HCSS API Definitions

HCSS API Definitions to provide business context/rules to the HCSS Reporting API Software Design Specification V9 Jun 2019

Clause	Field	Definition
3	**Service commencement**	**Service commencement refers to a series of steps undertaken when a client is onboarded to the service.** **Suppliers should send ACC data for service commencement when all the of the steps in the service commencement process are completed. If at the time of transmitting data, only some of the steps are completed the Supplier can either send the information that is complete, but will need to send the other data in the subsequent months reporting, repeating the claim information so that it can be made sense of at ACC's end OR you can withhold submitting the data until the reporting month when all the steps are complete.** **Note that service commencement refers to new clients or injuries and should NOT be used where an existing client has their service extended. In that scenario, either continue managing them under the existing service or if they are transitioning from one service type to another, submit a review.**
3.1	Supplier ID	Codes that ACC uses to uniquely identify Suppliers
3.2	Claim Number	Codes that ACC use to uniquely identify client injury claims
3.3	Service provided	Clients can receive one of three types of base service provision: Standard Support Extended Support SIP Clients who transition from one service type to another are captured in 4.7. A transition should NOT be counted as a service commencement. A client should always receive at least one of these services, and may have one or more additional services. The only exception is childcare, that is a client can recieve childcare services without receiving a SIP, Standard or Extended service. Those clients are not included in the API reporting as ACC will monitor this service via billing information.
3.4	Referral Date	The data that the referral was sent to the supplier by ACC or another Provider eg DHB This should be the date the referral was sent, not the date it was received, if there is a delay.
3.5	Client requested start date	ACC have adjusted the KPI to determine timeliness of service provision in relation to when the client had requested the service start, as opposed to the referral date. This means that where a Supplier receives an early referral, for example prior to hospital dsicharge, they are not detrimentally affected for not being able to put in place services immediately. For SIP clients, Suppliers should use the discharge date in this field.
3.6	First contact	The date that the Supplier first made contact with the client. Where a Supplier has been unable to sucessfully contact a client, Suppliers should note the date of the last attempt made.
3.7	First episode of care	The first time where support services are provided. First episode of care may also be counted as the initial face to face assessment / discussion of needs if this occurs first, and if it is assessed that support services can safely commence at a later date and that date is set during that assessment.
3.8	Service Plan submission	The date the completed plan is submitted to ACC containing input from all relevant health professionals.
3.9	SIP referral region	Select the DHB region that the SIP referral came from. If a referral comes from one DHB, but the client or the carer reside in different DHB domiciles, the Supplier should enter the DHB region the referral came from.

4	**Service review**	**For the purpose of reporting, a review may refer to EITHER:** **- The face to face reviews with the client as outlined in clause 6.5 of the sevice (every 12 weeks for Standard clients, every 26 weeks for Extended) OR** **- An extension or change to a service which changes it from one service type to another (eg SIP to Standard, Standard to Extended).** **These might occur at the same time or be two seperate events. If seperate events, they should be sent through as two reviews.** **For example, if a SIP package ends and further care is required, for the purposes of reporting this should be recorded as a first review and transition noted as SIP to Standard as follows:** **Service type: SIP** **Review type: First review** **Transition From: SIP to Standarrd** **If the Supplier then reviews the client in person 12 weeks later as per the contract requirements, they would send through a review as follows:** **Service type: Standard** **Review type: Subsequent review** **Transition from: No transition** **First review refers to the first review of the CLIENT, any reviews after that, of any kind, are subsequent, even if the service type has changed.**
4.1	Supplier ID	Codes that ACC uses to uniquely identify Suppliers
4.2	Claim Number	Codes that ACC use to uniquely identify client injury claims
4.3	Service provided	Clients can receive one of three types of base service provision: Standard Support Extended Support SIP Clients who transition from one service type to another are captured in 4.7. A transition should NOT be counted as a service commencement. A client should always receive at least one of these services, and may have one or more additional services. The only exception is childcare, that is a client can reveive childcare services without receiving a SIP, Standard or Extended service. Those clients are not included in the API reporting as ACC will monitor this service via billing information.
4.4	First episode of care	The first time where support services are provided and may also include the initial face to face assessment / discussion of needs, if it is assessed that support services can safely commence at a later date and that date is set during that visit.
4.5	First or subsequent review	Reviews are expected to occur as per the contract specifications outlined above meaning some clients will receive more than one review. A client should only have one first review per claim, all other reviews should be recorded as subsequent. At ACCs end, we will be able to determine timeframes between previously submitted first reviews and all subsequent reviews to determine whether the KPI is met.
4.6	Review date	This is the date the face to face interview with the client occurred. An updated service plan should be sent to ACC as soon as practicable after this, however you are not required to report this date. If a client has reached the end of the approved period and the Supplier receives or requests an extension to services, this should be reported as a review and the review date is the date that the Supplier receives an approval from ACC for ongoing services.
4.7	Service transition	Where a client has transitioned from one type of service to another, this should be treated as a review, and the type of transition noted according to the API service specifications. Where no transition has occurred, this should be noted.

5	**Service Consultations**	**This section allows ACC to capture the number of "add-on" services in addition to the base service type. Consultations refer to events where a nurse, physiotherapist or OT physically go to the clients home to provide treatment or to provide support to Support Workers. A consultation refers to one visit, regardless of visit length. If a health professional visits the home twice in one day, at seperate times, this should be counted as two consultations. Consultations exclude the initial service planning sessions, or support provided to other staff over the phone.**
5.1	Supplier ID	Codes that ACC uses to uniquely identify Suppliers
5.2	Claim Number	Codes that ACC use to uniquely identify client injury claims
5.3	Service provided	Clients can receive one of three types of base service provision: Standard Support Extended Support SIP Clients who transition from one service type to another are captured in 4.7. A transition should NOT be counted as a service commencement. A client should always receive at least one of these services, and may have one or more additional services. The only exception is childcare, that is a client can reveive childcare services without receiving a SIP, Standard or Extended service. Those clients are not included in the API reporting as ACC will monitor this service via billing information.
5.4	Nursing Consultations	A consultation refers to one face to face visit to the client, regardless of visit length. If a nurse visits the home twice in one day, at seperate times, this should be counted as two consultations. Consultations exclude the initial service planning sessions, or support provided to other staff over the phone. Nursing consults should only be counted where they are delivered under the IHCS contract. If they are being delivered under other services, they should be excluded from this reporting.
5.5	Physiotherapy Consultations	A consultation refers to one face to face visit to the client, regardless of visit length. Consultations exclude the initial service planning sessions, or support provided to other staff over the phone. Physiotherapy consults should only be counted where they are delivered under the IHCS contract. If they are being delivered under other services, they should be excluded from this reporting.
5.6	Occupational Therapy Consults	A consultation refers to one face to face visit to the client, regardless of visit length. Consultations exclude the initial service planning sessions, or support provided to other staff over the phone. OT consults should only be counted where they are delivered under the IHCS contract. If they are being delivered under other services, they should be excluded from this reporting. Where equipment needs to be ordered as a result of an OT consult, this should not be counted as a seperate consult, even if the equipment order is completed after the visit.
6	**Service completion**	**This section refers to the formal exit of the client from your services for the claim that they are being treated on.** **If a client has a second injury with a new claim and services are transferred to the new claim, services can be considered completed on the previous claim.** **If the client is exited from the service and has a relapse of the same injury requiring further homecare services, and the Supplier has already submitted the service completion information for this claim, treat this as a new service and undertake the service commencement reporting.** **Where you receive an extension of services, do NOT treat this as a service completion and new service commencement.**
6.1	Supplier ID	Codes that ACC uses to uniquely identify Suppliers
6.2	Claim Number	Codes that ACC use to uniquely identify client injury claims

6.3	Service provided	Clients can receive one of three types of base service provision: Standard Support Extended Support SIP Clients who transition from one service type to another are captured in 4.7. A transition should NOT be counted as a service commencement. A client should always receive at least one of these services, and may have one or more additional services. The only exception is childcare, that is a client can reveive childcare services without receiving a SIP, Standard or Extended service. Those clients are not included in the API reporting as ACC will monitor this service via billing information.
6.4	First episode of care	The first time where support services are provided and may also include the initial face to face assessment / discussion of needs, if it is assessed that support services can safely commence at a later date and that date is set during that visit.
6.5	Service completion date	The last day that service was provided to the client on this claim. See notes above about defintion of service completion.
6.6	SIP referral region	Select the DHB region that the SIP referral came from. If a referral comes from one DHB, but the client or the carer reside in different DHB domiciles, the Supplier should enter the DHB region the referral came from.
6.7	Standard Service outcome	Identify the outcome of the service from the options provided. As noted above, services should not be considered complete if an extension is received.
6.8	Other service outcome	Allows free text to explain an other outcome
6.9	Extended Service outcme	Identify the outcome of the service from the options provided. As noted above, services should not be considered complete if an extension is received.
6.10	Other service outcome	Allows free text to explain an other outcome
6.11	Nursing Support Included?	Confirmation of whether nursing consultations were completed for this client during their service. This exludes nursing involvement in the set up of the service plan, or provision of supervisory support to other staff.
6.12	Nursing Assessment Start	The date the assessment took plan to plan the nursing support. This may be the same date as the first episode of care or it may be a later date.
6.13	Nursing Support completion	The last date that nursing treatment was provided under this claim.
6.14	Total nursing consultations	Total treatment consultations, excluding service planning or nursing assessment
6.15	Allied Health Included?	Confirmation of whether allied health consultations (Physio or OT) were completed for this client during their service. This exludes PT/OT involvement in the set up of the service plan, or provision of supervisory support to other staff that occurred away from the client.
6.16	Allied health start	The date the assessment took plan to plan the allied health support. This may be the same date as the first episode of care or it may be a later date.
6.17	Allied Health completion	The last date that allied health treatment was provided under this claim. If both PT and OT are being delivered, record the date that the last of two professions met with the client.
6.18	Total PT hours	Total treatment consultations, excluding service planning or seperate assessment
6.19	Totsl OT hours	Total treatment consultations, excluding service planning or separate assessment
7.00	**Supplier Review**	**This is organisation level information that is not associated with individual clients.**
7.1	Supplier ID	Codes that ACC uses to uniquely identify Suppliers
7.2	Region	Regions have been aligned to DHB regions to maintain consistancy with question 3.9. Where staff work across multiple regions (eg Auckland), allocate them to one region where they predominantly work or live. They should only be counted once. We may amalgamate regions such as Auckland at our end to improve the visibility of staff accross a region. In terms of hours delivered, this should be in the region that the client lives.
7.3	Statistics per region	Defined individually below
7.3.1	Total staff employed	All support workers who deliver IHCS services in the region. Exclude administration staff. Exclude clinical staff as these are counted seperately.
7.3.2	Number of staff in training	All Support workers who do not have a qualification.

7.3.3	Number of staff qualified to L2	Count all support workers for whom this is their HIGHEST qualification (as it relates to IHCS)
7.3.4	Number of staff qualified to L3	Count all support workers for whom this is their HIGHEST qualification (as it relates to IHCS)
7.3.5	Number of staff qualified to L4	Count all support workers for whom this is their HIGHEST qualification (as it relates to IHCS)
7.3.6	Total nurses employed	All nurses who deliver IHCS services in the region
7.3.7	Total PTs employed	All PTs who deliver IHVS services in the region
7.3.8	Total OT's employed	All OTs who deliver IHVS services in the region
7.3.9	Family or nominated carers	All carers who have been employed at the request of the client, eg family members, neighbours etc. Exclude staff who were already support workers who were selected by the family. This is the only area of reporting where a staff member should be counted twice. For example a staff member might be a family member of a client and trained to L2 so should be counted in both 7.3.3 and 7.3.9.
7.3.10	Number of referrals declined	Any referral that was declined by the Supplier for any reason
7.3.11	Total number of service hours delivered	Total number of support worker hours, complex or other, for clients receiving SIP, Standard or Extended services, within the reporting period, that were actually delivered (not just rostered). Exclude nursing, physiotherapy, OT, service planning hours or consults.
7.3.12	Total number of hours not delivered	Defined as: • Hours that had been scheduled and were not delivered, where the Supplier (or its employees) were at fault and client was not notified prior. o Eg a support worker did not show up for a 2 hour shift. The client called later that day to complain no one had turned up and the agency rebooked a visit to occur at a later date. This should still be counted as 2 hours of care not delivered, because the client was not notified in advance. • Hours that were not completed because a staff member was late (late defined as more than 30 minutes) or the full shift was not completed for any other reason caused by the Supplier (or their employee) without the client being notified prior (eg Support worker left early) o Eg A support worker was scheduled to work for 4 hours and arrived 1 hour late and left 1 hour early. Hours not delivered should be reported as 2 hours. This is true even if those 2 hours were subsequently rescheduled, as the client was not notified beforehand. • Hours that were scheduled to be completed by an agency support worker that were then placed on a family member, even if that family member was paid for those hours o Eg a support worker was due to work from 9am-5pm but called in sick and a replacement could not come until 12pm. A family member, who is also employed by the agency but was not due to work, had to work from 9am – 12pm as the client requires 24/7 care. The family member was paid for these hours but they should still count as missed visits as they were not filled by the agency.”