NCR5212 – NCAMP 2021

Sector Consultation Business Requirements NCAMP 2021

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# Introduction

## Document purpose: Vehicle for discussion of NCAMP changes

**This document provides a vehicle for the discussion of the requests for changes to the National Collections and documents the requirements for the 2021 National Collections Annual Maintenance Project (NCAMP).**

**All feedback is welcomed and should be directed to** [**ncamp@health.govt.nz**](mailto:ncamp@health.govt.nz)

## Project Background: National Collections Annual Maintenance

NCAMP is run annually to perform maintenance on the Ministry’s National Collections and to ensure it meets its on-going statutory obligations. The project will deliver changes to the following National Collections/Systems:

* National Non-admitted Patient Collection (NNPAC)
* National Minimum Data Set (NMDS)
* Programme for the Integration of Mental Health Data (PRIMHD)

Some NCAMP changes require District Health Boards (DHBs), Non-Governmental Organisations (NGOs) and private hospitals reporting directly to national collections to implement changes to their Patient Administration Systems (PAS) (sometimes also referred to as Patient Management Systems (PMS). The annual process for making these changes is outlined in the Operational Policy Framework (OPF).

## NCAMP Goals and Objectives

* To improve data quality to enable the Ministry and DHBs to accurately report on the provision and funding of services or treatment, particularly in relation to inter-district flows.
* To ensure data quality and integrity is maintained to avoid substantial rework by both the Ministry, DHBs and NGOs.
* To improve the Ministry and DHBs ability to provide timely, accurate and comparative information. This will assist them to complete functions and meet objectives set out in the New Zealand Public Health and Disability Act 2000.
* To enable the Ministry to meet its obligations of providing high quality data to the DHBs, NGOs and other providers, particularly in relation to data processing and reporting, manual data entry, and application of data collection business rules.

# Background

## Assumptions

1. Maintenance items relating to the National Collections that do not impact DHB or NGO processes or systems may potentially be delivered in maintenance releases during the year.
2. Major increases in capability to the National Collections will be delivered through projects endorsed in the annual expenditure and are subject to business case approval.

## Business Rules

Where relevant, for clarity or additional detail, the business rules will be listed individually with each change. All rules and requirements etc are based on Ministry systems and care should be taken when analysing these taking into account local systems configuration.

## Relevant Facts

* The cut-off date for requests for NCAMP 2021 was 1 August 2020
* The proposed scope for NCAMP 2021 was finalised on 1 September 2020
* Formal change notices will be issued in December after Sector feedback is considered.

# NCAMP 2020 Completion

Changes notified for NCAMP 2020 will need to be implemented by those organisations that took the option to defer the changes due to COVID-19 activity.

The changes notices are available at:

https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/national-collections-annual-maintenance-project/ncamp-2020

# National Minimum Dataset (NMDS)

## Annual WIESNZ and Cost Weight Changes for 2021/22

The Weighted Inlier Equivalent Separation (WIES) is the methodology used to calculate the cost weight based on the assigned Australian Refined Diagnosis Related Groups (AR-DRG) codes. Minor revisions of WIES are made annually as part of NCAMP. More extensive revisions are made when the AR-DRG version is updated to align with the corresponding ICD-10-AM/ACHI Edition, which generally occurs on the third year after the implementation of the new ICD-10-AM/ACHI classification.

The 2021/22 New Zealand Casemix Framework for Publicly Funded Hospitals document (WIESNZ21) is expected to be available on the NCAMP website in December 2020.

* The casemix framework associated with WIESNZ21 is the same as WIESNZ20 except for the following: New and revised same day/one day designations for DRGs A08B, J06B and R63Z
* Revised Abdominal Aortic Aneurysm (AAA) co-payment to now include separate values for F08A (AAAA) 4.9466 and F08B (AAAB) 3.4141
* Revised Scoliosis co-payment definition by removing DRG I06Z and age criteria.  Co-payment value revised from 5.2673 to 5.6074
* Revised Electrophysiological Studies (EPS) co-payment definition to include DRGs F42x. Co-payment value revised from 1.7266 to 1.2278
* Revised Complex Traumatic Limb (TLC) definition by removing facilities Waikato (5311) and Canterbury (4011).  Co-payment value revised from 2.9934 to 3.1934
* Revised Gender Affirming Surgery (GR) definition to include the procedure ‘radical vaginal hysterectomy’.  Co-payment value revised from 1.5143 to 1.4871
* Reinstated co-payment from WIESNZ19 for Isolated Limb Infusion (ILI)
* New co-payment for Peritonectomy with HIPEC (PH)
* New co-payment for Pelvic Evisceration (PE) Surgery for Waitemata DHB
* Revised co-payment values for:
  + Atrial Septal Defect (ASD) co-payment value from 1.1613 to 1.2803
  + Ventricular Assist Devices (LVAD) for adults co-payment value from 22.5183 to 21.0526
  + Bilateral Mastectomy or Combined Mastectomy and Reconstruction co-payment values (MRA) from 1.0134 to 0.9438, (MRB) from 0.5507 to 0.7790 and (MRZ) from 1.1630 to 1.0177
  + Cardiac Lead Extraction (LE) co-payment value from 3.2179 to 2.4694
* Revised costweight values for NZ DRGs C03W from 0.06370 to 0.0812 and J11W from 0.23160 to 0.2252
* Moved section ‘Note on anaesthesia coding’ to be sequenced before exclusion rules that have an anaesthesia criteria.  Anaesthesia block [1910] *Cerebral anaesthesia* split to specify ‘general anaesthesia’ and ‘sedation
* Revised exclusion rule for ‘Same day pharmacotherapy for treatment of neoplasm’
* Revised ERCP exclusion rule definition by removing two stent procedure codes 3049100 and 3045102
* Revised the anaesthesia criteria for three scope (cystoscopies, gastroscopy procedures, bronchoscopy) exclusion rule definitions to only include sedation.

## Health Speciality Code (HSC) Consultation for NCAMP 2022

This is a consultation notice for a request for change in health specialty code that was received from the Sector and is detailed below.

Please submit feedback to: [ncamp@health.govt.nz](mailto:ncamp@health.govt.nz)

**Medical Oncology and Radiation Oncology Health Specialty Codes**

|  |  |  |
| --- | --- | --- |
| **Description** | | **Proposal to create a Radiation Oncology Health Speciality Code**  **Background**  Medical Oncology (MO) and Radiation Oncology (RO) are considered two separate disciplines within the Oncology umbrella. The departments are staffed separately, and the qualifications of the staff are different.  The DHB requesting the change of health speciality code stated the lack of separation between Medical and Radiation Oncology affects the collection of workload data in their patient management system, and as a consequence all of the many downstream systems.  A separate Radiation Oncology health specialty code would better support counting, planning, performance and quality purposes at the local, regional and national level for Oncology services.  **Impact**  Currently health speciality code (HSC) M50 *Oncology* includes Radiation Oncology and Medical Oncology events.  It has been proposed to retired HSC M50 *Oncology* and create two new HSCs for RO and MO to capture the separate disciplines within Oncology.  A related impact of this proposal is HSC M90 *Radiotherapy,* which is primarily used for radiotherapy volumes e.g. M50025 *Oncology-Radiotherapy, External Beam Megavoltage (linac).* However, it is more difficult to split Radiotherapy into oncology (cancer) and non- oncology (non-cancer) treatment.  If HSC M90 *Radiotherapy* was also retired with two new HSCs created, clear guidance would need to be developed for the use of the new Radiotherapy and Radiation Oncology codes, and how they would map to existing purchase unit codes (PUCs).  There are no plans to change existing oncology and radiation purchase unit codes.  **Questions**  How would this proposal impact your DHB?  Would the proposed new health specialty code for Radiation Oncology help solve the current problems and work arounds, or would it cause confusion? |
| ~~#~~ |  | |
| BR1. | Retire HSCs M50 *Oncology* and possibly also M90 *Radiotherapy* | |
| BR2. | Create new Medical Oncology health specialty code | |
| BR3. | Create new Radiation Oncology health specialty code | |
| BR4. | Possibly create two new Radiotherapy HSCs for oncology (cancer) and non-oncology (non-cancer) treatment. | |
| BR5. | Develop guidance for the use of the new Radiation Oncology and possibly the two new Radiotherapy health speciality codes, including the mapping to purchase unit codes. | |
| **SR1.** | A separate piece of work has started to look at reviewing the radiotherapy purchase unit codes, expected for implementation from 1 July 2022.  Consultation with Te Aho and ROWG will be undertaken and workshops initiated. | |

# Programme for the Integration of Mental Health Data (PRIMHD)

## Referral Discharge (RD) Record Code Sets

### Referral From (2.3.1.1) and Referral To (2.3.1.2)

The ‘Referral From’ identifies groups of services or people who are sources of mental health and addiction referrals.

The ‘Referral To’ identifies groups of services or people who are destinations of mental health and addiction referrals.

**Create new ‘Referral From’ and ‘Referral To’ Codes**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Description | | Create new Referral From, Referral To codes.  Currently in PRIMHD there is no way of indicating if forensic referrals have come specifically from corrections or court liaison and needs to be differentiated in PRIMHD. Some services are locally collecting this detail.  There is also a need to include a new Community Forensic’s referral to code option to better indicate inpatient Forensic discharges back into the care of community Forensic services. This will be used in particular for patients transitioning back into to the community.  Create new Referral From, Referral To codes CR, CO, FO   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Code** | **Description** | **Code Valid from** | **Code Valid To** | **Comment** | | CR | Corrections | 01-07-2021 | 30-06-2030 | Corrections, Prison. | | CO | Court Liaison | 01-07-2021 | 30-06-2030 | Court Liaison services i.e. referrals for court reports | | FO | Forensic Community | 01-07-2021 | 30-06-2030 | Any community Forensic services | |
| # |  | |
| BR1. | Add new ‘*referral from’* code ‘CR’, ‘CO’, ‘FO’ to database as per table above. | |
| BR2. | Add new ‘*referral to’* code ‘CR’, ‘CO’, ‘FO’ to database as per table above. | |
| BR3. | Update HISO PRIMHD Code Set Standard section 2.3.1.1 ‘*referral from’* code. | |
| BR4. | Update HISO PRIMHD Code Set Standard section 2.3.1.2 ‘*referral to’* code | |

**Amend Comment for ‘Referral From’ and ‘Referral To’ Codes**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Description** | | Update comment for existing Referral From and Referral To code  Update Referral From and Referral To comment JU   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Code** | **Description** | **Code Valid from** | **Code Valid To** | **Comment** | | JU | Justice | 01-01-1900 | 30-06-2030 | Courts, ~~Prison~~, ~~Corrections~~ or Youth Justice. | |
| # |  | |
| BR1. | Amend Comment for Referral Code JU as above table | |
| BR2. | Update HISO PRIMHD Code Set Standard section 2.3.1.1 ‘*referral from’* code. | |
| BR3. | Update HISO PRIMHD Code Set Standard section 2.3.1.2 ‘*referral to’* code. | |

### Referral End Codes (2.3.1.3)

**Create New Referral End Codes**

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| **Description** | | New Referral End Codes  A service transition is the process of managing the planned transfer of care for a Mental Health and Addiction (MHA) consumer who is transitioning between different health care providers, services or locations. It can be internal transfers (e.g. between a DHB inpatient and community team) or external transfers (e.g. discharge and referral to another organisation such as primary care).  Service transitions in the MHA sector are multiple and they are recognised as a potential risk to consumers, and their whānau and families. Some serious adverse events have been linked to a failed service transition, including suicide. The MHA sector has raised transitions as an important focus for the MHA quality improvement programme, facilitated by the Health Quality and Safety Commission (the Commission).  Currently PRIMHD does not accurately capture service transitions. The Commission, with review from the PRIMHD national stakeholder group, has developed proxy data definitions for selected MHA transitions. However, the confidence rating on some of these transitions is low, and there are opportunities to improve the PRIMHD data capture of transitions. For example, the MHA sector is not currently able to answer the relatively simple question of how many youth transition onto adult DHB community services. Changes to PRIMHD are necessary to improve data capture on transitions.  Create new Referral End Codes DY and DK   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Code | Description | **Code Valid from** | **Code Valid To** | Comment | | DY | Transfer to another MHA service within same organisation | 01-07-2021 | 30-06-2030 | Use this code for internal transfers between mental health and addiction teams. | | DK | Discharge of tangata whaiora/consumer to NGOs that provide MHA services | 01-07-2021 | 30-06-2030 | Use this code for transitions to NGOs when the NGO will be the primary provider of that consumer’s MHA services | |
| # |  | |
| BR1. | Add new ‘*referral end’* code ‘DY’, ‘DK’ to database as per table above. | |
| BR2. | Update HISO PRIMHD Code Set Standard section 2.3.1.3 ‘*referral end’* code. | |

**Amend Description & Comment for Referral End Codes**

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| Description | | Amend Description & Comment Referral End Codes DR, DT  Relevant facts   1. Relevant facts to new referral end code of discharge to a different MHA team within same org   The current related referral end codes are DR and DW. The PRIMHD code sets defines these codes as:   |  |  |  | | --- | --- | --- | | DR | Ended routinely | Completion of treatment / programme / goals / assessment.  Use this code for internal transfers between mental health teams. | | DW | Discharge to other service within same organisation | Discharge to a non-mental health and addiction service within the same organisation |   The notes for the code ‘DR’ show that it currently combines two very different concepts: completion of MHA treatment (‘Completion of treatment / programme / goals / assessment’) and planned transitions between MHA teams (‘Use this code for internal transfers between mental health teams’). ‘DW’ relates to a discharge to a non-MHA service in the same organisation.  Users need to be able to accurately measure all of these types of referral end.  To achieve this, a new referral end code is needed to capture discharges to an MHA team within the same organisation (for example, transitions from youth to adult services, from adult to older person services, and from DHB inpatient to DHB community services).   1. Relevant facts to new referral end code to NGOs   The current related referral end code is DT. The PRIMHD code sets defines this code as:  The code ‘DT’ does not allow users to identify whether the consumer was transitioned to an NGO providing MHA services, or to another healthcare organisation. An additional referral end code is necessary to distinguish between these two types of transitions.   |  |  |  | | --- | --- | --- | | DT | Discharge of tangata whaiora/consumer to another healthcare organisation | Discharge to another healthcare provider in a different organisation. Can be either a mental health or non-mental health organisation. |   [Whilst noting this proposed solution will still be limited as only one referral end code is allowed, and in some cases, consumers transition onto multiple services, such as an NGO and DHB community team. It is proposed the longer-term solution of a PRIMHD review should include an assessment of capturing transitions, and ability to capture transitions to concurrent services].   |  |  |  |  | | --- | --- | --- | --- | | Change | Code | Description | Comment | | Changed comment | DR | Ended routinely | Completion of treatment / programme / goals / assessment.  ~~Use this code for internal transfers between mental health teams.~~ | | Changed comment | DT | Discharge of tangata whaiora/consumer to another healthcare organisation (primary care, or non-MHA) | Discharge to another healthcare provider in a different organisation. Use this code for discharges to a non-MHA organisation, or to primary care~~. Can be either a mental health or non-mental health organisation.~~ | |
| # |  | |
| BR1. | Amend ‘*referral end’* code ‘DR’, ‘DT’ description and comment in database as per table above. | |
| BR2. | Update HISO PRIMHD Code Set Standard section 2.3.1.3 ‘*referral end’* code. | |

### Create New Referral End Code

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Description** | | Create New Referral End Code  Currently PRIMHD does not accurately capture a Referral End code for situations where a client is referred and the outcome, as well as the reason for referral in most cases, does not require a face to face assessment i.e. where an outcome will be that advice or information was given. The PRIMHD National Stakeholder group has a focus on improving Referral End code use nationally. and we want to ensure the appropriate options are available within the PRIMHD code set. Changes to PRIMHD are necessary to improve data capture for these situations.  DHBs and NGOs have to select Referral End codes that don’t truly reflect the reason for referral end. This also causes issues with MoH reporting and National KPI reporting An example when DHBs select an inappropriate Referral End code to exclude someone from the MoH Wait times report otherwise the wait time clock does not stop. This new referral end code would mean this incorrect practice could stop and the appropriate option could be used.  Create new Referral End Code DZ   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Code** | **Description** | **Code Valid from** | **Code Valid To** | **Comment** | | DZ | Routine discharge - no direct contact required | 01-01-2021 | 30-06-2030 | Use this code for referral discharges not requiring face to face assessment e.g. outcome includes information or advice given. | |
| # |  | |
| BR1. | Add new ‘*referral end’* code ‘DZ’ to database as per table above. | |
| BR2. | Update HISO PRIMHD Code Set Standard section 2.3.1.3 ‘*referral end’* code. | |

### New Activity Type Record Code

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| **Description** | | New Activity Type Code  The Government has/is investing heavily into improving access and choice (Access and Choice work Programme) for people requiring primary mental health and addiction wellbeing services.  The Access and Choice programme requires accountability and a demonstration of outcomes.  It is proposed to introduce an additional activity T code “Health Coaching Contact” for use only with referred from = AC, and by teams of type 24 (Integrated Primary access and Choice team)   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Code** | **Description** | **Code Valid from** | **Code Valid To** | **Comment** | | T52 | Health Coaching Contact | 01-07-2021 | 30-06-2030 | Health coaching provided to support clients to manage and maintain their own health and wellbeing as a component of the Access and Choice Integrated Primary Mental Health and Addiction (IPMHA) services. For PRIMHD purposes, these must be delivered by people who have received Health Coach training. To be used by Integrated Primary Access and Choice teams only (Team Type 24). | |
| # |  | |
| BR1. | Add new *‘Activity type code’* ‘T52’ Health Coaching Contact to database as per table above. | |
| BR2. | Update the Matrix for Team Type and Activity Type in PRIMD database | |
| BR3. | Update HISO PRIMHD Code Set Standard section 2.4.1.1 ‘*Activity Type’* code. | |
| BR4. | Update “Guide to PRIMHD Activity Collection and Use” document. | |
| BR5. | Update File Specification matrix in section 5.10.5 | |

### Update to Team code 24

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| **Description** | | Update to Team Code 24  The current team type 24 is being re-purposed to identify those NGO teams providing services to people as part of the access and choice Integrated Primary Mental Health and Addiction (IPMHA) service.  The change only impacts on NGOs with access and choice contracts.  Rational:  The current team type 24 has never been used so is being re-purposed to help ensure a more robust collection of access and choice activity in the relevant NGOs. This team type will also make it easier for analysts to identify this data for separate analysis or exclusion.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Code** | **Description** | **Code Valid from** | **Code Valid To** | **Comment** | | 24 | ~~Primary Health Service Team~~  Integrated Primary Access and Choice team | 01-01-2020 | 30-06-2030 | Mental health, addiction and wellbeing management services provided to clients as a component of the Access and Choice Integrated Primary Mental Health and Addiction (IPMHA) services. This includes services provided by HIPS, Health Coaches, Support Workers and Peer / Cultural workers. | |
| # |  | |
| BR1. | Amend ‘*Team Type’* ‘24’ to Integrated Primary Access and Choice team in database as per above table | |
| BR2. | Update HISO PRIMHD Code Set Standard section 2.9.1.2 ‘*Team Type’*. | |
| BR3. | Update File Specification matrix in section 5.10.5 | |

## Supplementary Consumer Records Removal of Business Rules

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| **Description** | | Supplementary Consumer Records Removal of Business Rules  There is a change in the requirements for when SCR records are expected to be reported to PRIMHD. The reporting guidelines have been updated to state that there is no expectation that a SCR is to be reported until there have been 3 face to face activities. This is in line with the pp7 reporting for wellness plans, and also general feedback from DHBs. In addition, we are now allowing for the fact that some organisations don't need to report them at all depending on the type of service they provide.  The proposal is to remove the business rules from PRIMHD relating to timing and submission of SCR records altogether - to be replaced with compliance reporting as it is for outcome collections now.  The following business rule validations and response messages are to be removed from PRIMHD   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Business Rule Reference | Business  Rule  Description | | Affected  Data | | | Response Message Reference | | BR-P121-10 | | * A *Referral Discharge* record which begins on or after 1 July 2016 should contain at least one *Supplementary Consumer Record* with a *Collection Date* within 91 days of the first face-to-face *Activity Start Date Time* unless the *Referral End Code* is DD, DG, DM, ID, RI, or RO. * “*Note SCRs are not required on all referrals. See the Guidelines for more details”* | | * Supplementary Consumer Record Collection Date * Activity Start Date Time | RM-P122-29 | | | BR-P121-11 | * For each *Supplementary Consumer Record* contained within a *Referral Discharge Record* beginning on or after 1 July 2016, the *Collection Date* should be fewer than or equal to 365 days before either the collection date of another SC record or the *Referral Discharge End Date Time.* This is unless the *Referral End Code* is DD, DG, DM, ID, RI, or RO. * “*Note SCRs are not required on all referrals. See the Guidelines for more details”* | | * Supplementary Consumer Record Collection Date * Referral Discharge End Date Time * Referral End Code | | | RM-P122-30 |  |  |  |  |  | | --- | --- | --- | --- | | BR-P121-12 | * A *Referral Discharge Record* which begins on or after 1 July 2016 should contain a *Supplementary Consumer Record* with a *Collection Date* within 91 days before the *Referral End Date Time* for an ended referral unless the *Referral End Code* is DD, DG, DM, ID, RI, or RO. * “*Note SCRs are not required on all referrals. See the Guidelines for more details”* | * Supplementary Consumer Record Collection Date * Referral End Date Time | RM-P122-31 |   Remove associated Response Messages   |  |  |  |  | | --- | --- | --- | --- | | Response Message Reference | Error or  Warning | Message  Title | Response  Message | | RM-P122-29 | | Warning | Warning – Missing Data | The RD record does not contain any SC records with a *Collection Date* within 91 days of the first face-to-face *AT record.* Note SCRs are not required on all referrals. See the Guidelines for more details | | RM-P122-30 | | Warning | Warning – Missing Data | The RD record does not contain a new SCrecord for each year that the RD record spans. Note SCRs are not required on all referrals. See the Guidelines for more details | | RM-P122-31 | | Warning | Warning – Missing Data | The RD record does not contain a SC record with a *Collection Date* within 91 days before the *Referral Discharge End Date Time.* Note SCRs are not required on all referrals. See the Guidelines for more details | |
| # |  | |
| BR1. | Remove validations for BR-P121-10, BR-P121-11 and BR-P121-12 from database | |
| BR2. | Remove response messages RM-P122-29, RM-P122-30 and RM-P122-31 from database | |
| BR3. | Remove application validation | |
| BR3. | Update PRIMHD file specification | |

## New Data Element for Activity (AT) Record Code Sets

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Description** | | *Background*  The involvement of family / whānau in relation to family members who are experiencing mental health and addiction problems has been identified by He Ara Oranga as critical to positive outcomes. Family / whānau Involvement can occur at any time during the patient journey and measuring the extent and context of these interactions is a key requirement.  The availability of this information will support improvement, development and promotion of care and treatment services that engage family / whānau while improving service accountability.  Currently PRIMHD is not able to collect comprehensive data on family / whānau involvement and this has been a limiting factor for our understanding of family / whānau involvement.  Mental health activity is reported to PRIMHD via Activity Record (AT) codes. There is a gap in the data relating to family /whānau involvement in community settings due to the lack of breadth in the existing code set.  There is a limited set of codes that report the involvement of family. Additional codes have been added over time to partially address this issue but this has added complexity for those collecting the data while still leaving gap, for example crisis contacts.  Solution  Create a new data element within the Activity (AT) Record Code Set for Family / Whānau involvement to be used with community AT records. A Yes/ No indicator would be set if family /whānau were involved in the activity.  The indicator would enable a comprehensive record of family /whānau involvement in any context. It would simplify the process of collecting the data and enable the retirement of some of the existing family codes.  *Family/Whanau Involvement*  *A code to identify if there was family/whanau involvement with the service user at an activity. See table below*   |  |  |  |  |  | | --- | --- | --- | --- | --- | | ***Code*** | ***Description*** | ***Code Valid from*** | ***Code Valid To*** | ***Comment*** | | 1 | Yes.  Client with whānau/family | 01-07-2021 | 30-06-2030 | Family / Whānau involved | | 2 | No.  Client only | 01-07-2021 | 30-06-2030 | Family / Whānau not involved | |
| # |  | |
| BR1. | Implement new mandatory ‘*Activity (AT) Record coded data element’ ‘Family / Whānau involvement’* | |
| BR2. | Add new element to PRIMHD Online | |
| BR3. | Add to application | |
| BR4. | Business rule and validation development | |
| BR5. | Update Schema’s REFERRAL\_DISCHARGE and PRIMHD\_ACK | |
| BR6. | Create database table and update links | |
| BR7. | Update HISO code set standard | |
| BR8. | Update PRIMHD file specification | |
| BR9. | Update “Guide to PRIMHD Activity Collection and Use” document. | |

## Advisory: HoNOS reasons for collection for community and Inpatient transfers

|  |  |  |
| --- | --- | --- |
| **Description** | | Advisory  PRIMHD was introduced in 2008. Accompanying its introduction was an ICP for the HoNOS family of measures (information collection protocol). The ICP has remained largely unchanged since its introduction. In the ICP community and inpatient are seen as two equally important settings and transfers between them require an end of treatment setting and admission collection to the new setting. This requires clinicians to complete two collections each time a transfer occurs or 4 collections for a transfer back to the originating setting.  Implications of ICP rules  There are three main implications to the current transfer collections in the ICP:-  1. Confusion for clinicians around when to complete and whether the same ratings can be used  2. Compliance with the ICP given four collections are required for transfers back to the originating setting. This places additional expectations upon clinicians completing the ratings.  3. Quality of collection ratings, given different clinicians often complete these four ratings.  Te Pou published a discussion document with two options. The outcome from that paper was a preference for option two to be adopted |
| # |  | |
| AD1. | **Option 2: No transfer rule** This option involves removing transfer collections altogether and simply having inpatient admission and discharge contain within the community episodes. The rationale for this option is to align collections with the client journey which is essentially a community-based experience. This option may well result in batter collections in the community settings.  This option may involve changes to current systems in use. | |

## Advisory: Referral from code AC – updated definition

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Description** | |  | Update to Referral From code AC  The current definition for the referral from code AC needs to be updated to better reflect how the code should be used.  Rational:  The updated definition will better align with further codes relating to Access and Choice IPMHA services being proposed for PRIMHD as part of NCAMP21.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Code** | **Description** | **Code Valid from** | **Code Valid To** | **Comment** | | AC | Access and Choice General Practice | 01-01-2020 | 30-06-2030 | ~~Access and Choice General Practice~~  For use by Integrated Primary Access and Choice teams only  (Team type 24) | |
| ~~#~~ |  | | |
| BR1. | Update HISO PRIMHD Code Set Standard section 2.3.1.1 ‘*Referral From*’. | | |

# National Non-admitted Patient Collection (NNPAC)

## Addition of Diagnosis & Procedure Reporting for Emergency Attendances

The National Non-admitted Patient Collection (NNPAC) provides nationally consistent data on non-admitted patient (outpatient and emergency department) activity. Its primary use is for the calculation of Inter District Flows (IDFs) but also provides information to measure health outcomes and inform decisions on funding allocations and policy.

The National Non-admitted Patient Collection (NNPAC) information includes event-based purchase units (PUs) that relate to medical and surgical outpatient and emergency department events.

In NCAMP 2019 it was proposed to report the presenting complaint, diagnosis and procedures using the clinical terminology SNOMED CT to NNPAC for emergency department (ED) attendances. The proposal called for a pilot group of DHB EDs to trial the reporting of SNOMED CT to better inform national implementation. The DHBs who participated in the pilot have now fully implemented SNOMED CT in their ED information systems and report ED attendance data using SNOMED to NNPAC.

For all other DHBs, the 2019/20 Annual Plan Guidelines required DHBs to provide a plan on how they would implement SNOMED CT in their ED and report data to NNPAC by 2021.

An NCAMP 2020 change notification invited further DHBs to implement SNOMED CT in their ED during the 2020/21 financial year.

For NCAMP 2021 implementation of SNOMED CT for ED attendances and reporting data to NNPAC becomes mandatory on 1 July 2021.

The Ministry of Health has worked with the sector to introduce standard SNOMED CT ED reference sets for chief presenting complaint, diagnosis and procedure/investigation in emergency care.

For information about SNOMED CT and to view the ED reference sets, see website link:

<https://www.health.govt.nz/nz-health-statistics/classification-and-terminology/new-zealand-snomed-ct-national-release-centre/snomed-ct-subsets-and-maps>

## Proposal

As indicated in NCAMP 2019 and 2020, reporting SNOMED concepts for Presenting Complaint, Procedure/Treatment and Diagnosis for emergency department attendances will become mandatory from 1 July 2021.

## SNOMED CT Reporting

|  |  |  |
| --- | --- | --- |
| **Description** | | Addition of extra values in the ‘Record Type’, ‘Event Type’ and ‘Event End Type Code’ fields.  As well as the addition of four new fields  Objectives of these changes are:   * To allow the collection of clinical information relating to Emergency Department events. * To record the total event time for all patients who attend the Emergency Department and better understand patient outcomes. |
| **Requestor** | | ACEM |
| # | **Requirements** | |
|  | Add new ‘Record\_Type’ ’Event\_Item’ | |
|  | Mandatory fields for Event\_Item:  ‘Event\_Type’  ‘Client\_System\_Identifier’  ‘PMS\_Unique\_Identifier’  ‘NHI’  ‘Clinical\_Code’  ‘Diagnosis\_Sequence’ | |
|  | Add new codes to “Event\_Type” field in NNPAC | |
|  | New code values to be added for Event Type are:   * PC (Chief Presenting Complaint) allowed **1** per attendance (mandatory) * PT (Procedure/Treatment) allowed **15** per attendance (optional)\* * DG (Diagnosis) allowed **5** per attendance (optional)\*   \* These codes will be made mandatory in 2021/22 | |
|  | Add new code to “Event\_End\_Type\_Code” field in NNPAC | |
|  | New code value to be added for Event End Type Code is:   * OB – Observation Unit | |
|  | OB is only valid if Event\_Type is ED | |
|  | If ‘Event\_End\_Type\_Code’ is OB then  “Datetime\_of\_Disposition” &  “Clinical\_Disposition” are mandatory | |
|  | Add new field “Datetime\_of\_Disposition” | |
|  | New “Datetime\_of\_Disposition” field to be added after ‘Alcohol Involved’ field | |
|  | Conditionally mandatory if Event\_End\_Type\_Code is OB | |
|  | Datetime\_of\_Disposition Format:   * Data Type: Date * Layout: CCYYMMDDhhmm * If not supplied this field will be set to 999912312359 (i.e. 31/12/9999 23:59) | |
|  | Add new field “Clinical\_Disposition” | |
|  | New “Clinical\_Disposition” field to be added after ‘Datetime\_of\_Disposition’ field | |
|  | Conditionally mandatory. Null if Event\_End\_Type\_Code is not OB | |
|  | Clinical\_Disposition\_Code Format:   * Data Type: varchar2(3) * Layout: AAA   Verification: Mandatory for ED events with Datetime of service on or after 1 July 2019 and Event\_End\_Type\_Code is OB  Must be a valid code in the Clinical Disposition table. | |
|  | Create new code table in Data Warehouse – Clinical\_Disposition\_Code | |
|  | Code values to be added for Clinical Disposition are:   * ODI – Discharge * OAD – Admit * OTO – Divert (triage only) * ODD – Died * ONW – DNW * OTR – Transfer * OSW – Self-Discharge with Indemnity * OSD – Self-Discharge without Indemnity | |
|  | Add new field “Clinical\_Code” | |
|  | Add new field “Clinical\_Code after ‘Clinical\_Disposition’ | |
|  | Only conditions and procedures listed within the HISO 10048 Emergency Care Data Standard are acceptable | |
|  | Format:   * Data Type: varchar2(2000) * Verification: Mandatory for event with Event Type PC, DG, PT | |
|  | Add new field “Clinical\_Code\_Sequence” after ‘Clinical\_Code’ | |
|  | Data Type: varchar2(2) | |
|  | Layout XX with leading zeros | |
|  | Range 01 to 21 | |
|  | SNOMED CT reporting will only be accepted in file version 7.0 | |
|  | SNOMED CT concept IDs to be validated against HISO ED code set [HISO 10048 Emergency Care Data Standard](https://www.health.govt.nz/publication/hiso-10048-emergency-care-data-standard-public-comment) | |
| # | **Supplementary detail** | |
|  | DHBs to report SNOMED CT for ED events to NNPAC from 2021. | |

# National Health Index (NHI)

## Advisory Change to National Health Index (NHI) Numbering System

The National Health Index (NHI) has assigned the majority of the currently available NHI numbering range. At current rates of allocation, there are only sufficient available NHI numbers for approximately another 7 to 8 years. All existing NHI numbers are forecast to be exhausted around 2025.

In late 2017, the NHI system was reviewed to establish options as to how to extend the available range of NHI numbers. Due to the impact of such a change and the relationship of the system to HISO 10046 Consumer Health Identity Standard, the Ministry decided to employ a HISO process to seek public comment – this was undertaken during July-August 2018. In September 2018, a working group (comprising seven representatives covering DHBs, PHOs, large and small vendors, Primary Practice management, Consumers and the Office of the Privacy Commissioner) reviewed the public comment feedback. The outcome of this review was presented to HISO in November 2018 and to the Ministry’s Executive Leadership Team (ELT) in December 2018.

The Ministry Identity and Eligibility Services team have now developed a suitable approach that both retains the existing numbers and allows for extended future use.

The existing approach provides a unique 7-character number in the format AAANNNC (3 alpha, 3 numeric and one numeric check digit). The new format is to take the form AAANNAX (3 alpha, 2 numeric, 1 alpha and one alpha check digit). This approach is detailed in the updated HISO standard. The two formats are to co-exist – ‘old’ format numbers will not be replaced.

<https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard>

### Situation

As the NHI number system is fundamental to health systems generally, it is essential that all system providers and users be given as much time as possible to become aware of and familiar with, the new approach. System vendors will also need significant lead time to adjust their products to handle the change of format and the supporting calculation process for the check digit.

### Summary

An update to the existing HISO 10046 Consumer Health Identity Standard (titled HISO 10046:2019 Consumer Health Identity) was published in September 2019. It details the change to the format of NHI numbers. New format NHI numbers are available in the pre-production compliance test environment. System vendors can begin testing use of the new format NHIs from that time. All systems should be changed to accommodate the new format by 1 July 2022 to allow a comfortable lead time before the first numbers are issued in the new format.

## Gender Diversity in the NHI

The Ministry has recently had a number of enquiries from members of the public to extend the options allowed for updating Gender on the NHI. The [HISO 10046 Consumer Health Identity Standard](https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard) and [Statistics New Zealand Level 1 Gender Classification](https://www.stats.govt.nz/reports/sex-gender-and-sexual-orientation) include a category for ’Gender Diverse’. The NHI upgrade currently under development will extend the gender options to align with these standards.

The NHI is currently limited to recording one of three gender categories (‘Male’, ‘Female’, ‘Unknown’).

The introduction of the Gender Diverse category will create a better alignment between the NHI functional implementation and existing standards and meet public expectations with regard to being able to properly identify their gender when interacting with the health system.

The NHI records Gender Identity, but some systems capture the attribute using a field labelled ‘Sex’. The concept of Sex and Gender Identity are different.

The National Collections will continue to collect sex for all events excluding PRIMHD which will accept the NHI gender code set. DHBs are required to update gender on the NHI and report sex to the National Collections (excluding PRIMHD).

This may require collecting both attributes at the local system level.

|  |  |  |
| --- | --- | --- |
| **Description** | | Create new Gender Diverse code O  Collect Gender Diversity in the NHI.  All other National Collections will continue to collect sex excluding PRIMHD and NPF which will accept the NHI gender code set. |
| # | **Requirements** | |
|  | Add O Gender Diverse to the list of available gender categories to be recorded in the NHI and accepted in PRIMHD effective 1July 2020. | |
|  | Update HISO PRIMHD Code Set Standard 2.1.1.1 by adding Code O (as per code set below). | |
| # | **Supplementary detail** | |
| SD1. | The storage of both sex and gender is likely to be appropriate at the local system level. | |
| SD2. | The additional category for gender diverse is applicable to the NHI only and is not to be submitted to National Collections (excluding PRIMHD and NPF which will accept the NHI gender code set).  DHB's need to ensure they continue to supply sex (‘M’, ‘F’, ‘I’, ‘U’) to the remaining national collections. | |

NHI Gender Code Set

| Code | Description | Note |
| --- | --- | --- |
| F | Female |  |
| M | Male |  |
| O | Gender Diverse |  |
| U | Unknown | Not stated, or inadequately described. |

Sex at Birth Code Set

| Code | Description | Note |
| --- | --- | --- |
| F | Female |  |
| M | Male |  |
| I | Indeterminate | Generally neonatal. Rarely used |
| U | Unknown | Not stated, or inadequately described. |

# NPF Optimal Date for Service - Advisory NCAMP 2022

**Background**

Currently waiting times reporting for planned care services (including elective surgery) are measured within set timeframes – i.e. all patients should receive surgery within a maximum of 4 months; patients should receive a CT/MRI scan within 42 days etc.

As part of the revised planned care programme, shifting to patient care being reported against clinically appropriate timeframes (within a maximum timeframe) has been identified as more appropriate for measuring the timeliness principle. The Optimal Date for Service within National Patient Flow was added as a field during the NPF build phase to collect this information however at time this information wasn’t widely captured within DHB systems, so the field was left as optional for submissions.

It was included in the NPF file spec that planned, staged and surveillance patients should have a date provided for Clinical Exclusion Code is “P – Planned”, "S - Surveillance" or "G - Staged" as these patients are currently not included in the maximum waiting time reporting of the ESPIs.

Performance reporting has yet to formally commence from NPF and data quality work continues to ensure that all in scope records are submitted.

Preliminary investigations suggest that the Optimal Date for Service field in is not widely submitted to, or default dates are submitted.

**Business Problem**

The lack of data on the optimal date for service affects the Ministry’s ability to report against clinically appropriate timeframes for patients and progression of the refined set of measures. The current outdated and less appropriate measures continued to be reported against.

This creates 2 problems:

1. patients who have a maximum timeframe (“N – Normal”) but should be treated sooner than the maximum do not have the clinically appropriate date recorded and therefore can’t be measured against this time
2. patients who do not fit within the maximum timeframe (“P – Planned”, "S - Surveillance" or "G - Staged") do not have accurate measurement timeframes where this date is not submitted.

Both problems result in inaccurate or incomplete reporting of patient waiting times

The shift to reporting against clinically appropriate timeframes and the use of NPF to collect this information was discussed and recommended by a group of MOH and sector representatives as part of the ministerial priority to refresh the scope, reporting and measurement of planned services during 2019 and 2020. It is supported by the Planned Care Sector Advisory group.

The collection of clinically appropriate timeframes data has been raised with Regional NPF Teleconferences. This information is currently inconsistently captured and recorded within DHB systems.

This may require DHBs to capture information that is not elsewhere collected or stored electronically.

The Ministry will undertake introductory reporting and produce guidance and other communications in the 20/21 and 21/22 years.

### NPF File Specification Section 10.10.9 Optimal Date for Service [O]

|  |  |
| --- | --- |
| **Definition** | The clinically appropriate time frame for the intended service to occur. May have been determined during an earlier activity. |
| **Data Type** | Datetime |
| **Layout** | YYY-MM-DDThh:mm:ss |
| **Data Domain** |  |
| **Obligation** | ~~Optional~~ Mandatory (from 2022) |
| **Guide for Use** | The Optimal Date for Service will be clinically determined and may be derived from the Responsible Health Specialty and Clinical Priority Score.  The expectation is that this will be a maximum of 120 days from the receipt of the referral unless a Clinical Exclusion Code other than 'Normal' is provided.  ~~Provide an Optimal Date for Service when the Clinical Exclusion Code is “N – Normal”, “P – Planned”, "S - Surveillance" or "G - Staged", “T – Clinical Trial”, “D – Donor”.~~ |

1. Definitions

| **Abbreviation** | **Definition** |
| --- | --- |
| ACEM | Australasian College of Emergency Medicine |
| ACHI | Australian Classification in Health Interventions |
| API | Application Programming Interface |
| AR-DRG | Australian Refined Diagnosis Related Groups |
| AT | Activity |
| BR | Business Requirement |
| CHIS | Cancer Health Information Strategy |
| DHB | District Health Board |
| ED | Emergency Department |
| ELT | Executive Leadership Team |
| FHIR | Fast Healthcare Interoperability Resources |
| GP | General Practitioner |
| HSC | Health Speciality Code |
| HISO | Health Information Standards Organisation |
| ICD-10-AM | International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification |
| ID | Identifier |
| IDF | Inter-District Flow |
| HSC | Health Speciality Code |
| MoH | Ministry of Health |
| NCAMP | National Collections Annual Maintenance Programme |
| NCR | National Collections and Reporting |
| NGO | Non-Government Organisation |
| NHI | National Health Index |
| NMDS | National Minimum Data Set |
| NNPAC | National Non-Admitted Patient Collection |
| NPF | National Patient Flow |
| NZ | New Zealand |
| OPF | Operational Policy Framework |
| OST | Opioid Substitution Treatment |
| PAS | Patient Administration System |
| PHO | Primary Health Organisation |
| PMS | Patient Management System |
| PRIMHD | Programme for the Integration of Mental Health Data |
| PU | Purchase Unit |
| QPI | Quality Improvement Indicator |
| SNOMED-CT | Systematized Nomenclature of Medicine – Clinical Terms |
| SOAP | Simple Object Access Protocol |
| SCI | Spinal Cord Injury |
| WIES | Weighted Inlier Equivalent Separation |
| WIESNZ | Weighted Inlier Equivalent Separation New Zealand |

1. Document Control
   1. Document Details

|  |  |
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