Monthly Activity Collection Manual

Statistical Services Branch

2016-17

Queensland Government

Monthly Activity Collection Manual

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Release History:

Date	Version	Pages	Details
Jul 2015	1.0	Numerous	Update of manual to align to 2015-16 reporting requirements as specified in MAC changes for 2015-16.
Jan 2016	1.1	Numerous	Update to advise that the reporting requirements for 47 previously declared public hospitals and the Island Medical Services have changed for 2015-16. Inclusion of a flow chart for reporting of MAC activity. Update to clarify scope of PCHSE reporting. Update to mapping table for Tier 2 clinic class mapping for Pain Management service events provided by Other Health Professional Provider Type (from General counselling to Neuropsychology).
Jun 2016	2.0	Numerous	Update of manual for new reporting year 2016-17

1. Introduction to the MAC

1.1 Overview

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

Data are submitted by each reporting entity to the Statistical Collections and Integration Unit (SCIU), Statistical Services Branch (SSB) of the Department of Health 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 Services (HHSs) Jurisdictional Health Authority (State)
Non-admitted patient (outpatient) (Non-ABF Primary and Community Health Services Clinics)	Primary and Community Health (PCH) Service Events	Hospital and Health Services (HHSs)
Non-admitted patient (emergency service care)	Emergency department stay	public acute hospitals 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, the HHS or the State. The term 'reporting entities' used in this manual refers collectively to the three hierarchical levels for monthly activity reporting ie the hospital, 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
Bed Availability	Beds/ Bed Alternatives	public acute hospitals public psychiatric hospitals public nursing homes/hostels/independent living units multi-purpose health services

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 SCIU using the MAC Online application.

This manual provides detailed information on 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 SCIU.

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

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

Refer to Section 1.4.9 for further information.

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].

[2] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary. <http://meteor.aihw.gov.au/content/index.phtml/itemId/270108)> Retrieved 15 March 2016

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 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 provided by Primary and Community Health Services clinics for which funding corresponds with cost centres designated as 'Non-ABF Service Categories' in the general ledger 'Funding Split Hierarchy'. See Non-admitted patient activity (outpatient 'Primary and Community Health (PCH) service events' (PCHSEs) - non-ABF PCH Service Types for scope.
- services funded by the Commonwealth.
- services provided to patients in the admitted or emergency department settings
- services that do not deliver clinical care eg activities such as home cleaning, meals on wheels or home maintenance. Whilst in the scope of MAC, these activities are not service events and are not reported to IHPA. The counting unit for this activity is 'Occasion of Service' (OOS) and are collected for State reporting purposes (refer to *Other Outreach Services* for more information).
- emergency service care

Reporting mandates

MAC data are the source for mandated Commonwealth and State government reporting requirements, Activity Based Funding (ABF), and local 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.

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[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, these clinic types must be reported.

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 following two national minimum data sets:

- *Public hospital establishments NMDS 2016-17* (PHE NMDS); and
- *Non-admitted patient care hospital aggregate NMDS 2016-17* (NAPC HA NMDS).

Independent Hospital Pricing Authority (IHPA)

In addition to the above reporting requirements for DoH and the AIHW, the Department of Health must provide non-admitted patient service event activity to IHPA[4] at both the aggregate-level as well as the patient-level.

Aggregate-level reporting

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

- *Non-admitted patient care hospital aggregate NMDS 2016-17* (NAPC HA NMDS).
- *Non-admitted patient care Local Hospital Network aggregate NBEDS 2016-17*[5] (NAPC LHNA NBEDS).

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

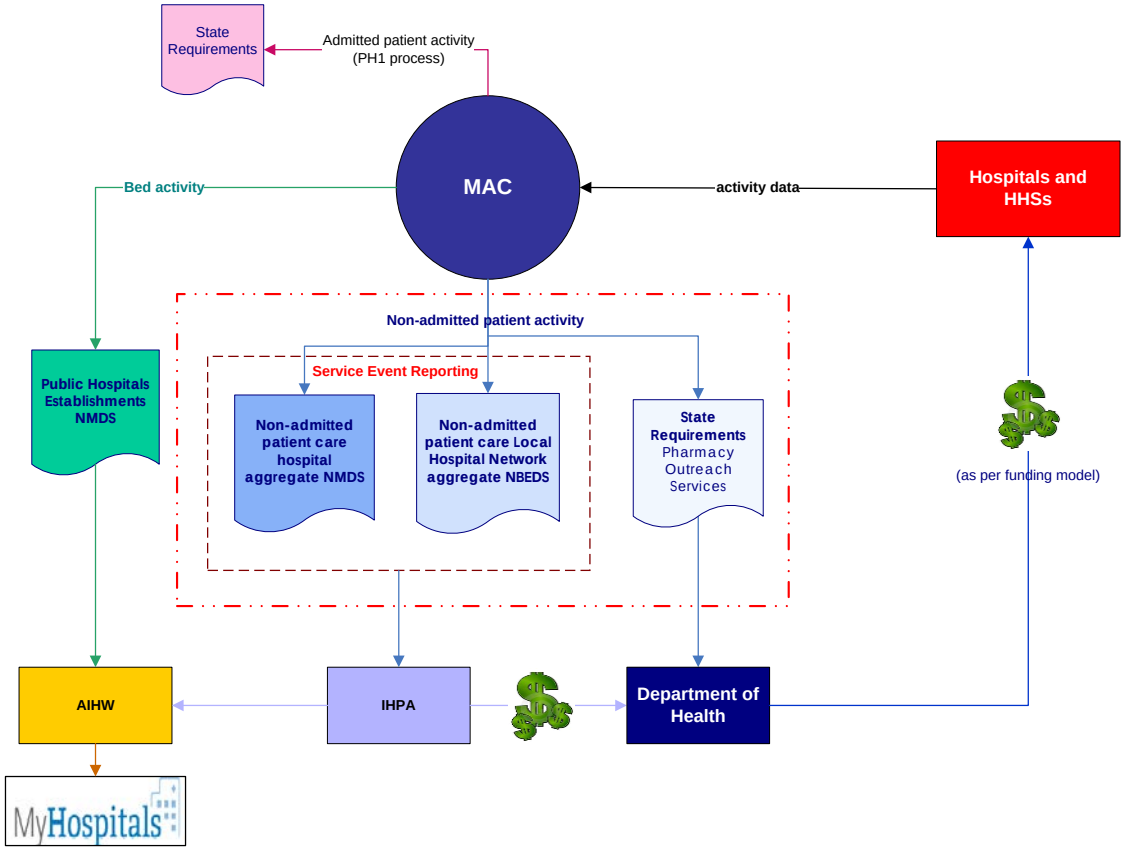
Prior to 1 July 2014, only non-admitted patient service activity that was delivered by public hospitals was reported in the MAC. However from this date, the scope of non-admitted patient service events reported in the MAC was expanded from those service events delivered by public hospitals to service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

Hierarchical level[6]	Data collected through
Public hospital	Non-admitted patient care hospital aggregate NMDS (NAPC HA NMDS) Public hospital establishments NMDS (PHE NMDS)

[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 15 March 2016. <Non-admitted patient care hospital aggregate NMDS 2016-17>

Hospital and Health Service	Non-admitted patient care Local Hospital Network aggregate NBEDS (NAPC LHNA NBEDS)
Jurisdictional health authority (State)	Non-admitted patient care Local Hospital Network aggregate NBEDS (NAPC LHNA NBEDS)

Overview of MAC Reporting



Clinic classifications and counting rules

The Tier 2 Non-Admitted Services Definitions Manual 2016-17 (hereafter referred to as the 'Tier 2 Manual' or 'Tier 2') defines the clinic classifications (classes) required for reporting 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.

- Tier 2 Non-admitted services compendium 2016-17 (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

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

Triage Category[25]

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

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

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

[25] Australian Government, Australian Institute of Health & Welfare. National Health Data Dictionary, retrieved 16 May 2016. http://meteor.aihw.gov.au/content/index.phtml/itemId/474185

Term	Explanation
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.

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 3.2).*

Day Surgery

For details on the definition of (day-only) surgical services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.2).*

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

For details on the definition of emergency services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.2).*

Intensive Care Unit – Level 4, 5 or 6

For details on the definition of an intensive care unit and its required clinical services level, refer to the *Clinical Services Capability Framework (version 3.2).*

Maternity

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

Neonatal Service Cots – Level 4, 5 or 6

For details on Neonatal Service Cots - Level 4, 5 or 6 and their service level criteria refer to the *Clinical Services Capability Framework (version 3.2).*

Non-NICU/Non-SCN Cots

Non-NICU and non-SCN cots – that is, cots for normal neonates - are those cots used for newborns other than Level 4, Level 5 and Level 6 Neonatal Service Cots. For details on neonatal services and their service level criteria refer to the *Clinical Services Capability Framework (version 3.2).*

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

For details on the definition of Children's Intensive Care Services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.2).*

Paediatric – General Paediatric

For details on the definition of general paediatric services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.2).*

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

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

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

For details on the definition of palliative care services and the required clinical services level, refer to the *Clinical Services Capability Framework (version 3.2).*

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

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 3.2).*

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 3.2) – Module 30. Mental Health Services*

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

Specialised Mental Health – Non-Acute Psychiatric

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

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

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

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

Secure, Dual Diagnosis, Psychogeriatric, Acquired 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 3.2).*

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

Specialised Mental Health Target Populations:

General

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

Medium Secure

These rehabilitation units provide a safe and structured environment for the medium to long term inpatient treatment and rehabilitation of consumers with persistent and

disabling symptoms of mental illness, who cannot be adequately supported in other inpatient or community settings.

Child and adolescent

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

Young persons

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

Older person's psychiatry

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

Forensic psychiatry

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

Legacy Intellectual Disability

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

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 (version 3.2).

Definitions of Bed Alternative Categories

All Other Bed Alternatives

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

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

Chemotherapy Chairs/Trolleys

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

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

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

Renal Dialysis Chairs/Trolleys

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

4.3.2 PH1 Form (MTHACPH1)

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

At most 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 Integrated Application Services, Technology Services Branch, eHealth Queensland, Department of Health). This preliminary form requires no user intervention and the quality of this data is as it is at the time of the extract.

Should amendments to the first submission be required, 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/ Hostels/ Independent Living Units and Multipurpose Health Services who are required to complete a NH2 or MP1 form respectively). Refer to MAC Reporting Entities and Form Requirements.

Form

PH1 Form

Definitions

Accrued Patient Days

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

Accrued patient days include:

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

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

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

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

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

Accrued patient days with a Standard Unit Code of HOME

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

Accrued patient days with a Standard Unit Code of HINH

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

Accrued patient days with a Standard Unit Code of PYAA

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

Accrued patient days with a Standard Unit Code of PYAQ

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

Accrued patient days with a Standard Unit Code of PYSH

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

Accrued patient days with a Standard Unit Code of PYSM

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

Accrued patient days with a Standard Unit Code of PYDD

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

Accrued patient days with a Standard Unit Code of PYPG

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

Accrued patient days with a Standard Unit Code of PYET

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

Accrued patient days with a Standard Unit Code of PYAW

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

Accrued patient days with a Standard Unit Code of PYCA

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

Accrued patient days with a Standard Unit Code of PYCW

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

Accrued patient days with a Standard Unit Code of PYYA

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

Accrued patient days with a Standard Unit Code of PYYW

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

Accrued patient days with a Standard Unit Code of PYGE

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

Accrued patient days with a Standard Unit Code of PYFA

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

Accrued patient days with a Standard Unit Code of **PYOA**

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

Accrued patient Days by Newborns with Status of Unqualified

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

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

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

Accrued patient days by Nursing Home Type Patients

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

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

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

Acute (Episodes of Care)

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

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

Admissions

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

An admission may be *formal* or *statistical*.

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

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

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

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

Admitted Patients

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

All other Modes of Separation

All formal separations for the period with a discharge status other than 'Transferred to Another Hospital' or 'Died in Hospital'.

Boarders

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

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

Classification Changes

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

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

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

Died in Hospital

All patients for the period that died during hospitalisation.

Eligible Compensable (Patients)

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

A compensable patient is a person who:

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

For the purposes of this Monthly Activity Form (PH1), Department of Veterans' Affairs (DVA) patients who are not compensable in the strict interpretation of the word, but are

patients for whom another agency (the DVA) has accepted responsibility for the payment of any charges relating to their episode of care, should be classified as eligible compensable patients.

Eligible Patients

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

Eligible Private (Patients)

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

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

Eligible Public (Patients)

Eligible patients who,

- elect to be treated as a public patient with their treating doctor nominated by the hospital or
- are receiving treatment in a private hospital under a contracted arrangement with a public hospital or health authority.
- are being treated by Medical Officers that are eligible to claim reimbursement for the service/s provided through Medicare Australia under the Rural & Remote Medical Benefit Scheme (RRMBS) or the Medicare Billing for Primary Care in Small Rural Hospitals arrangements (COAG 19.2).

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

Episode of Care

A phase of treatment described by one of the following types of care:

- acute
- geriatric evaluation and management
- maintenance
- rehabilitation
- palliative
- psychogeriatric
- newborn
- mental health or
- other care.

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

Formal Admissions

See Admissions.

Formal Separations

See Separations.

Geriatric Evaluation and Management (Episodes of Care)

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

Geriatric evaluation and management is:

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

Ineligible (Patients)

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

Maintenance (Episodes of Care)

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

Newborn (Episodes of Care)

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

Mental Health (Episodes of Care)

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

• is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health;

• is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and

• may include significant psychosocial components, including family and carer support.

NB: *Episodes with this new care type will be reported on the PH1 Form under the 'Other Care' care type category. The Monthly Activity Report extract (from HBCIS) is to be amended to include the 'Mental Health' care type category in the future HBCIS releases.*

On Leave

See Separations.

Other Care (Episodes of Care)

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

Overnight or Longer (Stay Patients)

Patients who are admitted to, and separated from the hospital on different dates.

This type of patient:

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

Boarders are excluded from this definition.

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

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

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

Palliative (Episodes of Care)

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

Palliative care is:

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

Psychogeriatric (Episodes of Care)

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

Psychogeriatric care includes:

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

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

Reference Month

The month to which the form refers.

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

Rehabilitation (Episodes of Care)

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

Rehabilitation care is:

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

Remaining in at Beginning (of the Reference Month)

Overnight or longer stay patients actually in the facility or on leave at midnight on the first day of the reference month.

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

Exclude same day patients.

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

Remaining in at End (of the Reference Month)

Overnight or longer stay patients actually in the facility or on leave at 11.59pm on the last day of the reference month.

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

Exclude same day patients.

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

Same Day Patients

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

This type of patient:

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

Boarders are excluded from this definition.

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

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

Separations

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

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

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

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

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

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

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

Statistical Admissions

See Admissions.

Statistical Separations

See Separations.

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

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

Transferred to another hospital

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

Admitted Patient Data Validations

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

The reconciliation of this data is as follows:

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

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

- *Total Overnight or Longer Separations* = grand total statistical + grand total formal overnight or longer separations from All Admitted Patients.
- *Total Same Day Separations* = grand total statistical + grand total formal same day separations from All Admitted Patients.

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

4.3.3 Multi Purpose Health Service Form (MTHACMP1)

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

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

Patients admitted to 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.

SCIU 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.

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

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

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
CE	Chief Executive
CEO	Chief Executive Officer
CIMHA	Consumer Integrated Mental Health Application
COAG	Council of Australian Governments
DoH	Department of Health (Commonwealth)
DVA	Department of Veteran's Affairs
EDIS	Emergency Department Information System
HBCIS	Hospital Based Corporate Information System
HHS	Hospital & Health Service
HIU	Healthcare Improvement Unit
IHPA	Independent Hospital Pricing Authority
ISOH	Information System Oral Health
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
QHNAPDC	Queensland Health Non-admitted Patient Data Collection
NBEDS	National Best Endeavours Data Set

Abbreviation	Description
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
OOS	Occasion/s of Service
P & F	Purchasing & Funding Branch, Healthcare Purchasing & System Performance Division
PCH	Primary and Community Health
PCHSE	Primary and Community Health service event
PHE NMDS	Public Hospitals Establishments NMDS
QHAPDC	Queensland Hospital Admitted Patient Data Collection
RRMBS	Rural and Remote Medicare Benefits Schedule
RSSU	Revenue, Strategy and Support Unit
SATr	Surgical Access Team repository
SCIU	Statistical Collections and Integration Unit
SE	Service Event
SUC	Standard Unit Code
SSB	Statistical Services Branch
UDG	Urgency Related Group