

Section 2: Concept and Derived Item Definitions

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Introduction

This section provides concept definitions and other information relating to data concepts that underlie the VINAH MDS. The data items listed in Section 3 relate to these concepts. Guidelines and other information about the clinical and business practice to which these data concepts relate can be found in the relevant policy documents.

This section also lists data items that the Department will derive from items collected by the VINAH MDS. These items are derived for the purposes of accountability reporting, analysis and monitoring of service activity, and service planning. Organisations **do not** need to report these items. However, organisations may wish to derive these items for their own internal reporting and planning purposes.

The definitions contained in this section are based, wherever possible, on the *National Health Data Dictionary* (version 13) and/or the DHS Common Client Data Set (CCDS) Version 2.

Changes for this edition

Below are listed the changes made to v3.0 (to create v3.1), in June 2007.

- *Client Service Event (Derived Item)*: As per HDSS Bulletin 114, *Contact/Client Service Event Client Present Status*, added to the list of data elements that must be the same (when calculating the number of Client Service Events).

Rationale: Erratum.

Concept Definitions

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

Section 2: Medicare Eligibility Status – Ineligible Person

Section 3: Account Class

Brokerage

Definition

Brokerage occurs when an organisation that is funded by DHS to deliver services that are in scope for VINAH reporting, and pays a third party (sub-contracts) to assist with service delivery.

Guide for use

Organisations that report HARP-CDM activity and are:

- Part of a HARP-CDM Service Agreement, should be identified individually in VINAH, and are not considered brokered services, even when the organisation is outside of a Health Service.
- Not part of a HARP-CDM Service Agreement, are considered brokered services.

PAC, Palliative Care and SACS services will report brokered services.

Brokered services are out of scope for Outpatients.

Refer to:

Section 3: Contact/Client Service Event Provider

Case

Definition

The case groups together all the services that report to VINAH, that are provided to a patient/client over a continuous period by an organisation.

Guide for use

A case:

- Is opened when an organisation first accepts responsibility for a patient/client, which results in an episode starting.
- Will contain at least one episode, and may contain two or more episodes where they overlap with each other, or are broken in time only by a referral received prior to all episodes closing, which results in another program/stream accepting the patient/client.
- Is closed when the patient/client has no open episodes or referrals without outcomes.

Case data may be used for retrospective analysis of patterns of service activity to contribute to policy development and service planning.

Refer to:

Section 2: Case End Date (Derived Item)

Section 2: Case Start Date (Derived Item)

Section 2: Episode

Section 3: Episode End Date

Section 3: Episode Start Date

Client Service Event

Definition A contact or series of contacts, between a patient/client or other, and one or more professionals associated with a program reporting via the VINAH MDS, that is intended to be unbroken in time, that results in dated entry(s) being made in the patient/client record.

Guide for use A client service event is intended to capture an instance of service provision from the point of view of the patient/client, rather than from the point of view the clinician or the organisation. A single client service event may therefore incorporate more than one contact. For example, if a patient/client attends a CRC and in one afternoon receives one-on-one interventions from a physiotherapist, an occupational therapist and a social worker (perhaps taking a short rest in between each session), this constitutes a single client service event.

Contacts are the smallest counting unit in the VINAH MDS, and must be reported for some programs. Other programs will use client service events as their smallest counting unit (such as for performance monitoring, target setting, feedback to organisations); for the reporting of activity for these programs areas, organisations have the option of reporting to VINAH at either the contact or client service event level.

Where the client service event is submitted rather than the contacts:

- The *Contacts* guide for use should be followed to determine which activity is in scope each program;
- The *Contact/Client Service Event Date/Time* of the first contact should be reported
- Within a client service event, *Contact/Client Service Event Professional Group* and *Contact/Client Service Event Main Purpose* may have multiple codes selected in order to appropriately describe the event.

Programs who will report activity at client service event level (and therefore health services have the option of submitting client service events rather than contacts) are:

- HARP-CDM
- PAC
- SACS

All activity for DVA, TAC and VWA patients, regardless of which Program the activity is occurring for, must be reported at the Contact level, rather than the Client Service Event level.

Refer to:

NHDD 000438 Non-admitted patient service event
Section 2: Client Service Event (Derived Item)
Section 2: Contact
Section 2: Group Session Count (Derived Item)
Section 2: Patient/Client
Section 3: Contact/Client Service Event Client Present Status
Section 3: Contact/Client Service Event Date/Time
Section 3: Contact/Client Service Event Delivery Mode
Section 3: Contact/Client Service Event Delivery Setting
Section 3: Contact/Client Service Event Inpatient Flag
Section 3: Contact/Client Service Event Main Purpose
Section 3: Contact/Client Service Event Professional Group
Section 3: Contact/Client Service Event Provider
Section 3: Contact/Client Service Event Session Type
Section 3: Contact/Client Service Event Specialist Palliative Care Provider
Section 3: Message Visit Indicator Code (Transmission Data Element)

Contact

Definition A contact between a patient/client or other relevant person (in scope), and a professional associated with a program reporting via the VINAH MDS that results in a dated entry being made in the patient/client record.

Guide for use A contact must meet all of the following criteria:

- Clinically significant in nature;
- Provided (or brokered) by an agency funded by a program area that requires reporting via the VINAH MDS;
- For a patient/client who has provided consent;
- Requires a dated entry in the clinical record of the patient/client (or a reference to a clinical record held by the brokered service).

For some programs, the following criteria must also be met:

- Have the patient/client directly participating, or
- Have a patient/client's family member/carer directly participating, or
- Other external health care professional directly participating.

There are different types of Contacts, and each program reporting via the VINAH MDS defines which types of Contacts are to be reported for that program. Below each type of Contact is defined; and at the end a matrix is provided as a reference as to which types of contacts should be reported for each program.

Service Contacts

Service contacts would either be with a patient/client, carer or family member or another professional involved in providing care and do not include contacts of an administrative nature.

Service contacts may be differentiated from administrative and other types of contacts by the need to record data in the clinical record. However, there may be instances where notes are made in the patient/client record that has not been prompted by a service contact with a patient/client (for example, noting receipt of test results that require no further action). These instances would not be regarded as a service contact.

Service contacts can be further categorised

- **Direct Contacts:** *Those contacts involving either the patient/client and/or the patient/client's family or carer(s).*

All programs require reporting of direct contacts that occur.

Only Outpatients also require the reporting of contacts that are scheduled but not attended. This is done through reporting the following values:

- o Contact/Client Service Event Client Present Status: 32 *Patient/Client/Carer(s)/Relative(s) not present: Scheduled appointment not attended*
- o Contact/Client Service Event Delivery Mode: 9 *Not Applicable*
- o Contact/Client Service Event Delivery Setting: 98 *Not Applicable*
- o Note: the following Data Elements should be reported as scheduled, even though the contact did not occur:
 - Contact/Client Service Event Date/Time
 - Contact/Client Service Event Main Purpose
 - Contact/Client Service Event Professional Group
 - Contact/Client Service Event Session Type

- **Indirect Contacts:** *Those contacts not involving either the patient/client and/or the patient/client's family or carer(s) but are still clinical in nature. This type of contact may include contact with another professional who may provide additional advice/information about the patient/client.*

Only the Palliative Care Program require reporting of indirect contacts. This is done through reporting the following values:

- *Contact/Client Service Event Client Present Status: 31 Client/Carer(s)/Relative(s) not present: Indirect Contact*
- *Contact/Client Service Event Delivery Setting: 98 Not Applicable*
- *Contact/Client Service Event Session Type: 3 Not Applicable – Indirect Contact Type*

Administrative Contacts

Administrative contacts are not to be reported to VINAH. They include activities such as, but not limited, to:

- Allocation meetings
- Appointment scheduling
- Administrative tasks
- Clinically related administrative work (such as reading or researching patient notes for any purpose)
- Clinical supervision
- Organisation of brokered services
- Record keeping
- Report writing or reviewing
- Research on any topic for any purpose
- Travel time

Contact Type and Reporting Requirements by Program

Contact Type	HARP-CDM	OPs	PAC	Palliative Care	SACS
Service					
- Direct					
- - Attended	Yes	Yes	Yes	Yes	Yes
- - Non-Attended		Yes			
- Indirect				Yes	
Administrative					

Each contact:

- May be delivered in a variety of settings (for example, home-based or centre-based), and via a number of delivery modes (for example, face to face or by telephone).
- May be delivered to a patient/client in either an individual or a group context.
- May be delivered when the patient/client is not present for the interaction but their carer or family is.
- Is delivered by one or more health professionals.
- May be aggregated to provide a count of client service events.

Separate data elements included in the VINAH MDS enable the delivery mode, setting and other attributes of a contact to be reported.

Each patient/client who attends a group session should be reported as having received a contact, independent of the number of patients/clients who participated in the group activity.

For output reporting purposes, certain contacts may be aggregated by DHS - see the derived data element Contact Count for more information.

Refer to:

NHDD 000438 Non-admitted patient service event
Section 2: Client Service Event (Concept Definition)
Section 2: Client Service Event (Derived Item)
Section 2: Contact Count (Derived Item)
Section 2: Group Session Count (Derived Item)
Section 2: Patient/Client
Section 3: Contact/Client Service Event Client Present Status
Section 3: Contact/Client Service Event Date/Time
Section 3: Contact/Client Service Event Delivery Mode
Section 3: Contact/Client Service Event Delivery Setting
Section 3: Contact/Client Service Event Inpatient Flag
Section 3: Contact/Client Service Event Main Purpose
Section 3: Contact/Client Service Event Professional Group
Section 3: Contact/Client Service Event Provider
Section 3: Contact/Client Service Event Session Type
Section 3: Contact/Client Service Event Specialist Palliative Care Provider
Section 3: Message Visit Indicator Code (Transmission Data Element)

Episode

Definition

An episode is the period during which a patient/client receives care within a defined stream under a program that reports to VINAH.

Guide for use

An episode:

- Is opened when an organisation first accepts responsibility for a patient/client. This occurs in response to a referral, when it is determined that the referral was appropriate.
- Will generally contain one or more contacts/client service events. However, there may be some situations where cases will be opened and then closed without containing any contacts/client service events. For example, the patient/client may die or move away before they can receive a contact/client service event, or contact with the patient/client may otherwise be lost. A patient/client might also decline the services offered.
- Is one of the building blocks from which a case is derived.
- Is closed when the criteria for keeping the patient/client in the program is no longer met (this may differ between programs).

Refer to:

Section 2: Case (Concept Definition)
Section 2: Case End Date (Derived Item)
Section 2: Case Start Date (Derived Item)
Section 2: Referral Process
Section 2: Program
Section 3: Episode End Date
Section 3: Episode Program/Stream
Section 3: Episode Start Date
Section 3: Message Visit Indicator Code (Transmission Data Element)

Group Sessions

Definition

Two or more patients/clients receiving the same services at the same time from the same staff.

Guide for use

In practice, this should be interpreted to mean that patients/clients are receiving precisely the same services, for example they might be part of a movement or hydrotherapy class where all participants are following the same intervention at the same time.

The following situations do **not** constitute group sessions:

- Where a clinician works one-on-one with several different patients/clients in the same space over a period of time but each patient/client is following their own personalised program (for example, where several patients/clients are scheduled to use the physiotherapy gym at once).
- Where multiple persons, such as several family members and carers, meet with a clinician to discuss one patient/client only.

Refer to:

Section 2: Group Session Count (Derived Item)

Section 2: Patient/Client

Section 3: Contact/Client Service Event Date/Time

Section 3: Contact/Client Service Event Session Type

Hospital Admission Risk Program – Chronic Disease Management (HARP-CDM)

Definition

HARP-CDM services provide comprehensive and specialist assessments, care coordination, review and monitoring for people with chronic diseases, such as heart failure or children with asthma, people with complex psychosocial needs such as people who are homeless or at risk of self harm and people with complex needs such as multiple co-morbidities or older people who are frail. In particular, HARP-CDM tries to provide more appropriate community services to people who frequently use hospitals or who are at imminent risk of hospitalisation.

Guide for use

HARP-CDM services are governed by a Local Alliance that shares responsibility for decision-making, risk and responsibility. While Health Services are the fund-holders, most HARP-CDM alliances include one or more community agencies.

HARP-CDM services will be provided directly by the Health Service and by other members of the Local Alliance (as documented in Service Level Agreements). HARP-CDM services may also be provided by others through brokerage arrangements.

Responsibility for reporting HARP-CDM activity lies with the Health Service as fund-holder, regardless of how a given service is provided, or by which provider.

Refer to:

Section 2: Program

Section 2: Programs Reporting to VINAH

Section 2: Stream

Section 3: Episode Program/Stream

Section 3: Referral Program/Stream

<http://www.health.vic.gov.au/harp-cdm/>

Medicare Eligibility Status - Eligible Person

Definition

The patient's/client'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

Section 2: Medicare Eligibility Status – Ineligible Person

Section 3: Account Class

http://www.medicareaustralia.gov.au/yourhealth/going_overseas/vtta.htm

Medicare Eligibility Status - Ineligible Person

Definition

The patient's/client'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/Client:****Exempt Patient/client**

- An ineligible, non-Australian resident specifically referred to Australia for hospital services not available in the patient's/client'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/Client

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/clients.

Refer to:

Section 2: Asylum Seeker

Section 2: Medicare Eligibility Status – Eligible Person

Section 3: Account Class

http://www.medicareaustralia.gov.au/yourhealth/going_overseas/vtta.htm

Outpatients

Definition

To be provided at a later point in time.

Guide for use

#

Refer to:

Section 2: Program

Section 2: Programs reporting to VINAH

Section 2: Stream

Section 3: Episode Program/Stream

Section 3: Referral Program/Stream

Palliative Care

Definition Community palliative care services provide a range of services to clients in their home including nursing, liaison with medical practitioners, counselling for the client and their family, allied health services, complementary therapies and coordination with other services. Services comprise multidisciplinary specialist assessment and intervention for pain, symptom control or prevention whilst being treated for a disease that can not be cured. Emotional, social, spiritual, cultural and physical aspects are considered in the provision of practical support to the patient, carers and family.

Guide for use Palliative care (WHO definition)

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intensds neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- in applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life and includes those investigations needed to better understand and manage distressing clinical complications.

Refer to:

Section 2: Program
Section 2: Programs reporting to VINAH
Section 2: Stream
Section 3: Episode Program/Stream
Section 3: Referral Program/Stream
www.health.vic.gov.au/palliativecare

Patient/Client

Definition A patient/client is a person for whom an organisation accepts responsibility for providing care delivered in programs reporting to VINAH.

Guide for use Note that providing care to a patient/client can encompass the provision of services (for example, counselling, education) to the patient's/client's carer(s) and/or family, whether or not the patient/client is present when these services are delivered. The carer is not, in these situations, considered to be a patient/client in their own right, even if the patient/client is deceased (which may be the case for the Palliative Care program).

Refer to:

Section 2: Client Service Event (Concept Definition)
Section 2: Contact
Section 2: Group Sessions
Section 3: Contact/Client Service Event Client Present Status

Post Acute Care

Definition Post Acute Care (PAC) provides services to people following discharge from a public hospital (acute or sub-acute) inpatient stay or following an emergency department presentation. The services provided are based on a person's individually assessed needs and delivered via a brokerage service model with the core function being care coordination.

Guide for use The PAC Program was established with the objectives of supporting recuperation after hospitalisation by providing an appropriate package of community-based supports to facilitate safe and timely discharge, and at the same time aims to prevent hospital readmission.

PAC delivers flexible service delivery and works in conjunction with but does not replace the services provided by other programs, such as Home and Community Care (HACC), Sub-acute Ambulatory Care Services (SACS), and Hospital Admission Risk Program - Chronic Disease Management (HARP-CDM). PAC offers short-term support to clients following hospitalisation and will continue to provide the support until the client is linked into ongoing community supports if required. The Department of Veterans Affairs and Transport Accident Commission clients can also access PAC services.

The most common services provided by PAC include:

- Community nursing
- Personal Care
- Home Care Services arranged by PAC are provided for the duration of the recuperative period and are generally of a short-term nature.

Care coordination, rapid response to short time frames, flexibility to deliver tailored packages and service interface between hospital and community sectors are core features of PAC that enable the delivery of its objectives.

Refer to:

Section 2: Program
Section 2: Programs reporting to VINAH
Section 2: Stream
Section 3: Episode Program/Stream
Section 3: Referral Program/Stream
<http://www.health.vic.gov.au/pac/>

Program

Definition Funding of care to meet specific objectives within an agreed framework. Each program has particular attributes, such as policy, objectives, eligibility and assessment/monitoring criteria.

Guide for use A program, for the purposes of VINAH:

- Is usually equivalent to a line of DHS funding, and/or
- Usually has a Unit within DHS which is responsible for activities such as policy development and liaison with organisations, in relation to this service.

Some programs are further broken down into streams.

Refer to:

Section 2: Hospital Admission Risk Program – Chronic Disease Management (HARP-CDM)

Section 2: Outpatients

Section 2: Palliative Care

Section 2: Post Acute Care (PAC)

Section 2: Programs Reporting to VINAH

Section 2: Stream

Section 2: Sub-Acute Ambulatory Care Services (SACS)

Section 3: Episode Program/Stream

Section 3: Referral Program/Stream

Programs Reporting to VINAH

Definition For 2007-08, the following programs report to DHS via the VINAH MDS:

- Hospital Admission Risk Program – Chronic Disease Management (HARP-CDM)
- Outpatients in scope (to be confirmed, only as a trial, National A and B Peer Group Hospitals only)
- Palliative Care
- Post Acute Care (PAC)
- Sub-acute Ambulatory Care Services (SACS)

Guide for use All contacts/client service events funded by these programs must be reported to VINAH according to the specifications in this manual.

Refer to:

Section 2: Hospital Admission Risk Program – Chronic Disease Management (HARP-CDM)

Section 2: Outpatients

Section 2: Palliative Care

Section 2: Post Acute Care (PAC)

Section 2: Program

Section 2: Stream

Section 2: Sub-Acute Ambulatory Care Services (SACS)

Section 3: Episode Program/Stream

Section 3: Referral Program/Stream

Other program specific documents, including policy documentation.

Referral Process

Definition The process by which a referral is received and processed.

Guide for use Conceptually this process includes four steps being:

- Receipt of referral;
- Referral acknowledgement
- Decision to accept or reject referral;
- Patient/Client consent to participate in care provision.

Different programs and or organisations may apply different business processes that may lead to the four steps of the referral process being undertaken with different timings.

There are Data Elements that capture the dates when each of the first three of these steps occur. These are respectively:

- *Date Referral Received*;
- *Date of Referral Receipt Acknowledgement*; and,
- *Episode Start Date* (where *Referral Outcome* is *1 Referral Accepted*).

These may be the same or different dates, depending on the workflow in different organisations.

The final step is required in order to schedule the first contact/client service event, however this date does not need to be reported to VINAH.

Each episode is required to be linked to a referral. However one referral may generate more than one episode; that is, one referral may result in more than one program/stream providing services to the patient/client.

Refer to:

Section 2: Episode
Section 3: Date of Referral Receipt Acknowledgement
Section 3: Date Referral Received
Section 3: Episode Program/Stream
Section 3: Episode Start Date
Section 3: Referral Outcome
Section 3: Referral Program/Stream
Section 3: Referral Source

Stream

Definition For the purposes of VINAH, a sub-grouping, usually clinical, within a program.

Guide for use A stream is a layer below the program; streams are usually based on the clinical attributes of patients/clients and/or the services/resources the patient/client receives.

Not all programs are split into streams.

Refer to:

Section 2: Hospital Admission Risk Program – Chronic Disease Management (HARP-CDM)

Section 2: Outpatients

Section 2: Palliative Care

Section 2: Post Acute Care (PAC)

Section 2: Program

Section 2: Programs Reporting to VINAH

Section 2: Sub-Acute Ambulatory Care Services (SACS)

Section 3: Episode Program/Stream

Section 3: Referral Program/Stream

Sub-acute Ambulatory Care Services (SACS)

Definition

Sub-acute Ambulatory Care Services (SACS) comprise non-admitted rehabilitation services that are complex, multidisciplinary, and/or interdisciplinary, as well as a suite of specialist assessment and management services. Rehabilitation services can be centre-based, for example, they may be provided through a Community Rehabilitation Centre (CRC), or may be provided in a client's home.

Guide for use

SACS provide a person and family centred, interdisciplinary model of care supported by flexible service delivery in a range of settings, and directed at improving and maintaining a person's functional capacity and maximising their independence. While the majority of SACS clients are older people, services for children and younger adults are currently being developed and expanded.

The aims of SACS are to:

- Improve, restore and/or maintain a person's functional capacity to achieve the highest possible level of independence physically, psychologically, socially and economically; and,
- Provide a coordinated and integrated service that delivers the appropriate care, in a timely manner, in the most appropriate setting and at the most appropriate cost.

SACS play a key role in supporting people to get safely home from hospital as soon as possible (for example after a stroke, hip replacement, or major trauma), and in helping them optimise their functional status and maintain their health independence. SACS also have a major role in preventing and diverting hospital admissions, by ensuring that multidisciplinary therapy and assessment services are available in non-admitted settings.

Refer to:

Section 2: Program

Section 2: Programs Reporting to VINAH

Section 2: Stream

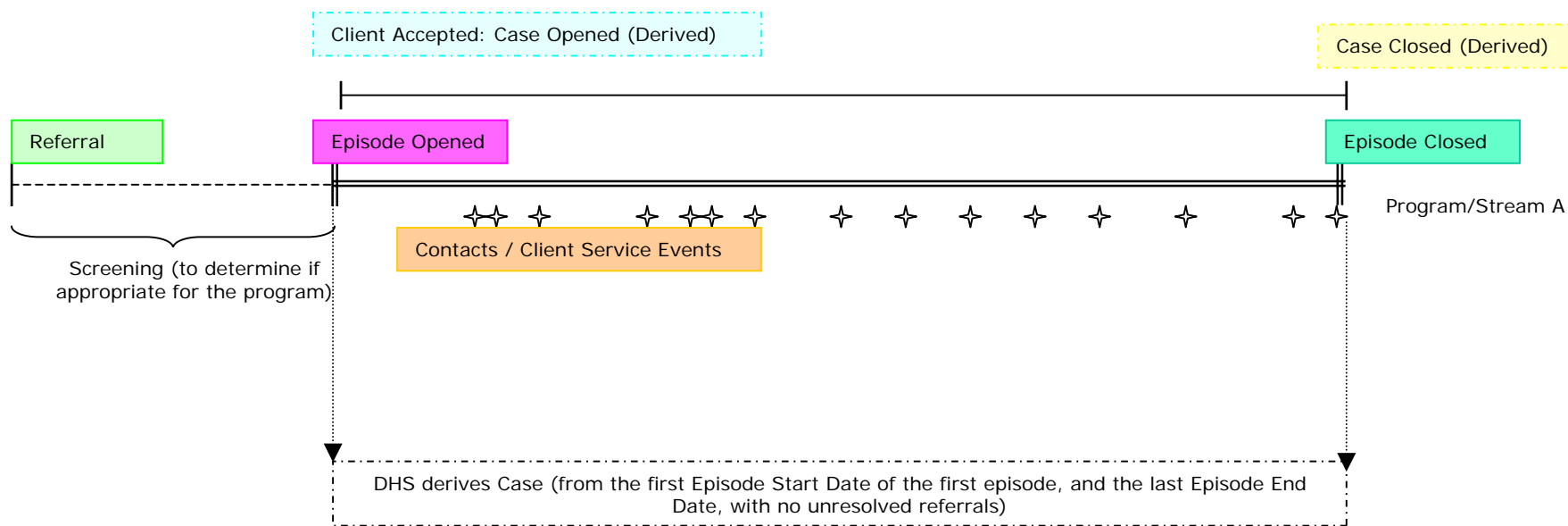
Section 3: Episode Program/Stream

Section 3: Referral Program/Stream

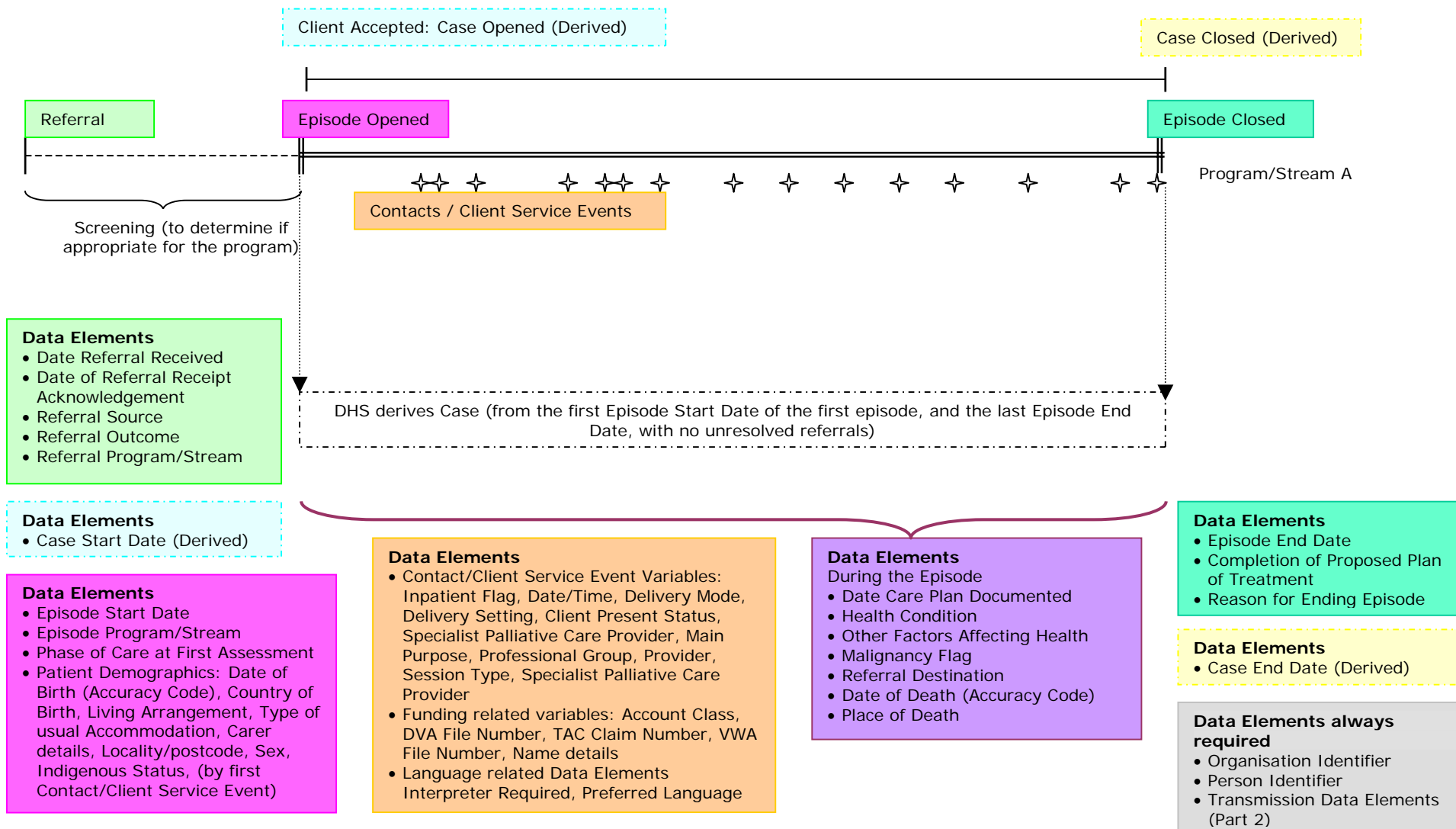
<http://www.dhs.vic.gov.au/health/subacute/>

Generic Process Diagrams

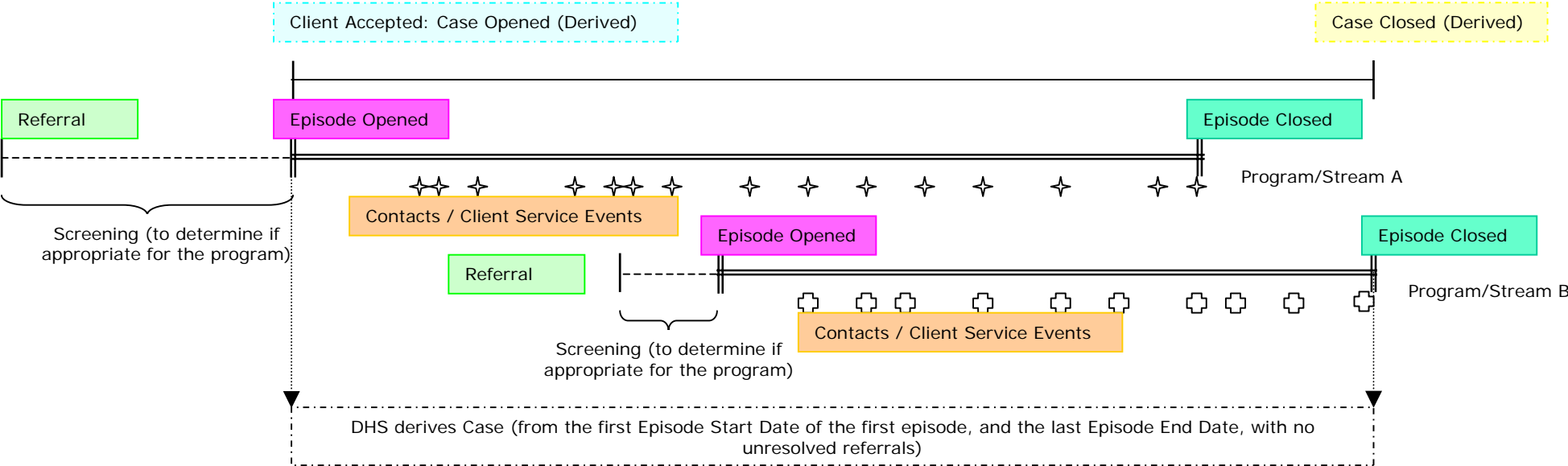
Generic Process (Concepts) 2007-08: 1 Episode per Case



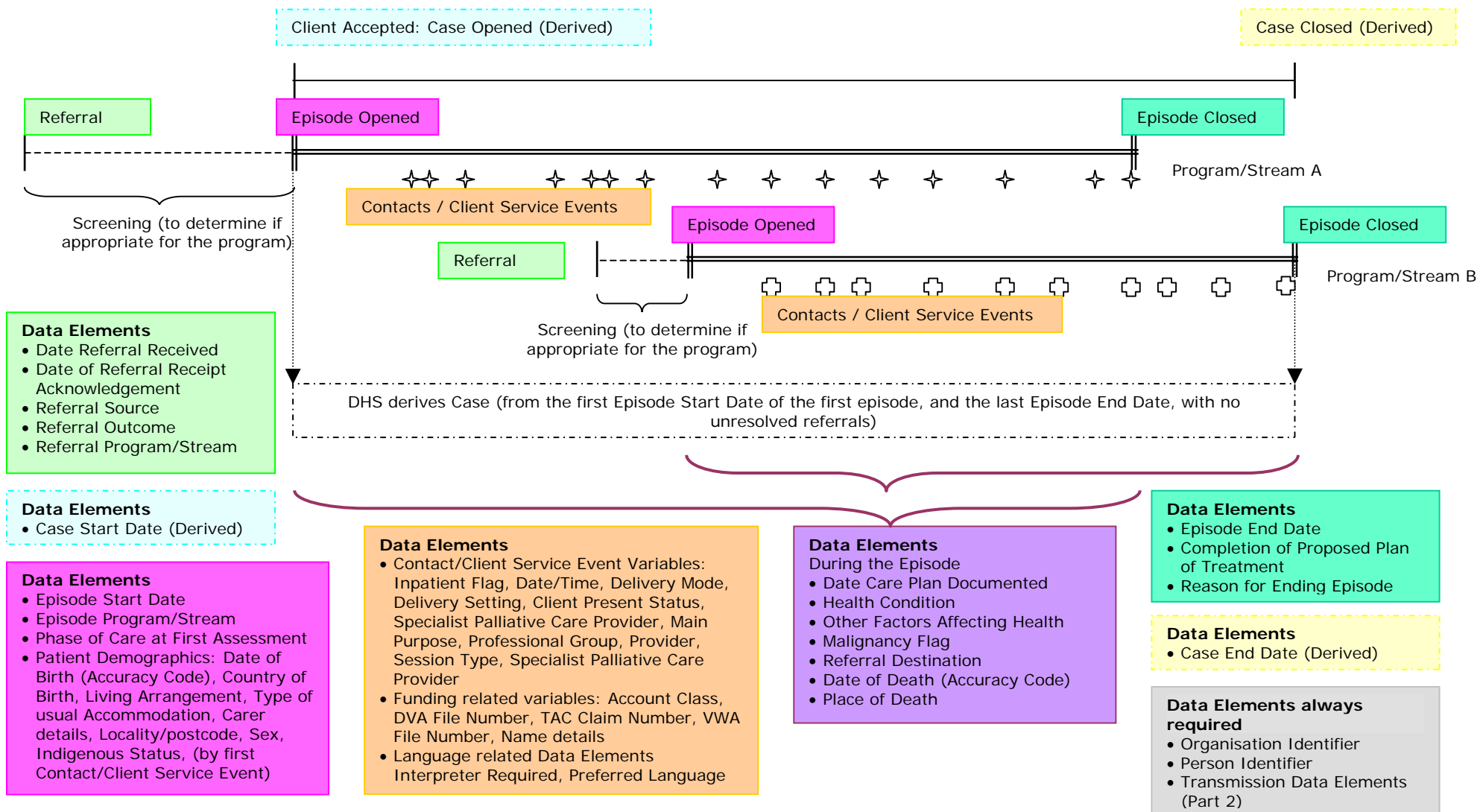
Generic Process (Concepts and Data Elements) 2007-08: 1 Episode per Case



Generic Process (Concepts) 2007-08: 2 Episodes per Case

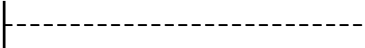


Generic Process (Concepts and Data Elements) 2007-08: 2 Episodes per Case

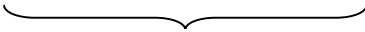


Generic Process (Concepts) 2007-08: Referral not resulting in an Episode

Referral



Episode not opened. Reasons for this may include that the patient died, moved away, did not meet the clinical criteria for the program, was ineligible for the program for another reason, or did not consent to being involved in the program.



Screening (to determine if appropriate for the program)

Generic Process (Concepts and Data Elements) 2007-08: Referral not resulting in an Episode

Referral

Episode not opened. Reasons for this may include that the patient died, moved away, did not meet the clinical criteria for the program, was ineligible for the program for another reason, or did not consent to being involved in the program.

Screening (to determine if appropriate for the program)

Data Elements

- Date Referral Received
- Date of Referral Receipt Acknowledgement
- Referral Source
- Referral Outcome
- Referral Program/Stream

List of Derived Items

Age

Definition The patient's age at the time of case start.

Guide for use Age is calculated as:
Episode Start Date minus *Date of Birth*.

Age is:
Used in analysis of data for service planning purposes.

Refer to:
Section 3: Date of Birth
Section 3: Episode Start Date

Case End Date

Definition The date the case for one patient/client, at one organisation ends.

Guide for use The case start date will be the *Episode Start Date* of the first episode (of possibly several overlapping episodes and referrals).

The case end date will be the date of:

- The *Episode End Date* when there is only one episode for a patient/client, or the latest *Episode End Date*, when there are two or more overlapping episodes, and
- There are no (incoming) referrals for a program/stream (*Date Referral Received*) that do not have a *Referral Outcome*.

Refer to:
Section 2: Case (Concept Definition)
Section 2: Case Start Date (Derived Item)
Section 2: Episode
Section 3: Date Referral Received
Section 3: Episode End Date

Case Start Date

Definition	The date the case for one patient/client, at one organisation begins.
Guide for use	<p>The case start date will be the <i>Episode Start Date</i> of the first episode (of possibly several overlapping episodes and referrals).</p> <p>The case will continue when:</p> <ul style="list-style-type: none">• The episode remains open (<i>Episode Start Date</i> present without a corresponding <i>Episode End Date</i>), or• There are additional episodes (with different programs/streams), that overlap in <i>Episode Start Date</i> and <i>Episode End Date</i>, or• There is at least one (incoming) referral for a program/stream (<i>Date Referral Received</i>) that does not have a <i>Referral Outcome</i>. <p>Refer to:</p> <p>Section 2: Case (Concept Definition) Section 2: Case End Date (Derived Item) Section 2: Episode Section 3: Date Referral Received Section 3: Episode Start Date Section 3: Referral Outcome</p>

Client Service Event

Definition	A contact or series of contacts, between a patient/client or other person in scope, and a professional associated with a program reporting via the VINAH MDS, that is intended to be unbroken in time, that results in a dated entry being made in the patient/client record.
Guide for use	<p>For reporting purposes for some program areas, multiple contacts that take place on the same day will be aggregated into a client service event. A single client service event will be derived within a single episode, where the following data elements for a patient/client, on the same day, are the same:</p> <ul style="list-style-type: none">• <i>Contact/Client Service Event Delivery Mode</i>;• <i>Contact/Client Service Event Delivery Setting</i>;• <i>Contact/Client Service Event Provider</i>;• <i>Contact/Client Service Event Session Type</i>. <p>Refer to:</p> <p>NHDD 000438 Non-admitted patient service event Section 2: Client Service Event (Concept Definition) Section 2: Contact Section 3: Contact/Client Service Event Date/Time Section 3: Contact/Client Service Event Delivery Mode Section 3: Contact/Client Service Event Delivery Setting Section 3: Contact/Client Service Event Provider Section 3: Contact/Client Service Event Session Type</p>

Contact Count

Definition Within a given time period, the number of contacts delivered by an organisation.

Guide for use For reporting purposes, counts of contacts will be aggregated as described below:

A count of one contact will be made for all Contacts within an organisation delivered to the same client at the same time.

This allows organisations flexibility in software design when submitting contact counts for multidisciplinary care, that is: They may submit one contact containing all the information about a multi-disciplinary care contact or several (for example, one for each clinician present.) It is important that if a contact is multi-disciplinary that all contributing contacts are reported with exactly the same *Contact/Client Service Event Date/Time*.

Refer to:

Section 2: Contact (Concept Definition)

Section 3: Contact/Client Service Event Date/Time

Section 3: Contact/Client Service Event Provider

Section 3: Message Visit Indicator Code

Group Session Count

Definition Within a given time period, the number of group sessions delivered by an organisation.

Guide for use For reporting purposes for some program areas, counts of group sessions will be aggregated as described below.

A count of one group session will be made for all Contacts/Client Service Events within an organisation where *Contact/Client Service Event Session Type* is *2-Group* and the following data elements have the same value:

- *Contact/Client Service Event Date/Time*;
- *Contact/Client Service Event Professional Group*;
- *Contact/Client Service Event Provider*;
- *Message Visit Indicator Code*.

Therefore it is important that if multiple group sessions are being delivered by the same mix of professionals at the same provider organisation at the same time that a minor differentiation be made in the *Contact/Client Service Event Date/Time* (for example: by reporting them 1 second apart.)

Equally, all patients/clients participating in the same group session must have exactly the same *Contact/Client Service Event Date/Time* reported in order for the correct Group Session Count to be derived.

The inclusion of *Message Visit Indicator Code* means that all contacts and client service events that contribute to a single group session must be reported as either all contacts or all client service events, not a mix of the two.

Refer to:

Section 2: Client Service Event (Concept Definition)

Section 2: Contact

Section 2: Group Sessions

Section 3: Contact/Client Service Event Date/Time

Section 3: Contact/Client Service Event Provider

Section 3: Message Visit Indicator Code