection may commence. Before a collection will be approved a feasibility study, pilot test and business case must be completed.
- Modifications to existing collections will not be made without a business case and approval at an appropriate level.
- All data collections will be subject to a regular review process. Collections will be accredited for a three year period, and at the end of this period a review must be conducted before the accreditation will be renewed.
- Health Services will not be required to provide data for any collection that does not have a current accreditation reference number.

This circular should be read in conjunction with the Information Privacy Code of Practice and the NSW Health Information Policy.
PROCESS FOR APPROVAL OF NEW OR MODIFIED
STATEWIDE DATA COLLECTIONS

Effective 1 September 1999

INFORMATION AND ASSET SERVICES DIVISION
Executive Summary

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Executive Summary

The NSW Information Management Strategy has identified that data collections have been established throughout the NSW health system often without consideration, or awareness of, existing collections containing the same information. The cost involved in the development and ongoing operation of data collections is significant, both financially and in terms of the considerable burden that it imposes on Area Health Service staff, and it is essential that processes be implemented to ensure the accountability of expenditure on data collection. Information is a critical resource to the Department, and to the health system as a whole, and must be managed as such, with regard to the cost of collection, quality of data collected and process undertaken in establishing new collections and justifying the continuation of existing collections.

A process has been developed to ensure that:
- A business case is prepared and approved for all new data collections before implementation;
- Any changes to existing collections are approved and submitted within a set timeframe; and
- All data collections are reviewed every three years to confirm that they are still meeting the needs for which they were established, and that there is still a justifiable requirement for their ongoing collection.

All new data collections, or proposed modifications to existing collections (other than minor changes specified in Section 4.2), will have to go through the following process.

Stage 1 Feasibility study – an initial study to identify the objectives of the collection, the scope of the collection, options for collection of the data (new collection or modified existing collection), data required and methodology.

Stage 2 Pilot test – a small scale “dress rehearsal” for the data collection carried out in a small number of sites to validate the data items, definitions and codesets, assess the burden on respondents and provide a means of estimating the costs of the collection, editing, analysis and dissemination of the data.

Stage 3 Business case – If the pilot has been successfully completed and the decision made to proceed, a business case should be developed, providing detailed cost and resource estimates and justifying the ongoing collection of the data.

Stage 4 Implementation – Key tasks during implementation include preparation and dissemination of data collection documentation, site training, implementation of a change management strategy where appropriate, implementing a help desk and a user group.

Stage 5 Review – a review to identify any problems with the collection, 3 to 6 months after implementation.

On implementation of this policy all currently approved collections will be allocated a temporary Accreditation Reference number. All collections will then have to undertake a review and submit a business case before being allocated an Accreditation Reference Number, if the business case is supported. This accreditation will then be valid for three years.

Area Health Services will not be required to provide data for any collection that does not have a current Accreditation Reference Number.
1. **Background**

This document outlines the process to be followed for:
- the establishment of a new data collection;
- approval for variation to an existing data collection; and
- ongoing review of existing data collections.

The NSW Information Management Strategy has identified that data collections have often been established throughout the NSW health system without consideration, or awareness of, existing collections containing the same information. The cost involved in the development and ongoing operation of data collections is significant, both financially and in terms of the considerable burden that it imposes on Area Health Service staff, and it is essential that processes be implemented to ensure the accountability of expenditure on data collection. Information is a critical resource to the Department, and to the health system as a whole, and must be managed as such, with regard to the cost of collection, quality of data collected and process undertaken in establishing new collections and justifying the continuation of existing collections.

From 1 September 1999, all Departmental statewide data collections will be subject to a regular review process. From this date until 30 June 2000 there will be a phased process to ensure that all data collections:
- have executive sponsorship;
- are endorsed by the Department’s executive;
- adhere to identified information standards; and
- have been provided with a valid accreditation reference number.

**Area Health Services will be advised that they are not required to provide data for any collections that have not been approved through this process.** Once a collection is authorised it will be issued an accreditation reference number through the Health Information Resources Directory (HIRD) for a set period of three years. The review of the collection must be completed before the end of the three year period. Reviews should be carried out using the process outlined below to ensure that there is still a valid requirement for collection. A data collection can be removed from the list of accredited collections at any point during the three year accreditation period if the Information Management Committee are notified that there is no longer an ongoing requirement for the data for any reason.

This document identifies the collections that will be subject to this review, and outlines the approval and review process. Templates to be used as part of this process have also been included.

2. **Scope**

The process for approval documented in these guidelines applies to all statewide data collections, including performance indicators. Administrative registers and data access mechanisms (such as HOIST) (defined in section 3) are not within the scope of these guidelines.

This process is mandatory for all current and proposed statewide data collections. A data collection is defined as any collection of data from a source, or sources, outside the nominating business area. This includes regular and ad hoc data collections, such as once off surveys, involving patient, service level or financial data. It does not cover administrative registers, which are maintained within a business unit as part of the operation of that unit (eg a register of nursing homes).
22. STATISTICAL INFORMATION AND DATA

3. Definitions

3.1 Data collection

An organised method of capturing specific information, either manually through a paper form, or electronically through a purpose built information system. It may be a by-product of routine administrative procedures, or a collection of data for a specific purpose not normally required by the business unit as part of the unit’s ongoing business processes.

The collection methods and timeframes of data collections vary from collection to collection (eg a collection may be a census or random sample survey, and may be collected monthly, quarterly, annually or on an ad hoc basis.

3.2 Administrative register

An administrative register is listing of people/property or items required to be held as part of the operation of a business unit. Examples are property registers, registers of services, etc.

3.3 Data access mechanisms

A data access mechanism is a system which consolidates data collected from different sources for ease of use, or which provides access to data in a more user friendly form to simplify analysis of data. Examples are HIE, HOIST, FlowInfo and the EIM.

3.4 Statewide

A statewide data collection is one initiated by the Department of Health and required by all Area Health Services which have services within the scope of that particular collection. For example all Areas contribute data to the Inpatients Statistics Collection, which is clearly a statewide collection. In contrast a statewide radiation oncology data collection may only collect data from a small number of Area Health Services as radiation oncology units are all concentrated in a small number of Areas.

3.5 Custodian

The custodian of a data collection is the person with responsibility for the ongoing development, data collection, maintenance and review of the collection. The data custodian is responsible for the data quality, security, timeliness and adherence to standards. The Information Privacy Code of Practice, second edition, outlines the roles and responsibilities of the data custodian (section 11.3.5, page 55).

3.6 Sponsor

The sponsor of a collection is the person who undertakes the responsibilities of ownership of the collection on behalf of the Department. The role of the sponsor is to justify the establishment of the collection, define the objectives of the collection, the data items and the reporting requirements. The Privacy Manual (Version 2), outlines the roles and responsibilities of the sponsor.

3.7 Health Information Resource Directory (HIRD)

The HIRD is a system that allows for the maintenance and management of details of information resources held by the Department of Health, including data collections, individual data items, codesets and definitions. The HIRD will provide the mechanism to allocate and maintain the accreditation reference numbers for data collections.
3.8 Pilot

A pilot test is a small “dress rehearsal” for a data collection, carried out in a reduced number of sites. The purpose of the pilot is to test the data collection instrument or system, and to test and refine the definitions and codesets to ensure that they are viable before a full scale implementation.

4. Approval process for data collections

4.1 Process for establishment of a new data collection

4.1.1 Introduction

There are five stages involved in the approval process for a new data collection. These stages are a feasibility study, pilot testing the new collection, development of a business case for implementation, implementation and review. The review stage is ongoing, and a review will be completed every three years for each collection. The following sections describe the process to be followed for each stage. A template is provided for supporting documents in Appendix 1. Information Development Unit can provide assistance at all stages of this process.

Ad hoc surveys also need to be approved using the same process. This is to ensure that the data to be collected are not already available in an existing collection, and that it will not impose an unreasonable burden on the respondents. While the same steps need to be followed and the same delegations apply for the development and implementation of a survey, the level of detail may be reduced. Instead of a regular review cycle, a report presenting the findings and issues that arose will be required.

4.1.2 Feasibility study

The purpose of the feasibility study is to identify the objectives, scope, data requirements and methodology of the proposed collection. This stage should also identify the output requirements and any alternative implementation options to be investigated. This should involve an analysis of existing data collections to determine whether new data items could be added into an existing collection instead of creating a new collection with overlapping items.

Specifically, the feasibility study should consider:

- What are the objectives of this data collection (ie what are the questions to be answered)?
- Who are the key stakeholders?
- What type of information do they require and in what format (eg what types of reports will need to be produced, what is the level of detail that is required, how often are reports required - annually, quarterly, monthly)?
- What are the data items needed to support these objectives and these reporting requirements?
- Are there existing codesets that can be used for this collection or will the results from the pilot be used to develop new codesets?

The feasibility study should also cover the technical resources that would be required to conduct a pilot test, proposed pilot sites, respondent burden evaluation and an evaluation methodology for the pilot. A preliminary estimate of the cost of the collection and the proposed source of funding is also required at this stage.

A feasibility study for a new collection should not be commenced unless the proposed collection has the support of the relevant Deputy Director-General.
The feasibility study should identify any methodological problems with the proposal that would affect the viability of the data collection.

4.1.3 Pilot test

A pilot test is undertaken to:
- refine the requirements for the collection;
- validate the data items and codesets to be implemented;
- confirm that the data items collected do answer the questions intended by the data collection;
- provide information to be used to refine estimates on the size of the collection, the resources that will be required for collection, data entry, editing, analysis and publication to feed into a detailed costing for the business case;
- estimate the level of respondent burden arising from the data collection; and
- determine whether to further develop the data collection or not.

The first step in conducting a pilot is to establish the project team, which should include subject area specialists (from the sponsoring Branch and the services from which the data are to be collected, key data users and representatives from IASD.

The first phase of the pilot is to undertake the detailed development of the content of the pilot and the methodology that will be used. Key questions to be answered at this point are:
- Are there existing, standard definitions for the data items that are required? If not these need to be developed.
- Are there any existing codesets that can be used? The HIRD provides a useful mechanism for identifying whether there are any appropriate standards that can be adopted.
- How will the data be captured – can it be extracted from operational systems, or will a paper based form need to be developed as an interim solution?
- Who will be providing the data? Will extra resources be required to undertake the data collection?
- How many responses would you expect during the pilot (e.g., how many patients in an emergency department, how many clients in a community health centre, how many patients in an outpatient eye clinic).
- Where there is a large number anticipated, do you only want to sample the clients for the pilot test?

In most cases the pilot will involve the development of a paper form, to be used until the requirements for the collection are finalised. A data dictionary providing definitions for each data item, codesets, guides for use (i.e., explanatory notes about how to record information for a particular item, which code to use in particular circumstances etc) should also be developed at this stage. The form and data dictionary should be circulated widely to stakeholders prior to the pilot to identify any major problems with definitions or codesets.

The pilot methodology needs to be determined, for example how many sites should be involved in the pilot, the time period to be covered (making sure that the period picked does not incorporate any events that would provide an uncharacteristic response in the data collection.
The scope of the data collection needs to be defined, with clear guidelines about inclusions and exclusions from the proposed data collection.

Method of data capture should also be considered, and alternative options to collection by paper form should be evaluated.

A plan for data entry, editing and analysis should be developed, taking into account an estimate of the number of responses expected over the period of the pilot.

The budget for the pilot should also be established at this stage, as well as the potential source of funds. Consideration should be given to:

- project team salaries and on-costs;
- potential site reimbursement (eg for backfilling positions for staff involved in the pilot);
- cost of travel for site co-ordinators to meetings and for project team members to visit pilot sites;
- printing of forms and other documentation;
- data entry and analysis costs.

Prospective pilot sites should be identified, taking into consideration the resources available within the site to undertake the pilot, and the characteristics of the pilot site to ensure that a good mix of sites is involved in the pilot and the size of the site. For example, a very small service may not have a broad enough client group to test all aspects of the collection.

Each site should have a nominated co-ordinator who is responsible for disseminating information about the pilot and pilot documentation, ensuring the quality of the data, providing a channel for questions about the pilot and batching and returning data to the Department.

Training for staff in the pilot sites should be provided one to two weeks before the planned commencement of the pilot. If there are a small number of sites this can be provided through a workshop. If this is not possible an information kit should be prepared and sent out to staff involved in the pilot. This kit should provide information about how to complete the questions, when the data should be provided and who to contact for questions.

Sites should receive feedback throughout the pilot on issues that arise affecting the data collection.

Once the pilot data have been analysed and the results written up, the report should be signed off by the Sponsor and the Director, Information Management and Clinical Systems Branch. The pilot report should identify any issues/problems that arose during the pilot and describe how these have been addressed.

### 4.1.4 Business case

If the pilot has been successfully completed and the decision made to proceed, a business case should be prepared, providing detailed cost and resource estimates and justifying the ongoing collection of the data. A suggested template for the business case is provided in Appendix 1.

The business case should provide background information identifying why the collection is required, how it conforms to the corporate plan, IM&T Strategy and Information Policy. It should provide information about:

- the data collection process that will need to be implemented to support the collection;
- the operational impact of the collection;
alternative solutions/options analysis;
- benefits identification and realisation, including benefits to health services;
- preferred solution analysis;
- cost of the collection over a three year period;
- implementation requirements;
- project management structure and responsibilities;
- management plan; and
- details of, and relevant issues arising from the pilot.

The business case should then be referred to the Information Management Committee which will advise the Director-General whether it should be endorsed, rejected or modified. Information about the proposed collection will be made available to the Senior Executive Forum for comment at this point, before approval for implementation is given.

Once the Director-General has approved a data collection for statewide implementation on the basis of the business case, an accreditation reference number will be allocated by the HIRD Manager to allow the collection to be registered on the HIRD.

4.1.5 Implementation

The fourth stage is implementation of the collection. Depending on the size and complexity of the collection, this can be undertaken on a statewide basis, or as a phased implementation, where data are collected initially from a subset of services increasing to full implementation over a period of time. Key tasks during the early implementation phase are:

- Preparation and dissemination of data collection manuals to all sites. These should have been written for the pilot phase and should only require minor modifications for implementation.

- Training of staff who will be involved in the collection. The importance of this task is often underestimated, but it has a critical role in ensuring the quality of the data. The training process should provide information on what the data will be used for, how to enter the data and what benefits they will get from the process.

- The introduction of a new data collection will often result in changes to work practices, in varying degrees depending on the size of the collection and the level of new technology associated with it. The pilot should provide a good indication of the level of change that will take place. In the period prior to implementation (at the latest, the process should start with the business case) a change management strategy should be developed and implemented. This strategy should consider the impact at local level (the people on the ground providing the data, specifically job design, collection process), the Area/division level (eg resource issues, technical issues) and at the corporate level (corporate policies/procedures, data and information management requirements). To be successful a change management strategy must be linked to benefits that will be achieved. The strategy should have:
  - visible management support;
  - clear communication with all staff involved about the purpose of the strategy and what is involved in implementing it;
  - consultation with all stakeholders in the development and implementation of the strategy; and
  - establishment of a monitoring and evaluation process with agreed performance indicators to measure if new work practices have been sustained.
More information on the development of a Change Management strategy can be found in the Information and Asset Services Division “Framework for Supporting Change Management Initiatives” document.

- A feedback mechanism to sites providing data should be put in place so that the process becomes a two way exchange. Ensuring that data providers get a tangible benefit from the data they collect is also critical is ensuring that the data provided are accurate and timely. As well as providing summary data back to sites, another communication mechanism such as a newsletter which can provide information relating to the collection is also worthwhile.

- A “help desk” should be established so that data providers can easily seek clarification of issues surrounding the collection process or interpretation of data items, and information about who to contact in case of problems or questions should be widely disseminated.

- A collection user group should be established with all key stakeholders (most of this group should have been involved in the initial design of the collection at the pilot stage) to advise on issues that arise during the collection.

- During the pilot phase a process to assess the impact of the new collection on data providers should have been developed. Once the collection has been implemented this should be put in place.

4.1.6 Review phase

Following implementation, an ongoing process of review of the collection is undertaken. Once the data collection process is well established (usually 3–6 months after implementation) an initial review should be performed. The nature of this review will be defined partly by criteria established in the change management strategy and in the benefits realisation strategy incorporated in the business case. The review should cover:

- Timeliness and quality of data submitted - do there appear to be any problems with interpretation of data items/codesets that require additional training/clarification through the newsletter or other means.
- Effectiveness of edits – are sufficient checks in place.
- Confirmation that the original objectives of the collection being met.
- Effectiveness of change management strategy – ie whether new work practices been sustained.
- Level of burden on data providers.
- Realisation of anticipated benefits (this may be not be feasible to achieve in full until the collection has been established for a longer period of time, but some benefits should be realised in the short term).
- An action plan for resolving any issues that were identified during the review.

The review report should be signed off by the sponsor and the Director, Information Management and Clinical Systems.

4.2 Process for approval of variation to existing collections

In many cases it will not be necessary to develop and implement a new data collection to satisfy an emerging information requirement. The feasibility study conducted as the first phase of the approval process should identify whether there is scope to add additional items to an existing collection, or whether a new collection is required if there are no existing collections that satisfy the new requirements.
A similar process is to be followed to request significant changes to an existing collection. However, the level of supporting documentation required will vary considerably depending on the extent of changes required to the collection. Some types of changes, such as changes to definitions used by a collection, will only require endorsement by the relevant user group and the Director, Information Management and Clinical Systems Branch. Examples below demonstrate the types of changes that would require a business case to be submitted for approval. Information Development Unit can provide advice on whether a business case is required for the proposed changes, and the level of detail that is appropriate. All proposed changes would have to be pilot tested before implementation, although the size of the pilot would be determined by the scale of the changes proposed.

The same delegations apply for variation to an existing collection as those for approval to develop and implement a new collection.

Approved requests for modifications to existing collections must be received at least 6 months prior to intended implementation date (eg changes for July 2000 must be received by December 1999). In cases where the changes are extensive, up to 12 months notice may be needed. This is to ensure that there is adequate time to modify and test source systems.

4.2.1 Addition of new data items to an existing data collection, items not currently collected by Area Health Services

If a requirement emerged for a number of new data items to be collected to supplement an existing data collection it would be necessary to undertake a feasibility study and pilot. This is to ensure that the proposed items can be collected accurately and consistently, and to confirm that they will provide the information required. Once this has been approved, a business case will need to be completed. The main aim of the business case in this instance is to ensure the viability of the new items, ensure that any relevant standards have been used, collection burden does not outweigh the benefits and to identify the costs of implementation. Less detail needs to be provided than would be the case for a new collection. A template is provided in Appendix 1.

4.2.1.1 Feasibility study

A feasibility study as outlined in section 4.1.2 is undertaken as the first stage. The purpose of this stage is to identify whether there is an existing collection that can be modified, or if a new collection is required. Where it is determined that modifications to an existing collection are possible, the feasibility study should be used to ensure that the data collected by the core collection and the scope are consistent with the objectives of the proposed collection. The template for the feasibility study is provided in Appendix 1. The feasibility study should take no longer than one month to complete.

4.2.1.2 Pilot test

A pilot test is still required for modifications to an existing collection, although in most cases this will be significantly smaller than the pilot required for a new collection. Regardless of the number of new data items it is important to test the clarity of the definitions and the validity of the code sets used to ensure the viability of the new items. The pilot should also test the practicality of collecting the new item, including the impact it will have on the data providers.

The size and duration of the pilot will be dependent on the number of proposed changes to the collection.

4.2.1.3 Business case

The business case should focus on:
the justification of the proposed changes with reference to the corporate plan;
the operational impact of the changes (eg change to source systems, business process changes, operational impact on data capture and dissemination);
the cost of the proposed changes;
the benefits anticipated.

In most cases the pilot test and development of a business case for changes to an existing system should be completed within 2 months.

4.2.1.4 Implementation and review

A similar process needs to be followed when implementing a modified data collection, as that outlined above for a new collection (see section 4.1.5). It is very important that information about the changes is widely disseminated, and that documentation about the modifications is provided in sufficient time for any necessary changes to source systems. If the changes are significant, there may be a requirement for additional training to be provided.

A post implementation review confirming the impact, benefits and costs of the new items should be conducted, as outlined in section 4.1.6.

4.2.2 Inclusion of new data items in reports; data already collected by Areas

In some cases a requirement may emerge within the Department to expand a data collection to capture some additional data items already collected by the Areas. In these cases a brief requesting the collection of the additional items, providing a justification, a breakdown of the additional costs that will be incurred by reporting the additional items (eg changes to extract files, etc) and a source of funds for these changes, should prepared. This must be signed off by the sponsor of the collection and the Director, Information Management and Clinical Systems Branch.

4.2.3 Changes to definitions

Minor changes to collections that arise out of routine on-going monitoring and quality improvement activities, such as changes to data item definitions, only need to be approved by the relevant user group and the Director, Information Management and Clinical Systems Branch. A short submission should be provided detailing the proposed changes and reason why the are recommended. Proposed changes must not be inconsistent with nationally agreed standards.

4.2.4 Population surveys

Population based surveys such as those conducted by the Health Survey Program, which have no impact on Area Health Service staff or systems are not within the scope of these guidelines. However, the Information Development Unit should be involved in the development of these surveys to ensure that existing standards are being used where available. Copies of survey documentation should be provided to the Director, Information Management and Clinical Systems Branch to ensure that these collections are included in the HIRD as an information resource.

4.3 Review process for existing data collections

From 1 September 1999 all data collections will be subject to regular review. This review will take place every three years. The purpose of this review is to:
22. STATISTICAL INFORMATION AND DATA

- Confirm the ongoing requirement for the collection (and on a more detailed level the individual items in the collection).
- Assess whether the data collected still meets the objectives of the collection. Factors such as changes in policy, evolving means of service provision and types of services mean that data requirements may change over time. It is important that the ongoing relevance of data items is regularly assessed.
- Determine whether the benefits of the data collection outweigh the costs associated with collecting and managing the data.

All currently approved collections will be allocated a temporary accreditation reference number from September 1999. This temporary reference number will have a set expiry date. The review of the collection must be carried out before this expiry date, or the status of the collection will be changed to unapproved, and the Area Health Services will not be obliged to report data for that collection. If the review cannot be carried out in this time frame, an appeal can be lodged with the Director, Information Management and Clinical Systems Branch for an extension in time to undertake the review.

The review should cover:
- Conformance with the Corporate plan/legislation (where relevant) – this may change over time.
- Operational impact of the collection.
- Quality, timeliness, accessibility, appropriateness of the data.
- Justification of data items in line with corporate/business area/legislative objectives.
- Benefits realisation (corporate information impact of this collection, tangible impacts (if any)).
- Revised costs of data collection, management and dissemination process.
- Recommendations for modifications.

For most collections the review should be completed within a month. Once completed the report must be signed off by the Sponsor.

4.4 Process for accelerated approval of urgent data collections.

In some cases there will be an urgent requirement to implement a data collection to provide data on a particular issue within a very short timeframe.

In these cases approval to fast track the development process must be obtained from the Director-General. A temporary accreditation reference number will be issued, subject to review within 6 months of implementation.

A feasibility study and pilot test must be completed in order to gain approval to fast track a collection. These stages are critical to validate the data to be collected and to identify any potential problems with the collection and cannot be bypassed. These can be undertaken within a short time period, and even during the pilot phase can provide valuable information on the issue.

Once the pilot has been completed and signed off, approval can be sought from the Director-General to implement the collection prior to completion of a business case. A temporary accreditation reference number will be allocated to the collection, providing the approval to collect the data. This accreditation will be valid for six months from date of issue. During this period a business case must be prepared and submitted or the accreditation will be removed.
5. **Delegations for approval of data collections**

The following delegations apply for each phase of the approval process to develop and implement a data collection.

5.1 Delegation for approval to conduct a feasibility study, pilot and business case

- Director-General
- Deputy Director-General
- General Manager, Information and Asset Services Division
- Director, Information Management and Clinical Systems Branch

5.2 Delegation for approval to implement a data collection

- Director-General

5.3 Delegation to approve variation in development timeframe

- Director-General

6. **Timing of submissions**

Planning, development and documentation of the feasibility study should take no longer than one month.

Depending on the size of the proposed collection, the conduct and evaluation of the pilot test and the development of the business case for implementation should take between three and six months.

The total time from initial concept to full implementation of a data collection will be between six and twelve months, again depending on the size and complexity of the collection.

The approval process for implementation of a data collection must begin at least eight months before the planned implementation date. Similarly, changes to an established statewide data collection require the submission of a business case six months prior to implementation.

Where there is an urgent requirement for a data collection to be developed within a shorter time frame than this, the variation in the timetable must be approved by the Director-General.

7. **Roles and responsibilities**

7.1 Nominating area

The Branch requesting the new data collection or modifications to an existing collection is responsible for:

- feasibility and pilot study (including providing funding for the study);
- business case development;
- data collection review.

Assistance with each of these will be provided by Information Management and Clinical Systems Branch, however the sponsoring area retains primary responsibility for undertaking this work.
7.2 IASD

- Evaluation of proposals.
- Providing expertise and assistance with feasibility studies, business case development and the review process.
- Managing and maintaining the Health Information Resources Directory as a register of approved collections.

7.3 Area Health Services

- Provision of accurate, timely data.
- Checking accreditation status of data collections.

7.4 Information Development Unit

- Provide advice and assistance on preparation of feasibility studies, pilot testing, business cases.
- Guidance on when a full business case is required for changes to an existing collection.
- Assistance to identify existing data sources and data standards.
- Appropriate level of detail for the business case.

8. Templates

Templates for the feasibility study and the business case are provided in Appendix 1, and an electronic version is available.

Points noted in these templates are intended to be a guide only - they are not exhaustive lists of everything that should be included. Equally, the level of detail will vary depending on the size of the proposed collection, the complexity of gathering the information and the potential sensitivity of the subject.

9. Further information

For further information about the approval process please contact:

Peter Williams
Director, Information Management and Clinical Systems Branch
Ph 9391-9110
Fax 9391-9762
Email pwill@doh.health.nsw.gov.au or

Joanna Kelly
Manager, Information Development Unit
ph 9391-9090
Fax 9391-9015
Email jkely@doh.health.nsw.gov.au

For assistance with developing a feasibility study, pilot test or business case:

Joanna Kelly
Manager, Information Development Unit
ph 9391-9090
Fax 9391-9015
Email jkely@doh.health.nsw.gov.au
Appendix 1: TEMPLATES

Feasibility study

Data collection name: ____________________________

Nominating Branch: ____________________________

Sponsor: ____________________________

Brief description of the proposed data collection

  Subject matter, Brief overview of why this collection is being requested; history behind it, etc.

Purpose of the collection

  What is this collection meant to achieve?

What are the objectives of this data collection?

  • What questions is it attempting to answer?
  • What business processes is it attempting to support etc?

What is the scope of this collection?

  • What types of services/patients does it cover?
  • Are these services located in all Area Health Services or a subset of Areas?

How does this collection contribute to the corporate plan?

  • How does this collection support the Department’s corporate plan?
  • What are the other key drivers (eg legislative requirement/regulatory role)?

Existing data

  • What similar collections exist?
  • Can they be modified?
  • Is there potential to add new items to an existing collection?
Proposed Methodology

- How is the feasibility study being carried out?
- What steps have been gone through to check that these data are not available from another source?
- Is anyone anywhere else doing anything similar?
- Are there any standards existing for this type of information?

Data items required

- What are the data items required for this collection; are there existing standards (eg for definitions, codesets)?
- Do new standards need to be developed and implemented?

Frequency of collection

- What is the collection cycle required – monthly, quarterly, annual?

What output is required from this collection?

- what reports are required?
- what format are they required in?
- how are they to be accessed?
- who will have access to data?

Preferred data collection method

- Is there an existing collection that could be modified or is a new collection required?
- If there is more than one option, justification for preferred alternative.

Stakeholders

- Who are the stakeholders in this collection?
- What is their role?
- What do they require from the collection?

Project Management

- Who are the Project team, are they existing staff or are additional staff required?
- What are their role?
- Timeframe of the project?
- Deliverables with expected completion date (eg pilot report, business case).
What technical resources are required for this data collection?
- *What technical resources will be required to conduct the pilot – will it be paper based, will it involve extracting data from existing systems?*
- *how will data be analysed, will programmers be required etc?*

What pilot sites will be involved?
- *Details about proposed pilot sites – how many, where they are, structure, characteristics, resources available within sites for pilot, assistance required for pilot?*

Respondent burden evaluation
- *What burden will this place on sites?*
- *What other data collections are they involved in?*
- *What resources (Human and technical) do they have available?*
22. STATISTICAL INFORMATION AND DATA

Business Case: New collection

Data collection name: ___________________________________________

Nominating Branch: ____________________________________________

Sponsor: ______________________________________________________

Brief description of the proposed data collection

Subject matter, Brief overview of why this collection is being requested; history behind it, etc.

Purpose of the collection

What is this collection meant to achieve?

What are the objectives of this data collection?
  • what questions is it attempting to answer?
  • what business processes is it attempting to support etc?

What is the scope of this collection?
  • what types of services/patients does it cover?
  • are these services located in all Area Health Services or a subset of Areas?

How does this collection contribute to the corporate plan/Strategic Direction for Health?
  • How does this collection support the Department’s corporate plan?
  • What are the other key drivers (eg legislative requirement/regulatory role)?

What is the primary reason for this data collection
  • Legislation, regulatory function, conformance with corporate plan et..

What is the proposed data capture process
  • Details about source of data,
  • process involved in the collection of this data,
  • frequency of collection, data to be collected,
  • source systems,
  • method of reporting to Department.
What process will be used to evaluate the outcome of the pilot for this collection

- How will the pilot be evaluated?
- how will the validity of the data be estimated, the value of the data, the cost of collection, the burden on respondents?

What is the estimated cost of data collection?

- Estimated cost of data collection (cost of collection, data entry, editing, analysis, system modifications, training, documentation (manuals, forms, etc).
- What is the source of funds?

Pilot results
What lessons were learned from the pilot?
Business Case: Modifications to an existing data collection

Data collection name: ____________________________________

Nominating Branch: _______________________________________

Sponsor: ____________________________________________

Brief description of the proposed changes to the data collection
- new data items, classifications etc
- change in scope of collection.

Why are these changes/additions required?
- what questions is it attempting to answer;
- what business processes is it attempting to support etc

How will information resulting from these changes to the collection contribute to the corporate plan/Strategic Direction for Health?
- How does this collection support the Department’s corporate plan?
- What are the other key drivers (eg legislative requirement/regulatory role)

What is the expected operational impact of these changes?
- Changes to source systems,
- network implications,
- business process change,
- Departmental resources required,
- operational impact on source, capture, dissemination.

Total cost of changes
- Financial analysis,
- capital and recurrent funding source over three year period.

Implementation requirements
- Software customisation,
- technical infrastructure change requirements,
- work practice change requirements

Pilot results
- issues arising from the pilot and how these were addressed
What is the expected operational impact of this data collection?

- Changes to source systems,
- network implications,
- business process change,
- Departmental resources required,
- operational impact on source, capture, dissemination.

Options analysis

*Summary of possible options for data collection (eg new collection, modification to existing collection through additional of new items, survey etc)*

Benefits realisation

*Corporate information impact (quality, accessibility, timeliness, appropriateness), tangible benefits (if any), benefits to health services.*

Preferred solution analysis

- Financial analysis,
- capital and recurrent funding source over three year period.

Implementation requirements

- Software customisation,
- technical infrastructure change requirements,
- work practice change requirements

Project management

*Project team, management of change process.*

*Project timetable, maintenance plan, version control, user advisory structure.*

Pilot test report

*Attach a copy of the pilot test report, highlighting issues/problems arising from the pilot and how these have been addressed.*
This circular supersedes Circular 2000/56 “Emergency Department Collection (EDC) - Reporting Requirements”. Changes in this circular relate only to Section 5 - Reporting Requirements. These updates provide the new due dates for the 2001/2002 collection year, including the 2001 Winter Strategy reporting requirements.

1. Introduction

1.1 This circular details the following issues in relation to the Emergency Department Collection (EDC) for Emergency Department presentations from 1 May 2001:
1. Introduction
2. Coverage
3. Data Items to be Reported
4. Data Quality and Error Correction
5. Reporting Requirements
6. Compliance Monitoring
7. Emergency Department Collection Coordinators
8. Security of Data
9. On-line Documentation
10. Contact Information

1.2 It is essential that this circular be distributed to all staff involved in collecting and supplying data for the Emergency Department Collection. This includes:
- Emergency Department Staff
- Emergency Department Collection Coordinators
- Health Information Exchange Coordinators

2. Coverage

2.1 The tables below lists the hospitals that must submit data to the Emergency Department Collection.

2.2 Table A indicates those hospitals which are required to submit an extract for each week during the Winter period (1 May to 30 September 2001). Outside this period these hospitals are required to report monthly.
Table A - Hospitals required to submit weekly Emergency Department data during the Winter Period and monthly throughout the rest of the year

<table>
<thead>
<tr>
<th>Hospital Code</th>
<th>Name of Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>A202</td>
<td>Canterbury Hospital</td>
</tr>
<tr>
<td>A237</td>
<td>Concord Repatriation Hospital</td>
</tr>
<tr>
<td>A208</td>
<td>Royal Prince Alfred Hospital</td>
</tr>
<tr>
<td>B210</td>
<td>Hornsby and Ku-Ring-Gai Hospital</td>
</tr>
<tr>
<td>B212</td>
<td>Manly District Hospital</td>
</tr>
<tr>
<td>B214</td>
<td>Mona Vale and District Hospital</td>
</tr>
<tr>
<td>B218</td>
<td>Royal North Shore Hospital</td>
</tr>
<tr>
<td>B224</td>
<td>Ryde Hospital</td>
</tr>
<tr>
<td>D201</td>
<td>Auburn District Hospital</td>
</tr>
<tr>
<td>D203</td>
<td>Blacktown Hospital</td>
</tr>
<tr>
<td>D218</td>
<td>Mount Druitt Hospital</td>
</tr>
<tr>
<td>D224</td>
<td>Westmead Hospital</td>
</tr>
<tr>
<td>D204</td>
<td>Blue Mountains Hospital</td>
</tr>
<tr>
<td>D210</td>
<td>Penrith/Nepean Hospital</td>
</tr>
<tr>
<td>D227</td>
<td>Bankstown/Lidcombe Hospital</td>
</tr>
<tr>
<td>N219</td>
<td>Bowral and District Hospital</td>
</tr>
<tr>
<td>D205</td>
<td>Camden Hospital</td>
</tr>
<tr>
<td>D215</td>
<td>Campbelltown Hospital</td>
</tr>
<tr>
<td>D206</td>
<td>Fairfield Hospital</td>
</tr>
<tr>
<td>D209</td>
<td>Liverpool Hospital</td>
</tr>
<tr>
<td>C208</td>
<td>Prince of Wales Hospital</td>
</tr>
<tr>
<td>C213</td>
<td>St George Hospital</td>
</tr>
<tr>
<td>A212</td>
<td>St Vincent’s Public Hospital</td>
</tr>
<tr>
<td>C214</td>
<td>Sutherland Hospital</td>
</tr>
<tr>
<td>C238</td>
<td>Sydney Children’s Hospital</td>
</tr>
<tr>
<td>A231</td>
<td>Sydney Eye Hospital</td>
</tr>
<tr>
<td>A216</td>
<td>Sydney Hospital</td>
</tr>
</tbody>
</table>
2.3 Table B lists hospitals that are required to extract and supply Emergency Department data on a monthly basis.

Table B: Hospitals required to submit monthly Emergency Department data

<table>
<thead>
<tr>
<th>Hospital Code</th>
<th>Name of Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q214</td>
<td>Belmont District Hospital</td>
</tr>
<tr>
<td>Q206</td>
<td>Maitland Hospital</td>
</tr>
<tr>
<td>Q211</td>
<td>Newcastle Mater Misericordiae Hospital</td>
</tr>
<tr>
<td>B202</td>
<td>Gosford District Hospital</td>
</tr>
<tr>
<td>B206</td>
<td>Wyong Hospital</td>
</tr>
<tr>
<td>P212</td>
<td>Illawarra Regional Hospital</td>
</tr>
<tr>
<td>P211</td>
<td>Shellharbour Hospital</td>
</tr>
<tr>
<td>P207</td>
<td>Shoalhaven and District Hospital</td>
</tr>
<tr>
<td>A207</td>
<td>The New Children’s Hospital</td>
</tr>
<tr>
<td>H214</td>
<td>Lismore Base Hospital</td>
</tr>
<tr>
<td>H223</td>
<td>Tweed Heads District Hospital</td>
</tr>
<tr>
<td>H208</td>
<td>Coffs Harbour Base Hospital</td>
</tr>
<tr>
<td>J225</td>
<td>Manning Base Hospital</td>
</tr>
<tr>
<td>H307</td>
<td>Port Macquarie Base Hospital</td>
</tr>
<tr>
<td>J216</td>
<td>Tamworth Base Hospital</td>
</tr>
<tr>
<td>K211</td>
<td>Dubbo Base Hospital</td>
</tr>
<tr>
<td>L201</td>
<td>Bathurst Base Hospital</td>
</tr>
<tr>
<td>L213</td>
<td>Lithgow District Hospital</td>
</tr>
<tr>
<td>L216</td>
<td>Orange Base Hospital</td>
</tr>
<tr>
<td>S201</td>
<td>Broken Hill Base Hospital</td>
</tr>
</tbody>
</table>
3. **Data Items to be Reported**

3.1 The following data items must be reported for all Emergency Department presentations:

**Data Supplied by Patient**
- Sex
- Date of Birth
- Country of Birth
- Indigenous Origin
- Language preferred
- Marital Status
• Address of Usual Residence
  • Street Number
  • Street Name
  • Locality
  • Postcode
• Interpreter Service
• Health Insurance Status
• Compensable Status

**Arrival Data Items**
• Facility Code
• Medical Record Number
• Mode of Arrival
• Type of Visit
• Ambulance Case Number
• Patient Arrival Date
• Patient Arrival Time

**Data Items**
• Triage Date
• Triage Time
• Triage Category
• Date Seen by Doctor
• Time Seen by Doctor
• Date Seen by Nurse
• Time Seen by Nurse

**Department Data Items**
• Departure Ready Date
• Departure Ready Time
• Actual Departure Date
• Actual Departure Time
• Mode of Separation
• Referred to on Departure

**Clinical Data Items**
• Primary Diagnosis
• Additional Diagnosis
• Principal Procedure
• Additional Procedures (1-4)

**System Derived Audit Data Items**
• Number of Times “Arrival Time” Changed
• Number of Times “Triage Time” Changed
• Number of Times “Triage Category” Changed
• Number of Times “Time Seen by Doctor” Changed
• Number of Times “Departure Ready Time” Changed
• Number of Times “Actual Departure Time” Changed
• Compliant Status
3.2 The reporting of these data items must comply with the business rules and classifications detailed in the Emergency Department Collection Instruction Manual, updates to the manual that may be made from time to time, and any related Information Bulletins.

3.3 Data submitted electronically must comply with the electronic file layout specifications for the Health Information Exchange.

4. **Data Quality and Error Correction**

4.1 Before data is submitted to the Health Information Exchange all data errors identified by the Emergency Department system must be corrected.

4.2 When the extract is uploaded into the Health Information Exchange, a second check of data quality will be undertaken using the Statewide standard suite of data quality (input edit) checks in the Health Information Exchange. An HIE report will show the records with errors. These records must be corrected in the source system before the extract for the next reporting period is made.

4.3 The date the correction is made to a record will be stored on the Emergency Department system and used to flag that record for inclusion in the next submission.

4.4 If the Emergency Department system has not been updated to the Statewide standards appropriate to the collection period, the record may fail data quality checks and need to be corrected and resubmitted after the system upgrade is installed.

5. **Reporting Requirements**

5.1 The table below shows the due dates for the hospitals listed in Table A, Section 2.2 of this Circular. These hospitals are required to report weekly during the 2001 Winter Strategy (1 May to 30 September 2001) and then monthly from 1 October 2001.

<table>
<thead>
<tr>
<th>Start Date - (12:00am) - Monday</th>
<th>End Date - (11:59pm) - Sunday</th>
<th>Due Date in HIE 5pm Thursday</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 April 2001</td>
<td>6 May 2001</td>
<td>10 May 2001</td>
</tr>
<tr>
<td>7 May 2001</td>
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<tr>
<td>6 August 2001</td>
<td>12 August 2001</td>
<td>16 August 2001</td>
</tr>
</tbody>
</table>
22. STATISTICAL INFORMATION AND DATA

<table>
<thead>
<tr>
<th>Start Date (12:00am) - First Calendar Day</th>
<th>End Date (11:59pm) - Last Calendar Day</th>
<th>Due Date in HIE - 5th Working Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 August 2001</td>
<td>19 August 2001</td>
<td>23 August 2001</td>
</tr>
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<td>10 September 2001</td>
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</tr>
<tr>
<td>24 September 2001</td>
<td>30 September 2001</td>
<td>4 October 2001</td>
</tr>
</tbody>
</table>

5.2 Each weekly data extract must be for the period 12:00am Monday to 11:59pm Sunday. Each monthly data extract must be for the period 12:00am of the 1st calendar day of the month to 11:59pm on the last calendar day of the month.

5.3 The table below shows the due dates for the hospitals listed in Table B, Section 2.3 of this Circular. These hospitals are required to report monthly from 1 May to 30 June 2002.

<table>
<thead>
<tr>
<th>Start Date (12:00am) B First Calendar Day</th>
<th>End Date (11:59pm) B Last Calendar Day</th>
<th>Due Date in HIE - 5th Working Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 May 2001</td>
<td>31 May 2001</td>
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<td>8 January 2002</td>
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<tr>
<td>1 January 2002</td>
<td>31 January 2002</td>
<td>7 February 2002</td>
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<tr>
<td>1 February 2002</td>
<td>28 February 2002</td>
<td>7 March 2002</td>
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<tr>
<td>1 March 2002</td>
<td>31 March 2002</td>
<td>8 April 2002</td>
</tr>
<tr>
<td>1 April 2002</td>
<td>30 April 2002</td>
<td>6 May 2002</td>
</tr>
<tr>
<td>1 May 2002</td>
<td>31 May 2002</td>
<td>7 June 2002</td>
</tr>
<tr>
<td>1 June 2002</td>
<td>30 June 2002</td>
<td>5 July 2002</td>
</tr>
</tbody>
</table>
5.5 Data for the Emergency Department Data Collection must be successfully uploaded into the Health Service’s Health Information Exchange (HIE) by the due dates listed in the due date tables. This local upload process will automatically copy the file and upload it into the Department’s Health Information Exchange.

5.6 In the event that the upload process into the local Health Information Exchange has not been successful by the due date, the Data Management Unit must be contacted before midday of that day and an direct submission direct to the Department arranged.

6. Compliance Monitoring

6.1 The NSW Health Department will monitor compliance with the reporting requirements set in this circular and produce compliance reports for each reporting period. The compliance will be based on the data in the NSW Health Department’s Health Information Exchange by the due date.

6.2 The monthly compliance reports will be distributed to the Health Service Chief Executive Officers, NSW Health Department’s Performance Monitoring Branch and the Performance and Finance Committee.

7. Emergency Department Collection Coordinators

7.1 It is a Health Service responsibility to assign a staff member as the Health Service’s Emergency Department Collection (EDC) Coordinator. At times when the usual EDC Coordinator is on leave or is absence for any other reason, another staff member must also be assigned to this role.

7.2 The contact details for the EDC Coordinator and the Acting/Backup EDC Coordinator must be registered with the Data Management Unit to enable ready communication with areas about Emergency Department data.

7.3 It is the role of the EDC Coordinator to:
- contact sites in advance of each due date to remind them about the reporting requirements (if this is required);
- monitor each facility’s progress towards meeting the reporting requirements in the days leading up to the due date and contact sites who do not appear to be on target;
- coordinate each upload of data relevant to the EDC into the HIE with the local HIE administrator;
- confirm that uploads to the HIE have been successful by the due date and liaise with sites and the HIE administrator to resolve any uploading issues;
- contact the Data Management Unit by midday of the due date if there are uploading issues, to arrange an alternative data submission for that period;
- monitor data quality;
- ensure error reports are distributed and errors are corrected and resubmitted;
- continue to pursue hospitals who failed to meet a reporting requirements until such time that the reporting requirements is met.
8. **Security of Data**

8.1 The Privacy Manual for Health Information (March 2015) must be observed for all data.

8.2 Data sent between sites in an electronic format (for example, via electronic mail over the Internet, or on media such as a diskette between hospitals, or between hospitals and Health Services) must be encrypted and password protected using a self-extracting encryption and compression package. The password must be provided separately. Commercial encryption programs are available from sellers of PC software.

8.3 Data sent in a hard copy (paper) format must be kept secure at all times. This means records must be transported in securely locked cases or be sent by secure post (or courier) using a service that records the name of persons handling the data.

9. **EDC Information - Access and Dissemination**

9.1 The NSW Health Department maintains the most up-to-date information about the Emergency Department Collection, and other data collections, on-line on HealthNet and HealthWeb (the NSW Health Intranet and Internet sites):


9.2 The EDC Coordinator, the acting/backup EDC Coordinator, and at least one staff member of each hospital’s Emergency Department must have access HealthNet and have an e-mail account. This is required for the efficient and direct distribution of information relating to the Emergency Department Collection. Error report distribution via e-mail to hospital Emergency Departments is recommended as a means of increasing timeliness.

10. **Contact Information**

10.1 For further information about this circular or the Emergency Department Collection, contact:

- **Roman Leszczynski**  
  Phone (02) 9391 9995; E-mail: rlesz@doh.health.nsw.gov.au

10.2 Requests for further information about this circular may also be faxed to the Data Management Unit on (02) 9391 9070.
This document supersedes PD2005_591 and is a Policy Directive that applies to the Department of Health and public health organisations listed under the Health Services Act and the Health Administration Corporation.

Introduction

This policy document relates to the continuation of the NSW Sub-acute and Non-Acute Patient Data Collection, which began on 1 July 1999. One of its primary functions is to assist in the development of the casemix classification for sub-acute and non-acute care. Its scope includes rehabilitation, palliative care, geriatric psychiatry, nursing home type maintenance care and some aged care. The project was undertaken in recognition that the DRG system is not appropriate for the classification of this form of care.

The collection has been modified from 1 July 2007 to ensure that it will:
- Continue to provide NSW with appropriate data for the casemix classification of sub-acute and non-acute patient care; and
- Satisfy all requirements for Commonwealth and NSW Health reporting.

Collection of all data elements should be backdated to 1st July 2007 to comply with Commonwealth reporting requirements.

Details of the following issues are included:
1. Summary of Changes
2. Intended Audience
3. Scope of the data collection
4. Reporting methods
5. Reporting requirements
6. Compliance Monitoring
7. Mandatory Data Elements/items
8. Data quality
9. Security of the data
10. Contact Information

1. Summary of Changes

- Submission deadline has been changed from “the fifth working day of the second month following end of each quarter” to “the last working day of the month following the end of each quarter”.
- Section 6 on Compliance Monitoring has been amended to reflect the specific areas for analysis and proposed feedback reporting to Area Health Services and submitting units.
- Data quality - validation and reconciliation instructions amended.
- Added list of abbreviations
22. STATISTICAL INFORMATION AND DATA

1.1 Added a list of abbreviations for reference purposes

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCA</td>
<td>Australian Health Care Agreements</td>
</tr>
<tr>
<td>AN-SNAP</td>
<td>Australian Sub-Acute and Non-Acute Patient Classification</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis Related Group</td>
</tr>
<tr>
<td>DVA</td>
<td>Department of Veterans’ Affairs</td>
</tr>
<tr>
<td>FIM</td>
<td>Functional Independence Measure</td>
</tr>
<tr>
<td>GEM</td>
<td>Geriatric Evaluation &amp; Management</td>
</tr>
<tr>
<td>HIE</td>
<td>Health Information Exchange</td>
</tr>
<tr>
<td>HoNOS</td>
<td>Health of the Nation Outcome Scales</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>PD</td>
<td>Policy Directive</td>
</tr>
<tr>
<td>RUG-ADL</td>
<td>Resource Utilisation Group – Assisted Daily Living</td>
</tr>
<tr>
<td>SNAP</td>
<td>Sub-Acute and Non-Acute Patient</td>
</tr>
</tbody>
</table>

1.2 Data items changed to “Optional”

Please note: Provision of these data items has been made “optional” and reporting of them through SNAPshot is no longer mandatory. SNAP Designated Units may still collect these data in the current software for local analysis and reporting purposes.

- Country of Birth
- Preferred Language
- Usual Address 1
- Usual Address 2
- Usual Suburb

1.3 Added data items

- Added Multidisciplinary Care Plan Established Prior to Discharge (Outpatient Care) - new data item for AHCA Quality Indicator Reporting) - added to collect data for referrals from SNAP Inpatient Rehabilitation services to Outpatient non-admitted patient care.
- Added Multidisciplinary Care Plan Established Prior to Discharge (Other Non-admitted Patient Care) - new data item for AHCA Quality Indicator Reporting) - added to collect data for referrals from SNAP Inpatient Rehabilitation services to Community and Outreach non-admitted patient care.

1.4 Modified data items

- Phase RUG-ADL scores - text change only.
- Date of FIM Assessment At Start of rehabilitation episode (FIM on Admission) (AHCA Quality Indicator Reporting)* - Removed repetition of long title “Functional Independence Measure” and added (AHCA Quality Indicator Reporting) in the text.
- Date of FIM Assessment At End of rehabilitation episode (FIM on Admission) (AHCA Quality Indicator Reporting)* - Removed repetition of long title “Functional Independence Measure” and added (AHCA Quality Indicator Reporting) in the text.
- Date Rehab Care Plan Established added but not a mandatory data item.
- Date Discharge Care Plan Established added but not a mandatory data item.
- GEM Data items for same as those reported for Rehabilitation Episodes and both case types have been bundled together.
- HoNOS (Health of Nation Outcome Scales) removed repetition of long title from text.
1.5 Changes to Code-sets

Mode of Episode End (Episode Type = 1)

1. Discharged to usual accommodation
2. Discharged to interim accommodation
3. Death - Bereavement phase end or death (Bereavement phase counted where Reason for Episode End = “Death” from 1st July 2007)
4. Discharged/transferred to another hospital
5. Changed from sub-acute/non-acute to acute care - different ward
6. Changed from sub-acute/non-acute to acute care - same
7. Change of care type within sub-acute/non-acute
8. Discharge at own risk
9. Other

Mode of Episode End - (Episode Type = 2, 3 or 4)

A. Discharge/case closure
B. Bereavement phase end or death
C. Admitted to inpatient SNAP Unit
D. Change from SNAP ambulatory to acute hospital care
E. Transfer to another SNAP service provider or primary care
F. Chg of epis type (between sameday admit, outpat or commun)
G. Not known

2. Intended Audience

This document is intended for distribution to staff involved in implementing, collecting and supplying data for the SNAP Data Collection. This includes:
- Area SNAP Data Collection Coordinators;
- Facility SNAP Data Collection Coordinators;
- Staff of SNAP services (palliative care, rehabilitation, psychogeriatric care, geriatric evaluation and management, and maintenance care services); and
- Medical records staff.

3. Scope of the data collection

The SNAP data collection is a statewide collection which allows for benchmarking of functional outcomes across services, the planning of services, providing appropriate funding and a greater understanding of the diversity that exists within sub-acute and non-acute care.

SNAP data must be collected for all overnight episodes of care with one of the following care/case types: palliative care, rehabilitation, psychogeriatric care, geriatric evaluation and management, and maintenance care, if the care is provided in a designated SNAP Inpatient service.

A Designated SNAP inpatient service is one that meets the following criteria:
- The service has a distinct area and location within a hospital campus.
22. STATISTICAL INFORMATION AND DATA

- The service has dedicated clinical staff.
- The service has 4 or more available beds.
- Patients who meet the definition of one or more of the sub-acute and non-acute care types (palliative care, rehabilitation, psychogeriatric care, geriatric evaluation and management, and maintenance care) account for a minimum of 75 percent of the occupied bed days for the service.
- Less than 75% of all episodes of care are classified as maintenance type

4. Reporting methods

Proprietary software called SNAPshot is currently used by most services to collect and submit SNAP data. The current version of the software, SNAPshot 3.8, includes enhanced reporting/extract capabilities, which allow for extracted data to be loaded into Area Health Information Exchange (HIE). Data submissions should be provided to the NSW Department of Health via the HIE.

5. Reporting requirements

Reporting of SNAP data in NSW is necessary in order to comply with Australian Health Care Agreement reporting of quality indicators.

Quarterly extracts must be made for the period of 12.00am of the 1st calendar day of the quarter to 11.59 pm on the last calendar day of the quarter.

The extracts should be submitted to Area Coordinators and pass data quality checks by the 15\(^{th}\) working day of the month following each quarter. The Area SNAP Data Collection Coordinator should review data for completeness and to address any identified errors found in local submissions. Following extensive quality checks, Area Coordinators are to submit the data to the NSW SNAP Coordinator by the last working day of the month following the end of each quarter. The following table summarises the due dates for data submission.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Submissions</th>
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<tbody>
<tr>
<td>Financial Quarter</td>
<td>Date Range</td>
</tr>
<tr>
<td>1 Jul-Sep</td>
<td>1 January - 31 March</td>
</tr>
<tr>
<td>2 Oct-Dec</td>
<td>1 April - 30 June</td>
</tr>
<tr>
<td>3 Jan-Mar</td>
<td>1 July - 30 September</td>
</tr>
<tr>
<td>4 Apr-Jun</td>
<td>1 October - 31 December</td>
</tr>
</tbody>
</table>

Each Area SNAP Coordinator must ensure that the SNAP data extract files have been loaded successfully into each Area Health Service HIE by the due dates listed in the above table. The Area Health Service HIE should automatically upload to the Department’s Health Information Exchange following loading of new data at the local level.

6. Compliance Monitoring

The NSW Department of Health will monitor compliance with the reporting requirements set in this policy and the quality of data submitted. It will provide an analysis of compliance issues including timeliness of submission, number and frequency of non-reporting of mandatory data items and comparisons with previous submissions. Failure to comply with all reporting requirements and within the submission deadlines may incur penalties.

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Quarterly compliance reports will be distributed to SNAP Coordinators, Area Chief Executives and Directors of Clinical Networks.

7. **Mandatory Data Elements/items**

The following data items, unless otherwise stated, are mandatory and must be collected and reported for all completed SNAP overnight admitted patient episodes of care provided in designated SNAP services in public facilities:

**Demographic elements**
- Accommodation post discharge
- Compensable status
- Date of Birth
- Department of Veterans’ Affairs (DVA) Card Type
- Department of Veterans’ Affairs File number
- Indigenous status
- Medical record number
- Mental health legal status
- Sex
- Type of accommodation prior to admission
- Usual Post Code

**Episode elements**
- Facility code
- Provider Unit code
- Episode Begin Date
- Mode of Episode Start
- Assessment Only
- Assessment Type
- Case Type
- Episode Type
- Funding source for hospital patient
- Model of Care
- Episode End Date
- Mode of Episode End
- Leave Days

**Palliative Care Phase elements**
- Palliative Care Phase Begin Date
- Palliative Care Phase
- Phase RUG-ADL scores At Start of phase
- Phase RUG-ADL scores At End of phase
- Reason for Phase End
- Palliative Care Phase End Date
- AN-SNAP Classification
- SNAP Class Status
- Length of stay - Palliative Care phase
Rehabilitation and Geriatric Evaluation and Management (GEM) Episodes
- Impairment code
- FIM scores, Motor and Cognitive, at start and at end of rehabilitation episode
- Date of FIM Assessment At Start of rehabilitation episode (FIM on Admission)
- Date of FIM Assessment At End of rehabilitation episode (FIM on Discharge)
- Multidisciplinary Care Plan Established Prior to Discharge (Outpatient Care)
- Multidisciplinary Care Plan Established Prior to Discharge (Other Non-admitted Patient Care)
- Barthel Index score - begin
- Barthel Index score - end
- Barthel Maximum score - begin
- Barthel Maximum score - end
- AN-SNAP Classification
- SNAP Class Status
- Length of stay - Overnight stay episode

Psychogeriatric Care Episodes
- Focus of Care
- HoNOS Scores At Start of episode
- HoNOS Scores At End of episode
- AN-SNAP Classification
- SNAP Class Status
- Length of stay - Overnight stay episode

Maintenance Care Episodes
- Maintenance Type
- RUG-ADL scores At start of episode
- RUG-ADL scores At End of episode
- AN-SNAP Classification
- SNAP Class Status
- Length of stay - Overnight stay episode

8. Data quality

Data quality checks are made to ensure that all fields are complete and there are no inconsistencies in the data in a particular record.

The quality of data submitted to the NSW Department of Health for the SNAP data collection will be determined using standard data quality checks by the NSW SNAP Coordinator and feedback will be provided to Area Coordinators in a timely manner.

Incomplete and/or records with errors will be returned to the area of origin and must be corrected and returned to the Department of Health within 15 working days of receipt of the Data Quality Feedback reports.

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1 AHCA Quality Indicator Reporting
2 ibid
3 Barthel scores required only where FIM Assessment scores not used
22. STATISTICAL INFORMATION AND DATA

In order to validate the number of SNAP episodes reported, Area SNAP Coordinators should reconcile the data submission against Health Information Exchange admitted patient episode data where possible.

9. Security of the data

Data not submitted through the Area and Departmental Health Information Exchange must comply with regulations outlined in the Privacy Manual for Health Information (March 2015) and the Privacy Management Plan (PD2015_036).

10. Contact Information

For further information about this policy or the NSW SNAP Data collection, contact:

Jill Marcus
NSW SNAP Coordinator
Phone: (02) 9391 9897
Email: jmarc@doh.health.nsw.gov.au
1. **Introduction**

This circular details the following issues in relation to the Inpatient Statistics Collection (ISC) from 1 July 2001:

1. Introduction
2. Scope and Coverage
3. Data Items to be Reported
4. Methods of Reporting
5. Data Resubmission
6. Data Quality
7. Reporting Requirements
8. Fines
9. Access to Penalty Payment Revenue
10. Compliance Monitoring
11. Roles and Responsibilities
12. Security of Data
13. Collection Resources
14. Tools and Access Required
15. Contact Information

1.2 It is essential that this circular be distributed to all staff involved in collecting and supplying data for the ISC. This includes ISC coordinators, medical record staff, admissions staff and Emergency Department staff who admit patients.

2. **Scope and Coverage**

2.1 The Inpatient Statistics Collection covers all patients admitted to public hospitals, public psychiatric hospitals, public multi purpose services, private hospitals, private day procedure centres, and sleep disorder centres. The collection excludes private residential aged care facilities, Commonwealth funded residential aged care facilities and beds, and hospital boarders.

2.2 An “admitted patient” is defined as a person who undergoes a hospital’s formal admission process to receive treatment and/or care. This treatment and/or care can occur in hospital and/or in the person’s home (for hospital-in-the-home patients). The patient may be admitted if one or more of the following apply:

- the patient’s condition requires clinical management and/or facilities not available in their usual residential environment;
- the patient requires observation in order to be assessed or diagnosed;
- the patient requires at least daily assessment of their medication needs;
- the patient requires a procedure, or number of procedures, that cannot be performed in a stand-alone facility, such as a doctor’s room without specialised support facilities and/or expertise available (eg cardiac catheterisation);
- there is a legal requirement for admission (eg under child protection legislation);
- the patient is aged nine days or less.
2.3 Persons seeking aged care respite at facilities with Commonwealth funded residential aged care beds should be registered as aged care residents at the facility, rather than admitted as patients, and are excluded from the collection. This activity is reported instead to the Residential Aged Care Collection. When respite is provided to a person for reasons other than he/she is requiring aged care (e.g. because the person requires respite care because he/she is intellectually impaired) the person should be admitted as a patient and reported to the Inpatient Statistics Collection.

2.4 The following facilities are in scope of the collection and must report inpatient activity to the Area Health Service and Department to the specifications in this circular.

### Central Sydney Area Health Service (X100)

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Code</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balmain Hospital</td>
<td>A201</td>
<td>Public</td>
</tr>
<tr>
<td>Canterbury Hospital</td>
<td>A202</td>
<td>Public</td>
</tr>
<tr>
<td>Concord Hospital</td>
<td>A237</td>
<td>Public</td>
</tr>
<tr>
<td>Royal Prince Alfred Hospital</td>
<td>A208</td>
<td>Public</td>
</tr>
<tr>
<td>Rozelle Hospital</td>
<td>A101</td>
<td>Dental</td>
</tr>
<tr>
<td>RPAH Institute of Rheumatology &amp; Orthopaedics</td>
<td>A239</td>
<td>Public</td>
</tr>
<tr>
<td>Thomas Walker Hospital</td>
<td>A236</td>
<td>Public</td>
</tr>
<tr>
<td>Tresillian Hospital Petersham</td>
<td>A230</td>
<td>Public</td>
</tr>
<tr>
<td>Tresillian Hospital Willoughby</td>
<td>A230</td>
<td>Public</td>
</tr>
<tr>
<td>United Dental Hospital</td>
<td>C153</td>
<td>Dental</td>
</tr>
</tbody>
</table>

### Northern Sydney Area Health Service (X105)

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Code</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gladesville Macquarie Hospital</td>
<td>B101</td>
<td>Psyc</td>
</tr>
<tr>
<td>Greenwich Home of Peace Hospital</td>
<td>B208</td>
<td>Public</td>
</tr>
<tr>
<td>Hornsby and Ku-ring-gai Hospital</td>
<td>B210</td>
<td>Public</td>
</tr>
<tr>
<td>Manly District Hospital</td>
<td>B212</td>
<td>Public</td>
</tr>
<tr>
<td>Mona Vale District Hospital</td>
<td>B214</td>
<td>Public</td>
</tr>
<tr>
<td>Neringah Hospital</td>
<td>B209</td>
<td>Public</td>
</tr>
<tr>
<td>Royal North Shore Hospital</td>
<td>B218</td>
<td>Public</td>
</tr>
<tr>
<td>Royal Rehabilitation Centre</td>
<td>B221</td>
<td>Public</td>
</tr>
<tr>
<td>Ryde Hospital</td>
<td>B224</td>
<td>Public</td>
</tr>
<tr>
<td>Sydney Dialysis Centre</td>
<td>B219</td>
<td>Public</td>
</tr>
</tbody>
</table>

### Western Sydney Area Health Service (X120)

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Code</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auburn Hospital</td>
<td>D201</td>
<td>Public</td>
</tr>
<tr>
<td>Blacktown Hospital</td>
<td>D203</td>
<td>Public</td>
</tr>
<tr>
<td>Cumberland Hospital</td>
<td>D102</td>
<td>Psyc</td>
</tr>
<tr>
<td>Lottie Stewart Hospital</td>
<td>D217</td>
<td>Public</td>
</tr>
<tr>
<td>Mount Druitt Hospital</td>
<td>D218</td>
<td>Public</td>
</tr>
<tr>
<td>St Joseph’s Hospital</td>
<td>D213</td>
<td>Public</td>
</tr>
<tr>
<td>Westmead Hospital</td>
<td>D224</td>
<td>Public</td>
</tr>
</tbody>
</table>
22. STATISTICAL INFORMATION AND DATA

### Wentworth Area Health Service (X125)

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Code</th>
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<tbody>
<tr>
<td>Blue Mountains District Anzac Memorial Hospital</td>
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</tr>
<tr>
<td>Nepean District Hospital, Penrith</td>
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<tr>
<td>Springwood Hospital</td>
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<tr>
<td>Tresillian Hospital Wentworth</td>
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### South Western Area Health Service (X130)

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<tr>
<td>Bankstown-Lidcombe Hospital</td>
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<tr>
<td>Bowral and District Hospital</td>
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<tr>
<td>Braeside Hospital</td>
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<tr>
<td>Camden Hospital</td>
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<tr>
<td>Campbelltown Hospital</td>
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<tr>
<td>Fairfield Hospital</td>
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<tr>
<td>Karitane Child &amp; Family Health Services</td>
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<td>Liverpool Hospital</td>
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### Central Coast Area Health Service (X135)

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<td>Long Jetty Hospital</td>
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<tr>
<td>Denman Hospital</td>
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<tr>
<td>Dungog and District Hospital</td>
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<tr>
<td>James Fletcher Hospital - Hunter Hospital Site</td>
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<tr>
<td>James Fletcher Hospital - Morisset Hospital Site</td>
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<tr>
<td>John Hunter Hospital</td>
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<tr>
<td>Kurri Kurri District Hospital</td>
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<tr>
<td>Maitland Hospital</td>
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<td>Muswellbrook District Hospital</td>
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<tr>
<td>Nelson Bay &amp; District Polyclinic</td>
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<td>Newcastle Mater Misericordiae Hospital</td>
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<tr>
<td>Royal Newcastle Hospital</td>
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<td>Scott Memorial Hospital</td>
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<td>Singleton District Hospital</td>
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<td>Coledale Hospital</td>
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<tr>
<td>David Berry Hospital</td>
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<tr>
<td>Milton-Ulladulla Hospital</td>
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<td>Port Kembla District Hospital</td>
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<tr>
<td>Shellharbour Hospital</td>
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<tr>
<td>Shoalhaven District Memorial Hospital</td>
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South Eastern Sydney Area Health Service (X155)

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<td>Gower Wilson Memorial Hospital</td>
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<td>Prince Henry Hospital</td>
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<td>Prince of Wales Hospital</td>
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<td>Royal Hospital for Women</td>
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<td>Sacred Heart Hospice</td>
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<tr>
<td>St George Hospital</td>
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<td>St Vincent’s Hospital</td>
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<td>Sutherland Hospital</td>
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<tr>
<td>Sydney Children’s Hospital</td>
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<td>Sydney-Sydney Eye Hospital</td>
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The Children’s Hospital at Westmead (X160)

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Corrections Health Service (X170)

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<td>Corrections Health - Mulawa</td>
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Northern Rivers Area Health Service (X400)

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<td>Ballina Hospital</td>
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<tr>
<td>Bonalbo Hospital</td>
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<tr>
<td>Byron District Hospital</td>
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<tr>
<td>Campbell Hospital</td>
<td>H205</td>
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<tr>
<td>Casino &amp; District Memorial Hospital</td>
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<tr>
<td>Grafton Base Hospital</td>
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<td>Kyogle Memorial Hospital</td>
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<td>Lismore Base Hospital</td>
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<td>Maclean District Hospital</td>
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<tr>
<td>Urbenville and District Multi-Purpose Centre</td>
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Mid North Coast Area Health Service (X410)

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<td>Coffis Harbour and District Hospital</td>
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<td>Dorrigo Multi-Purpose Centre</td>
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<tr>
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<tr>
<td>Kempsey District Hospital</td>
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<tr>
<td>Macksville &amp; District Hospital</td>
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<td>Manning River Base Hospital</td>
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<tr>
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<tr>
<td>Wingham &amp; District War Memorial Hospital</td>
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### New England Area Health Service (X420)

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<td>Barraba and District Hospital</td>
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<td>Bingara District Hospital</td>
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<td>Boggabri District Hospital</td>
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<td>Manilla District Hospital</td>
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### Macquarie Area Health Service (X430)

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<td>Coonabarabran District Hospital</td>
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### Mid Western Area Health Service (X440)

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### Great West Area Health Service (X450)

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### Greater Murray Area Health Service (X460)

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<td>Narrandera District Hospital</td>
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<td>Public</td>
</tr>
<tr>
<td>Temora and District Hospital</td>
<td>R216</td>
<td>Public</td>
</tr>
<tr>
<td>Tocumwal Hospital</td>
<td>M214</td>
<td>Public</td>
</tr>
</tbody>
</table>
### Data Items to be Reported

3.1 From 1 July 2001 the Inpatient Statistics Collection covers all data items reported to the HIE for admitted patients. Some data items are mandatory for every patient while other data items are mandatory for some patient groups only. Some data items are optional and only reported where collected as a matter of course.

3.2 In the table of data items below “Mandatory” indicates a valid value must be reported for every admitted patient. Where the value is unknown or unable to be determined, the code for “unknown” must be reported. “Conditional” indicates a valid value must be reported where the information is required for a particular type of patient (defined in the associated instruction), or only where the data is collected for a local requirement and thus available to report.

3.3 The data items listed for the collection include those required to derive a State standard data item, or comply with a Statewide policy, but not required for any other purpose by the Department. These data items, while included in the scope of the collection, may only need to be stored on the Area’s Patient Administration System or the Area’s Health Information Exchange (HIE). In the table of data items to follow (see section 3.5) data items that must be stored on the Area’s Patient Administration System only are flagged with “PAS”, data items that must be stored on the Area Area’s HIE are flagged with “Area” and data items that must be submission to the Department’s HIE are flagged with “DoH”.

<table>
<thead>
<tr>
<th>Southern Area Health Service (X470)</th>
<th>Facility Name</th>
<th>Code</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bateman’s Bay Hospital</td>
<td>N201</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Bega District Hospital</td>
<td>N202</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Bombala District Hospital</td>
<td>N203</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Boorowa District Hospital</td>
<td>N204</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Braidwood Multi-Purpose Centre</td>
<td>N205</td>
<td>MPS</td>
<td></td>
</tr>
<tr>
<td>Cooma Hospital</td>
<td>N206</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Crookwell District Hospital</td>
<td>N207</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Delegate Multi-Purpose Centre</td>
<td>N208</td>
<td>MPS</td>
<td></td>
</tr>
<tr>
<td>Goulburn Base Hospital</td>
<td>N209</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Kenmore Hospital</td>
<td>N101</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>Mercy Care Centre</td>
<td>N210</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Moruya District Hospital</td>
<td>N211</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Murrumburrah-Harden District Hospital</td>
<td>N213</td>
<td>Public</td>
<td></td>
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<tr>
<td>Pambula District Hospital</td>
<td>N214</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Queanbeyan District Hospital</td>
<td>N215</td>
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<tr>
<td>St John of God Hospital</td>
<td>N216</td>
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<tr>
<td>Yass District Hospital</td>
<td>N217</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>Young District Hospital</td>
<td>N218</td>
<td>Public</td>
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</tr>
</tbody>
</table>
The table below shows the codes used to describe the nature of any change to a data item since the previous collection year in the table of data items presented in section 3.5.

<table>
<thead>
<tr>
<th>Code</th>
<th>Indicates Y</th>
</tr>
</thead>
</table>
| L    | Data Item Label Change - The data item has had a label (i.e. name) change. Label changes may occur to align with national standards, improve user understanding or respond to recommendations from specialist groups.  
**Example:** “Indigenous Origin” has changed to “Aboriginal and Torres Strait Islander Origin” |
| B    | Business Rule Changes - The data item instructions contain a business rule related to this data item that has changed. This change is usually required to align with national reporting requirements or standardise business practice.  
**Example:** Business rules for “Urgency of Admission” have changed to reflect national reporting requirements for obstetric admissions. |
| A    | Annual Update - The data item has new or retired codes and this occurs each collection year.  
**Example:** “Reporting Facility” code set has new codes for private facilities that have opened in previous year, facility name changes, and closures. |
| U    | Updated Classification - The data items that have a classification that differs from the previous year. Such a change occurs to standardise information across collections and align with national reporting requirements.  
**Example:** “Country of Birth” will change to align with national standards, which are used in NSW Health community data collections. |
| O    | Other Change - The data item instruction has changed in another way, such as a change in the recommended local code/display values, or the data item should be reported using a different field length or set of fields.  
**Example:** “Client’s Name” has increased in length and must be reported in 3 separate fields. |
### 22. STATISTICAL INFORMATION AND DATA

#### 3.5

The list below identifies the data items covered by the Inpatient Statistics Collection from 1 July 2001.

<table>
<thead>
<tr>
<th>Data Item Label</th>
<th>Status</th>
<th>New Item</th>
<th>Change Type</th>
<th>HIE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Record Identifiers</strong></td>
<td></td>
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</tr>
<tr>
<td>Reporting Facility</td>
<td>Mandatory</td>
<td>No</td>
<td>A, L</td>
<td>DOH</td>
</tr>
<tr>
<td>Admitted Patient Stay Identifier</td>
<td>Mandatory</td>
<td>Yes</td>
<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Admitted Patient Episode Identifier</td>
<td>Mandatory</td>
<td>Yes</td>
<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Admitted Patient Record Update Date</td>
<td>Mandatory</td>
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<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td><strong>Stay Record Dates and Times</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Formal Admission Date and Time</td>
<td>Mandatory</td>
<td>No</td>
<td>L</td>
<td>DOH</td>
</tr>
<tr>
<td>Formal Discharge Date and Time</td>
<td>Mandatory</td>
<td>No</td>
<td>L, B</td>
<td>DOH</td>
</tr>
<tr>
<td><strong>Patient Identifiers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client’s Name</td>
<td>Mandatory</td>
<td>No</td>
<td>L, O</td>
<td>DOH</td>
</tr>
<tr>
<td>Client’s Alias Names</td>
<td>Conditional</td>
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<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Medical Record Number</td>
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<td>No</td>
<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>State Unique Identifier</td>
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<td>DOH</td>
</tr>
<tr>
<td>Medicare Card Number</td>
<td>Conditional</td>
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<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Department of Veterans’ Affairs Card Colour</td>
<td>Conditional</td>
<td>No</td>
<td>L, B</td>
<td>DOH</td>
</tr>
<tr>
<td>Department of Veterans’ Affairs Card Number</td>
<td>Conditional</td>
<td>No</td>
<td>B</td>
<td>DOH</td>
</tr>
<tr>
<td>Health Fund</td>
<td>Conditional</td>
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<td>O</td>
<td>DOH</td>
</tr>
<tr>
<td>Health Fund Membership Number</td>
<td>Conditional</td>
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<td>Nil</td>
<td>DOH</td>
</tr>
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<td>Ambulance Client Number</td>
<td>Conditional</td>
<td>No</td>
<td>B</td>
<td>DOH</td>
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<tr>
<td>Client’s Address of Usual Residence</td>
<td>Mandatory</td>
<td>No</td>
<td>A, O</td>
<td>DOH</td>
</tr>
<tr>
<td>Centrelink Client Number</td>
<td>Conditional</td>
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<td>n.a.</td>
<td>Area</td>
</tr>
<tr>
<td>Client’s Telephone Number Home/Work</td>
<td>Conditional</td>
<td>Yes</td>
<td>n.a.</td>
<td>Area</td>
</tr>
<tr>
<td>Name of Client’s Next of Kin</td>
<td>Conditional</td>
<td>Yes</td>
<td>n.a.</td>
<td>Area</td>
</tr>
<tr>
<td>Name of Client’s Mother and Father</td>
<td>Conditional</td>
<td>Yes</td>
<td>n.a.</td>
<td>Area</td>
</tr>
<tr>
<td>Maiden Name of Client’s Mother</td>
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<td>n.a.</td>
<td>Area</td>
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<td><strong>Patient’s Fixed Demographics</strong></td>
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<tr>
<td>Date of Birth</td>
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<td>Nil</td>
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<td>Estimated Date of Birth Flag</td>
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<td>DOH</td>
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<td>Sex</td>
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<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Country of Birth</td>
<td>Mandatory</td>
<td>No</td>
<td>U</td>
<td>DOH</td>
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<tr>
<td><strong>Patient’s Variable Demographics, Status and Elections</strong></td>
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<tr>
<td>Aboriginal and Torres Strait Islander Origin</td>
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<td>L</td>
<td>DOH</td>
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<td>Medicare Eligibility Status</td>
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<tr>
<td>Marital Status</td>
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<td>U</td>
<td>DOH</td>
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<tr>
<td>Preferred Language</td>
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<td>L</td>
<td>DOH</td>
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<tr>
<td>Hospital Insurance Status on Admission</td>
<td>Mandatory</td>
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<td>U</td>
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<tr>
<td>Private Health Insurance Claim</td>
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<td>Consent for General Practitioner</td>
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<td>PAS</td>
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<td>Data Item Label</td>
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<td>Change Type</td>
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<td><strong>Formal Admission Items</strong></td>
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<td>Urgency of Admission</td>
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<td>L, U</td>
<td>DOH</td>
</tr>
<tr>
<td>Intended Length of Stay</td>
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<td>L</td>
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<tr>
<td>Readmission within 28 Days</td>
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<td>DOH</td>
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<tr>
<td>Contract Status</td>
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<td>B, U</td>
<td>DOH</td>
</tr>
<tr>
<td>Source of Referral</td>
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<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Facility Referred From</td>
<td>Mandatory</td>
<td>No</td>
<td>A</td>
<td>DOH</td>
</tr>
<tr>
<td>Previous Specialised Treatment</td>
<td>Conditional</td>
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<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Year Last Admitted to Designated Psychiatric Unit</td>
<td>Conditional</td>
<td>No</td>
<td>B</td>
<td>DOH</td>
</tr>
<tr>
<td>Type of Accommodation</td>
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<td>n.a.</td>
<td>DOH</td>
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<tr>
<td><strong>Formal Discharge Items</strong></td>
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<td></td>
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<tr>
<td>Mode of Separation</td>
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<td>DOH</td>
</tr>
<tr>
<td>Facility Transferred To</td>
<td>Conditional</td>
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<td>A</td>
<td>DOH</td>
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<tr>
<td>Referred to on Separation</td>
<td>Mandatory</td>
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<td>DOH</td>
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<tr>
<td><strong>Event History Items</strong></td>
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<td>Event Start/End Date and Time</td>
<td>Conditional</td>
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<td>DOH</td>
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<tr>
<td>Financial Class - Master</td>
<td>Mandatory</td>
<td>No</td>
<td>Nil</td>
<td>DOH</td>
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<tr>
<td>Financial Class - Local</td>
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<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Bed Type - Master</td>
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<td>L</td>
<td>DOH</td>
</tr>
<tr>
<td>Mental Health Financial Sub-Program</td>
<td>Conditional</td>
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<td>Nil</td>
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<tr>
<td>Attending Medical Officer - Local</td>
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<td>n.a.</td>
<td>DOH</td>
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<tr>
<td>Ward - Local</td>
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<td>n.a.</td>
<td>DOH</td>
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<tr>
<td>Legal Status</td>
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<td>L, B, U</td>
<td>DOH</td>
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<tr>
<td>Patient Location</td>
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<td>Facility Contracted To/From</td>
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<tr>
<td>Leave Period Start/End Date and Time</td>
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<td>L</td>
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<tr>
<td><strong>General Episode Items</strong></td>
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<tr>
<td>Episode Start Date and Time</td>
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<td>L</td>
<td>DOH</td>
</tr>
<tr>
<td>Episode End Date and Time</td>
<td>Mandatory</td>
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<td>L</td>
<td>DOH</td>
</tr>
<tr>
<td>Service Category - Master</td>
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<td>Nil</td>
<td>DOH</td>
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<tr>
<td>Service Category - Local</td>
<td>Conditional</td>
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<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Mode of Separation for Episode</td>
<td>Mandatory</td>
<td>No</td>
<td>L</td>
<td>DOH</td>
</tr>
<tr>
<td>Palliative Care Status</td>
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</tr>
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<td>Total Hours on Mechanical Ventilation</td>
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<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Unplanned Visit to Theatre</td>
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<td>Nil</td>
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<td>Neonate Admission Weight</td>
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<tr>
<td>Source of Referral to Episode</td>
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<td>Nil</td>
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### Clinical Episode Items

<table>
<thead>
<tr>
<th>Data Item Label</th>
<th>Status</th>
<th>New Item</th>
<th>Change Type</th>
<th>HIE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Diagnosis</td>
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<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Additional Diagnosis</td>
<td>Conditional</td>
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<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Procedures</td>
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<td>Nil</td>
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<td>Date of First Listed Procedure</td>
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<td>Nil</td>
<td>DOH</td>
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<td>Procedure Locations</td>
<td>Conditional</td>
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<td>L, B</td>
<td>DOH</td>
</tr>
<tr>
<td>External Causes of Injury or Poisoning</td>
<td>Conditional</td>
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<td>Nil</td>
<td>DOH</td>
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<tr>
<td>Place of Occurrence of External Cause of Injury</td>
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<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Activity When Injured</td>
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<td>L, B</td>
<td>DOH</td>
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<tr>
<td>Clinical Coding Audit Flag</td>
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### Cancer Notification Items

<table>
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<tr>
<th>Data Item Label</th>
<th>Status</th>
<th>New Item</th>
<th>Change Type</th>
<th>HIE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Site of Cancer</td>
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<td>n.a.</td>
<td>DOH</td>
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<tr>
<td>Morphology of Primary Site of Cancer</td>
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<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Date of Diagnosis of Primary Cancer</td>
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<td>n.a.</td>
<td>DOH</td>
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<tr>
<td>State of Residence at Time of Diagnosis of Primary Cancer</td>
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<td>n.a.</td>
<td>DOH</td>
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<tr>
<td>Name of General Practitioner</td>
<td>Conditional</td>
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<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Mailing Address of General Practitioner</td>
<td>Conditional</td>
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<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>AMO Registration Number of Treating Doctor</td>
<td>Conditional</td>
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<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Laterality of this Primary Cancer</td>
<td>Conditional</td>
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<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Pathology Laboratory</td>
<td>Conditional</td>
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<td>DOH</td>
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<td>Best Basis for Primary Cancer Diagnosis at this Episode</td>
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<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Degree of Spread of Cancer at this Episode</td>
<td>Conditional</td>
<td>Yes</td>
<td>n.a.</td>
<td>DOH</td>
</tr>
</tbody>
</table>

### Attending Medical Officer Items

<table>
<thead>
<tr>
<th>Data Item Label</th>
<th>Status</th>
<th>New Item</th>
<th>Change Type</th>
<th>HIE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Code of Attending Medical Officer</td>
<td>Mandatory</td>
<td>Yes</td>
<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Local Name of Attending Medical Officer</td>
<td>Conditional</td>
<td>Yes</td>
<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Local Address of Attending Medical Officer</td>
<td>Conditional</td>
<td>Yes</td>
<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>NSW AMO Registration Number</td>
<td>Mandatory</td>
<td>No</td>
<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Medicare Provider Number</td>
<td>Mandatory</td>
<td>No</td>
<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Local Specialty</td>
<td>Mandatory</td>
<td>No</td>
<td>Nil</td>
<td>DOH</td>
</tr>
<tr>
<td>Master Specialty</td>
<td>Mandatory</td>
<td>No</td>
<td>Nil</td>
<td>DOH</td>
</tr>
</tbody>
</table>

### Ward Items

<table>
<thead>
<tr>
<th>Data Item Label</th>
<th>Status</th>
<th>New Item</th>
<th>Change Type</th>
<th>HIE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Code of Ward</td>
<td>Mandatory</td>
<td>Yes</td>
<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Local Name of Ward</td>
<td>Conditional</td>
<td>Yes</td>
<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Master Bed Type Default</td>
<td>Conditional</td>
<td>Yes</td>
<td>n.a.</td>
<td>DOH</td>
</tr>
<tr>
<td>Institution Type Default</td>
<td>Conditional</td>
<td>Yes</td>
<td>n.a.</td>
<td>DOH</td>
</tr>
</tbody>
</table>

3.6 The data items listed below are covered by the collection but are data items that will be derived from the collected data items listed above.

**PAS/HIE Derived Event History Data Items**
- Payment Status
- Election Status
- Financial Program
- Unqualified Baby Bed Days during Episode of Care
22. STATISTICAL INFORMATION AND DATA

- Hours in Intensive Care Unit during Episode of Care
- Total Involuntary Days Under *Mental Health Act* during Episode of Care
- Days in Designated Psychiatric Unit during Episode of Care
- Total Leave Days for Episode of Care

**HIE Derived Age Data Items**
- Age at Time of Formal Admission (Days, Months, Years)
- Age at Time of Formal Discharge (Days, Months, Years)
- Age at Start of Episode (Days, Months, Years)
- Age at End of Episode (Days, Months, Years)

**HIE Derived Data Items for National Reporting**
- NHDD: Area of Usual Residence - Version 3 (Statistical Local Area)
- NHDD: Health Insurance Status - Version 3
- NHDD: Department of Veterans’ Affairs Patient – Version 1
- NHDD: Compensable Status – Version 3
- NHDD: Hospital Insurance Status – Version 3
- NHDD: Inter-Hospital Contracted Patient – Version 2
- NHDD: Mode of Admission – Version 4
- NHDD: Mode of Separation – Version 3 #
- NHDD: Number of Qualified Days for Newborns – Version 2
- NHDD: Source of Referral to Public Psychiatric Hospital – Version 3
- NHDD: Mental Health Legal Status – Version 5 #
- NHDD: Funding Source for Hospital Patient – Version 1
- NHDD: Number of Leave Periods – Version 3
- NHDD: Care Type - Version 4
- NHDD: Establishment Identifier – Version 3
- NHDD: Establishment Type – Version 1
- NHDD: Medicare Eligibility Status – Version 1
- NHDD: Person Identifier – 1

*Note:* “NHDD” means “National Health Data Dictionary”, # Indicates item is required for AR-DRG V4.1 derivation.

**HIE Derived Episode Funding Data Items**
- Service Related Group - Version 4.1
- Emergency Department Status
- Intensive Care Unit Status
- Enhanced Service Related Group 2000
- High Costs Complexity Case
- Surgery/Medical/Procedure Indicator
- Casemix Policy Class
- Episode Type
- Length of Stay Trim Point
- Outlier Days 1 – Days above Trim Point to Step Down Point
- Outlier Days 2 – Day Step Down Point to 365 Days
- Cost Weight A1 – Cost Weight, All Costs – 2000 Policy
22. STATISTICAL INFORMATION AND DATA

- Cost Weight D1 – Cost Weight, Excluding ED and ICU – 2000 Policy
- Cost Weight E1 – Cost Weight, All Costs, No Discount – 2000 Policy
- Cost Weight A2 – Cost Weight, All Costs – Original Policy
- Cost Weight D2 – Cost Weight, Excluding ED and ICU – Original Policy

DOHRS Admitted Patient Activity Measures - Monthly Totals

- Number of Formal Admissions
- Number of Formal Discharges
- Number of Admitted Patients at Start
- Number of Admitted Patients at End
- Number of Sameday Episodes
- Number of Transfers In from Another Financial Program
- Number of Transfers Out to Another Financial Program
- Number of Occupied Bed Days
- Number of Never Qualified Births
- Number of Live Births
- Number of Unqualified Baby Bed Days
- Number of Patients Reclassified as a Nursing Home Type Patient
- Number of Formal Admissions for Overnight Renal Dialysis Treatment
- Number of Formal Admission for Overnight Sleep Disorder Treatment

3.7 The reporting of these data items must comply with instructions provided in the ISC Instruction Manual and updates to the manual that may be made from time to time (available on-line on HealthNet and HealthWeb).

3.8 “First Admission to Designated Psychiatric Unit” will cease to be included in the scope of the Inpatient Statistics Collection for separations dated from 1 July 2001. This concept will be captured by “Previous Specialised Treatment” for separation dated from 1 July 2001.

3.9 For separations dated from 1 July 2001, ICD10AM - Version 2 will continue to be the required classification for the reporting clinical codes and the Diagnosis Related Group (DRG) will be Version 4.1.

4. Methods of Reporting

4.1 All public sector facilities must use the HOSPAS, WinPAS, PiMS or Cerner patient administration system to report to the Inpatient Statistics Collection for formal discharges dated from 1 July 2001.

4.2 Facilities with low inpatient activity that do not have HOSPAS, WinPAS, PiMS or Cerner installed at the site may collect ISC data on paper forms for data entry and correction at another site within the Area Health Service that has one of these systems installed, provided due dates can be met.

4.3 Templates of the ISC forms developed by the NSW Health Department are available on Healthnet and HealthWeb. Carbon copy forms will no longer be supported by the Department for public sector sites as photocopies are more legible and last longer. Only forms for 2001/2002 may be used for reporting. Forms for prior years are not suitable as they do not capture the event history required for the 2001/2002 reporting requirements. Areas are responsible for designing and producing their own forms if they find the form supplied by the Department inadequate for their needs.
4.4 The NSW Health Department does not supply clinical coding, data entry, data correction or error report distribution services to public facilities.

5. Data Resubmission

5.1 It is an underlying principle of data warehousing that there should only be one version of information. For this reason, records that are updated in the source system (the patient administration system) must be resubmitted to both the Area HIE and the Department HIE. By default, HIE extracts will capture all new and updated records that occurred between the previous extract and the new extract date.

5.2 As standard practice, coded records may be submitted to the HIE, pass all data quality checks, then be updated and resubmitted at a later date when further relevant information become available (such as pathology reports and coroners reports). This practice allows due dates to be met without compromising data quality or integrity in the HIE.

6. Data Quality

6.1 The quality of data submitted to NSW Health for the Inpatient Statistics Collection will be determined using a standard suite of data quality (input edit) checks in the HIE. A list of the data quality checks is available in the ISC Instruction Manual and on-line through HealthNet at HealthWeb.

6.2 The Area Health Services will need to ensure that data is extract from the patient administration systems and loaded into the Area HIE well in advance of the due date so that error reports can be distributed, corrections can be made in the source system and the Area HIE can be updated with those corrections all before the due date. The Department recommends that data be first loaded in the Area HIE at least 8 to 15 days before the due date.

7. Reporting Requirements

7.1 The due dates for admitted patient dated from 1 July 2001 have been brought forward due to the increased need for accurate data available close to the event to which the information relates. Timely supply of quality data is required to increase the efficiency and effectiveness of business processes throughout NSW Health, reduce costs, and improve patient care.
22. STATISTICAL INFORMATION AND DATA

<table>
<thead>
<tr>
<th>Reporting Requirement</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For all sites</strong> 100% admission, separation and administrative event data (excluding clinical coding and cancer notification items) must be loaded into the Department HIE, and pass all associated data quality checks by the 14th day of the month after the month of the admission, separation or administrative event.</td>
<td>DOHRS admitted patient activity will be automatically calculated by the HIE from July 2001.</td>
</tr>
<tr>
<td><strong>Note:</strong> To support this requirement, HIE extracts have been specified to include every new and updated record since the last HIE extract date.</td>
<td>DOHRS figures must be reported monthly to the Performance and Finance Committee, and to NSW Treasury.</td>
</tr>
<tr>
<td><strong>For remote rural sites</strong> 100% of clinical coding and cancer notification items for DVA patients admitted patient must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 28th calendar day after the day of separation.</td>
<td>NSW Health Department reports to DVA on behalf of each Health Service.</td>
</tr>
<tr>
<td><strong>For remote rural sites</strong> 100% of clinical coding and cancer notification items for non-DVA admitted patient records must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 56th calendar day after the day of separation.</td>
<td>NSW Health has a contract with DVA and this contract requires data to be supplied by due dates.</td>
</tr>
<tr>
<td><strong>For all other sites</strong> 100% of clinical coding and cancer notification items for all admitted patient records must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 28th calendar day after the day of separation.</td>
<td>Timely casemix data is required by NSW Health in the Department and in the Health Service to support:</td>
</tr>
<tr>
<td></td>
<td>* episode funding</td>
</tr>
<tr>
<td></td>
<td>* budget holdings</td>
</tr>
<tr>
<td></td>
<td>* flow reversals</td>
</tr>
<tr>
<td></td>
<td>* capped interstate flow services</td>
</tr>
<tr>
<td></td>
<td>It is acknowledged that remote rural sites require additional time to submit coded data due to a limited coder workforce in remote rural areas.</td>
</tr>
</tbody>
</table>

**Note:** “Administrative Events” are status changes that occur during the patient admission and recorded as transactions on a patient administration system. These events include changes in bed, ward, doctor, financial class, service category, legal status, and leave periods.

7.2 Where additional information relating to a record becomes available (such as additional diagnosis codes obtained from a coroners reports, or a morphology code obtained from a pathology report), or a change is made to a record after the due date, the record must be resubmitted to the HIE with the additional information added. This update may occur after the due date without incurring a fine however any errors associated with that update must be corrected before the next compliance measurement date to avoid a fine.

7.3 To support these due dates Area Health Services will need to:
- create extracts from the patient administration system and submit that extract to the Area HIE at least once per week
  *(Note: this will support regular and timely data correction processes and evenly distributed error correction work loads.)*
• supply data from the Area HIE to the Department HIE by 8pm every Friday, and by 8pm every 14th calendar day of the month
(\textit{Note}: the method for supply data from the Area HIE to the Department HIE changes from file loading to table loading with Version 3.0 of the HIE).

Failure to follow these recommended procedures increases the risk of missed due dates.

8. Fines

8.1 Fines are applied for failure to comply with reporting requirements outlined in this policy. The fines are designed to reflect importance of timely supply of high quality data, and the high cost of non-quality/untimely information, to the NSW Health System.

8.2 An exemption from fines will apply until January 2002 because:
- the new reporting requirements listed in this document mean changes to current work practices and a temporarily increase in resources in medical record departments to clear information backlogs;
- the HIE extracts from PiMS and Cerner supporting the full scope of data required to meet the requirements of the Inpatient Statistics Collection will not be delivered by I-soft and Cerner until October/November 2001;
- the data warehouse functionality required to identify errors, and age errors when corrections are received, are unlikely to be delivered in a production version of the HIE until September 2001;
- after the full HIE extract and error check functionality has been delivered there may be a backlog of errors that needs to be cleared by sites – the extent this backlog will vary by Area Health Service because the investment in staff to monitor data quality and ensure standard correct work practices varies considerably.

8.3 The table below shows the proposed fines for failure to meet the reporting requirement to apply from January 2002.

<table>
<thead>
<tr>
<th>Reporting Requirement</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For all sites</strong> 100% admission, separation and administrative event data (excluding clinical coding and cancer notification items) must be loaded into the Department HIE, and pass all associated data quality checks by the 14th day of the month after the month of the admission, separation or administrative event.</td>
<td>$2 per record per day</td>
</tr>
<tr>
<td><strong>Note:</strong> To support this requirement, HIE extracts have been specified to include every new and updated record since the last HIE extract date.</td>
<td></td>
</tr>
<tr>
<td><strong>For remote rural sites</strong> 100% of clinical coding and cancer notification items for DVA patients admitted patient must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 28th calendar day after the day of separation.</td>
<td>$2 per record per week</td>
</tr>
<tr>
<td><strong>For remote rural sites</strong> 100% of clinical coding and cancer notification items for non-DVA admitted patient records must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 56th calendar day after the day of separation.</td>
<td>$2 per record per week</td>
</tr>
<tr>
<td><strong>For all other sites</strong> 100% of clinical coding and cancer notification items for all admitted patient records must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 28th calendar day after the day of separation.</td>
<td>$2 per record per week</td>
</tr>
</tbody>
</table>
8.4 It is proposed that from January 2002 there will be no exemptions from fines. This means there will be no exemptions when facilities migrate to new patient administration systems and that Health Services must manage their migrations in a manner that avoids delays to the data supply and any drop in data quality.

8.5 From January 2002, fine revenue will not be able to be accessed by sites that consistently fail to meet due dates – instead the fine revenue will be used to reward sites that meet due dates and to implement Statewide data quality and timeliness improvement initiatives determined by the Department.

8.6 While exemptions from penalties will not be available from January 2002, applications to exclude a data quality check from the list used to measure compliance with the requirement to “pass all admitted patient data quality checks” may be made where the data quality check is incorrect, is not applicable to admitted patients, or the data item is unable to be collected due to system limitations. System limitations exclude situations where functionality in the system is available and included in HIE extracts but the Area Health Service did not set-up the system in a manner that facilitates the collection of that data. Submissions of requests for data quality check exclusions must be directed to Manager, Patient Data Management Unit, NSW Health Department.

8.7 Area Health Services may review these fines and provide feedback or alternative recommendations to the Department by 31 October 2001. Correspondence should be directed to the Chief Information Officer, and copied to the Manager, Patient Data Management Unit.

8.8 Following review of the feedback and submissions, the proposed fines and exemption policies listed in this section will become policy from January 2002 unless this circular is superseded by another circular outlining alternative levels of fines and alternative exemption policies.

9. Access to Penalty Payment Revenue

9.1 The Department will use penalty payment revenue to reward sites that consistently meet due dates. This policy has been introduced because:

- sites that consistently meet due dates will be “best practice” sites and thus offer a good training environment for new staff, which may later flow to other sites in other Health Services – they should therefore have access to fine revenue to train more staff in that “best practice” environment;
- sites that consistently meet due dates are likely to have more time to spend on training and coaching than sites that are consistently failing to meet due dates and are likely to share “best practice” procedures with other sites for their benefit;
- there should be an incentive to invest additional resources to meet due dates before the due date, rather than an incentive to miss due dates and incur the fine so to retrospectively compensate for a lack of timely resourcing.

9.2 Sites eligible for the reward may submit fully costed projects proposals that have an outcome of improving data quality and timely reporting of admitted patient. Proposals should be submitted to the Manager, Patient Data Management Unit, Information Management and Support Branch. The Patient Data Supplier Advisory Committee will have an opportunity to advise the Department on the merit of proposals and the Department will ultimately decide how fine revenue will be distributed.
10. **Compliance Monitoring**

10.1 The NSW Health Department will monitor compliance with the reporting requirements set in this circular. The compliance will be based on the data in the NSW Health Department’s HIE by the due date.

10.2 The Data Management Unit will distribute compliance reports to Area Health Service Chief Executive Officers at least once a month, and to the Department’s Performance Monitoring Branch at least once a quarter. Between July and December 2001 the compliance reports will show the Health Service’s progress towards meeting the new due dates and the associated fine that would have been incurred had fines been applied in that period.

11. **Roles and Responsibilities**

11.1 It is the responsibility of the Health Service to assign a staff member as the Health Service’s ISC Coordinator. This position is key person for ensuring timely accurate data for the Health Service and it needs to be adequately resource. The role of the ISC Coordinator is to:

- contact sites in advance of each due date to remind them about the reporting requirements (if this is required);
- monitor each facility’s progress towards meeting the reporting requirements in the days leading up to the due date and contact sites who do not appear to be on target;
- monitor data quality including the coordination of output editing of data;
- coordinate the correction of errors that may be identified by knowledge workers;
- coordinate the extraction of data from patient administration systems and coordinate the uploading into the Area HIE in collaboration with the HIE Coordinator;
- continue to pursue hospitals who failed to meet a reporting requirements until such time that the reporting requirements is met;
- coordinate the distribution of information from the Department to the sites, and coordinate the reply return of information to the Department by the due date set;
- implement work practice changes to eliminate errors at point of first entry and consistently correct work practices at all sites;
- coordinate the migration of paper sites reporting via ISCOS to reporting via a patient administration system, including the coordination of any support that those staff involved in the migration may require;
- coordinate the updates to mapping tables in patient administration systems and check that mappings are correct;
- coordinate distribution of error reports, error correction and data resubmission.

11.2 It is the responsibility of the Health Service to assign a staff member as the Health Service’s HIE Coordinator. In relation to the Inpatient Statistics Collection this person’s role is to:

- Ensure admitted patient data is sent to the Department HIE from the Area HIE by the due dates given in this circular.
- Ensure all extract files from patient administration systems sent for loading into the Area HIE have loaded successfully by the due data.
22. Statistical Information and Data

- Ensure the ISC Coordinator or site is aware of any late, missing or failed extracts.
- Establish processes (automated where possible) and timetables for submissions from the patient administration system to the Area HIE.
- Ensure access to the HIE is available at each site in the medical records department, and that any site without access has an alternative method for accessing HIE error reports in a timely and convenient manner.
- Ensure test environments are available for HIE extract testing where the Area is participating in testing of patient administration system functionality.

11.3 It is the role of the Data Management Unit, NSW Health Department, to provide Statewide management and support for the collection. It is this unit’s role to:
- publish and maintain information about the collection on-line;
- provide advice to Area ISC Coordinators about coding rules, classification definitions, and business rules relating to ISC data items where published information does not adequately address the issue being raised;
- ensure a full range of input data quality checks are available in the HIE and the HIE data quality check functionality meets the business requirements;
- coordinate changes in patient administration systems and the HIE to support Statewide/national reporting requirements and accurate/timely reporting of data at the time of entry;
- issue collection policy, including due dates and penalties, and ensure these policies are appropriate for the business;
- ensure reference tables on the HIE are maintained and distributed in a timely manner to support accurate data quality checks;
- audit patient administration system setups, including mappings from local/display values to Statewide master values;
- ensure data received from Area Health Services has successfully loaded into the Department’s HIE and liaise with the Area HIE and ISC coordinators if a failure has occurred;
- report on data collection compliance to the Executive of the Area and Department, and to the Performance Management Branch.

12. Security of Data

12.1 The Privacy Manual for Health Information (March 2015) must be observed for all data relating to the Inpatient Statistics Collection. Any other related security policy issued by the Department must also be observed.

12.2 Data sent between sites via electronic mail over an open network such as the Internet, or on media such as a diskette between hospitals (or between hospitals and Health Services) must be encrypted and password protected using a self-extracting encryption and compression package. The password must be provided separately. Commercial encryption programs are available from sellers of PC software.

12.3 Data sent in a hard copy (paper) format must be kept secure at all times. This means records must be transported in securely locked cases or be sent by secure post (or courier) using a service that records the name of persons handling the data.
22. STATISTICAL INFORMATION AND DATA

13. Collection Resources

13.1 The NSW Health Department maintains the most up-to-date information about the Inpatient Statistics Collection, and other data collections, on-line on HealthNet and HealthWeb (the NSW Health Intranet and Internet sites). At least one staff member of each hospital’s medical record department should have access to either HealthNet or HealthWeb. The sites are located at the URLs below:


14. Tools and Access Required

14.1 To meet due dates medical record department staff must have at least one e-mail account and access to the HIE. This is required for the efficient and direct distribution of information relating to the Inpatient Statistics Collection, including compliance reports and data quality reports.

14.2 Medical records department staff will also require business objects for standard reports, and a tool to perform adhoc queries on the HIE.

15. Contact Information

15.1 For further information about this circular or the Inpatient Statistics Collection, contact:

Nora Etmekdjian Phone: (02) 9391 9097; E-mail: netme@doh.health.nsw.gov.au
Roman Leszczynski Phone (02) 9391 9995; E-mail: rlesz@doh.health.nsw.gov.au

15.2 Requests for further information about this circular may also be faxed to the Patient Data Management Unit on (02) 9391 9070.

CLIENT REGISTRATION POLICY (PD2007_094)

1. Introduction

1.1 What is client registration?

Client registration is the process of identifying and collecting data on an individual and recording of that data within an Area Health Service-wide client registration database for the purpose of uniquely identifying that individual. The allocation of an Area Health Service unique patient identifier, to be used as a unique key for that client/patient, is a product of this process.

The intent of client registration is to be able to link information held on a client/patient and thereby, support the delivery of services to that client/patient and the management and understanding of services and service needs.

Client registration involves all of the following:

- **Gathering minimum standard information** about a client/patient of a health service to ensure that the client/patient is properly identified.
- **Searching** the Area Health Service-wide client registration database to determine if the client/patient has already been registered.
• **Recording mandatory information** about the client/patient or **updating existing information** in the Area Health Service-wide client registration database, and populating any other copies of this information with the updated information, ensuring that information held by the health service is correct and up-to-date.

• **Allocating an Area Health Service unique patient identifier** to new clients/patients.

Registration is for the purpose of providing health care to the client/patient or other related functions.

### 1.2 Purpose of this policy directive

The purpose of this policy directive is to specify NSW Health policy in relation to the registration of clients, patients and other related people.

Standardised client registration leads to more effective health care in that it enables information relating to any previous care, including screenings, tests, medications, and alerts, to be readily accessible by health professionals, allowing them to provide the best possible care to each client/patient. This includes improving the quality and safety of health care by better targeting tests, investigative procedures and prescriptions, and reducing any duplication of these that may occur.

Standardised client registration also reduces the costs associated with disparate holdings of client/patient registration details within an Area Health Service.

### 1.3 Target audiences

This policy directive applies to all NSW public sector health services as follows:

**Public hospitals**
- Multi-purpose services
- Residential care facilities
- Supported living services
- Outreach services
- Community health services
- Public psychiatric hospitals
- Pathology, imaging, pharmacy and other support services located in a public health facility
- Ambulance Service of New South Wales
- Justice Health services

The policy covers health care provided by these services in any mode (e.g., telehealth) and any location (e.g., outreach).

Services that are not part of NSW Health and are not delivered in NSW Health facilities (e.g. Aboriginal Medical Services, the Royal Flying Doctor Service) are not subject to this policy.

The staff for which this policy is intended includes any staff involved in registering clients/patients, including:
- client services or registration staff
- support staff such as medical record staff, ward clerks or secretarial staff
- intake officers
- admission managers
- health information managers
- Area information system departments
- clinicians.
1.4 Replaced policy directives

This policy replaces the following policy directives:

- Client Registration Policy (PD2007_094)

2. Client Registration Process

2.1 Which services must register clients/patients?

The following NSW Health services must register clients/patients:

1. Public hospitals and public psychiatric hospitals, including:
   - admitted patient services
   - outpatient services
   - residential and transitional aged care services
   - emergency department services
   - allied health services
   - outreach services
   - confused and disturbed elderly services
2. Residential care facilities, including:
   - residential aged care services
   - brain injury rehabilitation/transitional living services
   - hostel services
   - group home services
   - supported living services
3. Community health services, including:
   - centre/campus based services
   - home based services
   - mobile services
   - outreach services
4. Multi-purpose services
5. Ancillary health services, including pathology, radiology and pharmacy
6. Community acute and post acute care services (including hospital in the home)
7. Ambulance Service of New South Wales
8. Justice Health services
9. HealthOne NSW services.

2.2 Who must be registered?

Mandatory registrations

The following clients/patients who receive a health care service, or who are booked to receive a health service, including those added to a waiting list, must be registered:

- Patients who are admitted or are planned to be admitted to a health facility, including hospital-in-the-home patients.
- Patients who receive services or are planned to receive services in an outpatient department of a hospital.
- Patients who present to an emergency department, including those who do not wait to receive the service and those who are dead on arrival.
- Community health clients or those that are planned to receive these services, including those receiving services off-campus, e.g., at home.
• Clients receiving pathology, radiology or pharmacy services from a public health service, including those who receive a service as a result of a request from an external and/or private health service provider.

• All babies born in public hospitals or a NSW Health birthing facility. Each baby in a multiple birth must be registered separately.

• Stillborn babies of 20 weeks gestation or more, or, if the period of gestation cannot be determined, with a body mass of 400 grams or more. This applies regardless of the delivery location of the stillborn (that is whether it occurs in hospital or prior to arrival).

• Babies up to 9 days old accompanying their mother during her admission to hospital, even if they are well. For this purpose, determine the baby’s age at the time of admission of the mother, calculating the day of birth as zero (0). If the baby’s age is less than or equal to 9 days old at this time, then the baby must be registered. Babies older than 9 days accompanying their mother to hospital who do not require clinical care should be classified as boarders. See ‘Optional registrations’ below for guidelines relating to boarders.

• Organ donors (dead or alive), but only within the Area Health Service in which the organ is harvested.

• Clients/patients who are residents in NSW Health facilities, including but not limited to: residential aged care, hostels, group homes, transitional and assisted living, brain injury rehabilitation, and facilities for confused and disturbed elderly.

• Clients/patients receiving respite care.

• Clients/patients receiving a service within a group situation where clinical notes need to be recorded in the individual client’s/patient’s health record, including clients/patients who may join the group for one or a limited number of sessions. Clients/patients who are located in one Area Health Service but who are provided a service by staff in another Area Health Service using telecommunication service contact modes, such as telehealth. In these instances, clients/patients should be registered at each health service.

• Clients of call-centre based services where identification and/or registration would not inhibit participation in the service. (See ‘Optional registrations’ below for call-centre based services where registration may inhibit participation in the service.) People receiving individual immunisation or screening services, e.g., breast screening.

• Clients/patients whose identity is unknown at the time of receiving a health care service. (See Section 2.3 for further guidance on this.)

• Clients/patients who wish to have their identity restricted. (See Section 2.3 for further guidance on this.)

• People who are certified as dead prior to arrival to hospital taken directly to the hospital morgue. (See section 3.5 for minimum data requirements for dead people.)

Optional registrations

It is not mandatory to register the following clients, patients and other people who have contact with NSW Health services:

• People receiving group immunisation or screening services (though a record including details of the people receiving these services needs to be kept for medico-legal and follow-up purposes).

• Recipients of health promotion services.
Clients/patients of the NSW public health system receiving a service that has been contracted out to a private sector or non-government organisation.

Clients of a needle exchange service or a supervised injecting room.

Clients of a service where identification and/or registration may inhibit participation in the service and where it is lawful and practicable to provide the service without identifying the client (e.g., crisis counselling, sexual health).

A family member, carer or support person who receives a service directly related to a client/patient, but who is not deemed clinically as being a client/patient in his/her own right.

A family member, carer or support person with whom the health service provider communicates regarding the client/patient.

People making general enquiries of a health service, e.g., about a health condition or about the nature of services available.

Boarders or other people receiving food and/or accommodation by the health service but who are not receiving treatment (e.g., a parent accompanying their sick child during a hospital admission). While there is no requirement under this policy directive to register these people, individual Area Health Services may set local policies that require registration for purposes such as delivery of meals or for accounting for hospital occupants in disaster or emergency situations.

### 2.3 Special circumstances

**Unidentified clients/patients:** Unidentified clients/patients are people for whom no registration details can be collected because the client/patient is unable to provide those details (e.g., the person is unconscious) and there is no other person (such as a relative or carer) who can provide this information. Unidentified clients/patients must be registered and assigned an Area Health Service unique patient identifier. Procedures for registering unidentified clients/patients detailed in the Client Registration Guideline (GL2007_024) must be followed, and attempts should be made to obtain the client/patient registration details from alternative sources, such as relatives or carers, where possible. People in Justice Health under a witness protection program are considered to be unidentified clients/patients for the purpose of this policy but in these instances no attempts should be made to obtain the client/patient registration details from alternative sources.

**Identity-restricted clients/patients:** An identity-restricted client/patient is one whose identity can be ascertained but there is a requirement to mask it in the registration system because the client/patient requests it, or for legal or other reasons. Identity-restricted clients/patients may include staff of a service; Very Important Persons (VIPs); or people receiving services of a sensitive nature. Clients/patients who wish to have their identity restricted or are required to have their identity restricted must still be registered and allocated an Area Health Service unique patient identifier. This should be managed by policies developed by the Area Health Service. See Client Registration Guideline (GL2007_024) for further guidance on the registration of identity-restricted clients/patients. Also, see the Privacy Manual for Health Information (March 2015).

**Telephone information, assessment and intake:** Clients/patients may or may not be registered in these instances, depending on the nature of the call. For example, if the call is purely a request for publicly accessible information (e.g., opening times or contact details for a service), registration is not required. However, if the call involves intake (e.g., screening or assessment for the provision of a service), or for an appointment for a service, client registration needs to occur and at least the minimum registration data items recorded (see section 3.2). See Section 2.2 for guidelines on crisis-lines.
2.4 When to register

Client registration must occur at the first point of contact with a health service, or as early as possible in the process of providing a service. The first point of contact may be at the time of booking or, in the case of drop-in services, at the time of first presentation. For people who are certified as dead prior to arrival to hospital, the first point of contact is when the hospital takes responsibility for the body.

If it is not possible to obtain all client registration details at the time the client/patient is being booked for a service, effort should be made to obtain as many of the mandatory registration items as possible and then to record the remaining mandatory items at the time that the service is actually provided. This practice also applies in instances when the Area Health Service-wide client registration database is not accessible, in which case local policies should be developed and followed to ensure that the minimum mandatory data items are collected and the remainder followed up later. See Section 3 for a listing of mandatory client registration data items.

2.5 How to register clients/patients and update details

Client registrations must be recorded electronically in a single Area Health Service-wide client registration database. Each client/patient must be assigned an Area Health Service unique patient identifier.

Prior to adding a new client/patient to the Area Health Service-wide client registration database, it is mandatory to search for an existing registration of the client/patient within that database using a variety of search criteria. The search criteria should be defined in an Area Health Service policy and should align with the criteria described in the Client Registration Guideline (GL2007_024) and section 3.1 of this policy directive.

Updates to client registration details must always be made in the Area Health Service-wide client registration database.

Where client registration details are required in applications other than the Area Health Service-wide client registration database, an electronic HL7 message should flow outbound from Area Health Service-wide client registration database to the other system when a client’s details are added, updated or requested by that system. For systems that are not compliant with HL7 messaging standards, the registration details will need to be entered manually into both the Area Health Service-wide client registration database and the non-HL7 compliant system - both sources must be kept consistent and up-to-date.

All alternative local identifiers (e.g. medical record numbers) assigned to the patient by other electronic systems, or by manual methods, must be stored in the Area Health Service-wide client registration database. This is required so that information from all source systems can be linked. Where functionality is available, the Area Health Service unique patient identifier must also be stored in the other source systems that hold a copy of client registration details, and transcribed onto all paper based medical records.

A ‘Privacy leaflet for patients’, as described in the NSW Health Privacy Manual, or similar, must be made available to clients/patients at every site performing client registration. This information should be prominently displayed (e.g. in admission areas, community health and hospital outpatient reception areas, emergency departments and hospital wards) and readily accessible to patients.
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2.6 When to update client registration details

Client/patient details should be checked and confirmed or updated, as appropriate, each time a client presents for a new phase of treatment.

A phase of treatment may involve a number of service events that occur within weeks or months. Where a phase of treatment goes beyond three months, the currency of client registration details should be checked and confirmed with the client/patient every three months at minimum.

On re-presentation, or at the time a new service is booked or scheduled, special consideration must be given to the currency of:

- Address of usual residence
- Mailing address
- Telephone number(s)
- Preferred language
- Interpreter required
- Medicare eligibility and Medicare number (if eligibility for Medicare is a factor in service provision or billing)
- Health fund and health fund membership number (if a claim is to be made for the client/patient)
- General practitioner details
- Person to contact

Under privacy laws it is a requirement to keep personal health information up-to-date and accurate. Corrections or updates to client registration details made following a request by a client/patient, or his/her authorised representative, must be actioned in the Area Health Service-wide client registration database and in all copies of that information. For further guidance on clients’ requests to make changes to their personal health information, see section 12.7 of the NSW Health Privacy Manual.

2.7 Area Health Service responsibilities

It is a mandatory requirement that each Area Health Service defines standard criteria for searching for client registrations that align with those described in the Client Registration Guideline (GL2007_024) and section 3.1 of this policy directive and to distribute them to all staff responsible for registering clients.

Area Health Services must ensure that all staff responsible for registering clients are trained in all aspects of registration (e.g., gathering of information from the client/patient, searching, recording information and assigning an Area Health Service unique patient identifier) before they are allowed to register clients/patients. Training should cover relevant policies and procedures, consequences and risks to patient health care and health service liability arising from duplicate registration and incorrect identification and matching of individuals.

Follow up training and education should be available for all relevant staff and procedures implemented to monitor the quality of registrations. Staff identified as having issues meeting the expected client registration standards, e.g., creating duplicate registrations or incorrectly matching clients/patients, should undergo structured remedial training and further monitoring to ensure that the training has been effective. Subsequent ongoing issues with registration should be addressed in accord with the local performance management framework and the staff member’s continued involvement in client registration examined.

Area Health Services should have a client registration policy that addresses the following:

- standard methodology for searching for existing registrations in the Area Health service-wide client registration database
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- training staff prior to allowing them to register clients
- follow-up training for client registration staff
- material to be covered in client registration training
- methods used to reduce duplicate registrations
- procedures to resolve potential duplicates
- how to register identity-restricted clients

2.8 When to implement

It is recognised that implementation of this policy directive may require changes to local business processes and, as such, will be introduced in a staged manner across NSW. The policy should be implemented across all services by 1 September 2008.

3. Client Registration Data to Collect

There are four groups of client registration data:
1. minimum data for searching for an existing registration;
2. minimum data for booking or scheduling the first service within the Area Health Service;
3. minimum data for provision of the first service within the Area Health Service;
4. additional data mandated for specific encounter types.

The NSW Health Data Dictionary is the authoritative source for data and classification standards for NSW Health. It also provides some business rules. Compliance with the dictionary is mandatory.

3.1 Information required to search for an existing registration

A search of the Area Health Service-wide client registration database must be conducted prior to registering a new client. This applies regardless of whether or not the patient states that they have previously been a client/patient of the service.

The priority information to be used for searching and matching is:
- Family name
- Initial of given name/given name
- Date of birth
- Sex

Highly desirable information for searching and confirming identity when results for a search have been returned are:
- Middle name(s).
- Alias name(s) (including maiden name and any other name used at any time).
- Address of usual residence.

Where only part of the information above can be obtained (e.g., in emergency situations), the search should use what information is available and reviewed at a later time when further information is available.

3.2 Information required for booking the first service

When a booking is made for the first service it is mandatory that the following information is recorded in the Area Health Service-wide client registration database:
- Family name
- Given name
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- Date of birth
- Sex
- Middle name(s)
- Alias name(s) (including maiden name and any other name used at any time)
- Address of usual residence
- Mailing address (if different from Address of usual residence)
- Telephone number(s) - home, work and/or mobile
- Preferred language
- Interpreter required

This information is required to enable the client/patient to be contacted when a planned service needs to be rescheduled, and for scheduling interpreter services if required.

In addition to these items, services may choose to record the extra items in section 3.3 to save having to enter them at the time of first service provision.

3.3 Information required at time of service provision

At the time the first service is provided, it is mandatory that the following information is recorded in the Area Health Service-wide client registration database:

- Family name
- Given name
- Date of birth
- Sex
- Middle name(s)
- Alias name(s) (including maiden name and any other name used at any time)
- Address of usual residence
- Mailing address (if different from Address of usual residence)
- Telephone number(s) - home, work and/or mobile
- Preferred language
- Interpreter required
- Country of birth
- Aboriginal or Torres Strait Islander origin
- Medicare eligibility and Medicare Number (if eligibility for Medicare is a factor in service provision or billing)
- Department of Veterans’ Affairs (DVA) file number and card type (if a DVA card holder)
- Health fund and health fund membership number (if the health service intends to make a claim against a private fund for services provided)
- Person to contact (name, address, telephone numbers, relationship to client/patient) - for clients/patients under 16 years of age

It is highly desirable that the following information is also recorded in the Area Health Service-wide client registration database:

- Person to contact (name, address, telephone numbers, relationship to client/patient) - for clients/patients 16 years of age or older.
- General practitioner name, address, telephone, email and facsimile numbers (for the purpose of corresponding with general practitioner about the client’s/patient’s ongoing care).

3.4 Additional data mandated for newborns

A baby born at or on the way to the hospital/birth centre must be registered as soon as possible after the birth. The information required for newborns is the same as the information required for other clients/patients, however the following additional information is also mandatory:

- Person to contact (name, address, telephone numbers, relationship to client/patient) - for clients/patients 16 years of age or older.
- General practitioner name, address, telephone, email and facsimile numbers (for the purpose of corresponding with general practitioner about the client’s/patient’s ongoing care).
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- Full name of mother.
- Mother’s medical record number/Area Health Service unique patient identifier.

It is also highly desirable to record:
- Full name of father.

Some details, such as address of usual residence, may be inherited (copied) from the mother’s registration details. However, Aboriginal or Torres Strait Islander origin of the baby should not be assumed to be the same as that of the mother. Staff should especially not assume that the newborn baby is not of Aboriginal or Torres Strait Islander origin when the mother has not identified as being Indigenous. The mother should be asked as to the status of the baby.

3.5 Information required for dead people

All hospitals must register, in the Area Health Service-wide client registration database, all people who die in hospital and those who are already dead who are brought to hospital. Specific information, outlined below, is required for the management of deceased people, and an additional register will need to be maintained where the Area Health Service wide client registration database does not accommodate all that information.

With respect to deaths, this policy directive should be read in conjunction with the following Acts and Policy Directives:
- State Records Act 1998
- PD2010_054 Coroners’ Cases and the Coroners Act 2009

Hospitals should ensure that proper procedures are followed at all times with respect to the identification of dead people as well as the subsequent removal of bodies from hospital premises.

When the body of a person who dies outside the hospital is brought to the hospital, the Area Health Service-wide client registration database should be searched in the same way as for all other clients/patients of the health service.

Information about the person’s identity and other details should, if possible, be obtained from the next of kin, other family members or friends. If this is not possible, then information should be obtained from the person bringing the body to the hospital and any documentation in relation to the person (e.g., death certificate).

Where only part of the information required for searching is available, the search should use what information is available and reviewed when further information is available.

If the person has not been registered in the Area Health Service-wide client registration database, data items that must be recorded for them in that database are as follows:
- Family name
- Given name
- Date of birth
- Sex
- Middle name(s)
- Alias name(s) (including maiden name and any other name used at any time)
- Country of birth
- Aboriginal or Torres Strait Islander origin
- Person to contact (name, address, telephone numbers, relationship to client/patient)
Other mandatory information required specifically for the management of dead people includes:

- Where the body came from
- Whether a death certificate was issued or the death has been reported to Coroner
- Whether an autopsy has been authorised
- Who the body is claimed by
- That an authority for removal of the body has been sighted
- Date and time of removal
- Signature of the person removing the body

If this additional mandatory information cannot be accommodated in the Area Health Service-wide client registration database, an additional register to record this information must be maintained. The Area Health Service unique patient identifier must be used in that register to enable the information in that register to be linked to the record in the Area Health Service-wide client registration database.

When a person is dead, it is also important to record this on the Area Health Service-wide client registration database. This is necessary for people that die in hospital, for people who die outside of hospital and are brought to the hospital (e.g., to the emergency department or to the morgue), and for other people when the health service obtains notice and confirmation of their death.

Recording that a person is dead will ensure that any outstanding appointments across the Area Health Service can be cancelled, and can prevent further activity in relation to the client/patient (such as automatically generated letters) where information systems check the deceased flag in the Area Health Service-wide client registration database before initiating such activity.

If the death of a client/patient is known, the following information fields must be updated on the client’s/patient’s registration record:

- Date of death.
- Date of death estimation flag.

Standards for recording date of death where it is unknown are described in the NSW Health Data Dictionary.

5. Related Documents and Definitions

4.1 Related policies

This policy directive should be read in conjunction with NSW information privacy policies, legislation and other relevant policy directives to ensure the proper collection, storage, use and disclosure of health information. Such policies and legislation currently include:

4. PD2010_054 Coroners’ Cases and the Coroners Act 2009, and

4.2 Related standards

The following standards and guidelines have been referenced in developing this policy directive:


Information contained in the Area Health Service-wide client registration database should be maintained according to guidelines in the current General Retention and Disposal Authority - Public Health Services: Patient/Client Records (GDA 17), NSW Department of Health Information Bulletin 2004/20.

4.3 Definition of a health service

In the context of this policy directive a health service is defined as a service that provides any of the following:

- Initial health care needs identification
- Comprehensive or specialist health assessment
- Therapy or clinical intervention, symptom control
- Pain management
- Palliative care
- Spiritual, personal and/or social support or care
- Case management and/or care coordination
- Follow up, monitoring, evaluation, review
- Provision of aids and appliances (including in the home)
- Preventative care
- Radiology, pharmacy or pathology services
- Supported living
- Education about health issues

4.4 Definition of an Area Health Service unique patient identifier

A unique identifier within the Area Health Service assigned to a client/patient to distinguish them from other clients/patients.

For The Children’s Hospital at Westmead, The Ambulance Service of New South Wales, and Justice Health, the Area Health Service unique patient identifier is the unique client/patient identifier assigned by those organisations respectively.

CLIENT REGISTRATION GUIDELINE (GL2007_024)


HEALTH ESTABLISHMENT REGISTRATION (PD2008_001)

1. PURPOSE

The purpose of this policy directive is to describe the mandatory requirement to register health establishment outlets and service units within NSW, and record the registration details in NSW Department of Health’s Health Establishment Registration Online (HERO) and the Human Services Network (HSNet’s) ServiceLink systems.
Registration of health services is necessary to:

- support rapid access by staff and clients to services
- support referrals of clients to appropriate services
- rationalise requirements to report information about health services
- manage data collections and performance reporting
- uniquely identify the source of data messages and data extracts for data collection management purposes
- support better planning of health services across NSW.

Prior to this policy directive, registration of health services within NSW has occurred on an ad-hoc basis, primarily for high-level organisational establishments such as hospitals. This policy directive formalises the existing registration practices, extends registration requirements beyond the hospital setting, and mandates the registration of service units within hospitals and community health services. It also describes the mandatory information that must be provided when registering entities.

2. WHAT IS HEALTH ESTABLISHMENT REGISTRATION?

For the purpose of this policy directive, ‘Health Establishment Registration’ is defined as the process of recording a core set of mandatory information about a health service in HERO and in HSNet’s ServiceLink.

The process of registering a health establishment in HERO will result in the automatic assignment of a statewide identifier for that entity, unique within the context of NSW Health.

For both HERO and HSNet ServiceLink, the registration process involves recording the following mandatory information:

- key details, such as name(s), open/close dates
- contact information such as address(es), telephone and facsimile number
- key attributes such as establishment type, clinical stream, health sector
- the web URL for additional information about the service.

For HERO, the registration process involves recording the following additional information:

- other attributes (e.g. paediatric service indicator, hospital peer group)
- other identifiers used for entity (e.g. the Health Information Exchange - HIE - facility Identifier)
- relationships to other entities (e.g. the Area Health Service in which it’s located and the ‘parent’ organisation)
- data collections to which the entity reports
- the start and end dates of reporting to each collection
- details of a contact person responsible for the information reported
- for data collections, the source system or method used to record activity or other information.

For HSNet, the registration process involves recording the following additional information:

- service delivery settings/methods
- nature of the service
- events/issues addressed by the service
- eligibility criteria
- cost and billing method
- intake/referral requirements
- physical access, including parking, public transport and disability access
- additional contact methods, including freecall telephone number, intake telephone number, and TTY number.
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- target population groups, such as children or the elderly, Indigenous people, sex/gender groups, cultural and ethnic groups, religious groups, and language groups.

3. WHO WILL ACCESS ESTABLISHMENT REGISTRATION DETAILS?

Access to the registration details held in HERO is restricted to staff working within the NSW public health system. HERO maintains information about establishments and services that are essential for internal information management processes and messaging interfaces. Such information is not relevant to staff working in external human services agencies. A subset of the HERO registration details may be extracted for use within information systems where lists of particular services are required - this may include some systems used in the private health sector.

Establishments registered in HSNet are accessed by staff working in the NSW human services sector via a secure website. HSNet includes access to ServiceLink - a directory of government and non-government human services across NSW, and an online electronic referral tool (available only to those specifically registered and trained in HSNet’s ReferralLink).

A limited set of information in HERO or HSNet ServiceLink may be published for use by the general public and staff on the NSW Department of Health’s or Area Health Services’ websites. Registration made in HERO or HSNet ServiceLink will be used to populate and maintain the NSW Department of Health Services Directory located at the following URL: http://www.health.nsw.gov.au/hospitals/pages/default.aspx.

The NSW Department of Health may provide a subset of information from registrations in HERO or HSNet to national service directories.

4. WHAT HEALTH ESTABLISHMENTS MUST BE REGISTERED?

The health establishments that must be registered include:
- all NSW health public sector establishments/organisations (service outlets)
- all NSW board-governed statutory health corporations (service outlets) (e.g., Ambulance Service of NSW)
- all NSW health service units/teams/clinics of NSW public sector establishments/organisations, board governed statutory health corporations and affiliated health organisations (including intake services of any of these groups)
- all NSW private sector health care establishments (but not their service units/teams/clinics)
- all interstate establishments that have high levels of inbound and outbound referrals or contractual arrangements (but not their service units/teams/clinics).

It is optional to register other entities such as service point locations, area sub-divisions, clusters, and clinical streams in HERO. Registering these types of entities allows the recording of the relationships between entities in HERO, such as the relationship between service units and the locations at which they deliver services, and the hospitals and community health services that are located within each Area Health Service sub-division or cluster.

For the initial registration in HERO and HSNet ServiceLink, only currently open establishments need to be registered. The NSW Department of Health may register closed establishments in HERO on a needs basis for the purpose of reporting historical data.

At the highest level, the following must be registered:
- federal government human service agencies
- state level health jurisdictions
- Area Health Services, including Justice Health and The Children’s Hospital at Westmead
Ambulance Service of New South Wales
private sector health care provider groups
state networks.

It is the responsibility of the NSW Department of Health to perform the initial registration of these establishments and maintain details over time.

At the next level, the following NSW health public sector establishments (outlets) must be registered:

- hospitals
- community health centres/services
- residential aged care facilities
- hospices
- community residential facilities
- supported accommodation services/group homes
- multi purpose services
- mothercraft services
- third schedule hospitals
- freestanding pathology laboratories
- freestanding radiology services
- freestanding pharmacy services
- public health units
- HealthOne services.

It is the responsibility of the Area Health Service to perform the initial registration of these establishments and maintain the details over time.

The following NSW private sector establishments (outlets) must be registered:

- hospitals
- day procedure centres
- residential aged care facilities
- pathology laboratories.

The NSW Department of Health’s Private Health Care Branch is responsible for notifying the NSW Department of Health’s Demand and Performance Evaluation Branch of all private sector hospital and day procedure centre openings and closures, their addresses and other contact details, and their licensee.

The NSW Department of Health’s Demand and Performance Evaluation Branch is responsible for monitoring the openings and closures of residential aged care facilities and pathology laboratories, and registering these establishments.

The following NSW private sector establishments must be registered if the Area Health Service has a contract with the private sector organisation to provide health services:

- radiology services
- pharmacy services
- patient transport services
- non-government organisations (NGOs) providing health services under a contract with NSW Department of Health or Area Health Services.

It is the responsibility of the Area Health Service to perform the initial registration of these establishments and maintain the details over time.
Interstate public and private sector establishments (outlets) must be registered if there are high levels of referrals with NSW health establishments, or contracts established to provide health services on behalf of NSW Health. This is necessary for planning purposes, to identify inbound or outbound referral patterns. The types of interstate public and private sector establishments that must be registered are:

- hospitals
- day procedure centres
- residential aged care facilities
- pathology laboratories
- radiology services
- pharmacy services
- patient transport services
- NGOs performing health services under a contract with NSW Department of Health or Area Health Service.

It is the responsibility of the Area Health Service to advise the Department of Health of the interstate establishments that need to be registered for the purpose of monitoring referrals to these so that they are appropriately flagged for inclusion in the initial registration and registration review processes.

It is the responsibility of the NSW Department of Health to perform the initial registration of these establishments and maintain the details over time.

Any health establishment or entity that reports to a NSW Department of Health data collection that is not listed above must also be registered. For these remaining entities, it is the responsibility of the data collection manager to coordinate the registration of the establishments in collaboration with each Area Health Service or branch. This responsibility extends to data collections managed by all branches of the NSW Department of Health, not just the Demand and Performance Evaluation Branch.

5. MANDATORY REGISTRATION OF HEALTH SERVICE UNITS

Service units within NSW public sector Area Health Services, hospitals, community health services and statewide networks must be registered as ‘child’ establishments (services) of the relevant higher level organisation (outlet).

It is the responsibility of the Area Health Service to perform the initial registration of public sector service units and maintain the details over time.

For the purpose of this policy directive and registrations within HERO, a ‘service unit’ is defined as a team of people that come together to deliver health services to patients/clients with a specific set of problems or issues. Service units are part of an organismal structure. They have one or more roles/positions within them, and there may be one or more incumbents working within those roles/positions. Where source systems are used to schedule or record activity, service units are clearly established and defined within those source systems as hospital outpatient clinics or community health centre service teams.

Examples of service units are provided below:

- intake services
- emergency departments
- public hospital outpatient service units
- hospital admitted patient service units
- public hospital outreach service units
- public hospital pathology laboratories
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- public hospital radiology services
- public hospital pharmacy services
- public sector community health service units
- public sector client information services/call centres/intake services
- public sector patient transport services
- public health unit service teams
- general practice services.

All health service units that deliver services on NSW Health campuses must be registered in HERO, even if they only deliver services on a privately referred non-admitted basis.

Service units that report directly to a state-wide network or program, such as oral health, immunisation, screening and needle exchange services may have a parent health establishment of a state network rather than an Area Health Service, but should be recorded in HERO as being located within the jurisdiction boundary of an Area Health Service.

6. OTHER ENTITIES THAT MAY BE REGISTERED IN HERO ON A NEEDS BASIS

HERO will support the registration of a broad range of health service establishments, reporting entities, and service point locations that are beyond the minimum mandatory registration requirements described in this policy directive. This allows the recording of relationships between each entity, including the range of locations at which services may be delivered.

Establishments, reporting entities, and service point locations that are not mandatory for registration may be registered where an Area Health Service or other business unit identifies a requirement to do so. For example, an Area Health Service may wish to register a specific outpatient service within a private hospital or interstate health services to facilitate the recording of referrals to or from that service.

7. HOW TO REGISTER ESTABLISHMENTS

Bulk initial registrations may be loaded into HERO and HSNet using a standard Microsoft Excel spreadsheet format issued by the NSW Department of Health. Each entity can be flagged for inclusion or exclusion from the HSNet load. It is the responsibility of the Area Health Service to decide which entities are appropriate to publish to HSNet, however, all services that clients can be referred to must be registered in HSNet.

Following the bulk load of initial registrations, health establishments and services must be registered directly into HERO and HSNet. Both systems are custom built web-based applications.

HERO is available via the NSW Department of Health Intranet (http://hero.health.nsw.gov.au).

HSNet is available via the Internet (http://www.hsnet.nsw.gov.au). (However, all staff working in the NSW public health care sector should be able to access this through their Intranet account. See section 9.1 which mandates this.)

Each Area Health Service and business unit required to register establishments must apply for HERO user accounts and nominate the required user class. The following types of accounts will be available:

- Department administrator: view, create, modify, and final rejection/approval rights after lower level approvals have been obtained.
- Area Health Service administrator: view, create, modify, and rejection/approval rights at the Area Health Service level after any lower level approvals have been made.
Local/business unit administrator: view, create, modify, and rejection/approval rights at any level below Area Health Service.

Local requester: view and create/modify rights but no reject/approval rights.

Additional users may be established with a general user account which gives rights to search and view, and run reports and extracts.

The role of the HERO Department Administrator will reside in the NSW Department of Health’s Demand and Performance Evaluation Branch.

HERO mandates the fields that must be completed prior to submitting a registration request. For the initial uptake using the spreadsheet, the mandatory fields are indicated in the column header of the spreadsheet. They are also listed below.

8. MINIMUM DATA ITEMS FOR REGISTRATION

The following data items comprise the minimum data set for health establishment registration in HERO:
- Establishment name - official standardised name
- Establishment name - abbreviated name
- Health sector
- Jurisdiction (e.g., Area Health Service)
- Administrative parent establishment
- Establishment type
- Open date
- Close date (where applicable)
- Physical address
- Telephone number (where applicable)
- HIE/FAMER identifier (for previously registered establishments only)
- Paediatric service indicator flag.

For each data collection that the establishment reports to, the following must be recorded in HERO:
- Data collection
- Reporting start date
- Method of reporting
- Identifier used for reporting
- Source system and version
- Contact name
- Contact position
- Contact address
- Contact telephone number
- Contact email address.

For each entity that is a service outlet (e.g. a hospital or community health centre) the following data items must be recorded in HSNet:
- HSNet display name
- Service description
- Opening times
- Physical address
- Main telephone number
- Main facsimile number (if applicable)
22. STATISTICAL INFORMATION AND DATA

- Main email address (if applicable)
- Catchment area (if applicable).

For each entity that is a service unit or team, the following data items must be recorded in HSNet:
- HSNet display name
- Service description
- Intake instructions
- Intake telephone number
- Freecall intake telephone number (if applicable)
- TTY telephone number (if applicable)
- Service eligibility criteria
- Target population groups (if any)
- Service fees charged (if any)
- Billing method (if charges apply)
- Settings/methods used to deliver services
- Target life events/issues
- Nature of service
- Outlet at which service is based.

9. REQUIREMENT TO PROVIDE ACCESS TO HSNET AND HERO URL

The relevant information technology support units of Area Health Services, NSW Health Technology, NSW Health Support, and the NSW Department of Health are required to provide general access to all staff with Intranet access to the HERO web site (http://hero.health.nsw.gov.au) and the HSNet website (https://www.hsnet.nsw.gov.au).

As it is important that all staff have ready access to information about other Government services that will assist clients, access to the HSNet and HERO URLs should not require the staff member to have general Internet access, or require use of a special username and password or require special permission to navigate to these two URLs.

10. DUE DATES FOR REGISTRATION

For initial uptake, the following due dates apply to establishment registrations:
- 31 January 2008 - for hospitals, community health centres and service outlets.
- 31 March 2008 - for service units.

For the ongoing registration of services and establishments, registration must be completed prior to providing services to clients/patients and prior to being activated within any source system.

11. REVIEW OF REGISTRATIONS

Registration details of entities must be updated and confirmed by the Area Health Service establishment registration manager when there is a significant change to a service (e.g., opening or closing, including temporary closures, of an outlet/service or change of establishment type). (See section 13 below for roles and responsibilities.)

Registration details of all entities must be reviewed, updated and confirmed by the Area Health Service establishment registration manager at least every six months. (See section 13 below for roles and responsibilities.)
12. USE OF HERO IDENTIFIER VERSUS HIE/FAMER FACILITY IDENTIFIER

When an establishment is registered in HERO, it will be assigned a unique identifier within the context of NSW Health. Alternative identifiers, such as the FAMER or HIE facility identifier, can be recorded in HERO to support the continued interim use of those existing identifiers in applications such as the HIE.

The HERO identifier must be used as the identifier for the entity in all new data collections or new applications where an identifier for an entity is required.

The HERO identifier must replace the existing FAMER or HIE facility identifier at the next logical change over point. Logical change over points include data collection re-design, data collection extract modification, source system change/migration, and migration of a data collection to a new data repository. Prior to the logical change-over point, the four-character FAMER or HIE facility identifier may continue to be used.

Some new establishments may be assigned both a new HERO identifier and a HIE facility identifier upon initial registration if they are covered by a reporting requirement still using the HIE facility identifier. The NSW Department of Health’s Demand and Performance Evaluation Branch will manually assign any HIE facility identifiers and record them in HERO against the relevant entity.

13. ROLES AND RESPONSIBILITIES

Each Area Health Service must assign a staff member as the establishment registration manager. This staff member is the point of contact for the NSW Department of Health and HSNet regarding any matter related to the registration of health establishments within the jurisdiction of the Area Health Service, and will have the highest level HERO registration approval rights within the Area Health Service.

The Area Health Service establishment registration manager is required to:

- Manage completion of the initial uptake spreadsheet for HERO and HSNet, including review, verification or correction of details relating to previously registered establishments.
- Ensure the health establishment identifier is provided back to the source system administrator, health service and any staff that use related data within the Area Health Service.
- Update the HERO and HSNet information holdings as required with information regarding service openings and closures (temporary or permanent), and contact personnel or changes to the nature of services, name, address or other details.
- Conduct a six-monthly audit of HERO and HSNet entries by 31 March and 30 September each year to ensure that the information is accurate and up-to-date.
- Establish and manage a process of approval for registration of new health service establishments within the Area Health Service.
- Contribute to the ongoing development of the standard classifications within HERO, and provide advice about any system refinement required.

It is the role of the NSW Department of Health’s Demand and Performance Evaluation Branch to provide statewide management and support for the registration system. The Branch is responsible for:

- Developing, updating and publishing all information, including policy directives, guidelines, data standards and instructions, that support health establishment registration.
- Training Area Health Service and other responsible staff to register and manage health service establishments within HERO.
- Establishing and maintaining HERO user accounts.
- Maintaining HERO code value reference tables.
- Coordinating changes to the HERO system.
22. STATISTICAL INFORMATION AND DATA

It is the role of each NSW Department of Health data collection manager to ensure the HERO system is fully populated with information relevant to their data collection.

It is the role of HSNet staff to provide training, assistance and clarification of information required in HSNet, and to work directly with Area Health Services to establish eReferrals.

14. METADATA REPOSITORY

The metadata for classifications used in HERO will be maintained in the Health Information Resources Directory (HIRD), which is accessible through the NSW Health Department’s Intranet. Within HIRD, the HERO resource will be referred to as the ‘Health Establishment Registration Online Data Dictionary’.

Metadata relating to HSNet registration details is available from HSNet directly.

15. CONTACT INFORMATION

For further information about this policy directive contact:

- Eui-Soo Choi - (02) 9391 9817, echoi@doh.health.nsw.gov.au
- Demand and Performance Evaluation Branch, Health System Performance Division

EMERGENCY DEPARTMENT DATA DICTIONARY (PD2009_071)

PURPOSE

One of the key functions of the Emergency Department Data Collection is to gather data on Emergency Department activity across the state.

The purposes of collecting Emergency Department (ED) data in NSW are:
- To assist clinicians in the management of patients; and
- To enable comparisons of performance in respect to access to services, quality clinical outcomes, patient management, customer satisfaction and cost effectiveness.

The Emergency Department Data Dictionary (Version 4) (refer to Attachment section below), provides definitions for key ED data items, including the mandatory extract for the NSW Health Information Exchange (HIE), which are outlined in the extract layout formats.

MANDATORY REQUIREMENTS

All facilities providing data to the Emergency Department Data Collection are required to comply with standards outlined in the Emergency Department Data Dictionary (Version 4) by 1 July 2010.

IMPLEMENTATION

Area Health Service Executive and Emergency Department Management, in conjunction with software vendors, are to ensure relevant staff are advised and consulted with on implementation of this policy.

Continued improvement in Emergency Department Performance remains a high priority for NSW Health. Consequently, the frequent provision of Emergency Department data to enable regular monitoring of Emergency Department performance and evaluation of strategies to address the issue is considered a high priority.
For this reason, Greater Metropolitan Emergency Departments are required to supply weekly data. The reference period for weekly data is 12:00am Monday to 11:59pm Sunday. The deadline for submission of data for loading to the Department’s Health Information Exchange is 5pm Wednesday following the reference week. All Rural and Regional Emergency Departments with electronic source system are required to submit data monthly, by the 5th working day in the month following the reference month.

All data submissions must comply with the Emergency Department Data Dictionary (Version 4).


DEFINITION AND CALCULATIONS FOR THE NATIONAL EMERGENCY ACCESS TARGET (NEAT) (IB2014_056)

PURPOSE

The purpose of this information bulletin is to provide clarity around the appropriate data items to calculate the National Emergency Access Targets (NEAT) Indicator.

The Ministry of Health would like to eliminate potential confusion across Local Health Districts (LHDs) and Health Networks by confirming the way the indicator is measured and the relevant data elements that are used for this purpose.

This information bulletin specifies which data items are to be used, depending on the patient’s mode of separation from the Emergency Department (ED), and ensure that the NSW data items used are in line with national definitions. This information bulletin is not meant to change current recording practices, unless those practices are not consistent with the current NSW Emergency Department Data Dictionary.

The outcome of this process is to ensure consistency of the measurement of NEAT, to improve the data quality of the relevant data items, and to ensure that NSW complies with the national definitions.

KEY INFORMATION

The calculation of the National Emergency Access Target indicator is a key component of the National Health Reform Agreement, specifically the National Partnership Agreement on Improving Public Hospital Services Schedule C (National Emergency Access Target - Facilitation and Reward Funding). It is also incorporated into the Local Health Districts’ and Specialist Health Networks’ Service Agreements.

The national definition is hosted on the AIHW METeOR site, and can be found using the following link: http://meteor.aihw.gov.au/content/index.phtml/itemId/489630

The measure is for the percentage of ED presentations where the total length of the emergency department stay is within 240 minutes (<= 4 hours).

The total length of the emergency department stay is calculated from the commencement to the completion of the emergency department stay, where:

- The commencement of the emergency department stay is the earlier of:
  - ‘presentation time’ OR ‘triage time’
22. STATISTICAL INFORMATION AND DATA

- The completion point of the emergency department stay is determined by the ‘ED Mode of Separation’:

<table>
<thead>
<tr>
<th>MODE OF SEPARATION (where ED Type of Visit is not 12 or 13)</th>
<th>DEPARTURE DESCRIPTION</th>
<th>DATA ITEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Admitted: To Ward/inpatient unit, not a Critical Care Ward</td>
<td>The date and time the patient physically left (or was transported from) the ED</td>
<td>Actual Departure Date and Time</td>
</tr>
<tr>
<td>10 Admitted: To Critical Care Ward (including HDU/CCU/NICU)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Admitted: Via Operating Suite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Admitted: Transferred to another hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02 Admitted &amp; discharged as inpatient within ED</td>
<td>The date and time the patient's emergency department non-admitted clinical care ended</td>
<td>The earlier of: Departure Ready Date and Time OR Actual Departure Date and Time</td>
</tr>
<tr>
<td>04 Departed: Treatment completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>05 Departed: Transferred to another hospital without first being admitted to the hospital from which transferred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09 Departed: for other Clinical Service Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06 Departed: Did not wait</td>
<td>The date and time the patient physically left the ED or was first noticed as having left</td>
<td>Actual Departure Date and Time</td>
</tr>
<tr>
<td>07 Departed: Left at own risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Admitted: Left at own risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03 Admitted: Died in ED</td>
<td>The time the body was removed from the emergency department</td>
<td>Actual Departure Date and Time</td>
</tr>
<tr>
<td>08 Dead on Arrival</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99 Registered in Error</td>
<td>Excluded from the NEAT calculation</td>
<td></td>
</tr>
</tbody>
</table>

**Departure Ready**

The NSW Emergency Department Data Dictionary (Version 4.0) states that a patient is considered to be ready for departure when the following conditions are met:

- For a non-admitted patient: This is the time at which the assessment and initial treatment of the person is completed such that if home arrangements of the person (including transport) were available the person could depart. This time is reached when the following steps are completed:
  1. Completion of MDT assessment and documentation of assessment, tests and treatment
  2. Completion of clerical registration details
- Patients with an ED Mode of Separation of “99” (Registered in Error) are excluded from the NEAT calculation.
- Patients with an ED Type of Visit of “12” (Telehealth Presentation) and “13” (Current Admitted Patient Presentation) are also excluded from the NEAT calculation.

**Data Quality**

The Ministry of Health understands that there are data quality issues with respect to the data reported in the Departure Ready and Actual Departure fields. On this basis, where the ‘Departure Ready Time’ is recorded as occurring later than the ‘Actual Departure Time’, the earlier time will be used for measuring the emergency department length of stay for those presentations ending in ‘Mode of Separation of 2, 4, 5 or 9.

It is expected that with the clarification provided by this information bulletin, LHDs will focus on these crucial data items and address any data quality issues that arise as a result.

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SUPPORTING INFORMATION

The National NEAT Definition:
(http://meteor.aihw.gov.au/content/index.phtml/itemId/489630)

The NSW NEAT documentation:

NSW Mode of Separation (ED) Codeset:

NSW Definition for Actual Departure Date:

NSW Definition for Departure Ready Date:
NON-ADMITTED PATIENT DATA COLLECTION TRANSITION FROM WEBNAP TO EDWARD REPORTING (GL2015_012)

PURPOSE
The purpose of this Guideline is to advise NSW Health non-admitted patient service providers and non-admitted patient activity source system support staff of the changes in requirements involved in the transition from reporting via WebNAP to reporting via the EDWARD.

An understanding of these differences, and the three phases of implementation, is required to reconfigure source system builds and patient level activity extracts, and redesign non-admitted patient activity reporting business processes.

KEY PRINCIPLES
In line with NSW Health’s strategic direction and the significantly increased volumes of non-admitted patient services being reported at the patient level by NSW Health services the Non-Admitted Patient Data Collection will transition to be reported via EDWARD rather than the interim system WebNAP.

The migration of the data collection to EDWARD will have significant benefits for Local Health Districts (LHDs) / Specialist Health Networks (SHNs) and other NSW Health agencies. LHDs / SHNs should expect higher data availability, more efficient data loading and resubmission processes, significantly improved data error reporting functionality and appropriately secured access to activity data.

When reported via EDWARD the non-admitted patient, admitted patient and emergency department activity data will be automatically allocated the appropriate National Weighed Activity Unit (NWAU) and integrated into a single data mart that supports full patient journey analysis utilising the Enterprise Patient Registry unique identifier.

USE OF THE GUIDELINE
In order to minimise the transition burden, requirements have been prioritised across three phases:

- **Phase 1**: Report current scope via EDWARD and decommission WebNAP
- **Phase 2**: Convert source system extracts and classifications to the EDWARD format
- **Phase 3**: Integrate additional reporting requirements for specific clinical streams The EDWARD Business Implementation (EBI) Program collaborating with the NSW Ministry of Health’s Health Systems Information and Performance Reporting (HSIPR) Branch will establish a small project team to support transition, testing and address queries as they arise during the migration period.

**Phase 1**
Implementation of phase 1 requires LHDs/SHNs to load WebNAP patient level and summary level extracts into EDWARD and to cease reporting to WebNAP. To support the transition to EDWARD reporting during Phases 1 and 2, a file upload, conversion and transfer tool, the EDWARD mLoad Tool, will be available for LHDs/SHNs to upload patient level and summary level data extracts from source systems in either the WebNAP extract format, or the EDWARD extract format.
The tool will apply the necessary file format conversions to WebNAP extracts compliant with the 2015/16 WebNAP reporting requirements and file format. It will also produce a container header file (based on user inputs) for both WebNAP and EDWARD flat file formats, and transfer files to the EDWARD drop zone where they will be automatically loaded into EDWARD.

During this phase LHDs / SHNs:

1. Must build EDWARD extracts for non-admitted patient source systems that are not yet reporting at the patient level
2. Must commence the reconfiguration of WebNAP extracts such that the source system can report activity directly in the EDWARD extract format
   3. May cease reporting summary level data for services reporting at the patient level once reporting through the EDWARD mLoad Tool
4. May commence (or fully implement any) transition steps outlined in later phases. Phase 1 must be completed by **30 June 2016**, to enable the decommissioning of WebNAP.

**Phase 2**
Implementation of Phase 2 requires LHDs / SHNs to complete the reconfiguration of WebNAP source system extracts into the EDWARD extract format and source systems to be fully aligned with the EDWARD classification standards.

During this phase any changes effective from 1 July 2016 will also need to be incorporated into the EDWARD extracts. During this phase LHDs/SHNs may implement Phase 3 implementation steps. Phase 2 must be completed by **30 June 2017**, to enable the decommissioning of the WebNAP patient level file conversion functionality, compliance with 2016/17 reporting requirements and to establish the foundations required for implementation of Phase 3.

**Phase 3**
Phase 3 involves reporting the additional data elements set aside in the EDWARD extract file format for the integration of other non-admitted patient data collections for specific clinical streams. It will involve decommissioning the legacy extracts and legacy data repositories (such as HIE and other disparate databases).

This phase may only impact selected source systems. For example, radiotherapy sources system would add data elements required for the integration of radiotherapy waiting times and non-admitted patient cancer notifications, while source systems used by Hepatitis, HIV/AIDS and sexually transmissible diseases services would add data elements pertaining to communicable diseases.

Phase 3 is expected to be completed by **30 June 2018**, to enable the decommissioning of the HIE and other legacy data repositories and to establish a single comprehensive non-admitted patient data collection.
FURTHER INFORMATION
The NSW Ministry of Health will provide advice and clarifications regarding the requirements for reporting non-admitted patient activity via EDWARD. Requests for advice should be directed to the Health System Information & Performance Reporting Branch, NSW Ministry of Health.

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A full copy of these guidelines can be downloaded at: