

# *Section 1: Introduction*



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# Foreword

To fund public hospitals equitably under the casemix system and to support health services planning, policy formulation and epidemiological research, the Department of Human Services maintains morbidity data on all admitted patient episodes of care provided in Victoria. These data must be consistent with the State's reporting obligations under the National Health Information Agreement and the Australian Health Care Agreement, and section 9 of the *Victorian Health Act 1958 (General Amendment 1988)* which requires the Secretary of the Department to establish a comprehensive information system on the:

- causes, effects and nature of illness among Victorians;
- determinants of good health and ill health; and
- utilisation of health services in Victoria.

Further to this, private hospitals and day procedure centres are required to submit data as specified in the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002*.

To meet these objectives, all public and private acute hospitals, including acute facilities in rehabilitation and extended care institutions and day procedure centres, are required to report the relevant minimum data set of admitted patient activity. These (de-identified) demographic, administrative and clinical data are then compiled into the Victorian Admitted Episode Dataset (VAED), previously known as the Victorian Inpatient Minimum Dataset (VIMD). Victorian hospitals must transmit data to the VAED via the PRS/2 system, an interface between a hospital's in-house patient management system and the VAED.

The Health Data Standards and Systems (HDSS) Unit (Metropolitan Health & Aged Care Division), manage the operations of the VAED, and Allegiance Systems provide technical services and support, from its Data Centre in Notting Hill, Victoria.

This Manual provides comprehensive information for hospitals on how the PRS/2 system works, the source data definitions and reporting requirements for all service types. The Manual will be made available on the Department's web site at:

<http://hdss.health.vic.gov.au>.

**MARK GILL**

Manager

Health Data Standards and Systems

# Manual Content Summary

The *VAED Manual, 13<sup>th</sup> Edition* (previously known as the *PRS/2 Manual*) is divided into ten sections. A detailed contents list is provided at the beginning of each section. A broad overview of each section is provided below.

**Section 1: Introduction**

This section includes introductory comments, and outlines the uses of the VAED, the PRS/2 and VAED data cycle, together with contact details, useful references and publications, and a list of abbreviations used in this manual.

**Section 2: Concept and Derived Item Definitions**

This section provides concept definitions that form the foundation of the VAED collection, and a reference to derived items. These derived items, when coupled with the data items supplied through PRS/2, make up the VAED.

**Section 3: Data Definitions**

This section presents the specifications for reporting to PRS/2. It includes data items relating to individual admitted patient episodes of care. The data items are arranged in alphabetical order.

Third-party software users who interface with PRS/2 should bear in mind that this manual describes the data as they should be transmitted to PRS/2. The hospital's system need not exactly replicate PRS/2 in all respects; however, the interface must be capable of formatting the data appropriately for transmission to PRS/2.

**Section 4: Business Rules**

This section draws together business rules (non-tabular and tabular) that incorporate a combination of two or more data items. The tabular business rules also provide a quick reference to edits that relate to the displayed business rules.

**Section 5: Compilation & Transmission**

Transaction Record file structures and descriptions are provided in this section, along with the specifications for reporting data items that do not relate to individual episodes of care (Section 3). These include summary statistics. The technical specifications are also detailed.

**Section 6: Request Reports**

This section describes the reports hospitals can request in the Header Record of any PRS/2 transmission. These reports seek to assist hospitals to manage their PRS/2 data reporting.

**Section 7: Control Reports & Reconciliation**

This section includes PRS/2 reports in their current format and a guide to assist with the reconciliation of PRS/2 reports with in-house data.

**Section 8: Editing**

Each PRS/2 edit message is listed in this section, in numerical order. The problem each edit message highlights is described and the remedy outlined. At the end there is an Edit Matrix, which details which data items are involved in the different edits.

**Section 9: Supplementary Code Lists**

This section draws together a range of lengthy code sets. (Most code sets are short and are included in Section 3). This section also provides lists of hospital

campuses that are authorised to provide (and therefore report to PRS/2) specific specialist services.

**Section 10: PRS/2 Testing**

This section outlines the process for undertaking PRS/2 testing.



# Scope of the VAED

The Victorian Admitted Episode Dataset (VAED) comprises demographic, clinical and administrative details for every admitted episode of care occurring in Victorian acute hospitals. The VAED is compiled in financial years (July to June). A list of all data fields stored in the VAED for any given year is available from the Department of Human Services.

In order to maintain and protect patient privacy, only the minimum data required for effective monitoring, funding and analysis purposes are collected. Information such as patient name and street address is not collected for the VAED.

Each patient in the VAED is denoted by a hospital controlled *patient identifier* code (Unit Record Number). Hence the admission, treatment and separation history of a particular patient contained in the VAED may be tracked within the same hospital over time but not between hospitals.

It is potentially possible to identify an individual from a combination of patient-level data fields (for example date of birth plus location of residence plus date of admission plus hospital code), thus specific limitations are placed upon the release of patient-level data. This is covered in more depth in *Data Release and Confidentiality* page 1-18.

Collection processes are based on standard definitions and collection protocols to ensure comparability over time and across geographical and agency boundaries. Definitions of patient categories and other terms used in the VAED are set out in this Manual, and these conform to the definitions in the *National Health Data Dictionary*, published by the Australian Institute of Health and Welfare (AIHW).

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## Contributing Health Agencies

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Under the terms of the relevant health service agreements or legislation, the Department of Human Services requires all acute hospitals registered under the *Health Services Act 1988* to report relevant admitted patient activity to the VAED using data formats and transmission protocols specified by the Department. The term *acute hospitals* refers to public, private and denominational hospitals, acute facilities in rehabilitation and extended care (subacute) facilities, day procedure centres and designated acute psychiatric units in public hospitals. It is not limited to hospitals recognised under the Australian Health Care Agreement (AHCA) between the Commonwealth and Victoria. Residential care (nursing homes), hostels, supported residential services and state managed psychiatric institutions are *excluded* from reporting to the VAED.

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## VAED File Consolidation

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The Department creates an annual consolidated file of the VAED by combining data from all contributing hospitals. This file is locked on 17 September each year, almost three months after the end of the financial year. Hospitals should have finalised and transmitted complete data for that financial year's separations by that date.

Once the consolidated file has been locked, the file is not amended or updated, thus maintaining the integrity of reports and datasets released for analysis. The Department maintains separate notes (metadata) on any significant data anomalies identified in the locked file.

Since the introduction of casemix funding in July 1993, the Department also produces quarterly archives of VAED public files.

Analyses may be undertaken on the VAED for the current year before it is locked, with the caution that some of the data may not have been finalised and could be subject to change.

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## Periods of Data Available

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The Department presently holds VAED annual consolidated files for all financial years since 1987-88. Limited data may be available from printouts for previous years (back to 1983-84 for specific hospitals only); refer to *History and development of the VAED*, page 1-22.

# Uses of the VAED

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## Morbidity Monitoring

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The Department of Human Services' Epidemiology Section uses the VAED to monitor population morbidity to inform health policy development including:

- Analysis of health outcome data to assist in informing health policy and program options;
  - Coordination and collation of data sources to provide accurate and timely information on the health status of the Victorian population;
  - Preparation of consolidated epidemiological reports such as *Victoria's Health, A First Report on the Health Status of Victorians*, April 1993; and
  - Compilation of a set of Victorian health indicators that can be used at state and regional levels to monitor the health needs in the community, the outcomes of interventions aimed at those needs and patterns of clinical practice.
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## Casemix Funding

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Casemix funding is a case payment system used in public and private hospitals providing acute health services. It is designed to provide financial incentives for hospitals to improve efficiency, effectiveness and accountability, by ensuring that hospitals are rewarded for the amount and type of work they do. The VAED is the primary source of data used to administer the casemix-based funding system for *public* hospitals in Victoria. For any given year, details of the Department's funding system are set out in *Victoria - Public Hospitals and Mental Health Services Policy and Funding Guidelines*. Refer to *Clinical Coding and Grouping*, page 1-19.

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## Performance Measurement

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Many of the Department's units use the VAED to monitor utilisation and performance of health services by:

- Evaluating the impact of casemix funding on public hospitals;
- Modelling adjustments to the casemix funding formula;
- Analysing variations in the utilisation of acute health services across Victoria to assist in determining the relationship between supply and demand;
- Modelling future demand for hospital services and alternative geographical distributions of hospital services; and
- Monitoring hospital performance in improving efficiency by making comparisons
  - across time periods and patient groups
  - with peer groups of hospitals
  - by benchmarking against best practice targets.

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# National Health Information Agreement

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Maintaining the VAED enables Victoria to meet its obligation under the National Health Information Agreement (NHIA) to contribute to the National Hospital Morbidity Database. The NHIA is an agreement between the Commonwealth and all State and Territory health authorities, the Australian Bureau of Statistics (ABS) and the AIHW, and operates under the auspices of the Australian Health Ministers' Advisory Council (AHMAC). The data provided conform to the data standards and definitions as stated in the AIHW's *National Health Data Dictionary (NHDD)*.

The Department provides data from the VAED to the AIHW within the terms of the agreement under strict conditions of confidentiality. AIHW does not release data without approval from the relevant State authorities.

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## Other Uses of the VAED

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The VAED is also used by the Department, its Regional Offices and other researchers authorised by the Department (including research agencies, government agencies, consultants, students and other members of the general public, hospitals and other institutions involved in the health industry) for purposes such as:

- Studying present patterns of treatment;
- Determining trends in hospital casemix;
- Epidemiological studies;
- Clinical research;
- Health care planning;
- Estimating the need for special care/specialised equipment;
- Making projections for workforce planning;
- Trends analysis;
- Monitoring quality indicators (for example unplanned readmissions and in-hospital mortality); and
- Publications.

# *Data Cycle: Patient Reporting System 2 (PRS/2) and the Victorian Admitted Episodes Dataset (VAED)*

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## **Are PRS/2 and the VAED the same thing?**

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No, they are different. The PRS/2 System is the interface between the hospital information system and the VAED. PRS/2 consists of three components:

1. The **PRS/2 Application** is a transaction processing system developed specifically for the purpose of processing the data supplied by hospitals with various controls and feedback loops to ensure that:
  - All data supplied by hospitals are validated (hospitals thus have an opportunity to re-submit corrected data), and
  - No data can be omitted, misfiled or incorrectly processed without a warning to the hospital that supplied the data.
2. **PRS/2 file formats** are defined by DHS, and refer to the file structure (that is, the order and content of data items within a PRS/2 transmission) used to allow the PRS/2 Application to transfer hospital data into the PRS/2 Database.
3. The **PRS/2 Database** is a collection of data obtained through the PRS/2 interface and is maintained at the Allegiance Systems' Data Centre.

The PRS/2 Application calculates or derives certain additional data items from the transmitted data. Some examples are listed below:

- Patient age (calculated as the difference between Birth Date and Admission Date)
- Statistical Local Area (SLA) of the patient's address (derived from the Postcode and Suburb fields)
- The Diagnosis Related Group (DRG) according to the edition used for that year (derived from the diagnosis and procedure codes, age, sex, separation mode, intended length of stay and admission weight (for newborns) by means of a software grouper)
- Length of stay (the total of the patient days in each status segment for that episode of care).

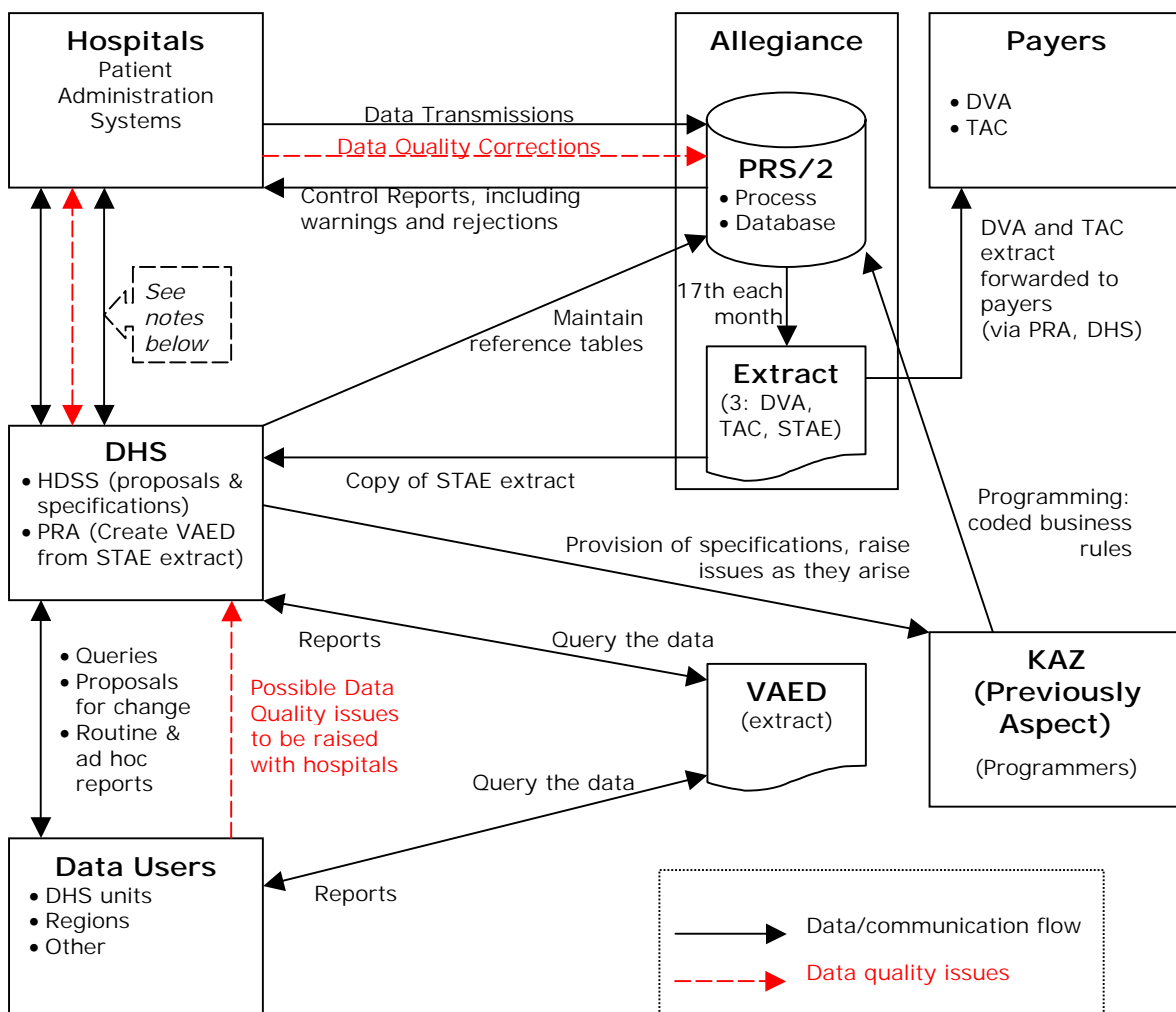
Alliance Systems sends a year to date copy of PRS/2 data to the Department once per month.

The Victorian Admitted Episodes Dataset (VAED) is the file and database that contains the majority of data submitted by hospitals through the PRS/2 process (excluding data required purely for the payers: DVA and TAC), plus the additional derived items added by DHS once the data has been received from Allegiance.

# Roles and Information capture and flow

The diagram below provides an outline of the sequence of data capture at the hospital and subsequent flow of information to the VAED and through to the end user. The following abbreviations are used in the diagram:

- DVA Department of Veterans Affairs
- HDSS Health Data Standards and Systems
- PRA Performance Reporting and Analysis
- PRS/2 Patient Reporting System (version 2)
- TAC Transport Accident Commission



**Notes (Between Hospitals and DHS)**

First arrow

- To hospitals: requests for proposals, specifications, VAED Manual, HDSS Bulletins and Coding Newsletter.
- To DHS: proposals for changes to PRS/2 and/or VAED, feedback on proposals.

Second arrow

- To hospitals: data quality reports, PICQ extracts etc.
- To DHS: responses to data quality issues

Third arrow

- To DHS: queries regarding VAED
- To hospitals: answers to questions

### **At the Hospital**

The flow of information to the VAED begins at the hospital when the patient is admitted and the patient registration and admission information is entered on the hospital's own patient administration system (PAS). At the time of separation, the hospital enters separation information onto the PAS. Diagnosis and operation (procedure) data are abstracted from the medical record and these codes are also entered on the hospital's PAS.

Currently each Victorian hospital selects its own PAS from commercial software suppliers operating in Victoria, or uses the Department's Admitted Patient Entry and Transmission System (APET) software. The hospital is responsible for mapping or deriving (where necessary) the fields and codes used in their system to the fields and codes defined for PRS/2. The system must also compile the counts of patient days, etc and a Header Record and Trailer Records for each PRS/2 data transmission.

The data should be checked and corrected by the hospital before transmission to Allegiance Systems (usually a hospital's PAS has the ability to print reports to facilitate this process). Upon completion of processing, Allegiance Systems sends the hospital a number of transmission reports:

- *Transmission Control and Reconciliation Reports* (produced with every transmission)
- *Hospital Activity and WIES Report* (produced only for *public* hospitals with the end of month transmissions)
- *Request Suite Reports* (produced at the hospital's request).

Periodically, hospitals will also receive a range of data quality reports from the Health Data Standards and Systems Unit (HDSS), including:

- Performance Indicators for Coding Quality (PICQ) extracts, to allow review of suspect coded data;
- Notifiable edits (commencing 1 July 2003); and
- Ad hoc data quality projects.

These should be actioned where appropriate, to ensure complete and accurate capture of data.

To assist hospitals in meeting their obligations, DHS provides documents such as the *VAED Manual*, *HDSS Bulletins*, and the *ICD Coding Newsletter*. A Help Desk facility is provided by HDSS to provide support to data collectors and users.

### **At Allegiance Systems: PRS/2 System**

Allegiance Systems is the facilities manager for the PRS/2 system, and manages the system in accordance with guidelines established by the Department.

When a transmission is received by Allegiance Systems this is loaded into the PRS/2 Application where an automatic edit check of data takes place. For each transmission, Allegiance Systems sends the hospital a Control and Reconciliation Report to identify any problem records and to enable the hospital to reconcile PRS/2 with their own patient information system. In addition, monthly reports such as the *Hospital activity and WIES report* are provided to the hospitals, summarising the data sent to PRS/2.

Until the financial year's data are locked on 17 September each year, a hospital can update or change information already held on the PRS/2 Database by generating and transmitting a new snapshot image of the relevant record. This new record overwrites the existing information held in PRS/2.

There is no manual data entry of patient-level data by the Department or Allegiance Systems. All public and private hospitals provide the data in computer readable form via direct telephone dial-up or diskette to Allegiance Systems.

### **At Allegiance Systems: Extracts**

For PRS/2 processing at Allegiance Systems, there is an NT server and a Unix server. The PRS/2 process runs on the NT server, which populates a database called 'staging', which resides in the Unix server.

On the 17th of each month, three processes extract the year to date data from the 'staging' database, and outputs it to 3 separate files: the DVA, TAC and STAE (staging) extracts, which are sent to DHS (via file transfer protocol).

#### **At KAZ (Previously Aspect Computing)**

KAZ is a company contracted by DHS to manage the programming required for the PRS/2 Application. The current PRS/2 System was developed by Aspect Computing and was implemented in late 2001.

#### **At the Department of Human Services: HDSS and PRA**

The Department regularly constructs VAED files from the STAE (staging) extract obtained from the Allegiance Systems' Data Centre. This process is generally completed on a monthly basis, after the 17th of each month.

Copies of the VAED data are supplied to the:

- Department's Regional Offices as required; this can include data relevant only to their region or it can be a full dataset; and
- Department's Epidemiology Section, for use in its work of epidemiological study and health status monitoring.

Standard VAED datasets are extracted from the annual consolidated file and are available to the public. To maintain confidentiality, only limited information for public hospitals is available.

Within the Department there are two business units that are primarily responsible for the management of the VAED:

- Health Data Standards and Systems (HDSS)—Responsible for defining the input standards: the content of the PRS/2 file format, and the related business rules. HDSS also undertake data quality activities on the VAED; and
- Performance Reporting and Analysis (PRA)—Responsible for defining the output: including handling extracts for the external payers, and allowing appropriate persons access to the VAED. PRA currently maintains the reference data tables (code sets) that are used by the PRS/2 Application.

#### **External payers: DVA and TAC**

Extracts containing data items required for payment of DVA and TAC payments are forwarded to the external payers by the PRA Unit. These extracts are specified by the external payers and are different to the STAE extract (which is used to formulate the VAED—see diagram on page 11), as different data items are required by each of the payers. For example, Given Name and Surname are sent to the payers, as these are a minimum requirement for payment, however these data items are not held at DHS on the VAED due to privacy concerns.

#### **Data Users**

Data users include various DHS units and regions, the Commonwealth and ad-hoc users. As well as receiving VAED reports (on a routine or ad hoc basis), users may query the quality of the data, which in turn may lead to HDSS contacting hospitals, or creating new edits.

# Data Transmission Timeline

A hospital must transmit data to the VAED at least monthly. Data may be transmitted more frequently, however no more than once per day. Under casemix funding, monthly deadlines for data transmission have assumed particular significance, as payments are based on the monthly VAED consolidated file data.

## *For Public Hospitals:*

- The hospital must transmit admission and separation details in any month in time for the VAED file consolidation of the following month.
- The hospital must transmit diagnosis and procedure details for separations in any month in time for the VAED file consolidation in the second month following the month of separation.
- The hospital must reconcile the transmission report and transmit any required corrections in the next transmission.
- The hospital must complete and transmit data for the financial year before the file is consolidated on 17 August, following the end of the financial year. The hospital must transmit any final corrections before the annual file is locked on 17 September.
- Episodes submitted after due dates are subject to financial penalty unless there have been extenuating technical difficulties (in which case, hospitals are required to notify HDSS).

## *For Private Hospitals:*

- The hospital should transmit in accordance with the same timelines as public hospitals and may be subject to financial penalties for late data submission under the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002*.

## Timeline Summary

<i>Day of month</i>	<i>Activity</i>
17th	<p>Final date for transmission of data. All hospitals must have their data received by Allegiance Systems by close of business on the 17th of each month:</p> <ul style="list-style-type: none"> <li>• Admission and separation details for all separations in the previous month</li> <li>• Diagnosis and procedure details for all separations in the month immediately preceding the previous month.</li> </ul> <p>IF SUBMITTING BY DISC, ALLOWANCE SHOULD BE MADE FOR WEEKENDS AND PUBLIC HOLIDAYS.</p>
18th	VAED data available for Department analysis by modem dial-up.

### **VAED Monthly Consolidated File**

The VAED is updated on the 17<sup>th</sup> day of each month (when Allegiance Systems copies data across from the PRS/2 database to three extracts—DVA, TAC, STAE) for each hospital.

### **VAED Annual Consolidated File**

The Department creates an annual consolidated file of the VAED by combining data from all contributing hospitals. This file is locked on 17 September each year, almost three months after the end of the financial year. Hospitals must have finalised and transmitted complete data for that financial year's separations by that date.

Once the consolidated file has been locked, the file is not amended or updated, thus maintaining the integrity of reports and datasets released for analysis. The Department maintains separate notes (metadata) on any significant data anomalies identified in the locked file.

There are two consolidated files created by the Department for each financial year:

- A public hospital file
  - A private hospital file
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## Data Quality

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Maintaining and improving data quality within the VAED has become an increasingly important issue since the introduction of casemix funding. In response to this, the Department of Human Services implemented a formal data quality review process. However, the maintenance of data quality is not the sole responsibility of the Department and various quality evaluations are performed at the hospital level and by Allegiance Systems Australia.

### At the Hospital

- Data entry from the source, rather than from a distant data entry site, using extracts of the full information, ensures that optimum accuracy is achieved. The hospital has access to the most detailed information to code from (that is, the medical record and, the clinicians responsible for the patient's care). Also, the direct transmission of data in a machine-readable format avoids any further typographical errors.
- Hospital PAS should contain system edits that upon data entry, block data entry or provide a warning for invalid or improbable data variables.
- Hospital PAS should incorporate the various files that validate or translate data (for example, the files for ICD-10-AM and Postcodes).
- Hospital personnel should reconcile their data against reports produced by PRS/2 and the Agency Information Management Systems (AIMS). Any differences may highlight possible transmission errors.
- All diagnostic and procedural information must be coded in accordance with the Australian Coding Standards relevant for that period. The National Centre for Classification in Health (NCCH) publishes material to assist hospitals to improve the quality of coded data. The hospital should enable staff to attend appropriate continuing education sessions. HDSS will periodically send PICQ extracts to hospitals, and these should be utilised.
- To conform to Accreditation requirements, hospitals must conduct quality improvement measures. These may involve quality assessment and improvement of the coded minimum dataset.

### At Allegiance Systems

- Extensive system edits (as specified by the Department) produce rejection, warning and notifiable edits for records containing invalid or inappropriate data. These edits provide a backup to any edits that may exist in a hospital's individual patient information system. A hospital must take the appropriate action for all edit messages received.
- A new hospital or a hospital that has changed its software supplier must undertake a testing process: two consecutive months' data are processed separately from the normal PRS/2 processing. HDSS and Allegiance staff review these test runs and liaise with the hospital and software supplier to rectify any problems encountered. Once the hospital has successfully completed the testing process, data transmission to the live system may commence.

## At the Department of Human Services

- A formal data quality review process was introduced in July 1993 to coincide with the introduction of casemix funding. Each issue is researched and the results fed back to the hospitals involved. If indicated, further guidance on coding policies and standards is provided. The Victorian Advisory Committee on Data Integrity (VACCDI) and the Victorian ICD Coding Committee are consulted as appropriate (see below). Quality issues that are detected:
  - Through regular analyses of the VAED;
  - By referrals from VACCDI (see below);
  - Through the Victorian VAED data audit (see below);
  - By referrals from the Victorian ICD Coding Committee (see below); and
  - From queries by hospitals, Allegiance Systems, Department officers and other users of the data.
- The Victorian Advisory Committee on Casemix Data Integrity (VACCDI) is responsible for reviewing and making recommendations regarding data definitions and standards and hospitals compliance with them. VACCDI oversees the coding and data quality audits and undertakes specific data quality investigations, as required. VACCDI comprises representatives of metropolitan hospitals, health services, the Department, and the Victorian Healthcare Association. See web site: <http://hdss.health.vic.gov.au/vaed/vaccdi.htm>
- VAED data audits have been conducted on separations in Victorian public hospitals for 1993-94 and 1995-96, and annually from 1998–1999 to 2000–2001. External consultancy firms conduct these audits and results indicate that, among jurisdictions that have conducted similar audits, Victoria has a high level of quality coding. See web site: <http://hdss.health.vic.gov.au/vaed/index.htm>
- The Victorian ICD Coding Committee comprises expert coders and is responsible for answering coding queries. It liaises with hospitals, health information managers, clinical coders and VACCDI to provide advice on specific coding issues. The Committee works with the National Centre for Classification in Health (NCCH) and contributes to the NCCH's ongoing development of the Australian coding system and standards. See web site: <http://hdss.health.vic.gov.au/icdcoding/codecommit/codcom.htm>
- HDSS produces the following publications. These are available for downloading from the HDSS website at: <http://hdss.health.vic.gov.au>:
  - A quarterly *ICD Coding Newsletter* providing information on clinical coding, data quality issues and coding advice to Victorian clinical coders; and
  - The *HDSS Bulletin*, providing advice on the VAED and data quality issues to agencies that contribute to the VAED (and other collections).
- The Department publishes a number of Reference Files that hospitals can incorporate into their systems to validate data at input to improve efficiency and data quality. These are available for downloading from the HDSS website at: <http://hdss.health.vic.gov.au>:
  - Library File of the ICD-10-AM diagnosis and procedure codes, including the Victorian edits applied to those codes. The Victorian file is available only to Victorian hospitals and their software suppliers, however others can purchase a file of codes and the national edits from the National Centre for Classification in Health; and
  - Reference Files of certain code sets (for example, postcode and locations; hospital codes to indicate patient transfers).
- The PRS/2 system provides a range of reports that hospitals should use to assist in data quality.
- The HDSS Unit provides a Helpdesk service, for advice by telephone and email. Refer to page 1-5 for contact details.

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## VAED Update Cycle

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Towards the end of each calendar year, the Health Data Standards and Systems Unit calls for submissions for revisions to the VAED with effect from the following 1 July. Revisions may be necessary, to provide data for a change in funding mechanism, to monitor a new policy, or to follow changes to the *National Health Data Dictionary*. Opportunities are also taken wherever possible to simplify and streamline the dataset. At all times, HDSS attempts to keep changes to a minimum.

The proposals are outlined in a *Proposals* document, which is circulated to hospitals, software suppliers and others. All parties have the opportunity to submit comments and questions on the proposals. A forum is then held to present the proposals in detail. Following this, a *Specification for Revisions* document is prepared, providing full details of the changes.

Software suppliers should then revise software ready to use from 1 July. Hospitals may also need to revise medical record stationery and train staff in any PAS changes.

Each 1 July may also see the introduction of other revisions, such as:

- A revised coding system (revised every second year, although small additions may be made in the intervening year)
- A new AR-DRG grouper
- Revised reference files, such as postcodes and hospital codes.

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## Accessing VAED data

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For access to VAED data contact the Victorian Health Information reporting System (VHIRS) helpdesk by calling 9616 6939 or email [vhirs.helpdesk@dhs.vic.gov.au](mailto:vhirs.helpdesk@dhs.vic.gov.au). Specify your name and contact details, your hospital, an outline of the data that you require and the reason that you require these data.

# *Data Release and Confidentiality*

The Department of Human Services has established an Ethics Committee for consultation, when necessary, on data release issues.

There are two major areas of sensitivity relating to data held in the VAED, namely the risk to patient confidentiality in releasing extracts of detailed aggregate data, and the risk to commercial confidentiality in releasing data from private hospitals.

Data that could potentially identify an individual private hospital will not be published or released to a third party without the written permission of that hospital.

In order to maintain and protect patient privacy, only the minimum data required for effective monitoring, funding, epidemiological and analysis purposes are collected. Information such as patient name and street address are not transmitted to the PRS/2 System Interface and therefore are not available on the VAED. Nevertheless, from the data held on the VAED, it is potentially possible to identify an individual from a combination of specific fields (for example, date of birth plus location of residence plus date of admission plus hospital code).

In releasing patient-level data or detailed aggregate data derived from patient-level data, the risks to confidentiality are minimised by:

- Limiting the release of data to the specific data fields necessary for the purpose of the study;
- Deleting, minimising combinations of, and/or broad banding of demographic variables (for example, hospital, local government area and postcode) and temporal variables (for example, admission date, separation date); and
- Attaching conditions to the release of data.

The Department attaches the following conditions to the release of any data files that are at risk, however minor, of potentially enabling patient identification:

- VAED data will not be used, published or disseminated in a way that might enable the identity of individual patients to be ascertained;
- VAED data are provided to the organisation and must not be communicated to other persons or organisations, or linked with files of personal information from other sources, without the prior agreement of the Department of Human Services;
- VAED data must be maintained and stored in a secure manner. When no longer required, the data files must be destroyed or returned to the Department of Human Services; and
- VAED data must not be linked with other data sources without reference to the Department of Human Services Ethics Committee, if there is potential for patient identification.

# Clinical Coding and Grouping

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## Clinical Coding

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A health classification consists of a hierarchical system of codes for diseases, manifestations, injuries and procedures as documented in health care services. One classification system is the World Health Organization's *International Classification of Diseases* (ICD). ICD's hierarchical structure permits data to be analysed at various degrees of detail (for example, at the level of an individual form of a disease, such as *type* of diabetes, or at the level of a disease, such as all diabetes, or at the level of a body system, such as the endocrine system). WHO revises the ICD system periodically. The first edition was published in 1900 and the current edition is ICD-10.

Clinical classification and coding is the translation of clinical data from a patient record into a coded format. The data collected for VAED is coded using ICD-10-AM, an Australian Modification to ICD-10.

Each code and group of codes has a title (rubric) but it is important to refer to the full coding text when interpreting data. The Department also strongly recommends that users consult an experienced clinical coder to aid their interpretation of coded data.

In Victoria, diagnosis and operation (procedure) data are coded from the medical record by qualified clinical coders using the appropriate edition of ICD-10-AM, in accordance with the relevant edition of the Australian Coding Standards. The codes are entered into the hospital's patient information system.

In Australia, since 1993, the coding authority has been the organisation now known as the National Centre for Classification in Health (NCCH). NCCH was formed in 1997 as a joint venture agreement between the National Coding Centre (NCC) [University of Sydney] and the National Reference Centre for Classification in Health (NRCCH) [Queensland University of Technology].

Before the establishment of NCC in 1993, the classification system used in Australia was produced in, and new codes issued from, the USA while coding standards were determined at a state level within Australia. The NCCH now sets Australian standards for coding diseases and procedures, and has developed the Australian adaptation of ICD-10, known as ICD-10-AM (Australian Modification). This includes *disease* codes based on the WHO ICD, plus a *procedure* classification (ACHI) based on the Australian Medicare Benefits Schedule.

Page 1-20 sets out a calendar of the editions of the coding systems used in Victoria. In the early years of the collection, Australian States and Territories decided individually which version of ICD, and which edition, to use. Gradually all States and Territories changed from ICD-9 to ICD-9-CM. States changed to ICD-10-AM on 1 July 1998 (Victoria, New South Wales, ACT and Northern Territory) or 1 July 1999 (remaining states).

Earlier editions of coding books may be available from specialist libraries. The edition of the coding books currently in use can be purchased in several formats from the National Centre for Classification in Health (refer to contact details, page 1-26). Since 1999, NCCH has published the National Minimum Edits (defining, where relevant, the age range and the sex appropriate for a code) although Victoria applies a more extensive and stringent set of edits.

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## Grouping for Casemix

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The purpose of grouping for casemix is to collapse, into a manageable number of categories, the more than 14,000 codes found in the ICD-10-AM coding system. AR-DRGs (Australian Refined – Diagnosis Related Groups) is an example of one casemix grouping system. There are approximately 600 groups (DRGs) in the AR-DRGs (the exact number depends on which version is used for any year).

AR-DRGs allocates each episode of care to a DRG according to diagnosis and procedure codes, and certain other relevant data (for instance, age, separation status).

For background to casemix, the following is suggested reading:

'Casemix and information systems', chapter 27 (pp 313-338), by Evelyn Hovenga, in *Health Informatics: An overview*. Edited by Evelyn Hovenga, Michael Kidd and Branko Cesnik. Churchill Livingstone, South Melbourne, 1996.

Further information regarding AR-DRGs can be found at <http://www.health.gov.au/casemix/>

Also see the introduction to the relevant DRG manual currently being used in Victoria. For 2003-2004, this is AR-DRG version 4.2.

Victoria makes certain adjustments to the grouping necessary for casemix funding purposes. For any year, refer to the appropriate *Policy and Funding Guidelines* publication for details.

In summary, casemix is a patient classification scheme that provides a clinically meaningful way of relating the number and types of patients treated in a hospital to the resources required by the hospital. Each DRG is designed to be resource-use homogeneous and clinically meaningful. Casemix is useful for comparative analyses of hospital admitted patient data and for performance monitoring. In Victoria, it is also used as the basis for funding.

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## Coding/grouping systems used in Victoria

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The calendar on the following page sets out, for each financial year, the edition of the ICD and DRG systems used by the Department of Human Services.

It is important to interpret coded data with reference to the *specific* edition of the coding or grouping version. The Department also strongly recommends that users consult an experienced clinical coder to aid their interpretation of coded data.

Fin. Year July/June	ICD ed: (edition/ release date) (a)	ICD ed: Vic	Coding Standards used in Victoria	Aust DRG version released	DRG version: Vic (b)	Codes input to DRG version: Vic (c)
03-04	No release	AM 3	Aust Standards AM 3rd ed. with some Vic Additions	No release	AR v4.2 *	AM 2
02-03	AM 3 (Jul 2002)	AM 3	Aust Standards AM 3rd ed. with some Vic Additions	AR v5.0	AR v4.2 *	AM 2
01-02	No release	AM 2	Aust Standards AM 2nd ed. with some Vic Additions	No release	AR v4.2 *	AM 2
00-01	AM 2 (Jul 2000)	AM 2	Aust Standards AM 2nd ed. with some Vic Additions	AR v4.2	AR v4.1 *	AM 1
99-00	No release except Amendment list	AM 1	Aust Standards AM 1st ed. with some Vic Additions	No release	AN v3.1 *	Aust CM 2
98-99	AM 1 (Jul 1998)	AM 1	Aust Standards AM 1st ed. with some Vic Additions	AR v4.1	AN v3.1 *	Aust CM 2
1.7.98	Victoria changed from ICD-9-CM to ICD-10-AM.					
97-98	No release	Aust CM 2	Aust Standards CM 2nd ed. with some Vic Additions	AR v4.0	AN v3.1 *	Aust CM 2
96-97	Aust CM 2 (Jul 96)	Aust CM 2	Aust Standards CM 2nd ed. with some Vic Additions	AN v3.1	AN v3.1 *	Aust CM 2
95-96	Aust CM 1 (Jul 95)	Aust CM 1	Aust Standards CM 1st ed. with some Vic Additions	AN v3.0	AN v1.0 *	U.S. 8
94-95	U.S. 10 (Oct 93)	U.S. 10	Vic Guidelines Revised, incorporating National Coding Standards	An v2.1	AN v1.0	U.S. 8
93-94	U.S. 9 (Oct 92)	U.S. 9	Vic Guidelines Revised, incorporating National Coding Standards	AN v2.0	AN v1.0	U.S. 8
1.7.93	Victoria introduced casemix funding					
92-93	U.S. 8 (Oct 91)	U.S. 8	Vic Guidelines 2nd ed (Revised)	No release	AN v1.0	U.S. 8
91-92	U.S. 7 (Oct 90)	U.S. 6	Vic Guidelines 2nd ed	AN v1.0	AN v1.0	U.S. 8
90-91	U.S. 6 (Oct 89)	U.S. 6	Vic Guidelines 2nd ed		HCFA v4	U.S. 2
89-90	U.S. 5 (Oct 88)	U.S. 5	Vic Guidelines 1st ed		HCFA v4	U.S. 2
88-89	U.S. 4 (Oct 87)	U.S. 2	Vic Guidelines 1st ed		HCFA v4	U.S. 2
87-88	U.S. 2 (Oct 86)	U.S. 2	(Victorian) VHSS guidelines		HCFA v4	U.S. 2
1.7.86	Victoria changed from ICD-9 to ICD-9-CM.					

- (a) U.S. = HICF ICD (release date in the USA), Aust CM = Australian ICD-9-CM (release date in Australia), AM = ICD-10-AM
- (b) DRG version used in Victoria (pre 1.7.1993) for any published grouped data and (post 1.7.1993) for casemix funding purposes.  
\* = years Vic adjusted DRGs for funding purposes (details in relevant year's *Public Hospital Policy and Funding Guidelines* or equivalent publication).
- (c) If ICD version: Victoria and Codes input to DRG version: Victoria columns differ, ICD codes were mapped from ICD version: Victoria to Codes input to DRG version: Victoria

# *History and Development of the VAED*

Due to the foresight of the former Victorian Health Commission, with the assistance of Health Computing Services (now Allegiance Systems Australia) and the cooperation of Victorian hospitals, patient level statistical information from public hospitals has been collected since 1979. This collection, previously known as the Victorian Inpatient Minimum Database (VIMD), has developed into the Victorian Admitted Episodes Dataset (VAED).

There have been many significant changes to the database since 1979 for a number of reasons:

- To meet national reporting requirements;
- To reflect the gradual introduction of the concept of episodes of care;
- To meet the requirements of changes to the funding formula (in particular, casemix funding); and
- To meet the increased need for information by providers and users of health services and other bodies.

The Department of Human Services seeks to minimise the annual changes to the VAED whilst ensuring that the collection maintains its integrity and continues to provide value.

## **1979-80 to 1986-87**

The collection started from 1 January 1979 with data from approximately 50 public hospitals, with more public hospitals gradually brought in to achieve full public hospital coverage. The availability of data from this period is limited. Data from this period may be available but only in hard copy in the form of standard reports and publications.

## **1987-88 and 1988-89**

VAED annual consolidated files are available for these years in a consistent format. This period predates the episode of care concept and it is not possible to identify reliably all periods of non-acute care: in particular periods of Nursing Home Type care that occurred following periods of acute care. This may limit the usefulness of the data obtained from the VAED in this time period for certain types of analysis that require accurate counts of length of stay for acute care.

## **1989-90 to 1991-92**

This period saw the introduction of care type as a sub-category of the patient's stay; this was achieved by a major change to the structure of the VAED with the introduction of *Status Segments*. Gradually, certain changes in care type became to require that a new episode be started while for others only a change to care type in the same episode. This concept was eventually recognised in the 1994 *National Health Data Dictionary*.

In each episode record transmitted to the VAED, there can be up to seven status segments containing different sets of account status details per episode together with a total of the patient days for that segment. For this period, each status segment held details of *Account Status*, *Accommodation Type* and *Care Type* together with the bed day counts. However, data extracts of the VAED will usually be provided showing only the Account Class, Accommodation Type and Care Type at separation, together with the total length of stay, omitting all status segments.

During this period, the *Care Type* field distinguished between four broad types of care the patient may have received during an admission:

- Nursing Home Type (NHT)
- Rehabilitation care (in a designated unit)
- Psychiatric care (in a designated unit)
- Other care - Acute

### **1992-93**

This period saw the introduction of episodes of care as the basic unit of measurement, ahead of the 1994 *National Health Data Dictionary*. New episodes of care occurred when the patient was admitted to the hospital or when a change in *Care Type* occurred. (However, changes to 'Nursing Home Type' did not constitute a new episode of care: the NHT days were recorded as the final days of an acute episode.)

### **1993-94**

On 1 July 1993, a number of significant revisions were made to the data collected in the VAED, to enable the introduction of casemix funding and to ensure consistency with the *National Health Data Dictionary*. Full details of these changes were set out in the following Departmental publications:

- *Circular 18/1993, Implementation of Definitions & Reporting Changes from 1 July 1993*, 10 May 1993;
- *Final Revisions to PRS/2 and the Victorian Inpatient Minimum Database for 1 July 1993*, May 1993; and
- *Definitions for Hospitals in Victoria*, May 1993.

The criteria for the commencement of a new episode of care were extended to encompass *all* changes in Care Type (including changes to Nursing Home Type).

### **1994-95**

For 1 July 1994, minor changes were implemented to reflect the development of new streams of care in geriatric centres. These were incorporated into the *Care Type* field. Full details of these changes were set out the following Departmental publications:

- *Final Revisions to PRS/2 and the Victorian Inpatient Minimum Database for 1 July 1994*, March 1994; and
- *Circular 15/1994, Definition and Reporting Changes from 1 July 1994*, 6 May 1994.

### **1995-96**

This year saw the introduction of the reporting by *public* hospitals of all newborn babies on the VAED as either 'qualified' or 'unqualified' babies; previously hospitals reported only newborns defined as qualified in the *Health Insurance Act 1973*. Reporting all newborns enabled casemix payments to be provided for all newborn episodes. The two neonatal Version 1 AN-DRGs were mapped to four Victoria-only DRGs, to give a more accurate representation of clinical resource utilisation for funding purposes.

New data items were introduced for all episodes with a rehabilitation Care Type. Full details of these changes are set out in the following Departmental publications:

- *Final Revisions to PRS/2 and the Victorian Inpatient Minimum Database for 1 July 1995*, April 1995;
- *Final Revisions to PRS/2 and the Victorian Inpatient Minimum Database for 1 July 1996, Addendum and Errata*, June 1995; and
- *Circular 17/1995, Definition and Reporting Changes from 1 July 1995: Newborns*, 30 June 1995.

### **1996-97**

This year saw the introduction of data items related to contracted hospital care. Full details of these changes are set out in the following Departmental publications:

- *Final Revisions to PRS/2 and the Victorian Inpatient Minimum Database for 1 July 1996*, April 1996; and
- *Final Revisions to PRS/2 and the Victorian Inpatient Minimum Database for 1 July 1996, Addendum and Errata*, May 1996.

### **1997-98**

There were no changes this year.

### **1998-99**

This year saw the introduction of data items on site identifier (for multi-campus hospitals), Duration of Stay in CCU and Reason for Critical Care Transfers. Full details of these changes are set out in the following Departmental publication:

- *Final Revisions to PRS/2 and the Victorian Inpatient Minimum Database for 1 July 1998*, March 1998.

### **1999-2000**

This year saw a revised file structure, new fields for Carer Availability and Separation Referral, revised fields for contracted hospital care and changes to the format for hospital codes, representing site and for transfers and contracts. Full details of these changes are set out in the following Departmental publications:

- *Final Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 1999*, December 1998; and
- *Final Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 1999, Addendum and Errata*, April 1999.

### **2000-2001**

This year saw the maximum number of diagnosis and procedure codes increased to 25 for each category. The field Carer Availability was limited only to sub acute Care Types and the field Reason for Critical Care was now reported by both sending and receiving hospitals. Full details of these changes are set out in the following Departmental publication:

- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2000*, April 2000.

### **2001-2002**

This year saw the revision of the Accommodation Type/Accommodation Type on Separation (to incorporate the concepts of NICU/SCN, Other accommodation for newborns, Short Stay Observation Units and Medical Assessment and Planning Units), Program Funding Source and Hospital Generated DRG (to incorporate AR-DRG Version 4.2) code sets. Full details of these changes are set out in the following Departmental publication:

- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2001*, May 2001;
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2001, Appendix A – New and Amended Edits*, May 2001; and
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2001, Appendix B – Hospital Code Table*, May 2001.

### **2002-2003**

This year saw new fields for Duration of Non-Invasive Ventilation, Date of Accident and TAC Claim Number. Code Sets that were revised included Care Type (for Interim Care patients), Account Class, Account Class on Separation, Contract/Spoke Identifier, Duration of Mechanical Ventilation, Patient Identifier and Program Funding Source. Additionally, changes were made to the V2 record, to enable collection of information for the Transport Accident Commission (TAC). Full details of these changes are set out in the following Departmental publication:

- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2002*, March 2002;
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2002, Appendix A – New and Amended Edits*, March 2002; and
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2002, Errata 1 & 2*, April 2002.

## 2003-2004

This year saw a revision of 23 code sets, including an extensive revision of Admission Source, Admission Type, Separation Type (now Separation Mode), Funding Arrangement, Carer Availability. The maximum number of Diagnosis and Procedure Codes increased to 40 for each category, and a new Rehabilitation Care Type was introduced. Three new data items were also introduced: ACAS Status, Preferred Language and Interpreter Required, and one data item was deleted: Program Funding Source. An extensive review of the edits was undertaken, including the implementation of edits between episodes. Full details of these changes are set out in the following Departmental publication:

- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2003*, February 2003;
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2003*, Appendix A, May 2003; and
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2003*, Appendix B, June 2003.

# *Publications and Contact Details Relevant to PRS/2 and the VAED*

## **Department of Human Services:**

*A Guide to the Development of Private Hospitals and Day Procedure Centres*

Also available on the Internet at:

[www.health.vic.gov.au/privatehospitals/pubs.htm](http://www.health.vic.gov.au/privatehospitals/pubs.htm)

## *Admitted Patient Entry & Transmission System (APET)*

The APET software was developed to be used as a solution for smaller hospitals and day procedure centres to transmit data to the VAED via a simple data entry system for separations. Further information is available on the Internet about the applicability and use of APET:

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

*Are you of Aboriginal or Torres Strait Islander Origin? Information for Hospital Staff who are responsible for collecting information on Patients who are admitted to Hospital or Patients who attend the Emergency Department*, Koori Health Unit, July 1998

<http://hdss.health.vic.gov.au/vaed/koori.pdf>

*Case studies of 'Best Practice' in Recording Aboriginality*, Koori Health Unit, July 1996

Available on the Internet at:

<http://koori.health.vic.gov.au/casestud/>

See also the Koori Health Unit website at:

<http://koori.health.vic.gov.au/>

## *Circulars*

Majority of circulars are available on the Internet at:

[www.dhs.vic.gov.au/ahs/circular/index.htm](http://www.dhs.vic.gov.au/ahs/circular/index.htm)

*Fees and Charges for Acute Health Services in Victoria – A Handbook for Public Hospitals* (Updated May 2001), also available on the Internet at:

<http://www.health.vic.gov.au/feesman/>

## *HDSS Bulletin*

Available on the Internet at:

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

## *ICD-10-AM Library File*

Available on the Internet at:

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

## *Postcode/Locality/SLA File (July 2003)*

DHS' postcodes and localities file is available on the Internet at:

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

## *Victorian Hospital Health Information*

Includes addresses and contact numbers

<http://www.health.vic.gov.au/services.htm>

Includes map and information is available on the Internet at:

[www.health.vic.gov.au/maps/index.htm](http://www.health.vic.gov.au/maps/index.htm)

*Victoria – Public Hospitals and Mental Health Policy and Funding Guidelines 2003-2004*

Also available on the Internet at:

<http://www.health.vic.gov.au/pfg2003/index.htm>

*Victorian Additions to Australian Coding Standards*, effective July 2001.

Also available on the Internet at:

<http://hdss.health.vic.gov.au/icdcoding/>

#### **Legislation:**

##### **Commonwealth:**

The following Commonwealth Acts are available on the Internet under the heading 'Commonwealth' at:

[www.austlii.edu.au/](http://www.austlii.edu.au/)

- *National Health Act 1953*
- *Health Insurance Act 1973*

##### **Victorian:**

The following Victorian Acts are available on the internet:

[www.dms.dpc.vic.gov.au/](http://www.dms.dpc.vic.gov.au/)

- *Aged & Disabled Persons Care Act 1954*
- *Annual Reporting Act 1983*
- *Health Act 1958*
- *Health Records Act 2001*
- *Health Services (Private Hospitals and Day Procedure Centre) Regulations 2002*
- *Health Services Act 1988*
- *Hospital & Charities Commission (Fees) Regulations 1986*

#### **Other useful publications and websites:**

*Australian Coding Standards for ICD-10-AM*, 3<sup>rd</sup> Edition, National Centre for Classification in Health, July 2000

<http://www2.fhs.usyd.edu.au/ncch//>

*Australian Health Care Agreement*, between Commonwealth Department of Health and Aged Care and Department of Human Services Victoria.

Available on the Internet at:

[www.health.gov.au/haf/docs/hca/index.htm](http://www.health.gov.au/haf/docs/hca/index.htm)

*Australia Post* web-site listing of postcodes and localities:

[www.austpost.com.au/](http://www.austpost.com.au/)

*Australian Standard Classification of Countries for Social Statistics*, Australian Bureau of Statistics (ABS), Catalogue No. 1269.0.

This document is only available on floppy disk. See also the ABS website at:

[www.abs.gov.au/](http://www.abs.gov.au/)

*Day Only Procedures Manual Supplement MBS Descriptions Effective 01 July 2001*, Commonwealth Department of Health and Aged Care.

The latest version (1 November 2001) is available on the Internet at:

Day Only Procedures Manual 1999:

[http://www.health.gov.au/privatehealth/providers/dayonly/dayonly\\_1999.htm](http://www.health.gov.au/privatehealth/providers/dayonly/dayonly_1999.htm)

Day Only Procedures Manual Supplement November 2001:

[http://www.health.gov.au/privatehealth/providers/dayonly/daymbs\\_nov2001.htm](http://www.health.gov.au/privatehealth/providers/dayonly/daymbs_nov2001.htm)

Day Only Procedure Manual Index:

<http://www.health.gov.au/privatehealth/providers/dayonly/index.htm>

*HIMAA Recruitment Services*

Available on the Internet:

[www.himaa.org.au/workweb1.html](http://www.himaa.org.au/workweb1.html)

*National Centre for Classification in Health*. Available on the Internet at:  
<http://www2.fhs.usyd.edu.au/ncch//>

*National Health Data Dictionary*, Australian Institute of Health and Welfare, Version 12, 2002.  
Available on the Internet at:  
<http://www.aihw.gov.au/publications/hwi/nhdd12/index.html>

White Pages web-site permits searches for postcodes and localities:  
[www.whitepages.com.au](http://www.whitepages.com.au)

# *Symbols Used in This Manual*

<	Less than
>	Greater than
=	Equal to
≠	Not equal to
&	And

# *Abbreviations Used in This Manual*

<b>ABS</b>	Australian Bureau of Statistics
<b>ACAS</b>	Aged Care Assessment Service
<b>AHCA</b>	Australian Health Care Agreement
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>AIMS</b>	Agency Information Management System
<b>AN-DRG</b>	Australian National Diagnosis Related Group
<b>AR-DRG</b>	Australian Refined Diagnosis Related Group
<b>ATSI</b>	Aboriginal and Torres Strait Islander
<b>BiPAP</b>	Bi-Level Positive Airway Pressure
<b>CALD</b>	Culturally And Linguistically Diverse
<b>CCIHT</b>	Critical Care Inter-Hospital Transfer
<b>CFS</b>	Coded Funded Separations
<b>CCU</b>	Coronary/Cardiac Care Unit
<b>CPAP</b>	Continuous Positive Airway Pressure
<b>CRAFT</b>	Casemix Rehabilitation and Funding Tree
<b>DHS</b>	Department of Human Services Victoria
<b>DRG</b>	Diagnosis Related Group
<b>DVA</b>	Department of Veterans' Affairs
<b>EMU</b>	Emergency Medical Unit
<b>EPC</b>	Early Parenting Centre
<b>ESAS</b>	Elective Surgery Access Service
<b>GEM</b>	Geriatric Evaluation and Management
<b>HDSS</b>	Health Data Standards and Systems, Metropolitan Health & Aged Care Division, DHS
<b>HIM</b>	Health Information Manager (also known as medical record administrator)
<b>HITH</b>	Hospital in the Home
<b>ICD-9-CM</b>	International Classification of Diseases - 9th Revision - Clinical Modification
<b>ICD-10-AM</b>	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
<b>ICU</b>	Intensive Care Unit
<b>IMV</b>	Intermittent Mandatory Ventilation
<b>IPPV</b>	Intermittent Positive Pressure Breathing
<b>ITH</b>	In The Home
<b>LOS</b>	Length of Stay
<b>MAPU</b>	Medical Assessment and Planning Unit
<b>MDC</b>	Major Diagnostic Category
<b>MTD</b>	Month to date
<b>MV</b>	Mechanical Ventilation
<b>NHDD</b>	National Health Data Dictionary
<b>NICU</b>	Neonatal Intensive Care Unit
<b>NIV</b>	Non-Invasive Ventilation
<b>NHT</b>	Nursing Home Type (patient/care)
<b>P/G</b>	Psycho-geriatric
<b>PRS/2</b>	Patient Reporting System, Version 2: Computer system by which hospitals transmit admitted patient data to Department of Human Services
<b>RITH</b>	Rehabilitation In The Home
<b>RPI</b>	Rural patients Initiative
<b>RUG-ADL</b>	Resource Utilisation Groups – Activities of Daily Living
<b>SCN</b>	Special Care Nursery
<b>SLA</b>	Statistical Local Area
<b>SOU</b>	Short Stay Observation Unit
<b>TAC</b>	Transport Accident Commission
<b>VAED</b>	Victorian Admitted Episodes Dataset
<b>VIC-DRG</b>	Victorian Adjusted Diagnosis Related Group

<b>VWA</b>	Victorian WorkCover Authority
<b>WIES</b>	Weighted Inlier Equivalent Separations
<b>YTD</b>	Year To Date
<b>the Department</b>	refers to the Victorian Department of Human Services

To	HDSS Help Desk Department of Human Services
Fax	<b>(03) 9616 7743</b>
Date	
From	

## ***VAED Manual Comments***

We have tried to make this Manual as useful and accurate as possible. If you have comments, suggestions or queries about this Manual or its contents, please fax them so future editions can better meet the needs of PRS/2 users.

### **Comments** (notes references to sections or page number where relevant)

### **From** (optional, however allows us to follow-up if required)

Name:
Site:
Email Address:
Contact Number:

If you have any queries, contact the HDSS Help Desk

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