

# ***HDSS Forum Notes***

## ***Friday 2 March 2001***

**Venue:** *Ella Latham Lecture Theatre,  
Royal Children's Hospital,  
Flemington Road, Parkville*

**Time:** *10:00am*

**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**

### **1.1 Welcome**

Mark Gill, Acute Health, Department of Human Services, opened the forum and welcomed those present. The Health Data Standards and Systems Unit (HDSS) representatives Irene Kearsey, Joanne McLachlan, Sara Harrison, Jenelle Hurley, Leanne Daking, Jennie Shephard and Anna Cooper were introduced.

Mr Gill advised that Wendy Dickins had recently commenced Maternity Leave and that both Shannon Watts and Sharnie McIntyre had left the Department to venture into other employment streams. The two vacancies created by these departures were identified for interested parties.

## **2 VAED PROPOSALS FOR REVISIONS**

### **2.1 Accommodation Type Changes for Nursery Services**

Dr Andrew Ramsden, Director Neonatal Services, Monash Medical Centre, provided background information on the establishment of the Neonatal Services Advisory Committee and the Data and Information Sub-Committee (DISC).

The DISC has proposed changes to the categories for the Accommodation Type data item collected in the VAED. The current VAED dataset gives no information on infant accommodation. It is envisaged that the proposed changes will assist in the accurate identification of nursery admissions, specifically those admissions to neonatal intensive care units (NICU) or special care nurseries (SCN) for all babies, not just newborns (less than ten days old at the time of admission).

With this change, it will be possible to obtain information from the VAED regarding the utilisation of NICU and SCN beds (currently analysed via manual collection methods for NICU only), identify NICU stays as compared to SCN stays and analyse and determine trends in neonatal service provision.

Additional benefits include the ability to analyse the data provided to match NICU and SCN stays with diagnostic codes to verify appropriate use of neonatal services, identify patterns in length of stay and movements between facilities.

Several edits affected by the proposed changes to the Accommodation Type data item were outlined.

### **2.2 Accommodation Type changes for Short Stay Observation Units and Medical Assessment and Planning Units**

Sue Daly, Project Officer, Department of Human Services, discussed the introduction of Short Stay Observation Units (SOU) and Medical Assessment and Planning Units (MAPUs) within Victorian hospitals.

It is proposed that two new codes be included in the Accommodation Type data item codeset. These codes would allow the identification of admissions to the SOUs and MAPUs registered with the Department.

SOU are designated units, usually under the responsibility of, and in close proximity to the Emergency Department, that provide observation, care and treatment to patients expected to have a length of stay of between four and twenty-four hours. Patient conditions treated are those that tend to be evolving and the unit provides the time required to investigate and manage the patient's condition quickly without occupying an ED or ward bed. The patient's presence within the hospital during this evolving period of their condition provides the opportunity for quick intervention if the need arises.

The units are designed to reduce patient length of stay, facilitate fewer diagnostic evaluations, reduce inappropriate discharges, and improve Emergency Department efficiency, patient satisfaction and utilisation of hospital beds.

MAPUs are designated units, managed by general physicians, that concentrate on all general medical emergency admissions, streamlining the patient assessment and care planning with a view of reducing the length of stay as a result of being very organised during the initial period of the stay. Patient conditions treated are often those not already dealt with by other specialised units (CCU, stroke units) such as chronic obstructive airways disease (COAD), chronic heart failure, bronchitis, seizures, chest pain and pneumonia. Focus is placed upon conditions with a medium length of stay with emphasis on the initial period of stay in order to expedite the patient's discharge.

Advantages of the MAPUs include a reduction in length of stay, fewer diagnostic evaluations, the early engagement of Allied Health staff as well as improved patient satisfaction and use of hospital beds.

The reporting of the SOU and/or MAPU Accommodation will enable the analysis of the operations and effectiveness of the units, facilitate the comparison of key performance indicators, identify any future opportunity for increases in operational efficiency and inform appropriate funding strategies. In addition SOUs aim to exclude patients from 12-hour waits in the ED. There is work to be done on how to appropriately reimburse hospitals for care affected by SOU stays and further observations of the MAPUs are necessary as currently no Victorian hospital has had a MAPU in operation for a full 12 months.

It is estimated that 80-85% of patients admitted to the SOU will be discharged on release from the unit with only 15% moving to another hospital ward. The figures are reversed with MAPU patients with approximately 80% being transferred to other hospital wards.

### **2.3 Proposed new data item: Date of First Procedure**

Peter Lewis, Department of Human Services, discussed the proposal, submitted by the Patient Management Taskforce, to commence collection of the date of first procedure for each elective surgery admission, in order to benchmark Day of Surgery Admission rates.

Consideration was given to using the Elective Surgery Information System (ESIS) dataset to collect these data, however this was not optimal because of the limited number of hospitals contributing to the dataset and the fact that ESIS procedures are not always the same as the procedure eventually performed when admitted.

Another alternative to using the VAED dataset is the regular submission of the require data via a manual collection.

Evaluation of available VAED data items determined that the use of Admission Type X 'Other planned admission (same day or overnight/multi-day)' was most appropriate for identifying admissions requiring entries in the new field.

Attendees raised the following concerns:

- The definition of 'first procedure', it was unclear whether this is the first procedure performed or the first procedure listed in the code string (principal diagnosis). Peter Lewis indicated that NSW compare the procedure for which the patient was placed on the waiting list and the procedure performed when admitted.
- It was also unclear how 'surgical procedure' would be defined for this purpose.

For example the use of Admission Type X would also include all procedures such as gastroscopies. Should such procedures be included?

- Whether the intent is to gather this item only for 'Elective' surgery. If so using ESIS may be more appropriate than VAED as ESIS makes it easier to extract the required information from the hospital system and surgery is already defined. However, as ESIS data are not submitted by all hospitals, only a subset of all episodes would be gathered. A review of the definition of 'Elective' may also be required.
- Theatre information systems are not usually connected to the hospital information systems from which VAED data are derived so coders would need to search the record for the required detail, an intensive manual effort.
- Whether the distinction between multi- and same-day patients would be based on intended length of stay or actual length of stay, and whether the item would be required for only multi-day stay episodes.

Mark Gill suggested that the Patient Management Taskforce collect this information manually for the first year pending the resolution of definitional issues.

### 3 VAED INFORMATION UPDATES

#### 3.1 Culture and Language Diversity

Mark Gill gave an update on this issue, which is currently being discussed by the National Health Data Committee (NHDC).

In January 2000, the data elements 'Main Language other than English Spoken at Home' and 'Proficiency in Spoken English' were detailed in the *Proposals for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for July 1 2000* document. The data elements were listed as having a proposed collection start date of 1 July 2001.

During 2000 the NHDC decided to include the data elements in Version 10 of the National Health Data Dictionary (NHDD). This version is due for release on 1 July 2001.

NHDC also decided that, as a part of its 2001 Work Program, it would further consider these data elements for possible inclusion in the National Minimum Data Set (NMDS) for Institutional Health Care. Inclusion in the NMDS would mean that all jurisdictions would be obliged to collect these data items and provide them nationally. The inclusion was considered at the February 2001 meeting.

At the meeting the following issues of concern were raised:

- Members were not convinced that collection of the Main Language data at the 4 digit level was appropriate in all cases and that a 2 digit list (as in *Preferred Language*) may be more suitable for hospital collections;
- Members were not convinced that the subjective and self-reporting nature of *Proficiency in Spoken English* would result in consistent interpretation by data providers and collectors.
- Routine hospital morbidity collections may not be the best way to collect this information – history has shown the biggest data quality issues relate to elements that are not used by the hospitals themselves. Trials were successful but these used face-to-face interview. Members suggested that strong consideration be given to collecting this information by survey rather than by routine data collection.
- There is an opportunity to ensure consistency of collection and timing across all jurisdictions. This opportunity rarely exists and should not be fumbled. These data elements should not be collected by any jurisdiction, nor mandated in an NMDS, until all States and Territories can ensure consistency of collection and timing.

A Working Group was formed to consider the collection issues outlined above. The Group will consist of Victoria (Chair), WA, SA, Commonwealth and the ABS.

In view of these strong recommendations at the national level, Mark Gill advised that Victoria would not introduce these items into its morbidity or other hospital data collections until a national implementation strategy has been agreed upon.

### 3.2 Consolidated File 2000-2001

Mark Gill reported the following summary statistics:

<b>Consolidated File by Sector</b>					
<b>Sector</b>	<b>1996-1997</b>	<b>1997-1998</b>	<b>1998-1999</b>	<b>1999-2000</b>	<b>2000-2001</b>
Total Separations					
Public	936,500	964,697	1,007,577	1,041,835	1,065,004 (a)
Private	458,635	484,236	495,700	519,838	458,052 (a)
Uncoded Separations					
Public	1,370	153	1,828	1,495	
Public (WIES funded)	5	59	93	13	
Private	410	502	2,240	3,181	
ALOS					
Public	4.09	3.96	3.80	3.77	3.74 (b)
Public (WIES funded)	3.32	3.22	3.09	3.01	2.97 (b)
Private	3.62	3.47	3.30	3.17	3.08 (b)
Same Day Admissions					
Public	391,231	415,278	450,809	485,794	293,930 (b)
Private	239,974	261,520	275,266	295,996	140,176 (b)
Overnight/Multi-day Admissions					
Public	492,288	490,406	489,673	491,786	279,872 (b)
Private	218,661	222,716	220,434	223,842	103,473 (b)

a) Figures for 2000-2001 are the projected total separations for both public and private hospitals. This figure has been estimated by taking the 6-month separation tally and doubling it.

b) Year To Date taken at consolidation on 21 February 2001.

The final consolidation of VAED data for the 2000-2001 financial year will be run on Friday 21 September 2001. The final date for transmissions to be received by Allegiance Systems will be Friday 14 September 2001.

The Health Data Standards and Systems Unit will apply considerable effort to ensure completeness of the VAED data at the end of the reporting year, involving weekly follow-up of hospitals, not meeting regular reporting deadlines.

### **3.3 TAC, WorkCover, Postcodes & SLAs**

Anthony LaSala from Information Analysis Unit (IAU), DHS provided the following updates:

#### **3.3.1 Postcode/Locality**

The postcode/locality file is updated every 12 months based on the National Localities Index and postcode/SLA concordance files from the ABS. The 2001-2002 file will be available from 1 July 2001. It should be noted that this is the file used by the dataset edits regardless of the Telstra White Pages listing. However, in order to maintain the completeness of this file, feedback and queries on how to deal with cases of new suburbs, etc are welcomed via the HDSS Help Desk. All notification of alterations to the postcode/locality tables are issued through the HDSS Bulletin upon completion.

The postcode/locality edits for VAED, ESIS and VEMD are based on a DHS file located at:

<http://www.dhs.vic.gov.au/ahs/hdss>

- PRS/2 – Victorian Admitted Episodes Dataset (VAED)
  - Selected Reference Files.
    - Postcode/Locality/SLA File June 2000 (self extracting file 227KB)

#### **3.3.2 TAC / WorkCover (VWA)**

For the 2000-2001 financial year the negotiation of WorkCover fees and admitted patient statements has not been completed in the timely manner that both the Department and hospitals would have wished.

TAC (and anticipated VWA) admitted and non-admitted patient fees have increased for the 2000-2001 financial year and admitted patient prices for the two authorities will be different for the first time. The non-admitted patient fees will be the same for the two authorities for the current financial year, but this is expected to change in the 2001-2002 financial year.

DHS continues negotiations with VWA in an effort to reach agreement on an acceptable outcome. When settled, the VWA fees will be communicated to hospitals via a HDSS Bulletin.

The Department has had discussions with Allegiance Systems regarding the possibility of Allegiance being able to generate WorkCover admitted patient statements without the need for data re-submission. The Department is hopeful of a positive outcome to these discussions.

### 3.4 Audit of VAED Data

Joanne McLachlan reported the following in regards to the VAED Audit.

#### 3.4.1 1999-2000

The audit of 1999-2000 VAED data represented the second year of a three-year project being conducted for this Department (DHS) by Healthcare Management Advisors Pty Ltd (HMA). Casemix auditors visited 43 randomly selected sites (hospital campuses and multi-purpose services) throughout Victoria. A further 12 sites were involved in follow-up audits, as the results of the audit of their 1998-1999 VIMD data exceeded expected levels of change in either DRG or WIES6 or both. Individual results will be assessed to determine whether supplementary audits, as provided for in the Policy and Funding Guidelines, are warranted. The HMA Final Report is available on the HDSS website. It is important to note that this is not a 'statewide' result, as not all hospital groups were represented.

<b>VAED Audit Results</b>				
	<b>Sites</b>	<b>Separations</b>	<b>% DRG Change</b>	<b>% WIES Change</b>
Random 1999-2000	43	3461	9.68%	+0.31%
Follow – up 1999-2000	12	5370	16.31%	+1.89%
Random 1998-1999	50	7004	13.04%	+0.93%

Overall the VAED Audit was well received and most participants were positive about it. Some interesting findings were:

- Indigenous Status was confirmed in over 60% of the annual sample, compared with a 1998-1999 figure of about 40% of the annual sample.
- Admission and Separation Times listed in the medical record and the hospital information system are not always uniform. These are obvious medicolegal implications for the hospital, and in some instances, the length of stay of the episode is altered. This is most often found in A&E admissions.
- A number of sites were not using Accommodation Type '6 – Emergency Department', as introduced on 1 July 1999.
- Joanne reminded all present to ensure that the staff at their hospital are up-to-date with the documentation received from the Department, including HDSS Bulletins, VAED changes documents and PRS/2 manuals. Auditors identified adequate documentation to justify admission in 70.27% of Type C cases in the 'annual' sample but only 53.75% of Type C cases in the 'follow-up' sample.

- Criterion for Admission ‘B’ was being used inappropriately in many of the same-day cases.
- The application of ACS 0010 General Abstraction Guidelines, as it refers to documentation requirements for investigation results was referred to the Victorian ICD Coding Committee for clarification, resulting in a public submission to the National Centre for Classification in Health (NCCH).

### 3.4.2 2000-2001

The audit of 2000-2001 VAED data will return to a year one format, within the two-year audit cycle commenced at the start of this three-year project. All hospital groups will be represented, so a new statewide result will be provided. The audit methodology will remain consistent with that used in previous years. Some hospitals will be audited using data from the final quarter of either the 1999-2000 or 2000-2001 financial years. All audit data is extracted from the most recent data available.

Terminology used to describe groups participating in this year’s audit was explained:

- ‘Annual’ sites are randomly selected, within DHS requirements
- ‘Follow-up’ sites have been selected by DHS because their ‘annual’ results the previous year exceeded expected parameters. Larger sample sizes are audited.
- ‘Supplementary’ sites are selected by DHS because the results of their ‘follow-up’ audit were again unsatisfactory.
- ‘Target’ audits will review specific topics: one will review data for sick newborns; a second will assess results from dual coding study sites.

The current audit will assess data at 71 sites with some ‘annual’ sites also hosting ‘target’ audits.

<b>2000-2001 VAED Audit Breakdown</b>					
	<b>Annual</b>	<b>Follow-up</b>	<b>Supplementary</b>	<b>Target Neonatal</b>	<b>Target DCS</b>
Sites	56	4	7	14	9
Separations	7700	1830	700	500	TBD

### 3.5 V4.2 / V5.0 AR-DRG Changes

Jennie Shephard advised those present that V4.2 AR-DRG software is now available.

Details of the software are available from the Department of Health and Aged Care (DHAC) website:

- [www.health.gov.au/casemix/grouper1.htm](http://www.health.gov.au/casemix/grouper1.htm)

Manuals are available by placing orders with NCCH. The new manual is to be used in conjunction with the existing 3-volume definitions manual for version 4.1.

A list of changes for version 4.2, many of which were already in place as Victorian DRGs is also available from the DHAC website  
-[www.health.gov.au/casemix/dev42.htm](http://www.health.gov.au/casemix/dev42.htm)

Jenny outlined the progress on the Version 4.1 anomalies reported in HDSS Bulletin 19, dated 27 October 2000. The following eight are rectified in Version 4.2 of the software.

- Arteriovenous fistula (AVF)  
AVFs that are formed in the upper or lower limbs were not included as procedures for MDC11, *Diseases and disorders of the kidney and urinary tract*. As most fistulas are formed for renal dialysis there was clearly an anomaly.
- Bilateral hip / bilateral knee replacement  
The logic for DRG I01Z, *Bilateral or multiple major joint procedures of lower extremity*, requires at least two codes from the relevant tables. As there is only one code for bilateral hip or knee replacement, the logic didn't work and cases that should have gone into this DRG went elsewhere.
- Hook needle localisation of breast lesion  
Hook needle localisation of breast lesion was recognised in AR-DRG 4.1 as an operating room procedure, which was inappropriate.
- Retained placenta & membranes without haemorrhage  
The codes for retained placenta and membranes without haemorrhage have been omitted from the tables for post-partum DRGs causing a problem when patients are admitted post-partum for these conditions. The cases grouped to a delivery DRG.
- Paraurethral injection  
N39.3, the code for stress incontinence, is grouped to MDC13 *Diseases and disorders of the female reproductive system*, and is not recognised as in MDC12 *Diseases and disorders of the male reproductive system*, leading cases to DRG 960Z, *Ungroupable*.
- Failed elective induction  
Failed elective induction was grouping to a delivery DRG in spite of there being no Z code to indicate that this was a delivery episode.

- Suction Termination of Pregnancy (STOP) and laparoscopic sterilisation  
Cases of STOP with a laparoscopic sterilisation taking place were grouping to the ectopic pregnancy DRG.
- Chemotherapy with loading of implantable infusion device  
Same day chemotherapy cases with loading of implantable infusion device were grouping incorrectly to DRG R04, *Other neoplastic disorders with other OR procedures*. The code 13939-00 has been removed from all the MDCs for which it was listed as an operating room procedure. (MDC 1, 4, 6-13, and 21).

The following nine anomalies have been recommended to the Commonwealth for consideration in the development of version 5.0.

- Bone marrow transplant  
Bone marrow transplants have been split on allogeneic and autologous (or non-allogeneic) for many years in Victoria. The Commonwealth has now recommended that this split be considered for version 5.0.
- Renal artery stenosis for angioplasty  
The angioplasty codes need to be included for all MDCs that have these procedures – currently they are listed only for MDC5 *Diseases and disorders of the circulatory system*. Renal artery stenosis is in MDC11 *Diseases and disorders of the kidney and urinary tract*, and mesenteric atherosclerosis is in MDC6 *Disease and disorders of the digestive system*.
- Mesenteric atherosclerosis with angioplasty  
The relevant procedure code is not recognised in MDC6 *Disease and disorders of the digestive system*.
- Peritonitis and percutaneous drainage  
Codes for percutaneous drainage of intra-abdominal or retroperitoneal abscess are new in 2nd edition ICD-10-AM, and are mapped to 30224-00 (MDC 1, 8, 9 and 21) but not MDC6, to which peritonitis groups. Unfortunately this anomaly was not detected in time for the change to be made for AR-DRG 4.2.
- Malignant neoplasm of peritoneum with hysterectomy  
There is inconsistency with the MDCs applied for associated diagnosis and procedure codes.
- Haemangioma of liver with procedure  
Haemangioma of liver as a principal diagnosis groups to MDC6 *Disease and disorders of the digestive system* and is not listed in MDC 7 *Diseases and disorders of the hepatobiliary system and pancreas*. When the patient has a procedure that is a hepatobiliary system procedure, the case groups to 901Z.

- Insertion of implantable vascular infusion pump  
The code for insertion of implantable vascular infusion pump is not listed for MDC5 *Disease and disorders of the circulatory system*. Many patients having an implantable infusion pump will have a circulatory system principal diagnosis. The code 34527-01 is listed for MDC s 1,4, 6-13, and 21.
- Family history of malignant neoplasm  
The codes for family history of malignant neoplasm of digestive system (Z80.0) and family history of malignant neoplasm of other organs (Z80.8) are treated differently in AR-DRG 4.1 from the other family history of malignant neoplasm codes.

They group to DRG Z40Z *Follow-up after completed treatment with endoscopy* or Z62Z *Follow-up after completed treatment without endoscopy*. Follow-up after completed treatment (with or without endoscopy), and the others group to Z64A *Other factors influencing health status age > 79* or Z64B *Other factors influencing health status age <80*. This is being looked at for version 5.0.

- Nasopharyngeal intubation  
New codes for nasopharyngeal intubation in ICD-10-AM 2nd edition were mapped incorrectly to a non-OR procedure code. This error was not corrected for version 4.2 but has been recommended for version 5.0

Several anomalies, of which we are currently aware, are not being considered for correction in version 5.0. These are:

- Change to birth weight rules  
There is no plan to amend the existing birth weight parameters as it is held that the low frequency of cases reported with exceptionally low birth weights do not support a revision.
- Excision of sacrococcygeal teratoma  
Although excision of sacrococcygeal teratoma currently groups to 902Z, Extensive OR procedure unrelated to principal diagnosis, there is no recommendation to amend this in version 5.0 due to the extremely low numbers of cases affected by the error.
- Peritoneal dialysis  
Again, there has been no recommendation made to amend the grouping of peritoneal dialysis in version 5.0 due to a very low incidence of episodes.

- Radiotherapy  
Australian Coding Standard 0229 Radiotherapy, results in a low incidence of episodes falling into the radiotherapy DRG. However, as a result of the *Victorian Additions to the Australian Coding Standards*, July 2000, Victoria reports many episodes in this DRG.

It is highly likely that none of these anomalies will be fixed until more data is available to support the changes.

Victorian has sent public submissions for the following anomalies, which were received for inclusion in HDSS Bulletin 19.

- Revision of burn scars
- Hyperparathyroidism secondary to renal disorder

### **3.5.1 New Structure for MDC14 *Pregnancy, childbirth and the puerperium***

Work is being undertaken to develop a new structure for MDC14 *Pregnancy, childbirth and the puerperium*. This will be based on the Z codes Z37 Outcome of delivery, Z39 Postpartum care and examination. It will reduce the problem of the cases that were grouping to a post partum DRG when they should have been in a delivery DRG, and vice versa.

In addition there will be a PCCL structure for MDC14. Currently those DRGs that are adjacent DRGs are assigned on the basis of having an appropriate code in one or more of the listed tables. In the new structure the additional codes will be assigned a CCL value to create a PCCL value for the case (the same as for non obstetric cases in version 4.1).

The consensus regarding cases being assigned to DRG 962Z *Unacceptable obstetric diagnosis combination* will be addressed as part of this review.

### **3.5.2 Hysteroscopy with Laparoscopic Division of Adhesions**

The problem for coders has been that when adding a hysteroscopy code to a case where a laparoscopic division of adhesions has already been coded results in the case grouping to a lower weighted DRG.

The cases are in fact grouping to DRG N10Z, *Diagnostic curettage and/or hysteroscopy*, which are located higher in the surgical hierarchy however it has a lower weight.

### 3.6 Other

Mark Gill outlined the proposal for the collection of information regarding the software upgrade process for the VAED, ESIS and VEMD data collections. It is envisaged that hospitals and software suppliers will provide HDSS with information regarding:

- Date hospitals send their specifications to software suppliers – these will contain the DHS dataset specifications but may also contain other requirements that are specific to hospitals sites.
- Date the software upgrade was first received by hospitals.
- Date the software upgrade was accepted as complete by hospitals.
- How many times the software needed to be changed before acceptance.

It is hoped that this collection will help the Department gain greater knowledge about the software upgrade procedures. It is intended that the results will be published for broad industry information.

## 4 ESIS Proposals for Revisions

Jenelle Hurley reported on the proposed changes to the ESIS dataset.

Changes to the ESIS data collection are necessary to ensure that Victoria continues to meet its national reporting obligations, and to assist planning and policy development by the DHS. The majority of the proposed revisions to the 2001-2002 dataset are adjustments to existing data items and edits only.

The document *Proposals for Revisions to the Elective Surgery Information System (ESIS) - February 2001* has been posted on HDSS website. The proposals process ensures that stakeholders have the opportunity to consider changes to the dataset and to provide comments, which will be assessed by the ESIS Technical Reference Group (the next meeting is scheduled for 6 March 2001) and a *Specification for Revisions for 1 July 2001* document will then be released.

It is hoped that the revisions document will be released by the end of March 2001. Following the release of this document, the *ESIS Manual, Version 4.0* will be revised and distributed, for implementation on 1 July 2001.

## 4.1 Proposed changes to ESIS for 1 July 2001

In order to ensure the accuracy of data submitted, it is proposed to:

- Expand/revise/combine edits relating to:
  - ‘Not Ready for Care Days’
  - ‘Booking details’
  - ‘Reason for Cancellation’
- Ensure ESIS software systems allow changes to data after patient has been admitted for the awaited procedure.
- Revise the definitions for ‘Total Waiting Time for Admitted Patients’, and ‘Total Waiting Time for Patients Remaining on the Waiting List’. This has been proposed to ensure that data supplied to national bodies is in accordance with the definitions specified in the NHDD.
- Expand the definition for ‘Reason for Not Ready for Care Status – Deferred’ to ensure consistent interpretation across all sites.
- Combine data items ‘Reason for Removal’ and ‘Reason for Cancellation’ to remove duplicate data.

## 5 ESIS Information Updates

### 5.1 Data Submission Progress 2000-2001

Anna Cooper delivered the 2000-2001 progress report for ESIS.

There are 24 hospitals that are currently reporting to ESIS and after a slow start all hospitals have submitted data for July 2000 to January 2001. The number of submissions per hospital per month ranges from 1 to 14, but hospitals are expected to keep the number of submissions down to a maximum of 5 per month.

#### ESIS Data Submissions, 2000-2001 YTD

Month	Passed	Incomplete
July	22	2
August	19	5
September	17	7
October	18	6
November	20	4
December	19	5
January	17	7

The most common edits encountered for the 2000-2001 ESIS collection are outlined below.

### **Type One Edits**

<b>Edit Number</b>	<b>Error Description</b>	<b>Average Occurrence Per Month (all hospitals)</b>
S004	Total number of records not equal to total patient records	191.1
S279	Invalid reason for rebooking	44.0
S083	Invalid combination Medicare code and DOB	11.9
S324	Negative waiting time (no urgency reassignment)	11.9
S291	Removal date prior to registration date	10.6
S280	Booking number mismatch between months	7.0

Type One edits should be corrected by the 21<sup>st</sup> day of the following month.

### **Type Two Edits**

<b>Edit Number</b>	<b>Error Description</b>	<b>Average Occurrence Per Month (all hospitals)</b>
S053	Record not removed last month missing from file	472.0
S295	Removal date not = scheduled admission date	19.4
S303	Blank insurance declaration	1.9
S115	Area of residence error	0.6
S116	Invalid locality	0.6
S120	Blank postcode	0.4

Type two edits should be corrected by the last day of the following month.

Eg January data must have all type ones cleared by the 21<sup>st</sup> of February and type twos by the 28<sup>th</sup> of February.

## Type Three Edits

<b>Edit Number</b>	<b>Error Description</b>	<b>Average Occurrence Per Month (all hospitals)</b>
S316	Clinical urgency Cat 2 patient waiting > 90 days	8129.9
S165	Patient already on waiting list for same PPP	1021.4
S171	New record, registration date prior to this month	538.9
S172	Registration date = Urgency reassignment date	489.1
S173	Registration date = Status reassignment date	460.4
S335	Hosp initiated postponement, rebooking reason not hosp initiated	123.0

Type three edits represent warnings. The data has been loaded in to ESIS, but a potential error has been identified. No timeframe is placed on correction of these edits.

## 6 VEMD Information Updates

### 6.1 Data Submission Progress 2000-2001

Anna Cooper delivered the 2000-2001 progress report on data submission to the VEMD. As at December 2000, there were 30 hospitals reporting to the VEMD, and after a slow start, all hospitals have submitted data from July 2000 through to January 2001. The one hospital that yet to submit January data is currently testing a new software system and until this is completed, they will be submitting paper based reports only.

#### VEMD Data Submission 2000-2001, YTD

	<b>Hospitals Passed</b>	<b>Hospitals Not passed</b>	<b>Un-submitted Files</b>	<b>Average Submissions</b>
July	29	0	0	5
August	29	0	0	4
September	28	1	0	4
October	28	1	0	3
November	27	2	0	3
December	27	3	0	3
January	22	7	1	3

The table above shows the decline in the average number of file submissions per month. The average number of attempts has improved over the previous year and through the current year, for which hospitals were commended.

The most common edits encountered for the 2000-2001 VEMD collection are outlined below.

### Seven Most Common Rejections

<b>Edit Number</b>	<b>Edit Description</b>	<b>Average Occurrence Per Month (all hospitals)</b>
RE182	First seen by treating nurse/doctor date/departure status combination invalid	6.6
RE217	Departure date conflicts with VEMD filename	4.1
RE218	Inappropriate arrival date	3.6
RE188	First seen by treating nurse/doctor time/departure status combination invalid	3.4
RE166	Triage date invalid	3.3
RE156	Arrival data invalid	3.3
RE211	Departure date invalid	3.3

### Six Most Common Warnings

<b>Edit Number</b>	<b>Edit Description</b>	<b>Average Occurrence Per Month (all hospitals)</b>
WE080	Medicare number blank	57.0
WE339	Inpatient bed request and Departure status combination invalid	1.9
WE103	Born overseas, treated same day	1.4
WE265	Diagnosis code and age unusual	1.3
WE337	Inpatient bed request time before arrival date	0.4
WE297	Injury cause code and age incompatible	0.1

## 7 VEMD Specifications for Revisions

Mark Gill presented an overview of the *Specifications for Revisions to the VEMD for 1 July 2001*.

The *Specification for Revisions to the Victorian Emergency Minimum Dataset (VEMD) for 1.7.2001* was distributed via e-mail and posted on the HDSS, VEMD website 22 February 2001 following consideration of proposals at the VEMD Forum and at subsequent EDIS Review Committee meetings.

## 7.1 Summary of Revisions

- **Departure Status:**  
Changes reflect the move to the use of Short Stay/Observation Units (SOUs) and Medical Assessment and Planning Units (MAPUs) as alternatives to traditional admitted accommodation for specific patient groups that require a more intensive initial period of assessment and re-evaluation over a shorter period.

Data on the use of SOUs are required to evaluate the value of the units for improving patient care practices, to measure and analyse a variety of performance measures to differentiate between patients who are managed within an SOU and those who are not, and to enable the exclusion of these patients from calculations of emergency patients who wait for more than 12 hour for admitted accommodation.

Therefore a new code (3 - SOUs) has been added and Code 2 has been amended to include MAPUs.

- **Description of Injury Event**  
Prompts are to be added to encourage the reporting of the required details.
- **Escort Source**  
Collection has been made optional.
- **Procedures**  
Collection has been made optional.
- **Referred by**  
The allocation of Code 7 – Nursing Home, has been clarified.

Related edits have been modified accordingly.

The work program for the VEMD includes the publication and distribution of Version 6.0 of the VEMD Manual, a focus on output editing, and the further improvement of the quality of data held in the VEMD dataset.

## **8 Other Business**

No other business discussed.

## **9 Date of Next Meeting**

Mark Gill advised that the next HDSS Forum is schedule for February 2002.

## **10 Close**

Mark Gill thanked all in attendance, those who presented, and the Health Data Standards and Systems Unit for the preparation and facilitation of the forum.

### **Please note:**

The notes of this HDSS Forum were prepared and distributed by the Department of Human Services, using the Department's PRS/2 Manual mailing list, unless otherwise notified.

**Please ensure circulation of these notes to all appropriate officers in your organisation**, including Managers of Medical Record/Health Information Services, Information Systems and Admissions Offices.

❖Software Suppliers represented:

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BICKNELL	Lisette	TRAK Systems
BORG	Rowena	iSOFT
BROWN	Ian	iSOFT
BUSCH	Ann	Working Systems
HINTERREITER	John	MCATS
HORVAT	Greg	IBA Technologies
LEANE	Marian	Allegiance Systems
MONTIERO	Terry	IBA Technologies
SMITH	Andrew	Health Technologies

❖Others in attendance

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AMBER	Magda	Royal Women's Hospital
ARRIGHINI	Carla	Williamstown Hospital
AYTON	Gary	Sunshine Hospital
BAHRO	Tanja	Royal Women's Hospital
BANKS	Sianne	Sunshine Hospital
BARTLETT	Bronwyn	St Vincent's Hospital
BAXTER	Kathryn	Southern Health
BEATTIE	Marlene	Bendigo Health Care Group
BEAUMONT	Tanja	Southern Health
BEGG	Stephen	Department of Human Services
BELL	Lyn	La Trobe Regional Hospital
BERRY	Helen	Southern Health
BOAL	Angela	Echuca Regional Health
BORGELT	Kaye	West Wimmera Health Service
BOYLE	Kaye	Mount Alvernia Mercy Hospital
BRADY	April	Royal Children's Hospital
BROWN	Marree	Mercy Hospital for Women
BROWN	Sharon	La Trobe Regional Hospital
BULJANOVIC	Lovorka	Caulfield General Medical Centre
BURGESS	Tracy	Sandringham Hospital
BURNS	Helen	Cabrini Hospital
BUTLER	Leanne	Department of Human Services
BYRNE	Frank	Melb Private Hospital / JF Hospital / FPH
CAMPBELL	Shahn	Department of Human Services
CARLESSO	Amber	Werribee Mercy Hospital
CASSIN	Kathy	Royal Children's Hospital
CAWOOD	Terri	Angliss Health Service
CHAN	KC	The Alfred
CHAO	Mabel	Tweddle Child & Family Health Service
CHRISTIE	Sally	Royal Women's Hospital
CLARE	Denis	Royal Children's Hospital
CLOWES	Melissa	Peninsula Health
COOPER	Anna	Department of Human Services
COWLING	Susan	Royal Children's Hospital
CRIPPS	Pauline	Box Hill Hospital
CUNNINGHAM	Glenda	Royal Talbot
D'ANGRI	Emma	St John of God Ballarat
DAKING	Leanne	Department of Human Services
DANIEL	Helena	La Trobe Regional Hospital
DARBY	Sue	Department of Human Services
DAVIS	Fina	Austin & Repatriation Medical Centre

DE VALLE	Lynette	Angliss Health Service
DUFFY	Joanne	Goulburn Valley Health
DWYER	Mal	Barwon Health
ELDRIDGE	Fiona	Angliss Health Service
ELLIOTT	Jane	Western Hospital
ELLIOTT	Elaine	Caulfield General Medical Centre
ENNO	Karen	Western Hospital
EVERTS	John	The Alfred Hospital
FARR	Brivana	Wimmera Health Care Group
FOX	Karen	The Alfred
FRANZONE	Angela	Southern Health
GAITANIS	Debbie	Royal Melbourne Hospital
GARDNER	Brendon	Peninsula Health
GILCHRIST	Kirrily	The Northern Hospital
GILL	Mark	Department of Human Services
GOODWIN	Neil	Royal Children's Hospital
GRAIN	Heather	La Trobe University
GREEN	Janet	Angliss Health Service
HABERMAN	Rebecca	Victorian WorkCover Authority
HARRISON	Sara	Department of Human Services
HARROP	Sarah	The Northern Hospital
HO	Bee	Cabrini Hospital
HOPE	Robyn	St Vincent's Hospital
HURLEY	Jenelle	Department of Human Services
HUTCHINSON	Kim	Barwon Health
IOANNIDIS	Sofie	Sunbury Private
JENKINS	Kris	Austin & Repatriation Medical Centre
JOLLY	Simon	Department of Human Services
JURISTA	Michael	Royal Children's Hospital
KAYE	Jane	Barwon Health
KEARSEY	Irene	Department of Human Services
KELLY	Leigh	Southern Health
KOTZ	Greg	Barwon Health
KOUVAS	Mary	Western Hospital
LAMBERS	Maria	Department of Human Services
LAMBERT	Lorraine	Werribee Mercy Hospital
LANSCHÉ	Gabrielle	Southern Health
LASALA	Anthony	Department of Human Services
LETIZIA	Terry	The Northern Hospital
LEWIS	Peter	Department of Human Services
LOWE	Nette	Department of Human Services
MAIN	Brenda	Royal Women's Hospital
MALIOS	Christine	Victorian WorkCover Authority
MATTHEWS	Rebecca	Bethlehem Hospital
McCARTHY	Mary	Mercy Hospital for Women
McCORMACK	Lena	Western District Health Service
McDONNELL	Andrea	Ballarat Health Services
McGREGOR	Natalie	Maroondah Hospital
McINTYRE	Fleur	Colac Community Health Services
McLACHLAN	Joanne	Department of Human Services
McLEOD	Jackie	The Northern Hospital
MILNE	Leesa	Wangaratta District Base Hospital
MONDS	Karen	Peter MacCallum Cancer Institute
MOORE	Robert	South West Healthcare
MORRIS	Pauline	Box Hill Hospital
MORSE	Adrian	The Alfred
NEAL	Jody	La Trobe Regional Hospital
NGUYEN	Hien	Wonthaggi Hospital

O'BRIEN	Helen	Peter James Centre
O'FARRELL	Tanya	Royal Victorian Eye and Ear Hospital
OLDHAM	Robyn	Freemasons Hospital
OLIVER	Jade	Royal Melbourne Hospital
PEAK	Karin	Bendigo Health Care Group
PERRY	Catherine	Goulburn Valley Health
PICKERSGILL	David	The Alfred
PRIESTLY	Angela	Freemasons Hospital
PROY	Silvio	Royal Children's Hospital
RAMSDEN	Andrew	Monash Medical Centre
RANDALL	Angela	QEC / O'Connell Family Centre
RAW	Josephine	Royal Women's Hospital
REDENBACH	Elva	Melbourne Extended Care & Rehab
REED	Amanda	The Avenue
RICHARDS	Carol	Croydon Day Surgery Centre
RICHTER	Rhonda	La Trobe University Medical Centre
ROBERTS	Maree	Department of Human Services
ROBINSON	Evelyn	Peninsula Health
ROBINSON	Ken	Royal Children's Hospital
ROWE	Melanie	Peninsula Health
RUSSELL	Margaret	Cliveden Hill Private Hospital
SAMUEL	Marcela	Southern Health
SAUVEY	Nick	Angliss Health Service
SHEPHEARD	Jennie	Department of Human Services
SIEBEL	Rachael	Epworth Hospital
SIMPSON	Jill	Southern Health
SLAMONICZ	Ron	St Vincent's Hospital
SMITH	Gill	Department of Human Services
SMITH	Tamera	Sunshine Hospital
SOLEKI	Gina	Melbourne Health
STANYER	Evan	Bendigo Health Care Group
STATHAKIS	Voula	Monash Uni Accident Research Centre
STEWART	Cathy	La Trobe Regional Hospital
STOCKX	Paul	Box Hill Hospital
SULLIVAN	Jackie	Alpine Health
SUTCLIFFE	Wendy	Wodonga Regional Health Service
TANTI	Ilona	Sunshine Hospital
TAYLOR	Odetta	Perinatal Unit – DHS
TAYLOR	Kate	Ballarat Health Services
THOMSON	Leanne	Southern Health
TOOHILL	Annette	Royal Children's Hospital
TOTH	Alexandra	West Gippsland Healthcare Group
TRIGLIA	Rita	Department of Human Services
TWOMEY	Wilma	Austin & Repatriation Medical Centre
VO	Lee	Western Hospital
WALKER	Karen	St Georges Health Service
WALSH	Dean	Mercy Hospital for Women
WATERS	Dot	Mildura Base Hospital
WECKE	Andrea	Royal Women's Hospital
WENDT	Rebekka	St Vincent's Hospital
WENDT	Kate	Broadmeadows Health Service
WIDDISON	Jane	Royal Children's Hospital
WILKINSON	Wendy	Bendigo Health Care Group
WONG	Kee	Noble Park Endoscopy Centre
WRIGHT	Joan	Maroondah Hospital
WYNN	Anita	Barwon Health
WYSMAN	Kirrilli	St Vincent's Hospital
YOUNG	Toni	Portland & District Hospital

