

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

for 1 July 2003

February 2003

**Metropolitan Health and Aged Care Services Division
Department of Human Services**



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Executive Summary of Changes

The PRS/2 transmission specification for 2003–2004 comprises the *VAED Manual, 12th Edition, 1 July 2002* and edit changes notified in HDSS Bulletins 49, 52 and 53, with amendments detailed in this document and the Appendices to be released at a later time.

New Concept Definitions

- Acute Care
- Hospital Stay
- Hub and Spoke
- Medi-hotel
- Sub-Acute Care
- Time of Death
- Transfer

Amended Concept Definitions

- Contracted Care
- Episode of Care
- Geriatric Respite
- Hospital In The Home
- Rehabilitation In The Home

New Data Items

- Aged Care Assessment Service (ACAS) Status
- Preferred Language
- Interpreter Required

Amended Data Items

- Accommodation Type
- Accommodation Type on Separation
- Admission Date
- Admission Source
- Admission Type
- Admission/Re-Admission
- Barthel Index on Admission
- Barthel Index on Separation
- Care Type
- Carer Availability
- Clinical Sub-Program
- Contract Type
- Contract/Spoke Identifier
- Diagnosis Codes
- Duration of Non-Invasive Ventilation
- Funding Arrangement
- Medicare Number
- Medicare Suffix
- Onset Date
- Procedure Codes
- Separation Date
- Separation Referral
- Separation Type (Mode)

Deleted Data Item

- Program Funding Source

Amended and new reference files are discussed, and files structures for data records have been amended and are provided in this document.

Edits and edit tables have been revised according to the changes listed above, as well as for other data quality and reporting purposes. These are presented in Appendix A, which is a separate document, and will be issued later.

Introduction

The need for PRS/2 interface modifications

From 1 July 2003, changes to the Victorian Admitted Episodes Dataset (VAED) are necessary to assist Victorian health program monitoring, planning and policy development by the Department of Human Services (DHS).

Comments from hospitals and software suppliers regarding the content of the document *Proposals for Revisions to PRS/2 and the VAED, November 2002* have been taken into account and where possible, suggestions have been accommodated.

Distribution and components of this document

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

- Amended, deleted and new concept definitions and data items
- Reference files to be updated for 1 July 2003
- Amended file structures
- New Supplementary Code List

Two additional documents will be released in April 2003 and May 2003 respectively:

- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2003, Appendix A*, will include new and amended edits and edit tables.
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2003, Appendix B*, will include:
 - Amended VAED Manual Structure
 - Arrangements for test transmissions of new 1 July 2003 software
 - Method for reporting patients remaining in hospital at midnight on 30 June 2003

The *VAED Manual, 13th Edition, July 2003* will be distributed at a later date. In the meantime, the *VAED Manual, 12th Edition, July 2002* (as amended by HDSS Bulletin 49, 52 and 53) together with this document form the admitted patient data transmission specification for 2003–2004.

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

The current *VAED Manual, 12th Edition, July 2002* may be accessed on the Internet at <http://hdss.health.vic.gov.au/vaed/index.htm>.

Any questions related to this document may be directed to the HDSS Help Desk on 9616 8141, or PRS2.Help-Desk@dhs.vic.gov.au.

Orientation to this document

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

- New values and definitions relating to *existing* items appear in boxes. Where the entire concept definition or data item is new this will appear in the normal layout without the boxes.
- ~~Redundant values and definitions relating to existing items are struck through.~~
- *[Comments relating to the specification 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) 12th 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 specification is provided.
- New and amended edits can be identified in this document by the asterisk printed beside the relevant edit number and descriptor. These edits will be detailed in Appendix A, which is to be released separately.

Abbreviations

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
AIHW	Australian Institute of Health and Welfare
ATSI	Aboriginal and Torres Strait Islanders
BiPAP	Bi-level Positive Airway Pressure
CALD	Culturally And Linguistically Diverse
CCU	Coronary/Cardiac Care Unit
CPAP	Continuos Positive Airway Pressure
DHS	Department of Human Services
DRG	Diagnosis Related Group
ESAS	Elective Surgery Access Service
GEM	Geriatric Evaluation and Management
HDSS	Health Data Standards and Systems
HITH	Hospital In The Home
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	Intensive Care Unit
IMV	Intermittent Mandatory Ventilation
IPPV	Intermittent Positive Pressure Breathing
NHDD	National Health Data Dictionary
NHT	Nursing Home Type
NICU	Neonatal Intensive Care Unit
NIV	Non-Invasive Ventilation
PRS/2	Patient Reporting System, Version 2
RITH	Rehabilitation In The Home
SCN	Special Care Nursery
VAED	Victorian Admitted Episodes Dataset

Amended/New Concept Definitions

Acute Care (New)

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 Care Type 5 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*.

Contracted Care (*Amended*)

Revision Summary	To accommodate the changes to Contract Type and Contract Identifier. Refer to page 85.
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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) for some or 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 Mode 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 Mode 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 commenced.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 7 *Contract Type (A)*.
- Contract Role code A *Hospital A*.
- Contract/Spoke Identifier: 0050 or 0070 *Interim Care Program*.
- Diagnosis and procedure codes including information provided by residential aged care facility (see *Responsibility for exchange of information* above).
- Separation date: actual date Interim Care finishes.

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 Mode.*

Episode of Care (*Amended*)

Revision Summary Additional information regarding patients moving to Rehabilitation Level 4.

Clarification of Palliative Care business rules.

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. Additionally, an episode beginning as Palliative Care may not change to another Care Type, the original episode must continue until there is a formal separation.
 - Public hospitals may use the Alcohol and Drug Care Type only on admission; it is not for use following another Episode of Care.

- Public hospital patients may not change Care Type between a Designated Rehabilitation Program: Level 1, 2 or 3; patients must stay at their original level. These patients should change Care Type when they move to or from Designated Rehabilitation Program: Level 1, 2 or 3 to Designated Rehabilitation Program: Level 4.

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* **Mode**.

Geriatric Respite (*Amended*)

Revision Summary Reflects the removal of the Admission Type G Geriatric Respite.

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*.~~

Hospital in the Home (*Amended*)

Revision Summary To take into account the addition of the Medi-hotel concept.
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Definition Provision of care to hospital admitted patients in their place of residence as a substitute for traditional hospital accommodation. Place of residence may be permanent or temporary.

Guide for use Place of residence includes residential facilities such as nursing homes, hostels or other forms of supported accommodation. Medi-hotels are excluded, no services are provided while the patient resides there.

Hospital in the Home (HITH) services might include treatment of orthopaedic conditions or the administration of intra-venous therapies. The use of HITH is voluntary for the patient. For a patient, the service might be a combination of hospital and home-based care or replace hospital care completely.

A public hospital must be designated in its Health Service Agreement to provide HITH services.

Currently, HITH is limited to public, private, DVA, TAC and WorkCover patients. However, for a hospital to treat private patients under HITH, they must apply for eligibility to admit private patients. Details regarding this are outlined in the following circulars:

- HBF 740 PH 474 Guidelines for Approved Outreach Services under the Health Legislation Amendment Act (No 1) 2001.
- HBF 747 PH 481 Amendment to Guidelines for the Establishment and Implementation of the Private Sector Outreach Services and other general information.

These circulars include the following:

- Facilities seeking to provide outreach [hospital in the home] services to private patients will be required to gain Federal Ministerial approval. Only those services that have been approved will be covered by hospital table health insurance and reinsurance arrangements (where eligible).
- Public hospital, private hospital and day facilities wishing to offer an approved outreach service are invited to make an application to the Private Health Industry Branch, Department of Health and Aged Care.

For the Hospital in the Home program, movement between ward accommodation and 'Hospital in the Home' accommodation is reported in the Status Segments within the same episode. (Note that the Rehabilitation in the Home program treats accommodation changes differently).

Patients receiving care under this program must meet one of the minimum criteria for admission, as HITH represents a substitute for acute admitted patient care provided in a traditional hospital setting.

Refer to:

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

Hospital Stay (*New*)

Definition The period of time between a formal admission and a formal separation.

Guide for use A hospital stay usually encompasses one episode.

More than one episode can make up a hospital stay where:

- The episodes occur at one hospital/hospital campus, *and*
- Where the first episode has a statistical Separation Mode, and the subsequent episode(s) has a statistical Admission Source.

In practice, it refers to the time elapsing between a patient entering the hospital and leaving the hospital, excluding leave (normal and contract) periods.

Refer to:

- Section 2: *Admission* page 2-#, and *Separation* page 2-#.
- Section 3: *Admission Source* and *Separation Mode*.

Hub and Spoke (*New*)

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. 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.

Reporting guidelines depend on whether the episode is same day or multi-day.

Same-day episodes

Same-day episodes should be reported by the hub hospital only, using the Funding Arrangement data item.

Hub Hospital records:

- Admission and separation dates.
- Funding Arrangement code 2 *Hub and Spoke*.
- Contract/Spoke Identifier code: report the relevant Hospital Campus Code that denotes the Spoke hospital.
- Diagnosis and procedure codes: all diagnosis and procedure codes undertaken at the Spoke hospital.

Spoke Hospital records:

- Nil.

Multi-day Episodes

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.

Hub Hospital records:

- Admission and separation dates.
- Funding Arrangement code 2 Hub and Spoke.
- Contract/Spoke Identifier code: report the relevant Hospital Campus Code that denotes the Spoke hospital.
- Diagnosis and procedure codes: all diagnosis and procedure codes undertaken at the Spoke hospital.

Spoke Hospital records:

- Admission and separation dates.
- Diagnosis codes: diagnosis codes should be assigned for conditions where care is provided by the spoke hospital. This includes conditions that require care at the spoke hospital prior to and/or after the procedure performed by the hub hospital.
- Procedure codes: assign codes only for procedures not undertaken by the hub hospital. Under no circumstances are procedure codes performed by the hub hospital to be assigned by the spoke hospital.

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*.

Medi-hotel (*New*)

Definition Provision of a non-ward residential service maintained and/or paid for by the hospital for the purpose of accommodating patients, as a substitute for traditional hospital ward accommodation.

Guide for use Non-ward accommodation provided by the hospital, excluding the Hospital In The Home (HITH) program. Unlike Hospital In The Home, no clinical services are provided. Thus a significant decline in medical condition would always necessitate return from Medi-hotel to the hospital's emergency department or other ward.

The Medi-hotel facility may or may not be on hospital property. Where it is on hospital property, this may be co-located in the same building as traditional wards.

Patients may reside in a Medi-hotel overnight, but during the day receive:

- Care/services/treatment that resembles traditional admitted care. (Same day or multi-day).
- Services/treatment that resembles non-admitted care.
- A combination, over a series of days, that resemble both admitted and non-admitted care.

A public hospital must be registered in its Health Service Agreement to provide a Medi-hotel service. The use of a Medi-hotel is voluntary for the patient.

The following guidelines shall be met when reporting Medi-hotel admitted episodes:

1. Where the use of the Medi-hotel involves care/service/treatment during the day that resembles traditional admitted care, the patient should be admitted.
2. For Medi-hotel, movement between ward accommodation and the Medi-hotel accommodation is reported in the Status Segments within the same episode, excluding notes listed in 4. The Accommodation Type shown for each patient day shall be:
 - 1 or 2 where the patient remains in a traditional hospital setting at midnight;
 - 7 when a patient is in a traditional hospital setting during the day and in a Medi-hotel at midnight.

For example, where a patient is admitted to a shared hospital ward on the 1 July 2003, moves to the Medi-hotel at 1700 on the 4 July 2003, and returns to the traditional hospital setting at 0900 on the 5 July 2003 where they are discharged at 1600, the Accommodation Type for the first three patient days is 2; and the Accommodation Type for the last patient day is 7.

3. The use of Medi-hotel should be recorded as leave in the following circumstances:
 - Where the patient receives two or more consecutive days of non-admitted services (not a substitute for traditional admitted care), with an intervening night in the Medi-hotel, and the patient receives admitted patient care both directly before and after this period.
 - Where the patient receives no care for two to seven consecutive days, with an intervening night(s) in the Medi-hotel, and the patient receives admitted patient care both directly before and after this period.
4. The use of Medi-hotel should not be recorded as part of an admitted episode in the following circumstances:
 - Where the patient is receiving only non-admitted services on the first day(s), or no services (for example, a night in Medi-hotel to facilitate an 07:00 Admission Time), the patient should be admitted on the day they first received admitted services.
 - Where the patient is receiving only non-admitted services on the last day(s), the patient should be separated at the time they left the admitted services area (to go to the Medi-hotel).

Refer to:

- Section 2: *Criteria for Admission*, page 2-#, *Hospital in the Home*, page 2-# and *Patient Day*, page 2-#.
- Section 3: *Accommodation Type*.

Rehabilitation in the Home (*Amended*)

Revision Summary	Reflects the addition of Care Type J Designated Rehabilitation Program: Level 4.
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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 admitted patient 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:

- | |
|---|
| <ul style="list-style-type: none">• Separation Mode S <i>Statistical Separation (Change in Care Type within this hospital).</i> |
|---|

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

For all admissions to RITH, use:

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

- | |
|--|
| <ul style="list-style-type: none">• Care Type J <i>Designated Rehabilitation Program: Level 4.</i> |
|--|

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

Note that the **Acute** 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*.

Sub-Acute Care (*New*)

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*.

Time of Death (*New*)

Definition For the purposes of reporting to the 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 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 Ventilation (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 Ventilation (NIV), Duration of Stay in CCU, Duration of Stay in ICU, and Separation Time.*

Transfer (New)

Definition Transfer refers to patients moving between two different hospitals or hospital campuses where:

- They were assessed or received care and treatment in the first hospital; and
- If it is intended that the patient receive admitted care in the second hospital.

Guide for use Reporting requirements are listed below:

Hospitals transferring admitted patients to a second hospital

- Separation Mode: T *Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre*
- Transfer Destination: Report appropriate hospital campus code.

Hospitals receiving patients from another hospital

- Admission Source: T *Transfer from acute hospital/extended care/rehabilitation/geriatric centre*
- Transfer Source: Report appropriate hospital campus code.

Refer to:

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

Amended/New Data Items (by topic)

Aged Care Assessment Service (ACAS)

Background

DHS wish 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.

This data item 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, and length of stay.

ACAS Status (New)

Specification

<i>Definition</i>	The type of involvement of the Aged Care Assessment Service (ACAS) in patient discharge.		
<i>Datatype</i>	Numeric	<i>Form</i>	Code
<i>Field size</i>	1	<i>Layout</i>	N or space
<i>Location</i>	Episode Record		
<i>Reported by</i>	Public hospitals		

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

And

Where the patient's age is equal to or greater than 50,

And

Where the episode is not a same day episode.

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

Code set Select the first appropriate category:

Code Descriptor

- | | |
|---|--|
| 1 | ACAS Assessment completed during this episode |
| 2 | ACAS assessment incomplete: referral to Sub-acute services |
| 3 | ACAS assessment incomplete: other reason |
| 4 | ACAS consultation only during this episode |
| 5 | No ACAS involvement during this episode |

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

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 (for example, 2624 certificate completed and signed if required).

2 ACAS assessment incomplete: referral to Sub-acute services

Use code 2 if the patient was seen by the ACAS who referred the patient to sub-acute services (for example, 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 3).
- Began an assessment that was completed in a subsequent statistical episode (use 3).
- Died (use 3).
- Left against medical advice (use 3).

3 ACAS assessment incomplete: other reason

Use code 3 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 2)

4 ACAS consultation only during this episode

Use code 4 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.

5 No ACAS involvement during this episode

Use code 5 if ACAS had no involvement with the patient.

Includes:

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

Edits

Incompat ACAS Status and Sep Referral

Related items Section 3: *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

Definition source DHS **Code set source** DHS

Admission and Separation Codes

Background

Over time the current fields have been amended, resulting in these fields containing more than one concept. Some values have been moved to different data items and some have been removed as they are obsolete or are duplicated elsewhere.

Separation Referral has been amended to capture:

- Referrals that have been made as part of discharge planning, and will be followed up by ACAS once the patient returns home.
- Referrals that have been made as part of discharge planning, and will be followed up by an ATSI service once the patient returns home.

Admission Date (*Amended*)

Revision Summary	Addition of information relating to statistical admissions.
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Specification

Definition Date on which an admitted patient commences an episode of care (formal or statistical).

Datatype Numeric **Form** Date

Field size 8 **Layout** DDMMCCYY

Location Episode Record
DVA and TAC Record

Reported by All Victorian hospitals (public and private).
[Private hospitals: Do not report a DVA and TAC Record.]

Reported for All admitted patient episodes of care.

Reported when The Episode Record or DVA and TAC Record is reported.

Code set Valid date.

Reporting guide **Admission of Birth Episode**

For the first episode of a Newborn, the Admission Date will be the Date of Birth, except in the unusual circumstance where the newborn is born before arrival at this hospital, and where the birth occurs just before midnight and the newborn arrives at this hospital after midnight.

Admission from Non-admitted Services

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care. For example, when a patient is admitted from the Emergency Department, then the admission time is the time treatment was started in the Emergency Department. That is, when the patient was first treated by a nurse or doctor, whichever comes first, rather than the time the decision is taken to admit the patient. In this context, 'treatment' includes commencement of baseline observations by a nurse and assessment of the patient by a doctor.

Statistical Admissions

Statistical admissions must have an Admission Date equalling the previous episode's Separation Date. Statistical separations and admissions cannot occur over midnight.

Edits

- 026 Zero Sep; Existing Not Discharged
- 027 Adm Record; Overlaps Existing
- 028 Prior Adm; No Sep Date
- 038 Invalid Adm Date
- 039 Invalid Adm Date; > Header
- 062 Duplicate Pt ID, Adm Date Time, Diff. Unique
- 063 Prior Not Discharged
- 064 Duplicate Pt ID, Date Time
- 069* Newborn From Overseas
- 080* Sex Indeterminate Age < 90 Days
- 102 Sep Date < Adm Date
- 112 Calc Los + Leave Not = Adm/Sep
- 115 Adm Time Not < Sep Time
- 122* Sameday Adm Source/Sep Type Mismatch
- 127* Nil Value DRG
- 160* AR - DRG Grouper GST Code > Zero
- 178 Trans Adm Not Same As Episode
- 186 Neonate MDC But Age > = 28 days
- 187 Adm Weight Too Low
- 188 Adm Weight Too High
- 189 Age < 365 Days But Weight Missing

-
- 190 Adm Wt Present But Not Aged< 365 Days
 - 215 Sex Indeterminate But Age >9 Days
 - 216 Newborn Qual Status But Age >9 Days
 - 217 Newborn Adm Crit But Age > 9 Days
 - ~~218 Newborn Adm Type But Age >9 Days~~
 - ~~219 Adm Type Not Newborn; Age <10 Days~~
 - ~~220 Newborn Adm Source But Age >2 days~~
 - ~~221 Invalid Adm Source For Newborn~~
 - 222* Unqual Newborn; Adm Date Not Birth
 - 226 Adm Date Before Birth Date
 - 227 Age Calculated As 120 Years & Over
 - 245 Adm Wt >9Kg But Age >5 Mth
 - 255* Rehab: Invalid Onset Date
 - 261 Newborn Care Type But Age >9 days
 - 262 Invalid Care Type For Newborn
 - 289* Adm Sc T'fer & Onset =Adm Date
 - 290* Stat Adm Sc, & Onset = Adm Date
 - 323 MV Duration > Total Stay
 - 329* Geri Respite Invalid Comb
 - 344* Invalid Comb For Family Choice
 - 353 Code & Age Incompatible
 - 397* Sep Referral Postnatal, Incompat Age/Sex
 - 400* Child, Incompatible Carer Availability
 - 401 Accom Type On Sep - Emerg, Not Same Day
 - 425* Incompat Sep Type, Age <8
 - 454* Incompat Fields for Interim Care

Incompatible Adm Source/Age
 ### Incompatible Age/Crit for Adm
 ### Medicare Code = 0, Age > 6 Months
 ### Medicare Code = 0, Age > 12 Months

Stat Episode: Adm Date ≠ Sep Date Prev Episode

Related items Section 2: Concept definitions *Age* and *Length of Stay, Overnight or Multi-day Stay Patient, and Same Day Patient*.
 Section 3: *Date of Birth* on page 3-#.
 Section 8: Editing Table *Criteria for Admission, Age, Admission Type and Admission Source*.

Administration

Purpose To enable (for data validation purposes) ‘patient days’ (patient’s length of stay) and normal leave days to be balanced with the difference between Admission Date and Separation Date.

Principal data users Automated PRS/2 processes.

Collection start 1979-1980

Definition source NHDD

Admission/Re-Admission to Rehabilitation (*Amended*)

Revision Summary	Change in reporting requirements (required for a new Care Type).
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Specification

Definition Indicates whether this is the first or subsequent rehabilitation episode for a particular injury/condition.

Datatype Alphanumeric **Form** Code

Field size 1 **Layout** N or space

Location	Sub-Acute Record						
Reported by	Public hospitals.						
Reported for	Care Types 2, 6, and 7. [For Care Types 8 and 9, report a space.]						
Reported when	A Separation Date is reported in the Episode Record.						
Code set	<table> <thead> <tr> <th>Code</th> <th>Descriptor</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>First rehabilitation admission</td> </tr> <tr> <td>1</td> <td>Re-admission for rehabilitation</td> </tr> </tbody> </table>	Code	Descriptor	0	First rehabilitation admission	1	Re-admission for rehabilitation
Code	Descriptor						
0	First rehabilitation admission						
1	Re-admission for rehabilitation						
Reporting guide	<p>0 First rehabilitation admission</p> <p>Patient's current admission is their first rehabilitation episode for this condition.</p> <p>1 Re-admission for rehabilitation</p> <p>Patient's current admission is a re-admission for rehabilitation for this condition.</p>						
Edits	<p>254* Rehab - Invalid Adm/Re-Adm to Rehab</p> <p>295 Adm/Readmit To Rehab Present</p>						
Related items	Section 2: Concept definition <i>Rehabilitation Care</i> .						

Administration

Purpose	To support and further develop casemix classifications for sub-acute episodes of care.
Principal data users	Sub-Acute Unit (Metropolitan Health & Aged Care, DHS).
Collection start	1995-1996
Definition source	DHS
Code set source	DHS

Admission Source (*Amended*)

Revision Summary	Collapse of the statistical admission codes into one code, relocation of two codes to another data item (Admission Type), removal of one obsolete code, and change in definition of two other codes.
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Specification

Definition Describes where the circumstances of patient was residing or living 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):***

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

Formal admissions:

Y	Birth episode
€	Emergency episode <i>[to be collected in Admission Type]</i>
L	Waiting list <i>[to be collected in Admission Type]</i>
T	Transfer from acute hospital/extended care/rehabilitation/geriatric centre
N	Transfer from aged care residential facility
A	Transfer from mental health residential facility
Z	Other formal admission source <i>[Obsolete]</i>
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 has commenced within the same hospital stay on the same hospital campus.

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*.
- Change between Rehabilitation Program/Units: Levels 2, 6 or 7 Care Types (2, 6 or 7).
- Change from or to Palliative Care (Care Type 8) as a Statistical Separation or a Statistical Admission. Patients already admitted in another Care Type may not change to Palliative Care. Patients admitted with a Care Type of Palliative Care must remain so until they are formally separated.

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~~ mental health admitted patient units

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~~ mental health residential facilities listed in Section 4 ~~can use~~ apply to this code.

Does not require a Transfer Source code.

Excludes:

- Mental health admitted patient units (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.
- Forensic hospital (Thomas Embling).
- Juvenile detention centre.
- Armed forces base camp/hospital.
- Homeless (shelters, half way houses).

Excludes:

- Aged care residential facility (use code N).
- Mental health residential facility (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
- 328* Early Parenting Centre - Invalid Comb
- 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

Incompatible Adm Source/Age
Incompatible Adm Source/Crit for Adm
Pall Care with Stat Adm Source
Stat Episode: Adm Source ≠ Sep Mode Prev Episode

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* Mode.

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

Admission Type (*Amended*)

Revision Summary	Change in name and meaning of two codes, removal of three obsolete codes, relocation of two codes (to Funding Arrangement) and addition of two additional codes that were relocated from Admission Source.
-------------------------	--

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 [to be collected in Funding Arrangement]
W	Elective Surgery Access Service [to be collected in Funding Arrangement]
L	Planned admission – Waiting List [previously collected in Admission Source]
X	Other planned admission (same day or overnight/multi-day)
C	Emergency admission through Emergency Department at this hospital [previously collected in Admission Source]
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.
<i>Excludes</i> second or subsequent admissions in the newborn period:
<ul style="list-style-type: none"> • 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 [Previously collected in Admission Source. Changes refer to what was previously listed in Admission Source]**

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 through Emergency Department at this hospital*** [Previously collected as part of Emergency Episode in Admission Source. Changes refer to what was previously listed in the Admission Source]

~~Emergency admission to this hospital.~~

Unscheduled admission that is not a planned or maternity admission, arising from presentation at the 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 that is not a planned or maternity admission, not arising from presentation at 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 Department.

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
- 328* Early Parenting Centre - Invalid Comb
- 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
- ### Incompatible Adm Type/Crit for Adm

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

Purpose To:

- Distinguish between emergency and non-emergency admissions.
- ~~Identify geriatric respite episodes.~~

<ul style="list-style-type: none"> • Monitor admissions from the Waiting List. • Identify data for maternity and birth episodes.
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Principal data users Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).
 Quality Branch (Metropolitan Health & Aged Care, DHS).

Collection start 1979-1980

Definition source	DHS	Code set source	DHS
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Barthel Index Score on Admission (a) (*Amended*)

Barthel Index Score on Separation (b) (*Amended*)

Revision Summary	Change in reporting requirements (required for a new Care Type).
-------------------------	--

Specification

Definition (a) Barthel Index Score, as assessed on admission.
(b) Barthel Index Score, as assessed on separation.

Datatype Alphanumeric **Form** Score

Field size 3 **Layout** NNN or spaces.
Right justified with leading zeros.

Location Sub-Acute Record

Reported by Public hospitals.

Reported for Care Types F, E, 2, 6, 7, 8 and 9 and J.
[For Care Type 8, report spaces.]

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

Code set Report a score in the range 000-100, using the following table:

Barthel Index

	Can do without aids	Can do with aids	Can do with help of someone else	Cannot do at all
Self Care Index				
Drinking from a cup	4	2	0	0
Eating	6	3	0	0
Dressing upper body	5	5	3	0
Dressing lower body	5	5	2	0
Putting on brace or artificial limb	0	0	-2	0 (if not applicable)
Grooming	5	5	0	0
Washing or bathing	4	4	0	0
Controlling urination	10	10	5 (accidents)	0
Controlling bowel movements	10	10	5 (accidents)	0
Care of perineum/ clothes at toilet	4	4	2	0
Mobility Index				
Getting in and out of chair	15	15	7	0
Getting on and off toilet	6	5	3	0
Getting in and out of shower/bath	1	1	0	0
Walking 50 yards on the level	15	15	10	0
Walking up/down one flight of stairs	10	10	5	0
If not walking				
Propelling or pushing wheelchair	15	5	0	0
TOTAL (out of 100)				

Reporting guide

Assessment of Barthel Indexes is required at admission and separation for all S2 Records (excluding Palliative Care) except when:

- Reporting an S2 record because this has started statistically after an episode for which a Separation Barthel had been reported – the Separation Barthel of that previous episode can be repeated as this episode's Admission Barthel.
 - Reporting an S2 record because the episode is ending statistically before another Interim Care episode - the Admission Barthel of this episode can be repeated as this episode's Separation Barthel.
- (a) The Barthel Index on Admission should be assessed within 48 hours of admission.
- (b) The Barthel Index on Separation should be assessed on the day on which the decision is taken to cease the Care Type.
- The Barthel Index on Separation for patients who die in hospital is 000.

Edits

- (a) 251* Invalid Adm Barthel
291* Adm Barthel > Sep Barthel
298 Adm Barthel Present
407* Rehab Level 2 or 3 W Low Adm Barth
- (b) 252* Invalid Sep Barthel
288* Sep Barthel & Sep Type Incompatible
291* Adm Barthel > Sep Barthel
292 Sep Barthel Present

Related items

Section 2: Concept definition *Rehabilitation Care*.

Administration

Purpose To support and further develop casemix classifications for sub-acute episodes of care.

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

Collection start 1995-1996

Definition source DHS **Code set source** Barthel Index

Carer Availability (*Amended*)

Revision Summary Change in reporting requirements (required for a new Care Type).
--

Specification

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

Datatype Alphanumeric **Form** Code

Field size 1 **Layout** N or space

Location Episode Record

Reported by Public hospitals.
[Private hospitals: Report a space in this field.]

Reported for

Admitted episodes with a Care Type of:

- 1 NHT/Non-Acute
- 2 Designated Rehabilitation Program/Unit: Level 1
- 6 Designated Rehabilitation Program/Unit: Level 2
- 7 Designated Rehabilitation Program/Unit: Level 3
- | |
|---|
| J Designated Rehabilitation Program/Unit: Level 4 |
|---|
- 8 Palliative Care
- 9 Geriatric Evaluation and Management Program
- F Interim Care Program – Nursing Home Type
- E Interim Care Program

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

Reported when

A Separation Date is reported in the Episode Record.

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

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

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

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

[Reporting guides relating to other values remain the same as per the VAED 12th Edition.]

Edits	
108*	Field(s) Missing From Sep
390*	Invalid Carer Availability
399*	Incompat Sep Type & Carer Availability
400*	Child, Incompatible Carer Availability
421*	Not Separated; Carer Avail Present
422*	Carer Avail Be 1

Related items Section 3: *Separation Type* Mode on page 3-75.

Section 8: Editing Table *Carer Availability and Separation Type* Mode

Administration

Purpose To enable monitoring of the impact of Carer Availability on discharge timing and use of ambulatory services, to support policy development and planning.

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

Collection start 1999-2000

Definition source NHDD **Code set source** NHDD (DHS modified)

Care Type (*Amended*)

Revision Summary	Addition of a new Care Type.
-------------------------	------------------------------

Specification

Definition The nature of the clinical service provided to an admitted patient during 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
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: Level 4
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 Manual 12th Edition.]*

J Designated Rehabilitation Program/Unit: Level 4

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 J 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 Mode 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 Sree & 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

- ### Care Type 2, 6, 7 or J, not approved for Rehab
- ### Care Type 5, not approved for Mental Health
- ### Care Type 8, not approved for Palliative Care Program
- ### Care Type 9, not approved for GEM
- ### Care Type F or E, not approved for Interim Care
- ### Pall Care with Stat Adm Source
- ### Pall Care with Stat Sep Mode
- ### Pall Care without Pall Care Diag

Related items

Section 2: Concept definitions *Admission, Admitted Patient, Episode of Care, Geriatric Evaluation and Management Program, Hospital Stay, 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

<i>Purpose</i>	To distinguish various types of care in order to:		
	<ul style="list-style-type: none">• Apply the appropriate funding formula to the episode.• Group episodes to facilitate analysis.		
<i>Principal data users</i>	Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS). Sub-Acute Unit (Metropolitan Health & Aged Care, DHS).		
<i>Collection start</i>	1995-1996		
<i>Definition source</i>	DHS	<i>Code set source</i>	DHS

Clinical Sub-Program (*Amended*)

Revision Summary	Change in reporting requirements (required for a new Care Type).
-------------------------	--

Specification

Definition The diagnosis, based on the body system manifesting the reason for rehabilitation.

Datatype Alphanumeric **Form** Code

Field size 3 **Layout** NNN
Right justify, leading zero.

Location Sub-Acute Record

Reported by Public hospitals.

Reported for Care Types 2, 6, and 7, and J.
[For Care Types 8 and 9, report spaces.]

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

Code set

Code	Descriptor
010	Stroke
020	Head Injury
Neurological	
031	Multiple sclerosis
032	Parkinsonism
033	Polyneuropathy
034	Guillain-Barre
039	Other neurological

Spinal Cord

- 041 Paraplegia incomplete
- 042 Paraplegia complete
- 043 Quadriplegia incomplete C1-4
- 044 Quadriplegia incomplete C5-8
- 045 Quadriplegia complete C1-4
- 046 Quadriplegia complete C5-8
- 049 Other spinal cord

Amputation of Limb

- 051 Upper extremity above elbow
Includes: shoulder disarticulation
- 052 Upper extremity below elbow
Includes: hand and/or finger(s) alone
double upper extremity of finger(s) alone
- 053 Single lower extremity above knee
Includes: hip disarticulation
- 054 Single lower extremity below knee
Includes: foot and/or toe(s) alone
- 055 Double lower extremity above knee
Includes: hip(s) disarticulation
- 056 Double lower extremity above/ below knee
Includes: hip disarticulation
feet and/or toes alone
- 057 Double lower extremity below knee
Includes: feet and/or toes alone
- 059 Multiple limbs
Includes: lower and upper extremities
double shoulder disarticulation
double upper extremities, includes both hands but
excludes if only fingers of both hands [052]

Arthritis

- 061 Rheumatoid
- 062 Osteoarthritis
- 069 Other arthritis

Pain

- 071 Neck pain
- 072 Back pain
- 073 Extremity pain
- 079 Other pain

Orthopaedic

- 081 Post hip fracture
- 082 Post femur (shaft) fracture
- 083 Post pelvic fracture
- 084 Post major multiple fracture
- 085 Post hip replacement
- 086 Post knee replacement
- 089 Other orthopaedic
- 090 Cardiac

Pulmonary

- 101 Chronic obstructive pulmonary disease
- 109 Other pulmonary

110 Burns**120 Musculoskeletal****Major Multiple Trauma**

- 131 Brain and spinal cord
- 132 Brain and multiple fracture/amputation
- 133 Spinal cord and multiple fracture/amputation
- 139 Other major multiple trauma
- 140 Other Disabling Impairment

150 Other Geriatric Management

Reporting guide Clinical sub-program should be assigned by the treating clinician. Sub-program assignment must be supported by the appropriate ICD-10-AM codes reported in the X2/Y2 Diagnosis/Extra Diagnosis Records.

Edits 253* Rehab Invalid Clin Sub-Prog
293 Clin Sub-Prog Present
405 Inapplic Clin Prog For Care Type 2

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

Administration

Purpose To support and further develop casemix classifications for sub-acute episodes of care.

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

Collection start 1995-1996

Definition source DHS **Code set source** DHS

Funding Arrangement (*Amended*)

Revision Summary Addition of two codes relocated from Admission Type.
--

Specification

Definition Identifies the specific funding arrangement, if any, that applies to this episode of care.

Datatype Alphanumeric **Form** Code

Field size 1 **Layout** N or space

Location Episode Record

- Reported by**
- Any Victorian public and private hospital involved in contracted care arrangements with another hospital (purchasers and providers of contracted care).
 - Any Victorian public hospital involved in the Healthstreams program.
 - Any Victorian public or private hospital treating a patient identified as a Coordinated Care Trial patient.

- Any Victorian public hospital involved in the Rural Patients Initiative program.
- Any Victorian public hospital involved in the Elective Surgery Access Service program (ESAS).

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

Reported for Episodes where an admitted service is provided under contract, hub and spoke, Healthstreams or Coordinated Care Trial, Rural Patients Initiative or Elective Surgery Access Service (ESAS) arrangements.

[Otherwise, report a space in this field.]

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

Code set

Code **Descriptor**

1 Contract

2 Hub and spoke

3 Healthstreams

4 Coordinated Care Trial

5 Rural Patients Initiative *[previously collected in Admission Type]*

6 Elective Surgery Access Service (ESAS) *[previously collected in Admission Type]*

Reporting guide ***[Reporting guides relating to other values remain the same as per the VAED 12th Edition.]***

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.

Edits

- 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

- ### Funding Arrangement 3, not approved for Healthstreams
- ### Funding Arrangement 5, not approved for Rural Patients Initiative
- ### Funding Arrangement 6, not approved for ESAS

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* Mode.

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

Onset Date (*Amended*)

Revision Summary	Change in reporting requirements (required for a new Care Type).
-------------------------	--

Specification

Definition

Date of admission for the acute episode for care, relating to an injury or disease condition, for which the person has now been admitted for a subsequent rehabilitation episode of care.

Datatype

Numeric

Form

Date

Field size

8

Layout

DDMMCCYY, or spaces.

Location

Sub-Acute Record

Reported by	Public hospitals.
Reported for	Episodes with Care Type 2, 6, 7 or 7 and J. [For Care Types 8 and 9, report spaces in this field.]
Reported when	A Separation Date is reported in the Episode Record.
Code set	Valid date.
Reporting guide	Onset Date must be equal to or earlier than the Admission Date, and after the Date of Birth. The Admission Date of the acute episode should be obtained from the acute hospital where the acute episode occurred. If the patient is admitted to rehabilitation directly from the community, this field should match the date of admission in the Episode Record.
Edits	255* Rehab: Invalid Onset Date 289* Adm Sc is T'fer & Onset = Adm Date 290* Stat Adm Sc & Onset = Adm Date 294 Onset Date Present
Related items	Section 2: Concept definition <i>Rehabilitation Care</i> .

Administration

Purpose	To enable measurement of the time elapsed since the initial acute episode, to support and further develop casemix classifications for sub-acute episodes.
Principal data users	Sub-Acute Unit (Metropolitan Health & Aged Care, DHS).
Collection start	1995-1996
Definition source	DHS

Separation Date (*Amended*)

Revision Summary	Addition of information relating to statistical admissions.
-------------------------	---

Specification

Definition Date on which an admitted patient completes an episode of care.

Datatype Numeric **Form** Date

Field size 8 **Layout** DDMMCCYY

Location Episode Record
DVA and TAC Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted patient episodes of care.

Reported when The episode of care is completed.

Code set A valid date.

Reporting guide The Separation Date must be at or after the Admission Date.
If no other separation details are submitted (patient not yet separated), zero-filled Separation Date is accepted,
The Separation Date may relate to a formal or statistical separation.

Statistical Separations

Statistical admissions must have an Admission Date equalling the previous episodes Separation Date. Statistical separations and admissions can not occur over midnight.

Edits

026	Zero Sep; Existing not Discharged
027	Adm Record; Overlaps Existing
028	Prior Adm; No Sep Date
063	Prior Not Discharged
065	Original Deleted Upd Sep < Cutoff
066	Sep Date Prior to Cutoff Date
101	Invalid Sep Date
102	Sep Date < Adm Date
108*	Field(s) are missing From Sep
112	Calc Los +Leave Not = Adm/Sep
115	Adm Time Not < Sep Time
119	Sep Time - No Sep Date
122*	Sameday Adm Source/ Sep Type Mismatch
160*	AR – DRG Grouper GST Code > Code
179	Trans Sep Not Same As Episode
193	Not Separated – Intent Readmit
196	X2 Record Epis. Not Separated
258*	Sub – Acute: No Sub Acute Record
259	Invalid Rehab/Subac – Episode Sep Date
265	Mental Health Status - Not Separated
269	PFS Not Separated
322	ICU/CCU Stay > Total Stay
323	MV Duration > Total Stay
352	Code Not Found On Code File
388	Sep Referral - Episode Not Separated
401	Accom Type On Sep – Emerg, Not Same Day
421*	Not Separated; Carer Avail Present
424*	Not Separated: Fund Arr S/Be Spaces
438*	NIV Duration >Total Stay
###	Stat Episode: Adm Date ≠ Sep Date Prev Episode

Related items

Section 2: Concept definitions *Length of Stay*, *Overnight or Multi-day Stay Patient*, and *Same Day Patient*.

Administration

Purpose To enable validation of patient days and to enable an episode of care to be placed into month and year of separation:

- For counting purposes.
- To check codes in the record against the valid codes for that year.

Principal data users Automated PRS/2 processes.

Collection start 1979-1980

Definition source NHDD

Separation Type Mode (*Amended*)

Revision Summary Collapse of the statistical admission codes into one code, removal of one obsolete code, and change in definition of three other codes.

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

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 (Care Type J).

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 between Rehabilitation Program/Units: Levels 2, 6 or 7 Care Types (2, 6 or 7).
- 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*.
- Change from or to Palliative Care (Care Type 8) as a Statistical Separation or a Statistical Admission. Patients already admitted in another Care Type may not change to Palliative Care. Patients admitted with a Care Type of Palliative Care must remain so until they are formally separated.

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-~~
mental health admitted patient units.

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 in Accommodation Type 4 In The Home 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 /her mother.

Excludes:

- Aged care residential facility (use N).
- Mental health residential facility (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

Pall Care with Stat Adm Source

Stat Episode: Adm Source ≠ Sep Mode Prev Episode

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 3-99.

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, Designated Rehabilitation Programs (2, 6, ~~7~~ and 8).*

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 source** DHS

Mapping between *Separation Type Mode* (PRS/2) and the Grouper *Mode of Separation*:

Separation Type Mode (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 or home	9	Other (includes to usual residence)
K	Other formal separation		
F, E, Numeric, S	Statistical separation	5	Statistical discharge-type change

Separation Referral (*Amended*)

Revision Summary	Addition of two new values.
-------------------------	-----------------------------

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 page 75.]
[For all other Separation Types **Modes**, 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:

Code	Descriptor
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
- K Referral to Aboriginal and Torres Strait Islander (ATSI) service, 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.

Where a patient is referred to a support service that may be represented by more than one of the categories, report both codes. For example, where F *Domiciliary postnatal care, arranged before discharge* is provided by a K *Referral to Aboriginal and Torres Strait Islander (ATSI) service, arranged before discharge*.

[Reporting guides relating to other values remain the same as per the VAED 12th 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.

K Referral to Aboriginal and Torres Strait Islander (ATSI) service, arranged before discharge

Discharge, with referral to an Aboriginal and Torres Strait Islander (ATSI) service arranged before discharge to own home or home of a relative or friend or other private accommodation.

Includes:

- Services provided by the local Aboriginal co-operative
- Designated Koori HACC services
- Designated Koori Alcohol and Drug Services

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 page 75.]~~

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

Incompat ACAS Status and Sep Referral

Incompat Sep Referral and Indigenous Status

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* Mode)

Definition source DHS **Code set source** DHS

Contract Type and Interim Care

Background

For 2002-2003 hospitals contracting out Interim Care to non-hospitals used 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. Contract/Spoke Identifier has also been expanded to capture the type of facility that is providing the Interim Care.

Contract Type (*Amended*)

Revision Summary	Addition of a new code, and a change to the meaning of one code.
-------------------------	--

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

Code	Descriptor
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.

Patient not present in the Contracting Hospital (A) for some or any time during the episode.

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

Purpose 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.

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

Collection start 1999-2000

Definition source NHDD **Code set source** NHDD

Contract/Spoke Identifier (*Amended*)

Revision Summary Addition of two new codes, and deletion of one code.
--

Specification

Definition This field identifies:

- The public or private hospital or day procedure centre involved in contracted care arrangements with this hospital (as purchaser *or* provider of contracted care).
- The *Spoke* hospital in a Hub and Spoke arrangement for this episode (the Spoke hospital does not report the episode).
- The exact nature of the contract involving an external purchaser.
- A non-hospital contracted to provide Interim Care services

Datatype Alphanumeric **Form** Code

Field size 4 **Layout** NNNN or spaces.

Location Episode Record

Reported by Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchases 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.

Code Descriptor

0050	Interim Care Program: Residential aged care facility
0070	Interim Care Program: Supported accommodation
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
8880	Interim Care Program: Non-hospital

Reporting guide

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

Codes 0050 and 0070 *Interim Care Program* shall only be used with Contract Type 7 *Contract Type (A)*.

0070 *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

Duration of Non-Invasive Ventilation

Background

Duration of Non-Invasive Ventilation (NIV) was originally specified to be in directly comparable with the Australian and New Zealand Neonatal Network definition. The rounding has now been removed, for ease of reporting. Data may be rounded at the DHS is required.

Duration of Non-Invasive Ventilation (NIV)(Amended)

Revision Summary	Reporting of exact hours, rather than rounding after 96.
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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

Location

Diagnosis Record

<i>Reported by</i>	<p>Reporting is MANDATORY for public hospitals providing NIV to patients while admitted to an approved:</p> <ul style="list-style-type: none"> • Level 3 nursery/Neonatal Intensive Care Unit (NICU) or • Level 2 nursery/Special Care Nursery (SCN). <p>Reporting is OPTIONAL for:</p> <ul style="list-style-type: none"> • Public hospitals providing NIV to patients while admitted to an approved Intensive Care Unit (ICU) • Private hospitals providing NIV in an approved NICU or SCN or ICU. <p>[Otherwise, report spaces.]</p>
<i>Reported for</i>	<p>Episodes of care for patients receiving NIV in a NICU and/or SCN and/or ICU.</p> <p>[Otherwise, report spaces.]</p>
<i>Reported when</i>	<p>A Separation Date is reported in the Episode Record.</p>
<i>Code set</i>	<p>A number in the range 0000 (4 spaces, blanks or null) to 9999 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>
<i>Reporting guide</i>	<p>Respiratory support by intubation and/or tracheostomy</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> <p>Counting duration of NIV</p> <ul style="list-style-type: none"> • 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 <i>counting of the duration of NIV starts when the patient enters the NICU or SCN or ICU</i>. • 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 <i>count of the duration should be suspended for the time the patient is out of the NICU or SCN or ICU</i>.

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 completed 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 [NIV] via nasopharyngeal intubation is reported in Duration of MV in ICU field)

Converter Chart for calculating NIV hours

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

ICD Codes

Background

Hospitals have requested an increase in the number of Diagnosis and Procedure Codes that can be reported. 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. Also 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. However this is not easily attained in our current record structure, which is currently under review. In the interim, the number of codes that can be transmitted has been increased, partly in view of the fact that AR-DRG Version 5 grouper considers up to 30 codes each.

Diagnosis Codes (Amended)

Specification

Definition At least one (principal diagnosis) and up to ~~25~~⁴⁰ ICD-10-AM (Third Edition) codes reflecting injuries, disease conditions, patient characteristics and circumstances impacting this episode of care.

Datatype Alphanumeric **Form** Code

Field size 8 (x ~~25~~⁴⁰) **Layout** AANNNNspacespace
Left justify, with trailing spaces.

Location Diagnosis Record (12)
Extra Diagnosis Record (~~13~~²⁸)

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

DHS ICD-10-AM Library File 2002~~3~~2003~~4~~, available at:

www.dhs.vic.gov.au/ahs/hdss/vaedlib.htm

Reporting guide

Report diagnoses in accordance with ICD-10-AM *Australian Coding Standards* and the *Victorian Additions* to these standards.

Omit punctuation as shown in ICD-10-AM books (that is, no dot or oblique in codes): for example, ICD-10-AM diagnosis code A00.0 *Cholera due to Vibrio cholerae* must be entered A000.

When a code is shown in ICD-10-AM with a symbol (dagger or asterisk), *omit* the symbol when transmitting to PRS/2.

The first character of the field is the prefix: P, A, C or M.

In the first diagnosis code field:

- *Character 1* must be P.
- *Next five characters* must contain an alpha/numeric code of three, four or five characters (with trailing spaces if required).
- *Characters 7 and 8* must be spaces.

For the remaining eleven diagnosis code fields, *if* a code is present:

- *Character 1* must be P or A or C or M.
- *Next six characters* must contain an alpha/numeric code of three, four, five or six characters (with trailing spaces if required).
- *Character 8* must be a space.

Morphology codes (where first character is M)

Submit without punctuation (oblique) and with M prefix: MM80703

Prefixes: Definitions for P, A, C, M

- Refer to the *Victorian Additions to the Australian Coding Standards*.

Effect of prefix A

If the patient's Account Class causes the production of a DRG Statement (TAC and WorkCover), the code prefix A will suppress printing of the code rubric on the DRG Statement.

Edits

127 Nil Value DRG

160 AR – DRG Grouper GST Code > Zero

186 Neonate MDC But Age >= 28 Days

- 195 Blank X2
- 197 Embedded Blank Diag Oper
- 230* Adm Type & Diag Incompatible
- 231 P - Diag Not Prefixed By P
- 232 Possible Coding or Sequencing Problem
- 329* Geri Respite - Invalid comb
- 334 Hosp Generated DRG Not = PRS/2 DRG
- 351 Illegal Code Format
- 352 Code Not Found On Code File
- 353 Code & Age Incompatible
- 354 Code & Sex Incompatible
- 355 Invalid Principal Diag - Rejection
- 355 Invalid Principal Diag - Warning
- 356 Non Specific Code
- 358 Area Code Restraint
- 361 External Cause Code Missing
- 362 Morphology Code Missing
- 363 External Cause needs Place Code
- 364 External Cause needs Activity Code
- 365 Ext Cause needs POO & Activity Code
- 403 Qual Newborn W/Out Justificat
- 406* Rehab Type W/Out Rehab DRG
- 411 Adm Wt > 1000g, No Matching Dx Code
- 412 Adm Wt 1000-2499g, No Matching Dx Code
- 413 Adm Wt > 6000g, No Matching Dx Code
- 426 Y2 Not Accompanied by X2
- 428 X2 Upd not Accompanied by Y2 Upd
- 442 NIV Duration for Healthy Newborn
- 447 Unqual Newborn; Age at Sep > 10 Days
- 449 Notifiable Disease Coded
- 450 Code Incompatible W Female Sex
- 451 Code Incompat W Male Sex
- 452 Place/Activity W/Out External Cause Code
- 453 Wrong PDx for Interim Care

Related items Section 2: Concept definitions *Principal Diagnosis* and *DRG Classification*.
 Section 3: *Hospital Generated DRG* page 3-#.
 Section 4: *Notifiable Infectious Disease ICD-10-AM Codes*

Administration

Purpose To:

- Facilitate epidemiological studies and other research.
- Identify episodes containing specified codes for co-payments.
- Facilitate grouping for casemix purposes.

Principal data users Multiple internal and external research users.

Collection start 1979-1980

Definition source	DHS	Code set source	ICD-10-AM Third Edition
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Procedure Codes (*Amended*)

Specification

Definition Up to 2540 ICD-10-AM Third Edition codes reflecting the interventions used for the diagnosis and/or treatment of ill health during this episode of care.

Datatype	Alphanumeric	Form	Code
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Field size	8 (x 2540)	Layout	NNNNNNN 8 th character - A or space. Left justified, trailing spaces.
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<i>Location</i>	Diagnosis Record (12) Extra Diagnosis Record (1328)
<i>Reported by</i>	All Victorian hospitals (public and private).
<i>Reported for</i>	All admitted patient episodes of care.
<i>Reported when</i>	A Separation Date is reported in the Episode Record.
<i>Code set</i>	DHS ICD-10-AM Library File 2002 ³ -2003 ⁴ , available at: www.dhs.vic.gov.au/ahs/hdss/vaedlib.htm [Where no procedures were performed, report spaces.]

Reporting guide

Character 1-7 must contain a numeric code of seven characters.

Character 8 must be F, N or space.

Report procedures undertaken during this episode of care in accordance with the ICD-10-AM *Australian Coding Standards* and the *Victorian Additions* to these standards.

Omit punctuation as shown in ICD-10-AM books (no dash in codes); for example, ICD-10-AM procedure code 40903-00 *Neuroendoscopy* must be entered 4090300. Do not transmit Block numbers.

Procedures performed under contract at another agency

Procedures performed *at another hospital under contract to this hospital* are recorded by both hospitals, but flagged in the *contracting* hospital only, by use of a flag in the eighth character allocated for each procedure code.

- 'F' indicating the procedure was performed at another hospital on an admitted basis.
- 'N' indicating the procedure was performed at another hospital on a non-admitted basis.

Edits

127	Nil Value DRG
160	AR-DRG Grouper GST Code>Zero
195	Blank X2
197	Embedded Blank Diag Oper
232	Possible Coding or Sequencing Problem
320	MV Duration But No Procedure Code
334	Hosp Generated DRG Not = PRS/2 DRG
351	Illegal Code Format
352	Code Not found On Code File
353	Code & Age Incompatible
354	Code & Sex Incompatible
356	Non Specific Code
358	Area Code Restraint
408	Contract Role 'A' W/Out Proc Flag
409	Proc Flag W/out Contract Role 'A'
428	X2 Upd not Accompanied by Y2 Upd
439	NIV Proc Code W/Out Duration in NICU/SCN
440	NIV Duration without NIV Proc Code
450	Code Incompatible W Female Sex
451	Code Incompat W Male Sex

Related items Section 2: Concept definitions *DRG Classification* and *Procedure*.
Section 3: *Hospital Generated DRG* page 3-#.

Administration

Purpose To facilitate:

- Epidemiological studies and other research.
- Grouping for casemix purposes.

Principal data users Multiple internal and external research users.

Collection start 1979-1980

Definition source DHS **Code set source** ICD-10-AM Third Edition

Language

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 admitted patient 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.

Preferred Language and Interpreter Required will form the basis for improved hospital and state-wide planning and monitoring of the expressed need for, and provision of, interpreter services. 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.

Preferred Language (New)

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 Preferred Language (<i>New</i>), page 123.

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 (for example baby, child or elderly):

Where a person is not able to consent for themselves (for example 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 (for example 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

- ### Invalid Preferred Language
- ### Preferred language = English but Interpreter Required
- ### ATSI identification but language ≠ English or Aboriginal
- ### Language is unspecified
- ### Language Not Stated must = Interpreter Required Not Stated
- ### Interpreter Required Not Stated; Language Invalid

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 Culturally And Linguistically Diverse (CALD) hospital service provision.

Principal data users Clinical Governance Unit, DHS.

Collection start	2003-2004	Collection start	2003-2004
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Definition source	NHDD	Code set source	NHDD; ABS mod Aust. Stand. Classification
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Interpreter Required (New)

Specification

Definition The patient's need for an interpreter, as perceived by the patient or person consenting for the patient.

Datatype	Numeric	Form	Code
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Field size	1	Layout	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.

Code set

Code	Descriptor
1	Yes
2	No
3	Not Stated

Reporting guide

Preferred Language to be asked before Interpreter Required.

If the Preferred language is English, Interpreter Required can be assumed to be 2 *No*.

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.

Edits

- ### Invalid Interpreter Required
- ### Preferred language = English but Interpreter Required
- ### ATSI identification but language ≠ English or Aboriginal
- ### Language is unspecified
- ### Language Not Stated must = Interpreter Required Not Stated
- ### Interpreter Required Not Stated; Language Invalid

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

Clinical Governance Unit, DHS.

Collection start

2003-2004

Definition source

DHS

Code set source

DHS

Medicare Number

Background

Medicare Suffix 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. Medicare number has been amended to reinforce this, as well as to tighten the rules regarding a valid Medicare number.

Medicare Number (*Amended*)

Revision Summary	Amend Medicare Number to specify that a zero-filled field is invalid.
-------------------------	---

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

- Valid:
- First character can only be a: 2, 3, 4, 5, or 6
 - Numeric or all blanks
 - Check digit (ninth character) is the remainder of the following equation: [(1st digit * 1) + (2nd digit * 3) + (3rd digit * 7) + (4th digit * 9) + (5th digit * 1) + (6th digit * 3) + (7th digit * 7) + (8th digit * 9)] / 10
- Invalid:
- Special characters (for example, \$, #)
 - Alphabetic characters
 - Zero-filled (if the Medicare Number is not available or not applicable, the Medicare Number must be left blank)

		Medicare	
		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.~~

Edits

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

- | | |
|-----|------------------------------------|
| ### | Medicare Code = 0, Age > 6 Months |
| ### | Medicare Code = 0, Age > 12 Months |

Related items Section 2: *Medicare Eligibility Status – Eligible Person*, and *Medicare Eligibility Status – Ineligible Person*.
Section 3: *Medicare Suffix*, page 3-114.

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*)

Revision Summary	Amend specifications to ensure Medicare Number filled with a valid number.
-------------------------	--

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:

Code Descriptor

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-#.
 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** -

Medi-Hotel

Background

Medi-hotel refers to accommodation provided at registered facilities as an alternative to traditional hospital accommodation.

Medi-hotel is utilised by both same day and multi-day stay patients. Multi-day stay patients are treated in traditional hospital settings during the day and reside in medi-hotel overnight. The patient does not receive care whilst residing in the medi-hotel.

In the absence of appropriate values to record this new type of accommodation for multi-day stay patients, hospitals are currently recording a separation for every day spent in the hospital. This has created multiple same day admissions, in place of a single multi-day episode.

By introducing an Accommodation Type of 7 *Ward Based and Medi-hotel*, the entire acute episode of care (including days spent in traditional hospital accommodation, HITH and Medi-hotel) will be reported as a single episode, preserving the integrity of the episode's data, including accurate data for the purposes of clinical review, clinical costing, daily hospital management of patients (including safety and security issues) and coding of the episode (including preserving ALOS for patients in particular DRGs). At the same time it allows analysis of the use of the Medi-hotel model of accommodation.

Accommodation Type (a) (Amended)

Accommodation Type on Separation (b) (Amended)

Revision Summary	Addition of new code to record use of Medi-hotel.
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Specification

Definition

- (a) The accommodation type or types occupied by the patient during their admission, including changes to this item during the episode.
- (b) The accommodation type occupied by the patient on their last (counted) patient day.

Datatype Alphanumeric **Form** Code

Field size 1 **Layout** N or A

Location (a) Status Segments of the Episode Record.
 (b) Episode Record.

Reported by All Victorian hospitals (public and private).

Reported for All admitted patient episodes of care.

Reported when (a) The Episode Record is reported. Any changes in Accommodation Type are reported in new Status Segments.
 (b) Once the Separation Date is reported in the Episode Record.

Code set	Code	Descriptor
	4	In the Home (Hospital - HITH)(Rehabilitation - RITH)
	7	Ward Based/Medi-hotel combination
	S	Short Stay Observation Unit
	M	Medical Assessment and Planning Unit
	6	Emergency Department accommodation
	C	Nursery accommodation: NICU/SCN (aged <3 months)
	B	Other nursery accommodation or mother's bedside (rooming in, aged <3 months)
	3	Same Day accommodation
	2	Overnight accommodation: single room
	1	Overnight accommodation: shared room

Reporting guide For data items (a) and (b), select the first appropriate category:

[Reporting guides relating to other values remain the same as per the VAED 12th Edition.]

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

Approved care in accommodation outside the hospital.

Includes:

- Under the Hospital in the Home (HITH) program, if the public hospital's Health Service Agreement specifies the hospital is participating in this program. HITH services can only be provided to public, private, DVA, TAC and WorkCover patients. Refer to: Section 4: *Hospital in the Home Program: Participating Hospitals*.
- Conducted by a Hospital with a designated Rehabilitation Unit (Level 2 or 3), or Geriatric Evaluation and Management (GEM) Program, where the providing care in the home has been agreed to by the Sub-Acute Unit.

Excludes:

- Accommodation in a Medi-hotel (use code 7).

7 *Ward Based/Medi-hotel combination*

For multi-day stay patients, where the patient receives treatment in a traditional hospital setting (ward) during the day and resides in the hospital's Medi-hotel overnight.

Includes:

- Accommodation in same day facilities during the day.
- Where the patient is cared for in the Medi-hotel by someone not arranged for, provided by, or paid for by the hospital, such as a relative or other carer.

Excludes:

- Accommodation In the Home (HITH)(RITH)(use code 4).

Edits

- (a) 076 Not Sufficient Fields First Status
- 077 Not Sufficient Fields Other Status
- 084* Invalid Accom Type
- 094* Combination A/C Accom Care Med Suff
- 117 Sep Accom Type Not In A Status Seg
- 240 Newborn Accom But Over 3 Months
- 329* Geri Respite - Invalid Comb
- 344* Invalid Comb For Family Choice
- 431 Newborn But Not Newborn Accom
- 432 MAPU or SOU >48 Hours
- 434 NICU/SCN Accom But Unqual Newborn
- 439 NIV Ptoc Code W/Out Duration in NICU/SCN
- 440 NIV Duration without NIV Proc Code
- 454* Incompat Fields for Interim Care
- 455* Inconsist Newborn Transferred/Unqual Data

Accom Type 7, not Care Type 4
Accom Type 7, not approved for Medi-hotel
Accom Type M, no registered MAPU
Accom Type S, no registered SOU

- (b) 106* Invalid Sep Accom
- 108* Field(s) Missing From Sep
- 117 Sep Accom Type Not In A Status Seg
- 401 Accom Type On Sep – Emerg, Not Same Day

Related items

Section 2: Concept definitions *Admitted Patient, Hospital in the Home, Intensive Care Unit, Medicare Eligibility Status – Eligible Person, Medicare Eligibility Status – Ineligible Person, Medi-hotel* and *Rehabilitation In The Home*.

Section 5: *Status Segments*.

Section 8: Editing Tables *Account Class, Accommodation Type and Program Funding Source* and *Account Class, Accommodation Type, Care Type and Medicare Suffix*.

Administration

Purpose

For analysis of patient movement during an episode.

~~(a) To identify:~~

- ~~• Days a patient spends in the Emergency department (for quality review).~~
- ~~• Days a patient occupies same day accommodation or either a single room or a shared room (for financial estimation purposes).~~
- ~~• Precise information regarding the utilisation of facilities for neonatal intensive care and special care.~~
- ~~• Days spent in Short Stay Observation Units and Medical Assessment and Planning Units to assess the value of these types of units within the Victorian Health context.~~
- ~~• Days a patient spends in the home.~~

~~(b) To identify:~~

- ~~• The type of accommodation a patient was occupying at separation, for use in summary analyses.~~

Principal data users

Continuity Unit (Metropolitan Health & Aged Care, DHS)

~~Hospital Emergency Demand Management Co-ordination Group (Metropolitan Health & Aged Care, DHS)~~

~~Inpatient Services Unit (Metropolitan Health & Aged Care, DHS)~~

Neonatal Services Advisory Committee

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

Collection start

1991-1992

Definition source

DHS

Code set source

DHS

Deleted Data Item

Program Funding Source

The data item of Program Funding Source will remain in the VAED, but will no longer need to be sent to PRS/2: instead it can be derived from Care Type and Hospital Code for public hospitals, as per the table below.

Program Funding Source	Derived From:
1 <i>Public Health</i>	All episodes with Care Type 0 <i>Alcohol and Drug Program</i> .
2 <i>Primary Health</i>	Episodes with Hospital Code 511 <i>Dental Health Service Victoria</i> .
3 <i>Youth and Family Services</i>	Episodes with a Hospital Code of 190 <i>Tweddle Child & Family Health Centre</i> , 210 <i>O'Connell Family Centre (Grey Sisters) Inc.</i> , or 311 <i>Queen Elizabeth Centre</i> .
4 <i>Acute Health</i>	All episodes with a Care Type of 3 <i>Family choice: Awake Attendant Care</i> , 4 <i>Other care (Acute) including Qualified newborn</i> , U <i>Unqualified newborn</i> , excluding episodes with a Hospital Code of 190, 210, 311, or 511.
7 <i>Mental Health</i>	All episodes with Care Type 5 <i>Approved Mental Health Service or Psychogeriatric Program</i> .
9 <i>Sub-Acute</i>	All episodes with a Care Type of 1 <i>NHT/Non-Acute</i> , 2, 6, 7 <i>Designated Rehabilitation Program/Unit</i> , 8 <i>Palliative Care Program</i> , 9 <i>Geriatric Evaluation and Management Program</i> , or E, F <i>Interim Care Program</i> .

Amended/New Reference Files

Hospital Code Table

Updates to the hospital code table during 2003–2004 will again be published in the *HDSS Bulletin*, with the web version being amended accordingly at:

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

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

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

ICD Library File

Separations on or after 1 July 2003 will be verified against the ICD-10-AM Version 3 Library File. Version 3 of ICD-10-AM was implemented in all Australian States for separations on or after 1 July 2002.

Updates to the ICD library file during 2003–2004 will again be published in the *HDSS Bulletin*, with the web version being amended accordingly at:

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

Postcode File

An updated postcode file will be loaded to PRS/2 and applied to all E2 Episode records transmitted to PRS/2 from 1 July 2003. This reference file is used for reporting in the Postcode and Locality fields.

Updates to the postcode file during 2003–2004 will again be published in the *HDSS Bulletin*, with the web version being amended accordingly at:

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

Preferred Language (New)

This classification is specified in the NHDD and is a modification of the 2-digit level Australian Standard Classification of Languages (ABS) classification. It is the same reference file currently used in the VEMD.

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

Amended File Structures

Episode Record

Episode Record File Structure

Revision Summary Additions to accommodate the new data items of Preferred Language, Interpreter Required, and ACAS Status.

Amendments to a number of code sets: Admission Type, Admission Source, Accommodation Type, Contract Type, Separation Referral, Separation Type Mode, Care Type.

Data item of Program Funding Source replaced with a filler value.

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, <input type="checkbox"/> L, <input type="checkbox"/> X, <input type="checkbox"/> C, O, Z

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Admission Source	1	81	A/N	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 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
	Status Segment 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, 7, 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 Mode	1	197	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, F, E, S, D, Z, T, N, A, H, K
1	Transfer Destination	4	198	A/N	NNNN or spaces Refer to Section 3

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
4	Separation Referral	4	202	A/N	F, P, M, B, U, C, S, D, G, A, K, 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, 7, B, C, M, S
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
	Filler	1	223	A/N	Spaces
6	Program Funding Source	4	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, 7 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	238	N	NN Refer to Section 3
M	Interpreter Required	1	240	N	N Refer to Section 3
11	ACAS Status	1	241	N	N Refer to Section 3

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
11	Filler	3	238	A/N	Spaces
		Total 240 241			

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 Mode = 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 Mode = 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 Mandatory for public hospital when Care Type is 1, 2, 6, 7, 8, 9, F or E, and patient age is greater than 50, and where the episode is not a sameday episode, but transmit only when Separation Date is transmitted, else spaces. Private hospitals report codes or spaces.

~~11 Must be spaces.~~

Reported by All Victorian hospitals (public and private).

Reported for All admitted patient episodes of care.

Diagnosis Record

Background

Reflect change in Duration of Non-Invasive Ventilation (NIV) data item.

Diagnosis Record File Structure

Revision Summary	Reflect change in Duration of Non-Invasive Ventilation (NIV) data item.
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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 rd edition Each left justified, trailing spaces
2	Procedure Code x 12 - each code	8 (8 x 12)	105	A/N	ICD-10-AM 3 rd edition Each left justified, trailing spaces
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

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
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 9999 ⁸⁴ or spaces
	Filler	13	228	A/N	Spaces
		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.

Extra Diagnosis Record

Extra Diagnosis Record File Structure

Revision Summary Increases the number of Diagnosis and Procedure Codes that can be reported per episode, to 40 of each. Record is still optional.

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 rd edition Each left justified and with trailing spaces
1	Procedure Code (13 to 25)	8 (8 x 13)	113	A/N	ICD-10-AM 3 rd edition Each left justified and with trailing spaces
	Diagnosis Code (26 to 40)	8 (8 x 15)	217	A/N	ICD-10-AM 3 rd edition Each left justified and with trailing spaces
1	Procedure Code (26 to 40)	8 (8 x 15)	337	A/N	ICD-10-AM 3 rd edition Each left justified and with trailing spaces
	Filler	24	217	A/N	Spaces
		Total 240 456			

M Mandatory

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

Sub-Acute Record

Sub-Acute Record

Revision Summary Reflect the addition of Care Type J *Designated Rehabilitation Program/Unit: Level 4.*

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	S2
M	Unique Key	6	3	A/N	Hospital generated
M	Patient Identifier	8	9	A/N	Hospital generated Right justified, zero filled
1,2,4	Barthel Index Score on Admission	3	17	A/N	Range 000 to 100 or spaces
1,2,4	Barthel Index Score on Separation	3	20	A/N	Range 000 to 100 or spaces
1	Clinical Sub-program	3	23	A/N	From code list or spaces
1	Onset date	8	26	N	DDMMCCYY or spaces
1	Admission/Re-admission to Rehabilitation	1	34	A/N	0, 1 or space
	User Flag	1	35	A/N	Optional field, free text
	Filler	2	36	A/N	Spaces
3	RUG ADL on Admission	2	38	A/N	Range 00 to 18 or spaces
3	RUG ADL on Separation	2	40	A/N	Range 00 to 18 or spaces
3	Source of Referral to Palliative Care	2	42	A/N	Range 01 to 09 or spaces
	Filler	197	44	A/N	Spaces
		Total 240			

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

M Mandatory

1 Mandatory if Care Type = 2, 6, 7 or J *Designated Rehabilitation Program/Unit*

- 2 Mandatory if Care Type = 9 *Geriatric Evaluation and Management Program*
- 3 Mandatory if Care Type = 8 *Palliative Care Program*
- 4 Mandatory if Care Type = F or E *Interim Care Program*

Reported by Public hospitals.
[Private hospitals: Do not report S2s.]

Reported for Care Types F, E, 2, 6, 7, 8, and 9, and J only.

Reported when A Separation Date is reported in the Episode Record.
Refer to: 'Data Transmission Scheduling', page 5-**Error! Bookmark not defined.**

Reporting guide **General**

The data items collected in the Sub-Acute Record are needed for the support and further development of casemix classifications for sub-acute patients.

Field	Rehab Care Type 2, 6, 7, J	Palliative Care Type 8	GEM Care Type 9	Interim Care Type F, E
Transaction Type	S2	S2	S2	S2
Unique Key	*	*	*	*
Patient Identifier	*	*	*	*
Barthel Index Score on Adm	*	Spaces	*	*
Barthel Index Score on Sep	*	Spaces	*	*
Clinical Sub-Program	*	Spaces	Spaces	Spaces
Onset Date	*	Spaces	Spaces	Spaces
Admission / Re-admission	*	Spaces	Spaces	Spaces

RUG ADL on Admission	Spaces	*	Spaces	Spaces
RUG ADL on Separation	Spaces	*	Spaces	Spaces
Source of Referral to Palliative Care	Spaces	*	Spaces	Spaces

Correction

To correct a Sub-Acute Record, re-transmit the entire Sub-Acute Record, including the corrections. This will overwrite the existing record held by PRS/2.

Re-transmitting the Sub-Acute Record causes the Episode Record to be re-edited.

Deletion

To delete a Sub-Acute Record, re-transmit Sub-Acute Record containing all 9s in the Clinical Sub-Program.

If an Episode Record is deleted, the Sub-Acute Record will automatically be deleted. Re-transmitting the Episode Record alone will not re-generate the Sub-Acute Record; the Sub-Acute Record must also be re-transmitted.

A record can be deleted and re-transmitted in the same transmission so long as the hospital sequences the deletion first.

Data Items

Transaction Type

The value identifying the Sub-Acute Record is 'S2'.

User Flag

This field has been added at the suggestion of a software supplier. Hospitals can use the field for data management purposes, perhaps to flag certain types of records, such as corrections.

The content of this field will be printed in PRS/2 Control Reports, when and where the Sub-Acute Record is printed.

Filler

Spaces must be reported in this field (field not presently in use).

New Supplementary Code List

As in past years, the Supplementary Code Lists will be updated. Approved Medi-hotels is a new list

In 2003/2004 many of these lists will play a more significant role, as new edits will be implemented that edit against these lists. Examples of this are (see Appendix A for full list):

- Care Type 5, but not Approved
- CCU Hrs, but not Approved CCU

The following lists will remain, but will relate to a Funding Arrangement value, rather than an Admission Type value:

- Rural Patients initiative: Approved for ~~Admission Type Q~~ Funding Arrangement 5
- Elective Surgery Access Service (ESAS): Approved for ~~Admission Type W~~ Funding Arrangement 6

Approved Medi-hotels (New)

Alfred, The
Austin & Repatriation Medical Centre [Heidelberg]
Box Hill Hospital
Royal Melbourne Hospital [Parkville]
St Vincent's Hospital (Melbourne) Ltd