

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

**Department of Human Services**

November 2002

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# Executive Summary

This document details the proposed revisions to the Victorian Admitted Episodes Dataset (VAED) for 1 July 2003. These proposed revisions are summarized below.

1. New name for Y2 Extra Diagnosis Record (*Y2 Extra Diagnosis Record 1*) with provision for extra Procedure Codes, plus an optional record type for additional Diagnosis and Procedure Codes (*Z2 Extra Diagnosis Record 2*).
2. Inclusion of two new fields relating to language (*Preferred Language* and *Interpreter Required*) to provide information in relation to the number of patients with a Culturally and Linguistically Diverse (CALD) background, and the demand for interpreter services.
3. Three new data items to capture information relating to ACAS Assessments (*ACAS Status*, *ACAS Recommendation* and *ACAS Assessment Date*).
4. Addition of a data item to capture the number of days a patient receives Palliative Care (*Palliative Care Patient Days*), regardless of the Care Type of the episode.
5. Addition of a new Contract Type to allow for the scenario of a hospital contracting with a residential aged care facility or supported accommodation, to provide Interim Care. The Contract/Spoke Identifier codes have also been expanded to differentiate between the different facilities providing Interim Care.
6. Change of various admission and separation data items (*Admission Source*, *Admission Type*, *Funding Arrangement* and *Separation Type*) to ensure that each data item contains only one concept.
7. A new Accommodation Type to capture patients spending a night in a Medi-hotel.
8. Review of Medicare Number to ensure consistency of reporting when the Medicare number is unavailable.
9. Change in mandatory reporting requirements for Duration of Non-Invasive Ventilation to include ICU, for public hospitals.
10. Addition of a new layer of edits (*notifiable*) and the inclusion of new edits.
11. Addition of five new concept definitions (*Acute Care*, *Hub and Spoke*, *Sub-Acute Care*, *Time of Death* and *Transfer*), and revision of the concept definition for Criteria for Admission.
12. Restructure of the VAED Manual to create a Business Rules section.

This document details the above proposals and describes the consultation process that will assist in the development and possible introduction of these revisions to PRS/2 and the VAED.

# Introduction

## The VAED Proposals Consultation Process

Each year the Department of Human Services (DHS) reviews the data elements and format of PRS/2 and the Victorian Admitted Episodes Dataset (VAED). This review seeks to ensure that the admitted patient collection supports the Department's national reporting obligations, and assists DHS planning and policy development.

This document is being distributed to all Victorian hospitals, to patient management system suppliers known to have Victorian clients, and to a range of industry bodies. It outlines *proposals* for changes to PRS/2 and the VAED, as at the time of its release in November 2002. This should not be regarded as a complete list of changes to be made for 2003—2004. Items in this publication cannot be guaranteed to change or to change in the form suggested here; nor does the absence of an item from this publication indicate it will not change from 1 July 2003. Confirmed changes will be published in the document '*Specification for Revisions to PRS/2 and the VAED for 1 July 2003*', which will be published in February 2003.

It is expected that release of these proposals will stimulate discussion within the health industry. **Prompt feedback is sought on these proposals.** Hospitals and software suppliers should review this document and assess the feasibility of the proposals. All are invited to provide written feedback to the Department by completing the proforma provided with this document, and forwarding it to the Department as indicated, **no later than Wednesday 20<sup>th</sup> November 2002.**

There will be a **summary presentation** of these proposals during the **HDSS Forum** to be conducted on **Monday 25<sup>th</sup> November 2002.** Responses to feedback received from hospitals and software suppliers during the feedback period will be addressed at this forum. If you have any questions or comments, it is important to notify these prior to the forum, as question time at the forum may be limited.

Constructive suggestions are welcomed, both for dealing with the proposed changes identified in this document, and of other alterations to PRS/2 and the VAED, to improve their utility for hospitals.

## Orientation to this Document

As this document provides 'proposals' for revisions, there are a few features that require explanation:

- New values and definitions relating to existing items appear in boxes
- ~~Redundant values and definitions relating to existing items are struck through.~~
- *[Comments relating to the proposal document only appear in square brackets and italics.]*
- Page numbers representing cross referencing to another section of the VAED Manual are represented by a #.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the *Victorian Admitted Episodes Dataset (VAED 12<sup>th</sup> Edition, 1 July 2002.*

*Specification:* details the reporting requirements for the item.

*Administration:* provides additional information including the purpose of the collection of the data item and the source of the code set and definitions.

- Further information such as the background to each proposal is provided.

## Abbreviations

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
AIHW	Australian Institute of Health and Welfare
CALD	Culturally And Linguistically Diverse
DHS	Department of Human Services
ESAS	Elective Surgery Access Service
HDSS	Health Data Standards and Systems
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
NHDD	National Health Data Dictionary
NICU	Neonatal Intensive Care Unit
NIV	Non-Invasive Ventilation
PRS/2	Patient Reporting System, Version 2
VAED	Victorian Admitted Episodes Dataset



# Proposed Additional Record Type

## *Proposal one*—Extra (2) Diagnosis Record

***It is proposed to*** Amend the Y2 Extra Diagnosis Record to 'fill' the record, and create another Extra Diagnosis Record (Z2) to capture additional Diagnosis and Procedure Codes.

***Proposed by*** Rhonda Carroll, Manager, Coding And Casemix Services  
The Alfred Hospital  
Phone: 9276 2128

***Implementation Date*** 1 July 2003

***Background*** A recent analysis of codes in terms of adverse events at The Alfred showed that 25 diagnosis codes were exceeded in 13% of episodes. This is partly due to the need for 'sets' of codes to describe certain conditions, eg an open fracture requires 5 codes, a complication may require 4 codes etc. The limitation on the number of procedure codes is also problematic. Now that all procedures in a particular operating room session need to be followed by the type of anaesthesia used, there is less flexibility to 'move' the more significant procedures up in the string of codes. Ideally, there should be no limitation on the number of codes able to be submitted and accepted.

It is impossible to describe the work done at The Alfred in code with the current restriction of 25 codes, this is particularly so with major trauma cases – multiple injuries, complications and multiple returns to the operating room. Transplants are also problematic when there are complications.

# Extra Diagnosis Record <sup>1</sup> (Y2)(Amended)

## Extra Diagnosis Record File Structure

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	Y2
M	Unique Key	6	3	A/N	Hospital generated
	Diagnosis Code (13 to 25)	8 (8 x 13)	9	A/N	ICD-10-AM 3 <sup>rd</sup> edition Each left justified and with trailing spaces
1	Procedure Code (13 to 25 <sup>28</sup> )	8 (8 x 13 <sup>16</sup> )	113	A/N	ICD-10-AM 3 <sup>rd</sup> edition Each left justified and with trailing spaces
	Filler	24	217	A/N	Spaces
		Total 240			

M Mandatory

1 Eighth character is F or N for procedure in *contracting* hospital, else space.

**Reported by** 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 episodes where more than 12 of either/both have been assigned.

**Reported for** Each episode that has more than 12 diagnosis and/or 12 procedure codes assigned.

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

**Refer to:** 'Data Transmission Scheduling', page 5-#.

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## Extra Diagnosis Record 2 (Z2)(New)

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### *Extra Diagnosis Record File Structure*

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	Z2
M	Unique Key	6	3	A/N	Hospital generated
	Diagnosis Code (26 to 41)	8 (8 x 16)	9	A/N	ICD-10-AM 3 <sup>rd</sup> edition Each left justified and with trailing spaces
1	Procedure Code (29 to 41)	8 (8 x 13)	136	A/N	ICD-10-AM 3 <sup>rd</sup> edition Each left justified and with trailing spaces
		Total 240			

M Mandatory

1 Eighth character is F or N for procedure in *contracting* hospital, else space.

***Reported by*** Public and private hospitals - **optional**.

That is, a hospital may choose whether or not to report more than 25 diagnosis and 28 procedure codes for episodes where more than 25 Diagnosis Codes and/or 28 Procedure Codes have been assigned.

***Reported for*** Each episode that has more than 25 Diagnosis and/or 28 Procedure Codes assigned.

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

**Refer to:** 'Data Transmission Scheduling', page 5-#.

# Proposed Revisions/Additions to Data Items

## *Proposal two—Language*

***It is proposed to*** Collect data items regarding the preferred language and whether there is a requirement for an interpreter.

***Proposed by*** Jackie Kearney, Acting Manager, Performance Unit  
Department of Human Services  
Phone: 9616 8381, Email: [Jackie.Kearney@dhs.vic.gov.au](mailto:Jackie.Kearney@dhs.vic.gov.au)

***Implementation Date*** 1 July 2003

***Background*** Approximately 23% of all Victorians are born in another country. 167 different languages are spoken in our State. According to current VAED data, 24.2% of all hospital inpatient separations have a country of birth where English is not the main language.

Information from the 2001 census tells us that 17.3% of Victorians speak a main language other than English at home, of these 43.7% report speaking English not at all, or not well. Importantly, 33% of all people who reported speaking a language other than English at home are born in Australia or another country that is predominately English speaking.

By using the data field Country of Birth, as the only indicator of interpreter need, it is calculated that about 33% of people who are likely to require interpreter services are not identified.

The Australian Bureau of Statistics (ABS) has developed a detailed 4-digit language classification of 193 language units that was used in the 2001 Census. Although it is preferable to use the classification at a 4-digit level, the requirements and extensive nature of administration collections have been recognised and the ABS has developed a classification of 86 languages at 2-digit level from those most frequently spoken in Australia. The classification used in this data element is a modified version of the 2-digit level ABS classification.

Consultations have occurred with representatives from 20 public hospitals involving ethnic liaison officers and health information managers to investigate what is currently being collected and reported regarding the provision of interpreting services. A meeting held with hospital representatives regarding the data proposals unanimously supported these proposals.

A sample survey of 14 public hospitals has also indicated that 6 already ask the questions specified (including same collection method). The sample survey indicated that most hospitals are collecting some form of information in relation to language spoken and need for interpreting services, however the questions vary, including main language spoken at home, what language do you speak, language descent.

Hospitals use a range of different software applications for hospital wide data collection. These variances also allow for discrepancies among the standards of data collected. By specifying the minimum level for reporting on language spoken and need for interpreter services data collection for monitoring, planning and funding purposes across and within hospitals will be consistent.

### **Purpose**

It is recognised that people from Culturally and Linguistically Diverse (CALD) backgrounds are high users of public hospital services. In addition, reports from the Health Services Commissioner identify 'communication' issues to be a primary or secondary cause of complaints about hospital services in 13% of all complaints recorded. It was established that there are elements of communication problems in every complaint received and this continues to be an issue in the resolution of complaints. While complaints from patients from CALD backgrounds are under-represented in this data, it is likely that not speaking English very well, or not at all may result in disadvantaged health outcomes and services quality compromises.

The proposed data items will form the basis for improved hospital and statewide planning and monitoring of the expressed need for, and provision of, interpreter services. In addition, the proposed fields provide more information about which language groups are the main users of hospital services, and within what geographical regions. This data is currently not consistently available using existing data fields, making sensitive statewide planning difficult. This will provide information about workforce capacity in interpreting services in specific language groups, as well as monitor those languages most likely to require an interpreter, ie recent arrivals. Data obtained from these fields will be analysed on an annual basis by the DHS for state-wide planning and policy development and will be reported back to hospitals for hospital level use in planning, monitoring and resource allocation decisions.

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## Preferred Language (*New*)

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### Specification

**Definition** The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English.

**Datatype** Numeric **Datatype** Code

**Field size** 2 **Layout** NN

**Location** Episode Record

**Reported by** Public hospitals (voluntary for private hospitals).

**Reported for** All admitted patient episodes of care.

**Reported when** The Episode Record is reported.

**Code set** See page Preferred Language – Code Set (*New*), page 10.

**Reporting guide** This information must:

- Be checked for every admitted patient episode.
- Not be set up to a default code on computer systems.
- Be collected on, or as soon as possible after, admission.

The standard question is:

What is [your] [the person's] preferred language?

**Patient is unable to consent (eg baby, child or elderly):**

Where a person is not able to consent for themselves (eg baby, child or elderly) then the language of the person who is consenting will be recorded. For example a guardian or someone with enduring power of attorney.

## **07 Australian Indigenous languages, NEC**

*Includes:*

- All Australian Indigenous languages not shown separately on the code list.

## **98 Not Stated**

*Includes:*

- Patients who are not able to respond to this question during their admission (eg unconscious).
- Child unaccompanied by an adult, who is too young to identify preferred language in relation to the ability to consent.
- This question on the form was not filled in or filled in correctly and cannot be verified throughout the admission.

### ***Edits***

- ### Preferred Language blank (rejection)
- ### Preferred Language invalid (rejection)
- ### Preferred language = English but Interpreter Required (rejection)
- ### ATSI identification but language ≠ English or Aboriginal (rejection) [*Include 02, 05, 07, 12, 19, 41, 42, 54, 55, 76, 82, 83, 85*]
- ### Language is unspecified (warning) [*Include 95, 96, 98*]
- ### Language Not Stated must = Interpreter Required Not Stated (rejection)
- ### Interpreter Required Not Stated; Language Invalid (rejection) [*Can only be in combination with 95, 96, 98*]

### ***Related items***

Section 3: *Country of Birth, Indigenous Status, and Interpreter Required.*

## **Administration**

### ***Purpose***

For planning and to form the basis for future funding allocation for CALD hospital service provision.

### ***Principal data users***

Performance Unit, DHS.

### ***Collection start***

2003-2004

### ***Collection start***

2003-2004

<b>Definition source</b>	NHDD	<b>Code set source</b>	NHDD; ABS mod Aust. Stand. Classification
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## Interpreter Required (New)

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### Specification

**Definition** The need for an interpreter, as perceived by the person.

<b>Datatype</b>	Numeric	<b>Form</b>	Code
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<b>Field size</b>	1	<b>Layout</b>	N
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**Location** Episode Record

**Reported by** Public hospitals (voluntary for private hospitals).

**Reported for** All admitted patient episodes of care.

**Reported when** The Episode Record is reported.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	Yes
	2	No
	3	Not Stated

**Reporting guide** Preferred Language to be asked before Interpreter Required.

This information must:

- Be checked for every admitted patient episode.
- Not be set up to a default code on computer systems.
- Be collected on, or as soon as possible after, admission.

The standard question is:

[Do you] [Does the person] [Does (name)] require an interpreter?

The provision of the question 'Do you require an interpreter?' is asked to determine patient need for an interpreter, not the capacity of the hospital to provide an interpreter.

**1 Yes**

Use code 1 if the patient indicates they need an interpreter.

**2 No**

Use code 2 if the patient indicates they do not need an interpreter.

*Includes:*

- Where the Preferred Language is English.

**3 Not Stated**

Use code 3 if the neither Yes nor No can be accurately ascertained.

*Includes:*

- Where the Preferred Language is 98 *Not Stated*.
- Some instances where the Preferred Language is 95 *Other Languages, nfd* or 96 *Inadequately described*.

**Patient is unable to consent (eg baby, child or elderly):**

Where a person is not able to consent for themselves (eg baby, child or elderly) then the need for an interpreter is recorded for the person who is consenting. For example a guardian or someone with enduring power of attorney.

<b>Edits</b>	### Interpreter Required blank (rejection)
	### Interpreter Required invalid (rejection)
	### Preferred language = English but Interpreter Required (rejection)
	### ATSI identification but language ≠ English or Aboriginal (rejection) <i>[Include 02, 05, 07, 12, 19, 41, 42, 54, 55, 76, 82, 83, 85]</i>
	### Language is unspecified (warning) <i>[Include 95, 96, 98]</i>
	### Language Not Stated must = Interpreter Required Not Stated (rejection)
	### Interpreter Required Not Stated; Language Invalid (rejection) <i>[Can only be in combination with 95, 96, 98]</i>

**Related items** Section 3: *Country of Birth, Indigenous Status, and Preferred Language.*

## Administration

**Purpose** For planning and to form the basis for future funding allocation for CALD hospital service provision.

**Principal data users** Performance Unit, DHS.

**Collection start** 2003-2004

<b>Definition source</b>	DHS	<b>Code set source</b>	DHS
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## Preferred Language – Code Set (New)

This classification is from NHDD Version 10.0 and is a modification of the 2-digit level Australian Standard Classification of Languages (ABS) classification.

<b>Code</b>	<b>Preferred Language</b>	<b>Code</b>	<b>Preferred Language</b>
00	Afrikaans	07	Australian Indigenous languages, NEC
01	Albanian	08	Bengali
02	Alyawarr (Alyawarra)	09	Bisaya
03	Arabic (including Lebanese)	10	Bosnian
04	Armenian	11	Bulgarian
05	Arrernte (Aranda)	12	Burarra
06	Assyrian (including Aramaic)		
10	Proposals for Revisions to PRS/2 and the VAED—November 2002		

<b><i>Code</i></b>	<b><i>Preferred Language</i></b>	<b><i>Code</i></b>	<b><i>Preferred Language</i></b>
13	Burmese	61	Samoan
14	Cantonese	62	Serbian
15	Cebuano	63	Sinhalese
16	Croatian	64	Slovak
17	Czech	65	Slovene
18	Danish	66	Somali
19	English	67	Spanish
20	Estonian	68	Swahili
21	Fijian	69	Swedish
22	Finnish	70	Tagalog (Filipino)
23	French	71	Tamil
24	German	72	Telugu
25	Gilbertese	73	Teochew
26	Greek	74	Thai
27	Gujarati	75	Timorese
28	Hakka	76	Tiwi
29	Hebrew	77	Tongan
30	Hindi	78	Turkish
31	Hmong	79	Ukranian
32	Hokkien	80	Urdu
33	Hungarian	81	Vietnamese
34	Indonesian	82	Walmajarri (Walmadjari)
35	Irish	83	Warlpiri
36	Italian	84	Welsh
37	Japanese	85	Wik-Mungkan
38	Kannada	86	Yiddish
39	Khmer	95	Other languages, nfd
40	Korean	96	Inadequately described
41	Kriol	97	Non verbal, so described (including sign languages eg: Auslan, Makaton)
42	Kuurinji (Gurindji)		
43	Lao	98	Not stated
44	Latvian		
45	Lithuanian		
46	Macedonian		
47	Malay		
48	Maltese		
49	Mandarin		
50	Mauritian Creole		
51	Netherlandic		
52	Norwegian		
53	Persian		
54	Pintupi		
55	Pitjantjatjara		
56	Polish		
57	Portuguese		
58	Punjabi		
59	Romanian		
60	Russian		

## **Proposal three—Aged Care Assessment Service (ACAS)**

- It is proposed to*** Create three additional data items to capture information surrounding ACAS Assessment, and amend Separation Referral to include referrals to ACAS.
- Proposed by*** Viki Perre, Manager, Assessment – Coordinated & Home Care Unit of Aged Care Branch  
Department of Human Services  
Phone: 9616-7095, Email: [Viki.Perre@dhs.vic.gov.au](mailto:Viki.Perre@dhs.vic.gov.au)
- Implementation Date*** 1 July 2003
- Background*** It is important for DHS to monitor the various roles played by ACAS in the acute and sub-acute areas, including the residential approval process, medical consultations, advice on care options and service availability with respect to an older person's discharge.
- Research carried out by the ACAS Evaluation Unit has identified that ACAS contribute to the discharge planning process for frail older people in addition to their role carrying out comprehensive assessments.
- The data items of ACAS Status, ACAS Assessment Date, and ACAS Recommendation, are already collected by at least one metropolitan hospital on their Patient Administration System.
- There is increasing pressure on hospitals and on the ACAS to undertake assessments in a timely fashion. Demand for assessments exceeds current resource capacity. The data items will allow the tracking of:
- The number of assessments and consultations, and trends over time for ACAS assessments in the hospital admitted patient setting.
  - Characteristics of assessed patients such as age, health status, length of stay, recommendations and discharge destination.
  - The number of days older people approved for residential care wait in public hospitals before they are placed.
  - ACAS recommendations.
- Amendment of Separation Referral captures referrals that have been made as part of discharge planning, and will be followed up by ACAS once the patient returns home.

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## ACAS Status (*New*)

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### Specification

**Definition** The type of involvement of the Aged Care Assessment Service (ACAS) in patient discharge.

**Datatype** Numeric **Form** Code

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

**Location** Diagnosis Record

**Reported by** Public hospitals

**Reported for** Episodes with Care Type 1, 2,4, 5, 6,7, 8, 9, F and E.  
[For Care Types 0, 3 and U, report spaces in this field.]

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

**Code set** Select the first appropriate category:

<b>Code</b>	<b>Descriptor</b>
1	ACAS Assessment completed during this episode
2	ACAS Assessment completed in previous episode this hospital stay
3	ACAS Assessment completed in last 12 months
4	ACAS assessment incomplete: referral to Sub-acute services
5	ACAS assessment incomplete: other reason
6	ACAS consultation only during this episode
7	No ACAS involvement in patient discharge during this episode

## **Reporting guide**

### **1 ACAS Assessment completed during this episode**

Use code 1 if the patient has received a comprehensive assessment by a member of the ACAS of their physical, medical psychological, social and restorative care needs with a recommendation for the patient's long term care setting and all the relevant paperwork completed (eg 2624 certificate completed and signed if required).

### **2 ACAS Assessment completed in previous episode this hospital stay**

Use code 2 if an ACAS assessment was completed in a previous episode during this hospital stay.

#### *Includes:*

- Where this episode has an Admission Source of S *Statistical* and Care Type F or E *Interim Care*, and the ACAS assessment was completed in the previous Acute admission.

#### *Excludes:*

- Where the ACAS Assessment took place in a previous formal episode (use 3).

### **3 ACAS Assessment completed in last 12 months**

Use code 3 if an ACAS Assessment was completed either in a hospital or in the community within the previous 12 months.

#### *Includes:*

- Where the ACAS Assessment was completed in a previous episode not included in this hospital stay.

#### *Excludes:*

- Where this episode has an Admission Source of S *Statistical* and Care Type F or E *Interim Care*, and the ACAS assessment was completed in the previous admission this hospital stay (use 2).

### **4 ACAS assessment incomplete: referral to Sub-acute services**

Use code 4 if the patient was seen by the ACAS who referred the patient to sub-acute services (eg GEM or rehabilitation) at this hospital or another campus/hospital.

*Excludes* when the assessment was not completed because the patient:

- Required further acute care to become medically stable (use 5).
- Began an assessment that was completed in a subsequent statistical episode (use 5).
- Died (use 5).
- Left against medical advice (use 5).

## **5 ACAS assessment incomplete: other reason**

Use code 5 if the patient was seen by the ACAS but a final care plan and long term care setting recommendation could not be made.

*Includes* when the assessment was not completed because the patient:

- Required further acute care to become medically stable.
- Began an assessment that was completed in a subsequent statistical episode.
- Died.
- Left against medical advice

*Excludes* when the assessment was not completed because the patient:

- Was referred to sub-acute services (eg GEM or rehabilitation)(use 4)

## **6 ACAS consultation only during this episode**

Use code 6 if the ACAS were consulted, or gave advice to the Hospital staff (discharge planner, social worker) about a patient's discharge and long term care setting and care plan options, but did not conduct a full assessment.

## **7 No ACAS involvement in patient discharge during this episode**

Use code 7 if ACAS had no involvement with the patient.

*Includes:*

- Patient referred to ACAS for a home-based assessment (record this scenario in Separation Referral).

This information should be noted in the patient's health record by staff members or by ACAS.

### ***Edits***

- ### ACAS Completed: Date not between Adm and Sep Dates (rejection)
- ### ACAS Previously completed: Date not before Adm Date (rejection)
- ### ACAS Previously completed: Date > 12 months old (rejection)
- ### ACAS Involvement; Patient aged < 50 (warning)
- ### ACAS Involvement, Patient aged < 20 (rejection)
- ### Interim Care but ACAS Recommendation not 2 or 3 (rejection)

### ***Related items***

Section 3: *ACAS Recommendation* page 3-#, *ACAS Assessment Date* page 3-#, and *Separation Referral* page 3-#.

## Administration

<b>Purpose</b>	Assist in measuring demand, and for planning of future services.		
<b>Principal data users</b>	Co-ordinated and Home Care Unit (Rural and Regional Health and Aged Care Services, DHS)		
<b>Collection start</b>	2003-2004		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

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## ACAS Recommendation (New)

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### Specification

<b>Definition</b>	ACAS Recommendation of patient long term care setting.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	N or space
<b>Location</b>	Diagnosis Record		
<b>Reported by</b>	Public hospitals		
<b>Reported for</b>	Episodes where the ACAS Status is 1 <i>ACAS Assessment completed during this episode</i> , 2 <i>ACAS Assessment completed in previous episode this hospital stay</i> , or 3 <i>ACAS Assessment completed in last 12 months</i> . [For all other ACAS Recommendations, report a space in this field.]		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		

**Code set**

Select the first appropriate category:

<b>Code</b>	<b>Descriptor</b>
1	Community
2	Supported Accommodation including SRS
3	Residential aged care facility: Low level care
4	Residential aged care facility: High level care
5	Other

**Reporting guide****1 Community**

Use code 1 for all private residences.

*Includes:*

- Retirement Villages
- Caravans
- Public rental or community housing

**2 Supported Accommodation including SRS**

Use code 2 for supported community accommodation including SRS or other small group supported housing.

**3 Residential aged care facility: Low level care**

Use code 3 for Residential aged care facility: Low level care.

**4 Residential aged care facility: High level care**

Use code 4 for Residential aged care facility: High level care.

*Includes:*

- Nursing Home Type: High level care

**5 Other**

Use code 5 for other recommendation.

*Includes:*

- Boarding house
- Other institutional accommodation



**Reported for** Episodes where the ACAS Status is 1 *ACAS Assessment completed during this episode*, 2 *ACAS Assessment completed in previous statistical episode*, or 3 *ACAS Assessment completed in the last 12 months*.  
[For all other ACAS Recommendations, report a space in this field.]

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

**Code set** A valid date.

**Reporting guide** Episodes where the ACAS Status is 1 *ACAS Assessment completed during this episode*, the ACAS Assessment Date must be on or between the Admission and Separation Dates.

Episodes where the ACAS Status is 2 *ACAS Assessment completed in previous statistical episode*, or 3 *ACAS Assessment completed in the last 12 months*, the ACAS Assessment Date must be on or between twelve months before the Admission and the Admission Date.

This information should be noted in the patient's health record by staff members or by ACAS.

**Edits**

- ### ACAS Completed: Date not between Adm and Sep Dates (rejection)
- ### ACAS Previously completed: Date not before Adm Date (rejection)
- ### ACAS Previously completed: Date > 12 months old (rejection)
- ### ACAS Involvement; Patient aged < 50 (warning)
- ### ACAS Involvement, Patient aged < 20 (rejection)

**Related items** Section 3: *ACAS Status* page 3-#, *ACAS Assessment Date* page 3-#, and *Separation Referral* page 3-#.

## **Administration**

**Purpose** Assist in measuring demand, and for planning of future services.

**Principal data users** Co-ordinated and Home Care Unit (Rural and Regional Health and Aged Care Services, DHS)

**Collection start** 2003-2004

## Separation Referral (*Amended*)

### Specification

**Definition** Clinical care and support services arranged by the hospital to meet the person’s recuperative needs when discharged to private accommodation or home.

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

**Field size** 4 **Layout** AAAA or spaces  
Left justified, trailing spaces.

**Location** Episode Record

**Reported by** Public hospitals.  
Private hospitals – Optional.  
[If the private hospital chooses not to report these data, report spaces in this field.]

**Reported for** Episodes where the Separation Type Mode is H *Separation to private accommodation or home residence/accommodation.* [Refer to proposal six.]  
[For all other Separation Types, report spaces in this field.]

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

**Code set** Select up to four options from list. Do not repeat codes. If more than four referrals have been made, select the first four listed:

<b>Code</b>	<b>Descriptor</b>
F	Domiciliary postnatal care, arranged before discharge
P	Post Acute Care Program services, arranged before discharge
M	Referral to a community rehabilitation centre arranged before discharge

- B Community palliative care support, arranged before discharge
- U Home nursing support, arranged before discharge
- C Mental health community services, arranged before discharge
- S Referral to private psychiatrist, arranged before discharge
- D Psychiatric disability support services, arranged before discharge
- G Referral to general practitioner, arranged before discharge
- A Referral to Aged Care Assessment Service (ACAS), arranged before discharge
- R Other clinical care and/or support services, arranged before discharge
- X No referral or support services arranged before discharge

***Reporting guide***

In arranging the referral of a patient to these services, the hospital would expect to receive confirmation from the referred provider of their preparedness to accept responsibility for delivering the required services to the patient upon discharge.

**Reporting guides relating to other values remain the same as per the VAED 12<sup>th</sup> Edition**

***A Referral to Aged Care Assessment Service (ACAS), arranged before discharge***

Discharge, with referral to Aged Care Assessment Service (ACAS) arranged before discharge to own home or home of a relative or friend or other private accommodation.

**Notes:**

\*Private accommodation comprises:

- Supported residential facilities, special accommodation houses, half-way houses, training centres for intellectually disabled persons, prisons, prison and armed forces hospitals.

and

- ~~Aged care residential facilities and mental health residential facilities if the patient is returning to the facility in which they live. [Refer to proposal six.]~~

*Includes:*

- A patient treated under the HITH program in private accommodation or residential facility who, on separation, remains in the same private accommodation.
- A newborn discharged with her his/her mother.

***Edits***

- 108 Fields(s) Missing From Sep
- 387 Sep Referral Not Left Justified
- 388 Sep Referral - Episode Not Separated
- 389 Invalid Sep Referral
- 394 Sep Type Mode Home, No Sep Referral
- 395 Sep Type Mode not Home, Sep Referral Present
- 396 Sep Referral, No Refer Plus Other Ref
- 397 Sep Referral Postnatal, Incompatible Age/ Sex
- 398 Sep Referral, Duplicates
- 454 Incompat Fields for Interim Care

***Related items***

Section 3: *Separation Type* Mode on page 3-#.

**Administration**

***Purpose***

To monitor discharge planning processes to inform policy and planning.

***Principal data users***

Sub-Acute Unit (Metropolitan Health & Aged Care, DHS).

***Collection start***

1999-2000 (Formerly a sub-set of Separation Type)

***Definition source***

DHS

***Code set source***

DHS

## **Proposal four—Palliative Care**

<b><i>It is proposed to</i></b>	Collect an additional data item to provide information about the number of patient days each patient receives palliative care, regardless of the Care Type of the episode.
<b><i>Proposed by</i></b>	Vivien Adler, Manager Continuity Unit, Quality & Care Continuity Branch Department of Human Services Phone: 9616 7100, Email: <a href="mailto:Vivien.Adler@dhs.vic.gov.au">Vivien.Adler@dhs.vic.gov.au</a>
<b><i>Implementation Date</i></b>	1 July 2003
<b><i>Background</i></b>	There is a need to collect information regarding the number of patient days each patient receives palliative care, regardless of the Care Type of the episode. This information is required for planning purposes.

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## **Palliative Care Patient Days (New)**

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### **Specification**

<b><i>Definition</i></b>	The total number of patient days the patient has received palliative care during the whole episode of care, excluding [normal] leave days.		
<b><i>Datatype</i></b>	Numeric	<b><i>Form</i></b>	Quantitative value
<b><i>Field size</i></b>	3	<b><i>Layout</i></b>	NNN or spaces
<b><i>Location</i></b>	Diagnosis Record		
<b><i>Reported by</i></b>	Public Hospitals		
<b><i>Reported for</i></b>	Episodes with Care Type 1, 2,4, 5, 6, 7, 8, 9, F and E. [For Care Types 0, 3 and U, report spaces in this field.]		

<b>Reported when</b>	A Separation Date is reported in the Episode Record.
<b>Code set</b>	A number in the range of 000 to 999.
<b>Reporting guide</b>	<p>Palliative Care Patient Days must be equal to or less than Patient Days Total.</p> <p>Where the Care Type is 8 <i>Palliative Care Program</i>, the Palliative Care Patient Days must equal Patient Days Total.</p> <p>Where the Diagnosis Code Z51.5 <i>Palliative Care</i> is present in the Diagnosis Code string, Palliative Care Patient Days must be greater than 000.</p>
<b>Edits</b>	<p>### Pall Care Pt Days &gt; Patient Days Total (rejection)</p> <p>### Care Type Pall Care: Pall Care Pt Days not = Pt Days Total (rejection)</p> <p>### Pall Care Diag without Pall Care Pt Days (rejection)</p> <p>### Pall Care Pt Days without Pall Care Diag (rejection)</p>

<b>Related items</b>	<p>Section 2: Concept definitions <i>Episode of Care</i>, <i>Leave [Normal]</i>, <i>Palliative Care</i> and <i>Patient Day</i>.</p> <p>Section 3: <i>Care Type</i>, page 3-#, <i>Diagnosis Code</i>, page 3-#, and <i>Patient Days Total</i>, page 3-#.</p> <p>Section 4: <i>Palliative Care Units Approved for Care Type 8</i>.</p>
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## Administration

<b>Purpose</b>	<p>To measure the demand for palliative care services for:</p> <ul style="list-style-type: none"> <li>• Planning of palliative care services</li> <li>• Managing funding arrangements for palliative care services</li> </ul>
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<b>Principal data users</b>	Continuity Unit, DHS.
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<b>Collection start</b>	2003-2004
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<b>Definition source</b>	DHS	<b>Code set source</b>	DHS
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## **Proposal five—Contract Type and Interim Care**

***It is proposed to*** Amend the code set for Contract Type to enable more appropriate reporting where hospitals contract out Interim Care to non-hospitals.

***Proposed by*** Catherine Perry and Simon Moy  
Department of Human Services  
Phone: 9616 6928, Email: [Catherine.Perry@dhs.vic.gov.au](mailto:Catherine.Perry@dhs.vic.gov.au)

***Implementation Date*** 1 July 2003

***Background*** For 2002-2003 hospitals contracting out Interim Care to non-hospitals use Contract Type 1 *Contract Type B* with Contract Spoke ID 8880 *Interim Care Program: Non-hospital*.

A new Contract Type is required to better capture this scenario, with additional changes to Contracted Care (concept definition), Contract/Spoke Identifier, and substantial changes to edits (which are not part of the initial proposal).

Contract/Spoke Identifier has also been expanded to capture the type of facility that is providing the Interim Care.

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## Contracted Care (Concept Definition *Amended*)

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### **Definition**

Contracted hospital care is provided to a patient under an agreement between a purchaser of hospital care (contracting hospital or external purchaser) and a provider of an admitted or non-admitted service (contracted hospital/facility).

A contract agreement can be formal or informal, written or verbal.

To be in scope, contracted care must involve all of the following:

- A purchaser, which can be a public or private hospital, or a health authority (Department of Human Services or a Health Region) or another external purchaser.
- A contracted hospital/facility, which can be a public or private hospital, or day procedure centre, residential aged care facility or supported accommodation.
- The contractor making full payment to the contracted hospital for the contracted service.

Thus, services provided to a patient in a separate facility during their episode of care where the patient is directly responsible for payment of this additional service are not considered contracted services for the purposes of PRS/2 reporting.

- The patient being physically present for the provision of the contracted service.

Thus, pathology or other investigations performed at another location on specimens gathered at the contracting hospital would not be considered contracted services for the purposes of PRS/2 reporting.

### **Guide for use**

Accurate recording of contracted care in both public and private hospitals is essential because:

- Funding arrangements require that the DRG assigned to a patient accurately reflect the total treatment provided, even where part of the treatment was provided under contract.
- Funding arrangements require that potential double payments are identified and avoided; the case payment will apply only to the contracting hospital and not the contracted hospital/facility.
- Unidentified duplication in the reporting of separations, patient days and procedures must be avoided to enable accurate analyses as required for funding, casemix, resource use and epidemiological purposes.
- The Commonwealth Department of Health and Aged Care requires details of contracted public patients attending private hospitals to be reported, under the Australian Health Care Agreement.

Related contracted hospital care data items should only be completed where services are provided which represent some, but not all of the contracted hospital's total services. That is, it is not necessary to complete contracted hospital care data items where all of the hospital services are contracted by a health authority, for example, privately owned and/or operated public hospitals such as Mildura Base Hospital.

### **Contract Leave**

Contract leave is a period spent as an admitted patient at a contracted (service provider) hospital, during an episode where the patient is also admitted to the contracting (purchasing) hospital.

Contract leave days are reported only by the contracting (purchasing) hospital and are treated as patient days and included in length of stay at that hospital. In PRS/2, contract leave days for the episode are reported in three Contract Leave Days fields: Month-to-date, Financial Year-to-date, and Total. There is no limit to the duration of contract leave.

Patients going on contract leave are not separated.

### **Identification of Contracted Episodes of Care**

In PRS/2, reporting 1 (Contract) in the Funding Arrangement field identifies episodes involving contracted care. The following fields are then reported:

- The type of contract involved is reported in the Contract Type field.
- The role of the hospital (contracting or contracted) is reported in the Contract Role field.
- The nature of the contract involving an external purchaser, or the other hospital involved in a contracted care or hub & spoke arrangement, is reported in the Contract/Spoke Identifier field.

### **Identification of Procedures Performed under Contract**

The contracting (purchasing) hospital is termed Hospital A.

The contracted (service provider) hospital is termed Hospital B.

In PRS/2, procedures performed at another hospital under contract to this hospital are recorded by both hospitals, but flagged only by the contracting hospital: Hospital A reports a flag in the eighth character of the (ICD-10-AM) codes relating to procedures performed under contract by Hospital B.

Flags used by Hospital A are:

- Character F on procedures performed by Hospital B on an admitted basis.
- Character N on procedures performed by Hospital B on a non-admitted basis.

Allocation of diagnosis and procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards, including the Victorian Additions to the Australian Coding Standards, should be applied when coding all episodes. In particular, procedures that would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (that is, not a recognised hospital) should be coded if appropriate but should not be flagged as contracted hospital procedures.

### **Types of Contracted Hospital Care**

The contracting (purchasing) hospital is termed Hospital A.

The contracted (service provider) hospital is termed Hospital B.

Brackets indicate the patient is not present in the hospital.

~~Six~~ Seven contract types are identified by the sequence of alpha characters, representing the movement of the patient between the contracting and contracted hospitals.

#### **1 Contract Type B**

A health authority/other external purchaser contracts **B** (hospital) for admitted service.

Examples include:

- Department of Human Services: HIV Aids
- St Vincent's Lithotripsy Service
- Individual contracts with international patients

Hospitals that believe they have a similar contract should contact the Department to discuss reporting arrangements.

#### **2 Contract Type ABA**

Patient admitted by Hospital **A**.

Hospital A contracts Hospital **B** for admitted or non-admitted patient service.

Patient returns to Hospital **A** on completion of service by Hospital B.

#### **3 Contract Type AB**

Patient admitted by Hospital **A**.

Hospital A contracts Hospital **B** for admitted or non-admitted patient service.

Patient does not return to Hospital A on completion of service by Hospital B.

#### **4 Contract Type (A)B**

Patient not present in the Contracting Hospital (**A**) at any time during the episode.

Hospital **A** contracts Hospital **B** for the whole admitted patient service.

An (A)B contract type cannot occur between two public hospitals unless approved by the Metropolitan Health & Aged Care Division of the Department. Where two public hospitals enter into a contract, the contracting hospital must admit and provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB and BA).

#### **5 Contract Type BA**

Hospital **A** contracts Hospital **B** for an admitted patient service following which the patient moves to Hospital **A** for the remainder of the episode of care.

#### **6 Contract Type A(B)**

Hospital **A** contracts Hospital **B** for the whole admitted patient service.

Hospital **B** provides the service at Hospital **A**.

Patient not present in the Contracted Hospital (**B**) at any time during the episode.

An A(B) contract type cannot occur between two public hospitals unless approved by the Metropolitan Health & Aged Care Division of the Department. Where two public hospitals enter into a contract, the contracting hospital must admit and provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB and BA).

#### **7 Contract Type (A)**

Hospital **A** contracts with a residential aged care facility or supported accommodation for provision of Interim Care.

Patient not present in the Contracting Hospital (**A**) at any time during the episode.

#### **PRS/2 Reporting for Contracted Hospital Care**

The contracting (purchasing) hospital is termed Hospital **A**.

The contracted (service provider) hospital is termed Hospital **B**.

***Responsibility for exchange of information:***

The contracting (purchasing) hospital (Hospital **A**) is responsible for ensuring that the contracted (service provider) hospital/facility (Hospital **B**/facility) provides adequate information for inclusion in the patient's record at Hospital **A** to (i) enable ongoing patient care at Hospital **A** and (ii) support the diagnosis and procedure codes reported to the VAED by Hospital **A**.

These ~~six~~ seven types of contracted hospital care should be recorded in the following ways:

**1 Contract Type B**

**B records:**

- Funding Arrangement code 1 *Contract*.
- Contract Type code 1 *Contract Type B*.
- Contract Role code B *Hospital B*.
- Contract/Spoke Identifier.

**2 Contract Type ABA**

**A records:**

- Admission date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 2 *Contract Type ABA*.
- Contract Role code A *Hospital A*.
- Contract/Spoke Identifier (Campus code) of Hospital **B**.
- Contracted Leave Days: report difference between date patient leaves **A** for treatment by **B** and date patient returns to **A**.
- Diagnosis and procedure codes: include any additional diagnoses identified by **B**, and procedures provided by **B** each with relevant contract procedure flag (F or N) (see *Responsibility for exchange of information* above).
- Separation date: being date patient left **A** after returning from **B**.
- Length of stay is Separation Date minus Admission Date minus Total [normal] Leave days; thus contract leave days are effectively treated as patient days and included in Length of Stay.

**If admitted by B, B records:**

- Admission date, being date of commencement of care at **B**.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 2 *Contract Type ABA*.
- Contract Role code B *Hospital B*.
- Contract/Spoke Identifier (Campus code) of Hospital **A**.
- Admission Source code T: requires Transfer Source code.
- Transfer Source: Contracting Hospital **A**.
- Diagnosis and procedure codes: only relating to care provided by **B**.
- Separation date: actual date separated from **B**.
- Separation Type  code T: requires Transfer Destination code.
- Transfer Destination: Contracting Hospital **A**.

**3 Contract Type AB**

**A records: (irrespective of the original intention for the patient to return or not):**

- Admission date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 3 *Contract Type AB*.
- Contract Role code A *Hospital A*.
- Contract/Spoke Identifier (Campus code) of Hospital **B**.
- Contracted Leave Days: report difference between date patient leaves **A** for treatment by **B** and date patient separated from **B**.
- If patient not admitted by **B**, contract leave is nil.
- Diagnosis and procedure codes: include any additional diagnoses identified by **B**, and procedures provided by **B** each with relevant contract procedure flag (F or N) (see *Responsibility for exchange of information* above).
- Separation date: report actual date patient separated from **B** if admitted by **B**, or date separated from **A** if not admitted by **B**.
- Separation Type  code T: requires Transfer Destination code.
- Transfer Destination: Contracted Hospital **B**.
- Length of stay is Separation Date minus Admission Date minus Total [normal] *Leave* days; thus contract leave days are effectively treated as patient days and included in Length of Stay.

**If admitted by B, B records:**

- Admission date, being date of commencement of care at **B**.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 3 *Contract Type AB*.
- Contract Role code B *Hospital B*.
- Contract/Spoke Identifier (Campus code) of Hospital **A**.
- Admission Source code T: requires Transfer Source code.
- Transfer Source: Contracting Hospital **A**.
- Diagnosis and procedure codes: only relating to care provided by **B**.
- Separation date: actual date separated from **B**.

**4 Contract Type (A)B**

**A records:**

- Admission date: actual date admitted by **B**.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 4 *Contract Type (A)B*.
- Contract Role code A *Hospital A*.
- Contract/Spoke Identifier (Campus code) of Hospital **B**.
- Diagnosis and procedure codes from information provided by **B**: each procedure with contract procedure flag for admitted services (F only) (see *Responsibility for exchange of information* above).
- Separation date: actual date patient separated from **B**.

**B records:**

- Admission date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 4 *Contract Type (A)B*.
- Contract Role code B *Hospital B*.
- Contract/Spoke Identifier (Campus code) of Hospital **A**.
- Diagnosis and procedure codes.
- Separation date.

## 5 Contract Type BA

The contract may be for non-admitted services.

### **B records:**

- Admission date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 5 *Contract Type BA*.
- Contract Role code B *Hospital B*.
- Contract Identifier (Campus code) of Hospital **A**.
- Diagnosis and procedure codes from information provided by **B**.
- Separation date: actual date patient separated from **B**.
- Separation Type Mode code T: requires Transfer Destination code.
- Transfer Destination: Contracting Hospital **A**.

### **A records:**

- Admission date: actual date admitted to **B**.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 5 *Contract Type BA*.
- Contract Role code A *Hospital A*.
- Contract Identifier (Campus code) of Hospital **B**.
- Admission Source code T: requires Transfer Source code.
- Transfer Source: Contracted Hospital **B**.
- Contracted Leave Days: report difference between date patient admitted by **B** and date patient separated from **B** to go to **A**. If patient not admitted by **B**, contract leave is nil. If patient not admitted by **B**, contract leave is nil.
- Diagnosis and procedure codes: include any additional diagnoses identified by **B**, and procedures provided by **B** each with relevant contract procedure flag (F or N) (see *Responsibility for exchange of information* above).
- Separation date: actual date patient separated from **A**.
- Length of stay is Separation Date minus Admission Date minus Total [normal] Leave days; thus contract leave days are effectively treated as patient days and included in Length of Stay.

## **6 Contract Type A(B)**

### **A records:**

- Admission date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 6 *Contract Type A(B)*.
- Contract Role code A *Hospital A*.
- Contract Identifier (Campus code) of Hospital **B**.
- Separation date.

**B** is not required to record any information about this episode.

## **7 Contract Type (A)**

### **A records:**

- Admission date: actual date Interim Care commences at residential aged care facility or supported accommodation.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 7 *Contract Type (A)*.
- Contract Role code A *Hospital A*.
- Contract/Spoke Identifier: 8850, 8860 or 8870 *Interim Care Program*.
- Diagnosis and procedure codes from information provided by residential aged care facility (see *Responsibility for exchange of information* above).
- Separation date: actual date Interim Care finishes at residential aged care facility or supported accommodation.

### **Elimination of duplicate procedures and patient days**

Each contract type is clearly distinguished by the combination of reporting in the Contract Type and Contract Role fields. Apart from the Type **B** and **A(B)** and **(A)** contracts, all other contract types may involve duplication of reporting some or all of the procedures and patient days.

At a State level, to determine total activity figures for procedures and patient days, it is possible to determine aggregate figures and then subtract those procedures and patient days performed in cases where the Contract Type is 2, 3, 4, or 5 and Contract Role is B (Hospital **B**).

However, for VAED reporting, no discounting of activity figures is required.

**Refer to:**

- Section 2: *Leave - Contract page 2-#, Interim Care page 2-#, and Patient Day page 2-#.*
- Section 3: *Contract Leave Days Financial Year-To-Date, Contract Leave Days Month-To-Date, Contract Leave Days Total, Contract Role, Contract/Spoke Identifier, Contract Type, Funding Arrangement and Procedure Codes.*
- Section 8: Editing tables *Contracting: Funding Arrangement and Contract Fields, Contracting: Contract Fields, Contract Leave and Funding Arrangement, and Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Type.*

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## Contract Type (*Amended*)

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### Specification

**Definition**

Describes the contract arrangement between the contractor and the contracted hospital/facility. Contract Types are distinguished by the physical movement of the patient between the contracting (where applicable) and contracted hospitals.

**Datatype**

Alphanumeric

**Form**

Code

**Field size**

1

**Layout**

N or space.

**Location**

Episode Record

**Reported by**

Victorian public and private hospitals involved in contracted care arrangements (purchases and providers of contracted care).

[All other sites, report a space in this field.]

**Reported for**

Episodes where the Funding Arrangement is 1 *Contract*.

[For all other episodes, report a space in this field.]

**Reported when**

This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.

**Code set**

<b>Code</b>	<b>Descriptor</b>
1	Contract Type B
2	Contract Type ABA
3	Contract Type AB
4	Contract Type (A)B
5	Contract Type BA
6	Contract Type A(B)
7	Contract Type (A)

**Reporting guide**

The contracting (purchasing) hospital (or authority) is termed Hospital **A**.

The contracted (service provider) hospital is termed Hospital **B**.

Contract Types are described by the sequence of the **A** and **B** characters, representing the movement of the patient between the contracting and contracted entities. Brackets indicate the patient was not physically present in one of either the contracting or contracted hospital. For example, (A) means the patient was not physically present in the contracting hospital.

**1 Contract Type B**

A (health authority/other external purchaser) contracts **B** (hospital) for admitted service; ~~or A (health authority) approves B (hospital) arranging for a non-hospital to provide Interim Care services under contract.~~

**2 Contract Type ABA**

Patient admitted by Hospital **A**.

Hospital **A** contracts Hospital **B** for admitted or non-admitted patient service.

Patient returns to Hospital **A** on completion of service by Hospital **B**.

**3 Contract Type AB**

Patient admitted by Hospital **A**.

Hospital **A** contracts Hospital **B** for admitted or non-admitted patient service.

Patient does *not* return to Hospital **A** on completion of service by Hospital **B**.

#### **4 Contract Type (A)B**

Patient is *not* present in the Contracting Hospital (A) at any time during the episode.

Hospital A contracts Hospital B for the *whole* admitted patient service.

An (A)B contract type cannot occur between two public hospitals unless approved by the Metropolitan Health & Aged Care Division of DHS. Where two public hospitals enter into a contract, the contracting hospital must provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB and BA).

#### **5 Contract Type BA**

Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for the remainder of the care.

#### **6 Contract Type A(B)**

Hospital A contracts Hospital B for the *whole* admitted patient service.

Hospital B provides the service at Hospital A.

Patient is not present in the Contracted Hospital (B) at any time during the episode.

An A(B) contract type cannot occur between two public hospitals unless approved by the Metropolitan Health & Aged Care Division of DHS. Normally where two public hospitals enter into a contract, the contracting hospital must admit and provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB and BA).

#### **7 Contract Type (A)**

Hospital A contracts a residential aged care facility or supported accommodation to provide Interim Care.

#### **Edits**

- 410 Illegal Comb Fund Arrange & Contract
- 417 Invalid Contract Type
- 423 Invalid Comb Fund/Contract/Transfer
- 454 Incompat Fields for Interim Care

#### **Related items**

Section 2: Concept definitions *Contracted Care* and *Leave - Contract*.

## Administration

<b>Purpose</b>	To identify the type of contract arrangement (if any) that applies to this episode, to make a link (if appropriate) to the record reported by the other party to the contract arrangement.		
<b>Principal data users</b>	Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).		
<b>Collection start</b>	1999-2000		
<b>Definition source</b>	NHDD	<b>Code set source</b>	NHDD

---

## Contract/Spoke Identifier (*Amended*)

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### Specification

<b>Definition</b>	This field identifies: <ul style="list-style-type: none"><li>• The public or private hospital or day procedure centre involved in contracted care arrangements with this hospital (as purchaser <i>or</i> provider of contracted care).</li><li>• The <i>Spoke</i> hospital in a Hub and Spoke arrangement for this episode (the Spoke hospital does not report the episode).</li><li>• The exact nature of the contract involving an external purchaser.</li><li>• A non-hospital contracted to provide Interim Care services</li></ul>		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	4	<b>Layout</b>	NNNN or spaces.
<b>Location</b>	Episode Record		
<b>Reported by</b>	Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchasers and providers of contracted care).		

[All other sites, report a space in this field.]

**Reported for**

This item is mandatory if Funding Arrangement is:

1 *Contract* or

2 *Hub/Spoke*

[Otherwise, report a space in this field.]

**Reported when**

This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.

**Code set**

Report the relevant Hospital Campus Code (refer to Section 4: *Hospital Code Table*), which identifies the other party to the contracted service arrangement, with the following exception.

When the Funding Arrangement is 1 *Contract* and the Contract Type 1 *Contract Type B* or 7 *Contract Type (A)*, report the code from the list below that identifies the external purchaser/program relevant to the episode of care.

<b>Code</b>	<b>Descriptor</b>
0100	Australian Health Care Agreement (AHCA) - Elective Surgery
0100	Australian Health Care Agreement (AHCA) - Elective Surgery
0200	Department of Human Services: HIV Aids
0300	Department of Veterans Affairs: Veterans Cardiac Agreement
0400	Individual contracts with international patients
0500	Transport Accident Commission: Alfred Road Trauma Unit
0600	Department of Human Services: Rural & Remote Health Agency Program
0700	Department of Human Services: Bowen Centre - ARMC
0800	Victorian Maintenance Dialysis Program
0900	St Jude Pacemaker Replacement Program
0910	St Vincents Lithotripsy Service - Bendigo Hospital
0920	St Vincents Lithotripsy Service - MMC Clayton
0930	St Vincents Lithotripsy Service - RCH
0940	St Vincents Lithotripsy Service - MMC Moorabbin
0950	St Vincents Lithotripsy Service - West Gippsland Healthcare Group
0960	St Vincents Lithotripsy Service - Ballarat Hospital
0970	St Vincents Lithotripsy Service - Geelong Hospital
0980	St Vincents Lithotripsy Service - Frankston Hospital

0990	St Vincents Lithotripsy Service - Goulburn Valley Health
8850	Interim Care Program: Commonwealth funded bed, residential aged care facility
8860	Interim Care Program: Unfunded bed, residential aged care facility
8870	Interim Care Program: Supported Accommodation
8880	<del>Interim Care Program: Non-hospital</del>

**Reporting guide**

Refer to Section 2: concept definition *Contracted Care*.

Codes 8850, 8860 and 8870 *Interim Care Program* shall only be used with Contract Type 7 *Contract Type (A)*.

**8870 *Interim Care Program: Supported Accommodation***

*Includes:*

- Supported Residential Service (SRS)

**Edits**

- 410 Illegal Comb Fund Arrange & Contract
- 419 Invalid Contract/Spoke Identifier
- 420 Contract/Spoke = Campus/Site

**Related items**

Section 2: Concept definitions Contracted Care and Leave - Contract.

**Administration**

**Purpose**

To enable monitoring of health services provided under contract in Victoria.

**Principal data users**

Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).

**Collection start**

1999-2000

**Definition source**

DHS

**Code set source**

DHS

## **Proposal six—Admission and Separation Codes**

***It is proposed to*** Amend the various admission and separation codes to ensure that only one concept is collected by each data item to assist analysis. This includes creating a new Care Type for Rehabilitation in the Home.

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***Implementation Date*** 1 July 2003

***Background*** Over time the current fields have been amended, resulting in these fields containing more than one concept. In this Proposal some values have been moved to different data items and some have been removed as they are obsolete or are duplicated elsewhere. For example Geriatric Respite is currently collected in Admission Type, but can simply be derived using Diagnosis Codes.

If this Proposal is implemented, a large number of edits will need to be deleted or amended, and some new edits will need to be created. These have not been detailed in these Proposals.

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## Episode of Care (Concept Definition *Amended*)

---

**Definition** The period of admitted patient care between admission and separation.

**Guide for use** An overnight or multi-day stay patient may receive more than one type of care during the period of hospitalisation. If so, the period of hospitalisation is broken into Episodes of Care, one for each type of care (Care Type).

An Episode of Care refers to a phase of treatment and is designed to reflect the changing diagnosis and/or treatment of the patient. The Episode of Care ends when the Care Type changes or the patient physically leaves the hospital.

There are some exceptions to rules inherent in the above definition:

- (Compulsory for public hospitals) A newborn changing Qualification Status during an Episode of Care may also require a change in Care Type. If a newborn initially receiving Unqualified Newborn Care changes Qualification Status, their Care Type for the entire episode is reported as Acute Care.
- A patient cannot have two changes of Care Type on the one day (that is, start the day as one Care Type, become another Care Type, and then revert to the original Care Type or transfer to a third Care Type). PRS/2's editing prevents such a sequence: to accept it would result in a single day being double-counted as a patient day (once in the same day episode and once as the admission day of the following episode). This circumstance most commonly occurs when a patient is treated as an Acute patient (Care Type) for a day in the middle of another Care Type episode (the same day episode should not be reported to the VAED). Where the patient reverts to the original Care Type, continue the original episode. Where the patient is transferred to a third Care Type, statistically end the original episode and start an episode for the third Care Type.
- Public hospitals may use the palliative Care Type only on admission, if the patient receives palliative care under the supervision of a palliative care specialist or physician. That is, public hospitals may not change a patient to palliative Care Type following another Episode of Care; the original episode must continue.
- Public hospitals may use the Alcohol and Drug Care Type only on admission; it is not for use following another Episode of Care.
- Public hospitals must separate and re-admit a patient admitted to a Designated Rehabilitation Program who then moves to the Rehabilitation In The Home program.

**Refer to:**

- Section 2: *Admission* page 2-#, *Geriatric Evaluation and Management* page 2-#, *Interim Care Program* page 2-#, *Newborn* page 2-#, *Nursing Home Type/Non-Acute* page 2-#, *Palliative Care* page 2-#, *Rehabilitation* page 2-#, *Rehabilitation in the Home* page 2-#, *Separation* page 2-#.
- Section 3: *Admission Source, Care Type, Qualification Status and Separation Type*.

---

## Geriatric Respite (Concept Definition *Amended*)

---

**Definition** Admission for care and support of a person with a stable, pre-assessed condition requiring accommodation, clinical and nursing care to provide relief for carers.

**Guide for use** Geriatric Respite includes both planned and unplanned respite:

- Planned geriatric respite care is provided for a planned or booked admission of a person in order to provide relief for carers.
- Unplanned respite provides accommodation and care when an emergency or crisis has occurred, including an episode of ill health for the carer.

In both cases, the patient does not require assessment or clinical care over and above that which would normally have been provided in the usual place of residence.

~~The program excludes Nursing Home Type/Non-Acute patients and patients awaiting placement in residential care. Geriatric respite is not available to residents of residential care facilities.~~

Admissions to Geriatric Respite must be formal admissions. **Geriatric Respite** excludes:

- Nursing Home Type/Non-Acute patients and patients awaiting placement in residential care (refer to Interim Care).
- Residents of residential care facilities.

Geriatric Respite patients may be reported with a:

- A Care Type of 4 or 9, depending on the Health Service Agreement of the hospital.

Geriatric Respite patients shall:

- Be denoted by the use of one of the following Diagnosis Codes:
  - Z75.5 *Holiday relief care*, or
  - Z74.2 *Need for assistance at home and no other household member able to render care*
- Have an Account Class of MR.

**Refer to:**

- Section 2: *Interim Care page 2-#, and Nursing home Type/Non-Acute Care page 2-#.*
- Section 3: *Admission Type.*
- Section 8: *Admission Type: Geriatric Respite.*

---

## Rehabilitation in the Home (Concept Definition Amended)

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**Definition**

Provision of rehabilitation care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.

**Guide for use**

When hospitals are reporting a rehabilitation episode, and part of the care is delivered in a home setting, the patient is to be ~~formally~~ statistically separated when leaving the inpatient unit. A new ~~formal~~ statistical admission is to be created for the portion of the episode of care received in the home, ~~therefore creating two formal admissions for the patient. This occurs even when the patient's Care Type changes from Care Type 2 in the admitted episode to Care Type 6 in the RITH episode (usually there can not be a statistical discharge and readmission between Rehabilitation Care Types).~~

For all separations to RITH, use:

- Separation Mode H *Separation to private residence/accommodation.*

~~• Separation Type K *Other formal separation*~~

For all admissions to RITH, use:

~~• Admission Source Z *Other formal admission source*~~

- Care Type J *Rehabilitation in the Home.*

- Accommodation Type 4 *In the Home (Hospital - HITH)(Rehabilitation - RITH).*

Note that the Hospital in the Home program treats accommodation changes differently.

**Refer to:**

- Section 2: *Hospital in the Home* page 2-#, *Non-Admitted Patient* page 2-#, and *Rehabilitation Care* page 2- #.
- Section 3: *Accommodation Type.*

---

## Admission Source (*Amended*)

---

### Specification

**Definition** Describes where the circumstances of patient was living/residing prior to the commencement of an episode of care.

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

**Field size** 1 **Layout** A or N

**Location** Episode Record

**Reported by** All Victorian hospitals (public and private).

**Reported for** All admitted patient episodes of care.

**Reported when** The Episode Record is reported.

**Code set** Select the first appropriate category:

**Code Descriptor**

***Statistical admissions (changes in Care Type within this hospital):***

<del>F</del>	<del>Change from Interim Care Program—Nursing Home Type</del>
<del>E</del>	<del>Change from Interim Care Program</del>
<del>1</del>	<del>Change from NHT/Non-Acute</del>
<del>2</del>	<del>Change from Designated Rehabilitation Program/Unit: Level 1</del>
<del>6</del>	<del>Change from Designated Rehabilitation Program/Unit: Level 2</del>
<del>7</del>	<del>Change from Designated Rehabilitation Program/Unit: Level 3</del>
<del>8</del>	<del>Change from Palliative Care Program</del>
<del>5</del>	<del>Change from Approved Mental Health Service or Psychogeriatric Program</del>
<del>9</del>	<del>Change from Geriatric Evaluation and Management Program</del>
<del>0</del>	<del>Change from Alcohol and Drug Program</del>
<del>3</del>	<del>Change from Family Choice: Awake Attendant Care</del>
<del>4</del>	<del>Change from Other (Acute) Care</del>
S	Statistical Admission (change in Care Type within this hospital)

***Formal admissions:***

Y	Birth episode
<del>C</del>	<del>Emergency episode [to be collected in Admission Type field]</del>
<del>L</del>	<del>Waiting list [to be collected in Admission Type field]</del>
T	Transfer from acute hospital/extended care/rehabilitation/geriatric centre
N	Transfer from aged care residential facility
A	Transfer from mental health residential facility
<del>Z</del>	<del>Other formal admission source [Obsolete]</del>
H	Admission from private residence/accommodation

## **Reporting guide**

An admission can be statistical or formal.

**Statistical:** Each change in Care Type involves completing the Episode Record and starting a new Episode Record. For changes in Care Type within this hospital, the code in Admission Source is the same code as the Care Type of the previous episode (that is, the episode that ended as this episode started).

**Formal:** The last referral source leading to this admission (the source from which the patient was admitted). For episodes with Admission Source T, the Transfer Source field identifies the specific health service from which the patient was transferred.

### **~~Statistical admissions (codes are alpha or numeric)~~**

#### **~~F~~ — ~~Change from Interim Care Program—Nursing Home Type~~**

~~Change from care in a unit designated to provide Interim Care Program—Nursing Home Type to another Care Type in this hospital. Use code F only if your health service has a designated unit to approved to provide Interim Care.~~

~~Private hospitals: Do not use code F.~~

#### **~~E~~ — ~~Change from Interim Care Program~~**

~~Change from care in a unit designated to provide Interim Care Program to another Care Type in this hospital. Use code E only if your health service has a designated unit to approved to provide Interim Care.~~

~~Private hospitals: Do not use code E.~~

#### **~~1~~ — ~~Change from NHT/Non-Acute~~**

~~Change from Nursing Home Type care or Non-Acute care to another Care Type in this hospital.~~

#### **~~2~~ — ~~Change from Designated Rehabilitation Program/Unit: Level 1~~**

~~Change from Rehabilitation Program/Unit Level 1 to another Care Type in this hospital, excluding another Rehabilitation Level. Use code 2 only if the public hospital's Health Service Agreement specifies that the hospital has a designated unit.~~

~~Private hospitals: Do not use code 2.~~

**~~6—Change from Designated Rehabilitation Program/Unit: Level 2~~**

~~Change from Rehabilitation Program/Unit Level 2 to another Care Type in this hospital, excluding another Rehabilitation Level. Use code 6 only if the public hospital's Health Service Agreement specifies that the hospital has a designated unit.~~

~~Private hospitals: Use code 6 only if registered under the Health Services Act 1988 for this category of care.~~

**~~7—Change from Designated Rehabilitation Program/Unit: Level 3~~**

~~Change from Rehabilitation Program/Unit Level 3 to another Care Type in this hospital, excluding another Rehabilitation Level. Use code 7 only if the public hospital's Health Service Agreement specifies that the hospital has a designated unit.~~

~~Private hospitals: Do not use code 7.~~

**~~8—Change from Palliative Care Program~~**

~~Change from Palliative care to another Care Type in this hospital. Use code 8 only if the hospital has a palliative care program.~~

~~Public hospitals: Do not use code 8, as statistical separation and admission to Palliative Care Program is not allowed.~~

~~Private hospitals: Use if the hospital operates a similar program and wishes to identify episodes of care as such.~~

**~~5—Change from Approved Mental Health Service or Psychogeriatric Program~~**

~~Change from an Approved Mental Health Service or Approved Psychogeriatric Program to another Care Type in this hospital. Use code 5 only if the public hospital's Health Service Agreement specifies that the hospital has such a service/program.~~

~~Private hospitals: use code 5 only if registered under the Health Services Act 1988 for this category of care.~~

**~~9—Change from Geriatric Evaluation and Management~~**

~~Change from Geriatric Evaluation and Management to another Care Type in this hospital. Use code 9 only if the hospital's Health Service Agreement specifies that the hospital has such a program.~~

~~Private hospitals: Use if the hospital operates a similar program and wishes to identify episodes of care as such.~~

### ~~0—Change from Alcohol and Drug Program~~

~~Change from Alcohol and Drug Program to another Care Type in this hospital. Use code 0 only if the patient was treated by a specialist physician for an alcohol or drug related condition that was the principal diagnosis.~~

~~Public hospitals: Do not use code 0, as statistical separation and admission to Alcohol and Drug Program is not allowed.~~

~~Private hospitals: Use if the hospital operates a similar program and wishes to identify episodes of care as such.~~

### ~~3—Change from Family Choice: Awake Attendant Care~~

~~Change from an authorised Family Choice Program where the child received overnight awake attendant care in the home. Use code only if the public hospital is authorised under this Program (Royal Children's Hospital only).~~

~~Private hospitals: Do not use code 3.~~

### ~~4—Change from Other (Acute) Care~~

~~Change from Other (Acute) Care (includes same day, acute except psychiatric) to another Care Type in this hospital.~~

## **S Statistical Admission (change in Care Type within this hospital)**

Assign this code when a new episode of care is commenced within the same hospital stay on the same hospital campus.

### *Includes:*

- Admissions to RITH where hospitals are reporting a rehabilitation episode under the CRAFT model and part of the care is delivered in a home setting.

### *Excludes:*

- Change from or to Unqualified newborn (Care Type U) as a Statistical Separation or a Statistical Admission. Changes between Qualified and Unqualified status of newborns is recorded in Status Segments using the Qualification Status field. Refer to Section 2: Concept Definition *Newborns*.

---

**Formal admissions (codes are alphabetic, excluding F and E)**

**Y *Birth episode***

Admission of newborn at or directly after birth (~~Qualified or Unqualified~~), ~~born in this hospital, or born before arrival at this hospital.~~

*Excludes* second or subsequent admissions in the newborn period:

- ~~• Newborns transferred to this hospital from another during first 9 days of life (use code T).~~
- ~~• Emergency admissions of Qualified newborns (use C).~~
- ~~• Non urgent admissions of Qualified newborns (use Z).~~

- Newborns admitted after the birth episode, while still nine (9) days old or less (use code T or H).

~~**C *Emergency episode***~~

~~Emergency admission to this hospital.~~

~~*Includes:*~~

- ~~• Admission through the Emergency Department.~~
- ~~• Emergency admission to a hospital without a formal Emergency Department.~~
- ~~• Emergency admission seen in the Outpatient Departments.~~
- ~~• Emergency admission of a Qualified newborn for a second or subsequent episode during the newborn period (first 9 days of life) where the newborn is not being transferred directly from another hospital.~~
- ~~• Referral by private medical practitioner or specialist directly for emergency admission~~
- ~~• Maternity patient admitted via the Emergency Department.~~

~~*Excludes:*~~

- ~~• Newborn born before arrival at this hospital (use code Y).~~
- ~~• Maternity patient not admitted via the Emergency Department (see Z).~~

### **~~L~~ *Waiting List***

~~Planned admission of a patient currently on the hospital's waiting list for elective medical or surgical treatment as an admitted patient. Waiting list patients include only those elective admissions for whom names, addresses and other necessary details are held by the hospital on a specific list prepared from a written request for admission from the patient's doctor.~~

~~Use of this code is not limited to those facilities that report elective surgery waiting list data to the Elective Surgery Information System (ESIS). Any hospital that maintains a formal waiting list for elective medical and/or surgical admissions should use this code.~~

~~Private hospitals: Do not use code L.~~

#### *~~Excludes:~~*

- ~~• Non-elective admissions managed through the use of a 'waiting list', for example rehabilitation episodes.~~
- ~~• Geriatric respite care patients (use Z).~~
- ~~• Maternity patients (use Z unless a Transfer from another acute hospital (T), from a mental health residential facility A), or Emergency Episode (C)).~~
- ~~• Private hospitals booked patients (use Z).~~

### **T *Transfer from acute hospital / extended care / rehabilitation / geriatric centre***

Admission to this hospital, directly from another acute hospital, extended care, rehabilitation or geriatric centre, regardless of whether the patient was admitted or not at the transferring hospital.

Requires a Transfer Source code.

#### *Includes:*

- Public and private acute, extended care and psychiatric hospitals.

#### *Excludes:*

- Aged care residential facilities (see code N below) (use code N)
- Mental health residential facility (use code A).

### **N *Transfer from aged care residential facility***

Admission to hospital directly from an aged care residential facility (includes nursing home and hostel).

Does not require a Transfer Source code.

**A *Transfer from mental health residential facility***

Transfer from mental health residential facility (includes psychogeriatric nursing homes and community care units) (Rehabilitation/Continuing Care/Other Care) funded by Mental Health Services. Only hospitals listed in Section 4 can use this code.

Does not require a Transfer Source code.

*Excludes:*

- Psychiatric hospitals (use code T).

**Z—~~Other formal admission source~~**

~~Admission from other sources, not elsewhere included.~~

~~*Includes:*~~

- ~~• Referral by private medical practitioner or specialist directly for admission (non-emergency).~~
- ~~• In private hospitals, patients admitted from a booking/waiting list.~~
- ~~• Geriatric respite care patients.~~
- ~~• Maternity patients unless transfer from another acute hospital (T), from an aged care residential facility (N), from a mental health residential facility (A), or as an Emergency Episode (C).~~
- ~~• Patients transferred from Prison Hospitals and Armed Forces Hospitals.~~
- ~~• Non-urgent second or subsequent admissions of newborns (that is, not the birth episode).~~

~~*Excludes:*~~

- ~~• Referral by private medical practitioner or specialist directly for emergency admission (use C).~~
-

## **H *Private Residence/Accommodation***

Place of residence immediately prior to admission.

### *Includes:*

- Home or home of relative or friend.
- Supported residential facilities.
- Special accommodation houses.
- Training centres for intellectually disabled persons.
- Prison.
- Juvenile detention centre.
- Armed forces base camp.
- Homeless (shelters, half way houses).

### *Excludes:*

- Aged care residential facility if this is the permanent place of residence occupied by the individual (use code N).
- Mental health residential facility if this is the permanent place of residence occupied by the individual (use code A).

**Edits**

- 041 Invalid Adm Source
- 051 Transfer Source Blank
- 056 Incompatible Adm Type/Source
- 120 Adm Source Matches Care Type
- 122 Sameday Adm Source/Sep Type Mode Mismatch
- 125 Adm Src & Care Type Both Rehab
- 220 Newborn Adm Source But Age > 2 Days
- 221 Invalid Adm Source For Newborn
- 223 Newborn; Adm Srce Not Newborn Trans
- 229 Care Zero; Source Statistical
- 238 Adm Crit is U But Adm Source Incorrect
- 239 Adm Crit Is N But Adm Source Not Valid
- 289 Adm Sc T'fer & Onset = Adm Date
- 290 Stat Adm Sc & Onset Date = Adm Date
- 329 Geri Respite – Invalid Comb
- 336 Invalid comb For Crit Care Transfer
- 344 Invalid Comb For Family Choice
- 423 Invalid Comb Fund/ Contract/Transfer
- 454 Incompat Fields for Interim Care
- 455 Inconsist Newborn Transferred/Unqual Data

**Related items**

Section 2: Concept definitions *Admission, Admitted Patient, Episode of Care, Geriatric Evaluation and Management Program, Interim Care, Newborns, Nursing Home Type/Non-Acute care, Palliative Care, and Rehabilitation Care.*

Section 3: *Transfer Source*, page 3-#.

Section 4: *Geriatric Evaluation and Management (GEM) Program Approved for Care Type 9, Interim care Program: Approved for Care Type F and E, Mental Health Service and Psychogeriatric Programs Approved for Care Type 5, Palliative Care Units Approved for Care Type 8, Rehabilitation Programs Designated for Care Type 2, 6 or 7.*

Section 8: Editing Tables *Admission Source and Admission Type, and Criteria for Admission, Age, Admission Type and Admission Source, and Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Type.*

## Administration

- Purpose** To: analyse patient movement.
- ~~Distinguish between formal and statistical admissions.~~
  - ~~Study patterns of Care Type changes by identifying the Care Type of the previous admission.~~
  - ~~Monitor admissions from the Waiting List.~~
  - ~~Identify any episode that began as a transfer.~~
  - ~~Study patterns of transfers between hospitals.~~

**Principal data users** Access Unit (Metropolitan Health & Aged Care, DHS).

**Collection start** 1979-1980

**Definition source** NHDD **Code set source** DHS

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## Admission Type (*Amended*)

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### Specification

**Definition** The category of admission (~~program, injury or patient characteristic~~) relating to this episode of care.

**Datatype** Alpha **Form** Code

**Field size** 1 **Layout** A

**Location** Episode Record

**Reported by** All Victorian hospitals (public and private).

**Reported for** All admitted patient episodes of care.

**Reported when** The Episode Record is reported.

**Code set** Select the first appropriate category:

**Code Descriptor**

- S ~~Not applicable:~~ Statistical admission **(change in Care Type within this hospital)**
- Y ~~Newborn~~ **Birth episode**
- M Maternity
- R ~~Road emergency~~ [use code C or O]
- I ~~Industrial (work) emergency~~ [use code C or O]
- G ~~Geriatric respite admission~~ [use code L, X, or O & identified by Diagnosis Codes Z75.5 and Z74.2]
- Q ~~Rural Patients initiative~~ [Funding Arrangement field]
- W ~~Elective Surgery Access Service~~ [Funding Arrangement field]
- L Planned admission – Waiting List [previously collected in Admission Source field]
- X ~~Other planned admission (same day or overnight/multi day)~~
- C Emergency admission from Emergency Department at this hospital [previously collected in Admission Source field]
- O Other emergency admission

**Reporting guide**

**S ~~Not applicable:~~ Statistical admission **(change in Care Type within this hospital)****

Used for statistical admissions when a new episode of care commences within the same hospital stay (~~numeric Admission Source codes~~).

*Excludes:*

- ~~Referral to the post acute program (use Separation Type Z).~~

**Y ~~Newborn~~ **Birth episode****

Used for all newborns, including emergency admission of newborns.

Admission of newborn at or directly after birth.

*Excludes* second or subsequent admissions in the newborn period:

- Newborns admitted after the birth episode, while still nine (9) days old or less (use code L, X, C or O).

## **M *Maternity***

Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy.

## **~~R—Road emergency~~**

~~Unscheduled admission for injuries received in a road accident. Applies only to admission for initial treatment of injury; follow-up admissions are code X *Other planned admission*.~~

### *Includes:*

- ~~• Road injury on way to/from/during work.~~

## **~~I—Industrial (work) emergency~~**

~~Unscheduled admission for injuries received in an industrial accident (that is, work-related other than road accidents). Applies only to admission for initial treatment of injury; follow-up admissions are code X *Other planned admission*.~~

### *Includes:*

- ~~• Any accident occurring during working time wherever it happened.~~

### *Excludes:*

- ~~• Road injury on way to/from/during work (use code R).~~

## **~~G—Geriatric respite admission~~**

~~Admission for geriatric respite care. Use code G only if the public hospital's Health Service Agreement designates that the hospital can admit such patients.~~

~~Private hospitals: Do not use code G.~~

## **~~Q—Rural Patients initiative~~**

~~Admission to Rural Patients initiative. Use code Q only if the public hospital has been allocated resources through the Rural Patients initiative.~~

~~Private hospitals: Do not use code Q.~~

## **~~W—Elective Surgery Access Service~~**

~~Admission to the Elective Surgery Access Service (ESAS). Use code W only if the public hospital has been allocated resources through the Elective Surgery Access Service.~~

~~Private hospitals: Do not use code W.~~

**L** **Planned admission – Waiting List** [Changes refer to what was previously listed in the Admission Source Field]

Planned admission of a patient currently on the hospital's waiting list for elective medical or surgical treatment as an admitted patient. Waiting list patients include only those elective admissions for whom names, addresses and other necessary details are held by the hospital on a specific list prepared from a written request for admission from the patient's doctor.

Use of this code is not limited to those facilities that report elective surgery waiting list data to the Elective Surgery Information System (ESIS).

~~Private hospitals: Do not use code L.~~

*Includes:*

- Non-elective admissions managed through the use of a 'waiting list', for example rehabilitation episodes.

*Excludes:*

- ~~Non-elective admissions managed through the use of a 'waiting list', for example rehabilitation episodes.~~
- ~~Geriatric respite care patients (use Z).~~
- ~~Maternity patients (use Z unless a Transfer from another acute hospital (T), from a mental health residential facility (A), or Emergency Episode (C)).~~
- ~~Private hospitals booked patients (use Z).~~

**X** **Other planned admission (same day or overnight/multi-day)**

Planned, routine or non-emergency admission regardless of expected length of stay, ~~excluding geriatric respite admission~~ where patient is not recorded on a waiting list.

*Includes:*

- Planned admission from Outpatient Department ~~or from booking/waiting list.~~
- Follow-up admission following a previous emergency admission.
- Routine admissions for procedures such as dialysis and chemotherapy.

**C** ***Emergency Episode admission from Emergency Department at this hospital*** [Changes refer to what was previously listed in the Admission Source Field]

~~Emergency admission to this hospital.~~

Unscheduled admission that is not a planned or maternity admission, arising from presentation at Emergency Department of this hospital.

Use of this code is not limited to those facilities that report to the Victorian Emergency Minimum Dataset (VEMD).

*Includes:*

- ~~• Admission through the Emergency Department.~~
- ~~• Emergency admission to a hospital without a formal Emergency Department.~~
- ~~• Emergency admission seen in the Outpatient Departments.~~
- ~~• Emergency admission of a Qualified newborn for a second or subsequent episode during the newborn period (first 9 days of life) where the newborn is not being transferred directly from another hospital.~~
- ~~• Referral by private medical practitioner or specialist directly for emergency admission~~
- ~~• Maternity patient admitted via the Emergency Department.~~
- Threatened miscarriage before 20 weeks.

*Excludes:*

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).
- ~~• Newborn born before arrival at this hospital (use code Y).~~
- ~~• Maternity patient not admitted via the Emergency Department (see Z).~~

---

### **O Other emergency admission**

Unscheduled admission ~~not admitted through the Emergency Department at this hospital~~ that is ~~not involving injuries from road or industrial accident~~, not a ~~planned~~ or maternity admission.

*Includes:*

- GP-referred admission or self-referral for acute illness (such as unstable diabetes, CCF, pneumonia, asthma attack) ~~directly for emergency admission~~.
- ~~Home accident.~~
- Threatened miscarriage before 20 weeks.

• Emergency admission to a hospital without a formal Emergency Department.

• Emergency admission seen in the Outpatient Departments.

*Excludes:*

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).

### **Edits**

- 052 Invalid Adm Type
- 056 Incompatible Adm Type/Source
- 057 Adm Type/Date of Birth
- 059 Maternity - Not Female
- 218 Newborn Adm Type But Age > 9
- 219 Adm Type Not Newborn; Age < 10 days
- 230 Adm Type & P Diag Incompatible
- 329 Geri Respite - Invalid Comb
- 336 Invalid Comb For Crit Care Transfer
- 344 Invalid Comb For Family Choice
- 432 MAPU or SOU > 48 Hours
- 454 Incompat Fields for Interim Care
- 455 Inconsist Newborn Transferred/Unqual Data

### **Related items**

Section 2: Concept definitions ~~Geriatric Respite~~ and *Newborn*.

Section 8: Editing Tables *Admission Source and Admission Type*, and ~~Admission Type: Geriatric Respite~~, and *Criteria for Admission, Age, Admission Type and Admission Source*.

## Administration

<b>Purpose</b>	To:		
		<ul style="list-style-type: none"><li>• Distinguish between emergency and non-emergency admissions.</li><li>• <del>Identify geriatric respite episodes.</del></li></ul>	
		<ul style="list-style-type: none"><li>• Monitor admissions from the Waiting List.</li></ul>	
		<ul style="list-style-type: none"><li>• Identify data for maternity and birth episodes.</li></ul>	
<b>Principal data users</b>	Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS). Quality Branch (Metropolitan Health & Aged Care, DHS).		
<b>Collection start</b>	1979-1980		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

---

## Care Type (*Amended*)

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### Specification

<b>Definition</b>	The nature of the clinical service provided to an admitted patient during an episode of care.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	A or N
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted patient episodes of care.		

**Reported when** The Episode Record is reported.

**Code set** Select the first appropriate category:

**Code Descriptor**

F Interim Care Program – Nursing Home Type

E Interim Care Program

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

J Designated Rehabilitation Program/Unit: In the home

8 Palliative Care Program

5 Approved Mental Health Service or Psychogeriatric Program

9 Geriatric Evaluation and Management Program

0 Alcohol and Drug Program

3 Family choice: Awake Attendant Care

4 Other care (Acute) including Qualified newborn

U Unqualified newborn

**Reporting guide** Reporting guides relating to other values remain the same as per the VAED 12<sup>th</sup> Edition

**J Designated Rehabilitation Program/Unit: In the home**

A patient who is admitted to, or transferred to, a designated Rehabilitation Program with the Accommodation Type of 4 *In the Home (Hospital - HITH)(Rehabilitation- RITH)*. Use code 2 only if:

- The public hospital's Health Service Agreement specifies that the hospital has such a designated unit.
- The public hospital has approval from the Sub-Acute Program to run a Rehabilitation in the Home program.

Private hospitals: Do not use code J.

---

**Additional Notes:****Newborns**

In a single episode, a newborn may change between being Qualified and Unqualified with such changes being recorded in the (Status Segment) Qualification Status field. Care Type may need updating if a newborn changes from being Unqualified to Qualified.

Refer to Section 2: Concept definition *Newborns*.

**All other episodes**

For all other episodes, if the Care Type changes during the episode, the date of that change must be reported in the Separation Date field and other Separation Status details completed; then a new Episode Record must be started (that is, a statistical separation and a statistical admission).

For example:

- If the patient is admitted to Acute care (Care Type 4) but later is transferred to an Approved Mental Health Service, the Care Type changes to Care Type 5, therefore the earlier Episode Record should be completed and a new Episode Record should be started.
- If the patient is admitted to one of the acute Care Types and after 35 days is deemed to require only NHT care (Care Type 1), the earlier Episode Record should be completed and a new Episode Record should be started.

This is summarised in Section 2: Concept definition *Episode of Care*, which also describes some circumstances when a new episode is not started.

A new Episode Record requires Diagnosis and Procedure Codes specific to that episode and therefore of a separate DRG. The Separation Type in the earlier Episode Record indicates the episode is being completed not because the patient has gone home, died or been transferred but because the Care Type has changed. The Admission Source of the new Episode Record indicates the new episode is starting not because the patient has been formally admitted but because the Care Type has changed.

**Edits**

094	Combination A/C Accom Care Med Suff
107	Invalid Care Type
120	Adm Source Matches Care Type
121	Sep Type matches Care Type
124	Sep Type & Care Type Both Rehab
125	Adm Srce & Care Type Both Rehab
222	Unqual Newborn; Adm Date Not Birth

229 Care Zero; Source Statistical  
 235 Adm Criterion is N But Care Not 4  
 250 Deleted – Episode is Sub-Acute  
 251 Invalid Adm Barthel  
 252 Invalid Sep Barthel  
 253 Rehab: Invalid Clin Sub-Prog  
 254 Rehab: Invalid Adm/Re-Adm to Rehab  
 255 Rehab: Invalid Onset Date  
 258 Sub- Acute: No Sub – Acute Record  
 260 Invalid Care For Qual  
 261 Newborn Care But Age > 9 Days  
 262 Invalid Care Type For Newborn  
 268 Inv Comb Legal, Care & PFS  
 285 Sub-Acute Record not required  
 289 Adm Sce T'fer & Onset = Adm Date  
 290 Stat Adm Sc & Onset = Adm Date  
 291 Adm Barthel > Sep Barthel  
 292 Sep Barthel Present  
 293 Clin Sub-Prog Present  
 294 Onset Date Present  
 295 Adm/Readmit To Rehab Present  
 297 Sep Rug ADL & Sep Type Incompatible  
 298 Adm Barthel Present  
 303 Pall Care But Invalid Adm Rug ADL  
 304 Pall Care But Invalid Sep Rug ADL  
 305 Adm Rug ADL Present  
 306 Sep Rug ADL Present  
 336 Invalid Comb For Crit Care Transfer  
 340 Invalid Source Refer to Pal Care  
 341 Source Refer to Pal Care Present  
 344 Ivalid Comb For Family Choice  
 390 Invalid Carer Availability  
 399 Incompat Sep Type & Carer Availability  
 400 Child, Incompatible Carer Availability  
 404 Unqual Care Type, Adm Wt < 1000g  
 405 Inapplic Clin Prog For Care Type 2

406	Rehab Care Type W/Out Rehab DRG
407	Rehab Level 2 or 3 W Low Adm Barthel
421	Not Separated; Carer Avail Present
422	Carer Avail Should Be 1
437	NIV Duration for Unqual Newborn
447	Unqual Newborn; Age at Sep
448	ICU Stay but Care Type not Acute
453	Wrong PDx for Interim Care
455	Inconsist Newborn Transferred/Unqual Data

**Related items**

Section 2: Concept definitions *Admission, Admitted Patient, Episode of Care, Geriatric Evaluation and Management Program, Interim Care, Newborns, Nursing Home Type/Non-Acute Care, Palliative Care, and Rehabilitation Care.*

Section 4: *Geriatric Evaluation and Management (GEM) Program Approved for Care Type 9, Interim care Program: Approved for Care Type F and E, Mental Health Service and Psychogeriatric Programs Approved for Care Type 5, Palliative Care Units Approved for Care Type 8, Rehabilitation Programs Designated for Care Type 2, 6 or 7.*

Section 5: *Status Segments.*

Section 8: Editing tables *Account Class, Accommodation Type, Care Type and Medicare Suffix, and Care Type: Family Choice, and Care Type: Interim Care Program (F & E), and Care Type: Designated Rehabilitation Program, and Newborns: Criteria for Admission, Qualification Status, Care Type, and Program Funding Source, Care Type and Mental Health Legal Status.*

**Administration**

**Purpose**

To distinguish various types of care in order to:

- Apply the appropriate funding formula to the episode.
- Group episodes to facilitate analysis.

**Principal data users**

Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).

Sub-Acute Unit (Metropolitan Health & Aged Care, DHS).

**Collection start**

1995-1996

**Definition source**

DHS

**Code set source**

DHS

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# Funding Arrangement (*Amended*)

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## Specification

<b>Definition</b>	Identifies the specific funding arrangement, if any, that applies to this episode of care.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	N or space
<b>Location</b>	Episode Record		
<b>Reported by</b>	<ul style="list-style-type: none"><li>• Any Victorian public and private hospital involved in contracted care arrangements with another hospital (purchasers and providers of contracted care).</li><li>• Any Victorian public hospital involved in the Healthstreams program.</li><li>• Any Victorian public or private hospital treating a patient identified as a Coordinated Care Trial patient.</li></ul> <div style="border: 1px solid black; padding: 2px;"><ul style="list-style-type: none"><li>• Any Victorian public hospital involved in the Rural Patients Initiative program.</li></ul></div> <div style="border: 1px solid black; padding: 2px;"><ul style="list-style-type: none"><li>• Any Victorian public hospital involved in the Elective Surgery Access Service program (ESAS).</li></ul></div> <p>[All other circumstances, report a space in this field.]</p>		
<b>Reported for</b>	Episodes where an admitted service is provided under contract, hub and spoke, Healthstreams or Coordinated Care Trial, <u>Rural Patients Initiative</u> or <u>Elective Surgery Access Service (ESAS)</u> arrangements. [Otherwise, report a space in this field.]		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	
	1	Contract	
	2	Hub and spoke	

3	Healthstreams
4	Coordinated Care Trial
5	Rural Patients Initiative
6	Elective Surgery Access Service (ESAS)

**Reporting guide**

**1 Contract**

Patient receiving contracted hospital care under an agreement between a purchaser of hospital care (contractor) and a provider of an admitted or non-admitted service (contracted hospital).

**2 Hub and Spoke**

Patient receiving a specialist service at another hospital site (spoke) under a hub and spoke arrangement. This hospital is the hub hospital. (Any service provided at a spoke hospital is reported by the hub hospital only.)

**3 Healthstreams**

Patient receiving admitted patient services under Healthstreams. (The majority of services provided under Healthstreams do not involve *admitted* patient services.)

**4 Coordinated Care Trial**

Patient identified as a Coordinated Care Trial patient.

**5 Rural Patients Initiative**

Admission under the Rural Patients Initiative. Use code 5 only if the public hospital has been allocated resources through the Rural Patients Initiative.

Private hospitals: Do not use code 5.

**6 Elective Surgery Access Service (ESAS)**

Admission under the Elective Surgery Access Service (ESAS). Use code 6 only if the public hospital has been allocated resources through the Elective Surgery Access Service.

Private hospitals: Do not use code 6.

---

<b>Edits</b>	108	Field(s) Missing From Sep
	410	Illegal Comb Fund Arrang & Contract
	416	Invalid Fund Arrangement
	423	Invalid Comb Funding/Contract/Transfer
	424	Not Separated: Fund Arr S/Be Spaces
	454	Incompat Fields for Interim Care

**Related items**      Section 2: Concept definition *Contracted Care*.

Section 3: *Contract Role* on page 3-#, *Contract/Spoke Identifier* on page 3-#, and *Contract Type* on page 3-#.

Section 8: Editing Tables *Contracting: Funding Arrangement and Contract Fields*, and *Contracting: Contract fields, Contract Leave and Funding Arrangement*, and *Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Type*.

## Administration

**Purpose**      To:

- Identify whether a specific funding arrangement applies to this episode.
- Facilitate health services planning and monitoring.

**Principal data users**      Financial Analysis and Purchasing Branch, Metropolitan Health & Aged Care, DHS (Contract; Hub and Spoke)

Rural Specialist Services Grant (Healthstreams)

Quality and Care Continuity (Coordinated Care Trial and Elective Surgery Access Service)

Rural & Regional Health Services (Rural Patients Initiative)

**Collection start**      1996-1997

**Definition source**      DHS      **Code set source**      DHS

---

## Separation Type **Mode** (Amended)

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### Specification

**Definition** Status at separation of the person (~~discharge/transfer/death/statistical separation~~), and place to which the person is released (where applicable).

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

**Field size** 1 **Layout** A or N

**Location** Episode Record

**Reported by** All Victorian hospitals (public and private).

**Reported for** All admitted patient episodes of care.

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

**Code set** Select the first appropriate category:  
~~**Statistical** separations (changes in Care Type within this hospital):~~

**Code Descriptor**

~~F Change to Interim Care—Nursing Home Type~~

~~E Change to Interim Care~~

~~1 Change to NHT/Non Acute~~

~~2 Change to Designated Rehabilitation Program/Unit: Level 1~~

~~6 Change to Designated Rehabilitation Program/Unit: Level 2~~

~~7 Change to Designated Rehabilitation Program/Unit: Level 3~~

~~8 Change to Palliative Care Program~~

~~5 Change to Approved Mental Health Service or Psychogeriatric Program~~

~~9 Change to Geriatric Evaluation and Management Program~~

~~3 Change to Family Choice: Awake Attendant Care~~

~~4 Change to Other (Acute) Care~~

Select the first appropriate category:

**Formal** separations:

Code	Descriptor
D	Death
Z	Left against medical advice
T	Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre
N	Separation and transfer to aged care residential facility
A	Separation and transfer to mental health residential facility
H	Separation to private accommodation or home private residence/accommodation
K	Other formal separation [use code H]

**Reporting guide**

~~A separation can be *statistical* or *formal*~~

~~**Statistical:** For changes in Care Type within this hospital during the episode of care, the code in Separation Type is the same code as the Care Type of the new episode (that is, the episode that started as this episode finished).~~

~~**Formal:** The destination of the patient on leaving the hospital (or death or discharge at own risk).~~

~~**Statistical separations**~~

~~**F—Change to Interim Care—Nursing Home Type**~~

~~Change to care in a unit designated to provide Interim Care—Nursing Home Type care from another Care Type in this hospital. Use code F only if your health service has a designated unit approved to provide Interim Care.~~

~~Private hospitals: Do not use code F.~~

~~**E—Change to Interim Care**~~

~~Change to care in a unit designated to provide Interim Care from another Care Type in this hospital. Use code E only if your health service has a designated unit approved to provide Interim Care.~~

~~Private hospitals: Do not use code E.~~

**~~1—Change to NHT/Non-Acute~~**

~~Change to Nursing Home Type care or Non-Acute care from another Care Type in this hospital.~~

**~~2—Change to Rehabilitation Program/Unit: Level 1~~**

~~Change to Rehabilitation Program/Unit Level 1 from another Care Type in this hospital. Use code 2 only if the public hospital's Health Service Agreement specifies that the hospital has such a designated program or unit.~~

~~Private hospitals: Do not use code 2.~~

**~~6—Change to Rehabilitation Program/Unit: Level 2~~**

~~Change to Rehabilitation Program/Unit Level 2 from another Care Type in this hospital. Use code 6 only if the public hospital's Health Service Agreement specifies that the hospital has such a designated program or unit.~~

~~Private hospitals: Use code 6 only if registered under the Health Services Act 1988 to provide this category of care.~~

**~~7—Change to Rehabilitation Program/Unit: Level 3~~**

~~Change to Rehabilitation Program/Unit Level 3 from another Care Type in this hospital. Use code 7 only if the public hospital's Health Service Agreement specifies that the hospital has such a designated program or unit.~~

~~Private hospitals: Do not use code 7.~~

**~~8—Change to Palliative Care Program~~**

~~Change to Palliative care from another Care Type in this hospital. Use code 8 only if the hospital has a palliative care program.~~

~~Public hospitals: Do not use code 8, as statistical separation and admission to Palliative Care Program is not allowed.~~

~~Private hospitals: Use if a hospital considers it operates a similar program and wishes to identify episodes as such.~~

**~~5—Change to Approved Mental Health Service or Psychogeriatric Program~~**

~~Change to an Approved Mental Health Service or Psychogeriatric Program from another Care Type in this hospital. Use code 5 only if the public hospital's Health Service Agreement specifies that the hospital has such a service/program.~~

~~Private hospitals: Use code 5 only if registered under the Health Services Act 1988 to provide this category of care.~~

**~~9—Change to Geriatric Evaluation and Management Program~~**

~~Change to Geriatric Evaluation and Management from another Care Type in this hospital. Use code 9 only if the public hospital's Health Service Agreement specifies that the hospital has such a program.~~

~~Private hospitals: Use if a hospital considers it operates a similar program and wishes to identify episodes as such.~~

**~~3—Change to Family Choice: Awake Attendant Care~~**

~~Change to an authorised Family Choice Program where the child will receive overnight awake attendant care in the home. Use code 3 only if the public hospital is authorised under this Program (Royal Children's Hospital only).~~

~~Private hospitals: Do not use code 3.~~

**~~4—Change to Other (Acute) Care~~**

~~Change to Other Care Type (includes same day and acute except psychiatric) from another Care Type in this hospital.~~

---

**S      *Statistical Separation (change in Care Type within this hospital)***

Assign this code when a new episode of care (change in care type) occurs within the same hospital stay.

*Includes:*

- Separations to RITH where hospitals are reporting a rehabilitation episode under the CRAFT model and part of the care is delivered in a home setting.

*It is not permissible to:*

- Change to Alcohol and Drug Program Care Type (Separation Mode 0) following another episode of care (for public hospitals).
- Change from or to Unqualified newborn (Care Type U) as a Statistical Separation or a Statistical Admission. Changes between Qualified and Unqualified status of newborns is recorded in Status Segments using the Qualification Status field. Refer to Section 2: Concept Definition *Newborns*.

**Formal Separations**

**D    *Death***

Died in hospital. ~~Time of separation is time of death (that is, brain death).~~

**Z    *Left against medical advice***

Patient absconds or leaves against medical advice, at own risk. This Separation Type ~~Mode~~ is significant in the allocation of some DRGs.

*Includes:*

- Newborns taken from the hospital against medical advice.

**T    *Separation and transfer to other acute hospital/extended care/rehabilitation/ geriatric centre***

Separation and transfer to another hospital, regardless of whether the patient is to be admitted at the receiving hospital.

Requires a *Transfer Destination* code.

*Includes:*

- Unqualified newborn being transferred to another hospital.
- Public and private acute, extended care and psychiatric hospitals.

*Excludes:*

- Aged care residential facilities ~~(report code N)~~ (use code N).
- ~~Mental health residential facilities (use code A).~~

**N *Separation and transfer to aged care residential facility***

Separation and transfer to an aged care residential facility (includes nursing home and hostel).

Does not require a Transfer Destination code.

~~Excludes~~ Includes:

- Patient returning to the aged care residential facility in which they live (H).

**A *Separation and transfer to mental health residential facility***

Separation and transfer to mental health residential facility (includes psychogeriatric nursing home and community care unit) funded by Mental Health Services.

Does not require a Transfer Destination code.

Includes:

- Patient returning to the mental health residential facility in which they live.

**H ~~Separation to home or usual place of private residence/accommodation~~**

~~Separation to own home or home of relative or friend or other private accommodation.~~

Place of residence immediately following separation.

Requires a *Separation Referral* code.

*Includes:*

- ~~Supported residential facilities, special accommodation houses, half way houses, training centres for intellectually disabled persons, prisons, prison and armed forces hospitals.~~
- ~~Aged care residential facilities and mental health residential facilities if the patient is returning to the facility in which they live.~~

• Home or home of relative or friend.

• Supported residential facilities.

• Special accommodation houses.

• Training centres for intellectually disabled persons.

• Prison.

• Juvenile detention centre.

• Armed forces base camp.

• Homeless (shelters, half way houses).

- A patient treated under the HITH program in private accommodation or residential facility who, on separation, remains in the same private accommodation.
- A newborn discharged with her ~~his~~/her mother.

*Excludes:*

• Aged care residential facility if this is the permanent place of residence occupied by the individual (use N).

• Mental health residential facility if this is the permanent place of residence occupied by the individual (use A).

**~~K Other formal separation~~**

~~Any other type of separation (see code H for categories of accommodation classified as private accommodation).~~

**Edits**

- 103 Invalid Sep Type **Mode**
- 108 Fields(s) Missing From Sep
- 109 Trans Dest Not Blank
- 110 Invalid Transfer Type
- 121 Sep Type Matches Care Type
- 122 Sameday Adm Source/ Sep Type **Mode** Mismatch
- 124 Sep Type **Mode** & Care Type Both Rehab
- 160 AR – DRG Grouper GST Code Zero
- 192 Invalid Comb Int. Readmit Sep Type
- 232 Possible Coding or Sequencing Problem
- 288 Sep Barthel & Sep Type **Mode** Incompatible
- 291 Adm Barthel > Sep Barthel
- 297 Sep Rug ADL & Sep Type **Mode** Incompatible
- 334 Hosp Generated DRG Not = PRS/2 DRG
- 336 Invalid Comb For Crit Care Transfer
- 344 Invalid Comb For Family Choice
- 394 Sep Type **Mode** Home, No Sep Referral
- 395 Sep Type **Mode** Not Home, Sep Referral Present
- 397 Sep Referral Postnatal, Incompat Age/Sex
- 399 Incompat Sep Type **Mode** & Carer Availability
- 400 Child, Incompatible Carer Availability
- 404 Unqual Care Type, Adm Wt< 1000g
- 422 Carer Avail Should Be 1
- 423 Invalid Comb Fund/ Contract /Transfer
- 425 Incompat Sep Type **Mode**, Age <8

**Related items**

Section 2: Concept definitions *Admission, Admitted Patient, Episode of Care, Geriatric Evaluation and Management Program, Interim Care, Nursing Home Type/Non-Acute care, Palliative Care, and Rehabilitation Care.*

Section 3: *Transfer Source*, page 3-86.

Section 4: *Geriatric Evaluation and Management (GEM) Program Approved for Care Type 9, Interim care Program: Approved for Care Type F and E, Mental Health Service and Psychogeriatric Programs Approved for Care Type 5, Palliative Care Units Approved for Care Type 8, Rehabilitation Programs Designated for Care Type 2, 6 or 7.*

## Administration

**Purpose**

To:

- Distinguish between formal and statistical separations.
- Study service patterns - Care Type changes, transfers.

**Principal data users**

Multiple internal and external research users.

**Collection start**

1979-1980

**Definition source**

NHDD

**Code set**

DHS

**source**

### Mapping between *Separation Type* **Mode** and the *Grouper Mode of Separation*:

Separation Type (PRS/2)		Mode of Separation (NHDD and Grouper)	
D	Death	8	Died
Z	Left against medical advice	6	Left against medical advice
T	Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre	1	Discharge/transfer to an(other) acute hospital
N	Separation and transfer to aged care residential facility	2	Discharge/transfer to a Residential Aged Care Service
		3	Discharge/transfer to an(other) psychiatric hospital
A	Separation and transfer to mental health residential facility	4	Discharge/transfer to other health care accommodation
		7	Statistical discharge from leave
H	Separation to private residence/accommodation <del>or home</del>	9	Other (includes to usual residence)
K	Other formal separation		
F, E, Numeric S	Statistical separation	5	Statistical discharge-type change

## **Proposal seven—Medicare Number**

**It is proposed to** Amend Medicare Number to specify that a zero-filled field is invalid.

**Proposed by** Catherine Perry  
Department of Human Services  
Phone: 9616 6928, Email: [Catherine.Perry@dhs.vic.gov.au](mailto:Catherine.Perry@dhs.vic.gov.au)

**Implementation Date** 1 July 2003

**Background** Medicare Number has a series of codes that should be used when a Medicare Number is unavailable or the patient is not eligible for a Medicare Number. These codes need to be used to provide consistency in the data.

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## **Medicare Number (*Amended*)**

---

### **Specification**

**Definition** Personal identifier allocated by the Health Insurance Commission to eligible persons under the Medicare scheme.

**Datatype** Numeric **Form** Code

**Field size** 11 **Layout** NNNNNNNNNNNN or spaces [(all zeros are invalid)]

**Location** Episode Record

**Reported by** All Victorian hospitals (public and private).

**Reported for** Public hospitals: All patients except in the circumstances covered under Medicare Suffix.

Private hospitals: All contracted patients and for all other patients, where possible. The exceptions are covered under Medicare Suffix.

**Reported when** The Episode Record is reported.

**Code set** The patient's Medicare Number and Code, issued by the Health Insurance Commission.

**Reporting guide**

		<b>Medicare</b>	
		3256112837	Medicare Number
Medicare Code	1	Jane A Citizen	
	2	John A Citizen	
		Valid to 08/04	

Medicare Number from the Medicare card, the eleventh character being the Medicare Code (the number printed on the Medicare Card, to the left of the printed name of the patient).

For newborns who have not yet been added to the family Medicare Card, and therefore have no Medicare Code, report zero (0) as the eleventh character in this field, with the mother's /family's Medicare Number reported in the first ten characters.

When the Medicare Number is provided, it must be numeric and contain the appropriate check-digit (second-last digit on the card). ~~Medicare Number can be blank if not available.~~ If the Medicare Number is not available or not applicable, the Medicare Number must be left blank (not zero-filled).

- Edits**
- 030 Invalid Medicare Number
  - 414 Medicare Last Zero; Suffix Not 'BAB'
  - 415 Suffix 'BAB'; Medicare Last Not Zero

**Related items** Section 2: *Medicare Eligibility Status – Eligible Person*, and *Medicare Eligibility Status – Ineligible Person*.  
Section 3: *Medicare Suffix*, page 3-80.

## Administration

- Purpose** To:
- Assist in monitoring continuity of care across hospitals.
  - Ensure eligibility for publicly funded health care.

**Principal data users** Purchasing Policy Unit (Metropolitan Health & Aged Care, DHS).

**Collection start** 1979-1980

**Definition source** NHDD

**Code set source** Health Insurance Commission

---

## Medicare Suffix (*Amended*)

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### Specification

**Definition** First three characters of patient's first given name (as it appears on the persons Medicare card).

**Datatype** Alphanumeric      **Form** Abbreviation/Code

**Field size** 3      **Layout** XXX or A-A

**Location** Episode Record

**Reported by** All Victorian hospitals (public and private).

**Reported for** All admitted patient episodes of care.

**Reported when** The Episode Record is reported.

**Code set** The first 3 characters of the patient's first given name.

Characters permitted:

- *Upper case* alphas
- Space as second and third characters
- Space as third character
- Hyphen *or* apostrophe as second character *or* hyphen *or* apostrophe as third character.

If Medicare Number is unavailable or the patient is not eligible for a Medicare Number, leave the Medicare Number blank (not zero-filled) and enter the appropriate suffix:

<b>Code</b>	<b>Descriptor</b>
C-U	Card unavailable/Not applicable
N-E	Not eligible for Medicare
P-N	Prisoner

**Reporting guide**

**Unnamed neonate**

For unnamed neonate where the family has a Medicare Number: use mother's/family's Medicare Number with suffix BAB.

**Edits**

031	Blank Medicare Suffix
032	Invalid Medicare Suffix
094	Comb A/C Accom Care Med Suff
344	Invalid comb For Family Choice
414	Medicare Last Zero; Suffix Not 'Bab'
415	Suffix 'Bab'; Medicare Last Not Zero

**Related items**

Section 2: *Medicare Eligibility Status – Eligible Person*, and *Medicare Eligibility Status – Ineligible Person*.

Section 3: *Medicare Number* on page 3-78.

Section 8: Editing table *Account Class, Accommodation Type, Care Type and Medicare Suffix*.

**Administration**

**Purpose**

To:

- Assist in monitoring continuity of care across hospitals.
- Ensure eligibility for publicly funded health care.

**Principal data users**

Purchasing Policy Unit (Metropolitan Health & Aged Care, DHS).

**Collection start**

1979-1980

**Definition source**

DHS

**Code set source** -

## **Proposal eight—Duration of Non-Invasive Ventilation**

***It is proposed to*** Amend Duration of Non-Invasive Ventilation (NIV) to require Public hospitals to report Duration of NIV provided to patients while admitted to an approved Intensive Care Unit (ICU)

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***Implementation Date*** 1 July 2003

***Background*** For analysis for possible use as severity index for patients in ICU.

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## **Duration of Non-invasive Ventilation (NIV) (Amended)**

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### **Specification**

***Definition*** Total number of hours of non-invasive ventilatory assistance given via any route other than intubation or tracheostomy, provided during this episode of care, to patients in an approved Neonatal Intensive Care Unit (NICU) or Special Care Nursery (SCN) or Intensive Care Unit (ICU).

By far the most common is Continuous Positive Airway Pressure (CPAP). Duration of the following, less common, methods of ventilatory assistance should also be reported in this field:

- Bi-level Positive Airway Pressure (BiPAP)
- Intermittent Positive Pressure Breathing (IPPB), and/or
- Intermittent Mandatory Ventilation (IMV)

***Datatype*** Numeric                      ***Form***                      Quantitative value

***Field size*** 4                                      ***Layout***                      NNNN or spaces.  
Right justified and zero-filled

<b>Location</b>	Diagnosis Record
<b>Reported by</b>	<p>Reporting is <b>MANDATORY</b> for public hospitals providing NIV to patients while admitted to an approved:</p> <ul style="list-style-type: none"> <li>• Intensive Care Unit (ICU)</li> <li>• Level 3 nursery/Neonatal Intensive Care Unit (NICU) or</li> <li>• Level 2 nursery/Special Care Nursery (SCN).</li> </ul> <p>Reporting is <b>OPTIONAL</b> for:</p> <ul style="list-style-type: none"> <li>• <del>Public hospitals providing NIV to patients while admitted to an approved Intensive Care Unit (ICU)</del></li> <li>• Private hospitals providing NIV in an approved NICU or SCN or ICU.</li> </ul> <p>[Otherwise, report spaces.]</p>
<b>Reported for</b>	<p>Episodes of care for patients receiving NIV in a NICU and/or SCN and/or ICU.</p> <p>[Otherwise, report spaces.]</p>
<b>Reported when</b>	A Separation Date is reported in the Episode Record.
<b>Code set</b>	<p>A number in the range 0000 (4 spaces, blanks or null) to 9984 (upper limit must be divisible by 24).</p> <p>Any whole number less than or equal to 96, or a number greater than 96 that is divisible by 24 (refer to Converter Chart for calculating NIV hours, listed at the end of the data item).</p>
<b>Reporting guide</b>	<p><b>Respiratory support by intubation and/or tracheostomy</b></p> <p>If CPAP, BiPAP, IPPB or IMV is performed by intubation or tracheostomy in an ICU or NICU, this duration should be reported in <i>Duration of Mechanical Ventilation in ICU</i>, and not <i>Duration of Non-invasive Ventilation</i>.</p>

### **Counting duration of NIV**

- All NIV hours given in NICU and SCN and ICU are counted.
- Reference below to '24-hour period' means 'midnight to midnight'.
- Where the NIV starts in an operating theatre, for the purpose of the Duration of NIV field, the *counting of the duration of NIV starts when the patient enters the NICU or SCN or ICU.*
- Where NIV starts in NICU or SCN or ICU, continues while the patient is in an operating theatre and on the patient's return to NICU or SCN or ICU, the *count of the duration should be suspended for the time the patient is out of the NICU or SCN or ICU.*

### **Calculation is in four stages:**

- 1 Counting non-intermittent NIV
- 2 Counting intermittent NIV
- 3 Counting Contracted NIV hours (if any)
- 4 Summing and rounding above calculations

#### **1 Counting non-intermittent NIV**

If the patient has more than one period of non-intermittent NIV during this episode, sum the duration of all such periods.

#### **2 Counting intermittent NIV**

If a patient is electively cycling on and off NIV (usually only for NICU/SCN patients):

- If NIV was given for *four or more hours* in the 24-hour period between midnight and midnight, count this as 24 hours.
- If NIV was given for *less than four hours* in the 24-hour period between midnight and midnight, count the actual number of hours.

#### **3 Counting Contracted NIV hours**

When a patient receives NIV provided in a NICU or SCN or ICU in Hospital B during a contracted service episode:

- Hospital B reports the duration of NIV calculated according to these rules;
- Hospital A also includes the NIV hours received in Hospital B in addition to any NIV hours the patient received at Hospital A, each calculated according to these rules.

#### **4 Summing and rounding above calculations**

Sum the resulting figures for non-intermittent and intermittent NIV (including any Contracted hours). Then round to the nearest hour (round up or down according to convention: for example 1 hour and 29 minutes is rounded down to 1 hour, whereas 1 hour and 30 minutes is rounded up to 2 hours).

If the resulting figure is less than or equal to 96 hours, report the *exact number of cumulative* hours in *Duration of NIV*.

If the resulting figure is greater than 96 hours, round to the closest 24-hour period (round up or down according to convention, for example 11 hours and 59 minutes is rounded down, whereas 12 hours is rounded up). For practical use, use the converter chart at the end of this data item definition. Report this rounded figure in *Duration of NIV*.

#### ***Edits***

- 435 Invalid NIV Duration
- 437 NIV Duration for Unqual Newborn
- 438 NIV Duration > Total Stay
- 439 NIV Proc Code W/Out Duration in NICU/SCN
- 440 NIV Duration without NIV Proc Code
- 441 Rounding Error NIV Duration
- 442 NIV Duration for Healthy Newborn
- 454 Incompat Fields for Interim Care

#### ***Related items***

Section 2: Concept definition *Intensive Care Unit*.  
Section 3: *Duration of ICU*, page 3- #.

### **Administration**

#### ***Purpose***

To facilitate the evaluation of the perceived need for a co-payment on specified DRGs. DHS has been advised that NIV hours represent a sound and clinically valid surrogate for illness severity.

#### ***Principal data users***

Financial Analysis and Purchasing Branch (Acute Health, DHS).

#### ***Collection start***

2002-2003

**Definition source** Australian and New Zealand Neonatal Network (amended: in PRS/2, CPAP via nasopharyngeal intubation is reported in Duration of MV in ICU field)

**Converter Chart for calculating NIV hours**

<b>Days</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>
<b>Hours</b>	120	144	168	192	216	240	264	288	312	336	360	384	408	432
<b>Days</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>	<b>30</b>	<b>31</b>	<b>32</b>
<b>Hours</b>	456	480	504	528	552	576	600	624	648	672	696	720	744	768

# Changes in Record Structures

## Episode Record

### *Episode Record File Structure*

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	E2
M	Unique Key	6	3	A/N	Hospital-generated
M	Patient Identifier	8	9	A/N	Hospital generated Right justified, zero filled
M	Site Identifier	1	17	A/N	0, 1, 2, 3, 4, 5, 6, 7, 8, 9
M	Medicare Number	11	18	N	NNNNNNNNNNNN or spaces
M	Medicare Suffix	3	29	A/N	AAA or A-A
M	Sex	1	32	A/N	1, 2, 3
M	Marital Status	1	33	A/N	1, 2, 3, 4, 5, 6
M	Date of Birth	8	34	N	DDMMCCYY
M	Postcode	4	42	N	NNNN Refer to Section 3
M	Locality	22	46	A/N	Refer to Section 3
M	Admission Date	8	68	N	DDMMCCYY
M	Admission Time	4	76	N	HHMM
M	Admission Type	1	80	A/N	S, Y, M, R, I, G, Q, W, L, X, C, O, Z
M	Admission Source	1	81	A/N	<del>0, 1, 2, 3, 4, 5, 6, 7, 8, 9,</del> F, E, S, Y, C, L, T, N, A, Z
1	Transfer Source	4	82	A/N	NNNN or spaces Refer to Section 3
	[Normal] Leave Days MTD	2	86	N	NN or spaces
	[Normal] Leave Days Financial YTD	3	88	N	NNN or spaces
	[Normal] Leave Days Total	3	91	N	NNN or spaces

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
	<b>Status Segment</b> Occurs 7 times				
2	Account Class	2	94, 107, 120, 133, 146, 159, 172	A/N	AA or AN Refer to Field specification
2	Accommodation Type	1	96, 109, 122, 135, 148, 161, 174	A/N	1, 2, 3, 4, 6, <u>7</u> , B, C, M, S
2	Qualification Status	1	97, 110, 123, 136, 149, 162, 175	A/N	N, U, X
2	Patient Days MTD	2	98, 111, 124, 137, 150, 163, 176	N	Must be present if other Status details are present
2	Patient Days Financial YTD	3	100, 113, 126, 139, 152, 165, 178	N	Must be present if other Status details are present
2	Patient Days Total	4	103, 116, 129, 142, 155, 168, 181	N	Must be present if other Status details are present
3	Separation Date	8	185	N	DDMMCCYY
3	Separation Time	4	193	N	HHMM
3	Separation Type <u>Mode</u>	1	197	A/N	<del>1, 2, 3, 4, 5, 6, 7, 8, 9, F, E, D, Z, T, N, A, H, K</del>
1	Transfer Destination	4	198	A/N	NNNN or spaces Refer to Section 3
4	Separation Referral	4	202	A/N	F, P, M, B, U, C, S, D, G, R, X or spaces Left justified, trailing spaces
5	Carer Availability	1	206	A/N	1, 2, 3, 4, 5, 6, 7, 8 or space
3	Account Class on Separation	2	207	A/N	AA or AN Refer to Section 3
3	Accommodation Type on Separation	1	209	A/N	1, 2, 3, 4, 6, <u>7</u> , B, C, M, S

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Care Type	1	210	A/N	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, U, F, E, J
M	Country of Birth	4	211	A/N	NNNN Refer to Section 3
M	Indigenous Status	1	215	A/N	2, 5, 6, 7
M 6	Criterion for Admission	1	216	A/N	B, C, N, U, O, S
M	Intended Duration of Stay	1	217	A/N	1, 2
M	Health Insurance Fund	3	218	A/N	Refer to Section 3
M	Level of Insurance	1	221	A/N	1, 3, 8, 6, 9
3	Mental Health Legal Status	1	222	A/N	1, 2, 9
6	Program Funding Source	1	223	A/N	1, 2, 3, 6, 7, 8, 9 or space
7	Funding Arrangement	1	224	A/N	1, 2, 3, 4, 5, 6 or space
8	Contract Type	1	225	A/N	1, 2, 3, 4, 5, 6 or space
8	Contract Role	1	226	A/N	A, B or space
9	Contract/Spoke Identifier	4	227	A/N	NNNN or spaces Refer to Section 3
10	Contract Leave Days - MTD	2	231	N	NN or spaces
10	Contract Leave Days - Financial YTD	2	233	N	NN or spaces
10	Contract Leave Days - Total	2	235	N	NN or spaces
	User Flag	1	237	A/N	Optional field, free text
M	Preferred Language	2	239	N	NN Refer to Section 3
M	Interpreter Required	1	240	N	N Refer to Section 3
11	Filler	3	238	A/N	Spaces
		Total 240			

All alpha characters uppercase. All numeric fields right justified and zero filled.

M Mandatory

- 1 Transfer Source: Mandatory if Admission Source = T, else spaces. Transfer Destination: Mandatory if Separation Type = T, else spaces.
- 2 Mandatory in first Status Segment. In any subsequent Status Segment, if any field is present, then all fields for that segment must be present.
- 3 Mandatory but transmit only when Separation Date is transmitted.

- 4 Mandatory for public hospital if Separation Type = H but transmit only when Separation Date is transmitted, else spaces. Private hospitals report codes or spaces.
- 5 Carer Availability: Mandatory for public hospitals when Care Type is 1, 2, 6, 7, 8, 9, F or E but transmit only when Separation Date is transmitted, else spaces. Private hospitals report a space.
- 6 Criterion for Admission: Code S only for use by Early Parenting Centres. Program Funding Source: Code 3 only for use by Early Parenting Centres.
- 7 Mandatory for all hospitals involved in contracted care, hub and spoke arrangements, or the Healthstreams Program, else space.
- 8 Mandatory for all hospitals involved in contracted care arrangements, else space.
- 9 Mandatory for all hospitals involved in contracted care or Hub and Spoke (only Hub reports) arrangements, else spaces.
- 10 Mandatory for contracting hospitals, in specific instances. Refer to Section 3.
- ~~11 Must be spaces.~~

**Reported by** All Victorian hospitals (public and private).

**Reported for** All admitted patient episodes of care.

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## Diagnosis Record

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### ***Diagnosis Record File Structure***

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	X2
M	Unique Key	6	3	A/N	Hospital generated
1	Diagnosis Code x 12 - each code	8 (8 x 12)	9	A/N	ICD-10-AM 3 <sup>rd</sup> edition Each left justified, trailing spaces
2	Procedure Code x 12 - each code	8 (8 x 12)	105	A/N	ICD-10-AM 3 <sup>rd</sup> edition Each left justified, trailing spaces

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
3	Admission weight	4	201	N	In grams, or spaces
M	Intention to Re-admit	1	205	A/N	0, 1, 2, 3, 4, 9
	User Flag	1	206	A/N	Optional field, free text
4	Duration of Stay in Intensive Care Unit	4	207	N	0000 to 9999 or spaces
5	Duration of Mechanical Ventilation in ICU	4	211	N	0000 to 9999 or spaces
6	Hospital Generated DRG	4	215	A/N	ANNA or NNNA or spaces
7	Duration of Stay in Coronary/Cardiac Care Unit	4	219	N	0000 to 9999 or spaces
8	Reason for Critical Care Transfer	1	223	A/N	X, E, J, W, Y, F, K, Z or space
9	Duration of Non-Invasive Ventilation	4	224	N	0000 to 9984 or spaces
10	ACAS Status	1	228	N	1, 2, 3, 4, 5, 6, 7 or spaces
11	ACAS Assessment Date	8	229	N	DDMMCCYY or spaces
11	ACAS Recommendation	1	237	N	1, 2, 3, 4, 5 or spaces
10	Palliative Care Patient Days	2	238	NNN	00 to 99 or spaces
	<del>Filler</del>	<del>13</del>	<del>228</del>	<del>A/N</del>	<del>Spaces</del>
		Total 240			

All alpha characters uppercase. All numeric fields right justified with leading zeros.

**M** Mandatory

- 1 First diagnosis code is mandatory.
- 2 Eighth character is F or N for procedures provided by contracting hospital, else space.
- 3 Mandatory if patient aged <365 days at admission, else spaces.
- 4 Mandatory for patients cared for in an ICU listed in Section 4, and by hospitals providing contracted services to those listed hospitals, else spaces.
- 5 Mandatory for patients who received mechanical ventilation in an ICU listed in Section 4, and by hospitals providing contracted services to those listed hospitals, else spaces.
- 6 Optional but recommended for all hospitals with grouping software; else spaces.
- 7 Mandatory for patients cared for in a CCU listed in Section 4, and by hospitals providing contracted services to those listed hospitals, else spaces.
- 8 Mandatory for public hospitals participating in the Critical Care Inter-hospital Transfer Program, listed Section 3, else space.
- 9 Mandatory for all patients treated in public hospitals who received non-invasive ventilation (NIV) in a NICU and/or SCN listed in Section 4, and by hospitals providing

contracted services to those listed hospitals, else spaces. Includes public contracted episodes. Optional for patients treated in private hospitals who received NIV in a SCN; and for patients treated in public or private hospitals who receive NIV in an ICU listed in Section 4, and by hospitals providing contracted services to those listed hospitals, else spaces.

10 Mandatory for all episodes, excluding Care Types 0, 3, and U.

11 Mandatory when ACAS Status is 1, 2 or 3, else spaces.

**Reported by** All Victorian hospitals (public and private).

**Reported for** All admitted patient episodes of care.

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

# Other Proposed Changes

## ***Proposal nine—Edits***

***It is proposed to*** Refine the edits in both content, and in the ways they are applied, including:

- Adding a new layer of edits; Warning (Notifiable).
- Designing edits that follow the AIHW's specifications

***Proposed by***

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***Implementation Date***

1 Jan 2002

***Background***

There is a subgroup of Warning edits where the data can be correct, but in reality only on extremely rare occasions (less than 50 state-wide for a year). For example it is possible for a newborn to be born overseas if the baby has been flown from overseas for emergency treatment on their date of birth, or was born in transit by air or sea from overseas; however this is extremely rare.

Examples of current edits that would be classed as notifiable are: 069, 080, 228, 289, 290, 297, 403, 406, 425, and 448.

It is proposed that 'Notifiable Edits' would be separately identified on Transmission Control Reports. Hospitals can contact DHS to confirm data or correct data as appropriate. However, on a bimonthly or quarterly basis, hospitals would be contacted about any episodes that trigger these edits (and have not been confirmed), asking them to look at the record and confirm that the information is correct.

In addition to the above edits, the AIHW require DHS to follow-up episodes that trigger edits they have in their system. This process occurs when DHS provides AIHW with an extract of VAED Data as required, which occurs after the Consolidated File for the financial year. Thus effort in rectifying this data is not reflected in the VAED. The additional edits will enable corrected data to be included in the VAED.

## **Proposal ten—Other Concept Definition Additions/Revisions**

***It is proposed to*** Amend some Concept Definitions, and define other concepts that are commonly referred to, but have not previously been included in the VAED Manual.

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***Implementation Date*** 1 July 2003

***Background*** The following concepts are frequently referred to by DHS, yet have not been formally defined for the purposes of the VAED. All definitions have originated from other documents where available:

- Acute Care
- Hub and Spoke
- Sub-Acute Care
- Time of Death
- Transfer

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## Acute Care (New)

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**Definition** Acute care is (admitted patient) care in which the clinical intent or treatment goal is to:

- Manage labour (obstetric);
- Cure illness or provide definitive treatment of injury;
- Perform surgery;
- Relieve symptoms of illness or injury (excluding palliative care);
- Reduce severity of an illness or injury;
- Protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; and/or
- Perform diagnostic or therapeutic procedures.

**Guide for use** Acute care is provided in Care Types 4 *Other care (Acute) including Qualified newborn* and 5 *Approved Mental Health Service or Psychogeriatric Program* (not all episodes will be acute).

All other Care Types are considered sub-acute, excluding Care Type U *Unqualified newborn*, which is neither acute or sub-acute.

**Refer to:**

- Section 2: *Admitted Patient*, page 2-#, *Episode of Care*, page 2-#, and *Sub-Acute Care*, page 2-#.
- Section 3: *Care Type* and *Qualification Status*.

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## Hub and Spoke (*New*)

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**Definition** A model of service delivery where highly specialised services are maintained at one or two locations ('hubs'), while high volume or lower complexity same day services will be provided by staff from the hub in distant locations, called 'spokes', in other Networks. The 'hub' supplies the staff and pays the 'spoke' only for the hire of facilities.

**Guide for use** This arrangement allows maintenance of centres of excellence in 'hub' locations, while improving access to high quality specialist services throughout the metropolitan area in 'spoke' locations.

Services particularly suited to 'hub and spoke' arrangements include specialist paediatric, obstetric, radiotherapy, ophthalmology and ECT services.

Reporting guidelines include:

- Same-day episodes should be reported by the 'hub' hospital only, using the Funding Arrangement data item.
- Where a multi-day episode in the 'spoke' includes a procedure completed by the 'hub':
  - The 'hub' should report a same day episode and;
  - The 'spoke' should report a multi-day episode excluding the Procedure performed by the 'hub'.
- Neither 'hub' nor 'spoke' hospitals should report these episodes as contracted care.

**Refer to:**

- Section 2: *Contracted care*, page 2-#.
- Section 3: *Contract/Spoke Identifier* and *Funding Arrangement*.

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## Sub-Acute Care (*New*)

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**Definition** Care (including admitted patient care) that does not meet the definition of Acute Care or Nursing Home Type/Non-Acute.

**Guide for use** *Includes* the following Care Types:

- Designated Rehabilitation Program
- Geriatric Evaluation and Management Program
- Interim Care
- Palliative Care Program
- May include patients from other Care Types, excluding 4 and U (see below)

*Excludes:*

- Care Type U *Unqualified newborn*, which is neither acute or sub-acute.

**Refer to:**

- Section 2: *Acute Care*, page 2-#, *Admitted Patient*, page 2-#, *Episode of Care*, page 2-#, *Geriatric Evaluation and Management Program (GEM)*, page 2-#, *Newborn*, page 2-#, *Nursing Home Type/Non-Acute Care*, page 2-#, *Palliative Care*, page 2-#, and *Rehabilitation Care*, page 2-#.
- Section 3: *Care Type and Qualification Status*.

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## Time of Death (*New*)

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**Definition** For the purposes of reporting to VAED, time of death is the time recorded by the clinician (or clinicians) as when respiration ceased or when the patient was declared brain-stem dead.

Circulation of oxygenated blood may be continued after this time by artificial/mechanical means for organ procurement purposes, without affecting the time of death.

**Guide for use** The time at of death is recorded as the Separation Time and is also the time at which the various counts must cease: Duration of MV in ICU, of Non-invasive NIV, of Stay in CCU, and of Stay in ICU

**Refer to:**

- Section 2: *Organ Procurement*, page 2-#
- Section 3: *Duration of MV in ICU, Duration of Non-invasive NIV, Duration of Stay in CCU, Duration of Stay in ICU, and Separation Time.*

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## Transfer (*New*)

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**Definition** Transfer refers to patients moving between two different hospitals or hospital campuses for immediate admitted care, where the patient has met the Criteria for Admission in the first campus/hospital.

**Guide for use** If Non-admitted (emergency or outpatient) Services only are provided at the first campus/hospital, which resulted in the patient being sent to another campus/hospital for immediate admitted services that cannot be provided at the first campus/hospital, this should also be considered a transfer.

This is because the patient met the Criteria for Admission at the first campus/hospital, but the facility could not provide the ongoing admitted care, which is why the patient was transferred. In this scenario the first campus/hospital can admit the patient as they meet the Criteria for Admission. For the purposes of reporting there is no need for the second campus/hospital to verify that the first campus/hospital admitted the patient.

**Refer to:**

- Section 2: *Campus* page 2-#, *Criteria for Admission* page 2-#, and *Hospital* page 2-#.
- Section 3: *Admission Source, Separation Mode*.

## **Proposal eleven—VAED Manual Structure**

***It is proposed to*** Create a Business Rules section in the VAED Manual.

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Department of Human Services  
Phone 9616 6928

***Implementation Date*** 1 July 2003

***Background*** To enable easier use of the VAED Manual, and to more easily attain all information relating to a particular topic, a Business Rules Section will be created. This will build on the work completed for the *VAED Manual 12<sup>th</sup> Edition*, which included the increased level of referencing, and the addition of the edit table matrix.

Currently the business rules for the VAED are scattered throughout the manual, primarily in the section 2: *Concept Definitions*, 3: *Data Definitions* and 8: *Edits*.