

Form S1: Acute Care Facilities

Admitted Patient Returns

—All Programs

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Reporting Requirements

Form S1 is used for reporting data on patients admitted to public hospital acute care facilities. A separate form must be completed for reporting services purchased by each output group, with one exception. Admitted patient episodes purchased by sub-acute services (output 305) are reported together with patient episodes purchased by acute health services on Form 111/S1.

The layout of the S1 form is identical for each output. The output groups that purchase admitted patient services are:

<i>Output Group</i>	<i>Output</i>
Acute Health Services	111
Aged and Home Care	129
Community Care	118
Dental Health Services	127
Mental Health Services	115
Sub-Acute Services	305 * report with acute health service episodes on Form 111/S1

The Health Service Agreement for each hospital documents the services purchased by output groups and hence indicates which forms are to be completed.

Acute and Sub-Acute Services (Form 111/S1)

Hospitals should complete Form 111/S1 for admitted patient episodes purchased by acute health services and sub-acute services. Admitted patient episodes purchased by the sub-acute program include rehabilitation, geriatric evaluation and management, geriatric respite and nursing home type.

Patients admitted to the designated 'Hospital in the Home' program should be counted as admitted patients and reported on Form 111/S1; services provided to these patients should not be reported on Form S2 (non-admitted patients).

Aged and Home Care (Form 129/S1)

Form 129/S1 is used to report admitted patient episodes purchased by Aged and Home Care. Palliative care is the only admitted service purchased by Aged and Home Care.

Data reported on Form 129/S1 must *exclude*:

- patients in residential care. These services are reported on the S5 return.
- sub-acute services. These services are reported on Form 111/S1.

Previously, this return was known as Form 113/S1 Aged Care Services.

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Community Care (Form 118/S1)

Form 118/S1 is used to report admitted patient services purchased by Community Care. Community Care purchases services for specialised hospitals (early parenting centres).

Dental Health Services (Form 127/S1)

Form 127/S1 is used to report admitted patient services purchased by Dental Health Services.

Mental Health Services (Form 115/S1)

Hospitals should complete Form 115/S1 where acute admitted episodes are purchased by Mental Health Services. Data should be reported for designated Acute Admission Units only.

Data reported on Form 115/S1 must *exclude*:

- separations and patient days for admitted psychiatric patients in acute beds not funded under Mental Health Services. These patients should be reported on Form 111/S1 or other appropriate form;
- non-acute admitted patients and residential clients funded by Mental Health Services. Services provided to these patients should be reported on Form 115/S5.
- psychiatric patients receiving non-admitted Mental Health Services. These services should be reported on Form 115/S2.

Return of Forms

Hospitals are to submit data to the Department via the AIMS OnLine Entry System *within seven working days* following the end of each month.

Printouts of the original signed forms must be retained by the hospital and be available to officers of the Department upon request.

Correction of Forms

Where an error is detected for any data item previously submitted to the Department, then a correction must be submitted. A correction can be made at any time.

Definitions

See also the Definitions section of the AIMS Manual for further information on definitions.

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Separations

A separation is the process whereby a same day patient or an overnight or multi-day stay patient completes an episode of care. A separation may be either *formal* or *statistical*.

Formal: The administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient. This will be because:

- the patient is discharged to private accommodation or other residence;
- the patient is transferred to other health care accommodation (unless there is an intention to return to this campus within seven days for continuation of the same treatment, in which case the patient should be placed on leave);
- the patient dies;
- the patient leaves against medical advice; or
- the patient fails to return from [normal] leave *within seven days* and is therefore discharged, effective from the first day of leave. (This limit does *not* apply to contract leave.)

Statistical: The administrative process by which a hospital records the completion of treatment and/or care and accommodation following a change of Care Type occurring within the one hospital stay. For example, transfer from acute to Nursing Home Type care or transfer from acute to rehabilitation in a designated rehabilitation program.

Record the total of both statistical and formal separations occurring during the month for which the return is prepared. Each separation is counted against the patient's account class at separation, or for qualified newborns, count the separation against the account class with the greatest number of days (see note below).

Includes same day separations (also reported in items 27 to 31 inclusive).

A change in a newborn's qualification status on the PRS/2 system is *not* a statistical separation. Newborn episodes where the newborn is a qualified newborn for either the entire episode, or part of the episode are counted against the Account Class where most patient days were accrued. Exclude unqualified newborns. *Unqualified newborns are counted separately under their own category in item 32.*

Patient Days

A *patient day* means a day or part of a day that a patient is admitted to receive hospital treatment. The patient day is the unit of measurement for the length of stay of an episode of care. The term *patient day* is synonymous with the term *bed day* as used in hospitals.

Report the patient days accrued during the month for which the return is being prepared including those patients not yet separated and qualified newborn patient days. Where a patient changed Account Class during the episode of care, distribute the patient days across the appropriate categories.

Includes patient days accrued by same day patients.

Includes contract leave days.

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Excludes days of stay accrued by unqualified newborns. Unqualified newborns are counted separately in item 33.

Note: Patient days are to be reported in whole days.

Same Day Separations

Record the number of separations for same day patients occurring during the month for which the return is prepared. Each separation is counted against the patient's Account Class at separation.

A same day patient is a patient who is admitted and separated on the same date, and who meets one of the following minimum criteria:

- That the patient receives same-day surgical and diagnostic services as specified in bands 1A, 1B, 2, 3 and 4 but excluding uncertified type C professional attention procedures within the health insurance basic table as defined in s.4 (1) of the National Health Act 1953 (Commonwealth); or
- That the patient receive type C professional attention procedures as specified in the health insurance basic table as defined in s.4 (1) of the National Health Act 1953 (Commonwealth) with accompanying certificate from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

A same day patient may be either a booked or an emergency patient.

A patient *cannot* be both a same day patient and an overnight or multi-day stay patient *at the one hospital*. Thus emergency treatment provided to a patient who is subsequently classified as an overnight or multi-day stay patient in the *same hospital* shall be regarded as part of the overnight or multi-day stay patient episode of care.

The category of *same day* is determined retrospectively; that is, it is not based on the intention to admit and separate on the same date. Rather, a patient is deemed to have been a same day patient if, in retrospect, it can be seen that the patient was admitted to, and separated from, the hospital on the same date. Therefore, patients who die, transfer to another hospital or leave of their own accord on their first day in the hospital are *included*. Booked same day patients who are subsequently required to stay in hospital for one night or more are *excluded*.

Acute Patient

An acute care patient is:

- a patient admitted to an acute care facility for the first 35 days of continuous hospitalisation, or
- a patient who has been in continuous hospital care for more than 35 days where an Acute Care Certificate (Form 918 from the Commonwealth Department of Health and Aged Care), or an equivalent form devised by the hospital, has been completed and

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signed by a medical practitioner indicating the patient is to remain as an acute care patient for a specified period.

Non-Acute Patient

A non-acute patient is:

- a nursing home type patient as defined in section 3 of the Health Insurance Act 1973 (Commonwealth); or
- a compensable or ineligible patient where such a patient has been admitted in one or more hospitals (public and private) for a continuous period of 35 days with a maximum break of seven consecutive days and who, if not a compensable/ineligible patient would be deemed to be a nursing home type patient. Under current legislation, compensable and ineligible patients cannot be categorised as nursing home type.

Public Patient

A public patient is:

- an eligible person who receives or elects to receive a public hospital service free of charge or
- an eligible public patient whose treatment is contracted to a private hospital.

Note: Public separations and patient days (items 1, 6, 7, 14, 19 and 20) include 'exempt' patients.

Private Patient

A person who elects in writing to be treated (in a public or private hospital) as an admitted patient by a medical practitioner of their own choice and to be responsible for paying the charges referred to in clause 57 of the 1999 Australian Health Care Agreement.

Includes

- A patient on whose behalf election has been made by another person with the patient's express or implied consent.
- A patient admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient's treatment.
- An eligible person whose charges are being paid for by the Department of Veterans' Affairs (DVA).

Clause 57 of the Australian Health Care Agreement states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria'.

Compensable Patient

An eligible person who is entitled under a law that is or was in force in Victoria, other than Veterans' Affairs legislation, to the payment of, or who has been paid compensation for, damages or other benefits (including a payment in settlement of a claim for compensation,

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damages, or other benefits) in respect of the injury, illness or disease for which he/she is receiving hospital services.

This category includes workers compensation, transport accident, criminal injury and common law cases and members of the Defence Forces and seamen with personnel entitlements.

Clause 57 of the Australian Healthcare Agreement states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria'.

Under current legislation, compensable patients cannot be categorised as Nursing Home Type. However, where a compensable patient would otherwise have been classed as a Nursing Home Type patient, they are deemed to be Non-Acute compensable.

Ineligible Person

A person who is not eligible under Medicare and therefore not exempt from fees.

A person ineligible for Medicare includes:

- a person who does not fit into one of the categories of eligibility;
- a visitor to Australia from a country with which Australia has a reciprocal health care agreement who elects to be treated as a private patient; or
- a foreign diplomat, or a member of their family, of a country with which Australia does not have a reciprocal health care agreement.

Clause 57 of the Australian Healthcare Agreement states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria'.

Note: An asylum seeker who has a valid temporary entry visa and is an applicant for a protection visa and has either work rights or a spouse, parent or child who is a permanent Australian resident, is eligible to apply for a Medicare card and is therefore an *eligible* person once they have their Medicare card.

Types of Ineligible Patient

An ineligible patient is further categorised as exempt or non-exempt.

Exempt Patient

- An ineligible non-Australian resident specifically referred to Australia for hospital services not available in the patient's own country and for whom the Secretary of the Department of Human Services has determined that no fee be charged.
- A person who has been declared a safe haven resident and whose treatment is provided or arranged by a designated hospital.

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Non-Exempt Patient

An ineligible patient not exempted from fees by the Secretary of the Department of Human Services.

Under current legislation non-exempt ineligible patients cannot be categorised as Nursing Home Type. However, where a non-exempt ineligible patient would otherwise have been classed as a Nursing Home Type patient, they are deemed to be Non-Acute ineligible.

Nursing Home Type Patient

A nursing home type (NHT) patient is defined in section 3 of Commonwealth *Health Insurance Act 1973*: after 35 days continuous hospitalisation, the patient *must* be classified as a NHT patient unless a medical practitioner certifies under section 3(B)(1) that the patient is in need of acute care. For example:

- professional attention for an acute phase of the patient's condition; or
- active rehabilitation; or
- continued management, for medical reasons, as an admitted patient.

A patient *cannot* be designated NHT before 35 days continuous hospitalisation (with a maximum break of seven consecutive days) even if a patient has been assessed by an Aged Care Assessment Team and holds a 2624 certificate (formerly NH5 form).

Although the Health Insurance Act 1973 (Commonwealth) applies directly to private patients using their health insurance for this episode, nationally the guidelines provided in the Act have been extended to all other patients for the purpose of data collection, analysis and funding.

Thus, following 35 days of continuous hospitalisation, a patient automatically becomes an NHT/Non-Acute patient with the following exceptions:

- A privately insured patient using their insurance for this episode of care when an Acute Care Certificate (3B) has been completed and signed by a medical practitioner indicating the patient is to remain an acute care patient for a specified period.
- Any other patient when an Acute Care Certificate, or an equivalent form devised by the hospital, has been completed and signed by a medical practitioner indicating the patient is to remain an acute care patient for a specified period.

Thus, in Victoria, a patient receiving any one of the admitted patient Care Types will become a NHT/Non-Acute patient if they receive 35 days of continuous hospitalisation and do not have certification allowing the present type of care to continue.

The decision for a patient to continue to receive acute care following 35 days of continuous hospitalisation is a clinical one, which needs to be clearly documented then communicated to the relevant staff who report data on admitted episodes of care. This enables the identification of episodes that continue beyond 35 days and thus do not require statistical separation from an acute episode and a statistical admission to commence an NHT/Non-Acute episode. This documentation can be subject to audit by DHS.

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It is important to note that 35 days of hospitalisation can be accrued *across* hospitals when a patient is transferred. Continuity is not broken by normal leave or when a patient is out of hospital for no more than seven consecutive days.

For example, a patient receives admitted patient care in a hospital for 20 days and is then transferred to another hospital. On the 16th day of the second admission, the patient becomes a Nursing Home Type patient (if an Acute Care Certificate or equivalent has not been signed). If, in this example, the patient was on normal leave for two days during the accrued period, the change to Nursing Home Type would not occur until the 18th day of the second admission (two days later).

If a NHT patient is out of hospital (other than for contracted services) for more than seven consecutive days, the 35 day count begins again.

NH5 Form

For AIMS reporting, a Nursing Home Type patient is further categorised as NH5 or Non NH5. NH5 refers to whether a patient has been assessed by an Aged Care Assessment Service and holds an approved *Application for Nursing Home Admission* form. This form was previously known as Form NH5 but has been replaced as a 2624 certificate.

2624 certificates are not limited to NHT patients (for example, a patient may have an approved Application for Nursing Home Admission form while an acute patient).

Unqualified Newborns

When a newborn does not meet one of the criteria for 'qualified newborn', then the newborn is an unqualified newborn.

Number of Entirely Unqualified Episodes

Total number of entirely unqualified episodes for unqualified newborns accrued during the month for which the return is prepared.

Number of Unqualified Days

Total number of unqualified days of stay for unqualified newborns accrued during the month for which the return is prepared. Includes unqualified days of stay accrued by newborns who were both unqualified and qualified during their stay.

Early Parenting Centre—Secondary Family Members

Early Parenting Centres may use items 34 and 35 for reporting the number of episodes and days accrued by secondary family members during the month being reported. These episodes and days must be excluded from items 1 to 31.

Average Available Beds for the Period

An average over each day in the period, including weekends and public holidays, of available and staffed beds, reported according to program funding source.

An available bed is a bed that is immediately available to be used by an admitted patient if required. A bed is immediately available for use if it is located in a suitable place for care

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with nursing and auxiliary staff available within a reasonable period. Both occupied and unoccupied beds are included.

Exclude surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorized or funded and beds designated for same-day non-admitted patient care. Beds in wards that are closed for any reason (except weekend closures for beds/wards staffed and available on weekdays only) are also excluded.

Calculate as follows:

Average Available Beds for the Period =
$$\frac{\text{Sum of available beds on each day of the period}}{\text{Number of days in the period}}$$

The number of available beds on each day is defined as:

- Occupied beds at midnight
- + unoccupied but staffed beds at midnight
- + day procedure beds which were staffed and available that day.

Note:

- 1 Exclude residential nursing home, hostel and other non-acute beds.
- 2 No adjustment should be made for contracted services (that is, a purchasing hospital should *not* add in beds purchased at a contracted hospital, *nor* should a contracted hospital delete beds sold to a purchasing hospital).

Reconciliation with PRS/2

Hospitals should ensure that separations reported on AIMS S1 forms reconcile with separations transmitted via the PRS/2 system. Although reconciliation may not always be achieved before the return is forwarded to the Department of Human Services, it should be undertaken as soon as possible thereafter. Tick the 'Yes' or 'No' box to indicate whether reconciliation has been completed between the hospital's aggregate year-to-date totals and the PRS2 system.

To assist hospitals, the User Reconciliation Report is produced by the PRS/2 system after each data transmission with an end of month file date. Summary statistics provided by the hospital's in-house system in the Trailer Record are reported against statistics calculated by PRS/2. The hospital should reconcile the figures and any differences between the in-house figures and the PRS/2 figures identified and corrective action taken.

The PRS/2 statistics include all records successfully meeting the edit requirements, and exclude rejected records. See the *PRS/2 Manual*, 10th Edition, for further information on the User Reconciliation Report.

If assistance is required with the reconciliation, please contact the Health Data Standards and Systems (HDSS) Help Desk on (03) 9616 8141.

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Signature of Chief Executive Officer and Date

The hospital's chief executive officer should sign and date each form submitted, acknowledging the data contained on the form and the accuracy of these data. The signed return should be retained by the hospital and be available to officers of the Department upon request.