HDSS Forum Notes

Thursday 13 December 2001

Venue: *Michael Chamberlin Lecture Theatre*
St Vincent's Hospital
Victoria Parade, Fitzroy

Time: *9:00am*

Participants:

- *Hospital representatives who work with PRS/2,VEMD or ESIS*
- *Software suppliers known to have an interest in transmissions to the VAED, VEMD or ESIS.*
- *Representatives of Acute Health, Department of Human Services.*
  (See Attachment 1 for lists of attendees and apologies).

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1 Opening – Morning Session

Mark Gill, Manager, Health Data Standards and Systems Unit, Department of Human Services (DHS), opened the Forum, welcomed those present and introduced Neil Currie.

2 Emergency Department Information System Review Project

Neil Currie, Clinical Nurse Specialist, seconded to DHS, provided information on the recent review he had conducted on Emergency Department Information Systems (EDIS).

Neil commented that EDIS development had been driven by:

- Need to gather management and research data
- Increasingly complex data reporting requirements of funding bodies
- High client loads
- High acuity of presentations
- Need to understand and manage Emergency Department efficiencies
- Need for comprehensive tools to analyse Emergency Department activities
- Feedback from Emergency Department personnel
- Inadequate systems
- Fragmented purchase and implementation of systems.

The Emergency Demand Management Strategy, Homer replacement project and hospital concerns regarding the quality and scope of the Victorian Emergency Minimum Dataset (VEMD) led to the three-month review of the Emergency Department Information Systems (EDISs).

The project was undertaken in consultation with 29 rural and metropolitan sites that contributed to the VEMD. Interviews were undertaken with EDIS software vendors discussing current and future products and the project utilised functional specifications from New South Wales. The scope of the project had been to assess existing EDISs, identify innovations, report on findings, and develop a business case to support recommendations.

To assess EDIS performance, key result areas were developed:

- Clinical
- Administrative
- Research
- Education
- Prevention

Results of the review were presented. Key factors found to impact on EDIS performance included:

- Hardware and communication issues
- IT support
- Administrative practices
- Provision of adequate resources at the time of system configuration

Innovations identified included:
- Hand held data acquisition devices: will be very important within 18 months to 2 years
- Bar code readers
- Security: password/PIN number system is the best method currently in use
- Voice recognition: still being developed: within the environment of an emergency data collection, needs to be very structured
- Data from physiological monitors: could be recorded directly from the machine
- Electronic whiteboards
- Department Map: drop and drag functionality; will display where everyone is located
- Electronic discharge summary to LMO
- Document printing – Triage and Medical: a lot of handwritten information is duplicated: enter into the system once, and print for use in other areas
- ED Workload index: would allow better matching of staffing levels, beds, etc. with number and type of patients presenting
- 12 lead ECG capture: frequently lost; if downloaded to a database this information would always be available and allow easy comparison; could also be shared between health care facilities
- Document scanning: pathology, x-ray, etc: easy to buy a scanner but much harder to get the information into a database.

Neil reported hospitals were currently undertaking projects to migrate from the existing Homer core Patient Administration System (PAS). This migration offers challenges and opportunities for Emergency Department system replacements. Other sites do not have Homer, and therefore there is a need to consider the future development of EDIS outside this project.

Recommendations of the EDIS project included:
- Improvements to hardware configuration, IT Support and administration processes are as critical as software
- Establish a project team, including a multidisciplinary team, to optimise EDIS performance
- Consider alternative funding arrangements
- Build on Homer replacement project for EDIS improvements

Neil stated that the following conclusion could be drawn from the EDIS review:
- Many EDISs do not support key result areas
- Software is not the only issue
- Hardware configuration, IT support and administrative practices need to be considered.
- Emergency Demand Management is dependent on EDIS improvement.

Mark Gill thanked Neil for his effort over past months. Questions on this project should be directed to the HDSS Help Desk.

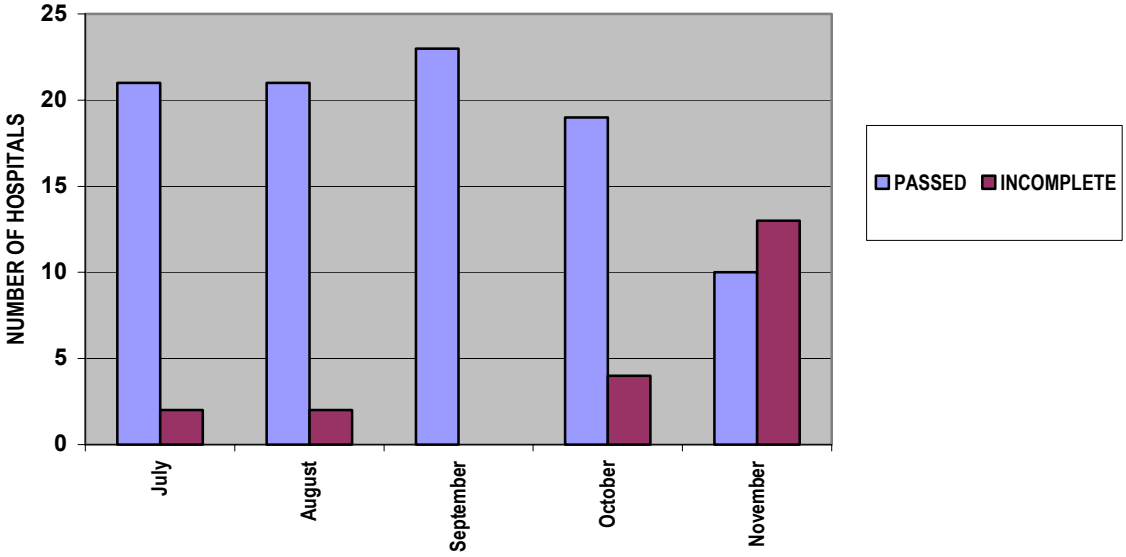
3 ESIS Information Update

Anna Cooper, HDSS, DHS, presented an update on the data submitted to the Elective Surgery Information System (ESIS) during 2001—2002.

There were 22 hospitals reporting as individual campuses to ESIS during this year and one Health Service reporting as a single entity on behalf of its 4 campuses. This reporting option was available to all multi-site health agencies.

Every site had submitted its ESIS data from July 2001 to November 2001, with September the only month where data had passed all rejection edits. There had been a significant improvement this year, with the number of submissions per month down from up to 14 per site last year, to between 1 and 6 per site this year.

ESIS 2001—2002 PASSED FILES YEAR TO DATE



The graph showed the number of hospitals that had submitted and completed each month's ESIS data, with September then the only month that had been completed for the year to date. Two campuses were still to complete both July and August submissions, while 10 sites had completed November data, well before the due date.

5 MOST FREQUENTLY REPORTED ESIS EDITS – 2001—2002

Edit #	Edit Description	Occurrence
S316	Clinical Urgency Cat 2 Patient Waiting > 90 Days	149228
S171	New Record, Registration Date Prior to this Month	70249
S053	Record not removed last month missing from file	36080
S001	Census Date not Valid	34984
S135	Patient already on waiting list for same PPP	27361

The 5 most frequently reported edits included both rejections (Type 2: 053; Type 1: 001) and warnings (316, 171 & 135).

4 Proposals for Revision to ESIS

4.1 Date of Procedure and Planned Length of Stay

Andrew Rothfield, Rothfield Health, discussed the introduction of a new ESIS data item, *Date of Procedure*, and the revision of an existing ESIS data item, *Planned Length of Stay*.

The Day of Surgery Admitted rate (DOSA) was introduced, in line with a key recommendation of the Patient Management Taskforce, as a key indicator of hospital performance. Admission on the day of surgery improved bed utilisation and therefore access to treatment.

Andrew explained the phrase 'DOSA rate', saying it indicated the:

- Proportion of ESIS patients
- Admitted electively to their intended hospital (Reason for Removal = W)
- With planned Length of Stay of overnight (= O)
- Who had a theatre procedure on their day of admission.

If all these criteria were met, the patient was a successful DOSA candidate.

In 2001—2002, hospitals were calculating their DOSA rates from their own ESIS data, which involved manual/computer assisted matching of ESIS records with operation records to determine whether surgery was performed on the day of removal from waiting list (= day of admission).

It was proposed that in 2002—2003, DHS would calculate the hospital's DOSA rates using submitted ESIS data. To be able to do this, DHS needed to know if the surgery was performed on the day of admission. It was proposed that *Date of Procedure* be added to the ESIS dataset. If the *Date of Procedure* field was left blank, it would be assumed the *Date of Procedure* was after the *Removal Date* and the episode would be counted as *not* being a DOSA episode. The implementation of the *Date of Procedure* field would affect hospitals reporting to ESIS, as the reporting system would need to examine Operating Theatre data for a matching case for each ESIS patient with Reason for Removal W (Admitted to this hospital).

Andrew noted there were concerns with matching data from the two systems due to cost, and that, at most sites, ESIS data and Operating Theatre data were held in standalone systems. He commented, that, with hindsight, the ESIS system should have been designed as a pre-admission system within the Victorian Admitted Episodes Dataset (VAED), rather than as a stand-alone system. There was discussion of which was the most appropriate system to gather the DOSA data

4.2 Campus/Health Service Code and Intended Treatment Campus

Jane McKercher, DHS, discussed the proposed introduction of a new ESIS date item, Intended Treatment Campus. This data item was developed in response to requests by Southern Health Service and Peninsula Health Service.

Jane commented that some Health Services managed waiting list data at the health service level, rather than at the campus level. As a result, it was important that ESIS reflected the way the data are managed. The proposed change would enable the recording of waiting list data at Health Service level, where applicable. Health Service codes would be allocated by DHS following advice that ESIS data would be reported at the Health Service level. There would be no impact where campus code continued to be reported in the Header Record.

Jane commented that it was important for ongoing analysis and consistency of counting of waiting list data to identify the campus to which it was intended the patient be admitted. This would enable comparison of "like" campuses and ensure that campus-level data were available if Health Services disaggregate. The data item would only need to be completed when a Health Service code was recorded in the Header Record. Where waiting lists continued to be reported at the campus level, no action would be required, as the Header Record would identify the campus to which the patient was waiting to be admitted.

The *Intended Treatment Campus* would be updated if it changed while the patient was on the waiting list. *Transfer Codes* T (Transfer of waiting list episode to another ESIS hospital) or N (Transfer of waiting list episode to another non-ESIS hospital) would only be used to signify movement of the waiting episode outside the Health Service.

4.3 Clinical Urgency

Associate Professor Colin Russell, member on the Advisory Committee on Access to Elective Surgery (ACAES), discussed the proposed revision to *Clinical Urgency*. The paper on access to elective surgery can be obtained from Jane McKercher (jane.mckercher@dhs.vic.gov.au or 9616-7896).

It was proposed that *Clinical Urgency* be split into 4 categories, rather than the existing 3 categories, aligning Australia with the UK and the USA. The 3 categories currently used in Australia were:

- 1 – Urgent (30 Days)
- 2 – Semi Urgent (90 Days)
- 3 – Non Urgent (No Maximum)

Since July 1998, there had been a marked increase in the number of category 2 patients (51%) compared with a 16% growth in the total waiting list during that time. Colin commented that 'streaming' had occurred, meaning that many patients were admitted to hospital shortly after they were placed on the waiting list, while others were admitted after comparatively long waits.

It was proposed to split category 2 into 2A and 2B: one category for more urgent category 2 patients and one for the less urgent. This would ensure patients in category 2 with 'unstable' conditions were not overlooked. The desirable time for admission for both sub-categories would remain at within 90 days.

The new categories would be:

- 2A – Semi Urgent (90 Days)

Admission within 90 days clinically desirable for a condition which severely impairs quality of life (pain, dysfunction, disability) and/or has a significant probability of deteriorating and/or where timely treatment will impact on outcome.

- 2B – Semi Urgent (90 Days)

Admission within 90 days clinically acceptable for a condition which causes mild to moderate impairment of quality of life (pain, dysfunction, disability) and/or which may deteriorate over time.

Irene Kearsey suggested that, if the proposal was accepted, there should be an additional field for the character A or B, rather than modifying the existing field.

4.4 Patient Identifier, Planned Length of Stay, Reason for Removal, Unique Key, ESIS Edits

Irene Kearsey, HDSS, DHS, discussed the proposed revisions to *Patient Identifier*, *Planned Length of Stay*, *Reason for Removal*, *Unique Key* and proposed changes to ESIS edits.

Irene discussed the proposal to revise the format of *Patient Identifier* to align it with the VAED and VEMD. To do this, data would be right justified and leading zero filled.

Planned Length of Stay, as mentioned previously, was proposed for revision as more guidance was required for assigning codes in this field. The proposed definition of *Planned Length of Stay* was:

'The intended length of stay for this patient taking into account:
- The surgery planned; and
- This patient's clinical and social circumstances.

This should be determined by the responsible clinician at the time the patient is first registered on the waiting list, but it can be revised at any time *before* the admission.'

Planned Length of Stay also includes Hospital In The Home (HITH) days.

In order to clarify their use, it was proposed to revise labels for some *Reason for Removal* codes.

Errata to *Proposals for Revisions to the Elective Surgery Information System (ESIS) for 1.7.2002* were provided as follows:
- Code X – This hospital arranged admission at another hospital *under contract*.
- Code T – Transfer of waiting episode to another ESIS hospital *or campus outside this Health Service*.

Irene noted the proposed revision of the format of *Unique Key* to align it with *Patient Identifier,* as proposed for revision for 1 July 2002, that is, right justified and leading zero filled. It would remain as 8 characters, not 10 as described in *Proposals for Revisions to the Elective Surgery Information System (ESIS) for 1.7.2002*.

Irene discussed proposed changes to ESIS editing, the aim of which was to tighten eliminate incorrect multiple waiting list registrations of the same patient.

It was proposed to strengthen Edit S135 *Patient already on waiting list for same PPP* to reduce duplications. However, this presented problems with procedures classified under 'Other'. One solution was to leave the edit as a 'warning'. Work would be undertaken on expanding the PPP list to reduce use of 'other' categories.

A new Type 1 Rejection edit was proposed to prevent repeated *Unique Keys* for the same patient, eliminating incorrect multiple registrations of the same patient on the waiting list. If the patient needed to be on the waiting list for multiple procedures, each registration would need a different *Unique Key*.

The proposed new field, *Date of Procedure*, would require completion if the *Removal Date* is on or after 1.7.2002. A number of edits had been proposed for use with the *Date of Procedure* field:

Rejection Edits

- Present when not required
  The record has a *Registration Date* on or after 1 July 2002 but the *Reason for Removal* is not W (Admitted to this hospital for awaited procedure).
- Invalid Date
  The record has a *Registration Date* on or after 1 July 2002 and the *Reason for Removal* is W (Admitted to this hospital for awaited procedure).
- Not logical sequence with *Removal Date*
  The record has a *Registration Date* on or after 1 July 2002 but the date in the *Date of Procedure* field is earlier than *Removal Date*.

Warning Edits

- *Date of Procedure* not = *Removal Date* but *Planned Length of Stay* = Same Day
  The record has a *Registration Date* on or after 1 July 2002 and the date in *Date of Procedure* is later than *Removal Date* but the *Planned Length of Stay* is 1 (Intended Same Day). This could be correct if, for example, the patient unexpectedly needed to stay overnight or longer.
- Missing when required
  This record has a *Registration Date* on or after 1 July 2002 and *Date of Procedure* is blank but *Reason for Removal* is W (Admitted to this hospital for awaited procedure). This will occur if admission occurs before a Census Date but the first procedure occurs after the Census Date.

Some edits proposed for use with the proposed new field, *Intended Treatment Campus* were discussed*:*

Rejection Edits

- Missing when reported by Health Service
  This record has been reported by a Health Service but the *Intended Treatment Campus* field is blank. Health Services must report the code for the *Intended Treatment Campus*.
- Present when not reported by Health Service
  This record has been reported by a Health Service but the *Intended Treatment Campus* code is not valid.

It was proposed to introduce a Type 1 rejection on the existing field, *Transfer Destination* to ensure only valid codes were entered.
It was proposed to introduce two Type 1 rejections on the existing fields, *Booking Number* and *Booking Date*. These edits would prevent incompatibility between these fields, ensure consistency, occur where the episode had a *Booking Date* but no *Booking Number* (it is blank or zero) or when the episode had no *Booking Date* but has a *Booking Number*.

The proposal to edit the relationship between *Clinical Urgency* and the fields *Date Last Clinical Urgency Increase* and *Urgency Reassignment Date* was discussed. The proposal was to ensure consistency between these fields by introducing two Type 1 rejections where fields were missing dates.

The proposal to include a warning edit on the fields *Booking Number* and *Reason for Removal* was discussed. The warning would occur if the *Reason for Removal* code was F (Failure of the patient to arrive for treatment) and the *Booking Number* was low (1 or 2) as it would not be appropriate to remove a patient from the waiting list for failing to arrive for treatment on the first or second occasion.

The final proposal discussed by Irene was the Type 1 rejection edit on *Patient Listing Status* and *Status Reassignment Date,* which would prevent incompatibility between these two fields.

5 Other ESIS Business

Mark Gill noted the National Health Data Committee (NHDC) had decided that recording of dates of all procedures would not be mandatory at this stage. It was agreed that different approaches to the recording of procedure dates that jurisdictions have or are adopting, would be assessed before national reporting requirements were decided.

Associate Professor Colin Russell noted the importance of being able to map any changes back to the original 3 categories of *Clinical Urgency,* noting that, when there is a choice of three categories, it is human nature to select the middle category. He said Category 1 was working well, and should not be altered; the problems were with Category 2. With the proposed changes, the true Category 2 patients would appear as Category 2A. Mark Gill queried whether it was intended that an urgency re-assignment be recorded when the new categories were introduced.

Peter Barnett (Royal Children's Hospital) asked what action was planned to address the findings of Neil Currie's EDIS project. Neil's work at DHS was concluded, however, the project had raised issues that were being considered by the Homer replacement project. The project had identified change as necessary, the findings had been presented to chief information officers, and it was intended that they also be presented to hospital CEOs.

Tanya Bahro (Royal Women's Hospital (RWH)) commented that the introduction of the *Date of Procedure* field could dramatically increase hospital workload where ESIS and hospital theatre systems don't interact. She said that RWH already collected DOSA rates at almost 100% accuracy and that the hospital would have to add 0.5 EFT to match the procedures with ESIS. Tanya suggested including this in the Homer replacement project, and making the field voluntary for DOSA 2002—2003.

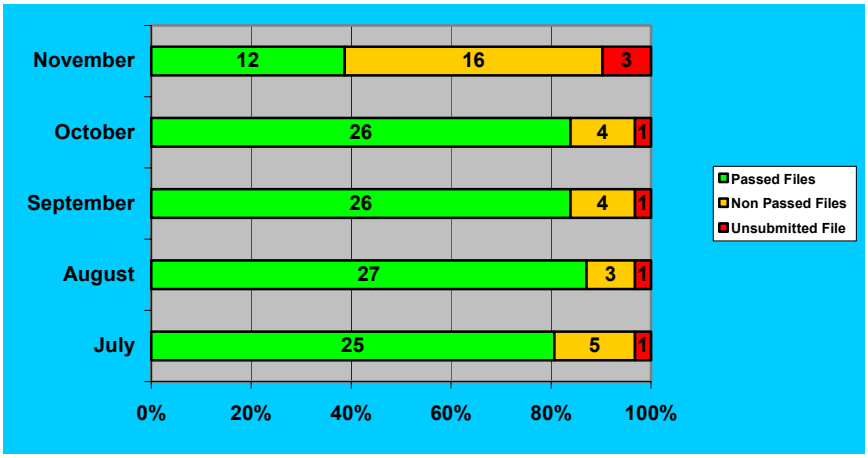
A further query concerned how the system would handle a patient admitted for two procedures. Andrew Rothfield commented that some software companies found it difficult to build the changes into their systems, noting the complexity and cost to combine the separate theatre systems with ESIS. He stated most agencies were currently collecting the data manually and suggested this may need to continue for another year.

Further suggestions and comments should be directed to the HDSS Help Desk.

6 VEMD Information Update

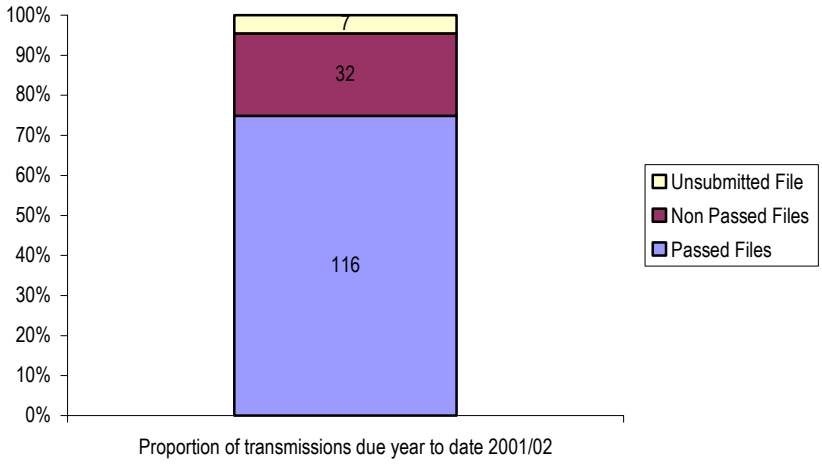
Anna Cooper, HDSS, DHS, reported on data transmissions to the Victorian Emergency Minimum Dataset (VEMD) for 2001—2002 to date, noting 31 hospitals were then reporting to the VEMD, of which 30 had submitted data to the end of October, and 28 had also submitted November data. The hospital yet to submit any data was undergoing testing. A few hospitals were yet to successfully transmit data for all months in the year to date.

VEMD 2001—2002 SUBMISSION PROGRESS



Presenting year to date data transmissions as percentages of total data expected showed the few sites yet to complete data transmissions represented a small proportion of all data.

VEMD Transmissions 2001 - 2002 YTD



The average number of file submissions per site per month for the current and previous financial years was presented, showing the average number for the current year ranged from 3 to 5, compared with up to 6 last year. Some hospitals had successfully completed their data with one submission.

Average Submission Attempts Until Pass VEMD

Month	01/02	00/01
July	5	5
August	4	6
September	4	5
October	3	4
November	3	2

Of the 5 most common VEMD edits for the year to date, 2 were warnings (080 & 339). None of these edits had been in the top 5 the previous year. The inpatient bed request details had caused a few problems, with beds being requested after the patient's discharge, or before they entered the Emergency Department.

VEMD 2001—2002 MOST COMMON EDITS

Rank	Edit #	Edit Description	Incidence YTD
1	80	Medicare Number Blank	149,064
2	52	Campus Code Does Not Match File Name	12,330
3	339	Inpatient Bed Request and Departure Status Combination Invalid	8,203
4	333	Inpatient Bed Request Time Invalid	7,995
5	331	Inpatient Bed Request Date Invalid	7,838

Anna commended those hospitals submitting VEMD data for the improvements noted.

7 Proposals for Revision to VEMD

7.1 Proposal # 8 – Submission & Processing Modification

Peter Darby, DHS, discussed the proposed change to VEMD data submission and processing.

The VEMD processing configuration at the time involved the following:

- Hospitals transmit monthly VEMD data to DHS
- DHS processes the file to identify any rejections and warnings
- A file containing rejections and warnings is returned to the hospital
- Hospital reviews file and corrects errors
- Hospital then retransmits entire month's file
- This process continues until the hospital has corrected all data.

Peter outlined the proposal for hospitals to send an initial file of the month's data, then to send only corrections to complete the month's data. Episodes submitted without error would be stored by DHS as completed data without the need to retransmit with resubmissions. The modification to the submission process would dramatically reduce the number of records submitted, memory requirements, and processing time.

7.2 Proposal # 1 – Admission Status

Bernadette O'Connell and Jane Fewings, Funding Policy Unit, DHS, presented the proposal for *Admission Status* to be included as a field within the VEMD.

Bernadette O'Connell explained the Emergency Services Categorisation and Funding Taskforce reviewed staffing and activity data, categorising hospitals annually to establish their non-admitted emergency services grant. Other emergency service funding sources included WIES funding for patients admitted through emergency departments, and other hospital-wide grants. The scope and calculation of non-admitted emergency services grants was under review.

Data requirements for emergency service categorisation, and data quality, were major concerns of the review. The current data provided useful information, but were incomplete. The data used for emergency services categorisation needed to be objective and describe both the volume and complexity of patients. Some measures of complexity were the percentage of patients admitted and the average WIES weight of admitted patients. Achieving a more precise account of emergency admitted and non-admitted patients was an important element in striking a balance between the availability and output components of the grant. Clarity would also assist hospitals' internal allocation processes in directing funds to emergency departments.

Jane Fewings explained it was proposed that the *Admission Status* of Emergency Department patients would be determined by matching emergency and inpatient episodes using UR numbers and date/time.

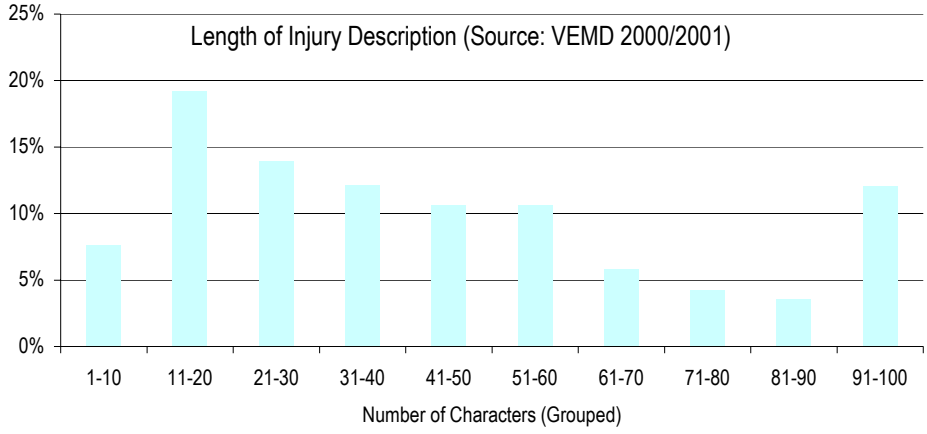
7.3 Proposal # 2 – New Diagnosis Code

Peter Barnett, Director of Emergency Department, Royal Children's Hospital presented the proposed revision to the current VEMD ICD-10-AM diagnosis code reference file: deletion of the existing diagnosis code *Q688 Subluxation of Radial Head* and introducing a new diagnosis code *S5319 Dislocation – Pulled Elbow (Subluxation of Radial Head)*, would involve modification of the *Nature of Main Injury*/*Body Region* and *ICD-10-AM Matrix*.

7.4 Proposal # 3,4,5,6,9,10,11

Greg O'Connell, HDSS, DHS, presented the proposed revisions to VEMD data items *Description of Injury Events*, *Diagnosis – Primary*, *Diagnosis – Additional Diagnosis 1* and *2*, *Departure Transport Mode* and *Departure Status*. The data items proposed for deletion, *Inpatient Bed Request*, *Body Region* and *Nature of Main Injury*, were also discussed. The aim of the changes was to eliminate redundancy in the dataset and improve data quality.

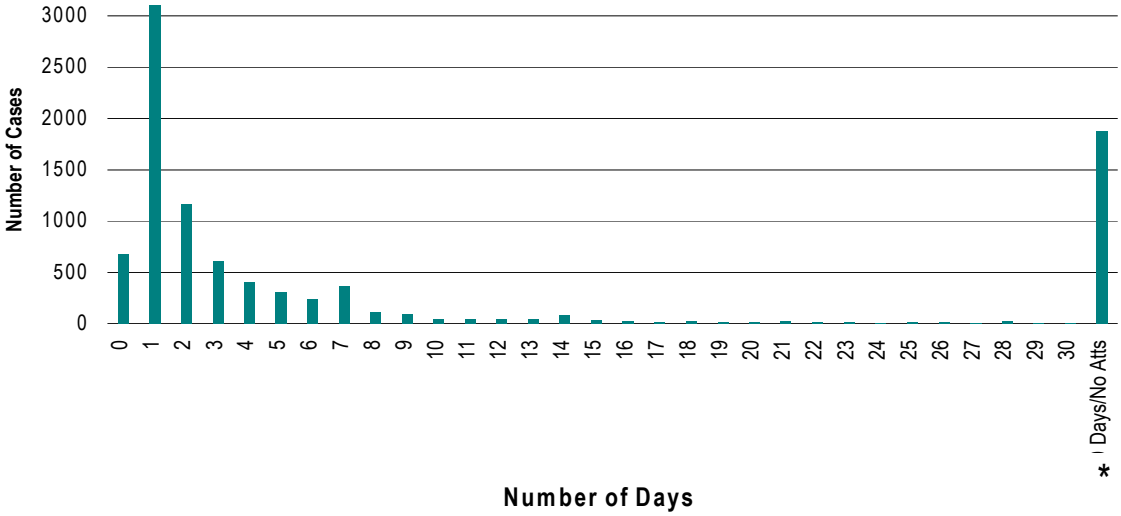
In 2001 – 2002, about 31,000 (12%) VEMD episodes had their injury descriptions truncated at the 100th character, so detailed descriptions recorded by hospital staff did not reach data users.



Greg commented there was no technical barrier to receiving the full injury description, and proposed to increase the size of the *Description of Injury Event* field from 100 to about 250 characters. He indicated increasing the field size would not add work for collection staff; would enable better use of data and provide more comprehensive and complete descriptions to VISAR (Victorian Injury Surveillance and Applied Research).

Greg outlined the revisions proposed to the fields *Primary Diagnosis* and *Additional Diagnoses 1* and *2*. Currently, the diagnosis code most commonly submitted to the VEMD was *Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment*. Greg noted that over 20% of all episodes with a *Primary Diagnosis* of 'Review' did not appear to have a previous Emergency Department attendance:

VEMD 2001—2002
NUMBER OF DAYS BETWEEN PREVIOUS ATTENDANCE AND REVIEW



** Greater than 30 days, or no previous attendance.*

In addition to this, the code does not specify the condition being reviewed, thus not adequately reflecting the complexity and diversity of the work undertaken in Emergency Departments. It was proposed that entering a *Primary Diagnosis* of 'Review' would require an Additional Diagnosis to identify the condition under review. A complicating factor was the use of Emergency Departments for reviews of former patients of admitted units, rather than for review of Emergency Department attendances. However, this problem may be resolved by clarifying the *Referred By* and *Type of Visit* fields to better measure the use of Emergency Departments for inpatient unit reviews.

Revision of the *Departure Transport Mode* field, as VEMD Proposal 5, was intended to ensure completion of this field only if the *Departure Status* was 4 – Transfer from this hospital to another hospital. The field should remain blank in all other circumstances. Based on this clarification, irrelevant *Departure Transport Mode* codes proposed for deletion were:

- 6 – Public transport, includes council (the other descriptors remain)
- 9 – Undertaker

Since the Proposals had been released, a number of hospitals had demonstrated the need for code 8 – Police Vehicle, to remain as a valid code. Some sites were reporting *Departure Transfer Mode* for patients that were dead on arrival (DOA). The proposed revision would mean that the *Departure Transfer Mode* field would be left blank for all DOAs.

Greg outlined VEMD Proposal 6, which involves revisions to two fields, *Diagnosis – Primary* and *Departure Status*. Some 13% of VEMD episodes with a *Departure Status* code 6 – Left before being seen by a doctor (or definitive service provider) were submitted with diagnosis codes. Greg noted, by definition, absconders (*Departure Status* code 6) left before being seen by a clinician and therefore a final diagnosis was not possible. The revisions proposed either having no diagnosis or a default diagnosis indicating the patient had not waited to be seen.

Proposal 9 was to delete the VEMD field *Inpatient Bed Request,* as it was redundant since all the information was already contained in the *Bed Request Date/Time* fields, and many sites did not collect this item, instead generating it at the point of extraction.

Proposals 10 and 11 were to delete two data items, *Body Region* and *Nature of Main Injur.* These redundant items were duplicated, to some extent, in the *Diagnosis* fields. The data items also added unnecessary layers of complexity to the collection and validation of the data and underlying database programming at each site, and were also a source of many errors.

It was proposed, with some minor modifications to the injury diagnosis data items to ensure a 1:1 relationship, the *Body Region* and *Nature of Main Injury* fields could be mapped from the *Diagnosis* fields. However, feedback suggested making these changes to the VEMD was a much larger undertaking than initially thought. The changes involved substantial reprogramming for some software vendors and would also involve revising codes for a large number of VEMD-ICD10 diagnoses and a further drift away from strict ICD. There was also a degree of concern from some hospitals about some software suppliers' capacity to make these changes while maintaining the existing front-end. End users may also have costly adaptations to make.

7.5 Proposal # 7 – Time to Treatment Calculation

David Pickersgill, Clinical Data Co-ordinator, The Alfred Hospital Emergency and Trauma, presented information on the proposal to revise the business rules for the calculation of *Time to Treatment*.

The *Time to Treatment* was a derived value, used to monitor the time between admission (attendance at an Emergency Department) and the first treatment undertaken for that patient, but with apparently no single, clear definition for 'treatment', and variations between service providers. David reported the *Time to Treatment* for Medical Officers was the first time the patient was assessed after the decision to Triage, while nurses were deemed to have treated a patient if they performed baseline observations after the decision to Triage.

One shortcoming of this definition was that a nurse may perform a procedure, such as an ECG, on a patient, but if a medical officer subsequently assessed the patient, the procedure performed by the nurse was not counted in the *Time to Treatment* calculation. However, if a medical officer performed the same procedure after the initial assessment, it could be included in the calculation. The procedure was the same, but the outcome was quite different.

The proposed change to the business rule for calculating the *Time to Treatment* focused on the actual time between the initial triage process and the time assessment or treatment commenced, regardless of who provided the service. Because it was a derived value, this proposal would not affect hospitals' operational practice and there would be no adverse effect on performance indicators.

David commented that, unless a hospital had a strict policy of medical officers assessing patients before the nursing staff, the result should be reduced *Time to Treatment* performance indicators. The only change would be in the calculation process carried out by the individual hospital data collection officer. It should be easier to calculate the Time to Treatment under the proposed new business rules.

8 Other Business – Morning Session

Mark Gill invited those present to raise items of other business, or to discuss further proposals raised earlier.

It was suggested that *Description of Injury Event* could be collected from the internal triage description, reducing the amount of text sent. However this may not be appropriate for inclusion in a state-wide database due to the large variation in the data collected across sites, and that sometimes identifiers appeared in this field, which tended to happen less in the injury description. With good software implementation, staff could enter the appropriate information once, with Triage Description in one field and Injury Description in another, without duplication. The software would ensure that both pieces of information were available to relevant users.

Mark Stokes from VISAR, stressed the importance of collecting the salient points relating to injury as this information was valuable for injury prevention, giving as an example a recent campaign where VEMD data highlighted the dangers of scooters, leading to changed purchasing patterns and reducing scooter injuries.

It was confirmed that Proposal 3 was a revision of an existing field, not the introduction of a new one, whereas Proposal 1, *Admission Status*, was a new field. Further discussion sought to clarify how it would be completed, with some variation of data source apparent between sites. Some felt this information was already collected from the *Departure Status* field, depending on the set-up of the information system, with some sites still automatically processing under the '4 hour rule'. It was noted that gathering the data for this proposed new field could avoid duplications caused when emergency patients do not go to the ward, and that this may also be the cleanest option for ensuring the data are available for important funding needs. The existence of different care modes within the Emergency Department, including Short Stay Observation Unit, was acknowledged. It was suggested there was some difficulty determining who made the decision to admit, and when that was reported.

Proposal 4, *Diagnosis – Primary,* in regard to the use of Review codes, was discussed further: it was suggested the field *Type of Visit* be used to gather data on review visits, and the proposal to gather an additional diagnosis would then be redundant. It was suggested that the proposed revision would result in more work on the software, but not resolve the problem, as there was not a strong correlation between *Diagnosis*, *Type of Visit* and *Referred By*.

Proposal 7, *Time to Treatment*, was discussed further: it was suggested the proposed change may corrupt the data and have implications on waiting time as more Category 4 and 5 patients would be seen within the first 10 minutes. It was noted, however, that there was room for corruption under existing arrangements, and that the proposal sought to remove the inequity in the system, especially with regard to Category 2, which included many cardiac patients.

9 Close – Morning Session

Mark Gill closed the morning session of the Forum, thanking all those in attendance.