Allied Health Data Set Specification and Data Definitions

Government
of South Australia

SA Health

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1. EXECUTIVE SUMMARY

In order to accurately capture all relevant patient level activity data, the following general rules should be observed.

1. Activity and time that provides a service to an individual, group or community to influence their health status is considered Clinical Care Activity.

2. Within Clinical Care, all activity/time that can be attributed to a specific patient with a unit record number (UR or URN) should be recorded against that patient. This includes group activity. This is considered 'UR attributable' data or Individual Patient Attributable data (IPA) data.

3. Clinical Care Activities that **cannot be attributed** to a specific patient but are provided to a group or community to influence health status should be recorded as Clinical Care Activity - Non-Individual Patient Attributable data (NIPA) data. This is considered non-UR attributable data.

4. A patient contact (PC) is the overarching term used to describe a direct interaction between a clinician and patient that involves therapeutic/clinical content such as an assessment, examination, consultation, treatment and/or education and is allocated irrespective of patient status i.e. admitted or non-admitted. A patient contact is recorded on initial contact and subsequent review(s) of the patient and/or their family/carer within an episode of care. Follow up activities related directly to the initial and review contacts (e.g. report writing, prosthesis modification, collecting equipment, analysis of results etc.) are not recorded as additional patient contacts however all the time involved in the provision of a service to the individual should still be recorded and would be classified as IPA data.

5. A patient contact is further defined in the **non-admitted/ABF** setting as a **service event** and an **occasion of service (OOS).** Service Events and Occasions of Service have discrete counting rules that must be applied when recording the non-admitted patient contact.

   * non –admitted/ABF setting is either a) a service that is provided in an outpatient or as an outreach of a hospital- it is a hospital funded service or b) a service recognized by the government as an ABF in scope service as it has been accepted as resulting in prevention of admission to hospital or substitution of hospital care.

6. Whilst there is a common premise for all recordable service contacts i.e. they must contain clinical content, be face-to-face or a substitution of face-to-face e.g. telephone and be verified by documentation in the patient's medical record and extend for 15 minutes or more, there are different definitions and hence counting rules for admitted and non-admitted patients (see Section 7).

7. Patients seen in the non-admitted/outpatient setting can be counted as having multiple patient contacts, OOS and service events on the same day; provided each visit meets the OOS and service event definitions and appointments are booked separately. This will be explained further within the document.

8. The involvement of more than 1 clinician **concurrently** (or other health service provider e.g. student or allied health assistant) in the delivery of a patient contact is counted differently depending on whether it occurs with an admitted or a non-admitted patient (see Appendix 5).

9. Patient contacts and intervention times provided directly to patients by students are recorded by the students following the same business rules as a qualified allied health professional. Supervisors are to record any time related to students that do not involve the supervisor delivering a clinical service to the patient as Clinical Services Support Activity- Teaching and Training.

10. Activities that cannot be attributed to Clinical Care Activity should be recorded as Clinical Services Support Activity. These may be classified as Clinical Services Management (CSM), Research (R), Teaching and Training (TT). Travel time associated with any of these activities should be identified and recorded against the correct activity branch.

2. BACKGROUND

The robust collection, recording and reporting of inpatient, outpatient and out of hospital activity data is a key strategy in supporting the performance monitoring, program measurement, service planning and funding. Such data is required at both state and commonwealth levels. Data informs state-based inpatient and outpatient costings via the SA Casemix Funding Model (Version 7) and provides costings under the Activity Based Funding (ABF) model. The consistent collection of data is also invaluable for the purposes of Allied Health benchmarking exercises both locally and nationally.

Allied health, for the first time, has agreed to align across the State the nationally mandated allied health data activity requirements for service delivery. This will capture an allied health clinician's time in relation to *Clinical Care activity* and *Clinical Services Support (non-clinical) activity*. *Clinical Care* activities will reflect individual patient-related (IPA) and non-individual patient-related (NIPA) activities including groups and clinics. Teaching and Training (TT), research (R) and clinical services management (CSM) activities and the time associated with undertaking them will be reflected as *Clinical Services Support (non-clinical) activity* activities.

To ensure reported activity is accurate, reproducible and standardised between and within professions and service locations *data definitions* are required. This document focuses on data definitions in relation to *allied health* workflows and as such should not be extrapolated to other professions.

The data definitions suit a number of purposes:

- Allied Health department management, benchmarking and workforce planning.
- SA Casemix Funding costing for inpatients and the Monthly Management Summary System (MMSS) for outpatients
- ABF requirements
- Information required for external submission (e.g. Health Round Table, site specific program funding etc.).

To facilitate uptake and ease of applicability the following data definitions have been informed by the Monthly Management Summary System Guidelines[1] (MMSS) and the *Independent Hospital Pricing Authority* (IHPA) non-admitted services related documents[2, 3], the National Health Data Dictionary[4] and the National Allied Health Data Set Specifications (in draft)[4].

It is acknowledged that due to the need for a consistency across a wide range of professions and service settings, there may be occasions where the proposed data definitions do not align strongly with the actual clinical presentation or scenario. In such circumstances, the best fit principle should be applied. Feedback regarding such instances are encouraged and this document will be updated as required.

Contact: [Allied and Scientific Health Office website](#) or
[alliedandscientifichealth@health.sa.gov.au](#)

Note: For EPAS users, this document is to be read in conjunction with the *Allied Health Business Rules.* The development and application of business rules and these data definitions will assist in driving improvements to the functionality and future build of the EPAS system for allied

health. *As EPAS develops, additional automation of data recording will occur to ease the collection of activity data for the clinician.*

Scope

The following allied health professions* across SA Health will be required to record activity data in line with these data definitions

- Audiology
- Art Therapy
- Diversional Therapy
- Exercise Physiology
- Music Therapy
- Nutrition/dietetics
- Occupational Therapy
- Orthoptics
- Orthotics
- Physiotherapy
- Podiatry
- Prosthetics
- Psychology
- Social Work
- Speech Pathology

In some settings/agencies, additional data may be required.

*The following allied health professionals/professions are **not** within the scope of this document:

- State-wide Clinical Services including Medical Radiation, Pharmacy and Medical and Grant Funded Scientists (SA Pathology);
- Cardiac Perfusionsists;
- Sonographers;
- Mental health professionals working in a dedicated purpose-funded mental health service.

This document and the Data Set (DS) and related definitions refer to data surrounding the services provided and the manner in which they were provided. It is understood that additional data items may be collected by some sites and services relating to client/patient characteristics e.g. demographics, diagnosis, client outcomes and characteristics of episodes of care e.g. open and close dates, referral dates.

Goal

Standardised clinical activity information and data entry within and between in scope *allied health professions and sites* and sites across SA Health.

Acknowledgement

This document follows extensive consultation with a range of state and interstate allied health clinicians, managers and performance, costing and data units. Those involved in providing examples and clarification of data definitions are recognised and thanked for their considerable contribution.

- The Data and Reporting Services team, SA Health.
- Queensland Health (2011) and the NSW South Eastern Local Hospital District, Illawarra Shoal Haven Local Hospital Districts and Sydney Children's Hospital (2012) who granted permission to use and modify their documents.

3. PRINCIPLES OF DATA COLLECTION

1. Data Collection Framework

The National Allied Health Casemix Committee (NAHCC) Health Activity Hierarchy (HAH v1.1) provides the basis for the classification of activity data[5]. For the purposes of further describing activities that do not fall under the Clinical Care Activity, the branch descriptor of Clinical Support Services Activity has been nominated.
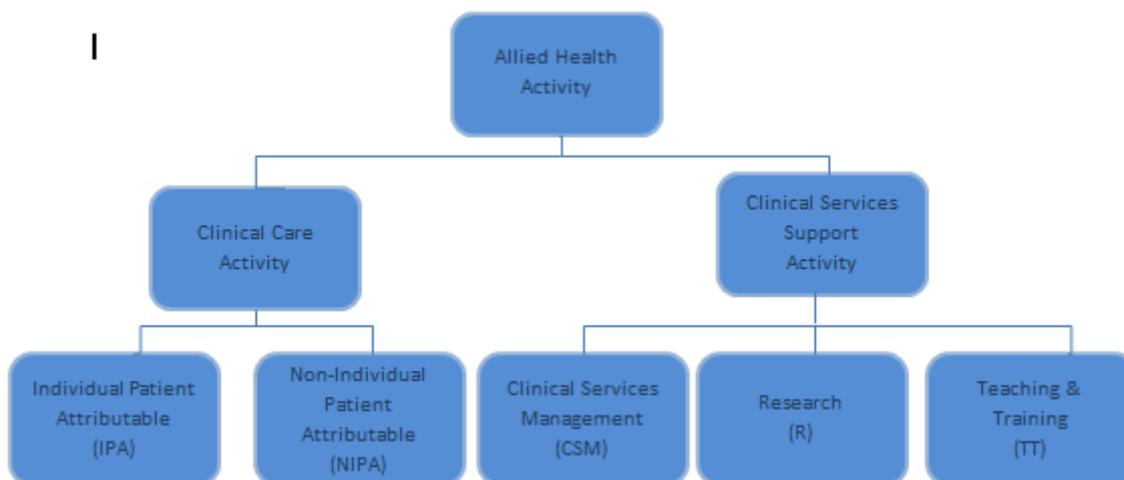
The first level (clinical decision) breaks the clinician's activity into Clinical Care and Clinical Services Support.

1.1 Clinical Care Activity:
Activities provided to an individual, group or community to influence health status. This includes Individual Patient Attributable (IPA) and Non-Individual Patient Attributable (NIPA) activity.

The second level of the Clinical Care Activity branch breaks clinical care activities into (1) Individual Patient Attributable (IPA) and (2) Non-Individual Patient Attributable (NIPA).

1.2 Clinical Services Support Activity:
Activities performed which are not directly related to a particular patient/individual, group or community to influence health status. These include activities that support and are in many settings integral to the delivery of clinical care such as teaching, research and administrative functions.

The second level of the Clinical Services Support Activity branch breaks activities into (1) Clinical Services Management, (2) Research (R) and (3) Teaching and Training (TT).

2. Data Set & Data Dictionary:

To ensure reported activity is accurate, reproducible and standardised between and within professions and service locations a standardized data set and data definitions are required. The SA Health Allied Health data set has been developed in alignment with the development of a national allied health data set specifications led by the National Allied Health eHealth Collaborative.

4. CLINICAL CARE ACTIVITY

This is data about activities which provide services to an individual, group or community to influence their health status.   Where ever possible and appropriate, **classify activity as Clinical Care.**

Clinical Care activities are separated into two categories - IPA and NIPA. Where possible and practical, clinicians should allocate time at the patient level **i.e. to a patient**. This will assist with providing an accurate reflection of activity costings which will ultimately inform service funding.

Individual Patient Attributable (IPA) Activity:

Any clinical care activity that **can** be assigned to an individual patient (including travel associated with care provision). This includes any *Direct* or *Indirect* patient care. Hence the patient does not need to be physically with the staff member in order for the staff member to attribute time to an IPA activity.

Example of *Direct* Individual Patient Attributable (IPA) data:

- Time spent in delivery of a clinical intervention/therapy with a patient

Examples of *Indirect* Individual Patient Attributable (IPA) Activity:

- Preparation of a handout or equipment for a patient
- Clinical record keeping or documentation without the patient present
- Activities such as session preparation or time spent waiting for the patient who fails to attend an appointment
- Travel to an individual patient's location in order to provide a clinical care activity
- Family or team meeting about a patient and their care needs
- Provision of supervision to a staff member relating to a patient or specific patients
- Patient related discussion (possibly as part of a formal supervision session)

Non-Individual Patient Attributable (NIPA) Activity:

Any clinical care activity that **cannot** be assigned to an individual patient(s).

Examples of NIPA activity:

- Groups where a person identifier for the patients attending is not available (e.g. "walk in groups")
- Design, preparation and implementation of clinical/education materials/resources/products for programs and services to which specific patients are yet to be allocated
- Clinical planning – time spent reviewing, developing and evaluating clinical services not specific to a patient
- Provision or receipt of supervision between colleagues relating to a particular clinical situation or client group/population where it is not possible to allocate activity to a specific patient
- Health promotion targeting a large group /population
- Situations where the identity of the patient(s) cannot be determined or is not a patient of the service i.e. general enquiries or the overhead to determine is excessive
- Travel related to a clinical activity but not specific to a specific patient.

5. CLINICAL SERVICES SUPPORT ACTIVITY

Definition:

Activities performed which are **not directly related** to a particular patient/individual, group or community to influence health status. These include activities that support and are an integral element to the delivery of clinical services such as teaching, research and administrative functions.

There are 3 categories of non-clinical allied health activity[5]:

1. Clinical Services Management (CSM)

   Professional and management activities which support and are essential to clinical care.

2. Teaching and Training (TT)

   Formal teaching or training activities which relate to the imparting of knowledge, skills and clinical competency to undergraduate and post graduate students, practitioners in own discipline, and other practitioners as part of a structured program.

3. Research (R)

   Activities undertaken to advance the knowledge of the delivery of care to an individual group or community. Research is limited to activities that lead to and follow formal approval of the project by a research committee or equivalent body.

6. ALLIED HEALTH DATA SET SPECIFICATIONS

The following Allied Health Data Set specifications and associated data items provide a consistent framework for the collection of administrative and activity related data. The data set is aligned with the draft National Allied Health Data Set Specifications[4] (NAHDSS) and has been informed by the SA Health data collection guidelines for outpatients (Monthly Management Summary System[1] (MMSS) and the *Independent Hospital Pricing Authority* (IHPA) recording and reporting requirements[2, 3].

The AHDSS is grouped into 2 sections- Administrative and Activity/Clinical Service Activity in line with the NAHDSS. In many sites, the Administrative data items will be captured via organisation wide systems as opposed to an allied health specific data collection system. Individual sites should endeavour to identify that these data items can be sourced from their respective sites or local health networks information systems. Where gaps are identified it is suggested that these are addressed by incorporating the missing elements into allied health data collection system or advocating for inclusion in the organisation data collection system.

Administrative Data Set	Activity/Clinical Data Set
1. Person Identifier	1. Admission Date
2. Sex	2. Service Date
3. Date of Birth	3. Referral Source
4. Indigenous Status	4. Client Type
5. Area of Usual Residence	5. Service Provider
6. Postcode	6. Provider Type
7. Telephone Number	7. Profession
8. Interpreter Services Required	***8. Attendance Type***
9. Preferred Language	***9. Service Delivery Setting***
10. Compensable Status	***10. Patient Contact***
11. Carer Availability	***10.1 Occasion of Service[1]***
	10.2 Service Event [2,5]
	11. Duration of Activity
	12. Contact Type
	13. Service Delivery Mode
	14. Medical Diagnosis
	15. Indicator for Intervention
	16. Allied Health Diagnosis/Clinical Finding
	17. Activity
	18. Non-Admitted/ Outpatient Clinic Type

Please note:
- *Bold highlighted data elements are described in more detail in section 7 and 8*
- *All Clinical/Clinical Service Activity data elements are also further detailed in Appendix 1 & 6 : Ready Reckoner*

7. CLINICAL ACTIVITY: KEY CONCEPTS DEFINED

7.1   Patient Contact
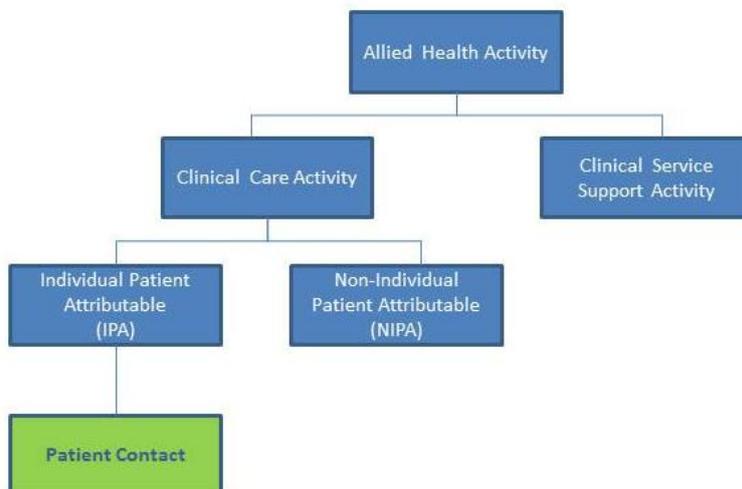
Patient Contact is the overarching term describing a direct patient interaction between a clinician and patient/s that involves therapeutic/clinical content and is irrespective of patient status i.e. admitted, non-admitted (outpatient or outreach) or out of hospital. One of its intended purposes is to assist in determining staffing inputs into the delivery of a direct patient service.

- An encounter with a patient during which an examination, consultation or treatment/intervention is provided.
- Include content relevant to the clinical management
- The contact must be of more than 15 minutes individualised duration to warrant recording as a patient contact.
- The contact must be face to face or a substitute for face to face e.g. telephone/telemedicine
- Each patient contact must be recorded in the patient's medical/clinical record.

The term "Patient contact" has been defined to simplify data collection for clinicians. It allows the clinician to record that a direct patient contact has been provided but is not constrained by reporting/recording rules that are aligned to state or federal government definitions for non-admitted activity data recording.

Non-hospital funded services and non–ABF funded services will record their direct patient contacts/interventions as 'patient contacts'. Services that do receive hospital funding or ABF funding will record data as 'patient contacts' for inpatient data and 'OOS' and 'service events' for outpatient /non-admitted data. For most of these sites they may also choose to record outpatient/non-admitted data as 'patient contacts' but this will be left for site determination (see Data Administrator's Note p16). EPAS sites will have the 'patient contact' field in their minimum data set in the discipline note and will be required to populate.

A Patient Contact (and any derivations of this) must meet the elements referred to above and constitute a minimum of 15 minutes to reflect clinical care activity, planning time, administration, and other activities and must include a direct patient interaction.

May Include:
- Individual and group activity
- Telephone/teleconference or telemedicine/telehealth calls initiated by the patient/carer or service provider where significant clinical information is discussed.
- Family conference where patient and/or carers are present
- Preparation and planning for a clinical activity performed on the same day.

Excludes:
- Services provided where an URN cannot be identified (i.e. NIPA)
- Phone contact from a patient to confirm an appointment where no therapeutic intent or provision is involved
- Medical/case note documentation/report writing that is not aligned to a clinical activity performed on the same day
- Case conferences (patient and/or carers are NOT present) / Case management
- Planning/preparation and administrative tasks associated with the service provision not performed on the same day as a direct clinical intervention

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Data Administrator's Note:

Patient Contact

The Patient Contact data item is not currently a reportable item to the state SA Health Data and Reporting services for non-admitted activity data for MMSS or ABF purposes.

Instances where more detail is required in recording and reporting

The data definitions have been written to capture all patient contacts and activity time however in some clinical environments, government reporting requirements apply. In the case of services provided in a non-admitted hospital setting or a hospital funded/auspiced service provided in a venue other than the hospital grounds, clinical activity must be described using specified terminology. The level of specificity in relation to further separating non-admitted/outpatient activity into OOS and service events (see 7.1.1-7.1.2) will be left to the site's discretion and undoubtedly will be influenced by the clinical information system being used. Sites will need to work with their respective ABF/patient costing/data reporting personnel to ensure the correct data is extracted and reported in line with ABF and MMSS requirements. For EPAS sites, this will be a more automated process.

Such sites who are required to record and report OOS and service event data for MMSS and ABF purposes may choose to not record patient contacts in these settings to minimise data collection.

7.1.1 Non- Admitted Services: Occasion of Service (OOS) *and*

7.1.2 Non- Admitted Services: Service Event
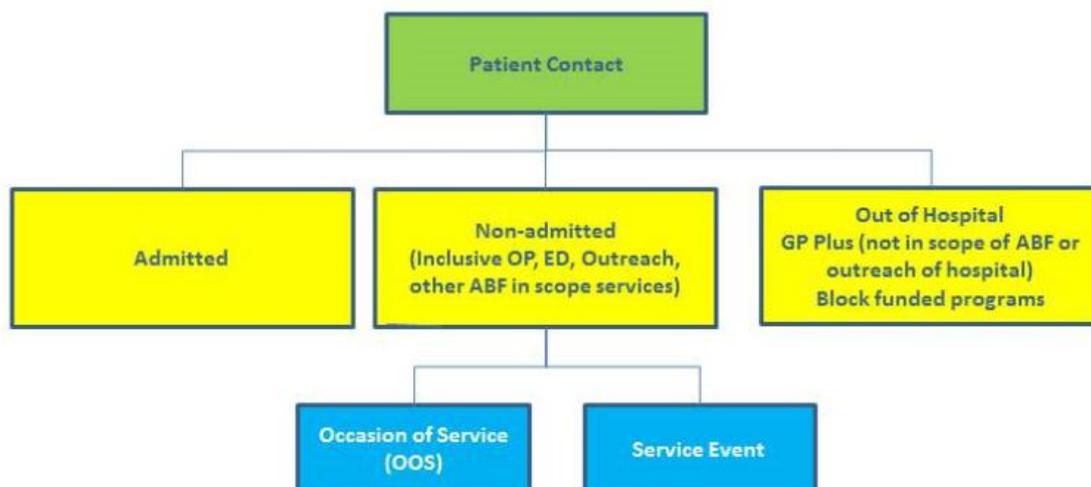
Some SA Health allied health services are required to report against services that are provided in their outpatient or non-admitted settings on a monthly basis. This activity has traditionally been recorded using the counting unit *Occasion of Service* (OOS). With the advent of Activity Based Funding an additional counting unit for non-admitted patient activity has been implemented by the Commonwealth – *the patient service event.*

An outpatient/non-admitted OOS is described as:

*"... any examination, consultation or treatment, or other health service provided to an outpatient or Emergency Department patient within **a functional unit of a hospital** [p20(1)]."*

A service event is described as:

"An interaction (assessment, examination, consultation, treatment and/or education) 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 [p51 (1)]".

Patients can be counted as having multiple non-admitted patient service events on the same day provided that every visit relates to a separate clinic* [p11(2)].

For eligible/in scope sites and services both counting units will be required in the short term. *Your Director of Allied Health and local health network patient costing unit should be able to identify whether your service is required to record and report service events in addition to OOS.*

Clinic is defined as ".. services provided through specific organisational units… where one or more specialist providers deliver care for booked patients [p15(1)]".

Whilst many of the counting principles for both service events and occasions of services are common and more often than not, they are 'like for like' there are however some distinct differences,

particularly in relation to the provision of group services. For this reason, it is necessary to distinguish between an OOS and service event when recording and reporting. It is acknowledged that without an automated clinical information system, this level of specificity will be challenging.

A site may consider using the *patient contact* data item to be synonymous with an OOS and service event count and only in circumstances where these 3 definitions do not align, do they specify OOS or service event.

The circumstances where they **do not** align are :

1) non-admitted group*

where :
n = number of patients participating
 patient contact =n , OOS = 1 (plus recording number of attendees (n)) ***and*** service events = n

> ** Note : Group is defined as more than 1 patient receiving treatment by a health professional where less than 15minutes of individualized treatment is provided to any individual within the session[(p30, 1).]*

2) non-admitted clinical interaction with multiple participants and AHPs. Each health professional provides the intervention to the group as a whole. This is still counted as a group session with the predominant profession /clinician counting the clinic against their service

where :
n = number of group participants
Predominant/ Lead Clinician:
        Patient contact = n, OOS =1 group (plus recording number of attendees) ***and*** service events = n

Secondary/Support Clinician:
        Patient contact = n, OOS =0, service event = 0

Other than these situations in the non-admitted/outpatient setting :

1 Patient contact = 1 OOS = 1 service event

7.2   New/Review Attendance Type

The attendance type indicates whether an interaction is either the initial (new) or subsequent (review) attendance during a single course of treatment (episode of care) from your service or profession. This applies to both admitted and non-admitted patients.

Definition:

New:
New attendance is defined as the first patient/ client contact or attendance to the service and/or profession (not to each clinician within the profession for that episode of care).

Review:
All other attendances following the initial (new) attendance for that episode of care within that profession.

Episode of Care:
An episode of care is a phase of treatment. For admitted patients, there may be more than one episode of care within the one hospital stay for a patient. An episode of care ends when the principle clinical intent changes or when the patient is formally separated from the facility.

Example:

A patient with a brain injury attends an outpatient clinic every 12 months for a reassessment. Usually this consult results in a further consultation being booked in 12 months' time. Each of these consultations are treated as new and the episode of care is closed after the appointment with the patient. This time however, the patient is offered 4 weeks of occupational therapy after this appointment.

Record:

Attendance Type = '**new**' for the 12 month review appointment and the subsequent 4 appointments are **'review'** attendances

Data Administrator's Note:

Attendance Type (New and Review) forms part of the minimum data set for non-admitted hospital activity funded via ABF. The definition for 'new' and 'review' from an ABF perspective differs to the allied health definition referred to above. Data and Reporting Services in SA Health consider only 1 presentation to a Tier 2 clinic within a 12 month calendar period as a 'New' attendance and any subsequent during that 12 month period are 'Reviews'. This is irrespective of whether this has occurred over 1 or multiple episodes of care and with multiple disciplines as it is patient centric. AHPs role in relation to this is only to ensure the correct Tier 2 code has been allocated for a non-admitted visit (if that is within their local services practices).

7.3   Duration of Activity

Definition: the total time attributable to a patient (direct or indirect) i.e. Clinical Care activities or clinical support service activities (teaching, research and administrative functions).

It is recognised that recording exact time may be difficult as many minor activities will occur during a clinician's working day (e.g. a brief 3 minute patient handover to a colleague). In an effort to reduce the overhead involved in recording all minor activities, only activities of 5 minutes duration or longer should be recorded. i.e. time is generally rounded to the nearest 5 minutes.

Clinical Care Activities:

Direct Activities:

Activities that involve the delivery of therapeutic intervention/service

Indirect Activities:

Indirect activities that may contribute to the delivery of a patient contact include:

- Medical note reading/writing

- Discussions specific to the patient with other members of the multi-disciplinary team e.g. medical, nursing, other allied health and support staff.
- Time spent in case conferences discussing specific patients planning/preparation time
- Travel time
- Time spent waiting for patient who fails to attend or is late.

Activity Duration:

It is recognized that some activities whilst not undertaken in the presence of the patient are an integral part of the delivery of a patient contact. As such the rules for the duration of a patient contact are:

1. The duration of a patient contact, service event or an OOS will be the count (in minutes) of direct time spent and indirect activities such as preparation ,planning, note writing, travel that is directly related and integral to the direct activity and occurring on the same day as the service.

    Advanced Data Collection: Some sites may choose to routinely record their activities to a level of specificity that identifies and separates direct and indirect activities either on an ongoing basis or periodically throughout the year. EPAS users have this functionality available to them in the professional structured note. In the event that direct and indirect activities are separated, the aggregate of the indirect and direct sub-totals to provide the total duration for the patient contacts/OOS/service event.

2. Where an indirect activity ***occurs on a day other than the day of the patient contact*** it relates to, it will be recorded separately as a standalone indirect activity and does not equate with a patient contact, service event or OOS.

Clinical Service Support Activities:

Clinical Service Support activities are activities that fall under the categories of Clinical Services Management, Teaching and Training, Research and travel associated with those activities. These are described in more detail in Section 8.

Activity Duration:

The duration of a clinical service support activity will be the count (in minutes) of any such activities undertaken in a day. The activities should be recorded under the broad headings of Clinical Services Management, Teaching and Training, Research and travel (or more detailed activity descriptors at the discretion of the site).

Example:

Clinical Care Activity Examples:

1) **A podiatrist sees a patient in outpatient clinic:**

   o Preparation time = 10 minutes reading a patient's medical notes immediately prior to session
   o Assessment = 45 minutes
   o Case note writing = 5 minutes
   o Patient related discussion with the multi-disciplinary team = 10 minutes

   Record:

   Total time *for the Patient Contact on that day = 70 minutes*

2) **An occupational therapist undertakes an off road driving assessment:**

   o Preparation time = 20 minutes
   o Assessment = 90 minutes
   o Case note writing = 10 minutes
   o Report writing and follow up = 60 minutes (undertaken the day following the assessment)

   Record:

   Total time *for the Patient Contact on that day = 120 minutes*

Clinical Service Support Activity Examples:

1) **A social worker catches up on some paperwork and also commences work on a clinical note audit:**

   o Paperwork/Administration = 60minutes

   o Clinical Case Note Audit = 120 minutes

   Record:

   Clinical Services Management* = 180 minutes

   * sites may choose to be more specific within this branch of the activity hierarchy and reflect the activity with more detailed descriptors e.g. Quality, Administration etc.

7.4   Contact Type

Definitions:

The *contact type* refers to the type of contact a clinician has in the course of delivering a service to either the patient or in the absence of the patient – a carer or third party.

- Individual
- Group (must also indicate number in the group)
- Third party
- Carer/ family

Individual:

Definition: Provision of a direct clinical intervention/service to one patient/client.

Group:

Definition: Group activity is recorded when two or more patients/clients receive the same service, at the same time, from the same health service provider. Groups can be inpatient or outpatient based and must contain content of therapeutic benefit.

Note: if a patient receives more than 15 minutes of individualised therapeutic intervention within the session, the session is eligible to be considered an individual patient contact and OOS if delivered in a non-admitted setting [p 30,1]

Third Party:

Definition: a person other than the patient or their carer. It may be another service provider.

Carer:

Definition: any person, for example, family, friend or neighbour who is giving regular, ongoing assistance to the identified patient without payment [4,]

7.5   Service Delivery Mode

Service Delivery Mode:

Contact mode refers to the <u>primary</u> method of communication used between the service providers and the clients (or other persons where the client is not present) during patient attributable contact.

<u>Telephone/teleconference</u>:

Definition: The healthcare provider delivers the service using a telephone[p47, (1)]. The encounter should satisfy the following criteria:
- A contact between a patient (or carer in lieu of a patient) and a health professional
- The encounter is a substitution for a face to face contact
- A principal diagnosis can be assigned or
- The patient has been previously treated for the condition by a health professional from the same clinic/department

Note: Administrative phone calls, booking schedules must not be counted as an occasion of service.

<u>Tele-medicine/videoconference</u>

Definition: as above for phones but communication occurring via secure telecommunication or video-communication mediums to patient or carer and must be a substitution for an in person consult.

<u>In Person</u>:

Definition: the healthcare provider delivers the service in the physical presence of the patient i.e. in the same room

<u>Postal/courier</u>:

Definition: Communication is made via a written document

<u>Electronic</u>:

Definition: Communication is made via electronic means e.g. email

<u>Other</u>
Definition: all other including not well defined elsewhere

Example:
A mother calls the Speech Pathology outpatient service and speaks to a Speech Pathologist regarding teat recommendations for bottle feeding her premature infant. The Speech Pathologist provides advice and recommendations over the phone and arranges for the infant and mother to attend an appointment in 2 weeks.   The Speech Pathologist makes a record of clinical recommendations in the patient's medical record. The appointment is created.

Record:

Service Delivery mode = Telephone

NB: this intervention is recorded against the infant as the patient, not the mother.

7.6 Client Type

A descriptor that assists with defining the funding category of the client and designed to comply with ABF and MMSS reporting requirements.

- Emergency Dept.
- Inpatient
- Outpatient
- Hospital funded outreach
- Same day admitted
- ABF funded primary care
- Primary care

Definitions:

Inpatient:
A patient **who undergoes** a formal admission process with an overnight stay.

Same Day Admitted:
A patient **who undergoes** a formal admission process, receives their treatment and then goes home on the same day.

Outpatient:
A person who attends, usually by appointment, the hospital to receive non-emergency outpatient care. An outpatient is not admitted as a patient of the hospital [p22-23(1)] .

Emergency Department:
A person who receives an unplanned (emergency –type) treatment in an emergency department.

Hospital Funded Outreach [p23(1)]:
Outreach/community care is care delivered by hospital employees to a *non-admitted* patient in the home, place of work or other non-hospital site. The distinction between outpatient patient care/ hospital funded primary care and outreach care is that for the outpatient patient care/ hospital funded primary care, the patient travels to the health care providers while for outreach care, the health provider's travel to the patients or another location to provide the service to the patients. Examples would include services provided in patient's homes, at special locations outside the hospital/primary care facility such as mobile clinics or remote clinics manned on a part-time basis

Note: Hospital funded outpatient clinics that have been transferred to a GP Plus Centre location of service delivery are considered Outreach Clinics as they are still funded by the hospital but are moved to a location of ease for the patient.

ABF funded Primary Care:

A number of services provided in the community by primary care services have been recognized as a substitute to hospital care. These services are funded via the activity based funding model. Funding may come via the local health network or centrally funded by SA Health.   Local Allied health managers or directors should be aware of which services are included in this category.

Primary Care:
Services provided to individuals and the community that are not funded via hospital funding streams. These services may be block funded by the state government or receive funding from other   sources.

7.7 Activity: UR # Attributable

Activity field describes both the direct and indirect allied health interventions.

Direct patient contact activities should be described using the code set reflected in Appendix 2 or codes that can be mapped to this code set. This code set is a selection of ACHI codes (ICD 10AM procedure codes). The code set is categorised into some discipline-specific as well as a generic profession code set and is represented as a 4 tiered classification system. Sites can determine to what level of detail they wish to record. Should they wish to continue to use an alternate code set , a mapping process should be developed to enable mapping to the ACHI code set.

Level 1 –describes the profession intervention using the profession descriptor

Level 2- describes the intervention across the descriptors: Assessment, Diagnostic Tests, Intervention, Skills Training, Counselling, Other Intervention

Level 3- describes the intervention in a more specific manner e.g. Counselling or education regarding assistive or adaptive device, aid or equipment

Level 4- describes the intervention using a more detailed descriptor

Sites may choose to use multiple descriptors to describe 1 direct intervention. Sites may choose to select descriptors across the different levels*.

*Note: be mindful that if using multiple descriptors for one intervention the aggregate of each description should equal the actual total duration of the patient contact

For an Allied Health Assistant working across professions, the intervention code should reflect the codes related to the discipline for which the most activity has been performed.

Indirect UR# attributable activities can be described under the broad headings of:

- Planning/preparation
- Patient Related Discussion
- Paperwork and reports
- Travel

Example:

A Dietitian who works in a community based setting visits a patient's home completes an assessment, provides intervention and documents in the medical notes.
Record:
Direct Activity:
Activity 1 = Therapeutic diet support = 30 mins
Activity 2 = Nutritional counselling or education = 30 mins
Indirect:
Activity Descriptor = travel

7.8 Outpatient/Non-Admitted Clinic Type Codes

Different services and organizations may use local code sets to describe their outpatient/non-admitted services. If a local code set has been used, these should be mapped back to the MMSS code and Tier 2 code set via a locally endorsed conversion process to enable appropriate costing in the Department of Health and Aging.

> Administrator's Note:
>
> Allied Health managers/directors should familiarise themselves with any mapping processes undertaken by hospital costing/casemix staff to ensure the mapping accurately reflects their services. For sites whose services are funded via ABF, it is preferable that they progress to using the Tier 2 code lists at the point of data collection to enhance validity of code allocation or ensure that local code lists are correctly mapped to a corresponding Tier 2 code.

7.8.1 Tier 2 Service Classification

The Tier 2 Service Classification data and definition set provide a framework for categorising, classifying and counting non-admitted patient interventions that have been identified as being funded under ABF. They are based on an assessment of both the type of clinician providing the service and the nature of the service provided. This has resulted in a number of classes (groupings) within an Outpatient Category that offer clinical meaningfulness and/or exclusivity across the spectrum of non-admitted services.

The classes are grouped into four categories that reflect the type of service provided and the clinicians that typically provide the service. Allied Health clinicians will enter against the *Allied health and/or clinical nurse specialist intervention category* and select the appropriate class/clinic (see Table 1 and Appendix 3).

Category	Description	Range of classes
Procedures	Procedures provided by a surgeon or other medical specialist.	10.01 – 10.18
Medical consultation	Medical consultations provided by a general physician or medical specialist	20.01 – 20.51
Stand-alone diagnostic	Diagnostic services, within a specific field of medicine or condition (e.g. epilepsy).	30.01 – 30.08
Allied health and/or clinical nurse specialist intervention	*Services provided by an allied health professional or clinical nurse specialist.*	*40.01 – 40.51*

Table 1: Tier 2 Non-Admitted Clinic Codes

A 'top-down' approach such as that referred to below and also in the   IHPA Tier 2 non – admitted services compendium 2014-15 [p8,2] is recommended when selecting tier 2 clinic codes :

- Intent of the Clinic – if the clinic had specific purpose or specialty e.g. continence (40.32) then that clinic code should be selected in lieu of the profession clinic code i.e. physiotherapy 40.09.
- Association with other clinics or services- if the clinic was a feeder clinic to other OPD medical clinics or medical units e.g. a preadmission clinic for orthopaedics – consider selecting Orthopaedics 40.44.
- Resources/Materials - Significant cost implications relating to resources/materials e.g. prostheses, aids and appliance. Where a service can satisfy the Aids and Appliances (40.03) definition (Tier 2 non admitted services definitions manual 2014-15 v3, p 100) the 40.03 code should be used.
- Profession - If the clinic was a generic profession outpatient clinic, then it would be more appropriate to use the profession clinic code.

7.8.2 MMSS codes

A standardized list of outpatient clinics is currently used by Department of Health and Aging. Typically these are not codes that allied health professionals are involved in entering but are instead mapped 'behind the scenes' by the facility's casemix/costing unit.

Example:

A patient attends an outpatient appointment for continence issues.

Record:

Local Clinic Name = Physiotherapy pulmonary rehab (PTREP)

MMSS code = 114 Physiotherapy

Tier 2 code = 40.32 Continence

7.8.3 Home Supports

The reporting of occasions of service and services events for MMSS and Activity Based funding purposes respectively differ to recording and reporting guidelines for other OOS and service events. This may be counted as an outpatient/non-admitted OOS and service event **without the presence of a healthcare provider** provided there is documentation of the procedure in the patient's medical record. Documentation should occur at the commencement of the outpatient episode of care (see new/ review section) and is entered indicating home supports are required. The appropriate Outpatient/Non-Admitted Service/clinic code should be recorded.

In the event that a patient is admitted to hospital, the service event total is less the number of days admitted to the hospital (see example 2)

Where allied health department may be responsible for recording and reporting a particular type of home support (i.e. TPN, enteral feeds, home oxygen) the following counting rules apply:

Home support	MMSS	ABF
TPN (10.17 Tier 2 code)	1 OOS per month	1 service event each day of the month patient not admitted to hospital
Enteral feed (10.18 Tier 2 code)	1 OOS per month	1 service event each day of the month patient not admitted to hospital
Home oxygen (10.19 Tier 2 code)	1 OOS per month	1 service event each day of the month patient not admitted to hospital

This data can be entered as an aggregate entry at the end of the month (see examples below)

Example:

A patient performs Home Enteral Nutrition (HEN) in their own home on a daily basis. There were no disruptions or changes to this routine in August (31 day month). The Dietitian enters into the clinical information system at the end of the month in 1 entry

Record:

Patient Contact = 0

OOS = 1

Service events = 31

Tier 2 code = 10.18

Example:

A patient performs HEN every day in their own home in October (a 31 day month), the patient is admitted to hospital for five days and during their admission HEN is performed by the patient in the hospital.

Record:

Patient Contact = 0

OOS =1

Service events = 26

Tier 2 code = 10.18

8. CLINICAL SERVICE SUPPORT ACTIVITY: KEY CONCEPTS DEFINED

8.1   Clinical Services Management

Professional and management activities which support and are essential to clinical care.

Includes:

General
- Staff meetings
- OHS activities
- Staff management
- Financial management
- Recruitment and performance appraisal
- Administration generally
- Travel related to any CSM activities
- Email management

Professional Development
- Attending in-services, lectures, interest groups, seminars and conferences or any other means of receiving teaching and training
- Journal reading and journal clubs

Quality
- Planning and conducting project work
- Activities in preparation for accreditation
- Program evaluation or new program development

Supervision
Supervision provided or received relating to general matters unrelated to a patient or patient /client population type. This includes:
- workload issues
- staff development issues
- discussion of staff development matters

Does NOT include:

- Student supervision or clinical education

- Supervision relating to a specific patient/s or patient/client group (this should be coded as a Clinical Care activity)

8.2   Teaching & Training

Formal teaching and training activities which relate to the *imparting* of knowledge, skills and clinical competency to undergraduate and postgraduate students, health practitioners within one's own professions or health practitioners from another profession, as part of a structured program.

Includes:

- Administration for general teaching and training activities
- Supervision of work experience placements
- Imparting knowledge, skills and clinical competency to undergraduate + postgraduate students, to practitioners within one's own profession and to other professions.
- The extension of a treatment/consultation session as a result of the session being used as a teaching and training opportunity for a student. (The standard duration of the session will be recorded as an IPA clinical care activity)
- Any travel involved in these activities

Excludes:

- one-to-one staff supervision (If involving/relating to a specific patient or patient/client group it should be recorded as a Clinical Care activity. All other supervision activities should be recorded as a CSM activity)
- informal or adhoc sessions with staff
- your own professional development (this should be classified as CSM)

8.3   Research

Activities undertaken to advance the knowledge of the delivery of care to an individual, group or community. Research is limited to activities that lead to and follow formal approval of the project by a research committee or equivalent body.

Includes:

- all time spent on research activities including meetings,

- telephone calls,

- administrative activities,

- consultation, preparation, planning, ethics committee approval and activities associated with the implementation phase of the research project, including the documentation and final reports of the project

- Any travel involved in these activities

Excludes

- Literature review (unless done as part of a formal research project).

9. ALLIED HEALTH ASSISTANT

Allied Health Assistants (AHAs) should record **all** their therapy time against specific patients wherever possible.

AHAs can also record a Patient Contact (and Service event/OOS for outpatients or non-admitted) where:

- *They are providing an intervention/therapy independent of other staff;*

- *Their intervention/therapy is documented separately in the patient's medical record;*

- *They provide an intervention for the patient alongside another health worker where they are required, for either assistance with the intervention or from a patient safety perspective.*

Example:

An AHA assists a patient to complete some paper based memory retraining activities set by the Speech Pathologist with the Stroke Rehabilitation Unit on an outpatient basis. The direct intervention takes 30 minutes and case note recording = 10 minutes. The Speech Pathologist is not present.

Record:
Patient Contact =1

OOS = 1

Service event = 1

Duration = 40 minutes

10. STUDENT

Student statistics must be captured as part of the service provision data. Accordingly the following model is recommended:

1. If student is treating the patient unaided **with** the supervisor observing
Student Records:
- Patient Contact = 1
- If in a hospital funded outpatient or non-admitted setting , additional recording is required;
  - Service Event = 1
  - OOS =1

Supervisor records:
    Clinical Service Support Activity – Teaching and Training.

2. If the student is treating a patient **without** a supervisor present
Student Records:
- Patient Contact = 1
- If in a hospital funded outpatient or non-admitted setting , additional recording is required;
  - Service Event = 1
  - OOS =1

Supervisor records:
- Time spent discussing the case, countersigning the notes etc. Recorded as Clinical Services Support – Teaching and Training.

3. The supervisor is treating the patient and a student is observing and/or participating in the treatment:
  Student Records:
- The student records **does not** record a patient contact

Supervisor records:
- Patient Contact = 1
- If in a hospital funded outpatient or non-admitted setting , additional recording is required;
  - Service Event = 1
  - OOS =1
- Any additional time taken due to the need to give explanations to student etc. should be entered as Clinical Services Support – Teaching and Training.

Example :

An Exercise Physiologist introduces themselves and their student to the patient on the ward. The supervisor discusses the treatment plan briefly with the patient (10 minutes) then allows the student to complete the treatment while the supervisor observes (20 minutes).
Record:

Supervisor:	Student:
Patient Contact = 1	Patient Contact = 0
Activity Descriptor 1 = Exercise Physiology	Activity Descriptor 1 = Exercise Physiology
Duration = 10 minutes	Duration = 30 minutes
Activity Descriptor 2 = Teaching and Training	
Duration = 20 minutes	

APPENDICES

APPENDIX 1: ALLIED HEALTH DATA SET SPECIFICATIONS

The following Allied Health Data Set specifications and associated data items provide a consistent framework for the collection of administrative and activity related data. The data set is aligned with the draft National Allied Health Data Set Specifications[4] (NAHDSS) and has been informed by the SA Health data collection guidelines for outpatients (Monthly Management Summary System[1] (MMSS) and the *Independent Hospital Pricing Authority* (IHPA) recording and reporting requirements[2, 3].

The AHDSS is grouped into 2 sections- Administrative and Activity/Clinical Service Activity in line with the NAHDSS. In many sites, the Administrative data items will be captured via organisation wide systems as opposed to an allied health specific data collection system. Individual sites should endeavour to identify that these data items can be sourced from their respective sites or local health networks information systems. Where gaps are identified it is suggested that these are addressed by incorporating the missing elements into allied health data collection system or advocating for inclusion in the organisation data collection system.

1.1 Administrative Data Set and Data Items

Data Element	Description	Reference Body
Person Identifier	*Person identifier unique within establishment or agency.*	*NHDD[6]*
Sex	*The biological distinction between male and female.*	*NHDD*
Date of Birth	*The date of birth of the person*	*NHDD*
Indigenous Status	*Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code. This is in accord with the first two of three components of the Commonwealth definition.*	*NHDD*
Area of Usual Residence	*Geographic location of usual residence as represented by a code. The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting state or territory, as defined in the Australian Standard Geographical Classification (ASGC).*	*NHDD*
Postcode	*Four digit postcode of area of the usual residence of the person.*	*NHDD*
Telephone Number	*The telephone number to contact the person.*	*NHDD*
Interpreter Services Required	*Whether an interpreter service is required by or for the person, as represented by a code.*	*NHDD*
Preferred Language	*The language (including sign language) most preferred by the person for communication, as represented by a code.*	*NHDD*
Compensable Status	*Whether or not a patient is a compensable patient, as represented by a code. A compensable patient is a person who:* • *Is entitled to claim damages under Motor Vehicle Third Party insurance **or*** • *Is entitled to claim damages under worker's compensation or* • *Has an entitlement to claim under public liability or common law damages.*	*NHDD*
Carer Availability	*The carer is any person, for example, family, friend or neighbour who is giving regular, ongoing assistance to the identified client without payment other than the pension or benefit.*	*NAHCC[5]/ NAHDSS[4]*

1.2 Clinical Activity Data Set and Data Items

* Note: underlined data elements are described in more detail in Section 7 & 8

	Data Element	Description	Format &/ Values	Standards Source/Origin	Health Activity Hierarchy	Mandatory Status	
						Core	Agency specific
1	*Admission Date*	• *Date on which an admitted patient commences an episode of care*	DDMMYYYY	NHDD[6] (via NAHDSS)	**Clinical Care:** IPA/NIPA		*Only facilities with admitting services*
2	*Service Date*	• *The date on which a service occurred*	XXX XXX	NHDD[6] (via NAHDSS)	**Clinical Care:** IPA/NIPA **Non Clinical Care :** CSM,R,TT	✓	
3.	*Referral Source*	• *A person or organisation from which a person or group of people is referred*	Local site determined	NHDD[6] (via NAHDSS)	**Clinical Care:** IPA	✓	
4.	*Client Type*	• *Describes the funding category the patient falls under* • ** referred to a 'client type' in National Allied Health Data Set*	• Emergency Dept. • Inpatient • Outpatient • Hospital funded outreach • Same day admitted • ABF funded primary care • Primary care	NAHCC HAH (via NAHDSS)	**Clinical Care:** IPA		✓ all hospital admitted or Tier 2 non-admitted services
5.	*Service Provider*	• *Identification of staff engaged in the service provision to the patient (either staff identification number or classification level)*	• Payroll/staff number • AHP classification	NHDD[6] (via NAHDSS)	**Clinical Care:** IPA/NIPA **Non Clinical Care :** CSM,R,TT	✓	

	Data Element	Description	Format &/ Values	Standards Source/Origin	Health Activity Hierarchy	Mandatory Status Core	Agency specific
6.	*Provider Type*	• *The designation of the health care provider who provided the clinical service e.g. allied health assistant, podiatrist*	Allied health professions, other position designations e.g. allied health assistant	NHDD (via NAHDSS)	**Clinical Care:** IPA/NIPA **Non Clinical Care :** CSM,R,TT	✓	
7.	*Profession*	• *The allied health profession the service is being delivered on behalf of*	Category of allied health profession e.g. speech pathology	NHDD (via NAHDSS)	**Clinical Care:** IPA/NIPA **Non Clinical Care :** CSM,R,TT	✓	
8.	*Attendance Type*	*Indicates whether an interaction is either the initial (new) or subsequent (review) attendance during a single course of treatment (episode of care) from your service or profession. This applies to admitted and non-admitted patients* **Note: This does not relate to the ABF definition of Attendance type and is more of an internal management tool.*	New Review N/A	NAHCC HAH (via NAHDSS)	**Clinical Care:** IPA	✓	
9.	*Service Delivery Setting*	• *Physical location of the patient when the service was provided* **referred to as ' health service setting' in National Allied Health Data Set specification*	local hospital campus work visit GP plus Private residence RACF Community Health Other hospital Unknown Other, specify …….	NHDD (via NAHDSS)	**Clinical Care:** IPA	✓	

	Data Element	Description	Format &/ Values	Standards Source/Origin	Health Activity Hierarchy	Mandatory Status Core	Agency specific
10	*Patient Contact*	• The overarching term describing a direct interaction between a clinician and patient that involves therapeutic/clinical content and is allocated irrespective of patient status i.e. admitted, non-admitted, out of hospital.	Numerical e.g. 1	ASHO	**Clinical Care:** IPA		✓ recommended for all to use but hospital/ABF services may choose not to use in outpatient /non-admitted setting and use OOS and service events only * Note: EPAS sites are required to record as it is part of the data set
10.1	*Occasion of Service[1]*	• A measure of any examination, consultation or treatment, or other health service provided to any **outpatients/non admitted patients or services identified as hospital –related services.** Used by SA government for the purposes of monthly reporting to the Department of Health, Government of South Australia	Numerical e.g. 1	MMSS Guidelines[1]	**Clinical Care:** IPA		✓ all sites providing recognised outpatient or emergency department (non-admitted) services
10.2	*Service Event[2,5]*	• 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. • The counting unit used in Activity based Funding for recording non-admitted patient care	Numerical e.g. 1	IHPA[2,3]	**Clinical Care:** IPA		✓ all sites providing recognised ABF non-admitted hospital funded services

	Data Element	Description	Format &/ Values	Standards Source/Origin	Health Activity Hierarchy	Mandatory Status Core	Mandatory Status Agency specific
11	Duration of Activity	*Total time recorded in minutes, attributable to an activity completed by the health care provider*	5 minimum increments	NAHCC HAH (via NAHDSS)	**Clinical Care:** IPA, NIPA **Non Clinical Care :** CSM,R,TT	✓	
12	Contact Type	Describes the type of contact with the patient	• Individual • Group (must also indicate number in the group) • Third party • Carer/ family	NAHCC HAH (via NAHDSS)	**Clinical Care:** IPA	✓	
13	Service Delivery Mode	Primary method of communication used between the service providers and the clients (or other persons where the client is not present) during patient attributable contact. (Referred to as Contact Mode and subset of 'Service Delivery mode' in NAHDSS) Referred to as service delivery mode in National Health Data Dictionary v16	• Telephone • In person • Telehealth • Postal/courier • Electronic mail • Other	NAHCC HAH (via NAHDSS) NHDD	**Clinical Care:** IPA, NIPA	✓	
14	Medical Diagnosis	The medical diagnosis/es of the client (optional for non-admitted clients)	• Selection from ICD-10AM	NAHCC HAH (via NAHDSS)	**Clinical Care:** IPA		**Admitted patients only**
15	Indicator for Intervention	The patient specific reason for allied health intervention/services. Does not refer to a medical condition/diagnosis or a particular treatment/therapy	*ASHO endorsed code set still under development*	NAHCC HAH (via NAHDSS)	**Clinical Care:** IPA	TBC	
16	Allied Health Diagnosis/Clinical Finding	The discipline specific diagnosis or outcome based on allied health clinical assessment.	*ASHO endorsed code set still under development*	NAHDSS	**Clinical Care:** IPA	TBC	

	Data Element	Description	Format &/ Values	Standards Source/Origin	Health Activity Hierarchy	Mandatory Status Core	Mandatory Status Agency specific
17	**Activity**	A task/treatment/service provided by an allied health professional that can be described to varying degrees of specificity dependent upon local site business practices.	Clinical Care Activity : IPA 3 levels of hierarchy available for UR attributable activity*; 1)Discipline intervention: E.g. physiotherapy 2)Broad descriptor: Assessment Intervention Skills training Counselling 3)Specific Descriptor: All codes map to an ACHI (ICD procedure) code NIPA Planning/Preparation Documentation/Reporting Patient Related Discussion Travel	ASHO NAHDSS	**Clinical Care:** IPA, NIPA **Non Clinical Care :** CSM,R,TT	✓	
18	**Non-Admitted/ Outpatient Clinic Type**	Classification system used to classify the outpatient clinic the patient was seen under	• ABF: Tier 2 Non-Admitted Clinic Codes &/or • MMSS clinic codes &/or • Site specific clinic codes- will be mapped to Tier 2 codes and MMSS codes	ASHO IHPA MMSS	**Clinical Care :** IPA		✓ **Hospital outpatient, outreach clinics & selected non –hospital based services**

APPENDIX 2: CLINICAL ACTIVITY CODES

Allied Health Generic

Code	Description	Level
01000000	Allied Health General	1
01010000	Assessment	2
01020000	Diagnostic Tests	2
01030000	Intervention	2
01040000	Skills Training	2
01050000	Counselling	2
01060000	Other Intervention	2

Audiology

Code	Description	Level
02000000	**Audiology**	**1**
02010000	**Assessment**	**2**
02020000	**Diagnostic Tests**	**2**
02020400	**Auditory function tests**	**3**
02020401	Air conduction audiometry, standard technique	4
02020402	Air conduction audiometry, visual reinforcement	4
02020403	Air & bone conduction audiometry, standard technique	4
02020404	Air & bone conduction audiometry, visual reinforcement	4
02020500	**Speech Audiometry**	**3**
02020501	Speech discrimination test	4
02020502	Speech discrimination test with background noise	4
02020503	Speech rollover test	4
02020600	**Speech audiometry involving central auditory function tests**	**3**
02020601	Staggered spondaic words (SSW) test	4
02020602	Filtered speech test	4
02020603	Synthetic sentence identification (SSI) test	4
02020700	**Auditory evoked potentials**	**3**
02020701	Brain Stem Evoked Response Audiometry	4
02020702	Electric Auditory Brain Stem Response Audiometry	4
02020800	**Impedance audiometry**	**3**
02020801	Tympanometry using standard probe tone	4
02020802	Tympanometry using high frequency probe tone	4
02020803	Acoustic reflex threshold	4
02020804	Acoustic reflex delay	4
02020805	Eustachian tube dysfunction test	4
02020900	**Vestibular function tests**	**3**
02020901	Caloric test of labyrinth	4
02020902	Simultaneous bithermal caloric test of labyrinth	4
02020903	Electronystagmography (ENG)	4
02020904	Other vestibular function tests	4
02030000	**Intervention**	**2**
02040000	**Skills Training**	**2**
02050000	**Counselling**	**2**
02060000	**Other Intervention**	**2**

Nutrition/Dietetics

Code	Description	Level
03000000	**Dietetics**	1
03010000	**Assessment**	2
03010300	**Assessment of personal care and other activities of daily/independent living**	3
03010305	Nutritional/dietary assessment	4
03020000	**Diagnostic Tests**	2
03030000	**Intervention**	2
03031701	Therapeutic diet support	4
03031702	Oral nutritional support	4
03031703	Enteral nutritional support	4
03031704	Parenteral nutritional support	4
03040000	**Skills Training**	2
03050000	**Counselling**	2
03050100	**Counselling or education relating to personal care and other activities of daily /independent living**	3
03050101	Preventative counselling or education	4
03050102	Nutritional counselling or education	4
03060000	**Other Intervention**	2

Occupational Therapy

Code	Description	Level
04000000	**Occupational Therapy**	1
04010000	**Assessment**	2
04010100	**Physiologic Assessment**	3
04010101	Other physiological assessment	4
04010102	Neurological assessment	4
04010109	Biomechanical assessment	4
04010110	Skin integrity assessment	4
04010300	**Assessment of personal care and other activities of daily/independent living**	**3**
04010301	Self-care/self-maintenance assessment	4
04010302	Health maintenance or recovery assessment	4
04010303	Assessment of need for assistive or adaptive device, aid or equipment	4
04010304	Review of assistive or adaptive device, aid or equipment	4
04010306	Prescribed/self-selected medication assessment	4
04010307	Home management assessment	4
04010308	Financial management assessment	4
04010309	Situational/occupational/environmental assessment	4
04010310	Parenting skills assessment	4
04010400	**Mental, behavioural or psychosocial assessment**	**3**
04010401	Psychosocial assessment	4
04010402	Alcohol and other drug assessment	4
04010403	Mental/behavioural assessment	4
04010500	**Other assessment, consultation, interview, examination or evaluation**	**3**
04010501	Ageing assessment	4
04010502	Other assessment, consultation or evaluation	4
04010503	Developmental testing	4
04020000	**Diagnostic Tests**	2
04020200	**Measurement or study of visual function**	**3**
04020201	Measurement of visual acuity	4
04020300	**Perimetry**	**3**
04020301	Manual perimetry, unilateral	4
04020302	Manual perimetry, bilateral	4
04020900	**Vestibular function tests**	**3**
04020904	Other vestibular function tests	4
04021100	**Exercise testing to assess respiratory status**	**3**
04021101	Exercise testing to assess respiratory status	4
04021500	**Other diagnostic tests, measures or investigations**	**3**
04021501	Noninvasive diagnostic tests, measures or investigations, not elsewhere classified	4
04030000	**Intervention**	**2**
04030600	**Dressing of burn**	**3**
04030601	Dress burn <10% body surface area dressed	4
04030602	Dress burn >=10% body surface area dressed	4
04030700	**Dressing of other wound**	**3**
04030701	Dressing of wound	4
04031600	**Interventions involving assistive or adaptive device, aid or equipment**	**3**

04031608	Noninvasive placement of bone growth stimulator	4
04031609	Manufacture of assistive or adaptive device, aid or equipment	4
04031610	Application, fitting, adjustment or replacement of other assistive or adaptive device, aid or equipment	4
04031611	Repair of assistive or adaptive device, aid or equipment	4
04031612	Removal of assistive or adaptive device, aid or equipment	4
04031800	**Alcohol and drug rehabilitation and detoxification**	**3**
04031900	**Psychological/psychosocial therapies**	**3**
04031901	Psychological skills training	4
04031903	Cognitive behaviour therapy [CBT]	4
04031904	Systems therapy	4
04031906	Music therapy	4
04031907	Behaviour therapy	4
04031908	Interpersonal psychotherapy [IPT]	4
04031911	Other psychotherapies or psychosocial therapies	4
04031912	Art therapy	4
04031913	Bibliotherapy	4
04031914	Narrative therapy	4
04031915	Supportive psychotherapy, not elsewhere classified	4
04032000	**Therapies using agents, not elsewhere classified**	**3**
04032001	Cold therapy	4
04032002	Heat therapy	4
04032004	Biofeedback	4
04032006	Therapeutic ultrasound	4
04032007	Stimulation therapy, not elsewhere classified	4
04032300	**Other therapeutic interventions on genitourinary system**	**3**
04032301	Bladder retraining	4
04032400	**Therapeutic interventions on musculoskeletal system**	**3**
04032401	Manipulation/mobilisation of joint, not elsewhere classified	4
04032402	Range of movement/muscle testing with specialised equipment	4
04032500	**Other therapeutic interventions**	**3**
04032501	Removal of sutures, not elsewhere classified	4
04032503	Removal of therapeutic device, not elsewhere classified	4
04032504	Noninvasive therapeutic intervention, not elsewhere classified	4
04032505	Acupuncture	4
04032506	Therapeutic massage or manipulation of connective/soft tissue, not elsewhere classified	4
04032700	**Assistance interventions**	**3**
04032701	Assistance with activities related to self-care/self-maintenance	4
04032702	Assistance with activities related to health maintenance	4
04032703	Assistance with application of assistive or adaptive device, aid or equipment	4
04032704	Assistance with activities related to body position/mobility/movement	4
04032705	Assistance with activities related to transfers	4
04032706	Assistance with activities related to home management	4
04032707	Assistance with activities related to parenting	4
04032800	**Other client support interventions**	**3**
04032801	Service co-ordination	4
04032802	Advocacy	4
04032803	Accompanying or transportation of client	4

04040000	**Skills Training**	**2**
04040200	**Skills training in relation to learning, knowledge and cognition**	**3**
04040201	Skills training in activities related to learning	4
04040202	Skills training in activities related to sensory/sensorimotor/sensorineural function	4
04040203	Skills training in activities related to memory, orientation, perception or attention	4
04040204	Skills training in activities related to executive skills	4
04040300	**Skills training in movement**	**3**
04040302	Exercise therapy, ocular muscles	4
04040304	Exercise therapy, shoulder joint	4
04040306	Exercise therapy, back or neck muscles	4
04040307	Exercise therapy, arm muscles	4
04040308	Exercise therapy, elbow joint	4
04040309	Exercise therapy, hand muscles, wrist or finger joints	4
04040310	Exercise therapy, hip joint	4
04040312	Exercise therapy, leg muscles	4
04040313	Exercise therapy, knee joint	4
04040314	Exercise therapy, foot muscles, ankle or toe joints	4
04040315	Exercise therapy, total body	4
04040316	Skills training in activities related to body position/mobility/movement	4
04040317	Skills training in activities related to transfers	4
04040400	**Skills training in body system functions**	**3**
04040402	Skills training for binocular vision	4
04040404	Exercise therapy, cardiorespiratory/cardiovascular system	4
04040500	**Skills training for personal care and other activities of daily/independent living**	**3**
04040501	Skills training in activities related to self-care/self-maintenance	4
04040502	Skills training in activities related to health maintenance	4
04040503	Skills training in use of assistive or adaptive device, aid or equipment	4
04040504	Skills training in activities related to home management	4
04040505	Skills training in activities related to financial management	4
04040506	Skills training in parenting techniques	4
04040507	Occupational/vocational skills training	4
04040508	Skills training in ergonomics	4
04040509	Play/leisure/recreation therapy	4
04040600	**Other skills training**	**3**
04040601	Skills training in water confidence techniques	4
04040602	Other skills training	4
04050000	**Counselling**	**2**
04050100	**Counselling or education relating to personal care and other activities of daily /independent living**	**3**
04050101	Preventative counselling or education	4
04050103	Counselling or education for visual loss or ocular disorder	4
04050105	Counselling or education regarding assistive or adaptive device, aid or equipment	4
04050106	Prescribed/self-selected medication counselling or education	4
04050107	Substance addiction counselling or education	4
04050109	Self-care/self-maintenance counselling or education	4
04050110	Counselling or education on health maintenance or recovery activities	4
04050111	Home management counselling or education	4
04050112	Financial management counselling or education	4

04050113	Situational/occupational/environmental counselling or education	4
04050114	Counselling or education on preparing for parenthood, parenting skills or family planning	4
04050200	**Psychosocial counselling**	**3**
04050201	Relationship counselling	4
04050202	Crisis situation/event counselling	4
04050203	Physical abuse/violence/assault counselling	4
04050204	Grief/bereavement counselling	4
04050205	Other psychosocial counselling	4
04050300	**Other counselling or education**	**3**
04050302	Resource education	4
04050303	Other counselling or education	4
04060000	**Other Intervention**	**2**

Orthoptics

05000000	Orthoptics	1
05010000	Assessment	2
05020000	Diagnostic Tests	2
05021600	Ultrasound of head or neck	3
05021601	Ultrasound of orbital contents	4
05030000	Intervention	2
05032100	Therapeutic interventions on eye, ear, nose, mouth and throat	3
05032101	Irrigation of eye	4
05032102	Eye occlusion therapy	4
05032500	Other therapeutic interventions	3
05032501	Removal of sutures, not elsewhere classified	4
05032502	Removal of foreign body without incision, not elsewhere classified	4
05032504	Noninvasive therapeutic intervention, not elsewhere classified	4
05032700	Assistance interventions	3
05032701	Assistance with activities related to self-care/self-maintenance	4
05032702	Assistance with activities related to health maintenance	4
05032703	Assistance with application of assistive or adaptive device, aid or equipment	4
05032704	Assistance with activities related to body position/mobility/movement	4
05032800	Assistance interventions	3
05032801	Service co-ordination	4
05032802	Advocacy	4
05032803	Accompanying or transportation of client	4
05040000	Skills Training	2
05040300	Skills training in movement	3
05040302	Exercise therapy, ocular muscles	4
05040400	Skills training in body system functions	3
05040402	Skills training for binocular vision	4
05040500	Skills training for personal care and other activities of daily/independent living	3
05040503	Skills training in use of assistive or adaptive device, aid or equipment	4
05040504	Skills training in activities related to home management	4
5040508	Skills training in ergonomics	4
05050000	Counselling	2
01060000	Other Intervention	2

Physiotherapy

Code	Description	Level
07000000	Physiotherapy	1
07010000	Assessment	2
07010100	Physiological Assessment	3
07010101	Other physiological assessment	4
07010102	Neurological assessment	4
07010103	Swallowing function assessment	4
07010109	Biomechanical assessment	4
07010110	Skin integrity assessment	4
07010200	Preoperative Anaesthesia Assessment	3
07010201	Routine preoperative anaesthesia assessment	4
07010202	Prolonged preoperative anaesthesia assessment	4
07010203	Emergency preoperative anaesthesia assessment	4
07010300	Assessment of personal care and other activities of daily/independent living	3
07010301	Self-care/self-maintenance assessment	4
07010302	Health maintenance or recovery assessment	4
07010304	Assessment of need for assistive or adaptive device, aid or equipment	4
07010304	Review of assistive or adaptive device, aid or equipment	4
07010306	Prescribed/self-selected medication assessment	4
07010307	Home management assessment	4
07010309	Situational/occupational/environmental assessment	4
07010400	Mental, behavioural or psychosocial assessment	3
07010401	Psychosocial assessment	4
07010402	Alcohol and other drug assessment	4
07010403	Mental/behavioural assessment	4
07010500	Other assessment, consultation, interview, examination or evaluation	3
07010501	Ageing assessment	4
07010502	Other assessment, consultation or evaluation	4
07010503	Developmental testing	4
07020000	Diagnostic Tests	2
07020300	Perimetry	3
07020301	Manual perimetry, unilateral	4
07020302	Manual perimetry, bilateral	4
07020900	Vestibular function tests	3
07020904	Other vestibular function tests	4
07021000	Measurement of respiratory muscle strength	3
07021001	Measurement of respiratory muscle strength involving transdiaphragmatic or oesophageal pressures	4
07021002	Measurement of respiratory muscle strength at multiple lung volumes	4
07021003	Measurement of respiratory muscle endurance or fatigability	4
07021004	Measurement of respiratory muscle strength before and after intravenous injection of placebo and anticholinesterase drugs	4
07021100	Exercise testing to assess respiratory status	3
07021101	Exercise testing to assess respiratory status	4
07021102	Spirometry with exercise testing	4

07021200	Other measurement of respiratory function	3
07021201	Bronchospirometry	4
07021202	Measurement of pulmonary distensibility	4
07021203	Measurement of total lung volume	4
07021204	Measurement of airway or pulmonary resistance	4
07021205	Inhalation provocation testing	4
07021206	Other measurement of respiratory function	4
07021400	**Other cardiovascular diagnostic tests, measures or investigations**	**3**
07021401	Cardiovascular stress test	4
07021402	Upright tilt table testing	4
07021403	Telemetry	4
07021500	**Other diagnostic tests, measures or investigations**	**3**
07021501	Noninvasive diagnostic tests, measures or investigations, not elsewhere classified	4
07030000	**Intervention**	**2**
07030100	**Airway management**	**3**
07030101	Management of endotracheal intubation, single lumen	4
07030102	Management of endotracheal intubation, double lumen	4
07030103	Management of nasopharyngeal intubation	4
07030104	Management of tracheostomy	4
07030105	Management of other intubation of respiratory tract	4
07030200	**Noninvasive ventilatory support**	**3**
07030201	Management noninvasive ventilatory support <= 24 hours	4
07030202	Management noninvasive ventilatory support > 24 < 96 hr	4
07030203	Management noninvasive ventilatory support >= 96 hours	4
07031600	**Interventions involving assistive or adaptive device, aid or equipment**	**3**
07031601	Application of hip spica	4
07031602	Application of shoulder spica	4
07031603	Application of plaster jacket	4
07031604	Application of halo	4
07031605	Application of halo and thoracic jacket	4
07031606	Application of halo femoral traction	4
07031607	Traction, not elsewhere classified	4
07031609	Manufacture of assistive or adaptive device, aid or equipment	4
07031610	Application, fitting, adjustment or replacement of other assistive or adaptive device, aid or equipment	4
07031611	Repair of assistive or adaptive device, aid or equipment	4
07031612	Removal of assistive or adaptive device, aid or equipment	4
07032000	**Therapies using agents, not elsewhere classified**	**3**
07032001	Cold therapy	4
07032002	Heat therapy	4
07032003	Extracorporeal shockwave lithotripsy [ESWL] of sites not elsewhere classified	4
07032004	Biofeedback	4
07032005	Hydrotherapy	4
07032006	Therapeutic ultrasound	4
07032007	Stimulation therapy, not elsewhere classified	4
07032200	**Other therapeutic interventions on respiratory system**	**3**
07032201	Respiratory medication administered by nebuliser	4
07032202	Other oxygen enrichment	4

07032203	Other control of atmospheric pressure and composition	4
07032204	Nonincisional drainage of respiratory tract	4
07032300	**Other therapeutic interventions on genitourinary system**	**3**
07032301	Bladder retraining	4
07032400	**Therapeutic interventions on musculoskeletal system**	**3**
07032401	Manipulation/mobilisation of joint, not elsewhere classified	4
07032402	Range of movement/muscle testing with specialised equipment	4
07032403	Phototherapy, joint	4
07032404	Phototherapy, soft tissue	4
07032500	**Other therapeutic interventions**	**3**
07032504	Noninvasive therapeutic intervention, not elsewhere classified	4
07032506	Therapeutic massage or manipulation of connective/soft tissue, not elsewhere classified	4
07032700	**Assistance interventions**	**3**
07032702	Assistance with activities related to health maintenance	4
07032703	Assistance with application of assistive or adaptive device, aid or equipment	4
07032704	Assistance with activities related to body position/mobility/movement	4
07032705	Assistance with activities related to transfers	4
07032706	Assistance with activities related to home management	4
07032800	**Other client support interventions**	**3**
07032801	Service co-ordination	4
07032802	Advocacy	4
07040000	**Skills Training**	**2**
07040200	**Skills training in relation to learning, knowledge and cognition**	**3**
07040202	Skills training in activities related to sensory/sensorimotor/sensorineural function	4
07040204	Skills training in activities related to executive skills	4
07040300	**Skills training in movement**	**3**
07040301	Exercise therapy, facial muscles/temporomandibular joint	4
07040302	Exercise therapy, ocular muscles	4
07040303	Exercise therapy, oesophageal muscles	4
07040304	Exercise therapy, shoulder joint	4
07040305	Exercise therapy, chest or abdominal muscles	4
07040306	Exercise therapy, back or neck muscles	4
07040307	Exercise therapy, arm muscles	4
07040308	Exercise therapy, elbow joint	4
07040309	Exercise therapy, hand muscles, wrist or finger joints	4
07040310	Exercise therapy, hip joint	4
07040311	Exercise therapy, pelvic floor muscles	4
07040312	Exercise therapy, leg muscles	4
07040313	Exercise therapy, knee joint	4
07040314	Exercise therapy, foot muscles, ankle or toe joints	4
07040315	Exercise therapy, total body	4
07040316	Skills training in activities related to body position/mobility/movement	4
07040317	Skills training in activities related to transfers	4
07040400	**Skills training in body system functions**	**3**
07040403	Exercise therapy, respiratory system [breathing]	4
07040404	Exercise therapy, cardiorespiratory/cardiovascular system	4
07040500	**Skills training for personal care and other activities of daily/independent living**	**3**
07040502	Skills training in activities related to health maintenance	4

07040503	Skills training in use of assistive or adaptive device, aid or equipment	4
07040504	Skills training in activities related to home management	4
07040508	Skills training in ergonomics	4
07040509	Play/leisure/recreation therapy	4
07040600	**Other skills training**	**3**
07040601	Skills training in water confidence techniques	
07040602	Other skills training	4
07050000	**Counselling**	**2**
07050100	**Counselling or education relating to personal care and other activities of daily /independent living**	**3**
07050101	Preventative counselling or education	4
07050105	Counselling or education regarding assistive or adaptive device, aid or equipment	4
07050106	Prescribed/self-selected medication counselling or education	4
07050110	Counselling or education on health maintenance or recovery activities	4
07050111	Home management counselling or education	4
07050113	Situational/occupational/environmental counselling or education	4
07050300	**Other counselling or education**	**3**
07050302	Resource education	4
07050303	Other counselling or education	4
07060000	**Other Intervention**	**2**

Podiatry

code	Description	Level
09000000	**Podiatry**	**1**
09010000	**Assessment**	**2**
09010100	**Physiological Assessment**	**3**
09010101	Other physiological assessment	4
09010102	Neurological assessment	4
09010108	Vascular assessment	4
09010109	Biomechanical assessment	4
09010110	Skin integrity assessment	4
09010200	**Preoperative Anaesthesia Assessment**	**3**
09010201	Routine preoperative anaesthesia assessment	4
09010300	**Assessment of personal care and other activities of daily/independent living**	**3**
09010301	Self-care/self-maintenance assessment	4
09010303	Assessment of need for assistive or adaptive device, aid or equipment	4
09010304	Review of assistive or adaptive device, aid or equipment	4
09010500	**Other assessment, consultation, interview, examination or evaluation**	**3**
09010502	Other assessment, consultation or evaluation	4
09020000	**Diagnostic Tests**	**2**
09021300	**Examination and recording of wave forms of peripheral vessels**	**3**
09021301	Examination and recording of wave forms of peripheral vessels before exercise and measurement of pressure after exercise	4
09021500	**Other diagnostic tests, measures or investigations**	**3**
19021501	Noninvasive diagnostic tests, measures or investigations, not elsewhere classified	4
09030000	**Intervention**	**2**
09030300	**Administration of agent into other musculoskeletal sites**	**3**
09030301	Administration of agent into joint/other synovial cavity, not elsewhere classified	4
09030302	Admin of other agent into soft tissue, not elsewhere classified	4
09030400	**Other application, insertion or removal procedures on other musculoskeletal sites**	**3**
09030401	Removal of pin, screw or wire, not elsewhere classified	4
09030500	**Excision procedures on other musculoskeletal sites**	**3**
09030501	Excisional debridement of soft tissue	4
09030502	Excision of soft tissue, not elsewhere classified	4
09030700	**Dressing of other wound**	**3**
09030701	Dressing of wound	4
09030800	**Administration of agent into skin and subcutaneous sites**	**3**
09030801	Administration of agent into skin lesion	4
09030900	**Removal of foreign body from skin and subcutaneous tissue**	**3**
09030901	Removal of foreign body from skin and subcutaneous tissue without incision	4
09031000	**Other application, insertion or removal precedures on skin and subcutaneous tissue**	**3**
09031001	Aspiration of haematoma of skin and subcutaneous tissue	4
09031002	Aspiration of abscess of skin and subcutaneous tissue	4
09031003	Other aspiration of skin and subcutaneous tissue	4
09031100	**Incision and drainage of skin and subcutaneous tissue**	**3**
09031101	Incision & drainage of abscess of skin and subcutaneous tissue	4
09031200	**Destruction of lesion of skin or cartilage**	**3**

09031201	Curettage of lesion of skin, single lesion	4
09031202	Curettage of lesion of skin, multiple lesions	4
09031300	**Excision of lesion(s) of skin and subcutaneous tissue**	**3**
09031301	Excision of lesion(s) of skin and subcutaneous tissue, foot	4
09031400	**Other debridement of skin and subcutaneous tissue**	**3**
09031401	Excisional debridement of wound of skin and subcutaneous tissue	4
09031402	Non-excisional debridement of wound of skin and subcutaneous tissue	4
09031500	**Excision of toenail**	**3**
09031501	Debridement of toenail	4
09031502	Removal of toenail	4
09031503	Partial resection of ingrown toenail	4
09031504	Radical excision of ingrown toenail	4
09031600	**Interventions involving assistive or adaptive device, aid or equipment**	**3**
09031609	Manufacture of assistive or adaptive device, aid or equipment	4
09031610	Application, fitting, adjustment or replacement of other assistive/ adaptive device, aid or equip/t	4
09031611	Repair of assistive or adaptive device, aid or equipment	4
09032000	**Therapies using agents, not elsewhere classified**	**3**
09032001	Cold therapy	4
09032002	Heat therapy	4
09032006	Therapeutic ultrasound	4
09032007	Stimulation therapy, not elsewhere classified	4
09032400	**Therapeutic interventions on musculoskeletal system**	**3**
09032401	Manipulation/mobilisation of joint, not elsewhere classified	4
09032402	Range of movement/muscle testing with specialised equipment	4
09032500	**Other therapeutic interventions**	**3**
09032501	Removal of sutures, not elsewhere classified	4
09032502	Removal of foreign body without incision, not elsewhere classified	4
09032503	Removal of therapeutic device, not elsewhere classified	4
09032504	Noninvasive therapeutic intervention, not elsewhere classified	4
09032600	**Conduction anaesthesia**	**3**
09032601	Infiltration of local anaesthetic ASA 19	4
09032800	**Other client support interventions**	**3**
09032801	Service co-ordination	4
09032802	Advocacy	4
09032803	Accompanying or transportation of client	4
09040000	**Skill Training**	**2**
09040300	Skills training in movement	3
09040310	Exercise therapy, hip joint	4
09040312	Exercise therapy, leg muscles	4
09040313	Exercise therapy, knee joint	4
09040314	Exercise therapy, foot muscles, ankle or toe joints	4
09050000	**Counselling**	**2**
09050100	**Counselling/eductn relating to personal care and other activities of daily/ind living**	**3**
09050101	Preventative counselling or education	4
09050105	Counselling or education regarding assistive or adaptive device, aid or equipment	4
09050109	Self-care/self-maintenance counselling or education	4
09050300	**Other counselling or education**	**3**

09050303	Other counselling or education	4
09060000	Other Intervention	2

Prosthetics/Orthotics

Code	Description	Level
08000000	**Prosthetics / Orthotics**	**1**
08010000	**Assessment**	**2**
08010100	**Physiological Assessment**	**3**
08010109	Biomechanical assessment	4
08010110	Skin integrity assessment	4
08010300	**Assessment of personal care and other activities of daily/independent living**	**3**
08010303	Assessment of need for assistive or adaptive device, aid or equipment	4
08010304	Review of assistive or adaptive device, aid or equipment	4
08020000	**Diagnostic Tests**	**2**
08030000	**Intervention**	**2**
08031600	**Interventions involving assistive or adaptive device, aid or equipment**	**3**
08031604	Application of halo	4
08031605	Application of halo and thoracic jacket	4
08031609	Manufacture of assistive or adaptive device, aid or equipment	4
08031610	Application, fitting, adjustment or replacement of other assistive or adaptive device, aid or equipment	4
08031611	Repair of assistive or adaptive device, aid or equipment	4
08031612	Removal of assistive or adaptive device, aid or equipment	4
08032700	**Assistance interventions**	**3**
08032703	Assistance with application of assistive or adaptive device, aid or equipment	4
08040000	**Skills Training**	**2**
08040500	**Skills training for personal care and other activities of daily/independent living**	**3**
08040503	Skills training in use of assistive or adaptive device, aid or equipment	4
08050000	**Counselling**	**2**
08050100	**Counselling or education relating to personal care and other activities of daily/independent living**	**3**
08050105	Counselling or education regarding assistive or adaptive device, aid or equipment	4
08060000	**Other Intervention**	**2**

Psychology

Code	Description	Level
10000000	**Psychology**	**1**
10010000	**Assessment**	**2**
10010100	**Physiological Assessment**	
10010107	Language assessment	4
10010300	**Assessment of personal care and other activities of daily/independent living**	**3**
10010308	Financial management assessment	4
10010309	Situational/occupational/environmental assessment	4
10010310	Parenting skills assessment	4
10010400	**Mental, behavioural or psychosocial assessment**	**3**
10010401	Psychosocial assessment	4
10010402	Alcohol and other drug assessment	4
10010403	Mental/behavioural assessment	4
10010500	**Other assessment, consultation, interview, examination or evaluation**	**3**
10010501	Ageing assessment	4
10010503	Developmental testing	4
10020000	**Diagnostic Tests**	**2**
10020100	**Other diagnostic neurological tests, measures or investigations**	**3**
10030000	**Intervention**	**2**
10031800	**Alcohol and drug rehabilitation and detoxification**	**3**
10031801	Alcohol rehabilitation	4
10031802	Alcohol detoxification	4
10031803	Alcohol rehabilitation and detoxification	4
10031804	Drug rehabilitation	4
10031805	Drug detoxification	4
10031806	Drug rehabilitation and detoxification	4
10031807	Combined alcohol and drug rehabilitation	4
10031808	Combined alcohol and drug detoxification	4
10031809	Combined alcohol and drug rehabilitation and detoxification	4
10031900	**Psychological/psychosocial therapies**	**3**
10031901	Psychological skills training	4
10031902	Psychodynamic therapy	4
10031903	Cognitive behaviour therapy [CBT]	4
10031904	Systems therapy	4
10031905	Clinical hypnosis	4
10031907	Behaviour therapy	4
10031908	Interpersonal psychotherapy [IPT]	4
10031909	Couples therapy	4
10031910	Sex therapy	4
10031911	Other psychotherapies or psychosocial therapies	4
10031915	Supportive psychotherapy, not elsewhere classified	4
10032000	**Therapies using agents, not elsewhere classified**	**3**
10032004	Biofeedback	4

10032800	**Other client support interventions**	**3**
10032801	Service co-ordination	4
10032802	Advocacy	4
10040000	**Skills Training**	**2**
10040200	**Skills training in relation to learning, knowledge and cognition**	**3**
10040201	Skills training in activities related to learning	4
10040203	Skills training in activities related to memory, orientation, perception or attention	4
10040204	Skills training in activities related to executive skills	4
10040500	**Skills training for personal care and other activities of daily/independent living**	**3**
10040504	Skills training in activities related to home management	4
10040506	Skills training in parenting techniques	4
10040507	Occupational/vocational skills training	4
10050000	**Counselling**	**2**
10050100	**Counselling or education relating to personal care and other activities of daily/independent living**	**3**
10050107	Substance addiction counselling or education	4
10050108	Gambling or betting addiction counselling or education	4
10050109	Self-care/self-maintenance counselling or education	4
10050110	Counselling or education on health maintenance or recovery activities	4
10050111	Home management counselling or education	4
10050112	Financial management counselling or education	4
10050113	Situational/occupational/environmental counselling or education	4
10050114	Counselling or education on preparing for parenthood, parenting skills or family planning	4
10050200	**Psychosocial counselling**	**3**
10050201	Relationship counselling	4
10050202	Crisis situation/event counselling	4
10050203	Physical abuse/violence/assault counselling	4
10050204	Grief/bereavement counselling	4
10050205	Other psychosocial counselling	4
10050300	Other counselling or education	3
10050301	Genetic counselling or education	4
10050302	Resource education	4
10060000	**Other Intervention**	**2**

Social Work

code	Description	Level
11000000	**Social Work**	**1**
11010000	**Assessment**	**2**
11010300	**Assessment of personal care and other activities of daily/independent living**	**3**
11010301	Self-care/self-maintenance assessment	4
11010302	Health maintenance or recovery assessment	4
11010307	Home management assessment	4
11010309	Situational/occupational/environmental assessment	4
11010310	Parenting skills assessment	4
11010400	**Mental, behavioural or psychosocial assessment**	**3**
11010401	Psychosocial assessment	4
11010402	Alcohol and other drug assessment	4
11010500	**Other assessment, consultation, interview, examination or evaluation**	**3**
11010501	Ageing assessment	4
11020000	**Diagnostic Tests**	**2**
11030000	**Intervention**	**2**
11031900	**Psychological/psychosocial therapies**	**3**
11031901	Psychological skills training	4
11031902	Psychodynamic therapy	4
11031903	Cognitive behaviour therapy [CBT]	4
11031904	Systems therapy	4
11031907	Behaviour therapy	4
11031908	Interpersonal psychotherapy [IPT]	4
11031909	Couples therapy	4
11031911	Other psychotherapies or psychosocial therapies	4
11031913	Bibliotherapy	4
11031914	Narrative therapy	4
11031915	Narrative therapy	4
11032800	**Other client support interventions**	**3**
11032801	Service co-ordination	4
11032802	Advocacy	4
11040000	**Skill Training**	**2**
11050000	**Counselling**	**2**
11050100	**Counselling or education relating to personal care and other activities of daily/independent living**	**3**
11050101	Preventative counselling or education	4
11050107	Substance addiction counselling or education	4
11050108	Gambling or betting addiction counselling or education	4
11050109	Self-care/self-maintenance counselling or education	4
11050110	Counselling or education on health maintenance or recovery activities	4
11050112	Financial management counselling or education	4
11050113	Situational/occupational/environmental counselling or education	4
11050114	Counselling or education on preparing for parenthood, parenting skills or family planning	4

11050200	Psychosocial counselling	3
11050201	Relationship counselling	4
11050202	Crisis situation/event counselling	4
11050203	Physical abuse/violence/assault counselling	4
11050204	Grief/bereavement counselling	4
11050205	Other psychosocial counselling	4
11050300	Other counselling or education	3
11050302	Resource education	4
11050303	Other counselling or education	4
11060000	Other Intervention	2

Speech Pathology

code	Description	Level
12000000	**Speech Pathology**	**1**
12010000	**Assessment**	**2**
12010100	**Physiological Assessment**	**3**
12010103	Swallowing function assessment	4
12010144	Voice assessment	4
12010105	Speech assessment	4
12010106	Fluency assessment	4
12010107	Language assessment	4
12010400	**Mental, behavioural or psychosocial assessment**	**3**
12010403	Mental/behavioural assessment	4
12010500	**Other assessment, consultation, interview, examination or evaluation**	**3**
12010501	Ageing assessment	4
12010503	Developmental testing	4
12020000	**Diagnostic Tests**	**2**
12020900	**Auditory function tests**	**3**
12020401	Air conduction audiometry, standard technique	4
12020403	Air & bone conduction audiometry, standard technique	4
12020500	**Speech audiometry**	**3**
12020501	Speech discrimination test	4
12020502	Speech discrimination test with background noise	4
12020503	Speech rollover test	4
12020600	**Speech audiometry involving central auditory function tests**	**3**
12020601	Staggered spondaic words [SSW] test	4
12020602	Filtered speech test	4
12020603	Synthetic sentence identification [SSI] test	4
12020700	**Impedance audiometry**	**3**
12020701	Tympanometry using standard probe tone	4
12020702	Tympanpometry using high frequency probe tone	4
12020703	Acoustic reflex threshold	4
12021500	**Other diagnostic tests, measures or investigations**	**3**
12021501	Noninvasive diagnostic tests, measures or investigations, not elsewhere classified	4
12030000	**Intervention**	**2**
12031600	**Interventions involving assistive or adaptive device, aid or equipment**	**3**
12031610	Application, fitting, adjustment or replacement of other assistive or adaptive device, aid or equipment	4
12031700	**Nutritional support interventions**	**3**
12031701	Therapeutic diet support	4
12032000	**Therapies using agents, not elsewhere classified**	**3**
12032004	Biofeedback	4
12032700	**Assistance interventions**	**3**
12032703	Assistance with application of assistive or adaptive device, aid or equipment	4
12032704	Assistance with activities related to body position/mobility/movement	4
12040000	**Skill Training**	**2**
12040100	**Skills training for voice, speech, fluency and communication**	**3**

12040101	Skills training for voice	4
12040102	Skills training for speech	4
12040103	Skills training for fluency	4
12040104	Skills training for language	4
12040200	**Skills training in relation to learning, knowledge and cognition**	**3**
12040201	Skills training in activities related to learning	4
12040203	Skills training in activities related to memory, orientation, perception or attention	4
12040204	Skills training in activities related to executive skills	4
12040400	**Skills training in body system functions**	**3**
12040401	Skills training for hearing	4
12040500	**Skills training for personal care and other activities of daily/independent living**	**3**
12040503	Skills training in use of assistive or adaptive device, aid or equipment	4
12050000	**Counselling**	**2**
12050100	**Counselling or education relating to personal care and other activities of daily/independent living**	**3**
12050101	Preventative counselling or education	4
12050102	Counselling or education regarding assistive or adaptive device, aid or equipment	4
12050104	Counselling or education for voice, speech, fluency or language	4
12050105	Counselling or education regarding assistive or adaptive device, aid or equipment	4
12050110	Counselling or education on health maintenance or recovery activities	4
12050300	**Other counselling or education**	**3**
12050303	Other counselling or education	4
12060000	**Other Intervention**	**2**

Exercise Physiology

code	Description	Level
13000000	**Exercise Physiologist**	**1**
13010000	**Assessment**	**2**
13010100	**Physiological Assessment**	**3**
13010101	Other physiological assessment	4
13010109	Biomechanical assessment	4
13010300	**Assessment of personal care and other activities of daily/independent living**	**3**
13010302	Health maintenance or recovery assessment	4
13020000	**Diagnostic Tests**	**2**
13021100	**Exercise testing to assess respiratory status**	**3**
13021102	Spirometry with exercise testing	4
13021200	**Other measurement of respiratory function**	**3**
13021203	Measurement of total lung volume	4
13021400	**Other cardiovascular diagnostic tests, measures or investigations**	**3**
13021401	Cardiovascular stress test	4
13021500	**Other diagnostic tests, measures or investigations**	**3**
13021501	Noninvasive diagnostic tests, measures or investigations, not elsewhere classified	4
13030000	**Intervention**	**2**
13032000	**Therapies using agents, not elsewhere classified**	**3**
13032005	Hydrotherapy	4
13032400	**Therapeutic interventions on musculoskeletal system**	**3**
13032402	Range of movement/muscle testing with specialised equipment	4
13032700	**Assistance interventions**	**3**
13032702	Assistance with activities related to health maintenance	4
13032704	Assistance with activities related to body position/mobility/movement	4
13040000	**Skills Training**	**2**
13040300	**Skills training in movement**	**3**
13040304	Exercise therapy, shoulder joint	4
13040305	Exercise therapy, chest or abdominal muscles	4
13040306	Exercise therapy, back or neck muscles	4
13040307	Exercise therapy, arm muscles	4
13040308	Exercise therapy, elbow joint	4
13040309	Exercise therapy, hand muscles, wrist or finger joints	4
13040310	Exercise therapy, hip joint	4
13040311	Exercise therapy, pelvic floor muscles	4
13040312	Exercise therapy, leg muscles	4
13040313	Exercise therapy, knee joint	4
13040314	Exercise therapy, foot muscles, ankle or toe joints	4
13040315	Exercise therapy, total body	4
13040316	Skills training in activities related to body position/mobility/movement	4
13040317	Skills training in activities related to transfers	4
13040400	**Skills training in body system functions**	**3**
13040404	Exercise therapy, cardiorespiratory/cardiovascular system	4
13040500	**Skills training for personal care and other activities of daily/independent**	**3**

	living	
13040501	Skills training in activities related to self	4
13040508	Skills training in ergonomics	4
13040509	Play/leisure/recreation therapy	4
13040600	**Other skills training**	**3**
13040601	Skills training in water confidence techniques	4
13040602	Other skills training	4
13050000	**Counselling**	**2**
13050100	**Counselling or education relating to personal care and other activities of daily /independent living**	**3**
13050101	Preventative counselling or education	4
13060000	**Other Intervention**	**2**

APPENDIX 3: INDIRECT CLINICAL ACTIVITY CODES

1. Planning/ Preparation
2. Documentation and reporting
3. Patient related Discussion
4. Travel

APPENDIX 4: ALLIED HEALTH AND/OR CLINICAL NURSE SPECIALIST INTERVENTIONS CLASSES TIER 2

40.01 Aboriginal and Torres Strait Islander Peoples Health Clinic	40.34 Specialist mental health.
40.02 Aged care assessment	40.35 Palliative care
40.03 Aids and Appliances	40.36 Geriatric Evaluation and Management (GEM)
40.04 Clinical Pharmacy	40.37 Psychogeriatric
40.05 Hydrotherapy	40.38 Infectious diseases
40.06 Occupational therapy	40.39 Neurology
40.07 Pre-Admission and Pre-Anaesthesia	40.40 Respiratory
40.08 Primary health care	40.41 Gastroenterology
40.09 Physiotherapy	40.42 Circulatory
40.10 Sexual health	40.43 Hepatobiliary
40.11 Social Work	40.44 Orthopaedics
40.12 Rehabilitation	40.45 Dermatology
40.13 Wound management	40.46 Endocrinology
40.14 Neuropsychology	40.47 Nephrology
40.15 Optometry	40.48 Haematology and immunology
40.16 Orthoptics	40.49 Gynaecology
40.17 Audiology	40.50 Urology
40.18 Speech pathology	40.51 Breast
40.21 Cardiac rehabilitation	40.52 Oncology
40.22 Stomal therapy	40.53 General medicine
40.23 Nutrition/dietetics	40.54 General surgery
40.24 Orthotics	40.55 Paediatrics
40.25 Podiatry	40.56 Falls prevention
40.27 Family planning.	40.57 Cognition and memory
40.28 Midwifery and maternity	40.58 Hospital avoidance programs
40.29 Psychology	40.59 Post-acute care
40.30 Alcohol and other drugs	40.6 Pulmonary Rehabilitation
40.31 Burns	
40.32 Continence	
40.33 General counselling	

APPENDIX 5: PRACTICAL APPLICATION OF FRAMEWORK: CLINICAL DATA COLLECTION EXAMPLES

5.1 CLINICAL CARE ACTIVITY: Individual Patient Attributable

Please Note: the following examples are recommendations only. The following scenarios may be recorded to either a greater or lesser degree of specificity based on your site's requirements. In the following examples, activity descriptors other than in the section specifically providing examples on that data item, reflect the broadest descriptor

5.1.1 Client Type

Example 1
A hospital employed Dietitian enters the ward, reads the medical notes, talks to the medical team, and assesses the patient. The Dietitian documents in the medical notes.

Record :

Data Item	Data Entry
Client Type	Inpatient/ Admitted

Example 2
An Occupational Therapist conducts a 'discharge home visit' for a patient admitted for a fractured neck of femur. The medical team is holding the bed open, awaiting clearance of the patient from the OT before they are discharged i.e. the patient is still an inpatient of the hospital. The patient is picked up from the ward and transported by hospital vehicle to their home where their equipment is set up and demonstrated. The Occupational Therapist, calls the medical team and confirms the patient is clear for discharge, returns to the hospital and makes a note in the patient's inpatient medical file.

Record:

Data Item	Data Entry
Client Type	Inpatient/ Admitted

Example 3
A Speech Pathologist who works in a Day Rehabilitation Unit (DRU) completes an assessment, provides aphasia intervention and documents in the medical notes. With each attendance, patients who attend the DRU undergo a formal admission process as same-day patients.

Record:

Data Item	Data Entry
Client Type	Same Day Admitted

Example 4
A patient attends a Day Rehabilitation Clinic and is seen by a geriatrician, a Physiotherapist, an Occupational Therapist and a Social Worker.

Record:

Data Item	Data Entry
Client Type	Same Day Admitted **Or** Non-admitted/Outpatient* *dependent on how the facility classifies this service

Example 5

A child attends GP Plus centre to attend an appointment under the Cystic Fibrosis program provided by the Women's and Children's Health network and is seen by a physiotherapist.

Record:

Data Item	Data Entry
Client Type	ABF primary care

Example 6

An elderly man presents to the hospital's emergency department from a local residential care facility (RCF) with a suspected chest infection. He was discharged to the RCF 1 month prior with a modified diet including thickened fluids. The RCF commencement thin fluids 1 week ago due to his non-compliance with the thickened fluids. The speech pathologist is called to assess the patient's swallowing.

Record:

Data Item	Data Entry
Client Type	Emergency Department

Example 7

A hospital funded clinician travels to a GP Plus centre to provide outpatient services every Tuesday.

Record:

Data Item	Data Entry
Client Type	Hospital funded outreach

Example 8

An occupational therapist visits a patient at their home following their discharge from hospital to assess how they are coping with their assistive devices and home modifications.

Record:

Data Item	Data Entry
Client Type	Hospital funded outreach

Example 9

A social worker sees a client for counselling at a GP Plus centre. The service is funded from the hospital budget.

Record:

Data Item	Data Entry
Client Type	Hospital funded outreach

Example 10

A child is seen by the child development team at a GP Plus Centre by the speech pathologist and occupational therapist. The service is funded by the local health network directly and is not recognized as a hospital avoidance/substitution service and does not receive Activity Based funding.

Record:

Data Item	Data Entry
Client Type	Primary Care

5.1.2 Client Type x Patient Contact, OOS, Service Events

The **Client Type** influences whether and how you count **OOS** and **Service Event.**

5.1.2.1 Single Clinician to Single Client

Example 1

A Physiotherapist receives a referral for a patient. The clinician performs the following activities: reading the patient record (10mins), assessment of respiratory status related to immobility, deep breathing exercises, range of motion exercises, (40mins), discusses patients and management requirements with the nurse and doctor (20mins) and documents all of the above (10mins).

Record:

Data Item	Data Entry
Client Type	*Inpatient*
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	New
Service Delivery Setting	local hospital campus
Patient Contact	**1**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy
Duration	80 minutes

Or

Data Item	Data Entry
Client Type	*Non-Admitted /Outpatient*
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	New
Service Delivery Setting	local hospital campus
Patient Contact	**1 (optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy
Duration	80 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40. 09 Physiotherapy

Or

Data Item	Data Entry
Client Type	*Primary Care*
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	New
Service Delivery Setting	GP Plus
Patient Contact	**1**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy
Duration	80 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.08 Primary care

Example 2

A Physiotherapist sees a patient in the afternoon subsequent to an initial assessment performed earlier in the day (see Example 1). He/she repeats the interventions from the earlier intervention (10 mins) and also walks the patient (10mins) and documents in the medical record (5 mins).

Record:

Data Item	Data Entry
Client Type	Inpatient
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	Review
Service Delivery Setting	local hospital campus
Patient Contact	1
OOS	0 (not an outpatient/non-admitted setting)
Service Event	0 (not an outpatient/non-admitted setting)
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy Intervention
Duration	25 minutes

Or

Data Item	Data Entry
Client Type	Non-Admitted /Outpatient
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	Review
Service Delivery Setting	local hospital campus
Patient Contact	1 (optional -site determined- see section 6.2 and 7.1)
OOS	1
Service Event	1
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy Assessment
Duration	25 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40. 09 Physiotherapy

Or

Data Item	Data Entry
Client Type	Primary Care
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	Review
Service Delivery Setting	GP Plus
Patient Contact	1
OOS	0 (not an outpatient/non-admitted setting)
Service Event	0 (not an outpatient/non-admitted setting)
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy Assessment
Duration	25 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.08 Primary care

Example 3

An Orthotist fits a custom made orthosis to a patient made from a cast taken at a previous encounter. Work performed on days prior to the visit include cast modification (120 mins), manufacture (180 minutes). On the day of the visit the Orthotist fits and adjusts the orthosis, provides device information and related patient education and writes in the patient notes (total time on day of fitting is 90 minutes).

Record:

Data Item	Data Entry
Client Type	*Inpatient*
Provider Type	*Orthotist*
Profession	*Orthotics*
Attendance Type	*Review*
Service Delivery Setting	*local hospital campus*
Patient Contact	*1*
OOS	*0 (not an outpatient/non-admitted setting)*
Service Event	*0 (not an outpatient/non-admitted setting)*
Contact Type	*Individual*
Service Delivery Mode	*In person*
Activity	*Orthotic Intervention*
Duration	*90 minutes*

Or

Data Item	Data Entry
Client Type	*Non-Admitted /Outpatient*
Provider Type	*Orthotist*
Profession	*Orthotics*
Attendance Type	*Review*
Service Delivery Setting	*local hospital campus*
Patient Contact	*1 (optional -site determined- see section 6.2 and 7.1)*
OOS	*1*
Service Event	*1*
Contact Type	*Individual*
Service Delivery Mode	*In person*
Activity	*Orthotic Intervention*
Duration	*90 minutes*
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.24 Orthotics

Or

Data Item	Data Entry
Client Type	**Primary Care**
Provider Type	*Orthotist*
Profession	*Orthotics*
Attendance Type	*Review*
Service Delivery Setting	*GP Plus*
Patient Contact	**1**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	*Individual*
Service Delivery Mode	*In person*
Activity	*Orthotic Intervention*
Duration	*90 minutes*
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.08 Primary care

5.1.2.2 Multiple Clinicians to Single Client

The **Client Type** influences whether and how you count **OOS** and **Service Event.**

Example 1

A Speech Pathologist performs a swallowing assessment and has a second clinician to assist with the assessment (45 mins) because of the difficulties with this particular patient. Clinician A also documents the assessment (15mins) and orders the diet (10mins). Both clinicians are involved in the delivery of an intervention of more than 15 minutes.

Data Item	Data Entry
Client Type	Inpatient
Provider Type	Speech Pathologist
Profession	Speech Pathology
Attendance Type	Review
Service Delivery Setting	Local hospital campus
Patient Contact	1 for each clinician
OOS	0 (not an outpatient/non-admitted setting)
Service Event	0 (not an outpatient/non-admitted setting)
Contact Type	Individual
Service Delivery Mode	In person
Activity	Speech pathology
Duration	Clinician A = 70 mins, Clinician B =45 mins

Or

Data Item	Data Entry
Client Type	Non-Admitted /Outpatient
Provider Type	Speech Pathologist
Profession	Speech Pathology
Attendance Type	Review
Service Delivery Setting	Local hospital campus
Patient Contact	1 (optional -site determined- see section 6.2 and 7.1)
OOS	1 for each clinician
Service Event	1 for clinician A, 0 for clinician B
Contact Type	Individual
Service Delivery Mode	In person
Activity	Speech Pathology
Duration	Clinician A = 70 mins, Clinician B =45 mins
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.18 Speech Pathology

Or

Data Item	Data Entry
Client Type	Primary Care
Provider Type	Speech Pathologist
Profession	Speech Pathology
Attendance Type	Review
Service Delivery Setting	GP Plus
Patient Contact	1 for each clinician
OOS	0 (not an outpatient/non-admitted setting)
Service Event	0 (not an outpatient/non-admitted setting)
Contact Type	Individual
Service Delivery Mode	In person
Activity	Speech Pathology
Duration	Clinician A = 70 mins, Clinician B =45 mins
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.08 Primary care

Example 2
A patient attends an outpatient falls and mobility clinic at the hospital and is seen sequentially by a nurse (30mins), a physiotherapist (20 mins), and a geriatrician (15mins). After wards, the healthcare providers have a case conference meeting to discuss the patient and treatment plans (30 mins).

Option 1 (preferred)
If the physiotherapy intervention was not dependent on the other consultations occurring on that day and can be considered its own clinic i.e. could have occurred irrespective of them being provided on that day and included independent documentation in the medical records, the physiotherapy consultation should be recognised as a recordable non-admitted service.

Record:

Data Item	Data Entry
Client Type	**Non-Admitted /Outpatient**
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	Review
Service Delivery Setting	Local hospital campus
Patient Contact	**1 (optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy
Duration	50 mins (session time + case discussion)
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.56 Falls Prevention

Option 2
If the facility/service requires the service to be recorded as only 1 clinic then…

Record:

Data Item	Data Entry
Client Type	**Non-Admitted /Outpatient**
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	Review
Service Delivery Setting	Local hospital campus
Patient Contact	**1 (optional -site determined- see section 6.2 and 7.1)**
OOS	**0*** [p20(1)]
Service Event	**0*** *service event will be allocated to nursing as the greatest time contributor to the clinic
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy
Duration	50 mins (session time + case discussion)
Outpatient/Non-Admitted Clinic Type	tier 2 classification: N/A for physiotherapy * *40.56 Falls Prevention will be recorded against nursing

Example 3
An infant attends the health service and is assessed by the Dietitian (20mins), Physiotherapist (20 mins), and Occupational Therapist (30mins) consecutively and independent of each other. The interventions are noted separately in the infant's medical record.

Record:

Data Item	Data Entry
Client Type	**Non-Admitted /Outpatient**
Provider Type	Dietitian , Physiotherapist & Occupational Therapist (separate entries)
Profession	Dietetics ,Physiotherapy & Occupational Therapy
Attendance Type	New per discipline
Service Delivery Setting	Local hospital campus
Patient Contact	**1 per clinician** *(optional -site determined- see section 6.2 and 7.1)*
OOS	**1 per clinician**
Service Event	**1 per clinician**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Dietetics ,Physiotherapy & Occupational Therapy
Duration	Dietetics = 20 mins, Physiotherapy =20mins, OT = 30mins
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.23 : nutrition/dietetics, 40.09 Physiotherapy & 40.06: Occ Therapy

Or

Data Item	Data Entry
Client Type	**Primary Care**
Provider Type	Dietitian , Physiotherapist & Occupational Therapist (separate entries)
Profession	Dietetics ,Physiotherapy & Occupational Therapy
Attendance Type	New per discipline
Service Delivery Setting	GP Plus
Patient Contact	**1 per clinician**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Dietetics ,Physiotherapy & Occupational Therapy
Duration	Dietetics = 20 mins, Physiotherapy =20mins, OT = 30mins
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.08 Primary Care per clinician

Example 4

A 60 minute case conference meeting is held to discuss a child's progress and plan for action with all agencies involved present ***including the parent***. Care planning and ongoing and future strategies to assist the child are discussed and explained. The child is currently seen in the outpatient department of the local hospital. A social worker, occupational therapist, nurse and speech pathologist form the team. Each health professional contributes more than 15 minutes of involvement in the discussion. The session can be considered as individual service delivery for each of the allied health professionals

Note:
- The parent is considered in this scenario to take the place of the child. The intervention should be documented in the child's case notes.

Record:

Data Item	Data Entry
Client Type	**Non-Admitted /Outpatient**
Provider Type	*Social worker, occupational therapist, speech pathologist*
Profession	*Social work, occupational therapy, speech pathology*
Attendance Type	*Review*
Service Delivery Setting	*Local hospital campus*
Patient Contact	**1 for each clinician**
OOS	**1 for each clinician**
Service Event	**1 for each clinician**
Contact Type	*individual*
Service Delivery Mode	*In person*
Activity	*Social work, occupational therapy, speech pathology*
Duration	*60 minutes per clinician*
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.11: social work, 40.18 speech Pathology & 40.06: Occ Therapy

or

Data Item	Data Entry
Client Type	**Primary care**
Provider Type	*Social worker, occupational therapist, speech pathologist*
Profession	*Social work, occupational therapy, speech pathology*
Attendance Type	*Review*
Service Delivery Setting	*GPPlus*
Patient Contact	**1 for each clinician**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	*individual*
Service Delivery Mode	*In person*
Activity	*Social work, occupational therapy, speech pathology*
Duration	*60 minutes per clinician*
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.08 Primary Care per clinician

5.1.2.4 Single Clinician to Multiple Clients (including group sessions)

The **_Client Type_** influences whether and how you count **_OOS_** and **_Service Event._**

Example 1

A family has twins with cystic fibrosis. The children attend a single review appointment of 60 mins duration. Both children's appointments have been booked separately. Therapeutic / clinical advice is provided by a physiotherapist for each child and an entry made into each child's medical records.

Record:

Data Item	Data Entry
Client Type	*Non-Admitted /Outpatient*
Provider Type	*Physiotherapist*
Profession	*Physiotherapy*
Attendance Type	*Review*
Service Delivery Setting	*Local hospital campus*
Patient Contact	**1 for each child** *(optional -site determined- see section 6.2 and 7.1)*
OOS	**1 for each child**
Service Event	**1 for each child**
Contact Type	*Individual*
Service Delivery Mode	*In person*
Activity	*Physiotherapy*
Duration	*Child 1 = 30 mins, Child 2 = 30 mins*
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.09 Physiotherapy

Or

Data Item	Data Entry
Client Type	*Primary Care*
Provider Type	*Physiotherapist*
Profession	*Physiotherapy*
Attendance Type	*Review*
Service Delivery Setting	*GP Plus*
Patient Contact	**1 for each child**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	*Individual*
Service Delivery Mode	*In person*
Activity	*Physiotherapy*
Duration	*Child 1 = 30 mins, Child 2 = 30 mins*
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.08 Primary Care

Example 2
A Social Worker provides advice to a husband and wife on the same home visit, so that both receive a separate individual service, and this is documented separately in each of their individual records i.e. they are both registered clients. This takes 90 minutes. The Social Worker drives 10 minutes to and from the patients' home. Total time = 110 minutes.

Record:

Data Item	Data Entry
Client Type	*Hospital funded outreach*
Provider Type	*Social worker*
Profession	*Social work*
Attendance Type	*Review*
Service Delivery Setting	*Private residence*
Patient Contact	**1 for each client** *(optional -site determined- see section 6.2 and 7.1)*
OOS	**1 for each client**
Service Event	**1 for each client**
Contact Type	*Individual*
Service Delivery Mode	*In person*
Activity	*Social work*
Duration	*Client 1 = 55minutes, client 2 = 55 minutes*
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.11 Social Work

Or

Data Item	Data Entry
Client Type	*Primary Care*
Provider Type	*Social worker*
Profession	*Social work*
Attendance Type	*Review*
Service Delivery Setting	*Private residence*
Patient Contact	**1 for each client**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	*Individual*
Service Delivery Mode	*In person*
Activity	*Social work*
Duration	*Client 1 = 55minutes, client 2 = 55 minutes*
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.08 Primary care

Example 3

An exercise physiologist runs a weekly 1 hour respiratory rehabilitation group with 6 patients who attend for an hour. Each attendance is recorded in the patients' individual records. Overall all participants receive the same input from the clinician i.e. not individual attention/intervention.

Record:

Data Item	Data Entry
Client Type	***Non-admitted/outpatient***
Provider Type	*Exercise physiologist*
Profession	*Exercise Physiology*
Attendance Type	*Review*
Service Delivery Setting	*Local hospital campus*
Patient Contact	**1 for each client = 6 patient contacts** *(optional -site determined- see section 6.2 and 7.1)*
OOS	**1 with 6 participants – session is recognised as a group**
Service Event	**1 for each client = 6 service events**
Contact Type	***Group***
Service Delivery Mode	*In person*
Activity	*Exercise physiology*
Duration	*60 minutes per patient*
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.40 respiratory

Or

Data Item	Data Entry
Client Type	***Primary Care***
Provider Type	*Exercise physiologist*
Profession	*Exercise Physiology*
Attendance Type	*Review*
Service Delivery Setting	*Local hospital campus*
Patient Contact	**1 for each client**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	***Group***
Service Delivery Mode	*In person*
Activity	*Exercise physiology*
Duration	*60 minutes per patient*
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.08 Primary care

Example 4

3 patients participate in a hydrotherapy sessions where a physiotherapist directs patients through a range of exercises for 60 minutes. Each patient receives an individualized program and receives at least 15 minutes of *individualized* time from the physiotherapist.

Record:

Data Item	Data Entry
Client Type	**Non-admitted/outpatient**
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	Review
Service Delivery Setting	Local hospital campus
Patient Contact	**1 for each client = 6 patient contacts** *(optional -site determined- see section 6.2 and 7.1)*
OOS	**1 for each client = 6 OOS (service is recognized as individual OOS because > 15min of individual attention was provided to the clients)**
Service Event	**1 for each client = 6 service events**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy
Duration	20 minutes per patient
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.09 Physiotherapy

Or

Data Item	Data Entry
Client Type	**Primary care**
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	Review
Service Delivery Setting	**Other- local public pool**
Patient Contact	**1 for each client = 6 patient contacts**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy
Duration	20 minutes per patient
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.08 Primary care

5.1.2.5 Multiple Clinicians to Multiple Clients: group sessions

The **Client Type** influences whether and how you count **OOS** and **Service Event.**

Example 1

A group of patients attend a weekly communication group at the local hospital run by the speech pathologist with joint participation by an assisting clinician from another health profession rotating each week. This week, a social worker is in attendance. 6 patients attend for 1 hour. Each attendance is recorded in the patients' medical records.

Primary Clinician Records: (must be determined between the clinicians- often based on majority of resource input into the group session)

Data Item	Data Entry
Client Type	*Non-Admitted/Outpatient*
Provider Type	*Speech Pathologist*
Profession	*Speech Pathology*
Attendance Type	*Review*
Service Delivery Setting	*Local hospital campus*
Patient Contact	**1 for each client = 6 patient contacts** *(optional -site determined- see section 6.2 and 7.1)*
OOS	**1 OOS (group) and number of attendees = 6**
Service Event	**1 for each client = 6 service events**
Contact Type	*Group*
Service Delivery Mode	*In person*
Activity	*Speech Pathology*
Duration	*1 hour per patient*
Outpatient/Non-Admitted Clinic Type	tier 2 classification: 40.18 speech pathology

Secondary Clinician Records:

Data Item	Data Entry
Client Type	*Non-Admitted/Outpatient*
Provider Type	*Social work*
Profession	*Speech Pathology*
Attendance Type	*Review*
Service Delivery Setting	*Local hospital campus*
Patient Contact	**1 for each client = 6 patient contacts** *(optional -site determined- see section 6.2 and 7.1)*
OOS	**0**
Service Event	**0**
Contact Type	*Group*
Service Delivery Mode	*In person*
Activity	*Social work*
Duration	*1 hour per patient*
Outpatient/Non-Admitted Clinic Type	tier N/A

5.1.3 Client Not in Attendance

Example 1

A Dietitian goes to the ward to review a patient. They read the patient's notes (10 mins). They are unable to talk with the patient due to the patient's condition but have a conversation with the patient's partner and provide an update regarding the patient's status for 15 minutes. This is followed by a phone call to the GP (15 mins) and then a discussion regarding the patient's plan with the medical team (15 mins) and documents in the notes and updates the patient's diet order in medical records (15 mins). The entire process takes 90 minutes.

Record:

Data Item	Data Entry
Client Type	**Admitted /Inpatient**
Provider Type	Dietitian
Profession	Nutrition/Dietetics
Attendance Type	Review
Service Delivery Setting	Local hospital campus
Patient Contact	**0**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	N/A
Service Delivery Mode	N/A
Activity	dietetics
Duration	90 minutes

Example 2

A community based Psychologist completes a home visit for a patient however on arrival the patient is not home. The Psychologist drives 15 minutes to the patient's home, waits 15 minutes and then drives back to their office (15 mins).

Record:

Data Item	Data Entry
Client Type	**Primary care**
Provider Type	Psychologist
Profession	Psychology
Attendance Type	Review
Service Delivery Setting	Private residence
Patient Contact	**0**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	N/A
Service Delivery Mode	N/A
Activity	psychology
Duration	45 minutes

Example 3

A Social Worker spends 90 minutes collating a report for a guardianship tribunal hearing for an outpatient, including compiling information gained from the patient's friends and family, liaising with Centrelink and writing the report.

Record:

Data Item	Data Entry
Client Type	***Non-Admitted /Outpatient***
Provider Type	*Social worker*
Profession	*Social work*
Attendance Type	*Review*
Service Delivery Setting	*Other*
Patient Contact	**0**
OOS	**0**
Service Event	**0**
Contact Type	*N/A*
Service Delivery Mode	*N/A*
Activity	*Social work*
Duration	*90 minutes*

Example 4

A 60 minute case conference meeting is held to discuss a child's progress and plan for action with all agencies. Neither the child or parents are present at the meeting. The child is currently seen in the outpatient department of the local hospital. A social worker, occupational therapist, nurse and speech pathologist form the team.

Record:

Data Item	Data Entry
Client Type	***Non-Admitted /Outpatient***
Provider Type	*Social worker, occupational therapist, speech pathologist*
Profession	*Social work, occupational therapy, speech pathology*
Attendance Type	*Review*
Service Delivery Setting	*Local hospital campus*
Patient Contact	**0 for each clinician**
OOS	**0 for each clinician**
Service Event	**0 for each clinician**
Contact Type	N/A
Service Delivery Mode	N/A
Activity	*Social work, occupational therapy, speech pathology*
Duration	*60 minutes per clinician*

Example 5

A 60 minute case conference meeting is held to discuss a child's progress and plan for action with all agencies involved present ***including the parent***. Care planning and ongoing and future strategies to assist the child are discussed and explained. The child is currently seen in the outpatient department of the local hospital. A social worker, occupational therapist, nurse and speech pathologist form the team. Each health professional contributes more than 15 minutes of involvement in the discussion. The session can be considered as individual service delivery for each of the allied health professionals

Note:
- The parent is considered in this scenario to take the place of the child. The intervention should be documented in the child's case notes.

Record:

Data Item	Data Entry
Client Type	**Non-Admitted /Outpatient**
Provider Type	Social worker, occupational therapist, speech pathologist
Profession	Social work, occupational therapy, speech pathology
Attendance Type	Review
Service Delivery Setting	Local hospital campus
Patient Contact	**1 for each clinician**
OOS	**1 for each clinician**
Service Event	**1 for each clinician**
Contact Type	individual
Service Delivery Mode	In person
Activity	Social work, occupational therapy, speech pathology
Duration	60 minutes per clinician

5.1.4 SERVICES DELIVERED VIA ICT

The *Client Type* influences whether and how you count *OOS* and *Service Event.*

Example 1
A patient and a hospital funded Social Worker cannot be in the same location for a consultation. They have a consultation using a telephone while the patient is located at home and the Social Worker is at the hospital. The Social Worker provides counselling, assists the patient with accessing services in their local area and documents the interaction in the patient's medical record. These activities take 55 minutes.

Record:

Data Item	Data Entry
Client Type	**Non-Admitted /Outpatient**
Provider Type	Social worker
Profession	Social work
Attendance Type	Review
Service Delivery Setting	Private residence
Patient Contact	**1(optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	**telephone**
Activity	Social work
Duration	55 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.11 Social Work

Example 2
A patient and a psychologist cannot be in the same location for a consultation. They have a consultation using a telephone while the patient is located at home and the psychologist is at the health service. The service in question is not funded by a hospital or recognized as an ABF service. The psychologist provides counselling, assists the patient with accessing services in their local area and documents the interaction in the patient's medical record. These activities take 70 minutes.

Record:

Data Item	Data Entry
Client Type	**Primary care**
Provider Type	psychologist
Profession	psychology
Attendance Type	**Review**
Service Delivery Setting	Private residence
Patient Contact	**1**
OOS	**0**
Service Event	**0**
Contact Type	Individual
Service Delivery Mode	**telephone**
Activity	psychology
Duration	70 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.08 Primary care

Example 3

A child with cerebral palsy cannot be in the same location as an Occupational Therapist who specializes in paediatric mobility issues due to the regional location of the child. The child and her mother attend an appointment at regional hospital (hospital A) with an occupational therapist from the local community health service, for a scheduled telehealth consultation with an Occupational Therapist at metropolitan children's hospital (hospital B). The Occupational Therapist at hospital B assesses the patient and provides advice on equipment and activities of daily living skills. The appointment takes 60 minutes. Both clinicians documents the session at 30 minutes.

Clinician at Hospital B

Records:

Data Item	Data Entry
Client Type	Non-admitted /outpatient
Provider Type	Occupational therapist
Profession	Occupational therapy
Attendance Type	Review
Service Delivery Setting	Other hospital
Patient Contact	1(optional -site determined- see section 6.2 and 7.1)
OOS	1
Service Event	1
Contact Type	Individual
Service Delivery Mode	telehealth
Activity	Occupational therapy
Duration	90 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.06 Occupational Therapy

Clinician at Hospital A

Records:

Data Item	Data Entry
Client Type	Non-admitted /outpatient
Provider Type	Occupational therapist
Profession	Occupational therapy
Attendance Type	Review
Service Delivery Setting	local hospital
Patient Contact	1(optional -site determined- see section 6.2 and 7.1)
OOS	0
Service Event	0
Contact Type	Individual
Service Delivery Mode	telehealth
Activity	Occupational therapy
Duration	90 minutes
Outpatient/Non-Admitted Clinic Type	N/A

Example 4

The hospital Occupational Therapist contacts the patient by phone to discuss their progress with the new equipment and home modifications and documents the outcome in the patient's medical record. Total time is 30 minutes.

Record:

Data Item	Data Entry
Client Type	**Non-admitted /outpatient**
Provider Type	Occupational therapist
Profession	Occupational therapy
Attendance Type	**Review**
Service Delivery Setting	Private residence
Patient Contact	**1(optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	**telephone**
Activity	Occupational therapy
Duration	30 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.06 Occupational Therapy

Example 5

A physiotherapist in Adelaide (hospital B) engages in a joint session with a physiotherapist and their client in a regional hospital (Hospital A) via a telehealth hook-up. The session lasts 60 minutes and both clinicians participate equally [p32(1)].

Clinician at Hospital A

Records:

Data Item	Data Entry
Client Type	**Non-admitted /outpatient**
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	**Review**
Service Delivery Setting	local hospital campus
Patient Contact	**1(optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	**telehealth**
Activity	Physiotherapy
Duration	60 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.09 Physiotherapy

Clinician at Hospital B

Records:

Data Item	Data Entry
Client Type	**Non-admitted /outpatient**
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	**Review**
Service Delivery Setting	other hospital
Patient Contact	**1(optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	**telehealth**
Activity	Physiotherapy
Duration	60 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.09 Physiotherapy

5.1.5 ACTIVITY

The **Client Type** influences whether and how you count **OOS** and **Service Event.**

Example 1

A Physiotherapist receives a referral for a patient on the ward. The clinician performs the following activities: reading the patient medical record (10mins), assessment of respiratory status related to immobility/bed rest (20mins), deep breathing exercises & range of motion exercises, (20mins), discusses patients and management requirements with the nurse and doctor (20mins) and documents all of the above (10mins).

Record:
Option 1- Broad Activity Description (Level1)

Data Item	Data Entry
Client Type	Admitted/Inpatient
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	New
Service Delivery Setting	Local hospital campus
Patient Contact	1
OOS	0 (not an outpatient/non-admitted setting)
Service Event	0 (not an outpatient/non-admitted setting)
Contact Type	Individual
Service Delivery Mode	Face to Face
Activity	**Physiotherapy**
Duration	**80 mins**
Outpatient/Non-Admitted Clinic Type	N/A

Option 2 – Broad Activity Description (Level 2)

Data Item	Data Entry
Client Type	Admitted/Inpatient
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	New
Service Delivery Setting	Local hospital campus
Patient Contact	1
OOS	0 (not an outpatient/non-admitted setting)
Service Event	0 (not an outpatient/non-admitted setting)
Contact Type	Individual
Service Delivery Mode	Face to Face
Activity 1	**Assessment**
Duration	**30 mins (Reading notes and Assessment)**
Activity 2	**Intervention**
Duration	**50mins (intervention and case note writing/pt related discussion)**
Total Activity	**80 mins**
Outpatient/Non-Admitted Clinic Type	N/A

Option 3- Detailed Activity Description (Level 3 & Indirect activity)

Data Item	Data Entry
Client Type	Admitted/Inpatient
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	New
Service Delivery Setting	Local hospital campus
Patient Contact	1
OOS	0 (not an outpatient/non-admitted setting)
Service Event	0 (not an outpatient/non-admitted setting)
Contact Type	Individual
Service Delivery Mode	Face to Face
Activity 1	**Physiological Assessment**
Duration	**30 mins (Reading notes and Assessment)**
Activity 2	**Assistance Intervention**
Duration	**30mins (intervention and case note writing)**
Activity 3	**Patient Related Discussion**
Duration	**20 mins**
Total Activity	**80 mins**
Outpatient/Non-Admitted Clinic Type	N/A

Example 2

An Occupational Therapist travels in a government vehicle (20mins) to visit a stroke patient who has just been referred and lives at home. Whilst there he/she performs the following interventions: initial assessment/evaluation (40mins), environmental modifications (20mins), equipment prescription (20mins), and documentation (15mins).   The Occupational Therapist returns to their service (20mins) and makes a phone call to the equipment supply company to arrange delivery of the equipment (15mins).

Record:
Option 1 - Broad Activity Description (Level1)

Data Item	Data Entry
Client Type	Outreach
Provider Type	Occupational Therapist
Profession	Occupational Therapy
Attendance Type	New
Service Delivery Setting	Private residence
Patient Contact	1 (optional -site determined- see section 6.2 and 7.1)
OOS	1
Service Event	1
Contact Type	Individual
Service Delivery Mode	Face to Face
Activity 1	**Occupational Therapy**
Duration	**150 mins**
Outpatient/Non-Admitted Clinic Type	Tier 2 Occupational therapy 40.06

Option 2 – Broad Activity Description (Level 2)

Data Item	Data Entry
Client Type	Outreach
Provider Type	Occupational Therapist
Profession	Occupational Therapy
Attendance Type	New
Service Delivery Setting	Private residence
Patient Contact	1 *(optional -site determined- see section 6.2 and 7.1)*
OOS	1
Service Event	1
Contact Type	Individual
Service Delivery Mode	Face to Face
Activity 1	**Assessment**
Duration	**60 mins (travel to and assessment)**
Activity 2	**Intervention (remainder of activities)**
Duration	**90 mins**
Total Duration	**150 mins**
Outpatient/Non-Admitted Clinic Type	Tier 2 Occupational therapy 40.06

Option 3- Detailed Activity Description (Level 3 & Indirect activity)

Data Item	Data Entry
Client Type	Outreach
Provider Type	Occupational Therapist
Profession	Occupational Therapy
Attendance Type	New
Service Delivery Setting	Private residence
Patient Contact	1 *(optional -site determined- see section 6.2 and 7.1)*
OOS	1
Service Event	1
Contact Type	Individual
Service Delivery Mode	Face to Face
Activity 1	**Assessment of personal care and other activities of daily/independent living**
Duration	**40 mins**
Activity 2	**Assistance interventions**
Duration	**55 mins (environmental mods, equipment prescription, phone call)**
Activity 3	**travel**
Duration	**40 mins**
Activity 4	**Documentation/Reporting**
Duration	**15 mins**
Total Duration	**150 mins**
Outpatient/Non-Admitted Clinic Type	Tier 2 Occupational therapy 40.06

5.1.6 DURATION

Example 1

On day 1:

An Occupational Therapist travels in a government vehicle (20mins) to visit a stroke patient who lives at home for a review. Whilst there he/she performs the following interventions: initial assessment/evaluation (40mins), environmental modifications (20mins), equipment prescription (20mins), and documentation (15mins).

On day 2:

 The Occupational Therapist returns to their service (20mins) and makes a phone call to the equipment supply company to arrange delivery of the equipment (15mins).

The *Client Type* influences whether and how you count *OOS* and *Service Event.*

Record Day 1:

Data Item	Data Entry
Client Type	Non-admitted /outreach
Provider Type	Occupational therapist
Profession	Occupational therapy
Attendance Type	Review
Service Delivery Setting	Private residence
Patient Contact	**1(optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Occupational therapy
Duration	**115 minutes**
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.06 Occupational Therapy

Record Day 2:

Data Item	Data Entry
Client Type	Non-admitted /outreach
Provider Type	Occupational therapist
Profession	Occupational therapy
Attendance Type	N/A
Service Delivery Setting	N/A
Patient Contact	0
OOS	0
Service Event	0
Contact Type	N/A
Service Delivery Mode	N/A
Activity	Occupational therapy
Duration	**35 minutes**
Outpatient/Non-Admitted Clinic Type	N/A

5.2 CLINICAL CARE ACTIVITY: Non- Individual Patient Attributable

Example 1

The service has identified a gap and the need to develop an educational resource. The Audiologist spends 75 minutes preparing an education package for patients. The Audiologist does not know the specific patients who will receive the resource.

Record:

Data Item	Data Entry
Client Type	N/A
Provider Type	Audiologist
Profession	Audiology
Attendance Type	N/A
Service Delivery Setting	N/A
Patient Contact	0
OOS	0
Service Event	0
Contact Type	N/A
Service Delivery Mode	N/A
Activity	Audiology
Duration	75 minutes
Outpatient/Non-Admitted Clinic Type	N/A

Example 2

Approval has been gained to develop, design and deliver a new outpatient service to patients with lower limb amputation. A Prosthetist spends 300 minutes preparing designing and developing specific program materials including session structure, content and research for the program including a literature review.

Record:

Data Item	Data Entry
Client Type	N/A
Provider Type	Prosthetist
Profession	prosthetics
Attendance Type	N/A
Service Delivery Setting	N/A
Patient Contact	0
OOS	0
Service Event	0
Contact Type	N/A
Service Delivery Mode	N/A
Activity	Prosthetics/Orthotics
Duration	300 minutes
Outpatient/Non-Admitted Clinic Type	N/A

Example 3

A community service provider offers a drop-in support group for patients with dementia and their carers. A Social Worker facilitates the group discussion and provides information on dementia and services that are available to patients and their carer. The numbers of members attending each month varies and no medical records are created. The group runs for 60 minutes.

Record:

Data Item	Data Entry
Client Type	N/A
Provider Type	Social worker
Profession	Social work
Attendance Type	N/A
Service Delivery Setting	N/A
Patient Contact	0
OOS	0
Service Event	0
Contact Type	N/A
Service Delivery Mode	N/A
Activity	Social work
Duration	60 minutes
Outpatient/Non-Admitted Clinic Type	N/A

5.3 WHEN THINGS GET COMPLICATED

Should you encounter difficulty in interpreting how an allied health activity should be recorded, please refer to the flow chart located at the end of this document. If you are still unsure of how to record your time and activity please contact your immediate manager. Managers are encouraged to send the example to their local data integrity committee for comment and further clarification if required. Resolved and unresolved examples can be emailed to the Allied and Scientific Health Office for consideration and/or resolution through the State-wide AH Executive Committee.

The result of the enquiry should be used to provide further education to all allied health staff to ensure consistency in data capture.
Some questions to help you in how/where to enter your stats may be:
- Can I identify a person identifier for this activity?
- Where did the activity take place?
- Whose medical record/health record is this being documented in? That person is the patient (even if you have been talking to someone else about an issue).
- Follow the 80/20 rule and record data that reflects the majority of your activity.

The following examples provide very detailed descriptions regarding the recording of time in various circumstances. It is likely that such detail is not required in a clinical setting and the examples provide more of a theoretical explanation of how the data could be reflected in alignment with recording rules.

Example 1
A Physiotherapist is running a pulmonary rehab exercise group for 10 patients for 80 minutes. 2 patients require individualized attention during the group and the Physiotherapist spends 10 minutes with each of them. All patients have an entry in their medical record for attending the group and specific entries are made for the 2 patients receiving individualised attention.

The *Client Type* influences whether and how you count *OOS* and *Service Event.*

Record:

Data Item	Data Entry
Client Type	**Non-admitted/outpatient**
Provider Type	physiotherapist
Profession	physiotherapy
Attendance Type	**Review**
Service Delivery Setting	Local hospital campus
Patient Contact	**10 (optional -site determined- see section 6.2 and 7.1)**
OOS	**1 Group with 10 participants** **plus** **2 individual OOS**
Service Event	**10**
Contact Type	Group for the activity recorded as group Individual for each of the single/individual OOS
Service Delivery Mode	In person
Activity	physiotherapy
Duration	Group:60 minutes against each group member who did not receive individual attention Group : 50 minutes for the 2 patients who received some individual attention Individual sessions : 10 minutes against the patients who received individual attention
Outpatient/Non-Admitted Clinic Type	N/A

Example 2

A Social Worker provides bereavement support via email to the adolescent child of a deceased patient who passed away a week ago.   The social worker was seeing the patient whilst they were admitted to hospital. The email correspondence takes 20 minutes to write. This is not able to be captured against the patient's medical file as this has been closed and should be recorded as Non-Individual Patient Attributable time.

If the social worker classifies the intervention as part of the episode of care for the deceased patient, the following data entry is suggested.

Data Item	Data Entry
Client Type	N/A
Provider Type	social worker
Profession	social work
Attendance Type	N/A
Service Delivery Setting	N/A
Patient Contact	0
OOS	0
Service Event	0
Contact Type	N/A
Service Delivery Mode	electronic mail
Activity	social work
Duration	20 minutes
Outpatient/Non-Admitted Clinic Type	N/A

If the Social Worker, determines that they are providing a therapeutic intervention to the adolescent and identifies the adolescent as a client/patient and creates and /or records the intervention in the adolescents medical record, the following is suggested:

Data Item	Data Entry
Client Type	non-admitted/outpatient
Provider Type	social worker
Profession	social work
Attendance Type	New
Service Delivery Setting	private residence
Patient Contact	1 (optional -site determined- see section 6.2 and 7.1)
OOS	1
Service Event	1
Contact Type	Individual
Service Delivery Mode	electronic mail
Activity	social work
Duration	20 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.11 Social Work

Example 3

A Psychologist provides 60 minutes of counselling to a paediatric patient's mother and father together. The parents are not being provided with education or training with regard to the child's therapy and plan for care but instead emotional support to the parents. The child is currently admitted to hospital. The intervention can either be recorded in the child's medical record and the activity against the child in the clinical information system (Option 1) or the parents can be recognised as patients (Option 2) and the intervention recorded in each of the parent's medical records and data recorded against their URN.

Record
Option 1

Data Item	Data Entry
Client Type	*Admitted/Inpatient*
Provider Type	*psychologist*
Profession	*psychology*
Attendance Type	*N/A*
Service Delivery Setting	*private residence*
Patient Contact	*0*
OOS	*0*
Service Event	*0*
Contact Type	*N/A*
Service Delivery Mode	*in person*
Activity	*psychology*
Duration	*60 minutes*
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.29 psychology

Option 2

Data Item	Data Entry
Client Type	*Hospital funded Outreach*
Provider Type	*psychologist*
Profession	*psychology*
Attendance Type	*New (per parent)*
Service Delivery Setting	*private residence*
Patient Contact	*1 per parent/patient (optional -site determined- see section 6.2 and 7.1)*
OOS	*1 per parent/patient*
Service Event	*1 per parent/patient*
Contact Type	*Individual*
Service Delivery Mode	*in person*
Activity	*psychology*
Duration	*30 minutes per parent*
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.29 psychology

Example 4
A patient is admitted to hospital for treatment of a cardiac condition. The patient has a pre-existing review outpatient appointment at the Audiology Department of the same hospital and is transported from the ward to attend this 30 minute appointment.

Record

Data Item	Data Entry
Client Type	**Non-Admitted/Outpatient**
Provider Type	Audiologist
Profession	Audiology
Attendance Type	**review**
Service Delivery Setting	local hospital campus
Patient Contact	**1 (optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	**in person**
Activity	Audiology
Duration	30 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.17 audiology

5.4 ALLIED HEALTH ASSISTANT

The *Client Type* influences whether and how you count *OOS* and *Service Event.*

Example 1

An OT assistant carries out one handed dressing practice for 1 hour for an inpatient. The assistant also educates the carer on how best to assist the patient to complete the tasks during this time.

Data Item	Data Entry
Client Type	**Admitted/In patient**
Provider Type	Allied Health Assistant
Profession	Occupational Therapy
Attendance Type	**review**
Service Delivery Setting	local hospital campus
Patient Contact	**1 (optional -site determined- see section 6.2 and 7.1)**
OOS	**0 (not an outpatient/non-admitted setting)**
Service Event	**0 (not an outpatient/non-admitted setting)**
Contact Type	Individual
Service Delivery Mode	**in person**
Activity	occupational therapy
Duration	60 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.06 Occupational Therapy

Example 2

The OT has requested that the AHA takes a patient to the ADL unit in the day rehabilitation centre and demonstrate how to use modified kitchen aids. The Physiotherapist attends at the same time to assess the patient's balance using a walking stick in the kitchen environment. The session takes 20 minutes. The AHA then gives the patient some documentation about suppliers and options of models/styles. This takes 10 mins.

OT AHA records:

Data Item	Data Entry
Client Type	**Non-Admitted/Outpatient**
Provider Type	Allied Health Assistant
Profession	Occupational Therapy
Attendance Type	**review**
Service Delivery Setting	local hospital campus
Patient Contact	**1 (optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	**in person**
Activity	audiology
Duration	30 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.06 Occupational Therapy

Physiotherapist records:

Data Item	Data Entry
Client Type	**Non-Admitted/Outpatient**
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	**review**
Service Delivery Setting	local hospital campus
Patient Contact	**1 (optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	**in person**
Activity	physiotherapy
Duration	20 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.09 physiotherapy

Example 3

An Exercise Physiologist conducts an exercise program for an outpatient and is assisted by an AHA. The intervention takes 60 minutes and recorded within the medical records. Both clinicians are required for conduction of the group and to ensure patient and staff safety.

Exercise Physiologists Records :

Data Item	Data Entry
Client Type	**Non-Admitted/Outpatient**
Provider Type	Exercise Physiologist
Profession	Exercise Physiology
Attendance Type	**review**
Service Delivery Setting	local hospital campus
Patient Contact	**1 (optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	**in person**
Activity	exercise physiology
Duration	60 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.21 Cardiac Rehabilitation or 40.40 Respiratory Note: a specific /dedicated exercise physiology tier 2 classification is required

AHA Records:

Data Item	Data Entry
Client Type	Non-Admitted/Outpatient
Provider Type	Allied health Assistant
Profession	Exercise Physiology
Attendance Type	review
Service Delivery Setting	local hospital campus
Patient Contact	1 **(optional -site determined- see section 6.2 and 7.1)**
OOS	0
Service Event	0
Contact Type	Individual
Service Delivery Mode	in person
Activity	exercise physiology
Duration	60 minutes
Outpatient/Non-Admitted Clinic Type	N/A

Example 4

The Occupational Therapist who has been completing the "Rehab in the Home-based" intervention, jointly visits to hand over the treatment program to an AHA. The therapist and AHA spend 30 minutes with the patient plus 20 minutes travel to and from the patient's home. Both clinician and AHA document in the patients' medical notes (5 minutes).

OT Records

Data Item	Data Entry
Client Type	Non-admitted/outreach
Provider Type	Allied Health Assistant
Profession	Occupational Therapy
Attendance Type	review
Service Delivery Setting	private residence
Patient Contact	1 (optional -site determined- see section 6.2 and 7.1)
OOS	1
Service Event	1
Contact Type	Individual
Service Delivery Mode	in person
Activity	Occupational Therapy (can be more specific with activity descriptors if wants to capture travel time separately)
Duration	75 minutes
Outpatient/Non-Admitted Clinic Type	tier 2 classification : 40.12 Rehabilitation

AHA Records

Data Item	Data Entry
Client Type	Non-Admitted/Outreach
Provider Type	Allied Health Assistant
Profession	Occupational Therapy
Attendance Type	review
Service Delivery Setting	private residence
Patient Contact	1 (optional -site determined- see section 6.2 and 7.1)
OOS	0 (doesn't count a service event as session wouldn't have occurred independently of Occupational therapist)
Service Event	0(doesn't count a service event as session wouldn't have occurred independently of Occupational therapist)
Contact Type	Individual
Service Delivery Mode	in person
Activity	Occupational Therapy (can be more specific with activity descriptors if wants to capture travel time separately)
Duration	75 minutes
Outpatient/Non-Admitted Clinic Type	N/A

Example 5

The AHA attends a 15 minute hand-over session with the Speech Pathologist and patient regarding the next extension steps for a communication program for an outpatient.

AHA Records :

Data Item	Data Entry
Client Type	**Non-Admitted/Outpatient**
Provider Type	Allied Health Assistant
Profession	Speech Pathology
Attendance Type	**review**
Service Delivery Setting	local hospital campus
Patient Contact	**0**
OOS	**0**
Service Event	**0**
Contact Type	N/A
Service Delivery Mode	**N/A**
Activity	speech pathology
Duration	15 minutes
Outpatient/Non-Admitted Clinic Type	N/A

Speech Pathologist Records

Data Item	Data Entry
Client Type	**Non-Admitted/Outpatient**
Provider Type	Speech Pathologist
Profession	Speech Pathology
Attendance Type	**review**
Service Delivery Setting	local hospital campus
Patient Contact	**0**
OOS	**0**
Service Event	**0**
Contact Type	N/A
Service Delivery Mode	**N/A**
Activity	speech pathology
Duration	15 minutes
Outpatient/Non-Admitted Clinic Type	N/A

5.5 STUDENT STATISTICS

Example 1

A Physiotherapist is supervising 5 students during an exercise rehabilitation class in for the physiotherapy outpatient department. Each student provides an hour of therapy to one patient each (total 5 patients). The Physiotherapist divides their attention evenly between the 5 students. The students write the medical note entry and this is countersigned by the supervisor.

Students Record

Each student records the following against the patient to whom they were providing treatment:

Data Item	Data Entry
Client Type	**Non-Admitted/Outpatient**
Provider Type	Physiotherapy student
Profession	Physiotherapy
Attendance Type	**review**
Service Delivery Setting	local hospital campus
Patient Contact	**1(optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Physiotherapy
Duration	60 minutes
Outpatient/Non-Admitted Clinic Type	Tier 2 classification 40.12 Rehabilitation

Supervisor Records

Data Item	Data Entry
Client Type	**N/A**
Provider Type	Physiotherapist
Profession	Physiotherapy
Attendance Type	**N/A**
Service Delivery Setting	N/A
Patient Contact	**0**
OOS	**0**
Service Event	**0**
Contact Type	N/A
Service Delivery Mode	N/A
Activity	Teaching and Training
Duration	60 minutes
Outpatient/Non-Admitted Clinic Type	N/A

Example 2

A speech pathologist introduces themselves and their student to an outpatient they are seeing. The supervisor discusses the treatment plan briefly with the patient (10 minutes) then allows the student to complete the treatment while the supervisor observes (20 minutes).

Student Records

Each student records the following against the patient to whom they were providing treatment:

Data Item	Data Entry
Client Type	***Non- Admitted/Outpatient***
Provider Type	*Speech Pathology student*
Profession	*Speech Pathology*
Attendance Type	***review***
Service Delivery Setting	*local hospital campus*
Patient Contact	***1(optional -site determined- see section 6.2 and 7.1)***
OOS	***1***
Service Event	***1***
Contact Type	*Individual*
Service Delivery Mode	*In person*
Activity	*Speech Pathology*
Duration	*20 minutes*
Outpatient/Non-Admitted Clinic Type	Tier 2 classification : speech pathology 40.18

Supervisor Records

Data Item	Data Entry
Client Type	***N/A***
Provider Type	*Speech Pathologist*
Profession	*Speech Pathology*
Attendance Type	***N/A***
Service Delivery Setting	*N/A*
Patient Contact	***0***
OOS	***0***
Service Event	***0***
Contact Type	*N/A*
Service Delivery Mode	*N/A*
Activity	*Teaching and Training*
Duration	*30 minutes*
Outpatient/Non-Admitted Clinic Type	N/A

Example 3

A Dietitian allows a student to conduct a nutritional assessment of an outpatient while they see another outpatient. The student takes 60 minutes to complete the assessment. The Dietitian and student spend 20 minutes discussing the case, ensuring the care plans are accurate and the supervisor countersigns the notes.

Student Records

Each student records the following against the patient to whom they were providing treatment:

Data Item	Data Entry
Client Type	*Non- Admitted/Outpatient*
Provider Type	Nutrition /Dietetics student
Profession	Nutrition /Dietetics
Attendance Type	*review*
Service Delivery Setting	local hospital campus
Patient Contact	*1(optional -site determined- see section 6.2 and 7.1)*
OOS	*1*
Service Event	*1*
Contact Type	Individual
Service Delivery Mode	In person
Activity	Nutrition/dietetics
Duration	80 minutes
Outpatient/Non-Admitted Clinic Type	Tier 2 classification : nutrition/dietetics 40.23

Supervisor Records

Data Item	Data Entry
Client Type	*N/A*
Provider Type	Dietitian
Profession	Nutrition /Dietetics
Attendance Type	*N/A*
Service Delivery Setting	N/A
Patient Contact	*0*
OOS	*0*
Service Event	*0*
Contact Type	N/A
Service Delivery Mode	N/A
Activity	*Teaching and Training*
Duration	20 minutes
Outpatient/Non-Admitted Clinic Type	N/A

Example 4

A podiatry outpatient would normally need to be treated by two people and a student and staff members are treating the outpatient together. This session takes 50 minutes to complete.

Student Records

Each student records the following against the patient to whom they were providing treatment:

Data Item	Data Entry
Client Type	**Non- Admitted/Outpatient**
Provider Type	Podiatry student
Profession	Podiatry
Attendance Type	**review**
Service Delivery Setting	local hospital campus
Patient Contact	**1(optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**0 ***
Contact Type	Individual
Service Delivery Mode	In person
Activity	Podiatry
Duration	50 minutes
Outpatient/Non-Admitted Clinic Type	N/A* student can't count the session as only 1 clinician can count a service event at the same time unless patient is having a session independently with each clinician

Supervisor Records

Data Item	Data Entry
Client Type	**N/A**
Provider Type	Podiatrist
Profession	Podiatry
Attendance Type	**N/A**
Service Delivery Setting	N/A
Patient Contact	**1(optional -site determined- see section 6.2 and 7.1)**
OOS	**1**
Service Event	**1**
Contact Type	Individual
Service Delivery Mode	In person
Activity	Podiatry
Duration	50 minutes
Outpatient/Non-Admitted Clinic Type	Tier 2 classification : podiatry 40.25

APPENDIX 6: READY RECKONER

Data Element Group	Definition & Guide for Use
Patient Contact	
Patient Contact	Any examination, consultation, treatment or other service provided by a health service provider to a client/patient. Can occur in any setting irrespective of funding source i.e. hospital funded versus primary care service funded etc. l The service must contain / be: ▪ clinical content ▪ Face to face or a substitute for face to face e.g. telephone and ▪ Documented in the patient's medical record, clinical file or information system.
Occasion of Service	
Occasions of Service	The term used to describe a hospital funded **outpatient s**ervice (including outreach) Any examination, consultation or treatment or other service provided by a health service provider provided to an outpatient or Emergency Department patient within a functional unit of a hospital (includes outreach services i.e. hospital funded services provided off–site) [p20 MMSS guidelines July 2014]. The service <u>must</u> contain / be: ▪ clinical content ▪ Face to face or a substitute for face to face e.g. telephone and ▪ Documented in the patient's medical record, clinical file or information system.
Service Event	
Service Event	The term used to describe a **non-admitted s**ervice provided to a patient and funded via Activity Based funding. An interaction between one or more healthcare providers with one non-admitted patient which must contain therapeutic /clinical content and result in a dated entry in the patient's medical record ([p14 IHPA Non admitted services definition manual 2014-15). The service <u>must</u> contain / be: ▪ clinical content ▪ Face to face or a substitute for face to face e.g. telephone and ▪ Documented in the patient's medical record, clinical file or information system.

New or Review	
New or Initial	The first patient attendance to the service / profession (not to each clinician within the profession for that episode of care)
Review or Subsequent	All other attendance following the initial (new attendance)
Episode of Care	An episode of care is a phase of treatment. There may be more than one episode of care within the one hospital stay. An episode of care ends when the principle clinical intent changes (and thus care type) or when the patient is formally separated from the facility
Referrals	Each episode of care requires a referral. The presentation of an unrelated illness or condition will initiate a new course of treatment (or episode of care) in which case a new referral is required.
Clinical Care Activity	
Clinical Care Activity	Activities provided to an individual, group or community to influence health status. Includes: Individual Patient Attributable (IPA) and Non-Individual Patient Attributable (NIPA) activity.
Individual Patient Attributable (IPA)	Any clinical care activity that can be assigned to an individual patient (including travel). This includes direct and indirect patient care (i.e. the patient does not need to be physically with the staff)
Non- Individual Patient Attributable (NIPA)	Any activity that **cannot** be assigned to an individual patient but is patient related.
Service Delivery Mode	
Telephone	Patient and provider(s) not in same physical location and communicating by telephone. Service provider(s) is talking directly to the patient or carer and must be a substitution for a face-to-face consult. Administrative phone calls, booking schedules must not be counted as an occasion of service.
In person	Patient is present at the time of the contact.
Telehealth/telemedicine/videoconference	Communication occurs via a secure telecommunication or video-communication mediums carer and must be a substitution for a face-to-face consult.
Postal/courier	Communication is made via a written document.
Electronic mail	Communication is made via electronic means e.g. email.
Other	All other methods not defined elsewhere.
Contact type	
Individual	Any examination, consultation, treatment or other service provided by a health service provider to a patient of a health service establishment.
Group	Group activity is recorded when two or more patients/clients receive the same service, at the same time, from the same health care employee. Groups can be in any clinical/health service delivery environment but must contain clinical content.

Client Type	
Admitted/ Inpatient	An admitted patient is an individual who undergoes a formal admission process into a SA Health hospital with an overnight stay.
Same Day Admitted	An admitted patient is an individual who undergoes a formal admission process into a SA Health hospital, receives treatment and then goes home on the same day.
Non-Admitted: Outpatient	A person who receives healthcare from a member of the hospital staff or receives healthcare at the hospital. They attend, usually by appointment, the hospital to receive non-emergency outpatient care. They are not admitted as a patient of the hospital.
Non- Admitted : Outreach	A person who receives healthcare usually by appointment from a hospital employee. The care is delivered at a location other than the location of the funding hospital. The service is purposefully delivered in a location of greater proximity /convenience to the client.
Non- Admitted :Emergency	*Emergency Department:* A person who receives emergency/unscheduled care in a hospital emergency department.
ABF Funded Primary Care	A person who receives services that have been identified as being within scope of activity based funding and provided by primary care service health service providers. Is similar to non-admitted outreach but the activity is still owned by the primary care service and reported monthly against their facility as opposed to the hospital's activity.
Primary Care	Services provided to individuals and the community that are not funded via hospital funding streams. They may be block funded by state or federal funding.
Activity	
Activity	A descriptor that defines the activity undertaken by the clinician. For clinical care activity, the ACHI code set is to be used . The level of specificity is determined at a local level. Activity descriptors used to reflect indirect clinical activities and non-clinical care activities are recommended.
Outpatient Clinic Codes (ABF)	
Tier 2 classification codes	Used for ABF Tier 2 funding. Hospital outpatient clinics and select other non-admitted services are required to report against Tier 2 code sets. The classes are grouped into four categories that reflect the type of service provided and the clinicians that typically provide the service. These include: - Procedures - Medical Consultations - Stand-alone diagnostic - Allied health and/or clinical nurse specialist intervention

Non-Clinical Activity Data Definitions	
Non-Clinical Care Activities	
Non-Clinical Care Activities	Activities performed which **are not** directly related to a particular patient/individual, group or community to influence health status. These include activities that support and are essential to clinical care. There are three categories of non-clinical care activity: 1. Clinical Services Management (CSM) 2. Teaching and Training (TT) 3. Research (R)
Clinical Services Management (CSM)	Professional and management activities which support and are essential to clinical care.
Teaching and Training (TT)	**Formal** teaching and training activities which relate to the *imparting* of knowledge, skills and clinical competency to undergraduate and postgraduate students, health practitioners within one's own professions or health practitioners from another profession, as part of a structured program. Includes preparation and delivery.
Research (R)	Activities undertaken to advance the knowledge of the delivery of care to an individual, group or community. Research is limited to activities that lead to and follow **formal approval** of the project by a research committee or equivalent body.

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Change History

Any printed version of this document may have been superseded. The current version of this document can be accessed via

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