Section 2:
Concept and Derived Item Definitions

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Introduction

This section lists concept definitions relating to data items collected by PRS/2, and in some cases provides a guide for their use. There is also a reference to VAED data items derived from data items collected by PRS/2.

Detailed specifications for reporting data to PRS/2 are provided in Sections 3, 4 and 5 of this Manual.

The definitions contained in this section are based, wherever possible, on the *National Health Data Dictionary* (version 12.0, including the version 12 Supplement 2004).

Concept Definitions

Acute Care

Definition

Acute Care is (admitted patient) care in which the clinical intent or treatment goal is to:

- Manage labour (obstetric);
- Cure illness or provide definitive treatment of injury;
- Perform surgery;
- Relieve symptoms of illness or injury (excluding palliative care);
- Reduce severity of an illness or injury;
- Protect against exacerbation and/or complication of an illness and/or injury; which could threaten life or normal function; and/or
- Perform diagnostic or therapeutic procedures.

Guide for use

Acute Care is always provided in Care Types 4 *Other care (Acute) including Qualified newborn*. Acute Care may be provided in Care Types 0 *Alcohol and Drug Program,* 5x *Approved Mental Health Service or Psychogeriatric Program* and U *Unqualified Newborn*.

Refer to:

- Section 2: *Admitted Patient*, page 2-3, *Episode of Admitted Patient Care*, page 2-16, *Nursing Home Type/Non-Acute* page 2-34, and *Sub-Acute Care*, page 2-43.
- Section 3: *Care Type* and *Qualification Status*.

Admission

Definition

An admission is a 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 [or multi-day] 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/or 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.

Guide for use

Refer to:

- Section 2: *Admitted Patient* page 2-3, *Criteria for Admission* page 2-11, *Episode of admitted patient care* page 2-16, *Hospital Stay* page 2-21, *Overnight or Multi-day Stay Patient* page 2-36, and *Same Day Patient* page 2-41.

Admitted Patient

Definition

A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in traditional hospital setting and/or in the person's home (under specified programs such as Hospital In The Home).

The patient may be admitted if one or more of the following apply:

- The patient's condition requires clinical management and/or facilities not available in their usual residential environment.
- The patient requires observation in order to be assessed or diagnosed.
- The patient requires at least daily assessment of their medication needs.
- The patient requires a procedure/s that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (for example cardiac catheterisation).
- There is a legal requirement for admission (for example under child protection legislation).
- The patient is aged nine days or less.

The items in the above list, in isolation, may not be sufficient to meet the Criteria for Admission.

Guide for use

The term admitted patient encompasses the term inpatient, as traditionally used in hospitals, but may also encompass other encounters with a hospital that may not traditionally have been termed inpatient encounters.

To be admitted, a patient must meet at least one of the minimum Criteria for Admission (see *Criteria for Admission,* page 2-11).

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:

- Section 2: *Admission* page 2-2, , *Criteria for Admission* page 2-11, *Episode of Admitted Patient Care* page 2-16, *Hospital Stay* 2-21, *Newborn* page 2-32, *Non-Admitted Patient* page 2-33, *Patient* page 2-37.

Age

Definition The patient's age at the time of admission.

Guide for use Age is calculated as:

- Admission Date minus Date of Birth.

Age is:

- Used in analysis of utilisation and in epidemiological studies.
- Used in various definitions, including newborn and neonate.
- One of the variables used in the DRG Classification.

Refer to:

- Section 3: *Admission Date* and *Date of Birth*.
- Section 4: Business Rules (tabular) *Admission Type and Age,* and *Age and Qualification Status.*

Asylum Seeker

Definition

An asylum seeker is deemed to be any person who has a current request for protection that is being assessed by the Commonwealth Government or who, being deemed by the Commonwealth not to be a person owed protection is seeking either a judicial review (through courts) or is making a humanitarian claim (to Commonwealth Minister) for residence.

Asylum seekers can be permitted to reside within the Australian community on one of several different visa types. Different visas carry different entitlements including work rights and Medicare eligibility. The visa type held by an asylum seeker can change throughout the process of seeking asylum.

Asylum seekers who are Medicare ineligible are those who:

- Have applied for asylum after being in Australia for 45 days (45 day rule);
- Have been released from mandatory detention on a bridging visa whilst determination of refugee status is assessed
  [*NOTE: People released from detention who hold a Temporary Protection Visa (TPV) have been assessed as being owed protection and hold full Medicare eligibility*];
- Have been found not to be owed protection by the Refugee Review Tribunal and are seeking either a judicial or Ministerial review; or
- Are on a bridging visa that carries no work rights and who are not being provided support by the Red Cross under the Commonwealth funded Asylum Seeker Assistance Scheme (ASAS) – General health scheme.

DHS Hospital Circular 27/2005 *Revised arrangements for Public Hospital Services to Asylum Seekers* advised public hospitals to cease raising charges against asylum seekers for necessary medical care where it is assessed that they have limited capacity to pay.

Guide for use

Identification of Medicare ineligible asylum seekers:

1. Determine Medicare ineligible status of any sort

- NO WORK clearly stated on visa in passport or on evidence card (Visa Condition 8101)
- Will **not** hold a Medicare card.

2. Determine asylum seeker status

- Evidence by supporting documentation from asylum seeker support group, or
- Evidence by receipt/letter from DIMIA, or
- Evidence by Visa class (bridging Visa E)
  Note: It will not always be possible to identify an asylum seeker from official government documentation, some discretion and judgement by hospital staff will be required.

3. Determine eligibility for ASAS or need for referral to specialist agency.

- Asylum seekers will generally be aware if they are eligible for ASAS [*Asylum Seeker Assistance Scheme (ASAS), can support asylum seekers during primary and review stages only. Recipients must:*
  - have lodged a valid protection visa application for more than 6 months,
  - hold a bridging visa,
  - demonstrate financial hardship, inability to work,
  - not have been released from detention on an undertaking of support and meet additional criteria.
  Further details are available from the Red Cross
  http://www.redcross.org.au/vic/services_asylumseeker.htm]
- If the patient identifies as receiving ASAS their status should be confirmed by contacting the Red Cross 'Point of Contact' for ASAS Tel: 8327 7883
- The Red Cross will advise if they should be billed on the patient's behalf.
- Assessment staff are encouraged to make appropriate referral of Medicare ineligible asylum seekers to an asylum seeker support agency. These include: Red Cross ASAS Tel: 8327 7883, Asylum Seeker Resource Centre Tel: 9326 6033 and Hotham Mission Asylum Seeker Project Tel: 9326 8343.

Refer to:

- Hospital Circular 27/2005: http://www.health.vic.gov.au/hospitalcirculars/circ05/circ2705.htm
- Section 2: *Medicare Eligibility Status – Eligible Person* page 2-*27*, and *Medicare Eligibility Status – Ineligible Person* page 2-30.
- Section 3: *Account Class*.

Boarder

Definition

A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

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 system must be able to identify boarders and exclude them from transmission to the VAED.

Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either a qualified or unqualified day.

An unqualified newborn remaining in hospital and not receiving clinical care when they turn ten days old becomes a boarder and should be separated.

Refer to:

- Section 2: *Criteria for Admission* page 2-11, *Newborn* page 2-32, and *Patient* page 2-37.
- Section 4*: Boarder*

Campus

Definition

A physically distinct site owned or occupied by a public 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.

Unless designated otherwise by DHS, 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.
- Have the same management at the public 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 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. Patient activity must be reported under the campus code at which it occurred. 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:

- Section 2: *Hospital* page 2-18, and *Transfer* page 2-44.
- Section 3: *Campus Code*.

Cardiac/Coronary Care Unit

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).

Care Type

Definition

An episode is not defined by the patient's arrival at, and departure from the hospital but rather by the start and completion of a 'type of care'. There are a number of types of care that a hospital can provide for admitted patients. A multi-day stay patient may receive more than one type of care during the period of hospitalisation: the period of hospitalisation is then broken into Episodes of Care, one for each type of care (Care Type). The Episode of Care ends when the Care Type changes or the patient separates from hospital.

Admitted patient episodes must be assigned a Care Type from the hierarchy within that data item.

Only one Care Type can apply per day of a hospital stay. If a change occurs twice in one day, only the Care Type applicable as of midnight should be reported.

Refer to:

- Section 2: *Episode of Admitted Patient Care* page 2-16, and *Hospital Stay* page 2-21.
- Section 3: *Care Type*.
- Section 4: Business Rules (non-tabular) *Reporting History of Code Changes* and *Episode of Care.*

Contracted Care

Definition

Contracted hospital care is provided to a patient under an agreement between a purchaser of hospital care (contracting hospital or external purchaser) and a provider of an admitted or non-admitted service (contracted hospital/facility).

A contract 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/facility, which can be a public or private hospital or day procedure centre, residential aged care facility or supported accommodation.
- The contractor making full payment to the contracted hospital for the contracted service.
  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 for the provision of the contracted service. 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.

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/facility.
- 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.
- Under the Australian Health Care Agreement, details of contracted public patients attending private hospitals are required to be reported to the Department of Health and Ageing.

Refer to:

- Section 2: *Hub and Spoke* page 2-21, *Leave - Contract* page 2-25.
- Section 3: *Contract Leave Days Financial Year-To-Date, Contract Leave Days Month-To-Date, Contract Leave Days Total, Contract Role*, *Contract/Spoke Identifier*, *Contract Type*, *Funding Arrangement* and *Procedure Codes.*
- Section 4: Business Rules (non-tabular) *Contracted Care*.

Criteria for Admission

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 Service as specified in Bands 1A, 1B, 2, 3 and 4 of the *Day Only Procedures Manual* and updates[1].

  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) The newborn is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient; or
  (ii) The newborn is, on that day, admitted to a facility approved by the Commonwealth Minister for the purpose of provision of intensive or special care (NICU/SCN); or
  (iii) The newborn is, on that day, 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 in points (i) to (iii).

  or

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

  or

- The patient has received continuous active management for at least four hours (at least half hourly observations of vital or neurological signs), and the appropriateness of the decision to admit the patient is determined and documented by a medical practitioner.

  or

- The patient is to receive a Type C Professional Attention Procedure as specified in the *Day Only Procedures Manual*[1] and updates. Accompanying documentation must be provided by the treating medical practitioner that justifies an admission on the grounds of the medical condition of the patient or other special circumstances that relate to the patient. Patients undergoing these procedures would not normally be admitted.

[1] *Day Only Procedures Manual 1999* is available at:
http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-privatehealth-providers-dayonly-dayonly_1999.htm
An updated list of Type B and C procedures (19 April 2006) is available in Schedule 3 of the following document:
http://www.comlaw.gov.au/ComLaw/Legislation/LegislativeInstrument1.nsf/all/search/BFAB0DB9B5F18813CA25714F00181B92

The Private Health Insurance Branch of the Department of Health and Ageing notifies amendments to the Basic Default Table of Health Insurance via circular. Circulars are available at http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-privatehealth-providers-circulars.htm

Guide for use

The Criteria for Admission reflect the **intended** level of treatment that the patient is to receive. 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.

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 from 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).
- A patient is admitted with a ruptured abdominal aortic aneurysm at 9:00am, and dies at 11:30am on the same day. The Criterion for Admission is O (expected to require hospitalisation for a minimum of one night), because at the time of admission the expectation is that the patient would receive care for more than one day. The fact that the patient died before this could occur does not alter the reported Criterion for Admission.
- A patient is admitted as a planned same day patient for a colonoscopy. However, during the colonoscopy the patient sustains a perforation to the bowel, which results in a laparoscopic repair of the bowel and a length of stay of 3 days. The Criterion for Admission is B (Day Only Bands 1A, 1B, 2, 3, and 4) as this was the intent at admission.
- A patient is admitted to a rural hospital at 4pm with 45% burns. After stabilisation, the patient is airlifted to a tertiary burns unit in Melbourne at 7pm on the same day. The Criterion for Admission is O (expected to require hospitalisation for a minimum of one night), as the patient is expected to require many days of treatment. The fact that this is to occur in more than one facility is immaterial.

Cancelled Treatment

There will be occasions where a patient who is admitted, subsequently has their planned treatment cancelled:

- If the episode of care could be justified as extended medical treatment and supporting documentation is provided, it can be reported to the VAED. Even though this assessment needs to be made, the original Criterion for Admission should not be changed.
- If the episode of care could not be justified as extended medical treatment, the admission should be cancelled.

For example:

- Patient admitted on day of surgery, which was cancelled due to lack of available beds. Patient sent home without treatment. Admission should be cancelled.
- Patient admitted on day of surgery, which was cancelled as patient had a slight upper respiratory viral infection. Patient sent home without further investigation, to return to have the procedure when the virus is resolved. Admission should be cancelled.
- Patient admitted on day of surgery, which was cancelled as patient had a fever and cough. Patient underwent an x-ray, blood tests and was observed for five hours. Diagnosis of mild pneumonia, patient sent home, to return to have the procedure when pneumonia resolved. This episode should be reported to the VAED.

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 may 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 of a level that meets the Criteria for Admission 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 occur in an admitted patient setting and be reported to the VAED accordingly. For example, patients should always be admitted for each episode involving renal dialysis, or for any procedure that requires intravenous sedation and/or anaesthetic, such as ECT and cardiac catheterisation.

Procedures that *are* listed in the Day Only Procedures Manual as a Type B procedure (and therefore meet the Criterion for Admission B), that may occur in an outpatient setting include, but are not limited to:

- Drainage: haematoma, abscess, carbuncle
- Excision of sinus
- Lumbar puncture
- Removal of foreign bodies with surgical exploration
- Repair of wound: skin and subcutaneous tissue or mucous membrane greater than 7cms
- Tendon repair

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.

Extended Medical Treatment

Extended Medical Treatment – Emergency, and Non-Emergency

It is expected that patients who meet the following criteria will be admitted:

- The appropriateness to admit the patient is determined and documented by a medical practitioner;

and

- The patient receives continuous active management for at least four hours (at least half hourly observations of vital or neurological signs).

The following examples of patient treatments provide guidance to the application of these criteria.

The patient would be considered to have received continuous active management for at least four hours in the following situations:

- Acute asthma: to ensure stabilisation prior to discharge, the patient receives Ventolin and requires continuous observation for at least four hours.
- Acute head injury requiring at least four hours of neurological observations on a continuous basis.
- An infant with gastroenteritis who is treated with oral re-hydration and receives at least four hours of continuous observation to manage their condition.

*The patient would **not** be considered to have received continuous active management for at least four hours in the following situations:*

- A patient with a migraine who is given analgesia and left to rest quietly for four hours.
- Passive waiting for test results or waiting for review by medical staff.

Type C Professional Attention Procedures

Type C Exclusion List

The exclusion list of procedures (the 'Type C Exclusion List') identifies services that would normally be undertaken on a non-admitted basis (including Outpatient and Emergency Department attendances) 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.

Type C Certification
Whilst the Type C Exclusion List identifies services that would not normally be accepted as same day admissions, there may 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 as follows:

For privately insured patients:
- The attending medical practitioner should complete the relevant section of the 'Private Patient Hospital Claim Form'.

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 reporting of Type C services as admitted episodes is warranted.

Common examples of episodes that would only be admitted where the treating medical practitioner assesses this as justified, and completes documentation of the medical condition, treatment and extenuating circumstances are:
- Patients attending a lactation or lymphoedema clinic,
- Patients undergoing (only):
- Aspiration or catheterisation of bladder
- Burns dressings
- Diagnostic tests: angiography, MRIs and CT scans (with or without contrast)
- Loading of ambulatory drug device or implanted pump or reservoir
- Regional or field nerve blocks

Refer to:
- Section 2: *Admitted Patient* page 2-3, page 2-5, *Newborn* page 2-32, and *Same Day Patient* page 2-41.
- Section 3: *Criterion for Admission*.

DRG Classification

Definition

The Diagnosis Related Group (DRG) classification system 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.

A single Diagnosis Related Group (DRG) can be derived for an episode of care, based on documentation in the patient's medical record. A DRG is assigned by computer software (Grouper) using codes for:

- The principal diagnosis,
- Procedures undertaken,
- The presence or absence of other diagnosis codes for co-morbidities and complications, and
- Other variables such as age, sex and discharge status, mental health legal status and, for neonates, admission weight.

Episodes can be grouped into multiple versions of the Grouper. The Department of Human Services is using Australian Refined Diagnosis Related Groups (AR-DRGs), v5.1, for funding in 2006-07.

The details of grouping logic and methodology are contained in the Commonwealth manual *Australian Refined Diagnosis Related Groups, Version 5.1* (vols 1, 2, 3)

For funding purposes, some adjustments are made to the original AR-DRG (version 5.1) and the result is stored in the VIC-DRG5 field. For details, see Victoria – Public Hospitals and Mental Health Policy and Funding Guidelines 2006-2007, available at: http://www.health.vic.gov.au/pfg/index.htm

Episode of Admitted Patient Care

Definition

The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type. Patient activity must be reported under the Campus Code at which it occurred.

Refer to:

- Section 2: *Admission* page 2-2, *Admitted Patient* page 2-3, *Care Type* page 2-8, *Newborn* page 2-32, and *Separation* page 2-42.
- Section 3: *Care Type*.
- Section 4: Business Rules (non-tabular) *Episode of Care*

Geriatric Evaluation and Management Program (GEM)

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 2: *Episode of Admitted Patient Care* page 2-16 and *Sub-Acute Care* page 2-43.
- Section 3: *Care Type*.
- Section 5: *Sub-Acute Record*.
- Section 9: Supplementary Code Lists: Care Type *Care Type 9: Approved Geriatric Evaluation and Management (GEM) Programs:* http://www.health.vic.gov.au/hdss/reffiles/index.htm

Geriatric Respite

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.

Refer to:

- Section 3: *Account Class*.
- Section 4: Business Rules (non-tabular) *Geriatric Respite*.

High Dependency (HDU) Bed

Definition

A High Dependency (HDU) bed must be located within a separate and self-contained critical care unit that is configured and equipped to ICU and/or HDU standards. This unit must be capable of providing basic multi-system life-support for a period of usually less than 24-hours. An HDU bed is staffed for not less than 1:2 nursing care and is fully configured to cater for an HDU patient.

High Dependency Care is delivered in one or more of the following circumstances:

- Single organ system monitoring and support but excluding advanced respiratory system support;
- General observation and monitoring: More detailed observation and the use of monitoring equipment that cannot safely be provided on a general ward, which may include extended post-operative monitoring for high risk patients; and/or
- Step-down care: Patients who no longer require intensive care but who are not well enough to be returned to a general ward.

Guide for use

Hospitals with a designated ICU may have HDU beds located within those units.

Refer to:

- Section 3: *Account Class*.

Hospital

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.

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, public health services, and privately operated (public) hospitals as defined in the Health Services Act 1988, as amended.
- 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:

- Section 2: *Campus* page 2-8 and *Transfer* page 2-44.
- Section 3: *Campus Code*.
- Section 9: Code Lists: *Hospital Code Table:* http://www.health.vic.gov.au/hdss/reffiles/index.htm.

Hospital in the Home

Definition

Provision of care to hospital admitted patients in their place of residence as a substitute for traditional hospital accommodation. Place of residence may be permanent or temporary.

Guide for use

Place of residence includes residential facilities such as nursing homes, hostels or other forms of supported accommodation. Medi-hotels are excluded, no services are provided while the patient resides there.

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.

A public hospital must be designated in its Health Service Agreement and/or Statement of Priorities to provide HITH services.

Currently, HITH is limited to public, private, DVA, TAC and WorkCover patients. However, a hospital must apply for eligibility to treat private patients under HITH. Details regarding this are outlined in the following circulars:

- HBF 740 PH 474 Guidelines for Approved Outreach Services under the Health Legislation Amendment Act (No 1) 2001.
- HBF 747 PH 481 Amendment to Guidelines for the Establishment and Implementation of the Private Sector Outreach Services and other general information.

These circulars include the following:

- Facilities seeking to provide outreach (hospital in the home) services to private patients will be required to gain Federal Ministerial approval. Only those services that have been approved will be covered by hospital table health insurance and reinsurance arrangements (where eligible).
- Public hospital, private hospital and day facilities wishing to offer an approved outreach service are invited to make an application to the Private Health Industry Branch, Commonwealth Department of Health and Aged Care.

For the Hospital in the Home program, movement between ward accommodation and 'Hospital in the Home' accommodation is reported in the Status Segments within the same episode.

Patients receiving care under this program must meet one of the minimum criteria for admission, as HITH represents a substitute for acute admitted patient care provided in a traditional hospital setting.

Where a Hospital in the Home patient does not receive any admitted type services on a particular date, this day should be recorded as a leave with permission day.

Refer to:

- Section 3: *Accommodation Type*.

Hospital Stay

Definition

The period of time between a formal admission and a formal separation.

Guide for use

A hospital stay usually comprises one episode of care.

A hospital stay may comprise more than one episode of care where:

- The episodes occur at one hospital campus; and
- Where the first episode has a statistical Separation Mode, and the subsequent episode(s) has a statistical Admission Source.

In practice, hospital stay refers to the time elapsing between a patient entering the hospital campus and leaving the hospital campus, excluding leave (normal and contract) periods.

Refer to:

- Section 2: *Admission* page 2-2, *Admitted Patient* page 2-3, *Care Type* page 2-8, *Episode of admitted patient care* page 2-16, and *Separation* page 2-42.
- Section 3: *Admission Source* and *Separation Mode*.

Hub and Spoke

Definition

A model of service delivery where highly specialised services are maintained at one or two locations (hubs), while high volume or lower complexity same day services will be provided by staff from the hub in distant locations, called spokes. The hub supplies the staff and pays the spoke only for the hire of facilities.

This arrangement allows maintenance of centres of excellence in hub locations, while improving access to high quality specialist services throughout the metropolitan area in spoke locations.

Services particularly suited to hub and spoke arrangements include specialist paediatric, obstetric, radiotherapy, ophthalmology and ECT services.

Hub and Spoke service delivery is reported under a specific funding arrangement and **not** as contracted care.

Refer to:

- Section 3: *Contract/Spoke Identifier* and *Funding Arrangement*.
- Section 4: Business Rules (non-tabular) *Hub and Spoke*.

Intensive Care Unit

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.

Guide for use

There are five different types and levels of ICU, 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.

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

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.

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.

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.

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.

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.

Refer to:
- Section 3: *Duration of Stay in ICU* and *Account Class.*

Interim Care Program

Definition

The Interim Care Program provides an appropriate mix of nursing, personal care and allied health care to maintain function to the extent possible and adequate levels of social work for patients who:

- have completed their acute or sub-acute episode of care;
- have been recently assessed by an Aged Care Assessment Service (ACAS) and recommended for high or low level aged residential care; and
- are suitable for immediate placement in a residential care facility if a place were available.

The focus of activity is on maintaining patient function while families/carers are assisted in securing appropriate longer term accommodation for each person. Interim Care can be externally contracted.

Guide for use

Only hospitals that have an Interim Care Program approved by the Metropolitan Health and Aged Care Division can report patients as having Interim Care.

While the details of the service model may vary between the sites, all people participating in an Interim Care project should have access to an appropriate mix of nursing and allied health care to maintain function to the extent possible. Projects are expected to include access to additional social work services to assist people to move to more appropriate long-term care. Interim Care provides additional time and assistance for families/carers to make arrangements for each person that suit their care needs. In some instances the patient may improve sufficiently or demonstrate the capacity to continue managing in the community or a low care facility.

The health service approved to provide the brokered Interim Care service is responsible for billing the patient for any contribution while a NHT patient (if the hospital decides to collect such contributions).

Refer to:

- Section 2: *Episode of Admitted Patient Care* page 2-16, and *Sub-Acute Care* page 2-43.
- Section 3: *Care Type*.
- Section 4: Business Rules (non-tabular) *Interim Care Program and Contracting Arrangements*.
- Section 5: *Sub-Acute Record*.
- Section 9: Supplementary Code Lists: *Care Type F and E: Approved Interim Care Programs:* http://www.health.vic.gov.au/hdss/reffiles/index.htm

Leave - Contract

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.

Refer to:

- Section 2: *Contracted Care* page 2-10, *Length of Stay* page 2-26, and *Patient Day* page 2-37.
- Section 3: *Contract Leave Days Financial Year-To-Date*, *Contract Leave Days Month-To-Date*, and *Contract Leave Days Total*.
- Section 4: Business Rules (non-tabular) *Contracted Care*, *Leave*.

Leave With Permission

Definition

Leave with permission 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.

Newborns are not permitted to go on Leave With Permission.

Leave with permission excludes Contract Leave.

Refer to:

- Section 2: *Nursing Home Type/Non-Acute Care* page 2-34, and *Separation* page 2-42.
- Section 3: *Leave With Permission Days Financial Year-To-Date*, *Leave With Permission Days Month-To-Date*, *Leave With Permission Days Total* and *Separation Date*.
- Section 4: *Leave* and *Length of Stay*.

Leave Without Permission

Definition

Where a patient absconds or leaves against medical advice.

As it is still the intention of the medical practitioner that the patient return within seven days to continue the current treatment, follow Leave With Permission guidelines and reporting.

Refer to:

- Section 2: *Leave With Permission* page 2-25 and *Separation* page 2-42.
- Section 3: *Leave Without Permission Days* and *Separation Date*.
- Section 4: Business Rules (non-tabular) *Leave* and *Length of Stay*.

Length of Stay

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 Admission Date from the Separation Date and deducting total leave with and without permission days.

Refer to:

- Section 2: *Leave - Contract* page 2-25, *Leave With Permission* page 2-25, and *Leave Without Permission* page 2-26.
- Section 3: *Admission Date*, *Patient Days Financial Year-To-Date*, *Patient Days Month-To-Date*, *Patient Days Total*, and *Separation Date*.
- Section 4: Business Rules (non-tabular) *Leave* and *Length of Stay*.

Live Birth

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.

Guide for use

Only live births are reported to PRS/2. Foetal deaths are not reported to PRS/2.

Refer to:

- Section 2: *Newborn* page 2-32, and *Qualification (Newborn)*, page 2-39.
- Section 4: Business Rules (non-tabular) *Newborn Reporting*.

Medicare Eligibility Status - Eligible Person

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, Ireland, Italy, Malta, the Netherlands, New Zealand, Norway, 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.

It should be noted that in some cases where the patient is an 'eligible person' they personally, or a third party, could be liable for the payment of charges for hospital services received, for example:

- Prisoners;
- Patients with Defence Force personnel entitlements;
- Compensable patients;
- Department of Veterans' Affairs beneficiaries;
- Nursing Home Type patients.

Newborn babies take the eligibility status of the mother.

Categories of Eligibility

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

- an Australian Resident;
- an Eligible Overseas Representative;
- a 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.

Patients in this category will hold a *green* Medicare Card or (if legally eligible and entitled to all health services with no restrictions) an Interim *blue* Medicare Card (also entitled to all health services with no restrictions).

Australians lose entitlement to Medicare if they have been living out of the country for five or more years (as do others with permanent visas for Australia). To become re-entitled to Medicare, they need to prove that they have returned to Australia to live (for example lease papers, employment statements).

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 *green* 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* in a country with which Australia has a RHCA, to access *immediately necessary* treatment of ill health *arising during the stay and which requires attention before the patient returns home*: *pre-arranged and elective treatment is not covered*. 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.

A RHCA patient may hold *yellow-green* RHCA Medicare Card (a lighter version of the green card). Not all persons entitled to care under a RHCA will hold a RHCA card.

The RHCA countries at June 2006 are:

- Finland;
- Ireland;
- Italy (Note 1);
- Malta (Note 1);
- Netherlands;
- New Zealand (Note 2);
- Norway;
- Sweden;
- United Kingdom (Note 3).

Note:

1. Persons from Italy and Malta are limited to the first six months of their visit only commencing on the date of arrival, 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. United Kingdom incorporates residents of England, Scotland, Wales, Northern Ireland, Isle of Man and the Channel Islands.

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.

Hospitals who are having difficulty in determining the eligibility for overseas residents should ring Medicare on 132011 (Medicare hotline) for advice between 8.30 am – 5.00 pm, Monday to Friday while the patient is still in hospital.

Backdating Medicare Eligibility

In the past there have been queries regarding the backdating of Medicare eligibility. Medicare Australia have provided the following answers to commonly asked questions.

Question: Does the backdating of Medicare eligibility occur?
Answer: Yes, infrequently.

Question: What evidence should the patient present to the hospital to show that they have been given backdated eligibility?
Answer: A letter from Medicare Australia, on Medicare Australia letterhead.

Question: Is the hospital obliged to return the money paid by the patient?
Answer: Yes. Hospitals should refund the money, and change the Account Class for the episode.

Question: Should the hospital check this information with Medicare Australia prior to a refund?
Answer: No. Medicare Australia would not release this information due to Privacy legislation.

Refer to:

- Section 2: *Asylum Seeker* page 2-5, *Medicare Eligibility Status – Ineligible Person* page 2-30.
- Section 3: *Account Class, Medicare Number*, and *Medicare Suffix*.
- http://www.medicareaustralia.gov.au/yourhealth/going_overseas/vtta.htm

Medicare Eligibility Status - Ineligible Person

Definition

The patient's eligibility 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, from a country with which Australia does not have a Reciprocal Health Care Agreement.
- Some Asylum seekers

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.
- Medicare Ineligible Asylum Seekers.

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. Non-exempt ineligible patients otherwise meeting Nursing Home Type patient criteria are deemed to be Non-Acute ineligible patients.

Refer to:

- Section 2: *Asylum Seeker* page 2-5, *Medicare Eligibility Status – Eligible Person* page 2-27.
- Section 3: *Account Class*, *Medicare Number* and *Medicare Suffix*.
- http://www.medicareaustralia.gov.au/yourhealth/going_overseas/vtta.htm

Medi-Hotel

Definition

Provision of a non-ward residential service maintained and/or paid for by the hospital for the purpose of accommodating patients, as a substitute for traditional hospital ward accommodation.

Guide for use

Non-ward accommodation provided by the hospital, excluding the Hospital In The Home (HITH) program. Unlike Hospital In The Home, no clinical services are provided. Thus a significant decline in medical condition would always necessitate return from Medi-Hotel to the hospital's Emergency Department or other ward.

The Medi-Hotel facility may or may not be on hospital property. Where it is on hospital property, this may be co-located in the same building as traditional wards.

Patients may reside in a Medi-Hotel overnight, but during the day receive care/services/treatment that resembles traditional admitted care (same day or multi-day).

Patients may be admitted to a Medi-Hotel when receiving outpatient care but this activity should not be reported to the VAED.

A public hospital must be registered in its Health Service Agreement and/or Statement of Priorities to provide a Medi-Hotel service. The use of a Medi-Hotel is voluntary for the patient.

Refer to:

- Section 2: *Criteria for Admission* page 2-11.
- Section 3: *Accommodation Type*.
- Section 4: Business Rules (non-tabular) *Medi-Hotel Reporting*.

Neonate

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

Guide for use DRG software allocates neonates to MDC 15 if the patient's age at admission is less than 28 (completed) days, or if the age is less than one year and the Admission Weight is less than 2500gms.

The formula for calculating age is Admission Date 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

Refer to:

- Section 2: *Age* page 2-4, *Live Birth* page 2-26, *Qualification (Newborn)*, page 2-39 and *Newborn* page 2-32.
- Section 3: *Admission Date*, *Admission Weight*, and *Date Of Birth*.
- Section 4: Business Rules (non-tabular) *Newborn Reporting*.

Newborn

Definition A live-born baby (live birth) who is nine days old or less, at the time of admission.

Guide for use The formula for calculating age is Admission Date 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

Refer to:

- Section 2: *Admitted Patient* page 2-3, *Age* page 2-4, page 2-5, *Criteria for Admission* page 2-11, *Episode of Admitted Patient Care* page 2-16, *Live Birth* page 2-26, *Neonate* page 2-32, *Qualification (Newborn)*, page 2-39 and *Sub-Acute Care* page 2-43.
- Section 3: *Account Class*, *Account Class on Separation*, *Admission Source*, *Admission Type*, *Care Type*, *Criteria for Admission*, and *Qualification Status*.
- Section 4: Business Rules (non-tabular) *Newborn Reporting*.

Non-Admitted Patient

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).

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.

Refer to:

- Section 2: *Admitted Patient* page 2-3, and *Patient* page 2-37.

Nursing Home Type/Non-Acute Care

Definition

Nursing Home Type
A Nursing Home Type (NHT) patient is defined in Section 3 of the Health Insurance Act 1973 (Commonwealth): after 35 days of 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 (or Rehabilitation, Palliative Care or Geriatric Evaluation and Management).

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 of continuous hospitalisation (with a maximum break of seven consecutive days) even if an approved 2624 certificate (formerly 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 the patient is deemed to be Non-Acute.

Guide for use

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.

Following 35 days of continuous hospitalisation, a patient automatically becomes NHT/Non-Acute 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 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 care (Acute) including Qualified newborn*) will become a NHT/Non-Acute patient (Care Type F *Interim Care Program – Nursing Home Type*, 1 *NHT/Non-Acute* or 5T *Mental Health Nursing Home Type*) if they receive 35 days of continuous hospitalisation and do not have certification allowing the present type of care to continue.

The decision for a patient to continue to receive acute care following 35 days of continuous hospitalisation is a clinical one, which needs to be clearly documented then communicated to the relevant staff who report data on admitted episodes of care. This enables the identification of episodes that continue 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 16th day of the second admission, the patient becomes a Nursing Home Type patient (if an Acute Care Certificate or equivalent has not been signed). If, in this example, the patient was on normal leave for two days during the accrual period, the change to Nursing Home Type would not occur until the 18th day of the second admission (two days later).

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

Supplies of Acute Care Certificates

Obtain supplies of Form 918 *Acute Care Certificates* from the Commonwealth Department of Health and Aged Care by:

- Obtaining a copy of the order form, by calling: (03) 9665 8356
- Fax the order form to: (03) 9665 8352 (Orders not taken over the telephone)

Refer questions about the form to:

- 1800 020 103 and ask for the Health Insurance Development Group.
- Health Industry Branch, Private Health Services Reform Section, email: HIS@health.gov.au

Refer to:

- Section 2: *Acute Care* page 2-2, and *Episode of Admitted Patient Care* page 2-16.
- Section 3: *Care Type*.

Organ Procurement - Posthumous

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.

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.
- Therefore, the count of hours in ICU and/or CCU, and the Duration of Mechanical Ventilation and Non-invasive Ventilation, reported to the VAED must cease at official separation, and the ICD-10-AM/ACHI Diagnosis and Procedure 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.

Refer to:

- Section 2: *Time of Death* page 2-43.
- Section 3: *Duration of Mechanical Ventilation in ICU*, *Duration of Non-invasive Ventilation (NIV)*, *Duration of Stay in Cardiac/Coronary Care Unit*, *Duration of Stay in Intensive Care Unit*, and *Separation Time.*

Overnight or Multi-day Stay Patient

Definition A patient who is admitted to and separated from the hospital on different dates.

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.

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 leave with or without permission 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:

- Section 2: *Admitted Patient* page 2-3, *Leave - Contract* page 2-25, *Leave With Permission* page 2-25, *Leave Without Permission* page 2-26, *Length of Stay* page 2-26, *Separation* page 2-42.
- Section 3: *Admission Date* and *Separation Date*.
- Section 4: *Leave*.

Palliative Care

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.

Refer to:

- Section 2: *Episode of Admitted Patient Care* page 2-16, and *Sub-Acute Care* page 2-43.
- Section 3: *Care Type*.
- Section 4: Business Rules (non-tabular) *Palliative Care Reporting*.
- Section 5: *Sub-Acute Record*.
- Section 9: Supplementary Code Lists *Care Type 8*: http://www.health.vic.gov.au/hdss/reffiles/index.htm

Patient

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.

Refer to:

- Section 2: *Admitted Patient* page 2-3, *Boarder* page 2-5, and *Non-admitted Patient* page 2-33.

Patient Day

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.

The term 'patient day' is synonymous with the term 'bed day' as used in hospitals.

Refer to:

- Section 2: *Length of Stay* page 2-26.
- Section 3: *Admission Date*, *Patient Days Financial Year-To-Date*, *Patient Days Month-To-Date*, *Patient Days Total*, and *Separation Date*.
- Section 4: Business Rules (non-tabular) *Contracted Care* and *Length Of Stay*.
- Section 5: *Status Segments*.

Principal Diagnosis

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).

Guide for use

The principal diagnosis must be determined in accordance with the ICD-10-AM Fifth Edition Australian Coding Standards. It is derived from and must be substantiated by clinical documentation.

Refer to:

- Section 2: *DRG Classification* page 2-16.
- Section 3: *Diagnosis Codes*.

Procedure

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.

Guide for use

The order of codes should be determined using the following hierarchy, in accordance with the ICD-10-AM Fifth Edition 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

Refer to:

- Section 2: *DRG Classification* page 2-16.
- Section 3: *Procedure Codes.*

Qualification (Newborn)

Definition

All newborn days are divided into categories of qualified and unqualified for the Australian Health Care Agreement and health insurance benefit purposes.

Guide for use

A newborn day is qualified if the newborn meets at least one of the criteria for admission.

A newborn day is unqualified if the newborn does not meet any of the criteria for admission.

Unqualified babies must be changed to boarders after they turn 9 days of age.

Refer to:

- Section 2: *Admitted Patient* page 2-3, *Criteria for Admission*, *Neonate* page 2-32, and *Newborn* page 2-32.
- Section 3: *Qualification Status*.
- Section 4: Business Rules (non-tabular) *Newborn Reporting.*

Rehabilitation Care

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

The Department defines three levels of designated rehabilitation programs. In addition to the three levels, rehabilitation may be provided in a non-designated rehabilitation program serving a specified geographical area.

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.

Non-Designated
Care in a public hospital in a non-designated Rehabilitation Program/ Unit. Non-Designated rehabilitation programs are where services are provided on the basis that rehabilitation type care is being delivered in a geographical area requiring the provision of such a service and where the agency is currently not seeking formal designation as a rehabilitation program. This rehabilitation type care is being delivered out of WIES funding.

Refer to:

- Section 2: *Episode of Admitted Patient Care* page 2-16, and *Sub-Acute Care* page 2-43.
- Section 3: *Care Type* and *Clinical Sub-Program*.
- Section 5: *Sub-Acute Record*.
- Section 9: Supplementary Code Lists *Care Types 2, 6, 7 & K*: http://www.health.vic.gov.au/hdss/reffiles/index.htm

Same Day Patient

Definition

A patient who is admitted and separated on the same date.

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. 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:

- Section 2: *Admitted Patient* page 2-3, *Criteria for Admission* page 2-11, *Length of Stay* page 2-26, and *Separation* page 2-42.
- Section 3: *Admission Date*, *Criteria for Admission* and *Separation Date*.
- Section 4: Business Rules (non-tabular) *Length of Stay*.

Separation

Definition

The process by which an episode of care for an admitted patient ceases.

A patient is separated at the time the hospital ceases to be responsible for the patient's care and the patient is discharged from hospital accommodation. Hospital waiting areas, transit lounges and discharge lounges are not considered hospital accommodation unless the patient is receiving care or treatment in these areas.

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

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

- Is discharged to private accommodation or other residence (no intention to return to this campus within seven days for continuation of the same treatment).
- Is transferred to another hospital campus of the same service.
- 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).
- Is discharged following a Type B procedure (even if the patient is returning within 7 days for another treatment).
- Dies.
- Leaves against medical advice, and does not return for continuing treatment within seven days.
- Fails to return from leave within seven days. The patient is separated effective from the first day of leave. (This limit does not apply to contract leave.)

Where a patient is separated, then deteriorates and returns to the hospital and is subsequently re-admitted, this should be recorded as two separate episodes, even where both episodes occur on the same day.

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 care in a designated rehabilitation program).

Where two episodes are created by a statistical separation, the Admission Time of the second episode must be one minute after the Separation Time of the first episode.

Refer to:

- Section 2: *Episode of Admitted Patient Care* page 2-16, *Hospital Stay* page 2-21, *Leave With Permission* page 2-25, *Leave Without Permission* page 2-26, *Overnight or Multi-day Stay Patient* page 2-36, and *Same Day Patient* page 2-41.
- Section 3: *Separation Mode*.

Sub-Acute Care

Definition

Sub-acute care is time limited, goal-orientated, individualised, interdisciplinary care that aims to help people who are disabled, frail, chronically ill or recovering from traumatic injury to regain and/or maintain optimal function to allow as many people as possible to maximise their independence and return to (or remain in) their usual place of residence. It is available to people of all ages on an admitted or ambulatory basis and may follow an admitted episode, ambulatory care or directly from the community. Sub-acute patients generally require:

- Assessment and/or oversight of their care plan by a specialist medical consultant.
- Therapy services in accordance with individual need as identified in their care plan (for example, physiotherapy, occupational therapy).

All admitted patients with episodes in the following Care Types are considered sub-acute:

- Designated and non-Designated Rehabilitation Programs
- Geriatric Evaluation and Management Program

Refer to:

- Section 2: *Acute Care* page 2-2, *Admitted Patient* page 2-3, *Episode of Admitted Patient Care* page 2-16, *Geriatric Evaluation and Management Program (GEM)* page 2-17, *Interim Care Program* page 2-24, *Nursing Home Type/Non-Acute Care* page 2-34, *Palliative Care* page 2-37, and *Rehabilitation Care* page 2-39.
- Section 3: *Care Type*.

Time of Death

Definition

For the purposes of reporting to the VAED, time of death is the time recorded by the clinician (or clinicians) as when respiration ceased or when the patient was declared brain-stem dead.

Circulation of oxygenated blood may be continued after this time by artificial/mechanical means for organ procurement purposes, without affecting the time of death.

Guide for use

The time of death is recorded as the Separation Time and is also the time at which the various counts must cease: Duration of Mechanical Ventilation in ICU, of Non-invasive Ventilation (NIV), of Stay in Cardiac/Coronary Care Unit, and of Stay in Intensive Care Unit.

Refer to:

- Section 2: *Organ Procurement - Posthumous* page 2-36.
- Section 3: *Duration of Mechanical Ventilation in ICU*, *Duration of Non-invasive Ventilation (NIV)*, *Duration of Stay in Cardiac/Coronary Care Unit*, *Duration of Stay in Intensive Care Unit*, and *Separation Time*.

Transfer

Definition

Transfer refers to patients moving between two different hospitals or hospital campuses where:
- They were assessed or received care and treatment in the first hospital; and
- It is intended that the patient receive admitted care in the second hospital.

Refer to:
- Section 2: *Campus* page 2-8, *Criteria for Admission* page 2-11, and *Hospital* page 2-18.
- Section 3: *Admission Source, Separation Mode, Transfer Destination, Transfer Source*.
- Section 4: Business Rules (non-tabular) *Transfer Reporting*.

Transition Care

Definition

Transition Care is a jointly funded program between the Department of Human Services and the Department of Health and Ageing which targets:

> 'older people at the conclusion of a hospital episode who require more time and support in a non hospital environment to complete their restorative process, optimise their functional capacity and finalise and access their longer term care arrangements'

Services provided include:
- Those that further improve functioning thereby improving the person's capacity for independent living; to
- Those that actively maintain the individual's functioning while assisting them and their family/carers make appropriate long-term care arrangements.

Services may be provided in a bed-based environment or at the person's home.

Eligible people will be separated from hospital.

Refer to:
- Section 3: *Admission Source, Separation Mode and Separation Referral*.

List of Derived Items

The VAED contains most of the information transmitted via PRS/2, plus data items derived from the PRS/2 information (some information transmitted in the V3 record is not stored in the VAED).

Of the derived items, some are derived at the time of PRS/2 processing (such as birth indicator, and length of stay), whilst others are derived when the extracts are provided to DHS (such as age in days, age in years, and sameday separation flag).

The following website for the Performance Reporting and Analysis Unit provides links to documents listing all of the fields in the VAED for recent financial years:
http://www.health.vic.gov.au/hosdata/datafields.htm