

NAPMDS Implementation Guide for Specialist Outpatient Clinics

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INTRODUCTION

As part of the National Health Reform agenda, the Victorian Government Department of Health (DH or 'the department') has recently introduced the Non-Admitted Patient Minimum Data Set (NAP MDS) as an initiative that will support the future development of Activity-Based Funding for non-admitted services within Victorian health services.

Patient level reporting for non-admitted services aims to provide an evidence base for health services to support health planning, clinic based performance and quality improvement, and contribute to government policy development and funding.

Patient level data is already collected through the VINAH (Victorian Integrated Non-Admitted Health) data collection for sub-acute, palliative care and a range of other non-admitted services. From July 1 2011, this will be extended to outpatient services (specialist clinics). The first phase of this process will focus on the 26 metropolitan and regional health services delivering 90 per cent of specialist clinic activity throughout Victoria.

PURPOSE

This Guide has been developed to assist specialist outpatient clinics within health services, and provide guidance on how to implement the operational changes required for the collection of the NAPMDS from 1 July 2011.

This Guide is to be read in conjunction with the *NAPMDS Implementation Framework for Specialist Outpatient Clinics* which provides a set of rules and working definitions of the required data.

The Guide does not intend to be prescriptive about how any health service should manage its operations; nor does it seek to mandate how to implement any necessary changes. However, it does provide an overview of what changes are required and what form those changes might take in readiness for implementation.

Other relevant documents that relate to the NAP MDS project are:

Victorian public hospital specialist clinics: Strategic framework

<http://docs.health.vic.gov.au/docs/doc/The-Victorian-public-hospital-specialist-clinics-strategic-framework---February-2009>

The framework presents the department's expectations in relation to the overall planning, organisation and provision of specialist clinic services. It also identifies three key objectives for specialist clinics – patient focus, timely access and sustainable services.

Victorian public hospital specialist clinics: Access guidelines

<http://docs.health.vic.gov.au/docs/doc/Specialist-Clinics-Access-Guidelines---September-2009>

The guidelines define best practice principles that public health services are expected to work towards. Health services are expected to work with all stakeholders, including patients, to identify and act on opportunities for continuous improvement in access to specialist clinics.

This document will be replaced by a Specialist Clinics Access Policy in 2011-12.

Victorian public hospital specialist clinics: Discharge guidelines

<http://docs.health.vic.gov.au/docs/doc/Discharge-guidelines>

The specific purpose of the discharge guidelines is to:

- provide a consistent understanding of key issues and challenges that impact on specialist clinics' discharge practices;
- identify good practices and innovations already occurring in the Victorian hospital system and in other jurisdictions;
- reinforce existing departmental policies relating to the appropriate use of hospital services and timely linkages to community based services;
- clearly outline the department's expectations of health services in the development and implementation of specialist clinics discharge protocols and practices; and
- provide authority to local policies and protocols.

Policy & Funding Guidelines - Conditions of funding (non submitted data penalties)

<http://www.health.vic.gov.au/pfg/>

THE VICTORIAN INTEGRATED NON ADMITTED HEALTH MINIMUM DATA SET (VINAH MDS)

The VINAH MDS is a patient-level electronic reporting system built around a generic framework suitable for reporting a wide range of non-admitted patient level data.

As organisations successfully transition to VINAH reporting, use of the AIMS S9 form and the S10 form for Tier 2 reporting will be phased out.

SUBMISSION GUIDELINES

Submitting health services and organisations are encouraged to transmit VINAH MDS data frequently and may transmit as often as desired. Submitting organisations must meet the following minimum requirements:

- VINAH data compliance is reckoned on a monthly basis. Data for each calendar month (reference month), as specified in the Reported When component of each data element in the VINAH Manual, must be transmitted as specified below.
- Submitting organisations must make at least one submission to the HealthCollect portal for the reference month by no later than 5pm on the tenth day of the month following the reference month.
- All errors are to be corrected in time for the VINAH MDS file consolidation at 5pm on the 17th day of the month following the reference month. It is expected that complete data for the month is transmitted by the 17th.
- Data for the financial year must be completed in time for the VINAH MDS file consolidation on 17 August.
- Any final corrections must be received at the Health Collect portal before finalisation of the VINAH MDS database on 10 September 2012.

It is the submitting organisation's responsibility to ensure that data is received by the department to meet the processing schedule above, regardless of the actual day of the week.

PENALTIES FOR NON-COMPLIANCE

Where submitting organisations do not comply with these timelines, the department may apply a penalty of up to:

- \$3,100 if an initial transmission of a reference month's activity for a program is not submitted by the timeline specified above.

- \$3,100 if a reference month's complete activity for a program is not submitted in accordance with the timeline specified above.
- Health services that have VINAH MDS reporting obligations for multiple programs (for example, SACS, HARP, PAC) should note that the above penalties apply per program.
- If difficulties are anticipated in meeting the monthly timelines, the health service must contact the department indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule.

EXEMPTIONS FROM PENALTIES

- Exemptions for late data penalties will only be considered for circumstances beyond the control of the hospital. Software problems are, of themselves, insufficient justification for late submission of data.
- Health services are expected to have arrangements in place with their software vendor to ensure statutory reporting requirements are met.
- Note that during the initial VINAH MDS implementation period for new organisations and program types, flexible arrangements may be negotiated with submitting organisations on a case-by-case basis.
- Health services still transitioning to VINAH reporting must continue to report data via AIMS until advised in writing to cease AIMS reporting.

GUIDE ON *HOW* TO IMPLEMENT OPERATIONAL CHANGES

The Guide addresses the following key business processes:

- Referral In
- Episodes
- Referral Out
- Contacts

OVERVIEW OF THE CHANGE METHOD

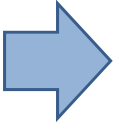




Achieving the outcomes of any program or policy change requires internal and external stakeholders to understand:

- What the changes will be;
- Why the changes will occur;
- What the impact of the change will be to the work of the individual, health service departments and the total health service; and
- How systems will be developed and people supported to achieve the outcomes.

The Guide will address these questions for each business process area as follows:

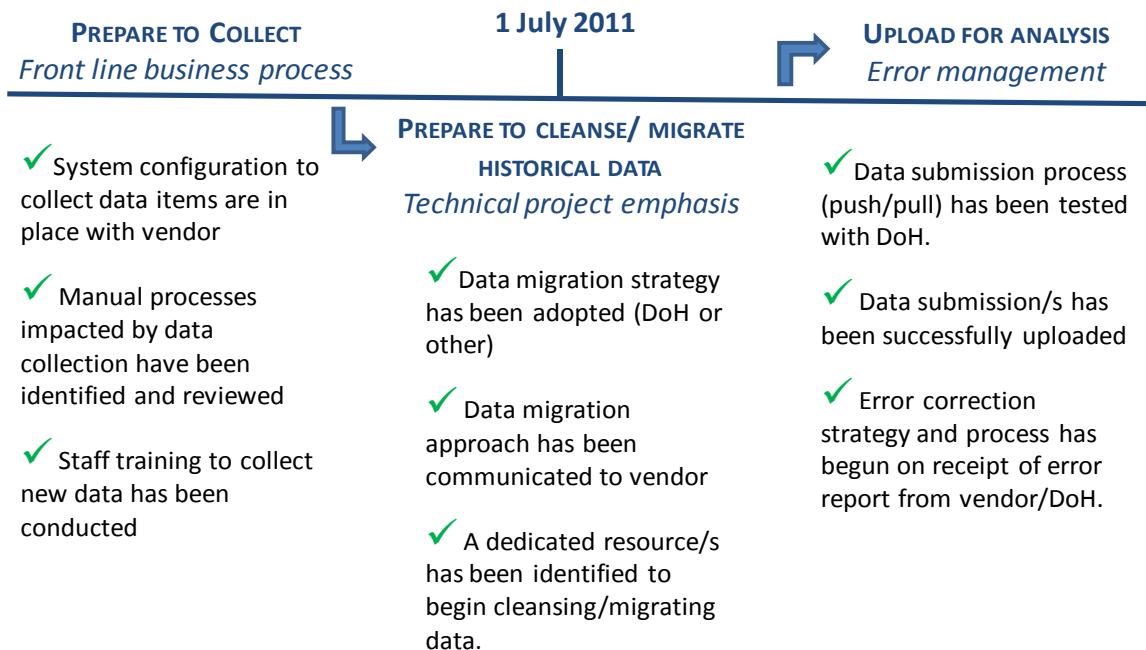
- What needs to be achieved;
- How to implement the change;
- Data element descriptions and business rules; and
- Further suggestions on implementation.

The following table describes the method a health service may wish to apply to achieve the desired change outcomes.

	Operational change impact	Description
	Business Process	<ul style="list-style-type: none"> • Document and understand the current processes and new processes and identify the areas for change. • Introduce the changes, as required, to procedures, work practices and job roles, data collection and reporting requirements, and systems related changes.
	Procedures	<ul style="list-style-type: none"> • Develop new procedures documentation required to support the change. Delete old documentation as appropriate. • Consider any legal, compliance and audit or quality control processes and procedure requirements. • Gain approval to put the changes into practice and communicate these accordingly.
	Work Practices/People Impact	<ul style="list-style-type: none"> • Identify staff and system users impacted and how they are affected by the changes and the impact on their work practices and roles. • Consider changes to job descriptions/job role statements. Identify any required skill changes, e.g. Requirement to use technology. • Develop training materials. Carry out targeted training of staff, as required. • Update work practice documentation e.g. User Guides, pocket guides etc.
	Data Collection & Reporting	<ul style="list-style-type: none"> • Identify NAPMDS requirements to be collected and reported to Department of Health. Determine how the data will be collected, validated, processed, checked and reported on a regular basis. • Determine the systems change requirements and implement the systems enhancements for 1 July 2011 operations.
	Communications	<ul style="list-style-type: none"> • Consider a stakeholder analysis of internal and external groups impacted by the change. • Develop a communications plan. • Develop internal communications materials for staff to describe the change impact on operations and its timing for introduction.

STAGES OF IMPLEMENTATION

Each Health Service will be using its own NAP MDS project plan, however, it is helpful to consider the project using the following stages of implementation. Each project stage will have key outcomes that indicate the Health Service is ready to move to the next stage.



REFERRAL IN

Refer to the NAPMDS Implementation Framework for Specialist Outpatient Clinics, Section 9, for the full set of *Referral In* Business Rules for implementation.

WHAT NEEDS TO BE ACHIEVED

- Health services are ready to collect and complete the Referral In data elements for all referrals received by the clinic, regardless of their source and whether or not the referral is accepted.
- Health services are ready to keep a record of all referrals, including rejected referrals.
- Health Services have implemented a standard screening process to determine whether a referral is to be accepted or rejected.
- Accepted referrals are able to be formally registered on the patient administration system and given a Unit Record (UR) number.

HOW TO IMPLEMENT THE CHANGE



- Review all current Referral In processes across specialist clinics.
- Identify where new processes will need to be included, specifically in relation to collecting and recording new data elements.
- Document new processes and clearly identify new elements of change in the process.



- Identify and review any existing Referral In policies and procedures documentation and update to reflect the new business rules and processes.



- Use new Referral In processes to identify who will be impacted by the changes and how they will be impacted.
- Identify where the referrals are received in the clinic and who enters the initial Referral In data. Who then decides if a referral is accepted or rejected? What referral information do staff need to make a Referral Outcome decision in a standard and consistent way?
- Review and update existing form and letter templates that are used throughout the process.
- Ensure that the appropriate staff responsible for referral screening and other referral management functions have adequate information and support.



- For each of the 5 data elements, determine how the data will be collected, validated, processed, checked and reported on a regular basis.
- Determine the systems change requirements for each data element and communicate with your vendor for implementation.



- Consider formally notifying regular or local referring practitioners of the information required in referrals to the clinic. This will avoid having to return to the referrer for further information in the future.

DATA ELEMENTS WORKING DEFINITIONS

Name	Reporting Obligation
1.1 Referral In Received Date	Mandatory
1.2 Referral In Service Type	Mandatory
1.3 Referral In Program Stream	Mandatory
1.4 Referral In Receipt Acknowledgement Date	Mandatory
1.5 Referral In Outcome	Mandatory

For a full description of data elements including field format details go to VINAH Manual, Section 3

1.1 Referral In Received Date

Description	The date that a referral, either written or verbal, is received. Reported for all referrals received during the current reporting period.
Purpose	Can be used with the Referral Receipt Acknowledgment Date to determine the response times to referrals.
Business Rules	<ul style="list-style-type: none"> This element should be recorded as the date that the referral is <u>first</u> received by the health service. This element should not be changed subsequently unless a clerical error has been made in recording the date. This applies even if the referrer is asked to provide additional information and completes the referral at a later date.

1.2 Referral In Service Type

Description	The person who, or service which, referred the patient/client.
Purpose	To assist in the analysis of patient/client flow and service planning.
Business Rules	This item should be reported for all referrals received, regardless of whether the referral is accepted or rejected.

1.3 Referral In Program Stream

Description	The program/stream to which the patient/client is referred, as per the current VACS categories.
Purpose	To allow national reporting requirements to be met and assist with service planning and monitoring.
Business Rules	<p>This item should be reported for all referrals received, regardless of whether the referral is accepted or rejected.</p> <p>This data element is similar to Episode Program/Stream. The difference is that there are additional codes in this value for:</p> <ul style="list-style-type: none"> • A generic access/referral point; this allows reporting of referrals where (in some organisations only), there is one access/referral point for multiple programs; for example, one access point for specialist clinics referrals. • Generic codes for Specialist Clinic (Outpatient) programs; this allows reporting of generic program specific referrals, where the referrer is requesting that a service be provided by a program, but does not specify the stream under which the patient/client is to be treated. • Report the program/stream to which the patient/client has been referred, not the intervention they are to receive. For example, do not report 605 Physiotherapy unless the referral is to the Physiotherapy Allied Health Clinic. Patients/clients can access physiotherapy in other programs/streams, such as some of the SACS and HARP-CDM streams. • The program/stream that the patient/client is referred to may not be the same as the program/stream that the patient/client is accepted for. For example, a patient/client may be referred to Cardiology (code '103'), but after assessment it is decided that the patient/client be seen by the Cardiothoracic clinic (code '202'); in this instance report code '103'.

1.4 Referral In Receipt Acknowledgement Date

Description	The date on which the referral was acknowledged. For specialist outpatient clinics the acknowledgement should be made to the referrer (or the patient in the case of self-referral). (For other reporting services, the acknowledgement date is the date on which the patient/client or carer was contacted to acknowledge the referral).
Purpose	This item is used together with Date Referral Received to measure the response time (days) between a referral being received and the response to the patients/clients or referrer.
Business Rules	<ul style="list-style-type: none"> • This acknowledgement may be in the form of a letter, fax or email, a telephone contact or in person. This interaction does not constitute a VINAH contact. • Health services are required to write to the referring practitioner (or the patient in the case of a self-referral) to acknowledge the receipt of the referral.

- This item should be reported for all referrals received, regardless of whether the referral is accepted or rejected.

Information for Implementation:

- To avoid unnecessary repeat communication with referrers, the written referral acknowledgement would normally occur at the point when the health service has determined the response to the referral – e.g. when it has been accepted (and the patient given an appointment or put on a waiting list), rejected or assessed as requiring more information.

1.5 Referral In Outcome

Description	The outcome of a referral.
Purpose	To support analyses of service provision by Referral Service Type.
Business Rules	<ul style="list-style-type: none"> • All referrals accepted by the health services are coded as ‘referral accepted’. • ‘Referral accepted’ includes patients/clients who are accepted into a program and who have been placed on a waiting list to receive services. • Where referrals are rejected, a code must be used to record the reason why the health service has not accepted the referral. • Referrals that are awaiting further information from the referrer should not be rejected; completion of the Referral In Outcome should be delayed and data element left blank until the information is received. • Referrals that have been delayed and do not receive further information within a reasonable period can be coded as ‘Referral withdrawn by referrer’ and the referrer advised accordingly. • Once a Referral In Outcome is accepted, then one or many episodes are created.

Information for Implementation:

- All other Referral In data elements should be entered when known, regardless of whether the Referral In Outcome has been determined.
- When deciding the appropriate coding option for rejected referrals, health services may determine that the patient:
 - does not require specialist clinic services;
 - does not meet established service criteria;
 - requires services that are not provided by specialist clinics at the receiving hospital; or
 - is unavailable for assessment/treatment.
- When a referral is deemed potentially appropriate for service, referrers may be asked to provide further information if:
 - The referral is unintelligible
 - The referral is missing key demographic, clinical or other information required to prioritise the referral and/or manage the patient's wait for services and care at the first appointment
 - It is not clear whether or not the specialist clinic is the most appropriate service for the patient.
- If a referral is incomplete and the Health Service is awaiting information and receives nothing back within a timeframe that is considered too long, the referral should be rejected by selecting 'withdrawn by referrer'.

REJECTED REFERRALS

Information for Implementation:

- Any referral that is rejected does not need a UR Number. Therefore the health service may wish to consider a standard approach or practice to managing rejected referrals.
- Health services are encouraged to work with software vendors to develop solutions that avoid the need to generate UR numbers for rejected referrals - e.g.:
 - Generic or dummy data elements
 - Attach rejected referrals to a single UR number used only to hold these referrals

EPISODES

Refer to the NAPMDS Implementation Framework, Section 10, for the full set of *Episodes* Business Rules for implementation.

Episodes are also referred to by different health services and vendors as ‘occasions of service’, ‘course of treatment’, ‘referral’ and ‘patient journey’.

WHAT NEEDS TO BE ACHIEVED

- Health services understand the Episode data definitions and identify the appropriate processes and points at which to collect the relevant information.

HOW TO IMPLEMENT THE CHANGE



- Document and understand the current Episode processes and new processes and identify the key dates in the process that need to be collected for the new data elements.
- Identify the process for clerical staff to follow up any outstanding information with the clinician - e.g. information required to determine if the patient episode has ended.



- Develop new procedures documentation, incorporating information about the point at which new data elements are entered into the system. The new procedures include recording dates when notifying patients of appointment dates by letter as well as telephone or face-to-face.
- Communicate the new procedures to all clerical staff within the clinic.



- Identify clerical and clinical staff that will be affected by new data collection and work practices.
- Develop training materials and cheat sheets that can remind staff of the dates and program streams they will need to identify.
- Review current information or templates that clerical staff will receive from clinical staff to know when an Episode has ended.



- Identify NAPMDS requirements to be collected and reported to Department of Health. Determine how the data will be collected, validated, processed, checked and reported on a regular basis.



- Clearly communicate the definitions of each data element to ensure all clerical and clinical staff have a shared understanding of the terms, to avoid confusion.

DATA ELEMENTS WORKING DEFINITIONS

Name	Reporting Obligation
2.1 Episode Start Date	Mandatory
2.2 Episode Program/Stream (Outpatient Clinic Type and Care Type)	Mandatory
2.3 Episode First Appointment Booked Date	Mandatory
2.4 Episode Patient/Client Notified of Appointment Date	Optional for 2011/12
2.5 Episode End Date	Mandatory

For a full description of data elements including field format details go to VINAH Manual, Section 3

2.1 Episode Start Date

Description	When a program/stream first accepts a patient/client. This occurs in response to a referral, when a referral is accepted.
Purpose	To allow calculation of the period for which a person is a patient/client of a program/stream.
Business Rules	<ul style="list-style-type: none"> This data element represents the date when it is determined that the outcome of the referral is 'Accepted'

Information for Implementation:

- Ensure that the Referral In process connects with this data element to ensure that once a Referral is accepted, it immediately triggers the entry of the Episode Start Date.

2.2 Episode Program/Stream

Description	The program/stream to which the patient's/client's episode relates.
Purpose	To allow national reporting requirements to be met and assist with service planning and monitoring.
Business Rules	<ul style="list-style-type: none"> The value of this data element cannot be changed after the episode has been opened. This data element relates to the program/stream to which the patient/client has been accepted, not the intervention they are to receive. This data element relates to the program stream for which the patient/client is accepted. This may be different to the program/stream to which the patient/client was referred. This data element must link to one of the 46 VACS codes, which represents a specialty clinic.

Information for Implementation:

- It is critical for staff to understand the program/stream selection relates to a funding outcome.

2.3 Episode First Appointment Booked Date

Description	The date of the patient's/client's first appointment booking.
Purpose	To assist in measuring access to specialist outpatient clinic services.
Notes	<ul style="list-style-type: none"> • This is not the date on which that booking was entered into the booking system. • Any subsequent changes to the date of the first appointment date must not be submitted unless the date entered for the first appointment was a data entry error. • Example: If an appointment scheduled for 30th October was entered into the system on the 1st September, the required value for the Episode First Booked Date data element is the 30th October.

Information for Implementation:

- If a change occurs to the first appointment booked date e.g. the appointment is rescheduled, the date remains as per the submitted data element. Even if the patient cancels, fails to attend, or if there is any other change to the original appointment date.

2.4 Episode Patient/Client Notified of Appointment

Description	The date the patient/client was first advised of their first appointment booking.
Purpose	To assist in measuring access to specialist outpatient clinic services.
Business Rules	<ul style="list-style-type: none"> • This notification may be in the form of a face-to-face discussion or telephone conversation or by letter. • This data element is for the notification date of the first appointment booking only, it does not apply to any further notifications. • The dates of notification of any subsequent changes to the date of the first appointment must not be submitted.

Information for Implementation:

- Initially the collection of this data element will be optional.
- This is a new data element to be collected for most health services; therefore, current processes will need to be examined to identify the areas of impact.
- If notification is by letter then the date on the letter would be the value used for this data element.
- If the health service prints notification letters in bulk, you may be able to derive correspondence dates for this data element.

2.5 Episode End Date

Description	The date when a patient/client no longer meets the criteria for a program/stream, and they cease to be a patient/client of the program/stream.
Purpose	To allow calculation of the period for which a person is a patient/client of a program/stream.
Business Rules	<ul style="list-style-type: none">• The criteria for the Episode End Date may differ between programs/streams.• An episode should not be closed simply because there is a waiting period for the specific service a patient/client requires.

Information for Implementation:

- Once the health service is notified that a patient is deceased, the Episode is automatically closed.

The *Victorian public hospitals specialist clinics: discharge guidelines* discusses appropriate discharge practice and criteria for specialist clinic patients.

<http://docs.health.vic.gov.au/docs/doc/Discharge-guidelines>

REFERRAL OUT

Refer to the NAPMDS Implementation Framework, Section 11, for the full set of *Referral Out* Business Rules for implementation.

WHAT NEEDS TO BE ACHIEVED

- Health Services understand the Referral Out data elements and identify the appropriate points in their current processes when the relevant information is collected.

HOW TO IMPLEMENT THE CHANGE



- Identify the process, within each specialist clinic, where staff become aware that a patient episode is completed and therefore Referral Out data elements can be collected and entered into the system.



- What procedural support do staff need to collect the Referral Out data? Document and distribute the agreed point in the clinics procedures where the Referral Out date and Referral Out Service Type data is collected.



- Ensure all staff are adhering to a common practice when it comes to collecting and entering the Referral Out data elements.



- Identify NAPMDS requirements to be collected and reported to Department of Health. Determine how the data will be collected, validated, processed, checked and reported on a regular basis.



- Clearly communicate the definitions of each data element to ensure all clerical and clinical staff has a shared understanding of the terms, to avoid confusion.

Referral out data is only mandatory if the health service records a referral out to another service.

DATA ELEMENTS WORKING DEFINITIONS

Name	Reporting Obligation
3.1 Referral Out Date	M (when a referral out occurs)
3.2 Referral Out Service Type	M (when a referral out occurs)

For a full description of data elements including field format details go to VINAH Manual, Section 3

3.1 Referral Out Date

Description	The date that a Referral Out was made.
Purpose	To assist in service planning.
Business Rules	<ul style="list-style-type: none"> This data element must fall within the start and end dates of the Episode from which the Referral Out originated.

3.2 Referral Out Service Type

Description	The person to whom or service to which the patient/client is referred.
Purpose	To assist in the analysis of patient/client flow and service planning.
Business Rules	<ul style="list-style-type: none"> Report the code appropriate for the referral service type where known. Code 30 or Code 50 may be reported if a further level of detail is unknown for mental health services and correctional services, respectively.

CONTACTS

Refer to the NAPMDS Implementation Framework for Specialist Outpatient Clinics, Section 13, for the full set of *Contacts* Business Rules for implementation.

WHAT NEEDS TO BE ACHIEVED

- Health services are able to collect and enter all data required in relation to any direct contact that occurs between the patient/client and a professional associated with a specialist clinic program.
- All relevant staff have a sound understanding of all contact criteria and data elements that define a contact.
- All relevant staff understand the difference between an administrative contact and a clinical contact for the purpose of data collection.

HOW TO IMPLEMENT THE CHANGE



- Identify and review current process when collecting the Contact Client Present Status.



- Document and distribute procedures and supporting resources that relate to any new or complex processes, for staff to use as a quick reference guide.



- Clinics may use SMS and email reminders to trigger a reminder to staff to collect specific data element entries.
- Ensure that the practice of recovering hardcopy medical records for each patient contact is aligned to the new process.
- Review contact templates, which may be currently used by professional clinicians, to ensure data elements align with new data requirements – e.g. Contact Professional Group.



- Identify NAP MDS requirements to be collected and reported to Department of Health.
- Determine how the Contact data will be collected, validated, processed, checked and reported on a regular basis.



- Clearly communicate the definitions of each data element to ensure all clerical and clinical staff have a shared understanding of the terms, to avoid confusion.
- Consider cheat sheets for staff or laminated lanyards with data definitions and codes for staff to use/refer to.

DATA ELEMENTS WORKING DEFINITIONS

Name	Reporting Obligation
4.1 Contact Account Class	Mandatory
4.2 Contact Client Present Status	Mandatory
4.3 Contacts Clinic Identifier	Mandatory
4.4 Contact Date	Mandatory
4.5 Contact Delivery Mode	Mandatory
4.6 Contact Delivery Setting	Mandatory
4.7 Contact Family Name	C2 (Refer to Section 3, pg 10)
4.8 Contact Given Name (s)	C2 (Refer to Section 3)
4.9 Contact Group Session Identifier	C13 (Refer to Section 3)
4.10 Contact Indigenous Status	Mandatory
4.11 Contact Inpatient Flag	C6 (Refer to Section 3)
4.12 Contact Interpreter Required	Mandatory
4.13 Contact Medicare Benefits Schedule Item Number	Optional (1 st 12 months)
4.14 Contact Preferred Language	Mandatory
4.15 Contact Professional Group	Mandatory
4.16 Contact Provider	Mandatory
4.17 Contact Purpose	Mandatory
4.18 Contact Session Type	Mandatory
4.19 Contact TAC Claim Number	C4 (Refer to Section 3)
4.20 Contact VWA File Number	C5 (Refer to Section 3)

For a full description of data elements including field format details go to VINAH Manual, Section 3

4.1 Contact Account Class

Description	The agency/individual chargeable for the contact and associated sub categories.
Purpose	To assist in analyses of service utilisation and facilitate reimbursement by third party paying organisations for patients/clients with entitlements.
Business Rules	<ul style="list-style-type: none"> This data element records the funding arrangement for the contact/appointment. VINAH codes define the criteria for the Account Class appropriate to the referral.

Information for Implementation:

- It is possible to have an episode of care with contacts that have different account classes - e.g. one episode with 7 contacts, 5 of which are VACS funded (public eligible) and 2 of which are MBS funded.

4.2 Contact Client Present Status

Description	An indicator of the presence or absence of a patient/client at a contact.
Purpose	To monitor and plan resource utilisation.
Business Rules	<ul style="list-style-type: none">• For specialist outpatient clinics all contacts must involve the patient/client• For this data element the carers and family members are not considered to be patients/clients in their own right.

Information for Implementation:

For specialist clinics, a contact can have one of the following four statuses associated with it:

- Attended: code 10 - Patient/client present with or without carers/relative(s). This code should be chosen if it is not known whether or not a carer/relative attended with the patient.
- Attended: code 11 – Patient/client present only
- Attended: code 12 – Patient/client present with carer(s)/relative(s)
- Failed to attend: code 32 - Patient/client/carer(s)/relative(s) not present, scheduled appointment not attended. This should be chosen if the patient did not attend the scheduled appointment.

4.3 Contact Clinic Identifier

Description	A health service assigned identifier for the specialist outpatient clinic that is providing services for a particular contact.
Purpose	To assist in developing clinical costing models for specialist outpatient clinic services.
Business Rules	

4.4 Contact Date/Time

Description	The date and start time of the contact.
Purpose	To enable derived reporting elements and to monitor reporting accountability.
Business Rules	<ul style="list-style-type: none">• Contact/client service events may be of any duration.• The contact end date or time is not required to be collected or recorded.

4.5 Contact Delivery Mode

Description	The mode of provision of the service during the contact.
Purpose	To monitor and plan resource utilisation.
Business Rules	<ul style="list-style-type: none">• The Delivery Mode can be 'face-to-face', 'telephone' or 'telehealth'.• For specialist clinics, the Delivery Mode of the patient/client is reported, as contacts involving only the carer(s)/relative(s) are not reported.• If a patient/client does not attend a scheduled appointment the Delivery Mode is reported as Not Applicable.

4.6 Contact Delivery Setting

Description	The type of setting in which the contact is experienced by the patient/client.
Purpose	To assist with service planning and monitoring.

Business Rules	<ul style="list-style-type: none"> This data element should be coded to reflect the delivery location from the patient's/client's perspective, not the location of the health service professional(s).
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Scenario: If a patient attends a Health Service outpatient clinic that is physically located off the Health Service site that is funded to provide the service, the delivery setting is where the patient received the service.

4.7 Contact Family Name

Description	The family name(s) of the patient/client.
Purpose	To facilitate reimbursement for compensable services (i.e. DVA, TAC or workcover etc) for patients/clients with entitlements. This data is processed differently from other VINAH data to ensure that personal information remains confidential.
Business Rules	<ul style="list-style-type: none"> Permitted characters: A to Z (uppercase), space, apostrophe, hyphen. The first character must be an alpha character. Where not required by the value of Account Class, must be left blank. Note that VINAH requires only 24 characters of the family name to be reported, Health Services may collect names longer than 24 characters in full for their own purposes. When instructed to leave or report blank, in VINAH this means that the corresponding field in the transmission file must be transmitted as a null or empty field

4.8 Contact Given Name(s)

Description	The given name(s) of the patient/client.
Purpose	To facilitate reimbursement for compensable services (i.e. DVA, TAC or workcover etc) for patients/clients with entitlements. This data is processed differently from other VINAH data to ensure that personal information remains confidential.
Business Rules	<ul style="list-style-type: none"> Permitted characters: A to Z (uppercase), space, apostrophe, hyphen. The first character must be an alpha character. Where not required by the value of Account Class, must be left blank. Note that while VINAH requires only 15 characters of the given name(s) to be reported, Health Services may collect names longer than 15 characters in full for their own purposes. When instructed to leave or report blank, in VINAH this means that the corresponding field in the transmission file must be transmitted as a null or empty field

4.9 Contact Group Session Identifier

Description	An identifier, unique to a Group Session within an organisation.
Purpose	To enable identification of unique group sessions for reporting accountability
Business Rules	<ul style="list-style-type: none">• This data element is used to determine which patients/clients were present in a given group session.• The same value must be reported in this data element for all patients/clients that were present in the same group session.• This data element may be automatically generated in the system.

4.10 Contact Indigenous Status

Description	Indigenous status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin.
Purpose	Required for service planning.
Business Rules	This information must be collected. Systems must not be set up to input a default code.

4.11 Contact Inpatient Flag

Description	An indication of whether the patient/client is an inpatient at the time of the contact.
Purpose	To allow national reporting requirements to be met and assist with outcome analyses and service planning.
Business Rules	<ul style="list-style-type: none">• For Outpatients, all services in scope should be reported to this collection.• The reporting of Inpatient Flag 'I' indicates that the outpatient service has been provided as part of the inpatient service and therefore will not be funded separately.• To determine whether an outpatient visit can be funded separately from an inpatient visit on the same day, refer to the Victorian health policy and funding guidelines 2011-12 (http://www.health.vic.gov.au/pfg/index.htm#1).

4.12 Contact Interpreter Required

Description	The patient's/client's need for an interpreter, as perceived by the patient/client or the person consenting for the patient/client.
Purpose	This information is essential to assist in planning for provision of interpreter services.
Business Rules	<ul style="list-style-type: none">• Preferred Language is to be asked before Interpreter Required.• If Preferred Language is English, it can be assumed that an Interpreter is not needed and this data element coded accordingly.• This data element must be checked for every contact/client service event.• This data element must not be set up to input a default code on computer systems.• This data element must be collected at, or as soon as possible after, the contact/client service event.• This data element does not record whether an interpreter was actually present at the appointment.

4.13 Contact Medicare Benefits Schedule Item Number

Description	The Medicare Benefits Schedule Item Numbers charged during this contact, or their uncharged equivalents for non-MBS-funded contacts.
Purpose	To help inform cost-weight setting for activity based funding.
Business Rules	<ul style="list-style-type: none">• When reporting this data element for Contacts with Contact Account Class, the MBS item numbers for the equivalent service should be reported.• Collection of this data element is encouraged but not mandatory in 2011-12.

4.14 Contact Preferred Language

Description	The language (including sign language) most preferred by the patient/client for communication during the provision of care. This may be a language other than English even where the person can speak fluent English.
Purpose	Required for service planning.
Business Rules	<ul style="list-style-type: none">• Four-digit codes as specified in ABS Australian Standard Classification of Languages,(2005-2006) (ABS ASCL (2005-06)) should be used.• One of the supplementary codes should be used where a patient's/client's preferred language is not stated or inadequately described:<ul style="list-style-type: none">- '0000-Inadequately described'- '0002-Not stated'• This information must be ascertained for each contact/client service event.• This information must be collected. Systems must not be set up to input a default code.

4.15 Contact Professional Group

Description	The professional group of professional(s) providing services for a contact.
Purpose	To monitor and plan resource utilisation.
Notes	Where multiple clinicians from different disciplines are involved in the same contact/appointment, <ul style="list-style-type: none">• 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 <i>Contact Date/Time</i>.

Information for Implementation:

- An outcome slip template may be designed to capture other professionals involved in the contact, and handed into outpatient clinic desk at the end of the contact.

4.16 Contact Provider

Description	An identifier, unique within the state, for the organisational unit providing services that are reportable to the VINAH MDS, for a particular contact.
Purpose	To monitor and plan resource utilisation.
Notes	<ul style="list-style-type: none"> • The Contact Provider identifies the specific unit providing the care for a particular contact/appointment. • A Contact Provider maybe a different campus/site within the same health service

4.17 Contact Purpose

Description	The purpose of the service provided within the contact.
Purpose	To allow national reporting requirements to be met and to monitor and plan resource utilisation.
Business Rules	<p>Every contact/appointment must have a purpose recorded. Multiple purposes can be reported if required. For specialist clinics, only the following two codes should be used:</p> <ul style="list-style-type: none"> • <i>New patient assessment/treatment</i>: Specialist clinics should use code 13 ('specialist assessment') for appointments where the purpose of the appointment is to conduct an initial assessment (including combined initial assessment and treatment). • <i>Review appointments</i>: Specialist clinics should use code 71 ('follow up/monitoring/evaluation/review') to record appointments that have the primary purpose of reviewing the patient following a previous specialist clinic appointment or reviewing the outcome of treatment provided as an inpatient or day surgery patient. • <i>Additional purpose</i>: Codes in addition to code 13 or code 71 may also be reported. • If a patient fails to attend their appointment, the purpose of the appointment could be coded according to the intention had the patient arrived. For example; code 13, 'new patient assessment', code 71, 'review appointment', etc. Where this is unclear code 99, 'other' could be used. (FTA appointments will not be used in the calculation of new to review ratios). If this patient attends a subsequent appointment, the purpose should be recorded as the actual purpose of that appointment (i.e. new patients who fail to attend their first appointment may have their second appointment recorded as code 13.)

Information for Implementation:

- A patient may undergo a new assessment *for different purposes* by different practitioners within the same episode stream. Therefore, it is possible to have more than one 'new' contact/appointment throughout an episode.
- If a review patient is seeing a particular practitioner for the first time (for example, because the specialist who did their initial assessment is not available), the purpose of the appointment is still 'review'.
- The appointment of a patient referred to specialist clinics from an inpatient unit or the ED may be 'new' or 'review', depending on the actual purpose of the appointment.
- Common scenarios will be:
 - Patient A is referred to outpatients by his GP and is seen on different occasions by a number of doctors within a speciality. He sees a consultant for the initial appointment, then sees a registrar for the 2nd appointment, a different registrar for the 3rd appointment, then the original consultant for the 4th appointment. In this case, the first appointment is a 'new' appointment (specialist assessment, code 13). All three follow up appointments within the speciality/program stream are 'review' appointments (code 71).
 - Patient B is admitted to a ward directly from the emergency department and has surgery. Her surgeon asks her to attend an outpatient appointment two weeks after discharge from the inpatient admission to review the outcome of the surgery. Even though Patient B has not been seen in outpatients before, the purpose of the appointment is still 'review.'
 - Patient B is referred by her surgeon to a physiotherapist for a course of physiotherapy. The first physiotherapy appointment will be 'new' as this is a different program stream and requires a new assessment for a particular purpose.

4.18 Contact Session Type

Description	The type of session in which the contact was provided to the patient/client.
Purpose	To monitor and plan resource utilisation, and for reporting to the Australian Government.
Business Rules	<ul style="list-style-type: none"> • This data element records whether the patient/client's service was provided individually or as part of a group. • The data element can be defined as a 'Group' where two or more patients/clients are receiving the same services at the same time from the same staff at the same location. • The data element can be defined as a 'Group – Individual Program' where a clinician is working one-on-one with several different patients/clients in the same space over a period of time, and each patient/client is following their own personalised program. • If provision of care to a patient/client encompasses the provision of services to the patient/client's carer(s) and family, the data element is defined as 'Individual'. • Only one Contact Session Type can be reported for a single contact. • If a patient/client receives care in both individual and group settings within a single attendance, this must be reported as two separate contacts.

4.19 Contact TAC Claim Number

Description	The Transport Accident Commission Claim Number of the patient/client, relating to this contact.
Purpose	To facilitate payment by TAC for TAC patients.
Business Rules	<ul style="list-style-type: none">• Where a TAC Claim Number is not available, use C-U.

4.20 Contact VWA File Number

Description	The WorkSafe Victoria (Victorian WorkCover Authority) file number applicable to the patient/client relating to this contact. Unique identifier for a claim.
Purpose	To facilitate reimbursement by VWA for patients/clients with entitlements. This data are processed differently from other VINAH data to ensure that personal information remains confidential.
Business Rules	<ul style="list-style-type: none">• This number must be recorded at each contact/client service event where a service is provided to a person who holds the entitlement for reimbursement purposes.• The VWA file number is obtained from the patient/client.

ACRONYMS

Term	Definition
ABF	Activity Based Funding
ACK	Acknowledgement
AIMS	Agency Information Management Systems
DVA	Department of Veterans' Affairs
ESIS	Elective Surgery Information System
FIP	Funding and Information Policy
FTAs	Failed To Attends
HDSS	Health Data Standards and Systems
ICT	Information and Communication Technology
iPM	iSOFT Patient Management Software
MBS	Medicare Benefits Schedule
MDS	Minimum Data Set
NAAD	Non-Admitted and Ambulance Data unit
NAP	Non-admitted Patients
NMDS	National Minimum Data Set
NPA	National Partnership Agreements
Specialist Clinics	Synonymous with 'outpatients'
VAED	Victorian Admitted Episodes Dataset
VACS	Victorian Ambulatory Classification System
VEMD	Victorian Emergency Minimum Dataset
VHIRS	Victorian Health Information Reporting System
VINAH	Victorian Integrated Non-Admitted Health Minimum Dataset

GLOSSARY

For a full definition of terms, refer to the VINAH Manual, Section 3 and 4.

Term	Definition
Activity Based Funding	A casemix model, where a health service funding is determined by the types of patients a service treats. Expected 2012 implementation.
Contact	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.
Episode	The period during which a patient/client receives services within a defined program and stream.
NAP MDS Implementation Framework	A published document that aims to provide VINAH information to Speciality Outpatient clinics to assist with the implementation of the NAP MDS project.
Referral In	The process by which a referral is received and processed.
Specialist Outpatient Clinic	Health services provided to patients needing specialist medical, paediatric, obstetric or surgical assessment and care. They also provide associated allied health services (such as physiotherapy) and diagnostic testing. These services are generally known as outpatient services, where a consultation or procedure is provided by a public hospital to a person in a non-admitted setting.
Stream	A sub-grouping, usually clinical, within a program.
VINAH Manual	A Manual that has been developed by Department of Health in collaboration with a working party comprised of managers and clinicians from the field. The Manual aims to align the VINAH data elements and definitions with those used in other Departmental collections such as the Victorian Admitted Episodes Dataset (VAED), and with the standard definitions used in the National Health Data Dictionary.

APPENDICES

DATA SUBMISSION TIMELINE

As of 1 July 2011, the Department of Health will be ready to receive outpatient VINAH data on a monthly basis.

Monthly data submission expectations are:

- VINAH data compliance is reckoned on a monthly basis. Data for each calendar month (reference month), as specified in the 'Reported When' component of each data element in the VINAH Manual, must be transmitted according to the following:
- Submitting organisations must make at least one submission to the HealthCollect portal for the reference month by no later than 5pm on the tenth day of the month following the reference month. Health services will receive an error report from the Department of Health.
- All errors are to be corrected in time for the VINAH MDS file consolidation at 5pm on the 17th day of the month following the reference month. It is expected that complete data for the month is transmitted by the 17th.
- File consolidation for VINAH data refers to the availability of data for reporting purposes only.

2012-13 REQUIREMENTS

From 1 July 2012 data must be submitted in VINAH 8 format. This will include four new data elements and changes to existing data elements. Refer to VINAH Manual 2012-13 for details.

ERROR MANAGEMENT & PROCESS

Refer to VINAH Manual Section 4 for more detail regarding the VINAH data Business Rules at: http://www.health.vic.gov.au/hdss/vinah/2010-11/manual/vinah6_sect4.pdf

Business Rules

In the context of VINAH, Business Rules are plain English statements which provide a constraint, condition or restriction on some aspect of the data collection.

Health Services are expected to ensure that any systems used to collect VINAH data adhere to the business rules specified in section 4 of the VINAH manual.

Data Quality Objectives

Each business rule is aligned to a data quality objective which will ensure that the rules are successfully observed and enforced. A data quality objective may be achieved by one or more business rules.

Data Quality Principles

Each data quality objective aims to uphold one or more of the following data quality principles:

Consistency

Although data is obtained from a variety of clinics within the health service, the data shall be comparable through the use of standardised coding methods.

Health Services are expected to use the VINAH manual and implementation guides to communicate single data definitions and data entry processes, consistently across its clinics.

Integrity

The data must maintain its integrity with reference to a number of aspects:

Structural – the encoded format of the data is of the appropriate format

Referential – other records or data exist where reference is made to them

Elemental – data elements meet its standalone definition

Health Services are expected to ensure that any systems used to collect VINAH data adhere to the business rules specified in section 4 of the VINAH manual.

Privacy

The privacy of individuals is maintained in accordance with established guidelines.

Security & Accountability

The source of the data must be a trusted and authorised individual.

Validations

A business rule may be enforced by one or more validations. These validations are the reaction to an instance of data violating a business rule.

If a business rule is not enforced by a validation, this does not mean that the business rule does not need to be observed. Some business rules are not enforced by validations, but may be enforced through other means such as data quality investigations and audit.

The validations are listed in Section 8 of the VINAH manual:
http://www.health.vic.gov.au/hdss/vinah/2011-12/Manual/vinah7_sect8.pdf

Error Correction

The type of common errors have been categorised as generally related and resolved through process, configuration or user entry, as follows:

Error type	Rule	Example
Process	Data elements that are dates must follow the logical sequence of the Patient Journey process.	Any date related to a contact must fall between the Episode Start Date and the Episode End Date. Any Referral In dates must be before the Episode Start Date.
Configuration	Data must appropriately relate with other data elements that are being entered regarding the patient.	Delivery mode of 'written' does not apply to Specialist Clinics.
Configuration	Health Service specific codes must be correctly mapped to valid VINAH codes.	All VACS clinics must be mapped to a valid VINAH Episode Streams.
User Entry	Data elements that are mandatory must be entered.	Episode Program Stream must be identified and entered by the system user.

Information for Implementation:

- Identify who will receive the error report within your Health Service.
- Consider separating error reports into process, configuration and user entry to prioritise and manage.
- Provide information/resources/scripts to staff who deal directly with data entry, about the ongoing and common errors.
- Implement a training and education process for all related staff once error reports are received by the Health Service.
- Determine a strategy to ensure that process errors are addressed at the source. For example, clerical staff wearing lanyards with data entry reminders.

FREQUENTLY ASKED QUESTIONS (FAQS)

FAQs are to be included to this guide throughout the implementation phase of the NAPMDS project

Episode

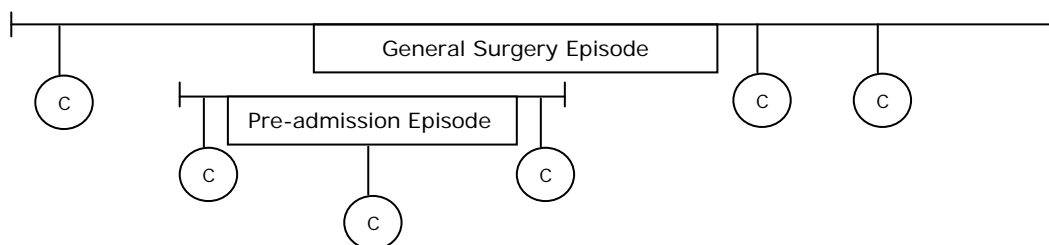
Preadmission services in VINAH

Preadmission contacts/appointments can be reported in one of two ways:

a) Separate episode of care

The program/stream of the episode is coded as 209 (i.e. the code corresponding to the 'preadmission' VACS category).

Scenario 1



b) As a contact at a Preadmission clinic within an episode of care

An episode is reported with various contacts at relevant clinics, one of which may be at a pre-admission clinic. The clinic identifier reported will be that of a registered pre-admission clinic.

Scenario 2

