

**Specification for Revisions to PRS/2  
and the  
Victorian Admitted Episodes Dataset  
(VAED)**

**for 1.7.2000**

*April 2000*



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# Executive Summary of Changes

The PRS/2 transmission specification for 2000–2001 comprises the *PRS/2 Manual, 9<sup>th</sup> Edition, 1 July 1999*, with the following amendments (detailed in this document):

## Data Item Revisions

### *Carer Availability*

Discontinue reporting this item for Care Types U, 0, 3, 4 and 5.  
Continue reporting this item for Care Types 1, 2, 6, 7, 8 and 9.

### *Hospital Generated DRG*

Report only AR-DRG, version 4.1 or Vic DRG, version 4.1 to this optional PRS/2 field. For 1999–2000 AN-DRG, version 3.1 was also accepted.

### *Patient Identifier*

Standardise the field layout — left justify with trailing blanks. The layout of this field has been discretionary in the past.

### *Reason for Critical Care Transfer*

Add four new values to enable *sending* hospitals participating in the Critical Care Inter-Hospital Transfer program to report Reason for Critical Care Transfer data. This field will now be completed by both *receiving* and *sending* hospitals.

### *Transaction Type*

Change the Transaction Type values for Trailer Records 1 (from T3 to T2) and 2 (from T4 to U2).

## New Transaction Record

Create a new (optional) record (Extra Diagnosis Record) to accommodate diagnosis and procedure codes 13 to 25.

## Updated Reference Files and Corresponding Data Items

- **Postcode File:** *Postcode and Locality.*
- **Hospital Code Table:** *Hospital Code, Site Identifier, Transfer Source, Transfer Destination and Contract/Spoke Identifier.*
- **ICD-10-AM DHS Library File:** *Diagnosis Codes and Procedure Codes.*

## Edits

A range of PRS/2 edits have been revised according to the changes listed above.

# Introduction

## *The need for PRS/2 interface modifications*

From 1 July 2000, changes to the VAED data collection are necessary to ensure that Victoria continues to meet its national reporting obligations, and to assist planning and policy development by the Department of Human Services (DHS).

Comments made by hospitals and software suppliers on the content of the document *Proposals for Revisions to PRS/2 and the VAED, January 2000* have been taken into account. Suggestions have been accommodated where possible, and changes to the collection kept to a minimum.

From 1 July 2000, changes to the VAED will be necessary to:

- Meet the evolving requirements of data collectors and users (*Hospital Generated DRG, Extra Diagnosis Record, Reason for Critical Care Transfer*).
- Facilitate the efficient processing of data transmitted to the RAPID Data Warehouse, via PRS/2 (*Transaction Type, Patient Identifier*).
- Discontinue the collection of data that is no longer required by data users (*Carer Availability* — selected Care Types only).
- Ensure the reporting of relevant information by the use of current reference files, as required by data users (ICD-10-AM DHS Library File, Postcode File, Hospital Code Table).

## *Distribution and components of this document*

This document has been distributed to all Victorian hospitals, to software suppliers known to have Victorian clients, to a range of industry bodies and DHS staff. It provides the following information:

- Details of each PRS/2 revision
- Reference file updates, including a hard copy of the Hospital Code Table
- Method for reporting patients remaining in hospital on 30 June 2000
- Arrangements for test transmissions of new 1 July 2000 software
- Outcomes of proposed VAED revisions
- PRS/2 File Structures
- New and amended edits

**The *PRS/2 Manual* will be updated with the changes detailed in this document, and distributed at a later date. In the meantime, the *PRS/2 Manual, 9<sup>th</sup> Edition, July 1999*, together with this document, form the admitted patient data transmission specification for 2000–2001.**

**Victorian hospitals are required to arrange for their software to be modified in accordance with the revised specifications.**

**The current PRS/2 Manual may be accessed on the internet at:**

**[www.dhs.vic.gov.au/ahs/hdss](http://www.dhs.vic.gov.au/ahs/hdss)**

**Any questions on this specification may be directed to the HDSS Help Desk on 9616 8141.**

# Abbreviations

<b>AN-DRG</b>	<b>Australian National Diagnosis Related Group</b>
<b>AR-DRG</b>	<b>Australian Refined Diagnosis Related Groups</b>
<b>CCIHT</b>	<b>Critical Care Inter-Hospital Transfer</b>
<b>CCU</b>	<b>Coronary/Cardiac Care Unit</b>
<b>DHS</b>	<b>Department of Human Services</b>
<b>DWH</b>	<b>Data Warehouse</b>
<b>HAP</b>	<b>Hospital Access Program</b>
<b>HL7</b>	<b>Health Level 7</b>
<b>ICD-10-AM</b>	<b>Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision, Australian Modification</b>
<b>ICU</b>	<b>Intensive Care Unit</b>
<b>MV</b>	<b>Mechanical Ventilation</b>
<b>NHDD</b>	<b>National Health Data Dictionary</b>
<b>PRS/2</b>	<b>Patient Reporting System 2</b>
<b>RAPID</b>	<b>Redevelopment of Acute and Psychiatric Information Directions</b>
<b>VAED</b>	<b>Victorian Admitted Episodes Dataset</b>

## *A Convention Used in this Document*

**New and amended edits are identified in the ‘PRS/2 Revisions’ section of this document by an asterisk (\*) appearing beside the relevant edit number and descriptor. These edits are detailed in Appendix B.**



# PRS/2 Revisions 1 July 2000

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## Carer Availability

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<b>Revision Summary</b>	<b>Discontinue the collection of Carer Availability data for Care Types U, 0, 3, 4 and 5.</b>  <b>Continue the reporting of these data for Care Types 1, 2, 6, 7, 8 and 9.</b>  <b>This field is retained in the Episode Record.</b>
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## Specification

**Definition** A record of whether a person has been identified, such as a family member, friend or neighbour, as providing regular on-going care or assistance which is not linked to a formal service.

**Datatype** Alphanumeric      *Form*      Code

**Field size** 1      *Layout*      N or space

**Location** Episode Record

**Reported by** Public hospitals only.  
  
Otherwise, private hospitals, report a space in this field.

**Reported for** Admitted episodes with a Care Type of:

- 1 NHT/Non-Acute
- 2 Designated Rehabilitation Program/Unit: Level 1
- 6 Designated Rehabilitation Program/Unit: Level 2
- 7 Designated Rehabilitation Program/Unit: Level 3
- 8 Palliative Care
- 9 Geriatric Evaluation and Management Program

Otherwise, report a space in this field.

***Reported when***      **A Separation Date is reported in the Episode Record.**

<b><i>Code set</i></b>	<b><i>Code</i></b>	<b><i>Descriptor</i></b>
	<b>1</b>	<b>Carer not needed/not applicable</b>
	<b>2</b>	<b>Lives alone, has a carer</b>
	<b>3</b>	<b>Lives alone, has no carer</b>
	<b>4</b>	<b>Lives with another, has no carer</b>
	<b>5</b>	<b>Lives with another, has a resident carer</b>
	<b>6</b>	<b>Lives with another, has a non-resident carer</b>
	<b>7</b>	<b>Lives in a mutually dependent situation</b>
	<b>8</b>	<b>Missing or not recorded</b>

## General Comments

Refer to page 22, for details on reporting data for patients remaining in hospital on 30 June 2000.

Support provided by a carer excludes (for VAED purposes) *formal* services such as delivered meals or home help, persons arranged by formal services such as volunteers, and funded group housing or similar services.

Availability infers carer willingness and ability to undertake the caring role and can apply when there are several carers. Where a potential carer is not prepared to undertake the role, or when their capacity to carry out necessary tasks is minimal, then the patient must be reported as not having an *informal* carer.

Where there are several carers, a decision should be taken as to which of these is the main or primary carer and report accordingly.

### **1 Carer not needed or need for carer not applicable**

Person able to self care and/or their therapeutic regime does not require the input of an informal carer, or reporting in this field is not applicable because this is a statistical separation, or the patient has been transferred to another hospital, left against medical advice or died.

#### *Includes*

- Those circumstances where it may be inappropriate for a carer at home to undertake a complex medical procedure requiring a high level of nursing skill.
- Person who is discharged to supported accommodation or other care facility that will provide the formal care required.

#### *Excludes*

- Circumstances where a relative or friend is available but is unwilling or unable to undertake a carer role (report 3 or 4).
- Children under eight years of age (report 4, 5 or 6).

**2 Lives alone, has a carer**

**Person lives alone and has an informal carer who is able and willing to attend to the person's recuperative needs on an ongoing basis.**

**3 Lives alone, has no carer**

**Person lives alone and does not have an informal carer willing and/or able to visit for the purpose of assisting with care on an arranged and regular basis.**

**4 Lives with another, has no carer**

**Person does not live alone but the co-resident/s is/are unable or unwilling to provide the care needed and there is no other external informal carer available.**

**5 Lives with another, has a resident carer**

**Household where the person lives with another who is willing and able to provide the care required for recuperation.**

***Excludes***

**Person whose potential co-resident carer is mutually dependent (report code 7).**

**6 Lives with another, has a non-resident carer**

**Person does not live alone but the co-resident/s is/are unable and/or unwilling to provide the care needed, but there is an external informal carer who is willing and able to provide this care.**

**7 Lives in a mutually dependent situation**

**Households where the service recipient and another person are mutually dependent. The critical aspect of such households is that if either member becomes unavailable for any reason, the other is either at high risk or unable to remain at home.**

**8 Missing or not recorded**

**Insufficient information to determine carer availability.**

***Edits***

**\*390 INVALID CARER AVAILABILITY**

**399 INCOMPAT SEP TYPE & CARER AVAILABILITY**

**400 CHILD, INCOMPATIBLE CARER AVAILABILITY**

**421 NOT SEPARATED; CARER AVAIL PRESENT**

**422 CARER AVAIL SHOULD BE SPACES**

**425 INCOMPAT SEP TYPE FOR AGE**

***Related items***

**Separation Referral, Separation Type, Care Type**

## Administration

<i>Purpose</i>	<b>To enable monitoring of the impact of carer availability on discharge timing and use of ambulatory services, to support policy development and planning.</b>		
<i>Principal data users</i>	<b>Sub-Acute Specialist Services Unit, Acute Health, Department of Human Services.</b>		
<i>Collection start</i>	<b>1 July 1999</b>	<i>Version</i>	<b>2 (1 July 2000)</b>
<i>Definition source</i>	<b>Australian Institute of Health and Welfare, National Health Data Dictionary, Version 8.0, 1999</b>	<i>Code set source</i>	<b>Australian Institute of Health and Welfare, National Health Data Dictionary, Version 8.0, 1999 - modified</b>

## Revision Background

Sub-acute patients, by their nature, generally have a longer length of stay than other types of patients. This is particularly so for the frail older patient. The focus of sub-acute care is to return the patient to a level of health and functioning to enable them to be discharged back into the community. In addition, there is an increased focus on ambulatory care for these people, through the use of Community Rehabilitation Clinics or Sub-Acute Specialist Clinics.

The timing of the discharge of these patients, and the ultimate destination of the patient at discharge is highly dependent on the ability of the person to live in the community. The availability of a resident or non-resident carer can have significant impact on both the timing of the discharge of sub-acute patients and the discharge destination.

The collection of Carer Availability data for all other episodes (Care Types U, 0, 3, 4 and 5) will be discontinued for separations on and from 1 July 2000. Sufficient data for the purposes of the Continuity Unit of Acute Health will be available via the Discharge Planning Audit, in future.

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## Extra Diagnosis Record

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<b>Revision Summary</b>	<b>Add a new (optional) Transaction Record (Y2) to accommodate extra diagnosis and procedure codes (13 to 25), as specified below.</b>
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### Specification

#### *Description*

The Extra Diagnosis Record accepts up to thirteen extra diagnosis and/or procedure codes, for each applicable episode. PRS/2, therefore, is able to accept a maximum of 25 diagnosis and 25 procedure codes. (The Diagnosis Record accepts the first twelve of each.)

#### *File Structure*

	Field Name	Maximum Characters	Record Position	Alpha/numeric	Format/Values
<i>M</i>	Transaction Type	2	1	A/N	Y2 (Was referred to as the 'X3' in the 'Proposals Document')
<i>M</i>	Unique Key	6	3	A/N	xxxxxx Hospital generated
	Diagnosis Code (13 to 25)	8 (8 x 13)	9	A/N	ICD-10-AM 2 <sup>nd</sup> Edition Each left justified and with trailing spaces
<i>I</i>	Procedure Code (13 to 25)	8 (8 x 13)	113	A/N	ICD-10-AM 2 <sup>nd</sup> Edition Each left justified and with trailing spaces
	Filler	24	217	A/N	Spaces
<b>Total 240</b>					

*M* Mandatory

*I* Eighth character is F or N for procedure in *contracting* hospital; else space

<i>Reported by</i>	<p>Public and private hospitals - optional. That is, a hospital may choose whether or not to report more than 12 diagnosis and 12 procedure codes for relevant episodes.</p>
<i>Reported for</i>	<p>Each episode which has more than 12 diagnosis and/or 12 procedure codes assigned.</p>
<i>Reported when</i>	<p>A Separation Date has been reported in the corresponding Episode Record (matching unique keys).</p>
<i>Reporting guide</i>	<p><b>General</b> Refer to page 22, for details on reporting data for patients remaining in hospital on 30 June 2000.</p> <p>Always transmit the Extra Diagnosis Record immediately following the corresponding Diagnosis Record (matching unique key).</p> <p>The Diagnosis Record and Extra Diagnosis Record will be edited each time they are transmitted.</p> <p>The Diagnosis Record and Extra Diagnosis Record will be re-edited if their corresponding Episode Record is re-transmitted.</p> <p>If an Episode Record is deleted, both Diagnosis Records will automatically be deleted from PRS/2. Re-transmitting the Episode Record alone will not regenerate the Diagnosis Record and Extra Diagnosis Record; they must also be re-transmitted.</p> <p><b>Correction/Update</b> To correct or update an Extra Diagnosis Record, re-transmit the Diagnosis Record immediately followed by the updated Extra Diagnosis Record. This will overwrite all fields already recorded, and re-assign the DRG.</p>
<i>Edits</i>	<p><b>*426 Y2 NOT ACCOMPANIED BY X2</b></p>

## Administration

<i>Purpose</i>	<b>The Extra Diagnosis Record accommodates additional diagnosis and procedure codes (13-25). These data will enable data users to access more complete information relating to complex episodes of care. These data support clinical research and payment systems.</b>
<i>Principal data users</i>	<b>Information and Performance Evaluation Section, Acute Health, Department of Human Services.</b>

## Revision Background

The development of this transaction record was initiated by the Victorian ICD Coding Committee. A number of factors led to the recommendation that more diagnosis and procedure codes be accepted by PRS/2. These include:

- **The AR-DRG Grouper, version 4.1, considers a maximum of 20 diagnosis and procedure codes when allocating a DRG. (Presently a maximum of 12 diagnosis and 12 procedure codes are collected by PRS/2.)**
- **Alterations to the Australian Coding Standards, particularly in the areas of anaesthetics and external cause coding, will result in a significant increase in the numbers of codes assigned to many episodes from 1 July 2000.**
- **Nationally there has been a move to the collection of at least 20 diagnosis and procedure codes for each episode. With the introduction of HL7, in future, an unlimited number of codes will be able to be accepted.**

When as least 20 codes are assigned to an episode but fewer are transmitted to PRS/2, a DRG may be assigned that does not reflect all of the events and circumstances of the episode. This potentially adversely impacts on funding and the availability of complete data to other data users.

Victorian guidelines for reporting coded data are being developed to address the situation where the diagnosis and/or procedure codes assigned to an episode exceed the limits of 12 and 25 codes able to be reported to PRS/2 via the X2 and X2/Y2, respectively.

Each of the PRS/2 Transaction Records has a fixed length of 240 characters. The X2 does not have the space to accommodate additional diagnosis and procedure codes. Hence the introduction of a new record (Y2) which is a continuation of the X2.

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## Hospital Generated DRG

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**Revision Summary** Report only AR-DRG, version 4.1 or Vic DRG, version 4.1 to this optional PRS/2 field.

For 1999–2000, either AN-DRG, version 3.1 or AR-DRG, version 4.1 groupings were accepted. From 1 July 2000 AN-DRG version 3.1 will not be accepted in this field.

### Specification

**Definition** The DRG (AR-DRG, version 4.1 or Vic DRG, version 4.1) generated by the in-house hospital grouper for each episode of care.

**Datatype** Alphanumeric *Form* Code

**Field size** 4 *Layout* ANNA or NNNA or spaces

**Location** Diagnosis Record

**Reported by** Public and private hospitals - optional.  
Reporting in this field is recommended for hospital quality control, if the hospital has onsite grouping facilities.

Otherwise, report spaces in this field.

**Reported for** Any/all episodes of care.

Otherwise, report spaces in this field.

**Reported when** The Separation Date has been reported in the corresponding Episode Record (matching unique keys).

**Code set** AR-DRG, version 4.1, value generated by the in-house grouper. (As specified by the Commonwealth Department of Health and Aged Care. [www.health.gov.au/casemix](http://www.health.gov.au/casemix))

*Collection guide* Refer to the *ICD Coding Newsletter, January 1999* for a summary of the differences between AN-DRG version 3.1 and AR-DRG version 4.1.

*Edits* 334 HOSP GENERATED DRG NOT = PRS/2 DRG

*Related items* Diagnosis and Procedure Codes, Admission Weight, Date of Birth, Sex, Separation Type, Hours of Mechanical Ventilation.

## Administration

*Purpose* To enable hospitals to detect differences between their grouping processes and those of DHS, which determine a significant portion of public hospital funding.

*Principal data users* Hospital Health Information Managers

*Collection start* 1 July 1998      *Version* 3 (1 July 2000)  
2 (1 July 1999)

*Definition source* HDSS      *Code set source* Commonwealth Department of Health and Aged Care, *Australian Refined Diagnosis Related Groups, version 4.1, Definitions Manual, 1998.*

## Revision Background

From 1 July 2000, DHS will be using Vic DRG, version 4.1 (based on AR-DRG, version 4.1), for funding purposes. The reference file for the Hospital Generated DRG field has been amended accordingly.

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## Patient Identifier

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<b>Revision Summary</b>	<b>Ensure that the Patient Identifier field reported in the Episode Record, Sub-Acute Record, and DVA Record are left justified with trailing blanks.</b>
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**In the past the layout of this field has been discretionary.**

### Specification

**Definition** Patient identifier, unique to this hospital or campus (patient's record number/unit record number).

**If multiple campuses transmit to PRS/2 in a single file, the Patient Identifier must be unique to the hospital. If the campuses transmit data separately to PRS/2, the Patient Identifier must be unique to each campus.**

<b>Datatype</b>	<b>Alphanumeric</b>	<b>Form</b>	<b>Code</b>
<b>Field size</b>	<b>8</b>	<b>Layout</b>	<b>XXXXXXXXX</b> <b>(Left justified, trailing blanks.)</b>

**Location** Episode Record  
Sub-Acute Record  
DVA Record

**Reported by** All hospitals.

**Reported for** All episodes of care.

**Reported when** An applicable PRS/2 Transaction Record is transmitted or updated.

**Code set** Hospital generated.

*Collection guide* Refer to page 22, for details on reporting data for patients remaining in hospital on 30 June 2000.

Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

All newborns must have their own Patient Identifier. This cannot be the newborn's mother's Patient Identifier but could be the mother's Patient Identifier with a prefix or suffix.

*Edits* 062 DUPLICATE ID, ADMIT DATE TIME, DIF. UNIQUE  
063 PRIOR NOT DISCHARGED  
064 DUPLICATE ID, DATE TIME

*Related items* Unique Key

## **Administration**

*Purpose* To enable relevant episodes to be updated and provide the potential for episodes to be linked across patient settings.

*Principal data users* Automated PRS/2 processes

*Collection start* 1 Jan 1979 *Version* 1

*Definition source* HDSS *Code set source* Hospitals

## **Revision Background**

For the PRS/2 field Patient Identifier, a justification requirement (left or right) is not currently specified in the PRS/2 Manual. In accordance with the program to standardise DHS data collections, and to facilitate future warehousing of these data, this item must be left justified and blank filled for all separations on and after 1 July 2000.

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## Reason for Critical Care Transfer

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<b>Revision Summary</b>	<p>Hospitals participating in the CCIHT program, report data on the reason a patient was transferred to another hospital for critical care, from the <i>receiving</i> <u>and</u> <i>sending</i> hospitals.</p> <p>Reason for Critical Care Transfer data were reported by the <i>receiving</i> hospital only for 1999–2000.</p> <p>This revision involves the addition of four values to this existing field:</p> <p><b>Y</b>      Transfer to acute hospital - Speciality not available at this hospital</p> <p><b>F</b>      Transfer to acute hospital - ICU bed not available at this hospital</p> <p><b>K</b>      Transfer to acute hospital - CCU bed not available at this hospital</p> <p><b>Z</b>      Other reason for transfer to acute hospital for critical care</p>
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### Specification

<i>Definition</i>	The reason a patient was transferred to another hospital for the provision of critical care.		
<i>Datatype</i>	Alphanumeric	<i>Form</i>	Code
<i>Field size</i>	1	<i>Layout</i>	A or space
<i>Location</i>	Diagnosis Record		

**Reported by** Public hospitals participating in the Critical Care Inter-Hospital Transfer (CCIHT) Program, as at April 2000, are:  
Austin and Repatriation Medical Centre  
Box Hill Hospital  
Dandenong Hospital  
Frankston Hospital  
Maroondah Hospital  
Monash Medical Centre  
Royal Melbourne Hospital  
St Vincent's Hospital (Melbourne)  
The Alfred  
The Angliss Health Services  
The Northern Hospital  
Western Hospital

**Private Hospitals: Reporting in this field is optional.**

**Public hospitals not participating in the CCIHT Program, and private hospitals that are not involved or choose not to collect these data, report a space in this field.**

- Reported if**
- This hospital is participating in the Critical Care Inter-Hospital Transfer (CCIHT) Program and admits (*receives*) a patient following their transfer from another hospital and
  - The patient receives care in the ICU or CCU during the admission.
- Or
- This hospital is participating in the Critical Care Inter-Hospital Transfer (CCIHT) Program and transfers (*sends*) an admitted patient to another hospital (public or private) for the provision of critical care.

**Otherwise, report a space in this field.**

**Reported when** A Separation Date has been reported in the corresponding Episode Record (matching unique keys).

**Code set** Hospitals that *receive* a patient following their transfer from another hospital for the provision of critical care, report the first appropriate value from:

<i>Code</i>	<i>Descriptor</i>
X	Transfer from acute hospital - Speciality not available at <i>sending</i> hospital
E	Transfer from acute hospital - ICU bed not available at <i>sending</i> hospital
J	Transfer from acute hospital - CCU bed not available at <i>sending</i> hospital

**W** Other reason for transfer from acute hospital for critical care

Hospitals that *send* an admitted patient to another hospital for the provision of critical care report the first appropriate value from:

<i>Code</i>	<i>Descriptor</i>
<b>Y</b>	<b>Transfer to acute hospital - Speciality not available at this hospital</b>
<b>F</b>	<b>Transfer to acute hospital - ICU bed not available at this hospital</b>
<b>K</b>	<b>Transfer to acute hospital - CCU bed not available at this hospital</b>
<b>Z</b>	<b>Other reason for transfer to acute hospital for critical care</b>

## *Collection guide*

### *General*

Refer to page 22, for details on reporting data for patients remaining in hospital on 30 June 2000.

### *Sent and Received*

Where, in a single episode, a patient was *received* by this hospital for the provision of critical care and *sent* by this hospital to another hospital for the provision of critical care, report the *sending* code only for this episode.

### *Receiving: X, Sending: Y Specialty not available*

An inter-hospital transfer of a patient:

- From a hospital without an ICU to a hospital with an ICU, for treatment in ICU.
- From a hospital to The Alfred Hospital for major burns, heart-lung transplant, pre-transplant mechanical cardiac supports or hyperbaric treatment.
- From a hospital to the Austin & Repatriation Medical Centre for spinal injury or liver transplant.
- From a hospital to The Alfred or the Royal Melbourne Hospital for bone marrow transplant or complication of a bone marrow transplant.
- From a hospital with a level 1, 2 or rural ICU to a hospital with level 3 ICU for neurology/neurosurgery, cardiac surgery or thoracic surgery, or treatment for major trauma.
- From Box Hill or Frankston Hospital to a hospital with level 3 ICU for neurology/neurosurgery, cardiac surgery.
- From the Western Hospital to a hospital with level 3 ICU for cardiac surgery.
- From a hospital without a CCU to a hospital with CCU, for treatment in CCU.
- From a hospital with a level 2 cardiac care service to a hospital with level 3 or level 4 cardiac care service for consideration or provision of angiography, angioplasty, cardiac surgery, assist device or electrophysiology.
- From St Vincent's to a hospital with level 4 cardiac care service for electrophysiology.
- From a hospital without the clinician responsible for the patient's original and on-going treatment to a hospital for on-going care by the original treating clinician.
- From a hospital without a requested or clinically needed specialist to one with a requested or clinically needed specialist.

**Receiving: E, Sending: F** *ICU bed not available*

An inter-hospital transfer of a patient to a hospital with an ICU for treatment in the ICU, outside the circumstances listed under X,Y.

Includes an inter-hospital transfer of a patient:

- From a hospital where the service, speciality or procedure is usually provided but the ICU bed, facilities, equipment or staff (medical/nursing/ancillary) are not available for the care of this patient.
- To the original *sending* hospital's ICU for recovery ('Down transfer').

**Receiving: J, Sending: K** *CCU bed not available*

An inter-hospital transfer of a patient to a hospital with a CCU for treatment in the CCU, outside the circumstances listed under X, Y.

Includes an inter-hospital transfer of a patient:

- From a hospital where the service, specialty or procedure is usually provided but the CCU bed, facilities, equipment or staff (medical/nursing/ancillary) are not available for the care of this patient.
- To the original sending hospital's CCU for recovery ('Down transfer').

**Receiving: W** *Other reason for transfer*

An inter-hospital transfer of a patient:

- But not to an ICU or CCU. However, the patient *later* spends time in the *receiving* hospital's ICU or CCU. (The *sending* hospital does not report a Reason for Critical Care Transfer in this instance.)
- For the provision of critical care in ICU/CCU when the *sending* hospital is able to provide the care required. Reasons for an inter-hospital transfer in this circumstance include:
  - Transfer to a hospital closer to home
  - Transfer to a hospital due to family convenience

**Sending: Z** *Other reason for transfer*

An inter-hospital transfer of a patient for the provision of critical care in ICU/CCU when the *sending* hospital is able to provide the care required. Reasons for an inter-hospital transfer in this circumstance include:

- Transfer to a hospital closer to home
- Transfer to a hospital due to family convenience

*Edits*

**\*335 INVALID REASON FOR CRIT CARE TRANSFER**

**\*336 INVALID COMB FOR CRITICAL CARE TRANSFER**

**\*337 CRIT CARE TRANSFER, NO ICU/CCU HRS**

*Related items*

**Duration of Stay in Intensive Care Unit, Duration of Stay in Cardiac/Coronary Care Unit**

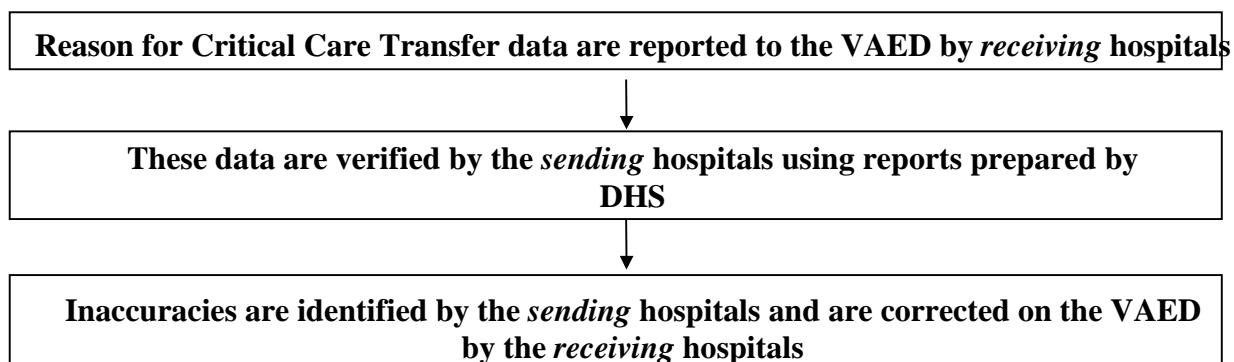
## Administration

<b>Purpose</b>	To provide data to support the Critical Care Inter-Hospital Transfer (CCIHT) component of the Hospital Access Program (HAP).		
<b>Principal data users</b>	Access Unit, Acute Health, Department of Human Services		
<b>Collection start</b>	1 July 1998	<b>Version</b>	2 (1 July 2000)
<b>Definition source</b>	Access Unit, Acute Health, Department of Human Services	<b>Code set source</b>	Access Unit, Acute Health, Department of Human Services

## Revision Background

In 1998–1999, the Critical Care Inter-Hospital Transfer (CCIHT) component of the Hospital Access Program (HAP) was introduced. Utilising a set of performance indicators and individual hospital targets, the aim of the program is to maximise bed availability and reduce the number of inappropriate inter-hospital transfers between public hospitals.

Currently (1999-2000), data flow supporting the CCIHT program is as follows:



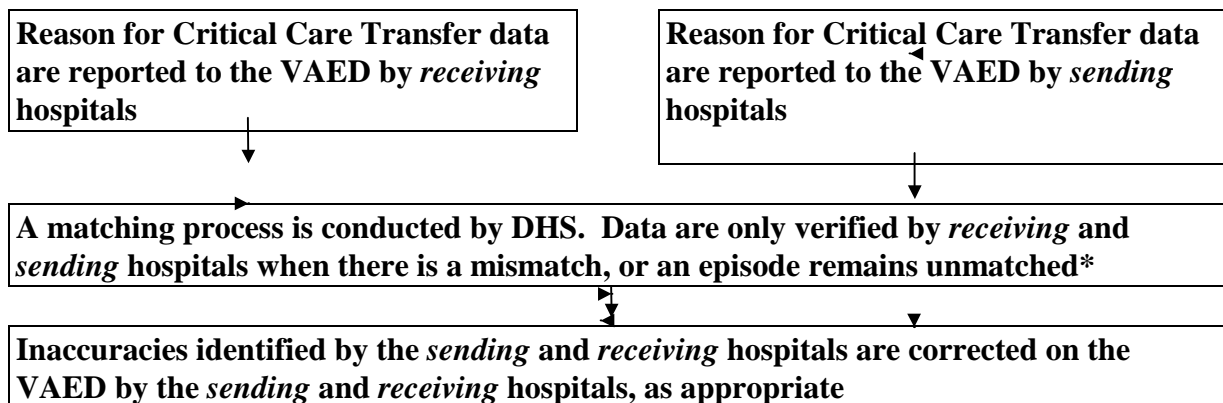
This approach was adopted following advice received by DHS that the information about transfers from *receiving* hospitals was likely to be of better quality than that of *sending* hospitals.

The Critical Care Inter-Hospital Transfer (CCIHT) Monitoring and Advisory Group includes intensive care clinicians, cardiologists and hospital administrators. This group advises DHS on the CCIHT component of the HAP Program and has recommended the revision detailed in this document.

The purpose of the specified change is to reduce the hospital workload involved with the validation of data reported to the VAED by facilitating the matching of data reported by *sending* and *receiving* hospitals. Only unmatched and mismatched records will

**require manual verification. It is intended that in future years, when the quality of the data have been verified, these data will only be reported by the *sending* hospital.**

The amended data flow to support the CCIHT program is as follows:



**\*1.** As transfers to private hospitals from the CCIHT program participants will be reported in 2000-2001, *sending* hospitals will need to manually confirm Reason for Critical Care Transfer data relating to patients transferred to private hospitals, for the provision of critical care. (This is unless the private hospital/s involved choose to transmit these data. Reporting Reason for Critical Care Data is optional for private hospitals.)

**\*2.** Similarly, patients who are transferred to another hospital and later receive care in an ICU/CCU (that is, the stay in ICU/CCU was not intended at the time of the patient transfer) will be reported by the *receiving* hospital only. Therefore, Reason for Critical Care Transfer data will need to be manually confirmed by the *receiving* hospital.

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## Transaction Type

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<b>Revision Summary</b>	<b>Change the Transaction Type value for Trailer Records 1 and 2 from T3 and T4 to T2 and U2, respectively.</b>
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### Specification

*Definition*                      **The identification label for each PRS/2 Transaction Record.**

*Datatype*                      **Alphanumeric**                      *Form*                      **Code**

*Field size*                      **2**                      *Layout*                      **AN**

*Location*                      **All PRS/2  
Transaction Records**

*Reported by*                      **All hospitals.**

*Reported for*                      **All PRS/2 Transaction Records.**

*Reported when*                      **A Transaction Record is transmitted to PRS/2.**

*Code set*

<i>Descriptor (Record Type)</i>	<i>Code 1999-2000</i>	<i>Code 2000-2001</i>
<b>Header Record</b>	<b>H2</b>	<b>H2</b>
<b>Episode Record</b>	<b>E2</b>	<b>E2</b>
<b>Diagnosis Record</b>	<b>X2</b>	<b>X2</b>
<b>Extra Diagnosis Record (new)</b>	<b>-</b>	<b>Y2</b>
<b>Sub-Acute Record</b>	<b>S2</b>	<b>S2</b>
<b>DVA Record</b>	<b>V2</b>	<b>V2</b>
<b>Trailer Record 1</b>	<b>T3</b>	<b>T2</b>
<b>Trailer Record 2</b>	<b>T4</b>	<b>U2</b>

<i>Collection guide</i>	Refer to page 22, for details on reporting data for patients remaining in hospital on 30 June 2000.
<i>Edits</i>	*004 UNKNOWN RECORD TYPE *427 TRANS TYPE INVALID COMB WITH SEP DATE
<i>Related items</i>	Separation Date, Start Date, End Date.

## Administration

*Purpose* To enable PRS/2 to efficiently identify the appropriate file structure against which to edit each Transaction Record.

*Principal data users* Automated PRS/2 processes.

<i>Collection start</i>	1 Jan 1979	<i>Version</i>	3 (1 July 2000) 2 (1 July 1999)
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<i>Definition source</i>	HDSS	<i>Code set source</i>	HDSS
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## Revision Background

The Transaction Type field is used to enable PRS/2 to efficiently identify whether a record (Header Records, Data Records, Trailer Records) should be edited against the file structure specification for 1999–2000 or 2000–2001. For 2000–2001 there are no changes to the field specifications (field length or datatype). The Transaction Types will be aligned at the beginning of each financial year and will only be incremented in future when the structure of a transaction record changes.

# Reference File Updates

## Postcode File

An updated postcode file will be loaded at Allegiance Systems and applied to all Episode Records transmitted to PRS/2 from 1 July 2000. This reference file is used for reporting in the Postcode and Locality fields.

The updated reference file will be available on our web site from June 2000 at:

[www.dhs.vic.gov.au/ahs/hdss](http://www.dhs.vic.gov.au/ahs/hdss)

Click on PRS/2 - VAED, then choose 'Postcode File' located under the 'Selected Reference Tables' section.

## Hospital Code Table

A new hospital code table was implemented for 1999–2000. Since then there have been a number of updates made to the file which have been published in the *HDSS Bulletin* (Issues 1, 7 and 8). The current Hospital Code Table appears in Appendix C and may be accessed on the internet at: [www.dhs.vic.gov.au/ahs/hdss](http://www.dhs.vic.gov.au/ahs/hdss)

Click on PRS/2 - VAED, then choose the 'Hospital Code Table' file located under the 'Selected Reference Tables' section.

This file also includes the following recent updates:

Private Hospitals	Former codes			New codes		
	Hosp Code	Site ID	Campus Code	Hosp Code	Site ID	Campus Code
Western Day Surgery (new hospital)	-	-	-	887	0	8870
Trethowan Private Hospital [Geelong] (closed)	888	0	8880	-	-	-

Updates to the hospital code table during 2000–2001 will again be published in the *HDSS Bulletin*, with the web version being amended accordingly.

This reference file is used for reporting in the following PRS/2 fields:

Hospital Code, Site Identifier, Transfer Source, Transfer Destination, Contract/Spoke Identifier.

## **Coding Classification and Grouper Versions**

**All separations on and after 1 July 2000 must be coded using ICD-10-AM, Second Edition. Once transmitted to PRS/2, ICD-10-AM data will be mapped back to ICD-10-AM, First Edition and grouped using AR-DRG version 4.1. The ICD-10-AM, Second Edition, DHS Library File will be available at the HDSS web site in May 2000 at: [www.dhs.vic.gov.au/ahs/hdss](http://www.dhs.vic.gov.au/ahs/hdss)**

**Click on PRS/2 - VAED, then choose 'ICD-10-AM 2<sup>nd</sup> Edition DHS Library File' located under the 'Selected Reference Tables' section.**

# Method for Reporting 'remaining ins' on 30 June 2000

Following is an explanation for reporting patients remaining in hospital on the night of 30 June 2000 and reporting episodes separated prior to 1 July 2000 but reported in the new financial year.

In summary, the Separation Date of an episode will determine the format and values to be reported for data records. For patients remaining in hospital on 30 June 2000, the header dates of a transmission will determine the format and values reported.

These arrangements are explained further and reinforced under the headings of 'General Rules' and 'Specific Rules'.

## *General Rules*

The following data rules apply for PRS/2 data transmissions before and after 1 July 2000:

- File transmissions with header dates prior to 1 July 2000 must contain records using the 1999–2000 format/values (H2, E2, X2, S2, V2, T3, T4).
- File transmissions with header dates of 1 July 2000 and beyond must contain header and trailer records using the 2000–2001 format/values (H2, T2, U2).
- File transmissions with header dates of 1 July 2000 and beyond must contain records of patients separated prior to 1 July 2000 using the 1999–2000 format/values.
- File transmissions with header dates of 1 July 2000 and beyond may contain records of unseparated patients (those remaining in on 30 June 2000); if present, those data records must use 2000–2001 format/values.
- File transmissions with header dates of 1 July 2000 and beyond must contain records of patients separated on and from 1 July 2000 using the 2000–2001 format/values.

### *Specific Rules*

The following, more specific, data rules apply for each admitted patient in hospital at the end of 30 June 2000:

#### **E2 (Episode Record)**

- An Episode Record (E2) for patients remaining in hospital on 30 June 2000 must be transmitted with the final June 2000 data transmission. This Episode Record must use the PRS/2 format/values applying for 1999–2000, and will have the Separation Date and associated fields blank.
- An Episode Record (E2) for patients remaining in hospital on 30 June 2000 must then be transmitted with the first July 2000 data transmission. This Episode Record must use the PRS/2 format/values applying for 2000–2001.
- Episode Records with admission and separation dates prior to 1 July 2000, but reported in transmissions with Header Record Start Date on or after 1 July 2000, should retain the file format and field values appropriate for 1999–2000.

#### **X2 (Diagnosis Record)**

- The Diagnosis Record file format relevant to the financial year in which the patient is separated must be used for transmission. That is, report the 1999–2000 format/values for separations prior to 1 July 2000, and the 2000–2001 format/values for separations on and after 1 July 2000.

#### **Y2 (Extra Diagnosis Record)**

- The Extra Diagnosis Record file format may be transmitted for episodes separated on and after 1 July 2000. This transaction record can only be sent in transmissions with header dates of July 2000 and beyond.

#### **S2 (Sub-Acute Record)**

- The Sub-Acute Record file format relevant to the financial year in which the patient is separated must be used for transmission. That is, report the 1999–2000 format/values for separations prior to 1 July 2000, and the 2000–2001 format/values for separations on and after 1 July 2000.

## **V2 (DVA Record)**

- **A DVA Record (V2) for patients remaining in hospital on 30 June 2000 must be transmitted with the final June 2000 data transmission. This DVA Record must use the PRS/2 format/values applying for 1999–2000, and will have the Separation Date and associated fields blank.**
- **A DVA Record must then be transmitted with the first July 2000 data transmission. This DVA Record must use the PRS/2 format/values applying for 2000–2001.**
- **DVA Records relating to episodes separated prior to 1 July 2000, but reported in transmissions with Header Record Start Date on or after 1 July 2000, should retain the file format and field values appropriate for 1999–2000.**

**The following data rules apply for PRS/2 header and trailer record reporting for the period prior to and following 1 July 2000:**

## **H2 (Header Record)**

**and**

## **T3/T2, T4/U2 (Trailer Records)**

- **File transmissions with header dates prior to July 2000 must contain header and trailer records in the 1999–2000 format (H2, T3, T4).**
- **File transmissions with header dates of 1 July 2000 and beyond must contain Header and Trailer Records in the 2000–2001 format (H2, T2, U2).**

## **Editing Note**

- **Non-adherence to any of the above rules will cause the transaction/transmission to reject.**

## **Collecting data for remaining ins**

**Hospitals need to take steps to ensure accurate information is reported on patients who are remaining in on 30 June 2000. The action required will vary according to the information already collected from/about patients, and the in-house system capabilities at each hospital.**

# Test Transmissions of New 1 July 2000 Software

Effective from 1 July this year, the PRS/2 interface is being revised to meet DHS admitted patient data requirements for the forthcoming financial year. The Department of Human Services recognises that software suppliers can experience difficulties making the 1 July revisions to their programs and that distributing untested programs to clients is unsatisfactory. It can also be difficult for hospitals to resolve problems caused by using untested software. Allegiance Systems will therefore be making a test facility available to software suppliers and encourages all suppliers to test new programs before using them to send live data to the VAED via PRS/2.

After making the necessary programming changes to meet the revised requirements, each software supplier can send up to two tests in public hospital format and two in private hospital format, without charge. Allegiance Systems will run additional tests at a charge (currently \$250 each), after the Department has approved the additional tests.

Each test can be made using the Hospital Code of a pilot hospital or using '500', the code for *dummy hospital* as used by Allegiance Systems.

Each test diskette must be externally labeled to inform Allegiance Systems whether the program is in the public hospital or private hospital format and, if not from a hospital, with the name of the software supplier.

For second or subsequent tests, Allegiance Systems requires advice as to whether or not previous test(s) are to be deleted before this test is run.

Turn-around time will depend on workload at Allegiance Systems.

Allegiance Systems will handle Control Reports produced for each test as follows:

- If Allegiance Systems knows the identity of the pilot hospital, the Control Reports will be sent to that hospital *unless that hospital has provided Allegiance Systems with written authorisation to send reports elsewhere* (a fax on letterhead is sufficient).
- If Allegiance Systems does not know the identity of the pilot hospital, Control Reports will be sent to the software supplier.

Staff at Allegiance Systems and the Department will, if requested, assist in identifying problems. However, there is no approval process for testing 1 July updates. Once the supplier and/or the hospital is satisfied that the new software meets the specifications as defined by the Department, live transmissions can begin.

# Outcome of Proposals for Revisions

This page includes a summary of the outcome of each of the proposals for the revisions to PRS/2 and the VAED contained in the document *Proposals for Revisions to PRS/2 and the VAED, January 2000* and the *HDSS Bulletin 9, March 2000*. The outcome of each item was the result of comments provided by hospitals during the period up until 24 March 2000, and ongoing review of PRS/2 and the VAED.

The contribution made to this process by those listed below, in alphabetical order, is much appreciated by DHS:

Pauline Basilio	St Vincent's Hospital
Jill Brooke	Kyabram & District Memorial Community Hospital
Janine Carter	Ballarat Health Services
Carolyn Gellert	Stawell District Hospital
Kirrily Gilchrist	The Northern Hospital
Kris Jenkins	Austin and Repatriation Medical Centre
Mary Kouvas	Western Hospital
Lorraine Lambert	Werribee Mercy Hospital
Marian Leane	Allegiance Systems
Pauline Morris	Box Hill
Judy Munro	St Vincent's Private Hospital
Nicolle Parrent	Australian Health Service Alliance
Shula Perelestein	Western Region, DHS
Don Peterson	Loddon Mallee Region, DHS
Elva Redenbach	Melbourne Extended Care and Rehabilitation Service
Rob Sands	Goulburn Valley Health
Alexandra Toth	West Gippsland Healthcare Group
Sophie Vlassis	Allegiance Systems
Juliette Wenn	Bairnsdale Regional Health Service

## **Main Language Other than English Spoken at Home**

### **Proficiency in Spoken English**

These items have been proposed for implementation from 1 July 2001. The feedback on these proposals has been provided to those proposing the change.

## **Reason for Critical Care Transfer**

This proposal is being implemented, with amendments.

## **New Transaction Record - Extra Diagnosis Record**

This proposal is being implemented, with amendments.

## **Discontinued Collection of Carer Availability Data for Some Care Types**

This proposal is being implemented, with amendments.

## **Layout of the Patient Identifier Field**

This proposal is being implemented.

