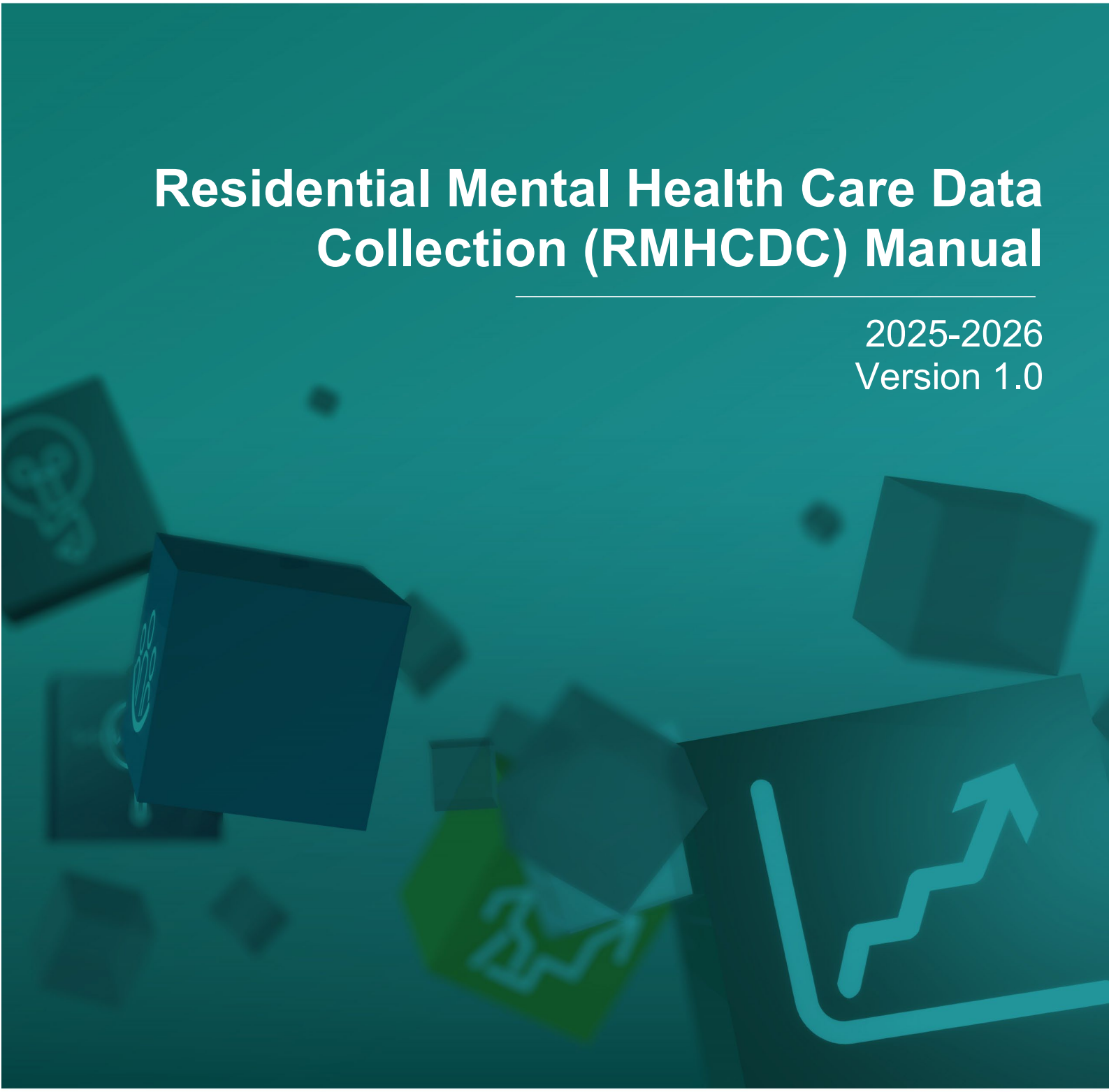
Residential Mental Health Care Data Collection (RMHCDC) Manual

2025-2026
Version 1.0



Residential Mental Health Care Data Collection (RMHCDC) Manual 2025-2026 Collection Year

Published by the State of Queensland (Queensland Health), June 2025

For more information contact:
Systems and Collections Team, Clinical Systems Collections and Performance Unit, Mental Health Alcohol and Other Drugs Branch, Department of Health, GPO Box 48, Brisbane QLD 4001, email mhadc@health.qld.gov.au, phone 07 3328 9168.

An electronic version of this document is available on request from the Systems and Collections Team.

Contents

1. INTRODUCTION

1.1 Overview

This manual provides an overview of the Residential Mental Health Care Data Collection (RMHCDC). It is a reference for all Queensland residential mental health care facilities, Hospital and Health Services (HHS) and Department of Health personnel who are involved in the collection, extraction and use of mental health consumer residential data.

This manual is intended to be used as a supplement to the manual for the Queensland Hospital Admitted Patient Data Collection (QHAPDC), available on the Queensland Health website (https://www.health.qld.gov.au/hsu/collections/qhapdc) or intranet, QHEPS (https://qheps.health.qld.gov.au/hsu/datacollections#qhapdc)).

This manual does not replace the Hospital Based Corporate Information System (HBCIS) user manual and is not intended to be, or replace, any other information system manual.

1.2 Purpose of the collection

The RMHCDC contains statewide information about ended episodes of residential mental health care from any specialised residential mental health care facility treating consumers. An ended episode is an inclusive phrase to describe an HBCIS episode of residential mental health care being closed. This includes closure reasons such as died, discharged, administratively ended at the end of financial year, left against clinical advice, transferred to hospital care, or sent to another residential mental health care service.

The RMHCDC complements the range of activity, diagnostic, demographic and outcome information collected to support understanding of mental health service delivery in Queensland.

The RMHCDC enables Queensland to meet local, state, and national reporting obligations, including a requirement to provide data to the Australian Institute of Health and Welfare (AIHW) under the National Health Care Agreement. The collection also supports funding of residential mental health care facilities.

For HHSs, reporting to the RMHCDC is a requirement of individual Service Agreements between the HHS and the Department of Health.

Data reported to RMHCDC satisfies the data provision requirements of the National Healthcare Agreement (available on METeOR) and the Residential Mental Health Care National Minimum Data Set (RMHC NMDS) and other State reporting requirements at the time of publication.

1.3 Scope of the collection

The scope of the RMHCDC is episodes of residential mental health care for consumers in all recognised government-funded specialised residential mental health care facilities in Queensland.

Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

(Ref: METeOR; Australian Institute of Health and Welfare Metadata Online Registry, Object Class Specialised mental health service)

A residential mental health care facility is identified as having a model of service, referral pathways and a clinical and operational governance structure overseen or managed by a local HHS or Queensland Health staff.

A residential mental health care facility is a community bed-based residential facility providing specialised mental health care to consumers on an overnight basis in a domestic-like setting that encourages the consumer to take responsibility for their daily living activities. Suitably trained mental health staff provide rehabilitation, treatment or extended mental health care on-site.

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

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.

(Ref: METeOR; Australian Institute of Health and Welfare Metadata Online Registry, Residential Mental Health Care Facility)

Residential mental health care services in scope for the RMHCDC include:

- Community Care Units (CCU)

- Step Up Step Down Units (SUSDU) including both Adult and Youth SUSDUs and other Residential Mental Health Models of Care that meet the scope's inclusion criteria

The following services are not part of the mandatory scope and are not reported in this collection during 2025/2026. They are under review for inclusion in future years.

- Youth Residential Rehabilitation Services (YRRS)

The following services are **not** in scope and are excluded from this collection:

- Housing and Support Program (HASP)
- Consumer Operated Services
- Temporary Support Accommodation
- Residential Aged Care Services

1.4 Confidentiality and privacy

Confidentiality applies to information that could reasonably lead to the identification of an individual. Apart from the obvious characteristics (such as name and address), there are other data items which, if seen together, may be sufficient to allow an individual to be identified.

All persons involved in the collection, management and use of consumer-related information must ensure that the uses of those data do not compromise the privacy of the individual to whom it relates. The management and use of consumer-related information will align with governing legislation, standards and guidelines.

All consumers receiving care in a residential mental health care facility must be asked for their consent to the release of their personal, admission and health details for statutory reporting and funding purposes.

The information that is released can only be used for the purposes for which it was given. A consumer's consent to release their information may not result in their information being released. Only those records required for statutory reporting and to inform or manage a funding arrangement will be released.

2. GUIDELINES FOR SUBMISSION OF DATA

2.1 Methods of submission

All HHSs offering specialised residential mental health care in facilities that are in scope for the RMHCDC are required to utilise the Hospital Based Corporate Information System (HBCIS) to capture and report data, via the Statistical Services Branch's (SSB) QHAPDC processing infrastructure, to the Analytics, Improvement and Transformation Unit (AITU), Department of Health.

Data supplied to the SSB relates to episodes of care as captured in HBCIS. One or more episodes of care will form a residential stay. A residential stay is the period of care beginning with a formal start of residential care and ending with a formal end of the residential care and accommodation. To identify residential stays, the separate episodes of care are stitched together during the load of data into the AITU processing infrastructure, the Mental Health Addictions Portal (MHAP).

HBCIS data is extracted, mapped and grouped to meet RMHCDC needs. The software used to achieve compatibility is the Homer Queensland Interface (HQI).

2.2 Data quality

Data supplied to the RMHCDC is expected to be of a high quality on submission.

Validation errors are generated following a successful load of RMHCDC data for a specific reference period into the QHAPDC processing infrastructure, and then again following a successful load into MHAP.

Residential mental health care facilities are notified of their QHAPDC errors on-line through the Electronic Validation Application (EVA Plus). MHAP errors are accessed via the RMHC validation dashboard available within the MHAP app.

Data errors are to be resolved within HBCIS, which will flag updated records automatically for resubmission.

2.3 Electronic Validation Application (EVA Plus)

Residential mental health care facilities are notified of their QHAPDC episode level validation messages on-line through the Electronic Validation Application (EVA Plus). EVA Plus provides facilities with the ability to record 'actions' that are required to rectify validation errors.

The EVA Plus user manual is provided on the Statistical Services Branch (SSB) intranet page (https://qheps.health.qld.gov.au/hsu/datacollections#qhapdc) or Queensland Health website

(https://www.health.qld.gov.au/hsu/collections/qhapdc).

Details regarding the validations applied to residential mental health care episodes are contained in Appendix L of the QHAPDC manual.

2.4 Mental Health Addiction Portal (MHAP)

Residential mental health care facilities can access their residential stay level validations on-line through the MHAP application (RMHC Validation Dashboard v1.0 - Power BI Report Server (health.qld.gov.au)). The validation dashboard and manual are available under folder 12. Validations.

When reviewing the MHAP validations, if the data is correct, copy the validation into an Excel spreadsheet or email, and send to MHADC@health.qld.gov.au with details of why the data is correct. AITU will then arrange to suppress the validation so that it does not occur again.

2.5 Due dates for data submissions

All residential mental health care facilities deemed in scope must submit RMHCDC to the SSB (on behalf of MHAODB [Mental Health Alcohol and Other Drug Branch]) by the 35th day following the calendar reference period.

The table below is an example of the RMHCDC reporting schedule:

Reporting Period	Finalised Data Due Date All Hospitals
July	4 September
August	5 October
September	4 November
October	5 December
November	4 January
December	4 February
January	7 March (6 in a leap year)
February	4 April
March	5 May
April	4 June
May	5 July
June	4 August

NOTE that the July load following the final June load (due 4 September) will include all updates to data for the previous financial year. This is the last opportunity for data providers to submit updates for the previous financial year. Prior to extracting the data, HHSs should ensure there are no errors that would result in episodes being excluded from the HQI extract.

For residential mental health care facilities, a Monthly Activity Report (PH2) due on the 4th day of each month following the reference month. A PH2 report is an aggregate-level report summarising activity for the specified reference month. For most facilities using HBCIS, the PH2 is generated and sent automatically using the 'Report Monitor' functionality in HBCIS.

3. DATA DEFINITIONS

This manual is a supplementary guide and should be used in conjunction with the QHAPDC manual.

Requirements for the RMHCDC conform largely to the requirements of the QHAPDC. This manual has been created to address data elements and guidelines that **differ** from QHAPDC and are specific to residential mental health care facilities. Where an item is not listed in this manual, the instructions within the QHAPDC manual should be followed.

3.1 Residential Mental Health Care Services

The residential mental health care service types listed in this section are in scope for the RMHCDC.

Facilities reporting to the RMHCDC must have been assigned a unique facility identifier (ID). The facility ID is a numerical code that uniquely identifies each Queensland Health care facility, including residential mental health care facilities. A list of specific residential facilities in scope for the RMHCDC and their facility ID is listed in Appendix A of this manual.

3.1.1 Community Care Units

A Community Care Unit (CCU) is a community based facility for mental health consumers who are in recovery but require additional support and life skills to successfully transition to independent community living. The CCU is a level 4 non-acute facility as outlined in the Clinical Services Capability Framework (CSCF). The service aims to promote an individual's recovery by providing opportunities to maximise their strengths and potential, with access to 24-hour mental health care, peer support and supervised consumer rehabilitation. Clinical interventions and living skill development or enhancement is provided by a multidisciplinary service to consumers who require medium to long term mental health care and rehabilitation.

CCUs offer an opportunity for consumers to learn or re-learn living skills to potentiate their capabilities and develop the skills to enhance their levels of independence and community integration. The clinical and rehabilitation support teams support consumers to acquire, access and maintain the daily living skills that will increase their capacity and confidence to function within the community.

The key functions of the CCU are:

- provision of 24-hour mental health care, peer support and rehabilitation for consumers with complex mental health needs and associated disabilities
- facilitation of living skills development in a community facility setting over a medium to long term time frame

- engagement of consumers to develop sustainable relationships with peers, family/carers and/or other supports to enable meaningful participation in their own community.

(Ref: Community Care Unit Model of Service, Queensland Public Mental Health Services, February 2015)

CCUs may be delivered in a partnership arrangement by HHS public mental health services (providing clinical support) and Community Managed Organisations (CMOs) to provide psychosocial rehabilitation support under service agreement arrangements. The clinical and psychosocial components of care are delivered as part of an integrated service.

3.1.2 Step Up Step Down Units

Step Up Step Down Unit (SUSDU) services are an integrated model of service delivered as a partnership between HHS mental health service and a non-government community managed organisation. These services aim to improve outcomes for people with a severe mental illness by providing clinical treatment alongside psychosocial support in a rehabilitative and residential environment. Importantly, by offering both step up and step down services, they assist with preventing avoidable admissions to acute inpatient units (step up) and avoidable re-admissions following an acute episode, as individuals can step down to alternate care.

These services provide time-limited (length of stay up to 28 days), bed-based 24-hour/7-days per week mental health care, delivered as a partnership/collaboration between clinical services and the community support sector.

The adult SUSDU is for adult consumers aged 18 to 65 years. The youth SUSDU is for young people aged 16 to 21 years.

SUSDU services aim to:

- prevent further deterioration of a person's mental state and associated disability, and so reduce the likelihood of admission to an acute inpatient unit (step up)
- enable early discharge from acute mental health inpatient units through the provision of an intensive safe and supportive sub-acute residential community program (step down)
- provide recovery-oriented care and support to minimise the trauma and impact of a first episode or relapse of a mental illness and to support transition back into the community
- provide an integrated approach to clinical recovery and psychosocial interventions with a focus on stabilisation and management of illness and, engagement or re-engagement in positive and supportive social, family, educational and vocational connections.

Service features

The SUSDU model is delivered as a partnership/collaboration between the HHS and the CMO. The HHS provides clinical support and the CMO delivers non-clinical support as an integrated service, at the same

residential unit.

SUSDU services are located in the community and operate as a component of the local HHS mental health alcohol and other drug service.

This category includes other Residential Mental Health Care Models of Service that share similarities with the Step Up Step Down model. These models are designed to support consumers with severe and complex mental illness and have been created as an alternative to hospital admissions. These services provide a residential alternative for consumers who require more support than is available in a non-residential setting, and also provide a transition between inpatient and community based services. These services include:

- Acmena House ATH (Alternatives to Hospitalisation) aims to support people to live in their community through comprehensive and effective discharge planning, linkages with appropriate support agencies and timely onward referral, guided by the Recovery Model.

- Gold Coast TRS (Transitional Recovery Service) and Day Program is an integrated model of service delivered by RFQ (psychosocial supports) in collaboration with the Gold Coast HHS (clinical supports). The model comprises of two programs of care: Intensive Residential Treatment and Support provided at two properties located in the same street in Robina (providing short term residential support for 7 – 14 days) and Capstone Program providing individual recovery support for up to four weeks following a consumer's stay at in the Residential program Concurrently the Capstone Program also provides a menu of evidence-based group activities up to 3 months.

- Sunshine Coast CSTARS (Community Subacute Transitional and Recovery Service) provide early intervention for people who are becoming unwell in the community and for those in the early stages of recovery from an acute psychiatric episode, to strengthen and consolidate gains from the inpatient setting.

3.2 Episode of Residential Care

An episode of residential care is the period of care between the start of residential care (either through the formal start of the residential stay or the start of a new reference period i.e. 1 July) and the end of the residential care (either through the formal end of residential care or the end of the reference period, i.e. 30 June).

The care delivered in residential mental health care facilities is intended to be on an overnight basis. This may occasionally include episodes of residential care that unexpectedly end on the same day as they started for example, the resident died or left against advice, or the episode began at the end of the reference period (i.e. starting care on 30 June).

It is important to note that to correctly capture episodes of residential care in HBCIS, all residential

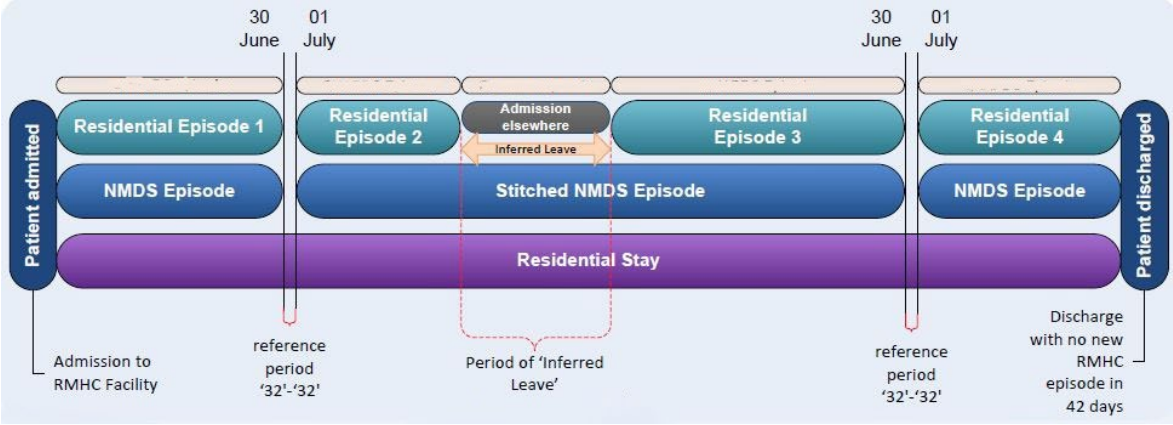
patients must be administratively ended on 30 June, and administratively started on 1 July. See section 4.2 and Appendix B.

3.3 Residential stay

A residential stay is the period of care beginning with a formal start of residential care and ending with a formal end of the residential care and accommodation. A residential stay may involve more than one reference period and more than one episode of residential care.

Residential stays are calculated by the MHAODB prior to submitting the RMHC NMDS by joining episodes of residential care across reporting periods (financial year) or joining episodes with inferred leave (see section 3.4).

Figure 1: Residential Stay



3.4 Leave

A consumer is on leave if they leave the specialised residential mental health care facility for short to medium term periods and intend to return to the facility to continue the current course of treatment / rehabilitation. Consumers receiving extended treatment can go on leave for a maximum of 42 days. However, for models of care with shorter treatment periods, such as Step Up Step Down units that have an expected length of stay of 28 days, leave periods are expected to be correspondingly shorter.

Leave can occur for a variety of reasons, including (but not limited to):

- treatment by specialised mental health service;
- treatment by non-specialised mental health service; and
- time in the community.

Date of starting leave

Record the full date (ddmmyyyy) on which the patient started leave.

Time of starting leave

Record the time on which the patient started leave.

Date returned from leave

Record the full date (ddmmyyyy) on which the patient returned from leave.

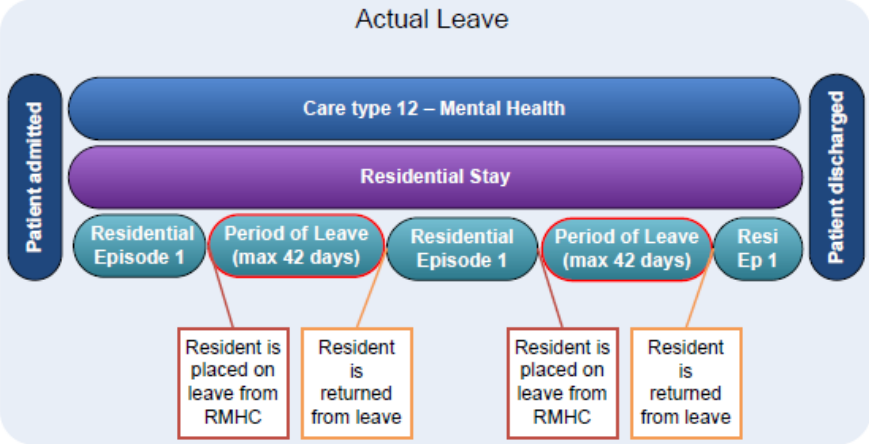
Time returned from leave

Record the time on which the patient returned from leave.

Leave category

For leave used in transitional leave scenarios (such as transition from residential mental health care to community mental health care), the 'Permanent' leave type is to be used for leave of extended periods, of up to 42 days when entering the leave in HBCIS (refer to figure below).

Figure 2: Leave



3.4.1 Inferred leave

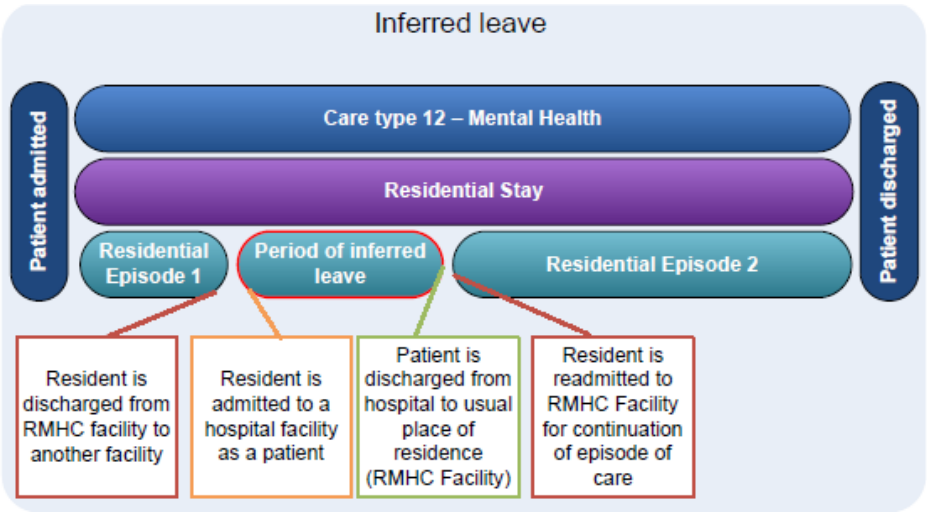
To satisfy the reporting requirements of the RMHC NMDS, MHAODB calculates inferred leave for consumers who meet specific criteria.

Where a consumer is transferred to a hospital for admission and the consumer returns as intended, the residential mental health care episode should be ended with a mode of separation code of '16 – Hospital transfer' and a new episode of residential mental health care created on return with a source of referral / transfer (admission source code) of '25 - Non-admitted patient referred from another hospital'. This business process should be followed irrespective of whether the consumer is intended to return to continue the current course of treatment / rehabilitation.

If the period between the residential mental health care episode ending and starting is less than 43 days,

the period of absence will be deemed to be inferred leave (refer to image below).

Figure 3: Inferred Leave



3.4.2 Calculation of leave days

The number of leave days for each leave period is calculated as the date the consumer returned from leave minus the date the consumer went on leave during a period of treatment or care. A day is measured from midnight to midnight. No leave day is counted where a consumer goes on leave and returns in a single day (i.e. is not out on leave at midnight).

The total number of leave days for an episode is calculated as the sum of all leave days for an individual.

The day the consumer goes on leave is counted as a leave day. The day the consumer returns from leave is a day of treatment and is not counted as a leave day.

Example
A consumer went on leave on 9 January and returned on 15 January. The consumer was on leave for 6 days.

A single period of leave cannot exceed 42 days.

Example
A consumer who commences leave on 9 May, must return to the residential mental health care facility on or before 20 June.

Calculation rules for leave days for residential mental health care facilities are consistent with the rules in

the QHAPDC manual except for the 7-leave day maximum rule.

3.4.3 Non-returned from leave

A consumer who goes on leave but does not return within the 42-day limit is to have their episode of residential care ended on the date that they left the facility (that is, on the date the leave commenced). The mode of separation (discharge status) for these episodes is to be recorded as '09 - - Non-return from leave'. For more information, see Non-return from leave in this manual.

3.5 Calculation of length of stay (LOS)

Calculation rules for length of stay (also referred to as a residential bed day) for residential mental health care facilities are consistent with the rules in the QHAPDC manual, except for the 7-leave day maximum rule.

3.6 Same day consumers

On rare occasions, a residential mental health care facility may have a same day consumer. A same day consumer is where a person's episode of residential mental health care starts and finishes on the same day. This consumer must:

- have had an intended stay of one night or more
- have been registered as a consumer at the facility
- meet the minimum criteria for care
- have undergone a formal process for the commencement of care
- have been separated prior to midnight on the day the episode started.

Note: For the purposes of the RMHCDC, same day consumers are assumed to be intended overnight stay consumers who were separated, died, or were transferred on their first day in the facility. **A special account class exists within HBCIS that should be used for these consumers – GPMLSSD**.

Consumers attending a day program at a residential facility are not considered to be residential consumers.

Additional information is provided in section 4.3.1 Account Class - Same Day Billing of this manual.

4. REPORTING GUIDELINES

The RMHC NMDS requires, as a minimum, episode details including episode start and end dates and times, source of referral, referral to further care, legal status, and diagnosis details. The RMHCDC has been expanded to include further details collected within QHAPDC including admission details, leave activity, morbidity details and mental health details. Guidelines for providing these details are available in the QHAPDC manual.

4.1 Consumer (patient) details

Please refer to Section 6 – Patient Details of the QHAPDC manual for information on reporting patient details. The following supplementary information is to be read in conjunction with the contents of the QHAPDC manual.

4.1.1 Address of usual residence

A patient may have one address or many addresses. For reporting purposes, the **permanent residential address** is the address extracted via the HQI. Residential addresses that reference a post office (PO) box **will not be accepted**.

The Australian Bureau of Statistics defines 'usual place of residence' as:

> *'the place where the person has or intends to live for 6 months or more, or the place that the person regards as their main residence, or where the person has no other residence, the place they currently reside' (in this case the residential mental health care facility).*

In the absence of a home address where the consumer is awaiting public housing, the address of usual residence may be reported as the address of the residential mental health care facility. This is also the case for episodes where the consumer stay extends across reporting periods (financial year), or for a transfer to another facility where a consumer is expected to return to this facility within 42 days.

Where the consumer episode of residential mental health care is ended (formally discharged), the address of usual residence should be the address to which the consumer is going.

The address of usual residence should be recorded following the guidelines provided in the QHAPDC manual. Note that the postcode should only be entered in the postcode field and should not be included as part of the suburb or town.

4.2 Change of reference period

All consumers remaining in residential mental health care facilities across financial years (reporting periods) must have their episode administratively ended at 23:59 on 30 June, using the mode of separation (discharge status) code '32 - Change of Reference period'. A new residential mental health

care episode should then be started using source of referral / transfer (admission source) code '32 - Change of Reference period' at 00:01 am on 1 July. This includes consumers who were admitted on 30 June.

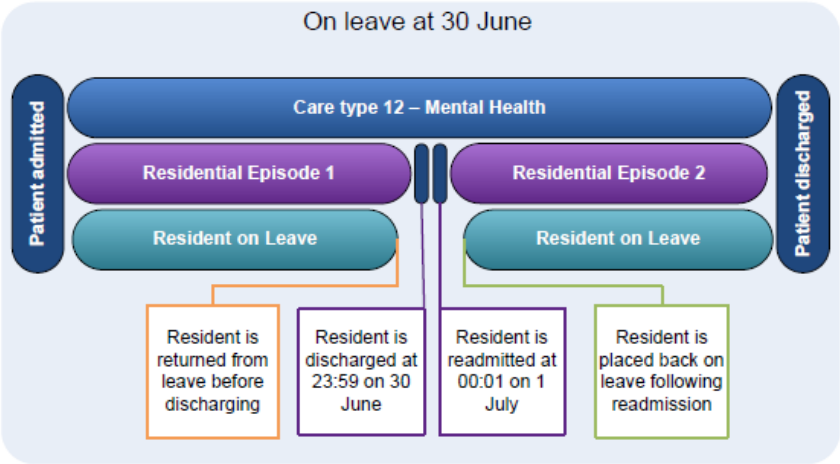
Important! Make sure you follow the steps in Appendix B to identify all consumers who are remaining in. HBCIS will not allow a consumer to be discharged until they have been administratively ended for all financial years in which they were remaining in. A missed consumer could result in needing to roll back a full year of transactions, fix the missed administrative ending, and re-enter the transactions for the year.

All mental health details for a consumer should be copied to the new episode from the previous episode. These details should be prefilled on the new episode in HBCIS. Note that the mental health data item 'referral to further care' should be coded as '98 - Not applicable' for end of financial year (reporting period) discharges.

Consumers who are on leave at 30 June should be returned from leave (administrative process only) at two minutes prior to midnight before their episode is administratively ended (i.e. returned from leave at 23:58, administratively ended at 23:59).

These consumers should then have a new residential care episode started using source of referral / transfer (admission source) code '32 - Change of Reference period' at 00:01 am 1 July. Once the new episode is created, these consumers should be placed back on leave a minute later at 00:02 am. The estimated date of return should be recorded as per the agreed clinical decision (maximum 42 days total period).

Figure 4: Change of reference period



4.3 Chargeable status

Consumers of residential mental health care facilities are considered to be public due to:

- consumers not having access to private doctors of their choice; and
- the private health insurance in Australia does **not** cover residential mental health care.

Residential facilities are not declared hospitals and therefore are not covered under the Private Health Insurance Act 2007.

A public consumer who is allocated single room accommodation is still a public consumer. Residential consumers should never be allocated a private account class.

Consumers who are being treated by a private clinician outside the facility should be considered public consumers for the purposes of treatment within the facility.

Fees and charges

The fees chargeable to consumers are set under the Queensland Health, Health Services Directive (QH-HSD-045:2016) and detailed in the Fees and Charges Register see:
https://www.health.qld.gov.au/directives/html/a#f

The principles of the Health Services Directive (HSD) are that the fees and charges be applied consistently and in a transparent way across all HHSs. The HSD also stipulates that fees raised do not exceed the amounts contained in the Queensland Health Fees and Charges Register.

Should it be determined, having assessed a consumer as being in circumstances of financial hardship, that fees be charged at a lower rate or waived, the processes in the local HHS Financial Management Practices Manual (FMPM) should be followed.

Medicare eligible

The Medicare eligibility of a patient depends on residency and other factors.

For further information see:

https://www.servicesaustralia.gov.au/individuals/services/medicare/medicare-card

Fees applicable to residential mental health care consumers are found in Section C of the Fees and Charges Register. These fees are the patient's contribution to their care and are based on a percentage of the pension.

Department of Veterans' Affairs (DVA)

Queensland Health and the DVA value the importance of Entitled Persons, and to the greatest extent possible, will ensure Entitled Persons have timely access to high quality treatment services.

Entitled Persons are consumers who hold either a Gold or White card. For more information in relation to DVA card holders in residential mental health care settings, please contact the DVA on 1300 550 457

(metropolitan) or 1800 550 457 (non-metropolitan).

A daily care fee (to contribute to their residential mental health care) may be required to be paid by the consumer.

Compensable

The National Health Reform Agreement defines a 'compensable consumer' as:

An eligible person who is;

- Receiving public hospital services for an injury, illness, or disease; and
- Entitled to receive or has received a compensation payment in respect of an injury, illness, or disease; or if the individual has died.

Follow local HHS processes for claiming against these insurers.

Prisoners

Prisoners are wards of the state and are therefore funded by the Queensland Government. There are no specific prisoner account class codes for mental health treatment, and they are not considered Medicare eligible whilst incarcerated. Any treatment should be coded using the Prisoner account class codes GPCS or GPCSSD in conjunction with the prisoner admission and/or separation codes.

Medicare Ineligible

An ineligible consumer is someone who does not hold a valid Medicare card.

4.3.1 Account class

The account class code identifies the billing classification of the consumer and determines the consumer's daily bed charge.

A residential mental health care facility, including a step up step down unit, should NOT use code GPE. This code is for public acute inpatients in a hospital setting only. In cases where the residential mental health care should not attract fees, code GPEMRC should be used. This code has a nil fee.

The account classes relevant for mental health consumer receiving residential mental health care are provided in the table below. Note that standard account class codes do not apply to prisoners. Refer to the section on prisoners above.

HBCIS Account Class	Account Class Code	Account Class Description
Public	GPEMRC	General Public Mental Health Residential Care
	GPMLS	Gen Public Mental Health Long Stay And Over 21 ETF – Public
	GPMLSSD	Gen Public Mental Health Long Stay And Over 21 ETF – Public Same Day (CCU use only)
	GPMLSDVA	Gen Public Mental Health Long Stay - DVA
	GPMLSU21	Gen Public Mental Health Long Stay – U21 and U21 ETF – Public
	GPETFU18	Extended Treatment Facility – U18
Partial	GPMLSP	Gen Public Mental Health Long Stay Partial and ETF – Partial
	GPMLSPDVA	Gen Public Mental Health Long Stay DVA - Partial
Ineligible	GPI	Medicare Ineligible
	GPILS	Medicare Ineligible Long Stay

4.4 Source of referral / transfer (admission source)

The source of referral / transfer (admission source) captures the referral point for a consumer immediately before they start a period of residential mental health care (either through the formal start of the residential stay or the start of a new reference period).

All consumers remaining in residential mental health care facilities across financial years (reporting periods) must have their episode administratively ended, with a subsequent administrative start, with a source of referral for the subsequent start being '32 - Change of Reference period'. Refer to 'Change of Reference Period' in this manual for further details.

A consumer cannot be transferred by a residential mental health care facility to itself. Where account class changes are required, this should be captured as an account class change, and not as an admission and discharge. Where a consumer is leaving the residential mental health care facility for short term care, they should either be transferred to another facility, or where the care is not at an established facility, they should either be put on leave or discharged to 19 'Other' and readmitted as '22 - Routine re-admission not requiring referral'.

Note: The source of referral / transfer (admission source) codes '24 - Admitted patient transferred from another hospital', '02 A&E', '03 Outpatient department', '33 Rapid Access – this hospital', '19 Retrieval from another hospital' and '06 - Episode change' are **not** valid for use by a residential mental health care facility, refer to section '4.12.1 Admitting consumers to a residential mental health care facility from hospital' for further details.

4.5 Care type

The term 'care type' refers to the nature of the treatment / care provided to a consumer during an episode of care. For all residential mental health care facilities, care type should be assigned as '12 – Mental Health 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.

At the time of mental health care type assignment, a multidisciplinary management plan may not be in place but the intention to prepare one should be known to the clinician assigning the care type.

Refer to section 7.15 Care Type of the QHAPDC Manual for definitions.

Note: As the care type for residential mental health care can only be '12 – Mental Health Care', residential facilities should never record an episode change with 06 as the source of referral / transfer (admission source) and mode of separation (discharge status).

As consumers in a residential facility should only have care type '12 - Mental Health Care', there will be no change in care type during a residential mental health care episode.

If a consumer is transferred to a hospital within the same HBCIS instance for treatment, please follow the business rules in Section 4.12 RMHCDC Business Rules Reference Guide.

4.6 Planned same day

As residential mental health care is intended to be provided on an overnight basis, the Planned Same Day flag should be coded as 'No'. On occasions, a consumer may stay for a single day. In this circumstance, the same day account class code should be used and the Planned Same Day flag be set to 'No'.

4.7 Standard unit code

Standard unit codes were developed by the Queensland Department of Health (DoH) due to a need to more readily analyse treating doctor unit / specialty information across all hospitals.

For residential facilities, the standard unit code represents the model of care for the specialised mental health treatment provided at the facility. All patients receiving this specialised mental health care should be assigned the correct standard unit code for the residential facility, regardless of which unit(s) the primary care doctor may be associated with.

The following standard unit codes are relevant for residential mental health care:

	Code	Description
HBCIS Facilities	PYRA	Psychiatric Adult Residential (CCUs)
	PYSA	Psychiatric Adult Step Up Step Down
	PYSY	Psychiatric Young Persons (Youth) Step Up Step Down

The code that best describes the service provided by the residential mental health care facility should be selected. Appendix C contains details on how to assign the correct residential standard unit code when the primary care doctor is not based within the residential care facility.

Note that outliers from the acute psychiatric inpatient unit at the hospital should not be coded as residential mental health care patients. See Appendix C for more information.

Code PYRA Psychiatric Adult Residential (CCUs)

Specialised residential mental health units principally targeting the general adult population (aged 18-64 years). These units provide medium to long-term 24-hour clinical care and supervised residential rehabilitation for adults whose level of mental illness and disability requires a structured living environment. These units are residential in nature and may be delivered in a collaboration between clinical and community support services. The facility is situated in the community, providing a multidisciplinary service that supports consumers to acquire and maintain daily living skills, increase capacity and confidence to function within and return to the community.

Code PYSA Psychiatric Adult - Step Up Step Down

Subacute specialised residential mental health units principally targeting the general adult population (aged 18-64 years). These units are residential in nature, delivered in collaboration between clinical and community support services, and provide short term (up to 28 days) 24-hour care for adults who need a level of support and clinical care that does not require admission into an inpatient unit but will benefit from more intensive clinical treatment and psychosocial support. Step Up Step Down units:

- prevent further deterioration of a person's mental state and associated disability, and in turn reduced likelihood of admission to an acute inpatient unit (step up); and
- enable early discharge from acute mental health inpatient units through the provision of an intensive safe and supportive subacute residential community program (step down).

Alternatives to Hospitalisation and Transitional Recovery Services deemed in scope for the RMHC DC will report using standard unit code PYSA.

Code PYSY Psychiatric Young Persons (Youth) - Step Up Step Down

Subacute specialised residential mental health units principally targeting the general young person's population (aged 16-21 years). These units are residential in nature, delivered in a collaboration between clinical and community support services, and provide short term (up to 28 days) 24-hour mental health care for young persons who need a level of monitoring and clinical care that does not require admission to an inpatient unit but will benefit from more intensive clinical treatment and psychosocial support. Youth Step Up Step Down Services:

- prevent further deterioration of a person's mental state and associated disability, and in turn reduced likelihood of admission to an acute inpatient unit (step up); and
- enable early discharge from acute mental health inpatient units through the provision of an intensive safe and supportive subacute residential community program (step down).

4.7.1 Standard ward code

The standard ward code relevant for residential mental health care facilities is MENR (Specialised Mental Health Residential). All episodes should be reported with this standard ward code. Standard ward code is set within HBCIS and HQI by your local HBCIS administrator.

4.8 Mode of separation (discharge status)

The mode of separation (discharge status) captures the place to which a consumer is referred immediately following exit from the residential mental health care facility, or reason why an episode of residential mental health care has ended.

A consumer cannot be transferred by a residential mental health care facility to itself. Where account class changes are required, this should be captured as an account class change, and not as an admission and discharge. Where a consumer is leaving the residential facility for short term care, they should either be transferred to another facility, or where the care is not at an established facility, they should either be put on leave or discharged to 19 'Other' and readmitted as '22 - Routine re-admission not requiring referral'. All consumers remaining in residential mental health care facilities across financial years (reporting periods) must have their episode administratively ended with a mode of separation (discharge status) of '32 - Change of reference period'. Refer to 'Change of reference period' in this manual.

A consumer who is sent to a hospital emergency department due to an emergency, accident or sudden exacerbation of an acute condition should be coded as 16 Transferred to another hospital, with a referral to further care as 07 Acute Hospital non-admitted patient. A consumer should NOT be recorded as 01 Home/usual residence in this situation.

Note: Consumers in residential facilities should only have care type '12 - Mental Health'. Refer to

Section 4.5 Care Type above.

The following mode of separation (discharge status) code is not valid for use by a residential mental health care facility:

- Mode of separation (discharge status) '06 - episode change' should not be used by residential mental health care facilities, as this code relates to a change in care type. As consumers in a residential facility should only have care type '12 - Mental Health', there will be no change in care type during an episode.

4.9 How to record leave

Leave is when the consumer leaves the residential facility for a period of not more than 42 days and intends to return to the facility to continue the current course of treatment.

Leave should only be reported if the consumer is absent from the facility at midnight. If a consumer goes on leave and returns in the same day, this is not included in the calculation of leave days.

A consumer who is transferred to a hospital for admission, should have their residential mental health care episode ended with a mode of separation (discharge status) code of '16 - Hospital transfer'. If they return, a new residential mental health care episode should be created with a source of referral / transfer (admission source) code '25 - Non-admitted patient referred from another hospital'. This business process should be followed irrespective of whether the consumer is intended to return to continue the current course of treatment / rehabilitation.

4.9.1 Non-return from leave

If a consumer goes on leave and does not return within the 42-day limit, the leave record should be removed, and the episode of residential mental health care ended on the day the leave commenced, with a mode of separation (discharge status) of 09 non-return from leave.

Where a consumer is on leave at the end of the reporting period (financial year), has been statistically discharged and readmitted following the end of year processing, and **does not return from leave in the new reporting period** (financial year):

- the leave record for the episode in the new reporting period should be deleted, along with the episode
- the leave record in the previous reporting period should be removed; and the consumer episode of residential care should be ended on the date they went on leave
- MHAODB should be contacted, as the previous year may have been closed off, requiring a manual update in all downstream reporting systems.

If the consumer subsequently returns to the residential mental health care facility after a non-return from

leave, a **new** episode of residential care is to be recorded.

4.10 Morbidity details

Morbidity details include the recording of codes for diagnoses (disease), chronic conditions, signs and symptoms, abnormal findings, social circumstances, external causes of injury or disease, morphology, and procedural information in relation to a consumer's episode of residential mental health care. Morbidity details are to be provided following the guidelines set out in the QHAPDC manual.

Note that the Principal Diagnosis should reflect the primary reason a consumer is receiving care in a Residential Mental Health Facility. For this reason, it is expected that the Principal Diagnosis would be a mental health related condition. If a consumer has a medical emergency or suffers an exacerbation of an acute condition, these should be recorded in additional diagnoses. They should NOT be recorded as the Principal Diagnosis in a residential mental health episode as these are not the primary reason the consumer is receiving residential mental health care.

4.11 Mental health details

These details should be captured for all consumers in residential mental health care facilities. Most mental health details are captured only once during the episode. The mental health details include:

- The type of usual accommodation prior to the formal commencement of residential mental health care.
- The self-reported employment status of the consumer immediately prior to the formal commencement of residential mental health care.
- The pension status of the consumer prior to the formal commencement of residential mental health care.
- Whether the consumer has previously been admitted to an acute or psychiatric hospital for psychiatric care prior to the formal commencement of residential mental health care. **Note**: This does not include previous entry into a residential mental health care facility.
- Where the consumer has been referred to for care after the residential mental health care episode has been completed.
- The legal status of the consumer indicating if their treatment was involuntary at any time during the residential mental health care episode.
- Whether the consumer has received any previous non-admitted treatment for a mental health condition prior to formal entry to the residential mental health care facility. **Note**: This includes previous residential mental health care.

Details for recording *Referral to further care* are listed below. All other mental health details are to be provided following the guidelines set out in the QHAPDC manual.

Note: When a consumer episode of residential care is ended due to remaining in at the end of the reference period (financial year), the mental health details for the new episode (excluding referral to further care) should be recorded as the **same as the previous episode**, to ensure continuity across the residential stay. Further details on the end of reporting period processes can be found at Appendix B.

4.11.1 Referral to further care

Referral to further care relates to the primary mental health care a consumer will receive following discharge from the residential mental health care facility.

Where a consumer has been referred to more than one type of ongoing care, the principal provider of continuing care should be entered, that is, the person or facility who is primarily responsible for managing the consumer's ongoing care.

All Facilities	Record the following codes to indicate the place to which the patient is referred	
	Code	**Description**
	01	Not referred
	02	Private psychiatrist
	03	Other private medical practitioner
	04	Mental health/alcohol and drug facility - admitted patient
	05	Mental health/alcohol and drug facility - non-admitted patient
	06	Acute hospital - admitted patient
	07	Acute hospital - non-admitted patient
	08	Community health program
	09	General Practitioner
	10	Residential mental health care facility
	29	Other
	98	Not applicable

Code 01 Not referred

Used for consumers who were not referred to further care. This includes consumers who left against medical advice or did not return from leave and therefore did not receive any referrals for ongoing care.

Note: consumers who died during their care should be coded as '98 Not applicable'.

Code 02 Private psychiatrist

Used for consumers who will receive ongoing care from a private psychiatrist. This includes consumers who were receiving care from a private psychiatrist during their residential care and intend to continue receiving care from the private psychiatrist following their exit from residential mental health care.

Code 03 Other private medical practitioner

Used for consumers who will receive ongoing care / management from a private medical practitioner who specialises in a field other than psychiatry and is not practicing as a general practitioner.

Code 04 Mental health / alcohol and drug facility – admitted patient

Used for consumers who are referred to a designated specialised mental health facility or a specialised alcohol and drug treatment facility as an admitted patient. This includes specialised mental health or alcohol and drug treatment units in acute hospitals, and psychiatric hospitals.

Consumers who are transferred to a designated specialised mental health facility for treatment of an acute mental health condition, and are expected to return to the residential facility, should have their further care coded as 04, regardless of any other ongoing care they may be receiving.

Consumers who are discharged to be transferred to hospital for treatment as part of their ongoing care (e.g. electro-convulsive therapy) and will return to the residential mental health care facility should have their referral to further care coded as 10 Residential mental health care facility.

Code 05 Mental health / alcohol and drug facility – non-admitted patient

Used for consumers who are referred to a specialised mental health facility or a specialised alcohol and drug treatment facility for non-admitted treatment. This includes outpatient or ambulatory programs run out of specialised units in acute hospitals or psychiatric hospitals, and services provided through a community mental health service or a community alcohol and other drug treatment service.

Code 06 Acute hospital – admitted patient

Used for consumers who are referred or transferred to an acute hospital for an acute condition. This includes consumers receiving care for a mental health condition in a hospital that does not have a designated specialised mental health unit, and consumers receiving care for a non-mental health condition.

Note that if a consumer is transferred to hospital for treatment as part of their ongoing care (e.g. electro-convulsive therapy) and will return to the residential mental health care facility, their referral to further care should be coded as 10 Residential mental health care facility.

Code 07 Acute hospital – non-admitted patient

Used for consumers who are referred to an outpatient or ambulatory program run from an acute hospital, or to an emergency department. This includes consumers receiving care for a mental health condition in a hospital that does not have a specialised mental health service, and consumers receiving care for a non-mental health condition. It also includes consumers who were sent to an emergency department as a result of an emergency or crisis at the residential mental health care facility.

Code 08 Community health program

Used for consumers who are referred to a community health program that is not a specialised community mental health service nor a specialised community alcohol and other drug treatment service.

Code 09 General practitioner

Used for consumers who will receive their ongoing care / management from a general practitioner, or a specialist practicing as a general practitioner. This does not include registered psychiatrists.

Code 10 Residential mental health care facility

Used for consumers who are transferred to another facility that meets the criteria for a residential mental health care facility, that is another Community Care Unit, Step Up Step Down Unit or a Youth Residential Rehabilitation Service. If the other facility does not meet the criteria for a residential mental health care facility, referral to further care should be coded as '29 Other'.

Also used for consumers who will return to this residential mental health care facility following admitted patient treatment required as part of their ongoing care that cannot be performed at this residential mental health care facility (eg electro-convulsive therapy).

Code 29 Other

Used for all care that does not meet the conditions of other codes. This includes referral to facilities managed by private or charity based organisations. It also includes referrals to private allied health practitioners, including private psychologists.

Code 98 Not applicable

This code should be used for administratively ending residential mental health care episodes where the consumer is remaining in at the end of the reference period (financial year), or where a consumer died during residential care.

4.12 RMHCDC Business Rules Reference Guide

4.12.1 Admitting consumers to a residential mental health care facility from hospital

For consumers starting a residential mental health care episode referred / transferred from a hospital (including emergency and outpatient departments), the following details should be used:

HBCIS Items	Details
Admission date	Date resident was admitted to the residential mental health care facility
Admission time	Time resident was admitted to the residential mental health care facility
Admission source	**25 – Non-admitted patient referred from another hospital**
Extended source	Facility ID of hospital the patient is transferring from

Admission source codes 19 Retrieval not from another hospital, 03 Outpatient department and 02 A&E should not be used by a residential mental health care facility. Where a consumer has left the residential mental health care facility (either against advice or for a medical emergency) and later been returned via an emergency department, admission source 25 should be used.

Assigning unit and treating doctor for a consumer whose treating doctor is not based at the residential facility

Where the doctor of the acute ward at the hospital retains the care of the consumer receiving residential mental health care in the residential facility, enter the correct unit for the residential facility. This will ensure the correct standard unit code is applied during extract.

Enter the correct doctor details for the treating doctor.

A warning message will be generated, informing the user that the treating doctor is not associated with the selected unit. Confirm at the prompt that both unit and treating doctor selected are correct and file the record.

Assigning unit and treating doctor for a consumer who is receiving acute care in a residential facility

On rare occasions, it may be necessary for a patient to be ‘admitted’ temporarily to a residential facility as an outlier from the hospital acute mental health inpatient unit. The acute mental health inpatient team retains responsibility for management and review of the patient in accordance with local outlier procedures.

In this case, within HBCIS, the acute patient is **not admitted** to a unit in the residential facility unit.

Instead, they should be admitted to a virtual ward / unit associated with the acute hospital with a naming convention that enables hospital staff to identify that the residential facility is the patient's physical location.

4.12.2 Transferring residential mental health care consumers to hospital

For consumers discharged from a residential mental health care facility for the purpose of accessing hospital-based admitted or emergency treatment (for either mental health reasons or to address physical health issues), the following discharge details should be used:

HBCIS Items	Details
Discharge date	Date resident was discharged from residential mental health facility
Discharge time	Time resident was discharged from residential mental health facility
Discharge code	**16 – Hospital transfer**
Destination	Facility ID of hospital the patient is transferring to
Referral to further care	**If admitted to the hospital** **04 - Mental health / alcohol and drug facility – admitted patient OR** **06 - Acute hospital - admitted patient** **If not admitted (eg sent to the emergency department)** **07 – Acute hospital – non-admitted patient**

Consumers accessing hospital-based outpatient or community treatment who intend to return to the residential mental health care facility for continued care should be placed on leave from the residential mental health care facility during the hospital treatment, and not discharged.

4.12.3 Transferring residential mental health care consumers to a different residential mental health care facility

For consumers discharged from a residential mental health care facility for the purpose of other residential mental health care treatment the following discharge details should be used:

HBCIS Items	Details
Discharge date	Date resident was discharged from residential mental health facility
Discharge time	Time resident was discharged from residential mental health facility
Discharge code	**31 – Residential mental health care**
Destination	Facility ID of residential care facility the patient is transferring to
Referral to further care	**10 – Residential mental health care facility**

Abbreviations

Abbreviation	Description
AIHW	Australian Institute of Health and Welfare
AITU	Analytics, Improvement and Transformation Unit
ATH	Alternatives to Hospitalisation
CCU	Community Care Unit
CIMHA	Consumer Integrated Mental Health and Addiction application
CMO	Community Managed Organisation
CRDS	Corporate Reference Data System
DoH	Queensland Department of Health
DVA	Department of Veterans' Affairs
ETF	Extended Treatment Facility
EVA Plus	Electronic Validation Application
EX	External Cause
HASP	Housing and Support Program
HBCIS	Hospital Based Corporate Information System
HHS	Hospital and Health Services
HQI	Homer Queensland Interface
ID	Identifier
ICD-10-AM	International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
METeOR	Metadata Online Registry
MHAODB	Mental Health Alcohol and Other Drugs Branch
MHAP	Mental Health Addiction Portal (app)
MHSO	Mental Health Service Organisation
NGO	Non-government Organisation
NMDS	National Minimum Data Set
OD	Other Diagnosis
PD	Principal Diagnosis
PR	Procedure
QHAPDC	Queensland Hospital Admitted Patient Data Collection
QHEPS	Queensland Health Electronic Publishing Service
RMHC	Residential Mental Health Care

Abbreviation	Description
RMHCDC	Residential Mental Health Care Data Collection
RMHC NMDS	Residential Mental Health Care National Minimum Data Set
SCT	Systems and Collections Team, Mental Health Alcohol and Other Drugs Branch
SSB	Statistical Services Branch, Healthcare Purchasing and System Performance Division
SUSDU	Step Up Step Down Unit
TRS	Transitional Recovery Service

Appendix A: List of Residential Mental Health Care Facilities in Queensland

The following facilities meet the criteria for a residential mental health facility and are in scope for the RHMCDC in 2025/2026.

HHS	Residential Facility ID	Residential Facility	Facility Type
Cairns and Hinterland	82008	Cairns Community Care Unit	CCU
	83005	Cairns Youth Step Up Step Down Unit	SUSDU
	83001	Cairns Adult Step Up Step Down Unit	SUSDU
Central Queensland	82010	Rockhampton Community Care Unit	CCU
	83004	Central Queensland Step Up Step Down Unit	SUSDU
Darling Downs	82009	Toowoomba Community Care Unit	CCU
Gold Coast	83014	Gold Coast Transitional Recovery Service	TRS
Mackay	83000	Mackay Step Up Step Down Unit	SUSDU
Metro North	82001	Pine Rivers Community Care Unit	CCU
	82002	Redcliffe-Caboolture Community Care Unit	CCU
	82003	Somerset Villas Community Care Unit	CCU
	83012	Caboolture Youth Step Up Step Down Unit	SUSDU
Metro South	82000	Coorparoo Community Care Unit	CCU
	82005	Bayside Community Care Unit	CCU
	82006	Logan Community Care Unit	CCU
	83002	Acmena House	SUSDU
	83011	Logan Youth Step Up Step Down Unit	SUSDU
Sunshine Coast	82004	Mountain Creek Community Care Unit	CCU
	83013	Sunshine Coast CSTARS	SUSDU
Townsville	82012	Charters Towers Community Care Unit	CCU
	82014	Townsville Community Care Unit	CCU
West Moreton	82011	Gailes Community Care Unit	CCU
Wide Bay	82007	Wide Bay Community Care Unit	CCU
	83003	Wide Bay Step Up Step Down Unit	SUSDU

Appendix B: End of reference period processing

The end of reference period process for residential mental health care facilities relies on specific dates and it is important that these steps are followed carefully.

It is recommended that these processes are actioned as close as possible following 1 July as any delay may cause increased workload such as the need to reverse progressive billing.

Note that there is an automated process in HBCIS that applies progressive billing on the first day of the month. If this process has occurred for July prior to the end of reference periods processing, there will be a need to reverse the progressive billing back to the June progressive billing run, OR to the consumer's admission date, whichever is later, for each consumer remaining in.

Pre-processing activities

Prior to processing the end of reference period, it is advisable to run the following reports, and remedy any anomolies:

- RMHC Incomplete MH Details Report (QLD)
  Use this report to update any missing details from the mental health screen.

- RMHC Reference Period 'Remaining In' Report (QLD)
  Use this report to identify consumers remaining in residential mental health care facilities across financial years. Please note this report lists all the current RMHC inpatients where the admission date is in a ***previous financial year***. Therefore, running this report prior to 1 July each year will not list all the remaining in RMHC inpatients for the ***current financial year***. It is best to wait until 1 July to run this report.

Consumers who are on leave at 30 June should be returned from leave (administrative process only) at two minutes prior to midnight before their episode is administratively ended (i.e. returned from leave at 23:58).

Important: make sure you include all consumers who are remaining in as part of the end of reference period processing. All consumers must be administratively ended for each financial year for which they were remaining in before they can be discharged. A missed consumer will result in a need to reverse all transactions including progressive billing at discharge.

End of reference period processing

Manually processing the end of reference period

If the end command is executed at any stage during the steps detailed below, the automated process will cease.

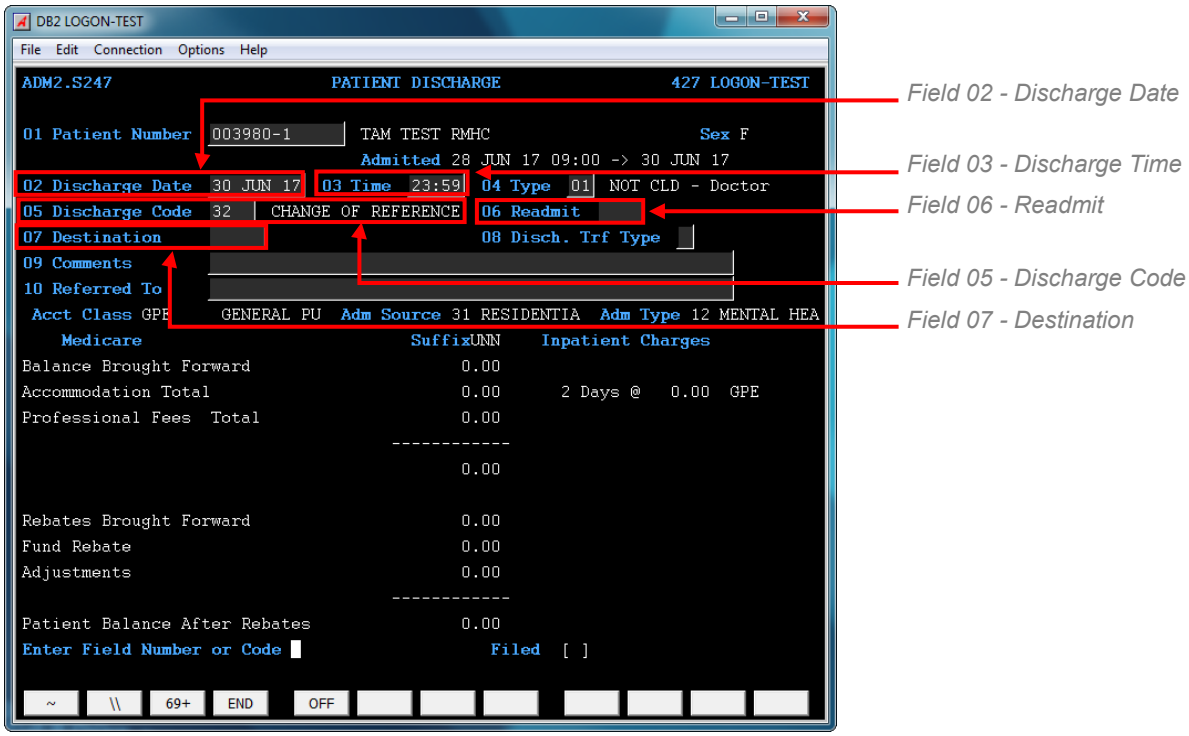
If this occurs, it will be necessary to follow the process without the automated HBCIS functionality (i.e. readmit manually where no fields will be pre-populated with previous admission data).

Menu Path

Admissions, Transfers and Discharges Main Menu > Inpatient Management Menu > Entry and Enquiry Menu > Patient Discharge

All consumers remaining in residential mental health care facilities across reference periods (financial years) must have their episode administratively ended at 23:59 on 30 June, using the mode of separation '32 - Change of reference period'.

Patient Disharge Screen:



The fields in the table below are to be completed for a statistical discharge.

HBCIS Item	Code	Details
Field 02	30 Jun	Discharge date must be '30 Jun YY'
Field 03	23:59	Discharge Time must be 23:59
Field 04	01	Type should not require entry, but if it does, enter 01 NOT CLD
Field 05	32	Discharge Code Change of Reference Period
Field 06	Y	If this field cannot be selected, just enter past and continue with the process. If you are able to select it, enter Y. Ensure the discharge type is 32.
Field 07	Destination	must be left blank

On filing this screen, HBCIS will automatically trigger the creation of a new residential mental health care episode with a source of referral '32 - Change of Reference period' at 00:01 on 1 July.

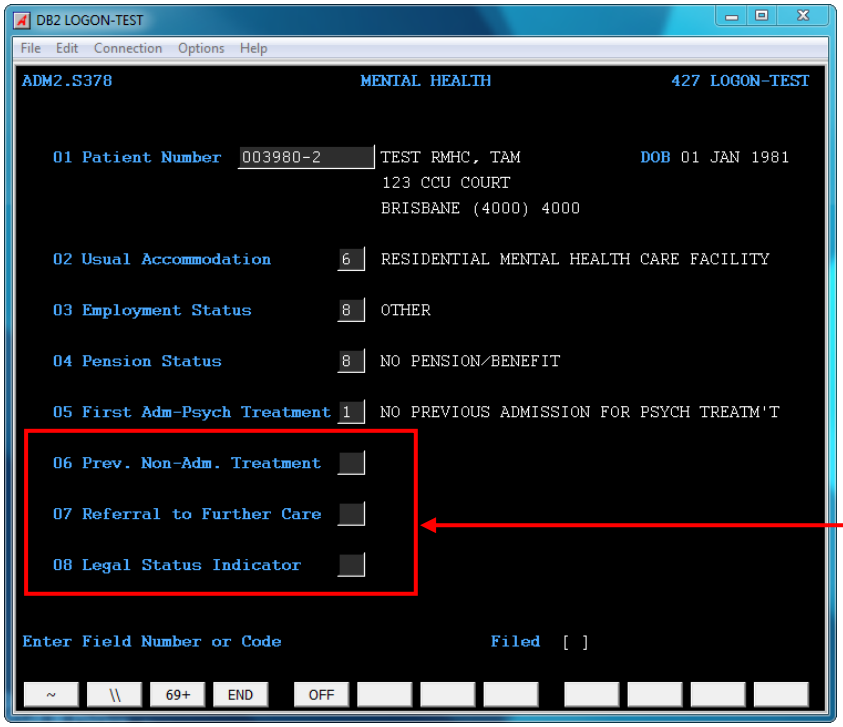
Menu Path

(Not required if processing following discharge code 32.)

HBCIS will automatically trigger the creation of a new residential mental health care episode following a mode of separation type of 32 and will pre-populate a number of fields on the patient admission screen. However, it is important to check the details and complete the remaining fields.

First, you will need to file the mental health details for the discharge:

Mental Health Details Screen



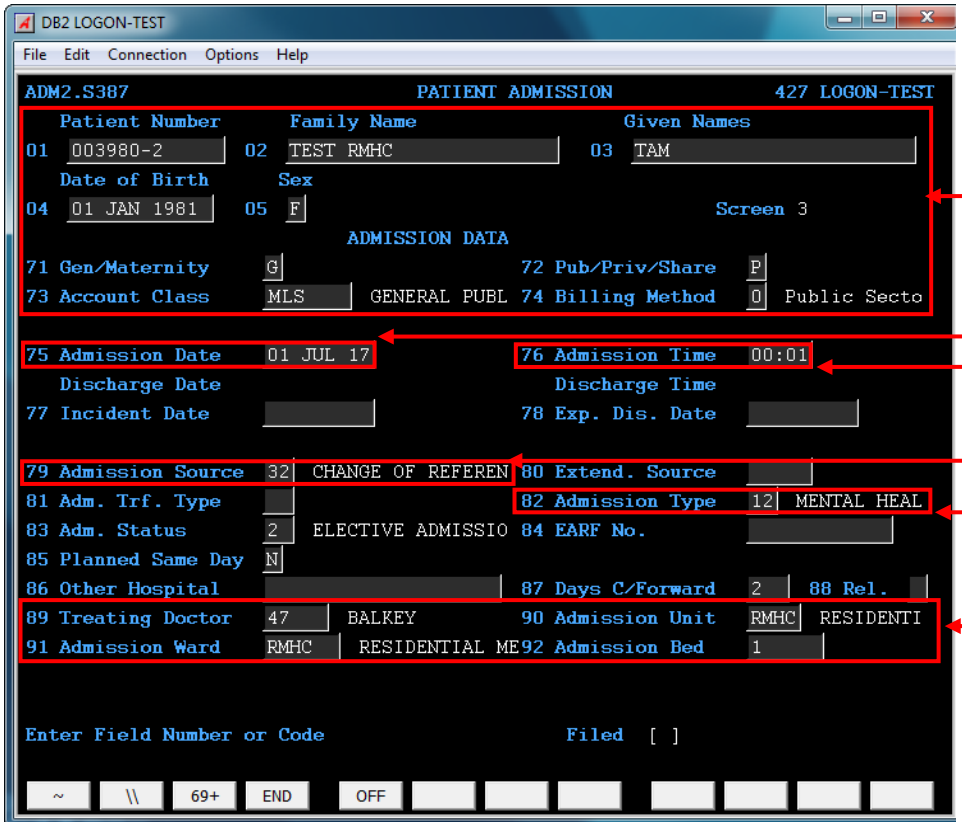
Field 06-08 for completion

The fields outlined in the following table will not be prefilled during the automated HBCIS functionality and will require completion prior to formally ending the residential mental health episode of care. It will be easier to complete these details if the RMHC Incomplete MH Details Report has been run prior. This should help with completing Fields 06 and 08.

HBCIS Item	Code	Recommended Data
Field 06		As previously entered
Field 07	98	Not Applicable
Field 08		Enter valid legal status – 1 if this person has been involuntary at any point in the episode; otherwise 2.

On filing this screen, HBCIS will open the readmission screen.

Patient Admission Screen 3

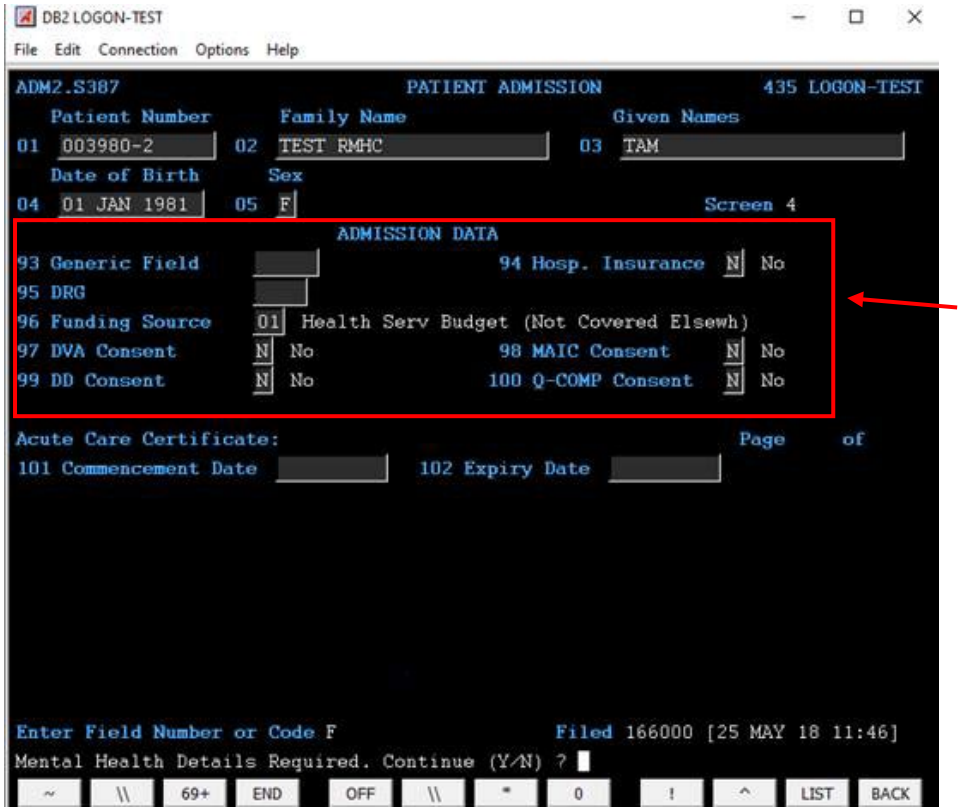


A number of fields will be pre-populated with information from the previous episode of residential care and some fields will require completion.

HBCIS Item	Code	Details
Field 01-74	Pre-Populated	As per the prior episode
Field 75	01 Jul YY	Admission time must be 01 Jul
Field 76	00:01	Admission time must be 00:01
Field 79	32	Admission Code must be Change of Reference Period
Field 82	12	Must be care type 12
Field 83	Pre-Populated	As per the prior episode
Field 85	Pre-Populated	As per the prior episode
Field 89-92	Pre-Populated	As per the prior episode

Once fields on screen 3 are completed, screen 4 will be displayed to complete additional data.

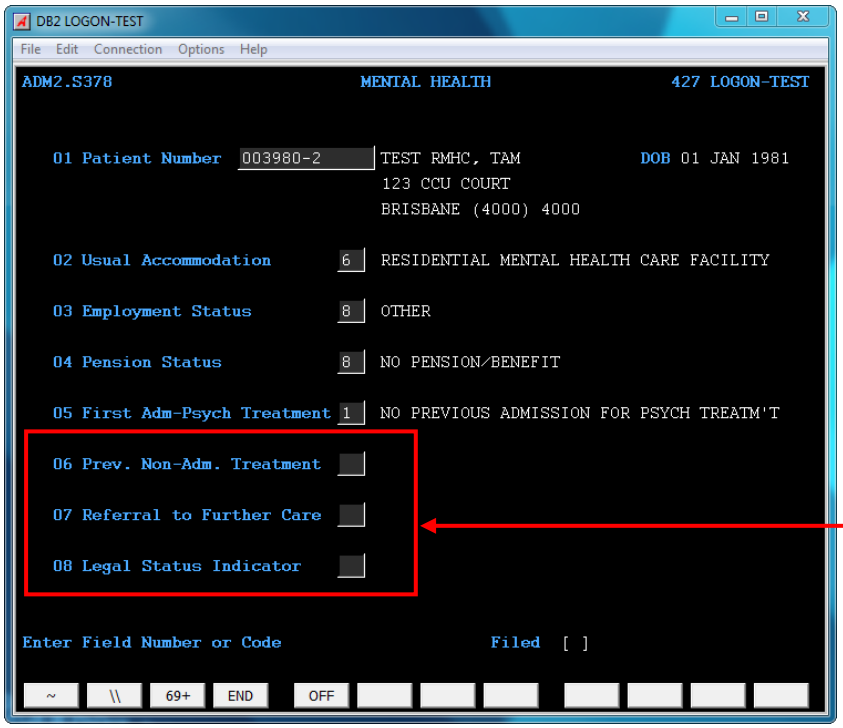
Patient Admission Screen 4



Admission Data for completion

On filing this screen HBCIS will prompt for user to update the Mental Health Details for the consumer. Enter 'Y' for Yes.

Mental Health Details Screen



Field 06-08 for completion

The fields outlined in the following table will not be prefilled during the automated HBCIS functionality and will require completion prior to formally ending the residential mental health episode of care.

HBCIS Item	Code	Recommended Data
Field 06		As per prior episode
Field 07		To be updated at the end of episode
Field 08		As per prior episode

On filing this screen, HBCIS will return the user to the Patient Admission screen. Once any additional prompts are completed, HBCIS will return the user to the Patient Discharge screen to process the next consumer record.

End of reference period processing when the consumer is on leave

Consumers who are on leave at 30 June should be returned from leave (administrative process only) at two minutes prior to midnight before their episode is administratively ended (i.e. returned from leave at 23:58).

The steps below are to be used in conjunction with the steps detailed in the 'End of reference period process' section of this appendix.

1. Returning a resident from leave

It is important to take note of the leave details prior to returning the consumer from leave. These details will be required when placing the consumer back on leave for the remainder of the leave period.

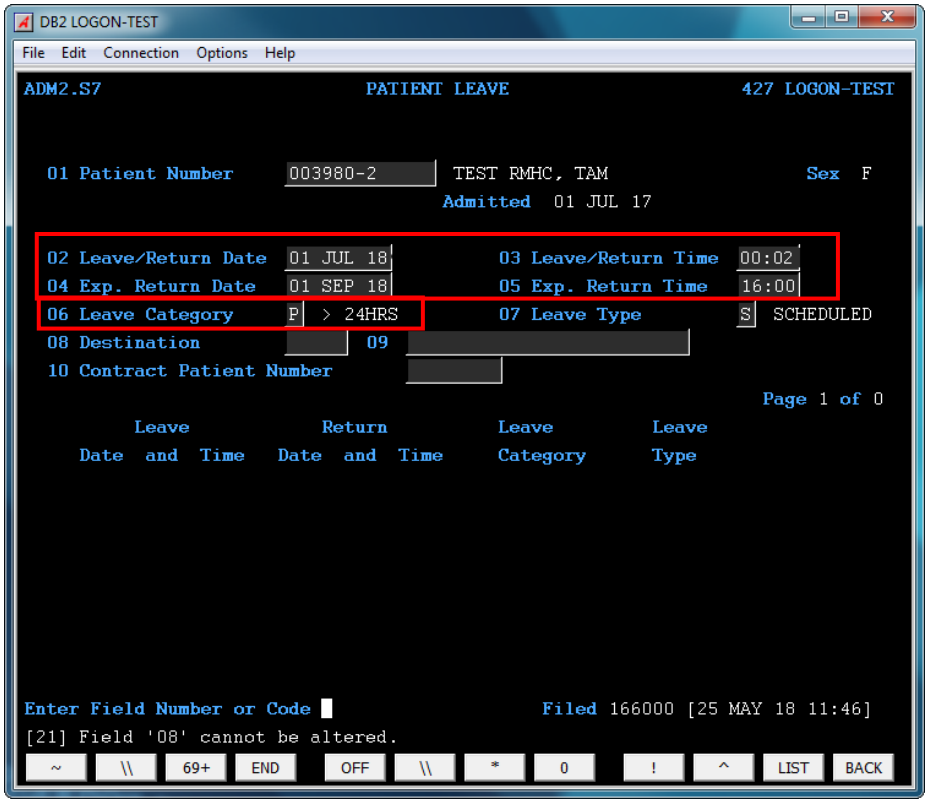
Return the consumer from leave by entering the following details into the Patient Leave screen.

HBCIS Item	Code	Details
Field 02	30/06/YY	The date must be 30 June
Field 03	23:58	The time must be 23:58

2. Complete the end of reference period process

3. Placing the consumer back on leave

Place the consumer back on leave by entering the following details in the Patient Leave screen.



HBCIS Item	Code	Details
Field 02	01/07/YY	The date must be 1 July
Field 03	00:02	The time must be 00:02
Field 04	DD/month/YY	Enter the original expected return date
Field 05	HH:MM	Enter the original expected return time
Field 06	P	Leave periods greater than 7 days require a leave category code of P
Field 07	S	Scheduled Leave
Field08-10		Re-enter the original values if they are recorded in the original leave screen, otherwise enter through and File the screen

RMHC Incomplete MH Details Report (QLD)

Menu Path

Admissions, Transfers and Discharges Main Menu > Inpatient Management Menu > Additional Reports Menu > RMHC Incomplete MH Details Report (QLD)

The Additional Reports Menu includes the RMHC Incomplete MH Details Report, designed to identify current residential mental health care consumers where their mental health details are incomplete or missing (fields 02 through 08).

The report will print with a page per residential mental health care facility that contains data, if the report contains no data it will print with ‘NOTHING TO REPORT’ in the report line.

```
11:58  01 JUN 18    DB2 - FUTURE RELEASE - TEST                                                    Page    2
(ADM2.P826)         RMHC INCOMPLETE MH DETAILS REPORT as at 01 JUN 18                          442 LOGON-TEST
                    Facility: 82008 CAIRNS COMMUNITY CARE UNIT

Patient                                                  <--Admission-->
Number        Patient Name                 Adm. Type     Date      Time    Ward    Unit

003966-2      MAR, NEW TEST 8              12 MENTAL HEALTH C  03 JUL 17  15:01  RMH2    PYSY PSYCHIATIRC YOUNG PE
003976-1      TEST, RMH2                   01 ACUTE CARE       01 JUN 17  10:09  RMH2    PYSD PSYCHIATRIC ADOLESCE
```

RMHC Reference Period ‘Remaining In’ Report (QLD)

Menu Path

Admissions, Transfers and Discharges Main Menu > Inpatient Management Menu > Additional Reports Menu > RMHC Reference Period ‘Remaining In’ Report (QLD)

The Additional Reports Menu includes the RMHC Reference Period Remaining In Report to identify residential mental health care consumers who have not had their end of reference period processing completed. This new report will return any consumers with an open episode of residential mental health care where their admission (start) date is in the prior financial year.

The report will print with a page per residential mental health care facility that contains data, if the report contains no data it will print with ‘NOTHING TO REPORT’ in the report line.

```
11:48  01 JUN 18    DB2 - FUTURE RELEASE - TEST                                                    Page    1
(ADM2.P825)         RMHC REFERENCE PERIOD 'REMAINING IN' REPORT as at 01 JUN 18                 442 LOGON-TEST
                    Facility: 82000 COORPAROO COMMUNITY CARE UNIT

Patient                                                  <--Admission-->                          On Leave
Number        Patient Name                 Adm. Type     Date      Time    Ward    Unit           Date

003911-1      RMHC, BILL                   12 MENTAL HEALTH C  15 JUN 17  08:08  COORP   RMHC RESIDENTIAL MENTAL H
003912-1      RMHC, SMITH                  12 MENTAL HEALTH C  20 JUN 17  08:10  COORP   RMHC RESIDENTIAL MENTAL H
```

Post-processing activities

It is recommended that sites run the RMHC Reference Period ‘Remaining In’ Report (QLD) once all consumers have been statistically discharged and readmitted.

This report should display ‘NOTHING TO REPORT’ as all consumers have been readmitted.

If consumers are still listed, an error has occurred and requires investigation. If patients are left on this report it indicates they have not been statistically discharged with the correct dates/times.

Please also check the HQI Extract Summary Report to ensure there are no HQI errors that would stop a residential episode from being extracted from HBCIS to the Residential Mental Health Care Data Collection.

Appendix C: Standard Unit Code in HBCIS

The standard unit code is located in the Homer Queensland Health Interface (HQI) module. A locally named unit code is mapped to the standard unit code in the translation code file maintenance menu (unit code). It is then extracted into the monthly file provided to the Residential Mental Health Care Data Collection (RMHCDC) via the HQI extract.

Mapping residential facility units to Standard Unit Code

Mapping a residential facility unit to the correct standard unit code is done within the HQI module.

The menu path for the mapping screen is Homer Queensland Health Interface Main Menu-> System Management Menu-> Translation Code File Maintenance Menu-> Unit Code.

Enter the residential facility unit code, then the required standard unit code from the above list of codes and file the screen.

Assigning unit and treating doctor for a consumer where the treating doctor is not based at the residential facility

It is sometimes necessary to start an episode of residential care for a consumer who has a treating doctor who is based at an acute hospital. In this scenario, enter the correct unit for the residential facility. This will ensure the correct standard unit code is applied during extract.

Enter the correct doctor details for the treating doctor.

A warning message will be generated, informing the user that the treating doctor is not associated with the selected unit. Confirm at the prompt that both unit and treating doctor selected are correct and file the record.

Assigning unit and treating doctor for a consumer who is receiving acute care in a residential facility

On rare occasions, it may be necessary for a patient to be ‘admitted’ temporarily to a residential facility as an outlier from the hospital acute mental health inpatient unit. The acute mental health inpatient team retains responsibility for management and review of the patient in accordance with local outlier procedures.

In this case, within HBCIS, the acute patient is **not admitted** to a unit in the residential facility unit. Instead, they should be admitted to a virtual ward / unit associated with the acute hospital with a naming convention that still enables hospital staff to identify that the residential facility is the patient’s physical location.

Updating the mapping for Standard Unit Code

Where the standard unit code has been mapped incorrectly in the HQI module, it can be updated by following the instructions on the previous page for “Mapping residential facility units to standard unit codes”.

It is important that the standard unit code mapping is not updated for a treating doctor based at the hospital. This could cause the acute patients for that doctor in the hospital to be extracted as residential consumers. In this case, the only way to update the standard unit code is to reverse the billing and update the treating doctor unit for the admission as per the instructions on the previous page for “Assigning unit and treating doctor for a consumer whose treating doctor is not based at the residential facility”.

Updating the mapped standard unit code can be done at any time without requiring billing to be reversed. All records that have already been extracted via the HBCIS HQI process will also need to be flagged for inclusion in a subsequent HQI extract.

The general process for re-flagging records is to step the discharge time forward by one minute.

However, when the record includes an administrative discharge for end of year reporting, HBCIS won’t allow the altering of the discharge time. In this case, a work around will be required.

The recommended work around is to make notes of the URN, admission number, and value in Field 04 ‘Type’. Update the value in Field 04 and file the screen. Complete this for all affected records, then run the HQI extract.

After confirming that Electronic Validation Application (EVA) validations for incorrect standard unit code are removed, retrieve the admission, and enter the original codes in Field 04 ‘Type’.