Section 1: Introduction

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Foreword

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

- Causes, effects and nature of illness among Victorians;
- Determinants of good health and ill health; and
- Utilisation of health services in Victoria.

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

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

The Health Data Standards and Systems (HDSS) Unit (Metropolitan Health and Aged Care Services Division) manages the operations of the VAED, and the PRS/2 system is maintained by a private facilities management company which provides technical services and support from its data centre in Notting Hill, Victoria.

This Manual provides comprehensive information for hospitals on how the PRS/2 system works, the source data definitions and reporting requirements for all service types. The Manual will be made available on the Department's web site at:
http://www.health.vic.gov.au/hdss/vaed/index.htm.

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Manual Content Summary

The *VAED Manual 17th Edition* is divided into ten sections. A detailed contents list is provided at the beginning of each section. A broad overview of each section is provided below.

Section 1: Introduction
Outlines the uses of the VAED, the PRS/2 and VAED data cycle, together with contact details, useful references and publications, and a list of abbreviations used in this manual.

Section 2: Concept and Derived Item Definitions
Provides definitions of concepts and derived items that contribute to the VAED.

Section 3: Data Definitions
Presents the specifications of data items relating to individual admitted patient episodes of care. The data items are arranged in alphabetical order.

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

Section 4: Business Rules
Details the business rules that apply for reporting VAED data. Tabular business rules provide a quick reference to edits relating to multiple data items.

Section 5: Compilation & Transmission
Provides the specifications for compiling a PRS/2 transmission, including summary statistics and PRS/2 interfacing technical specifications.

Section 6: Request Reports
Describes the reports that hospitals can request in the Header Record of any PRS/2 transmission. These reports can assist hospitals to manage their PRS/2 reporting.

Section 7: Control Reports & Reconciliation
Describes the PRS/2 control reports and provides a guide to assist with the reconciliation of PRS/2 reports with in-house (hospital) data.

Section 8: Editing
Lists each PRS/2 edit message and remedy (in numerical order). An edit matrix shows which data items relate to each edit.

Section 9: Supplementary Code Lists
Details a range of lengthy code sets for specific VAED data items (most code sets are short and are included in Section 3) and reference to lists of hospital campuses that are authorised to provide (and therefore report to PRS/2) specific specialist services (actual lists are now available in electronic format only on the HDSS webpage).

Section 10: PRS/2 Testing
Provides detailed information regarding the process for undertaking PRS/2 testing and issues to consider when changing software.

Scope of the VAED

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

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

Each patient in the VAED is denoted by a hospital-controlled *patient identifier* code (unit record number). Hence the admission, treatment and separation history of a particular patient contained in the VAED may be tracked within the same hospital over time but not between hospitals. Patient activity must be reported under the campus code at which it occurred.

It is potentially possible to identify an individual from a combination of patient-level data fields (for example date of birth plus location of residence plus date of admission plus hospital code), thus specific limitations are placed upon the release of patient-level data. This is covered in more depth in *Data Release and Confidentiality* page 1-17.

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

Contributing Health Agencies

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

VAED File Consolidation

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

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

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

Some preliminary analysis of the VAED file may be undertaken before it is locked, with the caution that some of the data may not have been finalised and could be subject to change.

Periods of Data Available

The Department presently holds VAED annual consolidated files for all financial years since 1987-88. Limited data may be available from printouts for previous years (back to 1983-84 for specific hospitals only); refer to *History and development of the VAED*, page 1-24.

Uses of the VAED

Morbidity Monitoring

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

- Analysis of health outcome data to assist in informing health policy and program options;
- Coordination and collation of data sources to provide accurate and timely information on the health status of the Victorian population;
- Preparation of consolidated epidemiological reports such as *Victoria's Health, Second Report on the Health Status of Victorians,* 1995; and
- Compilation of a set of Victorian health indicators that can be used at state and regional levels to monitor the health needs in the community, the outcomes of interventions aimed at those needs and patterns of clinical practice.

Casemix Funding

Casemix funding is a case payment system used in public and private hospitals providing acute health services. It is designed to provide financial incentives for hospitals to improve efficiency, effectiveness and accountability, by ensuring that hospitals are rewarded for the amount and type of work they do. The VAED is the primary source of data used to administer the casemix-based funding system for *public* hospitals in Victoria. For any given year, details of the Department's funding system are set out in *Victoria - Public Hospitals and Mental Health Services Policy and Funding Guidelines*. Refer to *Clinical Coding and Grouping*, page 1-20.

Performance Measurement

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

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

National Health Information Agreement

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

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

Other Uses of the VAED

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

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

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

Question: Are PRS/2 and the VAED the same thing?

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

1. The **PRS/2 Application** is a transaction processing system developed specifically for the purpose of processing the data supplied by hospitals with various controls and feedback loops to ensure that:
   - All data supplied by hospitals are validated (hospitals thus have an opportunity to re-submit corrected data), and
   - No data can be omitted, misfiled or incorrectly processed without a warning to the hospital that supplied the data.

2. **PRS/2 file formats** are defined by DHS, and refer to the file structure (that is, the order and content of data items within a PRS/2 transmission) used to allow the PRS/2 Application to transfer hospital data into the PRS/2 Database.

3. The **PRS/2 Database** is a collection of data obtained through the PRS/2 interface.

The PRS/2 Application calculates or derives certain additional data items from the transmitted data. Some examples are listed below:
- Patient age (calculated as the difference between Birth Date and Admission Date)
- Statistical Local Area (SLA) of the patient's address (derived from the Postcode and Suburb fields)
- The Diagnosis Related Group (DRG) according to the edition used for that year (derived from the diagnosis and procedure codes, age, sex, separation mode, intended length of stay, mental health legal status and admission weight (for newborns) by means of a software grouper)
- Length of stay.

A year-to-date copy of PRS/2 data is extracted from the PRS/2 database and provided to DHS once per month.

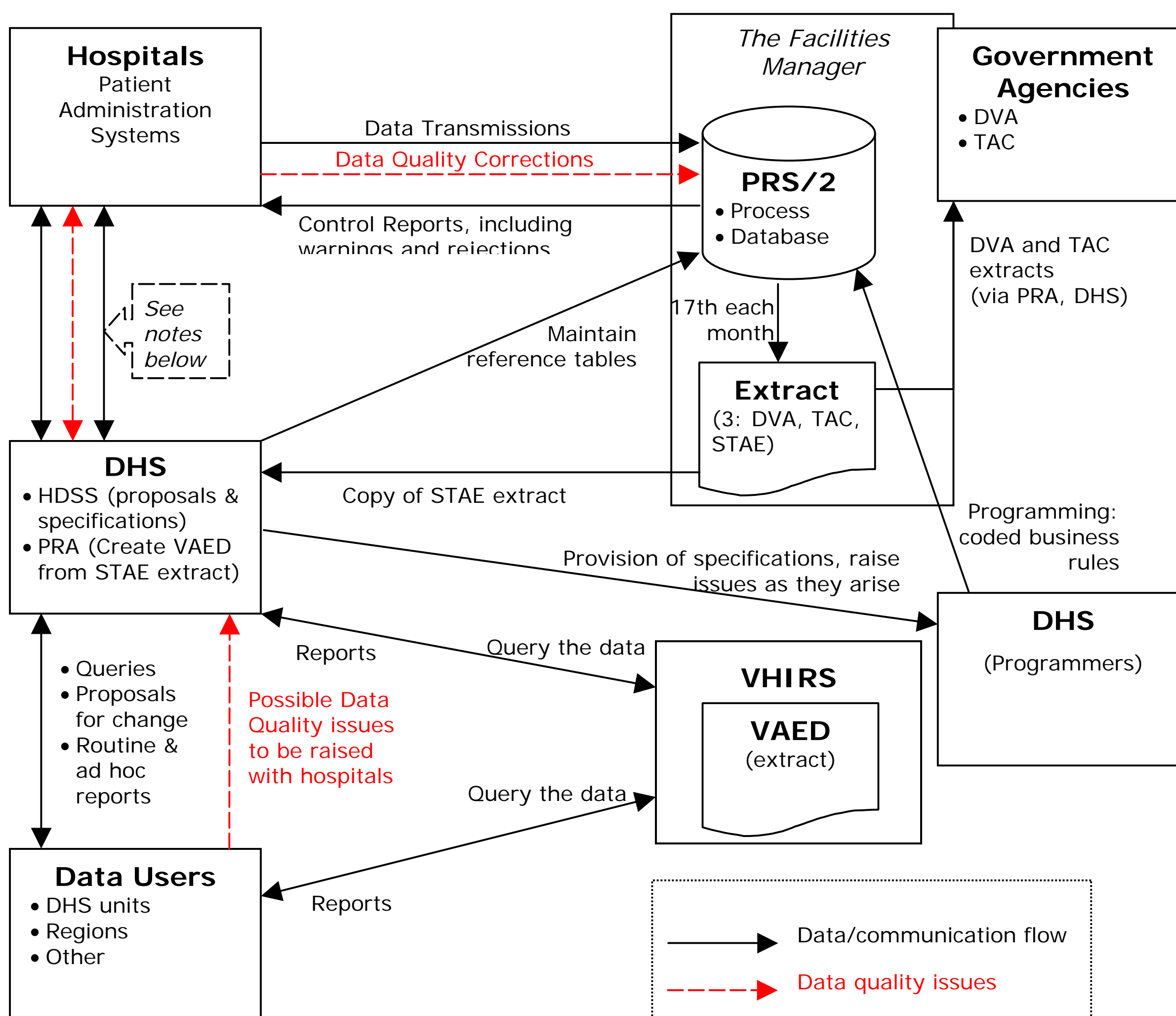
The **Victorian Admitted Episodes Dataset (VAED)** is the file and database that contains the majority of data submitted by hospitals through the PRS/2 process (excluding data required purely for the two Government agencies which directly fund DVA and TAC), plus the additional derived items added by DHS once the data has been received from the Facilities Manager.

Roles and Information capture and flow

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

DVA	Department of Veterans Affairs	TAC	Transport Accident Commission
HDSS	Health Data Standards and Systems	VHIRS	Victorian Health Information Reporting System
PRA	Performance Reporting and Analysis		

The Facilities Manager is the company DHS contracts to maintain the PRS/2 database and process PRS/2 files.



Notes (Between Hospitals and DHS)

First arrow

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

Second arrow

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

Third arrow

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

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

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

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

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

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

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

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

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

At the facilities manager: PRS/2 System
The facilities manager manages the PRS/2 system in accordance with guidelines established by the Department.

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

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

There is no manual data entry of patient-level data by the Department or the facilities manager. All public and private hospitals provide the data in the specified format to the facilities manager (see Section 5).

At the facilities manager: Extracts
PRS/2 processing populates a database residing on a Unix server.

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

At the Department of Human Services: HDSS and PRA
The Department regularly constructs VAED files from the STAE (staging) extract. This process is generally completed on a monthly basis after the 17th of each month. Data is the loaded into the Victorian Health Information Reporting System (VHIRS).

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

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

Within the Department there are two business units that are primarily responsible for the management of the VAED:
- Health Data Standards and Systems (HDSS)—Responsible for defining the input standards: the content of the PRS/2 file format, and the related business rules. Manages the programming required for the PRS/2 Application. HDSS also undertake data quality activities on the VAED; and
- Performance Reporting and Analysis (PRA)—Responsible for defining the output: including handling extracts for the external payers, and allowing appropriate persons access to the VAED.

External payers: DVA and TAC
Extracts containing data items required for payment of DVA and TAC payments are forwarded to the Government agencies which directly fund DVA and TAC, by the PRA Unit. These extracts are specified by the Government agencies and are different to the STAE extract (which is used to formulate the VAED—see diagram on page 9), as different data items are required by each of the agencies. For example, Given Name and Surname are sent to the Government agencies as these are a minimum requirement for payment, however these data items are not held at DHS on the VAED due to privacy concerns.

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

Software Selection and Minimum Features

Hospitals should select software that has the ability to collect all data items required for submission to the VAED, and can create a transmission file that complies with the required file format detailed in Section 5: *Compilation and Transmission*. Listed below are the minimum features that software should comprise:

- Collect all data items required for VAED, as specified in this manual and HDSS Bulletins.
- No data items should be transmitted with 'defaulted' values, that is, all code values for data items should be selected by the user.
- Values entered on the PAS must map correctly to VAED code values.
- Ability to create a transmission file in the required format.
- Commitment to update the software when VAED specifications are modified.
- Ability to send update or correction records.
- Ability to send deletion records as a function of the software, that is, not created manually by the software supplier.
- Ability to re-send header dates as a function of the software, that is, without the software supplier's intervention to 'rollback' header dates.
- Perform at least a minimum level of editing to reduce errors produced during processing.
- Provide a means to convey the transmission file to the facilities manager for processing, via disk or CD, or electronically via ftp, with the appropriate filename as specified in Section 5: *Compilation and Transmission*.

Data Transmission Timeline

A hospital must transmit data to the VAED at least monthly, but may transmit more frequently. Under casemix funding, monthly deadlines for data transmission have assumed particular significance, as payments are based on the monthly VAED consolidated file data.

For Public Hospitals:

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

For Private Hospitals:

- It is a condition of registration that private hospitals transmit data in accordance with the same timelines as public hospitals under the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002*.

Timeline Summary

Day of month	*Activity*
17th	Final date for transmission of data. All data must be received from hospitals by close of business on the 17th of each month: • Admission and separation details for all episodes in the previous month • Diagnosis and procedure details for all separations in the month immediately preceding the previous month. If submitting by disc, allowance should be made for weekends and public holidays.

VAED Monthly Consolidated File

The VAED is updated after the 17th day of each month (using the DVA, TAC and STAE extracts from the PRS/2 database) for each hospital.

VAED Annual Consolidated File

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

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

There are two consolidated files created by the Department for each financial year:
- A public hospital file
- A private hospital file

Data Quality

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

At the Hospital

- Data entry from the source ensures that optimum accuracy is achieved. The hospital has access to the most detailed information on which to base coding (that is, the medical record and the clinicians responsible for the patient's care). Also, the direct transmission of data in a machine-readable format avoids any further typographical errors.

- Hospital PAS should contain system edits which provide some level of validation upon data entry.

- Hospital PAS should incorporate the appropriate files that validate or translate data (for example, the files for ICD-10-AM and Postcodes).

- All diagnostic and procedural information must be coded in accordance with the Australian Coding Standards and any Victorian modifications relevant for that period. The National Centre for Classification in Health (NCCH) publishes material to assist hospitals to improve the quality of coded data. Hospitals should enable staff to attend appropriate continuing education sessions. HDSS may periodically send PICQ extracts to hospitals, and these should be utilised for data quality review.

- To conform to Accreditation requirements, hospitals must conduct quality improvement measures. These may involve quality assessment and improvement of the coded minimum dataset.

At the Department of Human Services

- Extensive system edits (as specified by the Department) produce rejection, warning, fatal and notifiable edits for records containing invalid or inappropriate data. These edits are further to any edits that may exist in a hospital's individual patient information system. A hospital must take the appropriate action for all edit messages received.

- A new hospital or a hospital that has changed its software must undertake a testing process: two consecutive months' data are processed separately from the normal PRS/2 processing. HDSS staff review these test runs and liaise with the hospital and software supplier to rectify any problems encountered. Once the hospital has successfully completed the testing process, data transmission to the live system may commence.

- A formal data quality review process was introduced in July 1993 to coincide with the introduction of casemix funding. Each issue is researched and the results provided to the hospitals involved. If indicated, further guidance on coding policies and standards is provided. The Victorian Advisory Committee on Data Integrity (VACCDI) and the Victorian ICD Coding Committee (VICC) are consulted as appropriate (see below). Quality issues are detected by one of the following:
  - Through regular analyses of the VAED;
  - By referrals from VACCDI (see below);
  - Through the Victorian VAED data audit (see below);
  - By referrals from the Victorian ICD Coding Committee (see below); and
  - From queries by hospitals, Department officers and other users of the data.

- The Victorian Advisory Committee on Casemix Data Integrity (VACCDI) is responsible for reviewing and making recommendations regarding data definitions and standards, and hospitals compliance with them. VACCDI oversees the coding and data quality audits and undertakes specific data quality investigations, as required. VACCDI comprises representatives of metropolitan hospitals, health services, the Department, and the Victorian Healthcare Association. See web site: http://www.health.vic.gov.au/hdss/vaed/vaccdi.htm

- VAED data audits have been conducted on separations in Victorian public hospitals for 1993-94 and 1995-96, and annually from 1998–1999 to 2000–2001. External consultancy firms conduct these audits and results indicate that, among jurisdictions that have conducted similar audits, Victoria has a high level of coding quality. See web site (for the 2000-2001 year): http://www.health.vic.gov.au/hdss/vaed/index.htm
  For previous years:
  http://www.health.vic.gov.au/hdss/archive/index.htm

- The Victorian ICD Coding Committee (VICC) comprises expert coders and is responsible for answering coding queries. It liaises with hospitals, health information managers, clinical coders and VACCDI to provide advice on specific coding issues. The Committee works with the National Centre for Classification in Health (NCCH) and contributes to the NCCH's ongoing development of the Australian coding system and standards. A database of queries submitted to the Victorian ICD Coding Committee and the responses from 2004 is available for search or download. See web site: http://www.health.vic.gov.au/hdss/icdcoding

- HDSS produces the following publications and information, which are available for downloading from the HDSS website at: http://www.health.vic.gov.au/hdss/:
  - DHS Admission Policy; and
  - The *HDSS Bulletin*, providing advice on the VAED and data quality issues to agencies that contribute to the VAED (and other collections).

- The Department publishes a number of Reference Files that hospitals can incorporate into their systems to validate data at input to improve efficiency and data quality. These are available for downloading from the HDSS website at: http://www.health.vic.gov.au/hdss/reffiles/index.htm
  - Library File of the ICD-10-AM diagnosis and procedure codes, including the Victorian edits applied to those codes. The Victorian file is available only to Victorian hospitals and their software suppliers, however others can purchase a file of codes and the national edits from the National Centre for Classification in Health; and
  - Reference Files of certain code sets (for example, postcode and locations; hospital codes to indicate patient transfers).

- The PRS/2 system provides a range of reports that hospitals should use to assist in data quality.

- The HDSS Unit provides a Helpdesk service for advice by telephone and email. Refer to page 1-32 for contact details.

VAED Update Cycle

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

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

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

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

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

Accessing VAED data

For access to VAED data contact the Victorian Health Information Reporting System (VHIRS) helpdesk by email vhirs.helpdesk@dhs.vic.gov.au. The Performance Reporting and Analysis Unit administers requests for access to data. Refer to the Hospital Data Reports website for more information on making a request:
http://www.health.vic.gov.au/hosdata/request.htm

Data Release and Confidentiality

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

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

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

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

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

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

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

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

HDSS Policy on Data Manipulation

Manipulation of Data Extracts

In the normal course of business HDSS will not condone manipulation of any data extracts (for example with Microsoft Excel, Notepad or any other data manipulation tool) that causes change in data values prior to processing by the Department. The rationale for this is as follows:

- It is expected that hospitals have a contractual arrangement with software vendors that obliges vendors to provide software to hospitals that allows them to meet their statutory reporting requirements. Hospitals are strongly advised to factor into contract negotiations the impact of data quality and timeliness penalties that may apply where the vendor fails to deliver a product that meets statutory reporting requirements. In effect, the vendor's software should be capable of producing an extract in the format required by HDSS. HDSS acknowledges that any software may have the potential to extract data that can trigger "Rejection" edits from time to time. Software vendors and hospitals should work together to ensure that, where this occurs, data can be and are corrected via the hospital's relevant operational database, thus eliminating the need for secondary data manipulation.
- 'Correcting' errors in the extract, but not in the hospital's operational database can lead to a misrepresentation of the hospital's true position.
- There is an audit requirement that data received by HDSS is an accurate reflection of the hospital's medicolegal system of record.

Responsibilities of the hospital

In situations where software does not allow the hospital to meet its reporting obligations, hospitals should, in the first instance, report the problem to their software vendor immediately. The terms of the contract should ensure that these problems are addressed as a priority. In these situations the use of third party data manipulation software may be an inevitable short-term consequence. In such cases the hospital must:

- Notify HDSS in writing of the specific problem, including the affected fields.
- Specify the plan and timeframe negotiated between the hospital and vendor for the resolution of the situation.
- Receive written permission from HDSS before proceeding with the proposed data manipulation.

HDSS will maintain a register of such occurrences. Failure to meet the above conditions may result in the application of data quality and timeliness penalties. The written permission advice will include a date by which HDSS expects the problem to be resolved and data manipulation to cease. If the problem has not been resolved by this date hospitals need to advise HDSS again of progress.

Responsibilities of HDSS

In rare circumstances a hospital may prefer HDSS to adjust an extract in order to address a specific data quality issue. HDSS will only consider this where:

- It believes that all other avenues have been exhausted, and
- The hospital requests the changes in writing, confirming that it has made the changes to its own data (or indicating that this is not possible), and
- That the changes accurately reflect the hospital's medicolegal system of record.

HDSS will maintain a register of such occurrences.

Clinical Coding and Grouping

Clinical Coding

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

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

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

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

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

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

Page 1-21 sets out a calendar of the editions of the coding systems used in Victoria. In the early years of the collection, Australian States and Territories decided individually which version of ICD, and which edition, to use. Gradually all States and Territories changed from ICD-9 to ICD-9-CM. Victoria, New South Wales, ACT and Northern Territory changed to ICD-10-AM on 1 July 1998 and the remaining states in 1 July 1999.

Earlier editions of coding books may be available from specialist libraries. The edition of the coding books currently in use can be purchased in several formats from the National Centre for Classification in Health (refer to contact details, page 1-29). Since 1999, NCCH has published the National Minimum Edits (defining, where relevant, the age range and the sex appropriate for a code) although Victoria applies a more extensive and stringent set of edits.

Grouping for Casemix

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

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

For background to casemix, the following is suggested reading:

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

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

Also see the introduction to the relevant DRG Definitions manual currently being used in Victoria. For 2007-08, this is AR-DRG version 5.2.

Victoria makes certain adjustments to the grouping necessary for casemix funding purposes. For any year, refer to the appropriate *Public Hospitals & Mental Health Services Policy and Funding Guidelines* publication for details (refer to publication details, page 1-29)

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

Coding/grouping systems used in Victoria

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

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

Fin. Year July/June	ICD ed: (edition/ release date) (a)	ICD ed: Vic	Coding Standards used in Victoria	Aust DRG version released	DRG version: Vic (b)	Codes input to DRG version: Vic (c)
07-08	No release	AM 5	Aust Standards AM 5th ed. with some Vic Additions	No release	AR v5.2	AM 5
06-07	AM 5 (Jul 2006)	AM 5	Aust Standards AM 5th ed. with some Vic Additions	AR v5.2 (Sep 2006)	AR v5.1*	AM 4
05-06	No release	AM 4	Aust Standards AM 4th ed. with some Vic Additions	No release	AR v5.0*	AM 3
04-05	AM 4 (Jul 2004)	AM 4	Aust Standards AM 4th ed. with some Vic Additions	AR v5.1 (Oct 2004)	AR v5.0 *	AM 3
03-04	No release	AM 3	Aust Standards AM 3rd ed. with some Vic Additions	No release	AR v4.2 *	AM 2
02-03	AM 3 (Jul 2002)	AM 3	Aust Standards AM 3rd ed. with some Vic Additions	AR v5.0	AR v4.2 *	AM 2
01-02	No release	AM 2	Aust Standards AM 2nd ed. with some Vic Additions	No release	AR v4.2 *	AM 2
00-01	AM 2 (Jul 2000)	AM 2	Aust Standards AM 2nd ed. with some Vic Additions	AR v4.2	AR v4.1 *	AM 1
99-00	No release except Amendment list	AM 1	Aust Standards AM 1st ed. with some Vic Additions	No release	AN v3.1 *	Aust CM 2
98-99	AM 1 (Jul 1998)	AM 1	Aust Standards AM 1st ed. with some Vic Additions	AR v4.1	AN v3.1 *	Aust CM 2
1.7.98	Victoria changed from ICD-9-CM to ICD-10-AM.					
97-98	No release	Aust CM 2	Aust Standards CM 2nd ed. with some Vic Additions	AR v4.0	AN v3.1 *	Aust CM 2
96-97	Aust CM 2 (Jul 96)	Aust CM 2	Aust Standards CM 2nd ed. with some Vic Additions	AN v3.1	AN v3.1 *	Aust CM 2

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

(a) U.S. = HICF ICD (release date in the USA), Aust CM = Australian ICD-9-CM (release date in Australia), AM = ICD-10-AM

(b) DRG version used in Victoria (pre 1.7.1993) for any published grouped data and (post 1.7.1993) for casemix funding purposes.
* = years Vic adjusted DRGs for funding purposes (details in relevant year's *Public Hospital Policy and Funding Guidelines* or equivalent publication).

(c) If coding version used (ICD version: Victoria) differs from that used by the grouper (Codes input to DRG version: Victoria), then the codes are mapped to that used by the grouper

History and Development of the VAED

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

There have been many significant changes to the dataset since 1979 for a number of reasons:
- To meet national reporting requirements;
- To reflect the gradual introduction of the concept of episodes of care;
- To meet the requirements of changes to the funding formula (in particular, casemix funding); and
- To meet the increased need for information by providers and users of health services and other bodies.

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

1979-80 to 1986-87
The collection started from 1 January 1979 with data from approximately 50 public hospitals, with more public hospitals gradually brought in to achieve full public hospital coverage. The availability of data from this period is limited. Data from this period may be available but only in hard copy in the form of standard reports and publications.

1987-88 and 1988-89
Annual consolidated files are available for these years in a consistent format. This period predates the episode of care concept and it is not possible to identify reliably all periods of non-acute care: in particular periods of Nursing Home Type care that occurred following periods of acute care. This may limit the usefulness of the data obtained from the VAED in this time period for certain types of analysis that require accurate counts of length of stay for acute care.

1989-90 to 1991-92
This period saw the introduction of care type as a sub-category of the patient's stay; this was achieved by a major change to the structure of the VAED with the introduction of *Status Segments*.

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

During this period, the *Care Type* field distinguished between four broad types of care the patient may have received during an admission:
- Nursing Home Type (NHT)
- Rehabilitation care (in a designated unit)
- Psychiatric care (in a designated unit)
- Other care - Acute

1992-93
This period saw the introduction of episodes of care as the basic unit of measurement, ahead of the 1994 *National Health Data Dictionary*. New episodes of care occurred when the patient was admitted to the hospital or when a change in *Care Type* occurred. (However, changes to 'Nursing Home Type' did not constitute a new episode of care: the NHT days were recorded as the final days of an acute episode.)

1993-94
On 1 July 1993, a number of significant revisions were made to the data collected in the VAED, to enable the introduction of casemix funding and to ensure consistency with the *National Health Data Dictionary*. Full details of these changes were set out in the following Departmental publications:

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

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

1994-95
For 1 July 1994, minor changes were implemented to reflect the development of new streams of care in geriatric centres. These were incorporated into the *Care Type* field. Full details of these changes were set out the following Departmental publications:

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

1995-96
This year saw the introduction of the reporting by *public* hospitals of all newborn babies on the VAED as either 'qualified' or 'unqualified' babies; previously hospitals reported only newborns defined as qualified in the *Health Insurance Act 1973*. Reporting all newborns enabled casemix payments to be provided for all newborn episodes. The two neonatal Version 1 AN-DRGs were mapped to four Victoria-only DRGs, to give a more accurate representation of clinical resource utilisation for funding purposes.

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

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

1996-97
This year saw the introduction of data items related to contracted hospital care. Full details of these changes are set out in the following Departmental publications:

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

1997-98
There were no changes this year.

1998-99
This year saw the introduction of data items on site identifier (for multi-campus hospitals), Duration of Stay in CCU and Reason for Critical Care Transfers. Full details of these changes are set out in the following Departmental publication:
- *Final Revisions to PRS/2 and the Victorian Inpatient Minimum Database for 1 July 1998,* March 1998.

1999-00
This year saw a revised file structure, new fields for Carer Availability and Separation Referral, revised fields for contracted hospital care and changes to the format for hospital codes, representing site and for transfers and contracts. Full details of these changes are set out in the following Departmental publications:
- *Final Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 1999*, December 1998; and
- *Final Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 1999, Addendum and Errata*, April 1999.

2000-01
This year saw the maximum number of diagnosis and procedure codes increased to 25 for each category. The field Carer Availability was limited only to sub acute Care Types and the field Reason for Critical Care was now reported by both sending and receiving hospitals. Full details of these changes are set out in the following Departmental publication:
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2000*, April 2000.

2001-02
This year saw the revision of the Accommodation Type/Accommodation Type on Separation (to incorporate the concepts of NICU/SCN, Other accommodation for newborns, Short Stay Observation Units and Medical Assessment and Planning Units), Program Funding Source and Hospital Generated DRG (to incorporate AR-DRG Version 4.2) code sets. Full details of these changes are set out in the following Departmental publication:
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2001*, May 2001;
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2001*, Appendix A – New and Amended Edits, May 2001; and
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2001*, Appendix B – Hospital Code Table, May 2001.

2002-03
This year saw new fields for Duration of Non-Invasive Ventilation, Date of Accident and TAC Claim Number. Code Sets that were revised included Care Type (for Interim Care patients), Account Class, Account Class on Separation, Contract/Spoke Identifier, Duration of Mechanical Ventilation, Patient Identifier and Program Funding Source. Additionally, changes were made to the V2 record, to enable collection of information for the Transport Accident Commission (TAC). Full details of these changes are set out in the following Departmental publication:
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2002*, March 2002;
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2002*, Appendix A – New and Amended Edits, March 2002; and
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2002*, Errata 1 & 2, April 2002.

2003-04
This year saw a revision of 23 code sets, including an extensive revision of Admission Source, Admission Type, Separation Type (now Separation Mode), Funding Arrangement, Carer Availability. The maximum number of Diagnosis and Procedure Codes increased to 40 for each category, and a new Rehabilitation Care Type was introduced. Three new data items were also introduced: ACAS Status, Preferred Language and Interpreter Required, and one data item was deleted: Program Funding Source. An extensive review of the edits was undertaken, including the implementation of edits between episodes. Full details of these changes are set out in the following Departmental publication:

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

2004-05
This year saw a revision of 24 data items, largely relating to 3 different areas: Admission Policy issues such as recording of Leave and Patient Days, reporting of zero versus null (affecting duration fields), and changes affecting Mental Health episodes. Diagnosis and Procedure Codes changed from ICD-10-AM Third Edition to Fourth Edition and were grouped by AR-DRG version 5.0 rather than version 4.2, seven additional Care Types were introduced, and one Care Type deleted. Four new data items were also introduced: Leave Without Permission Days Financial Year-To-Date, Leave Without Permission Days Month-To-Date, Leave Without Permission Days Financial Total, and Mental Health Statewide Patient Identifier. An extensive review of the edits was undertaken. Full details of these changes are set out in the following Departmental publications:

- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2004*, March 2004;
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2004, Appendix A*, May 2004.

2005-06

This year saw the removal of the Rehabilitation in the Home (RITH) Care Type, as this was no longer considered to be within the scope of the VAED.

A new data item Palliative Care Patient Days was added.

Amendments were made to: Admission Source, Separation Mode and Separation Referral for Transition Care, to capture data related to Transition Care; Indigenous Status, with the addition of two new codes to better describe non-response; Account Class, with the addition of three new private Account Classes; Accommodation Types, to remove the reference to age less than three months for newborns; and reporting requirements for Duration of Non-Invasive Ventilation (NIV) were relaxed.

A new type of Notifiable Edit (the Fatal edit) was added.

Changes to the ICD-10-AM Library File included updated edit parameters, addition of a new concept to indicate codes that may sometimes be followed by a morphology code, and the removal of two redundant concepts.

Full details of these changes are set out in the following Departmental publications:

- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2005*, April 2005;
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2005, Appendix A*, April 2005.

2006-07

- Site Identifier was changed to include both the three-digit Campus Code and the existing one-digit Site Identifier, removing the requirement for hospitals to change codes when merging or splitting from a service.
- All -2 record structures became -3, i.e. E2 changed to E3, etc.
- Two new data items were added: Functional Assessment Date on Admission and Functional Assessment Date on Separation, related to Barthel Index Score on Admission/Separation.
- Reason for Critical Care was removed. This item was not collected in 2005-06 and related definitions, data items, edit tables and edits were removed in 2006-07.
- Intention to Readmit was moved from the diagnosis to the episode record to avoid the existing editing problems.
- Version 5.1 AR-DRG introduced. Updated WIES calculations and weights.
- New ICD-10-AM/ACHI/ACS library file for Fifth Edition.

Full details of these changes are set out in the following Departmental publication:

- *Specifications for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2006*, May 2006;

2007-08

- Introduction of SACC Country of Birth codeset (replaces ACCSS Country of Birth codeset).
- Introduction of ASCL Preferred Language codeset (replaces DHS Preferred Language codeset).
- Addition of new Contract/Spoke ID codes to identify dialysis activity performed at 'satellite' sites.
- Addition of new Care Type code 'P' for Paediatric Rehabilitation.
- Amendment of DVA number format to disallow spaces between characters.
- Amendment to Level of Insurance codeset (removal of codes 1, 3, 6, 8 and introduction of codes 2 and 4).
- Change of name from 'Health Insurance Fund' to 'Hospital Insurance Fund'.
- Version 5.2 AR-DRG introduced. Updated WIES calculations and weights.
- Diagnosis Outstanding report made a Control Report.
- WIES values printed alongside every record.
- Admission weights between 100-399g no longer rounded to 400g for grouping.

Full details of these changes are set out in the following Departmental publication:

- *Specifications for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset for 1 July 2007*, May 2007

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

Department of Human Services:
A Guide to the Development of Private Hospitals and Day Procedure Centres
Also available on the Internet at:
http://www.health.vic.gov.au/privatehospitals/pubs.htm

Admitted Patient Entry & Transmission System (APET)
The APET software was developed for use as a solution for smaller hospitals and day procedure centres to transmit data to the VAED via a simple data entry system for separations. Further information is available on the Internet about the applicability and use of APET:
http://www.health.vic.gov.au/hdss/apet/index.htm

Case studies of 'Best Practice' in Recording Aboriginality, Koori Health Unit, July 1996
Available on the Internet at:
http://www.health.vic.gov.au/koori/archive/casestud/index.htm

See also the Koori Health Unit website at:
http://www.health.vic.gov.au/koori/

Circulars
Majority of circulars are available on the Internet at:
http://www.health.vic.gov.au/hospitalcirculars/

Fees and Charges for Acute Health Services in Victoria – A Handbook for Public Hospitals, also available on the Internet at:
http://www.health.vic.gov.au/feesman/

HDSS Bulletin
Throughout the year HDSS issues updates regarding reference files, data items, edits and other elements of the VAED to users via the HDSS Bulletin. All sites submitting data to the VAED must ensure that they are placed on the mailing list to receive this bulletin by contacting the HDSS Helpdesk on 03 9096 8141 or HDSS.Helpdesk@dhs.vic.gov.au. The bulletin is distributed via email and is also available on the HDSS website at:
http://www.health.vic.gov.au/hdss/bulletin/index.htm

ICD-10-AM/ACHI/ACS Library File
Available on the Internet at:
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Postcode/Locality/SLA File
DHS' postcodes and localities file is available on the Internet at:
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Protection and use of your health care records
Provides information to patients about the privacy and confidentiality of their health care records, their rights to access their records, and the rules about the use and disposal of their records.
http://www.health.vic.gov.au/healthrecords/healthrecords.pdf

Victorian Hospital Health Information
Includes addresses and contact numbers
http://www.health.vic.gov.au/services/

Includes map and information is available on the Internet at:
http://www.health.vic.gov.au/maps/index.htm

Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2007-2008
Also available on the Internet at:
http://www.health.vic.gov.au/pfg/index.htm

Victorian Additions to Australian Coding Standards
Also available on the Internet at:
http://www.health.vic.gov.au/hdss/icdcoding/index.htm

Legislation:
Commonwealth:
The following Commonwealth Legislation are available on the Internet under the heading 'Commonwealth' at:
http://www.austlii.edu.au/
- *National Health Act 1953*
- *Health Insurance Act 1973*
- *Privacy Act 1988*

Victorian:
The following Victorian Legislation is available on the internet:
http://www.dms.dpc.vic.gov.au/
- *Aged & Disabled Persons Care Act 1954*
- *Annual Reporting Act 1983*
- *Health Act 1958*
- *Health Legislation (Amendment) Act 2003*
- *Health Records Act 2001*
- *Health Services (Governance and Accountability) Act 2004*
- *Health Services (Private Hospitals and Day Procedure Centre) Regulations 2002*
- *Health Services Act 1988*
- *Hospital & Charities Commission (Fees) Regulations 1986*
- *Information Privacy Act 2000*

Other useful publications and websites:
Australian Coding Standards for ICD-10-AM, 5th Edition, National Centre for Classification in Health, July 2006
http://www3.fhs.usyd.edu.au/ncchwww/site/

Australian Health Care Agreement, between Commonwealth Department of Health and Aged Care and Department of Human Services Victoria.
Available on the Internet at:
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/Australian+Health+Care+Agreements-1

Australia Post web-site listing of postcodes and localities:
http://www.austpost.com.au/

Australian Standard Classification of Countries for Social Statistics, Australian Bureau of Statistics (ABS), Catalogue No. 1269.0.
This document is only available on floppy disk. See also the ABS website at:
http://www.abs.gov.au/

Day Only Procedures Manual Supplement MBS Descriptions Effective 01 July 2001, Commonwealth Department of Health and Aged Care.
The latest version (1 November 2001) is available on the Internet at:

Day Only Procedures Manual 1999:
http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-privatehealth-providers-dayonly-dayonly_1999.htm/$FILE/dayonly_1999.pdf
An updated list of Type B and C procedures (1 May 2007) is available in Schedule 3 of the following document::
http://www.comlaw.gov.au/ComLaw/Legislation/LegislativeInstrument1.nsf/0/4A140481341C7FBFCA2573590007113A/$file/1932007LI.pdf
Day Only Procedure Manual Index:
http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-privatehealth-providers-dayonly-index.htm

HIMAA Recruitment Services
Available on the Internet:
http://www.himaa.org.au/workweb1.html
National Centre for Classification in Health. Available on the Internet at:
http://www3.fhs.usyd.edu.au/ncchwww/site/

National Health Data Dictionary, Australian Institute of Health and Welfare, Version 13, 2006.
Available on the Internet at:
http://www.aihw.gov.au/publications/index.cfm/title/10326

Contacts

For queries or comments relating to the VAED (for example, those relating to the data items reported, the ICD-10-AM Library File, late transmission of PRS/2 data, or the content of this Manual) contact:

HDSS Help Desk:	☎	03 9096 8141
	🖹	03 9096 7743
	💻	HDSS.Helpdesk@dhs.vic.gov.au
HDSS Web Page:	💻	http://www.health.vic.gov.au/hdss/

For queries relating to PRS/2 data transmission (for example, those relating to if/when data were received for processing or the whereabouts of output reports) contact the VAED facilities manager:

The Facilities Manager	☎	9541 7575
one response network	☎	1800 331 946 (Country Areas)
		Help_desk@thepayoffice.net

Address PRS/2 test disks to:	RAPID Support *one response network* 680 Blackburn Road Notting Hill VIC 3168
Address live disks to:	Operations Division *one response network* 680 Blackburn Road Notting Hill VIC 3168

Symbols Used in This Manual

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

Abbreviations Used in This Manual

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
ACHI	Australian Classification of Health Interventions
AHCA	Australian Health Care Agreement
AHMAC	Australian Health Ministers Advisory Committee
AIHW	Australian Institute of Health and Welfare
AIMS	Agency Information Management System
AN-DRG	Australian National Diagnosis Related Group
APATT	Aged Psychiatric Assessment and Treatment Team
APET	Admitted Patient Entry Transmission system
APMHNH	Aged Person's Mental Health Nursing Home
AR-DRG	Australian Refined Diagnosis Related Group
ATSI	Aboriginal and Torres Strait Islander
BiPAP	Bi-Level Positive Airway Pressure
CALD	Culturally And Linguistically Diverse
CCIHT	Critical Care Inter-Hospital Transfer
CFS	Coded Funded Separations
CCU	Coronary/Cardiac Care Unit
CPAP	Continuous Positive Airway Pressure
CRAFT	Casemix Rehabilitation and Funding Tree
DHS	Department of Human Services Victoria
DRG	Diagnosis Related Group
DVA	Department of Veterans' Affairs
EMU	Emergency Medical Unit
EPC	Early Parenting Centre
ESAS	Elective Surgery Access Service
ESIS	Elective Surgery Information System
GEM	Geriatric Evaluation and Management
HDSS	Health Data Standards and Systems, Metropolitan Health & Aged Care Division, DHS
HIM	Health Information Manager (also known as medical record administrator)
HITH	Hospital in the Home
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICU	Intensive Care Unit
IMV	Intermittent Mandatory Ventilation
IPPV	Intermittent Positive Pressure Breathing
ITH	In The Home
LOS	Length of Stay
MAPU	Medical Assessment and Planning Unit
MDC	Major Diagnostic Category
MHSW PI	Mental Health Statewide Patient Identifier
MTD	Month to date
MV	Mechanical Ventilation
NCCH	National Centre for Classification in Health
NHDD	National Health Data Dictionary
NHIA	National Health Information Agreement
NHT	Nursing Home Type (patient/care)
NICU	Neonatal Intensive Care Unit
NIV	Non-Invasive Ventilation
NMDS	National Minimum Data Set
NOCC	National Outcome and Casemix Collection
ODS	Operational Data Store
P/G	Psycho-geriatric

PAS	Patient Administration System
PGNH	Psychogeriatric Nursing Home
PICQ	Performance Indicators for Coding Quality
PRA	Performance, Reporting and Analysis Unit, Metropolitan Health & Aged Care Services Division, DHS
PRS/2	Patient Reporting System, Version 2: Computer system by which hospitals transmit admitted patient data to Department of Human Services
RPI	Rural Patients Initiative
RUG-ADL	Resource Utilisation Groups – Activities of Daily Living
SACC	Standard Australian Classification of Countries
SCN	Special Care Nursery
SECU	Secure Extended Care Unit
SLA	Statistical Local Area
SOU	Short Stay Observation Unit
TAC	Transport Accident Commission
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VIC-DRG	Victorian Adjusted Diagnosis Related Group
VWA	Victorian WorkCover Authority
WIES	Weighted Inlier Equivalent Separations
YTD	Year To Date
the Department	refers to the Department of Human Services Victoria

To	**HDSS Help Desk** Department of Human Services
Fax	**(03) 9096 7743**
Date	
From	

VAED Manual Comments

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

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

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

Name:
Site:
Email Address:
Contact Number:

If you have any queries, contact the HDSS Help Desk

Telephone: (03) 9096 8141
Fax: (03) 9096 7743
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