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| Victorian Activity Based Costing |
| Victorian Cost Data CollectionPart A: VCDC Process, Data Definition Specifications and Standard Principles Version 3.5 |
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| **Victorian Activity Based Costing**Victorian Cost Data CollectionPart A: VCDC Process, Data Definition Specifications and Standard Principles Version 3.5 |
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Contents

[Glossary of acronyms and abbreviations 8](#_Toc144446742)

[Introduction 9](#_Toc144446743)

[Overview 9](#_Toc144446744)

[Victorian Cost Data Collection 9](#_Toc144446745)

[National requirements 10](#_Toc144446746)

[Victorian requirements 10](#_Toc144446747)

[Compliance 10](#_Toc144446748)

[References 10](#_Toc144446749)

[Victorian Health data standards and systems 10](#_Toc144446750)

[VCDC data definition specification (DDS) 11](#_Toc144446751)

[Australian Hospital Patient Costing Standards 11](#_Toc144446752)

[Australian Institute of Health and Welfare metadata online registry 12](#_Toc144446753)

[VCDC Process flow 12](#_Toc144446754)

[Phase 1 - receipt of submission 15](#_Toc144446755)

[Phase 2 - summary of submission and file validations 15](#_Toc144446756)

[Phase 3 - linking/matching VCDC to activity 16](#_Toc144446757)

[Phase 4 - data quality assurance checks 17](#_Toc144446758)

[Phase 5 - receipt of reconciliation report and Data Quality Statement (DQS) 18](#_Toc144446759)

[Communication of submission 18](#_Toc144446760)

[Annual change process 18](#_Toc144446761)

[File structure 18](#_Toc144446762)

[Data field requirements 19](#_Toc144446763)

[Episode program 19](#_Toc144446764)

[Stream codes 20](#_Toc144446765)

[Clinic IDs within Programs 20](#_Toc144446766)

[Service locations within Programs 20](#_Toc144446767)

[Service date 21](#_Toc144446768)

[Linking cost and activity 24](#_Toc144446769)

[Linking rules and requirements 24](#_Toc144446770)

[Cross program matching algorithms 29](#_Toc144446771)

[Standard Principles 31](#_Toc144446772)

[Scope of activity 31](#_Toc144446773)

[Activities costed 31](#_Toc144446774)

[Specific reporting of costed activities 34](#_Toc144446775)

[Scope of expenditure 39](#_Toc144446776)

[Expenses for costing 39](#_Toc144446777)

[Allocation of costs 40](#_Toc144446778)

[Work-in-progress patients 40](#_Toc144446779)

[Attachments 42](#_Toc144446780)

[Attachment 1: North-Western Mental Health (NWMH) 42](#_Toc144446781)

[Appendices 44](#_Toc144446782)

[Appendix 1: Document change history 44](#_Toc144446783)

Table of contents

[Table 1: VCDC actions and reporting timelines 12](#_Toc144446816)

[Table 2: Service location codes – Level 1 21](#_Toc144446817)

[Table 3: Service location codes – Level 2 21](#_Toc144446818)

[Table 4: Admitted reportable VCDC program codes and VAED care types 24](#_Toc144446819)

[Table 5: Admitted linking/matching rules 25](#_Toc144446820)

[Table 6: Emergency reportable VCDC program codes 25](#_Toc144446821)

[Table 7: Emergency linking/matching rules 26](#_Toc144446822)

[Table 8: Non-admitted reportable VCDC program codes 26](#_Toc144446823)

[Table 9: Non-admitted linking/matching rules 26](#_Toc144446824)

[Table 10: Mental Health reportable program codes 27](#_Toc144446825)

[Table 11: Mental Health linking/matching rules 28](#_Toc144446826)

[Table 12: Phase of Care file linking/matching rules 29](#_Toc144446827)

[Table 13: Episode program activity 31](#_Toc144446828)

[Table 14: Indirect allocation methods for Teaching & Training 35](#_Toc144446829)

Table of figures

[Figure 1: VCDC process flow 14](#_Toc144446936)

[Figure 2: Mental Health reporting hierarchy 37](#_Toc144446937)

[Figure 3: Work-in-progress categories 41](#_Toc144446938)

# **Glossary of acronyms and abbreviations**

AIMS Agency Information Management System

AHPCS Australian Hospital Patient Costing Standards

CCOA Common Chart of Accounts

CCU Community Care Unit

CMBS Commonwealth Medicare Benefits Schedule

CMI Clinical Management Information (Mental Health)

DH Department of Health

DDS Data definition Specifications

ED Emergency Department

ESSU Emergency Short Stay Unit

GL General Ledger

IHACPA Independent Health and Aged Care Pricing Authority

HEN Home Enteral Nutrition

HSA Health Services Agreement

LHN Local Health Network

MH Mental Health Service

NADC Non-Admitted Data Collection

NEC National Efficient Cost

NEP National Efficient Price

NHCDC National Hospital Cost Data Collection

NHRA National Health Reform Agreement

VAED Victorian Admitted Episodes Dataset

VCDC Victorian Cost Data Collection

VEMD Victorian Emergency Minimum Dataset

VINAH Victorian Integrated Non-admitted Health Dataset

VRMDS Victorian Radiotherapy Minimum Dataset

VTWG Victorian Technical Working Group

# **Introduction**

The purpose of the Victorian Cost Data Collection (VCDC) data specification, business rules and guidelines are to assist costing practitioners to identify and attain all the relevant information for allocation of resources to patients.

This document assists health services in the reporting and costing of any submission year patient level cost data. This documentation comprises of three parts:

**Part A: VCDC process, Data Definition Specifications and Standard Principles:**

* References - links to files and documentation relating to various sources of information and code sets to assist health services with their cost data submissions
* Process flow – outlines the processes that the files progress through the VCDC extract, transform and load process
* Data definition specifications – details of the requirements of the files to be submitted including the structure, values, and validation rules
* Standard Principles – includes scope of activity and expenditure

**Part B: Business rules and Specific costing guidance:**

* Business Rules – guidance on the reporting and costing requirements for submissions to the Victorian Cost Data Collection
* Specific Costing Guidance – guidance on specific criteria and conditions to be applied for the reporting of patient level cost data across diverse services

**Part C: Review, Reconciliation, and communication:**

* Review and reconcile – details of the data quality assurance checks and reconciliation requirements
* Communication – information on communication with health services at each stage of the submission process.

This document has been developed by the Department of Health (the department) in consultation with inter-departmental stakeholders and relevant external stakeholders and endorsed by the Victorian Cost Data Collection Technical Working Group (VTWG).

# **Overview**

## Victorian Cost Data Collection

Victorian public hospitals are expected to maintain patient level costing systems that monitor service provision to patients and determine accurate patient-level costs which are then to be reported annually for all hospital activity, regardless of funding source, to the Victorian Cost Data Collection (VCDC).

The VCDC acquires cost data from metropolitan, regional, and sub-regional health services as per the Victorian health policy and funding guidelines.

The cost data is used to:

* Refine the existing Victorian funding models
* Assist in the development of future funding models
* Enable analysis of cost data across health services
* Inform development of budget proposals
* Analyse the cost of health care
* Perform comparative benchmarking
* Inform best practice quality improvement initiatives and
* Meet the cost data requirements of the National Health Reform Agreement (NHRA), via the National Hospital Cost Data Collection (NHCDC).

## National requirements

As part of the NHRA, Victoria uses the VCDC as the base data for submission to the Independent Health and Aged Care Pricing Authority’s (IHACPA) NHCDC.

The NHCDC collects patient level cost data across the Commonwealth for the purposes of calculating national cost weights and determining the National Efficient Price (NEP) and National Efficient Cost (NEC).

## Victorian requirements

The policy and funding guidelines also prescribe the reporting requirement of the VCDC as outlined in the data requirements section found on the department’s [Policy and funding guidelines](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) web page.

*< https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>.*

## Compliance

To ensure there is consistent, reliable, and quality costed data, health services are to adhere to this document and any other documentation or guidance provided by the department as well as comply with the national Australian Hospital Patient Costing Standards (AHPCS) Version 4.1 or the most recent version available.

# References

This document refers to several sources of information and data code sets including:

Victorian Health data standards and systems

[Victorian Health data standards and systems](https://www.health.vic.gov.au/data-reporting/health-data-standards-and-systems)

*< https://www.health.vic.gov.au/data-reporting/health-data-standards-and-systems>*

The Department of Health and Human Services provides standards, specifications, and data quality processes for the following health data collections:

Victorian Admitted Episodes Dataset (VAED)

Victorian Emergency Minimum Dataset (VEMD)

Agency Information Management System (AIMS)

Victorian Integrated Non-Admitted Health Dataset (VINAH)

Victorian Cost Data Collection (VCDC)

Mental Health Client Management Interface (CMI)

Financial data collections

[Non-Admitted Clinic Management Systems](https://www.health.vic.gov.au/publications/non-admitted-clinic-management-system-nacms-manual) (NACMS) *<https://www.health.vic.gov.au/publications/non-admitted-clinic-management-system-nacms-manual>*

The department undertakes continual updates and improvements to their standards, specifications, and processes.

## VCDC data definition specification (DDS)

The following references that should be used in the preparation and reporting of the VCDC for a submission year can be found within the data collections list of reports for the [Victorian Cost Data Collection](https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc). *< https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc>*

### Data Request Specification (DRS)

* File Naming Convention - file specifications and file naming conventions
* LHN Naming Convention - lists the LHN names to be used in the naming of the file and shows all campuses for each LHN submitted to VCDC
* Episode Entity file specifications (EPI) - specifications of a patient records demographic details, valid values and validation rules
* Episode Costs file specifications (EPC) - specifications of a patient records cost details, valid values and validation rules

### Chart of Account (COA) mapping

Chart of Account mapping details for cost centres and account codes used for costing and reporting to the VCDC including the resource category matrix and relevant notes accompanying the mapping.

These details will be updated in accordance with the relevant submission year from the Department’s Finance COA.

### Other Reference files

• Campus code table • VINAH code list

• MH campus code • Procedure prostheses codes

• MH campus and sub-centre • Vic resource category matrix

• Episode program details • Stream

• Classification lists

## Australian Hospital Patient Costing Standards

The national [Australian Hospital Patient Costing Standards](https://www.ihacpa.gov.au/health-care/costing/australian-hospital-patient-costing-standards) (AHPCS) developed and maintained by the Independent Health and Aged Care Pricing Authority (IHACPA) are also to be observed by Victorian health services in applying best-practice principles to costing hospital products. Consistent application of the Standards will generate high quality, reliable and comparable data that can be used by regulators, funders, providers, and researchers to further develop the Australian hospital system.

The purpose of the document is to practically assist costing practitioners (and their stakeholders) to identify and attain all the relevant information for costing purposes both within their organisation and their respective jurisdiction to enable them to adhere to the Australian Hospital Patient Costing Standards (AHPCS) Version 4.1 or the most recent version available.

*< https://www.ihacpa.gov.au/health-care/costing/australian-hospital-patient-costing-standards>*

## Australian Institute of Health and Welfare metadata online registry

[Australian Institute of Health and Welfare metadata online registry](https://meteor.aihw.gov.au/content/181162)

METeOR is Australia's repository for national metadata standards for the health, community services and housing assistance sectors. The system was developed by the Australian Institute of Health and Welfare to replace the previous repository, the Knowledgebase.

*< https://meteor.aihw.gov.au/content/181162>*

# VCDC Process flow

The VCDC submission involves a five-phase process to ensure the data submitted meets the requirements specified in this documentation. The five phases include:

Phase 1 - receipt of submission

Phase 2 - summary of submission and file validations

Phase 3 - linking/matching VCDC to activity

Phase 4 - data quality assurance checks

Phase 5 - receipt of reconciliation report and Data Quality Statement (DQS)

Health services reporting VCDC data will be required to adhere to the minimum submission timelines as in **Table 1** below. Timelines are indicative of the process and health services may complete the submission process earlier. Health services may submit more frequently than the minimum standards in the table.

Table 1: VCDC actions and reporting timelines

|  |  |
| --- | --- |
| **Actions** | **Date** |
| VCDC Secure Data Exchange portal open | 23 September |
| First submission of files to VCDC - Phase 1 | 23-October |
| Following provision of report(s) - Complete Phase 2 and Phase 3  | Within 5 weeks |
| Following provision of report(s) - Complete Phase 4 | Within 4 weeks |
| Following final file - Submission of reconciliation report and Data Quality Statement\* | Within 1 week |
| DH to consolidate Victorian cost database | 15-January |

\* Signed Reconciliation Templates and Data Quality Statements, including a signed attestation, are to be submitted no later than five business days after the final submission of cost data.

\*\*Any major corrections to submissions that will impact on the costed results significantly, must be submitted two weeks before final consolidation of the cost database

**Figure 1** below shows the process flow of the VCDC files.

Figure 1: VCDC process flow



## Phase 1 - receipt of submission

Frequency of submission

1. Data is to be submitted for a complete fiscal year annually.

### Expected data

1. One annual submission including all discharged/completed records in the fiscal period regardless of funding. (Refer to section on Scope of activity)
2. The submission must contain the entire cost for each patient including those costs allocated in prior years. (Refer section on Scope of expenditure)
3. Files submitted must follow the naming conventions and file rules found in the DDS.
4. It is expected that health services undertake validation, reconciliation, and quality assure reviews of the data before submission.

### Submitting files – Secure data exchange

File submission is via the department’s Secure Data Exchange (SDE 3) portal facility using the dropbox section. The functions of the SDE 3 include:

* Sites transmitting files to the department (dropbox)
* The department transmitting files that can be downloaded by specific sites (download section)
* The health services transmitting files to the department (upload section)

It is recommended that at least two representatives from each health service register for access to the VCDC SDE by contacting the administrator via VCDCassist.

A copy of the SDE 3 user guide or for a list of registered users and any further information required please contact the VCDC Team at VCDCassist@health.vic.gov.au.

Resubmission

1. A resubmission must have all critical errors resolved before resubmitting the entire files within the timelines specified above.
2. Resubmitted files replace previously submitted files.
3. Files resubmitted must follow the naming conventions and file rules in section File structure.

## Phase 2 - summary of submission and file validations

### File summaries

File summaries show the direct, indirect, and total costs submitted along with the number of records by each program and campus submitted to the VCDC. There is also another tab showing all the non-admitted settings (Program NV, N1, N0, NN, C, U, UD, X, and W), the number of records and the costs by program, stream code, and clinic (where applicable).

#### How this is used

This summary should be reviewed by health services to ensure that the file received by the department contains the data that was intended to be submitted. It will assist with reconciliation and identify any issues regarding the programs, number of records and costs submitted.

1. The department will ensure:
	1. the naming convention follows the rules as found in section File structure.
	2. the file format is correct, and all valid fields are included.
2. Should the files not conform to point nine, the files will be rejected and require rectification by health services.

### File validation

The submitted files must be submitted as per the data request specifications (refer to reference section). To ensure this occurs, a set of validation rules are applied across the files where critical errors are identified that must be rectified by health services before the files can be progressed in the process. Warning errors flagged for potential fixes. (Please note warnings are not mandatory to be fixed and the file will progress through the process).

#### How this is used

The validations identify records that have been submitted which do not contain the values required. Health services must rectify all critical errors so the file and its contents can be progressed in the process and enable further use of the data.

1. The department will validate the files upon submission for file format, structure, and value ranges.
2. Where an error occurs on the file, health services and/or vendors will be notified of the error type, including the episode and file to which the error is related to.
3. Submissions containing critical errors must be rectified and resubmitted for the file to continue processing. These errors affect matching to activity and further use for analysis and reporting and incorporation into funding models.
	1. If critical errors are not rectified the file will not be progressed further. The department will work with health services, where possible, to resolve critical errors as quickly as possible.
4. Submissions containing warnings are at the discretion of the health service to rectify. These errors may impact on the matching to activity and further use for analysis and reporting. Should these not be rectified the file will still progress further.
5. If the files have been re-submitted, they will go through the process from the beginning.
6. If the files do not contain critical errors, it will automatically progress to the next phase.

## Phase 3 - linking/matching VCDC to activity

The VCDC files only contain some patient demographic IDs and/or fields that are used to link to the activity datasets where the full array of patient demographics and clinical details are obtained. This is to eliminate duplication of activity details already submitted by health services.

The expectation is that those records submitted to the activity datasets will have a corresponding costed record. The linking/matching reports identify any record(s) that cannot be linked to the activity datasets. There may be several reasons for these unmatchable records and this report will assist health services investigate the reasons for these, thereby improving the data costed and reported.

#### How this is used

Reviewing the linking report will help identify:

1. How the records have been matched – which criteria resulted in a match. The strongest match would be more applicable.
2. Identify those areas where further investigation is required to ensure a link can be made.
3. Identify whether the linking rules need to be modified.
4. All files will be matched and linked against specific activity data where required. (Refer to section Linking VCDC to activity).
5. There are various levels of matching/linking performed to enable a link to be made from activity records to the VCDC records and vice versa. Where no match found these will be outputted in the report for review, comment and/or rectification.
6. Health services are to review the levels of matching/linking of the VCDC data to the activity data and vice versa to ensure that all expected activities have been linked/matched.
7. Health services are to provide detailed comments as to why there are unmatched records. These comments are to be included into the linking report and submitted to the department via the SDE-upload section.
8. Health services are to ensure that data provided to VCDC have included activities that have been closed off and finalised for the reporting year. Costing practitioners are expected to liaise with their relevant stakeholders who provide the department with their health services’ final activity datasets to ensure that details required for costing are captured and reconciled.

## Phase 4 - data quality assurance checks

Quality Assurance (QA) checks provide a level of understanding of the usefulness of the patient level costed data for development of funding models and interpretation for analysis and reporting. QAs are performed on records within the admitted, emergency, non-admitted, subacute, and mental health settings. Further details regarding the QAs can be found in Part C.

1. Quality assurance (QA) checks will be performed on final submissions once the file format, structure and value ranges are validated to be correct and the matching levels are deemed valid.
2. The department will provide health services with records that have been flagged for review where they have met the criteria and tolerances.
3. Health services are to review and assess whether those records are valid or invalid and provide comments as to the validity within the QA reports. These comments are to be submitted via the SDE.

## Phase 5 - receipt of reconciliation report and Data Quality Statement (DQS)

Victorian health services are to attest that their cost data submitted has been reconciled and complete in accordance with the VCDC documentation and compliant to the AHPCS. To facilitate Victoria is compliant with the national requirement to the AHPCS standard six review and reconcile, health services are to complete and submit the following:

* Final submission comments on the linking reports and data quality assurance checks– refer to relevant section, as well as
* Reconciliation report – refer to Part C
* Data quality assurance statement – refer to Part C

## Communication of submission

The health service submitter is to confirm that a submission has been uploaded to the SDE dropbox and an acknowledgement from the department will be made via email. It is recommended that health services keep a copy of any submitted files for auditing purposes.

# Annual change process

The department’s annual change process now includes the Victorian Cost Data Collection.

Each year the Department of Health reviews the data elements and format of its key health services data collections.

This review - the annual change process - seeks to ensure that health data collected in Victoria:

* supports the department's state and national reporting obligations
* assists planning and policy development
* reflects changes in hospital funding and service provision arrangements for the coming fiscal year
* incorporates appropriate feedback from data providers on improvements.

Further information about the Annual Changes process can be viewed at the [HSD Website](https://www.health.vic.gov.au/data-reporting/annual-changes). <*https://www.health.vic.gov.au/data-reporting/annual-changes>*

# File structure

There are three files to be submitted.

1. The EPI (Episode Entity) - Each time a patient is discharged from hospital or presents for treatment on an ambulatory basis, it is counted as an episode of care. All completed episodes are to be reported to the VCDC including, but not restricted to the VCDC list of episode types.
2. The EPC (Episode Cost) - An episode will have a set of costs associated with it, which can be attributed as a direct cost for the care of the patient (e.g., imaging) and an indirect cost (e.g., overhead cost for payroll).
3. The EPC\_POC (Episode cost at phase of care) – The same requirement as the EPC except the details in this relates to Palliative Care and Mental Health (admitted and community) records by day of their stay/treatment. This file will assist in deriving a cost for a phase of care.

# Data field requirements

Victorian health services are required to report patient level cost data for the submitting year to the department in accordance with the policy and funding guidelines. This data must be reported to the VCDC in compliance with the DDS and relevant reference files.

Data reported to the VCDC reflects costs for ‘episodes of care’ provided to patients. Types of ‘episodes of care’ in the VCDC are defined by an ‘Episode Program’ (program field) code.

It is a requirement that each ‘episode of care’ contain cost information on the client at the cost area and account type level. This allows the cost data to be utilised for NHCDC reporting requirements, as well as prior year comparisons to Victorian cost groups and funding model developments.

Accurate allocation of resources and cost to appropriate patients and reported by product types is critical to the development of Victorian and national pricing and funding models. This will ensure the price weights and any adjustments (e.g., ICU adjustment) represent resource use.

For full details including the definitions, relevant categories and specific values that will enable linking to the appropriate activity datasets and further use for analysis please refer to the DDS found at [Victorian Health data standards and systems](https://www.health.vic.gov.au/data-reporting/health-data-standards-and-systems).

*<https://www.health.vic.gov.au/data-reporting/health-data-standards-and-systems>*

## Episode program

The program field (episode program) identifies the type of service for which the episode occurred. The categories applicable for a submission year cost data are categorised into a program setting as:

* Admitted including subacute and mental health
* Emergency including Urgent Care centres
* Non-Admitted including those reported to VINAH, NADC and AIMS
* Other non-admitted including unlinked diagnostic services and specific health service programs
* Community Health
* Radiotherapy where the service/treatment has not been linked to an admitted record
* Research where episodes and/or derived/virtual patients have identified research related costs
* Teaching and Training where episodes and/or derived/virtual patients have identified teaching & training related costs
* Boarders where costs of episodes provided services for a boarder staying in a health service
* Mental Health including community and residential as well as consultation liaison services

Further details can be found at section Scope of activity within this document.

## Stream codes

The stream field (Episode Program Stream) identifies the program, stream, or service for records to which the patient’s/client’s episode relates to. In the current reporting FY, which includes but not limited to:

* Reportable contacts through VINAH -– non- ABF in-scope, Program NV, N0, N1
* In scope ABF reportable VINAH contacts, Program NV and registered on NACMS
* In scope ABF reportable on AIMS S10 aggregate data, Program N0 and registered on NACMS
* In scope ABF reportable on AIMS S11 aggregate data, Program N1
* Unlinked diagnostic and/or therapeutic services, Program UD
* Unallocated for NHRA Services, Program U
* Unlinked Residential Aged Care, Program U
* Urgent Care Centres, Program EU
* Other Non-Admitted services not specified in other programs, Program U
* Community Health, Program C
* Ambulatory Radiotherapy - reported through AIMS S10 or S8, Program R
* Ambulatory Radiotherapy – reported through VRMDS and not associated to the other two specific cohorts identified above, Program R
* All other Mental health patient contacts including but not limited to community or residential mental health services, aged care, PARC, Program M; and
* Consultation and Liaison Mental Health Services, Program M

All the above must be reported with a value in the ‘stream’ field of the VCDC as specified in the reference file. Where it is not specified, a four (4) character value must be provided to identify the program, stream, or service. The code must be emailed to VCDCassist to ensure it forms part of the validation process.

For full details and valid stream values refer to the DDS found at [Victorian Health data standards and systems](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems).

## Clinic IDs within Programs

The clinic (Clinic ID) is the code used to uniquely identify a non-admitted clinic, program, or service within the health service.

The clinic ID is mandatory to be reported for records where a stream has been identified for those programs outlined in the above section except for the Urgent Care Centres (UCC).

Clinics that are registered within the department’s Non-Admitted Clinic Management System (NACMS), such as those under programs NV, N0 - Specialist Clinics Outpatients and specific programs – HEN, TPN, HDD, HDPD, and Radiotherapy consultations must report the same code in the ‘clinic’ field for VCDC.

## Service locations within Programs

The service location should be reported to identify where the service was ordered or if that is unknown, where it was delivered. Ideally the feeder system data should identify the location of where the service was ordered from. If this is not possible, then a match of the location of the patient on the date of service can be used.

Two levels of specificity can be reported. Reporting at level one is mandatory and outlined in **Table 2** whereas reporting at level 2 specific codes can be found in **Table 3**.

Table 2: Service location codes – Level 1

| **Level 1** | **Description** |
| --- | --- |
| 100 | Inpatient |
| 200 | Emergency Department |
| 300 | Non-Admitted |
| 400 | Community Health |

Table 3: Service location codes – Level 2

| **Level 2** | **Description** |
| --- | --- |
| 101 | Ward |
| 102 | Intensive Care Unit |
| 103 | Coronary Care Unit |
| 104 | High Dependency Unit |
| 105 | Neonatal Intensive Care Unit |
| 106 | Special Care Nursery |
| 107 | Operating Room |
| 108 | Specialist Procedure Suite |
| 109 | Hospital in the Home |
| 200 | Emergency Department |
| 301 | Specialist Consultation Suite |
| 302 | Other Procedure Suite  |
| 303 | Private Practice |
| 304 | Radiotherapy Service |
| 305 | Post Natal Domiciliary Nursing Service |
| 306 | Other Domiciliary Nursing Service |
| 307 | Medihotel |
| 400 | Community Health |

## Service date

A service date (ddMMMyyyy) is the date of when services are provided to a patient within an episode of care. This is useful if a service location cannot be identified via a feeder system, then a match of the location of the patient on the date of service can be used.

For admitted episodes, the date of service is only required for the first date of any service in each specific location when reporting at level 2 and should only change if the location changes. For example, when the patient moves from a ward to ICU then the date of service for reported costs in the ward will be the first day in the ward, and ICU cost will have the first day of admission to ICU. If a patient presents to ICU twice within an admitted episode, then cost records should be reported separately for each stay in ICU.

Ideally the feeder system data should identify the date of when the service was ordered or delivered for services that do not require ordering (that is example: bed days). If this is not possible, then the service date (that is test date) or the date that the service was provided to the patient (that is reporting date) should be used.

**Note: This field is an optional field within the main file and can be provided as a blank or NULL value.**

### Palliative care phase of care

All health services providing inpatient palliative care services are required to report data elements linked to the phase of care, including specific elements for the final phase. Costs at the phase level are required for palliative care as outlined in the Policy and Funding Guidelines.

In the reporting FY, the costs for palliative care phase of care data will need to be reported through the VCDC to enable a more accurate link of cost data to the phase of care. For further guidance on reporting the phase of care costs for palliative care patients refer to the file at **section 3 data field specifications**.

The date time of service is **a mandatory field** for reporting palliative care phase of care costs. The department will provide details of these records that will assist health services to report this cost data to the VCDC.

The main field to be used is the Phase of care date (PALL\_Bed\_dt) which depicts the data at a daily level for each phase including the admission and discharge phase of care dates. This field will allow the linking of the costs already at a date time of service level within costing systems to be matched to the relevant phase of care code (phaseofcare\_cd).

### Mental health care phase of care

#### National requirement

IHACPA has developed a new classification for mental health, known as the Australian Mental Health Care Classification (AMHCC). The classification has six major splitting variables known as phase of care. The first three variables are categorical variables, and the remaining variables are complexity variables.

For further details of the national requirements and classification development please refer to the [IHACPA site](https://www.ihacpa.gov.au/). < *https://www.ihacpa.gov.au*>

#### Victorian Costing requirement

To enable analysis and investigation into the relevancy to the new classification, the cost data needs to be provided at a phase of care level.

There is an additional requirement to also report the Mental Health costed activities by date of service. The format of phase of care reporting will be like palliative care phase of care file which reports the data at a date of service, the mental health (program MH and admitted care type 5) records are to be included at that level.

The reporting of the Mental Health activity includes admitted mental health (program MH) and CMI non-admitted mental health and residential bed-based (program M). Costing practitioners (with consultation with mental health stakeholders) already apportion expenses to the resources utilised by these activities at a day of service.

# Linking cost and activity

The cost data will be linked to the appropriate activity datasets based on various levels of matching detailed below. Some costs are combined to align with what is reported in the activity datasets and to allow back year comparisons. The processes of combining costs are performed through cross program matching algorithms or linking activity rules.

## Linking rules and requirements

The department relies on a ‘one submission, multiple use’ of dataset variables to reduce the duplication burden. It also ensures that the patients’ data variables when analysing, reporting and use in developing funding models are consistent.

To ensure that the cost data reported through the VCDC dataset can be linked to the appropriate patient level activity, a matching and linking process is undertaken by the department. The cost will be linked to the appropriate patient level activity datasets reported to the department and include:

* Victorian Admitted Episodes Dataset (VAED)
* Victorian Emergency Minimum Dataset (VEMD)
* Victorian Non-admitted Health Minimum Dataset (VINAH)
* Clinical Management Information System – Mental Health (CMI)
* Non-Admitted Data Collection (NADC) – specialist clinic data to be included. Other programs are being reviewed.

Health services are to provide comments on their final linking reports and return them to the department. It is expected health service will review the unmatched/unlinked records at patient level and comment the reason they are unlinked.

### Admitted linking/matching rules

Admitted patient level data reported to the department is identified in VAED by care type and VCDC by program as outlined below.

Table 4: Admitted reportable VCDC program codes and VAED care types

| **Program code** | **Program Description** | **Care Type** | **Care type description** |
| --- | --- | --- | --- |
| AO | Acute Other | 0 | Alcohol and Drug Program |
| NH | NHT/Non-Acute | 1 | NHT/Non-Acute |
| AC | Acute | 4 | Other care (Acute) including Qualified newborn |
| RH | Rehabilitation | 6 | Designated Rehabilitation Program/Unit |
| PC | Palliative Care | 8 | Palliative Care Program |
| GM | GEM | 9 | Geriatric Evaluation and Management Program |
| OG | Organ Procurement | 10 | Posthumous Organ Procurement |
| MH | Mental Health Acute | 5A | Acute, Adult Mental Health Service |
| MH | Mental Health Acute | 5E | Mental Health Secure Extended Care Unit (SECU) |
| MH | Mental Health Acute | 5G | Acute, Aged Persons Mental Health Service (APMH) |
| MH | Mental Health Acute | 5K | Child and Adolescent Mental Health Service (CAMHS) |
| MH | Mental Health Acute | 5S | Acute, Specialist Mental Health Service |
| MH | Mental Health Acute | 5T | Mental Health Nursing Home Type |
| MA | Maintenance Care | MC | Maintenance Care |
| RP | Paediatric Rehabilitation | P | Designated Paediatric Rehabilitation Program/Unit |
| AU | Acute Unqualified newborn | U | Unqualified newborn |

Table 5: Admitted linking/matching rules

| **Match level** | **VAED activity fields** |  | **VCDC fields** |
| --- | --- | --- | --- |
| **Where the values within the fields are the same then match** |  |  |
| 1 | Campus + UR + VAEDID | = | Campus + UR + DhKey |
| 2 | Campus + VAEDID | = | Campus + DhKey |
| 3 | Campus + UR + Episode Start Date/Time + Episode End Date/Time | = | Campus + UR + estart + eend |
| 0 | No match can be made |   |   |

*Please note: the fields containing date/time will only be evaluating the date component.*

### Emergency linking/matching rules

Emergency is identified by the VCDC program and includes all records in the VEMD.

Table 6: Emergency reportable VCDC program codes

|  |  |  |
| --- | --- | --- |
| **Program code** | **Program Description** | **Definition** |
| E | Emergency Presentations | Presentations reported to the Victorian Emergency Minimum Dataset (VEMD). |
| Co-located GP clinics within ED (departure status = 30) |
| Part of the admitted setting | ED Short Stay Unit | Emergency department (ED) short stay units are units designated and designed for the short-term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the ED. |
| EU | Emergency - Urgent Care Centres | Urgent Care Centres as reported through AIMS S10 and UCC form |

Table 7: Emergency linking/matching rules

| **Match level** | **VEMD activity fields** |  | **VCDC fields** |
| --- | --- | --- | --- |
| **Program E - Emergency VEMD** |  |  |
| **Where the values within the fields are the same then match** |  |  |
| 1 | Campus + UR + VEMDID | = | Campus + UR + DhKey |
| 2 | Campus + VEMDID | = | Campus + DhKey |
| 3 | Campus + UR + Episode Start Date/Time + Episode End Date/Time | = | Campus + UR + estart + eend |
| 0 | No match can be made |   |   |

Please note: the fields containing date/time will only be evaluating the date component.

### Non-Admitted linking/matching rules

The non-admitted data is identified in several ways to reflect the type of reportable activity and therefore linkable to cost data.

Table 8: Non-admitted reportable VCDC program codes

|  |  |  |
| --- | --- | --- |
| **Program code** | **Program Description** | **Definition** |
| NV | Non-Admitted VINAH | In scope ABF reportable VINAH contacts |
| Out-of-scope Reportable Programs through VINAH  |
| N0 | Non-Admitted AIMS | In scope ABF reportable on AIMS S10 aggregate data |
| N1 | In scope ABF reportable on AIMS S11 |
| NN | Non-Admitted Data Collection | In scope ABF reportable on NADC |

Further details of the program codes can be found in the VCDC documentation on the departmental website

#### Linking to VINAH

Table 9: Non-admitted linking/matching rules

| **Match level** | **VINAH activity fields** |  | **VCDC fields** |
| --- | --- | --- | --- |
| **Program NV - Non-Admitte9d VINAH** |   |   |
| **Where the values within the fields are the same then match** |   |   |
| 1 | Health service\* + Contact\_Clinic\_Identifier + Contact\_Identifier | = | Health service\*\* + Clinic + DhKey |
| 2 | Health service\* + Episode\_Program\_Stream\_Code + Contact\_Identifier | = | Health service\*\* + Stream + DhKey |
| 3\* | Health service\* + UR + Episode\_Program\_Stream + Contact\_Date | = | Health service\*\* + UR + Stream + Estart |
| 0 | No match can be made |   |   |
|  \* Health\_Service\_code determines the health service however for Mercy Health the Episode\_Campus\_Code is linked to the VAED campus code and mapped to the health service |
|  \*\* VAED campus code mapped to the health service |

*Please note: the fields containing date/time will only be evaluating the date component.*

#### Linking to NADC

The collection of NADC data is limited to those that report specialist clinic patient level details. Other programs reported to NADC are being reviewed.

* Where the VCDC campus + UR + dhKey+ estart + stream = NADC site\_id + person\_id + nade\_sk + service\_date + stream is the same in both datasets then match; else
* The record(s) could not be matched.

### Mental Health community and residential linking/matching rules

Mental health activity is identified in two ways; admitted which is reportable through VAED (Program MH) and community (Program M) which is reportable through CMI. This specific area refers to the latter however does include that mental health admitted services that are not reported in VAED such as residential services.

Table 10: Mental Health reportable program codes

|  |  |  |
| --- | --- | --- |
| **Program code** | **Program Description** | **Definition** |
| M | All other Mental health patient contacts including but not limited to community or mental health funded sub-acute and residential services (PARC, CCU, and aged persons mental health residential aged care services). | PARC - Prevention and Recovery Care |
| CCU - Community Care Unit |
| APMHR - Aged Persons Mental Health Residential aged care services (where not part of the acute admitted setting and reported under care Type 5T) |
| MH - Other Mental Health not specified |
| Mental Health - CL Services provided to emergency presentations | Consultation and Liaison contacts relating to VEMD reported patient |
| Mental Health - CL Services provided to admitted patients | Consultation and Liaison contacts relating to VAED reported patient |
| Mental Health - CL Services | Consultation Liaison contacts not part of an emergency or admitted patient |

 Further details of the program codes can be found in the VCDC documentation on the departmental website

#### Linking rules

* VCDC Program M where stream code = 2000 (PARC), 2001 (CCU), 2002 (APMHR) to CMI bed-based records
* CMI (bed based) to VCDC program M where stream code = 2000 (PARC), 2001 (CCU), 2002 (APMHR)
* VCDC Program M where stream code = 2003 (Other) to CMI (contacts)
* CMI (contacts) to VCDC Program M where stream code = 2003 (Other).

Table 11: Mental Health linking/matching rules

| **Match level** | **CMI activity fields** |  | **VCDC fields** |
| --- | --- | --- | --- |
| **VCDC Program M where stream code = 2000 (PARC), 2001 (CCU), 2002 (APMHR) to CMI bed-based records** |
| **Where the values within the fields are the same then match** |   |   |
| 1 | Health Service\* + Admission\_Id | = | Health Service\*\* + DhKey |
| 2 | Health Service\* + local\_ur + adm\_dttm + sep\_dttm | = | Health Service\*\* + UR + Estart + Eend |
| 0 | No match can be made |   |   |
|   |   |   |   |
| **VCDC Program M where stream code = 2003 (Other) to CMI (contacts)** |
| **Where the values within the fields are the same then match** |   |   |
| 1 | Health Service\* + Contact\_Id | = | Health Service\*\* + DhKey |
| 2 | Health Service\* + local\_ur + contact\_dttm | = | Health Service\*\* + UR + Estart |
| 0 | No match can be made |   |   |
|  |  |  |  |
| \*CMI campus code is mapped to the relevant VAED campus code to extract the Health Service |
| \*\*The VCDC campus code is mapped to the relevant VAED health service |

Please note: the fields containing date/time will only be evaluating the date component.

### Linking to phase of care

The records specific to Palliative Care and Mental Health have already been submitted at an episodic level through the main VCDC file. The linking of these records to the specific activity datasets have already been performed as prescribed above.

The linking of the phase of care is performed between the POC EPC file and the main VCDC file. This is to ensure that all records, their costs, and the date ranges submitted at an episodic level are replicated in the phase of care file at a complete date of service level.

There are two main evaluations performed between the files comparing the total costs, and the individual dates to the episodic dates as specified below.

Phase of Care file linking/matching rules are outlined in table 12 below.

Table 12: Phase of Care file linking/matching rules

|  |  |  |  |
| --- | --- | --- | --- |
| **Match level** | **Phase of Care VCDC fields** |  | **Main VCDC fields** |
| **Complete dates of a record** |
| **Where the values within the fields are the same then match for a distinct record** |
| 1 | Program PC, MH, or M + campus + UR + Ekey + DhKey + sdate | are inclusive | Program PC, MH, or M + campus + UR + Ekey + DhKey + estart + eend |
| 0 | No match can be made |
|  |  |  |  |
|  |  |  |  |
| **Complete costs of a record** |
| **Where the values within the fields are the same then match for a distinct record** |
| 1 | Program PC, MH, or M + campus + UR + Ekey + DhKey + sum of (dcost + icost) | = | Program PC, MH, or M + campus + UR + Ekey + DhKey + sum of (dcost + icost) |
| 0 | No match can be made  |

## Cross program matching algorithms

There are certain aspects of the collection that may require a transitioning of costs submitted through one program that should be linked to a record in another program. The nature of the VCDC collection requires certain activities to be reported in certain ways for consistency to the activity reportable data. However, to ensure that some records contain the total costs of treatment, some areas are transitioned. The following outlines those areas which are undertaken by the department.

### Radiotherapy (program R) to Admitted (program AC)

The costs for Radiotherapy services that relate to treatment received during an inpatient stay should be costed within that admitted record and reported as Program AC (Admitted Acute). However, there may be instances where that link has not been made. Therefore, for Program R records where it may relate to treatment received during an inpatient stay, those costs will be matched and redirected to report through Program AC. That process is undertaken by the department.

The matching algorithm follows the rules below where:

Campus and patient identifier (UR) of a Radiotherapy service (Program R) record occurs between the admission date/time and separation date/time (VAED, Program AC) is matched.

### Mental Health – consultation liaison services

The Consultation and Liaison service provide resources to various patients throughout a health service. These contacts originate from a sub-centre (cost area range H0602-H0650) and recorded in the CMI dataset. The costs for these contacts are then reported through the VCDC as program M with the relevant stream which identifies those relating to either an admitted (MHCA) or emergency (MHCE) or general (2004) setting.

Where some records relate to an inpatient or emergency stay, those costs will be matched and flagged for inclusion in the total episode cost for use in reporting, analysis, and funding models.

The matching algorithm follows the rules below where:

For Program M with stream = MHCA, MHCE or 2004 and campus\*\* + dhKey (cont\_adm\_id) where the episode starts date/time (eStart).

1. occurs between an admission and separation date/time for an admitted episode (VAED, program MH) then match; else
2. occurs between an admission and separation date/time for an emergency presentation (VEMD, program E) then match; else
3. The record(s) could not be matched and therefore remains as part of the Program M records.

\*\*Campus refers to the campus as identified in at[**Victorian Health data standards and systems**](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems)**.**

### Unqualified newborns

Where the cost episode submitted through the VCDC is related an admitted episode Program AU (care type U Unqualified Newborn), then those costs are matched and redirected to the mother’s admitted episode Program A.

The matching algorithm follows the rules below where Campus and Unqualified newborn (care type U):

1. episode VAED field MTHRS\_URNO matches the UR + admission and separation date/time of the admitted episode within an obstetric\* DRG then match, and costs redirected to the mother record.
2. where any residual unqualified newborn costs cannot be matched these are redirected by apportioning the costs across the obstetric\* DRGs based on the mother’s total costs only.

# **Standard Principles**

The standard principles of costing begin with a set of rules that are created to produce a level of uniformity, interchangeability, facilitate interoperability, reliability or means of comparison. They form the fundamental building blocks for activity-based costing by establishing consistent protocols that can be universally understood and adopted.

Health services will need to ensure the reporting of costs is in alignment with the DDS outlined in this document and subsequently the [AHPCS V4](https://www.ihacpa.gov.au/health-care/costing/australian-hospital-patient-costing-standards) or the most recent version. *<https://www.ihacpa.gov.au/health-care/costing/australian-hospital-patient-costing-standards>*

# Scope of activity

## Activities costed

Health services will allocate costs to all hospital activities surrounding but not limited to the categories below. These activities as well as other non-patient services, are categorised by a program value for reporting cost data to the VCDC. The expected costed activity is included in **table 13** but is not limited to the list.

Table 13: Episode program activity

| **Program value and description (from 2018-19)** | **Definition** | **Episode Type** |
| --- | --- | --- |
| **PROGRAM A = ADMITTED** |
| **AO** | **Acute Other** | Episodes relating to separations reported to the Victorian Admitted Episodes Dataset (VAED) including subacute and mental health patients reported to VAED.Also includes services reported as admitted including but limited to;MediHotel, Hospital Based Palliative Care Consultancy Team - training provided through an admission, Home Delivered Dialysis - training provided through an admission | Admitted [Care Types Section 3 – Data definitions Victorian Admitted Episodes Dataset (VAED) manual of the current submission year] |
| **NH** | **NHT/Non-Acute** |
| **AC** | **Acute** |
| **RH** | **Rehabilitation** |
| **PC** | **Palliative Care** |
| **GM** | **GEM** |
| **OG** | **Organ Procurement** |
| **MH** | **Mental Health Acute** |
| **MA** | **Maintenance Care** |
| **RP** | **Paediatric Rehabilitation** |
| **AU** | **Acute Unqualified newborn** |
| **PROGRAM E = EMERGENCY** |
| **E** | **Emergency Presentations** | Presentations reported to the Victorian Emergency Minimum Dataset (VEMD). | Emergency Department  |
| Co-located GP clinics within ED | Emergency Department  |
| ***ED Short Stay Unit - part of the admitted setting*** | *Emergency department (ED) short stay units are units designated and designed for the short-term treatment, observation, assessment, and reassessment of patients initially triaged and assessed in the ED.* | *Admitted - Emergency Short Stay Unit* |
| **EU** | **Emergency - Urgent Care Centres** | Urgent Care Centres as reported through AIMS S10 and UCC form | Urgent Care Centres |
| **PROGRAM N = NON-ADMITTED** |
| **NV** | **Non-Admitted VINAH** | Contacts (or equivalent) for non-admitted episodes that are in scope for activity-based funding under the National Health Reform Agreement. This includes but not limited to those that can be classified to a Tier 2 class (public and CMBS billed), or specific subacute and mental health clinics and other reportable services. | In scope ABF reportable VINAH contacts |
| **N0** | **Non-Admitted AIMS** | In scope ABF reportable on AIMS S10 aggregate data |
| **N1** | In scope ABF reportable on AIMS S11 |
| **NV** | **Non-Admitted VINAH** | Contacts (or equivalent) for non-admitted episodes that are out of scope for activity-based funding under the National Health Reform Agreement.  | Out-of-scope Reportable Programs through VINAH  |
| **NN** | **Non-Admitted Data Collection** | Patient level non-admitted data  | In scope ABF reportable NADC contacts |
| ***Training provided by Hospital Based Palliative Care Consultancy Team (HBPCCT) while an admitted patient - part of the admitted setting*** |
| **PROGRAM U = OTHER NON-ADMITTED** |
| **UD** | **Other Non-Admitted Diagnostic services** | Episodes reporting costs of services that cannot be linked to another episode type including but not limited to pathology, diagnostic imaging, pharmacy, etc. | Unlinked diagnostic and/or therapeutic services |
| **U** | **Other Non-admitted** | Palliative Care In scope ABF reportable on AIMS PCCP form | Unlinked Palliative Care |
| DH funded Public Sector Residential Aged Care Services (PSRACS) | Unlinked Residential Aged Care |
| Episodes identified as not in-scope for Non-Admitted NHRA services including but not limited to Victorian Perinatal Data, Home and Community Care, etc. | Unallocated for NHRA Services |
| Other specific activity/services/programs not specified in this program or another program | Other Specific activity |
| Other Non-admitted not specified in this program or another program. A health service identified program/service. | Other non-admitted Hospital defined programs/services |
| **PROGRAM C = COMMUNITY HEALTH** |
| **C**  | **Community Health** | Episodes reported by health services which are funded by the department Community Health Care program. | In scope ABF - reportable on the Community Health Minimum Dataset (CHMDS) |
| Out of Scope ABF - Reportable Community Health |
| Other Community Health |
| **PROGRAM R = RADIOTHERAPY** |
| ***Radiotherapy - part of the admitted setting*** | *All patient activity relating to radiotherapy treatment, planning and consultations treated in an admitted or non-admitted setting* | *Radiotherapy - linked to an admitted patient* |
| ***Radiotherapy - part of the non-admitted setting*** | *In scope ABF reportable VINAH contacts* |
| **R** | **Radiotherapy** | All patient activity relating to radiotherapy treatment, planning and consultations not part of the above | In scope ABF reportable on AIMS S8 aggregate data |
| Radiotherapy Services - Other |
| **PROGRAM S = RESEARCH** |
| **S**  | **Research** | Episodes reporting and/or derived/virtual patients where identified research related costs. | Research  |
| **PROGRAM T = TEACHING & TRAINING** |
| **T**  | **Teaching and Training** | Episodes reporting and/or derived/virtual patients where identified teaching and training related costs. | Teaching & Training  |
| **PROGRAM B = BOARDERS** |
| **B**  | **Boarders** | Reported costs of episodes provided services for a boarder staying in a health service. | Boarders  |
| **PROGRAM M = MENTAL HEALTH** |
| **M**  | **Mental Health** | Episodes and/or contacts relating to mental health that are not reported through the VAED or VEMD and under a program of A or E or only reported through CMI.Aged Persons Mental Health Residential (APMHR) aged care services report to the CMI and are in-scope for mental health establishment reporting. They are separate from activity in an admitted setting and general residential aged care services operated by health services whose costs should be reported under Program W. | Mental Health Resi |
| Other Mental Health not specified | Mental Health |
| **Mental Health - Consultation Liaison Services** | Consultation and Liaison Contacts that originate from a subcentre (cost area range H0602-H0650) and recorded in the CMI dataset | Mental Health |
| **PROGRAM X = OTHER NON-PATIENT** |
| **X**  | **Other Non-Patient** | Other non-patient identifiable services not in scope under the NHRA, not reported to the VAED or VEMD or relating to Radiotherapy, Mental Health or Community Health services. | Other Non-Patient  |
| **PROGRAM W = OTHER ADMITTED** |
| **W**  | **Other Admitted** | Admitted episodes not reported to VAED. | Other Admitted  |

For further details regarding the scope of activities please refer to the DDS at [Victorian Health data standards and systems](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems).

## Specific reporting of costed activities

### Boarders

Program value ‘B’ is valid for hospital boarders who are receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. Hospital boarders are not admitted to the hospital and not reported as unique episodes to the VAED. Babies in hospital at age nine days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Minimal expenses should be allocated to boarders reflecting only the cost of food and/or accommodation provided to them.

### Emergency

Program value ‘E’ is used to identify Victorian Emergency Minimum Dataset (VEMD) reportable activity belonging to a recognised Emergency Department (ED). The cost records associated with these activity episodes must reflect the care provided while the patient was in the ED.

Urgent Care Centres (UCC) are reported as program ‘EU.’ These records are to be reported to the VCDC as program EU (from 2018-19) with a stream code of UCC.

Emergency Short Stay Units (ESSUs) are considered admitted areas and reported to the VCDC through admitted program with VAED. ESSU should be reported with an area (dhCostArea) code in the range B0102-0200. Consequently, health services may need to separate these costs from other ED costs within the costing system if they are not separately reported in the GL.

Costing practitioners should consult with relevant stakeholders to determine the correct expenditure relating to ESSUs and EDs and UCCs.

### Teaching & Training - (Note Victoria in transition to full compliance)

In Victoria current HSA operating expenses relating to direct teaching & training activities are to be allocated to patient cost outputs. If feeder data exists then it should be allocated as direct products, or alternatively as indirect costs.

Cost should first be allocated to the most appropriate cost area within the costing system (e.g., medical units for teaching and training undertaken by medical staff) and then allocated to episodes using the most appropriate cost allocation. The following table outlines the preferred indirect cost allocation methods for the most common types of operating cost incurred with teaching and training activities.

Table 14: Indirect allocation methods for Teaching & Training

| **Expense Type** | **Allocation Method** |
| --- | --- |
| S W Medical | Medical EFT |
| S W Nursing | Nursing EFT |
| S W Allied Health | Allied Health EFT |
| S W Other | Other EFT |
| MS/GS | Expenditure |

Expenses, for direct and indirect teaching and training activities provided by the hospital, should be grouped to discreet final areas within the costing system. These areas will accumulate expenses for direct and indirect Teaching and Training activities respectively, including overhead expenses from the hospital as appropriate.

The department, together with the VTWG, will continue to develop more succinct Victorian guidance for allocation of teaching and training to ensure there is consistency and adherence to the national requirement.

#### National requirements

Costing practitioners (and their stakeholders) are to follow the national requirement and guidance within the AHPCS V4 (or most recent), Part 3: Costing guidelines, CG 4 Teaching, and training, where expenses relating to direct and indirect teaching and training activities are identified.

These activities refer to the activities provided by or on behalf of a public health service to facilitate the acquisition of knowledge, or development of skills. These activities are required for an individual to:

* attain the necessary qualifications or recognised professional body registration to practice:
* acquire sufficient clinical competence upon entering the workforce for practicing their discipline; or
* undertake specialist or advanced practice in medicine, dentistry, nursing, midwifery, or allied health.
* Several activities can be identified as teaching and training within a health service. These include:
* Direct activities – distinct and separable activities that occur outside an episode of care but are directed towards skills and knowledge development (in the case of teaching and training). Direct activities may include lectures, tutorials, simulations, and workshops.
* Overhead activities – ‘back office’ administrative and coordination activities undertaken by a health service that are essential to facilitate teaching and training activities. These activities may include the coordination of pre-entry student placements, rotations, educational program development or negotiation with higher education providers. The medical, nursing, and allied health administration departments usually coordinate these activities within health services.
* Embedded activities – describe where teaching and training occurs in conjunction with patient care.

### Research

As with teaching and training, costing practitioners (and their stakeholders) are to group cost centres where there are discreet direct areas identified relating to research activities.

The department, together with the VCDC Technical Working Group will continue to develop more succinct Victorian guidance for allocation of research to ensure there is consistency and adherence to the national requirement.

#### National requirement

Costing practitioners (and their stakeholders) are to follow the national requirement and guidance within the AHPCS V4 (or most recent), Part 3: Costing guidelines, CG 5 Research it outlines an approach for identifying the scope and source of expenses, activity and costing application, which relate to research.

These activities are undertaken in a public health service where the primary objective is the advancement of knowledge that aims to improve patient health outcomes or health system performance.

The activity must be undertaken in a structured and ethical way, be formally approved by a research governance or ethics body and have potential for application outside of the health service in which the activity is undertaken.

For activity-based funding purposes, the definition of research relates to the public health service's contribution to maintain research capability, excluding the costs of research activities that are funded from a source other than the state or territory or provided in-kind.

### Mental Health

Program value ‘M’ is valid for mental health services that are not reported to the VAED or VEMD. These include (but not limited to):

* all other mental health patient contacts including but not limited to community or mental health funded sub-acute and residential services (Prevention and Recovery Care (PARC), Community care units (CCU), and aged persons mental health residential aged care services)
* consultation and liaison contacts that originate from a sub-centre (cost area range H0602-H0650) and recorded in the CMI dataset

Figure 2 outlines the hierarchy which should be followed in considering whether an episode belongs to program M. For further details relating to inclusion of activity in program M refer to at [**Victorian Health data standards and systems**](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems)**.**

Figure 2: Mental Health reporting hierarchy

**Service Type/ Patient Setting VCDC Program**



Specific guidance for the North-Western Mental Health service is available at **Attachment 1 – North Western Mental Health (NWMH)**

### Radiotherapy

#### Victorian Radiotherapy Services costing guidance

Victorian radiotherapy services report service data quarterly using the Victorian Radiotherapy Minimum Data Set (VRMDS).

The dataset contains demographic, administrative and clinical data for admitted and non-admitted patients treated in Victorian radiotherapy facilities, in both the public and private sectors.

The department uses the data to inform service planning for radiotherapy facilities. It also assesses metrics associated with this, such as utilisation rate against optimal rate.

For more information, see the [Victorian Radiotherapy Minimum Data Set user manual](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Victorian-Radiotherapy-minimum-Data-set-User-Manual) *<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Victorian-Radiotherapy-minimum-Data-set-User-Manual>.*

#### Costing guidance

Radiotherapy services provided to patients who are generally either admitted to hospital during their radiotherapy treatment or are ambulatory. For costing purposes, admitted patients are those reported to the VAED, the ambulatory treatments comprise of those activities collected through AIMS S8 and other activities reported through the VRMDS.

#### General costing principles

1. Costing practitioners are to consult with their Radiotherapy service to ensure that all patients, resources, and expenses relating to providing this service is identifiable and used in the costing process.
2. Costing practitioners are to use discreet patient care areas for Radiotherapy expenses to be allocated to their activities.
3. Each individual activity and treatment should be costed separately.
4. Costing practitioners (with the stakeholders) are to review whether any overhead/indirect services should also be apportioned to the Radiotherapy direct patient care area and/or the Radiotherapy patient cohorts and update that allocation where appropriate. This will ensure that the complete patient level cost is recognisable.

#### Costing and reporting principles

##### Admitted Radiotherapy

All treatments, planning and consultation radiotherapy services provided and linked to an admitted patient are to be costed to that setting. This will ensure that all services provided to an admitted patient are complete.

These patients are reportable to the VCDC via programs as outlined for admitted found in table 11.

##### Ambulatory services

1. Where radiotherapy provides services that are reportable through AIMS S8 and/or S10 and/or have registered a clinic on the NACMS system that are mappable to a Tier2 classification as 20.43, 10.12 or 10.20, these are reportable to the VCDC as program R-Radiotherapy with a stream code of:
	1. RTHC – Radiotherapy consultation
	2. RTHT – Radiotherapy treatment
	3. RTHP – Radiotherapy simulation and planning

Please refer to the relevant reporting manual for further definitions.

1. All radiotherapy services that are not part of an admitted setting or one of the services as in point one above is reportable to the VCDC as program R-Radiotherapy with a stream code of RDTH.

For definitions of the Tier2 classifications please refer to the IHACPA website.

# Scope of expenditure

To understand the resource usage of a health services’ activities and assist in measuring their attributes, all expenses in the finance general ledger system used in delivering the care to patients, regardless of funding source should be allocated.

This is consistent with the national expectations where all costs incurred by or on behalf of the health service related to day-to-day delivery of services are included. (**Refer AHPCS V4 (or most recent) Part 1 - Standards Stage1 - Identify relevant expenses**).

## Expenses for costing

The design of finance general ledger systems is to meet the financial obligations of health services. This structure differs to the requirements for costing patient activities therefore deriving a costing general ledger within the costing systems. The health services will need to ensure that all expenses related to the relevant services are contained within the correct direct or overhead areas to be allocated to patients.

### Accrual cost general ledger

Matching of costs of resources to the period in which they actually incurred thereby adopting an accrual accounting ledger. This is consistent with the national expectations found in **AHPCS Part 1 - Standards 1.1 General**, where financial information of the organisation adheres to the Australian Accounting Standards.

### Derived patient episodes

Health services must allocate one hundred per cent of general ledger expenses in the costing process, to all patient episodes and where no patient activity exists, a derived patient episode may be created.

The level of derived episode created will depend on the granularity of the GL and activity data available. For example, if a health service provides several sub-acute ambulatory services to patients, they may wish to create only one derived episode per costing period (i.e., year, month or quarter depending on costing practices) to allocate all the costs for providing these services. Alternatively, more specific expenditure details may be available that allows the site to separate costs for different services; for example, Post-Acute Care (PAC) or Hospital Admission Risk Program (HARP).

### Non-Health Service Agreement expenses

Non- Health Service Agreement (non-HSA) expenses should not be included in the costing process unless they relate to the provision of patient services and can be allocated to the appropriate HSA funded activity. For example, expenses relating to private practice or Commonwealth funded activity should be included if the activity data is brought in from feeder systems or can be created as a derived patient.

Note: This Non-HSA costed activity is required to be identifiable for inclusion/exclusion of funding models (as required) through various classification group; for example, specified clinic codes. Further references: **AHCPS Part 1 - Standards 2.2 Matching Cost Objects and Expenses; AHPCS Part 2 - Business rules 1.1F Commercial business units**.

## Allocation of costs

Costs are allocated based on cost centres and account codes found within the COA. Cost centres will be categorised as either a direct or overhead areas.

Direct or patient care areas are those that relates to the delivery care to patients, affected by patient mix and throughput and are physically traceable to patients.

Overhead or indirect areas do not directly impact on patient care, not initially affected by patient mix and throughput, and support direct departments. Examples include and not limited: Finance, Human Resources, Utilities, Administration.

To allow the overhead costs to flow to patients they will need to be allocated to the direct areas usually through a simultaneous equation method. This is consistent with the national direction where costs accumulated in overhead cost centres shall be allocated to final cost centres.” (Refer AHPCS V4 Part 1 - Standards 3.2 Allocation of Expenses in Overhead Cost Centres, AHPCS V4 part 2 - Business rules 4.2A Overhead Allocation Statistics).

The account codes classify financial activities and balances within the General Ledger . Aggregating these into like expenses such as SWNurs (salary and wages Nursing) including such expenses like Basic Pay, Sick Pay, Overtime/Recall, Penalties, Public Holiday Penalties, Allowances. The COA mapping within the DDS outlines the how the cost centres are categorised, and the account codes grouped. A further reference on how these mappings is used to determine the resource categories can be found with the section on References.

## Work-in-progress patients

All patients who have consumed services within a fiscal year will be allocated a cost regardless of whether their treatment is still ongoing. That is, all patients/activities that have been treated within the submitting year will be allocated a cost.

Those patients who have completed their treatment within the submission year will report their total cost including any costs allocated from prior year(s) for those patients admitted in a prior year. The expected total cost reported should include all prior year(s) costs.

This is consistent with the national direction found in the AHPCS Part 1 - Standards 5.3 Work in Progress reporting of patient and other product costs.

#### Categories of patients’ progress:

1. Patients commencing treatment prior to the submission year and ending treatment within the submission year, (total costs including all prior year(s), to be reported to the VCDC
2. Patients commencing treatment within the submission year and completed within the submission year (total costs to be reported to the VCDC)
3. Patients commencing treatment prior to the submission year and yet to be completed within the submission year (costs to be held over until the patient has completed their treatment), to be included in the reconciliation report and
4. Patients commencing treatment within the submission year and yet to be completed within the submission year (costs to be held over until the patient has completed their treatment).
5. Where patients fall within the third, and fourth categories:
	1. those current year costs should be included in the VCDC reconciliation templates
	2. when discharged, all prior year and current year costs are submitted, and those prior year total costs are to be included in the reconciliation templates
6. Where patients fall within the first category, it is expected that all prior year and current year costs are submitted. Those prior year total costs are to be included in the reconciliation templates.

Figure 3: Work-in-progress categories



# **Attachments**

# Attachment 1: North-Western Mental Health (NWMH)

**Documentation prepared by RMH**

**Agreed between Melbourne Health, Northern Health, Western Health and the department**

**Overview**

As a result of NWMHS disaggregation, there are impacts on the reporting of mental health cost records for WIP patients. The situation is as follows (in dot-points):

* RMH commenced mental health costing in FY2011-12, first in UserCost/ComboCC and then moving to PPM for FY2016-17 costing onwards.
* The WIP costs from UserCost/ComboCC were prepared separately to be reported together with costed data from PPM to VCDC.
* There is one episode from WH which started in FY2009-10 – this episode would not have cost allocation in FY2009-10 and FY2010-11, and only have costs starting from FY2011-12 to FY2021-22.
* RMH holds cost records across multiple fiscal years (FY2011-12 onwards) for mental health patients who have not been discharged to date. These records have not yet been submitted to VCDC.
* Post-disaggregation, RMH will no longer be costing these WIP episodes. They will be costed at their disaggregated points (NH or WH) accordingly until such time when they are discharged.
* For these episodes, their cost records will be split over two reporting organisations (RMH and NH/WH) at time of cost reporting to VCDC. The proposed solution to formulate a complete cost record for these patients at separation in VCDC reporting is as follows.

**Proposed solution:**

* All WIP episodes at time of disaggregation will be “separated” from RMH. The date of disaggregation will form this separation date.
* RMH will input a “statistical discharge” date of the disaggregation date into the episode EndDateTime field for the disaggregated WIP episodes.
	+ For NH (except APMHP), it will be ‘2022-07-01 00:00:01’
	+ For WH (except APMHP), it will be ‘2023-06-30 23:59:59’ (assuming a disaggregation date of 1st July 2023)
	+ For APMHP, the Northern Health Aged services on NE campus were disaggregated on 7/11/2022, except AGED - BASICS NE and AGED - ICT NE/N. The disaggregation dates will be populated as statistical discharged date from RMH as ‘2022-11-06 23:59:59’
* As a result of this “separation” from RMH, RMH will submit all cost records that it holds for these WIP episodes up to VCDC.
* RMH will include ALL the cost records (across all FYs available) for these disaggregated WIP episodes into the RMH VCDC submission for FY2022-23.
* RMH will work with DH and NH/WH to ensure that:
* The cost records for these disaggregated WIP episodes can be identified within RMH’s FY2022-23 VCDC submission.
* The cost records (from RMH) for these disaggregated WIP episodes can be linked to subsequent NH/WH VCDC submissions so that DH can pick up the matching WIP cost records for these disaggregated episodes when their costs are reported up to DH via the VCDC at the time of when they are discharged.
* Data linkage specifications described in accompanying spreadsheet
	+ Data linkage should be able to be done via combinations of **[ur] + [campus] + [dhKey]** fields in the VCDC dataset

**Scope:**

RMH holds WIP cost records for the following VCDC Programs:

* **Program MH**
	+ VAED Reportable episodes
* **Program M**
	+ Stream 2000, PARC, VAED non-reportable
	+ Stream 2001, CCU, VAED non-reportable
	+ Stream 2002, Aged Residential, non-VAED reportable
	+ Stream 2003, CMI admissions not matching to a VAED reported episode

# **Appendices**

# Appendix 1: Document change history

| Date | Author | Change description |  Version  |
| --- | --- | --- | --- |
| July-23 | Department of Health | * Updated version of documentation
* Simplified introduction
* Updated VCDC submission timelines
* Updated quality assurance rules and tolerances
* Update guidance on NorthWestern Mental Health
* Guidance included for identifying patient transport expenses
* Guidance on costing and reporting activities from Non-Admitted Cost Collection (NADC)
* Patient transport costs relating to Nationally Funded Centres
* Outline the inclusion of the VCDC into the annual change process
 | 3.5 |
| Mar-22 | Department of Health | * Separated document into three parts
 | 3.4 |
| Feb-22 | Department of Health | * Update sections for 2021-22
 | 3.4 |
| Nov-20 | Department of Health and Human Services, Policy and Planning | * Update sections on review for 2020-21
 | 3.3 |
| April/June | Department of Health and Human Services, Policy and Planning | * Incorporated details in relation to the treatment and reporting of COVID-19 activities
 | 3.2 |
| Jan-20 | Department of Health and Human Services, Policy and Planning | * Update sections on review for 2019-20
 | 3.2 |
| May-19 | Department of Health and Human Services, Policy and Planning | * Updated sections for new program reporting requirements and the relevant sections affected
 | 3.1 |
| * Format and structure of document amended to ensure the flow of the details are logical.
 |
| * Incorporated a submission timeline diagram
 |
| * Updated and revised reconciliation report and sign-off requirement
 |
| * Incorporated specific guidance where finalised or at the draft final stage and Mental Health guidelines
 |
| * Incorporated the Mental Health costing guidelines document
 |
| * Included requirement to involve relevant stakeholders for endorsement of costing methodologies
 |
| * Requirement for a data quality statement (DQS) to be completed and signed by the CEO
 |
| 19/10/2017 | Department of Health and Human Services, Policy and Planning | * Update on Financial Reconciliations
 | 3.0 |
| 6/01/2018 | * Updated to be non-financial year specific
 | 3.0 |
| 08/012018 | * Format and structure of document amended to ensure the flow of the details are logical.
 | 3.0 |
| 25/01/2018 | * Update linking rules
 | 3.0 |
| 13/03/2018 | * Incorporated reference to AHPCS v4
 | 3.0 |
| 21/10/2015 | Department of Health and Human Services, Health Service Programs | * Updated, revised for last version (refer to the list of changes documentation)
 | 2.1 |
| 19/08/2015 | * Updated -for 2015-16 VCDC submission
 | 2.0 |
| 19/08/2015 | * Consolidate of the three 2014-15 documents
 | 1.1 |
| 1/09/2015 | Department of Health and Human Services, Systems Intelligence and Analytics | * 2. VCDC Business Rules for reporting 2014-15 data\_FINAL
 | 0.1 |
| 1/09/2015 | * 1. VCDC File Specifications for reporting 2014-15 data\_FINAL
 | 0.1 |
| 24/08/2015 | * 3. VCDC Reference Files for reporting 2014-15 data\_FINAL
 | 0.1 |