

Admitted Patient  
Entry & Transmission  
(APET) System  
July 2006

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# Introduction

The Admitted Patient Entry and Transmission (APET) software has been developed for hospitals that require a simple data entry system in order to transmit data to the VAED in the current file format. The system can be used either as a temporary measure or a long-term solution.

Facilities enter episode and diagnosis data into the APET system via the internet. APET will generate a file that is emailed to the Health Data Standards and Systems (HDSS) Unit of the Department of Human Services. The file is forwarded to the Facilities Manager for processing, and the reports generated from the process are despatched to the facility.

APET is not a Patient Management System; it is simply an interface between the health care facility and the PRS/2 processing system. It provides limited editing and users must correct errors and verify data using the control report. APET presents users with drop-down menus containing relevant VAED code sets without descriptors. To minimise errors and ensure quality of data, users should become familiar with the *VAED Manual 16<sup>th</sup> Edition*, especially Section 3: *Data Definitions*. To maximise efficiency, it is recommended that an admission form with the VAED data items in a similar sequence to the APET layout be utilised.

It is important to note that as APET is designed to be compatible with a diverse range of requirements from a variety of facilities it is therefore not feasible to tailor individual data items to the requirements of specific users.

This manual must be used in conjunction with the *VAED Manual, 16<sup>th</sup> Edition, 1 July 2006*, which provides detailed definitions and code sets for each of the VAED data items.

## Data Entry and Transmission Responsibility

Refer to the *VAED Manual, 16<sup>th</sup> Edition*, Section 5: *Compilation & Transmission* and Section 7: *Control Reports & Reconciliation*.

A hospital may transmit data to the VAED database as frequently as desired but must meet the minimum requirements set out in Section 5 of the VAED Manual.

It is necessary for the facility to extract the entered data on a regular basis and submit for processing through the PRS/2 interface. Once the extract has been processed a Transmission Report will be forwarded to the appropriate health care facility. This report will allow the facility to identify any record containing incorrect or suspicious data, providing the opportunity for corrective action to be taken.

Data may be entered progressively or all at one time at the end of a month. It is recommended that facilities enter data on a daily basis. This will help ensure that:

- all admissions are entered into the APET system
- files/cards are returned to storage as soon as possible after the compilation of the episode
- facilities do not have a backlog of data entry at any given time (allowing for periods of extreme activity or staff leave periods).

## Security of Data Entered

The facility's Hospital Code identifies the data entered in the VAED database. Access to the APET system is restricted by a User Login and Password that is exclusive to each individual site. The Health Data Standards and Systems (HDSS) Unit authorises access to the APET system.

Access to the AIMS and APET website is gained via the same website [<https://www.healthcollect.vic.gov.au/index1.htm/>] however, the two systems have different logins and passwords.

## Contacts

For general assistance in using this interface and queries relating to PRS/2 and the VAED, please contact the Health Data Standards and Systems (HDSS) HelpDesk:

Phone (03) 9096 8141  
Fax (03) 9096 7743  
Email [HDSS.HelpDesk@dhs.vic.gov.au](mailto:HDSS.HelpDesk@dhs.vic.gov.au)

**For queries relating to PRS/2 data transmission** (for example, those relating to the whereabouts of output reports) contact the VAED facilities manager:

*The Facilities Manager* ☎ 9541 7575  
*one response network* ☎ 1800 331 946 (Country Areas)

[Help\\_desk@thepayoffice.net](mailto:Help_desk@thepayoffice.net)

The APET User Manual may be downloaded from:

<http://www.health.vic.gov.au/hdss/apet/index.htm>

## Abbreviations Used In This Manual

AIMS	Agency Information Management System
APET	Admitted Patient Entry & Transmission System
BIS	Barthel Index Score
DVA	Department of Veteran's Affairs
E3	Episode Record
FYTD	Financial Year-To-Date
H3	Header Record
HDSS	Health Data Standards and Systems Unit
ICD—10—AM	International Statistical Classification of Diseases and Related Health Problems, 10 <sup>th</sup> Revision, Australian Modification, Fifth Edition
IT	Information Technology
MTD	Month-To-Date
PRS/2	Patient Reporting System, Version 2
RUG ADL	Resource Utilisation Groups – Activities of Daily Living Score
S3	Sub-Acute Record
TAC	Transport Accident Commission
T3	Trailer Record
U3	Trailer Record
UR Number	Unit Record Number
V3	Department of Veteran Affairs' or Transport Accident Commission Record
VAED	Victorian Admitted Episode Dataset
X3	Diagnosis Record
YTD	Year-To-Date
the Department	Department of Human Services

# Overview of the APET System

## System Editing

The APET system performs simple editing checks, such as those listed below, to ensure only valid codes can be entered into data fields:

- Existence of codes in reference files
- Field lengths
- Existence of entries into mandatory data items.

The system does not perform complex editing or data verification such as cross editing between data items, potentially allowing invalid combinations of data. For example, it does not cross edit diagnosis code against a patient's age or sex. Therefore, it is important for APET users to ensure a high degree of accuracy during data collection and data entry.

Facilities must check data quality and investigate errors by examining the control reports generated by processing.

A detailed list of edits is available in Section 8: *Editing* of the VAED Manual.

## Data Extraction

Once data entry is complete, use the *Create Transmission File* option to generate a file in the format required by the PRS/2 system. Once complete, this file is automatically emailed to the HDSS Unit, and is then forwarded to the Facilities Manager for processing.

A transmission file should be created at least once per month, in accordance with data deadlines described in Section 5: *Compilation and Transmission* of the VAED Manual. However, transmission files may be created more frequently, and may contain data for part or all of a month.

## Processing and Report Delivery


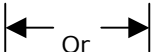
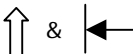



Your file is processed through the PRS/2 system and data is added to a central database. A control report, and any request reports that you have selected, will be generated and despatched to your facility. Reports may be posted or couriered. Contact the Facilities Manager to discuss report delivery.

## Getting Started – System Specifics

### Definitions

- Form** Refers to the screen or set of screens for each record type (E3, X3, S3 and V3), where the individual data items are entered.  
(See *VAED Manual* for information on Record Types).
- Record** Refers to: A patient episode that has been entered into the APET system and/or a PRS/2 record type, that is an E3, X3, S3 or V3.

### Moving Around the Forms

Key / Tool		Action
Mouse		To move between data items, Tabs (screens) and Forms.
Tab Key		To move between data items
Shift and Tab Keys together		To go back to the previous data item
Enter		Do Not Use, as will SUBMIT the form to the database
Arrow Keys		To move between Tabs within a form and between characters within a data item
Back Space		To delete an incorrect entry
Delete	Del	To delete an incorrect entry

### Drop Down Menus

The drop-down menus on the forms display a choice of the valid codes that can be selected using the mouse. The code descriptors are not provided in the drop down menus; users should refer to the Section 3: *Data Definitions* of the *VAED Manual* for comprehensive definitions of the VAED code sets and descriptors.

It is recommended that an admission form, with the VAED data items in a similar sequence to the APET layout, be utilised to ensure that data entry into the APET system is as straightforward as possible. It is suggested that the Unique Key is recorded on the admission form to enable the appropriate record to be found easily in the APET system.

## To Save and Close a Form

There are two options to save data in APET, using buttons displayed on each form:

- 1      SAVE            Allows the user to save the form as displayed on the screen and to remain in the current record.
- 2      SUBMIT          Allows the user to save and close the form. The Submit button returns user to the main menu.

Certain data items are compulsory and you will not be able to save nor submit the record until values have been entered into those fields. Refer to the list of mandatory data items in Appendix A.

If a Unique Key does not appear in the drop-down box on the main menu and the subsequent Unique Key is not displayed in the new E3 record field, the record was not accepted into the APET System and needs to be re-entered to ensure acceptance.

## Printing Forms

Each form (Episode, Diagnosis, Sub-Acute and DVA/TAC) can be printed by selecting the Print tab. This action will load the form into Adobe Acrobat. Select Print from the tool bar.

Press the Back tab to return to APET.

Note: Save the data on the form before printing to ensure data is not lost.

## Exit APET

To exit the APET application, simply browse to another website or close the internet browser.

## Date and Time formats

Dates must be entered in the DDMMCCYY format. The extraction process will convert date to VAED format (refer to Section 3: *Data Definitions* in the VAED Manual). Characters such as dots, hyphens or slashes must not be used.

Times must be entered in the HH:MM format, i.e. a colon is required between the hours and minutes. Characters such as hyphens, dots or slashes must not be used.

## Accessing the APET System

The APET System can be accessed as detailed below:

- Log on the Internet.
- Enter the address <https://www.healthcollect.vic.gov.au/index1.htm>  
This will take you to the Health Collect Home page.
- Click on the link APET On-Line Entry, located on the left side of the screen.
- Logon to the site using the allocated login and password codes.  
(Please note that the APET system will automatically log you out if no activity has been recorded after one hour.)
- Click on the APET folder, which should expand to reveal a direct link to APET.
- Click on this link to open the Record Selection Menu.

### Note:

Until the final consolidation of the previous financial year's admitted patient data on 21 September facilities will be able to access the APET Online Systems for both the current and previous financial year.

Please ensure that admitted patient data is being entered into the appropriate system. That is,

Separation prior to 1 July 2006

Entered into 2005—06 APET Online System

Separation on or after 1 July 2006

Entered into 2006—07 APET Online System

## Entering Data

State Government of Victoria, Australia, Department of Human Services  
Victorian Government Health Information  
Health Collect Home  
Admitted Patient Entry and Transmission (APET) System 1 July 2006 - 30 June 2007

**Record Selection Options**

Please make a selection from the drop down list of Agencies...

Agency: A Sample Campus

Select an existing record type from the options below...

Episode E3  
 Sub Acute S3  
 Diagnosis X3  
 DVA/TAC V3  
and a Unique Key...  
00000018

Or

Create New Episode E3  
with this Unique Key, or type in your new Unique Key...  
00000019

Then...  
Get Record

Or...  
Create Transmission File

Or...  
Rollback previous transmissions  
From: 12 July 2006 To: 12 July 2006  
Roll Back Transmission File

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From this screen the user can:

- Enter a new E3 Record
- Access an existing E3 Record for amendment
- Enter or Access a X3 Record for an existing E3 Record
- Enter or Access a S3 Record for an existing E3 Record
- Enter or Access a V3 Record for an existing E3 Record
- Roll back the extract dates to allow the re-extraction of previously submitted data
- Create a Transmission File.

## Functions of the Main Menu

### Record / Form Type

To select the Record Type you would like to enter or edit:

<b>E3</b>	Episode Record	[demographic & episode specific data]
<b>X3</b>	Diagnosis Record	[diagnosis & treatment data]
<b>S3</b>	Sub-Acute Record	[rehabilitation & palliative care data]
<b>V3</b>	DVA or TAC Record	[DVA or TAC data]

(Refer to the Section 5: *Compilation and Transmission* of the VAED Manual for Record Type Definitions.)

### Record Selection

The screen has a drop down menu that details the Unique Keys for all the E3 records that have been accepted into the APET system. If a Unique Key is not listed in the selection the record has either:

- Not been entered into the APET system; OR
- The submission was not accepted due to an error on the form.

The missing form will need to be re-entered to ensure that the admission is accepted into the APET system.

## Entering a New Episode (E3) Record

- From the main menu select *Create New Episode E3* with this Unique Key, or type in your new Unique Key...
- APET will display an initial nine-character Unique Key, as per system specifications. User can either opt to allow APET to allocate a progressive Unique Key to each E3 Record or type in their own Unique Key based on facility's specifications. Note that if the Unique Key is less than nine characters it must be right justified and filled with leading zeroes.

If you have entered anything other than a nine-character value, an error message will be displayed. Note: the Unique Key is not the same as the Patient Identifier or UR Number.

Once you have selected the first Unique Key, APET will automatically allocate subsequent Unique Keys in sequential order, providing the Unique Key is numerical and can be allocated in sequential order.

- Select *GET RECORD* and the E3 Record form will appear.

The screenshot shows the 'Episode (E3) Form' in a web browser. The form is divided into several sections:

- Header:** Includes 'Campus Name' (A Sample Campus), 'Campus Code' (9999), 'Unique Key' (000000019), 'Patient ID', 'Admission Date', and 'Separation Date'.
- Admission Details:** Contains fields for Admission Time, Intended Duration of Stay, Sex, Marital Status, Locality, Postcode, Date of Birth, Country of Birth, Indigenous Status, Preferred Language, Interpreter Required, Admission Type, Admission Source, Transfer Source, Insurance Level, Health Fund, Medicare Number, Medicare Suffix, Admission Criterion, Care Type, and Mental Health Patient ID.
- Separation Details:** Contains fields for Account Class, Accommodation Type, Qualification Status, Patient Days MTD, Patient Days FYTD, Patient Days Total, Account Class on Separation, Accommodation Type on Separation, ACAS Status, Leave With Permission Leave Days MTD, Leave With Permission Days FYTD, Leave With Permission Days Total, Leave W/o Permission Leave Days MTD, Leave W/o Permission Days FYTD, Leave W/o Permission Days Total, Contract/Spoke Identifier, Contract Leave Days MTD, Contract Leave Days FYTD, Contract Leave Days Total, Palliative Care Patient Days, Mental Health Legal Status, Separation Time, Separation Mode, Intention To Re-Admit, Transfer Destination, Separation Referral, Career Availability, Funding Arrangement, Contract Type, and Contract Role.
- Status Segments List:** Includes buttons for 'Add Item', 'Remove Item', 'Move Item Up', 'Move Item Down', and 'Remove all Items'.
- Footer:** Includes 'Print', 'Delete', 'Save', and 'Submit' buttons.

## Enter E3 Admission Details

- Enter the Patient Identifier, Admission Date and Separation Date (if the patient has been separated).

Note: The Patient Identifier (or UR Number) is a ten character value; leading zeroes must be used to fill the designated field length. For example, a Patient Identifier of '12345' must be entered as '0000012345'.

- Enter values for all data items relevant to your facility. Some data items are compulsory and you will not be able to save or submit the form until those items have been entered.

## E3 Status Segment Details

The Status Segment (refer to Section 5: *Compilation and Transmission* of the VAED Manual) is determined by the data entered into the following data items:

- Account Class
- Accommodation Type
- Qualification Status
- Patient Days MTD
- Patient Days YTD
- Patient Days TOTAL.

A patient may have more than one status segment during their stay. For example, if a patient moves from a shared to a private room, the number of days spent in each accommodation type will be reflected in two status segments.

- At least one status segment must be entered. Enter the Account Class, Accommodation Type and Qualification Status applicable at the time the patient was admitted.
- Enter the appropriate month-to-date, financial year-to-date and total Patient Days, for this combination of Account Class, Accommodation Type and Qualification Status. (For same-day admissions the count for all three Patient Day fields will be 1 – see below for explanation.)

Patient Days are calculated by subtracting the Admission Date from the Separation Date except for patients admitted and separated on the same date who are assigned 1 patient day. This means that for patients admitted and separated on different dates, the date of separation is not counted as a patient day.

For example, for a transmission file with header dates 1/8/2006 – 30/8/2006:

Admission Date	Separation Date	MTD	YTD	TOTAL DAYS
29/07/2006	02/08/2006	3	4	4
28/06/2006	07/07/2006		6	9
27/08/2006	Remaining in	4	4	4
04/08/2006	04/08/2006	1	1	1

- Select Add To List. All the details for this combination of data items, or Status Segment, will appear in the white box.
- Repeat for each different combination of Account Class, Accommodation Type and Qualification Status for the episode. This means that if at any time any one of the Account Class, Accommodation Type or Qualification Status data items change, another status segment must be created, indicating the patient days accrued for the new combination. (For same-day admissions there will be only one Status Segment entered.)

Note:

- Only days accrued before and between the transmission start and end dates should be recorded in the MTD figure. For example, a July Transmission (end date 31/07/2006) should not include patient days for August.

- Only days accrued after and including the commencement of the financial year (1 July) should be recorded in the YTD figure. For example, an August Transmission (end date 31/08/2006) should not include patient days for June but should include totals for days in July and August.
- All days accrued during an admission episode should be recorded in the TOT figure. For example, a July Transmission (end date 31/07/2006) for an episode with an Admission Date in April should include a count of patient days for April, May, June and July.
- The patient's length of stay for this episode should equal the sum of the patient days for each status segment.
- An incorrect status segment can be deleted by using the *REMOVE ITEM* button. Using the mouse, select the incorrect segment and then the Remove Item button.

## Dealing with Multi-Day Patients

APET does not have the capability to automatically update E3 episodes for patients that do not have a Separation Date, for inclusion in the next extraction file.

It is therefore necessary to edit each applicable E3 record (patients admitted in previous months and still remaining in as admitted patients) and update the status segment(s) to reflect the appropriate patient day counts. Patients can be identified through hospital or PRS/2 Census Reports (a census report is included with every Transmitted Transaction Report returned to the facility. Facilities should ensure that details for patients listed are updated as appropriate for subsequent month's extractions.

- Open applicable record.
- Highlight the status segment already entered into the record.
- Delete the existing status segment.
- Generate a new status segment(s) reflecting the appropriate counts for the patient days for:
  - month to date
  - year to date
  - total
- Add in the new status segment(s).
- Submit the amended record.

## Entering Diagnosis (X3) Details

Diagnosis (X3) records must be created once the patient has been separated. The E3 Record must be completed prior to entering the X3 Record. (Refer Entering a New E3 Record, page 10)

- From the main menu select the Diagnosis X3 option from the selection given under the heading: Select an existing record type from the options below...
- Select the appropriate Unique Key from the drop down menu. Only Unique Keys of submitted and accepted E3 Records will be listed in the menu.
- Once you have selected the appropriate Unique Key, Select *GET RECORD* and the X3 Record form (as displayed below) will appear.

The screenshot shows a web-based form titled "New Diagnosis (X3) Record". At the top left is the "VICTORIA" logo. The form contains several input fields: "Patient Name" (with a dropdown), "Patient ID" (with a dropdown), "Admission Date" (with a date picker), and "Discharge Date" (with a date picker). Below these are "Print", "Cancel", "Save", and "Submit" buttons. The main section is divided into three columns. The first column is "Diagnosis Codes List" with an "Add" button and a list box. The second column is "Procedure Codes List" with an "Add" button and a list box. The third column contains three input fields: "Admission Weight", "Duration ICU Stay", and "Hospital DRG".

- Using the mouse or tab key, place the cursor in the Diagnosis Code field. Enter the ICD—10—AM diagnosis code and select Add to add the Diagnosis Code, the code will then appear in the Diagnosis Code List. The first code in the list represents the Principal Diagnosis and must be prefixed with P.

Continue to add diagnosis codes to the list by clicking in the Diagnosis Code field, entering the code (including the prefix) and selecting Add.

- Using the mouse or tab key, place the cursor in the Procedure Code field. Enter the ICD—10—AM procedure code and select Add to add the Procedure Code, the code will then appear in the Procedure Code List.

Continue to add the procedure codes to the list by double clicking in the Procedure Code field, entering the code and selecting Add.

## Editing diagnosis and procedure codes

The following tools buttons may be used to edit the diagnosis and procedure codes:

### **Add (Diagnosis/Procedure Code)**

Enables codes to be inserted in the string of codes in sequence, without re-entering individual codes. Place the mouse in the position that the new code should be inserted and select Insert Diagnosis Code or Insert Procedure Code.

### **Delete (Diagnosis/Procedure Code)**

Enables the deletion of incorrect codes from the list. Place the mouse on the incorrect code and select Delete Diagnosis Code from List or Delete Procedure Code from List.

### **Move Up (Diagnosis/Procedure Code)**

Enables codes to be sequenced higher in the string of codes without re-entering individual codes. Select incorrectly sequenced code using the mouse and select Move Diagnosis Code up or Move Procedure Code up. This option will move the code up one position at a time.

### **Move Down (Diagnosis/Procedure Code)**

Enables codes to be sequenced lower in the string of codes without re-entering individual codes. Select the incorrectly sequenced code using the mouse and select Move Diagnosis down or Move Procedure Code down. This option will move the code down one position at a time.

### **Delete All (Diagnosis/Procedure Codes)**

The Delete All button will delete all the contents of the diagnosis/procedure code box.

## Entering a New Sub-Acute (S3) Record

The E3 Record must be completed prior to entering the S3 Record for separated patients. (Refer *Entering a New E3 Record*, page 10.)

Victorian Private Hospitals and Day Procedure Centres are not permitted to submit an S3 record.

- From the main menu select the Sub-Acute S3 option from the selection given under the heading: Select an existing record type from the options below...
- Select the appropriate Unique Key from the drop down menu. Only Unique Keys of submitted and accepted E3 Records will be listed in the menu.
- Once you have selected the appropriate Unique Key, Select *GET RECORD* and the S3 Record form (as displayed below) will appear.

The screenshot shows a web-based form titled "SubAcute (S3) Form". At the top, there are input fields for "Campus Name" (containing "A Sample Campus"), "Campus Code" (containing "1000"), "Unique Key" (containing "XXXXXXXXXX"), "Patient ID" (containing "XXXXXXXXXX"), "Admission Date" (containing "2007/2006"), and "Separation Date" (containing "2007/2006"). Below these fields are buttons for "Print", "Index", "Save", and "Submit". The main body of the form is divided into two columns. The left column is for "BIS on Admission" and includes dropdown menus for "Class of Sub-program", "Date of Referral", "BIS ADL on Adm", and "Functional Assessment Date". The right column is for "BIS on Separation" and includes dropdown menus for "Class of Sub-program", "Date of Referral", "BIS ADL on Sep", and "Functional Assessment Date". The form is displayed in a browser window with a taskbar at the bottom showing the time as 9:18 AM.

- Enter codes as required.
- Submit.

Details on relevant combinations and data definitions are described in Section 5: *Compilation and Transmission* of the VAED Manual.

## Enter a New DVA/TAC (V3) Record

The E3 Record admission details (as a minimum) must be completed prior to entering the V3 Record. (Refer *Entering a New E3 Record*, page 10).

Victorian Private Hospitals and Day Procedure Centres are not permitted to submit a V3 record.

- From the main menu select the DVA/TAC V3 option from the selection given under the heading: Select an existing record type from the options below...
- Select the appropriate Unique Key from the drop down menu. Only Unique Keys of submitted and accepted E3 Records will be listed in the menu.
- Once you have selected the appropriate Unique Key, Select *GET RECORD* and the DVA/TAC V3 Record form (as displayed below) will appear.



- Enter the DVA/TAC Number, Date of Accident (if applicable) Surname and Given Names.
- Submit.

Note: Date of Accident is relevant to TAC patients only.

Details on relevant combinations and data definitions are described in Section 3: *Data Definitions* of the VAED manual.

## Editing an E3, S3, V3 or X3 Record

Once a record has been edited and the alterations saved to the database, the record will be automatically flagged for transmission to PRS/2 in the next data extraction.

- Open the applicable form, as per previous instructions for entering data.
- Make the necessary amendments and submit the form.

Note: The Patient Identifier (Unit Record Number) cannot be edited after a record has been Saved or Submitted on APET. If an incorrect Patient Identifier has been entered, the record will need to be deleted and re-entered with the correct unit record number. See instructions below on how to delete a record. Separate instructions apply if the record has been sent to PRS/2 or if the record has not been sent to PRS/2.

## Deleting an E3, S3, V3 or X3 Record

### **If the record has been sent to PRS/2:**

If the record has been included in a submission file and was not rejected, then it will exist on the central PRS/2 database. Therefore, a deletion record must be sent in a transmission file to remove it, otherwise it will continue to be counted as an admission by the VAED.

To create a deletion record, open the Episode (E3) form for the patient and fill the Medicare Number field with 9s (i.e. '9999999999'). Press *Submit*. This will cause a deletion record to be added to the next transmission file.

Deleting the E3 record will delete any associated S3, V3 and X3 records from the PRS/2 database

To send a deletion record for a Sub-Acute (S3) record, open the S3 record for the patient and fill the Clinical Sub Program field with 9s.

DVA/TAC (V3) and Diagnosis (X3) records can only be deleted by sending an Episode (E3) record deletion.

E3 Records can be resubmitted, or un-deleted, by removing the 9s from the medicare number and pressing Submit. You can resubmit the record in the same transmission file as the deletion record, but must come after the deletion record, as records are processed sequentially.

### **If the record has not been sent to PRS/2:**

If a record has not been included in a submission file, you can delete the record by opening the applicable form and selecting the *Delete* button.

To delete an E3 record, you must first delete all other records (X3, V3, S3) attached to the Unique Key.

## Extracting Data from APET

From the menu screen of the APET System [Record Selection Options] select the button marked:

### Create Transmission File

This generates the extraction file in the correct format for submission to PRS/2.

Transmission Start Date	Enter the date for the first day of data extract. Format: DDMMCCYY
Transmission End Date	Enter the date for the last day of data extract. Format: DDMMCCYY
Transmission Number	Automatically generated number detailing the number of times data has been extracted from the APET system.

The Start Date will default to the day after the End Date of the previous transmission file. PRS/2 can only process dates following on from the previous transmission (with no gaps), or exactly the same dates as the previous transmission file.

For example, if the last file extracted had header dates 01/07/2006 – 15/07/2006, the next file can only have header dates 16/07/2006 onwards, or header dates 01/07/2006 – 15/07/2006. These are the only two allowable scenarios.

If you wish to resend all data previously sent, refer to the Rollback Function on page 18.

Select *Get TX Form*, which submits the transmission dates and generates the Transmission Form for completion.

The majority of the Transmission Form will be completed automatically based on the information held in the APET database and an analysis of the records identified for extraction.

The following fields must be completed:

Reporting Option	0	Full Transaction Trail, in order processed
	1	Warnings/Rejections/Notifiable records only
	2	Edit messages, then full (accepted) transaction trail

It is recommended that facilities chose Option 0 or 2 when generating extraction files.

Reporting Type Control (Selects options for the Control Report)	E	Electronic Only
	P	Paper Only
	B	Both Electronic and Paper

The default option will be Paper.

**All APET sites must select 'P-Paper'.**

Reporting Type Request	E	Electronic Only
(Selects options for the	P	Paper Only
Request Reports)	B	Both Electronic and Paper

The default option from PRS/2 will be Paper.

**All APET sites must select 'P-Paper'.**

Report 1 through 7	Used to select the production of Request Reports
	01 Diagnosis Outstanding Report
	02 DRGs For Review
	03 Census Report
	04 Sub-Acute Outstanding Report
	05 Hospital in the Home Report

More details on these reports can be located in Section 6: *Request Reports* in the VAED Manual, including the format for the parameters of each request report.

It is recommended that facilities regularly request the Diagnosis Outstanding Report. This report lists the details for Episode (E3) records that do not have a Diagnosis (X3) record accepted in the PRS/2 System. This may be the result of rejection or non-submission of the corresponding X3 record.

Submit the completed Transmission Form. APET will generate the extract file and email it to HDSS. You will receive a message confirming that the email has been sent to HDSS. If a message doesn't appear, the process has failed.

## Rollback Function

The *Rollback previous transmission* function is available on the main APET menu. This function is used when you wish to flag data that has already been sent to PRS/2 in a previous transmission to be sent again in the next transmission file. This function is commonly used by facilities when they are testing PRS/2, but can be used by any site wishing to resend data. All records which have separation dates, or were remaining-in, between the rollback dates selected will be flagged to be re-submitted. You do not have to use the same dates that you rollback for the next transmission file. See the example below.

For example, say you have sent transmission files for July, August and September but then find that most diagnosis (X3) records were rejected in the July file due to a problem with the diagnosis codes used. You can flag all July records (E3 and X3, and S3 and V3 if appropriate) to be re-submitted by selecting the Rollback previous transmission option and entering a start date of 01/07/2006 and an end date of 31/07/2006. Records for all patients separated or in your facility between those dates will be flagged. You must then make corrections to each diagnosis record and submit the record. When you are ready, select *Create Transmission File*. Because you have already sent a September file, you cannot re-use July header dates for your transmission file. You can either use September dates again (as the last file processed by PRS/2), or go on to October dates. If you select October dates, the transmission file will also contain data for October.

If you are in testing mode and are testing July and August data, you may need to resubmit each complete month several times until the month's data is accepted by HDSS. If you send July and the test is rejected, use the rollback function to flag all July records to be re-submitted. Make any corrections required and then create the transmission file using header dates 01/07/2006 – 31/07/2006.

## APET Error Messages

APET will generate an error message during data entry if validation rules are not adhered to. Below are some examples:

### **E3, X3, S3 or V3 error messages**

#### **Must have at least one Status Segment**

Message appears when you try to *Save* or *Submit* a record without at least one Status Segment. Ensure that you click on *Add to List* in the *E3 Status Segment* tab after entering values for all the fields displayed.

#### **You must enter...**

Message appears when you try to *Save* or *Submit* a record but not all of the mandatory fields have been entered. Enter a value for the required fields. Refer to Appendix: Mandatory Data Fields for a list of fields that must be completed.

### **Create Transmission File error messages**

#### **Start and end dates must be in the same month**

When creating the transmission file, you need to specify start and end dates within the same month. Refer to Extracting Data from APET.

#### **Start date must be later than last transmission end date (...)**

The start/end dates for the transmission file must be equal to or later than the start/end dates of the previous transmission file. Refer to Extracting Data from APET.

## PRS/2 Error Messages

The Control Reports provided by PRS/2 following each transmission indicate individual records with rejection, fatal, notifiable and warning edits. When PRS/2 checks a record and finds one or more problems, the Edit Message number or numbers are shown on the report in the far right column. Refer to the VAED Manual Section 7: *Control Reports and Reconciliation* for a guide on how to interpret PRS/2 Transmission [Control] Reports and reconcile these reports, and Section 8: *Editing* for specific details of each edit and action to be taken.

## Appendix: Mandatory Data Fields

Refer to Section 5: *Compilation and Transmission* of the VAED Manual.

### **E3 Records**

Admission Date  
Admission Time  
Intended Duration of Stay  
Sex  
Marital Status  
Locality  
Postcode  
Country of Birth  
Indigenous Status  
Admission Type  
Admission Source  
Insurance Level  
Health Fund  
Medicare Suffix  
Admission Criterion  
Care Type  
Status Segment  
Account Class  
Accommodation Type  
Qualification Status  
Patient Days MTD  
Patient Days FTYD  
Patient Days Total

### **When separated:**

Separation Date  
Account Class on Separation  
Accommodation Type on Separation  
Mental Health Legal Status  
Separation Time  
Separation Mode  
Intention to Readmit

### **Conditional Mandatory Fields**

Transfer Source, if Admission Source equals 'T-Transfer'  
Transfer Destination, if Separation Mode equals 'T-Transfer'

### **Optional for Private Facilities**

Preferred Language  
Interpreter Required  
ACAS Status  
Separation Referral  
Carer Availability

### **X3 Records**

Diagnosis

### **S3 Records**

Note: Private facilities are not permitted to transmit S3 Records

Completion of the S3 data fields is determined by the Care Type of the patient for which the record is being created.

#### Care Type: 2, 6 and 7

Barthel Index Score (BIS) on Admission  
Barthel Index Score (BIS) on Separation  
Functional Assessment Date on Admission  
Functional Assessment Date on Separation  
Clinical Sub Program  
Onset Date  
Admission / Readmission to Rehabilitation

#### Care Type: 8 and 9

Source of Referral  
RUG ADL on Admission  
RUG ADL on Separation

### **V3 Records**

Note: Private facilities are not permitted to transmit V3 Records

Completion of the V3 data fields is determined by the type of record being created.

#### DVA Record

DVA Number  
Surname  
Given Name

#### TAC Record

TAC Number  
Date of Accident  
Surname  
Given Name