Policy Directive

Ministry of Health, NSW
73 Miller Street North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Telephone (02) 9391 9000 Fax (02) 9391 9101
http://www.health.nsw.gov.au/policies/

Care Type Policy for Acute, Sub-Acute and Non-Acute and Mental Health Admitted Patient Care

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Functional Sub group Corporate Administration - Information and data
Corporate Administration - Governance

Summary This Policy Directive introduces the new Mental Health Care Type in NSW which is to be introduced across all Local Health Districts (LHDs) and Specialist Health Networks (SHNs) during 2016/17. Introduction within each LHD/SHN will be negotiated with the NSW Ministry of Health during the 2016/17.

Replaces Doc. No. Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care [PD2014_010]

Author Branch Health System Information & Performance Reporting

Branch contact HSIPR 02 9391 9710

Applies to Local Health Districts, Board Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Ministry of Health, Private Hospitals and Day Procedure Centres, Public Hospitals, NSW Health Pathology, Cancer Institute (NSW)

Audience Administration Staff, Clinical Staff

Distributed to Public Health System, Ministry of Health, Private Hospitals and Day Procedure Centres

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POLICY STATEMENT

CARE TYPE POLICY FOR ACUTE, SUB-ACUTE AND NON-ACUTE ADMITTED PATIENT CARE

PURPOSE

'Care type' refers to the overall nature of a clinical service provided to an admitted patient during an episode of admitted patient care.

Correct assignment of care type for admitted patient episodes will ensure that each episode is classified appropriately for Activity Based Funding. This is vital as the classification used will also determine how the episode is reported, weighted, costed and funded:

- Acute care is classified using the Australian Diagnosis Related Groups (AR-DRGs)
- Sub-Acute and Non-Acute care is classified using Australian National Subacute and Non-Acute (AN-SNAP) classification
- Mental health care is classified using the Australian Mental Health Care Classification.

This version of the Policy Directive introduces the mental health care type.

MANDATORY REQUIREMENTS

Local Health Districts (LHD) and Specialty Health Networks (SHN) are responsible for accurately reporting the clinical activity within their facilities to the NSW Ministry of Health in order to meet State and Commonwealth reporting requirements.

In order to do so, clinical services must ensure that episodes of patient care are classified using the care type that best reflects the primary clinical purpose or treatment goal of the care provided.

When the clinical purpose or treatment goal changes so must the care type.

The care type to which the episode is allocated must always be evidenced by documentation in the patient health record.

IMPLEMENTATION

Chief Executives are required to ensure that:

- Staff responsible for entering care type changes are made aware of and gain an understanding of the provisions of this policy directive, and
- Relevant staff comply with this Policy Directive.

REVISION HISTORY

Version	Approved by	Amendment notes
September 2016 (PD2016_039)	Deputy Secretary, Systems, Purchasing and Performance	Addition of mental health care type
April 2014 (PD2014_010)	Deputy Secretary, Systems, Purchasing and Performance	New policy.

ATTACHMENTS

1. Care Type Policy for Acute, Sub-Acute and Non-Acute Admitted Patient Care: Standard.

Care Type Policy for Acute, Sub-Acute, Non-Acute and Mental Health Admitted Patient Care

NSW GOVERNMENT Health

STANDARD

Issue date: September-2016

PD2016_039

CONTENTS

1 BACKGROUND

1.1 About this document

NSW Health Services have an obligation to count and classify activity in a meaningful and consistent manner. The Care Type Policy for Acute, Sub-Acute and Non-Acute and Mental Health Admitted Patient Care provides a framework to ensure assignment to and changes in care type occur appropriately and correctly. Implementation of this policy will contribute to ensuring that information reflecting the patient's episode of care is accurate and reflects the type of care provided to the patient.

In 2013 the Australian Institute of Health and Welfare (AIHW) developed a revised set of National care type definitions. This work was commissioned by the Independent Hospital Pricing Authority in order to achieve consistency in classification of admitted patient activity.

There are currently eleven (11) care types in use in New South Wales, they are:

- Acute Care
- Rehabilitation
- Palliative Care
- Maintenance Care
- Newborn Care
- Other Care (note: this category is included for completeness, but is not applicable for admitted patients in NSW. This care type generally applies to residential aged care patients only)
- Geriatric Evaluation and Management (GEM)
- Psycho-geriatric
- Organ Procurement
- Hospital Boarder
- Mental Health.

1.2 Key definitions

Care Type *(previously known as 'service category')*

Care type refers to the nature of the clinical service provided to an admitted patient during an episode of admitted patient care, or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care), as represented by a code. The care type selected must reflect the primary clinical purpose or treatment goal of the care provided. Where there is more than one focus of care, the care type selected must reflect the major reason for care.

Care Type Change

An admission or stay can consist of one or more episodes and therefore one or more care types. A care type change occurs when there is a change in the primary clinical purpose or treatment goal of the care provided to the patient. For example, a patient who is receiving acute intervention for a stroke will have a care type change to rehabilitation if and when the main focus of care changes from acute management to functional improvement.

When the intensity of treatment or resource utilisation changes but the primary clinical purpose or treatment goal does not change, a care type change is *not* warranted.

A reduction in the intensity of acute care does not trigger a change to a sub-acute care type if the patient is not receiving care that meets the definition of a sub-acute care type. It is therefore essential that any care type change reflects a *clear change* in the primary clinical purpose or treatment goal of care provide.

With respect to the mental health care type, for 2016/17 a type change is to occur when a patient is transferred into or out of a specialist mental health unit. Transfers between specialist mental health units will not trigger a care type change.

All care type changes must be clearly documented.

The 11 Care Types are defined below. A full list of definitions is also provided at Appendix 2.

2 PURPOSE

'Care type' refers to the overall nature of a clinical service provided to an admitted patient during an episode of admitted patient care.

Admitted patient care is provided in a variety of settings. The care type allocated to an episode of care is independent of the location of the patient, and reflects the primary clinical purpose of the care provided.

Correct assignment of care type for admitted patient episodes will ensure that each episode is classified appropriately for Activity Based Funding (ABF). This is vital as the classification used will also determine how the episode is reported, weighted, costed and funded:

- Acute care is classified using AR-DRGs
- Sub and Non-Acute care is classified using AN-SNAP.
- Mental Health care is classified using AR-DRGs(for 2016/17).

The care type to which the episode is allocated must be evidenced by documentation in the patient health record, i.e. if an episode is allocated to a rehabilitation care type, there must be evidence in the medical record that rehabilitation care, meeting the National Definition (refer below) is occurring.

The care type allocated *should not* reflect the care that is intended for the patient to receive at some time in the future when, for example, another service takes over care of the patient or when the patient is moved to a different ward.

3 INTENDED AUDIENCE

This policy applies to all staff responsible for the clinical care and / or admission details of patients at all facilities within NSW providing admitted patient care. This includes all medical, nursing, allied health staff and relevant administrative staff such as ward clerks, admission officers, admitted patient data co-ordinators, clinical coders and health information managers.

4 EXPECTED OUTCOMES

The expected outcomes are:

- The care type of all episodes in NSW Health facilities accurately reflects the care provided.
- Statistical information is accurate and timely.
- NSW Health submission requirements for the Admitted Patient Data Collection are met.
- NSW Health submission requirements for the AN-SNAP Data Collection are met.
- NSW Health submission requirements to the Activity Based Funding: Mental Health Care DSS are met.

- Data will be available to assist in ensuring facilities will receive appropriate funding for the care they provide.
- NSW Health submission requirements to the National Hospital Cost Data Collection (NHCDC) are met.

5 PURPOSE

Local Health Districts (LHDs) and Specialty Health Networks (SHNs) are responsible for accurately reporting the clinical activity within their facilities to the NSW Ministry of Health in order to meet State and Commonwealth reporting requirements.

In order to do so, clinical services must ensure that episodes of patient care are classified using the care type that best reflects the primary clinical purpose or treatment goal of the care provided.

When the clinical purpose or treatment goal changes, so must the care type.

6 NATIONAL CARE TYPE DEFINITIONS

6.1 Acute care type

The primary clinical purpose or treatment goal is to:

- Manage labour (obstetric)
- Cure illness or provide definitive treatment of injury
- Perform surgery (other than when the exceptions documented in the included guidelines apply)
- Relieve symptoms of illness or injury (excluding palliative care)
- Reduce severity of an illness or injury
- Perform diagnostic or therapeutic procedures, and / or
- Protect against exacerbation and / or complication of an illness and / or injury which could threaten life or normal function.

6.2 Rehabilitation care

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

The patient will be capable of actively participating. Rehabilitation is always:

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

6.2.1 Rehabilitation care guidelines

- When an acute patient is waiting for Rehabilitation, but Rehabilitation care has not yet commenced, a care type change to Rehabilitation cannot occur. The patient must remain in an acute care type until rehabilitation care begins. In some instances a care type change to maintenance may be warranted.
- If Rehabilitation is occurring on an acute ward, the Rehabilitation care type should be used, as care type is independent of patient location.
- The period of recovery at the end of an acute episode prior to separation (for example, the final 1-2 days after a joint replacement) is not necessarily a separate episode and should not trigger a care type change to rehabilitation. Even though the care has lower resource intensity and the patient may receive some allied health involvement, unless the definition of Rehabilitation (as stated above) is met, the care type remains acute.
- A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and / or carers.
- Patients who receive acute same day interventions, such as dialysis, during the course of a Rehabilitation episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the Rehabilitation episode of care.

6.3 Palliative care

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

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

6.3.1 Palliative care guidelines

- Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptom relief.
- Patients referred to the Emergency Department (ED) by a clinician for palliative care should have a care type of Palliative Care assigned from the ED time of admission.

6.4 Maintenance care

Maintenance (or non-acute) care is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition.

Following assessment or treatment, the patient does not require further complex assessment or stabilisation. Patients with a care type of 'maintenance care' often require care over an indefinite period.

6.4.1 Maintenance care guidelines

- Care provided to a patient, who would normally not require hospital treatment and would be more appropriately treated in another setting, which is unavailable in the short term, or where there are factors in the home environment making it inappropriate to discharge the patient in the short term. For example:
    - A patient requires home modifications in order to be safely discharged home. The modifications are not yet complete and therefore, although ready for discharge the patient cannot safely return home.
    - A patient requires nursing home placement and although ready for discharge a place is not yet available. The patient has a current acute care certificate.
- Nursing Home Type patients for whom there is no acute care certificate.
- Patients in receipt of care where the primary reason for admission is respite.

6.5 Newborn care

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the patient is separated.

6.5.1 Newborn care guidelines

- Patients who turn 10 days of age and require clinical care must continue in the newborn episode of care (that is "5 – Newborn") until separated. A type change to care type "1 – Acute" must not be performed.
- Patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders.
- Patients aged less than 10 days and not admitted at birth (for example, transferred from another hospital) are admitted with a newborn care type.
- Patients aged greater than 9 days not previously admitted (for example, transferred from another hospital) are either boarders or admitted with an acute care type.
- Within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day.
- A newborn is qualified when it meets at least one of the criteria detailed in Newborn qualification status, see Appendix 2 for details

- Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such
- This care type can only ever be allocated at the time of admission. As a result, there can never be a care type change to 'Newborn'.

6.6 Other care

Other admitted patient care is care that does not meet the definitions above.

6.6.1 Other care guidelines

- This care type is included for completeness only; it is not applicable to admitted patients in NSW.
- The purpose of care type of 'Other' is to collect non-admitted activity reported via a patient administration system (PAS). This activity may include community residential care, and residential aged care covered by Commonwealth Block funding.
- Activity collected using this care type is excluded from any reporting of admitted patient care in NSW. This activity is used in cost allocation of residential services in the DNR (District and Network Return)

6.7 Geriatric Evaluation and Management (GEM)

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

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

6.7.1 Geriatric Evaluation and Management guidelines

- When an acute patient is waiting for GEM, but GEM care has not yet commenced, a care type change to GEM cannot occur. The patient must remain in an acute care type until GEM care begins. In some instances a care type change to maintenance may be warranted.
- If GEM is occurring on an acute ward, the GEM care type should be used, as the care type is independent of patient location.
- The period of recovery at the end of an acute episode prior to separation (for example the final 1-2 days after a joint replacement), is not necessarily a separate

episode and should not trigger a care type change to GEM. Even though the care has lower resource intensity and the patient may receive some allied health involvement, unless the definition of 'GEM' (as stated above) is met, the care type remains acute.

- A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and / or carers.
- Patients who receive acute same day intervention(s) during the course of a GEM episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the GEM episode of care.

6.8 Psycho-geriatric

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

Psycho-geriatric care is always:

- Delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.
- Psycho-geriatric care is not applicable if the primary focus of care is acute symptom control.

6.9 Organ procurement – posthumous

Posthumous organ procurement is the procurement of human organ or tissue for the purpose of transplantation from a donor who has been declared brain dead.

6.9.1 Organ procurement care type guidelines

- Once clinical staff confirm and document brain death of the patient, a care type change to "Organ procurement – posthumous" must be performed. Date and time of the type change should be recorded as the date and time of documented death, not the date and time the organ or tissue harvest has been completed.
- The posthumous organ procurement care type is to be used for all posthumous organ procurement, irrespective of whether the deceased patient is kept in ICU for the preservation of organs that require oxygen (e.g., heart or lungs, etc.), or whether the deceased patient is transferred to the morgue to await the removal of other tissue (such as corneas, etc.).

- Patients in an Emergency Department (ED) who die in the ED or are dead on arrival do not meet the criteria for admission. However, such patients whose organs are to be procured are to be registered on PAS and be assigned an 'Organ procurement – posthumous' care type.
- All 'Organ procurement – posthumous' care type episodes are in scope of reporting to the Admitted Patient Data Collection, though the posthumous organ procurement component of the admitted patient stay may be excluded from the calculation of specific KPIs and other activity measures
- Diagnoses and procedures undertaken during this activity, including mechanical ventilation and organ procurement should be recorded in accordance with the relevant ICD-10-AM / ACHI Australian Coding Standards.

For more detail refer to the Admitted Patient Data Collection Intranet site.

6.10 Hospital boarder

A hospital boarder is a person who is receiving food and / or accommodation at the hospital but for whom the hospital does not accept responsibility for treatment and / or care. Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder.

Babies in hospital at age nine days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified. Unqualified newborn days (and separations consisting entirely of unqualified newborn days) are not to be counted for all other purposes, and they are ineligible for health insurance benefit purposes.

6.11 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.

6.11.1 Mental health care guidelines

- This care type is to be initially used for patients treated within a specialised mental health inpatient unit only. Other factors such as diagnosis, DRG assignment or treating specialist (where the patient is not in a specialised mental health unit are not to be used as criteria in assigning this care type.

- This care type is to be introduced across all LHDs and SHNs by 30 June 2017. For the 2016/17 reporting year, it will be used at a point as negotiated by the LHD or SHN and the NSW Ministry of Health during the 2016/17 reporting year.
- Assignment of this care type occurs when a patient is admitted or transferred into a specialised mental health unit. Movements into or out of a specialised mental health unit from other inpatient units, where it reflects a change in the primary clinical purpose or treatment goal of the inpatient episode, will trigger a type change, **with the following exceptions**:
    - Patients within non-mental health units who are transferred into ECT suites for regular ECT and then returned to the non-mental health unit following the ECT procedure are not to be type changed to the mental health care type for the provision of the ECT.
    - Patients within specialised mental health units who are transferred for regular procedures like chemotherapy or renal dialysis, or who go to an operating theatre, and who are returned to the specialised mental health unit following the procedure are not to be type changed from the mental health care type for the provision of the procedure.
- At the point of introduction by the LHD, all existing patients within specialised mental health units are to be type changed to this care type. The date for the type change can be either:
    - The date of the introduction of the care type by the LHD, or
    - The date when the patient was admitted or transferred into the specialist mental health unit. Under this criterion, long standing patients who were in the mental health unit prior to 1 July 2016 are to be backdated to 1 July 2016 only.
    - Note that the decision of which date to use is to be made by the LHD / SHN, and must be applied consistently across the entire LHD / SHN, and not on a facility by facility basis.
- Movements between acute mental health units and non-acute mental health units (rehabilitation or extended care mental health units) do not trigger type changes. They are all to be categorised within this single care type.

7 PROCEDURE FOR ASSIGNING CARE TYPES

7.1 Care type assignment upon admission

Only one care type can be assigned at a time. In cases where a patient is receiving multiple types of care, the care type that best describes the primary clinical purpose or treatment goal should be assigned. For example if a patient is primarily receiving acute care and an in-reach rehabilitation team is also involved with the patient, the care type will be acute. When the focus of care provided to the patient shifts to functional improvement, the care type should be changed to rehabilitation at the point this shift in focus occurs.

The care type is assigned by the clinician responsible for the management of the care, based on clinical judgements as to the primary clinical purpose of the care provided and, for subacute care types, the specialised expertise of the clinician who will be responsible for the management of the care.

For the mental health care type, the clinical judgement as to the primary purpose of the care forms part of the clinician's decision to admit a patient into the specialised mental health inpatient unit.

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

The clinician determining the appropriate care type to be assigned must ensure that clear documentation of the care type is recorded in the medical record. The clinician determining the appropriate care type to be assigned (or other authorised clinician) must ensure that the ward clerk (or staff member responsible for updating the Patient Administration System (PAS)) is informed of the care type decision.

The ward clerk (or staff member responsible for updating PAS) ensures the correct care type is assigned within the PAS.

7.2 Care type change during the admission event

During an admission or stay the primary clinical purpose or treatment goal of care may change. When this occurs, the care type also changes. It is essential that any change in care type is supported by documentation reflecting the change in purpose and goal of care.

Responsibility for the decision to change care type ultimately rests with the senior medical officer but may be delegated to other senior members of the clinical team. The process of care type change generally occurs as follows:

- Clinical staff assesses the patient, their clinical status and treatment needs and then determine the clinical purpose and goals of treatment. If the current care type accurately reflects the treatment goals and focus of care, no further action is required.
- If the current care type for the episode no longer reflects the clinical purpose and goals of treatment and the care provided fits the definition of another care type, then a care type change is warranted.
- The new care type is determined by the clinician who is taking over responsibility for the management of the care of the patient at the time of transfer. (Note, in some circumstances the patient may continue to be under the management of the same clinician).
- Two methods of initiating and informing the change to be made on the PAS are suggested, either:
    - On a form, or
    - In the healthcare record as a handwritten entry / label / stamp.

Local processes will determine which method is most suitable. Regardless of the method used, the medical officer must ensure that clear documentation of the care type is recorded in the medical record.

Documentation must include the following information:

- When a separate form rather than a notation or sticker in the record is used, the MRN and patient name must be noted on the form
- Date Effective: indicate the actual date the care type change is effective
- Time Effective: indicate the actual time the care type change is effective
- Indicate the new care type
- If there is an AMO change, document the new AMO and their specialty.

- The receiving or primary clinician must authorise the care type change by signing the documentation.
- The receiving or primary clinician must ensure that the ward clerk (or staff member responsible for updating PAS) is informed that the care type change has occurred.
- The ward clerk (or staff member responsible for updating the PAS), updates the care type in PAS, along with any other relevant information that may have changed such as ward or AMO. It is important that the date of change recorded in PAS matches the actual date and time of the care type change.

7.2.1 Additional guidelines for care type change during admission

- A care type change or admission under a sub-acute or non-acute care type may trigger collection of the AN-SNAP data variables.
- Where AN-SNAP data is collected, care must be taken to ensure reconciliation of care type and care type change dates between SYNAPTIX and the PAS.
- The clinician responsible for the management of care may not necessarily be located in the same facility as the patient. This may be the case when a ‘hub and spoke’ model of care is in place. In these circumstances, a clinician at the patient's location may also have a role in the care of the patient; the expertise of this clinician does not affect the assignment of care type.
- A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and / or carers.
- It is highly unlikely that, for care type changes involving sub-acute care types, more than one change in care type will take place within a 24 hour period. Changes involving sub-acute care types are unlikely to occur on the date of formal separation.
- Patients who receive acute same day intervention(s) during the course of a sub-acute or non-acute episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if

relevant) should be added to the record of the sub-acute or non-acute episode of care.

- Palliative care episodes can include grief and bereavement support for the family and carers of the patient where it is documented in the patient's medical record.
- All care type changes must be updated on the PAS at the time of (or as close to) the care type change.
- An Acute Care Certificate should not influence the classification of a patient to a particular care type. Patients may have an Acute Care Certificate and be classified as other than "1 – Acute".
- The completion of an Aged Care Client Record (ACCR) form should not influence the classification of a patient. For example patients may not have an ACCR form completed but the episode can still be care type 'Maintenance'
- Regular training sessions for ward and clinical staff should be conducted to ensure that reviewing patient care types becomes part of daily ward routine.

7.3 Retrospective care type changes not identified during the admission event

The care type should not be retrospectively changed unless it is:

- For the correction of a data recording error, or
- The reason for change is clearly documented in the patient's medical record and it has been approved by the hospital's director of clinical services or delegated officer, or
- As a result of the introduction of a new care type which can apply retrospectively.

It is the responsibility of the staff member identifying the retrospective care type change to ensure that the care type change details have been updated in the patient administration system and to notify staff responsible for patient movement reconciliation processes.

Appendix 1 contains a number of care type change scenarios.

8 REFERENCES AND RELATED POLICIES

- Inter-Government and Funding Strategies Branch (2008), *PD2008_063 Episode Funding Policy 2008/2009 – NSW*, NSW Health
- Admitted Patient Data Dictionary (2009), *Service Category*, NSW Health
- Casemix Policy Unit (2005), NSW SNAP Data Collection: Data Dictionary v 3.0, NSW Health
- Corporate Governance & Risk Management Branch (2007), *Section 5: Nursing Home Type - Fees Procedure Manual for Public Health Organisations*, NSW Health
- Finance Branch (2016), PD2016_011 Nursing Home Type Patients and the National Acute Care Certificate, NSW Health
- *Inter-Government and Funding Strategies Branch (2008), PD2008_028 SNAP Data Collection – Australian National Sub-Acute and Non-Acute Patient (AN_SNAP) Classification, NSW Health*
- Fees Procedure Manual for Public Health Organisations PD2007_050, NSW Health
- National care type definitions: http://meteor.aihw.gov.au/content/index.phtml/itemId/491557

9 LIST OF ATTACHMENTS

1. Appendix 1: Care type change scenarios
2. Appendix 2: Definitions of terms

Appendix 1: Care Type Change Scenarios

Temporary Care Type Escalation

(a) Overnight

***Example**: A patient is admitted to Rehabilitation on 01/01/11 for management of a brain injury. On 10/01/11, he falls out of bed and sustains a fractured neck of femur. The patient is transferred to Orthopaedic surgery for surgical management of the fracture. He remains in the Orthopaedics unit for two days and is transferred back to Rehabilitation on 13/01/11. The patient is discharged from hospital on 30/01/11.*

The care type should be updated on the PAS to reflect the change in the primary clinical purpose of care provided to the patient from rehabilitation to acute care.

The care type was changed in this scenario because the patient had a clear change in primary clinical purpose or treatment goal.

Episode Date Range	Care Type
01/01/11 – 10/01/11	Rehabilitation
10/01/11 – 13/01/11	Acute
13/01/11 – 30/01/11	Rehabilitation

(b) Same Day

***Example**: A patient is admitted to Rehabilitation on 01/01/11 for management of a brain injury. On 10/01/11, the patient is admitted to Neurosurgery for a burr hole procedure, and is transferred back to Rehabilitation on the same day. The patient is discharged on 30/01/11.* The care type is not changed, however the procedure is coded at the conclusion of the episode.

Episode Date Range	Care Type
01/01/11 – 30/01/11	Rehabilitation

(c) Surgical Interventions for a Palliative Care Patient

***Example**: A patient commences palliative care on 01/02/12. In order to better manage her pain, the patient is taken to theatres for insertion of an intrathecal catheter on 10/02/12. The patient is transferred back to palliative care on the same day. The patient dies on 03/03/12.*

The care type is not changed, however the procedure is coded at the conclusion of the episode.

Episode Date Range	Care Type
01/02/12 – 03/03/12	Palliative Care

(d) Surgical Interventions for a Palliative Care Patient

***Example**: A patient commences palliative care on 10/04/12. During the course of the palliative episode exacerbation of acute renal failure necessitated immediate transfer to the surgical ward. To provide acute care for the management of the renal failure ureteral stenting is performed on 10/05/12 with the patient remaining in acute post surgical care overnight. As the need for acute management subsides the patient is*

transferred back to the palliative care unit on 11/05/12 for ongoing palliative care management. The patient is discharged on 03/06/12.

In this example, the care type is changed as the focus of care in the surgical ward was to deal with the management of an acute condition.

Episode Date Range	Care Type
10/04/12 – 10/05/12	Palliative Care
10/05/12 – 11/05/12	Acute care
11/05/12 – 03/06/12	Palliative Care

9.1 Change in Intensity of Care

(a) Post-surgical allied health intervention

***Example**: A 70 year-old female patient is admitted to the acute cardiothoracic surgery inpatient unit on 01/01/11 for Coronary Artery Bypass Graft. Following surgery, the patient goes to HDU for five days for monitoring due to her rapid atrial fibrillation and hypertension. The patient then returns to the cardiothoracic surgery ward for ongoing management, concurrently she receives physiotherapy in preparation for discharge, due to post-acute de-conditioning. The patient is discharged on 07/01/11.*

The provision of physiotherapy does not on its own meet the definition of Rehabilitation. Therefore, the patient remains in the Acute care type as there has not been a clear documented change in the primary clinical purpose or treatment goal.

The care type was not changed in this scenario because the primary clinical purpose tor treatment goal of the episode did not change.

Episode Date Range	Care Type
01/01/11 – 07/01/11	Acute

9.2 Care Type Change due to Change in Focus of Care

(a) GEM

***Example**: An 80 year-old female patient is admitted to Neurosurgery on 01/01/11 for management of a cerebral aneurysm. Following surgery, the patient experiences left-sided weakness and moderate cognitive difficulties. The patient is referred for an Aged Care consult on 05/01/11. The Aged Care consult is completed on 06/01/11. The patient is accepted for Aged Care, however no beds are currently available and no intervention to facilitate functional improvement is provided. On 10/01/11 an Aged Care bed becomes available and the patient is transferred. Whilst in the Aged Care Unit, the patient receives interventions to increase her functional independence, ongoing monitoring of her medical condition and assistance to find supported accommodation. These interventions constitute a change of focus of care to GEM. The patient is discharged from Aged Care on 30/01/11.*

The care type was changed in this scenario on 10/01/11 because this is when GEM care commenced. Although the patient was identified as an appropriate GEM candidate on the 06/01/11 the care received did not change until the 10/01/11.The patient should remain as an acute patient for the period of time during which they are waiting.

Episode Date Range	Care Type
01/01/11 – 10/01/11	Acute
10/01/11 – 30/01/11	Geriatric Evaluation and Management (GEM)

(b) Maintenance

***Example**: A 95 year-old female patient is admitted via ED on 26/02/11 for treatment of fractured vertebrae. The patient is transferred to the Aged Care ward on 28/02/11. The patient has a history of falls, lower limb weakness, hypertension and diabetes. During the admission, the patient receives a bone scan, CT scan head and pelvis, and lower limb Doppler ultrasound. During this period of evaluation the patient concurrently receives multidisciplinary interventions aimed at improving her functional status and preparing her for discharge. On 14/03/11 the team determine that the patient will not benefit from Rehabilitation, is unable to return home and will require placement. Interventions are provided to maintain the patient's current functional status whist placement is organised. The patient is discharged to a nursing home on 21/03/11.*

The maintenance care type was used in this example as the patient was no longer receiving acute interventions and was awaiting placement.

Episode Date Range	Care Type
26/02/11 – 14/03/11	Acute
14/03/11 – 21/03/11	Maintenance

(c) Rural patient

***Example**: A 75 year-old patient is admitted by their GP to a small rural hospital on 1/9/12 with severe influenza. The patient has co-morbidities of diabetes and cardiovascular disease. The patient receives acute interventions to manage their illness. As they recover, it is evident that they are significantly de-conditioned and are unable to be discharged at their current functional level. The nursing staff request a consult by a visiting Physiotherapist and Occupational Therapist. The allied health staff complete their assessments on 18/9/12, including a formal functional assessment. In conjunction with the patient's GP, a clinician with extensive experience caring for older people with functional impairments, the therapists prescribe a rehabilitation plan that will be carried out jointly by the nursing staff and the therapists on the days that they attend the hospital. This rehabilitation plan includes treatment goals. Regular review of the plan and the patient's functional status is carried out. The patient is discharged home on 5/10/12*

Episode Date Range	Care Type
01/09/12 – 18/09/12	Acute
18/09/12 – 05/10/12	Rehabilitation

Mental Health

(a) Patients treated only within one or more specialised mental health unit(s) for the entire stay

***Example**: A patient is transferred from the ED to an associated PECC unit on 01/07/2016. On 03/07/2016, the patient is transferred to an acute mental health*

specialist unit. They remain there until 17/07/2016 when they are transferred to a mental health rehabilitation unit. They remain there until their discharge on 31/08/2016.

All care delivered within specialised mental health units, regardless of the intended clinical focus of the unit, is to be categorised under one care type, and thus treated as a single admission.

Episode Date Range	Care Type
01/07/16 – 31/08/16	Mental Health

(b) Patients treated across a number of units, including a specialised mental health unit

Example 1*: A patient is admitted on 21/07/2016 to an orthopaedic unit for a planned total hip replacement. After surgery on 22/07/2016, the patient returns to the orthopaedic unit. On 30/07/2016, the patient's co-morbid schizophrenia deteriorates and a decision is made to transfer the patient to the acute mental health unit. The patient remains there until 16/08/2016 when they develop pneumonia. The patient is transferred to a respiratory unit to manage the pneumonia. They remain there until 27/09/2016 when they are discharged.*

Any ongoing or continuous care that is delivered within a specialised mental health unit triggers a type change if they are transferred from another inpatient unit. Likewise, if the patient is transferred from a specialised mental health unit to another unit for ongoing or continuous care, this will also trigger a type change.

Episode Date Range	Care Type
21/07/16 – 30/07/16	Acute
30/07/16 – 16/08/16	Mental Health
16/08/16 – 27/09/16	Acute

Example 2*: A patient is admitted to a specialist acute mental health inpatient unit on 01/08/2016. On 29/09/2016, the patient is treated for their planned cataract surgery. The patient is transferred to the ophthalmology unit after the surgery, where they remain until the 30/09/2016. They are then transferred back to the mental health rehabilitation unit and remain there until their discharge on 22/03/2017.*

Any ongoing or continuous care that is delivered outside a specialised mental health unit triggers a type change if they are transferred from a specialised mental health unit and they are not returned directly back to the specialised mental health unit following treatment.

Episode Date Range	Care Type
01/08/16 – 29/09/16	Mental Health
29/09/16 – 30/09/16	Acute
30/09/16 – 22/03/17	Mental Health

(c) Patients treated for ongoing chronic conditions whilst admitted within a specialised mental health unit

***Example**: A patient is admitted on 31/07/2016 to an acute mental health inpatient unit, and they are discharged on 17/11/2016. During the period of treatment within the specialised mental health unit, they receive twice weekly dialysis, for which the patient is moved to the renal dialysis unit to receive the treatment, following which they are returned to the specialised mental health unit.*

Any non-mental health procedure that is provided to a patient who is currently in a specialised mental health unit will not trigger a type change if the patient is returned directly to the specialised mental health unit after the procedure is complete.

Episode Date Range	Care Type
31/07/16 – 17/11/16	Mental Health

(d) Patients with mental health conditions but not treated within a specialised mental health unit

***Example 1**: A patient is admitted on 03/08/2016 for a delivery of a newborn. On 07/08/2016, she develops post-natal depression for which she is treated in the maternity ward by a specialist mental health team via consultation liaison. She is discharged on 15/08/2016.*

Any mental health care that is not delivered within a specialised mental health unit, regardless of the diagnosis or the treating specialty, is not to be categorised under the mental health care type.

Episode Date Range	Care Type
03/08/16 – 15/08/16	Acute

***Example 2**: A patient is admitted on 05/10/2016 for treatment of a perforated gastric ulcer, and is discharged on 01/11/2016. During the admission, the patient continues to receive weekly ECT treatment, which is conducted in the ECT suite. After each ECT procedure is completed, the patient is returned to the gastroenterology unit.*

Any care that does not result in a continuous period of treatment in a specialised mental health unit is not to be type changed and categorised under the mental health care type. This includes where a patient is receiving individual courses of treatment in a specialised mental health treatment facility that sees them return directly to the non-mental health inpatient unit once the treatment or procedure is completed.

Episode Date Range	Care Type
05/10/16 – 01/11/16	Acute

(e) Existing patients treated within a specialised mental health unit

***Example**: A patient is admitted to a specialist acute mental health unit on 12/02/2016. On 16/03/2016, the patient is transferred to a specialist rehabilitation mental health unit. On 15/06/16 the patient is transferred to a respiratory unit for treatment of the patient's acute exacerbation of their COPD. They return to the specialist mental health rehabilitation unit on 19/07/16. On 15/08/2016, the facility introduces the mental health care type, and decides to backdate the care type introduction to the beginning of the financial year. The patient is discharged from the facility on 12/12/2016.*

For 2016/17, the assignment of the mental health care type for existing patients can be dated to either the date the care type is introduced, or if the LHD wishes to backdate the introduction of the care type, the date is to be either the date the patient was last transferred into the specialist mental health unit, or to the 1st of July 2016 if the continuous period in the specialist mental health unit began before 01/07/2016.

Episode Date Range	Care Type
12/02/16 – 16/03/16	Acute
16/03/16 – 15/06/16	Rehabilitation
15/06/16 – 19/07/16	Acute
19/07/16 – 12/12/16	Mental Health

Same Day Acute Procedures in Sub Acute Care

(a) Dialysis

Example*: A rehabilitation patient (from 01/03/11 to 13/03/11) receives haemodialysis twice a week. They receive haemodialysis and return to the rehabilitation ward on the same day.*

Although dialysis is a high cost and high volume service, national care type definitions state that same day acute interventions or procedures provided to an admitted patient in a sub or non-acute care type do not warrant a change in care type. The provision of dialysis should be captured as a procedure code during coding.

Episode Date Range	Care Type
01/03/11 – 13/03/11	Rehabilitation

(b) Chemotherapy/radiotherapy during a Palliative Care Episode

Example*: A Palliative Care patient (from 01/03/11 to 10/03/11) receives radiotherapy to assist with symptom management.*

There is no care type change in this scenario as the provision of radiotherapy or chemotherapy for symptom management meets the definition of palliative care and does not constitute a change in the focus of care.

Episode Date Range	Care Type
01/03/11 – 31/03/11	Palliative Care

(c) Non Weight Bearing Scenarios

Example 1*: A patient is admitted to hospital following a fall on 31/07/12 and has hip surgery on 01/08/12. After the surgery, the patient is transferred to the orthopaedic ward. The patient experiences post-surgical complications and on 05/08/12 the orthopaedic surgeon advises that the patient is to be non-weight bearing for a period of 6 weeks.*

The patient is medically stable, their wound is healing well and they do not require any ongoing acute interventions. The patient is referred to the rehabilitation service on 10/08/12, where the patient is assessed. The rehab team determine that the patient would benefit from interventions to increase their independence in sliding transfers,

wheelchair mobility and self care. The patient participates in a modified rehabilitation programme until they are cleared for weight bearing by the orthopaedic surgeon. Once able to resume weight bearing the patient receives ongoing rehab for a further 3 weeks. They are discharged home on 17/10/12.

Episode Date Range	Care Type
31/07/12 – 10/08/12	Acute Care
10/08/12 – 17/10/12	Rehabilitation

***Example 2**: A patient is admitted to hospital following a fall on 31/07/12 and has hip surgery on 01/08/12. After the surgery, the patient is transferred to the orthopaedic ward. The patient experiences post-surgical complications and on 05/08/12 the orthopaedic surgeon advises that the patient is to be non-weight bearing for a period of 6 weeks.*

The patient is medically unstable, experiencing intermittent chest pain and issues related to wound healing. They receive ongoing monitoring and care related to these medical issues. The patient is referred to the rehab service for assessment. The rehab team determine that the patient is not currently suitable for a rehabilitation program. On 12/09/12 the orthopaedic surgeon reviews the patient and clears them for weight bearing. The rehab team reviews the patient on 13/09/12 and determines that they are appropriate for rehab. The patient commences rehab on 14/09/12. They are discharged home on 17/10/12.

Episode Date Range	Care type
31/07/12 – 14/09/12	Acute Care
14/09/12 – 07/10/12	Rehabilitation

***Example 3**: A patient is admitted to hospital following a fall on 31/7/2012 and has hip surgery on 1/8/2012. After the surgery the patient is transferred to the orthopaedic ward. The patient experiences post surgical complications and on 5/8/2012 the orthopaedic surgeon advises that the patient is to be non weight bearing for a period of 6 weeks.*

The patient is medically stable. The patient is referred to the rehab service for assessment. On 06/08/12 the rehab team determine that the patient is not currently suitable for a rehab program. The patient is unable to be discharged home due to access and safety issues. The patient is transferred to a medical ward and receives ongoing minimal nursing care and occasional physiotherapy to maintain current physical status. On 12/09/12 the orthopaedic surgeon reviews the patient and clears them for weight bearing. The rehab team reviews the patient on 13/09/12 and determines that they are now an appropriate candidate for rehab. The patient commences rehab on 14/09/12. They are discharged home on 17/10/12.

Episode Date Range	Care type
31/07/12 – 06/08/12	Acute Care
06/08/12 – 14/09/12	Maintenance
14/09/12 – 17/10/12	Rehabilitation

Appendix 2: Definitions of Terms

Acute Care Certificate	After 35 days of hospitalisation, private and DVA patients in need of ongoing acute or sub-acute care must have an Acute Care Certificate completed by the registered doctor caring for them. The Acute Care Certificate is valid for a period of up to 30 days, after which a new certificate will need to be issued if the patient is still undergoing acute / subacute care in hospital. If an Acute Care Certificate cannot be issued by the treating doctor, a type change to Maintenance Care is required. The financial class must be reclassified to nursing home type and the appropriate charges to the patient must be organised. Note: For policy details regarding Acute Care Certificates see the *Public Fees Procedures Manual for Public Health Organisations* (Sections 2.56 to 2.67, as amended from time to time) and Policy Directive PD2016_011 *Nursing Home Type Patients and the National Acute Care Certificate*
AMO	Attending Medical Officer: the medical officer / senior clinician (a visiting medical practitioner, staff specialist or academic clinician) responsible for the care of the patient, and under whose care the patient is to be admitted. May also be referred to as *Admitting Medical Officer*.
Other Authorised Clinician	Clinical staff authorised by the AMO to be responsible for care type changes e.g. Registrar, Resident Medical Officer, Junior Medical Officer, Nursing Unit Manager or senior nursing staff.
APDC	Admitted Patient Data Collection: the framework for mandatory data reporting for all admitted patients within New South Wales.
Clinical Coding	Clinical Coding involves abstracting disease and procedure information from the medical record and then assigning codes using the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI). The process of Clinical Coding is performed by Clinical Coders.
Clinician	Medical, nursing and allied health staff involved in patient care
AR-DRGs	Australian Refined-Diagnosis Related Groups are the classification tool allocated to acute inpatients. DRGs are used to fund inpatient episodes of care for acute care.
Episode of Care	The period of admitted patient care between a formal or statistical admission and a formal or statistical discharge, characterised by one care type. (Refer *National Health Data Dictionary*)

Nursing Home Type Patient (NHTP)	A nursing home type patient is a patient who has been in one or more approved hospitals (public or private) for a continuous period of more than 35 days, without a break of seven days, and who is not deemed to be receiving acute care. After 35 days, the patient will be reclassified as a NHTP unless an Acute Care Certificate is issued by a medical practitioner to certify that the patient requires acute care. An Acute Care Certificate may be reissued every 30 days thereafter, for as long as the patient requires acute care. In the event of readmission to a hospital within 7 days (or transfer between hospital), the previous related inpatient periods will be regarded as contributing towards the period of 35 days hospitalisation. The periods of leave themselves are not counted towards the 35 day qualifying period. Hence, a patient who has been in hospital for 20 days and then leaves the hospital for 3 days, will start at day 21 when returning to hospital. However, where a patient is discharged and a period of more than 7 days elapses before readmission, the previous stay in hospital will not be counted. The date of discharge is not to be counted as one of the 7 days; seven days commences from the day after discharge or on leave. The nursing home type patient arrangement does not apply to Third Party, Workers' Compensation and other compensable patients, or patients who are ineligible under Medicare. For compensable patients, Acute Care Certificates should be issued where appropriate in case the patient's compensation claim is rejected.
PAS	Patient Administration System
Care Type (Previously known as 'service category')	Care type refers to the nature of the clinical service provided to an admitted patient during an episode of admitted patient care, or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care), as represented by a code. The care type selected must reflect the primary clinical purpose or treatment goal of the care provided. Where there is more than one focus of care, the care type selected must reflect the major reason for care. Reference:http://meteor.aihw.gov.au/content/index.phtml/itemId/491557
Care Type Change	An admission or stay can consist of one or more episodes and therefore one or more care types. A care type change occurs when there is a change in the primary clinical purpose or treatment goal of the care provided to the patient

AN-SNAP	Australian National Sub-Acute and Non-Acute Patient Classification: the framework for mandatory data reporting for all sub-acute and non-acute episodes within New South Wales designated services.
Stay	The period of admitted patient care between a formal admission and a formal discharge which comprises one or more episodes of care. Refer also 'Care Type Change'
Type Change	See 'Care Type Change'. This terminology is interchangeable with the term Care Type Change.
Newborn Qualification Status	A newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is 'qualified' if the infant meets at least one of the following criteria: • Is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient, or • Is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care, or • Is admitted to, or remains in hospital without its mother. A newborn patient day is 'unqualified' if the infant does not meet any of the above criteria. The day on which a change in qualification status occurs is counted as a day of the new qualification status. If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day. Reference: http://meteor.aihw.gov.au/content/index.phtml/itemId/327254