A. PURPOSE

This directive defines the requirements for the completion of Acute Care Certificates (ACCs) by public hospitals in WA.

B. BACKGROUND

In April 2007 the Commonwealth Government repealed Section 3B of the Health Insurance Act 1973. This section underpinned the requirement to complete ACCs for long stay patients. In repealing Section 3B, the Commonwealth stipulated that delineation of episode of care type (acute, maintenance, etc) was an issue to be resolved between hospitals and insurers.

However the requirement to accurately report episode of care type, under the terms of the Australian Health Care Agreements remains.

In addition the provisions for designating a patient as “Nursing Home Type”, after day 35 of continuous hospitalisation, are still in place.

To ensure consistency across all WA public hospitals, the Department of Health (DOH) has amended the original Commonwealth form and is advising staff to use the revised forms (see attached).

C. REPORTING REQUIREMENTS

Hospitals must ensure that an ACC is provided for any patient who remains in hospital, after day 35, due to the need for ongoing acute care.

An ACC is not required for patients who, after day 35, remain in hospital for:

- accommodation and nursing care as an end in itself (maintenance care) or
- other specific care types (palliative, rehabilitative).

Patients who, after day 35, remain in hospital for maintenance care only, are deemed nursing home type patients (NHTP). Such patients are re-classified from acute to maintenance care. The hospital may raise the applicable NHTP charges.
Some scenarios are provided in the attachments to assist in understanding the ACC requirement, along with sample copies of the revised forms for rural and metropolitan hospitals.

Electronic copies of the DOH ACC form will be available via TOPAS and HCARe. The HCN-generated version has also been amended.

It is recommended that all ACC are filed in the patient’s medical record and copies stored centrally within the Health Corporate Network for future reference. The availability of ACCs will ensure the State’s compliance with various contractual obligations and assist with any inquiries from private health insurers.

All hospitals are required to implement this circular and use the revised forms, which will be available on-line by end October 2008.

Dr Peter Flett
A/DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ATTACHMENTS

Some notes/scenarios to assist in understanding the ACC requirement

In general, calculate the length of stay (LOS) by normal counting rules (date of separation minus date of admission). If discharge today would result in a 35 day LOS then an ACC is required from tomorrow, OR, a change in care type must be effected today.

For more complex scenarios, which may include multiple hospitalisations with breaks or leave days, formal counting rules are provided below:

1. The admission date is counted as Day 0 and the separation date is counted in the total number of inpatient days.

2. A patient was admitted on 1 August 2006 as an acute patient and discharged on 6 September 2006. In this situation, 1 August 2006 should be counted as Day 0. The LOS and total number of acute days for the episode is 36 days. Therefore an ACC should be issued to cover the 36th day (6 September 2006).

3. Continuous episodes in different hospitals – Patient Day Continuity. The count towards 35 days of inpatient care is continuous across multiple admissions at one or more hospitals. Continuity ends only when the break between hospitalisations exceeds 7 days.

4. If continuous hospitalisation occurs in different hospitals, the date of the original admission should be recorded on the ACC form. Counting from the 36th day onwards, a certificate is required for each 30-day period or part thereof. The following table illustrates the ACC requirements for a continuous hospitalisation over 3 episodes in 2 hospitals.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Admission date</th>
<th>Separation date</th>
<th>Acute days</th>
<th>Cumulative acute days</th>
<th>ACC requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1 Aug 2006</td>
<td>15 Aug 2006</td>
<td>14</td>
<td>14</td>
<td>No ACC required</td>
</tr>
<tr>
<td>B</td>
<td>20 Aug 2006</td>
<td>27 Sep 2006</td>
<td>38</td>
<td>52</td>
<td>ACC is required for the period 11 Sep 2006 to 27 Sep 2006</td>
</tr>
</tbody>
</table>

Even where continuity is maintained, the actual days outside of hospital (either leave days or break days) are excluded from the day count. In the example above, continuity of patient day counting is maintained, since the break (15 August - 20 August) does not exceed 7 days. The count continues, excluding the break days.

For the purposes of acute care certification:
Admission / re-admission dates are never counted; separation dates are always counted. In the example above, 15 August is day 14. The count continues with 21 August as day 15. Day 35, in the example above, is September 10. An ACC is required to cover day 36 (September 11) and onwards.

If no ACC is provided, the patient’s care type should be re-classified to maintenance care before midnight on day 35 (September 10 in the example above). The patient becomes NHTP and the hospital may raise the applicable NHTP charges.
In order to establish the patient's category, please tick the appropriate box below and take action as outlined.

<table>
<thead>
<tr>
<th>Requires ACUTE CARE</th>
<th>Requires NURSING HOME TYPE CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete the &quot;Acute Care certificate&quot; below if the patient's status remains as requiring acute care.</td>
<td>If you have ticked Nursing Home Type Care do not complete certificate below.</td>
</tr>
</tbody>
</table>

Effective Date

If you ticked Nursing Home Type Care, please do not complete the ACUTE CARE CERTIFICATE below.

Please return this form to the Ward Clerk.

Doctors' Signature:

Consultant  
Registrar  
Intern

Acute Care Certificate

Issued under the terms of the Australian Health Care (Medicare) Agreement and the Private Health Insurance Act 2007

SECTION 1 – PARTICULARS OF PATIENT AND HOSPITAL

(To be completed by Hospital, Doctor or Patient)

<table>
<thead>
<tr>
<th>ACCOUNT NUMBER:</th>
<th>PATIENT NUMBER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT NAME:</td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>POSTCODE:</td>
<td></td>
</tr>
<tr>
<td>DATE OF BIRTH:</td>
<td></td>
</tr>
<tr>
<td>ADMIT DATE:</td>
<td>WARD:</td>
</tr>
<tr>
<td>FUND:</td>
<td>ACCOUNT TYPE:</td>
</tr>
<tr>
<td>MEMBERSHIP NO:</td>
<td></td>
</tr>
</tbody>
</table>

HOSPITAL OF ORIGINAL ADMISSION:

DATE OF ORIGINAL ADMISSION: / / (being the date from which the patient has been continuously a patient in this or any other hospital(s), without a break of more than seven days).

SECTION 2 – PATIENT AUTHORISATION

(To be completed by Patient, Parent or Guardian)

I, [Patient Name], authorise the Doctor [Name of Doctor] to release all information relevant to the condition(s) described in Section 3 below.

Signature: [Signature]

Relationship: [Relationship]

Date: / / (if you are not the patient)

SECTION 3 – CERTIFICATION OF PATIENT’S MEDICAL CONDITION

(To be completed by Doctor)

NOTES:
- A separate certificate is required for each 30 day period
- Select one (tick) (A) for prospective Certification OR (B) for retrospective Certification

I, [Name of Doctor], certify that the above patient;

(A) is, or will be, in need of Acute Care for at least the period commencing / / (no later than 14 days after signing Certificate) and ending / / (no later than 30 days from commencement);

(B) has been, or has been and remains, in need of Acute Care for at least the period commencing / / date prior to signing Certificate) and ending / / (no later than 30 days from commencement).

Please state:

(1) The condition(s) requiring Acute Care:

(2) Details of Hospital Treatment required and provided (e.g. medication or treatment not available in a nursing home, nature and frequency of rehabilitation treatment received, date and nature of surgery or acute medical episodes or complications, prognosis and opinion of probable duration of continuing need for acute care:

Signature: [Signature]

Date: / /
Section 1 – Particulars of Patient and Hospital (To be completed by Hospital, Doctor or Patient)

Patient’s Surname
Given Names
Address
Date of birth / / DVA Card Colour: Gold/White
DVA File Number:
Name of Private Health Fund:
Name of Hospital:
Date of original admission: / / being the date from which the patient has been continuously a patient in this or any other hospital(s), without a break of more than seven days.

Section 2 – Patient authorisation (To be completed by Patient, Parent or Guardian)

I, authorise Doctor
to release all information relevant to the condition(s) described in Section 3 below.
Signature Relationship Date / / 

Section 3 – Certification of patient's medical condition (To be completed by Doctor)

Use (A) for prospective Certification OR (B) for Retrospective Certification
(a separate certificate is required for each 30 day period)

I, of Telephone No. ( )
of: certify that the above patient:

A) is, or will be, in need of Acute Care for at least the period commencing / / (no later than 14 days after signing Certificate) and ending / / (no later than 30 days from commencement); OR

B) has been, or has been and remains, in need of Acute Care for at least the period commencing / / (date prior to signing Certificate) and ending / / (no later than 30 days from commencement).

Please state (1) The condition(s) requiring Acute Care:

2) Details of Hospital Treatment required and provided (e.g. medication or treatment not available in a nursing home, nature and frequency of rehabilitation treatment received, date and nature of surgery or acute medical episodes or complications, prognosis and opinion of probable duration of continuing need for Acute care):

Signature Date / /
ACUTE CARE CERTIFICATE (TOPAS VERSION)
(issued under the terms of the Australian Health Care Agreement/Private Health Insurance Act 2007)

SECTION 1 - PARTICULARS OF PATIENT AND HOSPITAL (To be completed by Hospital, Doctor or Patient)

ACCOUNT NUMBER: PATIENT No.: 
PATIENT NAME: 
ADDRESS: POST CODE: 
DATE OF BIRTH: 
ADMIT DATE: WARD: ACCOUNT TYPE: 
FUND: MEMBERSHIP No.: 

NAME OF HOSPITAL: 
DATE OF ORIGINAL ADMISSION: dd/mm/yyyy, being the date from which the patient has been continuously a patient in this or any other hospital(s), without a break of more than seven days.

SECTION 2 - PATIENT AUTHORISATION (to be completed by Patient, Parent or Guardian)

I, ______________________ authorise Doctor ______________________
to release all information relevant to the condition(s) described in Section 3 below.
Signature ______________________ Relationship ______________________ Date ______________________

SECTION 3 - CERTIFICATE OF PATIENT’S MEDICAL CONDITION (To be completed by Doctor)

Use (A) for Prospective Certification OR (B) for Retrospective Certification (a separate certificate is required for each 30 day period)

I, ______________________ Telephone No. ______________________
of, ______________________ certify that the above patient:

(A) is, or will be, in need of Acute Care for at least the period commencing dd/mm/yyyy (no later than 14 days after signing Certificate) and ending dd/mm/yyyy (no later than 30 days from commencement); OR

(B) has been, or has been and remains, in need of Acute Care for at least the period commencing dd/mm/yyyy (date prior to signing Certificate) and ending dd/mm/yyyy (no later than 30 days from commencement).

Please state (1) The condition(s) requiring Acute Care:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

(2) Details of Hospital Treatment required and provided (eg. medication or treatment not available in a nursing home, nature and frequency of rehabilitation treatment received, date and nature of surgery or acute medical episodes or complications, prognosis and opinion of probable duration of continuing need for Acute care):

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Signature ______________________ Date ____ / ____ / ______

Superseded By: OD: 0450/13