



# Allied Health Activity Data Set

## Physical Health

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*Change History*

Version	Effective from	Effective to	Change summary
1.4	Sept 2016	Dec 2018	First national release
2.0	Jan 2019	Dec 2019	Updated national release
3.0	Jan 2020	Jan 2021	Updated national release
4.0	Jan 2021	Jan 2022	Updated national release
5.0	Jan 2022	Jan 2023	Updated national release

*Key of changes made*

Type of change	Acronym
Change	C
New	N
Deleted	D

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## Introduction

This document sets out patient-level activity data to classify and describe clinical activities undertaken for consumers of allied health services in New Zealand.

## Purpose

The activity data set was developed for District Health Board (DHB) allied health services to provide a standardised code set. Standardised activity-level data set will generate information to support DHB's with service development and workforce planning. It will also support the progression of a national staffing methodology. It is intended that the activity data set compliments the HISO Allied Health (AH) Standard<sup>1</sup>, published 2018.

## Scope

This activity data set has been developed specifically for physical health inpatient settings but may have wider application. This data set is by no means exhaustive. The Allied Health Advisory Group (SSHU Unit) will undertake annual reviews to ensure its continued relevance for the sector.

The professional disciplines included in this data set are inter/ transdisciplinary, dietitian, occupational therapy, physiotherapy, social work and speech and language therapy. Role context is allied health practitioner, assistant, and student.

Codes (where possible) meet SNOMED CT terminology.

## Data set structure

The activity data set has been structured into two tiers to accommodate the various requirements stipulated by DHB allied health services.

Level 3 codes are the highest-level code and are broad activity descriptors. Level 4 codes are a subset of level 3 codes. These describe the activity in more granular detail. A level 4 code **must** always map to a level 3 code.

Local decisions should dictate whether level 3 codes, level 4 codes, or a combination of both are applied. This will depend on the level of detail required by the DHB or service and staff capacity to accurately record activity data. Level 3 data will limit any reporting to a broader, more general level. Level 4 data adds a significantly greater level of detail and can be rolled up to a higher level if reporting requires this.

Figure 1 shows the activity dataset hierarchy. There are five codes available at level 3. These should be used by all professions. A range of level 4 codes exist and always map back to one of the level 3 codes. Level 4 codes can be selected from the 'all professions' table and/ or from the appropriate 'profession specific' table which relate to initial and follow-up clinical activities.

A list of definitions for all codes is available at the end of this document.

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<sup>1</sup> HISO 10065:2018 Allied Health Data Standard, Ministry of Health, 2018

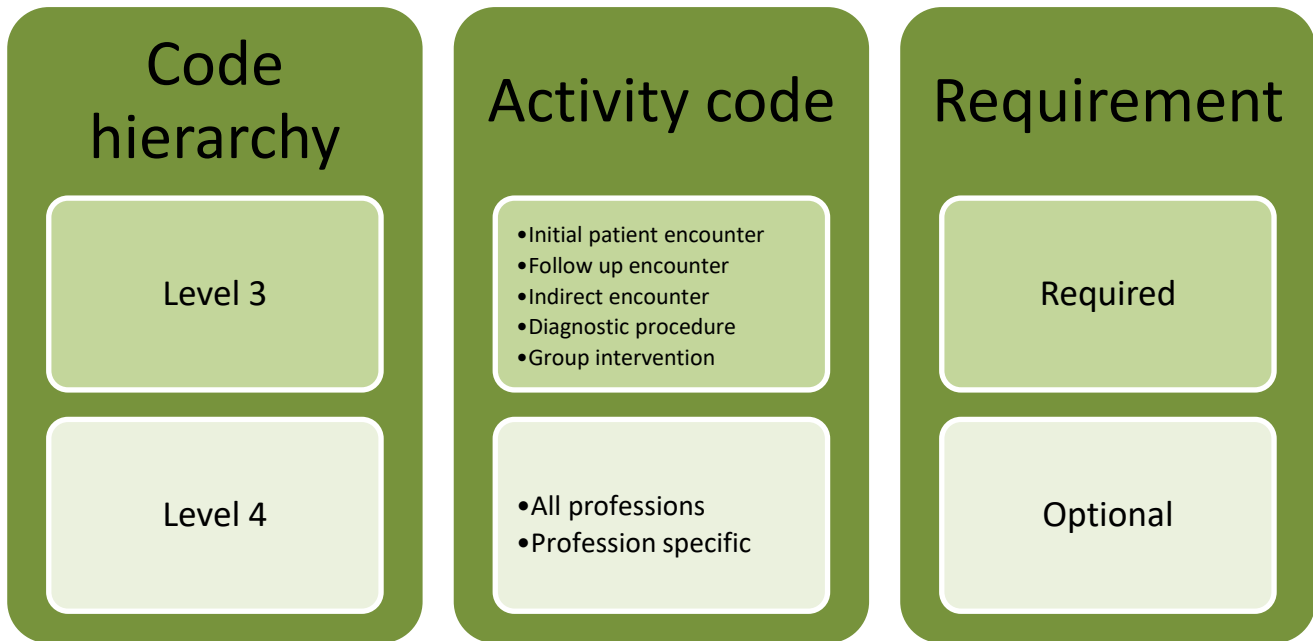


Figure 1 - Activity data set structure and requirements

## Activity code tables

### All professions (any profession able to select from this table)

Activity code	Level	Requirement	V5
<b>Initial patient encounter</b>	3	Required	
Family meeting	4	Optional	
Keyworker activity	4	Optional	
Home visit	4	Optional	
Off-site visit	4	Optional	
Patient/whanau/caregiver education	4	Optional	
Discharge planning	4	Optional	
<b>Follow up encounter</b>	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	
<b>Indirect encounter</b>	3	Required	
Documentation	4	Optional	
Liaising with agency	4	Optional	
Discussion with family	4	Optional	
Screening	4	Optional	
Liaising with MDT	4	Optional	
Keyworker activity	4	Optional	
Discharge planning	4	Optional	
<b>Diagnostic procedure</b>	3	Required	

<b>Group intervention</b>	3	Required	
Upper limb training	4	Optional	
Stroke education	4	Optional	
Exercise education	4	Optional	
Falls education	4	Optional	
Fatigue management	4	Optional	
Playroom session	4	Optional	
Hydrotherapy	4	Optional	
Leisure	4	Optional	
Trunk control	4	Optional	
Breakfast session	4	Optional	
Pulmonary rehabilitation	4	Optional	

### Allied Health Assistant

Activity code	Level	Requirement	V5
<b>Initial patient encounter</b>	3	Required	
Delegated task	4	Optional	
Joint session with therapist	4	Optional	
<b>Follow up encounter</b>	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	

### Dietetics

Activity code	Level	Requirement	V5
<b>Initial patient encounter</b>	3	Required	
Food and/ or nutrient delivery	4	Optional	
Nutrition education/ counselling	4	Optional	
Food service liaison	4	Optional	
<b>Follow up encounter</b>	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	

### Occupational Therapy

Activity code	Level	Requirement	V5
<b>Initial patient encounter</b>	3	Required	
Developmental	4	Optional	
Occupational performance	4	Optional	
Assessment of seating needs	4	Optional	
Positioning: wheelchair	4	Optional	
Neurology	4	Optional	
Postural management	4	Optional	
Cognition	4	Optional	
<b>Follow up encounter</b>	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	

## Physiotherapy

Activity code	Level	Requirement	V5
<b>Initial patient encounter</b>	3	Required	
Mobility	4	Optional	
Neurological	4	Optional	
Musculoskeletal care	4	Optional	
Orthopaedic	4	Optional	
Cardiorespiratory	4	Optional	
Neurodevelopmental	4	Optional	
Surgical	4	Optional	
Respiratory	4	Optional	
Postural management	4	Optional	
<b>Follow up encounter</b>	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	

## Social Work

Activity code	Level	Requirement	V5
<b>Initial patient encounter</b>	3	Required	
Psychosocial assessment	4	Optional	
Domestic partner abuse prevention	4	Optional	
Child protection procedure	4	Optional	
Elder abuse prevention	4	Optional	
Counselling	4	Optional	
Family counselling	4	Optional	
Legal system procedure	4	Optional	
<b>Follow up encounter</b>	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	

## Speech & Language Therapy

Activity code	Level	Requirement	V5
<b>Initial patient encounter</b>	3	Required	
Communication	4	Optional	
Feeding/swallowing	4	Optional	
Tracheostomy weaning	4	Optional	
FEES	4	Optional	
VFSS	4	Optional	
<b>Follow up encounter</b>	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	

## Definitions

### Activity not met/ unmet need

Due to staffing capacity or other circumstances, patient related intervention that is *indicated and planned for the day* may not be completed. Planned intervention should be in line with organisational prioritisation guidelines.

The primary reason for capturing this information is to help with capacity and demand management. This data provides a more complete picture of the demand on services and helps identify where capacity is insufficient to meet the total demand.

There are a range of reasons why planned intervention may not occur. These can also be useful to collect when considering outcomes and impacts at a patient and system level.

it is just as important to capture the activities that were planned but not able to be completed, as it is to capture the work that is completed.

### Collection & Frequency

Recorded for a patient once a day. Data is captured as a count.

### Reasons for activity not met/ unmet need

Reason	Definition	Requirement	Comment
Work exceeds usual staffing	There is normal rostered staffing (clinical and assistants) and you have not been able to see this patient today due to the volume of work.	Required	Staffing capacity is not able to meet the demand. VRM procedures would normally be evoked. Can cross reference with VIS and prioritisation guidelines.
Staff vacancy/leave	There is reduced staffing for the ward/ service due to leave or vacancy (planned or unplanned and not covered by casual staff) and you have not been able to see this patient today.	Required	Staffing capacity is not able to meet the demand. Unplanned or planned leave can leave roster gaps, especially where vacancy exists.
Patient not available	The patient may be off the ward in x-ray etc. or being visited by another staff member each time you have tried to see them today.	Optional	May result in limited or delayed therapeutic input which may impact on patient and system outcomes.
Patient unable to participate	The patient may be too sick, e.g.,, their blood pressure may be too high/low for the activity required, the patient may be delirious or may not be able to communicate sufficiently to complete the activity.	Optional	May result in limited or delayed therapeutic input which may impact on patient and system outcomes.
Patient declined	The patient declines your input on this occasion. This code may also be used if a patient declines input from your discipline altogether which	Optional	May result in limited or delayed therapeutic input which may impact on patient and system outcomes.



	would usually result in discharge from the service.		
Resources not available	Resources could include equipment, interpreter, medical notes, or procedural availability.	Optional	May result in limited or delayed therapeutic input which may impact on patient and system outcomes.
Patient discharged prior to session	The patient was due to be seen today but has been discharged from hospital prior to being seen.	Optional	May have negative impact on patient outcome and system level measures (i.e. acute readmission).
Unable to access caregiver	The patient's care plan / treatment requires access to a caregiver (i.e. hoist training, counselling, family meeting, education), which was not possible as they were unavailable or did not attend a scheduled appointment.	Optional	May result in limited or delayed therapeutic input/ training which may impact on patient and system outcomes.

## Activity Code Definitions

### All Professions

Activity code	Definition
Initial patient encounter	The first direct contact that the clinician has with the patient. This may include assessment, examination, consultation, treatment and/or education.
Follow up encounter	Every direct patient interaction (after the first contact) that the clinician has with the patient. This may include re-assessment, treatment, intervention and/or education.
Family meeting	Time spent in formal family meetings. If you are involved in coordinating the meeting include time spent organising, making phone calls, confirming meeting arrangements, documenting. The patient must be present, otherwise use 'discussion with family' code.
Keyworker activity	For wards with a Key Worker model of care only. Time includes specific tasks e.g., coordinating meetings, coordinating stroke folders, generic inter- disciplinary discharge planning conversations (not specifically related to your profession).
Home visit	Direct time spent with patient outside hospital grounds whilst they are still an inpatient, e.g., time spent with them during a home assessment visit.
Off-site visit	Direct time spent with patient outside hospital grounds (not at the home) whilst they are still an inpatient, e.g., time spent attending an appointment with them or rehabilitation activity.
Patient/whanau/caregiver education	Education provided to the family members or carers of the patient. 'Family' includes those identified as the patient's primary support person/ group and includes paid carers.
Indirect encounter	Discrete activity that occurs in the absence of a direct contact with the patient. This may include communication with the MDT or external agency, interaction with the patient's family/ carer, and screening activities. Includes documenting the indirect encounter type.
Documentation	Time spent recording clinical notes, assessment documents or preparing written materials for patient and/or family. Only select this code if the activity occurs in isolation of a direct or indirect contact type.
Liaising with agency	Any communication (discussion, email, phone call) with external service, including other DHB, ACC, Non-Government Organisations (NGOs) or other health agency, when not completed as part of the initial assessment or follow up.
Discussion with family	Time spent communicating with the patient's family/ carer either directly or indirectly when not completed as part of the initial assessment or follow up.
Screening	Time spent reviewing notes and talking to staff, in order to determine patient status or patient priority for assessment/ review when not completed as part of the initial assessment or follow up.
Liaising with MDT	Time spent liaising with colleagues regarding a patient when not completed as part of the initial assessment or follow up. Most MDT liaison will be completed as part of an initial assessment/ follow up.

Keyworker activity	For wards with a Key Worker model of care only
Discharge planning	Time spent specifically planning and coordinating a patient's discharge, which includes liaison with external agencies, family members and support services. Include time spent completing discharge summaries.
Diagnostic procedure	Time spent conducting an examination or test to help diagnose a disease or condition.
Group intervention	Patient attends a group education session. A 'group' is when two or more patients receive the same service, at the same time from the same health provider(s).
Upper limb training	Patient attends an upper limb therapy group
Stroke education	Patient attends stroke education / support group
Exercise education	Patient attends an exercise or orthopaedic exercise class
Falls education	Patient attends falls prevention group
Fatigue management	Patient attends a fatigue management group
Playroom session	Patient attends a playroom session
Hydrotherapy	Patient attends a hydrotherapy session
Leisure	Patient attends a leisure group
Trunk control	Patient attends a trunk control group
Breakfast session	Patient attends a breakfast therapy group
Pulmonary rehabilitation	Patient attends a pulmonary rehabilitation group

### Allied Health Assistant

Activity code	Definition
Delegated task	Carrying out a delegated activity under the direction of a registered health professional.
Joint session with therapist	Assisting a therapist with a joint treatment session.

### Dietetics

Activity code	Definition
Food and/or nutrient delivery	Assessment, treatment and/ or intervention for patients who require any dietetic intervention, for the provision of meals and snacks, enteral and parenteral feeding, and supplements. This includes gathering data, reading notes, talking to staff, seeing patient, assessment, organising intervention and education, MDT liaison and making phone calls.
Nutrition education/counselling	Assessment, treatment and/or intervention for patients who require instruction or training in a skill or knowledge related to food and nutrition, including enteral and parenteral nutrition and supplements.
Food service liaison	Food service feedback completion where errors with meal provision have been identified.

### Occupational therapy

Activity code	Definition
Developmental	Assessment, treatment and/ or intervention completing initial paediatric assessment. May include use of standardised assessments, e.g., Hammersmith.
Occupational performance	Assessment, treatment and/ or intervention with patient in relation to a functional task, e.g.,, washing and dressing, shopping, toileting.

Assessment of seating needs	Assessment and/ or intervention related to seating needs.
Positioning: wheelchair	Assessment, treatment and/ or intervention of patient in relation to correct positioning in seating and/or lying. May include static seating, wheelchair, cushion, etc. as well as assorted modifications required to customise equipment for the client.
Neurology	Assessment, treatment and/ or intervention with patient who has a neurological diagnosis such as stroke/GBS/ MS/ MND/ Myasthenia gravis.
Postural management	Assessment, treatment and/ or intervention with a patient who requires input predominantly for seating, lying and positioning.
Cognition	Assessment, treatment and/ or intervention related to a patient's cognition.

## Physiotherapy

Activity code	Definition
Mobility	Assessment, treatment and/ or intervention where the primary problem is related to mobility. Examples include post fall (no #), deconditioning, social admission or other secondary medical issues.
Neurological	Assessment, treatment and/ or intervention where the primary problem is neurological. Examples include stroke, brain injury, MS etc.
Musculoskeletal care	Assessment, treatment and/ or intervention where the primary problem is a musculoskeletal issue e.g., knee pain, back pain etc. Includes use of prefabricated orthotics.
Orthopaedic	Assessment, treatment and/ or intervention where the primary problem is orthopaedic. Examples include fractures, elective surgery, post-orthopaedic surgery e.g., management of #, shoulder reconstruction etc.
Cardiorespiratory	Assessment, treatment and/ or intervention where the primary problem is cardiorespiratory.
Neurodevelopmental	Assessment, treatment and/ or intervention of an infant or young child who presents with a neurological or developmental issue. Includes musculoskeletal conditions which impacts on development. May include a standardised assessment e.g., Hammersmith.
Surgical	Assessment, treatment and/ or intervention where the primary problem is post-surgical.
Respiratory	Assessment, treatment and/ or intervention where the primary problem is respiratory e.g., COPD, bronchiectasis, chest infection.
Postural management	Assessment, treatment and/ or intervention where the primary intervention is for 24-hour postural management. Examples include GMFCS Level III-V, night-time and daytime positioning needs and includes equipment provision.

## Social worker

Activity code	Definition
Psychosocial assessment	First psycho-social assessment. Includes: gathering information, reading notes, talking to staff, seeing patient for first time, making phone calls and documentation.
Domestic partner abuse prevention	Assessment and intervention related to family violence issues. Includes provision of emotional and practical support, e.g., assistance with Protection Orders, liaising with Refuge etc.
Child protection procedure	Assessment and intervention where child protection is the primary concern. Includes liaison with Oranga Tamariki and other agencies.
Elder abuse prevention	Activity related to older/vulnerable adult protection issues. Includes liaison with Age Concern and other agencies.
Counselling	Therapeutic counselling provided to the patient.
Family counselling	Therapeutic counselling provided to the family or caregivers of the patient.
Legal system procedure	Interventions relating to completion of legal paperwork / reports and any associated court appearance on behalf of a patient. Examples include Enduring Power of Attorney (EPOA) / Protection of Personal and Property Rights Act (PPPR Act) applications, Request for Information (Freedom of Information Act).

## Speech & language therapy

Activity code	Definition
Communication	Assessment, treatment and/ or intervention for a communication disorder.
Feeding/swallowing	Assessment, treatment and/ or intervention for a feeding or swallowing disorder.
Tracheostomy weaning	Assessment, treatment and/ or intervention related to tracheostomy.
FEES	Completion, review and reporting of FEES when done as one intervention.
VFSS	Completion, review and reporting of VFSS when done as one intervention.