Enterprise Data and Information

HOSPITAL IN THE HOME (HITH) DATA PROTOCOL

CONTENTS

1. EXECUTIVE SUMMARY

1.1 Purpose

The purpose of this protocol is to advise hospitals in South Australia of the processes and controls required to manage **Hospital in the Home** data as part of the Enterprise Data and Information (EDI) data assets. This includes the data quality controls applied to the hospital data received, processed, released for reporting, use, classification, and storage into EDI data assets.

1.2 Scope

The protocol applies to all **Hospital in the Home** arrangements between SA Health public hospitals and/or other licensed private hospital providers in South Australia.

This protocol applies to *Admitted Patient Care* (inpatient) data asset only.

1.3 Review

The Protocol will be reviewed annually or as required. This review will ensure the Protocol remains current to support SA Health in managing its **Hospital in the Home** arrangements.

2.   MANAGEMENT OF HOSPITAL IN THE HOME DATA

In South Australia, all public hospitals and most licensed private hospitals are required to manage the information collected and submitted to the Department for Health and Wellbeing's Enterprise Data and Information branch in accordance with the relevant EDI data asset reference manual which prescribes the data definitions and quality validations in place for each data asset.

Hospital in the Home provides treatment in the comfort and privacy of the patient's own home as an alternative to treatment in hospital. **Hospital in the Home** is widely used to effectively manage a range of conditions and is only available where care can be provided safely at home.

Hospital in the Home may be administered as a direct admission to a patient's **home**, or by initial admission to a **physical** hospital (e.g. a metropolitan hospital in Adelaide). Alternatively, **Hospital in the Home** may be administered by the movement of a patient between a **physical** hospital and the patient's **home**, typically represented as a ward transfer within the hospital and an administrative Episode of Care type change.

Six data elements are used to indicate that an episode of care is a **Hospital in the Home** admission:

- > **[Episode Of Care]**
- > **[Principal Diagnosis]**
- > **[Additional Diagnosis]**
- > **[Source Of Referral]**
- > **[Nature Of Separation]**
- > **[Referral For Further Health Care]**

There are two types of **Hospital in the Home** admissions:

- > **Direct admission**: A patient is admitted directly to their **home**.
- > **Subsequent admission**: A patient is moved from a **physical** hospital to their **home**.

Inclusions

Hospital in the Home is permitted for five Episodes of Care types:

- > **Acute**: which takes the abbreviation **Acute@Home**
- > **Rehabilitation**: which takes the abbreviation **Rehab@Home**
- > **Geriatric Evaluation and Management (GEM)**: which takes the abbreviation **GEM@Home**
- > **Homebirth**: which takes the abbreviation: **HomeBirth@Home**
- > **Mental Health**: which takes the abbreviation **MentalHealth@Home**

Exclusions

Hospital in the Home is not permitted for two Episode of Care types:

- > **Palliative Care**: which takes the abbreviation **PalliativeCare@Home**
- > **Maintenance Care**: which takes the abbreviation: **MaintenanceCare@Home**

Detailed below is a summary of the processes and controls in place to ensure the effective management of **Hospital in the Home** data and the supporting data quality standards.

The principles are applicable across the EDI data assets but only formalised within the data definitions in the *Admitted Patient Care* data collection.

2.1 Direct Admission

The one step process below describes the stages of a patient journey:

> To **home**

Direct admissions must contain the following attributes:

> **[Episode Of Care]**: *Hospital at Home/Rehabilitation at Home*
> **[Source Of Referral]**: either:
>   o *Casualty / Emergency*
>   o *Community health service*
>   o *Inter hospital transfer*
>   o *Private medical practice*
>   o *Other*
>   o *Outpatient department*
>   o *Unknown*
> **[Nature Of Separation]**: either:
>   o *Died: Autopsy*
>   o *Died: No autopsy*
>   o *Home*
>   o *Other hospital: Down transfer*
>   o *Other hospital: Up transfer*
>   o *Self discharge*
>   o *Unknown*

In addition to these three attributes, there are specific attribute usages which describe the type of Hospital in the Home admission.

2.1.1. Acute

In addition to the three attributes described under Direct Admission:

> **[Principal Diagnosis]**: As per *ACS 0001 Principal diagnosis*
> **[Additional Diagnosis]:**
>   o *≠ Z004: General psychiatric examination NEC*
>   o *≠ Z509: Care inv use of rehab procedure unsp*
>   o *≠ Z769: Pers encntr hlth service unsp circumst*
>   o *≠ Z370: Single live birth*
>   o *≠ Z371: Single stillbirth*
>   o *≠ Z372: Twins both liveborn*
>   o *≠ Z373: Twins one liveborn and one stillborn*
>   o *≠ Z374: Twins both stillborn*
>   o *≠ Z375: Other multiple births all liveborn*
>   o *≠ Z376: Other multiple births some liveborn*
>   o *≠ Z377: Other multiple births all stillborn*
>   o *≠ Z379: Outcome of delivery unspecified*

2.1.2. Rehabilitation

In addition to the three attributes described under Direct Admission:

> **[Principal Diagnosis]**: ≠ *Z519: Medical care unspecified*
> **[Additional Diagnosis]:**
>> o ≠ *Z004: General psychiatric examination NEC*
>> o *Z509: Care inv use of rehab procedure unsp*
>> o ≠ *Z769: Pers encntr hlth service unsp circumst*

2.1.3. Geriatric Management and Evaluation

In addition to the three attributes described under Direct Admission:

> **[Principal Diagnosis]**: ≠ *Z519: Medical care unspecified*
> **[Additional Diagnosis]:**
>> o ≠ *Z004: General psychiatric examination NEC*
>> o ≠ *Z509: Care inv use of rehab procedure unsp*
>> o *Z769: Pers encntr hlth service unsp circumst*

2.1.4. Home Birth (mother's episode of care)

In addition to the three attributes described under Direct Admission:

> **[Principal Diagnosis]**: ≠ *Z519: Medical care unspecified*
> **[Additional Diagnosis]:**
>> o ≠ *Z004: General psychiatric examination NEC*
>> o ≠ *Z509: Care inv use of rehab procedure unsp*
>> o ≠ *Z769: Pers encntr hlth service unsp circumst*
>> o *Z370: Single live birth*
>> o *Z371: Single stillbirth*
>> o *Z372: Twins both liveborn*
>> o *Z373: Twins one liveborn and one stillborn*
>> o *Z374: Twins both stillborn*
>> o *Z375: Other multiple births all liveborn*
>> o *Z376: Other multiple births some liveborn*
>> o *Z377: Other multiple births all stillborn*
>> o *Z379: Outcome of delivery unspecified*

2.1.5. Mental Health

In addition to the three attributes described under Direct Admission:

> **[Principal Diagnosis]**: ≠ *Z519: Medical care unspecified*
> **[Additional Diagnosis]:**
>> o *Z004: General psychiatric examination NEC*
>> o ≠ *Z509: Care inv use of rehab procedure unsp*
>> o ≠ *Z769: Pers encntr hlth service unsp circumst*

2.2   Subsequent Admission

The two step process below describes the stages of a patient journey:

> From **physical** hospital => to **home**

Stage 1: Physical hospital episode of care

The **physical** hospital admission must contain the following attributes:

> **[Episode Of Care]**: ≠ *Hospital at Home/Rehabilitation at Home*
> **[Principal Diagnosis]**: as appropriate
> **[Additional Diagnosis]**: as appropriate
> **[Source Of Referral]**: as appropriate
> **[Nature Of Separation]**: Administrative discharge
> **[Referral For Further Health Care]**: *Hospital at home / Rehabilitation at home*

Stage 2: Home episode of care

The **home** admission must contain the following attributes:

> **[Episode Of Care]**: *Hospital at Home/Rehabilitation at Home*
> **[Source Of Referral]**: *Administrative admission*
> **[Nature Of Separation]**: Neither:
>   o *Administrative discharge*
>   o *Discharge on leave*
>   o *End of quarter reporting*
>   o *Other health care accommodation*
>   o *Residential aged care facility*
>   o *Retrieval*
> **[Referral For Further Health Care]**: ≠ *Hospital at home / Rehabilitation at home*

In addition to these three attributes, there are specific attribute usages which describe the type of Hospital at Home admission.

2.2.1   Acute following Acute in hospital episode

In addition to the three attributes described under Stage 2: Home episode of care:

> **[Principal Diagnosis]**: *Z519: Medical care unspecified*
> **[Additional Diagnosis]**:
>   o *≠ Z004: General psychiatric examination NEC*
>   o *≠ Z509: Care inv use of rehab procedure unsp*
>   o *≠ Z769: Pers encntr hlth service unsp circumst*
>   o *≠ Z370: Single live birth*
>   o *≠ Z371: Single stillbirth*
>   o *≠ Z372: Twins both liveborn*
>   o *≠ Z373: Twins one liveborn and one stillborn*
>   o *≠ Z374: Twins both stillborn*
>   o *≠ Z375: Other multiple births all liveborn*
>   o *≠ Z376: Other multiple births some liveborn*
>   o *≠ Z377: Other multiple births all stillborn*
>   o *≠ Z379: Outcome of delivery unspecified*

2.2.2 Acute following Non-Acute in hospital episode

In addition to the three attributes described under Stage 2: Home episode of care:

> **[Principal Diagnosis]**: As per *ACS 0001 Principal diagnosis*
> **[Additional Diagnosis]**:
>   o *≠ Z004: General psychiatric examination NEC*
>   o *≠ Z509: Care inv use of rehab procedure unsp*
>   o *≠ Z769: Pers encntr hlth service unsp circumst*

2.2.3 Rehabilitation

In addition to the three attributes described under Stage 2: Home episode of care:

> **[Principal Diagnosis]**: *≠ Z519: Medical care unspecified*
> **[Additional Diagnosis]**:
>   o *≠ Z004: General psychiatric examination NEC*
>   o *Z509: Care inv use of rehab procedure unsp*
>   o *≠ Z769: Pers encntr hlth service unsp circumst*

2.2.4 Geriatric Evaluation and Management

In addition to the three attributes described under Stage 2: Home episode of care:

> **[Principal Diagnosis]**: *≠ Z519: Medical care unspecified*
> **[Additional Diagnosis]**:
>   o *≠ Z004: General psychiatric examination NEC*
>   o *≠ Z509: Care inv use of rehab procedure unsp*
>   o *Z769: Pers encntr hlth service unsp circumst*

2.2.5 Home Birth (mother's episode of care)

In addition to the three attributes described under Stage 2: Home episode of care:

> **[Principal Diagnosis]**: *≠Z519: Medical care unspecified*
> **[Additional Diagnosis]**:
>   o *≠ Z004: General psychiatric examination NEC*
>   o *≠ Z509: Care inv use of rehab procedure unsp*
>   o *≠ Z769: Pers encntr hlth service unsp circumst*
>   o *Z370: Single live birth*
>   o *Z371: Single stillbirth*
>   o *Z372: Twins both liveborn*
>   o *Z373: Twins one liveborn and one stillborn*
>   o *Z374: Twins both stillborn*
>   o *Z375: Other multiple births all liveborn*
>   o *Z376: Other multiple births some liveborn*
>   o *Z377: Other multiple births all stillborn*
>   o *Z379: Outcome of delivery unspecified*

2.2.6 Mental Health

In addition to the three attributes described under Stage 2: Home episode of care:

> **[Principal Diagnosis]**: ≠ *Z519: Medical care unspecified*
> **[Additional Diagnosis]**:
>> o *Z004: General psychiatric examination NEC*
>> o *≠ Z509: Care inv use of rehab procedure unsp*
>> o *≠ Z769: Pers encntr hlth service unsp circumst*

2.3 Examples

2.3.1 Direct Admission

For example: a patient is admitted directly to **home**:

Admitted Patient Care Data Elements	Physical Hospital record Value	Home record Value
[Hospital Number]		000X
[Admission Date]		DD-MM-YYYY
[Admission Time]		hh:mm
[Separation Date]		DD-MM-YYYY
[Separation Time]		hh:mm
[Patient Unit Record Number]		0000NNNNNN
[Principal Diagnosis]		**Acute@Home**: > As appropriate **Rehab@Home**: > *≠ Z519* **GEM@Home**: > *≠ Z519* **HB@Home**: > *≠ Z519* **MH@Home**: > *≠ Z519*
[Additional Diagnosis]		**Acute@Home**: > *≠ Z004* > *≠ Z509* > *≠ Z769* > *≠ Z370* > *≠ Z371* > *≠ Z372* > *≠ Z373* > *≠ Z374* > *≠ Z375* > *≠ Z376* > *≠ Z377* > *≠ Z379* **Rehab@Home**: > *≠ Z004* > *Z509* > *≠ Z769* **GEM@Home**: > *≠ Z004*

Admitted Patient Care Data Elements	Physical Hospital record Value	Home record Value
		> ≠ Z509
		> Z769
		HB@Home:
		> ≠ Z004
		> ≠ Z509
		> ≠ Z769
		> Z370
		> Z371
		> Z372
		> Z373
		> Z374
		> Z375
		> Z376
		> Z377
		> Z379
		MH@Home:
		> Z004
		> ≠ Z509
		> ≠ Z769
[Episode Of Care]		*Hospital at home / Rehab at home*
[Source Of Referral]		Either:
		> *Casualty / Emergency*
		> *Community health service*
		> *Inter-Hospital transfer*
		> *Other*
		> *Outpatient department*
		> *Unknown*
[Nature Of Separation][5]		Either:
		> *Died: Autopsy*
		> *Died: No autopsy*
		> *Home*
		> *Other hospital: Down transfer*
		> *Other hospital: Up transfer*
		> *Self discharge*
		> *Unknown*
[Referral For Further Health Care]		*≠ Hospital at home / Rehabilitation at home*

2.3.2 Subsequent Admission

For example: a patient admitted to a **physical** hospital as *Acute* and then moves to **home**:

Admitted Patient Care Data Elements	Physical Hospital record Value	Home record Value
[Hospital Number]	00XX	00XX
[Admission Date]	DD-MM-YYYY	DD-MM-YYYY
[Admission Time]	hh:mm	hh:mm
[Separation Date]	DD-MM-YYYY	DD-MM-YYYY
[Separation Time]	hh:mm	hh:mm
[Patient Unit Record Number]	0NNNNNNNNN	0NNNNNNNNN
[Principal Diagnosis]	As appropriate	**Acute@Home**: > *Z519* **Rehab@Home**: > *≠ Z519* **GEM@Home**: > *≠ Z519* **HB@Home**: > *≠ Z519* **MH@Home**: > *≠ Z519*
[Additional Diagnosis]	As appropriate	**Acute@Home**: > *≠ Z004* > *≠ Z509* > *≠ Z769* > *≠ Z370* > *≠ Z371* > *≠ Z372* > *≠ Z373* > *≠ Z374* > *≠ Z375* > *≠ Z376* > *≠ Z377* > *≠ Z379* **Rehab@Home**: > *≠ Z004* > *Z509* > *≠ Z769* **GEM@Home**: > *≠ Z004* > *≠ Z509* > *Z769* **HB@Home**: > *≠ Z004* > *≠ Z509* > *≠ Z769* > *Z370* > *Z371* > *Z372* > *Z373*

Admitted Patient Care Data Elements	Physical Hospital record Value	Home record Value
		> *Z374*
		> *Z375*
		> *Z376*
		> *Z377*
		> *Z379*
		MH@Home:
		> *Z004*
		> *≠ Z509*
		> *≠ Z769*
[Episode Of Care]	*≠ Hospital at Home/Rehabilitation at Home*	*Hospital at home / Rehab at home*
[Source of Referral]	As appropriate	*Administrative admission*
[Nature Of Separation][5]	*Administrative discharge*	Neither:
		> *Administrative discharge*
		> *Discharge on leave*
		> *End of quarter reporting*
		> *Other health care accommodation*
		> *Residential aged care facility*
		> *Retrieval*
[Referral For Further Health Care]	*Hospital at home / Rehabilitation at home*	*≠ Hospital at Home/Rehab at Home*

For example: a patient admitted to a **physical** hospital as *non-Acute* moves to **home**:

Admitted Patient Care Data Elements	Physical Hospital record Value	Home record Value
[Hospital Number]	00XX	00XX
[Admission Date]	DD-MM-YYYY	DD-MM-YYYY
[Admission Time]	hh:mm	hh:mm
[Separation Date]	DD-MM-YYYY	DD-MM-YYYY
[Separation Time]	hh:mm	hh:mm
[Patient Unit Record Number]	0NNNNNNNNN	0NNNNNNNNN
[Principal Diagnosis]	As appropriate	**Acute@Home**: > ≠ *Z519* **Rehab@Home**: > ≠ *Z519* **GEM@Home**: > ≠ *Z519* **HB@Home**: > ≠ *Z519* **MH@Home**: > ≠ *Z519*
[Additional Diagnosis]	As appropriate	**Acute@Home**: > ≠ *Z004* > ≠ *Z509* > ≠ *Z769* > ≠ *Z370* > ≠ *Z371* > ≠ *Z372* > ≠ *Z373* > ≠ *Z374* > ≠ *Z375* > ≠ *Z376* > ≠ *Z377* > ≠ *Z379* **Rehab@Home**: > ≠ *Z004* > *Z509* > ≠ *Z769* **GEM@Home**: > ≠ *Z004* > ≠ *Z509* > *Z769* **HB@Home**: > ≠ *Z004* > ≠ *Z509* > ≠ *Z769* > *Z370* > *Z371* > *Z372* > *Z373* > *Z374*

Admitted Patient Care Data Elements	Physical Hospital record Value	Home record Value
		> *Z375*
		> *Z376*
		> *Z377*
		> *Z379*
		MH@Home:
		> *Z004*
		> *≠ Z509*
		> *≠ Z769*
[Episode Of Care]	*≠ Hospital at home / Rehab at home*	*Hospital at home / Rehab at home*
[Source of Referral]	As appropriate	*Administrative admission*
[Nature Of Separation][5]	*Administrative discharge*	Neither:
		> *Administrative discharge*
		> *Discharge on leave*
		> *End of quarter reporting*
		> *Other health care accommodation*
		> *Residential aged care facility*
		> *Retrieval*
[Referral For Further Health Care]	*Hospital at home / Rehabilitation at home*	*≠ Hospital at Home/Rehab at Home*

Linkages between the **physical** hospital record and the **home** hospital record are shaded above:

> **Physical** hospital **[Hospital Number]** matches **home [Hospital Number]**

> **Physical** hospital **[Patient Unit Record Number]** matches **home [Patient Unit Record Number]**

> **Physical** hospital **[Separation Date]** and **[Separation Time]** is one minute prior to **home [Admission Date]** and **[Admission Time]**

2.4   Data Quality Principles - Other Data Sets

Hospital in the Home arrangements that are outside the scope of the *Admitted Patient Care* data asset should provide data in accordance with the relevant SA Health contract terms and conditions.

2.5   Data Submission Requirements

Data submitted shall be in accordance with the relevant data asset reference manual.

2.6 Bundling Requirements

There are two types of bundling:

> Hospital in the Home
> Mental Health

Hospital in the Home bundling creates a bundled record to amalgamate both Episode of Care types:

> Mental Health: Acute
> Mental Health Hospital in the Home

Mental Health bundling creates a bundled record to amalgamate both Episode of Care types:

> Mental Health: Acute
> Mental Health: Rehabilitation

In order to correctly bundle Mental Health records, Hospital in the Home bundling must be performed before Mental Health bundling.

3. COMPLIANCE

EDI data asset file submissions are assessed for data quality compliance in accordance with the relevant data asset manual and reported to the submitting hospital for assessment and correction as required.

Related data quality checks

2085: [Episode Of Care] of (7) NOT COMPATIBLE WITH [Nature Of Separation] of (0, 3, 4, A, E, or X)
2301: [Episode Of Care] of (5, or 7) NOT COMPATIBLE WITH [Hours In ICU] not (0)
2302: [Episode Of Care] of (5, or 7) NOT COMPATIBLE WITH [Hours On Mechanical Ventilation] not (0)
2580: [Episode Of Care] of not (1, 2, 3, 4, 5, 6, 7, 8, 9, I, J, K, L, or P) NOT COMPATIBLE WITH Age at admission of (> 9 days)
2720: [Referral For Further Health Care] of (07) REQUIRES [Nature of Separation] of (A)
2730: [Episode Of Care] of (7) NOT COMPATIBLE WITH [Referral For Further Health Care] of (07)
2750: [Episode Of Care] of (5, 6, 7, 8, or L) NOT COMPATIBLE WITH [Referral For Further Health Care] of (07) and [Nature Of Separation] of (A)
4046: [Additional Diagnosis] of (Z509) REQUIRES [Episode Of Care] of (4, or 7)
4824: [Episode Of Care] of (7) NOT COMPATIBALE WITH [Source Of Referral] not (A) and [Principal Diagnosis] of (Z519)

Further details for these data quality checks can be found in the **Admitted Patient Care - Data Quality Checks - Reference Manual 2020-2021**.

4. DOCUMENT CONTROL

4.1 Document Information

Title	Hospital in the Home (HITH) Data Protocol
Description	This document describes the protocols applicable in reporting Hospital at Home data elements applicable in the *Admitted Patient Care* EDI data asset.
Objective Reference	
Status	
Version	5.0
Version Date	19-Aug-2021
Document Owner	Susan Sander Manager, Data Governance & Quality Assurance
Classification	OFFICIAL

4.1 Change History

Document Version	Date	Updated By	Change Summary
1.0	23-Jul-2020	Damien Bourke Principal Data Governance Officer	Initial release.
2.0	13-Nov-2020	Damien Bourke Principal Data Governance Officer	Incorporate provisions for *Mental Health in the Home* service.
3.0	18-Feb-2021	Damien Bourke Principal Data Governance Officer	Update to reflect EDI-specific terminology.
4.0	14-Apr-2021	Damien Bourke Principal Data Governance Officer	Update to permit Inter-hospital transfers for patients on HITH.
5.0	19-Aug-2021	Damien Bourke Principal Data Governance Officer	Update to remove NDIS values from invalid **[Nature Of Separation]**; .Remove year from document title.

4.2 Document Approval

Governance Position	Person	Date
Executive Sponsor		
Business Sponsor	Rachel Trethewey Manager Coding and Health Records	19-Aug-2021
EDI Leadership Group	Susan Sander Manager, Data Governance & Quality Assurance	19-Aug-2021

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