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1. INTRODUCTION

1.1 Overview

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

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

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

1.2 Purpose of the collection

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

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

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

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

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

1.3 Scope of the collection

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

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

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

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

A residential mental health care facility is a service that:

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

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

Trained residential mental health care staff may include:

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

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

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

• Community Care Units (CCU)
• Adult and Youth Step Up Step Down Units (SUSDU)

The following services are not part of the mandatory scope and are not reported in this collection during 2020/2021. They are under review for inclusion in future years.

• Youth Residential Rehabilitation (YRR) Services

• Transitional Recovery Services

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

• Housing and Support Program (HASP)

• Consumer Operated Services

• Temporary Support Accommodation

• Residential Aged Care Services

1.4 Confidentiality and privacy

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

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

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

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

2.1 Methods of submission

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

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

2.2 Data quality

Data supplied to the RMHCDC is expected to be of a high quality on submission. Validation errors are generated following a successful load of RMHCDC data for a specific reference period.

Residential mental health care facilities are notified of their errors on-line through the Electronic Validation Application (EVA Plus). Data errors are to be resolved within HBCIS, which will flag updated records automatically for resubmission.

2.3 Electronic Validation Application (EVA Plus)

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


Details regarding the validations applied to residential mental health care episodes are contained in Appendix L of the QHAPDC manual.
### 2.4 Due dates for data submissions

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

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

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Finalised Data Due Date All Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>4 September</td>
</tr>
<tr>
<td>August</td>
<td>5 October</td>
</tr>
<tr>
<td>September</td>
<td>4 November</td>
</tr>
<tr>
<td>October</td>
<td>5 December</td>
</tr>
<tr>
<td>November</td>
<td>4 January</td>
</tr>
<tr>
<td>December</td>
<td>4 February</td>
</tr>
<tr>
<td>January</td>
<td>7 March (6 in a leap year)</td>
</tr>
<tr>
<td>February</td>
<td>4 April</td>
</tr>
<tr>
<td>March</td>
<td>5 May</td>
</tr>
<tr>
<td>April</td>
<td>4 June</td>
</tr>
<tr>
<td>May</td>
<td>5 July</td>
</tr>
<tr>
<td>June</td>
<td>4 August</td>
</tr>
</tbody>
</table>

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

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

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

3.1 Residential Mental Health Care Services

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

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

3.1.1 Community Care Units

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

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

The key functions of the CCU are:

- provision of 24-hour mental health care, peer support and rehabilitation for consumers with complex mental health needs and associated disabilities
- facilitation of living skills development in a community facility setting over a medium to long term time frame
• engagement of consumers to develop sustainable relationships with peers, family/carers and/or other supports to enable meaningful participation in their own community.

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

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

3.1.2 Step Up Step Down Units

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

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

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

SUSDU services aim to:

• prevent further deterioration of a person’s mental state and associated disability, and so reduce the likelihood of admission to an acute inpatient unit (step up)

• enable early discharge from acute mental health inpatient units through the provision of an intensive safe and supportive sub-acute residential community program (step down)

• provide recovery-oriented care and support to minimise the trauma and impact of a first episode or relapse of a mental illness and to support transition back into the community

• provide an integrated approach to clinical recovery and psychosocial interventions with a focus on stabilisation and management of illness and, engagement or re-engagement in positive and supportive social, family educational and vocational connections.

Service features

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

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

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

3.3 Residential stay

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

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

Figure 1: Residential Stay

3.4 Leave

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

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

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

**Date of starting leave**

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

**Time of starting leave**

Record the time on which the patient started leave.

**Date returned from leave**

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

**Time returned from leave**

Record the time on which the patient returned from leave.

**Leave category**

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

**Figure 2: Leave**
3.4.1 Inferred leave

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

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

If the period between the residential mental health care episode ending and starting is less than 43 days, the period of absence will be deemed to be inferred leave (refer to image on next page)
3.4.2 Calculation of leave days

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

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

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

**Example**

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

A single period of leave cannot exceed 42 days.

**Example**

A consumer who commences leave on Monday, 10 June, must return to the residential mental health care facility on or before Monday, 22 July.

Calculation rules for leave days for residential mental health care facilities are consistent with the rules in the [QHAPDC manual](#) except for the 7-leave day maximum rule.
3.4.3 Non-returned from leave

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

3.5 Calculation of length of stay (LOS)

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

3.6 Same day consumers

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

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

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

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

4.1 Consumer (patient) details

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

4.1.1 Address of usual residence

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

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

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

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

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

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

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

4.2 Change of reference period

All consumers remaining in residential mental health care facilities across financial years (reporting periods) must have their episode administratively ended at 11:59 pm on 30 June, using the mode of separation (discharge status) code ‘32 - Change of Reference period’. A new residential mental health care episode should then be started using source of referral / transfer (admission source) code ‘32 -
Change of Reference period’ at 00:01 am on 1 July. This includes consumers who were admitted on 30 June.

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

Consumers who are on leave at 30 June should be returned from leave (administrative process only) at one minute prior to having their episode administratively ended (i.e. returned from leave at 11:58 pm, administratively ended at 11:59 pm).

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

**Figure 4: Change of reference period**

4.3 Chargeable status

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

- consumers not having access to private doctors of their choice; and

- the private health insurance in Australia does **not** cover residential mental health care.

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

A public consumer who is allocated single room accommodation is still a public consumer. Residential consumers should never be allocated a private account class.
Consumers who are being treated by a private clinician outside the facility should be considered public consumers for the purposes of treatment within the facility.

**Fees and charges**


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

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

**Medicare eligible**

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

For further information see: [https://www.servicesaustralia.gov.au/individuals/services/medicare/medicare-card](https://www.servicesaustralia.gov.au/individuals/services/medicare/medicare-card)

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

**Department of Veterans’ Affairs (DVA)**

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

Entitled Persons are consumers who hold either a Gold or White card. For more information in relation to DVA card holders in residential mental health care settings, please contact the DVA on 1300 550 457 (metropolitan) of 1800 550 457 (non-metropolitan).

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

**Compensable**

The National Health Reform Agreement defines a ‘compensable consumer’ as:

An eligible person who is;

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

Follow local HHS processes for claiming against these insurers.

**Prisoners**

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

**Medicare Ineligible**

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

**4.3.1 Account class**

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

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

<table>
<thead>
<tr>
<th>HBCIS Account Class</th>
<th>Account Class Code</th>
<th>Account Class Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>GPMLS</td>
<td>Gen Public Mental Health Long Stay And Over 21 ETF – Public</td>
</tr>
<tr>
<td></td>
<td>GPMLSSD</td>
<td>Gen Public Mental Health Long Stay And Over 21 ETF – Public Same Day (CCU use only)</td>
</tr>
<tr>
<td></td>
<td>GPMLSDVA</td>
<td>Gen Public Mental Health Long Stay - DVA</td>
</tr>
<tr>
<td></td>
<td>GPMLSU21</td>
<td>Gen Public Mental Health Long Stay – U21 and U21 ETF – Public</td>
</tr>
<tr>
<td></td>
<td>GPETFU18</td>
<td>Extended Treatment Facility – U18</td>
</tr>
<tr>
<td>Partial</td>
<td>GPMLSP</td>
<td>Gen Public Mental Health Long Stay Partial and ETF – Partial</td>
</tr>
<tr>
<td></td>
<td>GPMLSPDVA</td>
<td>Gen Public Mental Health Long Stay DVA - Partial</td>
</tr>
<tr>
<td>Ineligible</td>
<td>GPI</td>
<td>Medicare Ineligible</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>GPILS</td>
<td>Medicare Ineligible Long Stay</td>
<td></td>
</tr>
</tbody>
</table>
4.4 Source of referral / transfer (admission source)

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

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

A consumer cannot be transferred by a residential mental health care facility to itself. Where account class changes are required, this should be captured as an account class change, and not as an admission and discharge. Where a consumer is leaving the residential mental health care facility for short term care, they should either be transferred to another facility, or where the care is not at an established facility, they should either be put on leave or discharged to 29 ‘Other’ and readmitted as ’22 - Routine re-admission not requiring referral’.

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

4.5 Care type

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

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

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

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

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

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

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

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

### 4.6 Planned same day

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

### 4.7 Standard unit code

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

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PYRA</td>
<td>Psychiatric Adult Residential (CCUs)</td>
</tr>
<tr>
<td>PYSY</td>
<td>Psychiatric Young Persons (Youth) Step Up Step Down</td>
</tr>
</tbody>
</table>

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

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

**Code PYRA  Psychiatric Adult Residential (CCUs)**

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

**Code PYSA  Psychiatric Adult - Step Up Step Down**

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

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

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

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

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

**4.7.1 Standard ward code**

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

**4.8 Mode of separation (discharge status)**

The mode of separation (discharge status) captures the place to which a consumer is referred immediately following exit from the residential mental health care facility, or reason why an episode of residential mental health care has ended.
A consumer cannot be transferred by a residential mental health care facility to itself. Where account class changes are required, this should be captured as an account class change, and not as an admission and discharge. Where a consumer is leaving the residential facility for short term care, they should either be transferred to another facility, or where the care is not at an established facility, they should either be put on leave or discharged to ‘29 ‘Other’ and readmitted as ‘22 - Routine re-admission not requiring referral’. All consumers remaining in residential mental health care facilities across financial years (reporting periods) must have their episode administratively ended with a mode of separation (discharge status) of ‘32 - Change of reference period’. Refer to ‘Change of reference period’ in this manual.

**Note:** Consumers in residential facilities should only have care type ‘12 - Mental Health’. Refer to Section 4.5 Care Type above.

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

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

### 4.9 How to record leave

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

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

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

#### 4.9.1 Non-return from leave

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

Where a consumer is on leave at the end of the reporting period (financial year), has been statistically discharged and readmitted following the end of year processing, and does not return from leave in the new reporting period (financial year):
• the leave record for the episode in the new reporting period should be deleted, along with the episode

• the leave record in the previous reporting period should be removed; and the consumer episode of residential care should be ended on the date they went on leave

• MHAODB should be contacted, as the previous year may have been closed off, requiring a manual update in all downstream reporting systems.

If the consumer subsequently returns to the residential mental health care facility after a non-return from leave, a new episode of residential care is to be recorded.

4.10 Morbidity details

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

4.11 Mental health details

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

• The type of usual accommodation prior to the formal commencement of residential mental health care.

• The self-reported employment status of the consumer immediately prior to the formal commencement of residential mental health care.

• The pension status of the consumer prior to the formal commencement of residential mental health care.

• Whether the consumer has previously been admitted to an acute or psychiatric hospital for psychiatric care prior to the formal commencement of residential mental health care. Note: This does not include previous entry into a residential mental health care facility.

• Where the consumer has been referred to for care after the residential mental health care episode has been completed.

• The legal status of the consumer indicating if their treatment was involuntary at any time during the residential mental health care episode.
• Whether the consumer has received any previous non-admitted treatment for a mental health condition prior to formal entry to the residential mental health care facility. **Note:** This includes previous residential mental health care.

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

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

### 4.11.1 Referral to further care

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Not referred</td>
</tr>
<tr>
<td>02</td>
<td>Private psychiatrist</td>
</tr>
<tr>
<td>03</td>
<td>Other private medical practitioner</td>
</tr>
<tr>
<td>04</td>
<td>Mental health/alcohol and drug facility - admitted patient</td>
</tr>
<tr>
<td>05</td>
<td>Mental health/alcohol and drug facility - non-admitted patient</td>
</tr>
<tr>
<td>06</td>
<td>Acute hospital - admitted patient</td>
</tr>
<tr>
<td>07</td>
<td>Acute hospital - non-admitted patient</td>
</tr>
<tr>
<td>08</td>
<td>Community health program</td>
</tr>
<tr>
<td>09</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>10</td>
<td>Residential mental health care facility</td>
</tr>
<tr>
<td>29</td>
<td>Other</td>
</tr>
<tr>
<td>98</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
Code 01 Not referred

Used for consumers who were not referred to further care. This includes consumers who left against medical advice or did not return from leave and therefore did not receive any referrals for ongoing care. **Note:** consumers who died during their care should be coded as ‘98 Not applicable’.

Code 02 Private psychiatrist

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

Code 03 Other private medical practitioner

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

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

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

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

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

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

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

Code 06 Acute hospital – admitted patient

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

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

**Code 07 Acute hospital – non-admitted patient**

Used for consumers who are referred to an outpatient or ambulatory program run from an acute hospital, or to an emergency department. This includes consumers receiving care for a mental health condition in a hospital that does not have a specialised mental health service, and consumers receiving care for a non-mental health condition.

**Code 08 Community health program**

Used for consumers who are referred to a community health program that is not a specialised community mental health service or a specialised community alcohol and other drug treatment service.

**Code 09 General practitioner**

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

**Code 10 Residential mental health care facility**

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

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

**Code 29 Other**

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

**Code 98 Not applicable**

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

**4.12 RMHCDC Business Rules Reference Guide**

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

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

<table>
<thead>
<tr>
<th>HBCIS Items</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission date</td>
<td>Date resident was admitted to the residential mental health care facility</td>
</tr>
<tr>
<td>Admission time</td>
<td>Time resident was admitted to the residential mental health care facility</td>
</tr>
<tr>
<td>Admission source</td>
<td>25 – Non-admitted patient referred from another hospital</td>
</tr>
<tr>
<td>Extended source</td>
<td>Facility ID of hospital the patient is transferring from</td>
</tr>
</tbody>
</table>

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

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

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

Enter the correct doctor details for the treating doctor.

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>HBCIS Items</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge date</td>
<td>Date resident was discharged from residential mental health facility</td>
</tr>
<tr>
<td>Discharge time</td>
<td>Time resident was discharged from residential mental health facility</td>
</tr>
<tr>
<td>Discharge code</td>
<td>31 – Residential mental health care</td>
</tr>
<tr>
<td>Destination</td>
<td>Facility ID of residential care facility the patient is transferring to</td>
</tr>
<tr>
<td>Referral to further care</td>
<td><em>10 – Residential mental health care facility</em></td>
</tr>
</tbody>
</table>
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>CCU</td>
<td>Community Care Unit</td>
</tr>
<tr>
<td>CMO</td>
<td>Community Managed Organisation</td>
</tr>
<tr>
<td>CRDS</td>
<td>Corporate Reference Data System</td>
</tr>
<tr>
<td>CSCPU</td>
<td>Clinical Systems Collections and Performance Unit</td>
</tr>
<tr>
<td>DoH</td>
<td>Queensland Department of Health</td>
</tr>
<tr>
<td>DVA</td>
<td>Department of Veterans' Affairs</td>
</tr>
<tr>
<td>ETF</td>
<td>Extended Treatment Facility</td>
</tr>
<tr>
<td>EVA Plus</td>
<td>Electronic Validation Application</td>
</tr>
<tr>
<td>EX</td>
<td>External Cause</td>
</tr>
<tr>
<td>HASP</td>
<td>Housing and Support Program</td>
</tr>
<tr>
<td>HBCIS</td>
<td>Hospital Based Corporate Information System</td>
</tr>
<tr>
<td>HHS</td>
<td>Hospital and Health Services</td>
</tr>
<tr>
<td>HQI</td>
<td>Homer Queensland Interface</td>
</tr>
<tr>
<td>ID</td>
<td>Identifier</td>
</tr>
<tr>
<td>ICD-10-AM</td>
<td>International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification</td>
</tr>
<tr>
<td>IHPA</td>
<td>Independent Hospital Pricing Authority</td>
</tr>
<tr>
<td>METeOR</td>
<td>Metadata Online Registry</td>
</tr>
<tr>
<td>MHAODB</td>
<td>Mental Health Alcohol and Other Drugs Branch</td>
</tr>
<tr>
<td>MHSO</td>
<td>Mental Health Service Organisation</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government Organisation</td>
</tr>
<tr>
<td>NMDS</td>
<td>National Minimum Data Set</td>
</tr>
<tr>
<td>OD</td>
<td>Other Diagnosis</td>
</tr>
<tr>
<td>PD</td>
<td>Principal Diagnosis</td>
</tr>
<tr>
<td>PR</td>
<td>Procedure</td>
</tr>
<tr>
<td>QHAPDC</td>
<td>Queensland Hospital Admitted Patient Data Collection</td>
</tr>
<tr>
<td>QHEPS</td>
<td>Queensland Health Electronic Publishing Service</td>
</tr>
<tr>
<td>RMHC</td>
<td>Residential Mental Health Care</td>
</tr>
<tr>
<td>RMHCDC</td>
<td>Residential Mental Health Care Data Collection</td>
</tr>
<tr>
<td>RMHC NMDS</td>
<td>Residential Mental Health Care National Minimum Data Set</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>SCT</td>
<td>Systems and Collections Team, Mental Health Alcohol and Other Drugs Branch</td>
</tr>
<tr>
<td>SSB</td>
<td>Statistical Services Branch, Strategy Policy and Planning Division</td>
</tr>
<tr>
<td>SUSDU</td>
<td>Step Up Step Down Unit</td>
</tr>
</tbody>
</table>
Appendix A: List of Residential Mental Health Care Facilities in Queensland

The following facilities meet the criteria for a residential mental health facility and are in scope for the RHMCDC in 2019/2020.

<table>
<thead>
<tr>
<th>HHS</th>
<th>Residential Facility ID</th>
<th>Residential Facility</th>
<th>Facility Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cairns and Hinterland</td>
<td>82008</td>
<td>Cairns Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td></td>
<td>83005</td>
<td>Cairns Youth Step Up Step Down Unit</td>
<td>SUSDU</td>
</tr>
<tr>
<td></td>
<td>83001</td>
<td>Cairns Adult Step Up Step Down Unit</td>
<td>SUSDU</td>
</tr>
<tr>
<td>Central Queensland</td>
<td>82010</td>
<td>Rockhampton Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td></td>
<td>83004</td>
<td>Central Queensland Step Up Step Down Unit</td>
<td>SUSDU</td>
</tr>
<tr>
<td>Darling Downs</td>
<td>82009</td>
<td>Toowoomba Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td>Mackay</td>
<td>83000</td>
<td>Mackay Step Up Step Down Unit</td>
<td>SUSDU</td>
</tr>
<tr>
<td>Metro North</td>
<td>82001</td>
<td>Pine Rivers Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td></td>
<td>82002</td>
<td>Redcliffe-Caboolture Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td></td>
<td>82003</td>
<td>Somerset Villas Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td></td>
<td>83012</td>
<td>Caboolture Youth Step Up Step Down Unit</td>
<td>SUSDU</td>
</tr>
<tr>
<td>Metro South</td>
<td>82000</td>
<td>Coorparoo Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td></td>
<td>82005</td>
<td>Bayside Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td></td>
<td>82006</td>
<td>Logan Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td></td>
<td>83011</td>
<td>Logan Youth Step Up Step Down Unit</td>
<td>SUSDU</td>
</tr>
<tr>
<td></td>
<td>83002</td>
<td>Acmena House</td>
<td>SUSDU</td>
</tr>
<tr>
<td>Sunshine Coast</td>
<td>82004</td>
<td>Mountain Creek Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td>West Moreton</td>
<td>82011</td>
<td>Gailes Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td>Wide Bay</td>
<td>82007</td>
<td>Wide Bay Community Care Unit</td>
<td>CCU</td>
</tr>
<tr>
<td></td>
<td>83003</td>
<td>Wide Bay Step Up Step Down Unit</td>
<td>SUSDU</td>
</tr>
</tbody>
</table>
Appendix B: End of reference period processing

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

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

Pre-processing activities

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

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

- RMHC Reference Period ‘Remaining In’ Report (QLD)
  Use this report to identify consumers remaining in residential mental health care facilities across financial years.

Consumers who are on leave at 30 June should be returned from leave (administrative process only) at one minute prior to have their episode administratively ended (i.e. returned from leave at 11:58 pm).
End of reference period processing

Manually processing the end of reference period

If the end command is executed at any stage during the steps detailed above the automated process will cease. If this occurs, it will be necessary to follow the process without the automated HBCIS functionality (i.e. manually).

Menu Path

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

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

Patient Discharge Screen:
The fields in the table below are to be completed for a statistical discharge.

<table>
<thead>
<tr>
<th>HBCIS Item</th>
<th>Code</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 02</td>
<td>30 Jun</td>
<td>Discharge date must be ‘30 Jun YY’</td>
</tr>
<tr>
<td>Field 03</td>
<td>23:59</td>
<td>Discharge Time must be 23:59</td>
</tr>
<tr>
<td>Field 05</td>
<td>32</td>
<td>Discharge Code Change of Reference Period</td>
</tr>
<tr>
<td>Field 06</td>
<td>Y</td>
<td>Must readmit with 32 following Discharge type 32</td>
</tr>
<tr>
<td>Field 07</td>
<td>Destination</td>
<td>must be left blank</td>
</tr>
</tbody>
</table>

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

Menu Path

(Not required if processing following discharge code 32.)

HBCIS will automatically trigger the creation of a new residential mental health care episode following a mode of separation type of 32 and will pre-populate a number of fields on the patient admission screen. However, it is important to check the details and complete the remaining fields.
Patient Admission Screen 3

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

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

On filing this screen, HBCIS will prompt the user for additional data to be updated.
Patient Admission Screen 4

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

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

<table>
<thead>
<tr>
<th>HBCIS Item</th>
<th>Code</th>
<th>Recommended Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 06</td>
<td></td>
<td>As per prior episode</td>
</tr>
<tr>
<td>Field 07</td>
<td></td>
<td>To be updated at the end of episode</td>
</tr>
<tr>
<td>Field 08</td>
<td></td>
<td>As per prior episode</td>
</tr>
</tbody>
</table>

On filing this screen, HBCIS will return the user to the Patient Discharge screen to process the next consumer record.
End of reference period processing when the consumer is on leave

Consumers who are on leave at 30 June should be returned from leave (administrative process only) at one minute prior to have their episode administratively ended (i.e. returned from leave at 11:58 pm).

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

1. Returning a resident from leave

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

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

<table>
<thead>
<tr>
<th>HBCIS Item</th>
<th>Code</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 02</td>
<td>30/06/YY</td>
<td>The date must be 30 June</td>
</tr>
<tr>
<td>Field 03</td>
<td>23:58</td>
<td>The time must be 23:58</td>
</tr>
</tbody>
</table>

2. Complete the end of reference period process

3. Placing the consumer back on leave

Place the consumer back on leave by entering the following details in the Patient Leave screen.
HBCIS Item | Code | Details
---|---|---
Field 02 | 01/07/YY | The date must be 1 July
Field 03 | 00:02 | The time must be 00:02
Field 04 | DD/month/YY | Enter the original expected return date
Field 05 | HH:MM | Enter the original expected return time
Field 06 | P | Leave periods greater than 7 days require a leave category code of P
Field 07 | S | Scheduled Leave
Field 08-10 | | Re-enter the original values

RMHC Incomplete MH Details Report (QLD)

Menu Path

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

A new option has been added to the Additional Reports Menu to identify current residential mental health care consumers where their mental health details are incomplete or missing (fields 02 through 06).

The report will print with a page per residential mental health care facility that contains data, if the report contains no data it will print with ‘NOTHING TO REPORT’ in the report line.
RMHC Reference Period ‘Remaining In’ Report (QLD)

Menu Path

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

A new option has been added to the Additional Reports Menu to identify residential mental health care consumers who have not had their end of reference period processing completed. This new report will return any consumers with an open episode of residential mental health care where their start date is in the prior financial year.

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

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

Mapping residential facility units to Standard Unit Code

Mapping a residential facility unit to the correct standard unit code is done within the HQI module. The menu path for the mapping screen is Homer Queensland Health Interface Main Menu-> System Management Menu-> Translation Code File Maintenance Menu-> Unit Code.

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

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

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

Enter the correct doctor details for the treating doctor.

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

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

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

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

Updating the mapping for Standard Unit Code

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

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

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

The general process for re-flagging records is to step the discharge time forward by one minute. However, when the record includes an administrative discharge for end of year reporting, HBCIS won’t allow the altering of the discharge time. In this case, a work around will be required.

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

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