

***Section 2:  
Concept Definitions***



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# ***Introduction***

This section provides concept definitions relating to the data items collected by PRS/2.

Detailed specifications for reporting data to PRS/2 are provided in Sections 3 and 5 of this Manual.

The definitions contained in this section are based, wherever possible, on the *National Health Data Dictionary*.<sup>1</sup>

<sup>1</sup>Australian Institute of Health and Welfare 2000. *National Health Data Dictionary*. Version 9. AIHW Catalogue no. HW124. Canberra: Australian Institute of Health and Welfare.

# Definitions

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## Admission

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**Definition**

An admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.

A **formal admission** is the administrative process by which a hospital records the commencement of treatment and/or care and accommodation of a patient.

A **statistical admission** is the administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within the one hospital stay.

*(National Health Data Dictionary, 2000, p 290)*

**Guide for use**

**Refer to:**

- 'Care Type/Episodes of Care', page 2-7.
- 'Criterion for Admission', page 2-18.
- Section 3, 'Admission Source'.

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# Admitted Patient

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**Definition** An admitted patient is a person who has been assessed by the treating clinician as meeting at least one of the minimum criteria for admission and who undergoes the hospital's formal or statistical admission process as either a same-day, overnight or multi-day stay patient.

**Guide for use** The term admitted patient is synonymous with the term inpatient, as used in hospitals.

The decision to admit a patient rather than to treat them as a non-admitted patient (outpatient or Emergency Department patient) should be made by a medical practitioner and cannot be delegated to administrative staff or automated. Thus Resident and Senior Medical Staff, Nursing Staff and personnel involved in the admission procedure within hospitals, including staff of the Admission Office, Medical Records Department and Hospital Information Systems Department, need to be fully acquainted with the application of this concept.

For statistical purposes, patients are counted as either same-day or overnight/multi-day stay patients retrospectively: it does not depend on the intention at admission.

**Refer to:**

- 'Admission', page 2-2.
- 'Criterion for Admission', page 2-18.
- 'Overnight/Multi-Day Stay Patient', page 2-48.
- 'Same Day Patient', page 2-53.

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# Boarder

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**Definition** A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.  
(*National Health Data Dictionary*, 2000, p 264)

**Guide for use** A boarder thus defined is not admitted to the hospital. However, the hospital, for its own purposes, may wish to record boarders in its in-house system; if so, the hospital's interface must be able to identify boarders and exclude them from transmission to the VAED.

An unqualified newborn remaining in hospital when he/she turns ten days old, becomes a boarder.

A newborn baby is a boarder in a second or subsequent stay in hospital that starts within the first nine days of life, if he/she does not meet any of the Criterion for Admission, as a qualified newborn.

**Refer to:**

- 'Criterion for Admission', page 2-18.
- 'Newborn', page 2-42.

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# Campus

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**Definition** A physically distinct site owned or occupied by a metropolitan health service/hospital, where treatment and/or care is regularly provided to patients.

**Guide for use** For the purposes of reporting to the VAED:

A **single campus hospital** provides admitted patient services at one location, through a combination of overnight stay beds and day stay facilities, or day stay facilities only.

A **multi-campus hospital** has two or more locations providing admitted patient services, where the locations:

- Are separated by land (other than public road) not owned, leased or used by that hospital.
- Has the same management at the metropolitan health service/hospital level.
- Each has overnight stay facilities. A separate location (see first dot point) providing day only services, such as a satellite dialysis unit, is considered to be part of a campus
- Are not private homes. Private homes, where Hospital in the Home services are provided, are considered to be part of a campus.

The Department holds that, as a general principle, VAED reporting should identify activity at each campus. Any multi-campus hospital not currently reporting on this basis, or intending to change from single to multi-campus or vice versa, should discuss this with DHS.

**Refer to:**

'Metropolitan Health Service', page 2-41.

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## Cardiac/Coronary Care Unit

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***Definition***

A Cardiac/Coronary Care Unit (CCU) is defined as a designated ward of a hospital which is specifically staffed and equipped to provide observation, care and treatment to patients with acute cardiac problems, such as acute myocardial infarction and unstable angina and who may have undergone interventional procedures from which recovery is possible.

The CCU provides special facilities and utilises the expertise and skills of medical, nursing and other staff trained and experienced in the management of these conditions.

(Ministerial Review of Coronary Care Services in Victoria – December 1996).

***Guide for use***

**Refer to:**

Section 3 'Duration of Stay in Cardiac/Coronary Care Unit'.

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## Care Type/Episode of Care

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### ***Definition***

An overnight or multi-day stay patient may receive more than one type of care during the period of hospitalisation. If so, the period of hospitalisation is broken into Episodes of Care, one for each type of care (Care Type).

An Episode of Care refers to a phase of treatment and is designed to reflect the changing diagnosis and/or treatment of the patient. The Episode of Care ends when the Care Type changes or the patient separates from hospital.

### ***Guide for use***

There are some exceptions to rules inherent in the above definition:

- (Public hospitals only.) A newborn changing Qualification Status during an Episode of Care may also require a change in Care Type. If a newborn initially receiving Unqualified Newborn Care changes Qualification Status, their Care Type for the entire episode is reported as Acute Care.
- A patient cannot have two changes of Care Type on the one day (that is, start the day as one Care Type, become another Care Type, and then revert to the original Care Type or transfer to a third Care Type). PRS/2's editing prevents such a sequence: to accept it would result in a single day being double-counted as a patient day (once in the same day episode and once as the admission day of the following episode). This circumstance most commonly occurs when a patient is treated as an Acute patient (Care Type) for a day in the middle of another Care Type episode (the same day episode should not be reported to the VAED). Where the patient reverts to the original Care Type, continue the original episode. Where the patient is transferred to a third Care Type, statistically end the original episode and start an episode for the third Care Type.
- In general, public hospitals may use the palliative Care Type only on admission, if the patient receives palliative care under the supervision of a palliative care specialist or physician. That is, public hospitals may not change a patient to palliative Care Type following another Episode of Care; the original episode must continue. The only exception to this rule is for transfer between funding sources; that is, if the patient is being transferred to palliative Care Type funded by the Aged Care Program from another Care Type.
- Public hospitals may use the Alcohol and Drug Care Type only on admission; it is not for use following another Episode of Care.

**Refer to:**

- Section 3 'Care Type'.
- 'Geriatric Evaluation and Management', page 2-24.
- 'Newborn', page 2-42.
- 'Nursing Home Type/Non-Acute, page 2-45.
- 'Palliative Care', page 2-49.
- 'Rehabilitation', page 2-52.

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## Contracted Care

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### ***Definition***

Care provided to a patient under an agreement between a purchaser of hospital care (contractor) and a provider of an admitted or non-admitted service (contracted hospital). Such an agreement can be formal or informal, written or verbal.

To be in scope, contracted care must involve all of the following:

- A purchaser, which can be a public or private hospital, or a health authority (Department of Human Services or a Health Region) or another external purchaser.
- A contracted hospital, which can be a public or private hospital or day procedure centre.
- The contractor making full payment to the contracted hospital for the contracted service.

Thus, services provided to a patient in a separate facility during their episode of care where the patient is directly responsible for payment of this additional service are not considered contracted services for the purposes of PRS/2 reporting.

- The patient being physically present in the contracted hospital for the provision of the contracted service.

Thus, pathology or other investigations performed at another location on specimens gathered at the contracting hospital would not be considered contracted services for the purposes of PRS/2 reporting.

### ***Guide for use***

Accurate recording of contracted care in both public and private hospitals is essential because:

- Funding arrangements require that the DRG assigned to a patient accurately reflect the total treatment provided, even where part of the treatment was provided under contract.
- Funding arrangements require that potential double payments are identified and avoided; the case payment will apply only to the contracting hospital and not the contracted hospital.
- Unidentified duplication in the reporting of separations, patient days and procedures must be avoided to enable accurate analyses as required for funding, casemix, resource use and epidemiological purposes.
- The Commonwealth Department of Health and Aged Care requires details of contracted public patients attending private hospitals to be reported, under the Australian Health Care Agreement.

Related contracted hospital care data items should only be completed where services are provided which represent some, but not all of the contracted hospital's total services. That is, it is not necessary to complete contracted hospital care data items where all of the hospital services are contracted by a health authority, for example, privately owned and/or operated public hospitals such as La Trobe Regional Hospital.

### **Contract Leave**

Contract leave is a period spent as an admitted patient at a contracted (service provider) hospital, during an episode where the patient is also admitted to the contracting (purchasing) hospital.

Contract leave days are reported only by the contracting (purchasing) hospital and are treated as patient days and included in length of stay at that hospital. In PRS/2, contract leave days for the episode are reported in three Contract Leave Days fields: Month-to-date, Financial Year-to-date, and Total. There is no limit to the duration of contract leave.

Patients going on contract leave are not separated.

### **Identification of Contracted Episodes of Care**

In PRS/2, reporting 1 (Contract) in the Funding Arrangement field identifies episodes involving contracted care. The following fields are then reported:

- The type of contract involved is reported in the Contract Type field.
- The role of the hospital (contracting or contracted) is reported in the Contract Role field.
- The nature of the contract involving an external purchaser, or the other hospital involved in a contracted care or hub & spoke arrangement, is reported in the Contract/Spoke Identifier field.

### **Identification of Procedures Performed under Contract**

The contracting (purchasing) hospital is termed Hospital A.

The contracted (service provider) hospital is termed Hospital B.

In PRS/2, procedures performed at another hospital under contract to this hospital are recorded by both hospitals, but flagged in the contracting hospital only (Hospital A). Hospital A reports a flag in the eighth character of the (ICD-10-AM) codes relating to procedures performed under contract by Hospital B.

Flags used by Hospital A are:

- Character F on procedures performed by Hospital B on an admitted basis
- Character N on procedures performed by Hospital B on a non-admitted basis

Allocation of diagnosis and procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards, including the Victorian Additions to the Australian Coding Standards, should be applied when coding all episodes. In particular, procedures that would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (that is, not a recognised hospital) should be coded if appropriate but should not be flagged as contracted hospital procedures.

### **Types of Contracted Hospital Care**

The contracting (purchasing) hospital is termed Hospital A.

The contracted (service provider) hospital is termed Hospital B.

Six contract types are identified by the sequence of alpha characters, representing the movement of the patient between the contracting (A) and contracted (B) hospitals.

#### **1 Contract Type B**

A (health authority/other external purchaser) contracts B (hospital) for admitted service.

External purchaser agencies include, but are not limited to:

- Department of Veterans' Affairs: Veterans' Cardiac Agreement
- Transport Accident Commission: Alfred Road Trauma Unit
- Individual contracts with international patients

Hospitals that believe they have a similar contract should contact the Department to discuss reporting arrangements.

#### **2 Contract Type ABA**

Patient admitted by Hospital A.

Hospital A contracts Hospital B for admitted or non-admitted patient service.

Patient returns to Hospital A on completion of service by Hospital B.

#### **3 Contract Type AB**

Patient admitted by Hospital A.

Hospital A contracts Hospital B for admitted or non-admitted patient service.

Patient does not return to Hospital A on completion of service by Hospital B.

#### **4 Contract Type (A)B**

Patient not present in the Contracting Hospital (A) at any time during the episode.

Hospital A contracts Hospital B for the whole admitted patient service.

An (A)B contract type cannot occur between two public hospitals unless approved by the Department. Where two public hospitals enter into a contract, the contracting hospital must admit and provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB and BA).

#### **5 Contract Type BA**

Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for the remainder of the episode of care.

#### **6 Contract Type A(B)**

Hospital A contracts Hospital B for the whole admitted patient service.

Hospital B provides the service at Hospital A.

Patient not present in the Contracted Hospital (B) at any time during the episode.

An A(B) contract type cannot occur between two public hospitals unless approved by the Department. Where two public hospitals enter into a contract, the contracting hospital must admit and provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB and BA).

#### **PRS/2 Reporting for Contracted Hospital Care**

The contracting (purchasing) hospital is termed Hospital A

The contracted (service provider) hospital is termed Hospital B.

These six basic types of contracted hospital care should be recorded in the following ways:

## **1 Contract Type B**

### **B records:**

- Funding Arrangement code 1 *Contract*.
- Contract Type code 1 *Contract Type B*.
- Contract Role code B *Hospital B*.
- Contract/Spoke Identifier (of specified contract).

## **2 Contract Type ABA**

### **A records:**

- Admission date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 2 *Contract Type ABA*.
- Contract Role code A *Hospital A*.
- Contract Identifier (Campus code) of Hospital B.
- Contracted Leave Days: report difference between date patient leaves A for treatment by B and date patient returns to A. Diagnosis and procedure codes: include any additional diagnoses identified by B, and procedures provided by B each with relevant contract procedure flag (F or N).
- Separation date: being date patient left A after returning from B.
- Length of stay is Separation Date minus Admission Date minus Total [normal] Leave days; thus contract leave days are effectively treated as patient days and included in Length of Stay.

### **If admitted by B, B records:**

- Admission date, being date of commencement of care at B.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 2 *Contract Type ABA*.
- Contract Role code B *Hospital B*.
- Contract Identifier (Campus code) of Hospital A.
- Admission Source code T: requires Transfer Source code.
- Transfer Source: Contracting Hospital A.

- Diagnosis and procedure codes: only in relating to care provided by B.
- Separation date: actual date separated from B.
- Separation Type code T: requires Transfer Destination code.
- Transfer Destination: Contracting Hospital A.

### **3 Contract Type AB**

#### **A records: (irrespective of the original intention for the patient to return or not):**

- Admission date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 3 *Contract Type AB*.
- Contract Role code A *Hospital A*.
- Contract Identifier (Campus code) of Hospital B.
- Contracted Leave Days: report difference between date patient leaves A for treatment by B and date patient separated from B.
- If patient not admitted by B, contract leave is nil.
- Diagnosis and procedure codes: include any additional diagnoses identified by B, and procedures provided by B each with relevant contract procedure flag (F or N).
- Separation date: report actual date patient separated from B if admitted by B, or date separated from A if not admitted by B.
- Separation Type code T: requires Transfer Destination code.
- Transfer Destination: Contracted Hospital B.
- Length of stay is Separation Date minus Admission Date minus Total [normal] *Leave* days; thus contract leave days are effectively treated as patient days and included in Length of Stay.

#### **If admitted by B, B records:**

- Admission date, being date of commencement of care at B.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 3 *Contract Type AB*.
- Contract Role code B *Hospital B*.
- Contract Identifier (Campus code) of Hospital A.
- Admission Source code T: requires Transfer Source code.
- Transfer Source: Contracting Hospital A.
- Diagnosis and procedure codes: only in relating to care provided

by B.

- Separation date: actual date separated from B.

#### **4 Contract Type (A)B**

##### **A records:**

- Admission date: actual date admitted by B.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 4 *Contract Type (A)B*.
- Contract Role code A *Hospital A*.
- Contract Identifier (Campus code) of Hospital B.
- Diagnosis and procedure codes from information provided by B: each procedure with contract procedure flag for admitted services (F only).
- Separation date: actual date patient separated from B.

##### **B records:**

- Admission date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 4 *Contract Type (A)B*.
- Contract Role code B *Hospital B*.
- Contract Identifier (Campus code) of Hospital A.
- Diagnosis and procedure codes.
- Separation date.

#### **5 Contract Type BA**

The contract may be for non-admitted services.

##### **B records:**

- Admission date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 5 *Contract Type BA*.
- Contract Role code B *Hospital B*.
- Contract Identifier (Campus code) of Hospital A.
- Diagnosis and procedure codes from information provided by B.
- Separation date: actual date patient separated from B.

- Separation Type code T: requires Transfer Destination code.
- Transfer Destination: Contracting Hospital A.

**A records:**

- Admission date: actual date admitted to B.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 5 *Contract Type BA*.
- Contract Role code A *Hospital A*.
- Contract Identifier (Campus code) of Hospital B.
- Admission Source code T: requires Transfer Source code.
- Transfer Source: Contracted Hospital B.
- Contracted Leave Days: report difference between date patient admitted by B and date patient separated from B to go to A. If patient not admitted by B, contract leave is nil. If patient not admitted by B, contract leave is nil.
- Diagnosis and procedure codes: include any additional diagnoses identified by B, and procedures provided by B each with relevant contract procedure flag (F or N).
- Separation date: actual date patient separated from A.
- Length of stay is Separation Date minus Admission Date minus Total [normal] Leave days; thus contract leave days are effectively treated as patient days and included in Length of Stay.

**6 Contract Type A(B)**

**A records:**

- Admission date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 6 *Contract Type A(B)*.
- Contract Role code A *Hospital A*.
- Contract Identifier (Campus code) of Hospital B.
- Separation date.

B is not required to record any information about this episode.

### **Elimination of duplicate procedures and patient days**

Each contract type is clearly distinguished by the combination of reporting in the Contract Type and Contract Role fields. Apart from the Type B and A(B) contracts, all other contract types may involve duplication of reporting some or all of the procedures and patient days.

At a State level, to determine total activity figures for procedures and patient days, it is possible to determine aggregate figures and then subtract those procedures and patient days performed in cases where the Contract Type is 2, 3, 4, or 5 and Contract Role is B (Hospital B).

However, for VAED reporting, no discounting of activity figures is required.

### **Refer to:**

Section 3 'Funding Arrangement', 'Contract Type', 'Contract Role', 'Contract/Spoke Identifier', and the 'Contract Leave Days' items.

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## Criterion for Admission

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### **Definition**

Minimum criteria, one of which must be met before a patient can be admitted:

- The patient is to receive a Same-day Surgical and Diagnostic Services as specified in Band 1A, 1B, 2, 3 and 4 as specified in the *Day Only Procedures Manual*.<sup>1</sup>

or

- The patient is to receive a Type C Professional Attention Procedure as specified in the *Day Only Procedures Manual*.<sup>1</sup> In these cases the medical record must contain documentation from the medical practitioner which justifies the admission on the grounds of the medical condition of the patient or other special circumstances that relate to the patient (for example, remote location, no-one at home to care for the patient).

or

- The patient is nine days old or less at the time of admission (newborn). All newborn days are further divided into categories of qualified and unqualified for the Australian Health Care Agreement and health insurance benefit purposes.

A newborn day is qualified if the newborn meets at least one of the following criteria:

- (i) Is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient; or
- (ii) Is admitted to a facility approved by the Commonwealth Minister for the purpose of provision of intensive or special care; or
- (iii) Is admitted to or remains in hospital without their mother.

A newborn day is unqualified if the newborn does not meet any of the criteria described above.

or

- The patient, following a clinical decision, is expected to require overnight or multi-day hospitalisation.

<sup>1</sup>Commonwealth Department of Health and Aged Care 1999. *Day Only Procedures Manual, 4<sup>th</sup> Edition*. Canberra.

[www.health.gov.au/pubs/circfinl/circulars/dayonlysept1999.htm](http://www.health.gov.au/pubs/circfinl/circulars/dayonlysept1999.htm)

### **Guide for use**

The criterion under which each patient is admitted does not have an impact on casemix funding.

If the care to be provided to a patient does not meet any of the criteria for admission, then the patient should not be admitted and the episode not reported to the VAED. Hospitals are responsible for ensuring that appropriate procedures and records are maintained to facilitate accurate reporting, and to justify the admission. The list of criteria for admission in the definition is complete – there are no other criteria for admission.

For example:

- Care provided to a patient in a non-admitted hospital setting over an extended period of time does not in itself constitute (conversion to) an admission. A patient in non-admitted care may only be admitted once at least one of the admission criteria is met.
- Under these criteria, the fact that a procedure is undertaken in an operating suite does not, in itself, justify admission.

### **Change To Planned Treatment**

Where a patient's condition requires a different course than that planned at admission, the hospital must retain on the VAED the original Criterion for Admission. For example, a newborn who changes Qualification Status must retain their original Criterion for Admission code (N or U).

### **Cancelled Treatment**

There will be occasions where a patient who is admitted, subsequently has their planned treatment cancelled and is separated on the same day:

- If the admission could be justified as extended medical treatment (refer to page 2-20) and supporting documentation is provided, the episode should remain and be reported to the VAED. Even though this assessment needs to be made, the original Criterion for Admission should not be changed.
- If the admission could not be justified as extended medical treatment, the admission should be cancelled.

The level of same-day admissions involving cancelled procedures is continually monitored.

### **Parentcraft**

'Parentcraft' describes the type of care provided by Early Parenting Centres but similar care may be provided by other hospitals. In regard to 'parentcraft' care and treatment, only those family members who satisfy the minimum criteria should be admitted. Whilst mother, father, baby and siblings may attend the hospital, normally only one member of the family should be admitted. In some instances, admission of two or more family members may be justified where they are affected by separate problems; or

where problems affect more than one member, such as breastfeeding difficulties, where care and treatment are required for both mother and baby.

### **Day Only Bands 1A, 1B, 2, 3 and 4**

It is expected that the majority of Type B procedures will (and should) occur in an admitted patient setting and be reported to the VAED accordingly. For example, it has consistently been agreed that patients should always be admitted for each episode involving renal dialysis.

For the purpose of VAED reporting, there is no significance in, nor requirement to, separately identify the various bands. They are included in the definition for the purpose of highlighting the consistency with the classification of private patients by hospitals for health insurance claim purposes.

When a private patient is admitted for a Type B intervention but stays overnight, the relevant section of the 'Private Patient Hospital Claim Form' must be completed. As advised in Circular 6/1998, the Commonwealth has phased out the use of form 1830 which was formerly used for certification purposes.

### **Type C Professional Attention Procedures**

#### ***Type C Exclusion List***

The exclusion list of procedures (the 'Type C Exclusion List') identifies services which would normally be undertaken on a non-admitted basis (outpatient, accident and emergency) and not normally accepted as same day admissions. However, if the patient's medical condition or other special circumstances justify admission, they can be admitted. This list overrides the general criteria listed under the definition of the bands.

#### ***Extended Medical Treatment – Emergency, and Non-Emergency***

It is acknowledged that the non-surgical component of day admissions is not well addressed in the *Day Only Procedures Manual*. In order to establish some consistency in data collection between hospitals, admission should be based on:

- The appropriateness to admit the patient as determined by a clinician; and
- Medical treatment involving constant nursing care and treatment under the supervision of a medical practitioner for a period of no less than four hours, excluding waiting time. (This is only a guideline: alone it does not provide justification for an admission; a clinical decision to admit is required and must be adequately documented.)

### ***Type C Certification***

Whilst the Type C Exclusion List identifies services which will not normally be accepted as same day admissions, there will be occasions when patient admission for the provision of Type C services is warranted on the grounds of the medical condition or other special circumstances that relate to the patient. These details must be documented.

#### ***For privately insured patients:***

The attending medical practitioner should complete the relevant section of the 'Private Patient Hospital Claim Form'. As advised in Circular 6/1998, the Commonwealth has phased out the use of form 1830 which was formerly used for certification purposes.

#### ***For patients other than privately insured patients:***

Documented justification of the admission for Type C procedures on clinical grounds must be included in the medical record. Audits of medical records may be conducted for the purpose of ensuring that Type C services provided in an admitted patient setting are warranted.

#### **Refer to:**

- Section 3 'Criterion for Admission'.
- 'Newborn, page 2-42.

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# Critical Care Inter-Hospital Transfer Program

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**Definition**      The Critical Care Inter-Hospital Transfer (CCIHT) Program commenced on 1 July 1998 to provide a financial incentive for hospitals to better manage their critical care bed availability, plan for peaks in demand, and keep the need for acute inter-hospital transfers to a minimum.

**Guide for use**      **Refer to:**  
Section 3 'Reason for Critical Care Transfer'.

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## DRG Classification

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### ***Definition***

The Diagnosis Related Group (DRG) classification system that clusters patients into groups that are clinically meaningful and resource use homogenous.

The concept of clinical coherence requires that patient characteristics included in the definition of each DRG relate to a common organ system or aetiology (disease cause), and that a specific medical specialty should typically provide care to the patients in that DRG.

### ***Guide for use***

A patient can be allocated to only one DRG for an episode of care. Allocation occurs on the basis of information contained in the patient's discharge abstract. A DRG is assigned by computer software using codes for:

- The principal diagnosis,
- Procedures undertaken for surgical cases,
- The presence or absence of other diseases or comorbidities and complications, and
- Other variables such as age, sex and discharge status and, for neonates, admission weight.

The Department of Human Services is using Australian National Diagnosis Related Groups (AN-DRGs), v4.1, for grouping VAED data in 2000-2001.

The details of grouping logic and methodology are contained in the Commonwealth document *Australian Refined Diagnosis Related Groups, Version 4.1*.

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# Geriatric Evaluation and Management Program (GEM)

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***Definition***

The GEM Program involves the sub-acute care of chronic or complex conditions associated with aging, cognitive dysfunction, chronic illness or disability. These conditions require patients to be admitted for review, treatment and management by a geriatrician and multi-disciplinary team for a defined episode of care.

The GEM client group is usually older people with complex, chronic or multiple health care conditions requiring treatment and stabilisation of those conditions and/or medical review for future treatment options or service planning.

***Guide for use***

The GEM Care Type is only reported to the VAED for patients admitted to a designated GEM Program.

**Refer to:**

Section 3 'Care Type'.

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# Geriatric Respite

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**Definition** Admission for care and support of a person with a stable, pre-assessed condition requiring accommodation, clinical and nursing care to provide relief for carers.

**Guide for use** Geriatric Respite includes both planned and unplanned respite:

- Planned geriatric respite care is provided for a planned or booked admission of a person in order to provide relief for carers.
- Unplanned respite provides accommodation and care when an emergency or crisis has occurred, including an episode of ill health for the carer.

In both cases, the patient does not require assessment or clinical care over and above that which would normally have been provided in the usual place of residence.

The program excludes Nursing Home Type/Non-Acute patients and patients awaiting placement in residential care. Geriatric respite is not available to residents of residential care facilities.

Admissions to Geriatric Respite must be formal admissions.

**Refer to:**

Section 3 'Care Type' (Value 4) and 'Admission Type' (Value G).

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# Hospital

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**Definition** A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit, and authorised to provide treatment and/or care to patients.

*(National Health Data Dictionary, 2000, p 213)*

**Guide for use** A hospital may be located at one physical site or may be a multi-campus hospital.

For the purposes of these definitions, 'hospital' includes satellite units managed and staffed by the hospital and private homes used for service provision under the Hospital in the Home program.

The definition includes public hospitals, denominational hospitals, metropolitan health services, and privately operated hospitals as defined in the Health Services Act 1988, as amended.

The definition includes private hospitals and day procedure centres registered under the Victorian Health Services Act 1988, as amended. Private hospitals are required to maintain separate registrations for each site.

Nursing homes and hostels which are now approved under the Aged Care Act 1997 (Commonwealth) are excluded from the definition, as are supported residential services registered under the Health Services Act 1988, as amended.

**Refer to:**

- 'Metropolitan Health Service', page 2-41.
- 'Campus', page 2-5.

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# Hospital in the Home

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**Definition**

Admitted patient services provided to people living in the community, in their own homes or in residential facilities such as nursing homes, hostels or other forms of supported accommodation.

Hospital in the Home (HITH) services might include treatment of orthopaedic conditions or the administration of intra-venous therapies. The use of HITH is voluntary for the patient. For a patient, the service might be a combination of hospital and home-based care or replace hospital care completely.

**Guide for use**

A public hospital must be designated in its Health Service Agreement to provide HITH services.

As at 1 July 2000, HITH is limited to public, DVA, TAC and WorkCover patients because insurers and the Commonwealth have not yet permitted private patients to be treated under this program. A private patient must not be reclassified to public in order to be treated under this program.

In the VAED, Hospital in the Home is reported in the field Accommodation Type. Moving between ward accommodation and 'Hospital in the Home' accommodation is reported in a new Status Segment within the same episode and does not represent a new episode following a formal separation or a statistical separation.

Patients receiving care under this program must meet one of the minimum criterion for admission, with the care provided representing a substitute for acute admitted patient care.

**Refer to:**

Section 3 'Accommodation Type'.

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# Intensive Care Unit

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**Definition**

An intensive care unit (ICU) is a designated ward of a hospital that is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.

*(National Health Data Dictionary, 2000, p214)*

**Guide for use**

There are five different types and levels of ICU, the details of which are listed below:

- Adult intensive care – level 3, level 2, level 1
- Paediatric intensive care
- Neonatal intensive care – level 3

As defined, ICUs do not include Special Care Nurseries, Coronary Care Units, High Dependency Units, Intensive Nursing Units or Stepdown Units.

**Adult Intensive Care Unit – Level 3:****Nature of Facility**

A level 3 adult ICU must be a separate and self contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period. It must be a tertiary referral centre for intensive care patients and have extensive back up laboratory and clinical service facilities to support this tertiary referral role.

**Care Process**

A level 3 adult ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardio-vascular monitoring for an indefinite period. These types of services are illustrative of the nature of care provided in a level 3 adult ICU but are not exhaustive of the possibilities.

### **Clinical Standards and Staffing Requirements**

An ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

### **Adult Intensive Care Unit – Level 2:**

#### **Nature of Facility**

A level 2 adult ICU must be a separate and self contained facility in the hospital capable of providing complex, multi-system life support.

#### **Care Process**

A level 2 adult ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardio-vascular monitoring for a period of at least several days. These types of services are illustrative of the nature of care provided in a level 2 adult ICU but are not exhaustive of the possibilities.

### **Clinical Standards and Staffing Requirements**

An ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

### **Adult Intensive Care Unit – Level 1:**

#### **Nature of Facility**

A level 1 adult ICU must be a separate and self contained facility in the hospital capable of providing basic multi-system life support usually for less than a 24-hour period.

#### **Care Process**

A level 1 adult ICU must be capable of providing mechanical ventilation and simple invasive cardio-vascular monitoring for a period of at least several hours. These types of services are illustrative of the nature of care provided in a level 1 adult ICU but are not exhaustive of the possibilities.

### **Clinical Standards and Staffing Requirements**

An ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

## **Paediatric Intensive Care Unit:**

### **Nature of Facility**

A paediatric ICU must be a separate and self contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period. It must be a tertiary referral centre for children needing intensive care and have extensive backup laboratory and clinical service facilities to support this tertiary role.

### **Care Process**

A paediatric ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardio-vascular monitoring for an indefinite period to infants and children less than 16 years of age. These types of services are illustrative of the nature of care provided in a paediatric ICU but are not exhaustive of the possibilities.

### **Clinical Standards and Staffing Requirements**

An ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

## **Neonatal Intensive Care Unit – Level 3:**

### **Nature of facility**

A level 3 neonatal ICU must be a separate and self contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period.

### **Care Process**

A neonatal ICU must be capable of providing mechanical ventilation and invasive cardio-vascular monitoring. These types of services are illustrative of the nature of care provided in a neonatal ICU but are not exhaustive of the possibilities.

### **Clinical Standards and Staffing Requirements**

An ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

### **Refer to:**

Section 3 'Duration of Stay in Intensive Care Unit'.

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## Leave - Contract

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**Definition** A period spent as an admitted patient at a contracted (service provider) hospital, during an episode where the patient is also admitted to the contracting (purchasing) hospital.

**Guide for use** Contract leave days are reported only by the contracting (purchasing) hospital, and are treated as patient days and included in the length of stay at that hospital. There is no limit to the duration of contract leave. Patients commencing a period of contract leave are not separated.

**Refer to:**

'Contracted Care', page 2-9.

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## Leave - Normal

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**Definition** Normal leave occurs when an overnight or multi-day patient leaves the hospital temporarily with the approval of the hospital and/or treating medical practitioner, with the intention that the patient will return within seven days to continue the current treatment.

**Guide for use** No patient day charges are raised, nor patient days counted, while the patient is on normal leave. Periods of normal leave are not counted as separations.

If the absence is planned to be greater than seven days or if the patient fails to return within seven days:

- The patient should be formally separated, effective from the date of leaving the hospital; this is counted as a formal separation. If the patient later returns to the hospital and is admitted, a new Episode Record is started; this is counted as a formal admission.
- Unless the patient is on contract or normal leave, an overnight or multi-day stay patient in one hospital campus cannot concurrently be a patient in another hospital campus. Such a patient must be separated from one hospital campus and admitted to the other hospital campus on each occasion of transfer.

Where it is intended that a patient return to the hospital within seven days for a related but different procedure (for example, a coronary angiogram is to be followed by heart surgery), the patient should be separated and re-admitted.

Where it is intended that a patient return to the hospital within seven days for a regular Type B procedure (dialysis, chemotherapy, plasmapheresis, etc), the patient should be separated and re-admitted.

However, where it is intended that a patient return to the hospital at regular intervals of not more than seven days for a series of non-Type B procedures, the patient is:

- A multi-day patient on leave between treatments; and
- Not a same day patient, even if the patient does not stay overnight in the hospital.

In such cases, documented justification for the admission must be provided (that is, to justify admitted care rather than non-admitted care).

A period of absence starting and ending on the same date is not counted as leave but the patient must be recorded as absent in his/her medical record. The patient may be recorded as absent in the hospital's computer system; however, the system must not report that day's leave to PRS/2 nor (if [normal] leave) deduct a patient day in other reporting.

**Refer to:**

'Length of Stay', page 2-34.

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# Length of Stay

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## **Definition**

The length of stay of an admitted patient is measured in patient days. A same day patient should be allocated a length of stay of one patient day. The length of stay of an overnight or multi-day stay patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting total leave days. Total contracted patient days are included in length of stay.

*(National Health Data Dictionary, 2000, p 449)*

## **Guide for use**

In practice, there are two methods for calculating length of stay:

- Retrospective: Separation Date minus Admission Date minus Total [normal] leave days; and
- Progressive: sum of patient days (including contract leave days) accrued to date.

By whichever method, the result must be the same at the conclusion of an individual patient episode.

### **Both methods of calculating LOS have some fundamental principles:**

- 1 The sum of patient days (including contract leave days) and [normal] leave days must equal the number of days elapsed between Admission Date and Separation Date.
- 2 For any given date, either a patient day (including a contract leave day) or a [normal] leave day may be counted, but not both.
- 3 Patient days are not accrued when the patient is out of the hospital on [normal] leave, regardless of whether a bed is 'being held' for the patient during his/her absence.  
  
Contract leave days are effectively treated as patient days and included in Length of Stay.
- 4 For patients admitted and separated on different dates: count one patient day for date of admission; count no patient day for date of separation.
- 5 For patients admitted and separated on the same date: count one patient day; no leave days; and LOS = 1 day.
- 6 A period of absence starting and ending on the same date is not counted as leave.

### **Some Specific Guidelines for Counting Patient Days, Contract Leave Days and [Normal] Leave Days, and Hence Calculating LOS**

- 7 A same day patient cannot go on either contract leave or [normal] leave. A same day patient is one who has completed their course of treatment and is separated on the same day.
- 8 A period of contract or [normal] leave starting and ending on the same date is not counted as a contract leave day or a [normal] leave day. To count a contract leave day or a [normal] leave day, the patient must be out of the hospital overnight.
- 9 A period of [normal] leave cannot exceed seven days. If a patient does not return to the hospital to continue this episode of care within seven days of starting [normal] leave, the patient is considered to have been separated on the date he/she started [normal] leave.
- 10 Count the day of going on contract leave or [normal] leave as a contract leave day or a [normal] leave day respectively. Count the day of returning from contract leave or [normal] leave as a patient day.
- 11 Notwithstanding point 10 above:
  - When, on the same date, a patient is admitted and goes on contract leave or [normal] leave, count this day as a patient day.
  - When, on the same date, a patient returns from contract leave and again goes on contract leave, count this day as a contract leave day.
  - When, on the same date, a patient returns from [normal] leave, is assessed as fit to continue on leave and again goes on [normal] leave, count this day as a [normal] leave day.
  - When, on the same date, a patient returns from [normal] leave, receives treatment, investigation and/or observation, and again goes on [normal] leave, count this day as a patient day.
  - When, on the same date, a patient returns from contract leave or [normal] leave and is separated, do not count this day as either a contract leave day or a [normal] leave day or as a patient day.
  - When, on the same date, a patient goes on contract leave and is separated from the contracted hospital, do not count this day as either a contract leave day or as a patient day.

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## Live Birth

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**Definition** A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

*(National Health Data Dictionary, 2000, p268)*

**Guide for use** Only live births are reported to PRS/2. Foetal deaths are not.

**Refer to:**

'Newborn', page 2-42.

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# Medicare Eligibility Status - Eligible Person

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## **Definition**

The patient's eligibility for Medicare as specified under the *Commonwealth Health Insurance Act 1973*. Persons eligible for Medicare include:

- A person who resides in Australia and whose stay in Australia is not subject to any limitation as to time imposed by law.
- Persons visiting Australia who are ordinarily resident in Finland, Italy, Malta, the Netherlands, New Zealand, the Republic of Ireland, Sweden or the United Kingdom as they are covered by reciprocal health care agreements (RHCA). However, persons from Malta and Italy are covered for six months only.
- A person or a class of persons declared eligible by the Commonwealth Minister of Health and Aged Care.

## **Guide for use**

This category does not include a foreign diplomat or family (except where eligibility is expressly granted to such persons by the terms of a reciprocal health care agreement).

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.

## **Categories of Eligibility**

A person eligible to receive Medicare benefits will be one of the following:

- Australian Resident
- Eligible Overseas Representative
- Person declared eligible by the Minister
- From a country with which Australia has a Reciprocal Health Care Agreement

## **Australian Resident**

A person who resides in Australia and fulfils one of the following criteria:

- Is an Australian citizen.
- Holds an entry permit not being a temporary entry permit.
- Holds a return endorsement or resident return visa.
- Has been granted refugee status.

- Is the holder of a valid temporary entry permit with an application for permanent residence, and has a spouse, parent or child who is the holder of a permanent entry permit, or has authorisation to work.

### **Eligible Overseas Representative**

A member of diplomatic or consular staff or a member of their family, of a diplomatic mission of a country with which Australia has a reciprocal health care agreement (RHCA) except New Zealand.

Eligible overseas representatives have full Medicare eligibility and are not limited to immediately necessary medical treatment. Such persons are issued with a Medicare card endorsed 'Visitor RHCA'.

### **Persons Declared Eligible by the Minister**

The Commonwealth Minister for Health and Aged Care also has a discretionary power to make persons eligible for Medicare. Such persons are eligible for, and generally will hold, a Medicare card.

### **Reciprocal Health Care Agreements (RHCA)**

Agreements negotiated by Australian authorities with other countries which enables visitors to Australia, who are ordinarily *resident* (check passport visa to verify resident country) in a country with which Australia has a RHCA, to access *immediately necessary* treatment. This agreement provides for admitted patient care, but only as a public patient, for such medical treatment as is clinically necessary for the diagnosis, alleviation or care of the condition requiring attention, on terms no less favourable than would apply to an Australian resident.

The RHCA countries at June 2000 are:

- Finland
- Italy (Note 1)
- Malta (Note 1)
- Netherlands
- New Zealand (Note 2)
- Republic of Ireland
- Sweden
- United Kingdom

Note:

- 1 Persons from Italy and Malta are limited to the first six months of their visit only except where a continuing course of treatment starts before and extends over the six month limit.

- 2 New Zealand diplomats and their families are not included in the Australian/New Zealand RHCA and are therefore not eligible persons.

For New Zealand residents, Medicare cover for private medical treatment was removed from September 1999. Medicare cards are no longer issued to New Zealand residents.

- 3 Students holding student visas from a country with which Australia has a RHCA are not eligible but should register with the Overseas Student Health Cover administered by Medibank Private.

**Refer to:**

'Medicare Eligibility Status – Ineligible Person', page 2-39.

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# Medicare Eligibility Status - Ineligible Person

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**Definition** The patient's ineligibility for Medicare as specified under the Commonwealth *Health Insurance Act 1973*.

Persons ineligible for Medicare include:

- Those who do 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.
- A foreign diplomat, or a member of their family, or a country with which Australia does not have a reciprocal health care agreement.

Guide for use **Types of Ineligible Patient:**

## **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 has determined that no fee be charged; or
- 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.

## **Refer to:**

'Medicare Eligibility Status – Eligible Person', page 2-37.

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## Metropolitan Health Service

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**Definition** Metropolitan health service is a term used in the Health Services Act 1988 to refer to a public hospital which is listed in schedule 5 of the Act. A metropolitan health service may consist of a number of campuses.

The metropolitan health services replaced health care networks on 1 July 2000. On that day each health care network was either transformed into a single new metropolitan health service, or was disaggregated and its various components were vested in new metropolitan health services.

**Guide for use** Refer to:

[www.dhs.vic.gov.au/metrohealth](http://www.dhs.vic.gov.au/metrohealth)

- 'Hospital', page 2-26.
- 'Campus', page 2-5.

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## Neonate

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**Definition** A live birth who is less than 28 days old.

(*National Health Data Dictionary*, 2000, 146)

**Guide for use** DRG software allocates neonates to MDC 15 if the patient's age at admission is less than 28 (completed) days. The formula for calculating age is Date of Admission minus Date of Birth.

So, when is a baby a neonate?

- Is baby born on the 1st of the month *a neonate* on the 29th of the month?  
 $29-1=28$  therefore Baby *is* a neonate
- Is baby born on the 1st of the month *a neonate* on the 30th of the month?  
 $30-1=29$  therefore Baby *is not* a neonate

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# Newborn

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**Definition** A newborn baby is a live birth who is nine days old or less, at the time of admission.

(*National Health Data Dictionary*, 2000, p339)

**Guide for use** The formula for calculating age is Date of Admission minus Date of Birth.

So, when is a baby a newborn?

- Is a baby born on the 1st of the month *a newborn* on the 10th of the month?

$10-1=9$  therefore Baby *is* a newborn

- Is a baby born on the 1st of the month *a newborn* on the 11th of the month?

$11-1=10$  therefore Baby *is not* a newborn

All newborn episodes of care:

- (In public hospitals) are paid by Casemix.
- Must have the same Account Class as their mother.
- Can have a different Level of Insurance from their mother.
- Cannot go on [normal] leave or contract leave.

The specific VAED fields containing 'newborn' information are:

<b>Field</b>	<b>Values</b>	<b>Applies</b>	<b>Allocated</b>
Criterion for Admission	<i>Qualified or Unqualified</i>	At admission	At admission, never revised
Admission Type	<i>Newborn</i>	At admission	At admission, never revised
Admission Source	<i>Newborn</i>	At admission	At admission, never revised
Qualification Status	<i>Qualified or Unqualified</i>	To <i>days</i> during the episode	At each change in Qualification Status during the episode
Care Type	<i>Acute or Unqualified</i>	To highest level of care during episode	At admission. However, if the newborn at admission does not meet any criterion to be Qualified but later does meet a criterion to be Qualified, the Care Type is <i>changed</i> to Acute

A newborn may be qualified, unqualified or a boarder:

- If the newborn meets one of the criteria for 'Qualified Newborn' on page 2-18: *Then the newborn is admitted as Qualified (Criterion for Admission).*
- If the newborn does *not* meet one of criteria for 'Qualified Newborn' the possibilities are:
  - This admission started with the birth, in this hospital, of the newborn or
  - The baby has not previously been admitted to another hospital (eg, born at home or on the way to this hospital).  
*Then the newborn is admitted as Unqualified (Criterion for Admission).*
  - The baby has previously been admitted to another hospital (eg, transferred, with mother, from birth hospital to another hospital to be closer to home).  
*Then the newborn is a Boarder (so do not report to the VAED).*

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## Non-Admitted Patient

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**Definition** A patient who does not undergo a hospital's formal admission process. There are three categories of non-admitted patient: emergency department patient, outpatient, and other non-admitted patient (treated by hospital employees off the hospital site —includes community/outreach services).  
(*National Health Data Dictionary*, 2000, p 258)

**Guide for use** The term non-admitted patient is synonymous with the term ambulatory, as used by hospitals.

Records for non-admitted patients should not be transmitted to the VAED.

Patients under the designated 'Hospital in the Home' program are admitted patients.

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## Nursing Home Type/Non-Acute Care

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### **Definition**

#### **Nursing Home Type**

A Nursing Home Type (NHT) patient is defined in section 3 of the *Commonwealth Health Insurance Act 1973*: after 35 days continuous hospitalisation, the patient is classified as a NHT patient unless a medical practitioner certifies under section 3B that the patient is in need of acute care.

For example:

- Professional attention for an acute phase of the patient's condition.
- Active rehabilitation.
- 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 an approved NH5 form 'Application for Nursing Home Admission' has been signed.

#### **Non-Acute Compensable and Non-Acute Ineligible**

Under current legislation, compensable and ineligible patients cannot be categorised as Nursing Home Type. However, where such a patient has been admitted in one or more hospitals (public and private) for a continuous period of more than 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, then these patients are deemed to be Non-Acute.

### **Guide for use**

Although the *Commonwealth Health Insurance Act 1973* 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, patients automatically become NHT/Non-Acute patients with the following exceptions:

- Privately insured patients 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.
- All other patients 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 as an acute care patient for a specified period.

Thus, in Victoria, a patient receiving any one of the admitted patient Care Types (not just '4' - Other Acute) will become a NHT/Non-Acute patient (Care Type '1' NHT/Non-Acute) 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 which continue to be acute 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.

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 accrual 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.

### **Supplies of Acute Care Certificates**

Contacts for obtaining supplies of Form 918 *Acute Care Certificates* from the Commonwealth Department of Health and Aged Care:

Telephone (03) 9665 8202

fax (03) 9665 8181

Orders must be *faxed* or *posted*.

Questions about the form should be referred to the Canberra office:

1800 020 103 and ask for the Health Insurance Development Group.

### **Refer to:**

Section 3 'Care Type'.

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## Organ Procurement - Posthumous

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**Definition** Organ procurement – posthumous is an activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.

*(National Health Data Dictionary, 2000, p 378)*

**Guide for use** Donor organs for transplant are procured in two circumstances:

Firstly, from a patient already admitted to the hospital who dies:

- Such a patient's time of separation is the official time of death (being brain death).
- Therefore, the count of hours in ICU reported to the VAED must cease at official separation, and the ICD-10-AM codes for the 'procuring' procedures must not be reported to the VAED

Secondly, from a person who is declared 'dead on arrival' at the hospital:

- Such a person cannot be 'admitted'.
- Therefore no episode can be reported to the VAED.

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## Overnight or Multi-day Stay Patient

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**Definition** A patient who, following a clinical decision, receives hospital treatment for a minimum of one night. That is, who is admitted to and separated from the hospital on different dates.  
(*National Health Data Dictionary*, 2000, p 259)

**Guide for use** The category of overnight or multi-day stay is determined retrospectively; that is, it is not based on the intention to admit for one night or more.

A patient is deemed to have been an overnight or multi-day stay patient if, in retrospect, it can be seen that the patient was admitted to, and separated from, the hospital on different dates. Therefore, a booked same day patient who is subsequently required to stay in hospital for one night or more is an overnight patient; a patient who dies, is transferred to another hospital or leaves of their own accord on their first day in the hospital is a same day patient, even if the intention at admission was that they remain in hospital at least overnight.

Unless the patient is on normal or contract leave, an overnight or multi-day stay patient in one hospital cannot be concurrently an overnight or multi-day stay patient in another hospital.

**Refer to:**

'Length of Stay', page 2-34.

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## Palliative Care

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**Definition** Care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and grief and bereavement support service for the patient and their carers/family.

*(National Health Data Dictionary, 2000, p 338)*

**Guide for use** The palliative Care Type is only reported to the VAED for patients admitted to designated programs.

**Refer to:**

Section 3 'Care Type'.

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## Patient

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**Definition** A patient is a person for whom a hospital accepts responsibility for treatment and/or care.

There are two categories of patient: admitted patient and non-admitted patient.

Boarders are not patients.

*(National Health Data Dictionary, 2000, p 255)*

**Guide for use** **Refer to:**

- 'Boarders', page 2-4.
- 'Admitted Patient', page 2-3.
- 'Non-admitted Patient', page 2-44.

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## Patient Day

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**Definition** 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.

**Guide for use** The term 'patient day' is synonymous with the term 'bed day' as used in hospitals.

PRS/2 does not calculate length of stay from admission and separation dates; it sums all Status Segment Total Patient Day fields transmitted by the hospital.

**Refer to:**

'Length of Stay', page 2-34.

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## Principal Diagnosis

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**Definition** The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility).

*(National Health Data Dictionary, 2000, p 139)*

**Guide for use** The principal diagnosis must be determined in accordance with the Australian Coding Standards. It is derived from and must be substantiated by clinical documentation.

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# Procedure

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**Definition**

A clinical intervention that:

- Is surgical in nature; and/or
- Carries a procedural risk; and/or
- Carries an anaesthetic risk; and/or
- Requires specialised training; and/or
- Requires special facilities or equipment only available in an acute care setting.

(*National Health Data Dictionary*, 2000, p 343)

**Guide for use**

The order of codes should be determined using the following hierarchy, in accordance with the ICD-10-AM Australian Coding Standards:

- Procedure performed for treatment of the principal diagnosis
- Procedure performed for treatment of an additional diagnosis
- Diagnostic/exploratory procedure related to the principal diagnosis
- Diagnostic/exploratory procedure related to an additional diagnosis

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# Rehabilitation Care

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**Definition** Care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by periodic assessment using a recognised functional assessment measure.

*(National Health Data Dictionary, 2000, p 337)*

**Guide for use** The DHS Rehabilitation Program excludes Nursing Home Type/Non-Acute patients and Geriatric Evaluation and Management patients.

The Department defines three levels of rehabilitation program:

**Level 1**

Care in a public hospital in a designated Level 1 Rehabilitation Program/Unit. Level 1 rehabilitation is for use by designated specialty programs providing rehabilitation following spinal cord injury, head injury or amputation and where the rehabilitation episode directly follows the acute care episode in which the injury is the principal diagnosis.

**Level 2**

Care in a public or private hospital in a designated Level 2 Rehabilitation Program/Unit. Level 2 are rehabilitation programs that fully meet the criteria for designation as set out in the document Designation of Rehabilitation Programs, November 1993.

**Level 3**

Care in a public hospital in a designated Level 3 Rehabilitation Program/Unit. Level 3 rehabilitation programs are where interim/transitional designation is provided based on agreed patient days where the minimum rehabilitation designation criteria were not met but geographical or other considerations require the continued provision of interim services pending improved service provision or the development of service capacity in other agencies.

**Refer to:**

Section 3 'Care Type'.

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## Same Day Patient

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### **Definition**

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 certification from a medical practitioner that on admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

(*National Health Data Dictionary*, 2000, p 260)

### **Guide for use**

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.

### **Refer to:**

'Length of Stay', page 2-34.

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# Separation

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**Definition** The process by which an episode of care for an admitted patient ceases.  
A separation may be formal or statistical.  
**Formal separation:** the administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.  
**Statistical separation:** the administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.

**Guide for use** Separation may be either formal or statistical.

**Formal:** Where the patient meets one of the following criteria:

- Is discharged to private accommodation or other residence.
- 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).
- Dies.
- Leaves against medical advice.
- 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:** Where a hospital records the completion of treatment and/or care and accommodation following a change of Care Type (transfer between Care Types) 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).

**Refer to:**

Section 3 'Separation Type'.