

Monthly Activity Collection Manual

Statistical Services Branch

2018-2019

Monthly Activity Collection Manual

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An electronic version of this document is available at

<http://qheps.health.qld.gov.au/hsu/datacollections.htm#mac>

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June2018	1.0	Numerous	Update of manual to align to 2018-19 data collection/ reporting requirements.

1. Introduction to the MAC

1.1 Overview

The Monthly Activity Collection (MAC) collects aggregate (or summary) level data on **'Admitted'** and **'Non-admitted' patient activity** and **'Bed Availability'**. These data are submitted monthly to the Department of Health by the in-scope 'reporting entities'¹ of the different levels of Queensland's public hospital system. Whilst data are primarily reported to comply with State and Commonwealth Government reporting requirements, there are additional uses of these data including informing cost modelling, funding, research and local business management.

Data are submitted by each reporting entity to the Statistical Collections and Integration Unit (SCIU), Statistical Services Branch (SSB) of the Department of Health where it is prepared for reporting purposes.

1.2 Uses of MAC activity data

MAC data are used as the source for mandated reporting requirements for the Commonwealth and State Governments, as well as the reporting requirements of the Department of Health and local management purposes.

Some examples include:

- MAC data are routinely published on the Department of 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.
- Non-admitted patient service event data are used for healthcare purchasing and Activity Based Funding (ABF) purposes including informing the service agreements between HHSs and Department of Health and subsequent monitoring and analysis.
- Non-admitted patient service event data are reported to the IHPA for funding purposes.
- Non-admitted patient service event data are reported to the AIHW for statistical reporting purposes.
- Bed availability data are provided to the State and Commonwealth Governments.
- Non-admitted patient service event data are used by Revenue, Strategy and Support, Finance Branch to assist with the reconciliation of compensable activity and to support Departmental arrangements with third party payers.
- MAC data are used at the state and local level for costing, financial and resource management purposes.

¹ The term 'reporting entity' used in this manual refers to one of the three hierarchical levels for reporting monthly activity data ie either the hospital, the HHS or the State. The term 'reporting entities' used in this manual refers collectively to the three hierarchical levels for monthly activity reporting being the hospital, the HHS and the State.

1.3 Type of MAC activity required by reporting entity

The type of activity and the unit of activity required to be reported by the type of reporting entity is as follows:

Type of Activity	Unit of Activity	Type of Reporting Entity
Non-admitted patient - outpatient service events	service event (refer to 2.1 Scope Statement)	public acute hospitals public nursing homes/hostels/independent living units <hr/> Hospital and Health Services <hr/> Jurisdictional Health Authority (State)
Non-admitted patient - Primary and Community Health service events	Primary and Community Health (PCH) service events (refer to 2.1 Scope Statement)	Hospital and Health Services
Non-admitted patient - emergency service care	Emergency department stay	public acute hospitals which do not use the Emergency Department Information System (EDIS)
Non-admitted patient registered for care	Separations*	public nursing homes/hostels/independent living units multi-purpose health services
Admitted patient	Separations	public acute hospitals public psychiatric hospitals public nursing homes/ hostels/independent living units* multi-purpose health services* residential mental health care facilities*

* Note: Residents of these types of facilities are not 'admitted' patients. The term 'separation' should be interpreted as a 'cessation of care'. Likewise, the term 'admission' for these facilities should be interpreted as a 'commencement of care'.

Type of Activity	Unit of Activity	Type of Reporting Entity
Bed Availability	Beds/ Bed Alternatives	public acute hospitals public psychiatric hospitals public nursing homes/hostels/independent living units multi-purpose health services
	Beds	residential mental health care facilities

To report this activity to the MAC, there are a number of MAC templates (referred to as MAC forms) which must be completed each month by each reporting entity. Completed MAC forms are uploaded through the MAC Online application where data entered are validated by the reporting entity prior to the form being submitted to SCIU.

This manual is intended as a reference for those who are responsible for reporting aggregate-level non-admitted/ admitted activity to the MAC to ensure that data is consistent according to the prescribed definitions.

Since 1 July 2015, facilities which are not 'declared hospitals' do not report activity to MAC as individual facilities. Declared hospitals are those on the 'Commonwealth Government's Declared Hospitals List'.

Activity from these facilities is to be aggregated and then reported on the relevant HHS form.

Refer to Section Reporting requirements of 'previously declared' public health facilities for further information.

2. Non-admitted patient activity data

2.1 Scope Statement

Non-admitted patient activity to be reported to the MAC includes:

- outpatient service events² (OSEs) provided by clinics deemed as 'in scope' for reporting as determined by the IHPA's General list of in-scope public hospital services. Whilst the 'General list' does not include Tier 2 clinic classes of 'General Practice and Primary Care' (20.06), 'Aged Care Assessment' (40.02), 'Family Planning' (40.27), 'General Counselling' (40.33), and 'Primary Health Care' (40.08) as in-scope public hospital services, these clinic types must be reported.

Classification of these clinic services will be to the appropriate CCC/Tier 2 clinic class for reporting at the jurisdictional health authority (Queensland Health), Hospital and Health Service (Local Hospital Network (LHN)) and hospital levels.

- Primary and Community Health service events³ (PCHSEs) provided by Primary and Community Health Services clinics that are not able to be classified to a CCC/ Tier 2 clinic class and for which funding corresponds with cost centres designated as 'Non-ABF Service Categories' in the general ledger 'Funding Split Hierarchy'. Classification of these clinic services will be to a service type identified in the [Service type classifications and counting rules](#) for reporting at the HHS level and may include activity for services that are outsourced. This activity does not fit the criteria prescribed in *General list of in-scope public hospital services* ie considered ABF in scope services, as these would be able to be reported against the appropriate Tier 2 clinic classification.
- occasions of service provided by clinics at the facility level that do not deliver clinical care eg activities such as home cleaning, meals on wheels or home maintenance. Whilst in the scope of MAC, these activities are not service events. This activity is collected for State reporting purposes (refer to [Other Outreach Services](#) for more information).

Further, this activity must:

- be activity that is funded by the jurisdictional health authority (Queensland Health), Hospital and Health Service, or hospital
- be irrespective of location (includes on-campus and off-campus), and
- be included regardless of setting or mode

Excludes:

²Outpatient service events must meet the definition of a service event being *an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record* Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary. <<http://meteor.aihw.gov.au/content/index.phtml/itemId/652089>> Retrieved 23/05/2018

³ A PCHSE is defined as an interaction between a client and one or more healthcare provider(s) containing therapeutic/clinical content, resulting in a dated entry in the patient's medical record, file or other client service record and occurring in a community setting, or under the auspices of a community health service.

- services provided from grants issued by the Commonwealth
- services that are the policy and funding responsibility of another state government department or the Commonwealth are not in scope for this collection, as activity would be reported elsewhere. Similarly, mental health and oral health service activity is reported via service specific information systems such as Consumer Integrated Mental Health Application (CIMHA) and Information System Oral Health (ISOH) and should therefore not be reported via the MAC.
- services provided by email.
- services provided to patients in the admitted, emergency department or emergency service care settings.

The OSE activity that is to be reported to the MAC is '*the total number of individual session non-admitted service events provided by an establishment*⁴' and '*the total number of group session non-admitted service events provided by an establishment*'⁵.

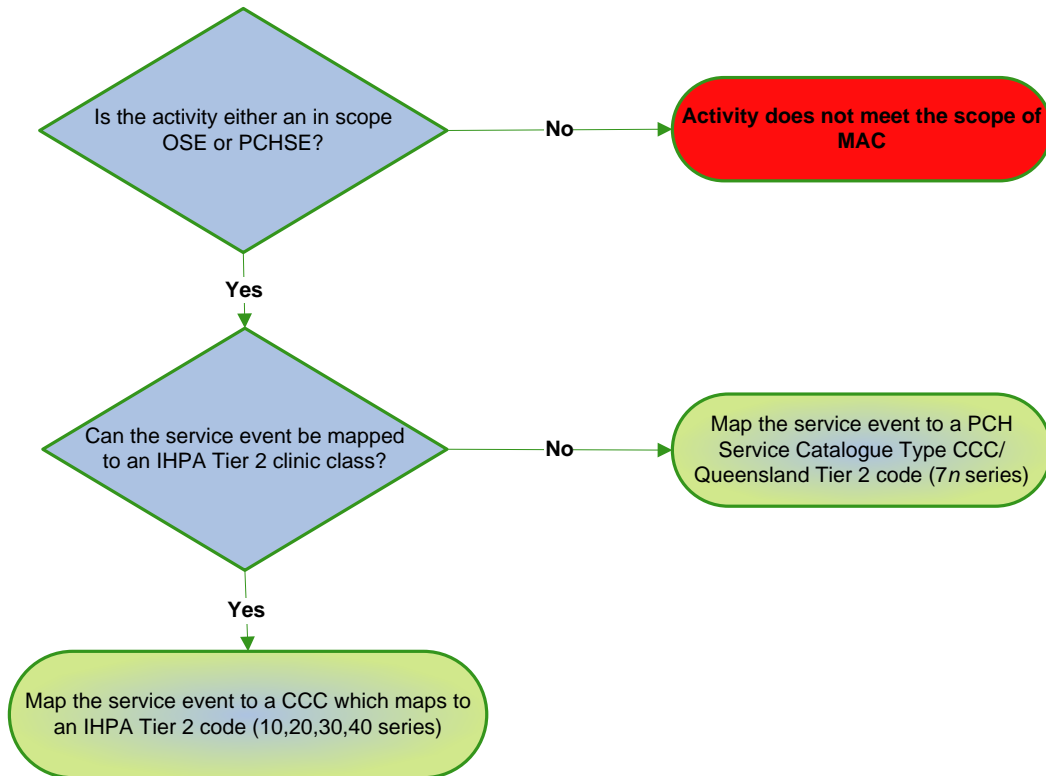
The PCHSE activity that is to be reported to the MAC for non-admitted patients is 'the total number of 'PCHSEs' provided to non-admitted patients in the reference period, for each of the Primary and Community Health service types.

⁴ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary. <<http://meteor.aihw.gov.au/content/index.phtml/itemId/679562>> Retrieved 23/05/2018

⁵ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary. <<http://meteor.aihw.gov.au/content/index.phtml/itemId/679572>> Retrieved 23/05/2018

2.1.1 Scope of MAC reporting diagrams

Reporting non-admitted patient service event activity to the MAC



2.1.2 Reporting mandates

MAC data are the source for mandated Commonwealth and State government reporting requirements.

Commonwealth Government Reporting Requirements

Department of Health (Commonwealth)

Under the National Healthcare Agreement, Queensland is required to supply the Commonwealth's Department of Health (DoH) with hospital activity data on Queensland's public health system.

Australian Institute of Health and Welfare (AIHW)

As a signatory to the National Health Information Agreement, Queensland is required to provide hospital activity data to the AIHW according to agreed National Minimum Data Sets (NMDSs).

To comply with these reporting obligations, data reported to the MAC for service events is used to meet the [Non-admitted patient care hospital aggregate NMDS 2018-19](#) (NAPC HA NMDS).

Independent Hospital Pricing Authority (IHPA)

In addition to the above reporting requirements for DoH and the AIHW, the Department of Health must provide non-admitted patient service event activity to IHPA⁶ at both the aggregate-level and the patient-level.

Aggregate-level reporting

The Department of Health provides aggregate level data as specified in the following two data set specifications:

- [Non-admitted patient care hospital aggregate NMDS 2018-19](#) (NAPC HA NMDS).
- [Non-admitted patient care Local Hospital Network aggregate NBEDS 2018-19⁷](#) (NAPC LHNA NBEDS).

These two data set specifications work in partnership to collect data on the public hospital system by collecting the same non-admitted activity data items but at different levels of the system. The NAPC HA NMDS collects data at the hospital level and since its introduction on the 1 July 2014, the NAPC LHNA NBEDS collects data at the HHS and Jurisdictional Health Authority (State) levels.

Prior to 1 July 2014, only non-admitted patient service activity that was delivered by public hospitals was reported in the MAC. However, from this date the scope of non-admitted patient service events reported in the MAC was expanded from those service events delivered by public hospitals to service events delivered by the three levels of the health system - the hospital, the HHS and those that are managed by the State.

Level	Data collected through
Public hospital	Non-admitted patient care hospital aggregate NMDS (NAPC HA NMDS) Public hospital establishments NMDS (PHE NMDS)
Hospital and Health Service (LHN)	Non-admitted patient care Local Hospital Network aggregate NBEDS (NAPC LHNA NBEDS)
Jurisdictional health authority (State)	Non-admitted patient care Local Hospital Network aggregate NBEDS (NAPC LHNA NBEDS)

⁶ The Independent Hospital Pricing Authority (IHPA) has been established under the NHRA and has a pivotal role in the administration of Activity Based Funding (ABF). IHPA also has other key responsibilities as outlined in the NHRA, such as setting the national efficient price for public hospital services and the efficient cost of block funding services in regional hospitals.

⁷ Local Hospital Networks (LHNs) are known as Hospital and Health Services (HHSs) in Queensland.

2.1.3 Counting rules

AIHW (NAPC HA NMDS)

Service event data that are reported nationally to the AIHW must be reported in accordance with the [NAPC HA NMDS](#).

The counting rules of the NAPC HA NMDS state:

- **All** non-admitted services that meet the criteria of a non-admitted patient service event should be counted, and be counted only once regardless of the number of health care providers present.
- Patients can be counted as having multiple non-admitted patient service events in one day, provided that every visit meets each of the criteria in the definition of a non-admitted patient service event.

It should be noted that this has always been the level of reporting to MAC to meet the requirements of the NMDS.

IHPA (NAPC HA NMDS)

Service event data that are reported nationally to the IHPA must also be reported in accordance in with the business rules prescribed in IHPA's [Tier 2 Non-Admitted Service Compendium](#).

The Compendium provides additional business rules and examples to assist with consistent counting, classification, and reporting of non-admitted activity data for ABF purposes.

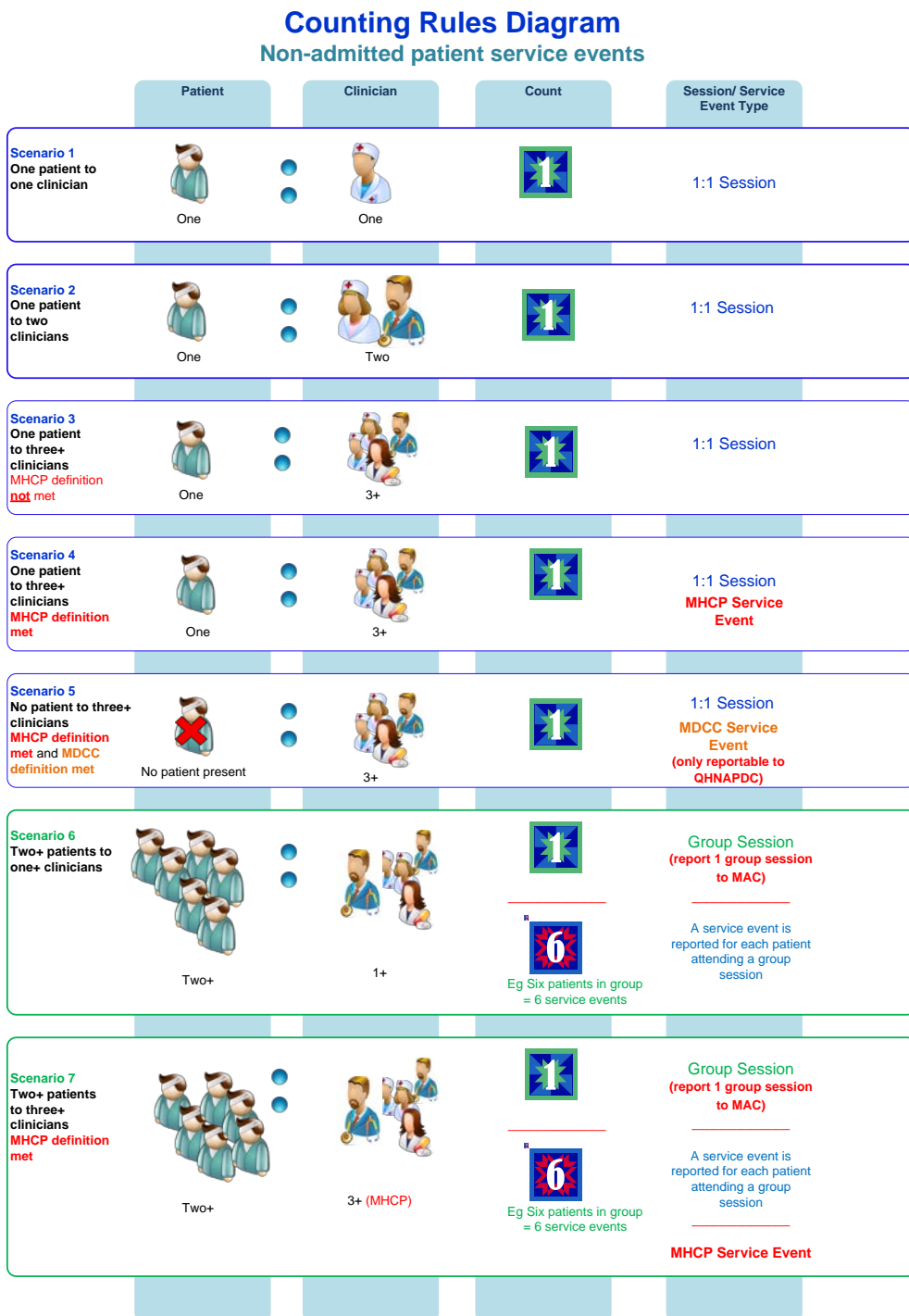
The general counting rules of the Compendium state that for ABF reporting purposes:

- Regardless of the number of health care providers involved, a non-admitted patient service event must be counted once only.
- **Only one** non-admitted patient service event may be counted for a patient at a clinic on a given calendar day.

This is referred to as the IHPA bundling rule where multiple public service events for the same patient, same day, same Tier 2 are only reported as one service event for reporting to the IHPA.

For the MAC data to be the single source for multiple reporting needs, and be compliant with both the mandated requirements of the NAPC HA NMDS and IHPA's counting rules, the Healthcare Purchasing and Funding Branch (HPFB) requested that HHSs also identify the number of 'public' service events to be excluded (from the total number reported) on the MAC 'IHPAEX' Form.

2.1.4 Counting Rules - Diagram



2.1.5 Classifications

Outpatient service events

Tier 2 clinic classifications

The [Tier 2 Non-Admitted Services Definitions Manual](#) (hereafter referred to as the 'Tier 2 Manual' or 'Tier 2') defines the clinic classifications (classes) required for reporting non-admitted services.

IHPA has also published the following two documents and recommends that these along with the Tier 2 Manual and the data set specifications above should be used collectively.

- [Tier 2 Non-admitted services compendium](#) (hereafter referred to as the 'Tier 2 Compendium') – this document provides details on the counting and classification rules associated with the Tier 2 non-admitted services classification as well as business rules and scenarios to assist users to consistently classify activity, and
- [Tier 2 Non-admitted services national index](#) (hereafter referred to as the 'Tier 2 Index') - this index assists users of the Tier 2 classification to allocate local clinics to a Tier 2 class in a consistent manner.

Note: IHPA publications must be referenced in conjunction with the Department of Health's HPFB resources and this manual as in some cases, local reporting rules and requirements take precedence over these national guidelines. Please contact the HPFB, Healthcare Purchasing & System Performance Division for further assistance.

Primary and Community Health (PCH) service events

Service type classifications and counting rules

PCHSEs are classified according to the following service types:

Primary and Community Health Service Catalogue for MAC Reporting

Service Type	Definition	Service
Care Co-ordination	Community services that involve coordination of other services to achieve the optimal outcomes for a non-admitted client (where the PCHSE definition is met).	Community Hospital Interface Program (CHIP) or similar community based co-ordination services if not for an ABF service. If CHIP is used for hospital avoidance this should be reported in the valid Tier 2 clinic code 40.58 Hospital Avoidance Programs.
		Liaison services including indigenous liaison officers
Child & Youth	Community services provided principally for an infant, child or a young person under 18 years of age. Whilst the service may be provided to a parent or guardian the focus is on supporting the health or development of the child or young person. Includes child protection services. Excludes oral health and community mental health services because activity for these services is collected in other systems (e.g. CIMHA).	Community Clinic Services
		Child/Infant development assessment and treatment
		Hearing Screening
		Child Protection Services
		Parenting support programs
Chronic Disease	Community services provided to identify and manage an illness or medical condition that lasts over a long period (e.g. more than 12 months) and sometimes causes a long-term change in the body.	School based health nurses
		Type 2 diabetes services, pulmonary services, cardiac services, renal services

Primary and Community Health Service Catalogue for MAC Reporting

Service Type	Definition	Service
Communicable Diseases	Community based surveillance and treatment of communicable and infectious diseases, including immunisations. Excludes sexually transmitted diseases (see Sexual Health) and Staff vaccinations.	Includes immunisations relevant for this service as well as activity pertaining to general communicable or infectious disease prevention, detection and response.
Community Palliative Care	Community palliative care services provided in the community or a patient's home. Includes care services purchased through non-government providers and equipment hire.	Includes heart failure.
Community Rehabilitation	Community based rehabilitation services for children and/or adults provided in a community setting (i.e. patients home or community centre), usually, but not always, following a hospital event. Includes care services purchased through non-government providers and equipment hire.	<p>Cardiac Rehabilitation</p> <hr/> <p>Pulmonary Rehabilitation</p> <hr/> <p>Acquired Brain Injury Rehabilitation</p> <hr/> <p>Spinal Injury Rehabilitation</p>
Maternal Health	Community based pre-natal and post-natal services provided to women/parents.	Antenatal and Postnatal Care (including postnatal contact/visits delivered under specific initiatives and government commitments). Excludes parenting support programs (see Child and Youth community health service type).

Primary and Community Health Service Catalogue for MAC Reporting

Service Type	Definition	Service
Offender Health Services	Health services provided to offenders/prisoners under the supervision of Queensland Corrective Services.	All community health services provided to offenders/prisoners fall into this category. Activity recorded could pertain to a range of service types across the community health service catalogue but the client/patient is an offender/prisoner.
Primary Health Care	GP type services provided in the community, including services to Medicare ineligible clients. (Includes services provided to indigenous persons/communities).	Refugee Health Primary Care Clinics (out of scope Tier 2 clinics)
Sexual Health	Services provided in the community to provide testing, support, education and advice for sexual health including transmission of sexually transmitted diseases and management and referral for sexual assault.	Sexual Assault Services Complex STIs Post Exposure Prophylaxis for HIV Testing, referral and counselling for sexual health
Women's and Men's Health	Community health services targeted to women or men for specific gender related health issues.	Family Planning Advice concerning breast health, gynaecological care, female genital mutilation and gynaecological oncology. Specific services may include early pregnancy clinic, fertility and reproductive endocrinology, urogynaecology sexual health and menopausal health. Excludes diagnostic screening.

Primary and Community Health Service Catalogue for MAC Reporting

Service Type	Definition	Service
		Advice concerning vasectomy, male infertility, penile and testicular problems, sexual function and dysfunction, sexual health and the prostate. Excludes diagnostic screening.

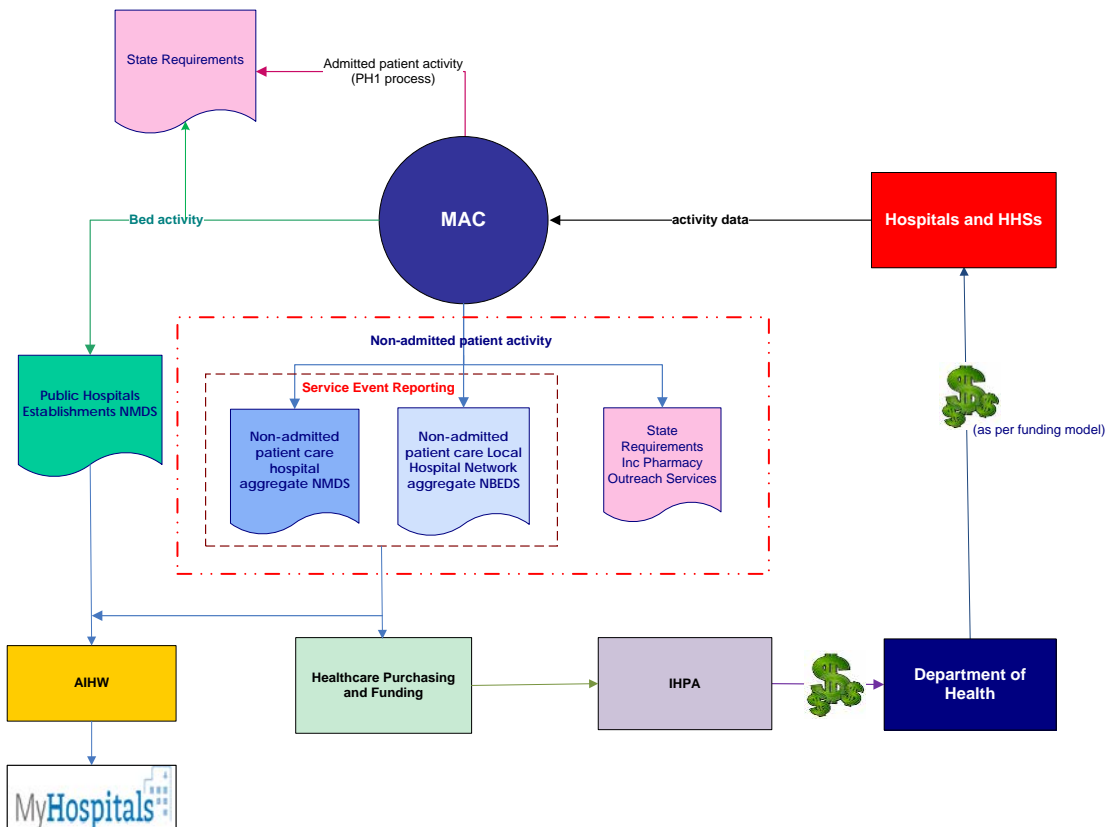
The counting rules for PCHSEs are as follows:

- 'client' is defined as the principal individual to whom therapeutic/clinical content is directed by a healthcare provider(s). Where carers and/or family members are also present during the interaction, only one PCHSE per client may be counted.
- one PCHSE is recorded for each interaction with a client, regardless of the number of healthcare providers present. Note: The reporting of multiple health care provider type activity is not required for PCHSE activity.
- services delivered via telehealth or telephone are included if they meet the definition of a PCHSE. Telehealth PCHSEs are reported by both the provider and receiver.
- one PCHSE is recorded for each client who attends a group session, regardless of the number of healthcare providers present. There is no requirement to separate these session types nor report the number of group sessions. For example, if five clients attended a group session, this would be reported as five PCHSEs.

Clinic Mapping Table

The [mapping table](#) provides mappings between MAC Clinic Types, IHPA's Tier 2 Clinic Classes and Corporate Clinic Codes for statistical reporting purposes.

2.2 MAC data flow diagram



2.3 Patient-level reporting - QHNAPDC

The Queensland Health Non-admitted Patient Data Collection (QHNAPDC) collects non-admitted patient data at the patient-level. SSB provides this data to the HPFB to report this data to IHPA. Refer to QHNAPDC manual for further details of this data collection.

2.3.1 MAC vs QHNAPDC Scope

MAC vs QHNAPDC Scope			
	Source of Funds	Report in MAC?	Report in QHNAPDC?
	Queensland Health (HHS Service Agreement)	Yes	Yes
	Queensland Health (Other Source)	Yes	Yes
	Commonwealth Grants Direct	No	Yes

2.4 Non-admitted patient activity (emergency service care)

Scope statement

The statistical unit is [emergency department stay](#) and is defined as *The period between when a patient presents at an emergency service and when that person is recorded as having physically departed the emergency service.*⁸

The activity that is in scope to be reported to the MAC for non-admitted patients (emergency service care) is activity that is performed by a hospital's emergency services which do not use the Emergency Department Information System (EDIS).

This activity is further defined as 'the care provided to patients in emergency services is, in most instances, recognised as being provided to non-admitted patients. Patients being treated in emergency services may subsequently become admitted. All patients remain in-scope for this collection until they are recorded as having physically departed the emergency service, regardless of whether they have been admitted.'

⁸ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 24/05/2018.

<<http://meteor.aihw.gov.au/content/index.phtml/itemId/646336>>

The scope also includes services where patients did not wait to be attended by a health-care professional; those dead on arrival; mental health-care provided in emergency services and patients with a Department of Veterans' Affairs or compensable funding source. Patient presentations that result in a referral to a GP co-located unit after registration, but before commencement of clinical care, are in scope.

Excluded from the scope are:

- *Care provided to patients in General Practitioner co-located units.*⁹

Reporting mandates

The Department of Health must provide hospital emergency services activity data as specified through the following two data set specifications:

- [Non-admitted patient emergency department care NMDS 2018-19](#) (patient-level), and
- [Activity based funding: Emergency service care NBEDS 2018-19](#) (aggregate-level) (ABF ESC NBEDS)

Data are reported to the relevant data set specification according to IHPA categorisation criteria for the hospital's emergency service.

Hospitals with emergency departments categorised as Levels 3B to 6 must comply with the [Non-admitted patient emergency department care NMDS 2018-19](#) (patient-level) with the data source being the EDIS data repository managed by HIU.

Hospitals with emergency services categorised as 1 to 3A must comply with the ABF ESC NBEDS. Hospitals in this category which do not have the corporate electronic system/s to record emergency service activity (eg EDIS) are mandated to provide emergency services activity data by completing the MACONES form in MAC Online.

Refer to IHPA's [Three Year Data Plan 2018-19 to 2020-21](#) for more information.

⁹ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 24/05/2018.
<<http://meteor.aihw.gov.au/content/index.phtml/itemId/676248>>

3. Admitted patient activity data

3.1 Admission, separations and classification changes

A summary of patient admissions, separations and classification changes must be provided to SCIU on the 4th of each month for the previous month. Data are mostly provided by automatic extract (from HBCIS) via the Monthly Activity Report (MAR). Following receipt, the data is loaded automatically into a PH1 form in MAC Online to be compatible with the MAC reporting processes. This summary data allows this admitted patient activity to be reported following the end of the reference month as the admitted patient-level data for the Queensland Hospital Admitted Patient Data Collection (QHAPDC) is not due until 35 days following the end of the reference month.

Once the patient-level data are submitted to the QHAPDC, it is reconciled to the summary-level admitted patient data on the PH1 (the total number of separated episodes of care along with the separation mode). The total number of separations and their respective modes reported to each data collection should equal.

Residential mental health care admissions (RMHC), separations and classification changes are also provided to SCIU on the 4th of each month for the previous month via the MAR. Data for RMHC facilities is loaded into the PH2 MAC Online form. For further details see section [4.3 Residential Mental Health Care services](#).

3.1.1 Scope statement

All public hospitals and public psychiatric hospitals in Queensland must provide this summary data (PH1).

RMHC services must also provide this summary data on the PH2 report. See section [4.3 Residential Mental Health Care services](#).

3.1.2 Reporting mandate

Data must be reported to SCIU by the 4th of each month for the previous reference month.

There are also State requirements for reporting the summary-level admitted patient data.

3.2 Bed Availability

Department of Health must have accurate data on the number of beds available in Queensland's public hospitals as well as RMHC facilities.

Bed availability is a key performance indicator for Department of Health as it represents a measure which is easily interpreted by the public.

3.2.1 Reporting mandate

There are Commonwealth requirements for reporting on the number of beds available in Queensland's public hospitals and State requirements for reporting on the number of beds available in Queensland's public hospitals and RMHC facilities.

Commonwealth Government Reporting Requirements

Department of Health (Commonwealth)

Under the National Healthcare Agreement, Queensland is required to supply the Commonwealth's Department of Health (DoH) with hospital activity data on Queensland's public health system.

Australian Institute of Health and Welfare (AIHW)

As a signatory to the National Health Information Agreement, Queensland is required to provide hospital activity data to the AIHW according to agreed National Minimum Data Sets (NMDSs).

To comply with these reporting obligations, data reported to the MAC for bed availability is used to meet the [Public hospital establishments NMDS 2017-18](#) (PHE NMDS)

4. Residential patient activity data

4.1 Multi-Purpose Health Services

Department of Health must have accurate data on Multi-Purpose Health Services to acknowledge the activity provided to non-admitted residents by a hospital or health service.

Scope statement

All Queensland public hospitals which provide a Multi-Purpose Health Service program.

Reporting mandate

Reporting of this activity is a State requirement.

Refer to section Multi-Purpose Health Service Form (MTHACMP1) for more information.

4.2 Nursing Homes

Department of Health must have accurate data on public nursing homes/hostels/independent living services to acknowledge the activity provided to non-admitted residents by a hospital or health service.

Scope statement

Public nursing homes/hostels/independent living services

Reporting mandate

Reporting of this activity is a state requirement.

Refer to Public Nursing Homes/Hostels/Independent Living Units Form (MTHACNH2) for more information.

4.3 Residential Mental Health Care services

The Mental Health Alcohol and Other Drugs Branch, Department of Health must have accurate data on Residential Mental Health Care facilities to acknowledge the activity provided to consumers of these mental health care services.

Scope statement

Residential mental health care facilities including Mental Health Community Care Units (CCUs) and Step Up Step down Units (SUSDU) inclusive of Prevention and Recovery Care (PARC) services.

Reporting mandate

There are Commonwealth requirements for reporting on the number of beds available in Queensland's public RMHC facilities and State requirements for reporting on the number of beds available in Queensland's public RMHC facilities. Refer to [10.4.3 Residential Mental Health Care \(RMHC\) Services](#)

Admission, separations and classification changes

These changes are required to be reported using the PH2 report. See 10.4.3 Residential Mental Health Care (RMHC) Services.

Bed availability

Bed activity is required to be reported on the MHBED report. See 10.4.3 Residential Mental Health Care (RMHC) Services.

5. Method of data collection

5.1 MAC forms

Queensland public hospitals, HHSs and the State (reporting entities) report their monthly activity data to SCIU each month (including the hospitals of the Mater Health Services) by completing relevant MAC form templates (MS Excel spread sheets). The MAC form types and the type of monthly activity data to be reported by these form types for each reporting entity are:

Outpatient service event forms

Reporting Entity Type	MAC Form Type	Type of Monthly Activity Data to Report
<ul style="list-style-type: none"> Hospital – public acute¹⁰ HHS State 	CLINIC (MACONCLNC)	<ul style="list-style-type: none"> one-to-one service events for consultation clinic types by medical officer and other health professional provider types.
<ul style="list-style-type: none"> Hospital – public acute HHS State 	DIAGNOSTIC & PROCEDURES (MACONDGPR)	<ul style="list-style-type: none"> one-to-one service events for procedure and diagnostic clinic types by medical officer and other health professional provider types and patient census data for home delivered procedure clinic types (home dialysis, nutrition and ventilation) and multiple health care provider service events for an agreed list of specific clinic types by medical officer and other health professional provider types and one to one and group Primary and Community Health Service Events by medical officer and other health professional provider types (HHS reporting only) and occasions of service for Pharmacy and Other Outreach Services clinic types.

¹⁰ Includes declared public hospitals as well as private hospitals that provide public health services under contractual arrangements with Department of Health.

Reporting Entity Type	MAC Form Type	Type of Monthly Activity Data to Report
<ul style="list-style-type: none"> Hospital – public acute HHS State 	<p>GROUP (MACONGRPS)</p>	<ul style="list-style-type: none"> group session service events (patients) and numbers of group sessions by clinic type by medical officer and other health professional provider types and group session multiple health care provider service events for an agreed list of specific clinic types by medical officer and other health professional provider types.
<ul style="list-style-type: none"> Hospital – public acute HHS State 	<p>TELEHEALTH (MACONTELP and MACONTELR)</p>	<ul style="list-style-type: none"> one-to-one service events for consultation and some procedure clinic types by medical officer and other health professional provider types which are provided by (MACONTELP) or received by (MACONTELR) telehealth. multiple health care provider service events for an agreed list of specific clinic types by medical officer and other health professional provider types which are provided by (MACONTELP) or received by (MACONTELR) telehealth. ‘Store and Forward’ image assessments for specific clinic types (MACONTELP).
<ul style="list-style-type: none"> Hospital – public acute HHS State 	<p>TELEHEALTH GROUPS (MACONGTLP and MACONGTLR)</p>	<ul style="list-style-type: none"> group session service events (patients) and numbers of group sessions by clinic type by medical officer and other health professional provider types and group session multiple health care provider service events for an agreed list of specific clinic types by medical officer and other health professional provider types which are provided by (MACONGTLP) or received by (MACONGTLR) telehealth.
<ul style="list-style-type: none"> Hospital – public acute HHS State 	<p>IHPA Exclusion (IHPAEX)</p>	<ul style="list-style-type: none"> one-to-one and group session service events to be excluded from IHPA reporting by clinic type by medical officer and other health professional provider types

Reporting Entity Type	MAC Form Type	Type of Monthly Activity Data to Report
• Hospital – public acute	PATHOLOGY (MTACPATH)	• pathology service events (Non-AUSLAB facilities only). See Exceptions below.

Non-admitted patient activity (emergency service) forms

Reporting Entity Type	MAC Form Type	Type of Monthly Activity Data to Report
• Hospital – public acute	EMERGENCY SERVICES (MACONES)	• emergency service stays (non EDIS sites) by 'Type of Visit' and 'Episode End Status/Triage category#'.

Admitted patient forms

Reporting Entity Type	MAC Form Type	Type of Monthly Activity Data to Report
Hospital – public acute and psychiatric	BED (BED)	• the number of available beds and available bed alternatives for admitted patients.
Hospital – public acute and psychiatric	PH1 (MTHACPH1)	• patient admissions, separations, and classification changes. See Exceptions below.

Residential patient* forms

Reporting Entity Type	MAC Form Type	Type of Monthly Activity Data to Report
Nursing homes, hostels, independent living units	NH2 (MTHACNH2)	<ul style="list-style-type: none"> resident admissions**, separations***, non-admitted patient service events and allocation of places.
Multi-Purpose Health Services	MP1 (MTHACMP1)	<ul style="list-style-type: none"> patient admissions**, separations*** and bed availability.
Residential Mental Health Care Facilities	MHBED (MHBED)	<ul style="list-style-type: none"> the number of available beds for residential mental health care consumers.
	PH2 (MTHACPH2)	<ul style="list-style-type: none"> consumer admissions**, separations***, and classification changes.

*patient – the term patient, resident and consumer are used according to the type of residential service provided.

**admissions – whilst residents/ patients/ consumers are not 'admitted' to the facility, the term 'admissions' in relation to residential care should be interpreted as 'commencement of care'.

***separations - whilst residents/ patients/ consumers are not 'separated' from the facility, the term 'separations' in relation to residential care should be interpreted as 'cessation of care'.

Once the MAC form is populated with the monthly activity data, it can then be uploaded to the MAC Online application where the data are validated (refer to the [MAC Online User Manual](#)) and submitted to SCIU.

Exceptions

There are two exceptions where monthly activity that is required to be reported to the MAC is not provided on a MAC form by a reporting entity. In these cases, data are provided from either a service provider or an automatic extract generated from a hospital system. These are:

- pathology service events. See [Pathology form \(MTACPATH\)](#) for more information.
- admitted patient separations. See [PH1 Form \(MTHACPH1\)](#) for more information.
- residential mental health care patient separations***. See [PH2 Form \(MTHACPH2\)](#) for more information

New/ updated versions of MAC forms

Generally, each financial year, MAC reporting requirements change. Changes are usually due to the mandated reporting requirements of the Commonwealth Government, however can also be requested by the State and business areas of the Department of Health. Reporting entities are notified as early as possible prior to the new financial year of the updated requirements through HPFB communication as well as forums, this manual and supporting information sessions and the IHPA 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 SSB.

5.2 MAC Online

MAC Online is a web based application developed by SSB, to enable a reporting entity to report monthly activity data on the required MAC form template, validate data entered and then upload the template to SSB.

Data validation

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).

Reporting entities must respond to validation exceptions with relevant and meaningful comments which detail the reason/s for the validation exception.

Comments provided in all MAC forms are retained within SSB databases and are utilised to respond to queries raised by various business areas in the Department of Health, the Minister and senior executive and also the Commonwealth Government. Therefore, it is very important that the comments provided clearly state the reasons for the variations.

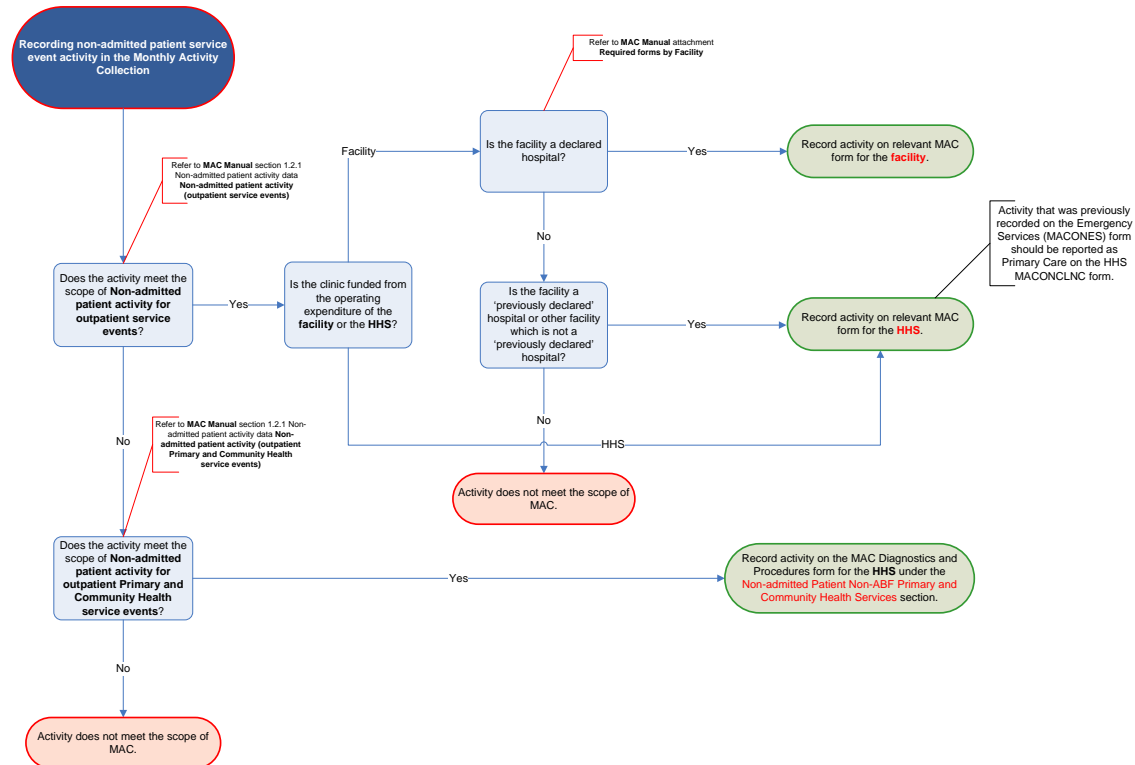
SCIU undertake a data quality process to ensure comments provided are relevant and sufficient. In the cases where comments provided do not clearly state the reasons for the variations, reporting entities will be requested to update the comment entered.

Reporting entities may also be contacted by SSB seeking additional information on data anomalies that appear following time series trend analysis or any other official enquiry where additional information is required.

Refer to the [MAC Online User Manual](#) for information on this application.

6. Reporting, timeframes, and data flow

6.1 Reporting Decision Tree (outpatient service events)



6.2 MAC monthly & quarterly reporting timeframes

All final (approved) versions of MAC reports must be submitted to SCIU by the 14th day¹¹ following the reference month (eg for the reference month of September, MAC reports must be submitted by 14th of October).

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

The Department of Health must provide non-admitted (aggregate-level) data to the IHPA as mandated in IHPA's [Three Year Data Plan 2018-19 to 2020-21](#). For 2018-19, this data is required to be reported on a quarterly basis in a submission containing data for each of the quarters elapsed in the year.

¹¹ Preliminary PH1 and PH2 (where relevant) reports are due on the 4th day of each month following the reference month. For most hospitals using HBCIS, these forms are generated and sent automatically using the 'Report Monitor' functionality. A final version is required on the 14th which should contain any amendments to the preliminary version.

Refer to the table below for 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	

*final submission due 30 August 2019

6.3 Chief Executive, HHS approval

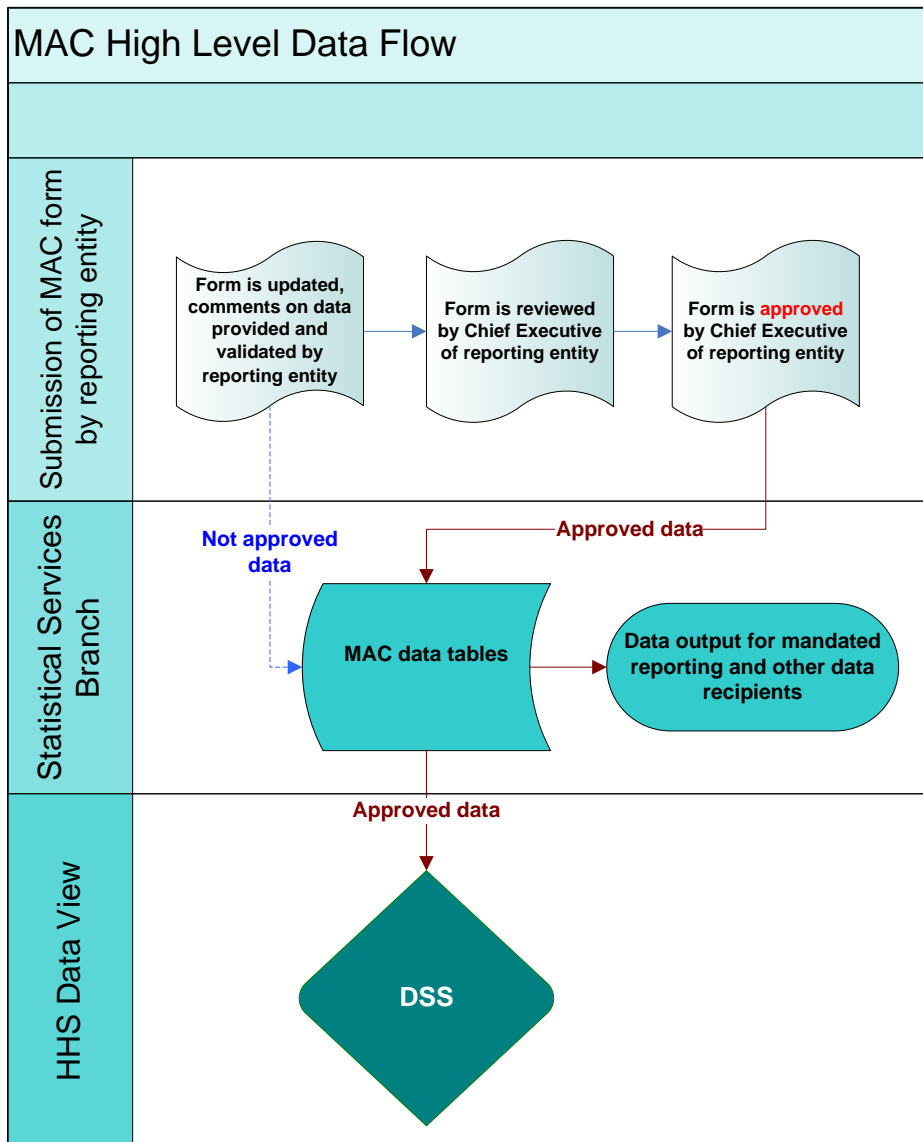
As MAC data are used to substantiate funding and purchasing allocations, Chief Executives (or their delegates) must approve the MAC SE forms (Clinic, Group Sessions, Diagnostics and Procedures, Telehealth, Telehealth Group Sessions and IHPA Exclusions) as well as the Emergency Service and Bed forms.

Refer to the [MAC Online User Manual](#) to set-up the HHS CEO user access level to enable the Chief Executive (CE) to approve the above mentioned MAC reports.

HHS CEs must request to update 'finalised' quarterly MAC data in writing to the Healthcare Purchasing and Funding Branch, Healthcare Purchasing and System Performance, Department of Health.

Only once this approval is obtained and provided to SSB by the facility, can the period be unlocked for MAC forms to be changed.

6.4 MAC form work flow



For a more detailed flow of MAC forms and processing statutes please refer to the [MAC Online User Manual](#).

6.5 Availability of MAC data in Decision Support System (DSS)

MAC forms submitted with non-admitted activity must have an 'Approved' status for the purposes of providing activity data for Weighted Activity Unit (WAU) reporting in DSS¹².

An 'approved' status is provided by HHS CE (or their nominated delegate) 'sign-off' in the MAC Online application. If MAC forms do not have an 'approved' status (prior to SSB's scheduled weekend processing), activity will not be reported.

¹² As per the Memorandum to HHS CEs dated 13th March 2013 from Executive Director, Healthcare Purchasing, Funding and Performance Management Branch.

This includes data in forms that may have been previously approved but then updated after the monthly deadline. If prior month forms require updating, it is recommended that sites ensure approvals can be processed within the week (and the form/s are returned to a status of 'approved') prior to the weekend processing cut off. If forms remain in status of 'draft', 'validated' or 'submitted' at the end of the week no data will appear in DSS for that month until the next weekend processing occurs. To support the management of MAC form status, HHSs are able check the status of the MAC forms in DSS in the 'MAC Forms' folder. This report is updated in line with the SSB's weekend processing of data each Sunday, otherwise for real-time status of forms, registered MAC Online users can continue to monitor it in the MAC Online application.

6.6 NIL activity report

Reporting entities that record no activity during the month are still required to submit the required MAC forms. The cells in which activity is recorded on the form must be left blank. Refer to the [MAC Online User Manual](#) for information on the supply of 'Nil Data'.

6.7 Provision of estimates

Estimated data should only be provided when significant events such as major computer system failure, industrial action, and natural disasters prevent the availability of data. Any data that is an estimate must be denoted as such in the submitted data (using MAC Online global comments section – see [MAC Online User Manual](#)) and updated with actual data by the date the next reference month is due.

6.8 Reporting Entities and Form Requirements

MAC Reporting Entities and Form Requirements

Reporting requirements of 'previously declared' public health facilities

Effective 1 July 2014, 62 Queensland public health facilities (47 public hospitals and the 15 primary health centres which make up the then Island Medical Services) were removed from the Commonwealth's declared hospital list.

At the time, as only declared public hospitals are required to report to MAC, SSB were requested by the then System Policy and Performance Division to continue to maintain existing MAC reporting arrangements for these previously declared facilities for a period of one year.

At the end of this one year period, from 1 July 2015, MAC reporting requirements for these previously declared hospitals then changed.

There was no longer the requirement to submit the following activity:

- summary level admitted patient activity (PH1 form (MTHACPH1))
- available beds and available bed alternatives (BED form (BA))

There was no longer the requirement to report the following activity at the **facility** level:

- non-admitted patient activity (outpatient service events)

no submissions of **facility** level MAC forms (Clinic (MACONCLNC), Diagnostics and Procedures (MACONDGPR), Groups (MACONGRPS), Telehealth (MACONTELP, MACONTELR, MACONGTLP, MACONGTLR) and Pathology forms (MTACPATH) were required.

- emergency service episodes

no submissions of ES forms (MACONES)) were required.

However, this activity must be reported at the **HHS** level as follows:

- non-admitted patient activity (outpatient service events)

submissions of HHS MAC forms (Clinic (MACONCLNC), Diagnostics and Procedures (MACONDGPR), Groups form (MACONGRPS), Telehealth (MACONTELP, MACONTELR, MACONGTLP, MACONGTLR) and Pathology forms (MTACPATH) are required.

The activity from each of the previously declared facilities as well as other activity that is in scope for HHS reporting is to be aggregated and reported on the relevant **HHS** MAC form.

Example

Scenario: An amputee rehabilitation clinic is provided by Chillagoe Hospital (a previously declared hospital), which is within the Cairns and Hinterland Hospital and Health Service. The activity of this clinic meets the scope of 'non-admitted patient activity (outpatient service events)', is provided by a physiotherapist as face to face, 1:1 service event and the clinic maps to the MAC clinic type of Physiotherapy.

To report this activity:

Record on the Cairns and Hinterland HHS form under the MAC clinic type of physiotherapy on the 'Service Events Delivered' side of the form under the 'Other Health Provider' section and the relevant compensable category. This activity must be aggregated with the other physiotherapy activity that is provided by any other previously declared hospitals in the HHS as well as any other physiotherapy activity that meets the scope of HHS reporting.

- emergency service episodes – to be reported as the MAC clinic type of 'Primary Care' by relevant provider type on the Clinic form (MACONCLNC).

Refer to the following documents for supporting information:

- List of Previously Declared Hospitals (provided at the end of [Required forms by Facility 2018-19](#))
- 'Recording non-admitted patient service event activity in the MAC'. Refer to Reporting Decision Tree [6.1](#) Reporting Decision Tree

7. MAC changes for 2018-19

Each financial year, reporting requirements change. Changes are mandated by the Commonwealth and State governments and can also be required by business areas of the Department of Health to meet their obligations. To accommodate changes to the collection of data to support new reporting requirements, a number of tasks are required to be undertaken which may include new/ amended data items, changes to source systems, amendment of reference files within source systems, updates to MAC templates and modification to the MAC Manual.

7.1 Changes to service event reporting

7.1.1 Clinic type classifications (Tier 2 clinic classes)

New IHPA Tier 2 clinic classes (for Queensland Health use only) for reporting Multidisciplinary Case Conferences (MDCCs)

This information is provided only to acknowledge the introduction of these two new clinic classes. **MDCCs are not to be reported at the aggregate-level to the MAC.** MDCCs are only reportable at the patient-level to the QHNAPDC and these two new clinic classes are only used by Queensland Health to report this activity to IHPA.

7.1.2 New Corporate Clinic Code

New CCC 377 *Interventional Radiology- consultation*

A new CCC 377 *Interventional Radiology - consultation* will be introduced from 01 July 2018 to report consultations occurring before and/or after an *Interventional Imaging procedure* (CCC 512/ Tier 2 10.02) provided only by the Medical Officer provider type 20008198 MO-Spec-Diagnostic Radiology.

This clinic type has been added to the **Clinic, Group, IHPAEx and Telehealth suite** of service event forms to report this activity.

7.1.3 Change to 'other' service type reporting

New Telehealth Store and Forward Image Assessment clinic type

An additional MAC clinic type of *Breast* has been introduced and added to the **Telehealth Provider form** to report [Telehealth Store and Forward Image Assessment](#) activity.

7.1.4 Addition of clinic type to list of MHCP clinic types

Addition of CCC 512 - *Procedure - Interventional Imaging* to be added as an MHCP clinic type

The clinic type of CCC 512 - *Procedure - Interventional Imaging* will be added to the static list of Multiple Healthcare Provider (MHCP) clinic types on the **Diagnostics and Procedures form**.

7.2 Changes to Residential mental health service reporting

From 1 July 2017, Mental Health Community Care Units (MHCCU) were classified as independent residential mental health care (RMHC) facilities. Previously, MHCCUs were remote wards of public hospitals.

From this date, the admissions/ classifications/ separations and bed activity for MHCCUs were out of scope of public hospital activity reporting and were required to be reported as RMHC service activity.

To support this change, two new MAC form types were introduced during 2017-18:

- the *Residential Mental Health Care* PH2 form to separately report the not admitted residential mental health care admissions/ classifications/ separations of the RMHC service **for care type of mental health only** as well as;
- the new *Residential Mental Health Care Bed* form (MHBED) to report the associated bed-based not-admitted activity.

From 01 July 2018, residential mental health care services have expanded to include *Step Up Step Down Units* following a review of their classification by the Mental Health Alcohol and Other Drugs Branch. The admissions/ classifications/ separations and bed activity for these RMHC services are also required to be reported on the PH2 and MHBED forms, along with this activity of the MHCCUs.

7.2.1 RMHC service admission, separations and classification changes (**care type Mental Health only**) (PH2)

Admission, separations and classification changes **for care type of mental health only**

These changes are required to be reported using the PH2 report. See [10.4.3 Residential Mental Health Care \(RMHC\) Services](#).

7.2.2 RMHC services bed reporting (MHBED)

Bed availability

Bed activity is required to be reported on the MHBED report. See [10.4.3 Residential Mental Health Care \(RMHC\) Services](#).

8. MAC form changes

8.1 Column/ row changes

8.1.1 Column changes

There are no column changes to MAC forms.

8.1.2 Row changes

Service event forms

See *Section 6.1 Changes to service event reporting*.

PH1 and PH2 forms

The following new Standard Unit Codes have been introduced from 01 July 2018. The HBCIS MAR report (usually generated automatically on the 4th of each month to report summary counts of admitted patient separations to the MAC) will be updated with these new codes for reporting accrued patient days to the Statistical Services Branch using the PH1/ PH2 form.

For hospital facilities only (PH1):

- Standard Unit Code PYAM – Mental Health Mothers and Babies

For residential mental health care services only (PH2):

- Standard Unit Code PYSA –Psychiatric Adult – Step Up Step Down
- Standard Unit Code PYSO –Psychiatric Adolescent – Step Up Step Down
- Standard Unit Code PYSY –Psychiatric Young Persons (Youth) – Step Up Step Down
- Standard Unit Code PYRY –Psychiatric Young Persons (Youth) – Youth Residential

9. MAC Definitions

9.1 Definitions of data items for non-admitted patient forms

[Definitions of general terms](#) provide definitions of the terms that underpin the collection of non-admitted patient data across all of the non-admitted patient MAC forms. Refer to MAC Forms for definitions that are unique to each form.

9.1.1 Definitions of general terms

[Non-admitted patient](#)¹³

A patient who does not undergo a hospital's formal admission process.

There are three categories of non-admitted patient:

- emergency department patient
- outpatient
- other non-admitted patient (treated by hospital employees off the hospital site - includes community / outreach services).

1:1 (One to One) session

Where one non-admitted patient received services by staff of the facility.

¹³ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 05 June 2017

<http://meteor.aihw.gov.au/content/index.phtml/itemId/268973>>

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.

Funding Split Hierarchy

A cost centre designation maintained by HHS's to facilitate analysis and reporting of expenditure by funding sources in the NECTO Decision Support System.

9.1.2 Definitions relating to non-admitted patients (outpatients)

Non-admitted patient service event¹⁴

An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

Service events are counting unit defined and specified for reporting non-admitted outpatient activity nationally for NMDS and NBEDSs.

Occasions of Service (OOS)

Although the counting unit Occasions of Service (OOS) was superseded from 30 June 2014, there are services that are provided by some hospitals which fall outside of the definition of a 'service event' as they do not provide clinical care. These services include 'Other Outreach Services' (eg home cleaning, meals on wheels or home maintenance) and 'Pharmacy' occasions of service.

Whilst these services are no longer required to be reported nationally, there is a requirement to report these services for state purposes to acknowledge the activity performed in the wider representation of the services provided by a hospital.

To continue to report this information, the term *occasion of service* will still apply to these services and be reported to the MAC, providing the activity is operated and managed by the reporting entity and funded by the reporting entity.

Other Outreach Services

Occasions of service to non-admitted patients, which involve travel by the service provider.

Travel does not include movement within a facility, movement between sites in a multi-campus facility, or between facilities.

It is intended that the 'Other Outreach Services' classification include activities such as home cleaning, meals on wheels and home maintenance.

¹⁴ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 08/06/2018.

<<http://meteor.aihw.gov.au/content/index.phtml/itemId/583996>>

Provider Type

The type of health professional that provides a service event to a non-admitted patient in an outpatient clinic.

Service Events Delivered

Non-admitted patient service events delivered by a hospital or a HHS to patients who are Eligible Public – Third Party compensable, Eligible Public, MBS Ineligible, Private (MBS and non MBS) and non-admitted patient service events for patients who are receiving treatment under contracted arrangements.

Service Events Contracted Out

Non-admitted patient service events contracted out by a hospital, HHS or the State (Department of Health).

Examples

- There is no Dermatologist working within the facilities of a HHS and a number of patients across the HHS require this service. To enable these public patients access to this clinical service, the HHS has contracted the care of these patients to a Dermatologist at the local private hospital. The non-admitted patient service events for these patients should be recorded against the relevant compensable/eligibility category on the 'Service Events Contracted Out' side of the MAC service event form.
- An example of a public authority (State) contracted service is the Department of Health's 'Surgery Connect' programme where a contracted arrangement is put in place between the Department of Health and private health care provider to deliver services for long wait patients of Queensland Health facilities.

9.1.3 Column definitions for SE forms

Columns of the SE forms (excluding IHPA Exclusion form)

The two tables below are the column titles of the MAC service event forms. On the forms, these two tables are joined (MACONGRPS is the exception as it has additional columns to capture the number of group sessions).

Table 1

1:1 SESSIONS																TOTAL No of Service Events (excluding Contracted Services and Private)
Service Events Delivered																
Eligible Public - Third Party									Contracted Services	Eligible Public	MBS Ineligible	Private				
Work Cover Qld	Work Cover Other	Motor Vehicle Qld	Motor Vehicle Other	Other Third Party	Other Comp.	Dept Veterans' Affairs	Dept of Defence	Correctional Facility	Delivered Under Contract	Other Public	19.2 RRMBS	Not Self Funded	Self Funded	MBS	Non MBS Not Self Funded	

Table 2

1:1 SESSIONS															
Service Events Contracted Out															
Eligible Public - Third Party									Eligible Public	MBS Ineligible	Private				
Work Cover Qld	Work Cover Other	Motor Vehicle Qld	Motor Vehicle Other	Other Third Party	Other Comp.	Dept Veterans' Affairs	Dept of Defence	Correctional Facility	Other Public	19.2 RRMBS	Not Self Funded	Self Funded	MBS	Non MBS Not Self Funded	Non MBS Self Funded

Columns of the IHPA Exclusion form

1:1 Session Service Events											Group Session Service Events									
IHPA Exclusion																				
Eligible Public																				
CLINIC - Other Public Delivered	CLINIC - Other Public Contracted Out	CLINIC - G20	DGPR - Other Public Delivered	DGPR - Other Public Contracted Out	DGPR - G20	Telehealth Provider - Other Public Delivered	Telehealth Provider - Other Public Contracted Out	Telehealth Provider - G20	Telehealth Receiver - Other Public Delivered	Telehealth Receiver - Other Public Contracted Out	Telehealth Receiver - G20	GROUP - Other Public Delivered	GROUP - Other Public Contracted Out	GROUP - G20	GROUP Telehealth Provider - Other Public Delivered	GROUP Telehealth Provider - Other Public Contracted Out	GROUP Telehealth Provider - G20	GROUP Telehealth Receiver - Other Public Delivered	GROUP Telehealth Receiver - Other Public Contracted Out	GROUP Telehealth Receiver - G20

Column definitions

Service Events Delivered

Refer to [Service Events Delivered](#) above.

Service Events Contracted Out

Refer to [Service Events Contracted Out](#) above.

Eligible Public

Eligible Public – Third Party (patients)

- **WorkCover Queensland**

Patients who are entitled to claim damages under the WorkCover Queensland Act.

- **WorkCover Other**

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

- **Eligible Motor Vehicle Queensland**

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**

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

Other Third Party

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

- **Other Compensable**

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.

- **Department of Veterans' Affairs**

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

- **Department of Defence**

Patients who identify as Department of Defence personnel.

- **Correctional Facility**

Patients from a correctional facility who have received a non-admitted service.

Eligible Public (patients)

An eligible public 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>

Other Public

Other Public patients are patients who:

- elect to be treated as a public patient with their treating doctor nominated by the hospital or
- are receiving treatment in a private hospital under a contracted arrangement with a public hospital or health authority
- are not 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).

19.2 RRMBS

19.2 RRMBS patients are patients who 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 COAG 19.2 patients under the Medicare Billing for Primary Care in Small Rural Hospitals arrangements.

Contracted Services

**Contracted
Services**

Delivered Under
Contract

Service events delivered under a contract.

MBS Ineligible

- **MBS Ineligible (Patients)**

Medicare ineligible patients for whom services cannot be billed to Medicare.

- **MBS Ineligible Not Self Funded**

A patient who is not eligible for Medicare and for whom services are not paid for by themselves, their family or friends, or by other benefactors. This could include patients who are overseas visitors for whom travel insurance is the major funding source.

- **MBS Ineligible Self Funded**

A patient who is not eligible for Medicare and for whom services are funded by themselves, their family or friends, or by other benefactors.

Private

- **Private (Patients)**

A private patient is a patient who elects to be treated by a doctor of their choice.

MBS

Private patients for whom services are billed to Medicare.

- **Non MBS Not Self Funded**

Private patients for whom services are not funded by the Medicare Benefits Scheme or by them themselves, their family or friends, or by other benefactors.

- **Non MBS Self Funded**

A private patient for whom services are funded by themselves, their family or friends, or by other benefactors.

9.1.4 Row definitions for SE forms

Appointment type - new patient/ review patient¹⁵

Whether a non-admitted patient service event is for a new problem not previously addressed at the same clinical service or for a clinical review.

New non-admitted patient service event

An initial service event for a patient at a given clinic (i.e. Corporate Clinic Code) for a condition. Excludes post-discharge review associated with an admitted patient episode.

Review non-admitted patient service event

Any subsequent service event in that given clinic (i.e. Corporate Clinic Code) required for the continuing management/treatment of that condition, up to the stage where the patient is discharged from that given clinic.

Includes post-discharge review associated with an admitted patient episode.

Where the patient requires ongoing review for the same condition at that given clinic after the referral has expired, an updated referral confirming the need for continued management (refer to Section 5.4 Appointment Management of the Implementation Standard, of the Outpatient Service Implementation Standard) is required and will NOT initiate a new course of treatment, and the next service event will be a REVIEW.

Clinic Types

A clinic type is 'the organisational unit or organisational arrangement through which a hospital provides a service to a non-admitted patient.'¹⁶

Refer to [Clinic classifications and counting rules](#) for more information.

Provider Type Medical Officer

Service events provided by medical officers, nurse practitioners and physician's assistants.

Provider Type Other Health Professional

Service events provided by non-medical officer health professionals eg nurses and allied health professionals.

Telephone Consultation

A [service event](#) delivered via the telephone can be included if it is a substitute for a face-to-face service event and the definition of a service event is met.

¹⁵ Queensland Government, Queensland Health, Queensland Health Data Dictionary. Retrieved 07/06/2018. <http://oascrasprod.co.health.qld.gov.au:7900/pls/crd_prd/f?p=103:7:::NO::P7_SEQ_ID:41907&cs=1D0B57B0A8A521B25F1870A58641F102E>

¹⁶ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 07/06/2018. <<http://meteor.aihw.gov.au/content/index.phtml/itemId/400596>>

9.2 Definitions of data items for admitted patient forms

Refer to [Admitted patient forms](#) for these definitions.

10. MAC Forms

10.1 Form Types for 2018-19

The MAC form types for reporting service events for non-admitted patient data for 2017-18 are:

- Clinic
- Diagnostics and Procedures
- Group Sessions
- Telehealth - Provider
- Telehealth - Recipient
- Telehealth Group Sessions - Provider
- Telehealth Group Sessions – Recipient

The MAC form type for reporting service events for non-admitted patient data to be excluded from IHPA reporting is:

- IHPA Exclusions

The MAC form type for reporting emergency department stays is:

- Emergency Services (non EDIS sites only – only public hospitals)

The MAC form type for Mater Health Services to report statewide urology services is:

- Urology (for Statewide Urology Outreach Service activity – Mater use only)

The MAC forms types for reporting bed availability and (summary-level) admitted patient separations are:

- BED
- PH1

The MAC forms for reporting residential mental health care facility bed availability and (summary-level) admitted patient admissions, separations and classification changes are:

- MHBED
- PH2

The MAC form types for reporting nursing home/ hostel/ independent living unit resident and multi-purpose health services resident data are:

- MP1
- NH2

10.2 Non-admitted patient service event forms

10.2.1 Clinic Form (MACONCLNC)

The Clinic form is used to report the total number of non-admitted patient service events for medical consultation clinic types that are delivered by a hospital, HHS or managed by the State (the reporting entity) or contracted out to another service provider. These service events are then reported by provider type (medical officer and other health professional), by clinic type (new, repeat or telephone) and also by the funding source of the patient.

Scope

The Clinic form must be completed by the three levels of the Queensland public hospitals system – the hospital, HHSs and at the State level. Refer to [MAC Reporting Entities and Form Requirements](#) for the forms required to be submitted by each reporting entity.

Form

[Clinic Form](#)

Definition/s unique to this form

Refer to [Definitions of data items for non-admitted patient forms](#) for the common data items collected on this form.

10.2.2 Group Sessions forms (MACONGRPS, MACONGTLP, MACONGTLR)

Group session clinics can be provided by one, two, many or ‘multiple health care providers’ by a hospital, HHS or managed by the State (reporting entity) or contracted out.

The ‘Group Sessions’, ‘Group Telehealth Provider’ and ‘Group Telehealth Recipient’ forms are used to report the two data items - [number of patients](#) (non-admitted patient service events) attending group sessions and the [Number of Group Sessions](#) that these patients attended for the reference period.

Group session clinics can be provided by both medical officers and other health professionals.

The ‘number of patients’ must be reported firstly by **Service Events Delivered** or **Service Events Contracted Out**, and then by clinic type (new or repeat), then the funding source categories as below.

Group Session Service Events (No of Patients)																																			
Service Events Delivered												TOTAL No of Service Events (excluding Contracted Services and Private)	Service Events Contracted Out																						
Eligible Public - Third Party											Contracted Services		Eligible Public		MBS Ineligible		Private		Eligible Public - Third Party											Eligible Public		MBS Ineligible		Private	
Work Cover Old	Work Cover Other	Motor Vehicle Old	Motor Vehicle Other	Other Third Party	Other Comp.	Dept Veterans Affairs	Dept of Defence	Correctional Facility	Delivered Under Contract	Other Public	19.2 RRMSB		Not Self Funded	Self Funded	MBS	Non MBS Not Self Funded	Non MBS Self Funded	Work Cover Old	Work Cover Other	Motor Vehicle Old	Motor Vehicle Other	Other Third Party	Other Comp.	Dept Veterans Affairs	Dept of Defence	Correctional Facility	Other Public	19.2 RRMSB	Not Self Funded	Self Funded	MBS	Non MBS Not Self Funded	Non MBS Self Funded		

The ‘number of group sessions’ is to be reported firstly by either **Number of Group Sessions Delivered** or by **Number of Group Sessions Contracted Out**, then by public, private (or ‘contracted services’).

Number of Group Sessions				
No of Group Sessions Delivered			No of Group Sessions Contracted Out	
Eligible Public	Private	Contracted Services	Eligible Public	Private
		Delivered Under Contract		

Refer to the [common data items](#) of the MAC SE forms for more information.

Note: The two tables above are joined to create one banner across the top of the form.

It is acknowledged that some group sessions will be a combination of the funding source categories. When this occurs, the category which represents the funding source of the majority of the patients attending the group session should be chosen as the category under which to report that group session.

Scope

The Group Sessions form and the Group Sessions Telehealth Provider and Recipient forms must be completed by the three levels of the Queensland public hospitals system – the hospital, the HHSs and at the State level. Refer to [MAC Reporting Entities and Form Requirements](#) for the forms required to be submitted by each reporting entity.

Forms

[Group Sessions](#) and [Group Sessions Telehealth Provider](#) and [Group Sessions Telehealth Recipient](#)

Definitions unique to these forms

Refer to [Definitions of data items for non-admitted patient forms](#) for the common data items collected on this form with the exception of [Group Sessions](#) and [Group Session Patients](#) which are unique to the Group Sessions form.

Number of Group Sessions¹⁷

The total number of groups of patients receiving services. Each group is to be counted once, irrespective of the size of the group of patients or the number of staff providing services.

A group is defined as two or more patients receiving the same services at the same time from the same hospital staff at the same clinics.

The following guides for use apply:

a group session is counted only for two or more patients attending in the capacity of patients, even if other non-patient persons are present for the service.

¹⁷ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 07 June 2018.

<<http://meteor.aihw.gov.au/content/index.phtml/itemId/336900>>

Spouses, parents or carers attending the session are counted for the group session only if they are also participating in the service as a patient.

A group session is counted for staff attending clinics only if they are attending as a patient in their own right. Staff training and education is excluded.

A group session may be delivered by more than one provider. A group session is counted for two or more patients receiving the same services, even if more than one provider delivers that service simultaneously.

Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or dialysis clinics are counted as group sessions, if two or more people are receiving the same services at the same time.

Where a patient receives multidisciplinary care within one booked clinic appointment as part of a group, one group session shall be recorded, regardless of the number of providers involved. For example, if a group session is jointly delivered by a physiotherapist and an occupational therapist, one group session is counted for the patients attending that session.

Note: whilst the national requirement for reporting the number of group sessions has been removed, it is still a state requirement to report this data. The definition that was used for national reporting has been maintained for state reporting purposes.

Number of group session non-admitted patient service events¹⁸ (Group Session Patients)

The total number of [non-admitted patient service events](#) provided as group sessions to non-admitted patients in an establishment.

Each patient attending a group session is counted as a non-admitted patient service event, providing that the session included the provision of therapeutic/clinical advice for each patient and that this was recorded using a dated entry in each patient's medical record.

Family members are only counted as attending a group session if they are participating in the non-admitted patient service event as a patient in their own right.

Each patient attending a group session is counted as one non-admitted patient service event, regardless of the number of health care providers present.

The total number of patients (non-admitted patient service events) attending group sessions is to be reported firstly by **Service Events Delivered** and **Service Events Contracted Out** then by clinic type and funding source categories for the reference period as with the other MAC SE forms.

Refer to [Definitions of data items for non-admitted patient forms](#) for the definitions of these data items.

¹⁸ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 07 June 2018.

<http://meteor.aihw.gov.au/content/index.phtml/itemId/652089>

10.2.3 Diagnostics and Procedures form (MACONDGPR)

The Diagnostics and Procedures form is used to report a range of non-admitted patient activity including:

Service event activity

- the total number of non-admitted patient service events for procedure and diagnostic clinic types reported by clinic type (new or repeat), by provider type (medical officer and other health professional) and also by the funding source of the patient.
- the total number of non-admitted patient service events for clinics which are provided by 'multiple health care providers' reported by clinic type (new or repeat), by provider type (medical officer and other health professional) and also by the funding source of the patient.

Patient census

- a patient census is required to be submitted for each home delivered procedure clinic type ie a count of patients for each home delivered procedure type (clinic type) should be undertaken on a specific date in the month and that figure reported by clinic type, and the funding source of the patient.

In addition, this census data are required to be reported separately for patients who reside within the HHS and those patients who reside outside of the HHS. There are two sections on this form to enable this further delineation.

'Occasions of service' activity

- 'occasions of service' for pharmacy and other outreach services that are delivered by a hospital, HHS or managed by the State (the reporting entities) or contracted out. These service events are then reported by the funding source of the patient.

Clinics provided by 'Multiple Health Care Providers'

- See *Service event activity* above.

Primary and Community Health (PCH) Service Events for HHS reporting only

- the total number of [non-admitted patient PCH service events](#) reported by Community Health service types (new or repeat), by provider type (medical officer and other health professional), and also by the funding source of the patient.

Scope

The Diagnostics and Procedures form must be completed by the three levels of the Queensland public hospitals system – the hospital, HHSs and at the State level. Refer to [MAC Reporting Entities and Form Requirements](#) for the forms required to be submitted by each reporting entity.

Form

[Diagnostics and Procedures form](#)

Definition/s unique to this form

Refer to [Definitions of data items for non-admitted patient forms](#) for the common data items collected on this form except for those below which are unique to the Diagnostics and Procedures form.

Non-admitted patient – home delivered procedures

Renal dialysis, Total Parenteral Nutrition (TPN), Home Enteral Nutrition (HEN), and home ventilation performed by the patient in their own home without the presence of a health care provider may be counted as a non-admitted patient service event, provided there is documentation of the procedures in the patient's medical record.

In 2018-19, temporal care bundling of these service events will apply.¹⁹

Refer to the counting rules of [IHPA's Compendium 2018-19](#) for the counting rules of home delivered renal dialysis, nutrition procedures and home ventilation. In this definition, IHPA refers to the patient census approach as 'bundling'.

Home dialysis

The Department of Health require home dialysis activity to be reported for the following five home-based modalities:

- Home - Home haemodialysis (standard prescription)
- Home - Extended hours home haemodialysis
- Home - Automated Peritoneal Dialysis (APD)
- Home - Continuous Ambulatory Peritoneal Dialysis (CAPD)
- Facility - Self-care haemodialysis

Further to support Home Based Renal Dialysis key performance indicators, the monthly census numbers reported to the MAC must be reported by the patient's usual place of residence being either 'Inside' or 'Outside' of the HHS's catchment area. Separate sections exist on the form to enable this separation in reporting.

Business rules for home dialysis

The following business rules have been developed and agreed to by Healthcare Improvement Unit in consultation with the Statewide Renal Clinical Network.

- Patients can be counted as undertaking home dialysis if they are participating in one of the following:
 - Home – Home haemodialysis (standard prescription)
 - Home – Extended hours home haemodialysis
 - Home - Automated Peritoneal Dialysis (APD)
 - Home - Continuous Ambulatory Peritoneal Dialysis (CAPD)
 - Facility - Self-care haemodialysis in a facility without assistance from paid healthcare professionals
- Patients in a dedicated home dialysis training pathway in a Queensland Health facility should be admitted for each treatment to HBCIS, and not considered a home patient until established at home permanently.

¹⁹ [Australian Government, Independent Hospital Pricing Authority, Tier 2 Non-admitted services compendium 2018-2019](#) Retrieved 07/06/2018

- Patients who are receiving dialysis during a 'transitory period' to determine the most appropriate treatment for end-stage kidney disease are to be included in facility-based dialysis counts, in accordance with the Queensland Health Admitted Patient Data Collection (QHAPDC) business rules, until they meet the definition of participating in home dialysis.

If a patient participates in two different home dialysis modalities in a single calendar month, the patient should be counted against the modality under which they dialysed for the majority of time for the month.

Definitions

Home Delivered Procedure	Definition
HOME DIALYSIS	
Home – Home haemodialysis (standard prescription)	Haemodialysis undertaken in a patient's home independently or with the assistance of a carer. Patients undertaking this modality are assumed to be dialysing for three and a half sessions per week with an average duration of five hours per session.
Home – Extended hours home haemodialysis	<p>Haemodialysis undertaken in a patient's home independently or with the assistance of a carer for longer duration, or more frequently, than the standard home haemodialysis prescription.</p> <p>Patients undertaking this modality are assumed to be dialysing for four and a half sessions per week with an average duration of eight and a half hours per session.</p>
Home - Automated Peritoneal Dialysis (APD)	<p>A form of peritoneal dialysis undertaken daily in the patient's home either independently or with the assistance of a carer.</p> <p>Patients undertaking this modality use a machine to cleanse their blood through the peritoneal membrane using a system of 'bag exchanges' (in many cases overnight).</p> <p>The consumables rather than the duration of the treatment are the primary cost drivers for this modality. Patients undertaking this modality are assumed to be undertaking four to six bag exchanges per day, equating to a maximum of eighteen litres of dialysate fluids in total per day.</p>

Home Delivered Procedure	Definition
Home - Continuous Ambulatory Peritoneal Dialysis (CAPD)	<p>A form of peritoneal dialysis undertaken daily in the patient's home either independently or with the assistance of a carer.</p> <p>Patients undertaking this modality manually cleanse their blood through the peritoneal membrane using a system of 'bag exchanges' and it is the consumables rather than the duration of the treatment that are the primary cost-drivers for this modality.</p> <p>Patients undertaking this modality are assumed to be undertaking four, one and half to three litre bag exchanges per day, equating to a maximum of twelve litres of dialysate fluids in total per day.</p>

Facility – Self-care haemodialysis	<p>Haemodialysis undertaken independently or with the assistance of a carer in a purpose-built facility but without the assistance of paid healthcare professionals.</p> <p>Patients who dialyse independently (or with the assistance of a carer) in a facility where <u>other</u> patients are receiving assistance from paid healthcare professionals can be counted as self-care <u>provided</u> that the patient themselves do not receive assistance from paid healthcare professionals during the session.</p> <p>Patients undertaking this modality are assumed to be dialysing for three and a half sessions per week with an average duration of four and a half hours per session.</p>
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NUTRITION

Home - Enteral Nutrition	Refer to IHPA's Tier 2 Compendium for
Home - Parenteral Nutrition	details of counting of home delivered renal dialysis, nutrition procedures, and home ventilation.

VENTILATION

Home-Ventilation

Refer to [IHPA's Tier 2 Compendium](#) for details of counting of home delivered renal dialysis, nutrition procedures, and home ventilation.

The six CCCs for Home Ventilation are:

- 701 Home Ventilation - Bi-level positive airway pressure (BiPAP)
- 702 Home Ventilation - Continuous positive airway pressure (CPAP)
- 703 Home Ventilation - Diaphragm Pacing
- 704 Home Ventilation - Ventilation via Tracheostomy
- 705 Home Ventilation - Other ventilation
- 706 Home Ventilation - High Cost Home Support Program (min 24 hours)

Activity for these CCCs should be aggregated and reported under the MAC clinic type of *Home Ventilation*.

Pharmacy

All occasions of service to non-admitted patients from pharmacy departments.

Multiple Health Care Provider (MHCP) service event

The data element [Non-admitted patient service event—multiple health care provider indicator](#) was introduced into MAC in 2015-16 through the *NAPC HA NMDS* and the *NAPC LHNA NBEDS* (and to the *QHNAPDC* through the patient-level *NAP NBEDS*) to report service events provided to non-admitted patients (outpatients) by multiple health care providers (MHCPs).

This data element definition of ‘*An indicator of whether a non-admitted patient service event was delivered by multiple health care providers*’ applies to all in-scope non-admitted patient service events funded by a hospital or HHS, or managed by the State.

The ‘Collection methods’ of the data element further explains ‘*multiple health care provider*’ means *three or more health care providers who deliver care either individually or jointly within a non-admitted patient service event. The health care providers may be of the same profession (medical, nursing or allied health). However, they must each have a different speciality so that the care provided by each provider is unique and meets the definition of a non-admitted patient service event. In practice, this should be*

*interpreted as meaning that the patient can separately identify the unique care provided by each healthcare provider.*²⁰ Refer to the data element for examples.

To report this activity, a list of clinic types for the financial year is provided on the DGPR form. This list was approved by HPFB and remains static for the financial year. Should service events be provided for clinic types not provided in this static list, a request for inclusion the following year should be made to HPFB for their approval.

10.2.4 Emergency Services form (MACONES)

The Emergency Services (ES) form is used to report **public** non-admitted patient emergency service episodes at public hospitals.

Under the National Health Reform Agreement, *an eligible patient presenting at a public hospital emergency department will be treated as **public** patient, before any clinical decision to admit.* Any questions regarding these arrangements should be referred to the Revenue Strategy and Support Unit.

Scope

The Emergency Services form must be completed by all public hospitals that do not use the EDIS System.

Refer to [MAC Reporting Entities and Form Requirements](#) for the reporting requirements of each reporting entity.

Note: 'Non-EDIS' sites were identified at the time of publishing this manual and as such are required to complete the ES form. Any site who implements EDIS during the reporting year will no longer be required to complete this form. Where EDIS is implemented during a month and activity is only partly captured electronically for that period, the hospital must report the full month's activity on the ES form to ensure that all of their activity (from both EDIS and the legacy recording mechanism) for the month is complete.

Hospitals moving to EDIS must advise SCIU of this change so that the MAC Online application can accommodate the change.

Form

[Emergency Services \(ES\) form](#)

²⁰ Queensland Health Data Dictionary, retrieved 07 June 2018
http://oascrasprod.co.health.qld.gov.au:7900/pls/crd_prd/f?p=103:7:0::NO::P7_SEQ_ID:43185

Definition/s unique to this form

Type of visit to emergency department²¹

The reason the patient presents to an [emergency department](#).

Type of Visit	Definition
Emergency presentation	<p>Where a patient presents to the emergency department for an actual or suspected condition which is sufficiently serious to require acute unscheduled care. This includes patients awaiting transit to another facility who receive clinical care in the emergency department, and patients for whom resuscitation is attempted.</p> <p>Exclusion: Where patients are awaiting transit to another facility and do not receive clinical care in the emergency department, the patient should not be recorded.</p>
Return visit, planned	<p>Where a patient presents to the emergency department for a return visit, as a result of a previous emergency department presentation or return visit. The return visit may be for planned follow-up treatment, as a consequence of test results becoming available indicating the need for further treatment, or as a result of a care plan initiated at discharge.</p> <p>Exclusion: Where a visit follows general advice to return if feeling unwell, this should not be recorded as a planned visit.</p>
Pre-arranged admission	<p>Where a patient presents to the emergency department for an admission to either a non-emergency department ward or other admitted patient care unit that has been arranged prior to the patient's arrival and the patient receives clinical care in the emergency department.</p> <p>Exclusion: Where a patient presents for a pre-arranged admission and only clerical services are provided by the emergency department, the patient should not be recorded.</p>

²¹ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 07/06/2018 <http://meteor.aihw.gov.au/content/index.phtml/itemId/327158>

Type of Visit	Definition
Dead on arrival	<p>Where a patient is dead on arrival and an emergency department clinician certifies the death of the patient.</p> <p>Exclusion: Where resuscitation of the patient is attempted, this should be recorded as an emergency presentation.</p> <p>Note: Where 'Dead on arrival' is recorded for a patient, the Episode end status²² 'Dead on arrival' should also be recorded.</p>

Episode end status

The status of the patient at the end of the non-admitted patient emergency department service episode.

NB: All patients remain in-scope for this collection until they are recorded as having physically departed the emergency service/urgent care centre, regardless of whether they have been admitted. For this reason, there is an overlap in the scope of this NBEDS and the Admitted patient care national minimum data set (APC NMDS)."

Episode end status	Definition
Admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward)	<p>Admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward)</p> <p>This code excludes patients who died in the emergency department. Such instances should be coded to 'Died in Emergency Department'.</p>
Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital	<p>Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital.</p> <p>This code includes patients who departed under their own care, under police custody, under the care of a residential aged care facility or other carer.</p> <p>This code excludes those who died in the emergency department as a non-admitted patient. Such instances should be coded to 'Died in emergency department'.</p>

²² Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 08/06/2018. <http://meteor.aihw.gov.au/content/index.phtml/itemId/685013>

Episode end status	Definition
Non-admitted patient emergency department service episode completed - referred to another hospital for admission	Self-explanatory
Did not wait to be attended by a health care professional	Self-explanatory
Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed	Self-explanatory
Died in emergency department	This should only be used for patients who die while physically located within the emergency department
Dead on arrival	<p>This should only be used for patients who are dead on arrival and an emergency department clinician certifies the death of the patient. This includes where the clinician certifies the death outside the emergency department (eg in an ambulance outside the emergency department).</p> <p>Exclusion: When resuscitation or any other clinical care for the patient is attempted, 'Dead on arrival' should not be used.</p> <p>Note: Where 'Dead on arrival' is recorded for a patient, a Type of visit to emergency department 'Dead on arrival' should also be recorded.</p>

Episode end status	Definition
Registered, advised of another health care service, and left the emergency department without being attended by a health care professional	<p>Registered, advised of another health care service, and left the emergency department without being attended by a health care professional</p> <p>Patients should be coded to this code if they meet all of the criteria (that is, they undergo a clerical registration process, are provided with advice about another health care service that could provide assessment and/or treatment of their condition, and leave the emergency department without receiving clinical care). However, patients should only be coded to this code if, at the time of their departure, they provided a reasonable indication that they did intend to seek assistance from another health care service including the service to which they were referred.</p> <p>They may leave the emergency department immediately after being advised of the other health care service, or may leave after a period of time.</p> <p>If it is unclear whether the person intended to seek further treatment from another health care service, they should be coded to 'Did not wait to be attended by a health care professional'.</p> <p>The health care service to which the patient is referred may include primary care/GP clinics, other clinics that provide specialised treatment (e.g. for mental health care or drug and alcohol care), or other health services (such as the patient's usual general practitioner). The service may be co-located with the hospital in which the emergency department is located, or may be a separate facility.</p>

[Triage Category](#)²³

This triage classification is to be used in the emergency departments of hospitals, where patients will be triaged into one of the five categories on the Australasian Triage Scale (as below) according to the triageur's response to the question: 'This patient should wait for medical care no longer than ...?'

The triage category is allocated by an experienced registered nurse or medical practitioner. If the triage category changes, both triage categories can be captured, but the original category must be reported.

²³ Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 07/06/2018 <http://meteor.aihw.gov.au/content/index.phtml/itemId/684872>

A triage category should not be assigned for patients who have a Type of visit of 'Dead on arrival'.

Triage Category	Definition
1	Resuscitation: immediate (within seconds)
2	Emergency: within 10 minutes
3	Urgent: within 30 minutes
4	Semi-urgent: within 60 minutes
5	Non-urgent: within 120 minutes

In addition, to report those patients who did not wait and were not assigned a triage category this category exists for reporting purposes only:

Did Not Wait - Triage Not Assigned

10.2.5 Telehealth Forms (MACONTELP, MACONGTLP, MACONTELR, MACONGTLR and PCHS section of MACONDGPR)

The Telehealth Support Unit has provided the following information. For further information please contact the unit directly - telehealth@health.qld.gov.au

Telehealth service events are non-admitted patient service events or group session service events delivered via videoconferencing technology.

Telehealth service events may be reported once by the provider facility and once by the receiver facility for:

- Specialist outpatient clinics
- Allied health/ clinical nurse outpatient clinics
- Non-admitted patient non-ABF primary and Community Health Services
- Procedure clinics
 - Oncology radiation therapy – simulation and planning
 - Oncology medical treatment chemotherapy
- Diagnostic clinics
 - General imaging
 - Magnetic resonance imaging (MRI)
 - Computerised tomography (CT)
 - Nuclear medicine
 - Position emission tomography (PET)
 - Mammography screening

- Clinical measurement

Telehealth service events may be reported for: one-to-one service events and group session service events, by provider type (medical officer, other health professional or multiple health care provider), by MAC clinic and appointment type and by compensable category.

Where scope permits, matching MAC clinic types should be reported on both the telehealth provider and recipient forms.

Scope

Provider:

- the service was a substitute for a face-to-face non-admitted patient service event.
- the service was delivered via videoconference technology.
- details of the service event are captured through an electronic or manual booking system.
- the services meet the definition of a [non-admitted patient service event](#).
- where the service is provided by Multiple Healthcare Providers (MHCP) the service must also meet the definition the [Non-admitted patient service event—multiple health care provider indicator](#). (*'multiple health care provider' means three or more health care providers who deliver care either individually or jointly within a non-admitted patient service event. The health care providers may be of the same profession (medical, nursing or allied health). However, they must each have a different speciality so that the care provided by each provider is unique and meets the definition of a non-admitted patient service event. In practice, this should be interpreted as meaning that the patient can separately identify the unique care provided by each healthcare provider²⁴*).
- in the event multiple providing facilities deliver the consultation only one provider facility can capture a multiple health care provider service event. Refer to Scenario 4.

Receiver:

- the service was a substitute for a face-to-face non-admitted patient service event.
- the service event was delivered via videoconference technology.
- medical officer/other health professional (located at the receiver end) was present for the entire service event.
- details of the service event are captured through an electronic or manual booking system.
- the services meet the definition of a [non-admitted patient service event](#).
- where the service is provided by Multiple Healthcare Providers (MHCP) the service must also meet the definition of the [Non-admitted patient service event—multiple health care provider indicator](#) (*'multiple health care provider' means three or more health care providers who deliver care either individually or jointly within a non-admitted patient service event. The health care providers may be of the same*

²⁴ Refer to Collection methods: <http://meteor.aihw.gov.au/content/index.phtml/itemId/584616>

profession (medical, nursing or allied health). However, they must each have a different speciality so that the care provided by each provider is unique and meets the definition of a non-admitted patient service event. In practice, this should be interpreted as meaning that the patient can separately identify the unique care provided by each healthcare provider²⁵).

- in the event multiple providing facilities deliver the consultation only one provider end facility can capture a multiple health care provider service event. Refer to scenario 4.

Excluded from this scope are:

- Telehealth Multi Disciplinary Case Conferences.
- all outpatient services provided to admitted patients (including services provided by staff working in non-admitted services who visit admitted patients in wards, or other types of consultation and liaison services involving inpatients).
- videoconferencing for the purposes of making an appointment or providing test results.

Forms



There are five MAC forms available to facilitate the reporting of telehealth service events:

Form	Completed by:
Provider	<u>MACONTELP</u> completed by provider facilities for 1:1 and multiple health care provider telehealth service events
	<u>MACONGTLP</u> completed by provider facilities for group telehealth sessions
Receiver	<u>MACONTELR</u> completed by receiver facilities for 1:1 and multiple health care provider telehealth service events
	<u>MACONGTLR</u> completed by receiver facilities for group telehealth sessions
Provider and Receiver	<u>MACONDGPR</u> Completed by provider or receiver for 1:1 Non-ABF primary and Community Health Services. HHS activity only, where the 'facility' is a Hospital and Health Service.



²⁵ Refer to Collection methods: <http://meteor.aihw.gov.au/content/index.phtml/itemId/652542>

Reporting Scenarios



Scenario 1

Facility A: Receiver		Facility B: Provider	
 <p>Scenario: non-admitted patient presents for a cardiac telehealth service event at Facility A.</p> <p>A clinician is not present with the patient at Facility A during the telehealth service event.</p>		 <p>Scenario: Cardiologist at Facility B provides the service event via videoconference.</p>	
Count:	N/A Out of scope.	Count:	One 1:1 telehealth service event
Service provider:	N/A Out of scope. A clinician is not present with the patient at Facility A during the telehealth service event	Service provider:	Medical Officer
MAC clinic type:	N/A Out of scope.	MAC clinic type:	Cardiology
Form:	N/A Out of scope.	Form:	Telehealth Provider MACONTELP




Scenario 2

Facility A: Receiver		Facility B: Provider	
 <p>Scenario: group of six non-admitted patients present for their group diabetes education session at Facility A.</p> <p>A Registered Nurse assists with the delivery of the service event.</p>		 <p>Scenario: An Endocrinologist at Facility B provides the service event via videoconference.</p>	
Count:	Six telehealth service events	Count:	One telehealth service event
Service provider:	Other Health Professional	Service provider:	Medical Officer
MAC clinic type:	Diabetes	MAC clinic type:	Diabetes
Form:	Group Telehealth Receiver MACONGTLR	Form:	Group Telehealth Provider MACONGTLP

Scenario 3

Facility A: Receiver		Facility B: Provider	
 <p>Scenario: non-admitted patient presents for a 1:1 post-surgical ENT telehealth service event at Facility A.</p> <p>A Registered Nurse assists with the delivery of the service event.</p>		 <p>Scenario: ENT Specialist, Audiologist and Speech Pathologist at Facility B provide the service event via videoconference.</p>	
Count:	One 1:1 telehealth service events	Count:	One 1:1 telehealth service event
Service provider:	Multiple Health Care Provider - Other Health Professional	Service provider:	Multiple Provider – Medical Officer
MAC clinic type:	Ear Nose and Throat Surgery	MAC clinic type:	Ear Nose and Throat Surgery
Form:	Telehealth Receiver MACONTELR	Form:	Telehealth Provider MACONTELP

Scenario 4

Facility A: Receiver		Facility B: Provider		Facility C: Provider
 <p>Scenario: non-admitted patient presents for a pre-admission clinic telehealth service event at Facility A. A Registered Nurse assists with the delivery of the service event.</p>		 <p>Scenario: Anaesthetist at Facility B provides the service event.</p>		 <p>Scenario: Clinical Pharmacist at Facility C provides the service event concurrently.</p>
Count:	One 1:1 telehealth service events	Count:	One 1:1 telehealth service event	Not reportable activity (activity can only be reported once by the providing facility)
Service provider:	Multiple Health Care Provider - Other Health Professional	Service provider:	Multiple Health Care Provider - Medical Officer	
MAC clinic type:	Pre-admission and Pre-anaesthesia	MAC clinic type:	Pre-admission and Pre-anaesthesia	
Form:	Telehealth Receiver MACONTELR	Form:	Telehealth Provider MACONTELP	

Store and Forward Telehealth Assessment (SAFT)

SAFT image assessment involves the acquisition and storing of an image for clinical purposes that is then forwarded to, or retrieved by, another clinician at another site for clinical evaluation.

SAFT activity related to non-admitted patients can be reported by the provider facility on the Telehealth Provider form (MACONTELP) under the SAFT section, for the following clinic types:

- Breast
- Burns
- Dermatology
- Ear, nose and throat
- Ophthalmology
- Wound management

Counting rules



A Non-admitted patient SAFT image assessment:

- can be reported by the provider facility only (i.e. the facility providing the SAFT assessment)
- may contain multiple image/s per patient
- must be of therapeutic/clinical content and result in a dated entry in the patient's medical record

Excluded from this scope are:

- image assessment for admitted patients and
- assessment of X-ray images and radiology reports

Scenario

Facility A (Patient location)		Facility B: Provider of SAFT Image Assessment	
 <p>Scenario: non-admitted patient presents for a 1:1 dermatology service event.</p> <p>The allied health professional delivering the service event at Facility A requires assessment of three medical images. After the service event is completed, the three images are forwarded to the Dermatologist located at Facility B for SAFT assessment.</p>		 <p>Scenario: Dermatologist at Facility B reviews the three medical images and provides an assessment to the allied health professional at Facility A.</p>	
Count:	1:1 face-to-face service event	Count:	1 Store and Forward Telehealth Assessment
Service provider:	Other Health Professional	Service provider:	Medical Officer
MAC clinic type:	Dermatology	MAC clinic type:	Dermatology
Form:	Clinic	Form:	Telehealth Provider MACONTELP SAFT section

Multidisciplinary Case Conference (MDCC) – Telehealth



Please note: Telehealth MDCC are not reportable to the Monthly Activity Collection (MAC) in 2018-19.

Healthcare providers participating in a Multidisciplinary Case Conference (MDCC) may attend via videoconference. MDCC service events delivered via telehealth may be reported if they firstly meet the definition of a service event





provided by [Multiple Healthcare Providers](#), as well as the definition of an MDCC and are within scope and according to the counting rules.

Telehealth MDCC are to be reported to the Queensland Hospital Non-Admitted Data Collection (QHNAPDC). For further information, please refer to the QHNAPDC 2018-19 Manual.

Telehealth MDCC – MAC reporting requirement

Facility A: Provider		Facility B: Provider	
	Scenario: A Registered Nurse participates in the MDCC via telehealth		Scenario: An ENT Specialist, Audiologist and Speech Pathologist at Facility B participate in the MDCC via telehealth
MAC Count:	Not reportable	MAC Count:	Not reportable
MAC Service provider:	Not reportable	MAC Service provider:	Not reportable
MAC clinic type:	Not reportable	MAC clinic type:	Not reportable
Please note:	<p>Telehealth MDCC are not reportable to the Monthly Activity Collection (MAC) in 2018-19.</p> <p>Telehealth MDCCs are to be reported to the Queensland Hospital Non-Admitted Data Collection (QHNAPDC) from 2018-19. For further information, please refer to the QHNAPDC 2018-19 Manual.</p>		

Non-admitted patient telehealth service event followed by telehealth MDCC – MAC reporting requirement

Part 1 – Telehealth non-admitted patient service event			
Facility A: Recipient		Facility B: Provider	
	<p>Scenario: A non-admitted patient presents for an Oncology Clinic</p> <p>A Registered Nurse assists with the delivery of the service event.</p>		<p>Scenario: An Oncologist and Pharmacist at Facility B provides the service event concurrently.</p>
MAC Count:	One 1:1 telehealth service events	MAC Count:	One 1:1 telehealth service event
MAC Service provider:	Other Health Professional	MAC Service provider:	Medical Officer
MAC clinic type:	Oncology	MAC clinic type:	Oncology
MAC Form	Telehealth Receiver MACONTELR	MAC Form	Telehealth Provider MACONTELP
Part 2 – Telehealth MDCC			
Facility A: Recipient		Facility B: Provider	
	<p>Scenario: A Registered Nurse participates in the MDCC via telehealth</p>		<p>Scenario: An Oncologist and Pharmacist participates in the MDCC via telehealth</p>
MAC Count:	Not reportable	MAC Count:	Not reportable
MAC Service provider:	Not reportable	MAC Service provider:	Not reportable
MAC clinic type:	Not reportable	MAC clinic type:	Not reportable
Please note:	<p>Telehealth MDCC are not reportable to the Monthly Activity Collection (MAC) in 2018-19.</p> <p>Telehealth MDCC are to be reported to the Queensland Hospital Non-Admitted Data Collection (QHNAPDC) from 2018-19. For further information, please refer to the QHNAPDC 2018-19 Manual.</p>		

10.2.6 IHPA Exclusions (IHPAEX)

The IHPA Exclusions form is used to report the following activity:

- the total number of public service events subsequent to the first service event for same patient, on the same day, at same tier 2 clinic, and
- the total number of public service events associated with diagnostics billed to MBS (as per NHRA G20 rule)

This activity that is to be excluded from IHPA reporting applies to the activity that is delivered by a hospital, HHS or managed by the State (the reporting entity) or contracted out to another service provider. These service events are to be reported by provider type (medical officer and other health professional), by clinic type (new, repeat or telephone) and also by the funding source of the patient.

Scope

The IHPA Exclusions form must be completed by the three levels of the Queensland public hospitals system – the hospital, HHSs and at the State level. Refer to [MAC Reporting Entities and Form Requirements](#) for the forms required to be submitted by each reporting entity.

Form

[IHPA Exclusions Form](#)

Definition/s unique to this form

Refer to [Definitions of data items for non-admitted patient forms](#) for the common data items collected on this form.

10.2.7 Pathology form (MTACPATH)

Department of Health's [Pathology Queensland](#) extracts pathology service event counts from the AUSLAB pathology system and provides them directly to SCIU.

Scope

Facilities that do not use AUSLAB are required to report pathology service events on the Pathology form and submit to SCIU using [MAC Online](#). Refer to [MAC Reporting Entities and Form Requirements](#).

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

Form

[Pathology Form](#)

Definitions

Pathology Service Events (Non-AUSLAB Facilities)

All pathology service events provided to non-admitted patients.

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

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 Service Events (AUSLAB Facilities)

All pathology service events provided to non-admitted patients from Department of Health's Pathology Queensland laboratories.

Each diagnostic test or group of diagnostic tests, as defined in Pathology Queensland's Test List, for the one patient referred to Department of Health's Pathology Queensland.

10.3 Admitted patient forms

10.3.1 Bed Availability Form (BED)

Available beds and available bed alternatives are reported using the Bed (BA) report in the [MAC Online](#) application.

A bed/bed alternative is only to be reported to MAC **if it is used exclusively or predominantly for admitted patients.**

To ensure the quality and integrity of bed availability information, HHS CEs or their delegate must verify and approve the monthly figures reported.

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.

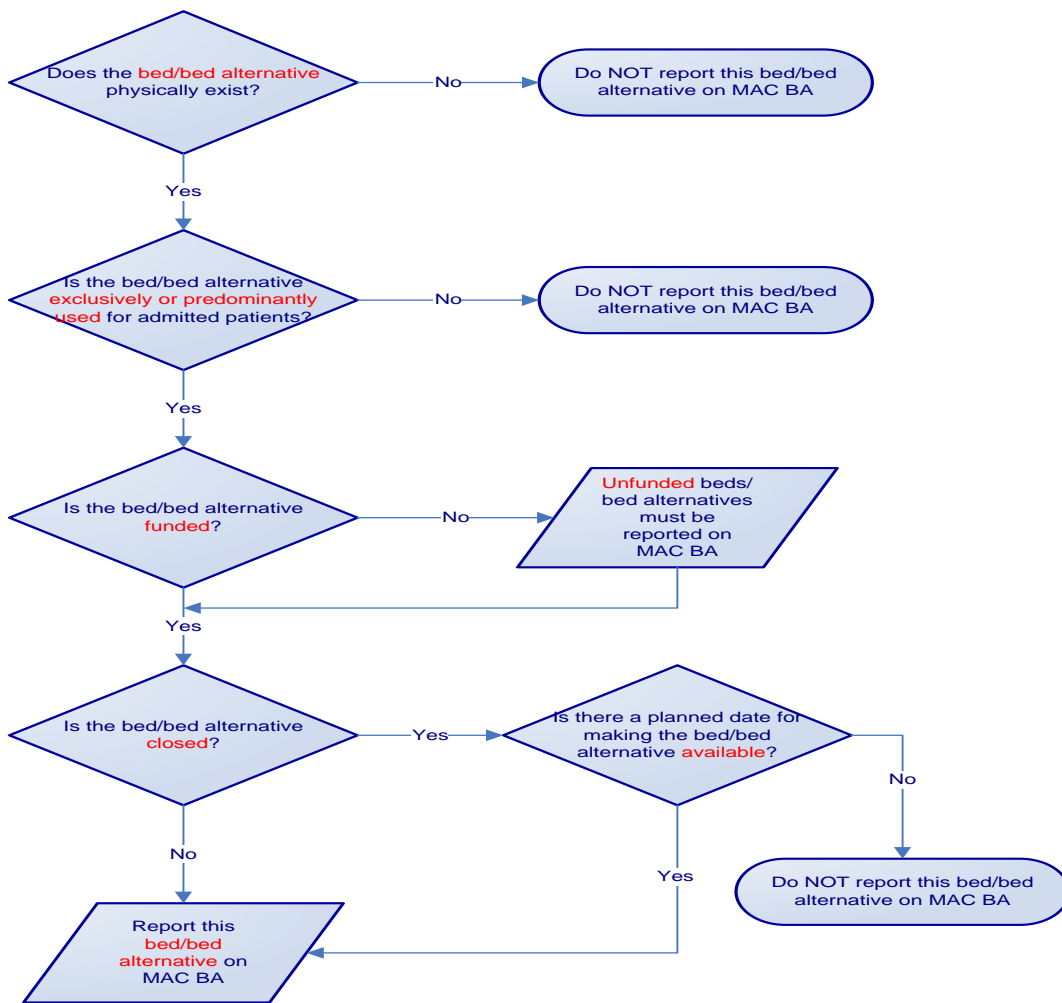
Note: It is very important to provide valid and meaningful comments on the BED form when validations are raised due to variations in counts. This information is widely scrutinised and sound comments are essential to respond to queries raised.

Scope

All hospitals must complete the Bed form (excluding Nursing Homes/ Hostels/ Independent Living Units and Multipurpose Health Services who are required to provide bed numbers on a NH2 or MP1 form respectively).

Refer to [MAC Reporting Entities and Form Requirements](#) for the forms required to be submitted by each reporting entity.

When to report beds/ bed alternatives to MAC



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	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 HHS CE. A funded bed/bed alternative must be reported on MAC.

Term	Explanation
Unfunded bed/bed alternative	An unfunded bed/bed alternative is one that exceeds the bed allocation approved by the HHS CE. 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.

Form

[Bed Form](#)

Definitions

Beds

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. See below.

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
Transit Lounge

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 \(version 3.2\)](#).

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 \(version 3.2\)](#).

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 \(version 3.2\)](#).

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 \(version 3.2\)](#).

Maternity

For details on the definition of maternity services and the required clinical services level, refer to the [Clinical Services Capability Framework \(version 3.2\)](#).

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 \(version 3.2\)](#).

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 \(version 3.2\)](#).

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 \(version 3.2\)](#).

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 \(version 3.2\)](#).

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 \(version 3.2\)](#).

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

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 \(version 3.2\)](#).

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

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, Forensic, 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 \(version 3.2\) – 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 Brain 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 \(version 3.2\)](#).

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

Specialised Mental Health Target Populations:

General

These services principally target the general adult population (aged 18–64 years) but may provide general services to children, adolescents, the aged or medium secure clients. Therefore, general psychiatry services are those services that are not specialist child and adolescent, older persons, or forensic services. General psychiatry inpatient services include hospital units in which the principal function is the provision of some form of specialised service to the general adult population.

Medium Secure

These rehabilitation units provide a safe and structured environment for the medium to long term inpatient treatment and rehabilitation of consumers with persistent and disabling symptoms of mental illness, who cannot be adequately supported in other inpatient or community settings.

Child and adolescent

These services principally target children and adolescents (aged 0–17 years).

Young persons

These services principally target young people (aged 16–24 years).

Older person's psychiatry

These services principally target people in the age group 65 years and over. This service category does not include the treatment of older people by general psychiatry services.

Forensic psychiatry

These services principally assess, treat and care for mentally disordered individuals whose condition has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated or contained. For the purposes of this collection, forensic psychiatry services also include all prison-based services. In Queensland, high secure inpatient facilities should be reported as forensic. Note that the employment of a forensic liaison officer in a community mental health team should not be reported separately as a specialised forensic service.

Legacy Intellectual Disability

Beds in units at Baillie Henderson Psychiatric Hospital for long term patients who have an intellectual disability. These units do not accept new admissions.

Transit Lounge

A transit lounge is a dedicated area used as an interim waiting area for admitted patients waiting discharge, bed allocation on admission, or an outpatient appointment. The transit lounge is suitable for patients awaiting transport home or to another facility, awaiting for discharge medications and/or letters, awaiting minor procedures before discharge, awaiting final dose of IV antibiotics and post removal of epidural catheter (4 hour observation period).

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.

Bed alternative categories

- Chemotherapy chairs and trolleys
- Renal dialysis chairs and trolleys – Primary
- Renal dialysis chairs and trolleys – Satellite
- Emergency Department chairs and trolleys (Emergency Services Level 4 or 5 or 6)
- All other bed alternatives
- Transit Lounge

Bed and bed alternative categories have been aligned where applicable to the [Clinical Services Capability Framework \(version 3.2\)](#).

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 - Primary

Renal Dialysis Chairs/Trolleys (primary) are bed alternatives that are specifically used for admitted patients receiving renal dialysis treatment from a dialysis service operated by a hospital and delivered at that location.

Renal Dialysis Chairs/Trolleys - Satellite

Renal Dialysis Chairs/Trolleys (satellite) are bed alternatives that are specifically used for admitted patients receiving renal dialysis treatment from a dialysis service operated by a hospital but delivered by that hospital at another location.

Transit Lounge

A transit lounge is a dedicated area used as an interim waiting area for admitted patients waiting discharge, bed allocation on admission, or an outpatient appointment. The transit lounge is suitable for patients awaiting transport home or to another facility, awaiting discharge medications and/or letters, awaiting minor procedures before discharge, awaiting final dose of IV antibiotics and post removal of epidural catheter (4 hour observation period).

10.3.2 PH1 Form (MTHACPH1)

Summary level admitted patient activity must be reported to SCIU by the 4th of each month. To do this, acute hospitals are required to lodge a PH1 form which SCIU 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 hospitals, 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 can 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 Integrated Application Services, Technology Services Branch, eHealth Queensland, Department of Health). This preliminary form requires no user intervention and the quality of this data is as it is at the time of the extract.

Should amendments to the first submission be required, hospitals can submit a second submission of the form by executing a manual process in HBCIS.

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 status.

Scope

All hospitals must submit a PH1 form (excluding Nursing Homes/ Hostels/ Independent Living Units and Multipurpose Health Services who are required to complete a NH2 or MP1 form respectively). Refer to [MAC Reporting Entities and Form Requirements](#).

Form

[PH1 Form](#)

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 Adolescent 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 Adolescent 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.

Accrued patient days with a Standard Unit Code of PYFA

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

Accrued patient days with a Standard Unit Code of PYOA

The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Young Persons (Youth) Acute Unit' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYRA

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

Accrued patient days with a Standard Unit Code of PYAM

The total number of accrued patient days where a Standard Unit Code of 'Mental Health Mother's and Babies' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYSA

The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Adult Step Up Step Down' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYSD

The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Adolescent Step Up Step Down' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYSY

The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Young Persons (Youth) Step Up Step Down' is identified within an episode of care for the reported period.

Accrued patient days with a Standard Unit Code of PYRY

The total number of accrued patient days where a Standard Unit Code of 'Psychiatric Young Persons (Youth) Residential' is identified within an episode of care for the reported period.

Accrued patient Days 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.

Accrued patient days 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.

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 an approved private practice arrangement with a HHS 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 with their treating doctor nominated by the hospital or
- are receiving treatment in a private hospital under a contracted 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
- mental health or
- other care.

Patients may receive more than one episode of care within one hospital stay. An episode of care ends when the primary clinical purpose or treatment goal of the patient 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)

Geriatric evaluation and management is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions relating to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Geriatric evaluation and management is:

- delivered under the management of or informed by a clinician with specialised expertise in geriatric evaluation and management and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological,

emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

Ineligible (Patients)

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

Maintenance (Episodes of Care)

Maintenance (or non-acute) care is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of maintenance care often require care over an indefinite period.

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.

Mental Health (Episodes of Care)

Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder. Mental health care:

- is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health
- is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan and
- may include significant psychosocial components, including family and carer support

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 primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is:

- delivered under the management of or informed by a clinician with specialised expertise in palliative care, and
- evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

Psychogeriatric (Episodes of Care)

Psychogeriatric care is care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, an age-related organic brain impairment or a physical condition.

Psychogeriatric care includes:

- delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care,
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

Psychogeriatric care is not applicable if the primary focus of care is acute symptom control.

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)

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation care is:

- delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability.

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.

Admitted Patient Data Validations

SCIU 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 their 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.

10.4 Residential patient forms

10.4.1 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.

MPHSs 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 a 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.

A 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).

Note: residents of a MPHS are not 'admitted' patients and are out of scope of the QHAPDC. The term 'admitted patient' should be interpreted as 'resident', the term 'admission' interpreted as 'commencement of care' and the term 'separation' interpreted as 'cessation of care'.

Scope

MPHSs must complete the MP1 form. Refer to section 6.8 [Reporting Entities and Form Requirements](#) for the forms required to be submitted by each reporting entity.

Patients who are residents of a MPHS are not admitted patients and are out of scope for the QHAPDC.

Form

[MPHS form](#)

Definitions²⁶

Accrued Patient Days

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

²⁶ Admitted patient terms are used in relation to residential care for the MAC forms of MP1, NH2 and for RMHC. Whilst residents are not 'admitted' to the facility, the term 'admissions' in relation to residential care should be interpreted as 'commencement of care'. For the term 'separations', whilst residents are not 'separated' from the facility, the term 'separations' in relation to residential care should be interpreted as 'cessation of care'.

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.

Validation

SCIU validates the number of available beds in the Available Beds section of the form for each reference period.

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

Public nursing homes/hostels/Independent Living Units (ILUs) must report details including the number of patients 'admitted' either as permanent residents or as respite residents to these facilities during the reporting period.

Note: residents of a nursing home, hostel, or ILUs are not 'admitted' patients and are out of scope of the QHAPDC. The term 'admitted patient' should be interpreted as 'resident', the term 'admission' interpreted as 'commencement of care' and the term 'separation' interpreted as 'cessation of care'.

Scope

The MTHACNH2 form must be completed by all public nursing homes/hostels/Independent Living Units (ILUs). Refer to [MAC Reporting Entities and Form Requirements](#).

Patients who are residents of public nursing homes/hostels/ILUs are not admitted patients as such and are out of scope for the QHAPDC.

Form

[NH2 form](#)

Definitions²⁷

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.

²⁷ Admitted patient terms are used in relation to residential care for the MAC forms of MP1, NH2 and for RMHC. Whilst residents are not 'admitted' to the facility, the term 'admissions' in relation to residential care should be interpreted as 'commencement of care'. For the term 'separations', whilst residents are not 'separated' from the facility, the term 'separations' in relation to residential care should be interpreted as 'cessation of care'.

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.

Commonwealth Funded Beds

All beds approved by the Australian Government (Commonwealth).

Extensive Care Residents

All non-respite admitted residents should be reported as Permanent Residents.

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.

Validation

SCIU validates the number of available beds in the Available Beds section of the form for each reference period.

10.4.3 Residential Mental Health Care (RMHC) Services

Definitions

Consumer

The subject of care receiving or accessing specialised mental health services. The term 'consumer' and 'patient' are synonyms for the Department of Health standard concept 'Health care client'.

Residential mental health care (RMHC) service

A residential mental health care facility is a service that:

- has the workforce capacity to provide specialised mental health services; and
- employs suitably trained mental health staff to provide rehabilitation, treatment or extended care on-site:
 - to consumers residing on an overnight basis;
 - in a domestic-like environment; and
 - encourages the consumer to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing (but the trained staff must be on site for a minimum of 6 hours a day and at least 50 hours per week).

Suitably trained residential mental health care staff may include:

- individuals with Vocational Education and Training (VET) qualifications in community services, mental health or disability sectors;
- individuals with tertiary qualifications in medicine, social work, psychology, occupational therapy, counselling, nursing or social sciences; and
- individuals with experience in mental health or disability relevant to providing mental health consumers with appropriate services.

Residential mental health care services include:

- Community Care Units (CCU)
- Step Up Step Down Units (SUSDU) inclusive of:
 - Prevention and Recovery Care (PARC) services

Admissions, separations and classification changes

Residential Mental Health Care (RMHC) facilities must report details including the number of consumers 'admitted' during the reporting period.

Note: consumers of an RMHC service are not 'admitted' patients and are out of scope of the QHAPDC and in scope for the Residential Mental Health Care Data Collection (RMHCDC). The term 'admission' should be interpreted as 'commencement of care' and the term 'separation' interpreted as 'cessation of care'.

Scope

The MTHACPH2 form must be completed by RMHC facilities for the care type of 'Mental Health' only.

Refer to [MAC Reporting Entities and Form Requirements](#).

Form

PH2 form

Definitions

Refer to relevant definitions provided for PH1 reporting in section [3.1](#).

Residential mental health care services bed reporting (MHBED)

Available beds are reported using the MHBED report in the [MAC Online](#) application.

Only available beds are required to be reported on the MHBED form and not bed alternatives.

A bed is only to be reported to MAC if it is used exclusively or predominantly for consumers of a residential mental health care facility.

To ensure the quality and integrity of bed availability information, HHS CEs or their delegate must verify and approve the monthly figures reported.

Form

MHBED form

The MHBED form contains the following categories for the reporting of bed availability.

MONTHLY ACTIVITY COLLECTION - RESIDENTIAL MENTAL HEALTH CARE BEDS FORM

FORM TYPE: VERSION:

MONTH: YEAR:

FACILITY: Facility Id:

Available Beds for Residential Mental Health Care Patients

Available	Temporarily Unavailable	TOTAL
As at the last Wednesday of the reference month		
Specialised Mental Health - General		0
Specialised Mental Health - Child & Adolescent		0
Specialised Mental Health - Young Persons		0
Total	0	0

Global Comment:

Definitions of these categories are:

Specialised Mental Health – General

These services principally target the general adult population (aged 18–64 years) but may provide general services to children, adolescents, older people or forensic clients. Therefore, general psychiatry services are those services that are not specialist child and adolescent, young persons, older persons, or forensic services.

Specialised Mental Health - Child and adolescent

These services principally target children and adolescents (aged 0–17 years). Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the service on children and adolescents.

Specialised Mental Health - Young persons

These services principally target young people (aged 16–24 years). Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the service on young persons.

Note: Validations will be raised where there is a variance in the activity reported between months. It is very important to provide valid and meaningful comments on the MHBED form when these validations are raised. This information is widely scrutinised and sound comments are essential to respond to queries raised.

Scope

RMHC services are required to provide available bed numbers.

Refer to [MAC Reporting Entities and Form Requirements](#) for the list of these facilities.

Abbreviations

The following terms and abbreviations are used throughout this document.

Abbreviation	Description
ABF	Activity Based Funding
AIHW	Australian Institute of Health and Welfare
CE	Chief Executive
CIMHA	Consumer Integrated Mental Health Application
COAG	Council of Australian Governments
HBCIS	Hospital Based Corporate Information System
HHS	Hospital & Health Service
HPFB	Healthcare Purchasing & Funding Branch
IHPA	Independent Hospital Pricing Authority
ISOH	Information System Oral Health
MAC	Monthly Activity Collection
MBS	Medicare Benefits Schedule
MPHS	Multi-Purpose Health Service
NAP	Non-admitted Patient
NBEDS	National Best Endeavours Data Set
NH	Nursing Home
NMDS	National Minimum Data Set
OSE	Outpatient Service Event
PCH	Primary and Community Health
PCHSE	Primary and Community Health service event
PHE NMDS	Public Hospitals Establishments NMDS
QHAPDC	Queensland Hospital Admitted Patient Data Collection
QHNAPDC	Queensland Health Non-admitted Patient Data Collection

Abbreviation	Description
RMHC	Residential Mental Health Care
RRMBS	Rural and Remote Medicare Benefits Schedule
SCIU	Statistical Collections and Integration Unit
SE	Service Event
SSB	Statistical Services Branch

