MINISTRY OF HEALTH
MANATŪ HAUORA

All District Health Boards

Common Counting Standards

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Contents

Change Log

Version 1.1a

V1.1a Includes updates to the Telehealth counting rules following the COVID-19 response, an administrative update to align the counting standards with the National collection rules, specifically those for admission.

Changes have been made to sections, for telehealth:

- 2 l) Telehealth general rules
- 7 & 9 FSA and FU
- 8 & 10 non-contact FSA and FU
- Appendix 1 Unit of measure “contact”
- Appendix 2 Reporting Mode of Delivery and examples

For alignment with National Collection rules:

- 1 Expanded the introduction
- 2 a) aligned with NMDS
- 2 f) expanded to include NBRS and NPF
- 3 Alignment with National Collections rules, and clarification
- 4 Update of health practitioners involved in AAU
- 6 ED attendance counting rules aligned with National Collection rules

1 Introduction

Purpose of the Common Counting Standards

The common counting standards (the Standards) 2013/14 were developed by the common counting technical advisory group[1] (CCTAG) at the request of the Ministry of Health for use in the New Zealand public health and disability sector.

These Standards are a mandatory component of the nationwide service framework that is described in the crown funding agreement's operational policy framework[2] (OPF). The Standards align where relevant, to the current version of the national collections' data dictionaries or code set/data set that published for each national collection. This ensures all data definitions that are used directly correspond with the national standard data definitions issued by the Ministry.

The Standards are used to support consistency of counting of mostly hospital service activity and describe how health activity is defined, measured and counted to support the planning of health and disability services. The Standards support funding and costing decisions and they contribute towards a sound platform from which DHB inter-district flow (IDF) pricing can be derived. They provide examples and clear business rules for a consistent approach when using existing purchase unit codes (PUCs) from the Purchase Unit Data Dictionary (PUDD), and when developing new PUCs.

The main objectives of the Standards are to:

- ensure that similar health activities can be consistently counted and compared across the health sector to support benchmarking
- clarify and consolidate the definitions for each set of counting rules within each visit type
- consistent differentiation of service measurement to support thorough analysis across the sector

The Standards support:

- integrated service management
- regionalisation of services
- improving the link between non-financial information (eg, service code definitions) and financial information such as costing systems and pricing of health and disability services.

There are some areas of the Standards that need further work to achieve an agreed consistent approach.

[1] CCTAG was a joint advisory group of the Ministry of Health and district health boards (DHBs).
[2] nsfl.health.govt.nz/accountability/operational-policy-framework-0

Document/Collections	Purpose	Document link
Common costing guidelines	Provides information on products that DHBs choose to allocate costs to patients' events, the type of costs that are allocated to each product.	nsfl.health.govt.nz/accountability/financial-standards-and-guidelines
Common chart of accounts (CCoA)	Provides a nationally consistent coding system for recording financial transactions by DHBs and the Ministry. Each purchase unit code (PUC) is linked to a General Ledger (GL) code (also known as natural account code).	nsfl.health.govt.nz/accountability/financial-standards-and-guidelines
New Zealand Casemix Framework for Publicly Funded Hospitals	Provides definitions for inclusion of hospital events in Casemix funding related to the calculation of cost weights and assignment of these events to PUCs. The Standards are aligned with Casemix exclusions and funding for hospital events.	www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations
Purchase unit data dictionary (PUDD)	The PUDD is a spreadsheet (updated twice a year) that contains PUCs for counting or purchasing services, mapping tables, definitions for units of measure and links to nationwide service specifications. Appropriate definitions are allocated to PUCs to support the correct and consistent use of the PU codes for costing analysis and service planning.	nsfl.health.govt.nz/purchase-units
Guide to Purchase Units and Purchase Unit Data Dictionary and Purchase Unit Request Template	The guide and template assists users when requesting new PUCs or proposing changes to existing PUCs in line with the agreed Standards and definitions.	nsfl.health.govt.nz/purchase-units
National Minimum Dataset (NMDS) – data dictionary of National Collections	Linking inpatient PUCs into NMDS through the national collections data dictionary to ensure consistent and accurate data collection of inpatient events.	www.health.govt.nz/publication/national-minimum-dataset-hospital-events-data-mart-data-dictionary
National Non-admitted Patient Collection (NNPAC) Data Mart of National Collections	Linking outpatient PUCs into NNPAC to ensure consistent and accurate data collection of outpatient non-admitted patient events.	www.health.govt.nz/publication/national-non-admitted-patient-collection-data-mart-data-dictionary
Appendix B National Collections Glossary	Provides definitions for concepts that span national collections to ensure consistency of counting for reporting.	www.health.govt.nz/nz-health-statistics/data-references/appendix-b-national-collections-glossary
Programme for the Integration of Mental Health Data (PRIMHD)	A Ministry data warehouse of national collection of mental health and addiction service information of activity and outcomes data for health consumers. Mental Health and Addiction PUCs are in the PUDD.	nsfl.health.govt.nz/service-specifications/current-service-specifications/mental-health-services-specifications (includes definitions and reporting requirements in the Reference Material section)

Contract Management System (CMS)	All PUCs, active and inactive are contained in CMS, also codes are used in Client Claims Processing System (CCPS), Proclaim, PharmHouse (for contracting purposes).	

Linkages of the standards to health sector documents, collections and systems.

To ensure national consistency in counting, funding, planning of health and disability services, pricing and data collection, the standards are linked with the following documents, collections and systems.

2 General Counting Standards

The following general counting standards apply.

a. Where there is a general standard and a specific standard related to the same area, the specific standard takes precedence. Example:

   General Standard: all patients who are treated in a hospital for three hours or more should be admitted and reported to the NMDS.

   Specific Standard: even though in-centre dialysis patients stay for three hours or more, they are not required to be admitted or reported to the NMDS. In-centre dialysis treatments are generally recurrent same day events that are not casemix funded. Due to these events being recurrent the additional clinical coding is resource intensive and does not add value to the patient or the national record. In-centre dialysis events should be reported to NNPAC.

b. For admitted events: The standards need to be read in conjunction with the *New Zealand Casemix Framework for Publicly Funded Hospitals, including WIES methodology and casemix PUC allocation for the current financial year*. This provides detailed rules for counting admitted events.

c. Counted events should be related to a patient and be able to be counted within the DHB's systems as an unique event.

d. Funded events should be output based, although there are exceptions such as temporary and full time equivalent (FTE) based PUCs.

e. All patient-related events should be able to be mapped to a PUC, thus submitted to a national collection even if the activity is not specifically described under this PUC, for example consumables used for diagnosis.

f. As a general rule an event must only be reported to one national data collection system (eg, NMDS or NNPAC), however there is flexibility to report a PUC to more than one collection system. The data collection and payment systems that PUCs can submitted to includes, but is not limited to, the following:

   - National Minimum Dataset (NMDS) for inpatient events
   - National Non-admitted Patient Collection (NNPAC) for outpatient events
   - Contract Management System (CMS) for payments between Ministry/DHB and NGO providers
   - Client Claims Processing System (CCPS)
   - Programme for the Integration of Mental Health Data (PRIMHD) applied only to mental health and addiction PUCs
   - National Immunisation Register (NIR) for all immunisation enrolments and events of children born since 2005
   - National Booking Reporting System (NBRS) provides information about patients waiting for treatment
   - National Patient Flow (NPF) provides information on the outcome of referrals from primary care to secondary care and the time it takes patients to access care.

g. One patient may have multiple events on the same day across a number of DHB services. If the event is weighted inlier equivalent separation (WIES) funded then only

one event (the admitted event) is counted for funding purposes. DHBs may have established internal systems that allow recognition of the multiple inputs into an inpatient stay but for national counting purposes, these are not recognised as separate events.

However, where at least **one** of the events is an admitted event, multiple events can be counted in the following circumstances.

- Where the admission is not WIES funded and a pre-booked event that is not related to the primary cause of admission occurs during the admission, For example when a patient is admitted for assessment, treatment and rehabilitation (AT&R) and also has a pre-booked ophthalmology outpatient appointment.
- Where a patient is booked for an outpatient visit (a planned event) and is admitted following that outpatient visit. For example, when a patient is booked for an orthopaedic follow up and during the course of that follow up, the decision is made to admit the patient.
- Where an outpatient visit occurs after an inpatient discharge, regardless of the specialty. For example, when a patient is discharged from cardiology and has a pre-booked renal follow up on the same day.
- Transfers between facilities where the patients are admitted are always treated as separate events regardless of whether they occur on the same day. For example, a patient transfer from Whakatane Hospital to Tauranga Hospital.
- Statistical discharges between major service groups are always treated as separate events (eg, between surgical and rehabilitation).

h. Where there are multiple events and **no admission** occurs each event should be counted. For example, a first specialist assessment (FSA) or follow up and a procedure if they are pre-booked as separate events. However, you cannot count more than one FSA for the same person on the same day in the same specialty in the same DHB. The NNPAC team has developed a list of PUCs that allow multiple events to be collected.

i. The allocation of health specialty codes[3] (HSCs) for both inpatient and outpatient events is dependent on the specialty for which the treating clinician is employed to perform those events. Emergency Department (ED) admitted patients discharged by a specialist who is not an emergency specialist should be assigned to the specialty of the discharging specialist. For example if a patient is discharged by an ophthalmologist then use HSC S40 *Ophthalmology*. PUC allocation for inpatient events is based on the HSC allocated, but this may not be the case for outpatients where other factors such as diagnostics and infrastructure may have a greater input into the cost of the service. The PUC is usually allocated on the clinic code, which could be different to the HSC.

j. All outpatient activity must be reported with Mode of Delivery (See appendix 2 for definitions and examples.)

k. Laboratory, radiology, cardiology and other diagnostic tests that have been generated from either an inpatient or outpatient event are not counted separately but should be an input into the event they are referred from (eg, a biopsy is part of a dermatology visit) unless there is a specific PUC, such as PET scans or scopes or when the diagnostic test is referred from a GP or private specialist (see chapter 15 Community referred tests).

[3] www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/health-specialty-code-table

l. Telehealth is the use of information and communication technologies to deliver health care when patients and care providers are not in the same physical location. For example, illnesses can be diagnosed and treatment provided via secure video conference. To be effective, telehealth relies on fast broadband internet services. Healthcare related education, research and evaluation can also take place using telehealth facilities.

   Treatment provided to a patient in another location should, so far as is possible, meet the same standard of care provided in an in-person consultation. This includes standards relating to patient selection, identification, cultural competence, assessment, diagnosis, consent and follow up. If, because of the limits of technology, the service is unable to be provided to the same standard as an in-person consultation then the patient must be advised of this. Refer to 'Statement on telehealth' of the Medical Council of New Zealand[4]

   The NZ Telehealth Forum and resource centre provides links to regulations, standards and guidelines. Guidelines or Best Practice guidance for telehealth from the practitioner's registering body or professional association apply. See for more detail on requirements for provision on telehealth: Statement on Telehealth, Medical Council of New Zealand, March 2020. For Allied Health service as best practise guide for telehealth is available[5]:As per the Eligibility Direction[6], publicly funded services provided by telehealth are only available to eligible people who are in New Zealand at the time they receive services.

   i. Telehealth can be provided by telephone, however increasing the use of video conference for mode of delivery is recommended. If telehealth is provided by telephone (voice only) telehealth standards apply. When reporting telehealth consultations DHBs must report the mode of delivery (See appendix 2).

   ii. Explicitly excluded from counting and reporting to NNPAC are communications between practitioner and client or between practitioners where the sole purpose of the contact is provision of supplies or consumables, reporting of results of diagnostic tests, advise on treatment without a change to the plan of care of the client. DHBs can record this activity locally if agreed with the funder.

   iii. email consultations are excluded from counting and reporting to NNPAC but could be recorded locally if agreed with the DHB funder.

[4] https://www.telehealth.org.nz/assets/standards/200327-Medical-Council-Statement-on-Telehealth-2020.pdf (March 2020 version)

[5] www.alliedhealth.org.nz/uploads/8/8/9/4/88944696/best_practice_guide_for_telehealth_-_april_2018.pdf

[6] Health and Disability Services Eligibility Direction 2011
www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf

3 Admission

Admission Definition

A patient is defined as an inpatient if they are admitted to a healthcare facility. For the purposes of the national collections, healthcare users who receive assessment and/or treatment for three hours or more, who have a general anaesthetic are admitted. This also applies to healthcare users of Emergency Departments (EDs). When calculating the three hours, exclude waiting time in a waiting room, exclude triage and use only the duration of assessment/treatment. If part of the assessment/treatment includes observation, then this time contributes to the three hours.

Assessment/treatment is clinical assessment, treatment, therapy, advice, diagnostic or investigatory procedures from a nurse (excluding triage nurse), Nurse Practitioner, doctor or other health professional.

Admission Rules

- Patients who receive assessment/treatment for three hours or more, **or have** a general anaesthetic **must** be admitted.
- Patients who receive treatment for less than three hours, **and do not have** a general anaesthetic and did not die in ED **should not** be admitted, the attendance should be reported to NNPAC.
- Start time for an admission includes ED activity, from the time the patient is seen by a nurse (excluding triage nurse), nurse practitioner, clinician or other health professional. Start time for an inpatient admission should be the same as the NNPAC datetime of first contact in ED
- Transfers within the same facility but between wards are included in the same admission except where transfer results in a statistical discharge between major service groups such as mental health.

Admission Types

a. **Acute Admission** - An unplanned admission on the day of presentation at the admitting healthcare facility. Admission may have been from the emergency or outpatient departments of the healthcare facility or a transfer from another facility. For example, the hospital has less than 24 hours notice that the patient is arriving and will be admitted.

b. **Arranged Admission** - A planned admission where the admission date is less than seven days after the date the decision was made by the specialist that this admission was necessary; or the admission relates to normal maternity cases of 37 to 42 weeks gestation delivered during the event. These maternity patients will have been booked into the admitting facility (national collections). For example, the hospital has between 24 hours and 7 days notice that the patient is arriving and will be admitted.

c. **Elective Admission** - Elective admission is a planned admission where the admission date is seven or more days after the date the decision was made by the specialist that this admission was necessary. For example, the hospital has 7 days or more notice of when the patient will arrive and be admitted.

Inter-hospital transfers are generally organised to facilitate the on-going care or treatment of a patient. Some examples are identified below.

- An acute admission for a patient requiring more complex treatment. For example, a patient with acute coronary syndrome, being transferred to a cardiac centre for angiogram or surgery

- A transfer for an elective patient who experiences a complication post operatively, that requires treatment in another facility. For example, a patient undergoing surgery who experiences vascular damage intra-operatively
- An acute trauma patient requiring tertiary treatment. For example, a patient with head or chest injuries stabilised in one facility and transferred to a neurosurgery or cardiothoracic centre.

In the above circumstances, the inter-hospital transfer steps are generally as follows:

1. A decision is made to seek treatment at another facility.
2. The receiving hospital is contacted to agree to receive the patient (clinician to clinician transfer of care).
3. The receiving hospital confirms the transfer based on patient stability and bed availability - this would generally be expected to occur within a few days.
4. The patient may be transferred back to the initial (referring) hospital (or another hospital) when they are well enough.

It is unlikely that a patient will be held in the referring hospital for more than seven days **unless** the receiving hospital has insufficient capacity to accept the patient earlier.

The principles to apply are:

(a) if an inter-hospital transfer is for the urgent treatment of a patient, and in clinically optimal circumstances, the transfer would occur within a timeframe of less than seven days, then the transfer will be an 'arranged admission', regardless of whether this takes longer than seven days.

(b) Where a patient is transferred from ED at hospital 1 to the ED at hospital 2 - both NMDS events should be reported as an AC- acute admission.

(c) Where the patient is being transferred back to their local DHB hospital for continuing care this will be reported as an AA - Arranged Admission.

Admitted Events PUC Allocation

PUC allocation for admitted patients is determined by the New Zealand Casemix Framework.

Non-Admitted Events

If a patient does not meet the guidelines for admission they are treated as non-admitted patients.

Admitted and/or non-admitted Events

4 Acute Assessment Unit (AAU) Events

AAU Events Definition

An acute assessment event is where the assessment is conducted by a nurse, (excluding triage nurse), nurse practitioner, clinician or other health professional in a designated AAU. A designated AAU is agreed with the DHB Funder.

AAU Events Rules

- Excludes ED attendances.

- Patients may be admitted if they meet the admission rules described above.

AAU Events Purchase Unit Allocation

- Non-admitted patients in AAU are counted under PUC MS02019 = Acute Assessment Unit attendance (less than three hours).
- The PUC allocation for admitted patients is determined by the NZ Casemix Framework document.
- Where there is no designated AAU and patients present acutely, the PUC allocation is dependent on the service specialty. For example, acute eye clinics are counted as ophthalmology FSA or follow up).

5 Procedures and Diagnostic Events

Procedures and Diagnostic Events Definition

A procedure is a discrete therapeutic or diagnostic intervention. Procedural and diagnostic activity occurs in many admitted and non-admitted events. However, there is a subset of activity that is counted under specific procedural PUCs.

Procedures and Diagnostic Events Rules

A procedure that is identified in the Casemix Framework document should be admitted when they meet the admission rules, but it is up to the DHB whether or not they admit procedural events.

Procedures and Diagnostic Events Purchase Unit Allocation

- The allocation of PUCs for the majority of procedures is defined in the NZ Casemix Framework document. However, there are a small number of minor procedures that are counted under specialty specific PUCs if the patient is not admitted (refer to the PUDD).
- Where there is a generic, non-specialty derived procedural PUC, this should be used in preference to the specialty derived PUCs
- When counting procedures, the default is to count the event, not the number of procedures performed during that event. For example, the skin lesion PUC definition allows multiple skin lesions to be counted under one event. There may be instances where the PUC specifically allows for multiple counts. This would be identified in the PUC definition and unit of measure.

6 Emergency Department (ED) Attendances

Emergency Department Attendance Definition

A healthcare user attends an ED and is assessed by a nurse (includes triage nurse), nurse practitioner, clinician or other health professional. The healthcare user receives treatment, therapy, advice, diagnostic or investigatory procedures.

Emergency Department Attendances Rules

- Patients receiving treatment for three hours or more within an ED must be admitted. When calculating the three hours, exclude waiting time in a waiting room, exclude triage (or time prior to triage) and use only the duration from commencement of assessment and/or treatment by a nurse (excluding triage nurse), nurse practitioner, clinician or other health professional. Time in the waiting room prior to triage is also excluded. Events where no treatment occurs in the ED are not counted as an ED attendance. This activity is reported as ED00002 (triage only).

Emergency Department Attendances PU Allocation

- Non-admitted events are allocated to a standard ED PUC.
- ED attendances where the patient is subsequently admitted to the same hospital are to be counted under the ‘counting only’ ED PUC ending in an "A". The admission is counted under the appropriate inpatient event.
- All the costs for the events ED attendance and subsequent admission should be attached to the inpatient event that will be the only one funded.
- The different levels of ED service provision is defined in the nationwide Tier two Emergency Department service specification.

Non-Admitted Events

7 First Specialist Assessment (FSA)

First Specialist Assessment Definition

An FSA is a patient’s first assessment by a registered medical practitioner of registrar level or above, or a registered nurse practitioner for a particular referral (or with a self-referral, for a discrete episode). The healthcare user receives treatment, therapy, advice, diagnostic or investigatory procedures within three hours of the start of the consultation. The service is provided in ward and/or designated outpatient clinic or by telehealth. Excludes ED and outpatient attendances for pre-admission assessment/screening (National Collections).

First Specialist Assessment Rules

- The event should be less than three hours from the start of the consultation.
- The service can be provided in the ward if the patient is not admitted. However, if the intent is to treat them for three hours or more, the admission rule is applied.
- Excludes ED attendances and outpatient attendance for pre-admission assessment/screening.
- Acute events outside of an acute assessment unit or ED are to be treated as an FSA.
- An FSA cannot be generated from a prior inpatient admission in the same specialty in the same DHB.
- An FSA can be generated from a prior inpatient admission in a different specialty in the same DHB.
- If it is a new referral to the DHB, regardless of whether the patient has been seen in another location as part of an outreach clinic or an inpatient consultation, then it can be counted as an FSA.
- An FSA may be delivered by telehealth.
- The patient is present either in person or via telehealth during the assessment.

First Specialist Assessment Purchase Unit Allocation

PUC allocation for outpatient FSAs are based on the specialty of the clinic the patient is attending. This is because there may be diagnostic tests or infrastructure requirements that are specific between clinics. The HSC is allocated based on the specialty for which the treating clinician is employed to perform those events, so it could be different to the specialty of the PUC. For example, a generalist physician who provides cardiology clinics in some small DHBs. See appendix 2 for rules on reporting mode of delivery of an assessment, such as when an assessment is delivered using telehealth.

8 Non-contact First Specialist Assessment (FSA)

Non-contact First Specialist Assessment Definition

A review is undertaken of patient records and any diagnostic test results by a registered medical practitioner of registrar level or above, or a registered nurse practitioner. A written plan of care is developed for the patient and provision of that plan and other necessary advice is sent to the referring clinician and the patient. The non-contact FSA does not include the triaging of referral letters. The patient must not be present during the non-contact FSA.

Non-contact First Specialist Assessment Rules

- The patient is not present during the review of patient records and any diagnostic test results.
- A written plan of care is required and must be able to be audited. This plandischarges the patient back to the original referrer.
- If the written plan of care is not completed and a patient is required to come in for an in-person assessment, then the non-contact FSA should not be counted.
- Triage of referrals cannot be counted as a non-contact FSA.
- A non-contact FSA can be referred from internal referrals from another specialty within the same DHB, or between the same specialty in different DHBs.
- A non-contact FSA cannot be generated after a FSA has occurred with the patient present (in-person or via telehealth) for the same condition with the same health practitioner.
- Any subsequent patient contact should be treated as a new referral when the patient's condition has changed.
- A follow up, with the patient present, can occur where a subsequent appointment is deemed necessary and relates to the original referral.

Non-contact First Specialist Assessment Purchase Unit Allocation

PUC allocation for non-contact FSAs: M00010 (Medical non-contact First Specialist Assessment - Any health specialty) and S00011 (Surgical non-contact First Specialist Assessment - Any health specialty). These PU codes are to be reported to NNPAC with the health specialty code as well as with the Mode of Delivery code 7 (non-contact).

9 Specialist Follow Up Assessment

Specialist Follow Up Definition

A follow up is a subsequent patient consultation with a registered medical practitioner of registrar level or above, or a registered nurse practitioner, for the same condition in the same specialty. The patient receives treatment, therapy, advice, diagnostic or investigatory procedures, is not admitted, does not receive a general anaesthetic and the specialist's intent is that they will finish the consultation within three hours.

Specialist Follow Up Rules

- The event should be less than three hours from the start of the consultation.
- The service can be provided in the ward if the patient is not admitted. However, if the intent is to treat them for three hours or more, the admission rule is applied.

- Subsequent presentations following an acute event outside of an acute assessment unit or ED are to be treated as a follow up.
- Includes post-discharge events from the prior inpatient admission in the same specialty even though an FSA may not have occurred.
- A follow up may be delivered by telehealth.
- Where a patient is transferred from one specialist to another specialist within the same DHB for the same condition, this is counted as a follow up and not an FSA.
- Excludes ED attendances and outpatient attendance for pre-admission assessment/screening.

Specialist Follow Up Purchase Unit Allocation

The PUC allocation for outpatient specialist follow up is based on the specialty of the clinic which the patient is attending. This is because there may be diagnostic tests or infrastructure requirements that are specific between clinics. The HSC is allocated based on the specialty for which the treating clinician is employed to perform those events, so therefore could be different to the specialty of the PUC such as, a generalist physician who is providing Cardiology clinics in some small DHBs. See Appendix 2 for reporting of telehealth activity.

Non-Contact Follow Up Assessment

Non-Contact Follow Up Definition

A review is undertaken of patient records and any other relevant diagnostic, radiology, laboratory or physiological assessment results by a registered medical practitioner of registrar level or above, or a registered nurse practitioner. The patient should not be present during this follow up. A written plan of care is developed for the patient and the plan and other necessary advice is sent to patient and, if appropriate, the referrer. Further diagnostics are only to be included in the plan if ordered by the DHB providing the non-contact follow up. A non-contact follow up can take place in both medical and surgical specialties.

Non-Contact Follow Up Rules

- A written plan of care is required and must be able to be audited.
- The patient is not present during the assessment
- Diagnostics are only to be included if ordered by the DHB providing the non-contact follow up.

Non-Contact Follow Up Purchase Unit Code Allocation

PUC allocation is S00012 Surgical non-contact Follow Up - Any health specialty or M00011 Medical non-contact Follow Up - Any health specialty These PU codes should be reported with the health specialty code to NNPAC as well as with the Mode of Delivery code 7 (non-contact).

10 Inter-disciplinary Clinics

Inter-disciplinary Clinics Definition

An inter-disciplinary clinic constitutes of a mix of clinicians meeting together with a patient present to provide an assessment, for example where an oncologist, surgeon and allied health specialist are present at the same appointment for the treatment of a cancer patient.

Inter-disciplinary Clinics Rules

- Inter-disciplinary clinics are a single event with many clinicians present in the same clinic. There are some PUCs that specifically require a single count where many clinicians are present, such as, pain triple assessments
- However, if multiple appointments for one patient with many different clinicians are created, then these constitute individual events and should be counted under the appropriate service PUCs

This definition excludes non-clinicians and cultural and support staff, which is primarily included under the mental health purchasing framework.

Inter-disciplinary Clinics Purchase Unit Allocation

PUC allocation for inter-disciplinary clinics are:W03007 Rhesus Clinics - multidisciplinary clinics, M03008 Maternity foetal medicine clinics - multidisciplinary clinics, W03009 Fetal medicine / anomalies clinics - multidisciplinary clinics, W03011 Maternity multidisciplinary non-specialist clinic, S25008 Multifaceted Specialist Clinics and PC0007 Pain IDT assessment. See appendix 2 for rules on reporting mode of delivery

11 Pre-admission

Pre-admission Definition

An assessment that is carried out for patients who will undergo a procedure where anaesthesia is required.

Pre-admission Rules

- These are not funded separately as part of the national purchase framework as they are funded as part of the inpatient event
- A pre-admission should be counted regardless if the patient has the procedure or not.

Pre-admission Purchase Unit Allocation

- PUC allocation is determined by the health specialty
- Pre-admit PUCs have a suffix of PRE.

Non-Specialist Outpatient Events

12 Allied Health Services

Allied Health Services Definition

Allied health services provided in an outpatient or domiciliary setting to disability support services, health of older people and personal health clients. This includes post discharge services and other DHB referrals as well as community-referred clients.

Allied Health services include the following

- Physiotherapy
- Social work
- Occupational therapy
- Speech language therapy
- Dietetics
- Podiatry
- Non-mental health psychology

Allied Health Services Rules

- There is no counting distinction between first and follow up allied health events, although DHBs may choose to count these at a local level.
- Allied health activity provided in an inpatient setting is not counted separately for national collections, although DHBs may choose to count these at a local level.
- Telehealth consultations (including by telephone) are counted for national collections (See chapter 2 l.l for Telehealth rules).
- Allied health is provided across all major service groups. For consistency of counting, this activity should be mapped to the allied health purchase unit, not the major service group purchase, e.g. physiotherapy provided in an AT&R setting should be counted under AH01005 (Physiotherapy).
- Activity of a health care assistant is not counted nationally as they are not a registered health professional and must always work under the supervision of a registered health care professional. DHBs may choose to count this activity at a local level.

Allied Health Services Purchase Unit Allocation

PUC allocation for allied health services is determined by the professional group of the health provider rather than condition which they are treating for example physiotherapy events will always be AH01005 regardless of whether they are treating cystic fibrosis patients or orthopaedic patients. The HSC for allied health services is A01, unless the allied health professional works solely within a specialty service. If this is the case the HSC of the specialty that they work within can be used. This is to provide additional information for service planning for specialties. Report AH purchase unit codes with the appropriate Mode of Deliver (MoD) for example 3, if allied health is provided in a group setting (1 clinician to many clients) or 6 if provided by telephone. If group session provided by video report MoD as 3.

13 Nurse Led Outpatient Clinic

Nurse Led Outpatient Clinic Definition

Assessment, treatment, education and/or management clinics led by a nurse specialist for specialist groups of clients.

It excludes education and management of diabetes, respiratory, and cardiac clients that are covered in other PUCs. It also excludes clinics led by a nurse practitioner.

Nurse Led Outpatient Clinic Rules

- There is no counting distinction between first and follow-up events, although DHBs may choose to count these at a local level
- Telehealth consultations (including by telephone) are counted for national collections (See chapter 2 l. for Telehealth rules). A nurse specialist is defined as a nurse who has been given delegated authority to provide clinical care in a certain specialty.
- It excludes inpatient and domiciliary nursing activity which are counted under different PUCs

Nurse Led Outpatient Clinic Purchase Unit Allocation

PUC allocation for nurse led clinics is MS01001 (Nurse Led Outpatient Clinics) regardless of what clinical specialty they are associated with. The HSC for nurse led clinics is the specialty for which that nurse is employed to perform those events. This is to provide additional information for service planning for specialties. If the nurse provides services across

specialties, the default HSC of N01 should be used. Report MS01001 with the appropriate Mode of Delivery (MoD) for example 3, if nurse provides education in a group setting (1 clinician to many clients) or 6 if provided by telephone. If group session provided by video report MoD as 3.

14 Antenatal & Postnatal Consultations

Antenatal and Postnatal Consultations Definition

Antenatal and postnatal consults by a DHB employed non-specialist practitioner providing maternity care to a woman.

Antenatal and Postnatal Consultations Rules

- There is no counting distinction between first and follow-up events, although DHBs may choose to count these at a local level.
- Telehealth consultations (including by telephone) are counted for national collections (See chapter 2 I. for applicable Telehealth rules). Employed DHB staff cannot make section 88 Claims.
- DHB employed GPs are to be included in the definition.

Antenatal & Postnatal Consultations Purchase Unit Allocation

PUC allocation is: W01007 DHB non-specialist antenatal consults and W01008 DHB non-specialist postnatal consults.

15 Community Referred Tests

Community Referred Tests Definition

Community referred tests are defined as tests referred by a GP or private specialist. It includes interpretation and reporting of the test but excludes tests for people who are under treatment by a DHB service (either as an inpatient or outpatient) for tests associated with that treatment.

The following tests can be community referred:

- audiology
- cardiology
- endocrinology (including bone densitometry)
- gastroenterology
- laboratory
- neurology
- radiology
- respiratory
- urology.

Community Referred Tests Rules.

- Radiology should be counted using a Relative Value Unit (RVU) scale as defined according to the College of Radiologists definition for RVUs and codes
- Tests referred by a DHB specialist are not counted as a community referred test. These tests are an input into the event that generated the order.

Community Referred Tests Purchase Unit Allocation

- The PUC allocation is determined by the class of test, eg. radiology etc.

Other (non-completed) events

There are a number of occasions where a patient is booked and does not present or presents but the activity is not completed. These are counted for national monitoring purposes. The rules around non-completed events for admitted patients are included in the Casemix framework document. If the patient was booked for a consultation by telehealth then report the non-completed event with the same mode of delivery as if the patient had attended.

16 Did Not Attend (DNA)

Did Not Attend Definition

A patient is classified as DNA if they did not attend the outpatient clinic appointment and there was no communication before the appointment. If there was communication, this is a cancellation.

Did Not Attend Rules

- There is no agreed timeframe for communication prior to cancellation. It is up to each DHB to determine this.
- DNAs are used for counting purposes only.

Did Not Attend Purchase Unit Allocation

DNAs are identified by attendance type in NNPAC. The PUC allocated is the same PUC that would have been allocated had the event taken place, where it is possible derive this, otherwise an FSA or follow up PUC should be allocated.

17 Did Not Wait (DNW)

Did Not Wait Definition

Used for ED where the patient is triaged but did not wait for treatment. Also used for general Outpatient services where the patient arrives but does not wait to receive service. DNW is only collected against ED in NNPAC. If the patient receives treatment and then self-discharges you cannot submit as a DNW.

Did Not Wait Rules.

DNWs are only used for counting purposes.

Did Not Wait Purchase Unit Allocation

DNWs are identified by attendance type in NNPAC for ED events. Used for ED where the patient did not wait. Also for use where general outpatient arrives but does not wait to receive service. The PUC allocated is the same PUC that would have been allocated had the event taken place, where it possible to derive this, otherwise an FSA or follow up PUC should be allocated

18 Abandoned

Abandoned definition

Event that was started but not completed. For example, Radiology: MRI started but not finished for patient reasons, such as claustrophobia.

Abandoned Rule

Event is counted and submitted, as if the event was completed.

Appendix 1 - Unit of Measure Definitions

Unit of Measure	Definition
Adjuster	Price adjustment for cost elements not adequately recognised within national purchase unit base prices.
Assessment	Number of assessments. Initial assessments and reassessments should be counted separately.
Attendance	Number of attendances to a clinic/department/acute assessment unit or domiciliary. (Includes telehealth as defined in Common Counting Standards)
Available bed day	Total number of inpatient beds that are available to be occupied during the period multiplied by the number of days they are available during that period. To be counted as available the bed must be resourced, and either empty or occupied by a user of this service.
Brachytherapy volume	The volume count of brachytherapy volumes in one day is up to a maximum of five. The specialist may or may not be in attendance. Includes all planning and simulation, and radioactive isotope implants or treatments
Case	Number of deceased persons. Used for 'OT02001 Coroner Deaths not requiring Post Mortem' only.
Check	Number of checks provided, and other information outlined in the B4 School Check - Minimum Requirements for Information. A check cannot be counted until it is complete
Claim	Number of claims
Client	Unique clients managed by the service in the reporting period - financial year - (period is annual 1st July - 30th June).
Clinical FTE	Full-time equivalent clinical staff member (health professional) involved in the direct delivery of services to consumers. Exclude time that is formally devoted to administrative or management functions eg. half-time coordination of a community team. This includes the non-clinical training component of Registrar and House Officer time.
Completed treatment	Number of clients seen during the period (period is annual 1st July - 30th June) for any one diagnosis for which there are no further sessions or treatments booked.
Consultation	Number of consultations
Contact	The number of contacts between a health professional and client or group of clients, for the provision of clinical services/interventions described in the service's specification. A contact is equivalent to a visit. A contact excludes: communications where the sole purpose of the contact is provision of supplies or consumables. Where a service is provided to a group of people simultaneously by one health professional it will be counted as one contact, one event. See reporting Mode of delivery for guidance on reporting telehealth or group consultations.
Cost Weighted Discharge	A numerical measure representing the relative cost of treating a patient through to discharge
Day	**For carer support and respite care subsidy claims only.** Subsidies can be claimed in full days where care provided is over 8 hours up to 24 hours, or in half days where care provided is between 4 and 8 hours. Periods of care less than 4 hours can be combined to claim half days or full days.
Day attendance	Number of attendances to a day session lasting 3 hours or more.
Discharge	The process of documentation that changes the status of an admitted healthcare user.

Emergency Department Attendance	An attendance at an Emergency Department where the service user is assessed by a Registered Medical Practitioner, Registered Nurse or Nurse Practitioner. The service user receives treatment, therapy, advice, diagnostic or investigatory procedures. Includes patients who are subsequently admitted.
Fee for Service	Payment per defined modules.
Fitting of a prosthetic eye	Building and fitting of a prosthetic eye when done in an outpatient setting
FTE	Full-time equivalent staff member (clinical or non-clinical) involved in direct delivery of services to consumers. Exclude time that is formally devoted to administrative or management functions eg, half-time co-ordination of a community team.
Hour	Number of hours provided.
International units	Standard definition relating to blood products. Number of International Units used.
Item	Number of items provided/repaired.
Item Dispensed	Number of items dispensed
Meal	Number of meals provided. Used for 'DOM106 Meals on wheels' only
New Client	Number of clients at end of the reporting period who were not included in the caseload for the previous reporting period (period is annual 1st July - 30th June).
Non-Clinical FTE	Full-time equivalent staff member (without health professional qualification) directly delivering clinical/therapeutic services to consumers. Exclude time that is formally devoted to administrative or management functions eg. half-time co-ordination of a community team.
Occupied bed day	Total number of beds that are occupied each day over a designated period. For reporting purposes, count beds occupied as at 12 midnight of each day. Leave days, when the bed is not occupied at midnight are not counted. Counting formula is discharge date less admission date less leave days.
Other Clinical FTE	Full-time equivalent clinical staff member (health professional - other than senior medical officer) involved in the direct delivery of services to consumers. Exclude time that is formally devoted to administrative or management functions eg. half-time coordination of a community team. This includes the non-clinical training component of Registrar and House Officer time.
Package of Treatment	Service purchased on a partial capitation basis (some capitated, some fee for service)
Patient	Unique patients receiving treatments in the monthly reporting period (eg, a patient who received 8 treatments in May is counted as 1 patient).
Percentage of Population enrolled	The level of funding paid to PHOs is dependent on the percentage of the eligible number of Care Plus patients receiving Care Plus services. Used for 'PHOC0011' Care Plus Services' only.
Person enrolled	Number of people enrolled
Prescription item	Number of items dispensed. Used for 'PH1032 Paediatric Seravit wholesaler dispersal' only.
Procedure	The number of individual operative/diagnostic/assessment procedures in the period (period is annual 1st July - 30th June).
Programme	A set of related measures or activities that is purchased in a block arrangement and is uniquely agreed at a local level
Project	Agreed lump sum amount. Service purchased in a block arrangement

Radiotherapy volume	The volume count of radiotherapy events in one day is up to a maximum of 10 if there are multiple cancer sites to be treated. The specialist may or may not be in attendance. Includes all planning and simulation, and radiation treatment
Relative Value Unit	An individual operative/diagnostic/assessment/procedure completed as defined in the appropriate service specification.
Residential bed day	Total number of beds that are occupied each day in a community residential facility over a designated period. Part days at start and end of the period are both counted as full days. Leave days up to an agreed maximum are also counted. Counting formula is service end date, less service start date, plus one (1) less leave days over agreed maximum
Review	Number of Reviews
Senior Medical Clinical FTE	Full-time equivalent senior medical staff member involved in the direct delivery of services to consumers. Exclude time that is formally devoted to administrative or management functions eg. half-time coordination of a community team. This includes Director Area Mental Health Service (DAMHS) positions. Registrars and House Officers are specifically excluded.
Service	Service purchased in a block arrangement uniquely agreed between the parties to the agreement
Subsidy	Number of subsidies granted.
Test	Number of separate tests purchased. (eg, one person receiving an ECG and a stress test equates to two tests). For laboratory a group test such as Liver function is counted as 1 test not each individual component. For test sets refer Laboratory Agreement schedule.
Treatment	Number of attendances for treatment.
Treatment Hour	Time, in hours, from patient entering to exiting hyperbaric chamber
Vaccination	Number of vaccinations given
Visit	Number of visits by health professionals to a client's place of residence
Written plan of care	Written plan of care provided by the specialist to the referring GP

Appendix 2 Reporting Mode of Delivery

All outpatient activity must be reported using the appropriate mode of delivery as per table below.

If a consultation is provided by telehealth with many clinicians or many patients present the activity should be reported with mode of delivery 2 or 3. The group aspect of the activity takes precedent over whether the activity is provided by telehealth, under the assumption that the number of clinicians or clients has a greater impact on the cost of the activity.

Examples: Pain clinic PC0007 (Pain IDT) 1 patient, 3 clinicians of which one is attending via video. Report with MoD 2 (1 patient to many clinicians)

For Remote patient monitoring report with MoD 4 (Pacemaker tests (M10012) may be reported with MoD 4, however it is per definition provided through remote monitoring)

Mode of Delivery field codes for reporting to NNPAC as per NNPAC data mart data dictionary (https://www.health.govt.nz/publication/national-non-admitted-patient-collection-data-mart-data-dictionary)

1	In person (1 patient to 1 clinician)	Individual in-person at the same location. *Where tests are performed the mode of delivery is in-person
2	In person (1 patient to many clinicians)	Multi-disciplinary meeting with patient present at the same location and time
3	In person (1 clinician to many patients)	Group of patients being seen by one or more clinicians at the same location and time
4	Remote patient monitoring	monitoring of patient's biometric health information communicated from a remote patient medical device
5	Telephone	Voice only contact between patient and clinician using telephone
6	Video	Communication via technology enabling remote visual and audio contact between patient and clinician(s)
7	Non-contact	An event where decisions about patient health care are made without the patient being present.

*Where tests are performed the mode of delivery is in person - *because at some point the patient was there* - e.g. bloods were taken etc.