Non-Admitted Patient Data Collection using Tier 2 — one state’s experience

Joanne Chicco

When the Independent Hospital Pricing Authority (IHPA) announced that all non-admitted patient (NAP) service events would be activity based funded via their Tier 2 Classification from 1 July 2013, many eyebrows were raised in New South Wales (NSW). We knew that we had ways of collecting the required data, but we knew that there would need to be a major paradigm shift in the method of collecting non-admitted patient data, which to date had been collected using non-admitted patient occasions of service (NAPOOS). Over the past 20 years, NSW had collected counts of NAPOOS using the Department of Health Reporting System (DOHRS). The data had been variously collected by an old computer system known as VAX DOHRS, Web DOHRS and, more recently, via a specially-designed system called WebNAP. A network of Non-Admitted Patient Data Coordinators had long been established across all Local Health Districts (LHDs) in NSW to collect and analyse NAP data. We knew that the challenges would be:

- shifting the focus from reporting occasions of services by practitioner to reporting by the Tier 2 clinic attended
- shifting the focus of reporting counts of occasions of service to reporting patient-level service events.

NSW is currently in the process of replacing the existing health repository, known as the Health Information Exchange (HIE) with the new Enterprise Data Warehouse for Analysis Reporting and Decisions (EDWARD). EDWARD is NSW Health’s Enterprise Strategic initiative to create a single data instance and source of truth across the Ministry of Health (MoH) and all the LHDs, promoting a culture of information sharing that provides the opportunity for the business to gain insights and make informed decisions to increase performance.

A cornerstone of EDWARD is the Health Establishments Registration Online (HERO) system, which creates a unique identifier for each health ‘establishment’ for reporting purposes. HERO identifiers exist for all service units and locations within the NSW health system, moving down from the high level of LHD to the lowest level which includes clinics, wards and operating theatres. It is the responsibility of each LHD to register all of their entities in HERO. Once the entity is in HERO and has a HERO Identifier, it can be reported via the HIE and via EDWARD.

IHPA’s Tier 2 Non-Admitted Services classification is a listing of clinics. It is divided into four class types:

- 10 Series – procedure classes
- 20 Series – medical consultation classes
- 30 Series – stand-alone diagnostic classes
- 40 Series – allied health and/or clinical nurse specialist interventions classes.

HERO was well placed to collect Tier 2 clinics. When designed and introduced in 2008, the HERO ‘establishment type’ was roughly based on the Tier 2 classes that existed at the time, but with more granularity in certain areas. When IHPA’s Tier 2 Non-Admitted Services classification was finalised in February 2013, HERO’s list of Establishment Types was updated to include all of the classes in IHPA’s Tier 2 classification, but there was not an exact one to one match. We were reluctant to give up the granularity of some of our classes in HERO, so we mapped many of our more granular classes to the less granular Tier 2 class. As well as the previously mentioned network of Non-Admitted Patient Data Coordinators, NSW also had a network of HERO Coordinators across the LHDs. In many cases the NAP Coordinator and the HERO Coordinator was the same person, but in many other cases the NAP coordinators did not have a close relationship with the HERO Coordinator. This created some difficulties with terminology and definitions which has since been addressed.

The principal problem we faced was the paradigm shift in the definition. In DOHRS and WebNAP we had been collecting NAPOOS. As of 1 July, we needed to start collecting non-admitted patient service events (NAPSE). This was defined as ‘an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient’s medical record’. NSW was in a good position to collect these data, as fortunately EDWARD had been designed for collecting patient level data. Nevertheless we faced some major issues:

- a very short timeframe for change (February to July 2013)
- educating frontline staff in LHDs on the differences between a NAPOOS and a NAPSE, and convincing them that only services that were documented in the patient’s record were in scope
- debunking the myth that LHD services would not be funded at all if they did not fit into a Tier 2 class
- convincing frontline staff that 2013-14 was a ‘trial’ funding year in order for IHPA to get baseline costs for non-admitted patient service events.

The other major issue that we faced was educating the data collectors and the NAP Coordinators that Tier 2 is
a classification of clinics and not a classification of service providers. The DOHRS data was based on the collection of occasions of service by practitioners, so the mindset was that they would be reporting the same data and they would receive a National Weighted Activity Unit for each of these services provided by individual practitioners. Education revolved around the LHDs having to identify each of the clinics that were provided by the LHD, classifying the clinic according to rules within the Tier 2 Definitions Manual and Compendium, ensuring all of the clinics were registered in HERO and ensuring that a HERO identifier was allocated against each WebNAP entity. The following are examples of difficulties that were discovered:

- The Tier 2 Non-Admitted Definitions Manual and the Tier 2 Non-Admitted Compendium were interpreted differently by many different stakeholders. In order to control for these varied interpretations, NSW set state-wide standard ‘rules’ to enable data consistency.
- In many cases, Tier 2 classes were not as granular as classes that already existed in HERO. For example, HERO had establishment types of Sexual Health and Sexual Assault, whereas IHPA’s Tier 2 Definitions Manual instructed that all NSW Sexual Assault Services would be grouped with Sexual Health Services, which seemed to be grouping two very unlike services together.
- All NAP entities that were already in HERO (approximately 10,000 clinics) needed to be re-classified according to the artificial split in Tier 2 relating to medical consultation classes and allied health / clinical nurse specialist classes.
- In the vast majority of cases there was not an exact match between WebNAP data and HERO data, so a major ‘re-engineering’ of systems had to occur within a very short period (February to July 2013).
- There were some obvious deficiencies in the Tier 2 services classification (e.g. Addiction Medicine medical consultation class)

As always occurs in the NSW Health system, dedicated MoH and LHD staff have managed to deal with a new and difficult situation in a very short period of time. NSW had 19 hospitals participating in IHPA’s non-admitted costing study. HERO Coordinators and NAP Coordinators have realised the importance of cooperation. NSW continues to provide advice and leadership on the current Tier 2 classification. NSW has provided many recommendations to IHPA for changes to Tier 2 and its documentation. And most importantly, in my opinion, NSW strongly supports the development of a new Australian classification of non-admitted patient services.

Joanne Chicco, BAppSc(HIM), MBA
Manager, Data Quality
NSW Ministry of Health
email: JCHIC@doh.health.nsw.gov.au