

***Form P1: Private Hospital and Day Procedure  
Centre Monthly Return—Admitted Patients***

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## ***Reporting Requirements***

The Health Services (Private Hospitals and Day Procedure Centres) (Interim) Regulations 2001 require private hospitals and day procedure centres to report occupancy data to the Secretary on a monthly basis. The data are collected on the Agency Information Management System's (AIMS) Form P1 *Private Hospitals and Day Procedure Centres Admitted Patients* return.

Form P1 collects an aggregation of separations and patient days occurring within a month for patients admitted to registered acute beds in private hospitals and day procedure centres, and available beds for the month.

The collection complements the Victorian Admitted Episodes Dataset, which collects patient level data via the PRS/2 system. Together these two systems incorporate the reporting requirements under existing Commonwealth and State agreements, including the Australian Health Care Agreement.

The monthly Form P1 collection commences from July 2002 and coincides with a move to Internet based data collection using the AIMS OnLine Entry System.

The revised format requires less information than the previous quarterly return. Information is required for the current month under review only; the Department no longer requires year-to-date calculations as these figures can be derive from the monthly data.

The AIMS OnLine Entry System will bring benefits to both agencies and the Department through reduced administrative tasks and automation of the data collection process.

The minimum requirements for agencies to access the AIMS OnLine Entry System are:

- An internet account with an internet service provider
- Internet access for data entry personnel
- Internet Explorer Version 5 Browser or greater (5.5 recommended, SP2—Service Pack 2) – available to download at no cost from [www.microsoft.com](http://www.microsoft.com).
- Adobe Acrobat Version 4 reader—available free of charge from [www.adobe.com](http://www.adobe.com)
- An agency specific username and password.

The agency username and password controls access to the system. Each agency will have access only to data specific to its username.

## **Return of Form**

Form P1 is to be submitted to the Department *within 15 days* following the end of each month. Print outs of the original signed forms are to be retained by the agency and be available to officers of the Department upon request. The statistical returns are provided to the Department on a 'Commercial-In-Confidence' basis.

In the event that a hospital ceases operation before the end of a month, a Form P1 is to be completed as at the last day the hospital was operational.

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## AIMS Help Desk

For assistance with any aspect of the AIMS system, agencies should contact the AIMS Help Desk on:

- Telephone: (03) 9616 8595
- Fax: (03) 9616 7743
- Email: [aimsmail@aims.dhs.vic.gov.au](mailto:aimsmail@aims.dhs.vic.gov.au)
- Address: Management Information Unit, Metropolitan Health and Aged Care Services, Department of Human Services, 4/555 Collins Street, Melbourne, 3000.

## Definitions

Definitions for completing the P1 return are below. See also the *Concept Definitions* section of the PRS/2 Manual for global definitions relating to acute hospital inpatient episodes. The definitions are based wherever possible on the National Health Data Dictionary that has been published by the Australian Institute of Health and Welfare and endorsed by the National Health Information Management Group.

## 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.

*Includes* same day separations (also reported in items 19 to 26 inclusive).

*Exclude* separations accrued by patients and paid for under contract to the public sector in lines 1 to 5. Contracted separations are reported in lines 6 to 9.

*Exclude* unqualified newborn data. A newborn that is unqualified for the entire duration of his/her stay is not eligible for health insurance benefits and should not be included.

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 the most patient days were accrued.

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Private hospitals and day procedure centres should note to *exclude* boarder babies from their counts. A boarder is not an admitted patient and therefore must *not* be counted.

### **Patient Days (Lines 10 to 18 inclusive)**

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.

*Include* patient days accrued by newborns during the periods where the newborn has been a qualified newborn.

*Exclude* days of stay accrued by *unqualified* newborns.

*Exclude* patient days accrued by patients and paid for under contract to the public sector in lines 10 to 14. Contracted patient days are reported separately in lines 15 to 18.

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

### **Patients treated and paid under contract to the public sector**

This includes patients treated under contract in private sector facilities but paid for by public hospitals or the Department of Human Services. It does not include Veterans' Affairs or compensable patients.

These may be categorised as *Public—Under Contract* or *Private—Under Contract* according to the terms of the contractual arrangement and category of patients contracted.

Note: Veterans' Affairs patients paid for by the Department of Veterans' Affairs and compensable patients are not included in this category.

### **Same Day Separations (Lines 19 to 26 inclusive)**

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:

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- 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*.

*Exclude* same day separations for patients treated under contract in private sector facilities but paid for by the public sector from lines 19 to 22. Contracted same day separations are reported in lines 23 to 26.

Note: For Day Procedure Centre facilities: separations, patient days and same day separations are the same for all categories. For example, total separations reported on Line 1 equals total patient days reported in Line 10 which equals total same day separations reported in Line 19. (Line 1 = line 10 = line 19).

## Patient Categories

### ***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 an 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'.

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

### **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 Services 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 that 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 the Department.

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 16<sup>th</sup> 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 18<sup>th</sup> 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.

### ***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, 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.

#### *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.

### **Average Available Beds for the Period (Item 27)**

An average over each day in the period, including weekends and public holidays, of available beds. Calculate as follows:

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

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.

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**Note:**

- 1 Exclude nursing home, hostel and other non-acute beds.
- 2 For day procedure centres only, the number of days in the period refers to the number of days that the agency was in operation.

**Reconciliation with PRS/2 (Item 28)**

Hospitals should ensure that the separations reported on AIMS Form P1, reconcile with data transmitted to the PRS/2 system. Although reconciliation may not always be achieved before the return is forwarded to the Department, it must be undertaken as soon as possible thereafter.

A report to assist hospitals reconcile data is produced by the PRS/2 system after each data transmission with an end of month file (cut off) date. Summary statistics provided by the hospital's in-house system in the Trailer Record are reported against statistics calculated by PRS/2 after processing transmitted data. 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, 9<sup>th</sup> Edition, Section D Transmission Control and Reconciliation Reports for further information on the User Reconciliation Report.

Remember to *exclude unqualified* newborn data on AIMS returns. A newborn that is unqualified for the entire duration of his/her stay is not eligible for health insurance benefits and should not be included.

If assistance is required with the reconciliation, please contact your Regional Office (rural hospitals) or the Department of Human Services PRS/2 Help Desk on (03) 9616 8141.

**Signature of Chief Executive Officer and Date**

The agency's Chief Executive Officer should sign and date each form submitted, acknowledging the data contained on the form and the accuracy of these data.