Monthly Activity Collection Manual

Statistical Collections and Integration

2014-2015

Monthly Activity Collection

Published by the State of Queensland (Queensland Health), July 2014

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An electronic version of this document is available at
http://qheps.health.qld.gov.au/hsu/datacollections.htm

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Document Information

Version: v14

Published by: Statistical Collections and Integration
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Date: July 2014

Available From: http://qheps.health.qld.gov.au/hsu/datacollections.htm

Release History:

Date	Release	Pages	Details
Jul 2009	Version 8	All	Removed the Dental collection component and MTHACPS1 report (Public Psychiatric Hospitals). Updated required definitional changes.
July 2010	Version 9	All	Updated to reflect the introduction of MAC Online. Clarification for the term Clinic. Removal of available bed days.
July 2010	Version 10	All	Includes updates following the initial to release QHEPS
July 2011	Version 11	All	Update of controlled document to reflect changes to forms and facilities within the scope of the collection
July 2012	Version 12	All	Updated to reflect the introduction of new Activity Based Funding requirements, the Corporate Clinic Code (CCC) list and updated bed availability categories.
July 2013	Version 13	Numerous	Updated Data Collections Unit (DCU) to Statistical Collections and Integration (SCI) and Health Statistics Centre (HSC) to Health Statistics Unit (HSU). Included Delegate of HHS CEO for the approval of the MAC forms. Included information regarding the ABF Emergency Services (ES) form. Added section on 'Other Outreach' and refreshed Section 4, Included new clinic types for 2013-14.
Sept 2013	Version 13.1	Numerous	Updated 'Home Delivered Procedures' to clarify business rules and amended the term 'Continuous Automated Peritoneal Dialysis' to 'Continuous Ambulatory Peritoneal Dialysis' as requested by CARU. Amended 3.1.6 Emergency Services (ES) Form to clarify public ES episodes, and amended form section to reflect amendments to the Emergency Services (MACONES) form. Occasions of Service definition clarified for Telehealth /telephone OOS, section. Amended 2.4.2.1 Availability of MAC data on the Decision Support System (DSS) to reflect ABF direction for MAC form approval process.
Feb 2014	Version 13.2	30-31	Update to Telehealth section as requested by Telehealth Support Unit, CARU. Update to current definitions for Palliative Care and Geriatric Evaluation and Management.(GEM)
July 2014	Version 14	Numerous	Update of manual to align to 2014-15 reporting requirements as specified in MAC changes for 2014-15. Most of the manual has been re-written or reorganised to improve readability.

1. Introduction to the MAC

1.1 Overview

The Monthly Activity Collection (MAC) contains aggregate (or summary level) data on '**Admitted**' and '**Non-admitted**' **patient activity** and '**Bed Availability**'. This data are submitted monthly to the Department of Health by the '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 benefits of the availability of this data including informing cost modelling, funding, research and local business management.

Data are submitted by the reporting entity to Statistical Collections and Integration (SCI), Health Statistics Branch (HSB) of the Department of Health each month where it is prepared for reporting purposes.

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 Event	• public acute hospitals • public nursing homes/hostels/independent living units • hospital and health service facilities • Hospital and Health Services (HHSs) • Jurisdictional Health Authority (State)
Non-admitted patient (emergency service care)	Emergency department stay	• public acute hospitals and hospital and health service facilities which do not use the Emergency Department Information System (EDIS).

[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/ hospital facility, the HHS or the State. The term 'reporting entities' used in this manual refers collectively to the three hierarchical levels for monthly activity reporting eg the hospital/ hospital facility, the HHS and the State.

Type of Activity	Unit of Activity	Type of Reporting Entity
Admitted patient	Separations	• public acute hospitals • public psychiatric hospitals • public nursing homes/hostels/independent living units • multi-purpose health services • hospital and health service facilities
Bed Availability	Beds/ Bed Alternatives	• public acute hospitals • public residential psychiatric hospitals • public nursing homes/hostels/independent living units • multi-purpose health services • hospital and health service 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. Data entered on to these MAC forms are validated prior to submission to SCI using the MAC Online application.

This manual provides a detailed overview of the MAC. It is intended as a reference for those who complete MAC forms to ensure that consistent data according to the prescribed definitions are reported to SCI.

1.2 Monthly activity data

1.2.1 Non-admitted patient activity data

Non-admitted patient activity (outpatient service events)

Scope statement

The service event (SE) activity that is to be reported to the MAC for non-admitted patients (outpatients) is '*the total number of service events provided to non-admitted patients in the reference period, for each of the clinical service types*'[2].

Non-admitted patient service events that are 'in scope' for reporting to the MAC for outpatients must:

- meet the definition of a non-admitted patient service event (an interaction between one or more healthcare provider(s) with one non-admitted patient, which must

[2] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary. Retrieved 30 May 2014 <http://meteor.aihw.gov.au/content/index.phtml/itemId/270108)>

contain therapeutic/clinical content and result in a dated entry in the patient's medical record)

- be provided as part of a non-admitted service which is a speciality unit or organisational arrangement under which a hospital or HHS provide, or the State manages non-admitted services
- be included in the ***General list of in-scope public hospital services***[3] (both Category A and Category B non-admitted services) determined by IHPA under the *National Health Reform Agreement (2011)*
- be activity that is operated and managed by the reporting entity and funded from the reporting entity's operating expenditure.

  Excluded from this scope are:

  - services funded by the Commonwealth.
  - all outpatient clinic services provided to admitted patients. Refer to IHPA's '*Tier 2 non-admitted services compendium 2014-15*' for more information.
  - service events that do not deliver clinical care eg activities such as home cleaning, meals on wheels or home maintenance. These activities are Occasions of Service (OOS) and whilst not collected for IHPA reporting purposes, these activities are collected for reporting to the Australian Institute of Health and Welfare (AIHW) National Minimum Datasets (NMDSs) (*Other Outreach Services*).
  - emergency service care

Reporting mandates

MAC data are the source for mandated Commonwealth and State government reporting requirements, Activity Based Funding (ABF), as well as for localised business management purposes.

Commonwealth Government Reporting Requirements

Department of Health (Commonwealth)

Under the National Healthcare Agreement (NHA), Queensland is required to supply the Commonwealth's 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 (NHIA), 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 is used to meet the *Public hospital establishments NMDS 2014-15* (PHE NMDS).

Independent Hospital Pricing Authority (IHPA)

[3] 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, for the purposes of state and local reporting these clinic types must be reported.

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 IHPA[4].

Prior to 01 July 2014, only non-admitted patient service activity that was delivered by public hospitals was reported in the MAC. However from this date, the non-admitted patient service events reported in the MAC have 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.

The Department of Health will provide this data as specified through the following two data set specifications:

1. *Non-admitted patient care aggregate NMDS 2014-15* (NAP NMDS)
2. *Non-admitted patient care Local Hospital Network aggregate DSS 2014-15*[5] (NAP LHN DSS)

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 NAP NMDS collects data at the hospital level and now the NAP LHN DSS collects data at the HHS and Jurisdictional Health Authority (State) levels.

Hierarchical level[6]	Data collected through
Public hospital	Non-admitted patient care hospital aggregate NMDS (NAP NMDS)
Hospital and Health Service	Non-admitted patient care Local Hospital Network aggregate DSS (NAP LHN DSS)
Jurisdictional health authority (State)	Non-admitted patient care Local Hospital Network aggregate DSS (NAP LHN DSS)

Clinic classifications and counting rules

The Tier 2 Non-admitted services definitions manual 2014-15—Version 3.0 (hereafter referred to as the 'Tier 2 Manual') defines the clinic classifications (classes) required for jurisdictional reporting of non-admitted services to the IHPA.

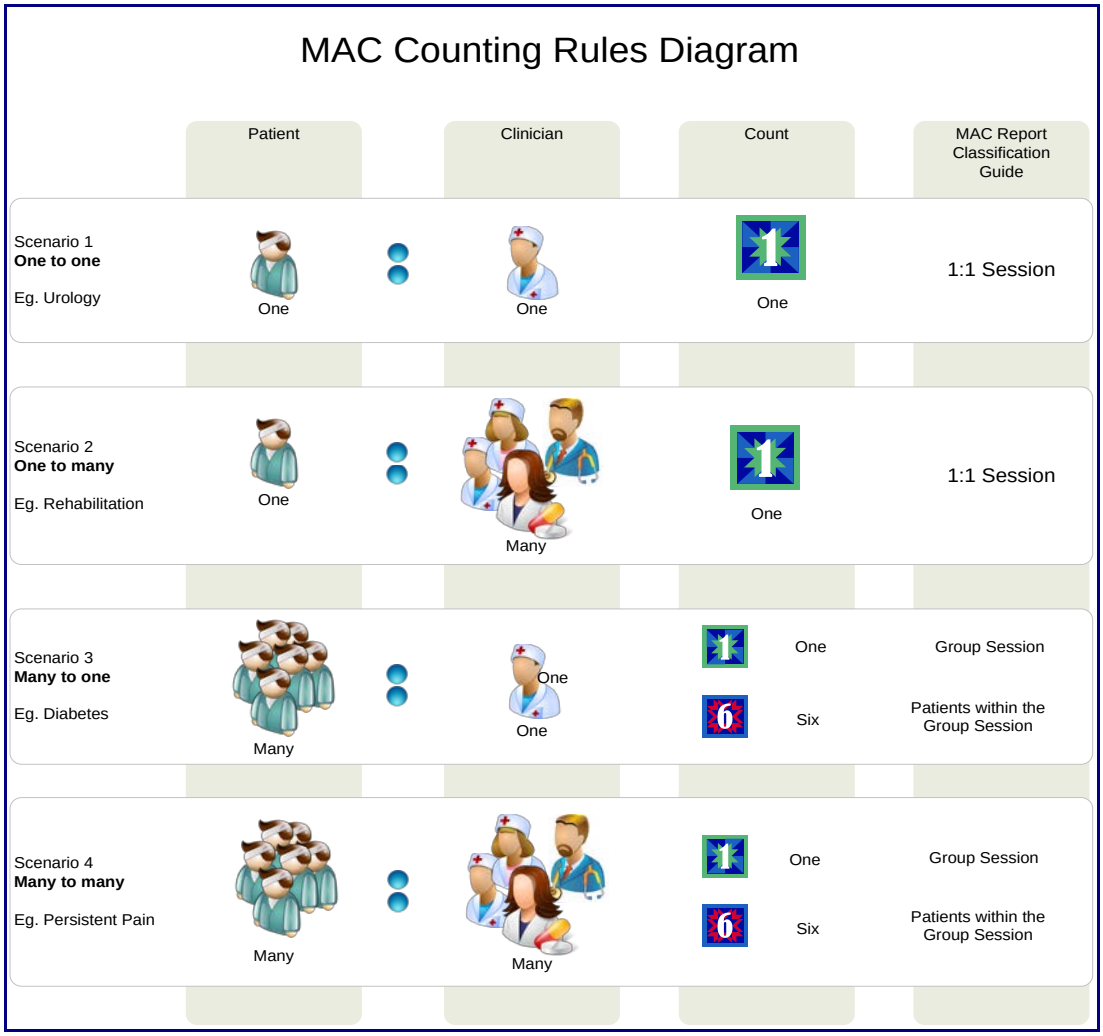
IHPA has also published the following two documents and recommends that these along with the Tier 2 Manual and the data set specifications above should be used collectively.

[4] 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 (NEP) for public hospital services and the efficient cost of block funding services in regional hospitals.
[5] Local Hospital Networks (LHNs) are known as Hospital and Health Services (HHSs) in Queensland.
[6] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 30 May 2014. <http://meteor.aihw.gov.au/content/index.phtml/itemId/547686)>

- Tier 2 Non-admitted services compendium 2014-15 (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 new index has been provided to assist users of the Tier 2 classification in allocating local clinics to a Tier 2 class in a consistent manner.

Note: These IHPA publications must be read in conjunction with the Department of Health's Healthcare Purchasing and ABF Model resources as well as this manual as in some cases, local reporting rules and requirements take precedence over these national guidelines. Please contact HealthCare Purchasing and Activity Based Funding (ABF) for further assistance.

The clinic types of the MAC incorporate the Tier 2 clinic classifications with some additions to cater for other NMDS and State reporting requirements. When service event data are reported to IHPA data set specifications, the required MAC clinic types are mapped to the appropriate Tier 2 clinic classes and reported. When data are reported to the data set specifications of AIHW or DoH then the MAC clinic types are mapped to the clinic classifications required to meet those specifications and reported.



Mapping Table of MAC clinic types/ Tier 2 clinic classes /Corporate Clinic Codes (CCC)

Non-admitted patient activity (emergency service care)

Scope statement

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/ or facility'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/ urgent care centres that is recognised as being provided to non-admitted patients. Patients being treated in emergency services/ urgent care centres may subsequently become admitted. The care provided to non-admitted patients who are treated in the emergency services/ urgent care centres prior to being admitted are included.*

Services where patient did not wait or died on arrival are also included.

***Excluded** from the scope is:*

- *Care provided to patients who are being treated in emergency services/urgent care centres as an admitted patient (e.g. in an observation unit, short-stay unit, emergency services ward or awaiting a bed in an admitted patient ward of the hospital)*
- *Where only a clerical service is provided to people supporting a pre-arranged admission*
- *Where people are awaiting transit to another facility and receive no clinical care.*
- *Care provided to patients in General Practitioner co-located units.'*[7]

Reporting mandates

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

1. *Non-admitted patient emergency department care NMDS 2014-15 (patient-level),* and
2. *Activity based funding: Emergency service care DSS 2014-2015 (Aggregate Level)* (ABF ESC DSS)

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 (by the IHPA) must comply with the *Non-admitted patient emergency department care NMDS 2014-15 (patient-level)* with the data source being the EDIS data repository managed by CARU.

[7] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 30 May 2014. <http://meteor.aihw.gov.au/content/index.phtml/itemId/564550)>

Hospitals with emergency services categorised as 1 to 3A (by the IHPA) must comply with the ABF ESC DSS. As most facilities in this category do not have 'corporate' electronic system/s to record emergency service activity, the ABF Program Office has mandated that non-EDIS sites must complete a MACONES form in MAC Online.

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

1.2.2 Admitted patient activity data

Admitted patient activity (separations)

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

Once the patient-level data are submitted to the QHAPDC, it is reconciled to the data supplied for the PH1. 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. The total number of separations (and their respective modes) reported to each data collection should equal.

Scope statement

All public hospitals in Queensland (includes both declared hospitals and those who are no longer declared hospitals) must provide this summary data.

Reporting mandate

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

Beds

Department of Health must have accurate data on the number of beds available in Queensland's public hospitals and health service facilities.

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

Scope statement

All Queensland public hospitals.

Reporting mandate

This data are required to be reported as part of the Public Hospital Establishments National Minimum Data Set. There are also State requirements for reporting this information.

1.2.3 Use of MAC Data

Non-admitted and admitted patient MAC data are used as the source for Commonwealth and State Government reporting requirements including those of the Department of Health as well as for local reporting needs.

Some examples include:

- MAC data are used for healthcare purchasing and ABF purposes including informing the service agreements between HHSs and Department of Health and subsequent monitoring.
- Non-admitted patient service event data are reported to the IHPA for funding purposes.
- Bed data are provided to the State Government.
- Non-admitted outpatient and emergency data are used by the Revenue, Resource and Strategy Unit (RSSU) to assist with the reconciliation of 'Eligible Public – Third Party' and '19.2 RRMBS' activity.
- 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.
- MAC data are used at the local level for costing, financial and resource management purposes.

1.3 Method of data collection

1.3.1 MAC forms

Queensland public hospitals, hospital facilities, HHSs and the State (reporting entities) report their monthly activity data to SCI each month (including the Mater Health Services and Noosa Hospital) 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:

Non-admitted patient activity (outpatients) service event forms

Reporting Entity Type	MAC Form Type	Type of Monthly Activity Data to Report
• Hospital – public acute[8] • HHS • State	**CLINIC** (MACONCLNC)	One-to-one service events for non-admitted medical officer and other health professional consultation clinic types.

[8] Includes declared/ undeclared 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
• Hospital – public acute • HHS • State	**DIAGNOSTIC & PROCEDURES** (MACONDGPR)	One-to-one service events for procedure and diagnostic clinic types, and home delivered procedure (dialysis, nutrition and ventilation) patient census data. Occasions of Service for Pharmacy and Other Outreach Services as well as 'Mums and Bubs' visits.
• Hospital – public acute • HHS • State	**GROUP** (MACONGRPS)	Group session service events (patients) and numbers of group sessions for non-admitted medical officer and other health professional consultation clinic types.
• Hospital – public acute • HHS • State	**TELEHEALTH** (MACONTELP and MACONTELR)	One-to-one service events, group session service events (patients) and numbers of group sessions for non-admitted specialist and allied health clinic types by service provider for which services are either provided (MACONTELP) or received (MACONTELR).
• Hospital – public acute • HHS • State	**TELEHEALTH GROUPS** (MACONGTLP and MACONGTLR)	Group session service events (patients) and numbers of group sessions for non-admitted medical officer and other health professional consultation clinic types for which services are either provided (MACONGTLP) or received (MACONGTLR).
• Hospital – public acute	**PATHOLOGY** (MTACPATH)	Pathology service events (Non-Auslab facilities only). See ***Exceptions*** below.

Non-admitted patient activity (emergency service care) forms

Reporting Entity Type	MAC Form Type	Type of Monthly Activity Data to Report
• Hospital – public acute	**EMERGENCY SERVICES** (MACONES)	Emergency department 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	**BED** (BED)	The number of available beds and available bed alternatives for admitted patients.

Reporting Entity Type	MAC Form Type	Type of Monthly Activity Data to Report
Hospital – public acute and psychiatric	**PH1** (MTHACPH1)	Patient admissions, separations, and classification changes. See ***Exceptions*** below.
Nursing homes, hostels, independent living units	**NH2** (MTHACNH2)	Resident admissions, separations, non-admitted patient occasions of service and allocation of places.
Multi-Purpose Health Services	**MP1** (MTHACMP1)	Patient admissions, separations and bed availability.

Once the spreadsheet is populated with the monthly activity data, it is then uploaded to the MAC Online application where the data are validated (refer to MAC Online) and submitted to SCI.

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.

New/ updated versions of MAC forms

Generally each financial year, MAC reporting requirements change. Changes are usually driven by mandated reporting requirements from the Commonwealth Government, however changes 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 this manual, information sessions and ABF forums. SCI also advise reporting entities of the availability of the new financial year templates on the SCI website through email to MAC Online users.

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 SCI.

MAC Reporting Entities and Form Requirements

1.3.2 MAC Online

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

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 are retained within SCI databases and are utilised to respond to queries raised by various business areas in the Department of Health including the Minister's Office, Office of the Director-General, Divisional Deputy Director-Generals, policy officers, data analysts and also the Commonwealth Government. Therefore, it is very important that the comments provided clearly state the reasons for the variations.

Reporting entities will be contacted by SCI seeking comments on data anomalies that appear following time series trend analysis where adequate comments are not provided.

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

1.4 MAC reporting timeframes, business rules and data flow

1.4.1 MAC monthly & quarterly reporting timeframes

All final versions of MAC reports must be submitted to SCI by the 14th day[9] following the reference month (eg for the reference month of September, MAC reports must be submitted by 14th of October).

The Department of Health must provide non-admitted (aggregate-level) data to the IHPA as mandated in the *IHPA Three Year Data Plan*.

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.

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

Reporting Quarter	Period	Due Date	Finalisation Date
September	July	14 August	14 November
	August	14 September	
	September	14 October	

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

Reporting Quarter	Period	Due Date	Finalisation Date
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	

1.4.2 Chief Executive, HHS approval

As MAC data are used to substantiate funding and purchasing allocations in Department of Health's 'purchaser / provider' model, Chief Executives (or their delegates) must approve the MAC SE forms (Clinic, Group Sessions, Diagnostics and Procedures, Telehealth, and Telehealth Group Sessions) as well as the Emergency Services and Bed form forms.

HHS CEOs must provide requests to update 'finalised' quarterly MAC data in writing to the Healthcare Purchasing, Funding and Performance Management Branch, Department of Health.

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

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

Refer to the MAC Online User Manual to set-up the HHS CEO access level for the Chief Executive (or Delegate) to enable them to approve the above mentioned MAC reports.

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

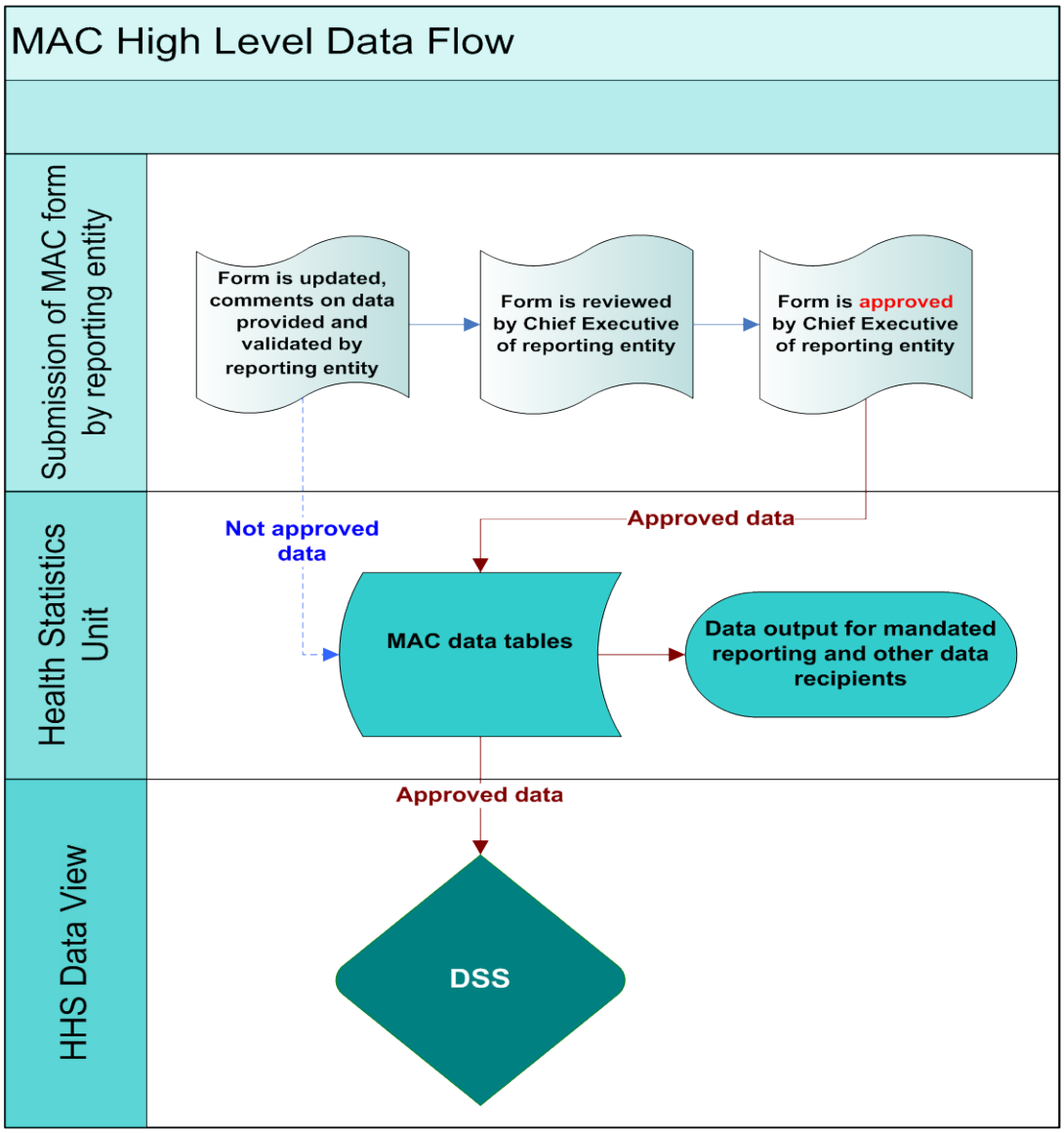
MAC forms submitted with non-admitted activity must have an 'Approved' status for the purposes of providing activity data for Weighted Activity Units (WAUs) reporting in DSS[10].

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

An 'Approved' status is provided by HHS Chief Executive sign-off (or their nominated delegate/s) in the MAC On-line application. If MAC forms do not have an ‘approved’ status (prior to HSU’s scheduled weekend processing), activity will not be reported. 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’ and or ‘submitted’ at the end of the week no data will appear in DSS for that month.

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 HSU’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.

1.4.4 Data collection work flow



For a more detailed flow of MAC forms and processing statutes please refer to the MAC Online Manual.

1.4.5 NIL activity report

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

1.4.6 Provision of estimates

Estimated data should only be provided when events such as major computer system failure, industrial action, natural disasters etc 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) and updated with actual data by the date the next reference month is due.

2. MAC changes for 2014-15

Each financial year, reporting requirements change. Changes are mandated by the Commonwealth and State governments and can also be requested 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 could include the amendment of reference files within source systems, updates to MAC templates and also modification to the MAC Manual.

2.1 Clinic type classifications (classes)

Since the introduction of ‘Tier 2’ clinic classes, amendments have been made each year and a new version of ‘Tier 2’ published to incorporate the amendments. Generally, these amendments include additions and deletions of clinic classes, and refining of definitional text.

For the reporting year of 2014-15, the ‘Tier 2’ changes required are detailed in this section.

2.1.1 New Tier 2 clinic type classes

The table below details the additional Tier 2 clinic classes for 2014-15 and the MAC forms which have been updated to incorporate the new requirements.

IHPA's 2014-15 Tier 2 Changes		MAC Form Changes		
New Clinic Classes	**Usual Provider of Clinic**	**MAC Clinic Type**	**MAC SE Forms**	**Comment**
Ventilation – Home Delivered (10.19)	N/A	Home – Ventilation	Diagnostics and Procedures form	IHPA's **'Tier 2 non-admitted services compendium 2013-2014'** Chapter 13 'Counting of home delivered renal dialysis and nutrition procedures' provides the counting rules and relevant examples and specifies that a patient census approach can be applied using agreed prescribing norms for counting non-admitted patient service events. A formula reflective of the 'prescribing norm' will be applied by Department of Health to the census figure for each home delivered procedure clinic class when reporting to IHPA. In addition, this census data are required to be reported separately for patients who reside within the HHS district and those patients who reside outside of the HHS district. There are two tables on the D&P form to enable this further delineation.
Radiation therapy – simulation and planning (10.20)	New medical consultation and allied health/clinical nurse specialist interventions clinic class	Oncology Radiation Therapy – simulation and planning	Diagnostics and Procedures, and both Telehealth Provider and Recipient forms	To be reported for both 'Medical Officer' and 'Other Health Professional' Provider Types.
Addiction Medicine (20.52)	New medical consultation clinic class	Addiction Medicine	Clinic, Group Sessions, both Telehealth Provider and Recipient forms and both Group Sessions Telehealth Provider and Recipient forms	To be reported for 'Medical Officer' Provider Type.

IHPA's 2014-15 Tier 2 Changes		MAC Form Changes		
Pulmonary rehabilitation (40.60)	New allied health/clinical nurse specialist interventions clinic class	Pulmonary rehabilitation	Clinic, Group Sessions, both Telehealth Provider and Recipient forms and both Group Sessions Telehealth Provider and Recipient forms	To be reported for 'Other Health Professional' Provider Type.

2.1.2 Existing Tier 2 classes now part of MAC

The table below details existing Tier 2 clinic classes which have previously not been collected on the MAC and the MAC forms which have been updated to incorporate the requirement to now report this information:

Existing Tier 2 Clinics Previously Not Reported	Usual Provider of Clinic	MAC Form Changes		
Dental (10.04)	Procedure clinic class that has previously not been reported to IHPA	Dental	Diagnostics and Procedures form	To be reported for Other Health Professional' Provider Type. Dental service events have been excluded from the MAC since 2008 as Department of Health's Oral Health Service reports oral health activity. ABF have requested the inclusion of this clinic in the MAC to report inscope dental service events.
Sexual Health (40.10)	Allied health/clinical nurse specialist interventions clinic class that has previously not been reported to IHPA.	Sexual Health	Clinic, Group Sessions, both Telehealth Provider and Recipient forms and both Group Sessions Telehealth Provider and Recipient forms	To be reported for 'Other Health Professional' Provider Type only. ABF have requested the inclusion of this clinic in the MAC to report inscope sexual health service events.

Existing Tier 2 Clinics Previously Not Reported	Usual Provider of Clinic	MAC Form Changes		
Specialist Mental Health (40.34)	Medical Officer and Allied health/clinical nurse specialist interventions clinic class that has previously not been reported to IHPA.	Specialist Mental Health	Clinic, Group Sessions, both Telehealth Provider and Recipient forms and both Group Sessions Telehealth Provider and Recipient forms.	To be reported for both 'Medical Officer' and 'Other Health Professional' Provider Types. ABF have requested the inclusion of this clinic in the MAC to report inscope specialist mental health service events.
Diagnostic Classes (30.01-30.08)	To be captured at the Tier 2 clinic level	General imaging	Diagnostics and Procedures and both Telehealth Provider and Recipient forms.	Reporting of diagnostic service events are now to be reported as per the Tier 2 clinic classes.
		Magnetic resonance imaging (MRI)		
		Computerised tomography (CT)		
		Nuclear medicine		
		Pathology (microbiology, haematology, biochemistry)		
		Positron emission tomography (PET)		
		Mammography screening		
		Clinical Measurement		

Some clinic classes have been renamed and some minor refinements have been made to the '*Inclusions*' and '*Exclusions*' sections of the 'Guide for Use' in the *Tier 2 Non-admitted Services Definition Manual (v0.3)* of some existing clinic classes. These are:

Class Number	Tier 2 v2.0 2013-14 (previous text)	Tier 2 v3.0 2014-15 (new text)	MAC Clinic Name/ Comment
10.03	***Inclusions:*** wound management	***Inclusions:*** surgical wound management	'Minor Medical Procedures'
10.11	**Name:** *Medical oncology (treatment)*	**Name:** *Chemotherapy (treatment)*	Existing MAC Clinic name of 'Oncology Medical Treatment Chemotherapy' will remain on Diagnostics and Procedures form.
10.11	***Inclusions:*** Chemotherapy infusion	***Inclusions:*** Chemotherapy	-
10.12	**Name:** *Radiation oncology (treatment)*	**Name:** *Radiation therapy (treatment)*	Existing MAC Clinic name of 'Oncology Radiation Treatment' will remain on Diagnostics and Procedures form.
10.12	***Inclusions:*** palliative radiation oncology	***Inclusions:*** palliative, adjuvant, neo-adjuvant and definitive radiation therapy	-
20.43	**Name:** *Radiation oncology consultation*	**Name:** *Radiation therapy consultation*	Existing MAC Clinic name of 'Oncology Radiation Consultation' will remain on Clinic form.
30.08	***Inclusions:*** pulmonary function tests	***Inclusions:*** pulmonary function test	-
30.08	***Inclusions:*** specialised cardiac tests	***Inclusions:*** specialised cardiac tests (including holter monitor services)	-
30.08	Nil	***Inclusions:*** clinical photography	-
40.05	Nil	***Inclusions:*** aquatic physiotherapy	-
40.44	***Inclusions:*** musculoskeletal disorders associated with autoimmune disorders	***Inclusions:*** musculoskeletal disorders	-

Class Number	Tier 2 v2.0 2013-14 (previous text)	Tier 2 v3.0 2014-15 (new text)	MAC Clinic Name/ Comment
40.44	Nil	***Inclusions:*** connective tissue disease	-
40.44	Nil	***Inclusions:*** autoimmune disease	-
40.51	Nil	***Inclusions:*** postmastectomy lymphoedema syndrome	-
40.59	***Exclusions:*** Hospital in the Home patients	Removed from Exclusions	-

2.2 New data element

2.2.1 'Funding Source for Hospital Patient'

This data element, whilst new to reporting for summary level non-admitted patient data, has been part of the Queensland Hospital Admitted Patient Data Collection (QHAPDC).

This data element is defined as '*The source of funds for an admitted patient episode or non-admitted patient service event, as represented by a code*'. The reference file for this data element is common to both admitted and non-admitted patients data collections and because of this there are some values which do not apply in a non-admitted setting.

The Activity Based Funding team have reviewed these reference values and have agreed to the collection of data for the values set out below with the corresponding new or existing MAC column.

It is important to note that the 'National Codeset' reference file in this table is the national codeset that Department of Health report to the Commonwealth. These codes will vary between hospitals based on the local software codes available in each system. The 'QHDD Codeset' reference file is the Queensland codeset which is used in the corporate system. The local/ Queensland software codes map to these national codes (generally upon data extract) for reporting purposes.

National Codeset	QHDD Codeset	Meaning	Existing or New MAC Column/s
01	01	Health service budget (not covered elsewhere)	Other Public
02	11	Health service budget (due to eligibility for Reciprocal Health Care Agreement)	Other Public
03	13	Health service budget (no charge raised due to hospital decision)	Other Public
04	07	Department of Veterans' Affairs	DVA
05	08	Department of Defence	Department of Defence NEW
06	09	Correctional facility	Correctional Facility NEW
07	14	Medicare Benefits Scheme	MBS
08	10	Other hospital or public authority (contracted care)	'Contracted Services' column for 'Service Events Delivered' and relevant Third Party payer/ Eligibility category for 'Service Events Contracted Out'. NEW
~~09~~	~~02~~	~~Private health insurance~~	~~Not applicable in non-admitted setting~~
10	04	Worker's compensation	Work Cover Qld, Work Cover Other
11	05	Motor vehicle third party personal claim	Motor Vehicle Qld, Motor Vehicle Other
12	06	Other compensation (e.g. public liability, common law, medical negligence)	Other Third Party, Other Comp.
13	03	Self-funded	MBS Ineligible Self Funded, Private Non MBS Self Funded NEW
88	12	Other funding source	MBS Ineligible Not Self Funded, Private Non MBS Not Self Funded NEW
~~98~~	~~99~~	~~Not known~~	~~Not applicable~~

2.3 MAC form changes

2.3.1 Global changes for service event forms 2014-15

New MAC forms

Group Sessions Form (MACONGRPS) and Group Sessions Telehealth Provider (MACONGTLP) and Group Sessions Telehealth Recipient (MACONGTLR)Forms

Group service events are to be reported on the new Group Sessions MAC forms. The columns for reporting group service events in past years have been removed from the Clinic, Diagnostics and Procedures and Telehealth Provider and Recipient forms and

are now included on the new Group Sessions form and Group Sessions Telehealth Provider and Recipient forms.

The separate Group Sessions forms were created to accommodate a number of changes required for this year which include:

- the ability to separate service events delivered by the reporting entity from those that the reporting entity contracted out. See Form structure change.
- additional columns under 'Eligible Public – Third Party' for Department of Defence and Correctional Facility funding sources.
- the ability to separate the number of group sessions delivered by the reporting entity from those that the reporting entity contracted out.
- the ability to group categories for reporting group session details to IHPA.

HHS/ State MAC reporting requirement

The introduction of the *Non-admitted patient Local Hospital Network care aggregate DSS 2014-15* (NAP LHN DSS) mandates the reporting of non-admitted patient service events provided by a HHS or managed by the State (Department of Health) which are on *General list of in-scope public hospital services*

So that this data can be reported, each HHS and initiatives/ programmes managed by the State have been allocated a new facility identifier so that the service events for each reporting entity can be reported.

In effect, HHSs which deliver non-admitted service events and the initiatives/ programmes which are managed by the State, will become 'facilities' in MAC Online for which MAC forms are to be completed.

'The principle should be applied that no activity is to be double-counted or included in both the *Non-admitted patient care hospital aggregate NMDS* and the *Non-admitted patient care Local Hospital Network aggregate DSS*'. This means that service events can only be reported at one of the hierarchical levels (hospital, HHS or State).

Form structure change

Separation of Service Events – delivered vs contracted out

The MAC SE forms have been divided into two overarching sections to distinguish between service events which are contracted out from those that are provided by the reporting hospital, HHS or managed by the State. See Service Events Delivered/ Service Events Contracted out in the Column changes to SE forms section for more information.

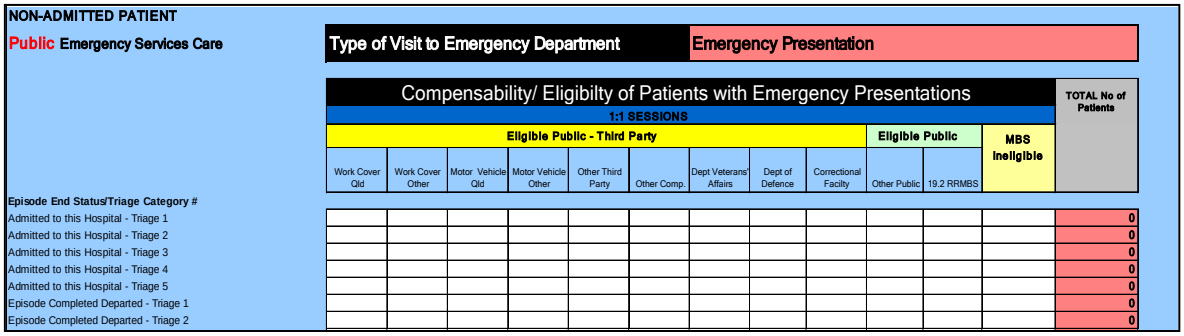
2.3.2 Global change to the Emergency Services (ES) form 2014-15

The ES form has been redesigned to incorporate all of the data items required to meet both Commonwealth and State requirements.

The 'Type of Visit to Emergency Department' is to be reported by the 'Episode End Status' and 'Triage Category' and also by the funding source of the patient.

Each 'Type of Visit' has its own section on the form to enable the reporting of the 'Episode End Status' and 'Triage Category' by the 'Type of Visit'.

Refer to Emergency Services form (MACONES) for further information.



NON-ADMITTED PATIENT

Public Emergency Services Care

Type of Visit to Emergency Department	Emergency Presentation

Compensability/ Eligibilty of Patients with Emergency Presentations												TOTAL No of Patients
1:1 SESSIONS												
Eligible Public - Third Party										Eligible Public		MBS Ineligible
Work Cover Qld	Work Cover Other	Motor Vehicle Qld	Motor Vehicle Other	Other Third Party	Other Comp.	Dept Veterans' Affairs	Dept of Defence	Correctional Facilty	Other Public	19.2 RRMBS		
Episode End Status/Triage Category #												
Admitted to this Hospital - Triage 1												0
Admitted to this Hospital - Triage 2												0
Admitted to this Hospital - Triage 3												0
Admitted to this Hospital - Triage 4												0
Admitted to this Hospital - Triage 5												0
Episode Completed Departed - Triage 1												0
Episode Completed Departed - Triage 2												0

2.3.3 Column/ Row changes for service event and emergency forms

To comply with Commonwealth Government, IHPA and State reporting requirements, new rows have been added to the SE forms and new columns have been added to both the SE and ES forms.

Column changes to SE forms

Service Events Delivered/ Service Events Contracted out

The MAC SE forms have two overarching sections to distinguish service events which are contracted out from those that are delivered by the reporting hospital, HHS or managed by the State.

Service Events Delivered	Service Events Contracted Out

Section Title	Description
Service Events Delivered	Non-admitted patient service events delivered by a hospital, HHS or managed by the State.
Service Events Contracted Out	Non-admitted patient service events which have been contracted out to another entity by a hospital, HHS or managed by the State.

The forms are sectioned into the above categories so that both SEs 'delivered' and SEs that are 'contracted out' can be also be reported by funding source which is both a Commonwealth and an ABF/ RSSU requirement to enable this data to be captured at this level.

Refer to Definitions of data items common across MAC SE forms for the definitions of these categories.

Column changes to SE and ES forms

Renaming of Eligible Public – Compensable to Eligible Public – Third Party

Previously:

Eligible Public - Compensable

Now:

Eligible Public - Third Party

This change was requested by RSSU as 'Third Party' more appropriately defines these compensable categories.

Inclusion of two additional Eligible Public – Third Party funding sources

Dept of Defence	Correctional Facility

'Department of Defence' and 'Correctional Facility' have been added under 'Eligible Public –Third Party' to accurately identify the funding source of the SE event.

Inclusion of

Contracted Services
Delivered Under Contract

This column has been added to the '**Service Events Delivered**' side of the service event forms to identify service events delivered under contracted arrangements.

Refer to Definitions of data items common across MAC SE forms for more information.

Row changes to SE forms

Clinic form

In addition to rows that will be added for the new clinic classes listed in New Tier 2 clinic type classes, new rows will be added to the Clinic form (MACONCLNC) as detailed below.

Telephone Service Events

Telephone service events are to be reported by clinic type and funding source. A row has been added for each clinic type on the MAC Clinic form to record telephone service events.

Cardiology new patient
Cardiology repeat patient
Cardiology telephone patient

Diagnostics and Procedures form

Removal of Community Health Services clinics

The clinic types listed below in which designated community health units provided occasions of service to non-admitted patients which were *funded from the facility's operating expenditure and operated and managed by the facility* are no longer required to be reported to the MAC under these headings. These clinic types may have included well-baby clinics, immunisation units and aged care assessment teams.

From 01 July 2014, these clinic types will not appear on the Diagnostics and Procedures form for either Medical Officer or Other Health Professional.

Community Health Services - Aged Care
Community Health Services - Geriatric
Community Health Services - Psychogeriatric
Community Health Services - Rehabilitation
Community Health Services - Other

Other Outreach Services which was included with the clinics above in previous years remains on the Diagnostics and Procedures form.

Enhanced Maternal and Child Health Service – Mums and Bubs Initiative

The Strategic Policy Priority Areas, Policy and Planning Branch of Department of Health administer the Mums and Bubs initiative. This unit has requested that MAC be the collection tool for Mums and Bubs data from 01 July 2014. As a result, Mums and Bubs visits are now to be reported on the Diagnostics and Procedures form.

This data, which previously has been reported by HHSs directly to the Strategic Policy Priority Areas, Policy and Planning Branch will now be provided on this MAC form.

Strategic Policy Priority Areas have provided the information on the collection of the data for this initiative and any questions should be directed to this area.

Data are to be reported in the section below on the Diagnostic and Procedures form:

MUMS AND BUBS ACTIVITY	Service Events Delivered		Service Events Contracted Out	
	No. of visits		No. of visits	
	0-2 Weeks (inc)	3-4 Weeks (inc)	0-2 Weeks (inc)	3-4 Weeks (inc)
Home Visit				
Fail to Attend				
	0	0	0	0

For further information on the counting rules for reporting this activity please refer to Definition/s unique to this form.

2.3.4 Row changes for admitted patient forms

Row changes to bed form

The Mental Health, Alcohol and Other Drugs Branch of the Department of Health have requested that admitted patient beds for ‘Specialised Mental Health - Acute Psychiatric’ and ‘Specialised Mental Health – Non-Acute Psychiatric’ be further split by the mental health target groups.

The rows added to the Bed form are:

Specialised Mental Health - Acute Psychiatric General
Specialised Mental Health - Acute Psychiatric Older Persons
Specialised Mental Health - Acute Psychiatric Child & Adolescent
Specialised Mental Health - Acute Psychiatric Young Persons
Specialised Mental Health - Acute Psychiatric Forensic
Specialised Mental Health - Non-Acute Psychiatric General
Specialised Mental Health - Non-Acute Psychiatric Older Persons
Specialised Mental Health - Non-Acute Psychiatric Forensic
Specialised Mental Health - Non-Acute Medium Secure
Specialised Mental Health - Non-Acute Legacy Intellectual Disability

Row changes to PH1 form

The Mental Health, Alcohol and Other Drugs Branch have requested the following changes to the 'Standard Unit Codes' from 01 July 2014.

As a result, the following codes have been added and descriptions updated:

Standard Unit Code Changes		
Code	**Description**	**Notes**
PYFA	Psychiatric Forensic Acute	New from 01/07/2014
PYYA	Psychiatric Adolescent Acute Unit	'Young People' removed and 'Adolescent' added to description from 01/07/2014
PYYW	Psychiatric Adolescent Acute Unit in Adult Ward	'Young People' removed and 'Adolescent' added to description from 01/07/2014
PYOA	Psychiatric Young Persons (Youth) Acute Unit	New from 01/07/2014

3. MAC Definitions

3.1 Definitions of data items for non-admitted patient forms

Definitions of general terms provides 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.

3.1.1 Definitions of general terms

Non-admitted patient[11]

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) sessions

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

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

Reference month

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

3.1.2 Definitions relating to non-admitted patients (outpatients)

Non-admitted patient service event[12]

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.

Occasion of Service (OOS)

The requirement to report Occasions of Service (OOS) for Commonwealth Government NMDS reporting has ceased and therefore the data item ‘occasion of service’ is no longer applicable as this was the counting unit defined and specified for this reporting.

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[11] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 30 May 2014. http://meteor.aihw.gov.au/content/index.phtml/itemId/268973>

[12] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 30 May 2014. <http://meteor.aihw.gov.au/content/index.phtml/itemId/400604>

The term ‘service event’ is now the counting unit defined and specified for reporting non-admitted outpatient activity.

There are services that are provided by some hospitals which fall outside of the definition of ‘Service Event’ as they do not provide clinical care. These services include home cleaning, meals on wheels or home maintenance and were a part of the national reporting requirements that are no longer required.

Whilst these non-clinical services are no longer reported nationally, it is important to continue to report this activity to provide the wider representation of the services provided by a hospital to acknowledge this activity performed.

Prior to 01 July 2014, these services met the definition of ‘occasions of service’ being an examination, consultation, treatment or other service provided to a patient in a functional unit of a health service establishment[13].

To continue to report this information, the term occasion of service will still apply to these services and be reported to the MAC providing they meet the scope statement.

Other Outreach Services

Occasions of service to non-admitted patients, which involve travel by the service provider, and are not classified as community health services or allied health services.

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 excludes medical, surgical, or psychiatric services as these should be reported under the appropriate clinic type on the MACONCLNC form.

Other Outreach Services does include activities such as home cleaning, meals on wheels and home maintenance.

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).

[13] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary (2013) Version 12 Volume 2.

Examples

1. 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 the local private hospital where a Dermatologist is available to see these patients. The non-admitted patient service events for these patients should be recorded against the relevant category compensable/ eligibility category on the 'Service Events Contracted Out' side of the MAC service event form.
2. 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 a private health care provider to deliver services for long wait patients of Queensland Health facilities.

3.1.3 Column definitions for SE forms

The two tables below are the form banners for the MAC service event forms. On the forms, these two tables are joined to create one banner (MACONGRPS is the exception as it has additional columns).

1:1 SESSIONS																	TOTAL
Service Events Delivered																	No of Service Events (excluding Contracted Services and Private)
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 Facilty	Delivered Under Contract	Other Public	19.2 RRMBS	Not Self Funded	Self Funded	MBS	Non MBS Not Self Funded	Non MBS Self Funded	

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 Facilty	Other Public	19.2 RRMBS	Not Self Funded	Self Funded	MBS	Non MBS Not Self Funded	Non MBS Self Funded

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

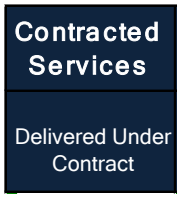
Other Public patients are patients who:

- elect to be treated as a public patient so cannot choose the doctor who treats them, 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 the Medicare Billing for Primary Care in Small Rural Hospitals arrangements (COAG 19.2).

Contracted Services



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)

Patients who have been treated by a doctor exercising a right of private practice at the facility irrespective of the source of funding (eg: Medicare Benefits Scheme, Workcover, third party, self funded etc).

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.

3.1.4 Row definitions for SE forms

Clinic Types

A clinic type is 'the organisational unit or organisational arrangement through which a hospital provides a service to a non-admitted patient.'[14]

[14] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 30 May 2014. <http://meteor.aihw.gov.au/content/index.phtml/itemId/400596)>

Refer to Clinic classifications and counting rules for more information.

Appointment type - new patient/ review patent[15]

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.

Provider Type Medical Officer

Service events provided by medical officers and nurse practitioners.

Provider Type Other Health Professional

Service events provided by non-medical officer health professionals eg: nurses, allied health professionals, and Aboriginal and Torres Strait Islander health workers.

3.2 Definitions of data items for admitted patient forms

Refer to Admitted patient service event forms for these definitions.

[15] Queensland Government, Queensland Health, Queensland Health Data Dictionary. Retrieved 30 May 2014 <http://oascrasprod.co.health.qld.gov.au:7900/pls/qhik_prd/qhik_data_elements.data_element_details?pCommand=SHOW&pResultSetID=5628&pde_seq_id=41907>

4. MAC Forms

4.1 Form Types for 2014-15

The MAC form types for reporting service events for non-admitted patient data to the MAC for public hospitals, health service facilities, HHSs, and State managed activity for 2014-15 are:

- Clinic
- Diagnostics and Procedures
- Group Sessions
- Telehealth - Provider
- Telehealth - Recipient
- Telehealth Group Sessions - Provider
- Telehealth Group Sessions - Recipient
- Emergency Services (non EDIS sites only – only public hospitals and health service facilities)

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

- Bed
- PH1
- Multi-Purpose Health Services
- Nursing Homes

4.2 Non-admitted patient service event forms

4.2.1 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 facility, 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 or repeat) 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 (including health service facilities), HHSs and at the State level. Refer to MAC Reporting Entities and Form Requirements for the forms required to be submitted by each facility.

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 with the exception of telephone consultations which are unique to the Clinic form.

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.

4.2.2 Group Sessions forms (MACONGRPS, MACONGTLP, MACONGTLR)

The Group Sessions form, Group Telehealth Provider and Group Telehealth Recipient forms are used to report the total number of non-admitted patients (service events) attending group sessions as well as the number of group sessions being provided. Group session clinics can be provided by a facility, HHS or managed by the State (reporting entity) or contracted out. Separate form to report group sessions only have been created (refer to Group Form (MACONGRPS) for more information).

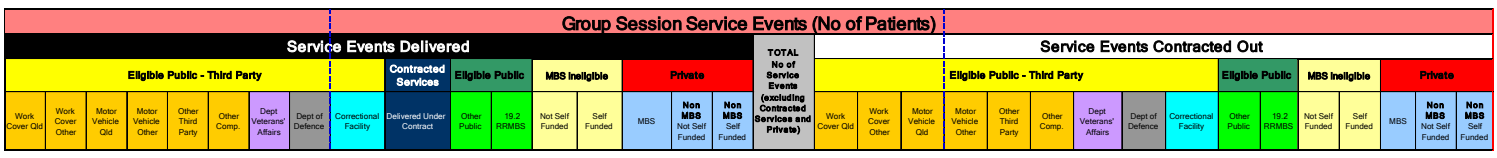
The Group Sessions forms are used to report the two data items 'number of patients' (non-admitted patient service events) attending group sessions and the '**Number of Group Sessions**' that these patients attended for the reference period.

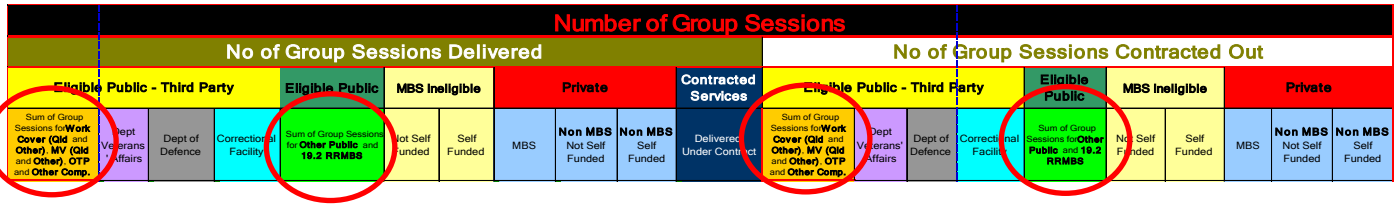
These two data items must be reported by the common data items of the MAC SE forms ie **Service Events Delivered** or **Service Events Contracted Out** then by clinic type (new or repeat), and funding source categories.

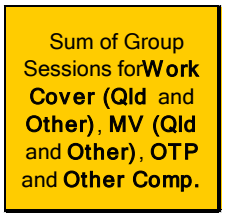
When reporting the funding source categories for the **Number of Group Sessions**, some of the funding source categories are combined to align to the IHPA reporting requirements. To assist in this process the funding source categories have been colour-coded in the form banner. The form banner for the Group Session form is provided below with the combined reporting categories circled and explanations

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

provided below.







This column is common to both sections of the **Number of Group Sessions** part of the form and is to be completed for both the Number of Group Sessions Delivered as well as **Number of Group Sessions Contracted Out** (where relevant). The total (sum) of the number of group sessions provided for Work Cover Qld, Work Cover Other, Motor Vehicle Qld, Motor Vehicle Other, Other Third Party and Other Comp. patients in the reference month are to be recorded.

It is acknowledged that some group sessions will be a combination of the various 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.

This column is common to both sections of the **Number of Group Sessions** part of the form and is to be completed for both the Number of Group Sessions Delivered as well as **Number of Group Sessions Contracted Out** (where relevant). The total (sum) of the number of group sessions provided for Other Public and 19.2 RRMBS patients in the reference month are to be recorded under the appropriate section.

It is acknowledged that some group sessions will be a combination of the various 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 (including health service facilities), the HHSs and at the State level. Refer to MAC Reporting Entities and Form Requirements for the forms required to be submitted by each facility.

Form

Group Sessions and Group Sessions Telehealth Provider and Group Sessions Telehealth Recipient

Definitions unique to this form

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.

Group Sessions

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 in their own right, even if other non-patient persons are present for the service.*
- *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[16]*.*

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[17]*.*

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[16] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 30 May 2014. <http://meteor.aihw.gov.au/content/index.phtml/itemId/336900>

[17] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 30 May 2014.<http://meteor.aihw.gov.au/content/index.phtml/itemId/497980)>

The total number of patients (non-admitted patient service events) attending group sessions is to be reported for the reference period by funding source categories, and as with the other MAC SE forms, also by **Service Events Delivered** and **Service Events Contracted Out**. Refer to Definitions of data items for non-admitted patient forms for the definitions of these data items.

4.2.3 Diagnostics and Procedures form (MACONDGPR)

The Diagnostics and Procedures form is used to report the total number of non-admitted patient service events for procedure and diagnostic clinic types as well as occasions of service for pharmacy and other outreach services that are delivered by a hospital (including health service facilities), HHS or managed by the State (the reporting entities) or contracted out. These service events are then reported by provider type (medical officer and other health professional), by clinic type (new or repeat) 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 (including health service facilities), HHSs and at the State level. Refer to MAC Reporting Entities and Form Requirements for the forms required to be submitted by each facility.

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 with the exception of those below which are unique to the Diagnostics and Procedures form.

Pharmacy

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

Non-admitted patient – home delivered procedures

Renal dialysis, Total Parenteral Nutrition (TPN), Home Enteral Nutrition (HEN), and invasive ventilation performed by the patient in their own home without the presence of a healthcare provider may be counted as a non-admitted patient service event, provided there is documentation of the procedures in the patient's medical record[18].

In accordance with the IHPA compendium's counting rules Chapter 13 Counting of home delivered renal dialysis, nutrition procedures and invasive ventilation 'a patient census approach using agreed prescribing norms may be used for counting non-admitted patient service events'.

[18] Australian Government, Independent Hospital Pricing Authority, Tier 2 Non-admitted services compendium 2014-2015 Retrieved 30 May 2014 <http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/tier2-non-admitted-services-compendium-2014%E2%80%932015-html~home-renal-dialysis)>

To report this activity, reporting entities are able to provide a patient census and when HSU report this activity, prescribing norms are applied to the census count to derive service events which are then reported to IHPA.

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 (KPIs), 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 tables exist on the form to enable this separation in reporting (which is also required for Home Nutrition and Home Ventilation patients).

Business rules for home dialysis

The following business rules have been developed and agreed to by Clinical Access Redesign Unit (CARU) in consultation with the Statewide Renal Clinical Network.

1. 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
2. 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.
3. 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.
4. To be included in the Monthly Activity Collection for home dialysis, a patient must have been undertaking dialysis for a *minimum of two weeks* out of the calendar month, which equates to ≥8 sessions of home haemodialysis per month or ≥16 days of peritoneal dialysis. Patients who have undertaken ≤ 7 haemodialysis sessions or ≤ 15 days of peritoneal dialysis in a calendar month cannot be included in the Monthly Activity Collection for 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	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. 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.
Home - Automated Peritoneal Dialysis (APD)	A form of peritoneal dialysis undertaken daily in the patient's home either independently or with the assistance of a carer. 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). 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.

Home Delivered Procedure	Definition
Home - Continuous Ambulatory Peritoneal Dialysis (CAPD)	A form of peritoneal dialysis undertaken daily in the patient's home either independently or with the assistance of a carer. 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. 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.
Facility – Self-care haemodialysis	Haemodialysis undertaken independently or with the assistance of a carer in a purpose-built facility but without the assistance of paid healthcare professionals. Patients who dialyse independently (or with the assistance of a carer) in a facility where other patients are receiving assistance from paid healthcare professionals can be counted as self-care provided that the patient themselves do not receive assistance from paid healthcare professionals during the session. 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.
NUTRITION	
Home - Enteral Nutrition	Refer to the definition in IHPA's Tier 2 Non-admitted services definitions manual 2014-15.

Home Delivered Procedure	Definition
Home - Parenteral Nutrition	Refer to the definition in IHPA's Tier 2 Non-admitted services definitions manual 2014-15.
VENTILATION	
Home-Ventilation	Refer to the definition in IHPA's Tier 2 Non-admitted services definitions manual 2014-15.

Enhanced Maternal and Child Health Service - Mums and Bubs Initiative

The Strategic Policy Priority Areas, Policy and Planning Branch have provided the following information for the counting of these visits.

For the purpose of these counting rules, mother refers to both the mother of the child or another person who has primary responsibility for the care of the baby.

- Visits must be home visits.
- The mother and baby are to be counted as one ie both the mother and baby are seen in the visit and are a count of one visit.
- A mother and baby can only receive two home visits. The mother and baby may receive more visits but these additional visits cannot be reported under this initiative.
- The number of visits are to be recorded according to the categories of '0-2 Weeks (inc)' and/ or '3-4 weeks (inc)' post the birth of the baby.
- Where a mother has had a multiple birth, a visit can be counted for each baby following the first. For example, the recording of visits for triplets should be recorded as a count of 3 under both categories of '0-2 Weeks (inc)' and/ or '3-4 weeks (inc)'.
- Visits are to be recorded according to whether the reporting entity delivered the 'service event' or contracted the 'service event' to another provider.
- Excludes service events which are provided through the Midwifery outpatient clinic types.
- Failure to attend (FTA) refers to instances where a home visit is booked but the mother and child are not at home when the service provider attends the home for the visit.

Please contact the Strategic Policy Priority Areas, Policy and Planning Branch of the Department of Health for further information.

4.2.4 Emergency Services form (MACONES)

The Emergency Services (ES) form is used to report **public** non-admitted patient emergency services stays.

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 (RSSU).

The ES form for this year is significantly different to previous years to meet increased reporting requirements.

Scope

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

Refer to MAC Reporting Entities and Form Requirements for the reporting requirements of each reporting entity.

'Non-EDIS' sites were identified at the time of publishing this manual as being 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 facility 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.

Facilities moving to EDIS must advise SCI of this change so that the MAC Online application can be updated accordingly.

Form

Emergency Services (ES) form

Definition/s unique to this form

Type of visit to emergency department

The reason the patient presents to an emergency department.

Type of Visit	Definition
Emergency presentation	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. 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.

Type of Visit	Definition
Return visit, planned	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. Exclusion: Where a visit follows general advice to return if feeling unwell, this should not be recorded as a planned visit.
Pre-arranged admission	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. 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.
Patient in transit	This code includes where the emergency department is responsible for care and treatment of a patient awaiting transport to another facility.
Dead on arrival	Where a patient is dead on arrival and an emergency department clinician certifies the death of the patient. Exclusion: Where resuscitation of the patient is attempted, this should be recorded as an ‘emergency presentation’. Note: Where a patient is recorded as ‘Dead on arrival’, an ‘Episode end status’ of ‘Dead on arrival’ should also be recorded.

Episode end status

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

Episode end status	Definition
Transferred for admitted patient care in this hospital (either short stay unit, hospital-in-the-home or other admitted patient care unit)	Transferred for admitted patient care in this hospital (either short stay unit, hospital-in-the-home or other admitted patient care unit) This code should only be used for patients who physically depart the emergency department because they are admitted to a short stay unit, hospital-in-the-home or other admitted patient care unit. Patients for whom the intention is to admit to a short stay unit, hospital-in-the-home or other admitted patient care unit, but who die or otherwise leave the emergency department should not be recorded as this code. This code excludes patients who died in the emergency department. Such instances should be coded to 'Died in emergency department'.
Emergency department stay completed - departed without being transferred to a short stay unit, hospital-in-the-home or other admitted patient care unit in this hospital or referred to another hospital	Emergency department stay completed - departed without being transferred to a short stay unit, hospital-in-the-home or other admitted patient care unit in this hospital or referred to another hospital. This code includes patients who either departed under their own care, under police custody, under the care of a residential aged care facility or under the care of another carer. This code excludes patients who died in the emergency department. Such instances should be coded to 'Died in emergency department'.
Emergency department stay 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

Episode end status	Definition
Died in emergency department	This code should only be used for patients who die while physically located within the emergency department
Dead on arrival	This code 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 (e.g. in an ambulance outside the emergency department). Exclusion: When resuscitation or any other clinical care for the patient is attempted, this code should not be used. Note: Where a patient is recorded as 'Dead on arrival', a 'Type of visit to emergency department' of 'Dead on arrival' should also be recorded.

Triage Category

The urgency of the patient's need for medical and nursing care as assessed at triage.

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 which are:

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

4.2.5 Telehealth forms (MACONTELP, MACONGTLP, MACONTELR and MACONGTLR)

The Telehealth Support Unit of the Clinical Access and Redesign Unit, Health Systems Innovation Branch of the Department of Health have provided the following information. For further information please contact Telehealth Support Unit.

Telehealth service events are non-admitted patient 1:1 consultations or group sessions delivered via videoconferencing technology.

1:1 consultations and group sessions delivered via videoconference can be counted as non-admitted patient telehealth service events if they are a substitute for a face-to-face consultation and they meet all the criteria included in the definition of a non-admitted patient service event.

A Telehealth service event can be reported once by the provider-end facility and once by the recipient-end facility, irrespective of the number of medical officers or other health professionals participating in the consultation or group session at either the provider-end facility or the recipient-end facility.

There are four MAC Telehealth forms to report non-admitted patient Telehealth service events:

MACONTELP	to be completed by provider-end facilities for 1:1 telehealth service events
MACONGTLP	to be completed by provider-end facilities for group telehealth sessions
MACONTELR	to be completed by recipient-end facilities for 1:1 telehealth service events
MACONGTLR	to be completed by recipient-end facilities for group telehealth sessions

Telehealth service events (1:1 service events or group sessions) are to be reported by service provider type (medical officer or other health professional) and by funding source for:

Specialist and allied health/ clinical nurse consultation clinic types

Procedure clinic type:

- Oncology Radiation Therapy – Simulation and planning;

Diagnostic clinic types:

- General Imaging
- Magnetic Resonance Imaging (MRI)
- Computerised Tomography (CT)
- Nuclear medicine
- Position Emission Tomography (PET)
- Mammography Screening
- Clinical Measurement

The recipient and provider end facilities should be reported against the clinic type that best matches the description of the clinic being delivered at their end

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) are not counted as non-admitted patient service events. Please refer to Chapter of the Queensland Hospital Admitted

Patient Data Collection (QHAPDC) Manual for details on reporting admitted patient telehealth events.

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

MACONTELP

Provider-end facilities should report 1:1 telehealth service events on the **MACONTELP** where:

- the service was a substitute for a face-to-face service event
- the services meets the definition of a non-admitted patient service event (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)
- details of the service event are captured through an electronic or manual booking system.

MACONGTLP

Provider-end facilities should report group session telehealth sessions on the **MACONGTLP** where:

- the service was a substitute for a face-to-face service event
- the services meets the definition of a non-admitted patient service event (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)
- details of the service event are captured through an electronic or manual booking system.

MACONTELR

Recipient-end facilities should report 1:1 telehealth service events on the **MACONTELR**

where:

- the service was a substitute for a face-to-face service event
- the services meets the definition of a non-admitted patient service event (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)
- details of the service event are captured through an electronic or manual booking system.

MACONGTLR

Recipient-end facilities should report group session telehealth sessions on the **MACONGTLR** where:

- the service was a substitute for a face-to-face service event

- the services meets the definition of a non-admitted patient service event (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)
- details of the service event are captured through an electronic or manual booking system.

Example 1

A non-admitted patient presents to Facility A for a 1:1 pre-admission clinic telehealth service event with Facility B.

Facility A is the recipient-end facility. The patient and a Registered Nurse are present at Facility A.

Facility A would report a 1:1 non-admitted patient Telehealth service event on the MACONTELR under the 'Other Health Professional' provider type, against the clinic type best matching the description of the clinic being delivered at the recipient end.

Facility B is the provider-end facility. An Anaesthetist is present at Facility B, and provides the consultation.

Facility B would report this non-admitted patient telehealth service event on the MACONTELP as a 1:1 telehealth service event under the 'Medical Officer' provider type, against the clinic type best matching the description of the clinic being delivered at the recipient end.

Example 2

A group of five non-admitted patients present to Facility A, for their group session diabetes clinic, with Facility B.

Facility A is the recipient-end facility. The group of five patients and a Registered Nurse are present at Facility A.

Facility A would report a non-admitted patient group telehealth session on the MACONGTLR under the 'Other Health Professional' provider type, against the clinic type best matching the description of the clinic being delivered at the recipient end.

Facility B is the provider-end facility. A Dietician is present at Facility B, and provides the consultation.

Facility B would report this non-admitted patient group telehealth session on the MACONGTLP under the 'Other Health Professional' provider type, against the clinic type best matching the description of the clinic being delivered at the recipient end.

4.2.6 Pathology form (MTACPATH)

Department of Health's Pathology Queensland extracts pathology service event counts from the Auslab pathology system and provides them directly to SCI.

Scope

Facilities that do not use Auslab are required to report pathology service events on the Pathology form and submit to SCI 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.

4.3 Admitted patient service event forms

Bed Availability Form (BED)

Available beds and available bed alternatives are reported using the Bed (BA) report in SCI's MAC Online application.

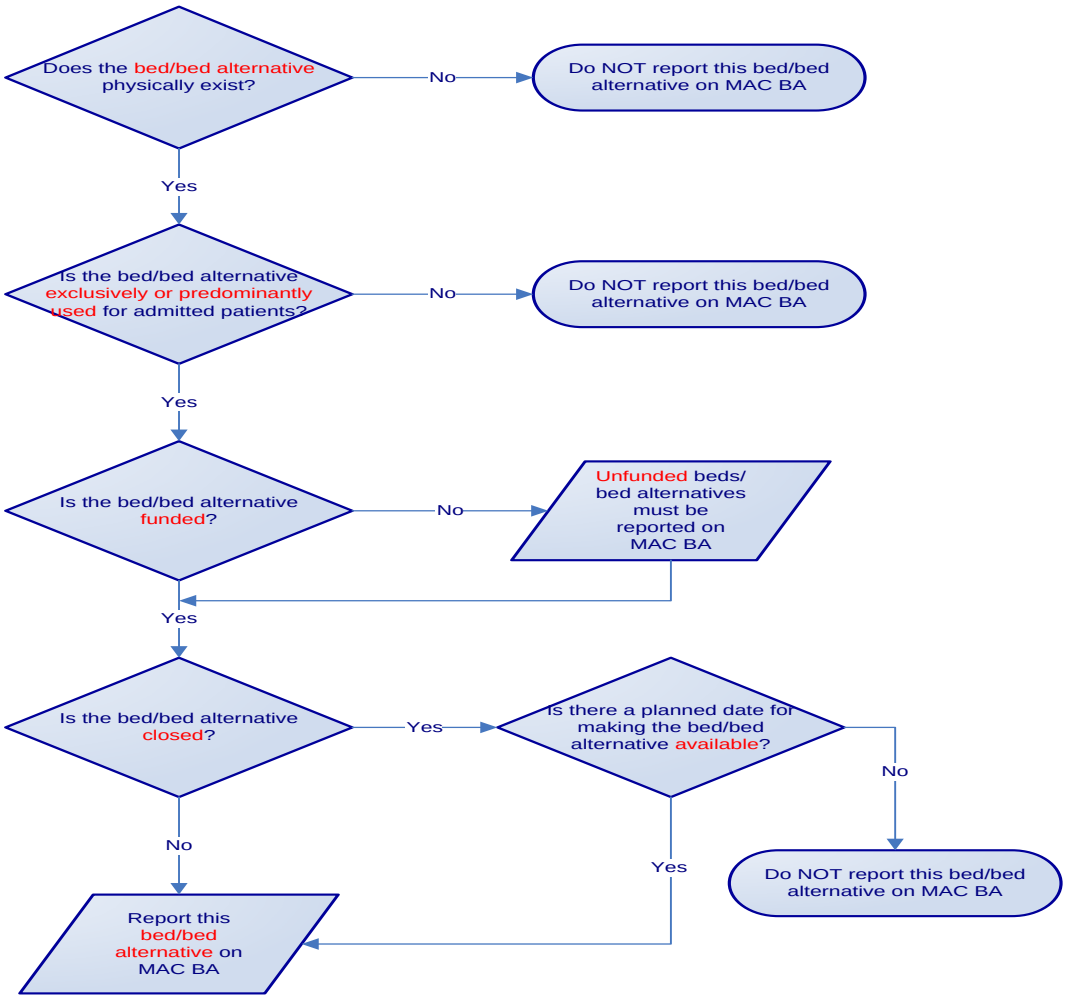
A bed/bed alternative is only to be reported to MAC if it is used exclusively or predominantly for admitted patients.

To ensure the quality and integrity of bed availability information, the Department of Health Executive Management Team (EMT) has directed the Chief Executives of HHSs to verify and approve the monthly figures reported in the Bed form.

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

To determine whether or not to report a bed/ bed alternative refer to this flowchart:

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

Scope

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

Refer to MAC Reporting Entities and Form Requirements for the forms required to be submitted by each facility.

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

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 3.1) – Module 25. Cardiac Services.*

Day Surgery

For details on the definition of (day-only) surgical services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.1) – Module 13. Perioperative Services*.

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

For details on the definition of emergency services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.1) – Module 14. Emergency Services*

Intensive Care Unit – Level 4, 5 or 6

For details on the definition of an intensive care unit and its required clinical services level, refer to the *Clinical Services Capability Framework (version 3.1) – Module 16. Intensive Care Services*

Maternity

For details on the definition of maternity services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.1) – Module 26. Maternity Services*

Neonatal Service Cots – Level 4, 5 or 6

For details on Neonatal Service Cots - Level 4, 5 or 6 and their service level criteria refer to the *Clinical Services Capability Framework (version 3.1) – Module 27. Neonatal Services*

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 3.1) – Module 27. Neonatal Services*

Paediatric – Children's Intensive Care Service Level 6 – (PICU)

For details on the definition of Children's Intensive Care Services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.1) – Module 17. Children's Intensive Care Services*

Paediatric – General Paediatric

For details on the definition of general paediatric services and the required clinical services level, refer to the Clinical Services Capability Framework (version 3.1) - Module 10. Children's Medical Services

Palliative – Designated (Palliative Care Service Level 4 or 5 or 6)

A designated palliative bed is a bed that is available for palliative care, in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure.

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

For details on the definition of palliative care services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.1) – Module 24. Palliative Care Services*

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

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

Rehabilitation – Designated (Rehabilitation Service Level 4 or 5 or 6)

A designated rehabilitation bed is a bed that is available for rehabilitation care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap.

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

For details on the definition of rehabilitation services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.1) – Module 28. Rehabilitation Services*

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

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

Specialised Mental Health – Acute Psychiatric

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

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

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

Specialised Acute Psychiatric Beds include beds provided for the following mental health programs: General (Adult), Older persons, 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 3.0) – Module 30. Mental Health Services*

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

Specialised Mental Health – Non-Acute Psychiatric

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

Rehabilitation: These services have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focussed on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid-term.

Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.

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

Specialised Non-acute Psychiatric Beds include beds provided for the following mental health programs:

Secure, Dual Diagnosis, Psychogeriatric, Acquired Brian Injury, Rehabilitation & Extended Treatment and Young Persons.

For details on the definition of mental health services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.1) – Module 30. Mental Health Services*

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.

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

Bed and bed alternative categories have been aligned where applicable to the Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3 (CSCF v3.1)

Definitions of Bed Alternative Categories

All Other Bed Alternatives

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

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

Chemotherapy Chairs/Trolleys

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

Emergency Department Chairs/Trolleys (ED Level 4, 5 or 6)

Emergency Department Chairs/Trolleys are bed alternatives specifically used for admitted patients receiving emergency services.

Renal Dialysis Chairs/Trolleys

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

4.3.1 PH1 Form (MTHACPH1)

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

At most facilities, HBCIS automatically generates a preliminary PH1 form on the 4th day of each month (ie: 00:01am on the 4th day). This PH1 contains data for the preceding month/s. The PH1 form is able to then be submitted electronically to MAC Online using Secure Transfer Service (STS). (For instructions on the use of STS when running the extract from HBCIS, please refer to the implementation and user guide supplied by Service Integration Management Team 1, 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, facilities 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 facilities must submit a PH1 form (excluding Nursing Homes and Multipurpose Health Services who are required to complete a NH2 or MP1 form respectively). Refer to 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.

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 so cannot choose the doctor who treats them, 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 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.

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.

Patient Days Accrued by Newborns with Status of Unqualified

The total number of days of stay for all admitted newborns with a qualification status of unqualified that were accrued during the reference month.

Accrued patient days for unqualified newborns includes those days accrued by unqualified newborns in the month who separate during the reference month and those

days accrued by unqualified newborns who are remaining in at the end of the reference month.

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

Patient Days Accrued by Nursing Home Type Patients

The total number of days of stay for all admitted patients who are classified as nursing home type that were accrued during the reference month.

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

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

Psychogeriatric (Episodes of Care)

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

SCI 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.

4.3.2 Multi Purpose Health Service Form (MTHACMP1)

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

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

Patients admitted to 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.

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

Scope

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

Form

MPHS 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, 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.

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

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

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

Scope

The MTHACNH2 form must be completed by all Public Nursing Homes/Hostels/Independent Living services. Refer to MAC Reporting Entities and Form Requirements.

Form

NH2 form

Definitions

Accrued Resident Days

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

Accrued resident days include:

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

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

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

Admissions

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

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

Admitted Residents

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

Available Beds

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

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

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

Boarders

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

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.

Abbreviations

The following terms and abbreviations are used throughout this document.

Abbreviation	Description
ABF	Activity Based Funding
AIHW	Australian Institute of Health and Welfare
CARU	Clinical Access Redesign Unit
CE	Chief Executive
CEO	Chief Executive Officer
COAG	Council of Australian Governments
DoH	Department of Health (Commonwealth)
DSS	Data Set Specification
DVA	Department of Veteran's Affairs
EDS	Emergency Department Stay
EDIS	Emergency Department Information System
HBCIS	Hospital Based Corporate Information System
HHS	Hospital & Health Service
HSB	Health Statistics Branch
IHPA	Independent Hospital Pricing Authority
KPI	Key Performance Indicator
LHN	Local Hospital Network
MAC	Monthly Activity Collection
MBS	Medicare Benefits Schedule
MPHS	Multi Purpose Health Service
NAP	Non-admitted Patient
NEP	National Efficient Price
NH	Nursing Home
NHA	National Healthcare Agreement
NHIA	National Health Information Agreement
NHRA	National Health Reform Agreement
NMDS	National Minimum Data Set
ODC	Outpatient Data Collection
OOS	Occasion/s of Service
QHAPDC	Queensland Hospital Admitted Patient Data Collection
RRMBS	Rural and Remote Medicare Benefits Schedule
RSSU	Revenue, Strategy and Support Unit

Abbreviation	Description
SATr	Surgical Access Team repository
SCI	Statistical Collections and Integration
SE	Service Event
SUC	Standard Unit Code
UDG	Urgency Related Group