Monthly Activity Collection

Data Collections Unit
Queensland Health

Year

2012-2013

MAC Manual

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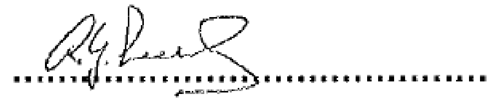

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Date	Release	Pages	Details
Jul 2009	Version 8	All	Removed the Dental collection component and MTHACPS1 report (Public Psychiatric Hospitals). Updated required definitional changes.
July 2010	Version 9	All	Updated to reflect the introduction of MAC Online. Clarification for the term Clinic. Removal of available bed days.
July 2010	Version 10	All	Includes updates following the initial to release QHEPS
July 2011	Version 11	All	Update of controlled document to reflect changes to forms and facilities within the scope of the collection
July 2012	**Version 12**	**All**	**Updated to reflect the introduction of new Activity Based Funding requirements, the Corporate Clinic Code (CCC) list and updated bed availability categories.**

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Glossary of Terms and Abbreviations

The following terms and abbreviations are used throughout this document.

Abbreviation	Description
ABF	Activity Based Funding
AIHW	Australian Institute of Health and Welfare
AIS	Access Improvement Service
DCU	Data Collections Unit
DSS	Data Set Specification
HHS	Hospital & Health Service
IHPA	Independent Hospital Pricing Authority
MAC	Monthly Activity Collection
MPHS	Multi Purpose Health Service
NAP	Non-admitted Patient
NEP	National Efficient Price
NH	Nursing Home
NHA	National Healthcare Agreement
NHIA	National Health Information Agreement
NHRA	National Health Reform Agreement
NMDS	National Minimum Data Set
ODC	Outpatient Data Collection
SATr	Surgical Access Team repository

1 Introduction

This manual provides an overview of the Monthly Activity Collection (MAC). It is designed to be a reference for those who are responsible for completing monthly activity forms to report Monthly Activity data to the Data Collections Unit (DCU), and other interested persons.

For users submitting MAC forms, this manual must be read in conjunction with the MAC Online User Manual.

1.1 National Health Reform

Commonwealth, State and Territory governments have agreed to transform the Australian health system. Queensland is now working towards the implementation of the reforms that will change the way public health and hospital services are managed.

The National Health Reform Agreement (NHRA) sets out the intention of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians. Through this national agreement, there will be enhanced focus on the equitable funding of public hospitals, local access to services, improved efficiency, accountability and transparency across the system, and financial sustainability into the future.

The Independent Hospital Pricing Authority (IHPA) plays a pivotal role in the introduction of Activity Based Funding (ABF) which is effective commencing the 2012-13 financial year. IHPA also has other key responsibilities as outlined in the NHRA, such as setting the national efficient price (NEP) for public hospital services and the efficient cost of block funding services in regional hospitals.

Refer to *Health Reform Queensland* on QHEPS for further information.

1.2 Australian Government Reporting Requirements

Under the National Healthcare Agreement, Queensland Health is required to supply the Australian Government Department of Health and Ageing with hospital activity data on Queensland's public health system.

As a signatory to the National Health Information Agreement, Queensland Health is also required to provide hospital activity data to the Australian Government Institute of Health and Welfare (AIHW) according to agreed National Minimum Data Sets (NMDS).

Data reported to the MAC is used to meet Public Hospital Establishments and the Outpatient Care NMDS reporting requirements.

For the 2012-13 financial year onwards, Queensland Health in addition to existing requirements must provide hospital activity data to IHPA as specified in two new data set specifications (DSSs) on a quarterly basis.

1. *Non-admitted Patient ABF Data Set Specification (Aggregate-Level);* "NAP Aggregate ABF DSS" and
2. *Non-admitted Patient ABF Data Set Specification (Patient -Level);* "NAP ABF DSS".

Refer to the IHPA website for details of these DSSs.

Data reported in the MAC will be used as the source to meet the NAP Aggregate ABF DSS reporting requirements. It is anticipated that the Outpatient Data Collection (ODC) will be used as the source to meet NAP ABF DSS requirements.

The *IHPA Three Year Data Plan* identifies the overarching jurisdictional requirements, processes and time frames through to 2015-16 inclusive.

2 The Monthly Activity Collection (MAC)

The Monthly Activity Collection (MAC) collects aggregate (or summary level) data on 'Admitted' & 'Non-admitted' patient activity and 'Bed Availability' from public acute hospital facilities, public residential psychiatric hospitals and public nursing homes/hostels/independent living units and multi-purpose health services each month.

There are a number of forms which facilities must complete each month to provide this information to the MAC to comply with State and Australian Government reporting requirements.

MAC data is routinely published on the Queensland Health Internet and Intranet sites as well as in Australian Government publications such as *Report on Government Services (ROGS)*, *Australian Hospital Statistics* and the *My Hospitals* web-site.

2.1 Scope of the MAC

All Queensland Health public facilities must complete the MAC forms required (for their facility) each month. Refer to Section 4, Forms Required by Facility by Hospital & Health Service for individual facility report requirements.

Activity that is required to be reported in the MAC is activity that is **operated and managed by the facility and funded from the facility's operating expenditure.**

2.2 MAC Online

MAC Online is a web based application, developed by DCU, which enables facilities to complete and upload a number of spreadsheet templates to DCU in order to report MAC data.

Refer to the MAC Online User Manual for information on this application.

2.3 MAC Changes from 2012-13

The DCU were requested to develop new MAC reports for collection of occasions of service data to meet quarterly ABF reporting requirements from 1 July 2012, in particular:

- implement the Australian Government's 'Tier#2 Outpatient Clinic' classification for all public hospital facilities (ie: both 'ABF' and 'Block' funded facilities); and
- incorporate the service provider type data concepts (medical or other health professional).

Following liaison with and endorsement by the ABF Technical Model Team and clearance through the A/Deputy Director-General Finance, Procurement and Legal Services, two new MAC Reports - one for *consultation clinics* (Clinics form) and one for *procedure clinics* (Diagnostics & Procedures form) were developed for reporting from 2012-13 financial year.

In addition, Statewide Telehealth Services endorsed a new dedicated Telehealth MAC form to enable the reporting of non-admitted telehealth activity against public, public compensable, ineligible and eligible other categories to meet their requirements.

2.4 MAC Reporting Requirements & Business Rules

2.4.1 MAC Monthly & Quarterly Reporting Timeframes

All final versions of MAC reports must be submitted to DCU by the 14th day[1] following the reference month (eg for the reference month of September, MAC reports must be submitted by 14th of October).

From 1 July 2012, (aggregate-level) non-admitted data for 2012-13 onwards must be provided on a quarterly basis to the IHPA, as per the *IHPA Three Year Data Plan* under ABF reporting arrangements.

As this information is also used to determine funding and purchasing allocations, data will be now be considered finalised on a quarterly basis, by the submission date following the reporting quarter.

[1] *A preliminary PH1 report is due on the 4th day of each month following the reference month. For most facilities using HBCIS, the PH1 is generated and sent automatically using the 'Report Monitor' functionality. A final version is required on the 14th which would contain any amendments to the preliminary version.*

Refer to the table below as an example of the quarterly reporting schedule:

Reporting Quarter	Period	Due Date	Finalisation Date
September	July	14 August	14 November
	August	14 September	
	September	14 October	
December	October	14 November	14 February
	November	14 December	
	December	14 January	
March	January	14 February	14 May
	February	14 March	
	March	14 April	
June	April	14 May	14 August
	May	14 June	
	June	14 July	

As the data will be used to substantiate funding allocations, HHS CEOs will be required to provide requests to update 'finalised' quarterly MAC data in writing to the Data Collections Unit, Health Statistics Centre.

Requests will be tabled at the 'Relationship Management Group' meetings for consideration and approval.

2.4.2 Chief Executive, HHS Approval

Currently Chief Executives approve the monthly Bed forms submitted to the MAC.

From 1 July 2012, 2012-13 non-admitted activity data will also require approval by the Chief Executives of the HHS, as the data will be used to substantiate funding and purchasing allocations in Queensland Health's new 'purchaser / provider' model.

Refer to the MAC Online User Manual to set-up 'approval' access for the Chief Executive (for the respective occasions of service MAC reports).

2.4.3 MAC Forms Required Summary

The new MAC forms for reporting of occasions of service data to the DCU (for all public hospital facilities) from 2012-13 are:

- Clinic;
- Diagnostics and Procedures; and
- Telehealth.

The new MAC forms supersede the MTACPH3X (3X), MTACPH3Y (3Y) and MTACPH4X (4X) reports.

The following MAC forms for reporting bed availability, (summary-level) admitted patient, nursing home and multi-purpose health services data continue to be:

- Bed;
- MTACPH1 (PH1);
- Multi Purpose Health Services (MP1)
- Nursing Homes (NH2)

The Bed form has been updated to align with version 3 of the Clinical Services Capability Framework.

2.4.4 MAC Forms Required by Facility Type

The table below shows which 2012/2013 MAC forms are used to collect data by facility type. It also includes the 2011/2012 MAC forms as a reference.

<table>
<tr><th>Facility Type</th><th>2011/2012 MAC Form Name</th><th>Data Collected</th><th>2012/2013 MAC Form Name</th><th>Data Collected</th></tr>
<tr><td>Hospital - acute</td><td>MTACPH3X (3X for larger facilities)</td><td>One-to-one occasions of service and group sessions for non admitted specialist and allied health clinic types.</td><td>CLINIC (MACONCLNC)</td><td>One-to-one occasions of service, group sessions and number of group session patients for non-admitted medical officer and other health professional clinic types.</td></tr>
<tr><td>Hospital - acute</td><td>MTACPH4X (4X smaller facilities)</td><td>One-to-one occasions of service and group sessions for Emergency, Outpatient, Diagnostic, Community Health, District Nursing, and Other Outreach Services and the number of births.</td><td rowspan="2">DIAGNOSTIC & PROCEDURES (MACONDGPR)</td><td rowspan="2">One to one occasions of service, group sessions and number of group session patients for hospital funded Community Health, Other Outreach and Procedure clinics, Emergency Services (non EDIS sites), Diagnostic Imaging, Pharmacy and Home Dialysis Patients census data.</td></tr>
<tr><td>Hospital - acute</td><td>MTACHP3Y (3Y for larger facilities)</td><td>One-to-one occasions of service and group sessions for Community Health clinics, Diagnostic, Pharmacy, Emergency Services and Home Dialysis activity.</td></tr>
<tr><td>Hospital - acute</td><td></td><td></td><td>TELEHEALTH (MACONTELE)</td><td>One-to-one occasions of service and group sessions for non-admitted specialist and allied health clinic types by service provider for which services are delivered by Telehealth.</td></tr>
<tr><td>Hospital - acute</td><td>Bed (BED)</td><td>The number of available beds and available bed alternatives for admitted patients.</td><td>BED (BED)</td><td>The number of available beds and available bed alternatives for admitted patients.</td></tr>
<tr><td>Hospital - acute</td><td>Pathology (MTACPATH)</td><td>Pathology occasions of service (Non-Auslab facilities only).</td><td>PATHOLOGY (MTACPATH)</td><td>Pathology occasions of service (Non-Auslab facilities only).</td></tr>
<tr><td>Hospital – acute and psychiatric</td><td>PH1 (MTHACPH1)</td><td>Admitted patient admissions, separations, and classification changes.</td><td>PH1 (MTHACPH1)</td><td>Admitted patient admissions, separations, and classification changes.</td></tr>
<tr><td>Nursing homes, hostels, independent living units</td><td>NH2 (MTHACNH2)</td><td>Admitted resident admissions, separations, non-admitted patient occasions of service and allocation of places.</td><td>NH2 (MTHACNH2)</td><td>Admitted resident admissions, separations, non-admitted patient occasions of service and allocation of places.</td></tr>
<tr><td>Multi Purpose Health Services</td><td>MP1 (MTHACMP1)</td><td>Admitted patient admissions, separations and bed availability.</td><td>MP1 (MTHACMP1)</td><td>Admitted patient admissions, separations and bed availability.</td></tr>
</table>

2.4.5 MAC Form Structure

The MAC form templates are in the format of MS Excel spreadsheets.

Facilities must use MAC form templates to upload their reported activity to MAC Online for submission to DCU.

These templates are provided to facilities prior to the beginning of each financial year and are available from the DCU website.

MAC form templates must not be altered in any way as they will not upload to MAC Online and data will not be submitted to DCU.

2.4.6 NIL activity report

Facilities that record no activity during the month are still required to submit required MAC forms. The cells in which activity is recorded on the form should be left blank.

2.4.7 Provision of Estimates

Estimated data should only be provided when it is not available because of events such as major computer system failure, industrial action, natural disasters etc. Any data that is an estimate must be denoted as such in the submitted data (using MAC Online comments) and updated with actual data by the date the next reference month is due.

2.4.8 Admitted Patient Data Validations

DCU validates the (summary-level) admitted patient activity by confirming, where applicable, the total number of separated episodes of care for each reference period.

The reconciliation of this data is as follows:

Total Overnight or Longer Separations + Total Same Day Separations reported on the MTHACPH1 (PH1 report) are reconciled to the total number of separations (episodes of care) for admitted patients reported to the Queensland Hospital Admitted Patient Data Collection (QHAPDC).

The total number of separations (and there respective modes) reported to each data collection should equal.

Total Overnight or Longer Separations = grand total statistical + grand total formal overnight or longer separations from All Admitted Patients.

Total Same Day Separations = grand total statistical + grand total formal same day separations from All Admitted Patients.

Episodes with a care type of ‘Boarder’ are excluded from this reconciliation. All episodes with a care type of ‘Newborn’ are included, regardless of qualification.

2.4.9 Non-admitted Patient & Bed Availability Data Validations

The MAC Online application validates each line of reported patient activity on the MAC forms. Validation exceptions are raised when the reported activity for the reference month is compared to the previous month and fails predetermined acceptance criteria (eg: variance percentage is high, same value both periods, null values etc).

Facilities must respond to validation exceptions with relevant and meaningful comments and provide details of the validation exception.

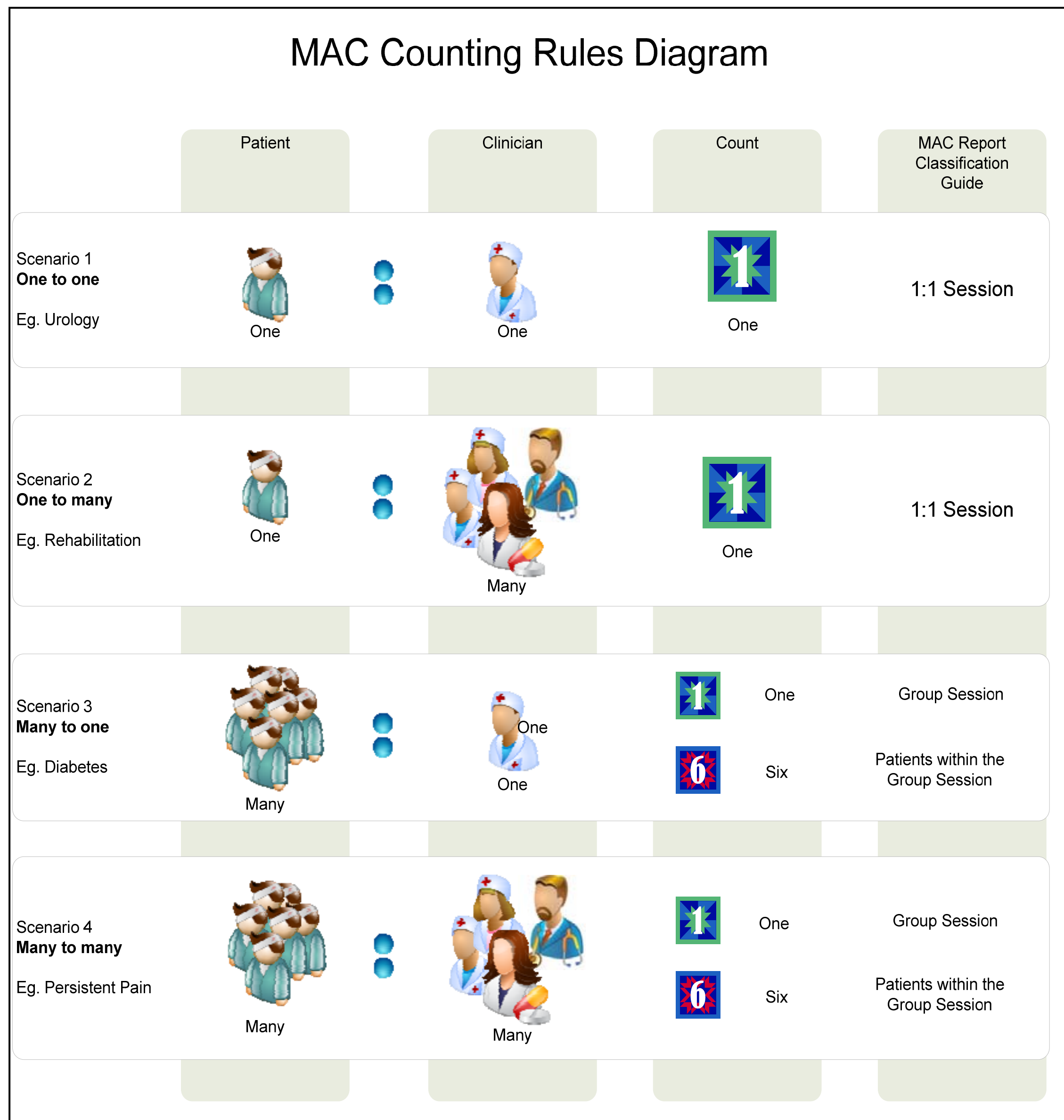
Comments provided by facilities are retained within DCU databases and are utilised to respond to queries raised by various business areas in Queensland Health, data analysts, Executive Management and also the Australian Government. Therefore, it is very important that the comments provided clearly state the reasons for the variations.

Where validation comments are not provided when required, DCU will contact the MAC On-line contact at the facility to obtain details for the data anomaly.

Facilities may also be contacted by DCU seeking comments on data anomalies that appear following time series trend analysis when required.

2.4.10 Counting Rules

The following diagram outlines the current counting rules for reporting of occasions of service to the MAC, as prescribed in national reporting standards.



3 MAC Form Information

3.1 Non-admitted Patient Activity Forms

3.1.1 Clinic Types and Clinic Definitions

Historically clinic types on MAC forms were aligned to the public hospital establishments NMDS. Overtime they were enhanced further to meet Queensland's Casemix reporting requirements.

From 2012-13 onwards clinic types on the new Clinic, Diagnostic and Procedures and Telehealth MAC forms are aligned to the new Queensland Health Corporate Clinic Codes (CCC).

This will ensure that Queensland is able to meet new ABF reporting requirements as the CCC also maps to the Australian Government's (IHPA's) *Tier 2* Outpatient Clinic Classification.

To review the CCC list refer to http://qheps.health.qld.gov.au/patientflow/docs/ccclist.pdf. This document should be read in conjunction with IHPA's *Tier 2 Outpatient Clinic Definitions*.

Queensland's decision to develop and implement the CCC provides a more granular list of clinics than currently available in the *Tier 2 Outpatient Clinic Classification*.

3.1.2 Clinic Form (MACONCLNC)

The Clinic form is used to report non-admitted patient activity by provider type (medical officer and other health professional), by clinic type (new or repeat) and also by the compensability/ eligibility of the patient.

The total number of one to one occasions of service, group sessions and number of group session patients should be recorded on this form.

Scope

The Clinic form must be completed by all Queensland Health public facilities. Refer to Section 4 for the forms required to be submitted by each Queensland Health facility.

Form

Clinic Form

Definitions

From 1 July 2012, the clinic types for reporting of non-admitted patient activity in the main are sourced from Australian Government's (IHPA's) Tier 2 Outpatient Clinic Classification; and Queensland Health's version of the same - the Corporate Clinic Code (CCC) list.

Refer to the IHPA's Tier 2 Outpatient Clinic Classification and the CCC document for definitions on the clinic types presented on this MAC form. Queensland Health Corporate Clinic Codes for non-admitted outpatient Tier 2 classification reporting v1.0.

Definitions of other data elements collected on this form are:

Department of Veterans' Affairs (Patients)
Patients for whom the Department of Veterans' Affairs has accepted responsibility for the payment of any charges relating to their treatment.

Eligible Motor Vehicle Queensland (Compensable Patients)
Eligible patients who are receiving treatment for conditions that resulted from accidents where liability lies with a Queensland registered vehicle. The patients have, or may have, an entitlement to claim damages under Motor Vehicle Third Party Insurance.

Eligible Motor Vehicle Other (Compensable Patients)
Eligible patients who are receiving treatment for conditions that resulted from accidents where liability lies with a vehicle registered elsewhere (not Queensland).

Eligible Other Compensable (Patients)
Patients who have, or may have, an entitlement to claim damages under public liability insurance, other than Motor Vehicle Third Party, WorkCover, or other third party.

Eligible Other (Patients)
Patients who can not be classified as Eligible Work Cover Queensland, Eligible Work Cover Other, Eligible Motor Vehicle Queensland, Eligible Motor Vehicle Other, Eligible Other Third Party, Eligible Other Compensable, Department of Veterans' Affairs, or Eligible Public.

In most cases, these patients will have been treated by a doctor with a right of private practice at the facility.

Eligible Other Third Party (Compensable Patients)
Patients who have, or may have, an entitlement to claim damages under third party insurance, other than Motor Vehicle Third Party insurance.

Eligible Patients
An eligible patient is one who is eligible for Medicare as specified under the Commonwealth Health Insurance Act 1973. For further information, please refer to http://meteor.aihw.gov.au/content/index.phtml/itemId/481841

Eligible Public (Patients)
Eligible public patients are patients who,

- elect to be treated as a public patient so cannot choose the doctor who treats them, or
- are receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority, or
- are being treated by Medical Officers that are eligible to claim reimbursement for the service/s provided through Medicare Australia under the Rural & Remote Medical Benefit Scheme (RRMBS) or the Medicare Billing for Primary Care in Small Rural Hospitals arrangements (COAG 19.2).

A public patient who is treated in single accommodation due to clinical need is still a public patient.

There are three sub-categories under Eligible Public that can be used to distinguish between face-to-face, telehealth/telemedicine and telephone consultation services. These three sub-categories are mutually exclusive.

Eligible WorkCover Queensland (Compensable Patients)
Patients who are entitled to claim damages under the WorkCover Queensland Act.

Eligible WorkCover Other (Compensable Patients)
Patients who are entitled to claim damages under a WorkCover Act other than Queensland's (eg, employees of the Australian Government).

Group Sessions (Total Number of Group Sessions)
Sessions where two or more non-admitted patients receive services at the same time from one or more facility staff.

Each group is to be counted once, irrespective of size or the number of staff providing services.

Where all individuals in the group belong to the same family, the session should be reported as being provided to an 'individual' (ie, as a 1:1 Session).

Group Sessions (Total Number of Patients)
Sessions where two or more non-admitted patients receive services at the same time from one or more facility staff.

The total number of patients attending Group Sessions is to be counted for the reference period.

Where all individuals in the group belong to the same family, the session should be reported as being provided to an 'individual' (ie, as a 1:1 Session).

Ineligible (Patients)
Patients who are deemed not to be eligible for Medicare services.

New Patient (Attendance)
The first attendance under the new specialist or a consultant physician's care would be classified as a 'new patient' occasion of service.

The presentation for an unrelated illness, requiring the referral of the patient to another specialist or a consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

The receipt by a specialist outpatient department of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving recording of a 'new patient' occasion of service.

However, where the referring practitioner

- deems it necessary for the patient's condition to be reviewed; and
- the patient is seen under the care of a specialist or the consultant physician outside the currency of the last referral; and
- the patient was last seen by the specialist or the consultant physician more than 12 months earlier; then
- the attendance following the new referral initiates a new course of treatment and therefore a 'new patient' occasion of service.

An update to the current definition is currently being undertaken by the Access Improvement Service with other business areas as part of the Outpatient Services Implementation Standard. Once this has been approved an addendum to the Manual will be provided.

Non-admitted Patients
Patients who do not undergo a hospital's formal admission process.

Non-admitted patients receive direct care within the emergency department, or as outpatients (including non-admitted day program patients), or through other non-admitted services such as community and outreach services.

Occasions of Service
Occasions of service include any examination, consultation, treatment or other service provided to a non-admitted patient in each functional unit of a health service facility, on each occasion such service is provided.

One to One (1:1) Sessions
Where one non-admitted patient received services by staff of the facility.

Services provided to a 'family unit' at the same time are also to be reported as a single one to one session.

Provider Type
The discipline of health professional that provides the occasion of service in the clinic.

Provider Type Medical Officer
Includes all medical officers eg: interns, registrars, specialist consultants.

Provider Type Other Health Professional
Includes all other non-medical health professionals eg: nurses, allied health professionals, technicians, aboriginal and Torres Strait islander health workers.

Reference Month
The month to which the form refers. Commences from midnight on the first day of the month up to and including 11.59pm of the last day of the month.

Repeat Patient (Attendance)
A subsequent attendance of a patient for a previously referred condition during a single course of treatment.

An update to the current definition is currently being undertaken by the Access Improvement Service with other business areas as part of the Outpatient Services Implementation Standard. Once this has been approved an addendum to the Manual will be provided.

Telephone Consultation
Consultations provided to eligible public patients over the telephone.

Such consultations should only be reported as an occasion of service on the Monthly Activity Form if:

- the service was a substitute for a face-to-face occasion of service, and
- a clinician (doctor, nurse, or allied health professional) spoke directly with a patient or with a parent / carer on behalf of the patient, and
- clinical notes were recorded in the patient's medical record.

Details of the consultation must be recorded through an electronic or manual booking system.

Telephone calls for the purposes of making an appointment or providing test results are excluded.

3.1.3 Diagnostics and Procedures Form (MACONDGPR)

The Diagnostics and Procedures form is used to report non-admitted patient activity by service provider type (medical officer or other health professional) and compensability/ eligibility for:

- community health services (hospital funded only)
- procedure clinics (also reported by the appointment type (new or repeat))
- emergency services attendances (non-edis sites)
- diagnostic imaging and pharmacy activity and
- home dialysis patients

Both the number of 'one to one' OOS, group sessions and number of group session patients should be recorded on this form.

Scope

The Diagnostics and Procedures form must be completed by all Queensland Health public facilities. Refer to Section 4 for the forms required to be submitted by each Queensland Health facility.

Form

Diagnostic and Procedures Form

Definitions

Refer to IHPA's Tier 2 Outpatient Clinic Classification and the CCC document for definitions on the clinic types presented on this MAC form.
Queensland Health Corporate Clinic Codes for non-admitted outpatient Tier 2 classification reporting v1.0.

Definitions of other items collected on this form are:

Community Health Services (Occasions of Service)

Occasions of service provided to non-admitted patients provided by designated community health units *funded from the facility's operating expenditure* that are operated and managed by the facility. Community health units may include well-baby clinics, immunisation units and aged care assessment teams.

It is intended that all community health services funded through the facility be reported, regardless of where the services are provided.

Separate identification of Community Health Services occasions of service provided to Rehabilitation and Geriatric Evaluation and Maintenance patients is required for national sub and non-acute patient reporting requirements.

Emergency Services

Only facilities that <u>do not</u> have the Emergency Department Information System (EDIS) need to report their emergency services activity data via the MAC.

Emergency services are the front door of the health facility and, for many people, form their primary contact with the health care system, providing an important interface between the community and the health facility.

Emergency services are responsible for the reception, triage, initial assessment, stabilisation and management of patients of all age groups presenting with acute and urgent aspects of illness and injury.

The role and level of function of a hospital-based emergency service depends on various factors, including the type of facility in which it is located, geographical location, location in the public or private sector, and the place of the facility within a health system network.

The term emergency department is generally used to describe facilities ranging from high-level departments with emergency medicine specialists and trainees employed 24 hours a day, through to rooms in small rural and remote hospitals staffed by rostered local general practitioners and generalist nursing staff.

Emergency Services Treated (Occasions of Service)
A service given to a non-admitted patient who receives treatment that was unplanned or provided by a hospital emergency service.

In general, it would be expected that most emergency services patients would receive surgical or medical treatment. However, where patients receive other types of treatment that are provided by the emergency service, report the activity here. The exceptions are endoscopy & related procedures which are to be reported against the separate category provided for reporting.

Emergency Services Did Not Waits
A person presenting to an hospital-based emergency service who undergoes a registration process (acknowledgement of arrival) but fails to commence either a triage process or assessment and management of their presenting problem as a result of their decision to leave the ED.

Department of Veterans' Affairs (Patients)
Patients for whom the Department of Veterans' Affairs has accepted responsibility for the payment of any charges relating to their treatment.

Diagnostic Imaging (aka Radiology and Organ Imaging) (Occasions of Service)
All occasions of service provided to non-admitted patients undertaken in radiology (X-ray) departments, as well as in specialised organ imaging clinics that carry out ultrasound, computerised tomography and magnetic resonance

imaging.

Each diagnostic test, or set of diagnostic tests, for the one patient referred to a radiology department constitutes one occasion of service.

Eligible Motor Vehicle Queensland (Compensable Patients)
Eligible patients who are receiving treatment for conditions that resulted from accidents where liability lies with a Queensland registered vehicle. The patients have, or may have, an entitlement to claim damages under Motor Vehicle Third Party Insurance.

Eligible Motor Vehicle Other (Compensable Patients)
Eligible patients who are receiving treatment for conditions that resulted from accidents where liability lies with a vehicle registered elsewhere (not Queensland).

Eligible Other Compensable (Patients)
Patients who have, or may have, an entitlement to claim damages under public liability insurance, other than Motor Vehicle Third Party, WorkCover, or other third party.

Eligible Other (Patients)
Patients who can not be classified as Eligible Work Cover Queensland, Eligible Work Cover Other, Eligible Motor Vehicle Queensland, Eligible Motor Vehicle Other, Eligible Other Third Party, Eligible Other Compensable, Department of Veterans' Affairs, or Eligible Public.

In most cases, these patients will have been treated by a doctor with a right of private practice at the facility.

Eligible Other Third Party (Compensable Patients)
Patients who have, or may have, an entitlement to claim damages under third party insurance, other than Motor Vehicle Third Party insurance.

Eligible Patients
An eligible patient is one who is eligible for Medicare as specified under the Commonwealth Health Insurance Act 1973. For further information, please refer to http://meteor.aihw.gov.au/content/index.phtml/itemId/481841

Eligible Public (Patients)
Eligible public patients are patients who,

- elect to be treated as a public patient so cannot choose the doctor who treats them, or
- are receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority, or
- are being treated by Medical Officers that are eligible to claim reimbursement for the service/s provided through Medicare Australia under the Rural & Remote Medical Benefit Scheme (RRMBS) or the Medicare Billing for Primary Care in Small Rural Hospitals arrangements (COAG 19.2).

A public patient who is treated in single accommodation due to clinical need is still a public patient.

There are three sub-categories under Eligible Public that can be used to distinguish between face-to-face, telehealth/telemedicine and telephone consultation services. These three sub-categories are mutually exclusive.

Eligible WorkCover Queensland (Compensable Patients)
Patients who are entitled to claim damages under the WorkCover Queensland Act.

Eligible WorkCover Other (Compensable Patients)
Patients who are entitled to claim damages under a WorkCover Act other than Queensland's (eg, employees of the Australian Government).

Group Sessions (Total Number of Group Sessions)
Sessions where two or more non-admitted patients receive services at the same time from one or more facility staff.

Each group is to be counted once, irrespective of size or the number of staff providing services.

Where all individuals in the group belong to the same family, the session should be reported as being provided to an 'individual' (ie, as a 1:1 Session).

Group Sessions (Total Number of Patients)
Sessions where two or more non-admitted patients receive services at the same time from one or more facility staff.

The total number of patients attending Group Sessions is to be counted for the reference period.

This is only required for Rehabilitation and Geriatric Evaluation and Management clinic types (ie Aged Care, Dementia, Falls, Geriatric Gerontology and Rehabilitation).

Where all individuals in the group belong to the same family, the session should be reported as being provided to an 'individual' (ie, as a 1:1 Session).

Home Dialysis Patients
Home dialysis refers to dialysis performed in a patient's home often with assistance of a carer.

Do not report this item as occasions of service. Instead, count the number of home dialysis patients for whom the facility pays the costs associated with the dialysis fluid, nursing products and ancillaries which are delivered directly to the patients' homes to enable home dialysis.

Not all facilities incur these expenditures.

For those facilities that do, the most frequently used modalities for dialysis at home are Home Haemodialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD), Automated Peritoneal Dialysis (APD). However, care should be taken to ensure correct recording of this information against the appropriate dialysis modality.

Self-care dialysis is dialysis that is managed by a patient and their carer following extensive training, and with support from a dialysis centre.

Ineligible (Patients)
Patients who are deemed not to be eligible for Medicare services.

New Patient (Attendance)
The first attendance under the new specialist or a consultant physician's care would be classified as a 'new patient' occasion of service.

The presentation for an unrelated illness, requiring the referral of the patient to another specialist or a consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

The receipt by a specialist outpatient department of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving recording of a 'new patient' occasion of service.

However, where the referring practitioner

- deems it necessary for the patient's condition to be reviewed; and
- the patient is seen under the care of a specialist or the consultant physician outside the currency of the last referral; and
- the patient was last seen by the specialist or the consultant physician more than 12 months earlier; then
- the attendance following the new referral initiates a new course of treatment and therefore a 'new patient' occasion of service.

An update to the current definition is currently being undertaken by the Access Improvement Service with other business areas as part of the Outpatient Services Implementation Standard. Once this has been approved an addendum to the Manual will be provided.

Non-admitted Patients
Patients who do not undergo a hospital's formal admission process.

Non-admitted patients receive direct care within the emergency department, or as outpatients (including non-admitted day program patients), or through other non-admitted services such as community and outreach services.

Occasions of Service
Occasions of service include any examination, consultation, treatment or other service provided to a non-admitted patient in each functional unit of a health service facility, on each occasion such service is provided.

One to One (1:1) Sessions
Where one non-admitted patient received services by staff of the facility.

Services provided to a 'family unit' at the same time are also to be reported as a single one to one session.

Pharmacy (Occasions of Service)
All occasions of service to non-admitted patients from pharmacy departments. When drugs are dispensed or administered in other departments, such as the emergency department or the outpatient department, this is to be reported as an occasion of service against the related clinic type.

Reference Month
The month to which the form refers. Commences from midnight on the first day of the month up to and including 11.59pm of the last day of the month.

Repeat Patient (Attendance)
A subsequent attendance of a patient for a previously referred condition during a single course of treatment.

An update to the current definition is currently being undertaken by the Access Improvement Service and other business areas as part of the Outpatient Services Implementation Standard. Once this has been approved an addendum to the Manual will be provided.

Telephone Consultation
Consultations provided to eligible public patients over the telephone.

Such consultations should only be reported as an occasion of service on the Monthly Activity form if:

- the service was a substitute for a face-to-face occasion of service, and
- a clinician (doctor, nurse, or allied health professional) spoke directly with a patient or with a parent / carer on behalf of the patient, and
- clinical notes were recorded in the patient's medical record.

Details of the consultation must be recorded through an electronic or manual booking system.

Telephone calls for the purposes of making an appointment or providing test results are excluded.

3.1.4 Telehealth Form (MACONTELE)

The Telehealth form is used to report non-admitted patient Telehealth activity by service provider type (medical officer or other health professional) and compensability and eligibility for:

- specialist and allied health clinics (also reported by the appointment type (new or repeat))
- community health services (hospital funded only)
- emergency services attendances
- diagnostic and pharmacy activity

Telehealth activity is activity that is either provided by, or received by the facility.

Both the number of 'one to one' OOS, group sessions and number of group session patients must be recorded on this form.

Telehealth occasions of service are consultations provided to non-admitted patients using videoconferencing technology.

Non-admitted patient Telehealth occasions of service should be reported on the MAC Telehealth report where:

- the service was a substitute for a face-to-face occasion of service;
- a clinician (doctor, nurse, or allied health professional) interacted with a patient or a parent/carer on behalf of the patient;
- clinical notes were recorded in the patients medical record; And
- details of the consultation are captured through an electronic or manual booking system.

Telehealth occasions of service can be reported by a facility when a clinician (medical officer or other health professional) is present during the occasion of service.

A Telehealth occasion of service can be reported once by the providing and once by the recipient facility. Each facility should report against the relevant provider type (medical officer or other health professional) and clinic type.

For example:
A non-admitted patient clinic delivered via video conference. At the providing facility an Anaesthetist has provided the consultation. At the recipient facility the patient and a Registered Nurse are located. In this example:

- Both provider and recipient facilities would report a Telehealth occasion of service on the MAC Telehealth report.
- An Anaesthetist is categorised as a "Medical officer" provider type. The providing facility would report this Telehealth occasion of service against the relevant clinic type under the "Medical Officer" provider type of the MAC Telehealth report.

- A Registered Nurse is categorised as "Other Health Professional" provider type. The recipient facility would report this Telehealth occasion of service against the relevant clinic under the "Other Health Professional" provider type of the MAC Telehealth report.

All Telehealth occasions of service including group sessions must be reported.

Telehealth occasions of service must be reported by compensability and eligibility status for:

- specialist and allied health clinics (new or repeat clinic types);
- community health services (hospital funded only);
- emergency service attendances (non-EDIS sites);
- clinical measurement; and
- diagnostic and pharmacy activity.

Videoconferencing for the purposes of making an appointment or providing test results is excluded.

Scope

The Telehealth form must be completed by all Queensland Health public facilities who provide or receive Telehealth OOS (both one to one and group sessions). Refer to Section 4 for the forms required to be submitted by each Queensland Health facility.

Form

Telehealth Form

Definitions

Refer to the IHPA's Tier 2 Outpatient Clinic Classification and the CCC document for definitions on the clinic types presented on this MAC form. Queensland Health Corporate Clinic Codes for non-admitted outpatient Tier 2 classification reporting v1.0.

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Definitions of other items collected on this form are:

Department of Veterans' Affairs (Patients)
Patients for whom the Department of Veterans' Affairs has accepted responsibility for the payment of any charges relating to their treatment.

Eligible Motor Vehicle Queensland (Compensable Patients)
Eligible patients who are receiving treatment for conditions that resulted from accidents where liability lies with a Queensland registered vehicle. The patients have, or may have, an entitlement to claim damages under Motor Vehicle Third Party Insurance.

Eligible Motor Vehicle Other (Compensable Patients)
Eligible patients who are receiving treatment for conditions that resulted from accidents where liability lies with a vehicle registered elsewhere (not Queensland).

Eligible Other Compensable (Patients)
Patients who have, or may have, an entitlement to claim damages under public liability insurance, other than Motor Vehicle Third Party, WorkCover, or other third party.

Eligible Other (Patients)
Patients who can not be classified as Eligible Work Cover Queensland, Eligible Work Cover Other, Eligible Motor Vehicle Queensland, Eligible Motor Vehicle Other, Eligible Other Third Party, Eligible Other Compensable, Department of Veterans' Affairs, or Eligible Public.

In most cases, these patients will have been treated by a doctor with a right of private practice at the facility.

Eligible Other Third Party (Compensable Patients)
Patients who have, or may have, an entitlement to claim damages under third party insurance, other than Motor Vehicle Third Party insurance.

Eligible Patients
An eligible patient is one who is eligible for Medicare as specified under the Commonwealth Health Insurance Act 1973. For further information, please refer to http://meteor.aihw.gov.au/content/index.phtml/itemId/481841

Eligible Public (Patients)
Eligible public patients are patients who,

- elect to be treated as a public patient so cannot choose the doctor who treats them, or
- are receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority, or
- are being treated by Medical Officers that are eligible to claim reimbursement for the service/s provided through Medicare Australia under the Rural & Remote Medical Benefit Scheme (RRMBS) or the Medicare Billing for Primary Care in Small Rural Hospitals arrangements (COAG 19.2).

A public patient who is treated in single accommodation due to clinical need is still a public patient.

There are three sub-categories under Eligible Public that can be used to distinguish between face-to-face, telehealth/telemedicine and telephone consultation services. These three sub-categories are mutually exclusive.

Eligible WorkCover Queensland (Compensable Patients)
Patients who are entitled to claim damages under the WorkCover Queensland Act.

Eligible WorkCover Other (Compensable Patients)
Patients who are entitled to claim damages under a WorkCover Act other than Queensland's (eg, employees of the Australian Government).

Group Sessions (Total Number of Group Sessions)
Sessions where two or more non-admitted patients receive services at the same time from one or more facility staff.

Each group is to be counted once, irrespective of size or the number of staff providing services.

Where all individuals in the group belong to the same family, the session should be reported as being provided to an 'individual' (ie, as a 1:1 Session).

Group Sessions (Total Number of Patients)
Sessions where two or more non-admitted patients receive services at the same time from one or more facility staff.

The total number of patients attending Group Sessions is to be counted for the reference period.

This is only required for Rehabilitation and Geriatric Evaluation and Management clinic types (ie Aged Care, Dementia, Falls, Geriatric Gerontology and Rehabilitation).

Where all individuals in the group belong to the same family, the session should be reported as being provided to an 'individual' (ie, as a 1:1 Session).

Ineligible (Patients)
Patients who are deemed not to be eligible for Medicare services.

New Patient (Attendance)
The first attendance under the new specialist or a consultant physician's care would be classified as a 'new patient' occasion of service.

The presentation for an unrelated illness, requiring the referral of the patient to another specialist or a consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

The receipt by a specialist outpatient department of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving recording of a 'new patient' occasion of service.

However, where the referring practitioner
- deems it necessary for the patient's condition to be reviewed; and
- the patient is seen under the care of a specialist or the consultant physician outside the currency of the last referral; and
- the patient was last seen by the specialist or the consultant physician more than 12 months earlier; then

- the attendance following the new referral initiates a new course of treatment and therefore a ‘new patient’ occasion of service.

An update to the current definition is currently being undertaken by the Access Improvement Service with other business areas as part of the Outpatient Services Implementation Standard. Once this has been approved an addendum to the Manual will be provided.

Non-admitted Patients
Patients who do not undergo a hospital's formal admission process.

Non-admitted patients receive direct care within the emergency department, or as outpatients (including non-admitted day program patients), or through other non-admitted services such as community and outreach services.

Occasions of Service
Occasions of service include any examination, consultation, treatment or other service provided to a non-admitted patient in each functional unit of a health service facility, on each occasion such service is provided.

One to One (1:1) Sessions
Where one non-admitted patient received services by staff of the facility.

Services provided to a 'family unit' at the same time are also to be reported as a single one to one session.

Reference Month
The month to which the form refers. Commences from midnight on the first day of the month up to and including 11.59pm of the last day of the month.

Repeat Patient (Attendance)
A subsequent attendance of a patient for a previously referred condition during a single course of treatment.

An update to the current definition is currently being undertaken by the Access Improvement Service with other business areas as part of the Outpatient Services Implementation Standard. Once this has been approved an addendum to the Manual will be provided.

3.1.5 Pathology Form (MTACPATH)

Queensland Health's Pathology Queensland extracts pathology OOS counts from the Auslab pathology system and provides them directly to DCU.

Scope

Facilities that do not use Auslab are required to record their pathology occasions of service on the Pathology form below and submit to DCU.). Refer to Section 4 for the forms required to be submitted by each Queensland Health facility.

Facilities using Auslab are not required to complete the Pathology form.

Form

http://qheps.health.qld.gov.au/hic/excel/1213_mac_path.xls

Definitions

Pathology (Occasions of Service) Non-AUSLAB Facilities

All occasions of service provided to non-admitted patients from designated pathology laboratories.

Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department constitutes one occasion of service.

Example: If 2 blood samples and a urine sample are taken from a single patient so that 2 separate sets of blood tests can be done (a set on each blood sample) and a single set of urine tests can be done, this should be counted as 3 occasions of service rather than one.

Pathology (Occasions of Service) AUSLAB Facilities

All occasions of service provided to non-admitted patients from Queensland Health Pathology and Scientific Services (QHPSS) laboratories.

Each diagnostic test or group of diagnostic tests, as defined in the QHPSS product list, for the one patient referred to Queensland Health Pathology and Scientific Services.

From 1 July 2009, Rural and Remote Pathology data is being provided by Queensland Health Pathology and Scientific Services (as per Eligible Patients).

3.2 Admitted Patient Activity Forms

3.2.1 Bed Availability Form (BED)

Queensland Health must have accurate data on the number of beds available in its hospitals. This data is required to be reported as part of the Public Hospital Establishments National Minimum Data Set.

Hospital bed availability is a key performance indicator for Queensland Health as it represents a measure which can be easily interpreted by the public.

Available beds and available bed alternatives are reported using the Bed (BA) report in DCU's MAC Online application. A bed/bed alternative can only be reported to MAC if it is used exclusively or predominantly for admitted patients.

The Bed form contains three sections for the reporting of bed availability. Section 1 of the form enables the reporting of beds, section 2 enables the reporting of bed alternatives and section 3 enables the reporting of non-NICU/non-SCN cots.

To determine whether or not to report a bed/ bed alternative refer to the Bed Flowchart.

To ensure the quality and integrity of bed availability information, the Queensland Health Executive Management Team (EMT) directed District CEO's to verify and sign off the monthly figures reported in the Bed report to DCU.

Further information on the use of MAC Online is available at
http://qheps.health.qld.gov.au/hic/products.htm#manuals

Scope

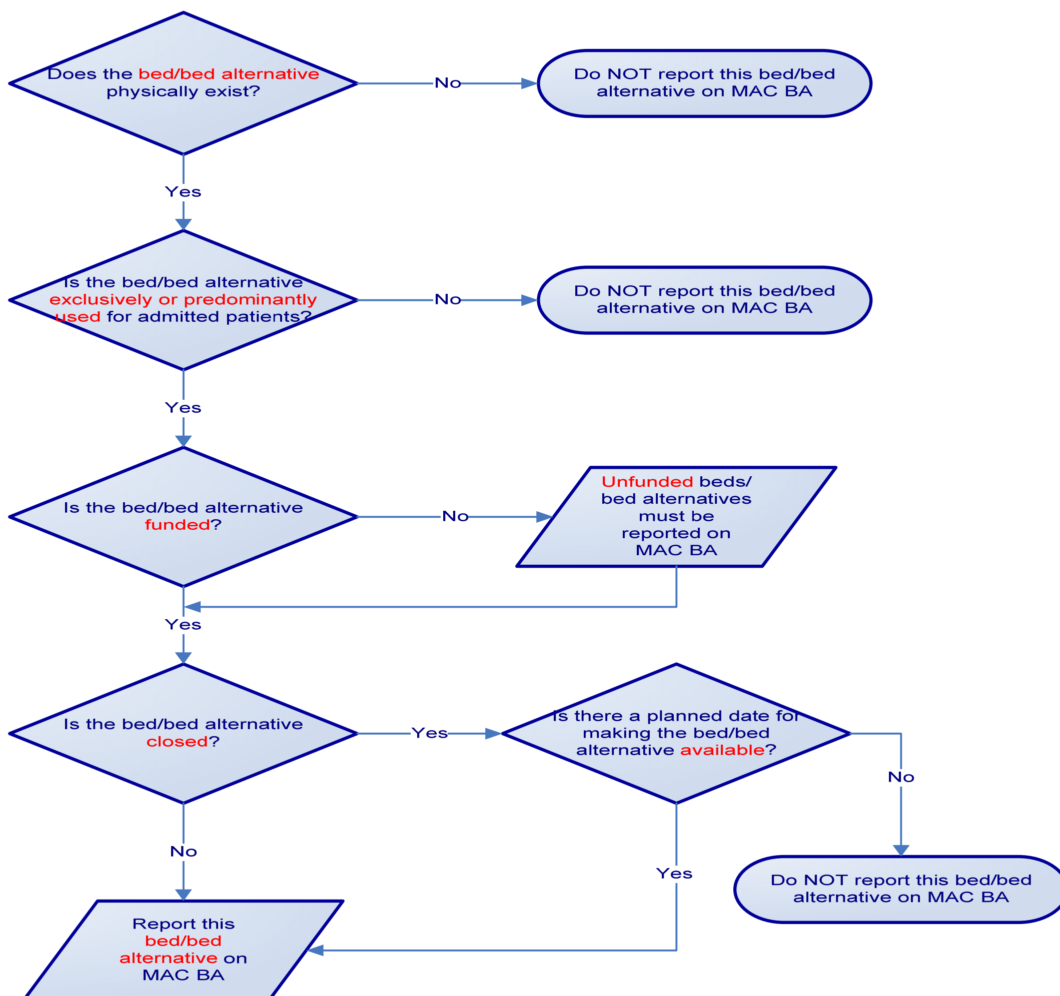
All Queensland Health facilities must complete the Bed form (excluding Nursing Homes and Multipurpose Health Services who are required to complete a NH2 or MP1 form respectively).

Refer to Section 4 for the forms required to be submitted by each Queensland Health facility.

Form

Bed form

Reporting bed/bed alternative MAC (BA) flowchart



Term	**Explanation**
Bed/ bed alternative	A bed/bed alternative can only be reported on MAC if it physically exists. A 'virtual' bed/bed alternative, such as a bed allocated for 'Hospital in the Home' treatment, is NOT to be reported on MAC. See definition below for more information.
Exclusively or predominantly used	From July 2009 a bed/bed alternative can only be reported on MAC if it is exclusively or predominantly used for admitted patients. If a bed/bed alternative is not used exclusively or predominantly for admitted patients, do NOT report it on MAC. This is subtly different from the previous definition where a bed/bed alternative could be reported on MAC if it was immediately available for use by admitted patients (regardless of whether or not the bed was predominantly used for admitted patients).
Funded bed/bed alternative	A funded bed/bed alternative is one that is resourced within the bed allocation approved by the CEO of the Hospital and Health Service. A funded bed/bed alternative must be reported on MAC.
Unfunded bed/bed alternative	An unfunded bed/bed alternative is one that exceeds the bed allocation approved by the CEO of the Hospital and Health Service. An unfunded bed/bed alternative must be reported on MAC.
Closed bed/bed alternative	A closed bed/bed alternative is one that is not available for use and there is no planned date for making it available for use. A closed bed/bed alternative is NOT to be reported on MAC.
Available bed/bed alternative	See definition below.

Definitions

Available/Temporarily Unavailable Bed/Bed Alternative

A bed/bed alternative is '**available**', if (on the last Wednesday of the reference month), it is immediately available for use by an admitted patient. The bed must be located in a suitable place for patient care, and there are nursing and auxiliary staff available, or who could be made available within a reasonable period (within 24 hours), to service patients who might occupy them.

A bed/bed alternative is '**temporarily unavailable**', if (on the last Wednesday of the reference month) it is NOT immediately available for use because of renovations, strikes, staff shortages etc, and there is a planned date for making the bed available. A bed that is not available for use and there is no planned date for making it available for use, is a 'closed' bed and it is NOT to be reported on MAC.

Bed/Bed Alternative Reporting

A bed or bed alternative can only be reported on the BA form if it is used exclusively or predominantly for admitted patients.

Bed

A bed does NOT include a surgical table, recovery trolley, discharge lounge bed/chair for a patient who has been formally discharged, medi-hotel bed, non-special care neonatal cot, hospital in the home bed, or a bed used exclusively or predominantly for a non-admitted patient. These items should not be reported in section 1 of the BA form.

A bed located in a hospital's delivery suite should normally NOT be reported unless the predominant practice at the hospital is for the mother to be admitted to the delivery bed, give birth in the delivery bed, and be formally discharged from the delivery bed. That is, the predominant practice at the hospital is not to transfer the mother to a maternity bed following delivery, and formally discharge the mother from a maternity bed.

A bed located in a birth centre attached to a hospital should normally be reported, as it is assumed that the predominant practice at the birth centre is for the mother to be admitted to the birth centre, give birth in the birth centre, and be formally discharged from the birth centre.

Bed Categories

- Neonatal Service Cots - Level 4 or 5 (SCN)
- Neonatal Service Cots - Level 6 (NICU)
- Paediatric – Children's Intensive Care Service Level 6 (PICU)
- Paediatric – General Paediatric
- Intensive Care Unit - Level 4
- Intensive Care Unit - Level 5
- Intensive Care Unit - Level 6
- Cardiac (Coronary) Care Unit - Level 4
- Cardiac (Coronary) Care Unit - Level 5
- Cardiac (Coronary) Care Unit - Level 6

- Specialised Mental Health – Acute Psychiatric
- Specialised Mental Health – Non-acute Psychiatric
- Palliative - Designated (Palliative Care Service 4, 5 or 6)
- Rehabilitation - Designated (Rehabilitation Service 4, 5 or 6)
- Maternity
- Day Surgery
- Emergency Department (Emergency Services 4, 5 or 6)
- All other overnight
- All other same day

Definitions of Bed Categories

All Other Overnight

A bed is an overnight bed if it used exclusively or predominantly to provide accommodation for overnight admitted patients.

All Other Overnight Beds are those overnight beds not reported against one of the bed categories in the first section of the Bed form.

All Other Same-day

A bed is a same-day bed if it is used exclusively or predominantly to provided accommodation for same-day admitted patients.

All Other Same-day Beds are those same-day beds not reported against one of the bed categories in the first section of the Bed form.

Cardiac (Coronary) Care Unit – Level 4, 5 or 6

For details on the definition of a coronary care unit and its required clinical services level, refer to the *Clinical Services Capability Framework (version 3.0) – Module 25. Cardiac Services.*

Day Surgery

For details on the definition of (day-only) surgical services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.0) – Module 13. Perioperative Services*.

Emergency Department (Emergency Services Level 4 or 5 or 6)

For details on the definition of emergency services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.0) – Module 14. Emergency Services*

Intensive Care Unit – Level 4, 5 or 6

For details on the definition of an intensive care unit and its required clinical services level, refer to the *Clinical Services Capability Framework (version 3.0) – Module 16. Intensive Care Services*

High Dependency Unit

From the 1 July 2012 High Dependency Unit Bed data is no longer required to be reported.

Maternity
For details on the definition of maternity services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.0) – Module 26. Maternity Services*

Neonatal Service Cots – Level 4, 5 or 6
For details on Neonatal Service Cots - Level 4, 5 or 6 and their service level criteria refer to the *Clinical Services Capability Framework (version 3.0) – Module 27. Neonatal Services*

Neonatal Service Cots – Level 5 or 6 equate to Level 2 (SCN) and Level 3 (NICU) neonatal cots defined in the previous version of the Clinical Services Capability Framework (version 2.0).

Non-NICU/Non-SCN Cots
Non-NICU and non-SCN cots – that is, cots for normal neonates - are those cots used for newborns other than Level 4, Level 5 and Level 6 Neonatal Service Cots. For details on neonatal services and their service level criteria refer to the *Clinical Services Capability Framework (version 3.0) – Module 27. Neonatal Services*

Paediatric – Children's Intensive Care Service Level 6 – (PICU)
For details on the definition of Children's Intensive Care Services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.0) – Module 17. Children's Intensive Care Services*

Paediatric – General Paediatric
For details on the definition of general paediatric services and the required clinical services level, refer to the Clinical Services Capability Framework (version 3.0) - Module 10. Children's Medical Services

Palliative – Designated (Palliative Care Service Level 4 or 5 or 6)
A designated palliative bed is a bed that is available for palliative 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.

Palliative care is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family.

For details on the definition of palliative care services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.0) – Module 24. Palliative Care Services*

Only report 'Designated - Palliative Beds' provided by Palliative Care Service Levels 4, 5 or 6 if delivered in a designated unit.

Refer to the QHAPDC Manual for a list of designated SNAP units in public hospitals.

Rehabilitation – Designated (Rehabilitation Service Level 4 or 5 or 6)
A designated rehabilitation bed is a bed that is available for rehabilitation care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap.

Rehabilitation care is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames, which are evaluated by a periodic assessment using a recognised functional assessment measure.

For details on the definition of rehabilitation services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.0) – Module 28. Rehabilitation Services*

Only report 'Designated - Rehabilitation Beds' provided by Rehabilitation Care Service Levels 4, 5 or 6 if delivered in a designated unit.

Refer to the QHAPDC Manual for a list of designated SNAP units in public hospitals.

Specialised Mental Health – Acute Psychiatric
A specialised mental health acute bed is a bed that is available for specialist psychiatric care, provided to a person who presents with an acute episode of mental illness.

This episode is characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on symptom reduction with a reasonable expectation of substantial improvement.

In general, acute psychiatric services provide short-term treatments. Acute services may be focussed on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms.

Specialised Acute Psychiatric Beds include beds provided for the following mental health programs: General (Adult), Older persons, Child and Young Persons mental health services.

For details on the definition of mental health services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.0) – Module 30. Mental Health Services*

The QHAPDC Manual has a list of specialised mental health psychiatric units in public hospitals.

Specialised Mental Health – Non-Acute Psychiatric
A specialised mental health non-acute bed is a bed that is available for specialist psychiatric care, provided to a person who requires rehabilitation and extended care mental health services as described below.

Rehabilitation: These services have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focussed on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.

Extended Care: These services provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment is focussed on preventing deterioration and reducing impairment. Improvement is expected to occur slowly.

Specialised Non-acute Psychiatric Beds include beds provided for the following mental health programs:
Secure, Dual Diagnosis, Psychogeriatric, Acquired Brian Injury, Rehabilitation & Extended Treatment and Young Persons.

For details on the definition of mental health services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.0) – Module 30. Mental Health Services*

Refer to the QHAPDC Manual for a list of specialised mental health psychiatric units in public hospitals.

Bed Alternative

A **bed alternative** is an item of furniture such as a chair or trolley that is used as an alternative to a bed.

A bed alternative does NOT include a chair/trolley for medical ambulatory care, discharge/transit lounge chair/trolley for a patient who has been formally discharged, a non-special care neonatal cot, or a chair/trolley used exclusively or predominantly for a non-admitted patient and therefore should not be reported in section 2 of the Bed form.

Bed alternative categories

- chemotherapy chairs and trolleys
- renal dialysis chairs and trolleys
- Emergency Department chairs and trolleys (Emergency Services Level 4 or 5 or 6)
- all other bed alternatives

Bed and bed alternative categories have been aligned where applicable to the Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3 (CSCF v3.0)

Definitions of Bed Alternative Categories

All Other Bed Alternatives
All Other Bed Alternatives are those bed alternatives not reported against one of the alternative bed categories in the second section of the Bed form. Some examples are:

- Discharge/transit lounge chairs/trolleys for patients who have NOT been formally discharged
- Day surgery chairs/trolleys used for admitted patients
- Day therapy chairs/trolleys used for admitted patients
- Observation ward chairs/trolleys/stretchers used for admitted patients

Chemotherapy Chairs/Trolleys
Chemotherapy Chairs/Trolleys are bed alternatives that are specifically used for admitted patients receiving chemotherapy treatment.

Emergency Department Chairs/Trolleys (ED Level 4, 5 or 6)
Emergency Department Chairs/Trolleys are bed alternatives specifically used for admitted patients receiving emergency services.

Renal Dialysis Chairs/Trolleys
Renal Dialysis Chairs/Trolleys are bed alternatives that are specifically used for admitted patients receiving renal dialysis treatment.

3.2.2 PH1 Form (MTHACPH1)

Summary level admitted patient activity must be reported to DCU on the 4th of each month. To do this, acute facilities are required to lodge a PH1 form which DCU uses to validate reported admitted patient activity by confirming, where applicable, the total number of separated episodes of care for each reference period.

At most facilities, HBCIS automatically generates a preliminary PH1 form on the 4th day of each month (ie: 00:01am on the 4th day). This PH1 contains data for the preceding month/s.. The PH1 form is able to then be submitted electronically to MAC Online using Secure Transfer Service (STS). (For instructions on the use of STS when running the extract from HBCIS, please refer to the implementation and user guide supplied by Service Integration Management Team 1, Queensland Health). This preliminary form requires no user intervention and the quality of this data is as it is at this time.

Sites should not submit a PH1 prior to the first automated version, but must send a second submission of the form via STS to MASMAIL within 14 days of the reference month.

The summary-level admitted patient data on the PH1 (the total number of separated episodes of care along with the separation mode) is reconciled to patient-level admitted patient data submitted to the Queensland Hospital Admitted Patient Data Collection (QHAPDC). The total number of separations (and their respective modes) reported to each data collection should equal.

Episodes with a care type of 'Boarder' are excluded from this reconciliation. All episodes with a care type of 'Newborn' are included, regardless of qualification.

Scope

All Queensland Health facilities must submit a PH1 form (excluding Nursing Homes and Multipurpose Health Services who are required to complete a NH2 or MP1 form respectively). Refer to Section 4 for the forms required to be submitted by each Queensland Health facility.

Form

http://qheps.health.qld.gov.au/hic/excel/1213_mac_ph1.xls

Definitions

Accrued Patient Days

The total number of days of stay for all admitted patients that were accrued during the reference month.

Accrued patient days include:

- those days accrued by patients who separate during the reference month; and
- those days accrued by patients who are remaining in at the end of the reference month.

Same day patients are to be counted as having a stay of one day.

Patients on contract leave should be treated as accruing patient days.

Patients on overnight leave should NOT be treated as accruing patient days.

If a patient has a classification change, for example from Eligible Private to Eligible Compensable, their patient days should be reported against each relevant category.

Accrued patient days with a Standard Unit Code of HOME
The total number of accrued patient days where a Standard Unit Code of 'Hospital in the home' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of HINH
The total number of accrued patient days where a Standard Unit Code of 'Hospital in Nursing Home' home' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYAA
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Adult Acute Unit' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYAQ
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Adult – Acquired Brain Damage Unit' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYSH
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Adult – Extended High Security Unit' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYSM
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Adult – Extended Secure Medium Unit' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYDD
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Adult – Extended Dual Diagnosis Unit' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYPG
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Adult – Extended Psychogeriatric Unit' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYET
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Adult – Extended Treatment Rehabilitation Unit' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYAW
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Adult Special Care Suite' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYCA
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Child Acute Unit' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYCW
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Child Acute Unit in Paediatric Ward' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYYA
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Young People Acute Unit' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYYW
The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Young People Acute Unit in Adult Ward' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYGE
The total number of accrued patient days where a Standard Unit Code of 'Psychogeriatric - Acute' is identified within an episode of care for the reported period.

Acute (Episodes of Care)
Care in which the principal clinical intent or treatment goal is one or more of the following:

- 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
- perform diagnostic or therapeutic procedures.

Admissions
An admission is the process by which an admitted patient commences an episode of care.

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 accommodation of a patient.

A ***statistical admission*** is the administrative process by which a patient who has been statistically separated recommences treatment and/or care and accommodation.

For example, if a patient changes from an acute episode of care to a maintenance episode of care, they are *statistically* separated from the acute episode of care and *statistically* admitted to the maintenance episode of care.

A statistical admission must always be reported with a corresponding statistical separation.

Admitted Patients
Patients who undergo a hospital's formal admission process and meet one of the criteria for admission. It includes patients who undertake overnight or longer stays, and same day patients.

All other Modes of Separation
All formal separations for the period with a discharge status other than ‘Transferred to Another Hospital’ or ‘Died in Hospital’.

Boarders
People who receive food and/or accommodation but for whom the facility does not accept responsibility for treatment and/or care.

Boarders **are not** to be recorded on the Monthly Activity forms.

Classification Changes
The administrative process used to report classification changes in the chargeable status or compensable status of admitted patients. The four classifications are Eligible Public, Eligible Private, Eligible Compensable and Ineligible.

Report any changes in a patient’s classification that occurs within an episode of care. For example, when a patient is re-classified from being an eligible private patient to an eligible compensable patient, they should be reported as having a classification change from eligible private to eligible compensable.

A classification change ‘from’ is always reported with a corresponding classification change ‘to’. If there is more than one classification change for a patient within any given day, report only the last classification change that occurred on that day.

Died in Hospital
All patients for the period that died during hospitalisation.

Eligible Compensable (Patients)
Eligible patients: who are entitled to the payment of, or have been paid compensation for damages or other benefits (including a payment in settlement of a claim for compensation, damages or other benefits) in respect of the injury, illness or disease for which he/she is receiving care and treatment.

A compensable patient is a person who:
- is entitled to claim damages under Motor Vehicle Compulsory Third Party insurance or
- is entitled to claim damages under the WorkCover Queensland Act or under a WorkCover Act other than Queensland's (eg. If an employee of the Australian Government (Commonwealth) or if employed interstate) or
- may be entitled to claim under public liability.

For the purposes of this Monthly Activity Form (PH1), Department of Veterans' Affairs (DVA) patients who are not compensable in the strict interpretation of the word, but are patients for whom another agency (the DVA) has accepted responsibility for the payment of any charges relating to their episode of care, should be classified as eligible compensable patients.

Eligible Patients
An eligible patient is one who is eligible for Medicare as specified under the Commonwealth Health Insurance Act 1973. For further information, please refer to http://meteor.aihw.gov.au/content/index.phtml/itemId/481841

Eligible Private (Patients)
Eligible patients who, by choosing the doctor who will treat them (provided the doctor has 'right of private practice' or is a general practitioner/specialist with admitting rights) has elected to be treated as a private patient. Their chargeable status is then 'private shared', unless they choose to be treated in single accommodation and accept further charges in which case their chargeable status is 'private single'.

A private patient, who is treated in single accommodation due to clinical need, rather than due to their choice, is still a private shared patient rather than a private single patient.

Eligible Public (Patients)
Eligible patients who,

- elect to be treated as a public patient so cannot choose the doctor who treats them, or
- are receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
- are being treated by Medical Officers that are eligible to claim reimbursement for the service/s provided through Medicare Australia under the Rural & Remote Medical Benefit Scheme (RRMBS) or the Medicare Billing for Primary Care in Small Rural Hospitals arrangements (COAG 19.2).

A public patient who is treated in single accommodation due to clinical need is still a public patient.

Episode of Care
A phase of treatment described by one of the following types of care:
- acute
- geriatric evaluation and management
- maintenance
- rehabilitation
- palliative
- psychogeriatric
- newborn or
- other care.

Patients may receive more than one episode of care within one hospital stay. An episode of care ends when the principal clinical intent of care changes or when the patient is formally separated from the hospital.

Formal Admissions
See Admissions.

Formal Separations
See Separations.

Geriatric Evaluation and Management (Episodes of Care)
Care in which the clinical intent or treatment goal is to maximise health status and /or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient.

This may include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames.

Geriatric evaluation and management includes care provided:
- in a geriatric evaluation and management unit or
- in a designated geriatric evaluation and management program or
- under the principal clinical management of a geriatric evaluation and management physician or
- in the opinion of the treating doctor
- when the principal clinical intent of care is geriatric evaluation and management.

Ineligible (Patients)
Patients who are deemed not to be eligible for Medicare services.

Maintenance (Episodes of Care)
Care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or

severe level of functional impairment. Following the assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting (eg at home, or in a nursing home,) by a relative or carer, that is unavailable in the short term.

Newborn (Episodes of Care)
All babies 9 days old or less should be admitted as a newborn episode of care. A newborn episode of care is initiated when the patient is 9 days old or less at time of admission and continues until the care type changes or the patient is separated. At any time during their stay the newborn has a qualification status of either acute or unqualified.

On Leave
See Separations.

Other Care (Episodes of Care)
A phase of treatment where the principal clinical intent does not meet the criteria for acute, rehabilitation, palliative, geriatric evaluation and management, psychogeriatric, maintenance or newborn episodes of care.

Overnight or Longer (Stay Patients)
Patients who are admitted to, and separated from the hospital on different dates.

This type of patient:

- has been registered as a patient at the hospital
- has met the minimum criteria for admission
- has undergone a formal admission process and
- remains in the hospital at midnight on the day of admission.

Boarders are excluded from this definition.

An overnight stay patient in one hospital cannot be concurrently an admitted patient in another hospital, unless they are on contract leave. If not on contract leave, a patient must be formally separated from one hospital and admitted to the other hospital on each occasion of transfer.

Treatment provided to an intended same day patient who is subsequently classified as an overnight stay patient shall be regarded as part of the overnight episode of care.

The definition of an overnight stay patient excludes patients who leave of their own accord, die, or are transferred on their first day in the hospital.

Palliative (Episodes of Care)
Palliative Care is 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 a grief and bereavement support service for the patient and their carers/family.

It includes care provided:

- in a palliative care unit or
- in a designated palliative care program or
- under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation.

Patient Days Accrued by Newborns with Status of Unqualified
The total number of days of stay for all admitted newborns with a qualification status of unqualified that were accrued during the reference month.

Accrued patient days for unqualified newborns includes those days accrued by unqualified newborns in the month who separate during the reference month and those days accrued by unqualified newborns who are remaining in at the end of the reference month.

Same day unqualified newborns are to be counted as having a stay of one day. Exclude all overnight leave days but include contract leave days.

Patient Days Accrued by Nursing Home Type Patients
The total number of days of stay for all admitted patients who are classified as nursing home type that were accrued during the reference month.

Accrued patient days for nursing home type patients includes those days accrued by nursing home type patients in the month who separate during the reference month and those days accrued by nursing home type patients who are remaining in at the end of the reference month.

Same day nursing home type patients are to be counted as having a stay of one day. Exclude all overnight leave days but include contract leave days.

Psychogeriatric (Episodes of Care)
Care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames.

It includes care provided:

- in a psychogeriatric care unit
- in a designated psychogeriatric care program or

- under the principal clinical management of a psychogeriatric physician or, in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatric care.

Reference Month
The month to which the form refers.

Commences from midnight on the first day of the month up to and including 11.59pm of the last day of the month.

Rehabilitation (Episodes of Care)
Is 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 a periodic assessment using a recognised functional assessment measure. It includes care provided:

- in a designated rehabilitation unit or
- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the State health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation or
- under the principal clinical management of a rehabilitation physician, or in the opinion of the treating doctor when the principal clinical intent of care is rehabilitation.

Remaining in at Beginning (of the Reference Month)
Overnight or longer stay patients actually in the facility or on leave at midnight on the first day of the reference month.

Count the number of overnight or longer stay patients as at this time.

Exclude same day patients.

This figure should be carried over from the remaining in at end figure for the previous reference month.

Remaining in at End (of the Reference Month)
Overnight or longer stay patients actually in the facility or on leave at 11.59pm on the last day of the reference month.

Count the number of overnight or longer stay patients as at this.

Exclude same day patients.

This figure should be carried over to the remaining in at beginning figure for the next reference month.

Same Day Patients
Patients who are admitted and separated on the same date, regardless of whether or not it was intended that they be admitted and separated on the same day.

This type of patient:
- has been registered as a patient at the hospital
- has met the minimum criteria for admission
- has undergone a formal admission process and
- is separated prior to midnight on the day of admission. That is, admitted to and separated from the hospital on the same date.

Boarders are excluded from this definition.

Treatment provided to an intended same day patient, who is subsequently classified as an overnight stay patient, should be regarded as part of the overnight episode of care.

Data on same day patients are derived by a review of admission and separation dates. The data excludes patients who were to be discharged on the same day but were subsequently required to stay in hospital for one night or more.

Separations
A separation is the process by which an admitted patient completes an episode of care.

A separation can be either *formal* or *statistical*.

A *formal separation* is the administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient (eg, through discharge, absconding, transfer, or death).

Patients whose leave of absence exceeds 7 consecutive days are categorised as having had a formal separation.

A *statistical separation* is the administrative process by which a hospital records the completion of each episode of care occurring within a single hospital stay.

For example, if a patient changes from an acute episode of care to a maintenance episode of care, they are *statistically* separated from the acute episode of care and *statistically* admitted to the maintenance episode of care.
A statistical separation must always be reported with a corresponding statistical admission.

Statistical Admissions
See Admissions.

Statistical Separations
See Separations.

Total Newborn Separations with a status of Unqualified the entire episode.

All newborn separations for the period that had a qualification status of ‘unqualified’ for the entire episode.

Transferred to another hospital

All separations for the period where the patient is transferred to another hospital for continuation of their admitted care and management.

3.2.3 Multi Purpose Health Service Form (MTHACMP1)

The joint Australian Government (Commonwealth)-State Multi Purpose Health Service (MPHS) program provides a flexible approach to the provision of health and aged care services in small rural communities. It typically involves the amalgamation of services ranging from acute hospital care to residential aged care, community health, home and community care and other health related services. This amalgamation of services is used to provide flexible care.

Multi Purpose Health Services must report the number of people accessing the flexible care services during the reporting period, including the level of care and the mix of residential and community care.

Patients admitted to an MPHS have to be allocated an appropriate account class code. The account class code selected is dependent upon the level of care and the length of stay for that patient (refer to 'High Level Care' and 'Low Level Care' definitions). Any change in care type from flexible care will require a discharge from the MPHS.

An MPHS should not charge DVA for clients receiving flexible care. Clients currently recorded as DVA at the acute hospital, but who are now receiving flexible care, should have their account class changed to reflect flexible care (refer to 'High Level Care' and 'Low Level Care' definitions).

Scope

The Queensland Health Multi Purpose Health Service facilities must complete the MP1 form. Refer to Section 4 for the forms required to be submitted by each Queensland Health facility.

Form

http://qheps.health.qld.gov.au/hic/excel/1213_mac_mp1.xls

Further information on the use of MAC Online is available at
http://qheps.health.qld.gov.au/hic/products.htm#manuals

Definitions

Accrued Patient Days

The total number of days of stay for all admitted patients that were accrued during the reference month.

Accrued patient days include:

- those days accrued by patients who separate during the reference month; and
- those days accrued by patients who are remaining in at the end of the reference month.

Same day patients are to be counted as having a stay of one day. Patients on **contract leave** should be treated as accruing patient days.

Patients on **overnight leave** should NOT be treated as accruing patient days.

If a patient has a classification change, their patient days should be reported against each relevant category.

Admissions
An admission is the administrative process by which a facility records the commencement of treatment and/or care and accommodation of a patient.

Admitted Patients
Patients who undergo a facility's formal admission process and meet one of the criteria for admission. It includes patients who undertake overnight or longer stays, and same day patients.

Available Beds
The number of beds, occupied or not, which were *immediately available* for use by flexible care patients. Beds are *immediately available* for use if they are located in a suitable place for patient care, and there are nursing and or other auxiliary staff available, or who could be made available within a reasonable period (within 24 hours), to service patients who might occupy them.

Exclude surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded, and beds designated for non-admitted patient care.

The ***Available Beds on Last Wednesday of Reference Month*** does not include beds temporarily unavailable on that day because of renovations, strikes, staff shortages, etc.

High Level Care
The number of patients with an account class of General Public Flexible High Level Care (GPFHLC) for overnight flexible high level care or General Public Flexible High Level Care Same Day (GPFHLCSD) for same day flexible high level care.

Low Level Care
The number of patients with an account class of General Public Flexible Low Level Care (GPFLLC) for overnight flexible low level care or General Public Flexible Low Level Care Same Day (GPFLLCSD) for same day flexible low level care.

Reference Month
The month to which the Form refers.

The reference month commences from midnight on the first day of the month up to and including 11.59pm of the last day of the month.

Remaining in at Beginning (of the Reference Month)
Overnight or longer stay patients actually in the facility or on leave at midnight on the first day of the reference month.

Exclude same day patients.

This figure should be carried over from the remaining in at end figure for the previous reference month.

Remaining in at End (of the Reference Month)
Overnight or longer stay patients actually in the facility or on leave at 11.59pm on the last day of the reference month.

Exclude same day patients.

This figure should be carried over to the remaining in at beginning figure for the next reference month.

Separations
A separation is the administrative process by which a facility records the completion of treatment and/or care and accommodation of a patient. (eg, through discharge, absconding, transfer, or death.)

Patients whose leave of absence exceeds 7 consecutive days are categorised as having a formal separation.

Temporarily Unavailable Beds (Last Wednesday of Reference Month)
Flexible care beds *temporarily* unavailable on the last Wednesday of the reference month because of renovations, strikes, staff shortages, etc.

DCU validates reported program activity by confirming, where applicable, that the number of patients ‘remaining in at end’ and ‘remaining in at beginning’ figures are consistent, as well as the feasibility of the numbers of ‘accrued patient days’ and ‘available beds’ provided for each reference period.

3.2.4 Public Nursing Homes/Hostels/Independent Living Units Form (MTHACNH2)

Public Nursing Homes/Hostels/Independent Living services must report details including the number of patients admitted either as permanent residents or as respite residents to these facilities during the reporting period.

To facilitate reporting, the form MTHACNH2 should be completed in MAC Online and submitted to DCU within 14 days of the end of the reference month.

Further information on the use of MAC Online is available at http://qheps.health.qld.gov.au/hic/products.htm#manuals

Scope

The Diagnostics and Procedures form must be completed by all Queensland Health Public Nursing Homes/Hostels/Independent Living services. Refer to Section 4 for the forms required to be submitted by each Queensland Health facility.

Form

http://qheps.health.qld.gov.au/hic/excel/1213_mac_nh2.xls

Definitions

Accrued Resident Days

The total number of days of stay for all admitted residents that were accrued during the reference month. Accrued resident days were previously referred to as occupied bed days or accrued patient days.

Accrued resident days include:

- those days accrued by residents who separate during the reference month; and
- those days accrued by residents who are remaining in at the end of the reference month.

Same day residents are to be treated as accruing one resident day. Residents on contract leave should be treated as accruing resident days. Residents on overnight leave should NOT be treated as accruing resident days.

If a resident has a status change, their patient days should be reported against each relevant category.

Admissions

An admission is the administrative process by which the facility reports the actual commencement of treatment and/or care and accommodation of an admitted resident.

For this Monthly Activity Report, an admission is also recorded following the separation that is recorded when an admitted resident's status changes, for example from respite to permanent.

Admitted Residents
People who are admitted as residents to the facility. It includes residents who undertake overnight or longer stays, and same day residents.

Available Beds
The number of beds, occupied or not, which were immediately available for use by admitted residents if required. Beds are immediately available for use if they are located in a suitable place for patient care, and there are nursing and or other auxiliary staff available, or who could be made available within a reasonable period (within 24 hours), to service patients who might occupy them.

Exclude surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded, and beds designated for non-admitted patient care.

The ***Available Beds on Last Wednesday of Reference Month*** does not include beds temporarily unavailable on that day because of renovations, strikes, staff shortages, etc.

Boarders
People who receive food and/or accommodation but for whom the facility does not accept responsibility for treatment and/or care. Boarders are not to be recorded on the Monthly Activity Reports.

Australian Government Funded Beds
All beds allocated by the Australian Government (Commonwealth) as approved beds.

Extensive Care Residents
All non-respite admitted residents should be reported as Permanent Residents, with effect from 1 February 1998.

Non-admitted Clients/Patients
Non-admitted clients/patients do not undergo a facility's admission process.
Non-admitted clients/patients can receive direct care as outpatients, or receive care through services such as community and outreach services.

Note: that non-admitted day program clients/patients should be reported as outpatients.

A non-admitted service provided to a client/patient, who is subsequently classified as an admitted resident, should also be reported against the admitted episode of care.

Occasions of Service
Occasions of service include any examination, consultation, treatment or other service provided to a non-admitted patient in each functional unit of a health service facility, on each occasion such service is provided.

Outpatients
Non-admitted clients/patients who receive direct care from a designated unit within the facility.

Outreach or Community Clients
Outreach clients/patients are non-admitted clients/patients who receive care from employees of the facility at their home, place of work, or other non-facility site. Care does not include activities such as home cleaning, meals on wheels, or home maintenance.

Community clients/patients are non-admitted clients/patients who receive care from employees of designated community health units funded from the facility's operating expenditure and operated and managed by the facility.

Community health units may include such things as aged care assessment teams.

It is intended that all community health services funded through the facility be reported, regardless of where the services are provided.

Permanent Residents
Residents admitted to a nursing home, hostel or independent living unit who are not Respite Residents.

Reference Month
The month to which the Report refers.
Commences from midnight on the first day of the month up to and including 11.59pm of the last day of the month.

4 Forms Required by Facility by Hospital & Health Service

Hospital & Health Service	Facility Name	Facility No	2012/2013 MAC Form Requirement							
			Clinic	Diag and Proc	Tele health	Bed	NH2	PH1	MP1	PATH
Cairns & Hinterland	ATHERTON HOSPITAL	211	●	●	●	●		●		
	BABINDA HOSPITAL	212	●	●	●	●		●		
	CAIRNS BASE HOSPITAL	214	●	●	●	●		●		
	CHILLAGOE HOSPITAL	215	●	●	●	●		●		
	CROYDON HOSPITAL	217	●	●	●	●		●		
	FORSAYTH HOSPITAL	218	●	●	●	●		●		
	GEORGETOWN HOSPITAL	219	●	●	●	●		●		
	GORDONVALE HOSPITAL	220	●	●	●	●		●		
	HERBERTON HOSPITAL	221	●	●	●	●		●		
	INNISFAIL HOSPITAL	222	●	●	●	●		●		
	MAREEBA HOSPITAL	223	●	●	●	●		●		
	MOSSMAN HOSPITAL	224	●	●	●	●		●		
	MOUNT GARNET OUTPATIENTS CLINIC	225	●	●	●	●		●		
	TULLY HOSPITAL	227	●	●	●	●		●		
	GURRINY YEALAMUCKA PRIMARY HEALTH CARE SERVICE	229	●	●	●	●		●		
	DIMBULAH OUTPATIENTS CLINIC	908	●	●	●	●		●		
	MALANDA OUTPATIENTS CLINIC	917	●	●	●	●		●		
	MILLAA MILLAA OUTPATIENTS CLINIC	920	●	●	●	●		●		
	RAVENSHOE OUTPATIENTS CLINIC	924	●	●	●	●		●		
	DOUGLAS SHIRE MULTI PURPOSE HEALTH SERVICE	1647							●	
Cape York	COOKTOWN HOSPITAL	216	●	●	●	●		●		
	WEIPA HOSPITAL	228	●	●	●	●		●		
	AURUKUN PRIMARY HEALTH CARE CENTRE	230	●	●	●	●		●		
	HOPE VALE PRIMARY HEALTH CARE CENTRE	231	●	●	●	●		●		
	WUJAL WUJAL	232	●	●	●	●		●		

Hospital & Health Service	Facility Name	Facility No	2012/2013 MAC Form Requirement							
			Clinic	Diag and Proc	Tele health	Bed	NH2	PH1	MP1	PATH
	PRIMARY HEALTH CARE CENTRE									
	LOCKHART RIVER PRIMARY HEALTH CARE CENTRE	233	●	●	●	●		●		
	KOWANYAMA PRIMARY HEALTH CARE CENTRE	253	●	●	●	●		●		
	PORMPURAAW PRIMARY HEALTH CARE CENTRE	254	●	●	●	●		●		
	COEN PRIMARY HEALTH CARE CENTRE	255	●	●	●	●		●		
	LAURA PRIMARY HEALTH CARE CENTRE	915	●	●	●	●		●		
	MALAKOOLA PRIMARY HEALTH CARE CENTRE	928	●	●	●	●		●		
	MAPOON PRIMARY HEALTH CARE CENTRE	965	●	●	●	●		●		
	COOKTOWN MULTI PURPOSE HEALTH SERVICE	1645							●	
	WEIPA INTERGRATED HEALTH SERVICE	1665							●	
Central Queensland	BARALABA HOSPITAL	132	●	●	●	●		●		
	BILOELA HOSPITAL	133	●	●	●	●		●		
	BLACKWATER HOSPITAL	134	●	●	●	●		●		
	EMERALD HOSPITAL	135	●	●	●	●		●		
	GLADSTONE HOSPITAL	136	●	●	●	●		●		
	MOUNT MORGAN HOSPITAL	139	●	●	●	●		●		
	MOURA HOSPITAL	140	●	●	●	●		●		
	ROCKHAMPTON HOSPITAL	141	●	●	●	●		●		
	SPRINGSURE HOSPITAL	142	●	●	●	●		●		
	THEODORE HOSPITAL	143	●	●	●	●		●		
	CAPRICORN COAST HOSPITAL AND HEALTH SERVICE	144	●	●	●	●		●		
	WOORABINDA HOSPITAL	145	●	●	●	●		●		
	NORTH ROCKHAMPTON NURSING CENTRE	613					●			
	BIRRIBI	616					●			
	EVENTIDE HOME ROCKHAMPTON	692					●			
	CAPELLA OUTPATIENTS CLINIC	905	●	●	●	●		●		

Hospital & Health Service	Facility Name	Facility No	2012/2013 MAC Form Requirement							
			Clinic	Diag and Proc	Tele health	Bed	NH2	PH1	MP1	PATH
	CRACOW OUTPATIENTS CLINIC	907	●	●	●	●		●		
	DUARINGA OUTPATIENTS CLINIC	910	●	●	●	●		●		
	GEMFIELDS OUTPATIENTS CLINIC	940	●	●	●	●		●		
	SPRINGSURE HOSPITAL MULTI PURPOSE HEALTH SERVICE	1643							●	
	THEODORE MULTI PURPOSE HEALTH SERVICE	1652							●	
	WOORABINDA MULTI PURPOSE HEALTH SERVICE	1653							●	
	BARALABA MULTI PURPOSE HEALTH SERVICE	1659							●	
	BLACKWATER MULTI PURPOSE HEALTH SERVICE	1661							●	
Central West	ALPHA HOSPITAL	131	●	●	●	●		●		
	ARAMAC PRIMARY HEALTH CARE CENTRE	151	●	●	●	●		●		
	BARCALDINE HOSPITAL	152	●	●	●	●		●		
	BLACKALL HOSPITAL	153	●	●	●	●		●		
	BOULIA PRIMARY HEALTH CENTRE	154	●	●	●	●		●		
	JUNDAH PRIMARY HEALTH CENTRE	155	●	●	●	●		●		
	LONGREACH HOSPITAL	156	●	●	●	●		●		
	MUTTABURRA PRIMARY HEALTH CENTRE	157	●	●	●	●		●		
	TAMBO PRIMARY HEALTH CARE CENTRE	158	●	●	●	●		●		
	WINTON HOSPITAL	159	●	●	●	●		●		
	ISISFORD PRIMARY HEALTH CENTRE	160	●	●	●	●		●		
	YARAKA CLINIC	161	●	●	●	●		●		
	WINDORAH CLINIC	162	●	●	●	●		●		
	BARCOO LIVING MULTI PURPOSE HEALTH SERVICE	1654							●	
	BARCALDINE MULTI PURPOSE HEALTH SERVICE	1655							●	
	ALPHA MULTI PURPOSE HEALTH SERVICE	1656							●	
	WINTON MULTI PURPOSE HEALTH SERVICE	1657							●	
Children's Health Queensland	ROYAL CHILDREN'S HOSPITAL	7	●	●	●	●		●		
	ELLEN BARRON FAMILY CENTRE	17	●	●	●	●		●		

Hospital & Health Service	Facility Name	Facility No	2012/2013 MAC Form Requirement							
			Clinic	Diag and Proc	Tele health	Bed	NH2	PH1	MP1	PATH
Darling Downs	CHERBOURG HOSPITAL	63	●	●	●	●		●		
	KINGAROY HOSPITAL	70	●	●	●	●		●		
	MURGON HOSPITAL	75	●	●	●	●		●		
	NANANGO HOSPITAL	76	●	●	●	●		●		
	WONDAI HOSPITAL	77	●	●	●	●		●		
	CHINCHILLA HOSPITAL	91	●	●	●	●		●		
	DALBY HOSPITAL	92	●	●	●	●		●		
	GOONDIWINDI HOSPITAL	93	●	●	●	●		●		
	INGLEWOOD HOSPITAL	94	●	●	●	●		●		
	JANDOWAE HOSPITAL	95	●	●	●	●		●		
	MILES HOSPITAL	97	●	●	●	●		●		
	MILLMERRAN HOSPITAL	98	●	●	●	●		●		
	OAKEY HOSPITAL	99	●	●	●	●		●		
	STANTHORPE HOSPITAL	100	●	●	●	●		●		
	TARA HOSPITAL	101	●	●	●	●		●		
	TAROOM HOSPITAL	102	●	●	●	●		●		
	TEXAS HOSPITAL	103	●	●	●	●		●		
	TOOWOOMBA HOSPITAL	104	●	●	●	●		●		
	WARWICK HOSPITAL	105	●	●	●	●		●		
	WANDOAN HOSPITAL	106	●	●	●	●		●		
	FARRHOME NURSING CARE UNIT	604					●			
	KARINGAL NURSING HOME	607					●			
	MT LOFTY NURSING HOME	611					●			
	DR E A F MCDONALD NURSING HOME	614					●			
	THE OAKS NURSING HOME	618					●			
	FOREST VIEW RESIDENTIAL CARE FACILITY	623					●			
	BAILLIE HENDERSON HOSPITAL	701	●	●	●	●		●		
	GLENMORGAN OUTPATIENTS CLINIC	912	●	●	●	●		●		
	MEANDARRA OUTPATIENTS CLINIC	919	●	●	●	●		●		
	MOONIE OUTPATIENTS CLINIC	935	●	●	●	●		●		
	MILTON HOUSE	1344					●			

Hospital & Health Service	Facility Name	Facility No	2012/2013 MAC Form Requirement							
			Clinic	Diag and Proc	Tele health	Bed	NH2	PH1	MP1	PATH
	TEXAS MULTI PURPOSE HEALTH SERVICE	1642							●	
	INGLEWOOD MULTI PURPOSE HEALTH SERVICE	1648							●	
	MILLMERRAN MULTI PURPOSE HEALTH SERVICE	1666							●	
Gold Coast	GOLD COAST HOSPITAL	50	●	●	●	●		●		
	ROBINA	934	●	●	●	●		●		
	GOLD COAST UNIVERSITY HOSPITAL	936	●	●	●	●		●		
	OZCARE PARKWOOD GARDENS	1421					●			
Mackay	CLERMONT HOSPITAL	171	●	●	●	●		●		
	COLLINSVILLE HOSPITAL	194	●	●	●	●		●		
	BOWEN HOSPITAL	192	●	●	●	●		●		
	MACKAY BASE HOSPITAL	172	●	●	●	●		●		
	MORANBAH HOSPITAL	173	●	●	●	●		●		
	PROSERPINE HOSPITAL	174	●	●	●	●		●		
	SARINA HOSPITAL	175	●	●	●	●		●		
	DYSART HOSPITAL	176	●	●	●	●		●		
	CLERMONT MULTI PURPOSE HEALTH SERVICE	1644							●	
	COLLINSVILLE MULTI PURPOSE HEALTH SERVICE	1658							●	
Mater *	MATER ADULT HOSPITAL	1	●	●	●	●		●		●
	MATER CHILDREN'S HOSPITAL	2	●	●	●	●		●		●
	MATER MOTHER'S HOSPITAL	3	●	●	●	●		●		●
Metro - North	THE PRINCE CHARLES HOSPITAL	4	●	●	●	●		●		
	REDCLIFFE HOSPITAL	16	●	●	●	●		●		
	CABOOLTURE HOSPITAL	30	●	●	●	●		●		
	KILCOY HOSPITAL	46	●	●	●	●		●		
	ROYAL BRISBANE & WOMEN'S HOSPITAL	201	●	●	●	●		●		
	JACANA CENTRE FOR AQUIRED BRAIN INJURED REHAB & RESIDENIAL CARE	601					●			
	HALWYN CENTRE	605					●			
	COOINDA HOUSE	615					●			
	ASHWORTH HOUSE NURSING HOME	624					●			

Hospital & Health Service	Facility Name	Facility No	2012/2013 MAC Form Requirement							
			Clinic	Diag and Proc	Tele health	Bed	NH2	PH1	MP1	PATH
	EVENTIDE HOME NURSING HOME SANDGATE	691					●			
Metro South	PRINCESS ALEXANDRA HOSPITAL	11	●	●	●	●		●		
	QUEEN ELIZABETH II JUBILEE HOSPITAL	22	●	●	●	●		●		
	WYNNUM HOSPITAL	24	●	●	●	●		●		
	MARIE ROSE CENTRE	25	●	●	●	●		●		
	REDLAND HOSPITAL	28	●	●	●	●		●		
	LOGAN HOSPITAL	29	●	●	●	●		●		
	BEAUDESERT HOSPITAL	41	●	●	●	●		●		
	MORETON BAY NURSING CARE UNIT	610					●			
	CASUARINA LODGE	625					●			
	REDLAND RESIDENTIAL CARE FACILITY	1404					●			
North West	BURKETOWN HEALTH CLINIC	241	●	●	●	●		●		
	CAMOOWEAL HEALTH CLINIC	242	●	●	●	●		●		
	CLONCURRY HOSPITAL	243	●	●	●	●		●		
	JULIA CREEK HOSPITAL	245	●	●	●	●		●		
	MOUNT ISA BASE HOSPITAL	246	●	●	●	●		●		
	NORMANTON HOSPITAL	247	●	●	●	●		●		
	MORNINGTON ISLAND HOSPITAL	249	●	●	●	●		●		
	KARUMBA HEALTH CLINIC	250	●	●	●	●		●		
	DAJARRA HEALTH CLINIC	251	●	●	●	●		●		
	DOOMADGEE HOSPITAL	252	●	●	●	●		●		
	CLONCURRY MULTI PURPOSE HEALTH SERVICE	1663							●	
South West	AUGATHELLA HOSPITAL	111	●	●	●	●		●		
	CHARLEVILLE HOSPITAL	112	●	●	●	●		●		
	CUNNAMULLA HOSPITAL	113	●	●	●	●		●		
	DIRRANBANDI HOSPITAL	114	●	●	●	●		●		
	INJUNE HOSPITAL	115	●	●	●	●		●		
	MITCHELL HOSPITAL	116	●	●	●	●		●		
	MUNGINDI HOSPITAL	117	●	●	●	●		●		
	QUILPIE HOSPITAL	118	●	●	●	●		●		
	ROMA HOSPITAL	119	●	●	●	●		●		
	ST GEORGE HOSPITAL	120	●	●	●	●		●		
	SURAT HOSPITAL	121	●	●	●	●		●		

Hospital & Health Service	Facility Name	Facility No	2012/2013 MAC Form Requirement							
			Clinic	Diag and Proc	Tele health	Bed	NH2	PH1	MP1	PATH
	THARGOMINDAH HOSPITAL	122	●	●	●	●		●		
	WALLUMBILLA OUTPATIENTS CLINIC	123	●	●	●	●		●		
	WAROONA MULTIPURPOSE CENTRE	621					●			
	WESTHAVEN NURSING HOME	622					●			
	BOLLON OUTPATIENTS CLINIC	903	●	●	●	●		●		
	MORVEN OUTPATIENTS CLINIC	921	●	●	●	●		●		
	DIRRANBANDI MULTI PURPOSE HEALTH SERVICE	1646							●	
	QUILPIE MULTI PURPOSE HEALTH SERVICE	1651							●	
	AUGATHELLA MULTI PURPOSE HEALTH SERVICE	1668							●	
	MUNGINDI MULTI PURPOSE HEALTH SERVICE	1669							●	
	MITCHELL MULTI PURPOSE HEALTH SERVICE	1670							●	
Sunshine Coast	CALOUNDRA HOSPITAL	43	●	●	●	●		●		
	MALENY HOSPITAL	48	●	●	●	●		●		
	NAMBOUR GENERAL HOSPITAL	49	●	●	●	●		●		
	GYMPIE HOSPITAL	68	●	●	●	●		●		
	GLENBROOK RESIDENTIAL AGED CARE FACILITY	612					●			
Torres Strait – Northern Peninsula	BAMAGA HOSPITAL	213	●	●	●	●		●		
	THURSDAY ISLAND HOSPITAL	226	●	●	●	●		●		
	ISLAND MEDICAL SERVICE	939	●	●	●	●		●		
Townsville	AYR HOSPITAL	191	●	●	●	●		●		
	CHARTERS TOWERS HOSPITAL	193	●	●	●	●		●		
	HOME HILL HOSPITAL	195	●	●	●	●		●		
	INGHAM HOSPITAL	196	●	●	●	●		●		
	JOYCE PALMER HEALTH SERVICE	197	●	●	●	●		●		
	THE TOWNSVILLE HOSPITAL	200	●	●	●	●		●		
	HUGHENDEN HOSPITAL	244	●	●	●	●		●		
	RICHMOND HOSPITAL	248	●	●	●	●		●		
	PARKLANDS RESIDENTIAL AGED CARE FACILITY	619					●			

Hospital & Health Service	Facility Name	Facility No	2012/2013 MAC Form Requirement							
			Clinic	Diag and Proc	Tele health	Bed	NH2	PH1	MP1	PATH
	EVENTIDE CHARTERS TOWERS	693					●			
	EVENTIDE HOME (CHARTERS TOWERS) - HOSTEL	697					●			
	CHARTERS TOWERS REHABILITATION UNIT	703	●	●	●	●		●		
	KIRWAN REHABILITATION UNIT	715	●	●	●	●		●		
	MAGNETIC ISLAND HEALTH SERVICE CENTRE	916	●	●	●	●		●		
West Moreton	IPSWICH HOSPITAL	15	●	●	●	●		●		
	BOONAH HOSPITAL	42	●	●	●	●		●		
	ESK HOSPITAL	44	●	●	●	●		●		
	GATTON HOSPITAL	45	●	●	●	●		●		
	LAIDLEY HOSPITAL	47	●	●	●	●		●		
	THE PARK CENTRE FOR MENTAL HEALTH	751	●	●	●	●		●		
Wide Bay	BIGGENDEN HOSPITAL	61	●	●	●	●		●		
	BUNDABERG BASE HOSPITAL	62	●	●	●	●		●		
	CHILDERS HOSPITAL	64	●	●	●	●		●		
	EIDSVOLD HOSPITAL	65	●	●	●	●		●		
	GAYNDAH HOSPITAL	66	●	●	●	●		●		
	GIN GIN HOSPITAL	67	●	●	●	●		●		
	HERVEY BAY HOSPITAL	69	●	●	●	●		●		
	MARYBOROUGH HOSPITAL	71	●	●	●	●		●		
	MONTO HOSPITAL	72	●	●	●	●		●		
	MOUNT PERRY HEALTH CENTRE	73	●	●	●	●		●		
	MUNDUBBERA HOSPITAL	74	●	●	●	●		●		
	YARALLA PLACE	609					●			
	MUNDUBBERA MULTI PURPOSE HEALTH SERVICE	1650							●	
	BIGGENDEN MULTI PURPOSE HEALTH SERVICE	1660							●	
	EIDSVOLD MULTI PURPOSE HEALTH SERVICE	1662							●	
	CHILDERS MULTI PURPOSE HEALTH SERVICE	1671							●	

5 Mapping between CCC, MAC and pre 2012 HBCIS Sub-specialty Codes

Corporate Clinic Code Description	Corporate Clinic Code	MAC Clinic Form Description	Tier 2 Clinic	Tier 2 Code	Pre July 2012 HBCIS Sub-Specialty Code	Pre 2012 HBCIS Sub-Specialty Code	Form Type			
							Medical Officer		Other Health Professional	
Aboriginal Health Clinic	130	Aboriginal Health Clinic	Aboriginal Health Clinic	40.01			C	T	C	T
Aged Care Assessment	135	Aged Care Assessment	Aged Care Assessment	40.02	AGED CARE	119	C	T	C	T
Aids and Appliances	540	Aids and Appliances	Aids and Appliances	40.03	PROSTHETICS	12			C	T
Alcohol and Other Drugs	140	Alcohol and Other Drugs	Alcohol and Other Drugs	40.30	PHARM/TOXIC - ALCOHOL&DRUG	64	C	T	C	T
Anaesthetics	150	Anaesthetics	Anaesthetics	20.02	ANAESTHETIC	114	C	T	C	T
Anti - Coagulant	155	Anti - Coagulant Screening and Management	Anti-coagulant Screening and Management	20.21	Anti Coagulant	23	C	T	C	T
Assisted Reproductive Technology	160	Assisted Reproductive Technology	Assisted Reproductive Technology	20.37			C	T	C	T
Audiology	165	Audiology	Audiology	40.17	AUDIOLOGY	1			C	T
Breast	170	Breast	Breast	20.32	Breast	94	C	T	C	T
Burns	175	Burns	Multidisciplinary Burns Clinic, Burns	20.48 40.31	Burns	95	C	T	C	T
Cardiac Rehabilitation	180	Cardiac Rehabilitation	Cardiac Rehabilitation	40.21			C	T	C	T
Cardiac Surgery - Cardiothoracic	186	Cardiac Surgery	Cardiothoracic	20.23	CARD SURG - CARDIO - THORASIC	98	C	T	C	T
Cardiac Surgery - Thoracic	187	Cardiac Surgery	Cardiothoracic	20.23	CARDIAC SURGERY - THORACIC	97	C	T	C	T
Cardiac Surgery General	185	Cardiac Surgery	Cardiothoracic	20.23	CARDIAC SURGERY – CARDIAC	96	C	T	C	T
Cardiology - Holter Clinic	196	Cardiology	Cardiology	20.22	CARDIOLOGY - HOLTER CLINIC	27	C	T	C	T
Cardiology - Hypertension	197	Cardiology	Cardiology	20.22	CARDIOLOGY - HYPERTENSION	28	C	T	C	T
Cardiology - Pacemaker	198	Cardiology	Cardiology	20.22	CARDIOLOGY - PACEMAKER	25	C	T	C	T
Cardiology - Stress Test	199	Cardiology	Clinical Measurement	30.08	CARDIOLOGY - STRESS TEST	26	C	T	C	T
Cardiology General	195	Cardiology	Cardiology	20.22	CARDIOLOGY - CARDIOLOGY	24	C	T	C	T
Clinical Pharmacy	205	Clinical Pharmacy	Clinical Pharmacology	40.04	CLINICAL PHARMACY	2			C	T
Community Health Services – Aged Care	210	Community Health Services – Aged Care	N/A	N/A	COMMUNITY	122	D	T	D	T
Community Health Services – Geriatric	211	Community Health Services – Geriatric	N/A	N/A			D	T	D	T

Corporate Clinic Code Description	Corporate Clinic Code	MAC Clinic Form Description	Tier 2 Clinic	Tier 2 Code	Pre July 2012 HBCIS Sub-Specialty Code	Pre 2012 HBCIS Sub-Specialty Code	Form Type			
							Medical Officer		Other Health Professional	
Community Health Services – Psychogeriatric	212	Community Health Services – Psychogeriatric	N/A	N/A			D	T	D	T
Community Health Services – Rehabilitation	213	Community Health Services – Rehabilitation	N/A	N/A			D	T	D	T
Community Health Services – Other	214	Community Health Services – Other	N/A	N/A			D	T	D	T
Community Mental Health	220	Out of scope	Community Mental Health	40.34						
Continence	240	Continence	Continence	40.32			C	T	C	T
Craniofacial	245	Craniofacial	Craniofacial	20.27			C	T	C	T
Dermatology	250	Dermatology	Dermatology	20.33	DERMATOLOGY – CRYOTHERAPY	31	C	T	C	T
Dermatology	250	Dermatology	Dermatology	21.33	DERMATOLOGY – DERMATOLOGY	30	C	T	C	T
Diabetes	255	Diabetes	Endocrinology, Diabetes	20.34 40.26	DIABETES – DIABETES	34	C	T	C	T
Diabetes Education	256	Diabetes	Endocrinology, Diabetes	20.34 40.26	DIABETES EDUCATION	3	C	T	C	T
Diagnostic - Clinical Measurement	260	Clinical Measurement	Clinical Measurement	30.08	CLINICAL MEASUREMENT	29	D		D	
Diagnostic - Computerised Tomography (CT)	261	Diagnostic Imaging	Computerised Tomography (CT)	30.03			D and T			
Diagnostic - General Imaging	263	Diagnostic Imaging	General Imaging	30.01	MEDICAL IMAGING	19	D and T			
Diagnostic - Mammography Screening	262	Diagnostic Imaging	Mammography Screening	30.07			D and T			
Diagnostic - Medical Resonance Imaging (MRI)	264	Diagnostic Imaging	Medical Resonance Imaging	30.02			D and T			
Diagnostic - Nuclear Medicine	265	Diagnostic Imaging	Nuclear Medicine	30.04			D and T			
Diagnostic - Pathology	266	Diagnostic Imaging	Pathology (Microbiology, Haematology, Biochemistry)	30.05	PATHOLOGY	84	D and T			
Diagnostic - Positron Emission Tomography (PET)	267	Diagnostic Imaging	Positron Emission Tomography (PET)	30.06			D and T			
Endocrine - Metabolic	281	Endocrinology	Endocrinology	20.34	ENDOCRINE – METABOL	37	C	T	C	T
Endocrine - Thyroid	282	Endocrinology	Endocrinology	20.34	ENDOCRINE – THYROID	36	C	T	C	T
Endocrine General	280	Endocrinology	Endocrinology	20.34	ENDOCRINE – ENDOCRINE	35	C	T	C	T
ENT	285	Ear Nose and Throat Surgery	Ear, Nose and Throat (ENT)	20.18	EAR NOSE & THROAT – ENT	101	C	T	C	T

Corporate Clinic Code Description	Corporate Clinic Code	MAC Clinic Form Description	Tier 2 Clinic	Tier 2 Code	Pre July 2012 HBCIS Sub-Specialty Code	Pre 2012 HBCIS Sub-Specialty Code	Form Type			
							Medical Officer		Other Health Professional	
ENT	285	Ear Nose and Throat Surgery	Ear, Nose and Throat (ENT)	20.18	EAR NOSE & THROAT – ORAL	103	C	T	C	T
Epilepsy	290	Epilepsy	Epilepsy	20.14			C	T	C	T
Exclusion	295	Not reported	N/A	N/A	Exclusion	999				
Family Planning	300	Family Planning	Family Planning	40.27			C	T	C	T
Gastroenterology	305	Gastroenterology	Gastroenterology	20.25	GASTRONENTEROLOGY	40	C	T	C	T
General Counselling	310	General Counselling	General Counselling	40.33			C	T	C	T
General Medicine	315	General Medicine	General Medicine	20.05	GENERAL INTERNAL MEDICINE	41	C	T	C	T
General Practice and Primary Care	320	Primary Care	General Practice and Primary Care, Primary Health Care	20.06 40.08	PRIMARY CARE	126	C	T	C	T
General Surgery	330	General Surgery	General Surgery	20.07	GEN SURG - GEN SURG	104	C	T	C	T
General Surgery - Colorectal	331	General Surgery	General Surgery	20.07	GEN SURG - COLO - RECTAL	105	C	T	C	T
Genetics	335	Genetics	Genetics	20.08	GENETIC	42	C	T	C	T
Geriatric Evaluation and Management (GEM)	340	Geriatric Evaluation and Management	Geriatric Evaluation and Management (GEM)	20.49			C	T	C	T
Geriatrics	341	Geriatric	Geriatric Medicine	20.09	GERIATRICS	120	C	T	C	T
Geriatrics	341	Geriatric	Geriatric Medicine	20.09	GERONTOLOGY	121	C	T	C	T
Gynaecology	345	Gynaecology	Gynaecology	20.38	GYNAECOLOGY – GYNAECOLOGY	77	C	T	C	T
Gynaecology	345	Gynaecology	Gynaecology	20.38	GYNAECOLOGY – MENOPAUSE	78	C	T	C	T
Gynaecology Oncology	346	Gynaecology Oncology	Gynaecology Oncology	20.39	GYNAECOLOGY – ONCOLOGY	79	C	T	C	T
Haematology	350	Haematology	Haematology	20.10	HAEMATOLOGY	43	C	T	C	T
Hepatobiliary	355	Hepatobiliary	Hepatobiliary	20.26			C	T	C	T
Hepatology	360	Hepatology	Hepatobiliary	20.26			C	T	C	T
Hydrotherapy	365	Hydrotherapy	Hydrotherapy	40.05					C	T
Immunology - Allergy	371	Immunology - Allergy	Immunology	20.41	IMMUNOLOGY – ALLERGY	21	C	T	C	T
Immunology General	370	Immunology	Immunology	20.41	IMMUNOLOGY – IMMUNOLOGY	22	C	T	C	T
Infectious Diseases	375	Infectious Diseases	Infectious Diseases	20.44	INFECT DIS - HEP C	49	C	T	C	T
Infectious Diseases	375	Infectious Diseases	Infectious Diseases	20.44	INFECT DIS - HEP B	48	C	T	C	T
Infectious Diseases	375	Infectious Diseases	Infectious Diseases	20.44	INFECT DIS - INFECT DIS	47	C	T	C	T
Metabolic Bone	380	Metabolic Bone	Metabolic Bone	20.28			C	T	C	T

Corporate Clinic Code Description	Corporate Clinic Code	MAC Clinic Form Description	Tier 2 Clinic	Tier 2 Code	Pre July 2012 HBCIS Sub-Specialty Code	Pre 2012 HBCIS Sub-Specialty Code	Form Type			
							Medical Officer		Other Health Professional	
Midwifery	385	Midwifery	Midwifery	40.28			C	T	C	T
Neonatal	390	Neonatal	Paediatric Medicine	20.11	NEONATAL	86	C	T	C	T
Nephrology	395	Nephrology	Nephrology	20.35	NEPHROLOGY	51	C	T	C	T
Nephrology	395	Nephrology	Nephrology	20.35	DIALYSIS EDUCATION	128	C	T	C	T
Nephrology	395	Nephrology	Nephrology	20.35	NEPHROLOGY – RENAL	52	C	T	C	T
Neurology	400	Neurology	Neurology	20.15	NEUROLOGY	53	C	T	C	T
Neuropsychology	405	Neuropsychology	Neuropsychology	40.14					C	T
Neurosurgery	410	Neurosurgery	Neurosurgery	20.16	NEUROSURGERY	106	C	T	C	T
Nutrition / Dietetics	415	Nutrition	Nutrition/Dietetics	40.23	NUTRITION/DIETETICS	5			C	T
Obstetrics - Antenatal	420	Obstetrics	Obstetrics	20.40	OBSTETRICS – ANTENATAL	82	C	T	C	T
Obstetrics - Postnatal	421	Obstetrics	Obstetrics	20.40	OBSTETRICS – POSTNATAL	83	C	T	C	T
Occupational Therapy	425	Occupational Therapy	Occupational Therapy	40.06	OCCUPATIONAL THERAPY	6			C	T
Oncology - Medical Oncology Consultation	430	Oncology Medical Consultation	Medical Oncology (Consultation)	20.42	ONCOL - MED ONCO CLINIC	57	C	T	C	T
Oncology - Radiation Oncology Consultation	431	Oncology Radiation Consultation	Radiation Oncology (Consultation)	20.43	ONCOL - RADIAT ONCO CLINIC	59	C	T	C	T
Ophthalmology	435	Ophthalmology	Ophthalmology	20.17	OPHTHALMOLOGY	107	C	T	C	T
Optometry	440	Optometry	Optometry	40.15	OPTOMETRY	7			C	T
Orthopaedics - Fracture Clinic	446	Orthopaedic Surgery	Orthopaedics	20.29	ORTHOPAEDICS – FRACTURE	110	C	T	C	T
Orthopaedics - Hand	447	Orthopaedic Surgery	Orthopaedics	20.29	ORTHOPAEDICS – HAND	109	C	T	C	T
Orthopaedics - Scoliosis	448	Orthopaedic Surgery	Orthopaedics	20.29	ORTHOPAEDICS – SCOLIOSIS	111	C	T	C	T
Orthopaedics General	445	Orthopaedic Surgery	Orthopaedics	20.29	ORTHOPAEDICS – ORTHOPAED	108	C	T	C	T
Orthoptics	455	Orthoptics	Orthoptics	40.16	ORTHOPTIC	8			C	T
Orthotics	460	Orthotics	Orthotics	40.24	ORTHOTICS	9			C	T
Other Outreach Services	635	Other Outreach Services	N/A		OTHER OUTREACH SERVICES	124	D	T	D	T
Paediatric - Rehabilitation	468	Rehabilitation	Rehabilitation	20.47	PAED - OTHER - REHABILITATION	91	C	T	C	T
Paediatric Medicine	465	Paediatric Medicine	Paediatric Medicine	20.11	PAEDIATRIC – MEDICINE	87	C	T	C	T
Paediatric Surgery	466	Paediatric Surgery	Paediatric Surgery	20.12	PAEDIATRIC – SURGERY	88	C	T	C	T
Paediatrics - Development	467	Paediatrics Development	Developmental Disabilities	20.04	PAED - OTHER - DEVELOPMENT	90	C	T	C	T
Pain Management - Persistent Pain	476	Pain Management - Persistent Pain	Pain Management	20.03	PAIN MGMT - PERSISTENT PAIN	129	C	T	C	T

Corporate Clinic Code Description	Corporate Clinic Code	MAC Clinic Form Description	Tier 2 Clinic	Tier 2 Code	Pre July 2012 HBCIS Sub-Specialty Code	Pre 2012 HBCIS Sub-Specialty Code	Form Type			
							Medical Officer		Other Health Professional	
Pain Management General	475	Pain Management - General	Pain Management	20.03	PAIN MANAGEMENT	62	C	T	C	T
Palliative Care	480	Palliative Care	Palliative Care	20.13	PALLIATIVE CARE	61	C	T	C	T
Physiotherapy	485	Physiotherapy	Physiotherapy	40.09	PHYSIOTHERAPY	10			C	T
Plastic and Reconstructive Surgery	490	Plastic and Reconstructive Surgery	Plastic and Reconstructive Surgery	20.46	PLASTIC SURGERY	112	C	T	C	T
Podiatry	495	Podiatry	Podiatry	40.25	PODIATRY	11			C	T
Pre - Admission and Pre - Anaesthesia	500	Pre - Admission and Pre - Anaesthesia	Pre-Admission and Pre-Anaesthesia	40.07	PRE - ADMISSION	113	C	T	C	T
Procedure - Angioplasty/Angiography	505	Procedure - Angioplasty/Angiography	Angioplasty/Angiography	10.05			D		D	
Procedure - Dental	506	Out of scope	Dental	10.04	DENTAL	18				
Procedure - Endoscopy - Gastrointestinal	507	Endoscopy - Gastrointestinal	Endoscopy - Gastrointestinal	10.06			D		D	
Procedure - Endoscopy - Respiratory/ENT	508	Endoscopy - Respiratory/ENT	Endoscopy - Respiratory/ENT	10.09			D		D	
Procedure - Endoscopy - Orthopaedic	509	Endoscopy - Orthopaedic	Endoscopy - Orthopaedic	10.08			D		D	
Procedure - Endoscopy - Urological/Gynaecological	510	Endoscopy - Urological/Gynaecological	Endoscopy - Urological/Gynaecological	10.07	ENDOSCOPY & RELATED PROCE	127	D		D	
Procedure - Hyperbaric Medicine	511	Hyperbaric Medicine	Hyperbaric Medicine	10.01	HYPERBARIC MEDICINE	46	D		D	
Procedure - Interventional Imaging	512	Interventional Imaging	Interventional Imaging	10.02			D		D	
Procedure - Minor Medical Procedures	513	Minor Medical Procedures	Minor Medical Procedures	10.13			D		D	
Procedure - Minor Surgical	514	Minor Surgical	Minor Surgical	10.03			D		D	
Procedure - Oncology Medical Chemotherapy	515	Oncology Medical Chemotherapy	Medical Oncology (Treatment)	10.11	ONCOLOGY – CHEMOTHERAPY	56	D		D	
Procedure - Oncology Medical Other Treatment	516	Oncology Medical Treatment Other	Medical Oncology (Treatment)	10.11	ONCOL - MED ONCOL TREATMENT	58	D		D	
Procedure - Oncology Radiation Treatment	517	Oncology Radiation Treatment	Radiation Oncology (Treatment)	10.12	ONCOL - RADIAT ONCO TREATMT	60	D		D	
Procedure - Pain Management Interventions	518	Pain Management Interventions	Pain Management Interventions	10.14			D		D	
Procedure - Renal Dialysis	519	Renal Dialysis	Renal Dialysis	10.10			D		D	
Psychiatry	545	Psychiatry	Psychiatry	20.45	PSYCHIATRY	93	C	T	C	T
Psychogeriatric	555	Psychogeriatric	Psychogeriatric	20.50			C	T	C	T

Corporate Clinic Code Description	Corporate Clinic Code	MAC Clinic Form Description	Tier 2 Clinic	Tier 2 Code	Pre July 2012 HBCIS Sub-Specialty Code	Pre 2012 HBCIS Sub-Specialty Code	Form Type			
							Medical Officer		Other Health Professional	
Psychology	550	Psychology	Psychology	40.29	PSYCHOLOGY	13			C	T
Rehabilitation	560	Rehabilitation	Rehabilitation	20.47	REHABILITATION	65	C	T	C	T
Respiratory - Asthma	566	Respiratory - Asthma	Respiratory, Asthma	20.19 40.19	RESP - ASTHMA	66	C	T	C	T
Respiratory - Chronic Obstructive Pulmonary	567	Respiratory - Chronic Obstructive Pulmonary Disease	Chronic Obstructive Pulmonary (Disease)	40.20			C	T	C	T
Respiratory - Cystic Fibrosis	568	Respiratory - Cystic Fibrosis	Respiratory - Cystic Fibrosis	20.20	RESP - CYSTIC FIBROSIS	67	C	T	C	T
Respiratory - Sleep	569	Respiratory - Other	Respiratory	20.19	RESP – SLEEP	68	C	T	C	T
Respiratory - Thoracic	570	Respiratory - Other	Respiratory	20.19	RESP –THORACIC	70	C	T	C	T
Respiratory General	565	Respiratory - Other	Respiratory	20.19	RESP – RESP	69	C	T	C	T
Rheumatology	580	Rheumatology	Rheumatology	20.30	RHEUMATOLOGY	71	C	T	C	T
Sexual Health	585	Out of scope	Sexual Health	40.10						
Sleep Disorders	590	Sleep Disorders	Sleep Disorders	20.51			C	T	C	T
Social Work	595	Social Work	Social Work	40.11	SOCIAL WORK	14			C	T
Speech Pathology	600	Speech Pathology	Speech Pathology	40.18	SPEECH PATHOLOGY	15			C	T
Spinal	605	Spinal	Spinal	20.31	SPINAL	72	C	T	C	T
Stomal Therapy	610	Stomal Therapy	Stomal Therapy	40.22	STOMAL THERAPY	16	C	T	C	T
Transplants	615	Transplants	Transplants	20.01	TRANSPLANTS	73	C	T	C	T
Urology	620	Urology	Urology	20.36	UROLOGY	115	C	T	C	T
Vascular Surgery	625	Vascular Surgery	Vascular Surgery	20.24	VASCULAR SURGERY	116	C	T	C	T
Wound Management	630	Wound Management	Wound Management	40.13	WOUND MANAGEMENT	17	C	T	C	T
N/A	*N/A*	Pharmacy	*N/A*	*N/A*	*N/A*	*N/A*	D and T			
N/A	*N/A*	Emergency Services Treated	*N/A*	*N/A*	*N/A*	*N/A*	D and T			
N/A	*N/A*	Emergency Services Did Not Waits	*N/A*	*N/A*	*N/A*	*N/A*	D and T			
N/A	*N/A*	Home - Automated PD	*N/A*	*N/A*	*N/A*	*N/A*	D			
N/A	*N/A*	Home - CAPD	*N/A*	*N/A*	*N/A*	*N/A*	D			
N/A	*N/A*	Home - Haemodialysis	*N/A*	*N/A*	*N/A*	*N/A*	D			
N/A	*N/A*	Facility - Self Care Dialysis	*N/A*	*N/A*	*N/A*	*N/A*	D			
					COMMUNITY	122				
					ENDOSCOPY & RELATED PROCE	127				

Corporate Clinic Code Description	Corporate Clinic Code	MAC Clinic Form Description	Tier 2 Clinic	Tier 2 Code	Pre July 2012 HBCIS Sub-Specialty Code	Pre 2012 HBCIS Sub-Specialty Code	Form Type	
							Medical Officer	Other Health Professional
					ENT - MAXILLO - FACIAL	102		
					GYNAECOLOGY - COLPOSCOPY	76		
					GYNAECOLOGY - PAP SMEAR	80		
					OBSTETRICS – OBSTETRICS	81		
					PHARMACOLOGY/TOXICOLOGY	63		
					FALLS	39		
					OCCUPATIONAL MEDICINE	54		
					ONCOLOGY – ONCOLOGY	55		
					OTHER ALLIED HEALTH	125		
					PAED - OTHER - ASSESSMENT	89		
					PHARMACY	92		

C	**MACONCLNC (Clinic form)**
T	**MACONTELE (Telehealth form)**
D	**MACONDGPR (Diagnostic and Procedures form)**