Section 2 – Concepts and derived items

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Introduction

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

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

The definitions contained in this section are based, wherever possible, on the National Health Data Dictionary (version 15).
Concepts

Acute care

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

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

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

Refer to:
Section 2: Admitted Patient, Episode of Admitted Patient Care, Nursing Home Type/Non-Acute, and Sub-Acute Care.

Section 3: Care Type and Qualification Status.

Admission

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

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

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

Guide for use
Refer to:
Section 2: Admitted Patient, Criteria for Admission, Episode of admitted patient care, Hospital Stay, Overnight or Multi-day Stay Patient, and Same Day Patient.
Admitted Patient

Definition

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

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

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

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

Guide for use

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

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

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

Refer to:

Section 2: Admission, Criteria for Admission, Episode of Admitted Patient Care, Hospital Stay, Newborn, Non-Admitted Patient, Patient.
Age

Definition
The patient’s age at the time of admission

Guide for use
Age is calculated as:
Admission Date minus Date of Birth.

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

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

Asylum Seeker

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

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

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

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

Determine Medicare ineligible status of any sort

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

Determine asylum seeker status

- Evidence by supporting documentation from asylum seeker support group, or
- Evidence by receipt/letter from DIMIA, or
- Evidence by Visa class (bridging Visa E)

Note: It will not always be possible to identify an asylum seeker from official government documentation, some discretion and judgement by hospital staff will be required.

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

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

Refer to:

Hospital Circular 27/2005:

Section 2: Medicare Eligibility Status – Eligible Person, and Medicare Eligibility Status – Ineligible Person.

Section 3: Account Class.
Boarder

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

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

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

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

Refer to:
Section 2: Criteria for Admission, Newborn, and Patient.
Section 4: Boarder

Campus

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

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

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

Unless designated otherwise by the department, a **multi-campus hospital** has two or more locations providing admitted patient services, where the locations:

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

The department holds that, as a general principle, VAED reporting should identify activity at each campus. Patient activity must be reported under the campus code at which it occurred. Any multi-campus hospital not currently reporting on this basis, or intending to change from single to multi-campus or vice versa, should discuss this with the department.

Refer to:
Section 2: Hospital, and Transfer.
Section 3: Campus Code.
Cardiac/Coronary Care Unit

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

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

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

Care Type

Definition
An episode is not defined by the patient’s arrival at, and departure from, the hospital but rather by the start and completion of a ‘type of care’.

There are a number of types of care that a hospital can provide for admitted patients. A multi-day stay patient may receive more than one type of care during the period of hospitalisation: the period of hospitalisation is then broken into Episodes of Care, one for each type of care (Care Type).

The Episode of Care ends when the Care Type changes or the patient separates from hospital.

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

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

Refer to:
Section 2: Episode of Admitted Patient Care, and Hospital Stay.
Section 3: Care Type.
Contracted Care

Definition

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

A contract agreement can be formal or informal, written or verbal.

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

- A purchaser, which can be a public or private hospital, or a health authority (Department of Health or a Health Region) or another external purchaser.
- A contracted hospital/facility, which can be a public or private hospital or day procedure centre, residential aged care facility or supported accommodation.
- The contractor making full payment to the contracted hospital for the contracted service.
- Services provided to a patient in a separate facility during their episode of care where the patient is directly responsible for payment of this additional service are not considered contracted services for the purposes of PRS/2 reporting.
- The patient being physically present for the provision of the contracted service.
- Pathology or other investigations performed at another location on specimens gathered at the contracting hospital would not be considered contracted services for the purposes of PRS/2 reporting.

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

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

Adult Retrieval Victoria

Adult Retrieval Victoria (ARV) provides services to coordinate the transfer of patients requiring critical care where services are not available in the originating hospital. Patients may be transferred from a public hospital which does not have critical care facilities, or from a public hospital which has critical care facilities but is unable to accept the patient for other reasons.

For public hospitals without critical care services, ARV is financially responsible for the patient. These patients will be separated from the hospital and transferred to the private hospital (if they were admitted before transfer).

For public hospitals with critical care services, the public hospital will be financially responsible for the patient. The patient activity should be reported as contracted care in order for the public hospital to receive funding for the patient. The patient should be reported by both the public and private hospitals, according to the business rules details in Section 4 Contracted Care.
Criteria for Admission

Definition

The Criteria for Admission reflect the intended level of treatment that the patient is to receive. The decision to admit is based on Criteria so the decision should not precede consideration of the Criteria. The criterion under which each patient is admitted does not have an impact on casemix funding.

Hospitals are responsible for ensuring that appropriate procedures and records are maintained to facilitate accurate reporting, and to justify the admission. The list of criteria for admission in the definition is complete – there are no other criteria for admission.

Care provided to a patient in a non-admitted hospital setting over an extended period of time does not in itself constitute (conversion to) an admission. A patient in a non-admitted care setting may only be admitted after at least one of the admission criteria is met.

Under these criteria, the fact that a procedure is undertaken in a procedure room does not, in itself, justify admission.

The Criterion for Admission is determined at the point of admission and does not change even if the patient’s circumstances change.

There are seven Criteria for Admission. These are outlined below. Supporting information, including examples are provided in the Admission Policy and Factsheets available at www.health.vic.gov.au/hdss.

Guide for use

N: Qualified Newborn

The patient is nine days old or less at the time of admission and meets at least one of the following criteria:

- The newborn is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient; OR
- The newborn, on that day, requires intensive or special care and is admitted to a facility approved by the Commonwealth Minister for Health for the purpose of provision of that care; OR
- The newborn is, on that day, admitted to or remains in hospital without their mother.

U: Unqualified Newborn

The patient is nine days old or less at the time of admission but does not meet any of the criteria for Type N.

Unqualified newborns who are still in the hospital when they turn 10 days old become boarders, and because boarders are not required to be reported to the VAED they must be separated.
O: Patient expected to require hospitalisation for minimum of one night

The patient is expected to require overnight or multi-day hospitalisation. Type O should be used where there is an expectation that the patient will require ongoing admitted care.

Type O includes:

- Patients who present to the Emergency Department, but die within a few hours, despite intensive resuscitative treatment but whose treatment plan initially included an expectation that they would require hospitalisation for a minimum of one night.
- Patients who are transferred to another hospital where the intention is that they will require hospitalisation for a minimum of one night, having received active treatment and stabilisation at the original hospital.

Type O excludes:

- Patients whose treatment is expected to be concluded on the same day.
- Patients whose care is provided over more than one date (for example, a patient presenting at 11pm and departing at 2am), but for whom the intention is not for ongoing overnight care.

B: Day-only Automatically Admitted Procedures

In order to meet Criterion for Admission B, it must be the intention that the patient will:

- Receive at least one procedure listed on the Automatically Admitted Procedure List; AND
- Receive treatment on a day-only basis.


Where a patient is expected to require treatment on an overnight or multi-day stay basis while receiving an Automatically Admitted Procedure, they should be admitted as Criterion for Admission Type O.

Same day IV therapy is included as a Type B procedure, but non therapeutic IV administration is excluded (for example, administration of contrast for radiological procedures). Placement of an IV cannula alone, or injection via an IV cannula, does not warrant admission.

E: Day-only Extended Medical Treatment

Criteria for Admission E should be used where patients receive a minimum of four hours of continuous active management consisting of:

- Regular observations (which may include diagnostic or investigative procedures); OR
- Continuous monitoring.

When determining a patient’s eligibility for admission as Criteria for Admission E, the following factors could be taken into account:

Regular observations may include:

- Observations of vital or neurological signs provided on a repeated and periodic basis during the patient’s treatment.
• Provision of repeated and periodic diagnostic or investigative procedures or provision of treatment.

Hospitals are encouraged to develop local policies or guidelines as to what constitutes regular observations. These guidelines should be consistent with established clinical pathways, protocols or accepted clinical practice.

Continuous monitoring could include:

• Continual monitoring via ECG or similar technologies. (Note: continual blood pressure and/or pulse monitoring is not considered a sufficient level of continual monitoring for these purposes).
• Continuous active supervision or treatment by clinical staff.

Type E excludes:

• Patient has been provided with clinical intervention/s for their condition and requires time to rest prior to discharge home.
• Patient has a length of stay of more than four hours, primarily consisting of waiting for results of diagnostic tests.
• Patient has been present at the hospital for more than four hours, but has not been engaged in treatment or diagnosis.

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode.

When a patient is transferred from the Emergency Department to a ward (including short stay units), the Admission Time is the time treatment was started in the Emergency Department rather than the time it was decided to transfer the patient. Any intervention provided after treatment commences should be recorded and identified as part of the admitted patient’s episode of care.

C: Day-only Not Automatically Qualified Procedures

The Not Automatically Qualified for Admission List identifies procedures that would normally be undertaken on a non-admitted basis and therefore not normally accepted as admissions in their own right.

In order to meet Criterion for Admission C, a patient must:

• Receive a procedure on the Not Automatically Qualified for Admission List; AND
• Be intended to be treated on a day-only basis; AND
• The treating doctor must provide evidence that the patient’s special circumstances justify admission for the purpose of having this procedure. This evidence must be documented in the patient’s medical record.

Audits of medical records may be conducted for the purpose of ensuring that treatment of such patients in an admitted patient setting is warranted.

A patient who does not undergo a procedure listed on the Not Automatically Qualified for Admission List cannot meet Criterion for Admission C.


A patient who is intended to receive a procedure on the Not Automatically Qualified for Admission List as part of an overnight or multi-day stay should be admitted as Criteria for Admission O.
S: Secondary Family Member

A person who does not meet any of the Criteria for Admission but is accompanying a patient who is admitted. Only Early Parenting Centres can report this category.

Change To Planned Treatment

Where a patient's condition requires a different course from that planned at admission, the hospital must retain the original Criterion for Admission on the VAED.

For example:

- A newborn who changes Qualification Status must retain their original Criterion for Admission code (N or U).
- A patient is admitted with a ruptured abdominal aortic aneurysm at 9:00am, and dies at 11:30am on the same day. The Criteria for Admission is O (Patient expected to require hospitalisation for a minimum of one night), because at the time of admission the expectation is that the patient would receive care for more than one day. The fact that the patient died before this could occur does not alter the reported Criterion for Admission.
- A patient is admitted as a planned same day patient for a colonoscopy. During the colonoscopy the patient sustains a perforation to the bowel, which results in a laparoscopic repair of the bowel and a length of stay of three days. The Criterion for Admission is B (Day Only Automatically Admitted Procedure) as this was the intention at admission.
- A patient is admitted to a rural hospital at 4pm with 45% burns. After stabilisation, the patient is airlifted to a tertiary burns unit in Melbourne at 7pm on the same day. The Criterion for Admission is O (Patient expected to require hospitalisation for minimum of one night), as the patient is expected to require many days of treatment. The fact that this is to occur in more than one facility is immaterial.

Cancelled Treatment

There will be occasions where a patient who is admitted, subsequently has their planned treatment cancelled. Whether such episodes are reported to the VAED will depend on the circumstances:

If the patient received care or treatment by clinical staff, even if the level of care/treatment would not fulfil the original criteria for admission, the episode should be admitted with the original criteria for admission reported. Audits of medical records may be conducted where the patient’s care does not match the original criteria of admission.

Cancellation is appropriate when:

- Patient admitted on day of surgery, which was cancelled due to lack of available beds. Patient sent home without treatment. Admission should be cancelled.
- Patient admitted on day of surgery, which was cancelled as patient had a slight upper respiratory viral infection. Patient sent home without further investigation, to return to have the procedure when the virus is resolved. Admission should be cancelled.
- If the patient did not receive any care beyond that provided by the admitting staff (such as blood pressure monitoring), prior to the cancellation of the intended procedure. The episode should be cancelled, and not reported to the VAED.
- If the patient did not receive any care beyond a simple review by clinical staff prior
to the cancellation of the intended procedure. The episode should be cancelled, and not reported to the VAED.

Cancellation is not appropriate when:

Patient admitted on day of surgery, which was cancelled as patient had a fever and cough. Patient underwent an x-ray, blood tests and was observed for several hours. Diagnosis of mild pneumonia, patient sent home, to return to have the procedure when pneumonia resolved. This episode should be reported to the VAED with the Criterion of Admission as originally intended.

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

Hospital in the Home (HITH)

HITH patients must fulfil the same Criteria for Admission as any other admitted patients.

Hospital in the Home can only be reported to the VAED when the patient has been visited in their home (or other residential service not providing admitted care) by clinical staff providing admitted services to the patient.

When a patient is admitted to HITH either prior to their in-hospital stay or is transferred from in-hospital based care, this is considered continuous care. The criterion for admission that applies to the hospital component of their stay is also valid for the HITH component. There is no requirement to code the HITH episode separately.

Parentcraft and Early Parenting Centres

‘Parentcraft’ describes the type of care provided by Early Parenting Centres. Parentcraft does not meet admission criteria but is reported to the VAED by Early Parenting Centres for statistical purposes and is not WIES funded. Parentcraft cannot be reported by any other hospitals.

In regard to ‘parentcraft’ care and treatment, only those family members who satisfy the minimum criteria in an Early Parenting Centre may be admitted. Whilst mother, father, baby and siblings may attend the hospital, normally only one member of the family should be admitted. In some instances, admission of two or more family members may be justified where they are affected by separate problems; or where problems affect more than one member.

Refer to:

Section 2: Admitted Patient, Newborn, and Same Day Patient.

Section 3: Criterion for Admission.

Victorian Hospital Admission Policy:
DRG Classification

Definition

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

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

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

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

Episodes can be grouped into multiple versions of the Grouper. The Department of Health is using Australian Refined Diagnosis Related Groups (AR-DRGs), v6.0, for funding in 2010-11.

The details of grouping logic and methodology are contained in the Commonwealth manual *Australian Refined Diagnosis Related Groups, Version 6.0* (vols 1, 2, 3)

For funding purposes, some adjustments are made to the original AR-DRG (version 6.0) and the result is stored in the VIC-DRG field. For details, see Victoria – Public Hospitals and Mental Health Policy and Funding Guidelines 2010-2011, available at: [http://www.health.vic.gov.au/pfg/index.htm](http://www.health.vic.gov.au/pfg/index.htm)

Episode of Admitted Patient Care

Definition

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

Refer to:

Section 2: Admission, Admitted Patient, Care Type, Newborn, and Separation

Section 3: Care Type

Section 4: Business Rules (non-tabular) Episode of Care
Geriatric Evaluation and Management Program (GEM)

**Definition**

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

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

**Guide for use**

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

Refer to:

- Section 2: *Episode of Admitted Patient Care* and *Sub-Acute Care*
- Section 3: *Care Type*
- Section 5: *Sub-Acute Record*
- Section 9: *Supplementary Code Lists: Care Type Care Type 9: Approved Geriatric Evaluation and Management (GEM) Programs:*
  

Geriatric Respite

**Definition**

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

**Guide for use**

Geriatric Respite includes both planned and unplanned respite:

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

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

Refer to:

- Section 3: *Account Class.*
- Section 4: *Business Rules (non-tabular), Geriatric Respite.*
**High Dependency (HDU) Bed**

**Definition**

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

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

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

**Guide for use**

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

Refer to:

Section 3: Account Class.

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**Hospital**

**Definition**

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

A hospital may be located at one physical site or may be a multi-campus hospital.

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

**Definition:**

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

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

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

Refer to:

Section 2: Campus and Transfer

Section 3: Campus Code

Section 9: Code Lists: Hospital Code Table:

A hospital may be located at one physical site or may be a multi-campus hospital.

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

The definition includes:

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

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

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

Refer to:
Section 2: Campus and Transfer
Section 3: Campus Code
Section 9: Code Lists: Hospital Code Table:

Hospital in the Home

**Definition**

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

**Guide for use**

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

The use of HITH is voluntary for the patient. For a patient, the service might be a
combination of hospital and home-based care or replace hospital care completely.

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

Currently, HITH is limited to public, private, DVA, TAC and WorkCover patients.
However, a public hospital should seek approval from a patient’s insurer before
admitting private patients to HITH. Details regarding this are outlined in the following
circular:

18/2008 Public Hospital fees – Changes

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

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

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

Refer to:
Section 3: Accommodation Type
**Hospital Stay**

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

**Guide for use**  
A hospital stay usually comprises one episode of care.  
A hospital stay may comprise more than one episode of care where:  
- The episodes occur at one hospital campus; and  
- Where the first episode has a statistical Separation Mode and the subsequent episode(s) has a statistical Admission Source.

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

Refer to:  
Section 2: Admission, Admitted Patient, Care Type, Episode of admitted patient care, and Separation.  
Section 3: Admission Source and Separation Mode.

**Hub and Spoke**

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

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

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

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

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

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

**Guide for use**
There are five different types and levels of ICU, details of which are listed below:

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

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

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

**Adult Intensive Care Unit – Level 3**

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

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

**Adult Intensive Care Unit – Level 2**

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

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

**Adult Intensive Care Unit – Level 1**

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

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

**Paediatric Intensive Care Unit**

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

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

**Neonatal Intensive Care Unit – Level 3**

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

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

Refer to:

Section 3: Duration of Stay in ICU and Account Class
**Interim Care Program**

**Definition**

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

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

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

**Guide for use**

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

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

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

Refer to:

Section 2: Episode of Admitted Patient Care, and Sub-Acute Care

Section 3: Care Type

Section 4: Business Rules (non-tabular) Interim Care Program and Contracting Arrangements

Section 5: Sub-Acute Record

Section 9: Supplementary Code Lists: Care Type F and E: Approved Interim Care Programs:

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

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

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

Newborns are not permitted to go on Leave with Permission.

Leave with permission excludes Contract Leave.

Refer to:
Section 2: Nursing Home Type/Non-acute Care and Separation
Section 3: Leave with Permission Days Financial Year-To-Date, Leave with Permission Days Month-To-Date, Leave with Permission Days Total and Separation Date.
Section 4: Leave and Length of Stay.

Leave without Permission
Definition
Where a patient absconds or leaves against medical advice.

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

Refer to:
Section 2: Leave with Permission and Separation
Section 3: Leave without Permission Days and Separation Date.
Section 4: Business Rules (non-tabular) Leave and Length of Stay.
Length of Stay

Definition

The length of stay of an admitted patient is measured in patient days. A same day patient should be allocated a length of stay of one patient day. The length of stay of an overnight or multi-day stay patient is calculated by subtracting the Admission Date from the Separation Date and deducting total leave with and without permission days.

Refer to:

Section 2: Leave – Contract, Leave with Permission and Leave without Permission
Section 3: Admission Date, Patient Days Financial Year-To-Date, Patient Days Month-To-Date, Patient Days Total, and Separation Date.
Section 4: Business Rules (non-tabular) Leave and Length of Stay.

Live Birth

Definition

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

Guide for use

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

Refer to:

Section 2: Newborn, and Qualification (Newborn).
Section 4: Business Rules (non-tabular) Newborn Reporting.
Medicare Eligibility Status - Eligible Person

Definition


Persons eligible for Medicare include:

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

Guide for use

This category does not include a foreign diplomat or family (except where eligibility is expressly granted to such persons by the terms of a Reciprocal Health Care Agreement).

An asylum seeker who has a valid temporary entry visa and is an applicant for a protection visa and either has work rights or a spouse, parent or child who is a permanent Australian resident, is eligible to apply for a Medicare card and is therefore an eligible person once they have their Medicare card.

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

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

A newborn will usually take the Medicare eligibility status of the mother. However, the eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother. For example, if the mother of a newborn is an ineligible person but the father is eligible for Medicare, then the newborn will be eligible for Medicare.

Categories of eligibility

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

• An Australian Resident;
• An Eligible Overseas Representative;
• A person declared eligible by the Minister;
• From a country with which Australia has a Reciprocal Health Care Agreement.
**Australian Resident**

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

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

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

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

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

**Eligible overseas representative**

A member of diplomatic or consular staff or a member of their family, of a diplomatic mission of a country with which Australia has a Reciprocal Health Care Agreement (RHCA), except New Zealand.

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

**Persons declared eligible by the minister**

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

Agreements negotiated by Australian authorities with other countries which enable visitors to Australia, who are ordinarily resident in a country with which Australia has a RHCA, to access immediately necessary treatment of ill health arising during the stay and which requires attention before the patient returns home: pre-arranged and elective treatment is not covered. This agreement provides for admitted patient care, but only as a public patient, for such medical treatment as is clinically necessary for the diagnosis, alleviation or care of the condition requiring attention, on terms no less favourable than would apply to an Australian resident.

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

**RCHA countries and commencement dates**

<table>
<thead>
<tr>
<th>RCHA country</th>
<th>RCHA formally commenced on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium (Note 4)</td>
<td>1 September 2009</td>
</tr>
<tr>
<td>Finland</td>
<td>1 September 1993</td>
</tr>
<tr>
<td>Italy (Note 1)</td>
<td>1 September 1988</td>
</tr>
<tr>
<td>Malta (Note 1)</td>
<td>6 July 1988 (amended 1 June 1998)</td>
</tr>
<tr>
<td>New Zealand (Note 2)</td>
<td>1 July 1986 (amended 1 September 1999)</td>
</tr>
<tr>
<td>Norway</td>
<td>1 March 2004</td>
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<tr>
<td>Sweden</td>
<td>1 May 1989 (amended 1 February 1995)</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>4 January 1992</td>
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<tr>
<td>United Kingdom (Note 3)</td>
<td>1 July 1986 (amended 8 March 2000)</td>
</tr>
</tbody>
</table>

**Note:**

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

2. New Zealand diplomats and their families are not included in the Australian/New Zealand RHCA and are therefore not eligible persons.
   For New Zealand residents, Medicare cover for private medical treatment was removed from September 1999. Medicare cards are no longer issued to New Zealand residents.

3. United Kingdom incorporates residents of England, Scotland, Wales, Northern Ireland, Isle of Man and the Channel Islands.

4. Persons from Belgium require a European Health Insurance Card to enrol in Medicare. They are eligible until the expiry date indicated on the card, or the length of their authorised stay if earlier.

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

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

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

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

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

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

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

Refer to:

Section 2: Asylum Seeker, Medicare Eligibility Status – Ineligible Person.
Section 3: Account Class, Medicare Number, and Medicare Suffix.

Medicare Eligibility Status - Ineligible Person

**Definition**  

Persons ineligible for Medicare include:

- Those who do not fit into one of the categories of eligibility.
- A visitor to Australia from a country with which Australia has a Reciprocal Health Care Agreement who elects to be treated as a private patient.
- A foreign diplomat or a member of their family, from a country with which Australia does not have a Reciprocal Health Care Agreement.
- Some Asylum seekers

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

**Exempt Patient**

- An ineligible, non-Australian resident specifically referred to Australia for hospital services not available in the patient’s own country and for whom the Secretary of the Department has determined that no fee be charged; or
- A person who has been declared a safe haven resident and whose treatment is provided or arranged by a designated hospital.
- Medicare Ineligible Asylum Seekers.

**Non-Exempt Patient**

An ineligible patient not exempted from fees by the Secretary of the Department of Health.

Under current legislation non-exempt ineligible patients cannot be categorised as Nursing Home Type. Non-exempt ineligible patients otherwise meeting Nursing Home Type patient criteria are deemed to be Non-Acute ineligible patients.

Refer to:

Section 2: Asylum Seeker, Medicare Eligibility Status – Eligible Person

Section 3: Account Class, Medicare Number and Medicare Suffix.

**Medi-Hotel**

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

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

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

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

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

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

Refer to:

Section 2: Criteria for Admission

Section 3: Accommodation Type

Section 4: Business Rules (non-tabular) Medi-Hotel Reporting

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**Neonate**

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

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

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

**When is a baby a neonate?**

Is baby born on the 1st of the month a neonate on the 28th of the month?  
28-1=27 therefore baby is a neonate

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

Refer to:

Section 2: Age, Live Birth, Qualification (Newborn), and Newborn

Section 3: Admission Date, Admission Weight, and Date Of Birth

Section 4: Business Rules (non-tabular) Newborn Reporting
Newborn

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

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

When is a baby a newborn?

Is a baby born on the 1st of the month a newborn on the 10th of the month?
10-1=9 therefore baby is a newborn

Is a baby born on the 1st of the month a newborn on the 11th of the month?
11-1=10 therefore baby is not a newborn

Refer to:

Section 2: Admitted Patient, Age, Criteria for Admission, Episode of Admitted Patient Care, Live Birth, Neonate, Qualification (Newborn), and Sub-Acute Care.

Section 3: Account Class, Account Class on Separation, Admission Source, Admission Type, Care Type, Criteria for Admission, and Qualification Status.

Section 4: Business Rules (non-tabular) Newborn Reporting.

Non-Admitted Patient

Definition  A patient who does not undergo a hospital's formal admission process. There are three categories of non-admitted patient: Emergency Department patient, outpatient, and other non-admitted patient (treated by hospital employees off the hospital site — includes community/outreach services).

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

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

Refer to:

Section 2: Admitted Patient and Patient
Nursing Home Type/Non-Acute Care

Definition

A Nursing Home Type (NHT) patient is defined in Section 3 of the Health Insurance Act 1973 (Commonwealth): after 35 days of continuous hospitalisation, the patient is classified as a NHT patient unless a medical practitioner (or their delegate in the case of public patients in public hospitals) certifies that the patient is in need of acute care (or Rehabilitation, Palliative Care or Geriatric Evaluation and Management).

For example:

• Professional attention for an acute phase of the patient’s condition.
• Active rehabilitation.
• Continued management, for medical reasons as an admitted patient.

A patient cannot be designated NHT before 35 days of continuous hospitalisation (with a maximum break of seven consecutive days) even if an Aged Care Client Record (ACCR) has been signed.

Non-Acute Compensable and Non-Acute Ineligible

Under current legislation, compensable and ineligible patients cannot be categorised as Nursing Home Type. However, where such a patient has been admitted in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days and who, if not a compensable/ineligible patient would be deemed to be a Nursing Home Type patient, then the patient is deemed to be Non-Acute.

Guide for use

Although the Health Insurance Act 1973 (Commonwealth) applies directly to private patients using their health insurance for this episode, nationally the guidelines provided in the Act have been extended to all other patients for the purpose of data collection, analysis and funding.

Following 35 days of continuous hospitalisation a patient becomes NHT/Non-Acute unless the patient continues to receive acute care.

In public hospitals

For public patients, a medical practitioner or their delegate must provide certification that the patient requires acute care after 35 days of continuous hospitalisation.

For private and compensable patients, a medical practitioner must provide certification that the patient requires acute care after 35 days of continuous hospitalisation.

Thus, in public hospitals in Victoria, a patient receiving any one of the admitted patient Care Types (not just 4 Other care (Acute) including Qualified newborn) will become a NHT/Non-Acute patient (Care Type F Interim Care Program – Nursing Home Type, 1 NHT/Non-Acute or 5T Mental Health Nursing Home Type) if they receive 35 days of continuous hospitalisation and do not have certification allowing the present type of care to continue.
The decision for a patient to continue to receive acute care following 35 days of continuous hospitalisation is a clinical one, which needs to be clearly documented then communicated to the relevant staff who report data on admitted episodes of care. This enables the identification of episodes that continue to be acute beyond 35 days and thus do not require statistical separation from an acute episode and a statistical admission to commence an NHT/Non-Acute episode. This documentation can be subject to audit by DH.

Note that 35 days of hospitalisation can be accrued across hospitals when a patient is transferred. Continuity is not broken by normal leave or when a patient is out of hospital for no more than seven consecutive days.

For example:

A patient receives admitted patient care in a hospital for 20 days and is then transferred to another hospital. On the 16th day of the second admission, the patient becomes a Nursing Home Type patient (if acute care certification does not exist). If, in this example, the patient was on normal leave for two days during the accrual period, the change to Nursing Home Type would not occur until the 18th day of the second admission (two days later).

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

Refer to:

Section 2: Acute Care, and Episode of Admitted Patient Care
Section 3: Care Type

Organ Procurement - Posthumous

Definition

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

Guide for use

Donor organs for transplant are procured in two circumstances:

1. From a patient already admitted to the hospital who dies:
   • Such a patient’s time of separation is the official time of death.
   • Therefore, the count of hours in ICU and/or CCU, and the Duration of Mechanical Ventilation and Non-invasive Ventilation, reported to the VAED must cease at official separation, and the ICD-10-AM/ACHI Diagnosis and Procedure Codes for the ‘procuring’ procedures must not be reported to the VAED.

2. From a person who is declared ‘dead on arrival’ at the hospital:
   • Such a person cannot be ‘admitted’.
   • Therefore no episode can be reported to the VAED.

Refer to:

Section 2: Time of Death
Section 3: Duration of Mechanical Ventilation in ICU, Duration of Non-invasive Ventilation (NIV), Duration of Stay in Cardiac/Coronary Care Unit, Duration of Stay in Intensive Care Unit, and Separation Time
**Overnight or Multi-day Stay Patient**

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

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

Therefore, a booked same day patient who is subsequently required to stay in hospital for one night or more is an overnight patient; a patient who dies, is transferred to another hospital or leaves of their own accord on their first day in the hospital is a same day patient, even if the intention at admission was that they remain in hospital at least overnight.

A patient transferred to another campus but intending to return to this campus should be placed on leave for the duration of stay at the other campus. If the patient attends the other campus as a day-only admission, the leave should be recorded on the patient’s record but should not be reported to the VAED.

Unless the patient is on leave with or without permission or contract leave, an overnight or multi-day stay patient in one hospital cannot be concurrently an overnight or multi-day stay patient in another hospital.

Refer to:
Section 2: Admitted Patient, Leave - Contract, Leave with Permission, Leave without Permission, Length of Stay, Separation
Section 3: Admission Date and Separation Date
Section 4: Leave

**Palliative Care**

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

Refer to:
Section 2: Episode of Admitted Patient Care, and Sub-Acute Care.
Section 3: Care Type.
Section 4: Business Rules (non-tabular) Palliative Care Reporting.
Section 5: Sub-Acute Record.
Section 9: Supplementary Code Lists Care Type 8:
**Patient**

**Definition**

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

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

**Boarders are not patients.**

Refer to:

Section 2: *Admitted Patient, Boarder* and *Non-admitted Patient*

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**Patient Day**

**Definition**

A day or part of a day that a patient is admitted to receive hospital treatment. The patient day is the unit of measurement for the length of stay of an episode of care.

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

Refer to:

Section 2: *Length of Stay*

Section 3: *Admission Date, Patient Days Financial Year-To-Date, Patient Days Month-To-Date, Patient Days Total, and Separation Date.*

Section 4: *Business Rules (non-tabular) - Contracted Care and Length Of Stay.*

Section 5: *Status Segments*

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**Principal Diagnosis**

**Definition**

The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code.

**Guide for use**

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

Refer to:

Section 2: *DRG Classification*

Section 3: *Diagnosis Codes*
Procedure
Definition
A clinical intervention that:
• Is surgical in nature; and/or
• Carries a procedural risk; and/or
• Carries an anaesthetic risk; and/or
• Requires specialised training; and/or
• Requires special facilities or equipment only available in an acute care setting.

Guide for use
The order of codes should be determined using the following hierarchy, in accordance with the ICD-10-AM/ACHI Seventh Edition Australian Coding Standards:
• Procedure performed for treatment of the principal diagnosis
• Procedure performed for treatment of an additional diagnosis
• Diagnostic/exploratory procedure related to the principal diagnosis
• Diagnostic/exploratory procedure related to an additional diagnosis

Refer to:
Section 2: DRG Classification
Section 3: Procedure Codes

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

Guide for use
A newborn day is qualified if the newborn meets at least one of the criteria for admission.
A newborn day is unqualified if the newborn does not meet any of the criteria for admission.
Unqualified babies must be changed to boarders after they turn 9 days of age.

Refer to:
Section 2: Admitted Patient, Criteria for Admission, Neonate and Newborn
Section 3: Qualification Status
Section 4: Business Rules (non-tabular) - Newborn Reporting
Rehabilitation Care

Definition

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

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

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

Level 1 - Care in a public hospital in a designated Level 1 Rehabilitation Program/Unit.

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

Level 2 - Care in a public or private hospital in a designated Level 2 Rehabilitation Program/Unit.

Level 2 are rehabilitation programs that fully meet the criteria for designation as set out in the document Designation of Rehabilitation Programs, November 1993.

Level 3 - Care in a public hospital in a designated Level 3 Rehabilitation Program/Unit.

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

Non-Designated - Care in a public hospital in a non-designated Rehabilitation Program/Unit.

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

Paediatric - Care in a public hospital in a designated Paediatric Rehabilitation Program/Unit.

Paediatric rehabilitation is for use by designated specialty programs providing rehabilitation to persons generally under 18 years of age.

Refer to:
Section 2: Episode of Admitted Patient Care, and Sub-Acute Care
Section 3: Care Type and Clinical Sub-Program
Section 5: Sub-Acute Record
Section 9: Supplementary Code Lists Care Types 2, 6, 7, K & P:
**Same Day Patient**

**Definition**  
A patient who is admitted and separated on the same date

**Guide for use**  
A same day patient may be either a booked or an emergency patient. A patient cannot be both a same day patient and an overnight or multi-day stay patient at the one hospital. Thus emergency treatment provided to a patient who is subsequently classified as an overnight or multi-day stay patient in the same hospital shall be regarded as part of the overnight or multi-day stay patient episode of care.

The category of ‘same day’ is determined retrospectively; that is, it is not based on the intention to admit and separate on the same date. Therefore, patients who die, transfer to another hospital or leave of their own accord on their first day in the hospital are included. Booked same day patients who are subsequently required to stay in hospital for one night or more are excluded.

Refer to:

Section 2: Admitted Patient, Criteria for Admission, Length of Stay and Separation

Section 3: Admission Date, Criteria for Admission and Separation Date

Section 4: Business Rules (non-tabular) Length of Stay
Separation

Definition

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

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

A separation may be formal or statistical.

**Formal separation**: the administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.

**Statistical separation**: the administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.

Guide for use

**Formal**:

Where the patient meets one of the following criteria:

- Is discharged to private accommodation or other residence (no intention to return to this campus within seven days for continuation of the same treatment).
- Is transferred to another hospital campus of the same service.
- Is transferred to other health care accommodation (unless there is an intention to return to this campus within seven days for continuation of the same treatment, in which case the patient should be placed on leave).
- Is discharged following a procedure from the Automatically Admitted Procedure List (even if the patient is returning within 7 days for another treatment).
- Dies.
- Leaves against medical advice, and does not return for continuing treatment within seven days.
- Fails to return from leave within seven days. The patient is separated effective from the first day of leave. (This limit does not apply to contract leave.)

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

**Statistical**:

Where a hospital records the completion of treatment and/or care and accommodation following a change of Care Type (transfer between Care Types) occurring within the one hospital stay (for example, transfer from Acute to Nursing Home Type care or transfer from Acute to Rehabilitation care in a designated rehabilitation program).

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

Refer to:

Section 2: Episode of Admitted Patient Care, Hospital Stay, Leave with Permission, Leave with Permission, Overnight or Multi-day Stay Patient, and Same Day Patient

Section 3: Separation Mode.
**Sub-Acute Care**

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

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

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

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

Refer to:

Section 2: Acute Care, Admitted Patient, Episode of Admitted Patient Care, Geriatric Evaluation and Management Program (GEM), Interim Care Program, Nursing Home Type/Non-Acute Care, Palliative Care, and Rehabilitation Care

Section 3: Care Type

**Time of Death**

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

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

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

Refer to:

Section 2: Organ Procurement - Posthumous

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

**Definition**
Transfer refers to patients moving between two different hospitals or hospital campuses where:

- They were assessed or received care and treatment in the first hospital; and
- It is intended that the patient receive admitted care in the second hospital.

Refer to:

Section 2: Campus, Criteria for Admission, and Hospital

Section 3: Admission Source, Separation Mode, Transfer Destination, Transfer Source

Section 4: Business Rules (non-tabular) - Transfer Reporting

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**Transition Care**

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

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

Services provided include:

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

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

Eligible people will be separated from hospital.

Refer to:

Section 3: Admission Source, Separation Mode and Separation Referral
Derived items list

The VAED contains most of the information transmitted via PRS/2, and data items derived from the PRS/2 information (some information transmitted in the V4 record is not stored in the VAED).

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

The following website for the Health Policy Reporting and Analysis Unit provides links to documents listing all of the fields in the VAED for recent financial years: