Section 2 – Concepts and derived items

Victorian Integrated Non-Admitted Health (VINAH) minimum dataset manual
14th edition, July 2018
Version 1.0
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Introduction

This section lists concept definitions relating to data items reported to VINAH, and in some cases provides a guide for their use. There is also a reference to VINAH data items derived from data reported. Detailed specifications for reporting data to VINAH are provided in Sections 3, 4 and 5 of this manual.

Concepts

Brokerage

Definition
Brokerage occurs when an organisation that is funded by DHHS to deliver services that are in scope for VINAH reporting, and pays a third party (sub-contracts) to assist with service delivery.

Guide for use
Organisations that report HARP activity and are:
- Part of a HARP Service Agreement, should be identified individually in VINAH, and are not considered brokered services, even when the organisation is outside of a health service.
- Not part of a HARP Service Agreement, are considered brokered services.
- PAC, PC and SACS services will report brokered services.

Brokered services are out of scope for Outpatients.

Refer to
Section 3: Contact provider

Campus

Definition
A physically distinct site owned or occupied by a public health service/hospital, where treatment and/or care is regularly provided to patients.

Guide for use
For the purpose of reporting:
A single campus hospital provides non-admitted patient services at one location only.
Unless designated otherwise by the department, a multi-campus hospital has two or more locations providing admitted patient services, where the locations:
- are separated by land (other than public road) not owned, leased or used by that hospital
- have the same management at the public health service/hospital level
- each has overnight stay facilities. A separate location (see first dot point) providing day only services, such as a satellite dialysis unit, is considered to be part of a campus
- are not private homes. Private homes where hospital services are provided are considered to be part of a campus.
**Episode Campus Code**

The campus responsible for delivering the service to the patient is described by the Episode Campus Code data element. The code list of campuses is found in Section 9 and the table identifier HL70115. The campus responsible for delivering the service may be the same as, or different to, the campus providing the service.

**Contact Provider**

A campus of a hospital or health service that provides the service to the patient is described by the Contact Provider data element. The code list of providers is found in Section 9 and is table identifier 990012. A Contact Provider may also be an organisation which is not a campus of a health service or hospital.

**Local Identifier Assigning Authority**

A campus of a hospital or health service that has assigned the Patient Identifier for the patient is described by the Local Identifier Assigning Authority (LAA) data element. The code list of LAA’s is found in Section 9 and is table identifier HL70300. *Note: If the Patient Identifier is common across the organisation, LAA can be reported as a code from the Organisation Identifier table.*

**Refer to**

Section 3: Contact provider
Section 3: Episode campus code
Section 3: Local identifier assigning authority

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**Case**

**Definition**

The case:

- is opened when an organisation first accepts responsibility for a patient/client, which results in an episode starting
- will contain at least one episode, and may contain two or more episodes where they overlap with each other, or are broken in time only by a referral received prior to all episodes closing, which results in another program/stream accepting the patient/client
- is closed when the patient/client has no open episodes or referrals without outcomes.

Case data may be used for retrospective analysis of patterns of service activity to contribute to policy development and service planning.

**Refer to**

Section 2: Case end date (derived element)
Section 2: Case start date (derived element)
Section 2: Episode
Section 3: Episode end date
Section 3: Episode start date
**Contact**

**Definition**

A contact between a patient/client or other relevant person (in scope), and a professional associated with a program reporting via the VINAH MDS that results in a dated entry being made in the patient/client record.

**Guide for use**

A contact must meet all of the following criteria:

- Clinically significant in nature;
- Provided (or brokered) by an agency funded by a program area that requires reporting via the VINAH MDS;
- For a patient/client who has provided consent (either implied or explicit);
- Requires a dated entry in the clinical record of the patient/client (or a reference to a clinical record held by the brokered service).

For some programs, the following criteria must also be met:

- Have the patient/client directly participating, or
- Have a patient/client’s family member/carer directly participating, or
- Other external healthcare professional directly participating.

The availability of individual code values to a Program/Stream does not inherently mean that a contact that uses that code value is appropriate to be reported to VINAH. For example, Contact Delivery Mode has a code for ‘Written’ modes of service delivery. In order to report a contact using this code, the contact must meet all of the criteria listed above or it cannot be reported as a direct contact.

Contacts must be reported according to VINAH business rules, and within the scope of VINAH, and not according to the end use of the data. For example, the derivation of service events may be different for Activity-Based Funding than for reporting purposes. Therefore, services should ensure they report according to the definitions and business rules of VINAH and the department will derive data appropriately for the given purpose.

There are different types of Contacts, and each program reporting via the VINAH MDS defines which types of Contacts are to be reported for that program. Each type of Contact is defined below.

**Contact type and reporting requirements by Program**

<table>
<thead>
<tr>
<th>Contact type (service)</th>
<th>Palliative Care</th>
<th>FCP</th>
<th>HARP</th>
<th>HBPCCT</th>
<th>HEN</th>
<th>PAC</th>
<th>SACS</th>
<th>Specialist Clinics (Outpatients)</th>
<th>TCPTPN</th>
<th>Victorian HIV</th>
<th>RIR</th>
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<tr>
<td>Direct</td>
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<tr>
<td>• Attended</td>
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<td>Yes</td>
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<tr>
<td>• Non-attended</td>
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<td>Administrative</td>
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</tbody>
</table>
Each contact:

- may be delivered in a variety of settings (for example, home–based or centre–based), and via a number of delivery modes (for example, face to face or by telephone)
- may be delivered to a patient/client in either an individual or a group context
- may be delivered when the patient/client is not present for the interaction but their carer or family is
- is delivered by one or more health professionals
- may be aggregated to provide a count of client service events.

Separate data elements included in the VINAH MDS enable the delivery mode, setting and other attributes of a contact to be reported.

Each patient/client who attends a group session should be reported as having received a contact, independent of the number of patients/clients who participated in the group activity.

**Direct contacts**

Contacts would either be with a patient/client, carer or family member or another professional involved in providing care and do not include contacts of an administrative nature.

Contacts may be differentiated from administrative and other types of contacts by the need to record data in the clinical record. However, there may be instances where notes are made in the patient/client record that have not been prompted by a contact with a patient/client (for example, noting receipt of test results that require no further action). These instances would not be regarded as a contact.

For Contacts that relate to brokered services, a Contact may be able to be reported if the Contact Provider is not a healthcare professional. Providing that all other criteria of a direct service contact are met, a Contact may be recorded. In these instances, the Contact Professional Group must be recorded as a ‘non-professional healthcare provider’.

Contacts that are scheduled but not attended are reported using the following values:

- Contact Client Present Status: 32 Patient/Client/Carer(s)/Relative(s) not present: Scheduled appointment not attended;
- Contact Delivery Mode: 9 not applicable;
- Contact Delivery Setting: 98 not applicable - Patient/Client not present.

**Note:** the following data elements should be reported as scheduled, even though the contact did not occur:

- Contact Date/Time
- Contact Main Purpose
- Contact Professional Group
- Contact Session Type.
Indirect contacts
Those contacts not involving the patient/client and/or the patient/client’s family or carer(s) but are still clinical in nature. This type of contact may include contact with another professional who may provide additional advice/information about the patient/client.

- Only the Palliative Care program requires reporting of indirect contacts. This is done through reporting the following values:
  - Contact Client Present Status: 31 Client/Carer(s)/Relative(s) not present: Indirect contact
  - Contact Delivery Setting: 98 not applicable – Patient/Client not present
  - Contact Session Type: 3 not applicable – Indirect contact type.

Administrative contacts
Administrative contacts are not to be reported to VINAH. They include activities such as, but not limited, to:

- allocation meetings
- appointment scheduling
- administrative tasks
- clinically related administrative work (such as reading or researching patient notes for any purpose)
- clinical supervision
- organisation of brokered services
- record keeping
- report writing or reviewing
- research on any topic for any purpose
- travel time.

Refer to
METeOR Identifier 400604 Non-admitted patient service event

Section 2: Client service event (concept definition)
Section 2: Client service event (derived element)
Section 2: Contact count (derived element)
Section 2: Group session count (derived element)
Section 2: Patient/Client
Section 3: Contact client present status
Section 3: Contact date/time
Section 3: Contact delivery mode
Section 3: Contact delivery setting
Section 3: Contact inpatient flag
Section 3: Contact main purpose
Section 3: Contact professional group
Section 3: Contact provider
Section 3: Contact session type
Section 3: Contact specialist palliative care provider
Section 3: Message visit indicator code (transmission data element)
**Episode**

**Definition**
An episode is the period during which a patient/client receives services within a defined program and stream.

**Guide for use**

An episode:

- is opened when an organisation first accepts responsibility for a patient/client. This occurs in response to a referral, when it is determined that the referral was appropriate
- will generally contain one or more contacts. However, there may be some situations where cases will be opened and then closed without containing any contacts. For example, the patient/client may die or move away before they can receive a contact, or contact with the patient/client may otherwise be lost. A patient/client might also decline the services offered
- is one of the building blocks from which a case is derived
- is closed when the criteria for keeping the patient/client in the program is no longer met (this may differ between programs).

The department will, for some accountability purposes, ‘roll-up’ multiple episodes for a patient where more than one episode is open for the same program stream at the same time. This ‘roll-up’ is an example of the ‘Case’ concept.

When rolling up overlapping episodes, values of data elements will usually take either the value from the episode with the earliest Episode Start Date or the value from the episode with the latest Episode End Date.

The following data elements will take their value from the episode with the earliest Episode Start Date:

- Episode Start Date
- Episode Identifier
- Episode Campus Code
- Episode Care Plan Documented Date
- Referral In Elements
- Episode Impairment Onset Date
- Episode Hospital Discharge Date
- Episode First Appointment Booked Date
- Episode Patient/Client Notified of First Appointment Date
- Episode Health Conditions.

**Note:** Episode Health Condition(s) with Observation Sequence Number 1 will be taken as main Episode (Case) Health Condition (i.e. will have Observation Sequence 1). All other Episode Health Condition(s) values will be assigned an unspecified sequence within the data element, following removal of any duplicate values.

The following data elements will take their value from the episode with the latest Episode End Date:

- Episode End Date
- Episode Proposed Treatment Plan Completion.
The following data element takes it value by applying a rule:

- **Episode First Consultancy Flag**: If any of the episodes have a value of ‘T’ (True), then the Episode (Case) First Consultancy Flag will be set to ‘T’.

All values of the following data elements will be maintained, as they are repeatable:

- Episode Assessment Score
- Episode Assessment Date/Time
- Episode TCP Care Transition Date.

It is important to note that the department will report back to the health services about Cases after the Episode roll-up functionality has been applied, thus there may be differences in data within health services’ internal systems and the Case data reported for accountability purposes. Further, this Case data may change over time as overlapping episodes are closed. Consequently, health services may wish to consider developing internal reporting to duplicate the above roll-up rules.

**Refer to**
- Section 2: Case (concept definition)
- Section 2: Case end date (derived element)
- Section 2: Case start date (derived element)
- Section 2: Referral process
- Section 2: Program
- Section 3: Episode end date
- Section 3: Episode program/stream
- Section 3: Episode start date
- Section 3: Message visit indicator code (transmission data element)

**Family Choice Program (FPC)**

**Definition**

Family Choice Program is a state-wide program which provides home based support to families of children with high levels of complex ongoing medical care needs. The support provided is flexible and tailored to the needs of the particular family based on a case management and individualised medical care plan approach. Children aged between 0 - 17 years of age are eligible to apply, where it is expected that the family will experience difficulty in maintaining the high level of ongoing medical care at home.

Includes Ventilation self-administered by the patient or the patient’s carer. Ventilatory support is a process by which gases are moved into the lungs by a device that assists respiration by augmenting or replacing the patient’s own respiratory effort.

**Guide for use**

Activity for patient/clients enrolled in the Family Choice program will be collected at the episode level. An episode is to be opened for the duration during which a patient/client is responsible for their administration of the treatment and the episode is to be closed when the patient/client ceases home self-administration of their treatment.
The department will count one non admitted service event per calendar month for episodes that have been active during the month.

FCP funded contacts should be reported under the FCP episode. Non FCP funded contacts should be reported separately to the FCP episode to the appropriate program/stream.

For example, if a patient has a consultation with a Physiotherapist in an outpatient clinic, this should be reported to under the ‘OP’ program.

Refer to
Section 2: Program
Section 2: Programs reporting to VINAH
Section 2: Stream
Section 3: Episode program/stream
Section 3: Referral in program/stream

Group sessions

Definition
A group session is defined as two or more patients/clients receiving services as part of a group program or group individual program that occurs on the same date from the same clinician/s at the same location.

Guide for use
In practice, this should be interpreted to mean that patients/clients are receiving precisely the same services, for example, a movement class or a chronic disease education class, where all participants are following the same intervention on the same date and/or where the group nature of the activity is conceived as part of the benefit to the patient/client.

In situations where a clinician/s is working one-on-one with several different patients/clients at the same location, the same date and each patient/client is following their own personalised program (for example, in a physiotherapy gym in a CRC), each of these clients should be coded as having a Contact Session Type of ‘4 – Group Individual Program’ as the services provided to each patient/client are not the ‘same’ but rather individualised programs.

Note that providing care to a patient/client can encompass the provision of services (for example, counselling, education) to the patient/client’s carer(s) and family, whether or not the patient/client is present when these services are delivered. The carer/family member is not, in these situations, considered to be a patient/client in their own right. Thus, for example, if a single patient/client and several members of their family were the only attendees at a centre-based contact, the Contact Session Type coded for that contact would still be ‘1- Individual’.

Only one Contact Session Type can be reported for a single contact.
Should a patient/client receive care in both individual and group settings within a single attendance, this must be reported as two separate contacts. E.g. One contact for ‘Group – group program’ and one contact for ‘Group –individual program’. Multiple session types cannot be reported within a single contact.
Home Enteral Nutrition (HEN)

**Definition**

The administration of nutrition either orally or by feeding tube directly into the gastrointestinal tract self-administered by the patient or carer.

Home Enteral Nutrition is performed by the patient or carer in their home.

**Guide for use**

Activity for patient/clients enrolled in the Home Enteral Nutrition program will be collected at the episode level. An episode is to be opened for the duration during which a patient/client is responsible for their administration of the treatment and the episode is to be closed when the patient/client ceases home self-administration of their treatment.

The department will count one non admitted service event per calendar month for episodes that have been active during the month.

HEN funded contacts should be reported under the HEN episode. Non HEN funded contacts should be reported separately to the HEN episode to the appropriate program/stream.

For example, if a patient has a consultation with a Dietician in an outpatient clinic, this should be reported under the ‘OP’ program.

**Hospital Admission Risk Program (HARP)**

**Definition**

HARP services provide comprehensive and specialist assessments, care coordination, review and monitoring for people with chronic diseases, such as heart failure or children with asthma, people with complex psychosocial needs such as people who are homeless or at risk of self-harm and people with complex needs such as multiple co-morbidities or older people who are frail. In particular, HARP tries to provide more appropriate community services to people who frequently use hospitals or who are at imminent risk of hospitalisation.

**Guide for use**

HARP services are governed by a Local Alliance that shares responsibility for decision-making, risk and responsibility. While health services are the fund-holders, most HARP alliances include one or more community agencies.

HARP services will be provided directly by the health service and by other members of the Local Alliance (as documented in Service Level Agreements). HARP services may also be provided by others through brokerage arrangements.
Responsibility for reporting HARP activity lies with the health service as fund-holder, regardless of how a given service is provided, or by which provider.

For more information, visit: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program

Refer to  
Section 2: Program  
Section 2: Programs reporting to VINAH  
Section 2: Stream  
Section 3: Episode program/stream  
Section 3: Referral In program/stream

**Hospital Based Palliative Care Consultancy Team (HBPCCT)**

**Definition**  
HBPCCT are interdisciplinary services funded by the DHHS, providing medical, nursing and allied health advice and support to treating teams in hospitals and community palliative care services in order to support people with end of life needs in their care. Consultancy teams also provide direct care for people with very complex end of life care needs and provide education and training about palliative care to other clinicians.

**Guide for use**  
For more information, visit: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care

Refer to  
Section 2: Program  
Section 2: Programs reporting to VINAH  
Section 2: Stream  
Section 3: Episode program/stream  
Section 3: Referral program/stream

**Medicare eligibility status**

**Definition**  

**Guide for use**  
An eligible person includes a person who resides in Australia and is:

- An Australian citizen
- A permanent resident
- A New Zealand citizen
- A temporary resident who has applied for a permanent visa and who has either
  - An authority to work in Australia or
  - can prove relationship to an Australian citizen (other requirements may apply)

Other persons who are eligible for Medicare in certain circumstances include: Visitors to Australia from a country that has a Reciprocal Health Care Agreement

In practice, the primary method for ascertaining Medicare eligibility is sighting the patient’s Medicare card.
For further information regarding eligibility to Medicare refer to:

Refer to
Section 3: Contact Account Class
Section 3: Contact Medicare Number

**Medi-Hotel**

**Definition**
Provision of a non-ward residential service maintained and/or paid for by the hospital for the purpose of accommodating patients, as a substitute for traditional hospital ward accommodation.

**Guide for use**
Non-ward accommodation provided by the hospital, excluding the Hospital In The Home (HITH) program. Unlike (HITH), no clinical services are provided. Thus a significant decline in medical condition would always necessitate return from Medi-Hotel to the hospital’s Emergency Department or a ward.

The Medi-Hotel facility may or may not be on hospital property. Where it is on hospital property, this may be co-located in the same building as traditional wards.

Patients may be accommodated in a Medi-Hotel when receiving outpatient care and this activity should be reported to VINAH.

A public hospital must be registered in its Health Service Agreement and/or Statement of Priorities to provide a Medi-Hotel service. The use of a Medi-Hotel is voluntary for the patient.

**Palliative Care (PC)**

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

**Guide for use**
Palliative care (WHO definition):

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy,
and includes those investigations needed to better understand and manage
distressing clinical complications.

Community palliative care services provide a range of services to clients in their
home including nursing, liaison with medical practitioners, counselling for the
client and their family, allied health services, complementary therapies and
coordination with other services. Services comprise multidisciplinary specialist
assessment and intervention for pain, symptom control or prevention whilst being
treated for a disease that cannot be cured. Emotional, social, spiritual, cultural
and physical aspects are considered in the provision of practical support to the
patient, carers and family.

For more information, visit: https://www2.health.vic.gov.au/hospitals-and-health-
services/patient-care/end-of-life-care/palliative-care

Refer to
Section 2: Program
Section 2: Programs reporting to VINAH
Section 2: Stream
Section 3: Episode program/stream
Section 3: Referral in program/stream

Patient/Client
Definition
A patient/client is a person for whom an organisation accepts responsibility for
providing treatment and/or care delivered in programs reporting to VINAH.

Guide for use
Services provided to the patient/client's carer(s) and/or family (for example,
counselling, education) may be reported on the patient/client's episode, whether
or not the patient/client is present when these services are delivered. The carer
is not, in these situations, considered to be a patient/client in their own right,
even if the patient/client is deceased (which may be the case for the Palliative
Care program).

Refer to
Section 2: Client service event (concept definition)
Section 2: Contact
Section 2: Group sessions
Section 3: Contact client present status

Post Acute Care (PAC)
Definition
Post Acute Care (PAC) provides services to people following discharge from a
public hospital (acute or subacute) inpatient stay or following an emergency
department presentation. The services provided are based on a person's
individually assessed needs and delivered via a brokerage service model with
the core function being care coordination.

Guide for use
The PAC program was established with the objectives of supporting recuperation
after hospitalisation by providing an appropriate package of community-based
supports to facilitate safe and timely discharge, and at the same time aims to
prevent hospital readmission.

PAC delivers flexible service delivery and works in conjunction with but does not
replace the services provided by other programs, such as Home and Community
Care (HACC), Subacute Ambulatory Care Services (SACS), and Hospital Admission Risk Program (HARP). PAC offers short-term support to clients following hospitalisation and will continue to provide the support until the client is linked into ongoing community supports if required. The Department of Veterans’ Affairs and Transport Accident Commission clients can also access PAC services.

The most common services provided by PAC include:

- community nursing
- personal care
- home care services arranged by PAC are provided for the duration of the recuperative period and are generally of a short-term nature.

Care co-ordination, rapid response to short time frames, flexibility to deliver tailored packages and service interface between hospital and community sectors are core features of PAC that enable the delivery of its objectives.

Refer to

Section 2: Program
Section 2: Programs reporting to VINAH
Section 2: Stream
Section 3: Episode program/stream
Section 3: Referral in program/stream

Program

Definition

A grouping of services or patients/clients within an agreed framework, generally along departmental funding lines. Each program has particular attributes, such as policy, objectives, eligibility and assessment/monitoring criteria.

Guide for use

A program:

- is usually equivalent to a line of DHHS funding, and/or
- usually has a unit within DHHS which is responsible for activities such as policy development and liaison with organisations, in relation to this service.

Some programs are further broken down into streams.

Refer to:

Section 2: Family Choice Program (FCP)
Section 2: Home Enteral Nutrition (HEN)
Section 2: Hospital Admission Risk Program (HARP)
Section 2: Hospital Based Palliative Care Consultancy Team (HBPCCT)
Section 2: Specialist (Outpatient) Clinics (OP)
Section 2: Palliative Care (PC)
Section 2: Post Acute Care (PAC)
Section 2: Programs Reporting to VINAH
Section 2: Residential In-Reach (RIR)
Section 2: Stream
Section 2: Subacute Ambulatory Care Services (SACS)
Section 2: Total Parenteral Nutrition (TPN)
Section 2: Transition Care Program (TCP)
Section 3: Episode program/stream
Section 3: Referral in program/stream
Programs reporting to VINAH

Definition

For 2018-19, the following programs report to DHHS via the VINAH MDS:

- Family Choice Program (FCP)
- Home Enteral Nutrition (HEN)
- Hospital Admission Risk Program (HARP)
- Hospital Based Palliative Care Consultancy Team (HBPCCT)
- Medi-Hotel
- Specialist Clinics (OP)
- Palliative Care (PC)
- Post Acute Care (PAC)
- Residential In-Reach (RIR)
- Subacute Ambulatory Care Services (SACS)
- Total Parenteral Nutrition (TPN)
- Transition Care Program (TCP)
- Victorian HIV Service (VHS)
- Victorian Respiratory Support Service (VRSS)

Guide for use

All contacts funded by these programs must be reported to VINAH according to the specifications in this manual.

Refer to

- Section 2: Hospital Admission Risk Program (HARP)
- Section 2: Hospital Based Palliative Care Consultancy Team (HBPCCT)
- Section 2: Specialist (Outpatient) Clinics (OP)
- Section 2: Palliative Care (PC)
- Section 2: Post Acute Care (PAC)
- Section 2: Program
- Section 2: Residential In-Reach (RIR)
- Section 2: Stream
- Section 2: Subacute Ambulatory Care Services (SACS)
- Section 2: Transitional Care Program (TCP)
- Section 3: Episode program/stream
- Section 3: Referral In program/stream

Other program specific documents, including policy documentation.

Referral process

Definition

The process by which a referral is received and processed.

Guide for use

Conceptually this process includes four steps being:

- receipt of referral;
- referral acknowledgement;
- decision to accept or reject referral;
- patient/client consent to participate in care provision.

Programs and/or organisations may apply different business processes that may lead to the four steps of the referral process being undertaken with different timings.
There are data elements that capture the dates when each of the first three of these steps occur. These are respectively:

- Referral in received date;
- Referral in receipt acknowledgement date; and,
- Episode start date (where Referral in outcome code is 010, 020, 1 or 3).

These may be the same or different dates, depending on the workflow in an organisation.

The final step is required in order to schedule the first Contact; however this date does not need to be reported to VINAH.

Each episode must be linked to a Referral. However one Referral may generate more than one Episode; that is, one Referral may result in more than one program/stream providing services to the patient/client.

Refer to
Section 2: Episode
Section 3: Referral in receipt acknowledgement date
Section 3: Referral in received date
Section 3: Episode program/stream
Section 3: Episode start date
Section 3: Referral in outcome
Section 3: Referral in program/stream
Section 3: Referral in – service type
Section 3: Referral out date
Section 3: Referral out – service type
Section 3: Referral out – place

Residential In-Reach (RIR)

Definition
Residential In-Reach services provide an alternative to the emergency department (ED), where appropriate and safe, for people living in residential aged care services (RACS). Specifically, Residential In-Reach services provide assessment and management (in appropriate circumstances) of residents with an acute medical conditions, which would otherwise result in a resident of a RACS unnecessarily presenting to an Ed or being admitted to hospital.

Guide for use
Residential In-Reach services provide a person-centred model of care supported by flexible service delivery in RACS. Health services providing Residential In-Reach services have a dedicated telephone number(s) for receiving referrals.

The support provided by health services includes:

- telephone consultation and liaison with RACS staff
- GPs and other providers
- assessment and management of the resident’s acute medical condition at the aged care facility in collaboration with the resident and their representatives (RACS staff and the resident’s GP).

Residential In-Reach services aim to:
• reduce the need for residents of RACS to be transferred to an ED in circumstances where appropriate and safe care can be provided within the RACS, and
• improve communication between RACS and health services.

Communication with the residents’ general practitioner is essential. Residential In-Reach services are not intended to replace or substitute for the care provided by the resident’s doctor or RACS.

Specialist Clinics (OP)

Definition
Services provided to non-admitted, non-emergency department patients registered for care by specialist outpatient clinics of public hospitals classified as principal referral and specialist women’s and children’s hospitals and large hospitals (Peer Group A or B).

Guide for use
Hospitals use the term ‘clinic’ to describe various arrangements under which they deliver specialist outpatient services to non-admitted non-emergency department patients. For the purpose of this collection, an outpatient clinic is a specialty unit or organisational arrangement under which a hospital provides outpatient clinic services. The nature of the service provided by the clinic is classified by ‘clinic type’. All outpatient clinic types are included, except specialised mental health and alcohol and other drug treatment services.

Outpatient clinic services should be interpreted as encompassing services provided through specific organisational units staffed to administer and provide a certain range of outpatient care:
• in defined locations;
• at regular or irregular times; and

where one or more medical, surgical, allied health or nursing specialist providers deliver care to booked patients.

Generally, in such clinics, a booking system is administered and patient records are maintained to document patient attendances and care provided.

Included in scope are:
All arrangements made to deliver specialist care to non-admitted, non-emergency department patients whose treatment has been funded or managed through the hospital, regardless of the source from which the hospital derives these funds.

Excluded from scope are:
• stand-alone diagnostic clinics (Tier 2 classes 30.01 – 30.08).
• services funded by another Program reporting to VINAH (for example, Health Independence Programs)
• services which are not funded through the hospital and/or which deliver non-clinical care (activities such as home cleaning, meals on wheels, home maintenance)
• community-based services.
• all services covered by data collections for:
  – admitted patient care
admitted patient mental health care
– alcohol and other drug treatment services
– community mental health care
– non-admitted patient emergency department

Excluded from scope for 2018-19:
• Radiation therapy treatment (Tier 2 class 10.12) and Radiation therapy – simulation and planning (Tier 2 class 10.20). Note: Radiation therapy consultations are in scope.)
• Home-based self-administered services, including dialysis and ventilation
• Integrated Hepatitis C program
• Genetics program (where funding is provided for specialist genetics services)
• Domiciliary post-natal care
• Cystic fibrosis

Services provided to admitted patients may be reported providing the Inpatient Flag is reported as ‘I’.

Refer to
Section 2: Program
Section 2: Programs reporting to VINAH
Section 2: Stream
Section 3: Episode program/stream
Section 3: Referral In program/stream

Stream
Definition
A sub-grouping, usually clinical, within a program.

Guide for use
A stream is a layer below the program; streams are usually based on the clinical attributes of patients/clients and/or the services/resources the patient/client receives. Not all programs are split into streams.

Refer to
Section 2: Family Choice Program (FCP)
Section 2: Home Enteral Nutrition (HEN)
Section 2: Hospital Admission Risk Program (HARP)
Section 2: Hospital Based Palliative Care Consultancy Team (HBPCCT)
Section 2: Specialist (Outpatient) Clinics (OP)
Section 2: Palliative Care (PC)
Section 2: Post Acute Care (PAC)
Section 2: Program
Section 2: Programs reporting to VINAH
Section 2: Residential In-Reach (RIR)
Section 2: Subacute Ambulatory Care Services (SACS)
Section 2: Total Parenteral Nutrition (TPN)
Section 2: Transition Care Program (TCP)
Section 3: Episode program/stream
Section 3: Referral In program/stream
Subacute Ambulatory Care Services (SACS)

Definition
Subacute Ambulatory Care Services (SACS) comprise non-admitted rehabilitation services that are complex, multidisciplinary, and/or interdisciplinary, as well as a suite of specialist assessment and management services. Rehabilitation services can be centre-based, for example, they may be provided through a Community Rehabilitation Centre (CRC), or may be provided in a client's home.

Guide for use
SACS provide a person- and family-centred, interdisciplinary model of care supported by flexible service delivery in a range of settings, and directed at improving and maintaining a person’s functional capacity and maximising their independence. While the majority of SACS clients are older people, services for children and younger adults are currently being developed and expanded.

The aims of SACS are to:
• improve, restore and/or maintain a person’s functional capacity to achieve the highest possible level of independence physically, psychologically, socially and economically and,
• provide a coordinated and integrated service that delivers the appropriate care, in a timely manner, in the most appropriate setting and at the most appropriate cost.

SACS play a key role in supporting people to get safely home from hospital as soon as possible (for example after a stroke, hip replacement, or major trauma), and in helping them optimise their functional status and maintain their health independence. SACS also have a major role in preventing and diverting hospital admissions, by ensuring that multidisciplinary therapy and assessment services are available in non-admitted settings.

For more information, visit: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program

Refer to
Section 2: Program
Section 2: Programs reporting to VINAH
Section 2: Stream
Section 3: Episode program/stream
Section 3: Referral in program/stream

Total Parenteral Nutrition (TPN)

Definition
The administration of nutrition by means of an infusion of an intravenous nutrition formula self-administered by the patient. Total Parenteral Nutrition (TPN) is generally only used when it is not possible to meet a patient’s nutrition requirements through an oral or enteral route.

Total parental nutrition is performed by the patient or carer in their home.

Guide for use
Activity for patient/clients enrolled in the Total Parenteral Nutrition program will be collected at the episode level. An episode is to be opened for the duration during which a patient/client is responsible for their administration of the treatment and the episode is to be closed when the patient/client ceases home self-administration of their treatment.
The department will count one non admitted service event per calendar month for episodes that have been active during the month.

TPN funded contacts should be reported under the TPN episode. Non TPN funded contacts should be reported separately to the TPN episode to the appropriate program/stream.

For example, if a patient has a consultation with a Dietician in an outpatient clinic, this should be reported to under the ‘OP’ program.

Refer to
Section 2: Program
Section 2: Programs reporting to VINAH
Section 2: Stream
Section 3: Episode program/stream
Section 3: Referral in program/stream

**Transition Care Program (TCP)**

**Definition**
The Transition Care Program (TCP) is a national program that is jointly funded by the Australian and State/Territory Governments to assist older people complete their restorative process following their hospital episode of care with a package of services that includes low intensity therapy. The services are delivered by a multidisciplinary team with medical oversight by a general practitioner and geriatrician where appropriate. The client also has a designated case manager, who assists the client to prepare for or access suitable long term care arrangements. The program is flexible in its service delivery, as it can be provided in the individual’s usual place of residence (that is, home based) or in an approved residential care facility (that is, bed based).

**Guide for use**
The TCP is located at the interface of the acute, subacute, residential aged care and community care sectors. The TCP provides a time-limited, goal oriented and therapy-focused program safeguarding older people from remaining in hospital unnecessarily for an extended period of time and entering residential care prematurely. It is person- and family-centred and flexible in its care delivery. It is considered a specialist service as it is supported by a multidisciplinary team with aged care expertise and is focused on maintaining or improving the client’s physical, cognitive and psychosocial functioning and their capacity for independent living. The primary function of the TCP is therapeutic and not administrative. The case manager will assist the client and their family to access the required information so that they may make an informed decision and finalise long term care arrangements in a timely manner.

Access to the TCP requires an initial approval by the Aged Care Assessment Service (ACAS). As all TCP clients are discharged from hospital, they may access the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Schedule (MBS). A client can also move between the two care settings (that is, the community or residential arm of the program) within the one episode of care as deemed appropriate to their care needs.

Refer to

- Section 2: Program
- Section 2: Programs reporting to VINAH
- Section 2: Stream
- Section 3: Episode program/stream
- Section 3: Referral in program/stream
## Derived items list

### Age

**Definition**
The patient's age at the time of episode start.

**Guide for use**
Age is calculated as:

\[
\text{Age} = \text{Episode Start Date} - \text{Patient/Client Birth Date}
\]

Age is:

- Used in analysis of data for service planning purposes.

**Refer to**
- Section 3: Patient/Client birth date
- Section 3: Episode start date

### Case end date

**Definition**
The date the case for one patient/client at one organisation ends.

**Guide for use**
The Case Start Date will be the Episode Start Date of the first Episode (of possibly several overlapping Episodes and Referrals).

The Case End Date will be the date of:

- the Episode End Date when there is only one episode for a patient/client, or
- the latest Episode End Date, when there are two or more overlapping Episodes, and
- there are no (incoming) Referrals for a Program/Stream (Referral In Received Date) that do not have a Referral Outcome.

**Refer to**
- Section 2: Case (concept definition)
- Section 2: Case start date (derived element)
- Section 2: Episode
- Section 3: Referral in received date
- Section 3: Episode end date

### Case start date

**Definition**
The date the case for one patient/client at one organisation begins.

**Guide for use**
The Case Start Date will be the Episode Start Date of the first episode (of possibly several overlapping Episodes and Referrals).

The case will continue when:

- the Episode remains open (Episode Start Date present without a corresponding Episode End Date), or
- There are additional Episodes that overlap in Episode Start Date and Episode End Date, or
- there is at least one (incoming) Referral for a Program/Stream (Referral In Received Date) that does not have a Referral Outcome.
Contact count

Definition
The count of non-admitted contacts delivered to a patient/client by an organisation within a given time period.

Guide for use
Any contact that occurs between a patient/client and a professional associated with a Program Reporting to VINAH. Contacts are not aggregated.

Refer to
Section 2: Contact

Group session count

Definition
The number of group sessions delivered by an organisation within a given time period.

Guide for use
For reporting purposes for some program areas, counts of group sessions will be aggregated as described below.

A count of one group session will be made for all Contacts/Client Service Events within an organisation where Contact Session Type is “2 – Group” and the following data elements have the same value:
- Contact Date/Time;
- Contact Professional Group;
- Contact Provider;
- Message Visit Indicator Code.

Therefore it is important that if multiple group sessions are being delivered by the same mix of professionals at the same provider organisation at the same time that a minor differentiation be made in the Contact Date/Time (for example: by reporting them 1 second apart).

Equally, all patients/clients participating in the same group session must have exactly the same Contact Date/Time reported in order for the correct Group Session Count to be derived.

The inclusion of Message Visit Indicator Code means that all Contacts and Client Service Events that contribute to a single group session must be reported as either all contacts or all Client Service Events, not a mix of the two.

Refer to
Section 2: Client service event (concept definition)
Section 2: Contact
Section 2: Group sessions
Section 3: Contact date/time
Section 3: Contact provider
Section 3: Message visit indicator code
Service events

Definition
A Contact or series of Contacts, between a patient/client or other person in scope, and a professional associated with a program reporting via the VINAH MDS, that is intended to be unbroken in time, and that result in a dated entry being made in the patient/client record.

Guide for use
VINAH collects information about services provided to non-admitted patients at the lowest, contact, level. Multiple Contacts for one patient that take place on the same day can be derived into ‘service events’.

Depending on the intended use of the data, the rules used in the derivation of service events may vary.

For activity based funding, multiple contacts delivered on the same day may be bundled into one service event. For acute non-admitted services (that is, those reported under the Specialist (Outpatients) Clinics program/stream) VINAH bundles contacts into service events when contacts delivered on the same day meet the following criteria:

- Contact Session Type is not equal to ‘3 - Not applicable - Indirect contact’
- Contact Client Present Status = ‘10’, ‘11’, ‘12’ or ‘13’ (Patient/Client present)
- Contact Delivery Mode is not equal to ‘9 - Not applicable’
- Contact Delivery Setting is not equal to ‘13 - Hospital Setting - Emergency Department’
- Contact Inpatient Flag <> ‘I’ (Inpatient/Admitted)
- The following data elements for all contacts have the same value:
  - Contact Account Class (changes between ‘Public’ (‘MP’), ‘Self-funded’ (‘PO’, ‘PS’) or ‘Compensable’/‘Ineligible’ (‘CL’, ‘OO’, ‘XX’) values in multiple contacts will not trigger a new Service Event)
  - Patient Identifier
  - Organisation Identifier
  - Contact Clinic Identifier (Program/Stream ‘OP’ only)
  - Contact Date
  - Contact Delivery Mode
  - Contact Delivery Setting
  - Contact Indigenous Status
  - Contact Session Type (‘1’ and ‘4’ both indicate individual sessions)
  - Episode Campus Code
  - Episode Identifier
  - Episode Program/Stream

For other purposes, such as reporting of the Outpatient Care NMDS, the derivation may vary according to the specifications of the dataset. If further detail is required, contact the HDSS.Helpdesk@dhhs.vic.gov.au.
Refer to

METeOR Identifier 583996 Non-admitted patient service event
Section 2: Client service event (concept definition)
Section 2: Contact
Section 3: Contact account class
Section 3: Contact date/time
Section 3: Contact delivery mode
Section 3: Contact delivery setting
Section 3: Contact provider
Section 3: Contact session type
Generic process diagrams

Generic process (concepts): 1 Episode per Case

- Referral
- Screening (to determine if appropriate for the program)
- Contacts
- Episode opened
- DHHS derives Case (from the first Episode Start Date of the first episode, and the last Episode End Date, with no unresolved referrals)
- Program/Stream A
- Case closed (derived)
Generic process (concepts and data elements): 1 Episode per Case

Client accepted: Case opened (derived)

Episode opened

Referral

Episode closed

Case closed (derived)

Program/Stream A

Data Elements
- Episode End Date
- Proposed Treatment Plan Completion
- Episode End Reason

Data Elements always required
- Organisation Identifier
- Person Identifier
- Transmission Data Elements (Part 2)

Referral in data elements
- Clinical Referral Date
- Clinical Urgency Category
- Received Date
- Receipt Acknowledgement Date
- Service Type
- Place
- Outcome
- Program/Stream

Data Elements
- Case Start Date (derived)

Data Elements
- Episode start date
- Episode Program/Stream
- Episode Campus Code
- Patient demographics: Birth Date (accuracy code), Country of Birth, Living Arrangement, Type of Usual Accommodation, Carer Details, Locality/Postcode, Sex, Indigenous Status, (by first Contact)

Data Elements
- Contact variables: Medicare Number, Care Model, Care Phase, Inpatient Flag, Date/Time, Delivery Mode, Delivery Setting, Client Present Status, Clinic Identifier, Group Session Identifier, Preferred Care Setting, Preferred Death Place, Purpose, Professional Group, Provider, Session Type, Specialist Palliative Care Provider
- Funding related variables: Account Class, DVA File Number, TAC Claim Number, VWA File Number, Name Details
- Language related data elements: Interpreter Required, Preferred Language

DHHS derives Case (from the first Episode Start Date of the first episode, and the last Episode End Date, with no unresolved referrals)

Data Elements
- Case End Date (derived)

Contacts

Data Elements
- Episode End Date
- Proposed Treatment Plan Completion
- Episode End Reason

Data Elements
- Organisation Identifier
- Person Identifier
- Transmission Data Elements (Part 2)

Data Elements
- Case Start Date (derived)

Data Elements
- Episode start date
- Episode Program/Stream
- Episode Campus Code
- Patient demographics: Birth Date (accuracy code), Country of Birth, Living Arrangement, Type of Usual Accommodation, Carer Details, Locality/Postcode, Sex, Indigenous Status, (by first Contact)
Generic process (concepts): 2 Episodes per Case

Client accepted: Case Opened (derived)

Episode opened

Contacts

Episode opened

Contacts

Episode closed

Case closed (derived)

Referral

Screening (to determine if appropriate for the program)

Program/Stream A

Program/Stream B

DHHS derives Case (from the first Episode Start Date of the first episode, and the last Episode End Date, with no unresolved referrals)
Generic process (concepts and data elements): 2 Episodes per Case

Client accepted: Case Opened (derived)

Episode opened

Contacts

Program/Stream A

Episode closed

Program/Stream B

Screening (to determine if appropriate for the program)

Contact variables: Medicare Number, Care Model, Care Phase, Inpatient Flag, Date/Time, Delivery Mode, Delivery Setting, Client Present Status, Clinic Identifier, Group Session Identifier, Preferred Care Setting, Preferred Death Place, Purpose, Professional Group, Provider, Session Type

DHHS derives Case (from the first Episode Start Date of the first episode, and the last Episode End Date, with no unresolved referrals)

Data elements
- Case Start Date (derived)
- Case End Date (derived)
- Episode Start Date
- Episode Program/Stream
- Episode Campus Code
- Patient demographics: Birth Date (accuracy code), Country of Birth, Living Arrangement, Type of Usual Accommodation, Carer Details, Locality/Postcode, Sex, Indigenous Status, (by first Contact)

Data elements always required
- Organisation Identifier
- Person Identifier
- Transmission Data Elements (Part 2)

Data elements
- Episode End Date
- Completion of Proposed Plan of Treatment
- Reason for Ending Episode

Data elements
- Episode End Date
- Completion of Proposed Plan of Treatment
- Reason for Ending Episode

Data elements
- Clinical Referral Date
- Clinical Urgency Category
- Received Date
- Receipt Acknowledgement Date
- Service Type
- Place
- Outcome
- Program/Stream

Referral in data elements
- Clinical Referral Date
- Clinical Urgency Category
- Received Date
- Receipt Acknowledgement Date
- Service Type
- Place
- Outcome
- Program/Stream

Referral

Screening (to determine if appropriate for the program)

Episode open

Contacts

Episode closed

Case closed (derived)
Generic process (concepts): Referral not resulting in an Episode

- Referral
  - Episode not opened. Reasons for this may include that the patient died, moved away, did not meet the clinical criteria for the program, was ineligible for the program for another reason, or did not consent to being involved in the program.

- Screening (to determine if appropriate for the program)

Generic process (concepts and data elements): Referral not resulting in an Episode

- Referral in
  - Episode not opened. Reasons for this may include that the patient died, moved away, did not meet the clinical criteria for the program, was ineligible for the program for another reason, or did not consent to being involved in the program.

- Screening (to determine if appropriate for the program)

Refferal in data elements
- Clinical Referral Date
- Clinical Urgency Category
- Received Date
- Receipt Acknowledgement Date
- Service Type
- Place
- Outcome
- Program Stream